The Royal Orthopaedic Hospital NHS Foundation Trust

Trust Board (Public) March

6th March 2024 09:00h-11:20h

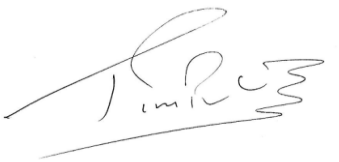
Boardroom, Trust Headquarters

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

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 6th March 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

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

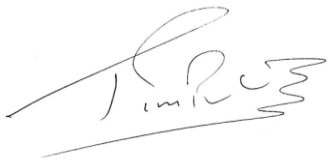
1 March 2024

Notice of a meeting of the Board of Directors

Notice is hereby given to all the members of the Board of the Royal Orthopaedic Hospital NHS Foundation Trust that the following meetings of the Trust Board will be held in the Boardroom, Trust HQ on Wednesday, 6 March 2024:

Meeting	Timing
Non-Executives pre-meet – Director of Finance's Office	08:00 – 08:45
Public Board meeting – Boardroom, Trust HQ	09:00 – 11:20
Private Board meeting – Boardroom, Trust HQ	11:20 – 13:15

The business to be transacted is provided on the private and public agendas enclosed or attached with this letter.



Tim Pile
Chair

The Royal Orthopaedic Hospital NHS Foundation Trust

AGENDA
TRUST BOARD PUBLIC

Venue Boardroom, Trust Headquarters **Date** 6 March 2024: 09:00h – 11:20h

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)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance

Ms Elaine Bethell	Lead Tissue Viability Nurse	(EB)	[Item 1]
Ms Rachel Richards	Private Patient Service Manager	(RR)	[Item 23]
Mrs Michelle Hubbard	Acting Executive Chief Operating Officer	(MH)	
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Mrs Rebecca Crowther	Deputy Chief People Officer	(RC)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
09:00	1	Staff story	Presentation	EB
09:20	2	Apologies: Marie Peplow, Sharon Malhi	Verbal	Chair
	3	Declarations of Interest	ROHTB (3/24) 001	Chair
	4	Minutes of Board Meeting held in Public on 7 February 2024: *for approval*	ROHTB (2/24) 028	Chair
	5	Actions from previous meetings in public: *for assurance*	ROHTB (2/24) 028 (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 (3/24) 002 ROHTB (3/24) 002 (a)	TP/JW
09:45	8	Wellbeing update: *for assurance*	ROHTB (3/24) 003 ROHTB (3/24) 003 (a)	RC

09:55	9	Update from the Wellbeing Guardian: *for assurance*	ROHTB (3/24) 004 ROHTB (3/24) 004 (a)	AA
10:05	10	Health Inequalities Plan: *for assurance*	ROHTB (3/24) 005 ROHTB (3/24) 005 (a)	NB
10:25	11	Liberty Protection Safeguards update: *for assurance*	ROHTB (3/24) 006	NB
	GOVERNANCE AND COMPLIANCE			
10:35	12	CQC readiness plan: *for assurance*	ROHTB (3/24) 007 ROHTB (3/24) 007 (a) ROHTB (3/24) 007 (b)	SGL
10:45	13	Board topics 2024/25: *for approval*	ROHTB (3/24) 008 ROHTB (3/24) 008 (a)	SGL
10:55	14	Nomination & Remuneration Committee Terms of Reference: *for approval*	ROHTB (3/24) 009 ROHTB (3/24) 009 (a)	SGL
11:00	**BREAK**			
	UPWARD REPORTS FROM THE BOARD COMMITTEES			
11:15	15	Upward reports from the Board Committees: • Finance & Performance Committee • Charitable Funds Committee	ROHTB (3/24) 010 ROHTB (3/24) 011	LW AA
	MATTERS TO BE TAKEN BY EXCEPTION ONLY			
	16	Performance Reports: *for assurance* a) Finance & Performance b) Quality	ROHTB (3/24) 012 ROHTB (3/24) 013	
11:20	**CLOSE: Date of next meeting: Wednesday, 10 April 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	✓	✓	✓	✓	✓	✓	✓	✓	A		
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 • Member of the Chartered Institute of Personnel and Development • Vice Chair of Leicester, Leicestershire & Rutland Integrated Care Board (LLR ICB)	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
Richard Phillips **Non Executive Director**	• Member, Longstanding member of the Institute of Healthcare Management • Director, Association of British Healthcare Industries Ltd	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
Simon Page **Non Executive Director**	• Deputy Chair, South Warwickshire NHS Foundation Trust (SWFT) • Owner, Weathervane Consultancy	Yes
Jenny Belza **Non Executive Director**	• Vice Chair and Non Executive Director, Birmingham Community Healthcare Trust • Governor, University College Birmingham	Yes

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board PUBLIC - DRAFT Version 0.1

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

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)
Mrs Jenny Belza	Non-Executive Director	(JB)
Mr Simon Page	Non-Executive Director	(SP)
Mrs Jo Williams	Chief Executive	(JW)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mr Matthew Revell	Executive Medical Director	(MR)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance:

Mrs Florence Dowling	Learning Disability Nurse	(FD) [Item 1]
Ms Sally Wilson		(SW) [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]
Mr Rob Rowberry	Trust Governor (Public Governor)	(RR)

1. Patient story (FD)	**presentation**
Florence Dowling (FD) & Sally Wilson (SW), Learning Disability Nurses, were introduced by NB. NB highlighted the importance of sharing the journey of one of our patients who experienced neurodiversity and ensuring we maintained a patient centre approach in supporting these individuals through their episode of care. The video was circulated prior to the Board meeting to allow time for questions. GH thanked Charis (the patient) for sharing her story. Tt was very appreciated and	

presented really helpful and enlightening information to understand her experience. The signage issue Charis described had been raised before and GH asked how quickly can this be resolved.

ACTION – Update on when signage will be updated. NB

JB also thanked Charis and questioned how we take this learning and share with our colleagues to help them understand our patient needs. FD explained that engagement across the departments takes place so that all these learnings are shared and communicated.

TP thanked the staff as it was clear that the amount of training that is undertaken to help support patients is considerable. TP enquired how many patients we treated with such conditions. FD confirmed there are 950 patients, with 450 that are listed on our patient administration system (PAS) as having autism. This data does not include therapies patients. TP questioned whether the support Charis needed was a high-level need. FD explained that Charis was one of the easier patients to take care of and that for Charis this was about communicating to staff members what they could expect and how to best support the patient.

JW thanked FD and her team for the work they do. JW asked whether there is anymore the Board can do to support the clinicians. FD explained the Oliver McGowan training has been launched, and in the future this will be face to face training depending on type of work they undertake. The prime focus will be clinicians to start with. FD has been trained as a trainer to deliver this course. FD explained the team also try to support fellow staff through signposting but with workload have to be mindful of what help they can give.

TP asked for thanks to be passed back to Charis and want to acknowledge how brave Charis was to share her story. Also, thanks to the team who support our patients.

NB explained that the team are very responsive to the needs of the patients. NB confirmed training and learnings are shared so that the service is patient centred. NB explained that operationally, treating complex patients can put pressure on as lists, etc need to be considered when making plans. NB explained engagement with the patient in the process is key.

IR raised non statutory training comes at a cost so how do we make sure we are getting the return on investment. NB explained that we need to show the difference it makes to the patient, which is difficult to cost. SM explained that we need to do more work on training interventions. We need to find the value between quality and cost and there are other ways we can evaluate our training which we have not been doing. JB explained that we need to look at how this links with our health inequalities work, the benefits this brings and how it links back to our overall strategy.

2. Apologies: (Chair)	**verbal**
Welcome to Jenny Belza and Simon Page who have joined the Board as Non-Executive Directors. Welcome, and thank you, to Michelle Hubbard who is covering for Marie Peplow as Acting Chief Operating Officer. Apologies have been received Marie Peplow and **accepted** by the Board.	
3. Declarations of Interest (Chair)	**ROHTB (2/24) 001**
There was one new declaration to note. Simone Jordan has been appointed as Vice Chair at Leicester, Leicestershire and Rutland Integrated Care Board.	
4. Minutes of board meeting held in public on 6 December 2023: *for approval* (Chair)	**ROHTB (12/23) 019**
The minutes of the meeting in public held on 6th December 2023 were **approved** subject to the following amendments: GH highlighted the word 'with' was missing in the sentence 'working the imaging team'.	
5. Actions from previous meeting in Public: *for assurance* (SGL)	**ROHTB (12/23) 019(a)**
SGL provided an update on the following actions: • ROHTBACT.216 NetZero Update – discussed at last Board meeting and will be included in Board forward plan so should be closed. • ROHTBACT.221 Wellbeing Plan – confirmation that this will be discussed at SE&OD meeting in March. SM queried action with regards to disciplinary process and sought the assurance that was being requested. SGL explained the minutes of October would provide clarity of what is needed. TP explained that the Board need to be made aware of any issues arising from the disciplinary proceedings that could end up in the public domain.	
6. Questions from members of the public (Chair)	**verbal**
No questions in advance of the meeting.	
7. Chair's and Chief Executive's update: *for information and assurance* (TP/JW)	**ROHTB (2/24) 002** **ROHTB (2/24) 002 (a)**
<u>Chief Executive Update</u> Following the circulation of the report JW highlighted the key points: • Welcome to Simon Page and Jenny Belza to the Royal Orthopaedic Hospital. • Blue Heart Awards – 75 nominations have been received to date. Dates will	

be circulated to ensure all Board members are aware.

- 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. The theme was centred around gaining global consensus on Chondrosarcoma and Infected Oncology Reconstruction. The plan is to invite the Oncology Team to present at Board an update.
- Jonathan Pearson, Chair of the Birmingham Health Partners visited the Trust. It was a great opportunity to showcase the services across the Trust that we provide. The invitation has been extended to Aston University to see the work taking place in the Dubrowsky lab.
- 'Check and Chat' in December – JW visited Outpatients and was a great opportunity.
- 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. SGL and NB will continue to build a relationship with the new inspectors just has they have with our outgoing CQC Inspector, Coral Peczek.
- Apologies were offered to the local residents who may have experienced delays due to the MRI replacement arriving and blocking the Bristol Road. This has been an extremely challenging time for our Imaging, Operational and Estates teams and would like to express thanks for ensuring our patients remain at the centre of everyone's thoughts and plans.
- BSol is currently seeing an increase in the number of cases of measles; there is pressure on the system to inoculate as quickly as possible.
- GH queried the corporate policies that have been approved recently, in particular special leave. SM explained that the update this includes the new Carers Leave Act and a general refresh of the policy.
- JB highlighted measles prevalence in Birmingham is the highest in the country and enquired whether we know how many of our colleagues are vaccinated against measles. NB explained that work is taking place with Occupational Health to understand figures, however there is no statutory requirement to be vaccinated. NB explained the Trust is taking a broad approach, ensuring risk assessments in place, appropriate PPE is in place and patients are being screened. We are writing to all members of staff to invite them to be vaccinated if they have not done so already. JW explained that it is not easy to find out when a person has had the MMR vaccinations as NHS records do not make it easy to find.

Chair Update

TP added in addition to the Chief Executive update: • Further to the update on the recent site visits by stakeholders, it is felt we need to identify a list of people we would want to extend an invitation to visit the Trust. • TP visited the Governance area and it highlighted that as part of this, he had noted that there are parts of the estate that are underutilised, and we need an estates plan. TP requested SW to bring an update to a future Board meeting. JW explained that there will be a proposal to come to Board in March/April that will ensure the use of onsite accommodation for nurses and doctors is for no more than 6-8 weeks. • MR explained that the BOOM Conference was funded by the charity and was greatly appreciated. It took place at The Grand Hotel in Birmingham.	
7.1 Update from Council of Governors (SGL)	**verbal**
SGL provided an update on the Council of Governors that took place on 18th January. The format of the meeting this month was to share information with our Governors, this included: • The ROH Strategy; • Presentation on Osseointegration and JointCare; • Update Governors on the new CQC inspection framework;and • Update Governors on the engagement plan to help ensure they feel informed and involved. TP explained that Governors are invited to the next Board meeting.	
8. Wellbeing update: *for assurance* (SM)	**ROHTB (2/24) 027** **ROHTB (2/24) 027 (a)**
SM picked out key highlights of the report that was shared. • Hardship Fund – uptake continues and the turnaround is quick for the applicants to receive the funds. • Wellbeing Week – engagement numbers have been provided in the report. Feedback has been taken on board from the Staff Experience & OD Committee and Trust Board and now ensures this time every area of the Trust was visited. • Wellbeing Action Plan – this has been aligned to high sickness rates across the trust so this links to the priorities in the plan. SM explained the data will be reviewed and the plan will be aligned to this. ○ TP requested a one page summary of how the plan is developed and	

ensure it is covering everything we want it to. **ACTION SM** ○ AA agreed that this will help form and develop the plan over the next few months. JW thanked the Charitable Funds team for supporting the hardship funds and reiterated this still remains anonymous. NB enquired as to whether we are seeing an increase trend in patient requests. SM explained it remains consistent.	
9. Race Code Adoption: *for approval* (SM)	**ROHTB (2/24) 003** **ROHTB (2/24) 003 (a)**
SM explained that a commitment from System Chief Executives recently is that collectively we work together on the RACE code adoption as a System piece of work. This has previously been discussed at Board and it was agreed further work was needed as a Trust. This is a Board-level accountability framework which details the minimum requirement. SM highlighted this document has been considered through a number operational committees and the Staff Experience & OD Committee prior to this meeting. JW explained that the proposal to the Board is to undertake the adoption of the RACE code through a Board Development session and would look to invite and external individual who previously presented to the ICB to challenge the Trust around its compliance with the code. GH commended the ICB for wanting to adopt to this but queried what is happening to other organisations and their footprint, and what does the reporting framework look like and what are they trying to achieve. GH enquired what is the timeline for delivery. SM explained as the Senior Responsible Officer (SRO) for Equality, Diversion and Inclusion (EDI) and part of the EDI strategy development this is being reviewed. SM explained there is work to do as a system as to how the governance will work on this. The Open Conversation has reinforced this, and this has been talked about for a long time in BSol. The focus is now on putting the time into change and the adoption will look different for each organisation. Challenges around equality are different, but ambition needs to be aligned. GH asked what role the Non-Executive Directors should play in this. SM asked that Non-Executive Directors continue the challenge where we need to do more, or where it is clear we not aligned to our own values. LW queried if we have analysis where we sit against the standards, a corporate understanding is needed and then an action plan to support this. SM explained that the work with planned will enable us to undertake a baseline assessment. JW explained initially Board support needed to be secured before reaching out further. The Board would be updated as to what the likely timescale will be when it next meets. **ACTION – Prepare a Board Development Workshop proposal for RACE Code**	

Adoption. JW/SM RL highlighted that with the new appraisal framework all leaders should have an objective linked to this. IR enquired if there are other frameworks in use with a similar ambition and whether they been considered. IR asked for clarification as to what the Board was being asked of it today JW explained that the Board is being asked to approve the adoption of the RACE Code. Following a query from SGL, SM explained that following conversations with Inclusive Companies this is deemed one of the best frameworks and was also endorsed by NHS England. SM confirmed that a wider review has not taken place as an ICB. SJ highlighted that this is a positive document and set a clear ambition. TP explained that this is the Code that has been adopted by the ICS, and therefore the adoption by ROH will lead to an action plan that SM will bring to the Board. TP recommended the Board approve the adoption of the RACE Code adoption. The Board **APPROVED** the adoption.	
10. Equality Delivery System (EDS) 2: *for assurance* (SM)	**ROHTB (2/24) 004** **ROHTB (2/24) 004 (a)**
SM explained this is an annual return and there are little changes to previous submissions. Work has taken place with the ICS so that a peer review could take place. The Trust has been given a rating of 2, and it is recognised there is more we can do. There is a specific action plan, and this will be aligned to our Inclusion Action Plan. SM explained this assessment now needed to undergo validation with system partners. SM proposed that should there be any changes prior to submission it would be circulated via email to the Board for final approval as a further Trust Board meeting will not take place before the date of submission. SM assured the Board that there would likely be minimal changes however. JW thanked Clare Mair, Head of OD and Inclusion, on the production of this document. The evidence provided was significant. GH raised that throughout the document it states about bringing a family member with them but following the previous patient story where the family member was also the interpreter, how do we ensure that the patient voice is heard and not the family member. NB explained the family member is there to support only. SM agreed this needs to be made clearer in the document and would take this away as an action to revise the document to ensure this is clear.	

ACTION – Ensure the EDS document is updated to reflect the correct language is used when we talk about family members attending appointments with relatives. SM LW queried whether the staff survey results relating to ensuring staff are free from abuse, harassment, bullying and physical violence was correct. SM explained that needs to be updated now the unweighted data has been received and will be reflected in the updated document that will be circulated prior to submission. TP recommended that the Board approve the submission and SM confirmed the document will be circulated before submission. The Board **APPROVED** the recommendation.	
11. Freedom to Speak Up Update: *for assurance* (CJ)	**ROHTB (2/24) 005** **ROHTB (2/24) 005 (a)**
TP welcomed Claudette Jones, Freedom to Speak Up Guardian, to the meeting. SGL introduced and explained that an annual update is required to come to the Trust Board. The Board was reminded that CJ had provided an interim update in October but today CJ is here to present the annual report. CJ presented the statutory requirement of the annual FTSU update. CJ explained that is important that our colleagues feel safe in speaking up. There are now eight FTSU Champions following the retirement of one of the champions. There is great interest in the role and CJ has a list of those that wish to be part of the FTSU team to replace the individual. The Champions facilitate awareness, signpost and encourage workers so that they feel safe to come and speak up. The Trust is looking to strengthen the team and PDRs and training will be providing to those who take on the role of Champion. CJ updated the Board on the actions of the team. A six weekly meeting takes place where the benchmarking is reviewed. The FTSU team is supported by the Executive and Non-Executive Directors. The Team also feeds up into the Health and Safety Group to raise any issues of safety concerns. At the last Board it was raised that administration support was required and this has now been provided. A safe space for the FTSU Guardian to be based was important and this has now been secured. CJ highlighted that as per the request from the Board the report includes the types and examples of concerns that have been received. CJ highlighted the escalation process is working, and staff often raise concerns to the FTSU when the cases are taking too long to get resolution through other routes.	

With the information received we learn and improve. Feedback from colleagues is they are listened to, taken seriously and training arranged to improve the culture in the organisations from people speaking up. On many occasions the advice given is more akin to signposting. In terms of learning and development, there are online modules. They are not mandated but available on ESR and we are encouraging colleagues to do the training to help improve the culture. The national Speaking Up campaign will take place in October again and the plan is to host across the whole month again. CJ explained the success of this campaign and the activities that took place to emphasise the role of the FTSU Champions. The support of the Non-Executive Director during this month was greatly appreciated. Focus is now on how we make a bigger impact for this October. GH thanked all the champions for all the work they do, thanked SGL for sorting the administration support and accommodation for the team. GH highlighted that given the work we have done we should be seeking an award of some kind. JB queried whether there any areas of concern and if data is collected to support improvement. CJ explained that the data is gathered, now looking at how we triangulate the data and identify themes of where it is coming from so that we can provide training. AA raised that the work taking place would work well with the wellbeing work being undertaken. JW praised that there are no anonymous escalations this year, which highlighted that our staff feel comfortable and safe to be open to speak up. TP queried the reference to 'permissions not given to escalate' and asked what this means. CJ explained that sometimes the colleague just needs signposting or wanted to discuss a matter without it being taken any further. TP asked that the report be worded differently to reflect that these are resolved issues. MH asked that an Operations Lead is linked in with the work CJ is doing with Emma Steele, Deputy Chief Nurse. IR queried how confident are we that concerns will be raised following the Royal College of Surgeons report into sexual safety. SM confirmed that the culture is changing and there is work being undertaken with NB on Sexual Safety policy that is being produced. MR confirmed we are being proactive and the FTSU route to raise concerns mean people feel there are channels for people to share.	
12. Controlled Drugs Annual Report*: for approval* (NB)	**ROHTB (2/24) 006** **ROHTB (2/24) 006 (a)**

NB presented the annual report for Controlled Drugs which has been considered by Quality & Safety Committee and is looking for the Board to approve publication of the document. NB confirmed we have seen a reduction over the past two years of incidents related to Controlled Drugs. The Trust is slightly higher than our peers on opioid usage and comparison work is taking place against other trusts to understand the reasons behind the differences. NB provided assurance to the Board that there are no serious concerns but we do monitor the opioid usage. IR confirmed a good discussion was held at Quality & Safety Committee and that the Committee supports the annual report. LW queried the removal of paper records and asked what effect this will have. NB explained that we are exploring mini Omnicell, but this would come at a cost. A trial has taken place but would need to weigh up the cost versus the benefits. LW questioned what does STOMP meant. This needs to be clear in the papers what this means. NB confirmed it means stopping over medication of people with learning disability, autism or both, and would ensure the paper was updated to reflect the full detail and not abbreviations. The Board **approved** the annual update for Controlled Drugs for publication.	
13. Infection Prevention & Control Annual Report*: for approval* (NB)	**ROHTB (2/24) 007** **ROHTB (2/24) 007 (a)** **ROHTB (2/24) 007 (b)**
NB presented to the Board the annual report for Infection Prevention and Control and explained this is a statutory requirement to publish. Key highlights from the report include: • We reported higher than our threshold in terms of *Clostridium difficile* (*C.diff*) but we have seen marked improvements this year. There are however new strains with more prevalence. • Things to celebrate including reporting no MRSA cases in 10 years at the Trust, positive PLACE results, team are actively promoting the work they are doing. TP thanked NB for the report. JW commended the IPC team for the work they do and the very positive report.	

JB queried the surgical site infections, and asked what work has been done around understanding the causes. NB explained a focus group was set up to address the issues. In the first two quarters of this year we had seen a reduction. The focus group had reviewed the end to end processes in theatres and an annual deep clean took place last year. NB offered to take JB through the work and discussions taken place in previous Quality and Safety Committees outside of the meeting. TP queried the *C. diff* increase and asked is that just this Trust. NB confirmed that there has been a national increase and across the Chief Nurse team discussions learnings are shared. NB explained that our patients on high dose antibiotics can be more susceptible to *C.diff.* The Board **approved** the publication of the annual report.	
14. Patient Safety Incident Response Framework (PSIRF) Update*: for assurance* **(AR)**	**ROHTB (2/24) 008** **ROHTB (2/24) 008 (a)**
AR joined the meeting and highlighted the key points from the Patient Safety Incident Response Framework (PSIRF) update report that had been shared. There is an amendment to the PSIRF plan to infection reported incidents following a review by NHSE and ICBs. This has been through our internal governance groups and will be included into our PSIRF document. AR confirmed engagement across the Trust has taken place along with Rebecca Hipwood, Patient Safety Lead. Matt Revell has supported in the engagement of our clinicians. One focus of the moment is a review of our duty of candour process. Looking at our we can engage our patients more as part of the investigations. AR explained focus is now looking at investigation templates. Previously we had the RCA so with this removed looking to still use them as a quick triage of incident by using the revised templates that have been created. There is a current trial underway with these. PSIRF is discussed in the biweekly divisional governance meeting, using the terminology of PSIRF now which will help us with our investigation responses, rather than looking for causes now looking at the learnings. The implementation includes a review the Quality report to incorporate the PSIRF, so a draft report is being pulled together and an implementation plan created to detail the definite date we will be following PSIRF wholly as a Trust. This will link with the continuous improvement work we are undertaking as a Trust. In terms of review, following an implementation period we will do a review of PSIRF in April which will be 6 months since go live.	

IR emphasised that there is a transitional phase, but emphasised that there was a need to take a pragmatic review of when we confirm we are now using PSIRF in totality. SM queried how we will ensure internally the communications and links with quality improvement are shared. AR explained that the LOOP document was our first trial which has allowed us to share the information. JW queried how do we widen culture of not looking to blame someone and move to this learn from the incident approach. NB explained there have been study days and workshops throughout the year and this plan is being review. This will be shared with the Staff Experience & OD Committee. JB suggsted that a go live date just needs to be agreed and committed to. AR explained that from a governance point of view we are now there to be able to do that.	
15. Board Assurance Framework – Quarter 3 Update*: for assurance* (AR)	**ROHTB (2/24) 009** **ROHTB (2/24) 009 (a) – (l)**
SGL introduced the item and explained the significant work that has taken place on this to realign to the new strategy. Structure is one high level risk that is underpinned by aligned committee corporate risks. Summary of the Board Assurance Framework (BAF) will be provided to the Board which will be a bespoke report. SGL confirmed there is some cleansing of the underpinning risks needed but AR will explain the plan. AR explained that the previous BAF was not directly aligned so with the new Trust strategy the risks are now aligned to the six strategic objectives. The BAF is aligned to the strategy highlighting the risks to delivery of the six strategic objectives. AR explained that ask of the Board is to review the six strategic risks and going forward note that workplans that sit alongside the six objectives, and the risk will be evidenced through the workplans. The Board will receive updates on the strategy workplan, and they can use these updates alongside the BAF which should provide assurance on the delivery of mitigating the risk. The Board are asked to review the narrative before this is taken forward periodically to review. AR explained that the structure of the BAF has been devised based on the feedback from KMPG.	

JW confirmed that Executives have discussed this in detail and cleansing is required. The aim is to bring back to the April meeting. **The cleansed version will return to the Board in April. ACTION AR**	
16. EPRR Position Statement*: for assurance* (SW)	**ROHTB (2/24) 010** **ROHTB (2/24) 010 (a)**
SW highlighted to the Board that the EPRR self-assessment was undertaken last summer, and we scored ourselves as having 10 areas of partial compliance. Following review from NHSE there is now 33 areas of partial compliance. As a Trust it will always be hard for us to demonstrate compliance against all standards as we do not have emergency services so there are certain items where we cannot comply as this is not core work for the Trust. We scored the self-assessment based on what we can do. NHSE has however taken the approach you have to fully meet all of the areas, including those that we are never going to be able to reach. SW confirmed there are learnings we can take away. NHSE has acknowledged what our role is as a Trust and is happy our plans indicate that but the queries remain; the System is aware. The other area to improve is business continuity plans and staff training in business resilience. The training is varied, and the challenge is to get staff enthused as it does not happen here often, so we need to overcome this to get the engagement. TP queried when things are not relevant the usual approach would be to mark these as 'not applicable'. SW confirmed the system agreed with us but NHSE nevertheless has stipulated we have to report on all areas so we are at a disadvantage. SW highlighted there are no areas of non-compliance so that is positive. TP questioned on the areas where we can improve and asked if there a plan in place. SW confirmed that an action plan has been created and another tabletop exercise will take place. LW queried where does EPRR report to in the Board's committee structure. SGL confirmed it is reported directly to Board. TP queried when will the next report come to Board. SW confirmed an update will come following the next assessment in the summer. **ACTION SW**	
17. Position Statement and Gap Analysis against the NHS Workplace Health & Safety Standards*: for assurance* (SGL)	**ROHTB (2/24) 011** **ROHTB (2/24) 011 (a)**
SGL updated the Board on the NHS Workplace Health & Safety Standards as part	

of his role covering Health & Safety. 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. The self-assessment and action plan is reviewed at the Health & Safety Group. An upward report from the Health & Safety Group is then provided into Quality & Safety Committee. SGL confirmed that overall compliance is very positive with few gaps or non-compliance identified. SJ queried how do we handle those that working at home, and ensure their wellbeing is catered for. SM explained that risk assessments are encouraged, the launch of the flexible working policy includes home working. SJ queried do we ensure colleagues have the right equipment to work at home. SM explained that this is picked up in DSE assessments that we encourage these to take place but is a wider piece of work the Trust is currently looking at. SGL confirmed monitoring will continue and a further update will come to the Board.	
18. Proposed changes to Trust Constitution*: for assurance* (SGL)	**ROHTB (2/24) 012**
SGL explained that the proposed changes presented in the paper circulated to the Board have been approved by the Council of Governors on 18th January 2024 The recommendation to the Board is to approve the proposed changes to the Trust constitution as per the paper. The Board **approved** the changes proposed.	
19. Assurance Report from the Non-Executive Champion for Security*: for assurance* (SGL)	**ROHTB (2/24) 013** **ROHTB (2/24) 013 (a)**

LW provided an update to the Trust Board as the Champion for Security.
 	
• Security management covers three different and apparently disparate areas:
  • Physical security of estates and assets
  • Counter fraud identification and prevention
  • Prevention and reduction of violence and aggression towards staff
• Therefore, three Executive Directors have responsibilities – the Director of Governance, Chief People Officer and Chief Finance Officer
• Topics reported on to four Board sub-committees	

• Quality and Safety, Staff Experience and Organisation Development, Audit and Finance and Performance • LW confirmed the following has been undertaken • Met with relevant colleagues including Health and Safety Adviser, Carl Measey, who also fulfils role of Local Security Management Specialist – meet on a quarterly basis • Became familiar with national guidance • Report shared as part of the Board papers gives detail of status of strategies and policies. • In conclusion LW provided assurance that policies are robust and proportionate arrangements are in place. • Actions going forward are set out, including proposals for Committees to lead on specific areas, to provide focus and avoid duplication: • Quality and Safety to oversee Health and Safety policy, with update to SE&OD • Staff Experience and Organisation Development to oversee Prevention of Violence and Aggression with update to Q&S • Audit to receive regular briefing and update from Local Security Management Specialist	
UPWARD REPORTS FROM THE BOARD COMMITTEES	
20. Finance & Performance Committee (LW)	**ROHTB (2/24) 014** **ROHTB (2/24) 014 (a)** **ROHTB (2/24) 014 (b)**
LW provided an update to the Board on the Finance & Performance Committee that took place on 30th January. • Operational Performance still broadly good ○ Removal of all patients waiting over 65 weeks still on target to be achieved, early for majority of patients, end February for spinal. ○ Activity generally high, even with industrial action, and most targets achieved or exceeded, including stretch plan. ○ All cancer targets met; diagnostics exceptionally good. ○ Improvements in Length of Stay - at 2.8 for primary hips and knees, close to target of 2.7 days, and in Physio waits (adults from 44 weeks in July to 31 weeks) • Financial Position remains difficult ○ Deficit position deteriorated in December, £477k deficit in month vs £158k planned surplus. ○ Pay costs increased, agency spend decreased again, but nursing costs increased within that, £130k on bank, £77k on agency.	

○ Weekend operating costs remain high, theatre productivity needs further work as discussed last week. ○ Cash still very tight, SW discussing ICS support with System's CFO ○ CIP and private patient income still performing well. ○ Good news on Bad Debt, with £900,000 agreed from several ICSs, but not resolved with Hereford and Worcester and Black Country ICSs yet – to be factored in in Month 12 ○ Achieving forecast break even by year end looks increasingly difficult. • Workforce ○ December was challenging – high levels of sickness absence and high number of leavers versus starters. ○ Sickness absence policy relaunched. • Agreed revised terms of reference, and remit of Committee now includes digital, recommend the Board approve the revised terms of reference for Finance and Performance Committee. The Board **approved** the revised terms of reference that were circulated as part of the Board papers.	
20. Audit Committee (GH)	**ROHTB (2/24) 015**
GH highlighted three points to bring to the Board attention: • 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.	
20. Staff Experience & OD Committee (SJ)	**ROHTB (2/24) 016**
SJ highlighted to the Board that HR metrics remain a concern in particular sickness, turnover, bank & agency spend. SM explained that we have had a spike in December, but we are not an exception to other trusts. The concern is on the impact on the organisation and focus is on the wellbeing plan to help mitigate the	

issue. IR queried what affect the opening of the new private hospital in Harborne has had on us. NB confirmed we have lost colleagues in recent weeks. JW raised that the national guidance to dealing with coughs/colds means colleagues are not allowed to work and this is having an impact on attendance. JB queried the fire safety training and the executives assured that this is a focus and SGL also confirmed it is on the Health & Safety agenda this week. TP requested further work to be reviewed on the migration to the private hospital. JW to raise at the next system Chief Executive meeting.	
20. Quality & Safety Committee (IR)	**ROHTB (2/24) 017**
IR highlighted that a number of the items have been included on the agenda today. Key points to raise: • Good progress was reported against all Quality Priorities for 2023/24. • CNST premiums have come down so against national trend which was welcomed information. • Progress on benchmarking on PALS and complaints with Robert Jones and Agnus Hunt is being made. • Endoscopic surgery update provided and the timeline to restart is being produced.	
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**
CLOSE: Date of next meeting: Wednesday, 7 February 2024 @09:00	

PUBLIC SESSION

Next Meeting: 6 March 2024, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 29 February 2024

Reference	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT.221	Wellbeing Plan	ROHTB (10/23) 005 ROHTB (10/23) 005 (a)	04/10/2023	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	
ROHTBACT.222	Equality & Diversity Improvement Plan	ROHTB (10/23) 008 ROHTB (10/23) 008 (a)	04/10/2023	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	
ROHTBACT.231	Wellbeing update	ROHTB (12/23) 004 ROHTB (12/23) 004 (a) ROHTB (12/23) 004 (b)	06/12/2023	circulate feedback from the Inclusive Company with Board Members for information ahead of the next Board meeting	SM	07-Feb-24	To be circulated. Feedback not yet received so unable to circulate at present.	
ROHTBACT.217	Stories for the Board	ROHTB (10/23) 001 ROHTB (10/23) 001 (a)	04/10/2023	Liaise with NB with regard to how we bring together the learning from the stories on an annual basis	ES	10-Apr-24	Annual report on patient and staff stories to be presented in April 2024. ACTION NOT YET DUE	
ROHTBACT.225	Retention & Recruitment update	ROHTB (11/23) 006 ROHTB (11/23) 006 (a)	01/11/2023	Add update on visit to Jaguar Land Rover to a future agenda	TF	06-Mar-24	Verbal update to be provided at March Board meeting under Private Board.	
ROHTBACT.229	Wellbeing update	ROHTB (12/23) 004 ROHTB (12/23) 004 (a) ROHTB (12/23) 004 (b)	06/12/2023	Provide an update on the Health & Wellbeing Guardian role at a future Board meeting	AA	06-Mar-24	Included on agenda for March Board meeting	

ROHTBACT.232	National Food Standards update	ROHTB (12/23) 005 ROHTB (12/23) 005 (a) ROHTB (12/23) 005 (b)	06/12/2023	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	05-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)	06/12/2023	Use benchmarking information as part of reports being prepared for the Trust Board and relevant committees	All Execs	10-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)	06/12/2023	Invite Mr Jamie McKenzie to attend the Board to present his independent view	TF	10-Apr-24	Invited and agreed to attend the April 2024 meeting	
ROHTBACT.235	Wellbeing Update	ROHTB (2/24) 027 ROHTB (2/24) 027 (a)	06/02/2024	Provide a one page summary of the wellbeing action plan.	SM	10-Apr-24	ACTION NOT YET DUE	
ROHTBACT.236	Race Code Adoption	ROHTB (2/24) 003 ROHTB (2/24) 003 (a)	06/02/2024	Prepare a board development workshop proposal for RACE Code adoption.	JW/SM	10-Apr-24	ACTION NOT YET DUE	
ROHTBACT.238	Board Assurance Framework	ROHTB (2/24) 009 ROHTB (2/24) 009 (a - i)	06/02/2024	Cleansed version of the BAF to be return to the Board in April	AR	10-Apr-24	ACTION NOT YET DUE	
ROHTBACT.239	EPRR Position Statement	ROHTB (2/24) 010 ROHTB (2/24) 010 (a)	06/02/2024	Provide an update on the EPRR Position Statement following the next assessment	SW	04-Sep-24	ACTION NOT YET DUE	

ROHTBACT.216	Net Zero progress update	ROHTB (9/23) 022 ROHTB (9/23) 022 (a)	06/09/2023	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~~ ~~November~~ December. **INCLUDED ON THE AGENDA OF THE FEBRUARY BOARD MEETING.**	6/12/2023	Green Board update presented to FPC in September and further update to Board in
ROHTBACT.237	Equality Delivery System	ROHTB (2/24) 004 ROHTB (2/24) 004 (a)	06/02/2024	Update the EDS document to reflect the correct language is used when we talk about family members attending the appointments with relatives and circulate final document to Board before submission	SM	06-Mar-23	Paper updated and circulated to Board members on 27 Feb 2024	
ROHTBACT.227	Update from CQC Engagement meeting	ROHTB (12/23) 003 ROHTB (12/23) 003 (a)	06/12/2023	Present at the February Board meeting an overview of concerns raised to the Care Quality Commission	NB	07-Feb-24	Included on the agenda of the private session of the February meeting	
ROHTBACT.228	Wellbeing update	ROHTB (12/23) 004 ROHTB (12/23) 004 (a) ROHTB (12/23) 004 (b)	06/12/2023	Provide an update on the Health & Wellbeing week at the February Board meeting	SM	07-Feb-24	Included as part of the wellbeing report to be considerd at the February 2024 meeting	
ROHTBACT.226	Risk Appetite	ROHTB (11/23) 009 ROHTB (11/23) 009 (a)	01/11/2023	Arrange for AR to attend future Board meeting to discuss the BAF risk appetite	TF	07-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:	**6 March 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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

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

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board meeting on 7 February 2024 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. We have received over 500 nominations which is incredible. The judging process commences over the next few weeks, and I look forward to sharing more information over the coming months. Congratulations to all those who will find out shortly that they have been nominated.

2.2 Congratulations to the Clinical Education Team which has also been nominated for an award at the Nursing Times awards in April 2024.

