The Royal Orthopaedic Hospital NHS Foundation Trust

Trust Board (Public)

Wednesday 10th April 09:00h-11:45h

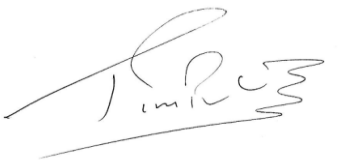
Boardroom, Trust Headquarters

Notice of Trust Board Meeting in Public on Wednesday, 10 April 2024

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 10th April 2024, in the Boardroom, Trust HQ commencing at **09:00.**

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

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



Tim Pile
Chair

The Royal Orthopaedic Hospital NHS Foundation Trust

AGENDA
TRUST BOARD

Venue Boardroom, Trust Headquarters **Date** 10 April 2024: 09:00h – 11:45h

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 Jan Teo	Non Executive Director	(JT)
Mrs Jo Williams	Chief Executive	(JW)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mr Mathew Revell	Executive Medical Director	(MD)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance

Mrs Chris Terry	Patient	(CT)	[Item 1]
Ms Sharon Latham	Head of Patient Experience	(SL)	[Item 1]
Mr James McKenzie	Guardian of Safeworking	(JM)	[Item 8]
Mr Chidi Ukaegbu	Quality Improvement Nurse	(CU)	[Item 10]
Mrs Emma Steel	Deputy Chief Nurse	(ES)	[Item 10]
Mrs Michelle Hubbard	Acting Executive Chief Operating Officer	(MH)	
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
09:00	1	Patient story	ROHTB (4/24) 026	CT
09:20	1.1	Patient/Staff Story Annual Report: *for assurance*	ROHTB (4/24) 001 ROHTB (4/24) 001 (a)	NB
09:30	2	Guardian of Safeworking Update: *for assurance*	ROHTB (4/24) 002 ROHTB (4/24) 002 (a)	JM
09:40	3	Apologies: Marie Peplow	Verbal	Chair
	4	Declarations of Interest	ROHTB (4/24) 003	Chair
	5	Minutes of Board Meeting held in Public on 6 March 2024: *for approval*	ROHTB (3/24) 019	Chair
	6	Actions from previous meetings in public: *for assurance*	ROHTB (3/24) 019 (a)	SGL

09:45	7	Questions from members of the public	Verbal	Chair
09:46	8	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (4/24) 004 ROHTB (4/24) 004 (a)	TP/JW
10:15	9	Service Accreditation: *for assurance*	ROHTB (4/24) 006 ROHTB (4/24) 006 (a)	CU/ES
10:35	**BREAK**			
10:50	10	'Flu vaccination update: *for assurance*	ROHTB (4/24) 007 ROHTB (4/24) 007 (a)	NB
	GOVERNANCE AND COMPLIANCE			
11:00	11	Fire Safety Annual Report: *for approval*	ROHTB (4/24) 008 ROHTB (4/24) 008 (a)	SGL
11:10	12	Board Topics Plan 2024/25: *for approval*	ROHTB (4/24) 009	SGL
11:15	13	Freedom to Speak Up Assurance Report: *for assurance*	ROHTB (4/24) 010 ROHTB (4/24) 010 (a)	GH
	UPWARD REPORTS FROM THE BOARD COMMITTEES			

11:20	14	Upward reports from the Board Committees:
		• Finance & Performance Committee
		• Staff Experience & OD Committee
		• Quality & Safety Committee
		  ○ Quality & Safety Annual Report
		  ○ Quality & Safety Terms of Reference
			ROHTB (4/24) 011
			ROHTB (4/24) 012
			ROHTB (4/24) 013
			ROHTB (4/24) 013 (a) & (b)
			ROHTB (4/24) 013 (c) & (d)
				LW
				SJ
				IR

11:35	**MATTERS TO BE TAKEN BY EXCEPTION ONLY**			
	15	Gender Pay Gap Report: *for assurance*	ROHTB (4/24) 014 ROHTB (4/24) 014 (a)	
	16	RACE Code Adoption plan: *for information*	ROHTB (4/24) 015	
	17	Performance Reports: *for assurance* a) Finance & Performance b) Quality	ROHTB (4/24) 016 ROHTB (4/24) 017	
11:45	**CONFIDENTIAL SESSION**			
	CLOSE: Date of next meeting: Wednesday, 1 May 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)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Christine Fearns	✓	✓	**A**	**A**	**A**						2/5
Ian Reckless	**A**	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/10
Richard Phillips	✓	✓	✓	✓	✓	✓	✓	✓			8/10
Simone Jordan	✓	✓	✓	✓	**A***	**A**	✓	✓	✓	✓	8/10
Gianjeet Hunjan	**A**	✓	✓	✓	✓	✓	✓	✓	✓	✓	9/10
Ayodele Ajose	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Les Williams	✓	✓	✓	**A**	✓	✓	✓	✓	✓	✓	9/10
Simon Page									✓	✓	2/2
Jenny Belza									✓	✓	2/2
Jo Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	10/10
Matthew Revell	✓	✓	✓	✓	**A***	✓	✓	✓	✓	✓	9/10
Nikki Brockie	✓	✓	✓	✓	✓	**A**	✓	✓	✓	✓	9/10
Marie Peplow	✓	✓	✓	✓	✓	✓	✓	✓	A	A	8/10
Stephen Washbourne	✓	✓	✓	✓	✓	**A**	✓	✓	✓	✓	9/10
Sharon Malhi	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	9/10
Simon Grainger-Lloyd	✓	**A**	✓	✓	✓	✓	✓	✓	✓	✓	9/10

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

The Royal Orthopaedic Hospital NHS Foundation Trust

Christine's Story

Where it all began….

Christine is a qualified nurse and was referred to the Royal Orthopaedic Hospital as she needed a left ankle fusion. She had her first surgery here in 2013.

Once she had been here as a patient Christine knew that she wanted to work here and applied to work as a Bank Staff Nurse and worked on the wards here alongside working at the Q.E until 2020.

Christine still does some work here as an interviewer and has gone on to have several more surgeries at the Royal Orthopaedic Hospital, most recently a partial right sided knee replacement in November 2023.

Last story….

Chris attended ROH in November 2022 for a Total Ankle Replacement and at that time she compiled her story for presenting at Board, her surgery was successful her experience as an inpatient was not completely satisfactory and learning and actions were identified.

Learning Identified -

- POAC documentation was lost
- Arrived fasted and had to wait 7 hours before surgery
- No formal ward round within 24 hours of surgery and had to request to see a doctor
- Concern about the room size and access for emergency, door was wedged open, unable to mobilise with a zimmer frame.
- Food was good but pudding went cold quickly when served with main meal

You said - We did

- POAC – “synopsis” electronic admission system now in place. Patients now only input information once and it is stored for future use
- “Sip to Send” policy is now in place
- Side room has been risk assessed against DOH 2013 guidance and has been discontinued as a patient area.
- Puddings served after a hot meal

Pre-Admission

The Synopsis pre op health questionnaire was easy to access and easy to complete and although there were some access issues initially with “My Recovery App” that also helped with pre op exercises and helping me feel prepared for the surgery and involved in my treatment and recovery.

When I attended POAC the staff were all friendly, I was seen on time and was in one room where the different healthcare staff came to me, there was no unnecessary repetition of questions as the online responses were available. I was given all the useful paperwork pre admission and my only comment would be the seating arrangements in POAC are placed in a way that can feel quite confrontational facing each other but otherwise it is a nice environment.

Admission Day

I arrived at 09.30, I was updated regularly in POAC regarding timings and was anaesthetised at 12.45. The anaesthesia staff were very good at putting me at ease and helping me to feel a little “in control” of my care. When I awoke in pain the anaesthetist was called to review me and I wasn’t transferred to the ward until my pain was more under control.

Ward 12

I was welcomed onto the ward by the ward sister “Hello My Name Is Cheryl”
I was made comfortable, offered refreshments and observations completed, my pain was assessed regularly and analgesia was given as needed.
My room was clean, spacious enough and the information board was kept updated as my needs and mobility changed. The call bell was always within my reach and answered speedily on each occasion I used it.
When my partner visited staff were always friendly and welcoming and I was seen daily by medical staff who were fully updated on my current condition
My stay on the ward was overall a really positive experience with only a few concerns most of which were heard and addressed immediately

Positive Highlights

- I was pleased to be able to administer my own enoxaparine injections while still in hospital thus preparing me for self administration post discharge
- The NHS free wifi was much appreciated for entertainment and occupying time.
- My permission was asked prior to any intervention taking place and all interactions were kind, professional and unhurried
- When I was tearful and in pain I had psychological care offered to me by two separate HCAs giving me time to talk and offer me reassurance, the domestic was also a wonderful person to chat to giving me time to talk.
- Physiotherapy was great – kind, responsive and patient
- Porters were kind, gentle and great to chat to
- The volunteers were really helpful especially at the front door
- The grounds are lovely to look at and walk through

Post Discharge

- Physio at College Green is a lovely environment and my physio was great, he spotted immediately that my flexion was no sufficient and referred for hydrotherapy.
- Hydrotherapy started within a week of referral and it's a great environment, it's good that the physio is in the pool alongside the patients and it helps it to be encouraging and supportive.
- In Outpatients both pre and post op myself and my partner have been treated kindly, respectfully and have never been rushed. As a nurse I have been given the time to look at my scans etc and talk to the doctor about them

Concerns

When I attended for my MRI the person who did the scan was wearing what looked like a long outdoor coat with blue hospital gloves. She didn't introduce herself and was not wearing any visible ID. She didn't explain anything about the procedure or the noise and movement the scanner would make.
When the scan finished the table just jolted backwards scaring me to the point that I screamed. When I opened my eyes, she stood there and just said "all finished" and walked off. I asked her colleague and the receptionist what her name was but both professed not to know. I now regret not having taken this further at the time.