2.3 I am delighted to advise that the ROH's preceptorship programme has successfully achieved the National Preceptorship Quality Mark for nursing.

The National Preceptorship Nursing Programme was developed to support newly qualified professionals and give them the best possible start in their careers. The ROH Preceptorship is a multi-professional programme for all newly qualified registered practitioners and all internationally educated recruits. The programme includes all Nursing and Midwifery Council and Health and Care Professional Council registrants.

The 12-month programme supports staff through the duration of their first year and includes self-directed and collaborative workshops during their transition period, covering wellbeing, self-management, managing risk, communication skills, and preparing for the future.

The programme was developed by Clinical Educator, Sam Scone, with the rest of the Clinical Education Team

2.4 On Tuesday, 27 February, the Executives undertook their routine 'Chat and Check' visits. Three areas were visited this time: Therapies, Records Management and Finance/Clinical Coding/Business Intelligence. The Executives were welcomed by the teams who shared their experiences of working at the ROH. It was pleasing to see that some environmental improvements had been made in some of the areas, which had been matters of concern raised when the areas had been visited before. Staff described the ROH as being 'friendly' and a 'family' and there were no major concerns raised. The next visits are planned for end of March.

2.5 The data for the Gender Pay Gap will be submitted by 31 March 2024. This data was reviewed by Trust Board in July 2023. A full annual report will be presented at People & OD Group and Staff Experience & OD Committee in March which will include an action plan. This work has been supported by members of the Women's Network and Matt Revell, Chief Medical Officer (CMO) linked to his EDI objective.

2.6 In April 2024, the Trust will launch its new appraisal process across the organisation, seeing all appraisal being completed during April – July. The form will be electronic and held within ESR, with a full training package and support for all managers.

2.7 The National Staff survey results will be published on Thursday 7 March 2024 at 9.30am. We plan to share the results with the organisation later that day with a big launch with stakeholders across the Trust to review the results and agree next steps on 12 March 2024.

2.8 In April 2023, the British Medical Association (BMA) launched a pledge to end sexism in medicine and invited organisations to collaborate with them on working towards the pledge and goals. 63 organisations have signed up, including six NHS trusts. The full list can be found here.

The BMA has contacted the ROH and asked that given the great work we have already done towards the goals and our important voice in encouraging good practice, whether we would we sign the pledge. We are delighted to support the request and have signed the pledge. This will work in alongside the work we have already commenced with the NHS Sexual Safety Charter.

3. BSol ICS (Integrated Care System) and Partner 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 The next meeting for Birmingham Health Partners will be held on Tuesday 5 March 2024.

4 NHS England (NHSE) /National updates

4.1 On Wednesday 28 February, NHSE launched its Leadership competency framework for board members. The NHS Leadership Competency Framework (LCF), is for all board members of NHS providers, ICBs and NHS England's Board.

The LCF has been designed with engagement and support from a significant number of NHS chairs, chief executives and other stakeholders, and using insight into best practice in other industries.

The LCF provides a framework for board member recruitment and appraisal and will inform future board leadership and management training and development. It has been developed in response to a recommendation from the Tom Kark KC (2019) as part of his review of the Fit and Proper Persons Test. The LCF provides a consistent competency and skills benchmark against which board members will individually self-assess as part of the annual 'fitness' attestation.

This is described in the NHS England Fit and Proper Person Test Framework for board members, published in August 2023.The LCF is based on six domains, each with a range of competencies. For each domain there is a description of what good looks like, as well as an optional scoring guide to help with self-assessment and development.

The six competency domains are required to be incorporated into all NHS board member role descriptions and recruitment processes from 1 April 2024. They should also form a core part of board member appraisals and the ongoing development of individuals and the board as a whole. The competency domains will also be built into national leadership programmes and support offers for board directors and aspiring board directors.

A revised Chair Appraisal Framework has been published for use in 2023/24 chair appraisals, and includes the competencies outlined in the LCF. A new Board Member Appraisal Framework will also be launched this autumn.

In the meantime, all board members are required to self-assess against the LCF and discuss findings with their chair or chief executive as part of their 2023/24 annual appraisal.

The three frameworks are part of a wider programme of management and leadership development being led by NHS England with education partners, staff and

stakeholders, to implement the recommendations in the Health and social care review: leadership for a collaborative future (known as the Messenger Review), as well as the recommendations from other reviews and reports on NHS leadership and management. NHSE will publish a three-year roadmap setting out more details of this work shortly.

NHSE will review the LCF as part of the planned review in 2025 of the Fit and Proper Persons Test Framework.

5 POLICY APPROVAL

5.1 Since the Trust Board last sat, no corporate policies have been approved by the Chief Executive on the advice of the Executive Team.

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

29 February 2024

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:	**6th March 2024**

EXECUTIVE SUMMARY:

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

Positive assurance

- A review of the hardship funding led by Charities team has highlighted key areas that may need additional support and also the themes of requests being received
- 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.
- Key initiatives to support colleagues through the cost of living crisis will continue for the next few months with different funding available

Current issues

- Continuing issue to ensuring all managers attend the Wellbeing Conversation Training and undertake wellbeing conversations with Team members. The new appraisal approach will support this work
- Securing funding for future initiatives with current financial constraints

Next steps

- Continue work on 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
- Review different funding options for future initiatives

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

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 –January 2024 Wellbeing update - SE&OD committee – January 2024 People and OD Group February 2024 ROH Comms information

Trust Board – March 2024

Update on Cost of Living and Wellbeing

1. Cost of Living

Royal Orthopaedic Charity Initiative: The ROC Hardship Fund

The information below gives an overview of the funding requests since June 2023, how the process works and the areas for focus that have been identified.

Hardship Fund

Month	Patient	Amount	Colleague	Amount
June 23	0	0	4	£475.00
July 23	2	£164.00	5	£500.00
August 23	2	£204.00	2	£500.00
October 23	2	£371.50	5	£500.00
November 23	5	£336.75	4	£400.00
December 23	0	0	15	£473.33
January 24	4	£118.25	4	£355.00
February 24	0	0	2	£214.14
Total		**£238.08**		**£449.96**

Count of Themes for reporting Row Labels	June-23	July-23	August-23	October-23	November 2023	December 2023	January 2024	February 2024
Patient								
Appointment related travel & accommodation		2	1	2	5		2	
Patient side effects needs private support							1	
Increase of bills and food cost							1	
Staff								
Broken essential equipment				1		3	1	1
Outstanding bills	2	2			1	4		1
Reduced bank shifts resulting in reduced paye							1	
Sick leave resulting in reduced paye								
Carer needing support with food expenses	1							
Single parent with outstanding debt	1	1						
Unforeseen allergys resulting in increase costs		1						
Relocation resulting in increase of bills			1	1	1			
Family member with disability and increasing costs of childcare				1				
Abusive relationship resulting in debt					1			
Increase of bills and food cost					1	1	2	
Family member illness and lack of income						1		
Pregnant individual without statutory income						1		
Broken relationship resulting in court costs						1		
Medical diagnosis causing financial issues						3		
increase in bills						1		
Grand Total	4	7	3	7	9	15	8	2

Information on reasons for funds being given:

- Side effects to oncology treatment
- Further treatment needed
- Reduced bank shifts meaning reduction in pay
- Broken essential household items and outstanding bills

Hardship panel

The panel discusses at length any case put forward and recommends financial wellbeing support including using information from Citizen's Advice Birmingham.

Application analysis

- Financial wellbeing support has been targeted in the two areas identified as patterns of colleagues applying for funds. The trust has provided these areas with additional financial signposting and support. The Engagement and Wellbeing officer has followed up by attending team meetings for these areas. The Trust has also contacted Citizen's Advice Birmingham via the ICS link to see if they can attend on site to provide bespoke support.
- The Hardship Fund panel will continue to review the information to identify any areas to focus on and then provide specific support.
- The Trust also receives continued support from HSBC Financial Support who offer the following
  1) **Always on** - webinars on different financial subjects continue to shared with colleagues in the Trust.

  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.

Key update information on Cost of Living Initiatives

Winter Grant – The Trust are looking at storage solutions to store items for the ROH Pantry and Sanitary Products for the Blue Bag project. The remaining Winter Grant money needs to be spent by March 24 and the intention is to stock pile goods for the next few months.

Free Porridge – The Trust launched **free porridge** at the start of Wellbeing Week in November and will continue throughout the winter months until the end of March. Positive feedback has been received through Wellbeing surveys and on 45 portions are served each day. Porridge Oats and milk has also been delivered to College Green to ensure they are also included

ROH Pantry – continuing to keep the **pantry** restocked over the winter months, using the Winter Grant. This pantry was re stocked on 5th February. Between 5th and 27th February, 31 counters were placed in the box by individuals to show they had accessed provisions.

Out of hours food, Blue Bag Project and Toiletry Packs have all been re stocked using the order received on 5th February.

Wellbeing plan

Work continues to review the metrics for each of the wellbeing priorities to ensure there are clear actions that can measure impact.
4 key areas of focus in the wellbeing plan are:

1. **MSK** – quicker referral, accessibility and support for colleagues and managers supporting colleagues with MSK
2. **Stress and Mental Health** – the trust have some funding which we are planning to use to take Wellbeing Trollies around the trust. This will be in April as part of Stress Awareness Month, the trust will also share signposting and support around stress.
3. **Cost of Living –** Winter Grant available until March 24, the Trust is looking at storage solutions as discussed above.
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. This will be completed by the end of March 2024

Additional wellbeing actions:

Wellbeing Dome– The Wellbeing Team and ROC have partnered together to apply for a charity grant to ensure there is disabled access to the Wellbeing Dome from the Knowledge Hub corridor. The Trust conducted a wellbeing survey and key comments were about access. Between January 1st and January 31st there were 68 door swipes from the Knowledge Hub corridor to the Wellbeing Dome.

Menopause Training – 22 Managers joined the Managers Session 7th February. The General Awareness Session 27th February will be recorded meaning we can share across the trust.

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.

Post Graduate Doctors – Wellbeing support and signposting was offered at the Post Graduate Doctors event on 7th February.

Sharon Malhi, Chief People Officer will be presenting at the next national Health and Wellbeing at Work conference in Birmingham in March.

Laura Tilley-Hood

Engagement and Wellbeing Officer

March 2024

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Health and Wellbeing Guardian assurance report**
SPONSOR (NON EXECUTIVE DIRECTOR):	**Ayodele Ajose, Non-Executive Director**
AUTHOR:	**Ayodele Ajose, Non-Executive Director** **Clare Mair, Head of OD and Inclusion**
DATE OF MEETING:	**6th March 2024**

EXECUTIVE SUMMARY:

This document outlines the first assurance report for the Health and Wellbeing Guardian. The outline of the report is:

- Definitions and scope of responsibility
- Operational and Executive Leads with responsibility for Security Management
- Activity
- Status of relevant strategies and policies
- Matters of escalation/key points of assurance to the Board

Positive assurance

- Clear progress has been made over the last 12 months
- Policies and procedures have been updated to support wellbeing work

Current issues

- Ensure staff have access to a range of Health and Wellbeing interventions to support varying needs
- Ensure metrics are developed further to identify outcomes and impact

Next steps

- Confirmed action plan based on 4 priority areas identified through HR metrics and staff feedback
- Continued support of the Cost of Living initiative provided through the Trust and with external funding
- Review of Hardship funding options to include possible support from external funding
- Continued review of the Employee Assistance Programme (EAP)
- Annual review of the NHS Health and Wellbeing framework to identify any gaps as part of action planning
- Finalise submission for Thrive at Work -silver level

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

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	X
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:
First assurance report Monthly Trust Board Wellbeing and Cost of Living updates

ASSURANCE REPORT FROM THE NON- EXECUTIVE CHAMPION

FOR HEALTH AND WELLBEING

Definitions and scope of responsibility	The role of the Health and Wellbeing Guardian in the NHS is clearly defined and supports the following points: • NHS England has committed to regularly review the health and wellbeing guardian function and the supporting guidance • The guidance has been simplified. • The previous name of '**wellbeing guardian**' has been evolved to now become, **health and wellbeing guardian**. This decision has been made based on feedback from wellbeing guardians that the title needed to reflect the full breadth of both health and wellbeing aspects of what the function covers • The previous '**wellbeing guardian principles**' have evolved into the **new key responsibilities** for health and wellbeing guardians. These outline how health and wellbeing guardians are to champion a health and wellbeing culture, seek assurance and hold to account their senior leadership team • Removal of the previous 'wellbeing guardian principle' in relation to suicide postvention, which has now been superseded by the new national suicide prevention and postvention guides. This removes any requirement of the health and wellbeing guardian to oversee any postvention investigations • **Appendix 5** of the guidance documents provides guidance for those who support the health and wellbeing guardian strategically and operationally, such as human resource (HR) directors and occupational health (OH) and wellbeing teams. Function Responsibilities include: • Championing a health and wellbeing culture • Holding to account

	• Clarification that it is not a 'doing role', it's an assurance function • Seeking assurance - The organisation understands the diverse health and wellbeing needs of its employees - There is a holistic strategy for improving occupational health and wellbeing for all employees - Senior leaders continually review and act on employee health and wellbeing data and metrics - There is an inclusive approach to providing occupational health and wellbeing services and support for all employees
Operational and Executive Leads with responsibility for Security Management	• Sharon Malhi, Chief People Officer • Becky Crowther – Deputy Chief People Officer • Clare Mair – Head of OD and Inclusion • Laura Tilley-Hood, Engagement and Wellbeing Officer
Activity this period (March 2023 – March 2024)	• Confirmation of Wellbeing Plan in line with the People Plan • Collaborative working with managers and colleagues across the Trust including: - Safeguarding team - Network Chairs - Charities - NCP - Regional and National NHS Wellbeing Leads • Discussions with Directors, senior leaders, managers and staff as appropriate • Regular meetings with Health and Wellbeing Guardian and operational leads • Engagement and wellbeing officer supported by Health and Wellbeing Guardian on engagement events across the Trust including Ward Trolley round • Bi annual wellbeing event run for colleagues including ward and department rounds to share information and wellbeing products • Confirmed Wellbeing Plan in line with People Plan • Continues to support the Hardship fund as panel member and wellbeing adviser (since June 2023) • Regular events run in departments include offsite e.g. College Green

	• Updated format and training for Wellbeing conversation • Introduction of new initiatives - Period Dignity - Wellbeing Dome - £1 meals and free porridge - School uniform donation for local community - Menopause awareness session
Status of relevant strategies and policies	• Wellbeing plan completed in September 2023 • Stress policy – at final sign off • Menopause policy in draft • Annual Wellbeing action plan to support objectives of the Wellbeing plan • Four priorities identified based on metrics and feedback from staff through engagements
Matters of escalation/key points of assurance to the Board	• Ensure staff have access to a range of Health and Wellbeing interventions to support varying needs • Ensure metrics are developed further to identify outcomes and impact • No overall concerns to raise
Actions planned for next period	• Confirmed action plan based on 4 priority areas identified through HR metrics and staff feedback • Continued support of the Cost of Living initiative provided through the Trust and with external funding • Review of Hardship funding options to include possible support from external funding • Continued review of the Employee Assistance Programme (EAP) • Annual review of the NHS Health and Wellbeing framework to identify any gaps as part of action planning • Finalise submission for Thrive at Work -silver level

Ayodele Ajose – Non Executive Director

March 2024

REPORT REF: ROHTB (3/24) 005

TRUST BOARD

DOCUMENT TITLE:	**Health Inequalities**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Executive Chief Nurse**
AUTHOR:	**Nicola Brockie, Executive Chief Nurse**
PRESENTED BY:	**Nicola Brockie, Executive Chief Nurse**
DATE OF MEETING:	**6th March 2024**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The work on Health Inequalities was reviewed by our Internal Audit function, KPMG in FY22/23 as part of the annual audit programme. As a result, the Chief Nurse was identified as the Trust lead and has been working with Rebecca Lloyd, Deputy Director of Strategy, & Amos Mallard, Head of Communications, to develop a trust wide plan to develop the Health Inequalities framework in the organisation. This presentation is offered to outline the work underway to date.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
• Good progress with the work to date and setting the plan for tackling Health Inequalities and embedding it within the Trust	• Set of recommendations for developing the framework further received from the outcome of the KPMG audit

NOT APPLICABLE	

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to: RECEIVE and ACCEPT the presentation

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

Financial		Environmental/Net Zero		Communications & Media	x
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:

Health Inequalities is fundamental part of the Trust's 5 year strategy

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

A key aim of the work of the ICB is to address Health Inequalities at a regional and national level

PREVIOUS CONSIDERATION:

Audit Committee in January 2023

HEALTH INEQUALITIES PLAN 2023 - 2028

NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

Health Inequalities

KPMG reported the following in July 23:

- **Strategic Approach**
  - Development of a strategic approach document to support coordination and prioritisation of activities.
  - The strategic approach is underpinned by core metrics to measure delivery.
- **Development of action plans**
  - Development of SMART action plans in line with the establishment of the strategic approach. This should include ownership and timescales for actions to be undertaken in order to facilitate effective action monitoring and oversight.
- **Governance of progress against the strategy**
  - Detail planned governance arrangements for the strategic approach to health inequalities, including reporting lines to the Board
  - Review the Trust risk registers to consider whether the risk associated with health inequalities is sufficiently reflected
- **Using data to drive improvements**
  - The Trust should establish standardised reporting to facilitate the consistent evaluation of health inequalities.
  - Include a disaggregation of waiting lists by ethnicity and deprivation group in board reporting.
- **Improving data completeness**
  - The Trust should set a target for completeness of ethnicity data, and track progress against it.
- **Alignment with system working**
  - Map out communications with the ICS, to ensure that there is consistent messaging and sharing of plans.

CONTEXT

People in our communities face a number of significant challenges related to health inequality and musculoskeletal health. It is only through understanding the challenges people face that we are able to provide the support and services people need.

A PUBLIC HEALTH PROFILE OF PEOPLE IN BIRMINGHAM AND SOLIHULL

Total population: 1.3m

Age

20%	65%	14%
Under 15 years old	15-64 years old	Over 65 years old

Ethnicity

59.6%	25.1%	8.1%	5.2%	2%
White	Asian	Black	Mixed	Other

Sexual orientation and gender identity

Between 2.5 - 5% of our population identify as lesbian, gay, bisexual, trans or with another non-heterosexual identity.

Disability

18.1% of people have long term health conditions and disabilities that limit their activities of daily living a lot

Disease and inequality

The main diseases causing inequality in life expectancy are infant death, lung disease, heart disease and cancer

- Heart disease
- Lung disease
- Cancer
- Infant death

Infant mortality

England average	3.6 deaths per 1000 live births
Birmingham average	6.6 deaths per 1000 live births
Solihull average	4.7 deaths per 1000 live births

Life expectancy

England average	Women = 82.6 years	Men = 78.7 years
Birmingham average	Women = 80.5 years	Men = 75.8 years
Solihull average	Women = 83.1 years	Men = 78.1 years

Poverty and unemployment

Birmingham	Households have £49 less per week than the uk average. The unemployment rate is 7.3%
Solihull	Households have £80 more per week than the uk average. The unemployment rate is 4.1%

THE MUSCULOSKELETAL (MSK) HEALTH OF PEOPLE IN BIRMINGHAM AND SOLIHULL

30% MSK conditions account for 30% of GP consultations in England

8.85 million Chronic joint pain or osteoarthritis affects more than 8.75 million people in the UK.

2x People living in deprived areas are twice as likely to wait more than a year for joint replacement

Physical inactivity

Birmingham	24.8% inactive adults in Birmingham
Solihull	23.2% inactive adults in Solihull

1/10 Supporting inactive people (those doing less than 30 minutes per week) to become more active could prevent 1 in 10 cases of stroke and heart disease.

Working days lost to MSK conditions

Birmingham	17.9%
Solihull	21.5%

57.8% The employment rate for people with a long term MSK condition is only 57.8%, compared to 82.2% for people without a long-term health condition

People from disadvantaged communities are less able to participate in physical activity and do not tend to engage with traditional exercise programme delivered within the NHS

NHS MSK conditions are one of the most common causes of sickness absence in the local NHS (a workforce of 70,000).

Alignment with system working

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities can arise due to unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs.

National context for health inequality reduction

Tacking health inequalities is a priority for the whole NHS. NHS England have developed a Healthcare Inequalities Improvement Dashboard that is available to all regions, systems and providers to see their own local data. The Dashboard provides key strategic indicators with an aim to measure, monitor and inform insight to make actionable change in narrowing health inequalities. NHS England have also developed five key priority areas which underpin the work of the National Healthcare Inequalities Improvement Programme:

1. Priority 1: Restore NHS services inclusively
2. Priority 2: Mitigate against digital exclusion
3. Priority 3: Ensure datasets are complete and timely
4. Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
5. Priority 5: Strengthen leadership and accountability

NHS England have also developed the Core20Plus5 approach to support the reduction of healthcare inequalities. The Core20PLUS5 approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

The priorities in this plan have been aligned to these strategic priorities.

Local context for health inequality reduction

Birmingham and Solihull Integrated Care System
Caring about healthier lives

Birmingham and Solihull Integrated Care System Inequality Strategy

Strategic priorities

1. Maternity Care & Infant Mortality
2. Better Start for our Children
3. Better Prevention, Detection & Treatment of Major Diseases
4. Better Outcomes for People with Mental Illness
5. Better Outcomes for People with Disabilities including Learning Disability
6. Improved Outcomes for Inclusion Health Groups

Six building blocks for delivery

1. Insight & Impact.
2. Pathway Improvement
3. Targeting our Prevention Programmes
4. Working with Communities
5. Supporting Health Literacy
6. Anchor institutions

Find our more about health inequalities

OUR STRATEGIC FOCUS AREAS AND ENABLING PRIORITIES

STRATEGIC FOCUS PRIORITIES

These are the five high-impact areas where we will focus in the future to help reduce health inequalities

1. Partnership building
2. Up-stream intervention
3. Service Improvement
4. System Improvement
5. Access & BSol waiting list

ENABLING PRIORITIES

These are the five enabling priorities that will enable us to create the right structure to tackle health inequalities

- DATA AND INSIGHT
- GOVERNANCE AND MONITORING
- SYSTEM ALIGNMENT
- CAPACITY AND SUPPORT
- IMPROVEMENT INTERVENTIONS

STRATEGIC PRIORITY

Our Trust Strategy 2023-2028 has a clear and ambitious critical success metric around health inequality (see green box right). In order to achieve it we must build the right relationships, share our knowledge, support preventative interventions and take a holisitic and collaborative approach to supporting people.

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.

ENABLING PRIORITIES

Building on the report we commissioned from KPMG *'Health Inequalities: Trust Approach'* (July 2023) we have identified five enabling priorities that will allow us to build the right foundations to better understand and tackle health inequality.

DATA AND INSIGHT

Introduce a clear framework for collecting health inequalities data and create a dashboard to support insight and improvement.

GOVERNANCE AND MONITORING

Ensure that our governance supports consistent monitoring of health inequalities data to enable improvement.

SYSTEM ALIGNMENT

Ensure that the data we collect and actions we take, aligns with the strategic approach of BSol ICS in tackling health inequality.

CAPACITY AND SUPPORT

Build adequate leaderhsip, capacity, support and resources to deliver our health inequalities agenda.

IMPROVEMENT INTERVENTIONS

Create a high impact action plan that prioritises measureable improvement interventions that reduce health inequality.

KEY ACTIONS

Action	Date required	Responsible
Identify all health inequalities data sources and any gaps	Jan 2024	Business Intelligence Team
Identify solutions for collecting and collating data gaps, prioritising highest impact data	April 2024	All
Create a health inequalities dash board and framework which brings together all data and insight	April 2024	Business Intelligence Team
Create a timeline for disaggregation of waiting lists by ethnicity and deprivation for Trust Board reports	Nov 2023	Governance

Action	Date required	Responsible
Detail planned governance arrangements for the strategic approach to health inequalities, including reporting lines to the Board	April 2024	Governance Team
Review the Trust risk registers to consider whether the risk associated with health inequalities is sufficiently reflected	April 2024	Governance Team
Ensure there are clear lines of ownership and accountability around health inequalities improvement	April 2024	Executive Team

Action	Date required	Responsible
Ensure we are represented at key BSol ICS health inequalities forums	Nov 2024	Executive Team
Ensure our action plan is aligned to the six system priorities wherever possible	April 2024	H.I lead
Identify where sharing of data is useful to promote system level insight and improvement	April 2024	H.I lead
Map out communications with the ICS, to ensure that there is consistent messaging and sharing of plans	April 2024	Communications Team
Maximise impact by sharing learning and success stories across the BSol ICS	April 2024	Communications Team

Action	Date required	Responsible
Utilise £X funding to build capacity to deliver the health inequalities agenda	Nov 2024	Executive Team
Identify where sharing of data is useful to promote system level insight and improvement	April 2024	H.I lead, B.I Team
Map out communications with the ICS, to ensure that there is consistent messaging and sharing of plans	April 2024	Communications Team
Maximise impact by sharing learning and success stories across the BSol ICS	April 2024	Communications Team

Next steps

- Working group established to focus on two areas:
  - Data gathering (what we already have and what we require)
  - Developing a clear understanding of what work is already underway e.g. LD & Austin strategy, Quality Priorities
- Governance structure being agreed
- CNO connecting with system Health Inequalities meetings and other groups such as BLACHIR
- Develop of an overarching action plan against the six key priorities
- Carried out a survey of staff to understand ‘what they understand about health inequalities’ – Feb 24 live.
- Education about health inequalities – elifeforlearning offer two models for all staff
- Work with Versus Arthritis to look at 'The State of MSK Health' for Birmingham and Solihull to better understand the MSK needs of our communities
- Develop an agreed timeline with milestones for delivery

Appendix A

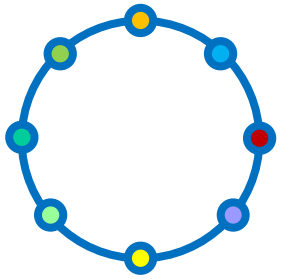
Health inequalities journey

Opportunities for improvement at the ROH

Introduction

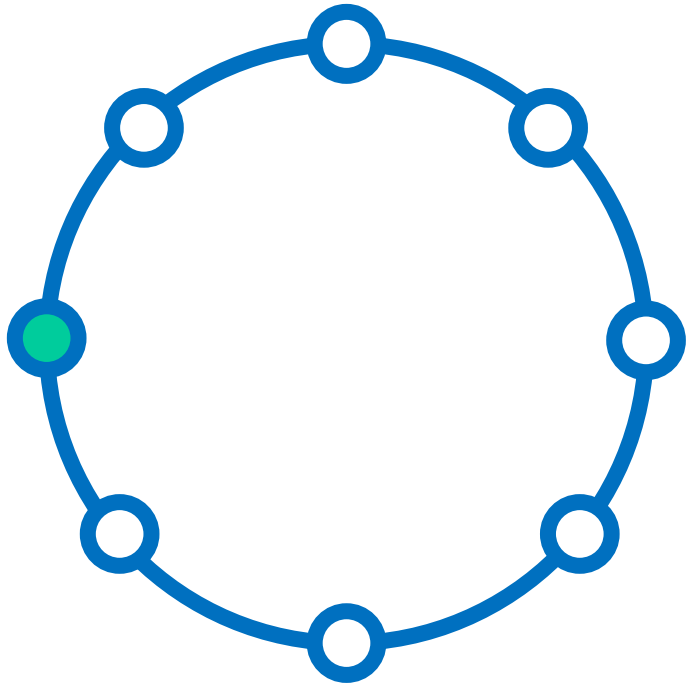
There are eight general stages of the patient journey where we can have an impact on addressing health inequalities:

- Knowledge and health literacy
- Access to supported self-management
- Access to Primary Care
- Access to MSK support
- Access to the ROH
- Suitability of services
- Support for recovery
- Support to stay well



Health inequalities journey

- **Knowledge and health literacy**
- Access to supported self-management
- Access to Primary Care
- Access to MSK support
- Access to the ROH
- Suitability of services
- Support for recovery
- Support to stay well

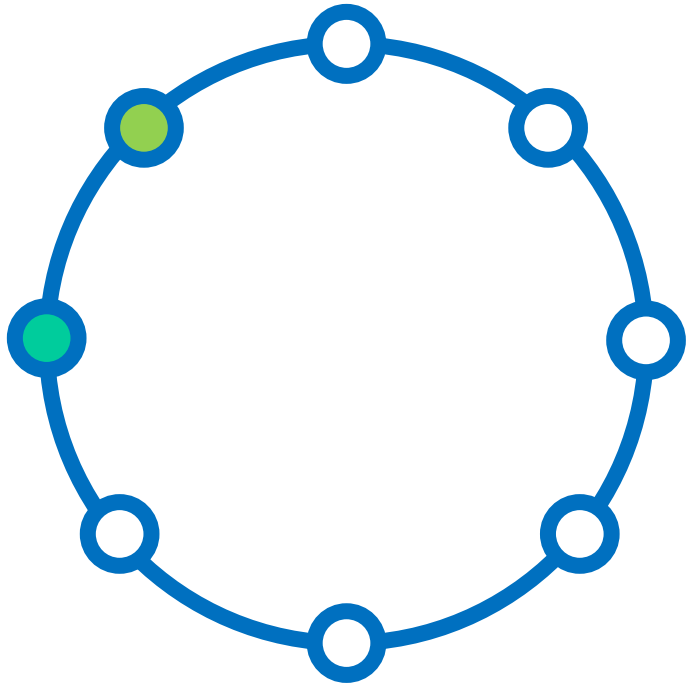


Question: how much does this person know about maintaining good MSK health?

Opportunity: can we share more knowledge about MSK health in our communities and provide more digital support?

Health inequalities journey

- Knowledge and health literacy
- **Access to supported self-management**
- Access to Primary Care
- Access to MSK support
- Access to the ROH
- Suitability of services
- Support for recovery
- Support to stay well

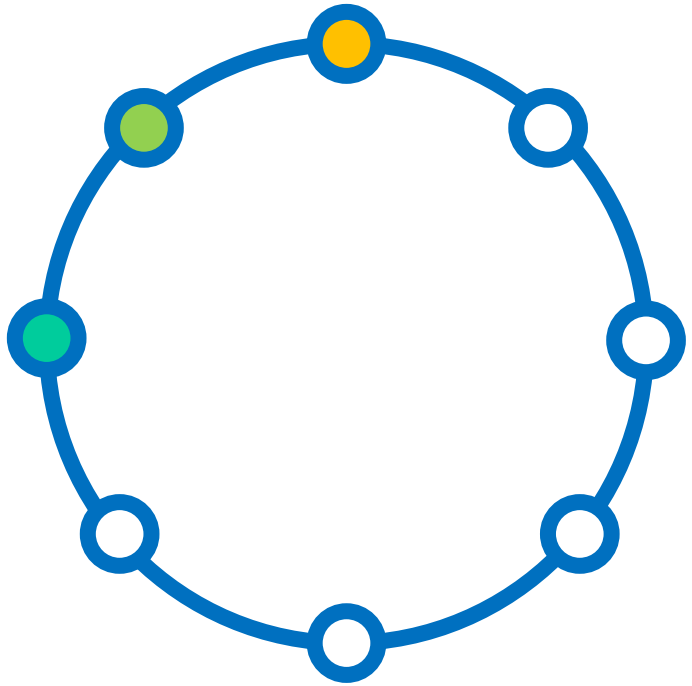


Question: What self-management support and services are in their community, and do they know about them?

Opportunity: Can we work with the third sector and partners to help make good resources and support more available to support prevention and proactive MSK health/

Health inequalities journey

- Knowledge and health literacy
- Access to supported self-management
- **Access to Primary Care**
- Access to MSK support
- Access to the ROH
- Suitability of services
- Support for recovery
- Support to stay well

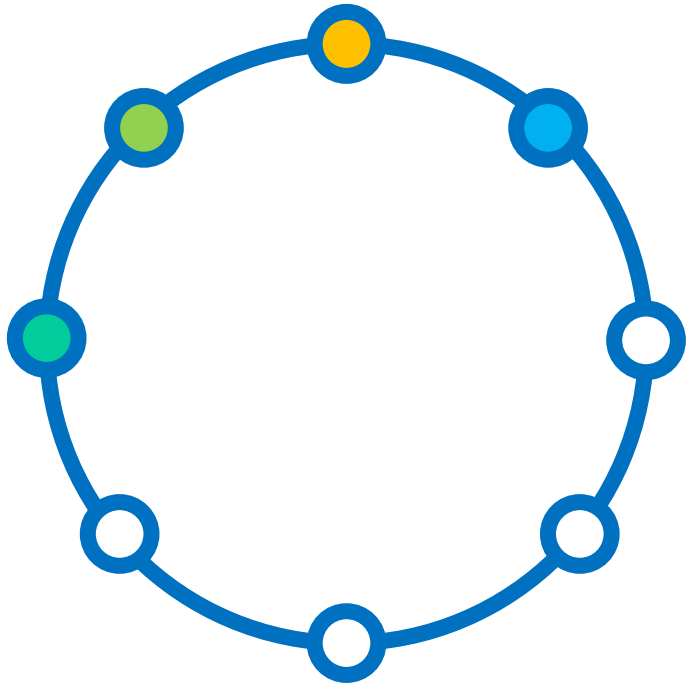


Question: How easy it for this person to access primary care in their community?

Opportunity: Work with system partners to develop a singe point of access model across community and primary care, including improved access to First Contact Practitioners, social prescribers and physiotherapy

Health inequalities journey

- Knowledge and health literacy
- Access to supported self-management
- Access to Primary Care
- **Access to MSK support**
- Access to the ROH
- Suitability of services
- Support for recovery
- Support to stay well

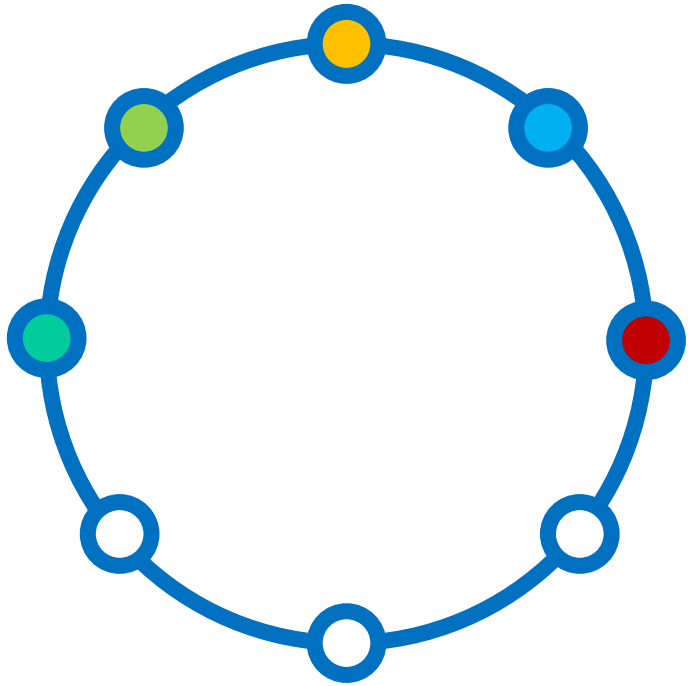


Question: What standard of MSK support can this person access through Primary Care?

Opportunity: Can we proactively engage, provide more resources and work through the BSol MSK Transformation Programme to reduce variation?

Health inequalities journey

- Knowledge and health literacy
- Access to supported self-management
- Access to Primary Care
- Access to MSK support
- **Access to the ROH**
- Suitability of services
- Support for recovery
- Support to stay well

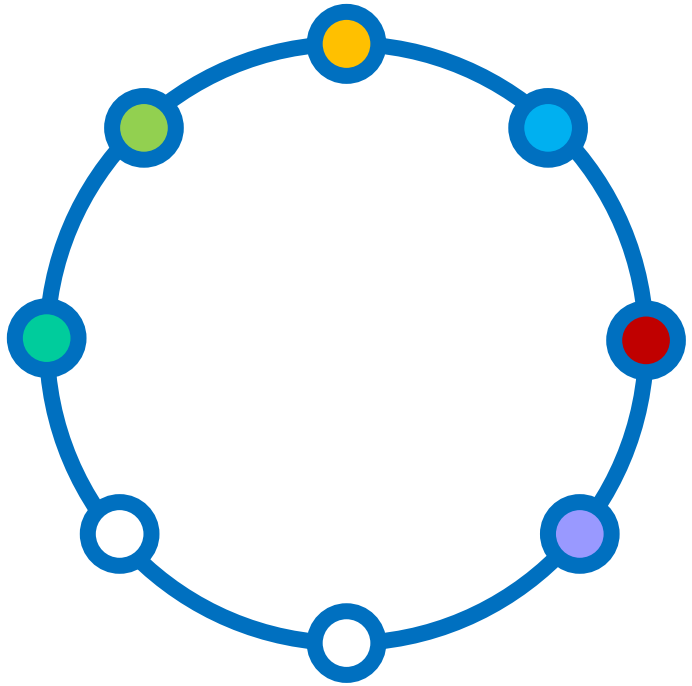


Question: What standard of MSK support can this person access through Primary Care?

Opportunity: How accessible is the ROH and what prevents people from accessing our services?

Health inequalities journey

- Knowledge and health literacy
- Access to supported self-management
- Access to Primary Care
- Access to MSK support
- Access to the ROH
- **Suitability of services**
- Support for recovery
- Support to stay well

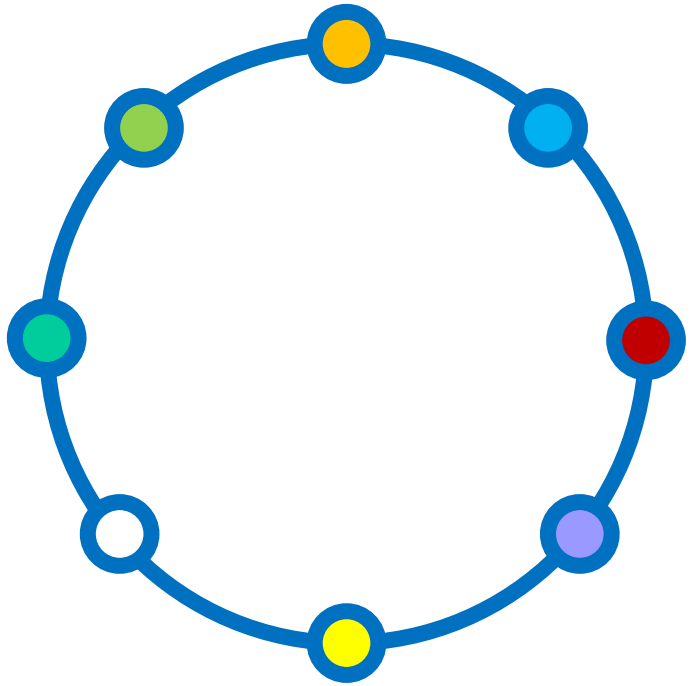


Question: When this person attends the hospital, do our services meet their needs?

Opportunity: Can we develop services and training for our staff which supports the delivery of care which meets needs, e.g. is culturally sensitive, gender affirming, disability friendly, etc.

Health inequalities journey

- Knowledge and health literacy
- Access to supported self-management
- Access to Primary Care
- Access to MSK support
- Access to the ROH
- Suitability of services
- **Support for recovery**
- Support to stay well

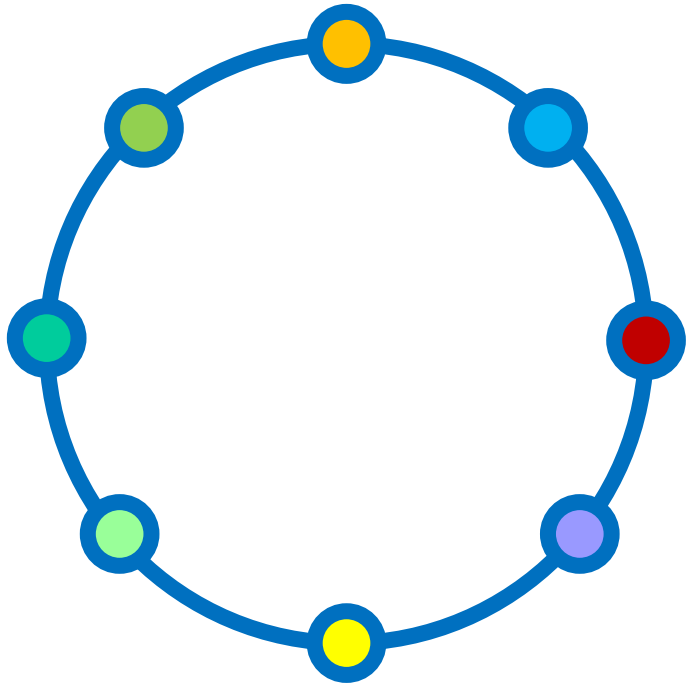


Question: When this person goes home, are we ensuring that they are not only safe, but adequately supported in a way which meets their needs and accounts for their circumstances?

Opportunity: What can we offer patients and their families to improve their recovery, i.e. improved outreach support, improved post-discharge support packs

Health inequalities journey

- Knowledge and health literacy
- Access to supported self-management
- Access to Primary Care
- Access to MSK support
- Access to the ROH
- Suitability of services
- Support for recovery
- **Support to stay well**



Question: How do we support this person to stay health and connected in their community, and make the most of their recovery?

Opportunity: How do we continuously improve the network of support to patients within their local community, so that they feel empowered to stay well?

REPORT REF: ROHTB (3/24) 006

TRUST BOARD

DOCUMENT TITLE:	**Liberty Protection Safeguards update**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Executive Chief Nurse & Executive for Safeguarding**
AUTHOR:	**Evelyn 'O'Kane, Senior Matron for Safeguarding & Nicola Brockie Chief Nurse**
PRESENTED BY:	**Nicola Brockie, Executive Chief Nurse & Executive for Safeguarding**
DATE OF MEETING:	**6 March 2024**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Liberty Protection Safeguards (LPS) were introduced in the Mental Capacity (Amendment) Act 2019 with the express purpose of replacing the current Deprivation of Liberty Safeguards (DoLS) system. The Liberty Protection Safeguards promise to deliver improved outcomes for people who are or who need to be deprived of their liberty.

During 2022, the Department of Health and Social Care (DHSC) held a consultation regarding the new LPS system, and MCA Code. Following this consultation, the implementation was postponed (multiple times previously) which culminating in the DHSC announced on the 5 April 2023 that the implementation of the Liberty Protection Safeguards (LPS) will not go ahead until after the general election (anticipated to be in Autumn 2024). The government stated at the time this was to allow them to focus on adult social care critical priorities.

In the interim the DHSC recommend health and social care providers should continue to make Deprivation of Liberty Safeguards (DoLS) applications in line with the Mental Capacity Act 2005 to ensure that the rights of those who may lack the relevant capacity are protected.

This was met with disappointment and concern with by several organisations, including the Association of Directors of Adult Social Services and, the British Association for Social Work. On 26 May 2023, the Parliamentary Joint Committee on Human Rights ("the Joint Committee") wrote to the Minister of State for Social Care to express its "deep concern". The letter repeats the concerns expressed by the Joint Committee in 2018 and 2022 about the problems with the current DoLS system, and highlights that those problems appear to be getting worse.

Highlighted concerns:

- Only a fifth of standard DoLS applications are approved within the 21 days required by law, with the average timescale for approval being 153 days. It highlights that this means that in 80% of cases the individual has been deprived of their liberty, without authorisation, for a substantial

period of time.

- Concerned was raised regarding non-means-tested legal aid that continues to be unavailable for challenges to a deprivation of liberty where authorisation is delayed, or where authorisation is granted directly by the Court of Protection.

- It also stated that, as care providers have been focussing on planning for the introduction of LPS, some providers are not maintaining their level of understanding about DoLS. This has led to what the Joint Committee calls a "general poor understanding" of the system which currently applies.

The Joint Committee posed four questions to the Government and requested a response by 14th June. The questions posed were:

1. Does the Government still believe that the system of DoLS is in need of reform? If so, given the delay in the implementation of the LPS, are any reforms of the system currently planned in the interim?
2. What steps are being taken to address the delays to the processing and completion of DoLS applications, with the aim of ensuring that no one is unlawfully deprived of their liberty in a care setting?
3. Will the availability of non-means-tested legal aid be extended to include those who may be subject to deprivation of liberty in care settings without an authorisation in place?
4. What steps are being taken to ensure that those involved in making DoLS decisions receive adequate human rights training, and fully understand the operation of DoLS?

The UK governments response is as follows:

The Government acknowledges the challenges facing the current DoLS system and states that the decision to delay the implementation of the LPS was "not taken lightly". Key points from the Government's response are as follows:

- The Government recognises the importance of updates to the Mental Capacity Act Code of Practice (MCA Code) being taken forward irrespective of LPS, to ensure all those practicing in this space have accurate and up-to-date guidance. The Department of Health and Social Care (DHSC) and the Ministry of Justice (MoJ) intend to work together to consider the feedback and publish a response to the consultation.

- The Chief Executive of Social Work England and the DHSC continue to work together on launching a consultation on refreshed standards for Best Interest Assessor Training to ensure the ongoing quality of all those carrying out this role under DoLS.

- Legal aid will still be unavailable to those who are subject to deprivation of liberty in care settings where no authorisation is yet in place or in cases where the Court of Protection needs to make a deprivation of liberty order outside the DOLS regime. However, if the application to the Court of Protection is made on behalf of an under 18-year-old, they will benefit from the decision to

introduce non-means tested civil legal aid representation for all under 18s.

- The government highlights access to available resources through Health Education England's e-learning for health platform as well as the Social Care Institute for Excellence's website.

What is being done to prepare for implementation of LPS at ROH:

- Work continues to improve the standard of documentation and recording of detailed capacity assessments. Audits are carried out to monitor and evidence MCA and DoLS practice.
- Clear MCA/DoLS training is available to ensure staff are appropriately trained in MCA/DoLS. This includes:
    - A variety of learning opportunities including scenario or role-based learning. SG Lead Nurse provides monthly face to face session on the completion of MCA assessment and DoLS request for authorisation for all registered staff.
    - Updates reflect any changing case-law or guidance provided in Trusts Safeguarding quality report.
    - Training opportunities given and shared with the C&YP dept staff in terms of LPS for 16–17-year-olds preparation.
    - Work has started and been led by Gavin Newman to prepare for the minim data set required when LPS is introduced.
    - Work has started with PICS team to develop the relevant care plans & assessment tools-documentation to be updated following release of updated Code of Practice.
    - Continue to monitor the current DoLS applications - note data is reported monthly as part of SG quality reports and Trust quality reporting.
- Staff guarding team have raised a risk which is monitored via the Safeguarding Committee.

BSOL ICS actions:

- Safeguarding (SG) Lead Nurse attends the BSOL System Wide Implementation Network Groups (SWING) Meetings – chaired by SG Designated Nurse Responsible.
- Data collection as required - data collection and reporting on LPS activity will also be a new responsibility LPS implementation: draft LPS National Minimum Data Set (England) is being work towards.
- Staff completing understanding an application of new training requirements for LPS implementation.
- NHS England events, Midlands MCA and LPS Forum. Updates and learning are shared in training

and updates to the Trust SG Committee.

- SG Lead Nurse attendance and works with the Mental Capacity Community of Practice Groups local and nationally, to share learning best practice and implementation plans and communication.

- BSOL Safeguarding Health Board attendance by Chief Nurse and SG Lead Nurse provides updates; this includes LPS changes to practice and training requirements for staff.

What further work is required for LPS full implementation:

- **Trusts MCA Policy** – this will be update at the time to reflect the changes to the Code of Practice once the DHSC/LPS implementation is released.

- **Mental Capacity Assessments** - Good quality mental capacity assessments and legally robust recording will reduce the time needed to review the documentation.

- **AMCP Provision & Cost Funding** – It remains unclear who will fund, whether the ICB or local authority BIA's will re-direct current budget to providers. It is also expect additional legal costs will be incurred.

- **Business case for LPS related costs for the LPS Code of Practice (COP) and Impact**. Forward planning on the potential cost implications to be discussed with ICB and local and national leads and Trust Chief Nurse. This includes Band 7 practitioner with a clear lead role on MCA and LPS for the Trust being supported. To work in the Safeguarding Team. As per business case proposal last year 22/23.

- **Under 18-year-olds** - Need to plan & prepare to ensure that all staff working with this age group are aware of LPS and how to implement in practice.

- **Prevalence survey needs to be undertaken** on the possible number of children that would require an application under LPS in the future.

ASSURANCE PROVIDED BY THE REPORT:	
POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
• ROH - MCA and DOLS training is up to date with current legislation. • Work has started on the minimum data set requirements.	• No further update is expected until after the next election. • Data collection requirement and the IT support to meet demand. • Unknown financial burden on Trust. • Staff need to re-train prior to go-live. • Failing to carry out sufficiently detailed capacity assessment can expose the person

	to substantial risk.

NOT APPLICABLE	

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to note and accept report at this time.

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

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

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

Mental Capacity (Amendment) Act 2019, Safeguarding plan.

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

BSOL Safeguarding Health Board

PREVIOUS CONSIDERATION:

Safeguarding Annual report. Report to Trust Board in January 2023.

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**CQC Readiness update**
SPONSOR (NON EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**6 March 2024**

EXECUTIVE SUMMARY:

This paper provides a summary of the new CQC Single Assessment Framework (SAF) including additional detail published around the metrics and information that will be used to make a judgement against the new Quality Standards.

Also included is the plan to prepare for the next inspection, including self-assessment, engagement & education, walkabouts and evidence collection.

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Trust Board is asked to:
REVIEW and SUPPORT the readiness plan

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

Regulatory requirements associated with registration with the CQC

PREVIOUS CONSIDERATION:

September 2023

CQC Readiness Update – March 2024

1. New CQC Assessment Framework

1.1 In July 2022, the Care Quality Commission (CQC) announced that it would be changing its assessment framework. Since the last updates to the Board on this new and emerging approach in July and September 2023, there has been additional clarity around the changes and the details related to the new Single Assessment Framework (SAF). The changes principally involve:

- a departure from the 'Key Lines of Enquiry' (KLOE) methodology and a move to assessment against a set of Quality Statements (We Statements) under which sit a set of 'I statements', which focus on individual care experiences;
- a move away from a physical, 'on site' inspection in all cases, to judgements which can be made remotely using evidence that is more current than may have been the case previously;
- no minimum inspection frequency and although detail on this is yet to be published, it is likely to be based, as it was previously, on risk and previous CQC ratings;
- more complex scoring mechanisms and algorithms to arrive at a rating;
- one overall rating to be applied at trust-level, this being based on a score out of 100;
- the assessment against the well-led domain will be given greater prominence on the assertion that if an organisation is well-led, then this translates into an environment which is safe, caring, responsive, and effective;
- New categories of evidence will be used to inform the assessment as follows:

✓ ***People's experience of health and care services*** – phone calls, emails and 'Give feedback on care' forms received by CQC; interviews with people and local organisations who represent them or act on their behalf; survey results; feedback from the public and people who use services obtained by: community and voluntary groups, health and care providers; local authorities; groups representing: people who are more likely to have a poorer experience of care and poorer outcomes, people with protected equality characteristics; unpaid carers;

✓ ***Feedback from staff and leaders*** – results from staff surveys and feedback from staff to their employer; individual interviews or focus groups with staff; interviews with leaders; feedback from people working in a service sent through our 'Give feedback on care' service; whistleblowing;

✓ ***Feedback from partners*** – commissioners; other local providers; professional regulators; accreditation bodies; royal colleges; multi-agency bodies;

✓ ***Observation*** – Most observation will be carried out on the premises by CQC inspectors and Specialist Professional Advisors (SpAs). External bodies may also carry out observations of care and provide evidence, for example, Local Healthwatch. Where the evidence from organisations such as Healthwatch is specifically about observation of the care environment, the CQC will include it in this category, and not in the people's experiences category. All observation is carried out on site.

✓ ***Processes*** – results from audits a provider has developed or from national programmes (for example, the National Clinical Audit and Patient Outcomes Programme); findings and learning from safety incidents; access times for treatment and care; case note reviews of people's care or clinical records

✓ ***Outcomes*** – mortality rates; emergency admissions and re-admission rates to hospital; infection control rates; vaccination and prescribing data. Information is sourced from: patient

level data sets, national clinical audits and initiatives such as the patient reported outcome measures (PROMs) programme

1.2 The new SAF has been introduced incrementally, starting with some pilot assessments in November 2023. The SAF being introduced into the Midlands and North was one of the final stages to full implementation, this being from 6 February 2024.

1.3 As reported in the Chief Executive's update last month, there has also been a move away from a single relationship manager with responsibility for a particular set of trusts or care providers, to a team-based approach. The ROH as expected, is within the remit of the Midlands region and the operational managers within this will lead the quarterly engagement process, the details of which are yet to be received.

2 Organisational preparation

2.1 Given the new approach, it is clear that the Trust needs to prepare now for an inspection by the CQC to ensure that the exceptional care and staff experience delivered is understood by the CQC and is recognised in its assessment of the ROH. A number of initiatives are already underway to understand how the Trust measures up against the new SAF:

2.1.2 Quality Assurance Walkabouts

The quality assurance walkabouts have been undertaken over the past year, lead by the senior nursing team and involving a cross section of managers and staff from a number of corporate and clinical teams. The walkabouts conduct an assessment of clinical areas based on the previous guidance around what 'Outstanding' looks like, however this is being amended to align the assessment to the new SAF Quality Statements.

Walkabouts to date, have not identified any clinical area as being below a 'Good' rating. Each clinical area is assessed twice yearly on an ongoing basis, with a check that any actions arising from the previous walkabouts having been completed.

In terms of assurance and follow up on the outcome of walkabouts, this is done periodically through Clinical Quality Group, Quality and Safety Executive and Quality and Safety Committee.

2.1.3 Well-Led Self-Assessment

Given the prominence of the well-led assessment as part of the new framework, it places an imperative on understanding the Trust's position against the Quality Statements in this domain and identifying any potential gaps and actions to address these.

Attached is a self-assessment template (Appendix 1) that has been developed, which will be populated over the next few weeks by Executive colleagues. The Board will be presented with this self-assessment and actions to address any shortfalls or areas that require strengthening will be monitored by the Staff Experience & OD Committee.

2.1.4 Engagement and Education Plan

Clarifying expectations of Trust colleagues around the new SAF and the likely experience in terms of inspection and assessment will be critical. As such, an engagement and education plan will be established and developed.

It is proposed that we embark on an engagement process with staff that takes some of the myth and fear out of an inspection and empowers staff to see it as an opportunity to celebrate the excellent work that goes on right across the whole Trust.

A further briefing on the proposed engagement and education plan will be brought back to a future meeting, however the plan in overview will include:

- Updates to staff on the new CQC assessment process through existing and new routes, including Team Brief, 100-day induction, divisional governance, all staff briefings, daily communications, corporate meetings and Council of Governors events;
- Mock focus groups which aim to emulate some of the fora that the CQC will arrange to inform their assessment. These will span staff, governor, patient and stakeholders and the lines of discussion will be aligned to the key Quality Statements;
- Board and governor briefing packs, which intend to provide Board members and governors with a pack of information that summarises some of the key information relating to the Trust at a high level; this information is often tested as part of CQC assessments to understand whether Non Executive Directors, for instance, are engaged and aware of some of the processes and sources of information that they use as assurance that the organisation is running effectively and safely. Topics within these packs will include for instance:
    - ROH 'At a Glance', which summaries the key metrics and information related to the ROH, such as bed stock, staff numbers, financial position, performance against patient experience indicators and activity levels;
    - Summary of the organisation's top risks on the Corporate Risk Register and Board Assurance Framework;
    - Governance architecture of the ROH;
    - FTSU process in summary;
    - Continuous improvement framework;
    - Organisational chart showing portfolios and responsibilities under each Executive Director;
    - Summary of patient stories heard;
    - Trust strategy on a page;
    - Board and Council of Governors composition;
    - Summary of performance against the national Constitutional Standards.

2.1.5 Data Request library

Although the SAF will be less dependent on extensive on-site inspections, there is no suggestion that the burden imposed by the data requests will be reduced. On the contrary, if there is to be less on-site observation and challenge, then the opposite may be true. Collection of evidence requested needs to be systematic and include a quality assurance process before being released so that there is assurance that material being provided, on which the organisation will be assessed, is accurate and conveys a comprehensive picture.

An outline 'library' for collection and storage of evidence will be created in readiness for the assessment, so the organisation can respond swiftly to requests for information. As it has done

before, it is proposed that this be co-ordinated by the Governance Team, who will hold the central repository of information and act as the hub for requests from the CQC.

2.1.6 Prior CQC action plans

Although it has been some time since the CQC last inspected, work is currently underway to revisit the previous CQC action plan to confirm that actions raised in 2019 have been closed and that where they have been noted to have completed previously, that changes made have been sustained.

2.1.7 Other work planned or underway

As the new and embellished **Fit and Proper Persons** requirements have recently been introduced, the CQC will be keen to see how organisations have implemented this. Work is underway to ensure that all personnel files of those individuals covered by the CQC regulations, are up to date and for those new Non Executive Directors, that there is clear evidence that the range of checks and assurance required is in place. Board members will shortly be asked to undertake a self-attestation, a process which will be annual and will inform the end of year declaration from the Chair to NHS England that all Board members satisfy the requirements of the new FPPT. Given that it is three years since the last DBS checks for many Board members, this process will also be repeated in line with the Trust's policy.

Much work has been undertaken over the past year to ensure that the Trust's **corporate policies** are all within their agreed review date. This process will be given greater focus over the next three months to ensure that there is clear escalation where a policy is beyond its review date or is due for review imminently.

3 Next steps

3.1 The work articulated above will be developed into a plan, with Executive and Operational leads identified for each piece of work. This will be considered at every other meeting of the Executive Team, with any exceptions reported to the Trust Board or through the Board Committee structure.

4 Recommendation

4.1 The Trust Board is asked to:

RECEIVE and SUPPORT the plan to ensure that the organisation is ready for the next assessment by the CQC.

Simon Grainger-Lloyd
Director of Governance

29 February 2024

CQC Well led domain – self-assessment

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

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

SHARED DIRECTION AND CULTURE		
QUALITY STATEMENT: *We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Leaders ensure there is a shared vision and strategy and that staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them		
Staff and leaders ensure that the vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners		
Staff and leaders demonstrate a positive, compassionate, listening culture that promotes trust and understanding between them and people using the service and is focused on learning and improvement		
Staff at all levels have a well-developed understanding of equality, diversity and human rights, and they prioritise safe, high-quality, compassionate care		
Equality and diversity are actively promoted, and the causes of any workforce inequality are identified and action is taken to address these		
staff and leaders ensure any risks to delivering the strategy, including relevant local factors, are understood and have an action plan to address		

them. They monitor and review progress against delivery of the strategy and relevant local plans		
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
PROPOSED 'OUTSTANDING' EVIDENCE		

SUBTOPICS THIS QUALITY STATEMENT COVERS

- Strategy and vision
- Organisational culture
- Values
- Addressing social impact

CAPABLE, COMPASSIONATE AND INCLUSIVE LEADERS		
QUALITY STATEMENT: *We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Leaders have the experience, capacity, capability and integrity to ensure that the organisational vision can be delivered and risks are well managed		
Leaders at every level are visible and lead by example, modelling inclusive behaviours		
High-quality leadership is sustained through safe, effective and inclusive recruitment and succession planning		
Leaders are knowledgeable about issues and priorities for the quality of services and can access appropriate support and development in their role		
Leaders are alert to any examples of poor culture that may affect the quality of people's care and have a detrimental impact on staff. They address this quickly		
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
PROPOSED 'OUTSTANDING' EVIDENCE		

SUBTOPICS THIS QUALITY STATEMENT COVERS

- Leadership competency, support and development
- Safe recruitment of leaders/FPPR
- Compassionate and capable leaders
- Roles and accountability
- Succession planning/talent management

FREEDOM TO SPEAK UP		
QUALITY STATEMENT: *We foster a positive culture where people feel that they can speak up and that their voice will be heard*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Staff and leaders act with openness, honesty and transparency		
Staff and leaders actively promote staff empowerment to drive improvement. They encourage staff to raise concerns and promote the value of doing so. All staff are confident that their voices will be heard		
There is a culture of speaking up where staff actively raise concerns and those who do (including external whistleblowers) are supported, without fear of detriment. When concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on		
When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again		
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
PROPOSED 'OUTSTANDING' EVIDENCE		

SUBTOPICS THIS QUALITY STATEMENT COVERS

- Speaking up culture
- Freedom to speak up guardian
- Whistleblowing
- Closed cultures

WORKFORCE EQUALITY, DIVERSITY AND INCLUSION		
QUALITY STATEMENT: *We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Leaders take action to continually review and improve the culture of the organisation in the context of equality, diversity and inclusion		
Leaders take action to improve where there are any disparities in the experience of staff with protected equality characteristics, or those from excluded and marginalised groups. Any interventions are monitored to evaluate their impact		
Leaders take steps to remove bias from practices to ensure equality of opportunity and experience for the workforce within their place of work, and throughout their employment. Checking accountability includes ongoing review of policies and procedures to tackle structural and institutional discrimination and bias to achieve a fair culture for all		
Leaders take action to prevent and address bullying and harassment at all levels and for all staff, with a clear focus on those with protected characteristics under the Equality Act and those from excluded and marginalised groups		
Leaders make reasonable adjustments to support disabled staff to carry out their roles well		

Leaders take active steps to ensure staff and leaders are representative of the population of people using the service		
Leaders ensure there are effective and proactive ways to engage with and involve staff, with a focus on hearing the voices of staff with protected equality characteristics and those who are excluded or marginalised, or who may be least heard within their service. Staff feel empowered and are confident that their concerns and ideas result in positive change to shape services and create a more equitable and inclusive organisation		
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
PROPOSED 'OUTSTANDING' EVIDENCE		

SUBTOPICS THIS QUALITY STATEMENT COVERS

- Fair and equitable treatment of staff
- Staff human rights

- Well-being of workforce
- Gender pay gap
- Workforce diversity
- Flexible working arrangements
- WRES and WDES

GOVERNANCE, MANAGEMENT AND SUSTAINABILITY		
QUALITY STATEMENT: *We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
There are clear and effective governance, management and accountability arrangements. Staff understand their role and responsibilities. Managers can account for the actions, behaviours and performance of staff		
The systems to manage current and future performance and risks to the quality of the service take a proportionate approach to managing risk that allows new and innovative ideas to be tested within the service		
Data or notifications are consistently submitted to external organisations as required		
There are robust arrangements for the availability, integrity and confidentiality of data, records and data management systems. Information is used effectively to monitor and improve the quality of care		
Leaders implement relevant or mandatory quality frameworks, recognised standards, best practices or equivalents to improve equity in experience and outcomes for people using services and tackle known inequalities		

KEY ACTIONS REQUIRED TO ADDRESS GAPS
PROPOSED 'OUTSTANDING' EVIDENCE

SUBTOPICS THIS QUALITY STATEMENT COVERS

- Roles, responsibilities and accountability
- Governance, quality assurance and management
- Cyber security and data security and protection toolkit (DSPT)
- Emergency preparedness, including climate events
- Sustainability, including financial and workforce
- Data security/data protection
- Statutory and regulatory requirements
- Workforce planning
- External recommendations, for example safety alerts
- Records/digital records

PARTNERSHIPS AND COMMUNITIES		
QUALITY STATEMENT: *We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Staff and leaders are open and transparent, and they collaborate with all relevant external stakeholders and agencies		
Staff and leaders work in partnership with key organisations to support care provision, service development and joined-up care		
Staff and leaders engage with people, communities and partners to share learning with each other that results in continuous improvements to the service. They use these networks to identify new or innovative ideas that can lead to better outcomes for people		
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
PROPOSED 'OUTSTANDING' EVIDENCE		

SUBTOPICS THIS QUALITY STATEMENT COVERS

- Sharing good practice and learning
- Integration health and social care
- Partnership working and collaboration

LEARNING, IMPROVEMENT AND INNOVATION		
QUALITY STATEMENT: *We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Staff and leaders have a good understanding of how to make improvement happen. The approach is consistent and includes measuring outcomes and impact		
Staff and leaders ensure that people using the service, their families and carers are involved in developing and evaluating improvement and innovation initiatives		
There are processes to ensure that learning happens when things go wrong, and from examples of good practice. Leaders encourage reflection and collective problem-solving		
Staff are supported to prioritise time to develop their skills around improvement and innovation. There is a clear strategy for how to develop these capabilities and staff are consistently encouraged to contribute to improvement initiatives		
Leaders encourage staff to speak up with ideas for improvement and innovation and actively invest time to listen and engage. There is a strong sense of trust between leadership and staff		
The service has strong external relationships that support improvement and innovation.		

Staff and leaders engage with external work, including research, and embed evidence-based practice in the organisation		
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
PROPOSED 'OUTSTANDING' EVIDENCE		

SUBTOPICS THIS QUALITY STATEMENT COVERS

- Innovation
- Learning and improvement
- Research
- Learning from deaths

ENVIRONMENTAL SUSTAINABILITY – SUSTAINABLE DEVELOPMENT		
QUALITY STATEMENT: *We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS**
Staff and leaders understand that climate change is a significant threat to the health of people who use services, their staff, and the wider population		
Staff and leaders empower their staff to understand sustainable healthcare and how to reduce the environmental impact of healthcare activity		
Staff and leaders encourage a shared goal of preventative, high quality, low carbon care which has health benefits for staff and the population the providers serve, for example, how a reduction in air pollution will lead to significant reductions in coronary heart disease, stroke, and lung cancer, among others		
Staff and leaders have Green Plans and take action to ensure the settings in which they provide care are as low carbon as possible, ensure energy efficiency, and use renewable energy sources where possible		
Staff and leaders take active steps towards ensuring the principles of net zero care are embedded in planning and delivery of care. Low carbon care is resource efficient and supports care to be delivered in the right place at the right time		

KEY ACTIONS REQUIRED TO ADDRESS GAPS
PROPOSED 'OUTSTANDING' EVIDENCE

SUBTOPICS THIS QUALITY STATEMENT COVERS

- Staff awareness and education
- Carbon reduction. For example, within travel and transport, medicines, and supply chain
- Health promotion and prevention
- Estates and Facilities. For example, energy saving measures, lower carbon options and waste reduction including recycling
- Efficient service delivery with resource optimisation

NHS
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NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Board discussion areas 2024/25**
SPONSOR (EXECUTIVE DIRECTOR):	**Tim Pile, Trust Chair**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**6 March 2024**

EXECUTIVE SUMMARY:

The attached provides an overview of some of the key areas of Board discussion during the next financial year.

The Board is asked to note that in some cases there is a considerable alignment to elements of the sustainability development programme, drafted in response to the Board development session in late January.

The report also details a number of more operational or routine matters on which the Board will be sighted, that fall outwith the usual cycle of business.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- ACCEPT and SUPPORT the proposed approach and range of Board discussion items

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

Accept	Approve the recommendation	Discuss
x		

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

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

Comments:

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

Aligned closely to the Trust's strategic plan and a number of items on the Board Assurance Framework

PREVIOUS CONSIDERATION:

None

BOARD DISCUSSION PLAN – 2024/25

Report to the Trust Board on 6 March 2024

1.0 BACKGROUND

1.1 As part of considering the focus for the Board each year, a list of suggested items of focus and discussion is gathered together based on contributions from Executive members and thoughts offered by the Non Executives.

1.2 The long list of items has been circulated to Board members for comment, which has generated a view that a number so closely align to the strategic plans within the overall sustainability development programme, that it would be appropriate to consider them as part of these discussions.

1.3 A number of items in the list are seen to be operational or not significant enough to warrant a detailed Board debate and therefore these will be built into the overall cycle of business for the Board.

1.4 Some key items that will be included on the Board agenda for the coming year, for which additional time will be provided for full Board discussion, will be:

Use of technology to enhance productivity, including theatre productivity – this will be considered under the 'Improved Productivity' theme in the sustainability strategic development programme, alongside the Theatre First, service-level pathway configuration and Artificial Intelligence plans

EPR/ Digital, data and technology forward look – as part of the 'Reduce Costs' theme in the sustainability strategic development programme

Strategic partnerships plan, GP liaison/marketing plan and private patient ambition – as part of the 'Transforming our Business Model' theme, alongside low complexity workplan and the ROH product commercial plan

1.5 Other items for which additional Board time will be dedicated for discussion include:

- Estates plan
- Provider Collaborative
- Day case business case
- Clinical plan
- Continuous improvement

These are all allied to one of the six themes within the sustainability strategic programme, however are sufficiently significant to warrant a discrete discussion and the interdependency with the other plans will also be built into the debate.

1.6 Matters that will be included within the routine cycle of business for the Board to consider or on which an update will be provided are:

- Well led update
- CQC preparation plan – included on the agenda of today's meeting
- Race Code gaps analysis/check and challenge
- Charity update & Trustee training
- Staff engagement
- Research & Development
- Divisional lookback for 2023/24
- Health inequalities
- Service accreditation

1.7 The timing for the items, where known, will be built into a Board plan that will be received at the April 2024 meeting.

2.0 RECOMMENDATION

2.1 The Trust Board is asked to:

RECEIVE and COMMENT on the proposed plan and approach.

Simon Grainger-Lloyd
Director of Governance

29 February 2024

NHS
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NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Nominations & Remuneration Committee terms of reference**
SPONSOR (EXECUTIVE DIRECTOR):	**Simone Jordan, Chair of the Nominations & Remuneration Committee**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**6 March 2024**

EXECUTIVE SUMMARY:

In line with the requirement to review the Committee's terms of reference on an annual basis, the attached are the latest version.

No changes are proposed as part of the annual review aside from the removal of references to NHS Improvement and minor clarifications under the committee procedures.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- APPROVE the amendments to the terms of reference

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

Accept	Approve the recommendation	Discuss
	x	

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

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

Comments:

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

Delivered by highly motivated, skilled and inspiring colleagues

PREVIOUS CONSIDERATION:

February 2024 – Nominations & Remuneration Committee

NOMINATIONS AND REMUNERATION COMMITTEE
CHIEF EXECUTIVE & EXECUTIVE DIRECTORS

Terms of Reference

1. Purpose

The Nomination and Remuneration Committee (Executive Directors) is constituted as a standing Committee of the Trust Board.

The Committee is authorised by the Trust Board to act within its terms of reference, as set out below, subject to amendments at future meetings of the Trust Board.

The Committee is authorised by the Trust Board to obtain such internal information as it considers necessary for or expedient to the exercise and fulfilment of its functions. All members of staff of the Trust are directed to cooperate with any request made by the Committee.

The Committee is authorised by the Trust Board to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to exercise its functions.

2. Duties/Responsibilities

2.1 Nominations

- To regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Trust Board and make recommendations to the Board with regard to any changes. To receive results of annual audit of Board skills, knowledge and experience and advise accordingly
- To give consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed in future.
- Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.
- Be responsible for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.
- Before an appointment is made, to evaluate the balance of skills, knowledge and experience on the Trust Board and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates the Committee shall use open advertising or the services of external advisors to facilitate the search; consider candidates from a wide range of backgrounds; consider candidates on merit against objective criteria.

- To consider any matter relating to the continuation in office of the Chief Executive and any Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust.
- To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of the Committee's responsibilities.
- Receive the annual declaration of the Chief Executive in respect of the Trust's compliance with the Fit and Proper Persons regulation and receive evidence-based assurance that all newly appointed Executive Directors, including the Chief Executive are deemed Fit and Proper
- Approve any remedial action plan to address non-compliance with the Fit and Proper Persons Regulation

2.2 Remuneration

- To decide upon and review the terms and conditions of office of the Trust's Chief Executive and Executive Directors in accordance with all relevant Trust policies, including:
  - salary
  - provision for other benefits
  - allowances

- To adhere to all relevant laws, regulations and Trust policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate the Chief Executive and Executive Directors whilst remaining cost effective.
- To advise upon and oversee contractual arrangements for the Chief Executive and Executive Directors, including but not limited to termination payments.
- To determine arrangements for annual salary review for all staff on Trust contracts.

2.3 Performance, development and succession planning

To monitor and evaluate the performance of the Chief Executive and Executive Directors
To receive and approve the annual objectives for the above
To receive and consider the outcome of annual appraisals for the above
To receive and consider annually the Talent Management and Succession Plans for the above, along with that for other identified business critical senior leader posts

3. Accountable to

The Committee is accountable to the Trust Board

4. Reports to and Method (including minutes circulation)

The minutes of all meetings of the Committee shall be formally recorded and shall be retained by the Director of Governance on behalf of the Chair, and shall not be shared with the Executive Directors or Chief Executive in relation to matters pertaining to that postholder.

The Director of Governance, on behalf of the Chair, shall ensure that the work of the Committee is accurately reported in the Annual Report and Accounts in accordance with any direction from NHS ~~Improvement~~England.

5. Membership

Chairing

Members
All Non Executive Directors shall be members.
Chief Executive (to be excluded during matters pertaining to that postholder)

Regular attendees

- Chief People Officer

Serviced by
Director of Governance

6. Quorum

A quorum shall be three members, all of which shall be Non Executives.

7. Meeting Frequency and Procedures (minimum if applicable)

Meetings shall be held as and when required, but at least twice per year.
Papers will be issued five working days in advance of each meeting
Meetings can be held virtually if necessary and members can attend virtually if necessary
Agreed workplan and order of business
Declaration of interests
Exclusions of members if they have an interest

8. Process for Reviewing Effectiveness

The effectiveness of the Committee will be monitored on an annual basis via the following:

- Annual review of the Terms of Reference by the Trust Board

- Report of Committee's work and attendance register in Annual Report and Accounts in accordance with direction.

9. Reporting Structure (list of Groups/Committees which report to this Committee)

None.

10. Review Terms of Reference

Undertaken at least annually or as required.