During my admission

- No one asked about or to see my pressure areas despite being on bed rest with very limited mobility.
- I never received a rubbish bag despite asking every member of staff who cleared away my rubbish
- I didn't see many people completing hand hygiene despite there being a sink and alcohol gel in my room
- The dressing on my knee was very obvious and I was surprised that on 2 occasions staff very roughly removed and reapplied the dressing with no regard for the pain that this caused.
- Not all of the night staff were bare below the elbow.
- I didn't see an occupational therapist and no-one looked at the pre-op measurements that I'd been asked to provide
- There were no opening times for Café Royale on display and when I was wheeled down there it was closed and the drinks machine was broken

and finally……

The pudding was still served at the same time as the main course so it was cold by the time it came to eat it

Actions

- MRI / Imaging Department have an action plan in place to address Staff Behaviours and Patient Perception which is being monitored by the Head of Imaging
- Matron and Ward Manager made aware of inpatient concerns and will be addressing actions required
- Patient Experience team are planning an information booklet for patients on admission which will contain useful information including Café Royale opening times, in the interim all wards will be asked to ensure that they have the opening times clearly displayed.

Thank you for listening to my story.

REPORT REF: ROHTB (4/24) 001

TRUST BOARD

DOCUMENT TITLE:	**Board Patient and Staff Experience Stories 2023/2024**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Executive Chief Nurse**
AUTHOR:	**Sharon Latham, Head of Patient Experience**
PRESENTED BY:	**Nicola Brockie, Executive Chief Nurse**
DATE OF MEETING:	**10th April 2024**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Royal Orthopaedic Hospital NHS Foundation Trust is committed to improving our services and patient experiences by learning from complaints, feedback, comments, and compliments raised by our patients, their carers, family, friends, and members of public who have contact with the Trust.

The Trust is dedicated to continuously improving our services by listening to our service users and their families. We want to ensure that we learn from our patients lived experience, thus helping us to improve our care and services. Capturing and sharing patient lived experience and stories add value and support the Board to have focus on the daily experiences within the Trust.

This report provides assurance regarding the patient experience stories brought to Board in the previous financial year.

During the year, it was agreed that the Board stories would alternate between staff and patients. Given that only two stories from staff have been heard during the year, the summary of these and the actions arising will be included in the next full annual report.

ASSURANCE PROVIDED BY THE REPORT:

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

NOT APPLICABLE – For Information	X

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to: Note for Assurance

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

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

ALIGNMENT TO TRUST STRATEGY, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Trust Strategy 2023-2024
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
None specifically.
PREVIOUS CONSIDERATION:
Board Patient Experience Stories 2023/24

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

Board Patient Experience Stories 2023/2024

Report to Trust Board April 2024

1 Purpose of the Report

1.1 This paper provides a summary of the patient stories presented to the Royal Orthopaedic Hospital (ROH) Trust Board throughout 2023/24.

2 Context and Background

2.1 The Royal Orthopaedic Hospital NHS Foundation Trust is committed to improving our services and learning from complaints, feedback, comments, and compliments raised by our patients, their carers, family, friends, and members of public.

2.2 The Trust is dedicated to continuously improving our services by listening to our service users and their families. We want to ensure that we learn from our patients lived experience, thus helping us to improve our care and services. Capturing and sharing patient lived experience and stories adds value and supports the Board to focus by doing the following:

- Connecting with our patients and relatives.
- Learning from lived experience and stories to help us to improve our services.
- Connecting with front line staff and understanding the impact that involvement with harm or near miss incidents can have. We should never underestimate the emotional effect on staff involved in incidents of patient harm. It can be an opportunity for staff to talk in depth about an event and discuss with senior leaders their thoughts and opinions on why it happened and how it could be avoided in future.
- Improve understanding of human factors in harm and error. Boards are advised to concentrate on strategy, but an in-depth story can give useful detail that provides a window into the workings of the system. This can be particularly useful in building understanding of what it means to have a culture that is just; one that recognises why people make mistakes and exactly what they are asking of their staff when they put them to work in their organisation.
- Make patient safety personal. When stories of patient harm appear in the media it is not uncommon for healthcare leaders to feel such an event would not happen in their organisation. Hearing stories of their patients who have been harmed or had a near miss brings it into their own sphere of accountability – 'this is here, we did this'.

2.3 The Trust has Patient or Staff Stories scheduled at each Board meeting. The stories are usually told by the subject of the story (patient or staff member) but they may choose to have a representative tell the story on their behalf. The Patient Experience Team and Executive colleagues support staff and patients to prepare for the Board meeting and to share their story. The Patient Experience Team will actively seek patients who are willing to share their stories with the Board. This paper will only focus on the patient stories for 2023/24:

3 Preparation for Presenting

3.1 Patients, in preparation for presenting at Board, are asked to consider the following questions:

- **Summary of their journey.**
- **Things that went well.**
- **Things that could be improved.**
- **What did we as a Trust do to improve your experience whilst in hospital (if applicable).**
- **Actions and any solution.**
- **How will we embed learning from this patient experience around the Trust?**

3.2 At the end of each financial year, the Patient Experience Team will provide a summary report to the Board of the previous year's stories, learning and actions.

4 Board stories over 2023 / 24

4.1 The following stories have been presented to the Board in the financial year 2023/2024

4.3 March 2023: Emergency surgery

Presented by: Simon Hughes, Spinal Oncology Consultant

Situation:

The patient, referred from University Hospital Wales, had presented with paraplegia subsequent to an emergency procedure that had been carried out to decompress a tumour in his neck. The patient also had a history of head injury and required more time to process and ask questions.

Experience:

The ROH team collaborated with regional teams in London and Manchester, to facilitate the spinal cord surgery which was successfully completed without spilling the tumour. Due to the additional needs of the patient, the family were supported with overnight accommodation which lessened the family's and the patient's anxiety.

Learning:

- It was NOTED that the advantage that the Trust provided was that it was small and specialist. It was also NOTED that ROH was in a unique position to be able to communicate with specialist units around the country.

4.4 April 2023: Dementia patient's story

Presented by: Kim Macken, Ward Manager on Ward 1

Situation: The patient story outlined the concerns of an individual who experienced dementia and displayed behavioural issues during his time in the Trust.

Experience:

It was reported that at times he became physically and verbally aggressive towards staff and family members, however the teams at the ROH had managed this well and supported the patient, his family and each other throughout the episode of care.

Learning:

- All staff receive dementia learning Level 1. Level 2 (full day) training had been suspended during COVID and had failed to resume. This is currently being re-modelled and will be rolled out in 2024/25 to key staff. However, the Trust has successfully recruited and embedded a Dementia lead, who has carried out a gap analysis and developed an action plan to support Dementia patients, carers and families.
- 'This is Me' document is now shared ahead of admission and the introduction of Synopsis has support early intervention.
- The 'Butterfly scheme' was agreed in 2023/24 and is being implemented at present. This will raise awareness and support family to have confidence to raise concerns.

4.5 May 2023: Child at risk patient story

Presented by: Candy Brown & Jenny Spotswood, Staff Nurses that worked in the Children's Outpatients Department.

Situation:

The CYP team shared a moving story of a 4-year-old child who was 'was not brought' to clinic a number of times. Further investigation highlighted the child has missed 32 appointments across varies providers in BSOL.

Experience:

Following a series of missed appointments, the team followed the Trust Was-Not-Brought Process, whereby, if a child was not brought on two consecutive appointments, lateral safeguarding checks are completed. It transpired that the child had missed 32 appointments at another hospital, and was also missing school and respite care, resulting in no time away from its parents.

Concerns over the father's controlling behaviour were also raised. The concerns were escalated to the child's Social Worker's Team Manager and, after further investigation, a Section 47, Child Protection Removal from Family order, was issued.

Learning:

- Shared information across BSOL was highlighted as an area of concern. The Chief Nurse & the Safeguarding lead continue to attend the Safeguarding Board meeting and work closely with partner to improve communication.
- Ensuring the 'voice of the child' – the trust continue to work with patient's, carers and families to ensure the voice of the child is heard.

4.6 June 2023: Patient's care post Total ankle replacement

Presented by: Nikki Brockie, Chief Nurse.

Situation:

57-year-old lady (Nurse) underwent a Total Ankle replacement on 3rd November 2022.

Experience:

This lady shared her story from start to finish, highlighting a number of areas that required improvement:

- POAC Documentation was lost.
- Arrived at 7am, surgery was 7 hour later, and this lady was fasted all this time.
- On return to ward (Side room 14 on Ward 12) patient had concern about the room size and access for emergency. The room was also difficult to clean, access and doors had to be wedge open. It also made post-operative mobilisation with a Zimmer frame difficult.
- Food was served together and went cold. Resulting in reduced nutritional intake post-surgery.
- Reviewed by doctor was from the door and infrequently.
- Patient was relieved when moved on to the main ward - the staff were kind, caring, and respond to buzzers.