11. Date of adoption

February 2024

12. Date of Review

February 2025

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 27 February 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• For the previous month, activity was reported to have been below plan, this being associated with industrial action and environmental issues in theatres. The position was likely to be recovered by performance in the current month however. • There had been a reduction in theatre utilisation, associated with the issues described above. There had also been a higher number of 'on the day' cancellations for the same reasons. • There continue to be delays in the receipt of histology results, a matter which had been escalated further. • In Month 10, a £801k deficit had been delivered, creating a year to date deficit of c. £5m, and it will not be possible to achieve breakeven by year end. • There had been pressure in terms of non-pay spend particularly in theatres. Work was underway to address this through various means, including reducing loan stock. There was also a focus on ensuing that consumables were routinely scanned so that there was accurate information on cost per procedure and an understanding of variations. • For the end of year position, there was noted to be a risk around potential mismatch between NHSE income and activity delivered. There were some high value, complex procedures undertaken where tariff did not fully reimburse the cost of delivery. • An update on the latest planning for 2024/25 was presented which indicated a risk across Birmingham Solihull given that all Providers and the ICB were forecasting a deficit plan. There were specific risks to the ROH plan around the lack of clarity as to the impact of the Elective Recovery Fund (ERF), uncertainty over contract values, the efficiency target that would be set and above inflationary costs that may materialise.	• Work is underway to develop a list of longest waiting times broken down by speciality. • A 'standby' patient list had been developed for patients from University Hospitals Birmingham NHSFT (UHB) and a ROH contingency list was being developed.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• It was reported that there were no patients waiting in excess of 78 or 104 weeks. The number of patients waiting in excess of 65 weeks was also improving and it was expected that this would achieve the national target of 0 waiting by the end of March. • Performance for Patient Initiated Follow Up (PIFU) was noted to be better than that of peers. • The level of virtual consultations was reported to have increased. • All cancer and diagnostics targets were reported to have been met for the month. • Length of stay continues to improve further towards the 2.7 day ambition. • Private patient income was noted to be higher than planned. • CIP performance remains above plan. • The use of Limited Liability Partnership (LLP) sessions was noted to have impacted positively on the 52 week position in various specialities. • Pay costs were noted to have reduced and agency spend continues to decline. • The Committee received a detailed plan for Private Patient work for the next three years which was ambitious around significantly improving income, improving the patient experience and drawing on innovation.	• The Committee approved its annual workplan, subject to minor amendment.

Chair's comments on the effectiveness of the meeting: The Committee ran with a tight agenda but covered some complex and important items. The Committee welcomed Simon Page, new Non Executive Director, to his first meeting. Thanks were given to Simone Jordan who had attended previously for her contributions and support.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM CHARITABLE FUNDS COMMITTEE

Date Group or Board met: 14 December 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Disappointing net return of just 0.53% recorded on the Cazenove asset statement as at 1 June 2023 was discussed. SW is carrying out a piece of work to consider the Trust's risk appetite relating to the investment of the funds and reporting back to members of the committee on this and other potential options at the next meeting in April 2024.	• The slight restructure of the Charity Team due to Ali being on maternity leave was shared and Ruth's new appointment as Funding Raising Manager and Charlotte's new role as Community Fundraiser was highlighted, along with Elaine Bunn's return from maternity leave. • With regard to recruitment, the Band 6 Grants, Trusts, and Major Donor Officer position is closed and interviews took place on 12 December 2023. £30,000 had been awarded from NHSCT to support this post following a successful development grant application submitted by the Charity. • Charity Football Match & Family Fun Day on Saturday 15 July 2024 was a remarkable success raising over £2,335.33 with more donations expected. • The Digital Patient Information System (DPIS) was installed in June 2023 and work was taking place with IT and the Communications Team to ensure feedback is received from patients on the impact of this system. The Charity Team will be regularly attending the Trust's feedback sessions including Coffee Catch up sessions to collate live feedback from patients. A full review of the expenditure will be reported at the next committee. The Communications Team will be releasing an article in the New Year to promote this. • The Christmas Appeal was a great success raising just under £8,500.00.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• Members agreed with the content contained within the Mental Health Training Report. • The funding in respect of the Development and Optimism of Multi-Functional Bioactive Materials for Bone Cancer Therapy was noted to have been invaluable along with the impact this has had on patients. The funding has also allowed the team to improve and move on with their investigations. • A summarised update on the Dubrowsky Laboratory Report was received and excellent progress was noted, including the lab now being in operation, expansion of the capacity, the use of equipment is being explored, three new people are starting full time in the lab, including a new Research Assistant and a placement student from Aston, all of whom are progressing extremely well. This has all been funded from the Dubrowsky legacy which includes the funding of salaries. Bids are being received through R&D and there was much to celebrate with the work continuing in the lab and keen support from Aston University was noted. Clinical Trials are also taking place in the Trust along with other many projects that are happening, including bioactive glasses for use with bone cancer.	• Members of the Committee agreed to an additional £10,000 for the Hardship fund, with delegated authority to AA if another £10,000 was needed before the next Charitable Funds Committee. • Members of the Committee approved the Charitable Fund Annual Report as a charity going concern and delegated authority to tidy up the final small amendments outside of the Committee. • The following three bids were approved by the Committee: #250 Charity Audit Fee 2021-22 #255 Charity Audit Fee 2022-23: #235 National Celebration Days • Members agreed to a New Fund Opening Request for Oncology.

Chair's comments on the effectiveness of the meeting: The meeting was both effective and productive and the enthusiasm of the Chair was noted.

Finance and Performance Report

Month 10

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.

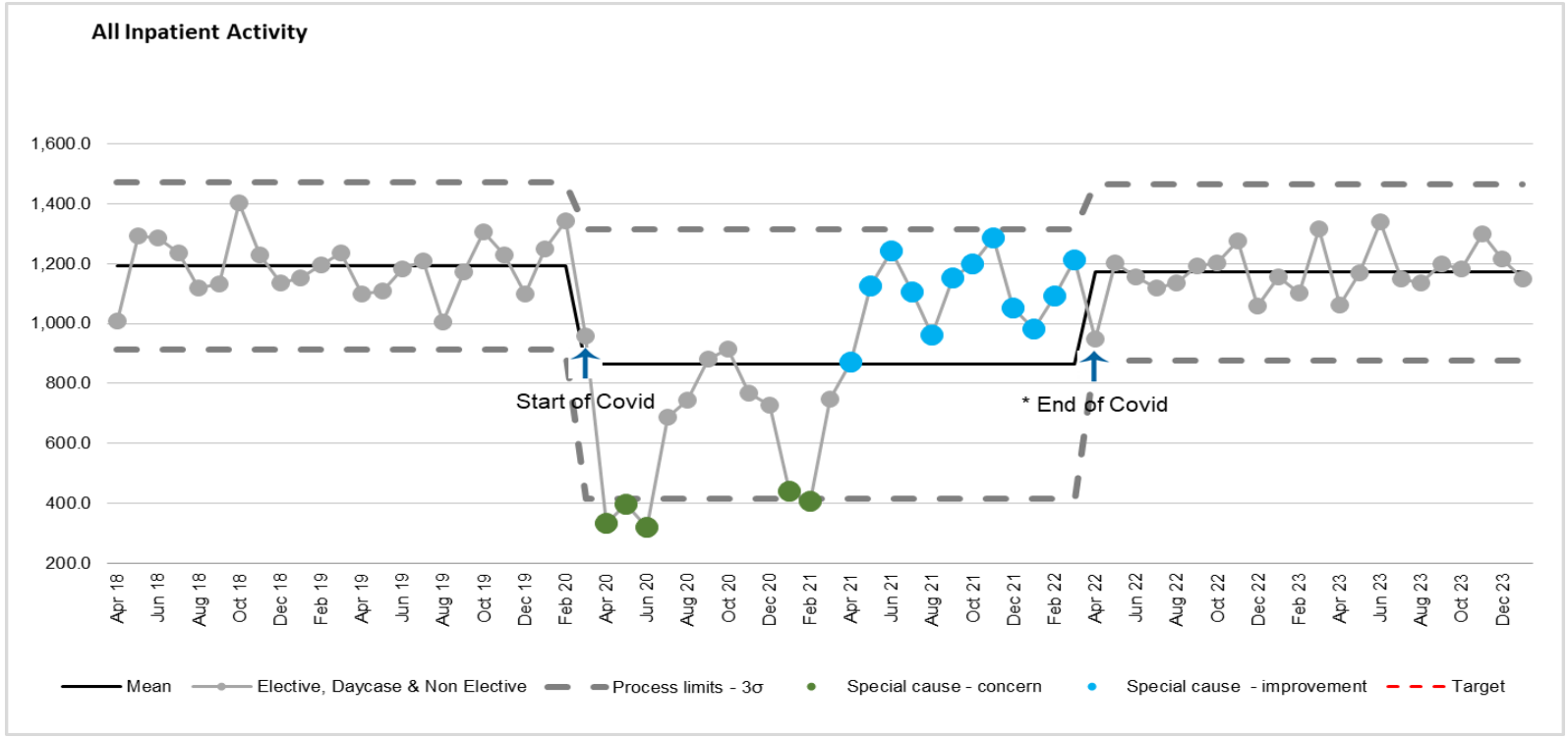
Operational Performance Summary

Performance to end January 24	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	50.65%	50.60%	92%		F
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	83	87	0	L	F
52 week waits (52 – 64 Weeks)	428	474	0	H	F
All activity YTD (compared to plan)	11,901	10,750	11,866		P
Outpatient activity YTD (compared to plan)	55,232 100.7% Cumulative	49,349 100.3% Cumulative	54,837 YTD Target		P
Outpatient Did Not Attend (YTD)	7.6%	7.8%	8%		P
PIFU (trajectory to 5% target)	490 8.6%	392 9.1%	193 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	10.5%	8.4%	19%		F
FUP attendances(compared to 19/20)	90.5%	90.6%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	109.5%	110.1%	120%		F
Diagnostics volume YTD (compared to plan)	20,660 Cumulative	18,571 Cumulative	15,690 YTD Target		P
Diagnostics 6 week target	99.3%	99.7%	99%		P

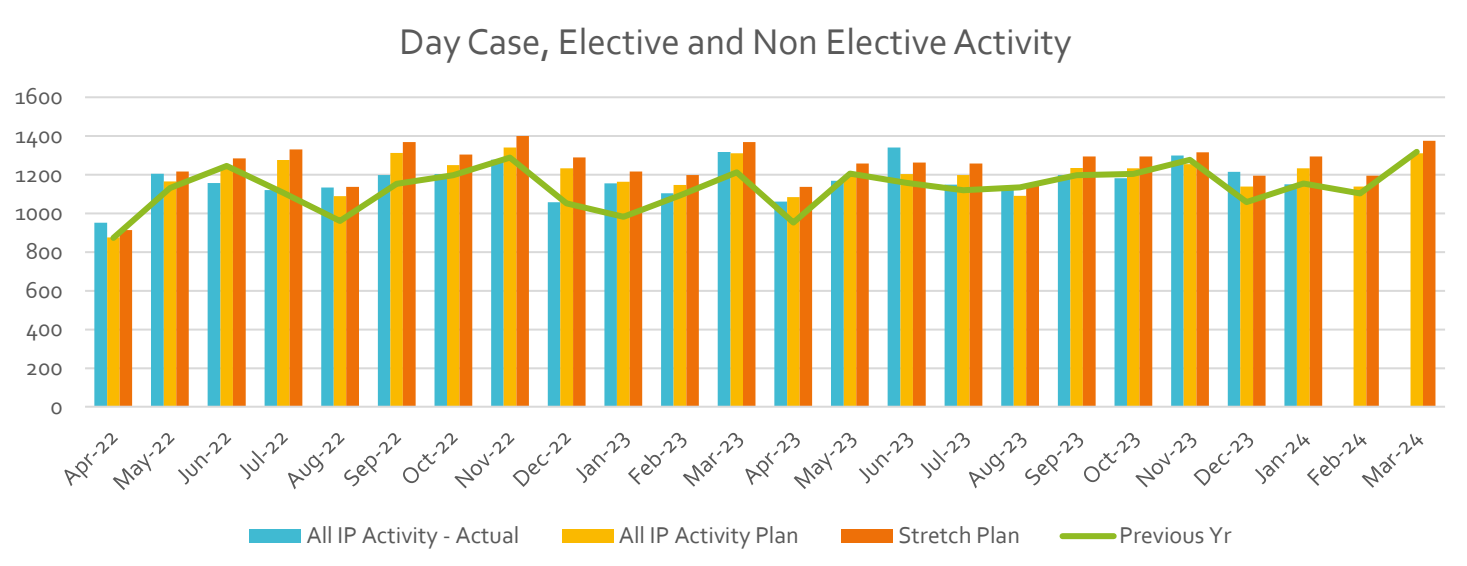
Operational Performance Summary

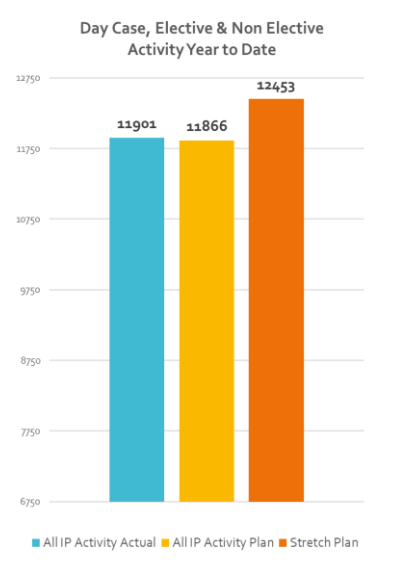
Performance to end January 24	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (Uncapped)	82.0%	83.07%	85%		F
Cancer - 31 day first treatment	100%	100%	96%		P
Cancer - 62 day (traditional)	85.7%	85.7%	85%		P
28 day Faster Diagnosis Standard (FDS)	75.3%	100%	75%		P
Patients over 104 days (62 day standard)	1	0	0		No Target
POAC activity volume (YTD)	21,511 Cumulative	19,031 Cumulative	19,326 Cumulative		P
LOS - excluding Oncology, Paeds,YAH, Spinal	3.16	3.56	n/a		No Target
LOS - elective primary hip	2.90	2.80	2.7		F
LOS - elective primary knee	2.80	2.80	2.7		F
BADS Daycase rate (Note: due to time lag in month is Oct'23)	77.0%	77.0%	85%		F

1. Activity Summary



1. Activity Summary

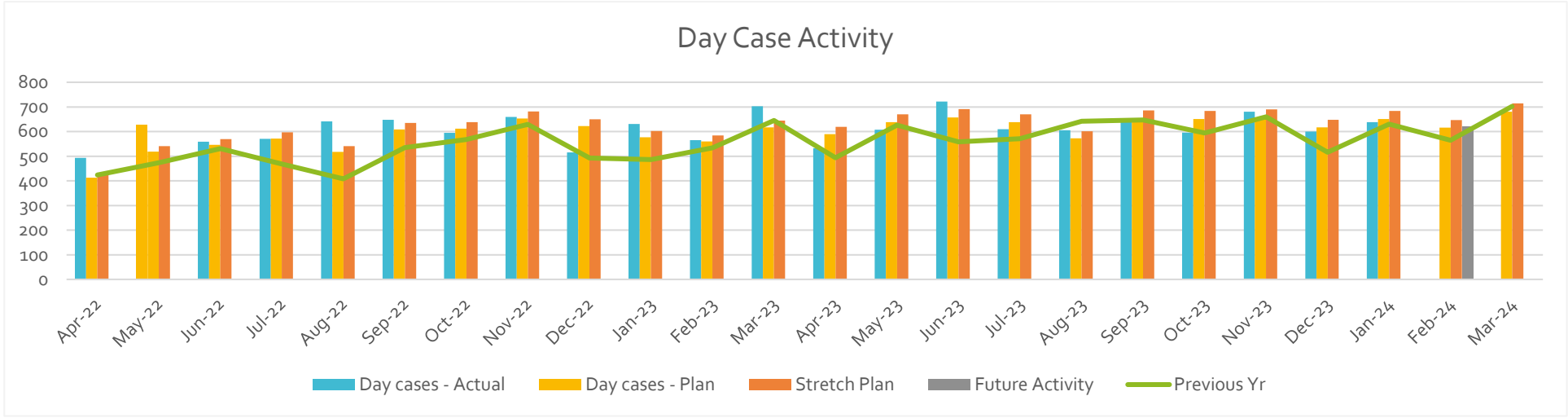


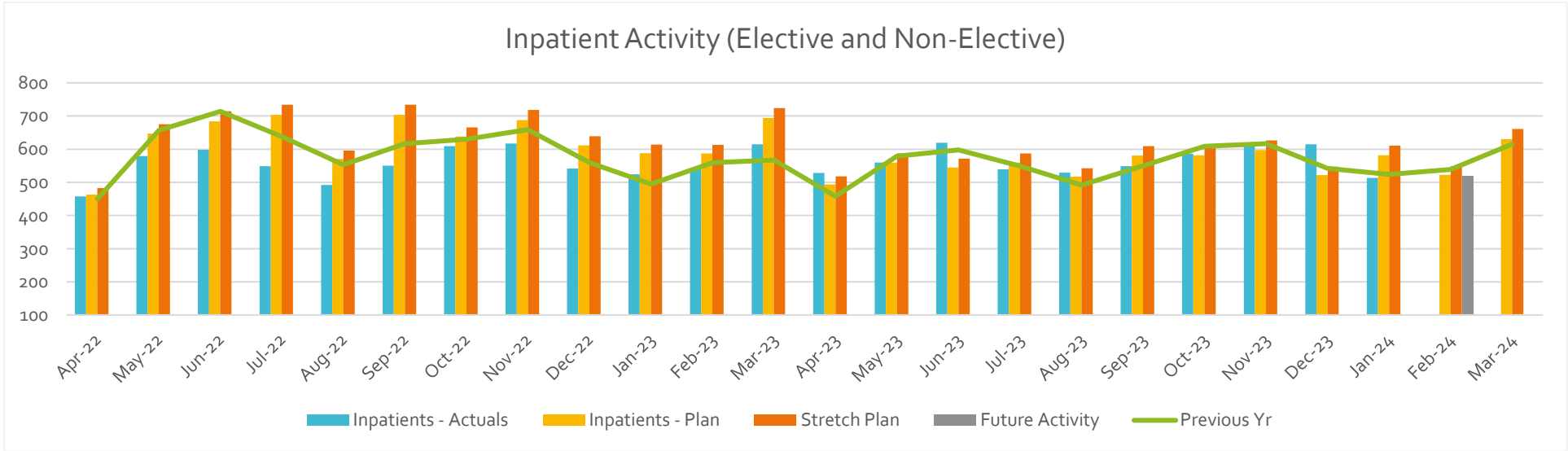


		Plan												Plan	Actual	% Achieved	Variance
	Activity Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Year to Date	Year to Date	against plan	Year to Date
Trust Plan	Inpatient	483	547	533	547	505	568	569	584	510	569	511	616	5415	5421	100%	6
	Daycase	590	638	658	638	573	653	651	657	617	651	616	681	6326	6244	99%	-82
	NEL	11	13	12	13	12	13	13	13	12	13	12	14	125	236	189%	111
	All Activity	**1084**	**1198**	**1203**	**1198**	**1090**	**1234**	**1233**	**1254**	**1139**	**1233**	**1139**	**1311**	**11866**	**11901**	**100.3%**	**35**
Stretch Plan	Inpatient	507	574	560	574	530	596	597	613	536	597	537	647	5686	5421	95%	-265
	Daycase	620	670	691	670	602	686	684	690	648	684	647	715	6642	6244	94%	-398
	NEL	11	13	12	13	12	13	13	13	12	13	12	14	125	236	189%	111
	All Activity	**1138**	**1257**	**1263**	**1257**	**1144**	**1295**	**1294**	**1316**	**1195**	**1294**	**1195**	**1376**	**12453**	**11901**	**96%**	**-552**

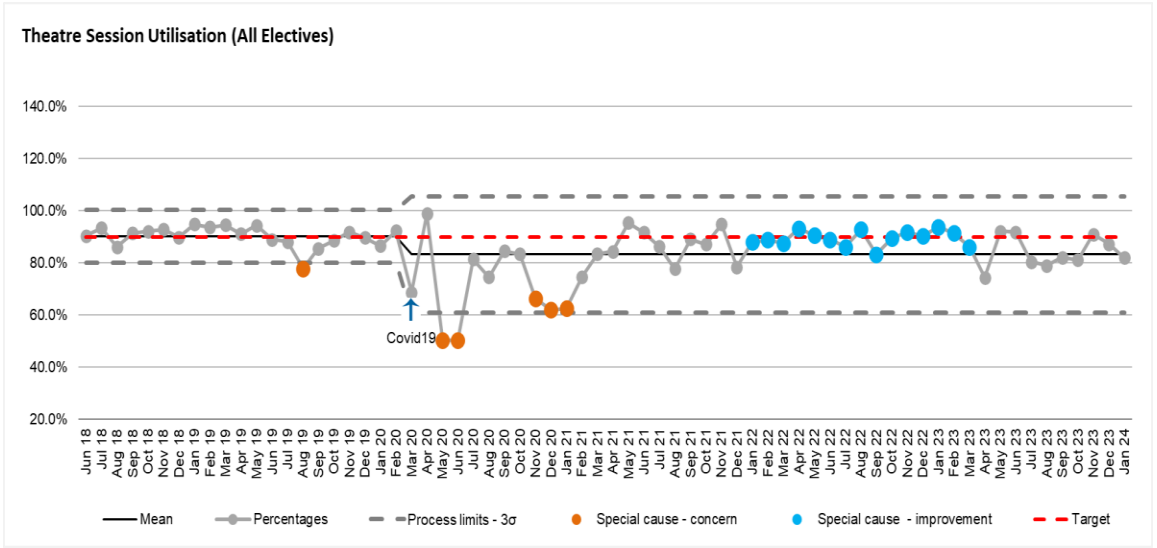
January 2024
Actual Monthly 1151 vs 1233 System Monthly Plan (Variance - 82)
YTD position against Actual vs System plan is 100.3% (Variance +35)

1. Activity Summary

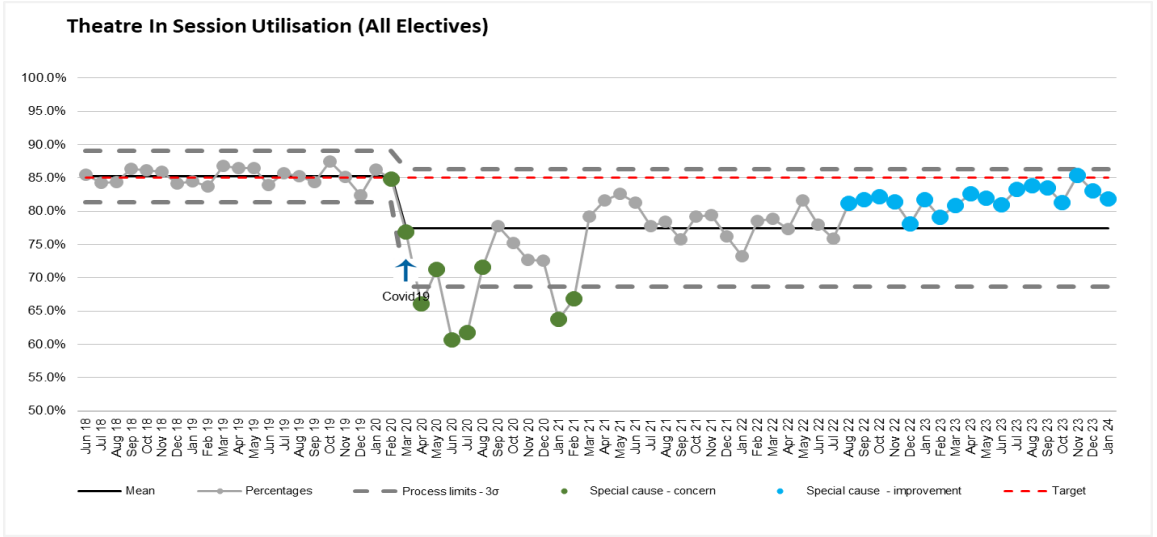




2. Theatre Utilisation



Elective Session Utilisation (January 2024)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	484	401	83	82.85%
UHB	77	59	18	76.62%
Totals	**561**	**460**	**101**	**82.00%**



Elective In Session Utilisation (January 2024)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1766	1448	317	82.03%
UHB	260	210	50	80.85%
Totals	**2026**	**1659**	**367**	**81.88%**

2. Theatre Utilisation

SUMMARY

Overall theatre session utilisation for January was **82.00%** which was below the Trust target of **85%.**

There were 7 days of industrial action during January, if this had not taken place then utilisation would have been 85.66%

The overall in-session utilisation for January 24 was 81.88%.

Environmental issues impacted the use of 2 to 4 theatres week commencing 22.01.24 that had a further impact on utilisation.

AREAS FOR IMPROVEMENT

Ongoing close monitoring of UHB theatre utilisation continues with Acting COO oversight. An action plan has been developed and discussed with senior UHB colleagues and shared at SOG.

Additional POAC clinics have been created at the weekends to support with the increasing demand for POAC capacity, some of which is ring fenced for UHB patients as well as in week clinic slots.

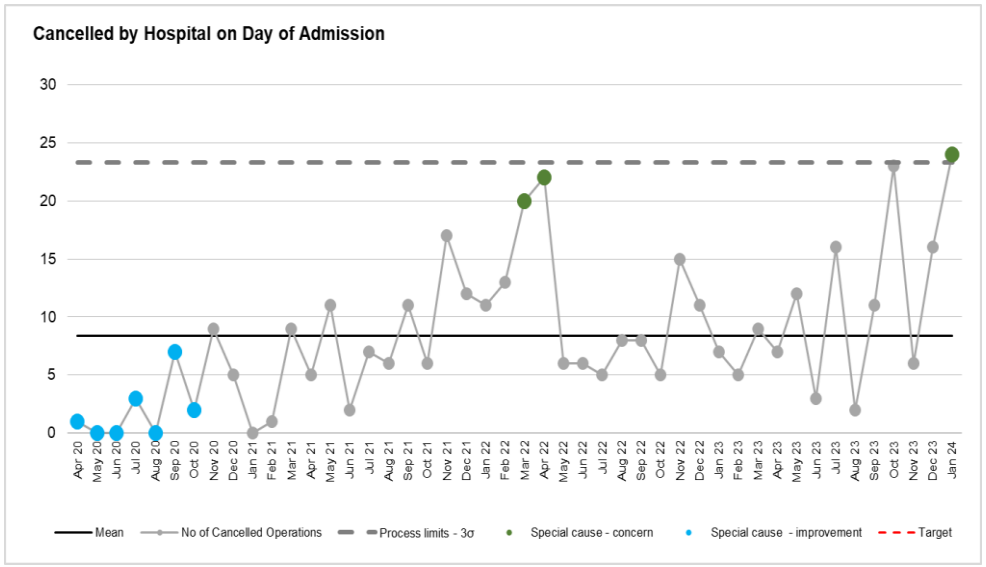
Activity is monitored daily by the Div 1 Associate Director of Operations to maximise existing capacity with the team continuing to have a theatres 1st focus.

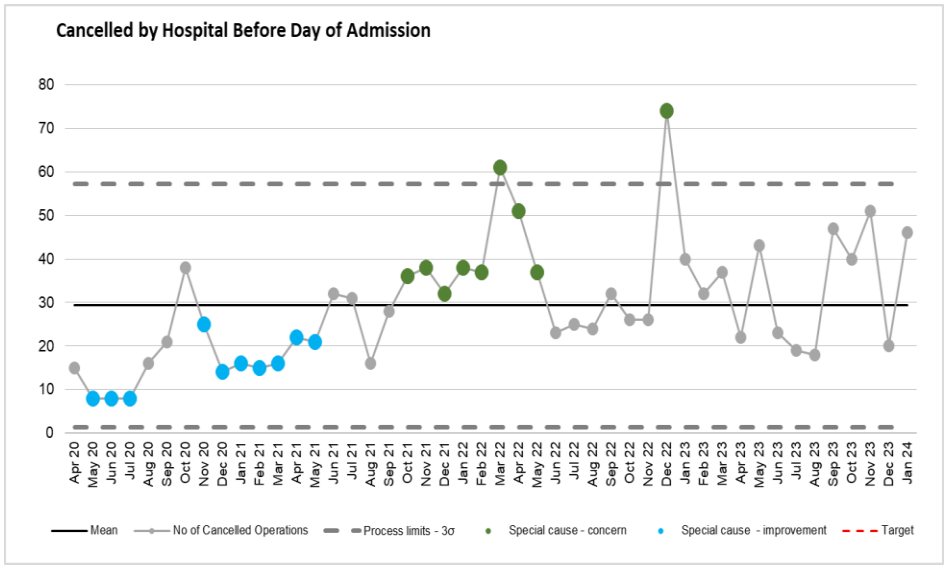
RISKS / ISSUES

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.

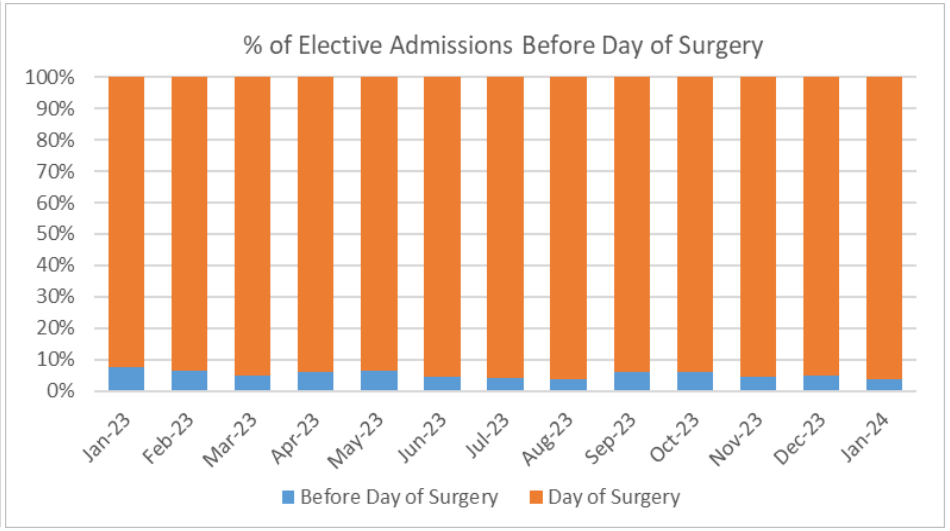
UHB theatre utilisation is now being monitored at the weekly SOG and some lists were impacted due to environmental issues experienced in theatres.
With senior input from both organisations the session utilisation is beginning to improve and the team are getting closer to the allocated activity target in February 24.

2. Theatre Utilisation/ Hospital Led Cancellations





Year - Month	Cancelled by Hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by Hosp. Before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
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
Jan-24	24	27	46	97	0
Total	**143**	**322**	**440**	**905**	**0**



2. Theatre Utilisation/ Hospital Led Cancellations

SUMMARY

The number of cancellations / deferrals detailed on the previous slide do not include patients who were either emergency or urgent cases.
These cases are more difficult to avoid due to very short notice bookings. The table below provides details of the cancellations for January 24:

Patients cancelled on the day x 24	Patients admitted and had treatment deferred x 27	Patients cancelled by the hospital the day before the date of admission x 46
2 x Medically unfit /change in clinical condition / further tests required 6 x Clinician unavailable/unwell ** 5 x Environmental issues within theatres 1 x Replaced by more urgent case 1 x Interpreter unavailable – booked over phone instead of face to face 5 x change in TCI date – e.g. deferred to next day 2 x Equipment unavailable – needed to support an urgent case 1 x patient declined on the day 1 x Lack of theatre time	18 x Medically unfit / Covid/Flu related/change in clinical condition / not stopped meds 1 x Clinician unavailable/unwell ** 5 x Procedure abandoned/ Change in plan pt no longer wanted the procedure 1 x Equipment unavailable – kit booked out and in use in another theatre 1 x Lack of theatre time – due to complex cases	14 x Medically unfit / Covid/Flu related/change in clinical condition / not stopped meds 12 x Change in TCI date 9 x Clinician unavailable/unwell - Emergency Leave 6 x Environmental issues within theatres 3 x Industrial action 1 x Replaced by more urgent case 1 x Lack of specific equipment

Please note that the numbers quoted against environmental issues were higher than referenced, however, patient selection to cancellation was influenced by another factor, such as, a surgeon requiring emergency leave during this time.

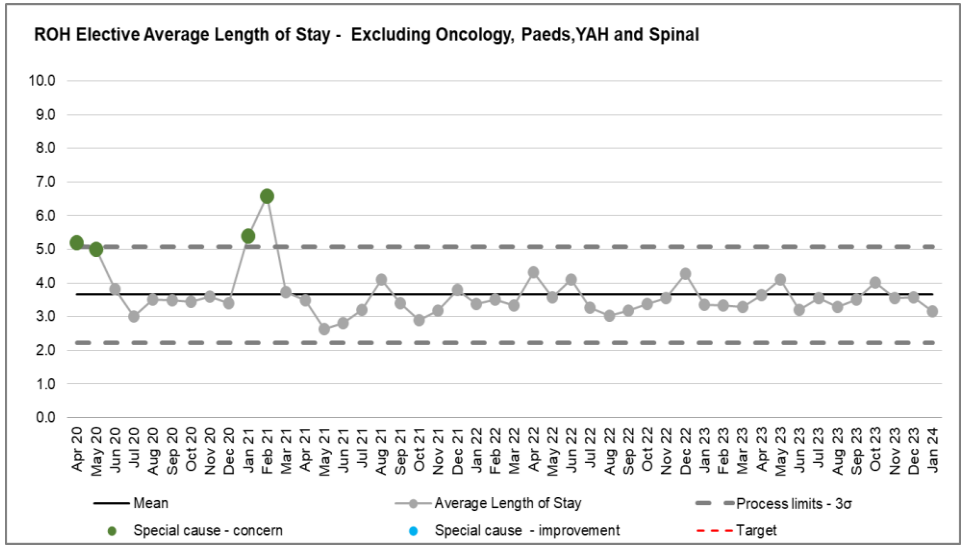
AREAS FOR IMPROVEMENT/ RISKS/ISSUES

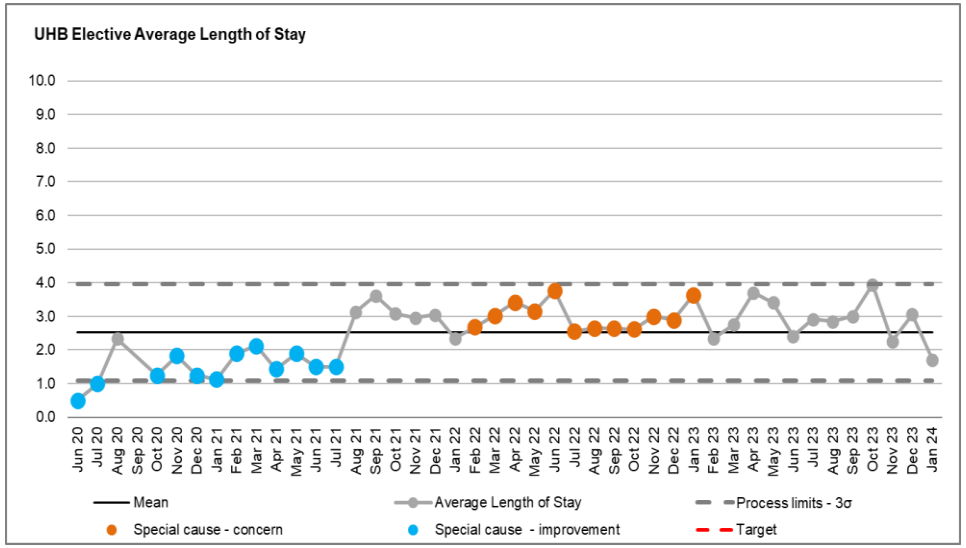
Increasing number of patients being assessed as medically unfit and the risk of this increasing further due to covid and usual winter medical conditions.
Daily monitoring of cancellations for non-clinical reasons that must be approved by Deputy COO, COO or Exec on call.

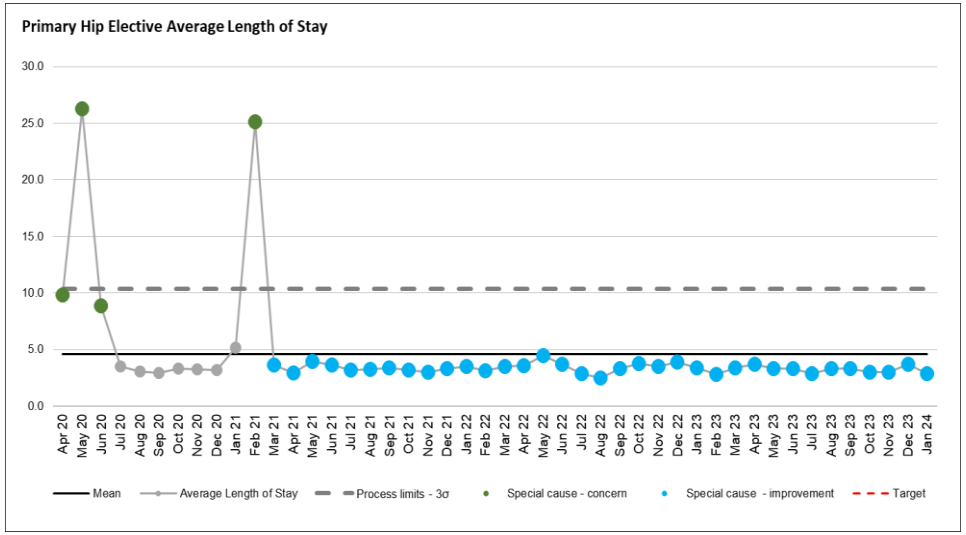
Non-clinical cancellations increased due to environmental issues with likely root cause found. February performance to date will offset the capacity lost in January 24.
Theatre lookback meeting continues to review short notice cancellations with a view to identify opportunities to improve.

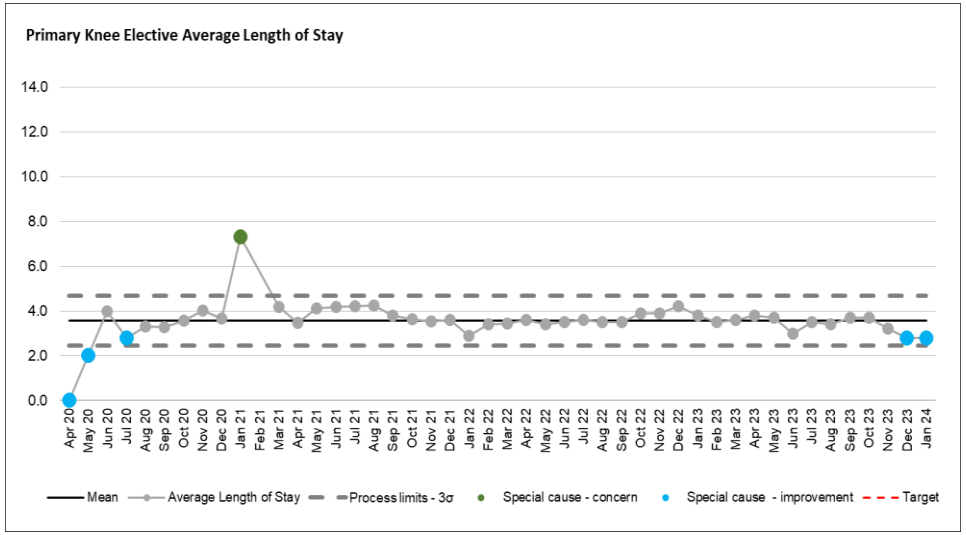
Seamless Surgery week is being scheduled for April 24

3. Length of Stay









3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips increased slightly to 2.9 days (2.8 days December 23) and primary Knees has remained at 2.8 days (2.8 days December 23).

The average length of stay for ROH patients excluding Oncology, Young Adult Hip and spinal has reduced to **3.16 days** (3.56 December).

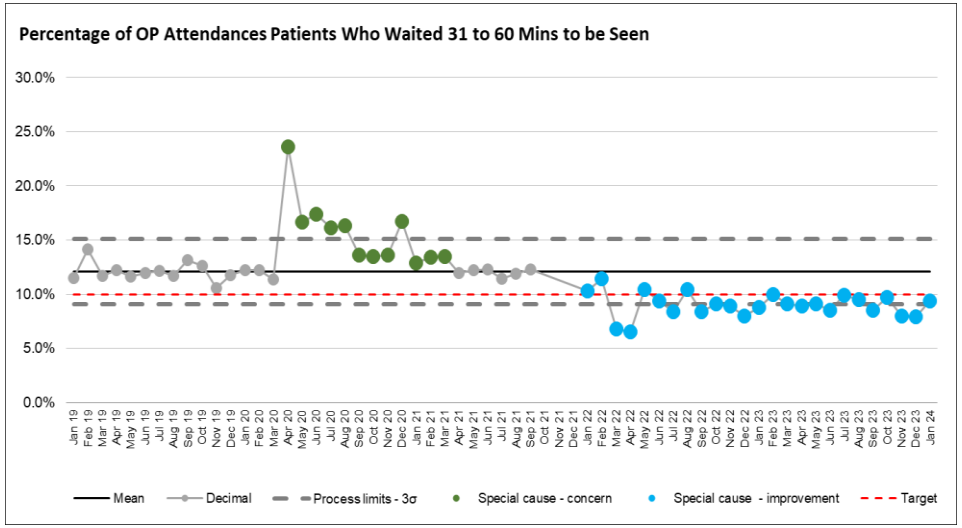
A review of the ROH primary arthroplasty and oncology arthroplasty patients, identifies a further reduction in the number of patients with LOS >/= to 8 days. 11 patients stayed >/= to 8 days compared to 2 in December 23. 1 was Oncology arthroplasty, other 10 were arthroplasty.

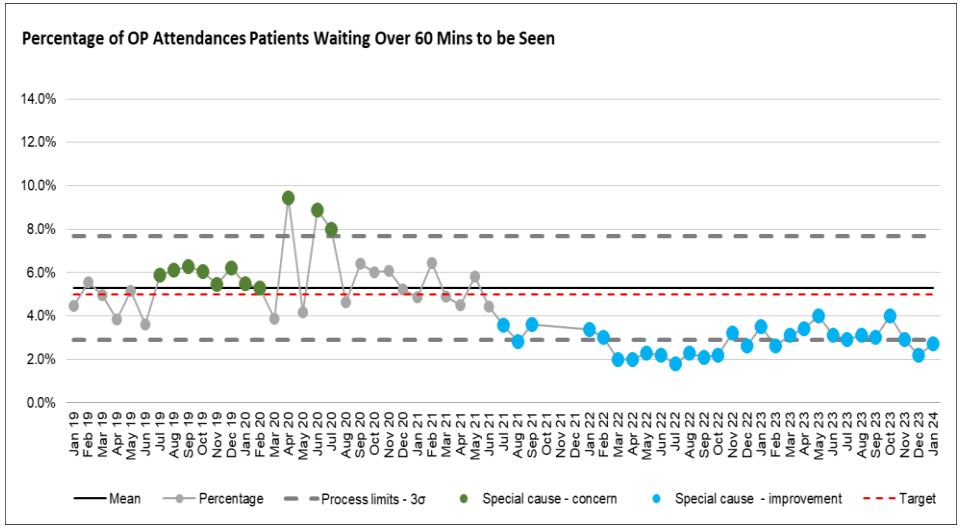
Review of records identifies that there was no theme with regards to surgeon. All had extended length of stay due to not being medically fit or Therapy safe for discharge. 1 was under the care of the Bone Infection Service, 3 required discharge with either Package of Care or to a Rehab facility.

AREAS FOR IMPROVEMENT / ACTION PLAN

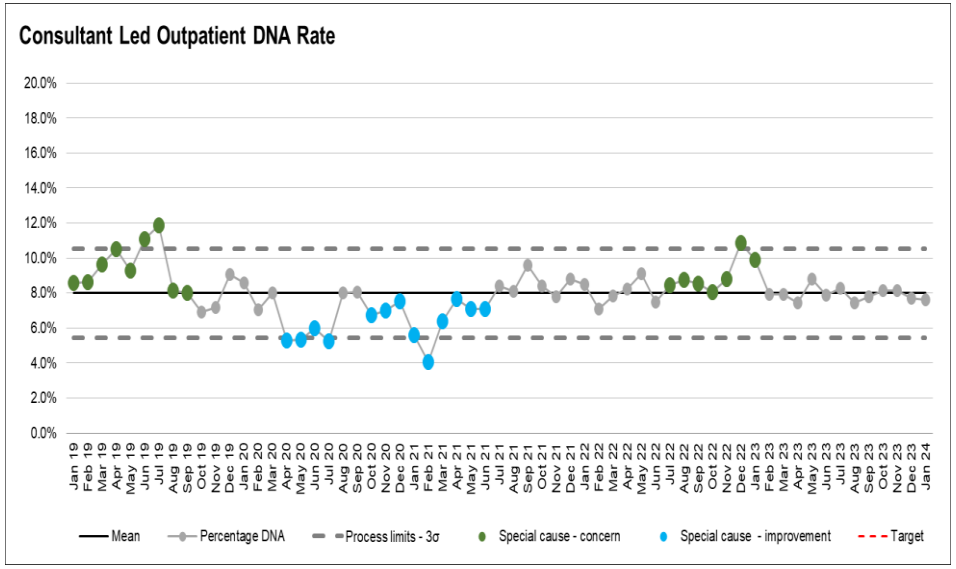
- Review and develop documented process/pathway for default to day case primary hip/knee procedure and how information is captured.
- MDT discussion involving medical, nursing and therapy colleagues to identify barriers to day case procedures and reducing length of stay for primary hips and knees.
- 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.

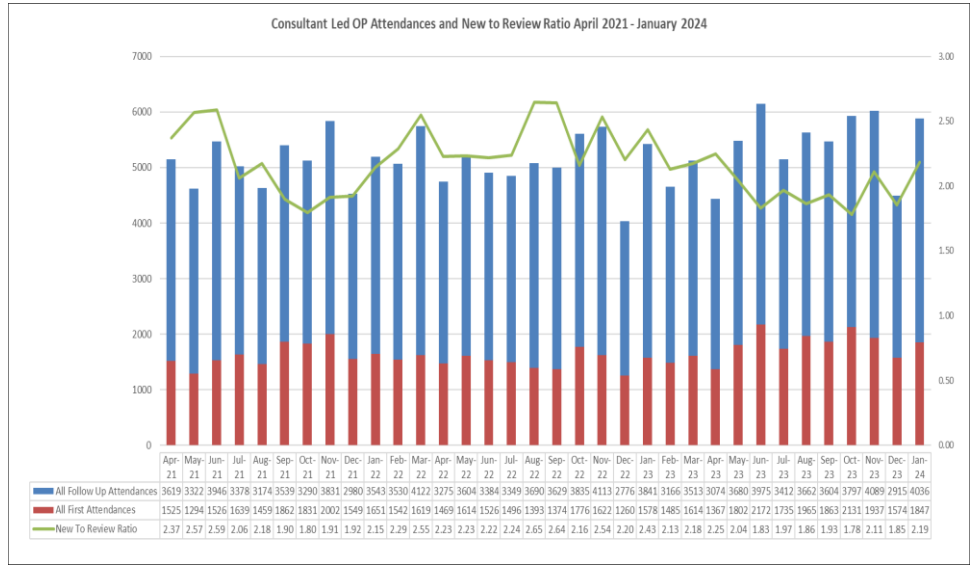
4. Outpatient efficiency



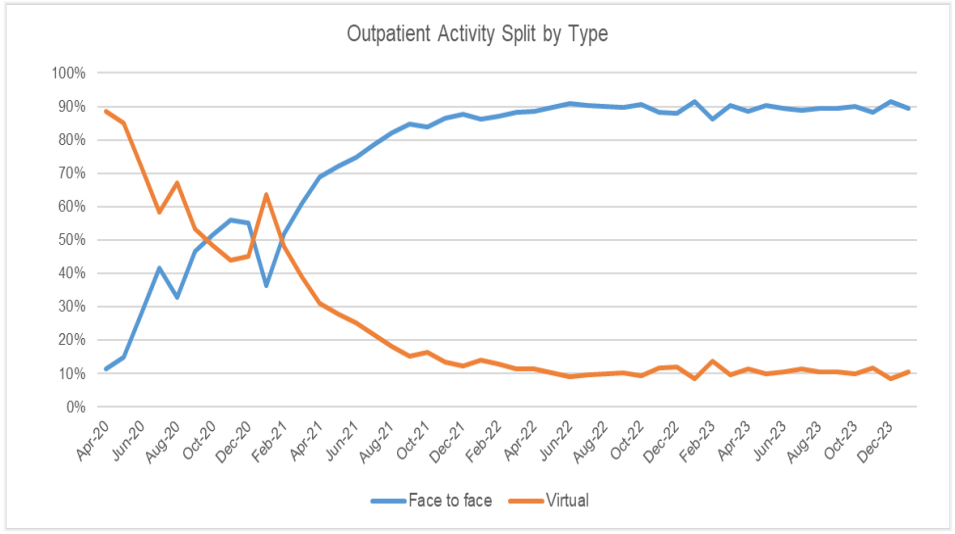


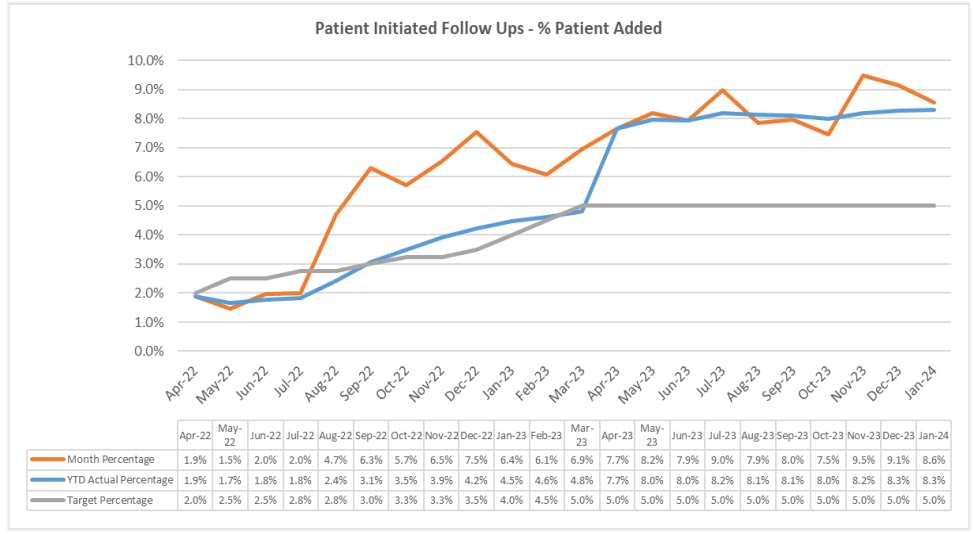
4. Outpatient efficiency





	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	Jan-24
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	4036
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	1847
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	2.19





	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
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%	8.6%
YTD Actual Percentage	1.9%	1.7%	1.8%	1.8%	2.4%	3.1%	3.5%	3.9%	4.2%	4.5%	4.6%	4.8%	7.7%	8.0%	8.0%	8.2%	8.1%	8.1%	8.0%	8.2%	8.3%	8.3%
Target Percentage	2.0%	2.5%	2.5%	2.8%	2.8%	3.0%	3.3%	3.3%	3.5%	4.0%	4.5%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

4. Outpatient efficiency

SUMMARY

January 2024 performance is as follows:

Overall Outpatient activity was 0% variance against the Trust trajectory with January delivering 5,897 (New and Review) episodes. However, our delivery of outpatient episodes was +1,359 against December activity -995 against the System trajectory for December 20

- 5,267 face to face and 616 virtual appointments
- 10.47% virtual in total.
- 8.6% of outpatient attendances moved to the PIFU waiting list. The overall YTD position is **8.3**%.
- 7.63% DNA rate – lower than Trust target of 8% DNA rate

- **Clinic Waiting Times**
- 30-minute delays **– within trust target at 9.4% (Target 10%)**
- 60-minute delays – **within trust target at 2.7% (Target 5%)**

AREAS OF IMPROVEMENT

Missed Appointments (Previously recorded as DNAs)
The Outpatients CSM is now chairing a DNA Group. The first meeting was held on 31.1.24 to focus on the outcomes from the audit and improve communication with our patients. Work within the group includes Text messaging in different languages and video instructions to patients on how to use the Dr Doctor app.Further information is included in the outpatient transformation section.

Appointments
Outpatient and Appointment KPIs are monitored with weekly oversight to the Acting Chief Operating Officer.
The KPI's offer assurance that the booking process, referral pathways and the ongoing training currently being undertaken by the appointments team is being monitored. This allows additional focus on areas that require improvement.

Outpatient Review Waiting List
Patients have received a Dr Doctor communication via text messaging to validate that patients still require their review consultation. This will help reduce the DNA rate by having 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

- PIFU relaunch is underway with progress as follows:
- Second PIFU working group held January 2024.
- Communication strategy confirmed for March/April 2024 for patients and staff.
- Use of NHS Futures and GIRFT in place.
- Dr Doctor PIFU module being scoped.

Reduction in Missed Appointments (MA)

- MA audit has been completed with 200 patients contacted to get feedback.
- First MA working group held January 2024.
- Work has commenced for TIARA to go live for Dr Doctor messages.
- Patient portal and options for direct messaging to be confirmed.
- Successful bid for funding to support DrDoctor including MA package and DrDoctor.

Reduction in Follow Ups

- The MSK team are working on online interactive forms to assist with patient management.
- Conversation planned with Oncology in March to discuss outpatient transformation.
- Validation of OPFU being planned via Quick Question.

Clinical Pathways (e.g. Specialist Advice)

- Clinical Pathways landing page in ICB is in development. First scoping meeting held with Young Adult Hips in January 2024 as pilot site.
- Advice & refer is under review in parallel with referral mapping exercise with Appointments.
- System Wide Access Policy under review.

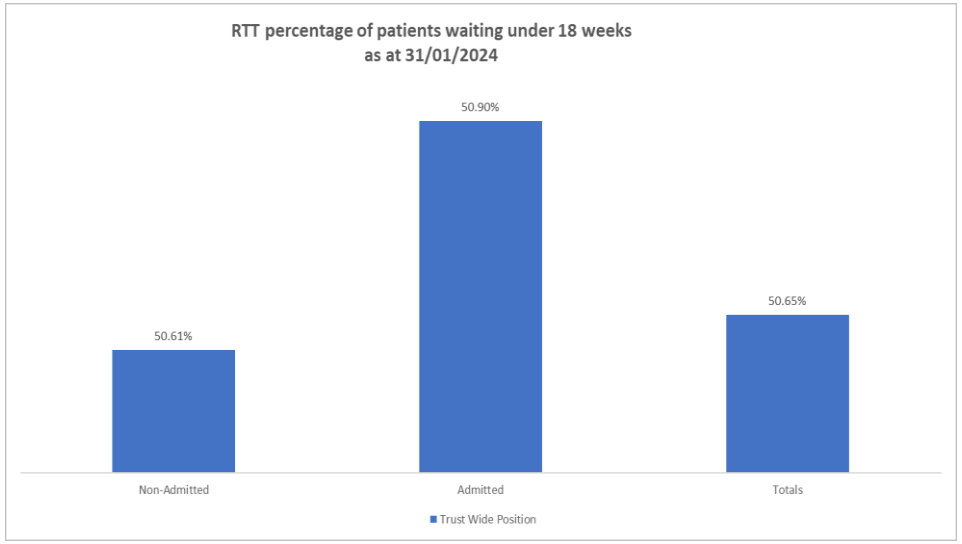
Productivity & Efficiency

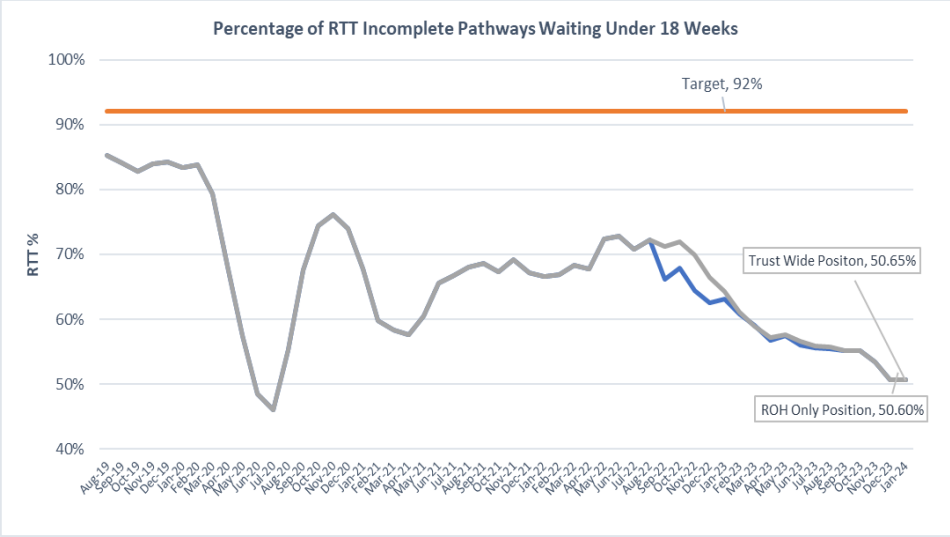
- Appointments team have carried out a review of activity over the last 4 years and identified areas which have lower throughput post covid. The output of this piece of work is to be shared in March 2024.
- GIRFT Outpatient Further Faster information disseminated to specialties via OPTG.

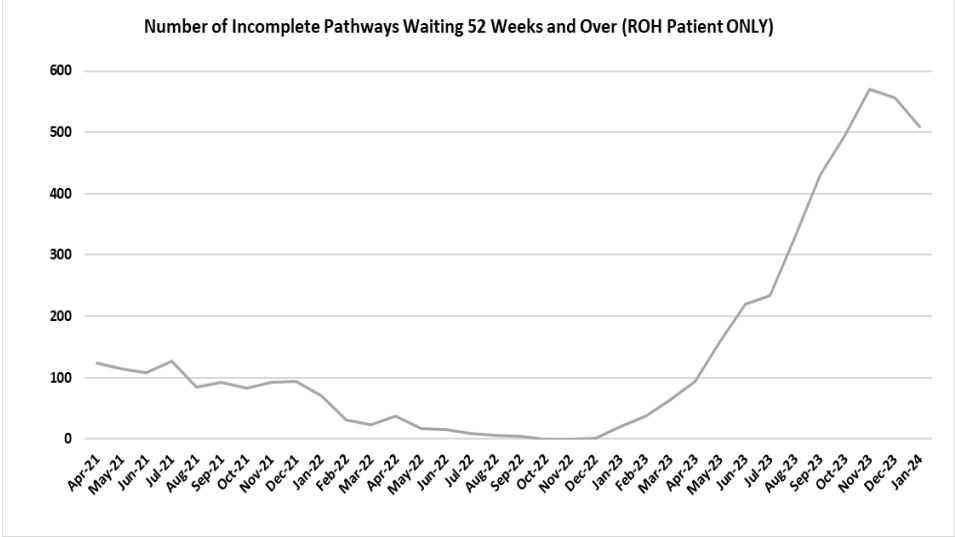
5. Referral to Treatment

	Trust Wide Position		
Weeks Waiting	Non-Admitted	Admitted	Totals
0-6	2,751	508	3,259
7-13	2,676	483	3,159
14-17	1,360	252	1,612
18-26	2,523	439	2,962
27-39	2,581	435	3,016
40-47	872	160	1,032
48-51	252	50	302
52 weeks and over	396	115	511
Total	13,411	2,442	15,853

Weeks Waiting	Non Admitted	Admitted	Totals
Under 18	6,787	1,243	8,030
18 and over	6,624	1,199	7,823
Month End RTT %	**50.61%**	**50.90%**	**50.65%**

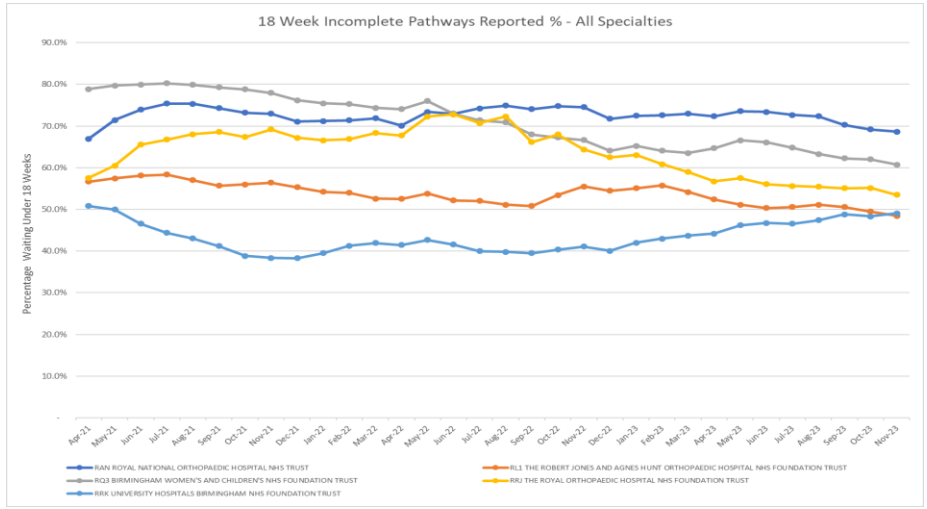


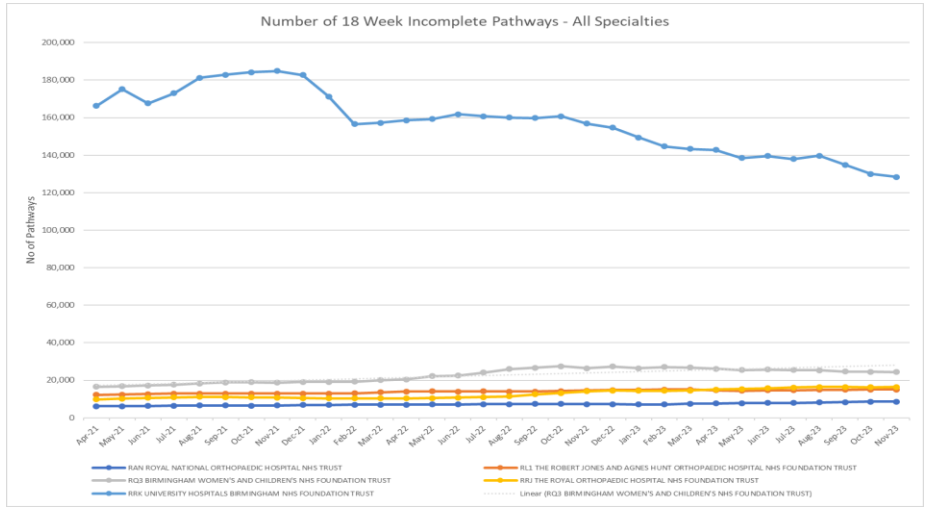


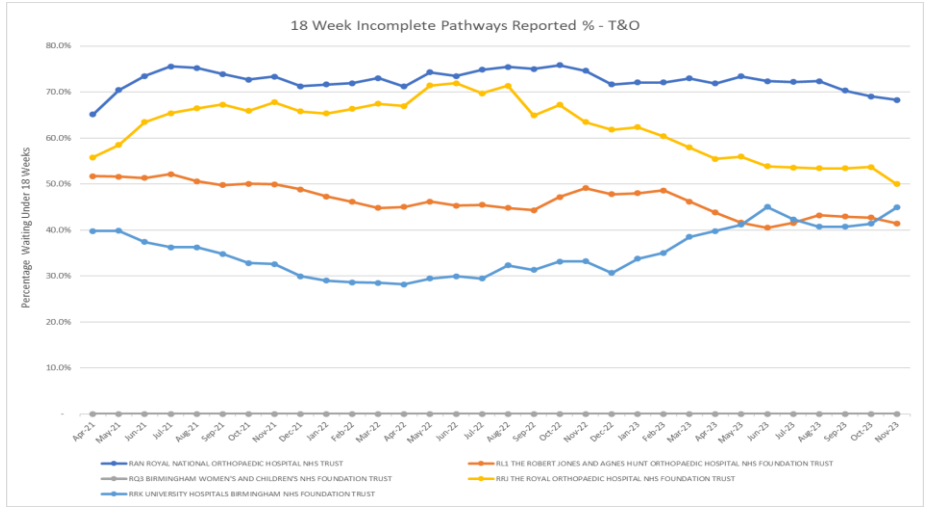


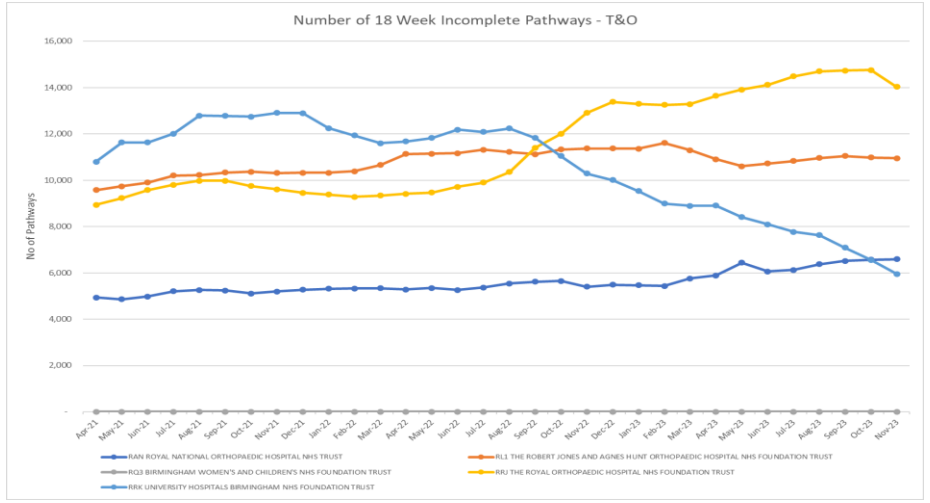
5. Referral to Treatment

18 Week Incomplete Pathways Benchmarking





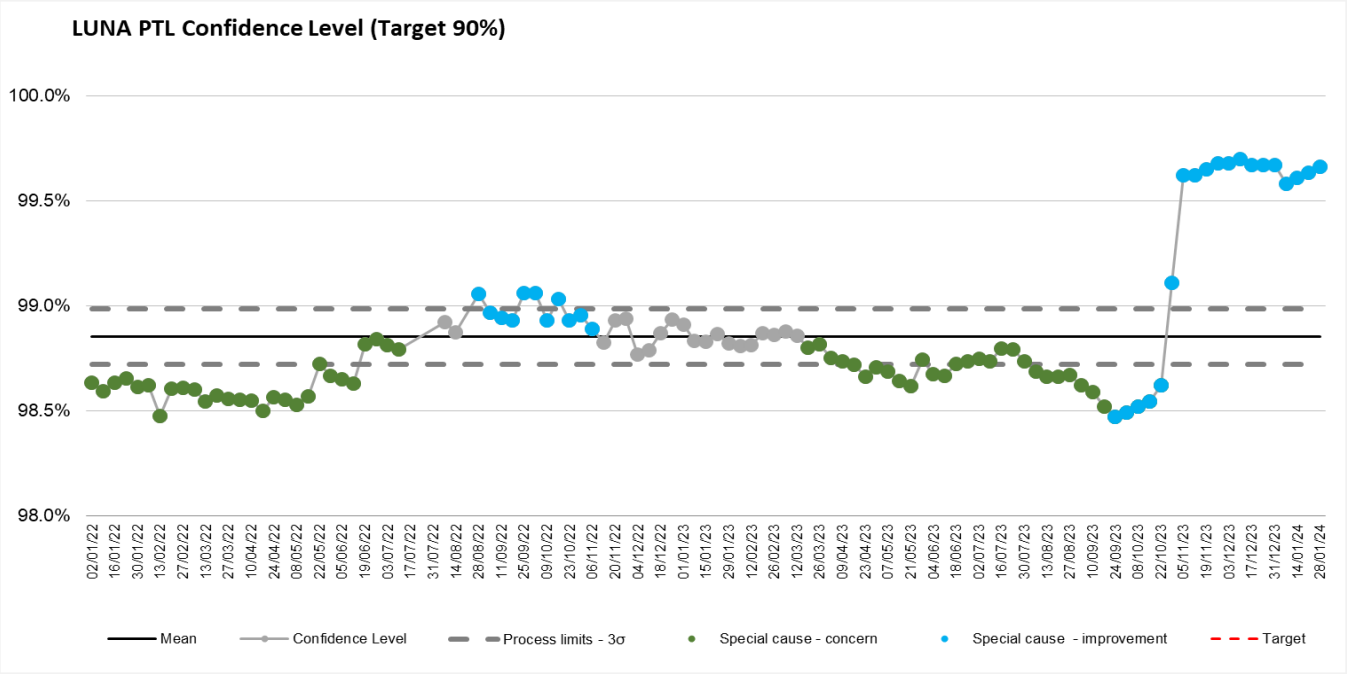




5. Referral to Treatment

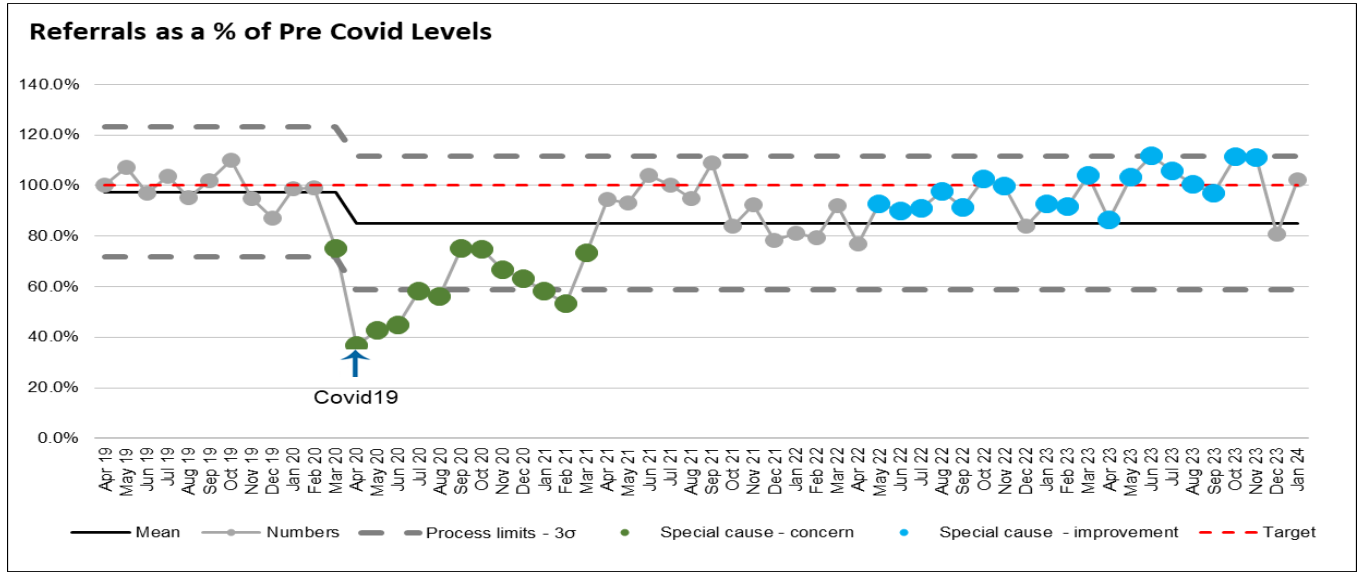
Luna Data

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	2763														
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%	102.18%														

5. Referral to Treatment

SUMMARY

The Referral To Treatment (RTT) position for January was **50.65%** against the National Constitutional Target of 92%. This represents a 0.05% increase compared to the December reported position of **50.60%** that includes patients transferred from other providers**.** The LUNA report for data quality validation is consistently above 98%.

There were **511** patients waiting over 52 weeks in January, a decrease from the trust wide position in December which was **561** 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 capacity is based on the specialty backlog clearance required to support the national delivery of zero 65-week waiters by March 2024.

During January 24, ROH received 2,763 referrals (102.18%) compared to pre covid levels. 2,704 is the average monthly referrals received Pre-Covid.

AREAS FOR IMPROVEMENT

RTT training currently underway focusing on appointments and Outpatients as the first phase.
Weekly specialty meetings chaired by the Performance lead focus on our longest waiting patients and achieving the 0 x 65 weeks national target by 31.03.24. 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 continue to provide extra support to spinal services to help manage patients through their pathway. All Patient waiting over 12 weeks on an RTT pathway have been sent a text message to determine whether they wish to remain on the waiting list in line with national guidance.

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.