Learning:

- Pre-operative Assessment improvements – synopsis in place. Electronic admission system. Patient only need to in put information once and its recorded.
- Hydration - '*Sip to send*' policy has now been embedded in practice with marked improvement in local audits.
- Side room risk assessed as two small against The Department of Health (2013) guidance. Side room closed following assessment.
- Food provision - Puddings to be served after hot meal (not together).

4.7 September 2023: Patient's experience in an MRI scanner
Presented by: Steven Beaumont, Interim Deputy Chief Nurse

Situation:
Patient claustrophobia in MRI scanner. The patient had a history of failed MRI scans due to their condition and the possibility of an open MRI scan was considered. However, an open MRI would have required additional funding and the external provider with the appropriate equipment could only offer an appointment date which would have resulted in a breach of the 78-week target.

Experience:
There was pro-active communication with the patient who was encouraged to approach their GP for sedation and the patient was given the option for the procedure to be undertaken on the new scanner which has a wider bore. The patient agreed to the sedation and a bespoke pathway was developed which included patient preferences such as an early morning appointment and a member of staff staying with the patient during the procedure. The MRI scan was successfully completed, and the patient was very happy with their experience.

Learning:
- The new scanner with a wider bore is being promoted to support patients with claustrophobia. The team support a patient-centred approach to ensure all patients needs are met.

4.8 February 2024: Video clip from Neurodiverse patient (shared prior to Board)
Presented by: Florence Dowling (FD) & Sally Wilson (SW), Learning Disability Nurses

Situation: One of our patients who experiences neurodiversity had created a patient experience presentation and voiceover for the Champions Day and this was shared with the Board with the patient's agreement.

Experience:
The presentation detailed the patients experience and observations throughout their treatment journey and had been shared with the Board prior to the meeting to allow for questions.

Learning:
- Signage around the hospital – plans to review and include neurodiverse patients. (Funding is also being sought to fund signage for young people).
- The patient is also supporting the Trust by producing shorter clips to support awareness and educational needs of staff.
- Communication box – are being refreshed and are due to be re-introduced early in 2024.

6. Patient / staff story for 2024/25

Board Date	
April 2024	Patient Story - *'You said', 'we did'* story – Chris (Patient story from June 23)
May 2024	Staff story
June 2024	Patient Story
July 2024	Staff story
Sept 2024	Patient Story
Oct 2024	Staff story
Nov 2024	Patient Story
Dec 2024	Staff story
Feb 2024	Patient Story
Mar 2024	Staff story

6.1 The Trust Board is asked to accept and note the report.

Sharon Latham
Patient Experience lead
April 2024

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Update from the Guardian of Safe Working – Report for April 2024**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive Officer**
AUTHORS:	**Jamie McKenzie, Guardian for Safe Working Hours**
DATE OF MEETING:	**10th April 2024**

EXECUTIVE SUMMARY:

The Guardian for Safe working has confirmed no concerns for the last quarter with respect to the safety of post-graduate (PG) doctors.

The document describes the team overseeing PG doctors working and the current work in progress to improve both patient and employee experience.

REPORT RECOMMENDATION:

The Trust Board is asked to:
RECEIVE and ACCEPT the assurances provided by the report, and SUPPORT the following intentions:

- To provide continued support for the key individuals working to support post graduate doctors' working conditions, especially those involved directly in health and wellbeing.
- Improving working conditions and wellbeing for postgraduate doctors as a priority for the trust.
- Ensure that when changes occur that impact doctors, the doctors are involved in those changes and the doctors' concerns are addressed

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

Accept	Approve the report	Discuss
X	**x**	**x**

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

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

Comments:

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

Aligned to Trust Objectives

BAF Risk WF21 – Failure to attract and retain the skills and number of staff to secure financial sustainability

PREVIOUS CONSIDERATION:

December 2023

The Royal Orthopaedic Hospital NHS Foundation Trust

FOR ASSURANCE

UPDATE FROM THE GUARDIAN OF SAFE WORKING

REPORT TO THE TRUST BOARD – 10th April 2024

1.0 Situation

1.0.1 The Guardian for Safe Working is required to raise concerns about Safe Working for Post-Graduate (PG) Doctors by exception. Exception reports are the mechanism by which post-graduate doctors record unscheduled episodes of work outside their normal working pattern. As of 30th March 2024, there have been no exception reports raised in the last quarter.

1.1 Wellbeing

1.1.1 There is a well-documented crisis in the workforce generally. (https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/workforce/nhs-medical-staffing-data-analysis) This is complex and multifactorial. The British Medical Journal has an article describing workforce problems affecting PG doctors almost every week. PG doctors are campaigning to improve conditions and are continuing with industrial action.

1.1.2 The GMC National Training Survey 2023 suggests there's clear evidence that workplace stress in healthcare organisations has a negative impact on the quality of patient care, as well as profound consequences for doctors' own health. It's imperative the ROH board and management consider this in all decisions. The report goes on to say: '**Embedding cultures which make healthcare professionals feel valued is vital, not only to doctors' wellbeing and patient care, but also to the future of the health service.**'

1.1.3 A BMJ paper from 2021, looking at the workforce retention crisis, concluded: 'this review builds on findings of related literature regarding working environments, isolation, stigma, and desire for autonomy, and highlights additional issues around learning and training, flexibility, feeling valued, and patient care. **It goes on to present recommendations for tackling poor retention of UK junior doctors, highlighting that the complex problem requires evidence-based solutions and a bottom-up approach in which junior doctors are regarded as core stakeholders during the planning of interventions**.'

1.1.4 Organisations like the ROH can make a difference to PG graduate doctors' autonomy, self worth and value. https://www.som.org.uk/sites/som.org.uk/files/LTF_SOM_mental_health_of_doctors.pdf

1.1.5 The NHS constitution states: All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, actively listened to and provided with meaningful feedback. They must be treated with respect at work, have the tools, training and support to deliver compassionate care, and opportunities to develop and progress.

1.1.6 Successful programmes like the Welldoctor project focus on issues like respect, resting/recharging opportunities etc.

2.0 Background

2.1 Leadership Team

The current team looking after middle grade doctors has input from the clinical service managers.

2.1.1 Clinical rotas are prepared by the Administrative Specialist Registrar (SpR), nominated 6-monthly. Mr Jones and Mr Politis support the Admin SpR balancing the educational and training opportunities with the service requirement of the organisation. Through regular contact and meetings with trainees and management, the leadership team ensure safe, effective and rewarding postgraduate training. This is monitored by the leadership team and a rapid and effective response is ensured when concerns, challenges and opportunities are identified. Formal feedback via anonymous surveys including the GMC trainee-satisfaction survey and the Job Evaluation Survey Tool (JEST) (now NETS – National Education and Training Survey) is similarly monitored and responded to.

2.1.2 The current consultant staff post holders are:

Mr Morgan Jones	Post Graduate Clinical Tutor	All postgraduate medical and surgical trainees (ST1+) at the Royal Orthopaedic Hospital
Dr James Brunning	Tutor	Anaesthetics
Mr Angelos Politis	Clinical Lead for Mid-Level Care Providers	Locum doctors & Fellows
Mr Jamie McKenzie	Guardian for Safe Working	Safe working conditions of trainee doctors
Mr Khalid Baloch	Director of Medical Education	
Mr Matthew Revell	Medical Director	

2.1.3 There are regular medical workforce meetings arranged as part of normal operations.
In addition, there is a regular Post Graduate doctors' forum attended by the leadership team and all Post Graduate doctors are invited.

2.1.4 The Post Graduate Clinical Tutor, Medical Director and Safeguarding lead provide input to the doctors' induction meetings. The Medical Director and Post Graduate Clinical Tutor each have

2-monthly meetings with the GP trainees and contribute to the training programme as speakers and medical educators.

2.1.5 All clinical supervisors and allocated educational supervisors are accredited as per the GMC and Academy of Medical Educators directive. Maintenance of accreditation is appraisee-led and recorded via the annual appraisal process. Consultants are currently supported in providing evidence of accreditation to their appraisers. This process is changing under the guidance of the new director of medical education.

2.1.5 A new post of ROH Director of Medical Education has been established. Khalid Baloch has taken on the role with zest. Mr Baloch's role as Training Programme Director has been taken over by a consultant colleague from Wolverhampton Hospital, Mr Shree Deshpande, who is very able and committed.

3.0 Junior Doctor Establishment

3.1 *Specialist Registrars (SpRs) and Fellows Training in Orthopaedic Surgery*

3.1.1 There is presently a combination of Specialist Registrars and Fellows on the Royal Orthopaedic Hospital roster. All contribute significantly to the safe working of the Trust on a day-to-day basis, being timetabled for ward-round cover, theatres and outpatient clinics, as well as on-calls. Fellows do not normally take part in the on-call rota.

3.1.2 12 new T&O SpR trainees started in February 2024. Face to face teaching is on-going on Fridays.

3.1.3 No payroll issues have been reported which is reassuring. HR staff to be commended.

3.1.4 The most recent GMC national training survey results have been sent to stakeholders in the last few days. It will be interesting to see progress as last year there were three domains where the ROH were placed in the lowest quartiles. Consent training, surgical numbers and feedback were all highlighted as areas for improvement. These have been addressed.

3.1.5 There have been roster issues due to switchboard unable to see which trainees were on call. Now resolved with changes/training in switchboard.