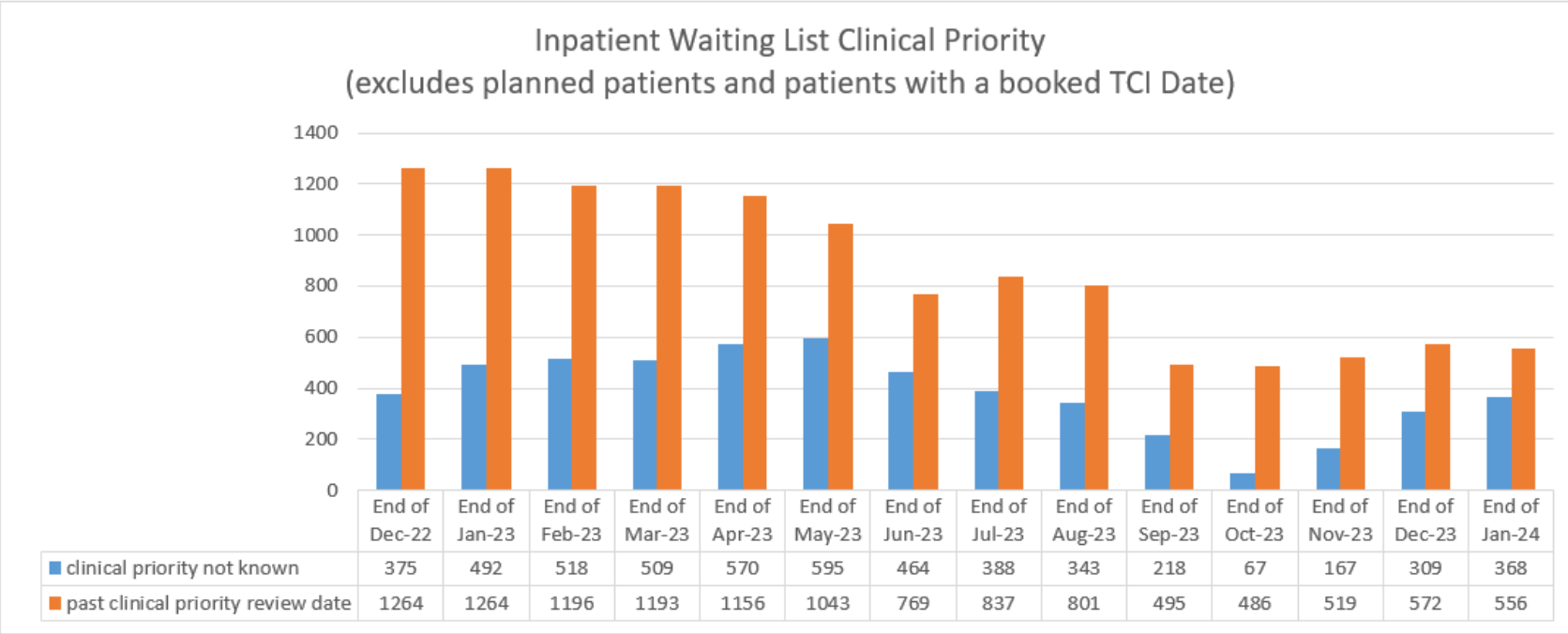
5. Referral to Treatment

Below is a table showing the current RTT % by speciality. The table supports the area of focus on backlog recovery in Spinal :

Specialty	RTT % as of 20.02.24
Arthroplasty	67.4%
Arthroscopy	47.7% - specialist surgeon with long waits
Clinical Support	56.1%
Foot and Ankle	43.3%
Hands	38.7% - long waiters taken from UHB
Oncology	80%
Oncology Arthroplasty	39.4%
Paeds / Young Adult Hips (YAH)	53%
Spinal	30.2%
Spinal Deformity	37.1%
YAH	63.6%

5. Referral to Treatment

Overdue Clinical Priority:

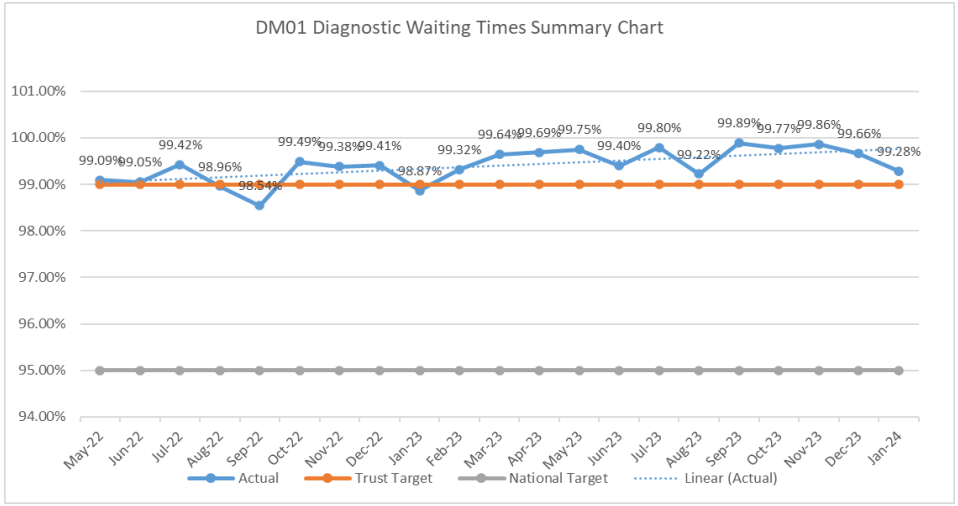


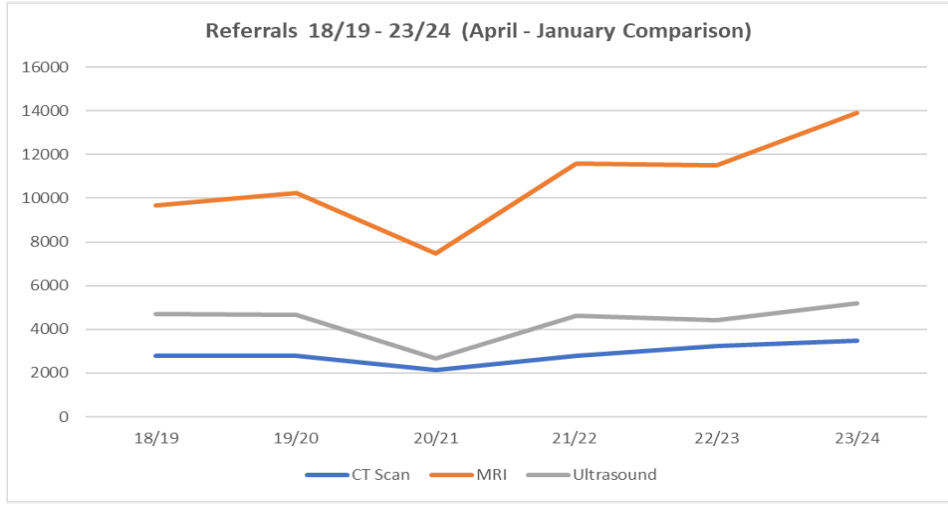
	End of Dec-22	End of Jan-23	End of Feb-23	End of Mar-23	End of Apr-23	End of May-23	End of Jun-23	End of Jul-23	End of Aug-23	End of Sep-23	End of Oct-23	End of Nov-23	End of Dec-23	End of Jan-24
clinical priority not known	375	492	518	509	570	595	464	388	343	218	67	167	309	368
past clinical priority review date	1264	1264	1196	1193	1156	1043	769	837	801	495	486	519	572	556

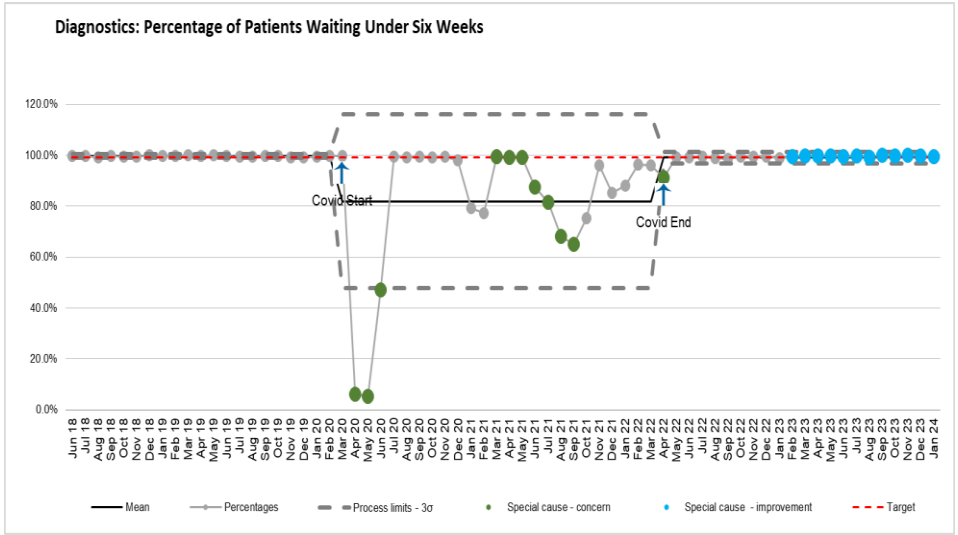
There has been an increase in the clinical priority not known within January 24. UHB patients often don't have the priority score included and this has been raised at the UHB/ROH Strategic Oversight Group on 22.02.24. The Deputy Medical Director is also raising this with the Clinical Service Leads to advise all consultant colleagues to review patients past their clinical priority date.

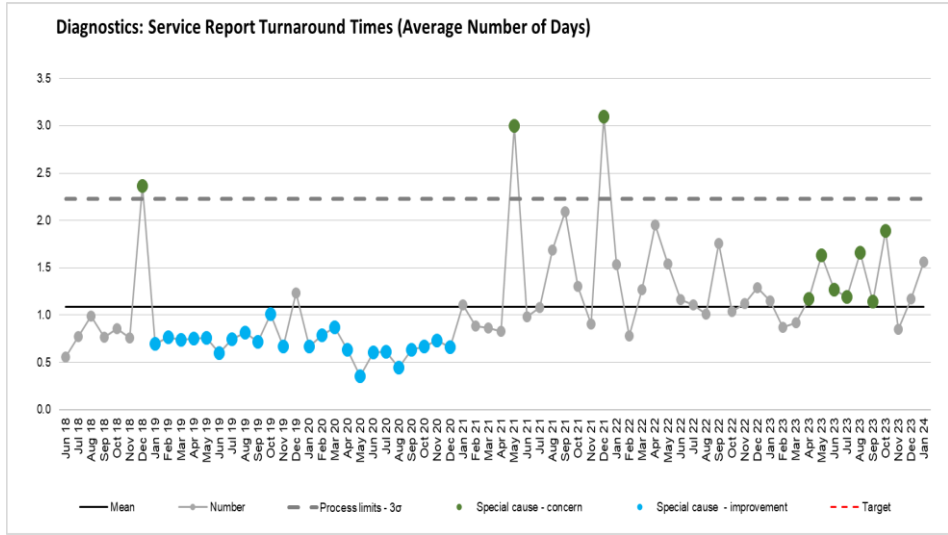
6. Diagnostic Performance

% 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 January 2024 closing the month at 99.28% despite a eduction in capacity due to an MRI machine quench. Mobile CRIS has been implemented to support electronic referrals.

The National 23/24 operational target remains at 95% which ROH consistently continues to achieve.

AREAS FOR IMPROVEMENT

Ensuring that all capacity is fully utilised and minimise missed appointments supported by the use of Dr Doctor sending text messages at 1 week and 48 hours prior to appointments; improvements in MRI missed appointments 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 March 2024 once a CRIS upgrade is required to enable this to happen.

RISKS / ISSUES

Following a spontaneous quench of the 1.5T 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. The 3T MRI scanner was out of action due to upgrade. The MRI service continued with a mobile / static MRI scanner with Oncology patients 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 and prolonged down time of the 1.5T MRI scanner has been carefully managed by the Imaging team and available capacity maximised to reduce any impact on patients waiting times. Inpatient MRI capacity is now back to normal and the mobile scanner left the site on 16.02.24.

Referral rates are increasing for all modalities and the reduction in missed appointment rates is helping to mitigate this risk.

8. Cancer Performance

Summary Performance Figures – December 2023 (February 2024 Submission)

Target Name	National Standard	December 23 (Complete) %	In target	Breach	Total
31 DTTD to Treatment	96%	100%	15.0	0.0	15.0
62 day RTT to Treatment	85%	85.7%	12	2	14
28 day FDS	75%	75.3%	55	18	73
Patients over 104 days (62 day standard)				1	

Target Name	National Standard	December 23 (Old Standards) %	In target	Breach	Total
2 WW	93%	95.9%	73.0	3.0	76.0
31 First	96%	100%	10.0	0.0	10.0
31 day subsequent	94%	100%	5.0	0.0	5.0
62 day Standard	85%	100%	4.0	0.0	4.0
62 day (Cons Upgrade)	n/a	80.0%	8.0	2.0	10.0
28 day FDS REPORTED	75%	75.3%	55.0	18.0	73
Patients over 104 days (62 day standard)				1	

Performance

The trust was compliant against all three cancer standards for December 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 target. We were compliant with the 28 days FDS standard achieving 75.3% 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;

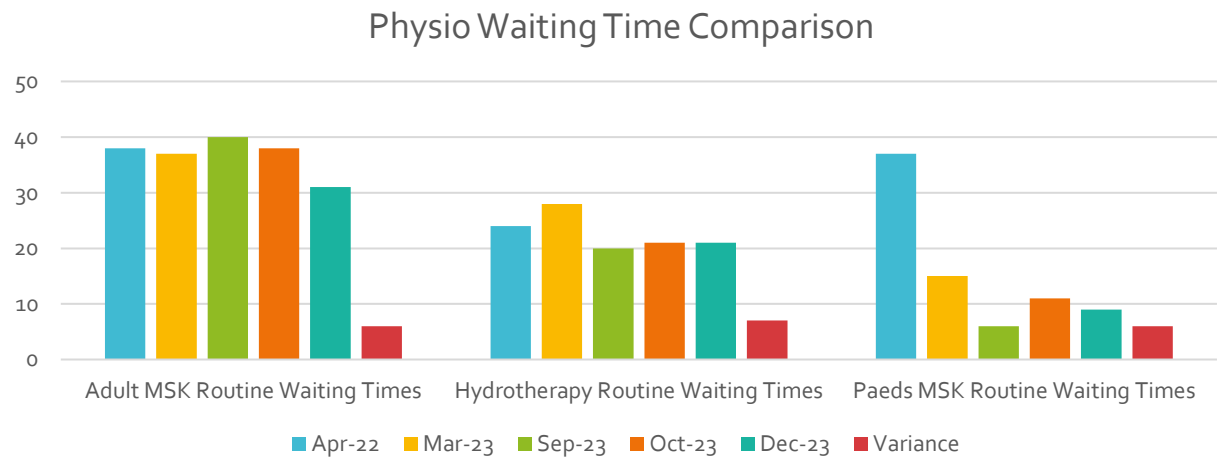
- 1 x full breach – Patient upgraded at MDT by clinical team for suspected malignancy. Root cause of delay was due to complex diagnostics with a contributed delay of patient choice. Patient initially delayed diagnostic biopsy which delayed the pathway by 32 days. Patient then required a repeat CT guided biopsy due to complex diagnosis. Patient was treated on day 105.
- 1 x full breach -This patient was a consultant upgrade from DMDT. Root cause of delay was complex treatment planning resulting in late tertiary referral to local oncologist. Patient underwent Tru cut biopsy in clinic and diagnosed on day 26 of their pathway. Patient was then seen in joint plastic-ortho clinic to discuss resectability of tumour. Following clinic discussion patient then needed further MRI and consensus of TMDT was to refer out for pre-op radiotherapy in the first instance. Patient referred out on day 48 to local oncologist and 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 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 continue to be escalated to UHB DOP for an expedited resolution.

9. MSK Waits

Physio Wait Comparison April 22 vs March and Dec (as at 17th)



Summary – data as per 31.01.24

Paediatric Physio waits continue to be maintained below 12 weeks with the January position ending at 7 weeks..
Hydrotherapy waits have reduced from 21 weeks to 20 weeks.
Adult physio waiting times have reduced from 44 weeks in June/July to 28 weeks with a trajectory to continue reducing waits.
Back Pain waiting times reduced from 39 weeks in Sept 23 to 27 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 50 inpatients treated privately in January
- The service has exceeded its inpatient activity plan in month by 21 patients and YTD by 178 patients.
- There is no outpatient target, however there were 124 private outpatient appointments, and the service has booked 1092 outpatient appointments YTD.
- The service overachieved against its income target in January by £99k and is over its YTD position by £283k.

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	YTD
Income Plan £000	306	306	306	306	255	253	325	361	209	289	2916
Activity Plan	9	24	35	24	37	28	29	36	11	29	262
Income to be collected £000	353	229	254	397	255	314	347	354	308	388	3199
Activity actual	47	37	41	55	38	39	46	48	39	50	440

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:

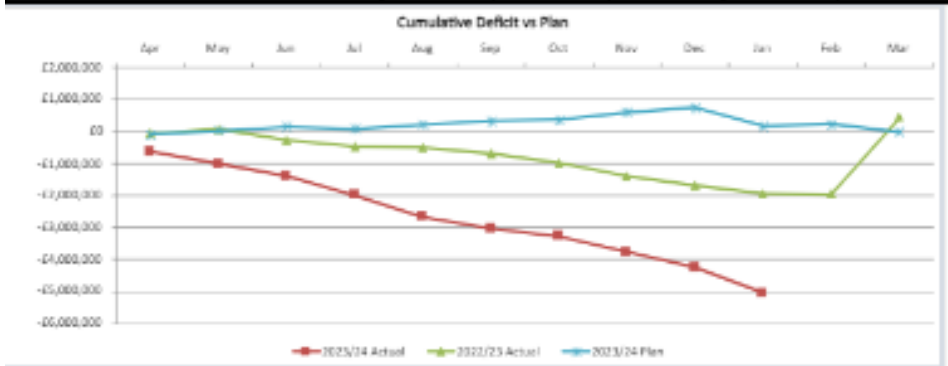
A) Submission of 3-year strategic plan to Trust Board March 2024 – copy provided as a separate report
B) Re-negotiation with AXA and subsequently BUPA to agree tariff pricing for the new financial year
C) Uplift on self-funding package pricing
D) Completion of the patient experience report
E) Business 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 10

FINANCIAL PERFORMANCE

Income and Expenditure category	£'000s								
	In Month			Year to date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Pay	£6,173	£5,763	£410	£62,276	£62,768	£963	£74,746	£75,646	£900
Non Pay	£4,109	£5,420	£1,311	£43,033	£48,432	£4,828	£51,756	£53,150	£1,394
Income from patient care activities	£10,199	£10,044	£155	£102,413	£102,014	£399	£122,811	£123,099	£288
Other income	£422	£429	£7	£4,220	£5,089	£869	£5,064	£5,911	£847
Non operating costs	£121	£98	£23	£1,210	£1,038	£149	£1,455	£1,267	£188
Remove capital donations	£7	£7	£0	£70	£76	£0	£82	£92	£10
TOTAL	£225	£801	£1,026	£184	£5,057	£5,023	£0	£961	£961



Agency as a % of paybill 8.2%

Recurrent efficiency % of forecast 100%

Efficiencies	YTD	Forecast
Plan	£4,138	£5,076
Actual	£4,281	£5,076
Variance	£143	£0

Capital	YTD	Forecast
Plan	£2,950	£3,909
Actual	£2,961	£3,614
IFRS 16	£0	£1,134
Variance	£11	£839

Better Payment practice code	YTD	% move't prev month
Non-NHS		
By number	88.6%	0.3%
By Value	90.1%	0.0%
NHS		
By number	44.7%	2.7%
By number	10.1%	0.2%
Total		
By number	87.5%	0.4%
By Value	79.6%	0.8%

9. Overall Financial Performance

SUMMARY

The Trust delivered a deficit in month of £801k against a planned deficit of £583k, generating a £218k adverse variance, resulting in a year to date deficit of £5,057k against a surplus plan of £184k, generating an adverse variance of £5,057k.

Income year to date is £470k ahead of plan.

Pay expenditure is overspent by £491k. Non pay expenditure is overspent against plan with an adverse variance of £5,399k.

Agency spend remains a concern – the spend in month was 6.1% of paybill, with a year to date position of 8.2%.

The key drivers for the non pay overspend is indicating above inflationary pressures across clinical supplies, utilities and other supplies.

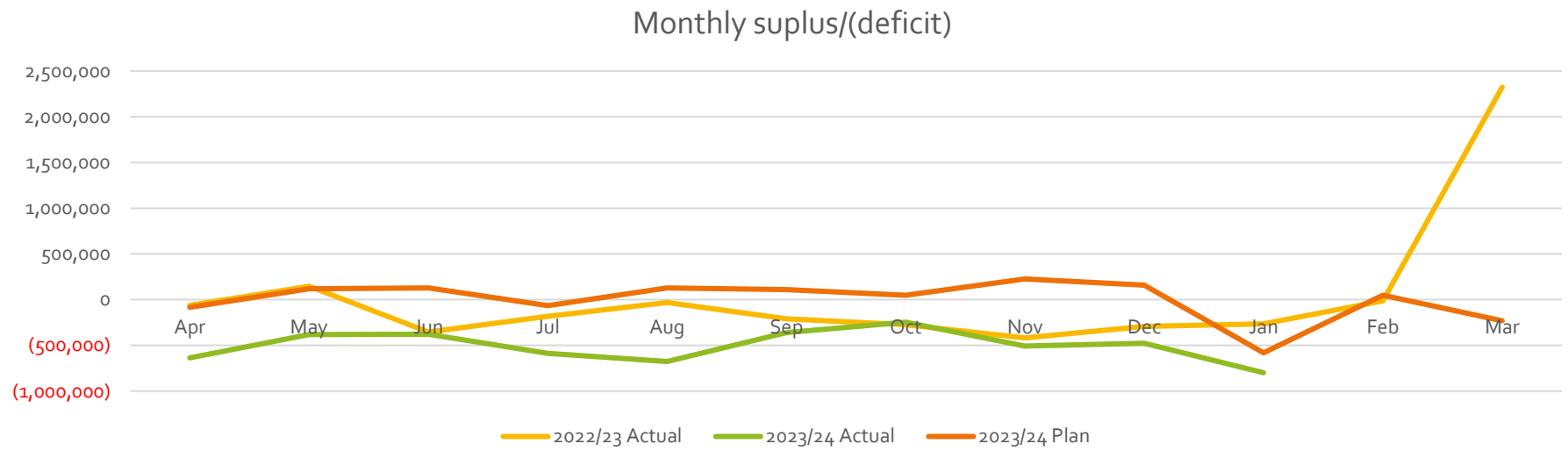
Forecast has been further adjusted to account for the impact of industrial action in December and January with a forecast deficit now expected of £961k.

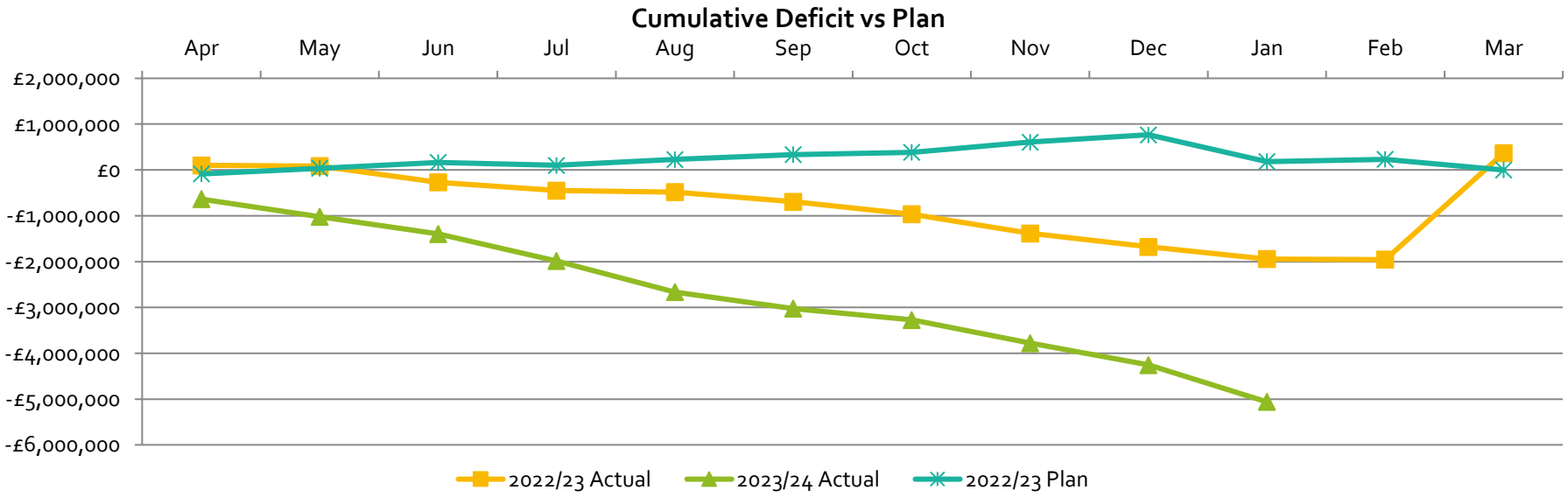
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	470	(491)	(5,399)	180	(5,241)
Year to date plan	106,633	(62,277)	(43,033)	(1,140)	184
Year to date actual	107,103	(62,768)	(48,432)	(960)	(5,057)
Variance compared previous month	(149)	472	(565)	31	(218)
Forecast Variance	1,135	(900)	(1,394)	198	(961)

9. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	102,413	102,014	(399)
Other Operating Income (Excluding top up)	4,220	5,089	869
Employee Expenses (inc. Agency)	(62,276)	(62,769)	(493)
Other operating expenses	(43,033)	(48,432)	(5,399)
Operating Surplus	**1,324**	**(4,096)**	**(5,420)**
Net Finance Costs	(1,210)	(1,038)	172
Net surplus/(deficit)	**114**	**(5,134)**	**(5,248)**
Remove donated asset I&E impact	70	76	6
Adjusted financial performance	**185**	**(5,057)**	**(5,241)**

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**
Updated recovery trajectory	**132**		**(362)**	**(246)**	**(439)**	**49**	**178**	**178**	**3,438**
Updated trajectory cumulative including M1-5 actual)			**(3026)**	**(3272)**	**(3711)**	**(3662)**	**(3484)**	**(3306)**	**132**
Actual performance			**(326)**	**(246)**	**(507)**	**(478)**	**(801)**		
Monthly Variance to revised trajectory			**36**	**0**	**(68)**	**(527)**	**(979)**	**(178)**	**(3438)**
Cumulative Variance to revised trajectory			**(2628)**	**(2628)**	**(2696)**	**(3223)**	**(4202)**		

10. Income

SUMMARY

Income year to date is £470k ahead of plan. £630k of the overperformance related to education and training income and £361k to support IFRS16 transition. ICB and NHS England patient related income is lower than plan as a result of accounting for convergene and removal of growth from these contract values. The discussions continue around these issues with commissioners.

Elective recovery performance is showing an underperformance year to date by £727k, which is still being validated.

Private patient income is performing well against plan with a year to date overperformance of £207k..

AREAS FOR IMPROVEMENT

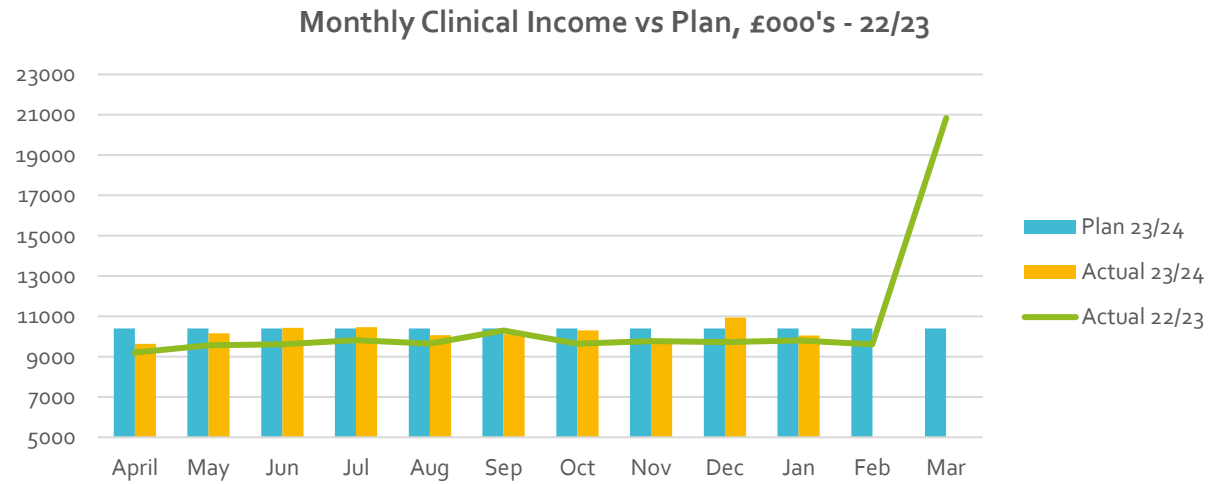
Elective recovery target delivery during the year to maximise income generation.

RISKS / ISSUES

Elective recovery target delivery during the year remains a risk. Discrepancies between NHS England published ERF performance for Months 1 –7 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



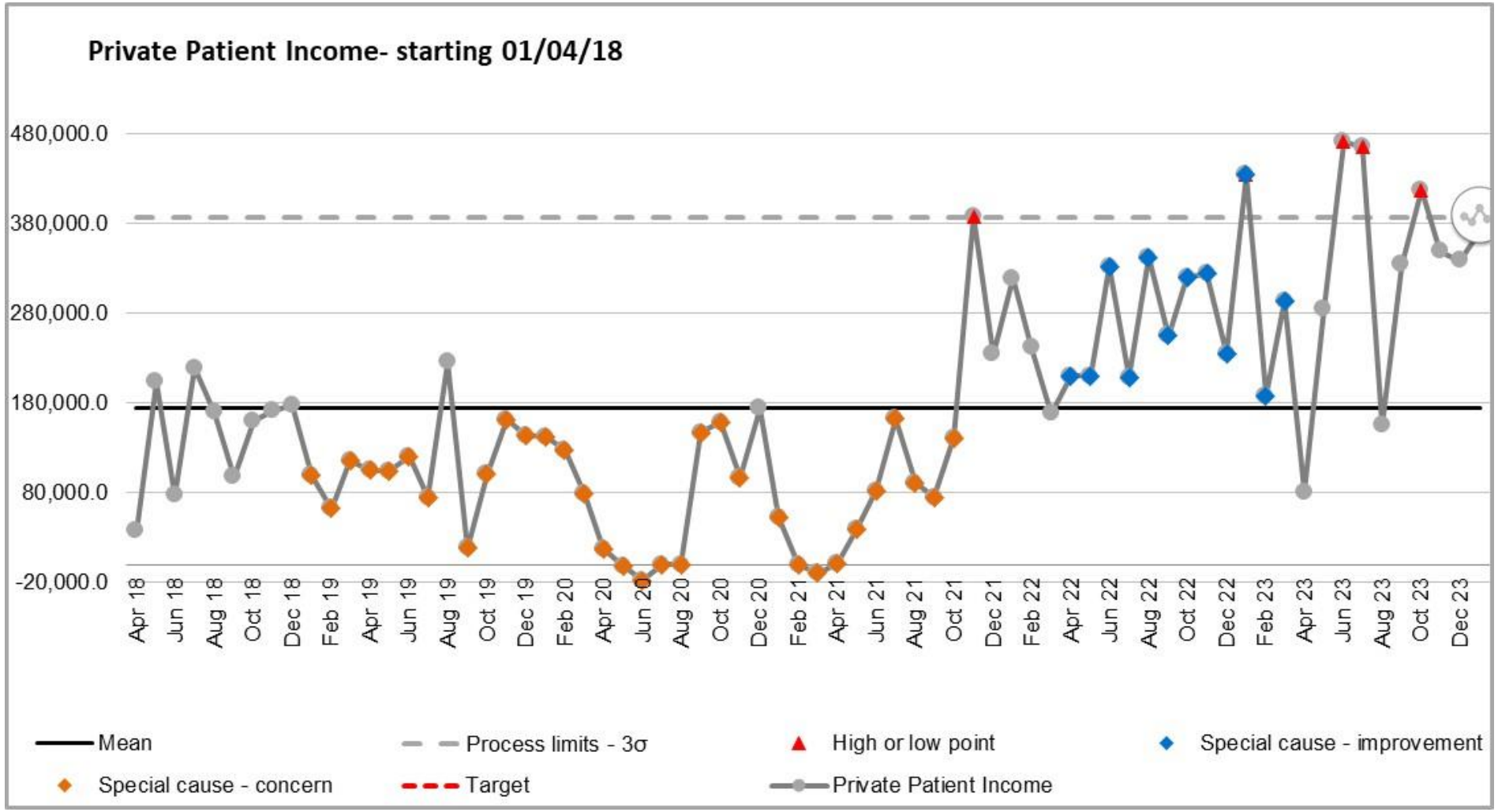
Confirmed performance by NHE England for Months 1-7 is an underperformance against revised target, with the largest variance against specialised commissioning. Work is ongoing to understand variances between internal performance calculations and NHS England performance, therefore the year to date position has not been adjusted for this performance. The performance over the year has improved, in particular NHS England performance which has been overperforming since July. A significant amount of the underperformance was generated in April, 49% of M1-7 underperformance was generated in April.
Forecast trajectory based on activity plan is an expected overperformance against target which has been included within the recovery plan.

	M1-7 Target	YTD 23/24 Actuals	over/(under) performance	% Performance
Elective Recovery Fund	£29,625,408	£28,897,419	£727,989	98%
ICB	£24,287,968	£23,986,802	£301,166	99%
NHS England	£5,337,439	£4,910,616	£426,822	92%

Cummulative Variance	April	May	June	July	August	September	October
ICB	£330,775	£309,753	£481,222	£163,847	£124,490	(£153,504)	(£301,166)
NHSE	(£685,970)	(£740,950)	(£1,108,748)	(£966,513)	(£667,583)	(£507,048)	(£426,823)

10. Income

Private patient income



11. Expenditure

SUMMARY

Pay expenditure is overspent by £491k. Non pay expenditure is overspent against plan with an adverse variance of £5,399k.

Agency spend remains a concern – the spend in month was 6.1% of paybill, with a year to date position of 8.2%. Spend has reduced in month compared with month 9, with a significant reduction seen in non clinical agency spend.

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%.

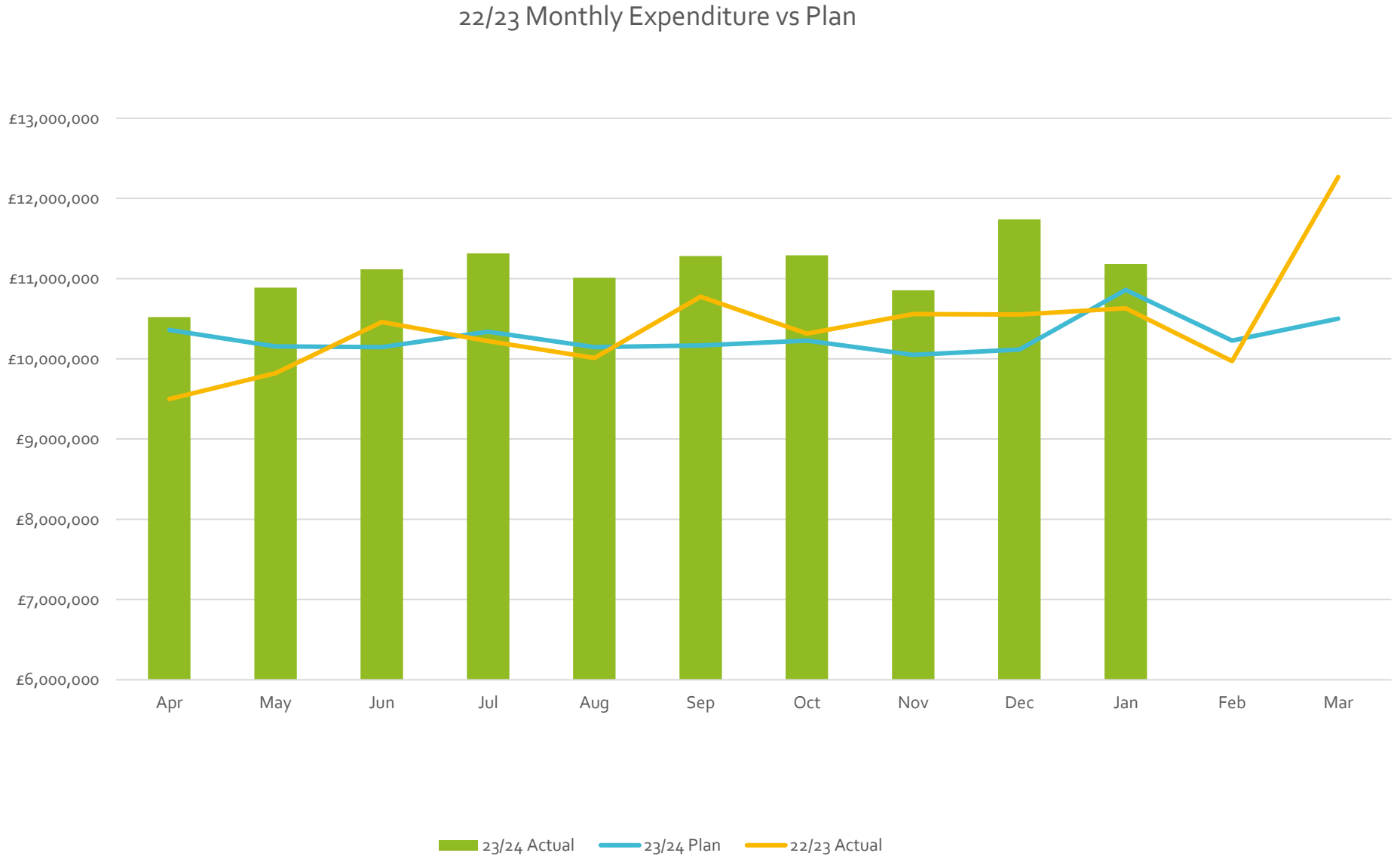
Theatre consumable spend reducing to planned levels.

LLP expenditure reduction.

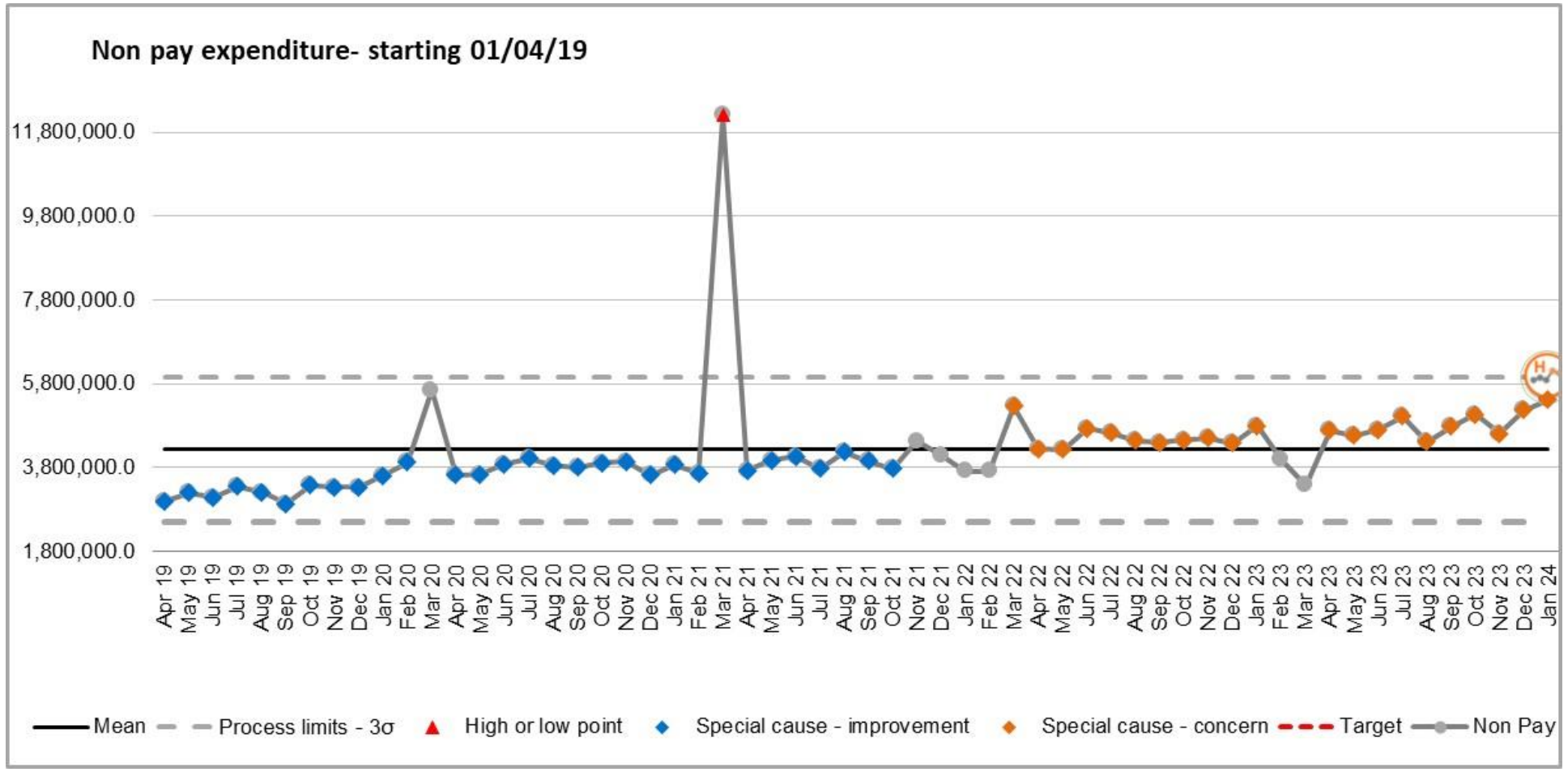
RISKS / ISSUES

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

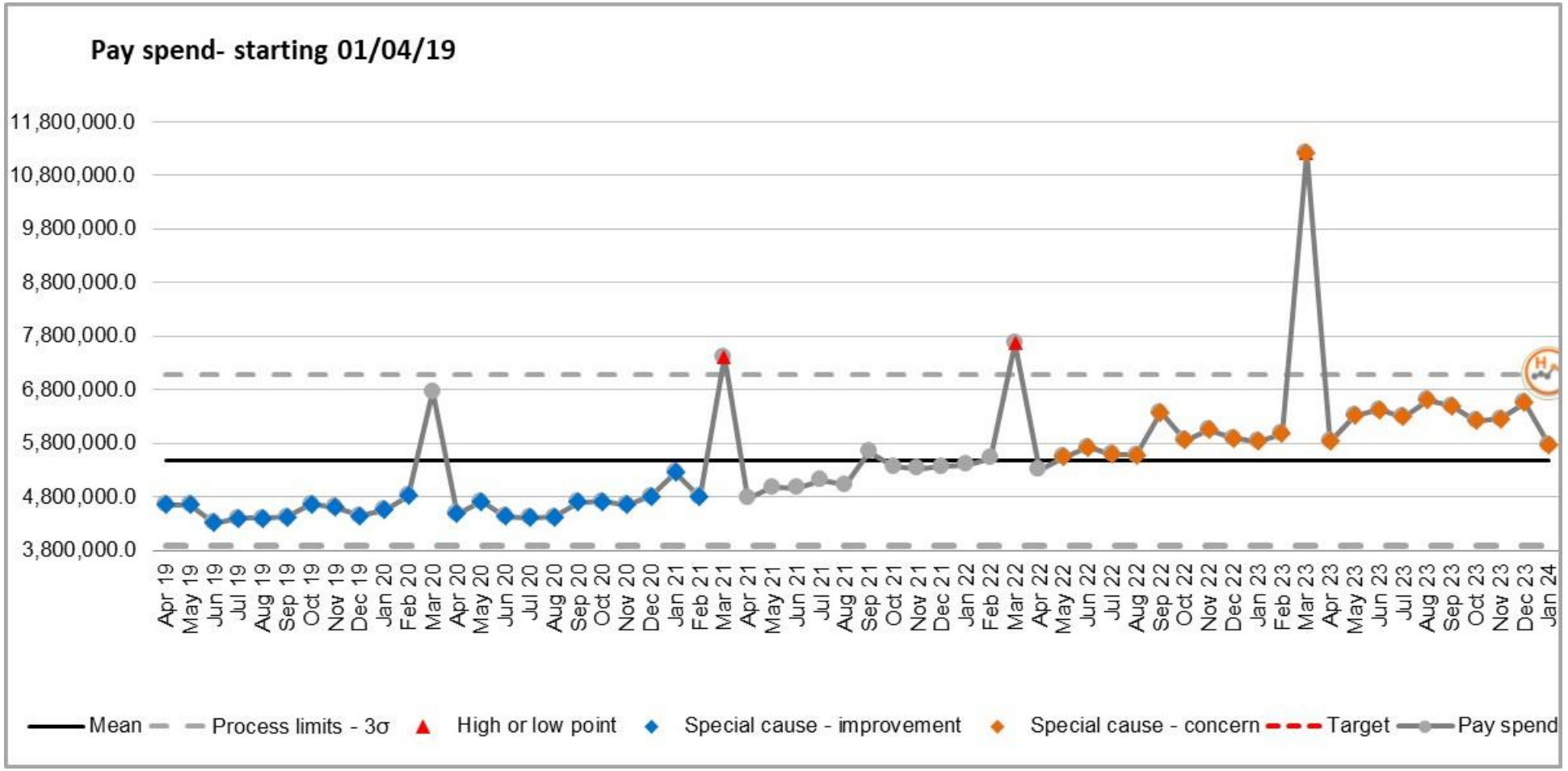
11. Expenditure



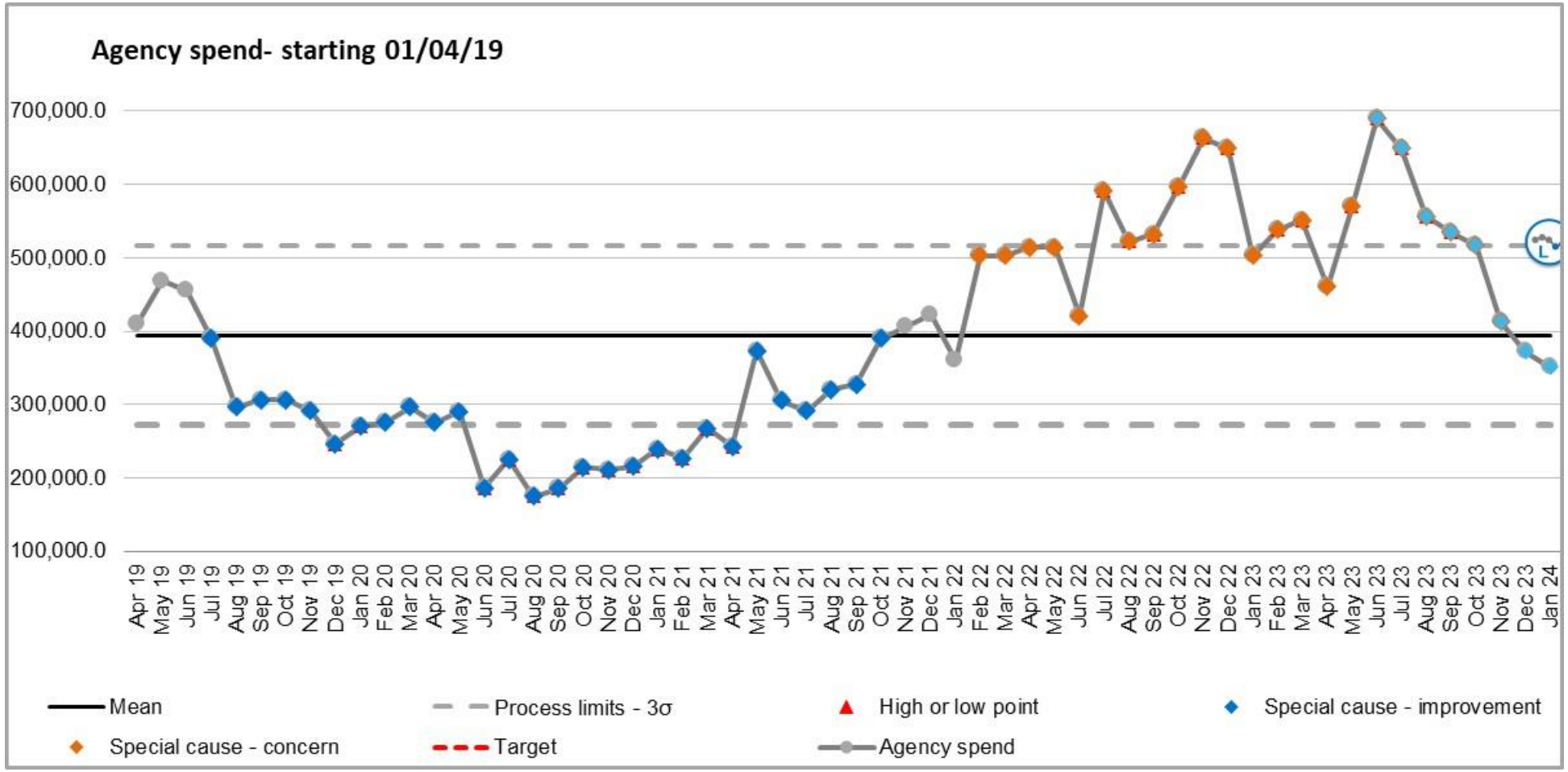
12. Non Pay Expenditure



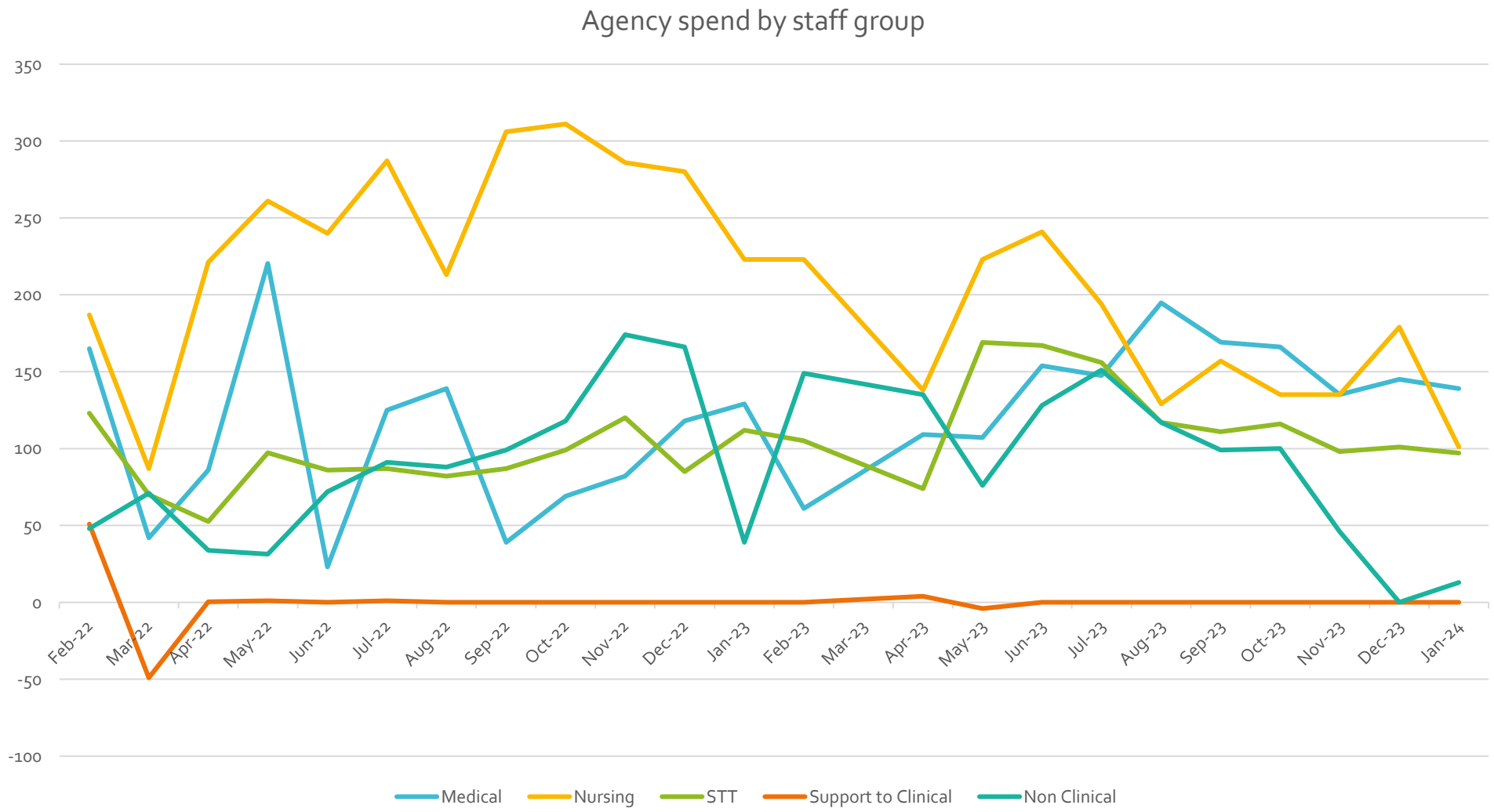
13. Pay Expenditure



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	Mth 10	Total
Nursing	138	223	241	194	129	157	135	135	179	101	1,632
STT	75	150	138	140	91	202	116	98	101	97	1,206
Medical	60	70	123	133	138	361	166	135	145	139	1,467
Non-Clinical	135	76	128	151	117	99	100	46	-53	13	812
	408	**518**	**630**	**618**	**475**	**818**	**517**	**413**	**372**	**350**	**5,117**

Actual	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	Mth 10	Total
Nursing	138	223	241	194	129	157	135	135	179	101	1,632
STT	79	165	167	157	117	111	116	98	101	97	1,206
Medical	110	109	155	148	194	169	166	135	145	139	1,467
Non-Clinical	135	76	128	151	117	99	100	46	-53	13	812
	462	**572**	**691**	**650**	**557**	**535**	**517**	**413**	**372**	**350**	**5,117**

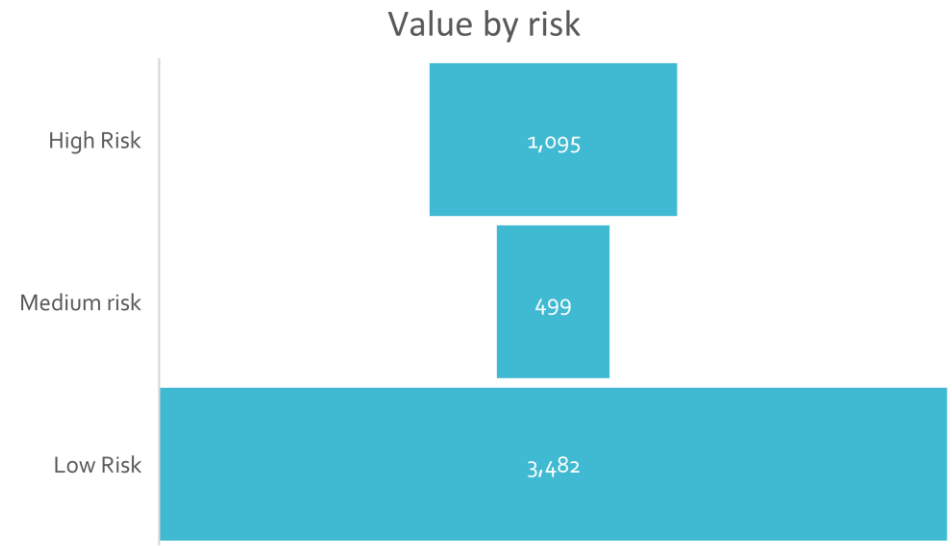
Variance	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	Mth 10	Total
Nursing	-	-	-	-	-	-	-	-	-	-	-
STT	-4	-15	-29	-17	-26	91	-	-	-	-	-
Medical	-50	-39	-32	-15	-56	192	-	-	-	-	-
Non-Clinical	-	-	-	-	-	-	-	-	-	-	-
	-54	**-54**	**-61**	**-32**	**-82**	**283**	**-**	**-**	**-**	**-**	**-**

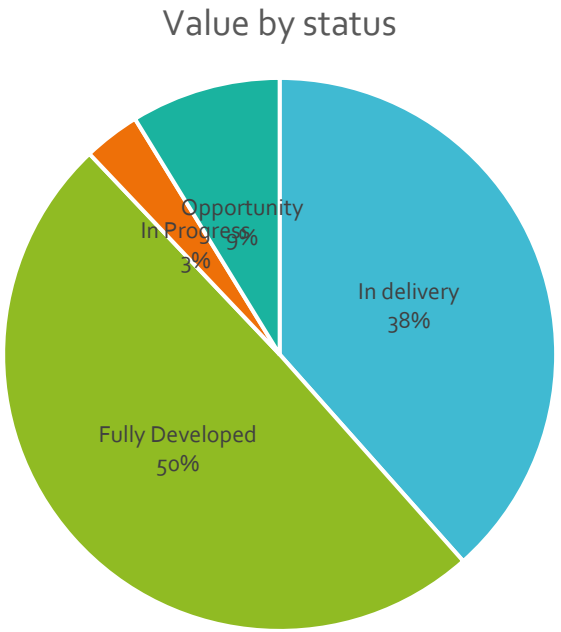
15. Cost Improvement Programme Summary

SUMMARY

Year to date savings totalling £4,281k have been delivered, against a plan of £4,138k, delivering a positive variance of £143k. 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	£531	£25	(506)	25
Non pay	£3,191	£4,133	942	4,928
Income	£417	£123	(294)	123
Grand Total	**£4,138**	**£4,281**	**143**	**5,076**





16. Statement of Financial Position

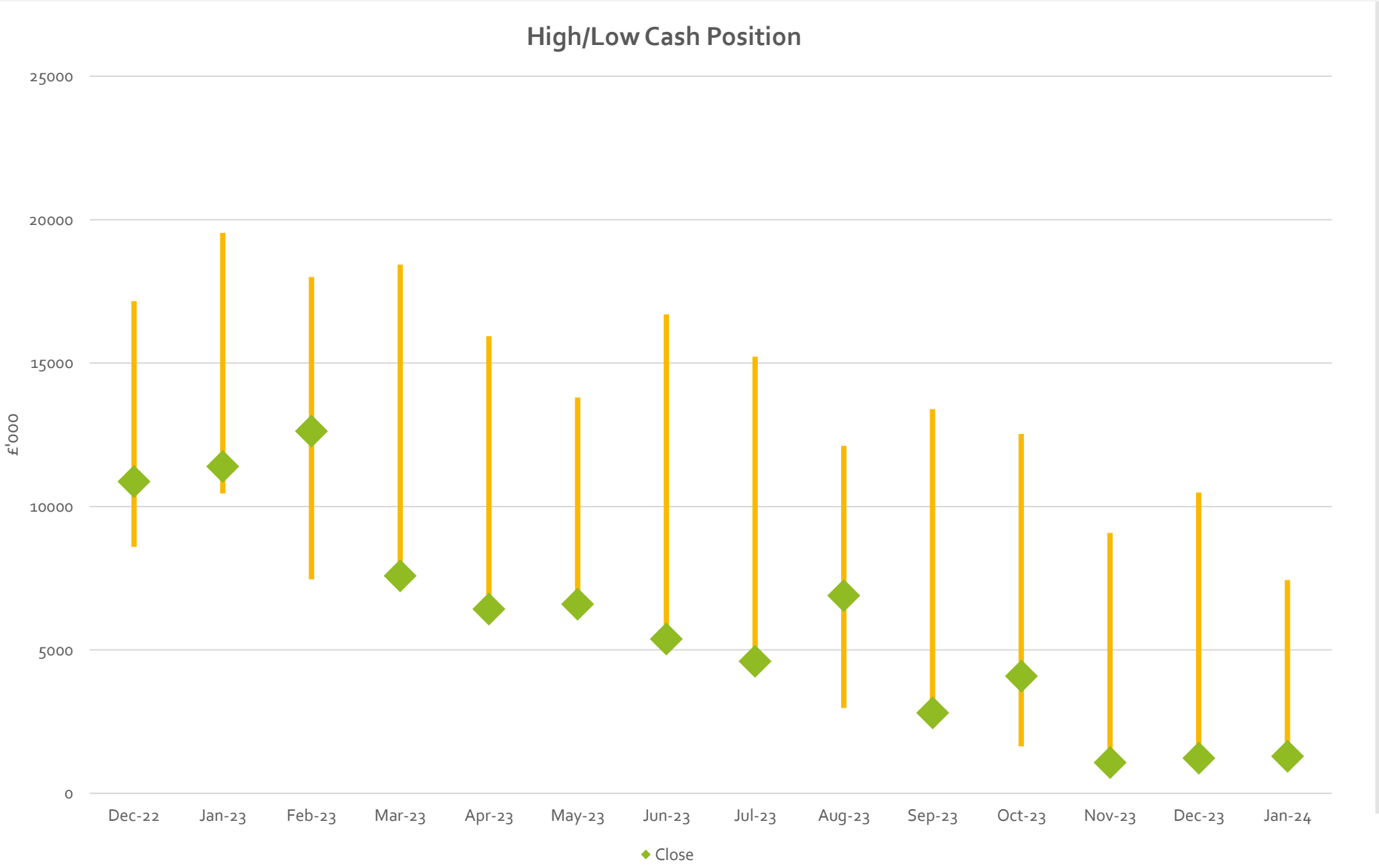
SUMMARY

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, with BSOL ICS supporting the trust in the short term. Continued focus is being places on ensuring that cash is being managed robustly, whilst also trying to maximise Better Payment Practice Performance.

	2022/23 M12	2023/24 M10	Movement
		(£'000)	
Intangible Assets	1,339	1,045	(294)
Tangible Assets	69,123	67,318	(1,805)
Total Non Current Assets	**70,462**	**68,363**	**(2,099)**
Inventories	19	19	-
Trade and other current assets	12,839	11,769	(1,070)
Cash	7,591	1,183	(6,408)
Total Current Assets	**20,449**	**12,971**	**(7,478)**
Trade and other payables	(20,229)	(16,392)	3,837
Borrowings	(18,339)	(16,704)	1,635
Provisions	(1,329)	(1,292)	37
Other Liabilities	(273)	(2,370)	(2,097)
Total Liabilities	**(40,170)**	**(36,758)**	**3,412**
Total Net Assets Employed	**50,741**	**44,576**	**(6,165)**
Total Taxpayers' and Others' Equity	**50,741**	**44,576**	**(6,165)**

17. Cash


High/Low Cash Position
25000
20000
15000
10000
5000
0
£'000
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Close

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	62,150	602,348	597,652	944,468
Strategic Estates	Appointments team office space *	100,000	0	0	100,000	0
Strategic Estates	Relocation of Facilites to the Old Pharmacy building	310,000	253,304	256,727	53,273	6,582
Strategic Estates	Porters Lodge**	50,000	0	201,978	(151,978)	0
Strategic Estates	ROH Creative Design Studio	55,000	51,246	51,246	3,754	0
Strategic Estates	Omnicell installation	70,000	58,471	58,471	11,529	0
Strategic Estates	Replacement for room 3 from a fluoroscopy room to a digital x-ray room	30,000	26,362	26,362	3,638	1,439
Strategic Estates	Café Royale Refurbishment	210,000	184,712	184,712	25,288	2,000
Green estate	Pool	100,000	125,373	215,373	(115,373)	0
Estates Maintenance	Pool	375,000	337,129	340,732	34,268	0
Equipment	Anaesthetic machines x 6	477,004	428,032	428,032	48,972	0
Equipment	Replacement of 3T MRI scanner	275,000	451,629	451,629	(176,629)	0
Equipment	Pool	200,000	124,147	124,147	75,853	0
Information Technology		0	103,283	103,283	(103,283)	0
Reserve	Potential Additional schemes (TBC)	46,996	0	362,885	(315,889)	0
SCIF		410,000	0	0	410,000	0
TOTAL		**3,909,000**	**2,205,839**	**3,407,924**	**501,076**	**954,489**

Strategic Estates	2,025,000	636,246	1,381,844	643,156	954,489
Green estate	100,000	125,373	215,373	(115,373)	0
Estates Maintenance	375,000	337,129	340,732	34,268	0
Equipment	952,004	1,003,808	1,003,808	(51,804)	0
Information Technology	0	103,283	103,283	(103,283)	0
Reserve / SCIF	456,996	0	362,885	94,111	0
	3,909,000	**2,205,839**	**3,407,924**	**501,076**	**954,489**

19. System

SUMMARY

The M10 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.

M10

Organisation	Surplus / (Deficit) - Adjusted Financial Position						Trajectory		Better/(worse) than trajectory	
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Plan Year Ending £000	Forecast Year Ending £000	Variance Year Ending £000	Trajectory YTD £000s	Trajectory FOT £000s	YTD £000s	FOT £000s
Birmingham and Solihull ICB	2,846	21,128	18,282	0	26,711	26,711	18,598	26,711	2,530	0
Birmingham And Solihull Mental Health NHS Foundation Trust	-	1,374	1,374	0	4,002	4,002	1,328	4,053	46	(51)
Birmingham Community Healthcare NHS Foundation Trust	180	418	238	0	1,030	1,030	411	1,030	7	0
Birmingham Women'S And Children'S NHS Foundation Trust	0	(904)	(904)	0	3,598	3,598	(597)	5,198	(307)	(1,600)
The Royal Orthopaedic Hospital NHS Foundation Trust	184	(5,074)	(5,258)	0	-462	(462)	(3,484)	131	(1,590)	(593)
University Hospitals Birmingham NHS Foundation Trust	(3,600)	(47,499)	(43,899)	0	-45,700	(45,700)	(41,988)	(37,123)	(5,511)	(8,577)
ICS Total	(390)	(30,557)	(30,167)	0	-10,821	-10,821	(25,733)	0	(4,825)	(10,821)

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

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY AND SAFETY REPORT

February 2024 (January 2024 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 – February 2024 (January 2024 Data) – Summary Dashboard

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	2022/2023	2023/24
Incidents	283 (↓)	292 (↑)	374 (↑)	269(↓)	378 (↑)	341 (↓)	323 (↓)	297 (↓)	411 (↑)	354 (↓)	354	303 (↓)	297 (↓)		
Serious Incidents	0 (↓)	2 (↑)	0	1(↑)	1	0	0	0	0	0	0	0	1 (↑)	8	3
Inpatient Deaths	0	0	0	0	1 (↑)	0	1 (↑)	0	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	3 (↓)	7 (↑)	5 (↓)	12(↑)	9 (↓)	7 (↓)	7	8 (↑)	8	7 (↓)	8 (↑)	6 (↓)	6	79	78
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)	0	1	0	0	0	0	0	0	0	0	0	0	0	2	0
Infections	0	1 (↑)	0	0	0	1 (↑)	1	2	1	0	1	1	1	9	8
Complaints	2	4 (↑)	1 (↓)	3(↑)	2 (↓)	2	5 (↑)	1	3	3	3	1 (↓)	4 (↑)	45	27
Litigation	0	2 (↑)	2	0	0	0	3 (↑)	0	0	1 (↑)	0	0	0	9	4
Coroners	0	0	0	0	1 (↑)	0	1 (↑)	0	0	0	1	0 (↓)	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 January 2024, there were a total of **297** Incidents reported on the Ulysses Incident Management System. The breakdown of those incidents is as follows;

No Harm = 217
Low Harm = 65
Moderate Harms = 8
Severe Harm = 1
Near Miss = 6

3. Patient Deaths

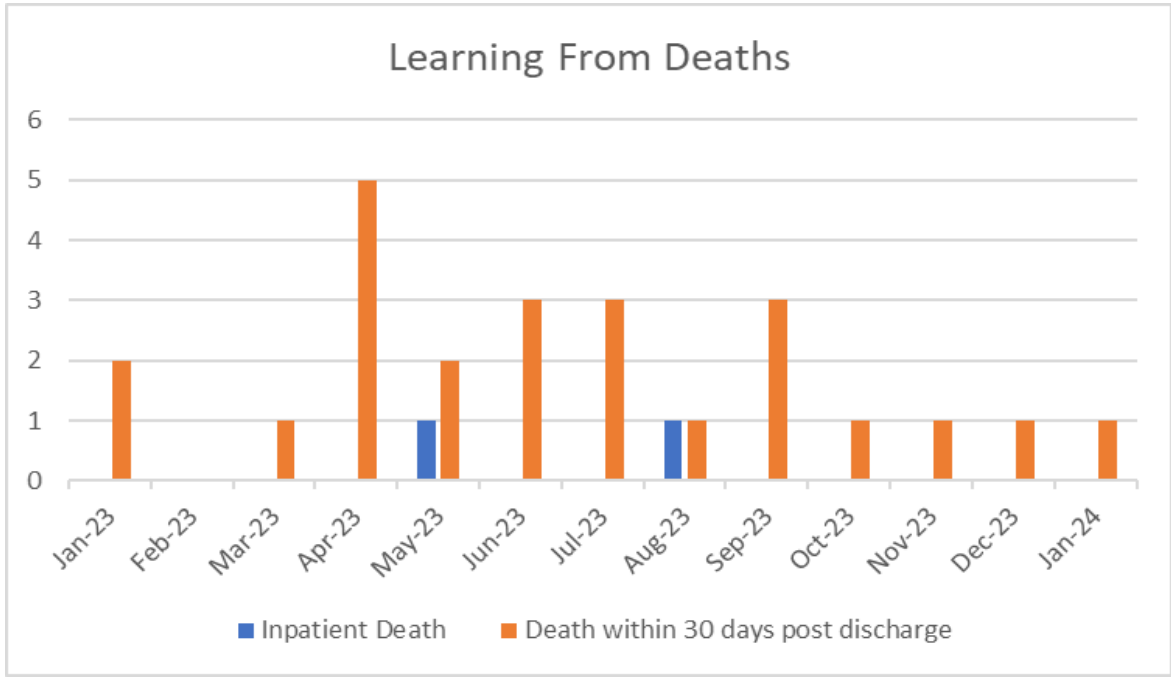
Inpatient Deaths

There were 0 inpatient deaths reported during January 2024

Deaths within 30 days post discharge

There was 1 patient death that occurred within 30 days post discharge during January 2024. This death was reported on 26.01.2024.

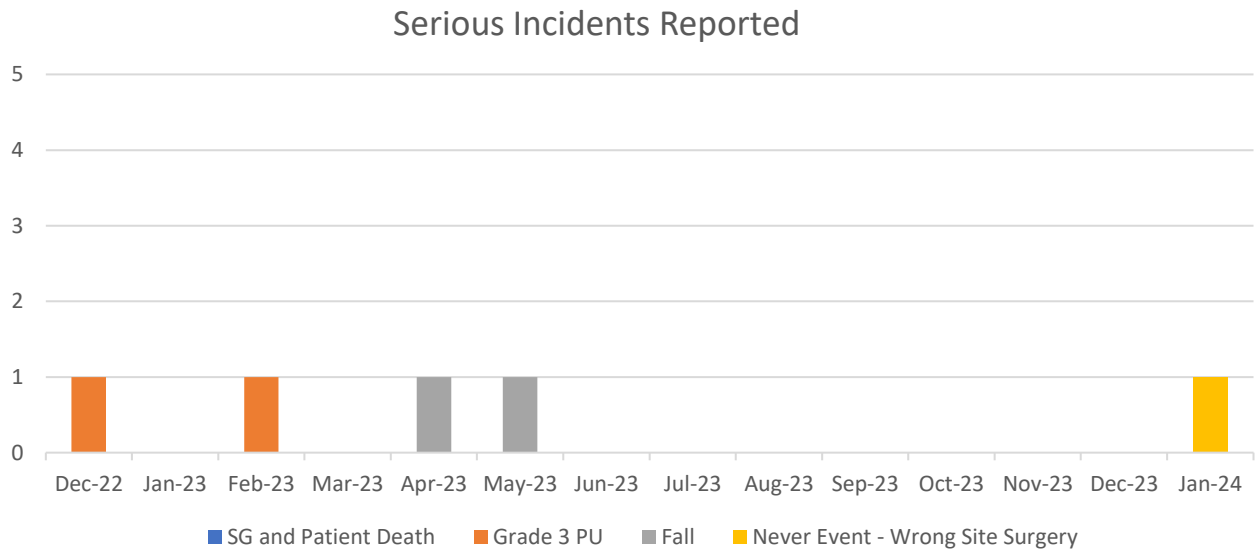
This death is currently undergoing an After Action Review (AAR) and a Structured Judgement Review (SJR) as part of our learning from deaths process.



4. Serious Incidents

There was 1 Serious Incident reported in January 2024.

<u>Wrong Site Surgery Never Event</u>
Reported on 24.01.2024 - Joint ROH /UHB Pathway patient.
In line with Trust PSIRF Plan a Patient Safety Incident Investigation (PSII) is underway and remains in progress.
Incident has been reported to BSOL ICB as per usual STEIS process



5. Potential Moderate Harm & Severe Harm Incidents

There were **8 potential Moderate Harm** incidents and **1 potential Severe Harm** incident reported in January 2024.

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 1** – SSI related Incident
- **1 x Ward 3 –** SSI related Incident
- **1 x Spasticity –** Medication
- **1 x Spinal –** Potential Wrong side block
- **1 x OPD** – VTE
- **1 x OPD** – Emergency Transfer into Trust
- **2 x Ward 3** – VTE - 2nd incident is a duplicate Incident
- **Summary of Potential Severe Harm Incidents**
- **1 x Emergency Transfer Out -** Cardiac arrest & subsequent death (see also section 3 of this report)

6. Update on Moderate Harm Incidents from December 2023

There were 7 potential Moderate Harm incidents reported in December 2023. An update on each of these incidents can be found below:

- **1 x Ward 12 – SSI related Incident**
  46075 – Remains as Moderate Harm. IPC, using new IPC PSIRF Framework, have completed review. No further action required.
- **1 x Ward 3 – SSI related Incident**
  46072 - Remains as Moderate Harm. Non – reportable SSI. IPC have oversite for management.
- **2 x Appointment – Delay**
  46135 – **Downgraded to No Harm.** Managed by team. Confirmed no harm to patient and will now be seen routinely in 3 months.
  46023 – Remains as Moderate Harm and under review.
- **1 x Theatre 14 – Cardiac Arrest Call**
  46038 - Remains as Moderate Harm. 1st draft of SNR received and discussed within Divisional Governance, remains under review
- **1 x Rapid Response – Medical Emergency**
  46244 - **Downgraded to No Harm.** Managed well by team, no further action required.
- **1 x ADCU – Partial Digit Amputation**
  46267 – Remains as Moderate Harm. AAR and LOOP completed.

7. Near Miss Incidents

There were 6 Near Miss incidents reported in January 2024

All incidents have been tabled at Divisional Governance Meetings.

Summary of Incidents

1 x OPD – Data Quality. Remains under review

1 x Imaging – Medical Device / Equipment. Managed locally and closed by CSSM.

1 x POAC – Specimen Results Issue. Managed locally and closed by POAC Manager.

1 x Oncology – Cancer Target Breach. Managed locally and closed by CSSM.

1 x Ward 3 –Patient Documentation. Managed locally and closed by Ward 3 Manager

1 x Theatres – Environmental.. Remains under review, work ongoing.