3.1.6 On call rooms have been moved from the old nurses' home to old Ward 10. The old rooms were not great, but it was a reasonably quiet area, with equipped kitchens, multiple showers and toilets, a quiet room and a lounge area to rest and eat in. Doctors were able to use the area at all times of the day or night without special passes, keys or permission. It was an area that was safe and allowed doctors to recharge and reflect. This has been a chaotic and poorly advertised move; not discussed with doctors. The old rooms have been slowly removed from service, fridges taken away and access to lounges etc removed. The new system is more cumbersome and is a step backwards. The porters have been frustrated but very helpful, and facilities have

been forced to provide some extra rooms to cover the reduction in available space. Projects like this need to involve all doctors. Project managers need to engage with those doctors, especially when it involves PG doctors who are at the 'coalface' of the care that we provide at the ROH. The new rooms have more space, more comfortable beds and ensuite showers. Further adjustments are being made thanks to the involvement of senior staff, mainly James Brunning. The move could have been a great success if managers had asked the doctors what they required at the start. There are lessons to be learnt.

3.2 *GP Trainees*

3.2.1 There are a variable number of GP trainees at the ROH (1-10). There is currently only one. There is on-going work with the GP dean to ensure GP trainees are encouraged to choose the ROH and it is acknowledged that they receive excellent education when here. Real attempts are continuing to support their wellbeing using several channels including the postgraduate doctors' forum. This is a voluntary post for the GP trainees and their rotation is now for only 4 months, so this will be an on-going challenge. Morgan Jones is tasked to see how this can be resolved.

3.2.2 Remaining posts at Senior House Officer level are filled with locums or, more preferably, substantive mid-level care providers (MLCPs) where possible. The aim is to reduce the reliance on locum cover by appointing doctors into 2-year fixed appointments when possible. A new policy on mid-level providers has been produced. Jo Thomas, associate medical director, is examining these issues to try to reduce locum cover.

4.0 Postgraduate Doctors' Forum (formerly *Junior* Doctors' Forum)

4.1 The Post Graduate doctor's forum meetings provide an opportunity for the leadership team, including management, to discuss and plan improvements. Encouraging trainees and other medics to attend is a priority.

4.2 Wellbeing has been raised as an important issue. This is being addressed in several fora, including at every induction for all medical staff, with Angelos Politis as lead. There is a suggestion box in the junior doctors' lounge and requests continue to be acted on. Additionally, wellbeing packs are available in the postgraduate doctors' lounge and there is a freezer providing ready meals.

4.3 The induction process is constantly being improved, often due to direct input at the PG doctors' forum. The induction handbook is undergoing some improvements in collaboration with the trainee doctors themselves. Overseas medical graduates have a separate induction process.

4.4 Those postgraduate doctors that work regularly in theatres have brought up time and again that there is little or no space to store their clothes in the locker rooms. There are not enough lockers, even for consultants. Visiting surgeons often comment on the state of the theatre changing

rooms as shocking in an otherwise exemplary hospital. The board is asked to specifically consider the needs of postgraduate doctors when further changes are made to theatres or further expansion is planned. This issue is still outstanding. The current locker room floor is being re-laid but there has been no communication about a substantial programme for improvement. This may be a missed opportunity. It is an example of PG doctors needs not being considered when changes are made.

5.0 About the Guardian for Safe Working Role

5.1 During negotiations on the junior (now post graduate) doctor contract, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for postgraduate doctors.

5.2 The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the post graduate doctors employed by it. It should report into different management structures, including the local negotiating committee (LNC) and the trust board, but will also have a regular input into PG doctor forums.

5.3 The guardian is responsible for overseeing compliance with the safeguards outlined in the 2016 terms and conditions of service (TCS) for doctors and dentists in training. The post holder is to identify and either resolve or escalate problems, and act as a champion of safe working hours for post graduate doctors.

5.4 The guardian provides assurance to the employer or host organisation, that issues of compliance with safe working hours will be addressed, as they arise.

5.5 The guardian is accountable to the board and should not hold any other role within the management structure of the employer. The line management arrangements for the guardian should be independent of the medical director and other medical managers to ensure appropriate independence.

5.6 The post holder should have regular meetings with doctors in training, the champion of flexible training, the Director of Medical Education (DME) and any associate DMEs, educational, clinical and academic supervisors, the postgraduate dean, other senior staff within the HEE area office/deanery, the LNC, the PG doctors' forum, and both executive and non-executive Board members.

5.7 The guardian has a page on the ROH external website with contact details and a description of the role. The role is explained at post graduate doctors' induction and leaflets are distributed with further details. The guardian attends the PG doctors' forum meetings, and they are easily and frequently contacted.

6.0 Recommendations and Ongoing Work

The Trust Board is asked to:
RECEIVE and ACCEPT the assurances provided by the report
SUPPORT the following intentions:

- To provide continued support for the key individuals working to support post graduate doctors' working conditions, especially those involved directly in health and wellbeing.
- Improving working conditions and wellbeing for postgraduate doctors as a priority for the trust.
- Ensure that when changes occur that impact doctors, the doctors are involved in those changes and the doctors' concerns are addressed.

Jamie McKenzie, Guardian for Safe Working
30th March 2024

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
Michelle Hubbard **Acting Executive Chief Operating Officer**	• None Declared	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 • Acting Chair of Leicester, Leicestershire & Rutland Integrated Care Board (LLR ICB). Substantive role as Vice Chair of LLR ICB.	Yes

Name	Interest	Voting Member
Les Williams **Non Executive Director**	• None declared	Yes
Gianjeet Hunjan **Non Executive Director**	• Non Executive Director, Black Country ICB • Lay Member, National Clinical Impact Awards - National Main Committee and West Midlands Committee • Governor, Oldbury Academy • Governor, Ferndale Primary School • Member of IHSCM • Member of HFMA • Fellow of Chartered Institute of Public Finance and Accountancy (CIPFA) • Member of Nishkam Healthcare Trust at local Gurdwara	Yes
Ayodele Ajose **Non Executive Director**	• 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 • Appointed as Chief Medical Officer at Bedfordshire, Luton and Milton Keynes Integrated Care Board. This role is carried out alongside substantive post at Milton Keynes University Hospital (0.4 WTE secondment) as of 15 April 2024 for six months.	Yes

Name	Interest	Voting Member
Simon Page **Non Executive Director**	• Deputy Chair, South Warwickshire NHS Foundation Trust (SWFT) • Owner, Weathervane Consultancy	Yes
Jenny Belza **Non Executive Director**	• 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, Trust Headquarters **Date** 6 March 2024: 0900h - 1120h

Members attending:

Mr Tim Pile	Chair	(TP)
Ms Simone Jordan	Vice Chair & Independent Director	(SJ)
Mr Les Williams	Non-Executive Director	(LW)
Mrs Gianjeet Hunjan	Non-Executive Director	(GH)
Dr Ian Reckless	Non-Executive Director	(IR)
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)
Mr Steve Washbourne	Executive Director of Finance	(SW)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance:

Ms Elaine Bethell	Lead Tissue Viability Nurse	(EB) [Item 1]
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]

1 Staff story – Continuous Improvement (EB)	**Presentation**
Elaine Bethell (EB), Lead Tissue Viability Nurse, was welcomed to the Board meeting. EB explained her story was both a staff story and also a patient story. EB described the different dressings that are used on our patients and the issues that arise with the different types used. EB explained that a number of patients suffered with blisters from the covers being used and resulted in some having severe reactions. Feedback was given to the supplier, and they were of the view that this was not a widespread issue. A number of incidents arose where patients were experiencing reactions and as a Trust we looked at what could cause this. This included looking at technique of how it was applied or whether it was only happening in certain areas, but there was no trend identified. Following this, it was noted that we would need to change the supplier. Research commenced into	

looking at a suitable alternative. EB worked with the clinicians on getting evaluations on the product that was being proposed as an alternative. EB explained that the response from the patients was very positive. The change in product also made a financial saving as well as enhancing our patient experience. MR commended the surveillance work that took place to identify the issue, gathering the evidence and making a change to the benefit of the patient. NB gave thanks to EB and the team, and the Royal Orthopaedic Community Service (ROCS) for dealing with this. The quality improvement work has been very positive. TP queried how the previous company had responded. EB explained that they were not keen to engaged in the feedback. JW thanked EB for her leadership in engaging everyone to make this change.	
2 Apologies (chair)	**Verbal**
Apologies were received from Marie Peplow and Sharon Malhi. The apologies were **accepted** by the board. Welcome to Rebecca Crowther, Deputy Chief People Officer, who is representing Sharon Malhi in her absence. Steve Washbourne will join the Board meeting later.	
3 Declarations of Interest (chair)	**ROHTB (3/24) 001**
The are no new declarations to record.	
4 Minutes of Board Meeting held in Public on 7 February 2024: ***for approval*** **(chair)**	**ROHTB (2/24) 028**
The minutes of the meeting held in public on 7th February 2024 were **approved** by the board subject to a few minor amendments identified by GH.	
5 Actions from previous meetings in public: *for assurance* (SGL)	**ROHTB (2/24) 028 (a)**
SGL provided an update on the following actions: • ROHTBACT.222 Disciplinary Process– confirmation that this will be included on the Staff Experience & OD Committee agenda and discussed at the March meeting. • ROHTBACT.221 Wellbeing Plan – confirmation that this will be included on the Staff Experience & OD Committee agenda and discussed at the March meeting. • ROHTBACT.231 Inclusive Company Feedback – SGL proposed this action can	

now be closed as the feedback will be circulated after the meeting. BC offered to provide the feedback to the Board based on the information that she had received.	
6 Questions from members of the public (chair)	**verbal**
No questions were received in advance of the meeting.	
7 Chair's and Chief Executive's update: *for information and assurance* (TP/JW)	**ROHTB (3/24) 002** **ROHTB (3/24) 002 (a)**

Chief Executive Update

Following the circulation of the report, JW highlighted the key points:

- Blue Heart Awards: The nominations have now closed and we have received 651 nominations. The judging process will commence shortly, and JW expressed thanks to all those that have agreed to be part of this process. All those longlisted will then be written to so they know they have been nominated.
- 'Chat and Check': Routine visits took place on 27th February by the Executive Team. Three areas were visited, and the Executives were welcomed by the teams who shared their experiences of working at ROH. The feedback has been welcomed and we have seen a number of positive changes. The next planned visits are at the end of March.
- Internationals Women's Day: Celebrations are being planned by the Communications Team on Friday for International Women's Day.
- Appraisal Process: This has been reviewed and will be launched in April. The new system will take place as a window cascade and a training package will be launched in April.
- Staff Survey: 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.
- British Medical Association - 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 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.
- ICB update: The Birmingham and Solihull (BSol) Integrated Care Board (ICB)

meets bimonthly, and next public meeting is being held on 11 March 2024. TP enquired whether there is a template that is used for 'Chat and Check' and can this be shared with the Non-Executives. JW explained that a template is used as a guide rather than formal document to complete. As a group, the Executives come back and share the feedback from each of the areas they have visited. JW suggested that an update could come to the Board of the themes/feedback received from the sessions in future. The Board welcomed this suggestion. SGL offered to share the template for 'Chat & Check' which he highlighted could also be used for governor walkabout sessions. **ACTION: Share the 'Chat and Check' walkabout template for Non-Execs. SGL** **ACTION: Themes/feedback to come back to Board twice a year as an update. JW** **Chair Update** • JW and TP attended a Birmingham Health Partners (BHP) meeting attending on Tuesday 5th March. It was forum that has potential. • Radiology Visit: A very rewarding visit and very informative. There is clear ambition of what more they can do which was really encouraging to see. • Consultant interviews: These were undertaken last week, and the applicant quality was exceptional. One has been appointed substantively, and one appointed as a locum. This reflects the reputation of the Trust as people are applying from around the world. • Extension of Non-Executive Term of Office: Thanks to AA and LW for agreeing to extend their terms of office for a further three years. GH welcomed the preceptorship that has been established and asked whether an update could be provided at a future Board meeting. NB agreed that this would be done explained that this also includes Allied Health Professionals (AHPs). SGL suggested an update via a staff story which was agreed. **ACTION: Preceptorship update via a staff story to be provided in approx. 8 months to Board. NB**	
8 Wellbeing Update: *for assurance* (RC)	**ROHTB (3/24) 003** **ROHTB (3/24) 003 (a)**
RC highlighted the key points provided in the circulated update: • Review, lead by the Charity, has been undertaken on the hardship fund. The key themes have been reviewed and there is now a focus on targeting support in these areas as there may be other staff also struggling but may not have asked for help. • Reviewing the impact on the wellbeing support being provided. In ROH	

Pantry counters are now in place to try and to understand how many colleagues have used the pantry, one counter for every visit is put into a tub on exit. Work is taking place on the funding stream to help support the replenishment of the pantry. • Colleagues are taking advantage of the free porridge and cheaper lunches that are available daily. • There is focus on one of the four key areas – stress and mental health; a new sub group has been created. Managers are being encouraged to undertake the 'Managing Wellbeing of Colleagues' training. JW highlighted we need to consider the impact of the increase in council tax for Birmingham residents. JB thanked RC for the update, and queried are we evaluating how our colleagues feel this all helps them. RC confirmed that work is taken place in the network groups and feedback is gathered from these groups. LW praised the initiative. LW queried would the funding support from Birmingham City Council continue. RC explained that we are not expecting this funding to continue so looking to source other funds. TP queried how much funding is being sought. JW explained for the ROH pantry we need approximately £1000 per month. JW explained that we need to widen our partnerships and approach our local supermarkets such as Sainsbury's. **ACTION: Approach local supermarkets for possible partnership working to stock the pantry. JW/TP** TP queried why are managers not able to attend the managing wellbeing conversation training. RC explained capacity is the biggest issue and the team are looking at other ways of being able to cascade the training to meet the needs of those that need the training. RC highlighted that work is also being done on the employee assistance program (EAP) to direct colleagues to the support available there too. SJ queried if there is there an option for colleagues that want to give to be able to give from their salary. JW explained that this has been considered before but will be explored further. **ACTION: Review options to donate through salary sacrifice. RC/SM**	
9 Update from Wellbeing Guardian: *for assurance* (AA)	**ROHTB (3/24) 004** **ROHTB (3/24) 004 (a)**
AA highlighted key points from the assurance report as the Health & Wellbeing	

Guardian for the Trust. • Following a recent NHSE meeting the title has been changed to Health and Wellbeing Guardian. At this meeting it clarified it should be a Non-Executive role and is there for assurance; it is not an operational role. • AA explained that the role should model what we are doing as an organisation. Networking is key in the role. • The next step is to have an action plan for the four key priorities areas, continue support for cost of living, review the hardship fund, continue to review the Employee Assistance Programme (EAP), undertake an annual review of the NHS Health and Wellbeing Framework, and achieve silver level in Thrive at Work accreditation. AA confirmed that she was confident in giving assurance to the Board that the Trust are delivering on wellbeing for our colleagues. LW raised this could be used to promote the Trust and queried whether the ambition should be to get to gold for Thrive at Work. RC confirmed the ambition is to get to gold, but silver is first. JW raised we are the only employer in the local area who is a Thrive at Work employer. TP queried what is the plan for metrics. AA highlighted it is not easy to measure. SJ raised we can use counting the interventions as the metric but suggested that we need more qualitative data developed.	
10 Health Inequalities: *for assurance* (NB)	**ROHTB (3/24) 005** **ROHTB (3/24) 005 (a)**
NB/RL presented to the Board, following a visit from KMPG, the issues that were highlighted on addressing the health inequalities at the Trust. NB explained that a focus group has been created and the purpose of the presentation today is to provide an update of the work that is being undertaken to address the issues highlighted. Once a timeline and milestones were agreed a further update will come to the Board for approval. KMPG highlighted 5 key areas that we need to focus on, and work has now commenced on how we align to our strategy as well as the wider BSol strategy. NB explained that work is in progress, and this was not for approval today but to give assurance that work is taking place on addressing this. NB highlighted that updates for governance and monitoring purposes will come through various committees including Quality & Safety Committee and also Staff Experience & OD Committee. NB explained that over the past few weeks a survey has taken place to understand what staff know about health inequalities. RL explained that the data and	

responses were a snapshot of what broad understanding our colleagues have. This is being used as a baseline assessment.

RL explained that a question was asked if training would be welcomed on health inequalities and 68% of those that responded said they would welcome this.

RL highlighted that it was clear from the responses that communication is key and needs to be considered. There are a number of projects that are already underway, for example, the Outpatient's transformation programme. The plan is to ensure that the questions and opportunities for health inequalities are always considered in every programme of work we do.

RL explained that the focus group have lots of research to do and the starter will be engaging with staff networks.

JB raised that it is key that the focus group includes partnership and community representation. There needs to be focus, with clear timelines and specific actions. NB agreed that the small changes that make impact will be part of the focus group work. NB explained that a piece of work that has taken place as part of the MSK transformation work has provided the data to inform the direction of the work. This will highlight the communities that we need to focus on.

MH raised that there is a BSol single patient tracking list (PTL), and this is a starting point to see the challenges across the system. MH highlighted that part of the data capture that is taking place is capturing ethnicity and patients will be encouraged to register this.

JW highlighted that it is in within our gift to ensure the knowledge of what health inequalities is and what we can do to make the difference.

IR queried what can we specifically do as a Trust, working with the Integrated Care System (ICS), to improve health inequalities. We need to be working in partnership with primary care networks to deal with those that patients we need to focus on based on the metrics that state over 50% of our patients who are waiting for joint replacement are in socially deprived areas, and this would provide a SMART metric that we can act upon.

JW confirmed that we do actively work on our waiting list, but the data is part of a wider waiting list under the BSol system. MH confirmed that we do not have any patients on our waiting list who are waiting more than 52 weeks and we have worked closely with University Hospital Birmingham to get this result.

SP raised that focus groups only focus on what they know, and we may need to consider insights from elsewhere to direct the discussions at these meeting.