8. Learning from Incidents

There was **1** RCA closed in January 2024**.**

Ward 3 DVT

Outcome

Unavoidable

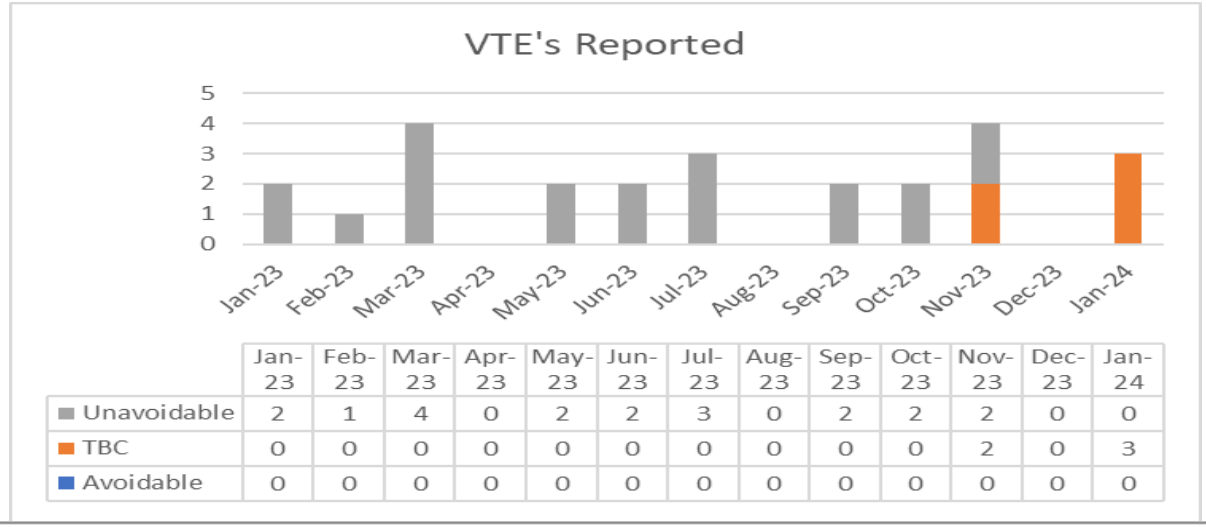
Actions / Recommendations

- Staff to clearly document if Anti Embolic Stockings (AES) and/or sequential devices (SCD) are insitu and to document any valid clinical reasoning as to why only insitu on one leg and not both.
- Staff to clearly document the removal and application of AES and SCD daily.
- Clinical staff VTE training compliance to be 100%.
- Unless specific instruction by anaesthetist no patient should be completely Nil By Mouth pre-op.
- To utilise Sip Til Send policy.

9. Venous Thromboembolism (VTE) Incidents

There were 3 VTE incidents reported in January 2024. Two incidents were related to the same patient. The incident is under investigation by transferring hospital.

Of the 4 VTE incidents reported in November 2023 2 remain under investigation. Provisional conclusion pending sign off at Divisional Governance is that they were unavoidable. The remaining 2 from November 2023 were both deemed unavoidable .



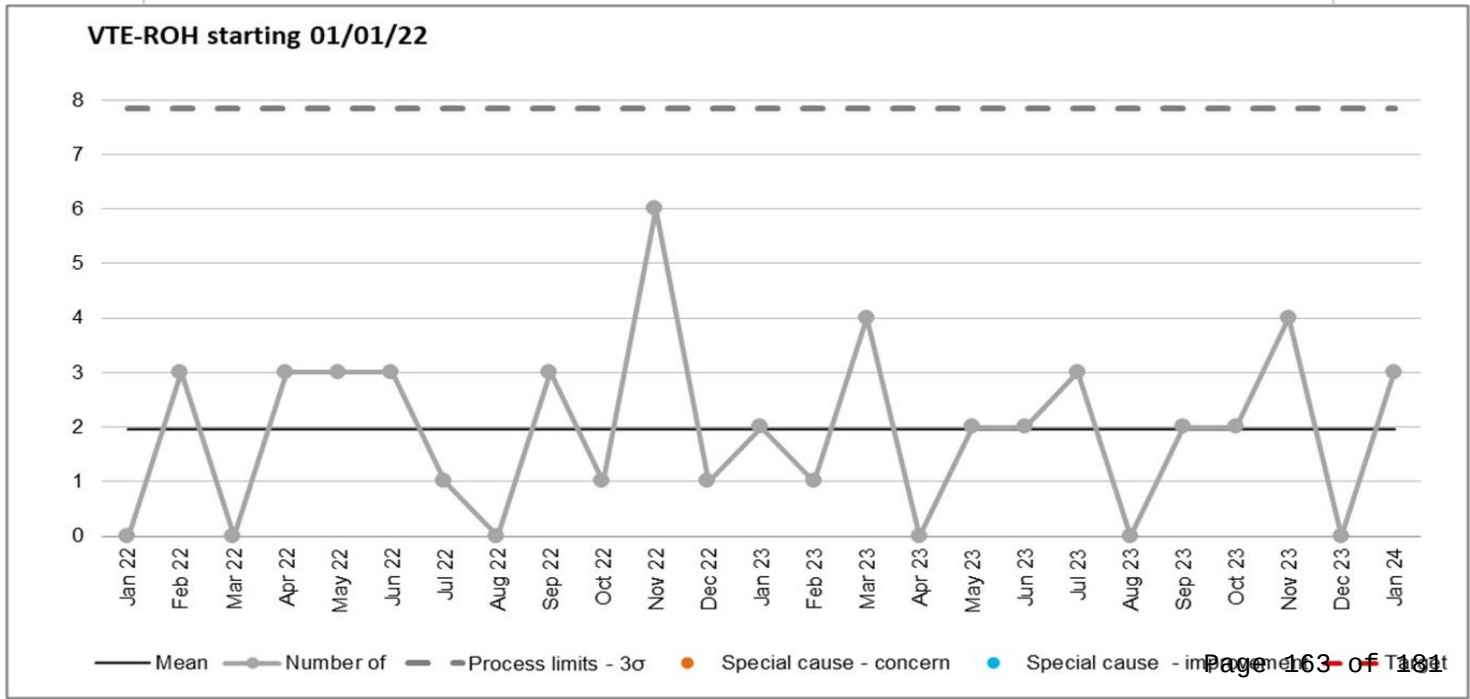
	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Unavoidable	2	1	4	0	2	2	3	0	2	2	2	0	0
TBC	0	0	0	0	0	0	0	0	0	0	2	0	3
Avoidable	0	0	0	0	0	0	0	0	0	0	0	0	0

<u>VTE On Admission Assessment Compliance</u>

Compliance figure for January 2024 = 95.38%

<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.



10. Falls

6 Inpatient falls incidents reported in January 2024

No Harm = 6

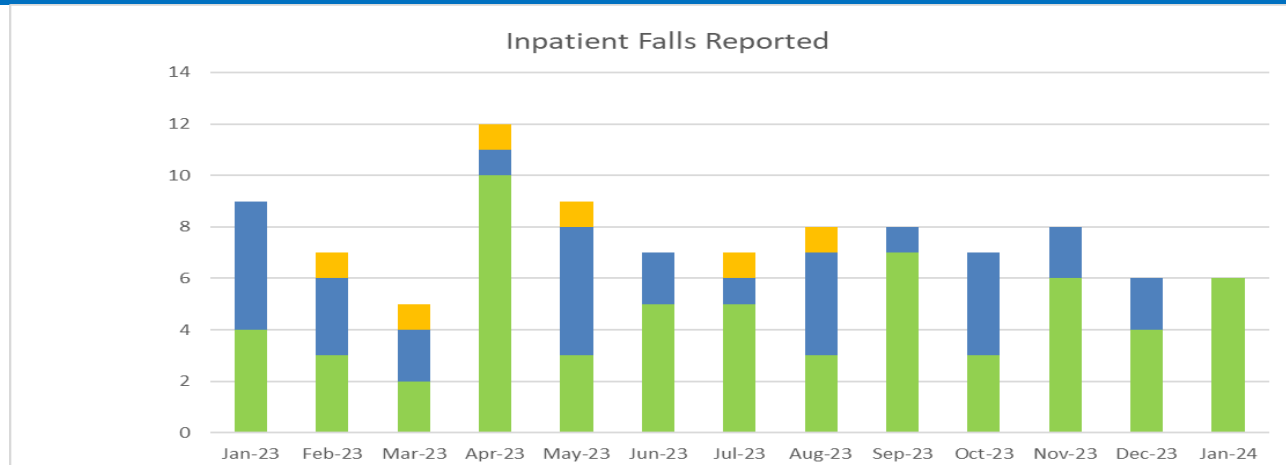
Trends

4 were unwitnessed falls, 1 was a witnessed fall when being supported to the bathroom, 1 was a patient fall when patients mother attempted to transfer patient from toilet to wheelchair.

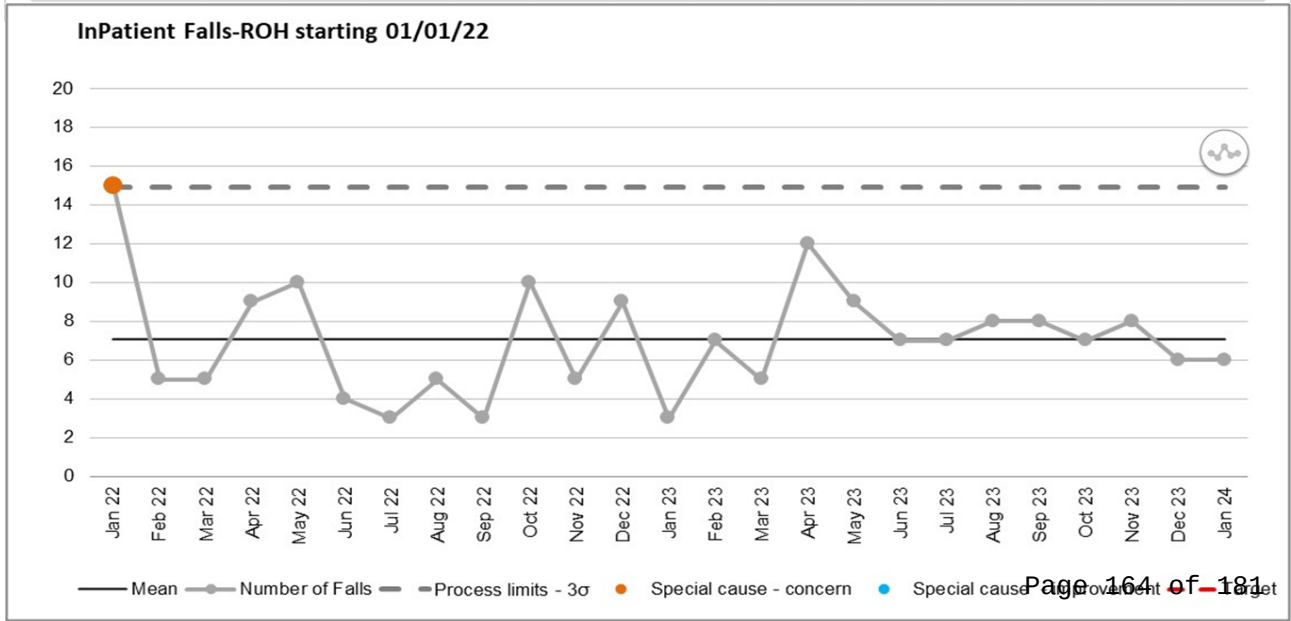
4 of the falls involved patients deemed safe to mobilise however became unstable.
2 of the falls involved patients mobilising against advice.

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



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	1	1	1	1	0	1	1	0	0	0	0	0
Low Harm	5	3	2	1	5	2	1	4	1	4	2	2	0
No Harm	4	3	2	10	3	5	5	3	7	3	6	4	6



11. Pressure Ulcers

0 Category 3 or 4 PU incidents reported in January 2024.

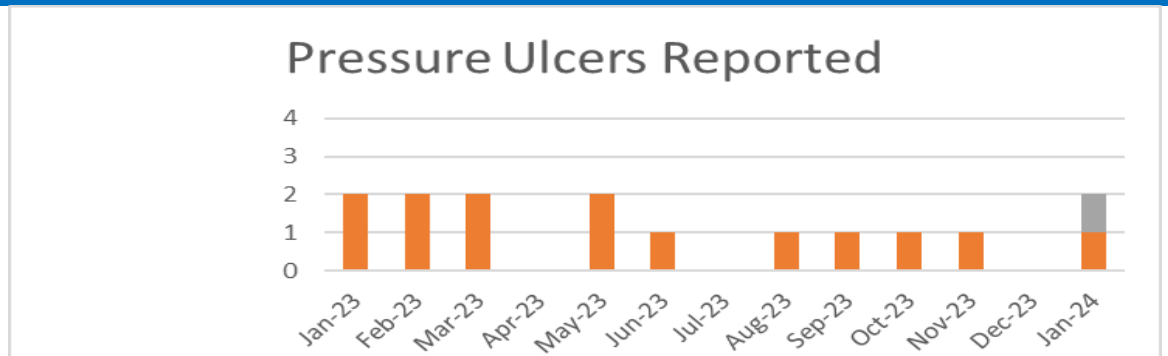
2 Category 2 PU incidents reported in January 2024.

1 x Theatres – No lapses.
1 x Ward 3 – Remains under review

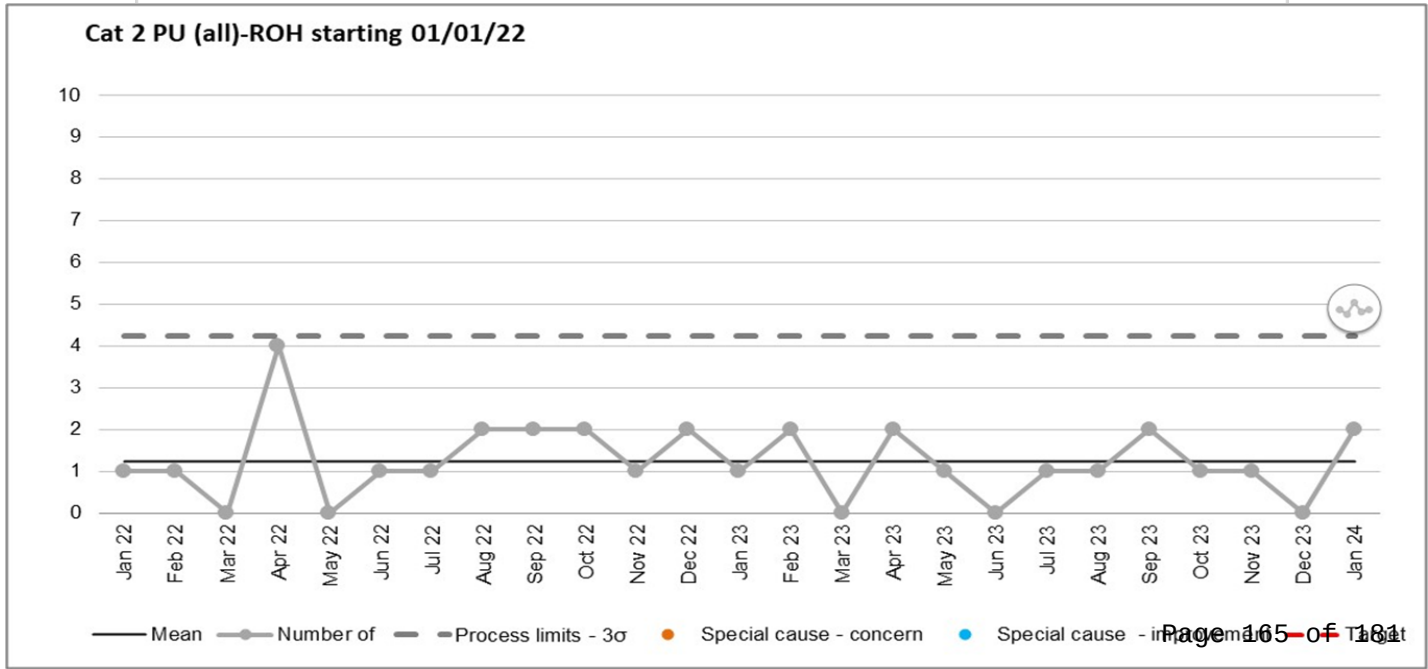
<u>Quality Improvement work planned/underway</u>

New NWCSP "Pressure Ulcer Recommendations and Clinical Pathway" have been released. Changes will need to be made to the PU categorisation and reporting process. TVN Lead undertook a gap analysis and sent summary report to Clinical Quality Group on 05/02/24. Task and finish group to be arranged to discuss the new NWCSP "Pressure Ulcer Recommendations and Clinical Pathway" and propose a new pressure ulcer risk assessment tool.

In addition, work undertaken by teams in the Trust regarding switching from Aquacel Surgical dressing to Mepilex Border Post-op – an abstract has been accepted as an E poster at a National wound care conference in March 2024.



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Sum of TBC	0	0	0	0	0	0	0	0	0	0	0	0	1
Sum of Unavoidable	2	2	2	0	2	1	0	1	1	1	1	0	1
Sum of Avoidable	0	0	0	0	0	0	0	0	0	0	0	0	0



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)	January 2024	YTD
Methicillin-Resistant *Staphylococcus aureus* (MRSA) bloodstream infection	0	0
HOHA/COHA toxin positive *Clostridioides difficile* infection (CDI)	0	2
Methicillin-Sensitive *Staphylococcus aureus* (MSSA) bloodstream infection	0	1
E.coli bloodstream infection	1	3
Klebsiella spp. bloodstream infection	0	0
Pseudomonas aeruginosa bloodstream infection	0	0

Complaint Information

The Trust received **4** complaints in January 2024 and 1 request for information on a previous complaint raised by the patients solicitor

Below are the departments for complaints received

1. Imaging
2. Spinal x3
3. Large Joints / Radiology

In January 2024, the complaints team closed **4** formal complaints.
At the time of producing this report we currently have **7** open formal complaints. 1 complaint is a resolution meeting request, all current complaints are within timeframes at the time of writing this report.

Below are the departments for complaints received

1. Spinal x4
2. Spasticity
3. Large Joints
4. Ward 1

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

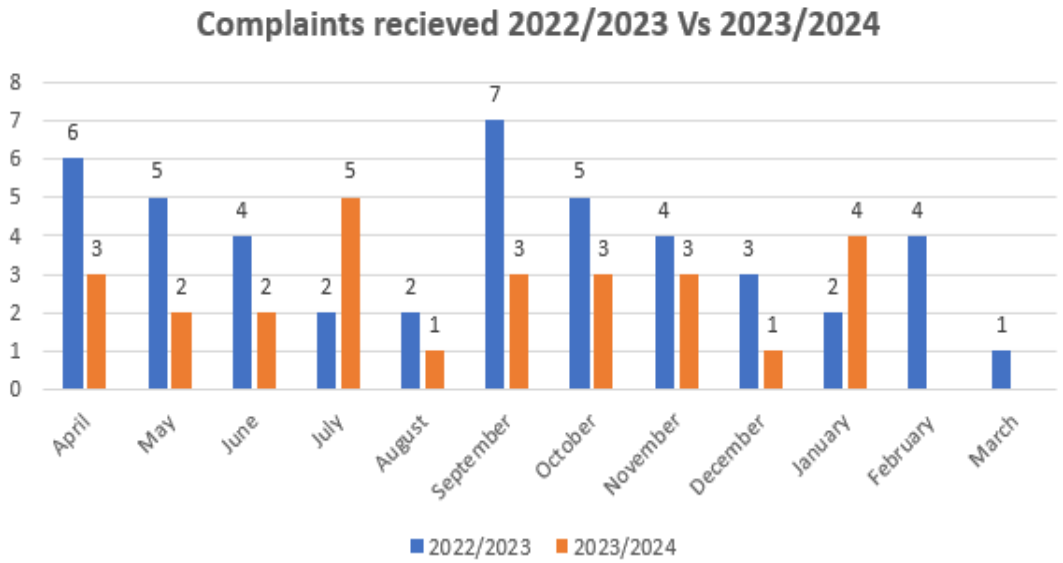
In January, the Trust received **0 reopened complaints.**

In January 2024, the Trust conducted **1 complaint resolution meeting,** which was closed to the complainant's satisfaction

RISK AND ISSUES WITHIN PATIENT EXPERIENCE

Increased volume in phone calls, causing a higher number of contacts who go through to answerphone, therefore risking increase of patient dissatisfaction.

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 – January 2024	31

Complaints KPI's

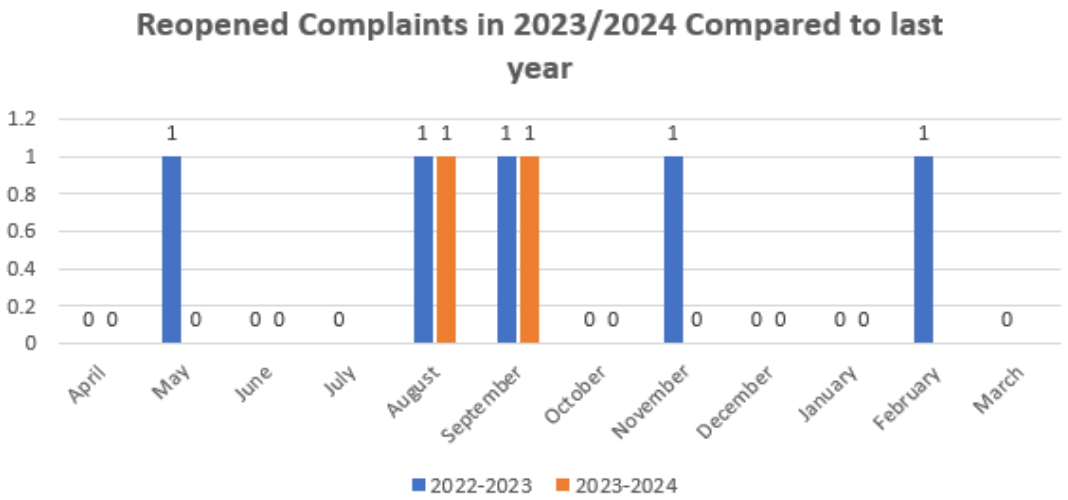
KPI	Complaints %
April 2023	100%
May 2023	67%
June 2023	75%
July 2023	100%
August 2023	0%
September 2023	100%
October 2023	77%
November 2023	100%
December 2023	0%
January 2024	0%

0%-79%
80%-90%
91%-100%

Actions from Complaints

In January 2024 3 actions were identified, which 2 remain open
No Immediate action plans were completed by the triumvirate for any of the complaints received in January.

Complaint Themes



Reopened complaints

The Trust received no reopened complaints in January 2024. This can be attributed to the complaints previously resolved being 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.

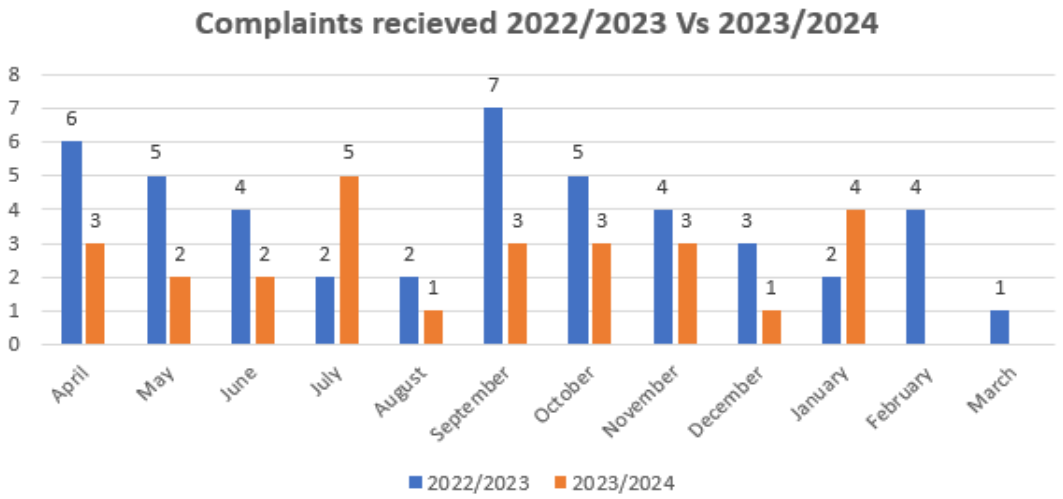
Themes

1. Communication

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

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 – January 2024	31

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%
January 2024	0%

0%-79%
80%-90%
91%-100%

Actions from Complaints

In January 2024 3 actions were identified, which 2 remain open
No Immediate action plans were completed by the triumvirate for any of the complaints received in January.

15. Litigation and Coroners

New claims

0 new claims were received in January 2024.

Pre-Application Disclosure

0 new requests for Pre-Application Disclosure of medical records were received in January 2024.

Coroner's Inquests

0 Inquests in which the Trust was an 'interested person' were held in January 2024.

16. WHO Surgical Safety Checklist

Theatre Audit

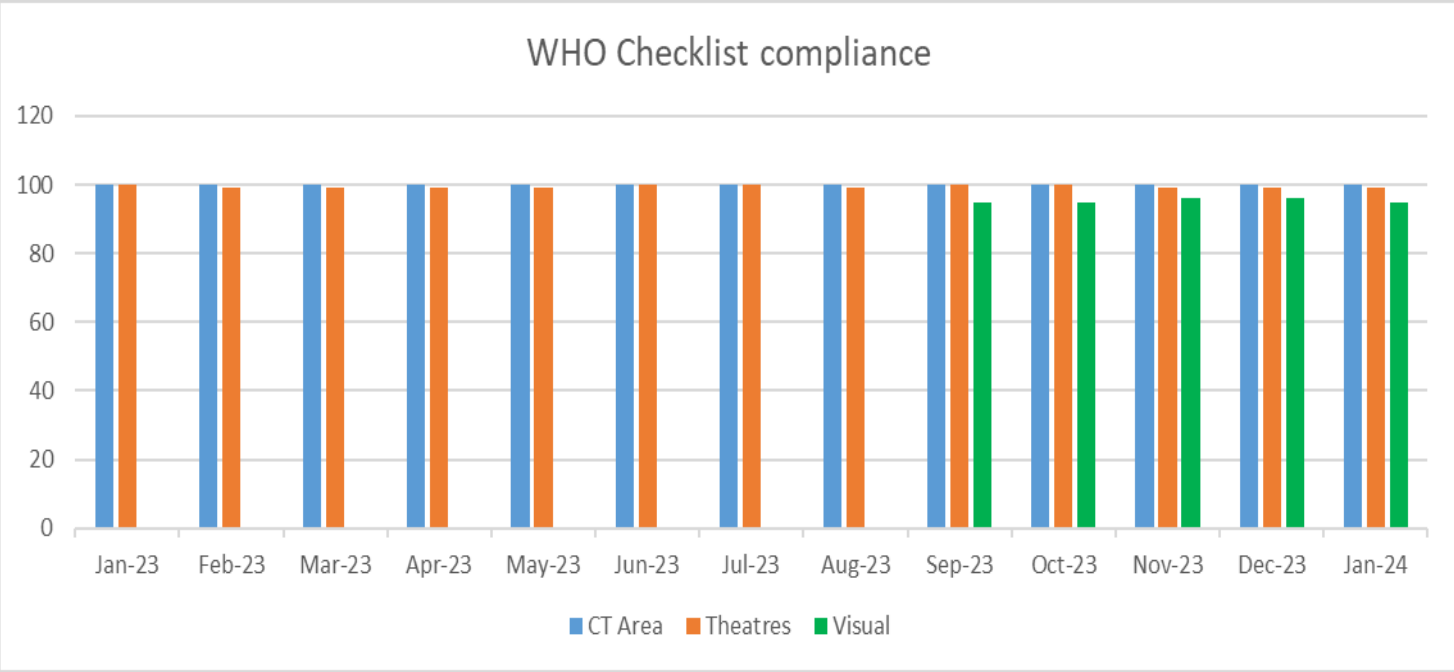
	Scores	Percentages
Team Brief	895/895	100%
Sign In	895/895	100%
Time Out	895/895	100%
Sign Out	895/895	100%
Team Debrief	893/895	99%
Total	895/895	99%

CT Area Audit

	Scores	Percentages
Team Brief	114/114	100%
Sign In	114/114	100%
Time Out	114/114	100%
Sign Out	114/114	100%
Team Debrief	114/114	100%
Total		100%

Visual Audit

	Scores	Percentages
Team Brief	26/26	100%
Sign In	23/26	88%
Time Out	26/26	100%
Sign Out	26/26	100%
Team Debrief	23/26	88%
Total		95%



17. CAS Alerts

There were **2** new CAS alerts issued in January 2024

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2024/002/NHSPS	Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks. This National Patient Safety Alert, issued by the NHS England National Patient Safety Team, and co-badged by the Association of Anaesthetists, Royal College of Anaesthetists, and the Safe Anaesthesia Liaison Group, instructs all relevant NHS funded providers to complete the transition to NRFit connectors for all intrathecal and epidural procedures, and delivery of regional blocks by 31 January 2025.	National Patient Safety Alert - NHS England Patient Safety	31-Jan-24	Assessing relevance.	31 Jan 25
NatPSA/2024/001/DHSC	Shortage of GLP-1 receptor agonists (GLP-1 RA) update. The supply of glucagon-like peptide-1 receptor agonists (GLP-1 RAs) continue to be limited, with supply not expected to return to normal until at least the end of 2024. The supply issues have been caused by an increase in demand for these products for licensed and off-label indications. This National Patient Safety Alert provides further background and clinical information and actions for providers.	National Patient Safety Alert - DHSC	03-Jan-24	**10 Jan 24:** **Chief Pharmacist:** *'We wouldn't initiate any of these therapies and if the patient ran out, we would refer to the GP for specialist advice and follow up'.* Assessed - not relevant to organisation's services.	28 Mar 24

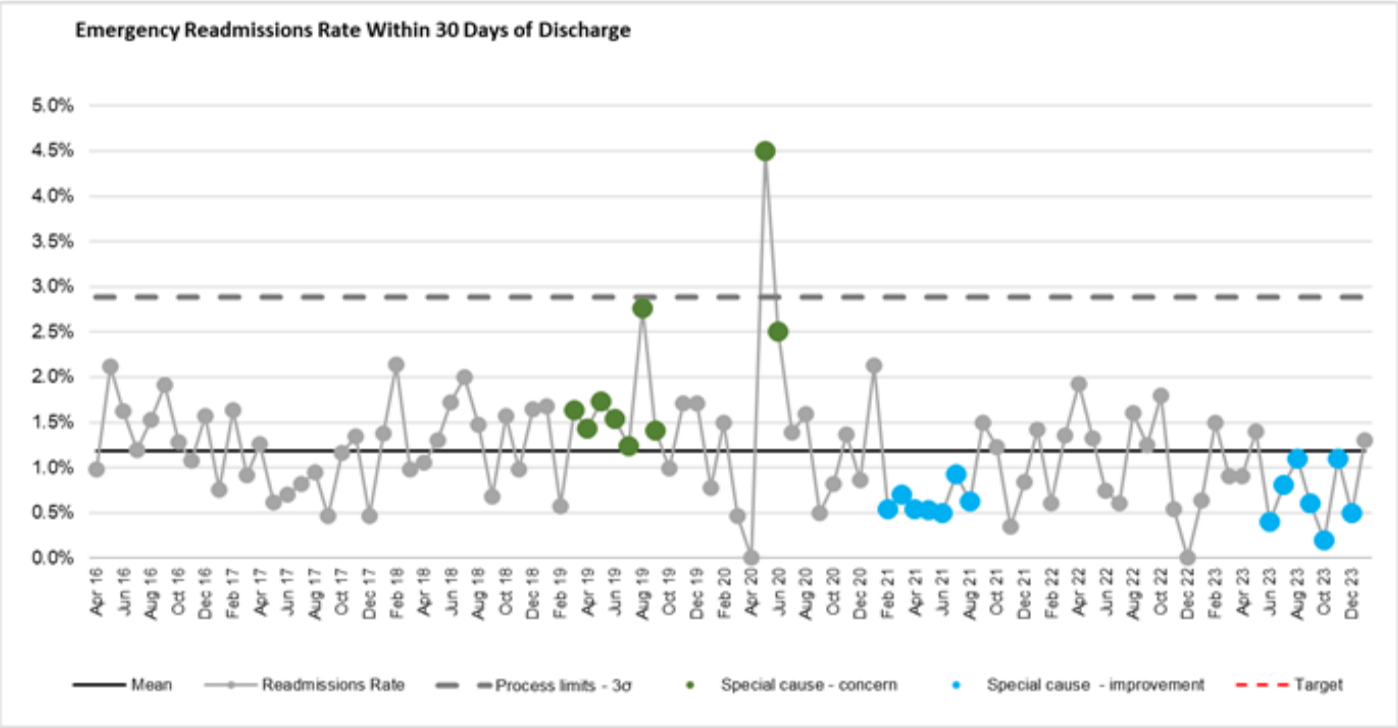
17. Cas Alerts Continued - Outstanding Alerts from Previous Month

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'.* **Estates:** Beds tagged to aid compilation of Estates inventory. **Estates:** Beds & bedrails will now be serviced iaw Arjo's yearly service schedule by our in-house engineers. On-going...	1 Mar 2024

18. Safeguarding

KPI	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Dec-23	Dec-23
Safeguarding Adult Notifications	31	35	17	43	21	44	43	47	37	47	58	65
Safeguarding Children Notifications	26	76	23	37	29	55	51	42	25	35	40	45
Adult Level 2 - 85%	81.83%	80.28% (↓)	80.19% (↓)	82.27% (↑)	83.12% (↑)	84.68% (↑)	86.22% (↑)	86.22%	85.48% (↓)	86.86% (↑)	88.7% (↑)	88.97% (↑)
Adult Level 3 - 85%	75.68%	75.2% (↓)	76.37% (↓)	77.84% (↑)	80.15% (↑)	83.02% (↑)	83.11% (↑)	82.06% (↓)	83.15% (↑)	83.83% (↑)	86.03% (↑)	84.11% (↓)
Level 4 - 90%	75.00%	60% (↓)	80.0% (↑)	80.00%	80.00%	80.00%	100% (↑)	100% (↑)	100.00%	80% (↓)	80.00%	80.00%
Child Level 2 - 85%	81.16%	79.93% (↓)	79.85% (↓)	82.18% (↑)	82.86% (↑)	84.68% (↑)	86.14% (↑)	86.12% (↓)	85.23% (↓)	86.7% (↑)	88.46%(↑)	88.89% (↑)
Child Level 3 - 85%	75.29%	75.2% (↓)	76.37% (↑)	78.03% (↑)	80.15% (↑)	82.82% (↑)	83.11% (↑)	81.68 (↓)	82.8% (↑)	83.46% (↑)	85.84% (↑)	83.96% (↓)
Mental Capacity Act MCA - 85%	81.67%	80.19% (↓)	80.36% (↑)	82.44% (↑)	83.21% (↑)	84.85% (↑)	86.39% (↑)	86.35% (↓)	85.88% (↓)	87.11% (↑)	88.62% (↑)	88.97% (↑)
Deprivation of Liberty Safeguards DoLs - 85%	81.58%	79.93% (↓)	79.93%	82.09% (↑)	82.95% (↑)	84.68% (↑)	86.22% (↑)	86.27% (↑)	85.63% (↓)	86.95% (↑)	88.54%	88.89% (↑)
Prevent Awareness - 90%	89.88%	89.40%	88.96%	90.14%	89.86%	90.49%	91.24% (↑)	91.32% (↑)	89.98% (↓)	94.48% (↑)	91.38%	90.33% (↓)
WRAP (prevent level 3) - 85%	81.06%	78.55% (↓)	80.2% (↑)	82.19% (↑)	83.89% (↑)	85.68% (↑)	87.89% (↑)	87.41% (↓)	86.15% (↓)	85.51% (↓)	86.25% (↑)	85.22% (↓)
FGM	1	2	1	3	0	1	0	5	2	3	1	1
DOLS	6	4	0	7	0	6	4	4	2	5	3	6
MCA	4	0	1	3	4	1	4	2	7	5	6	7
PIPOT cases	0	1	0	0	0	0	1	0	0	0	0	1
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0	0	0

19. Patients Readmitted to a Hospital Within 30 Days of Being Discharged



	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
No of Readmissions	7	5	4	7	2	4	5	3	1	6	3	6
Denominator	468	546	465	494	554	482	469	492	543	553	557	462
% Readmissions	1.5%	0.9%	0.9%	1.4%	0.4%	0.8%	1.1%	0.6%	0.2%	1.1%	0.5%	1.3%

20. Freedom to Speak Up Update

Concerns Raised

There were 28 concerns raised in January 2024 in relation to the following themes:-

- Worker safety and wellbeing
- Attitude and behaviour
- Bullying and harassment

Learning and Outcomes:

Escalation of an issue affecting a number of staff within a department to HR – awaiting outcome of HR review

Finance and Performance Report

Month 09

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 January 24	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	50.65%	50.60%	92%		F
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	83	87	0	L	F
52 week waits (52 – 64 Weeks)	428	474	0	H	F
All activity YTD (compared to plan)	11,901	10,750	11,866		P
Outpatient activity YTD (compared to plan)	55,232 100.7% Cumulative	49,349 100.3% Cumulative	54,837 YTD Target		P
Outpatient Did Not Attend (YTD)	7.6%	7.8%	8%		P
PIFU (trajectory to 5% target)	490 8.6%	392 9.1%	193 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	10.5%	8.4%	19%		F
FUP attendances(compared to 19/20)	90.5%	90.6%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	109.5%	110.1%	120%		F
Diagnostics volume YTD (compared to plan)	20,660 Cumulative	18,571 Cumulative	15,690 YTD Target		P
Diagnostics 6 week target	99.3%	99.7%	99%		P

Operational Performance Summary

Performance to end January 24	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (Uncapped)	82.0%	87.2%	85%		
Cancer - 31 day first treatment	100%	100%	96%		
Cancer - 62 day (traditional)	85.7%	85.7%	85%		
28 day FDS	75.3%	100%	75%		
Patients over 104 days (62 day standard)	1	0	0		
POAC activity volume (YTD)	21,511 Cumulative	19,031 Cumulative	19,326 Cumulative		
Bed Occupancy (excluding CYP and HDU)	62.6%	67.8%	82-85%		
LOS - excluding Oncology, Paeds,YAH, Spinal	3.16	3.56	n/a		
LOS - elective primary hip	2.90	3.70	2.7		
LOS - elective primary knee	2.80	2.80	2.7		
BADS Daycase rate (Note: due to time lag in month is Oct'23)	77.0%	77.0%	85%