TP confirmed that health inequalities is the number one priority for BSol. This is

bigger than something ROH can resolve. We need to address the inequality we come across in our role, recognise the breath of offer we have and the geography we have. Focus and prioritisation needs to be on what we can make a difference on rather than have a list of actions that will take years to deliver. It is imperative we are disciplined in making a difference in whatever capacity we can. **ACTION: Action plan for delivery to return to the Board once completed. NB**	
11 Liberty Protection Safeguards Update: for assurance (NB)	**ROHTB (3/24) 006**
NB presented an update on the latest guidance concerning the introduction of Liberty Protection Safeguard, following a request from a previous Board meeting. NB updated the Board that there would be no change until the general election is complete. NB explained that we continue to work towards implementation, including commencing training and collecting data. NB highlighted there will be no change to the existing ROH policy. However, the next steps had been worked through should any changes be made by the Government. NB explained there will be legal ramification if this is approved and we would need to seek legal advice. NB explained that we had one Deprivation of Liberty Safeguards (DoLs) last year. NB provided assurance that we do have a robust process in place that is undertaken by our safeguarding team. NB highlighted this would come back to the Board should this be approved by the Government. SP queried the risk, and asked are we operating within NHS guidelines. NB confirmed we have a full policy that we follow. AA questioned are we satisfied that we are not exposed. NB confirmed we are doing the same as all other NHS organisations and there was a good governance process including a reporting framework including the ICB. IR queried how many of our patients we deal with that don't have capacity. NB confirmed this information could be provided at Quality & Safety Committee, and a safeguarding upward report is coming to the next Committee. JW provided assurance that all Executives and Managers have undertaken Safeguarding training to cover this to ensure it is done correctly. **ACTION NB to provide Safeguarding information to the next meeting of the Quality & Safety Committee**	
GOVERNANCE AND COMPLIANCE	
12 CQC Readiness Plan*: for assurance* (SGL)	**ROHTB (3/24) 007** **ROHTB (3/24) 007 (a)**

	ROHTB (3/24) 007 (b)
SGL provided an update on the latest developments in terms of the CQC assessment framework. SGL confirmed that there is now more clarity on the CQC assessment now. SGL highlighted to the key changes and planned work to prepare for an inspection including: • Less onsite visits • Categories of evidence have been shared, one of the big changes is gathering evidence from the partners. • Update provided on what is needed to demonstrate how we are well led. • Quality walkabouts, template created, communication across the Trust, set of Board and Governor briefing packs will be shared with a set of topics to focus on. SGL asked for any other suggestions to be emailed to him. SGL explained that there will be a repository of information available to help with the process and guide Non-Executive Directors through the inspection. SGL highlighted that the Fit and Proper Person Test is a new set of guidance that has come in so this may be tested with regards to the implementation. The corporate policy will be updated to reflect all these changes and the next steps for the Governance team is to create an action plan. JW queried in the past we have undertaken preparation for Non-Executives prior to any interviews, and questioned would this continue. SGL confirmed that this would continue, and briefing packs would help. SP queried do we know what outstanding looks like. SGL explained that this is something that we don't know so we have been gathering the evidence to create a view as to what we as a Trust regard to be 'Outstanding'. TP confirmed as a Board our ambition is to be Outstanding. NB explained following a training course last week we can shape our rating and what Outstanding looks like. NB raised if you ask our colleagues they will state they think we are Outstanding. TP enquired what the timing looks like on this. SGL explained we do not know when the next assessment will be, but the plan is to bring the well led inspection plan to the next Board meeting. ACTION: SGL to bring back the well led self-assessment to the April meeting	
13 Board Topics 2024/25*: for approval* (SGL)	**ROHTB (3/24) 008** **ROHTB (3/24) 008 (a)**

TP thanked those that had responded to the prioritisation process. TP explained that the focus was identifying those items that would benefit conversation/debate at a Board meeting. SGL explained that the operational items will be built into the cycle of business. TP welcomed comments from the Board members on the proposal. The Board members were satisfied with the proposal and the recommendation was taken as **approved.**	
14 Nomination & Remuneration Committee Terms of Reference*: for approval* (SGL)	**ROHTB (3/24) 009** **ROHTB (3/24) 009 (a)**
SGL highlighted the changes made to the Terms of Reference for Nomination and Remuneration committee as per the paper circulated to the Board. The recommended changes to Terms of Reference were **approved** by the Board.	
BREAK	
UPWARD REPORTS FROM THE BOARD COMMITTEES	
15 Upward reports from the Board Committees: (cttee chairs) **a) Finance & Performance Committee** **b) Charitable Funds Committee**	**ROHTB (3/24) 010** **ROHTB (3/24) 011**
<u>Finance & Performance Committee Upward Report - LW</u> LW highlighted the key points from the Finance and Performance Committee held on 27th February 2024. • Activity to end of January slightly below plan, due to industrial action and environmental issues in theatres, but already recovered during February. o Positive progress on reducing numbers waiting over 65 weeks to zero – on track to meet national target by year end. o Good performance continues in many areas – PIFU, virtual consultations, cancer, diagnostics, LOS, reduced agency spend, CIP and private patient activity and income. • Financially very difficult and challenging position o Deficit increased in month by £801k, to around £5m by year end. o Will not achieve planned breakeven. o Non-pay pressures predominant, including high costs of LLPs, prostheses and loan kits in theatres – further detailed work on cost reduction being undertaken.	

- Continuing negotiations with ICBs and NHS England to secure appropriate income for activity undertaken.
- Moving towards agreement with BSol on cash support

- Reviewed planning for 24/25, further discussion in Private Agenda, but noted lack of government guidance until after Budget today – makes work of planning next year extremely difficult and of course subject to change at very short notice.
- Discussed and supported private patient three-year strategic plan as one of key elements of improving service and financial position.
- Approved annual forward plan of work for Committee, which includes digital as part of expanded brief for Committee.

JW confirmed a Chief Executive Officer/Chief Finance Officer call at 5pm today will take place with NHS England.

Charitable Funds Committee - AA

AA provided an update on the Charitable funds committee that took place on 14th December.

AA highlighted that there had been a disappointing net return of just 0.53% recorded on the Cazenove asset statement as of 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.

Restructure of the charity team was discussed, which included the addition of a Band 6 Grants Trust Officer. At the time of this report this had not been appointed to. Funding had been given from NHS Charities for this role. RL provided an update on the recruitment for this post and explained that following a second attempt of recruitment had not been successful so following a conversation with NHS Charities the Charity is working with a freelance grants officer who will work specific days and will have very focussed targets.

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.

AA explained that a request was made to the Committee that updates were provided on the funding approvals to understand the impact this funding made.

AA highlighted that this Committee fits well with the role of the Health & Wellbeing Guardian.

MATTERS TO BE TAKEN BY EXCEPTION ONLY

16 Performance Reports: *for assurance*

• **Finance & Performance** • **Quality & Safety**	**ROHTB (3/24) 012** **ROHTB (3/24) 013**
IR queried the 23/24 position on ERF and asked for clarification on the 50% funding. SW explained that there are a number of elements that builds this. There is block funding, the activity we undertake that is ERF, and as we are an elective trust it falls under ERF. Majority of ICB activity is ERF. SW explained that we are measured on the additional activity above the 19/20 baseline and our result is within target.	
Date of next meeting: Wednesday, 10 April @ 0900h	

PUBLIC SESSION

Next Meeting: 10 April 2024, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 2 April 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)	10/4/2023	Present the revised leadership framework to Staff Experience & OD Committee in October 2023	SM	~~25/10/2023~~ ~~27/03/2024~~ 26/06/2024	Deferred to the ~~January March~~ June 2024 meeting	
ROHTBACT.222	Equality & Diversity Improvement Plan	ROHTB (10/23) 008 ROHTB (10/23) 008 (a)	10/4/2023	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~~ 26/06/2024	Deferred to the ~~March~~ June 2024 meeting	
ROHTBACT.233	National Food Standards update	ROHTB (12/23) 005 ROHTB (12/23) 005 (a) ROHTB (12/23) 005 (b)	12/6/2023	Use benchmarking information as part of reports being prepared for the Trust Board and relevant committees	All Execs	~~10/04/2024~~ 01/05/2024	To be built into the cover sheet of papers and new report templates	
ROHTBACT.238	Board Assurance Framework	ROHTB (2/24) 009 ROHTB (2/24) 009 (a - i)	2/6/2024	Cleansed version of the BAF to be return to the Board in April	AR	~~10/04/2024~~ 01/05/2024	**Deferred to May meeting.**	
ROHTBACT.235	Wellbeing Update	ROHTB (2/24) 027 ROHTB (2/24) 027 (a)	2/6/2024	Provide a one page summary of the wellbeing action plan.	SM	~~10/04/2024~~ 01/05/2024	**Deferred to May Board meeting**	
ROHTBACT.225	Retention & Recruitment update	ROHTB (11/23) 006 ROHTB (11/23) 006 (a)	11/1/2023	Add update on visit to Jaguar Land Rover to a future agenda	TF	~~06/03/2024~~ 10/04/2024	Verbal update to be provided at March Board meeting under Private Board. **Deferred to April.**	

ROHTBACT.217	Stories for the Board	ROHTB (10/23) 001 ROHTB (10/23) 001 (a)	10/4/2023	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. **Included on April Agenda.**	
ROHTBACT.232	National Food Standards update	ROHTB (12/23) 005 ROHTB (12/23) 005 (a) ROHTB (12/23) 005 (b)	12/6/2023	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	5-Jun-24	ACTION NOT YET DUE	
ROHTBACT.234	Guardian of Safe Working update	ROHTB (12/23) 008 ROHTB (12/23) 008 (a)	12/6/2023	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. **Included on April agenda.**	
ROHTBACT.236	Race Code Adoption	ROHTB (2/24) 003 ROHTB (2/24) 003 (a)	2/6/2024	Prepare a board development workshop proposal for RACE Code adoption.	JW/SM	10-Apr-24	**Included on April agenda.**	
ROHTBACT.239	EPRR Position Statement	ROHTB (2/24) 010 ROHTB (2/24) 010 (a)	2/6/2024	Provide an update on the EPRR Position Statement following the next assessment	SW	4-Sep-24	ACTION NOT YET DUE	
ROHTBACT.241	Chief Executives Update	ROHTB (3/24) 002 ROHTB (3/24) 002 (a)	3/7/2024	Provide an update on themes/feedback from 'Check and Chat' sessions to Board twice a year.	JW	3-Jul-24	ACTION NOT YET DUE	
ROHTBACT.242	Chief Executives Update	ROHTB (3/24) 002 ROHTB (3/24) 002 (a)	3/7/2024	Provide a preceptorship update via a staff story in approx 8 months.	NB	4-Dec-24	ACTION NOT YET DUE	

ROHTBACT.243	Wellbeing Update	ROHTB (3/24) 003 ROHTB (3/24) 003 (a)	3/7/2024	Review options available to colleagues to donate through salary sacrifice.	SM/RC	1-May-24	ACTION NOT YET DUE	
ROHTBACT.244	Health Inequalities	ROHTB (3/24) 005 ROHTB (3/24) 005 (a)	3/7/2024	Provide an update on the Health Inequalities action plan, detailting how it will be delivered.	NB	5-Jun-24	ACTION NOT YET DUE	
ROHTBACT.245	CQC Readiness Plan	ROHTB (3/24) 007 ROHTB (3/24) 007 (a) ROHTB (3/24) 007 (b)	3/7/2024	Send follow up email to all Non Executive Directors requesting suggestions of focus topics to be included.	SGL	10-Apr-24	**Revised Board topics included on the April Board agenda.**	
ROHTBACT.231	Wellbeing update	ROHTB (12/23) 004 ROHTB (12/23) 004 (a) ROHTB (12/23) 004 (b)	12/6/2023	circulate feedback from the Inclusive Company with Board Members for information ahead of the next Board meeting	SM	7-Feb-24	To be circulated. Feedback not yet received so unable to circulate at present. **Circulated by Rebecca Crowther. Propose closure.**	
ROHTBACT.240	Chief Executives Update	ROHTB (3/24) 002 ROHTB (3/24) 002 (a)	3/7/2024	Circulate the 'Chat and Check' walkabout template to Non Executive Directors for information.	SGL	10-Apr-24	Circulated to SJ for comment. **Action proposed for closure.**	
ROHTBACT.229	Wellbeing update	ROHTB (12/23) 004 ROHTB (12/23) 004 (a) ROHTB (12/23) 004 (b)	12/6/2023	Provide an update on the Health & Wellbeing Guardian role at a future Board meeting	AA	6-Mar-24	Included on agenda for March Board meeting. **Propose for closure**	

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:	**10 April 2024**

EXECUTIVE SUMMARY:

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

The report has been refreshed to frame it within the context of the Trust's new strategy and this month includes a specific focus on the recently published national planning guidance.

REPORT RECOMMENDATION:

The Board is asked to note the contents of this report andf offer any observations on the new style and format.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

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

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

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

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

PREVIOUS CONSIDERATION:

None

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to the Trust Board (in Public) on 10 April 2024

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board on 6 March 2024 from the Chief Executive's position. This includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 Our Care

2.1.1 I wanted to start by sharing a patient story which is an incredible testament to the Trust and the team who treated Kath. The story demonstrates what is at the heart of our strategy, 'Less pain; More independence; Life changing care'. Kath's story is summarised below, but you can also listen to her in her own words. I would like to thank Kath for sharing her experience. [Royal Orthopaedic Hospital - Life Beyond Arthritis - Kath's Story (roh.nhs.uk)]



Kath had always been active – a PE teacher until retirement. She absolutely loves walking, going outdoors into the countryside with her dog, swimming and has a garden that she adores. But arthritis was getting in the way, *"Everything that made me a person was being steadily ripped away. It was a combination of two things really, severe pain and an inability to move. My quality of life had been steadily tumbling down a hole for probably many years, but the steepness of the curve of the troubles got that much more difficult. I just felt my life was being taken away from me and it's only in retrospect I can say that. All the things that were my life were just becoming more and more impossible. I just felt like I was at a dead end.*

"I chose the Royal Orthopaedic Hospital because when I spoke to a few of my friends, I've got a few fairly athletic friends, they all had very good outcomes at the Royal Orthopaedic. I'd also spoken to my partner who found that by actually making more of an intervention in the selection in this process you can feel more in control and that you're determining your own outcomes. I thought I really should put my perspective in right in the beginning and I'm so glad I did".

"Meeting my surgeon, Mr Yuvraj Agrawal, well it was an amazing experience. I mean he was so clear and so definite and so reassuring that this could all be resolved. So that took a bit of absorbing, I had to get on the phone to my partner and I was so pleased at the response I got, as I was told, you just can't live like this Kath, and it was so caring and so helpful and it gave me the confidence I needed at that time.

"It took months to recover, but I got a life I never lived before, a life where I was free to garden, exercise and swim pain free. I had forgotten what that was like. And the joy of being able to do those things, that were my life. It was a treasured gift is all I can say".

2.1.2 As part of the organisation's CQC readiness work, it was agreed to undertake an initial self-assessment against the Well Led domain. This domain is given specific focus as part of the new inspection framework, given the assertion that if an organisation is well led, then it is likely to be caring, effective, responsive, and safe.

Our initial assessment forms part of the Board pack and provides an initial view of the organisation's compliance with the new quality statements under the Well Led domain. On reflection, it is encouraging to see that we have good compliance in several areas and there are examples proposed of where there is evidence of 'Outstanding' practice. The report also identifies areas where work is required, and this is being progressed.

2.2 **Our Services**

2.2.1 Our financial position remains a continuous focus in our activities, with our year-to-date deficit at the end of February 2024 at £4.2m against a surplus plan of £231k. Agency expenditure reduced again in month; this has been an area of real focus for the ROH and we can see a real improvement in driving down the use of bank and agency staff during the year. Agency spend has been reducing month on month since the peak seen in June 2023. Reducing agency spend as a percentage of pay bill has been improving but remains higher than the target of 3.7%, with a year-to-date performance of 8.4% and an in-month performance of 5.7%. We have reduced the run-rate by more than £300k per month since June.

2.2.2 Our efficiency programme is ahead of plan year to date at £4,636m against a target of £4,607m. It was an ambitious target and I am grateful to colleagues across the Trust for the engagement and delivery of these plans.

2.2.3 As we move into 2024/25 it will be more important than ever to look at our productivity, spend, and to utilise every opportunity for delivering quality care more efficiently. Our Board workshop in January 2024 has been a catalyst to this work and

we are currently working with the wider leadership team to prioritise and implement delivery plans for the key initiatives.

2.2.4 Activity in February 2024 was strong, delivering 1288 cases against a system plan of 1139. Despite the impact of industrial action, theatre session utilisation was 92.5% against a target of 85%.

2.2.5 53 private patients were treated throughout the month which takes the Trust above the year-to-date target, exceeding the plan by 219 cases. Work is ongoing to operationalise the strategic private patient plan which was approved at Board in March 2024.

2.2.6 Operational performance targets performed well in February 2024, with a reduction in the number of patients waiting over 65 weeks now at 68, (January 83), predominantly in Spinal Services.

The Trust has no patients waiting over 78 or 104 weeks. Our focus is on clearing the number of patients waiting over 65 weeks ahead of the national target of September 2024. Working with all specialities, trajectories are in place to treat patients waiting over 52 weeks. Some teams are close to this target and it is great to see the energy and ambition to continue to reduce waiting times for our patients. MSK waits across all areas continued to reduce in line with plans shared at Finance & Performance Committee.

2.2.7 The diagnostic standard of 99% was achieved in month (99.9%) which is testament to the fantastic team we have in our Imaging Services across all areas. All cancer targets were achieved with the exception of the 31-day target which was one breach and the patient has been subsequently treated.

2.2.8 'Seamless Surgery' week will take place across the Trust week commencing 29 April 2024, supporting the Getting It Right First Time (GIRFT) good practice and learning

from other sites. The initiative is to support our continuous improvement programme, improving and refining our patient pathways.

2.3 **Our People**

2.3.1 Following the national publication of the staff survey results in March 2024 and the big launch with managers at the ROH on 12 March, the Staff Experience and Organisation Development (SE&OD) Committee held a workshop to review the finding and agree some of the key areas of focus for this year. A series of staff workshop and briefings are planned across the Trust over the next few months. Some of the points of discussion arising from this workshop are captured within the upward report from the Staff Experience & OD Committee.

2.3.2 On 28 March 2024, the shortlisting panel had the very difficult task of having to select the finalists for the Staff Blue Heart Award ceremony. With over 600 nominations, it was a privilege to read all the citations from staff and patients. Good luck to all the finalists and congratulations to all if you have been nominated.

2.3.3 It is encouraging to see staff retention reduce again in month remaining under the KPI of 11.5% (10.59%). This continues to be a key focus for us, ensuring that the Trust remains an attractive employer for all to flourish and thrive. A reminder to all staff that mandatory training is a key priority for all, and we expect to see this improve throughout the next few months.

2.3.4 On 21 March we held our scheduled development day for our 'Leaders Who Care' programme which includes all our Executives and senior leaders across the organisation. It was a great opportunity to recap on the learning to date with the main session concentrated around our financial sustainability. There was a high level of engagement and lots of ideas suggested which will form part of a wider Board discussion. Thank you to Tim Pile, our Chair, for joining part of the session and all colleagues for their active participation - it was a great day.

2.4 Our Expertise

2.4.1 I wanted to take a moment to inform you that the Birmingham Sarcoma Service website has recently gone live, an exciting step in our work to enhance sarcoma care across our system. The website, funded by the West Midlands Cancer Alliance and developed in collaboration with clinicians from The Royal Orthopaedic Hospital (ROH), University Hospitals Birmingham (UHB) and Birmingham Women's and Children's Hospital (BWC), aims to streamline the referral process and provide resources for patients.

The development of this website has been a collaborative endeavour, initiated before the pandemic and recently resumed to fruition. The ROH has spearheaded the coordination of this website creation, aiming to create a unified platform that simplifies the referral process and offers information about sarcoma services across Birmingham. We are currently working with all stakeholders to ensure that it meets everyone needs and we envision a phased approach, softly launching the website initially, followed by a more robust promotional effort during the Sarcoma awareness month in July 2024. You can access the website at https://birminghamsarcomaservice.nhs.uk/

2.5 Our Collaboration

2.5.1 On Monday 18 March I had the opportunity to meet with Professor Aleks Subic, Vice-Chancellor & Chief Executive at Aston University. We discussed a range of areas for further collaboration whilst reviewing our work together to date. It is a very valued relationship and I look forward to seeing how this develops further over this year.

2.5.2 On Tuesday 9 April we are delighted to be meeting with colleagues on site at Jaguar Land Rover (JLR) to continuing our learning good practice from others. Thank you to

the team for hosting us and I am looking forward to sharing further updates next month at Board.

2.5.3 We are pleased to welcome three new appointed governors to the Council of Governors:

- Cllr Jamie Tenant – Councillor for Weoley & Selly Oak Ward, Birmingham City Council
- Professor Chris Langley – Deputy Dean of the College of Health and Life Sciences, Aston University
- Dr Eliot Marsden - Deputy Director of Operations (Research & Development), University of Birmingham

We look forward to their valuable contributions to the discussions of the Council of Governors in the coming months.

2.6 Our Community

2.6.1 Thank you to the Communications Team for commencing a series of wellbeing messages which are being shared across social media signposting across a range of initiatives for patients and staff. This is very much a key strand in our strategy, and it is good to see prevention as a key feature in the planning guidance.

3 BSol ICS (Integrated Care System) Updates

3.1 The Birmingham and Solihull (BSol) Integrated Care Board (ICB) meets bimonthly, and next public meeting is being held on 13 May 2024.

3.2 The next meeting for Birmingham Health Partners will be held on 19 June 2024.

3.3 The next meeting of all BSol Chief Executives and Executive Directors is scheduled for Friday, 26 April 2024.

4 NHS England (NHSE) /National updates

4.1 On 27 March, NHS England (NHSE) published the 2024/25 priorities and operational planning guidance. In line with the 2023/24 guidance, the most immediate priority continues to be the recovery of core services and productivity following the pandemic, while making further improvements to access, quality and safety.

4.2 The 2024/25 planning guidance reiterates the overall priority remains to be the recovery of core services and productivity, following the disruption caused by the pandemic.

In summary the key priorities are:

- Maintaining the collective focus on the quality and safety of services, with specific reference to maternity and neonatal services.
- An improvement to ambulance response and accident and emergency (A&E) waiting times.
- A reduction in waits of over 65 weeks for elective care and an improvement in core cancer and diagnostic standards.
- Improving access to community and primary care services, including dentistry.
- Improving access to mental health services for patients across all age groups.
- Improving staff experience, retention and attendance
- Integrated care boards (ICBs), trusts and primary care providers to work together to plan and deliver a balanced net system financial position

4.3 The guidance also sets out several key areas where systems are asked to develop longer-term plans to meet the demands of the future:

- Improving health and joining up care – systems are asked to update their five-year joint forward plans (JFPs) by June 2024 and set out the steps they will take to better join up care and address the causes of morbidity and premature mortality.

- Growing the workforce – systems are asked to include workforce plans in their JFPs, outlining their staff and skill requirements to meet the needs of their populations.
- Modernising infrastructure – systems are asked to develop long term infrastructure strategies to underpin their JFPs, outlining a shared view of priorities for estates and capital investment. Guidance on developing a 10-year infrastructure strategy has also been published.
- Harnessing data, digital and technology – systems are asked to support improving provider digital maturity across all sectors, with a focus on deploying and upgrading electronic patient records and the use of the NHS App.

4.4 NHSE has published two-year revenue allocations for 2023/24 and 2024/25 in January 2023. The 2024/25 planning guidance confirms that NHS England has updated revenue allocations with a further 1% increase in baseline allocations to factor in additional pressures.

4.5 The guidance confirms that the 2024/25 payment system will continue with the activity-based payment model for planned elective activity. Activity targets will be agreed through the planning process, and it is expected that the revenue finance and contracting guidance for 2024/25 will set out further information.

4.6 Integrated Care Boards (ICBs) and providers are expected to work together to meet the minimum 2.2% efficiency target and raise productivity levels. Systems are expected to:

- Improve operational and clinical productivity and make best use of the opportunities provided by Getting It Right First Time (GIRFT), the Model Health System and other benchmarking and best practice guidance.
- Improve workforce productivity and reduce agency spend as a percentage of the total pay bill.

- Release efficiency savings through reducing variation, optimising medicines value and complying with best value frameworks. Systems are also asked to develop action plans to improve workforce productivity, identifying the rationale for increases in staffing since 2019/20, based on outcomes, safety, quality, or new service models.

4.7 The guidance restates the need for trusts and systems to maintain a focus on the quality and safety of all services provided, with a requirement to apply the Patient Safety Incident Response Framework (PSIRF) to all patient safety incident response policies and plans.

Additionally, trusts and systems are expected to:

- Complete the NHS Impact self-assessment to create and embed a shared and measurable improvement approach to delivery.
- Ensure a robust governance and reporting framework is in place drawing on the forthcoming The Insightful Board guidance
- Embed a robust quality and equality impact assessment (QEIA) process as part of financial and operational decision making.
- Improve the engagement of patients and families in incident responses.
- Use the Learn from Patient Safety Events (LFPSE) service to support learning.
- Support the uptake of training under the NHS Patient Safety Syllabus
- Appoint at least two patient safety partners to safety-related governance committees.

4.8 The guidance says NHSE will begin implementing Martha's Rule over 2024/25. NHSE have invited expressions of interest to participate in the first phase of the programme, and participating provider sites will be supported with a standardised approach to all three elements of Martha's Rule.

4.9 Systems are asked to:

1. Maintain expanded capacity

a. Maintaining G&A beds at 2023/24 levels.

b. Ensure utilisation of virtual ward beds is consistently above 80%.

c. Expand intermediate care capacity.

d. Maintain ambulance service capacity and support reducing ambulance conveyance to acute hospitals.

2. Improve productivity, efficiency, and clinical outcomes to maintain or improve length of stay. Achieved through reducing admitted and non-admitted time in emergency departments, reducing the length of stay for patients medically fit to be discharged, reducing ambulance handover delays, and using more community beds to improve hospital flow.

3. Continue to develop services that shift activity from hospitals to more clinically appropriate settings. The guidance aims to increase referrals to urgent community response services (with an increase to their capacity). Type 1 providers have a same day emergency care service in place for 12 hours a day, 7 days a week, and an acute frailty service in place for 10 hours a day, 7 days a week.

4.10 The guidance calls for increased use of community pharmacies for lower acuity and common conditions through the new Pharmacy First service, and on improving access to GP services using digital tools and cloud-based telephony.

4.11 Systems are asked to develop a full understanding of demand and capacity in primary care across their local populations.

They are also asked to:

- Develop plans to reduce waiting times for community services, including waits of over 52 weeks for children's community services, by June 2024.
- Support the adoption of faster data flows to help improve the understanding of care backlogs.
- Implement annual sight and dental checks for special day and residential schools during 2024/25.

Trusts should appoint a designated lead for the primary-secondary care interface, responsible for tackling the four key areas set out in the primary care recovery plan.

4.12 For elective care, NHSE recognises the impact that industrial action has had on the ability to deliver the elective recovery plan. The immediate priority is to eliminate 65-week waits by 30 September 2024, with systems also asked to reduce the overall size of the waiting list and improve productivity.

Key actions include:

- Increasing productivity by making improvements towards the 85% day case and 85% theatre utilisation expectations, using GIRFT, and moving procedures to the most appropriate settings.
- Ensuring robust procedures are in place to avoid unnecessary referrals to secondary care.
- Significantly expanding patient choice at the point of referral by actively encouraging access to non-local NHS providers or the independent sector where this can shorten waiting times.
- Continuing to reduce waits for first outpatient appointments, including through bringing in a metric, measuring the proportion of outpatient attendances that are first or follow up appointments against a nation ambition of 46%.
- Improving patient and list management including via a strong focus on validation – with an expectation that 90% of patients waiting over 12 weeks are validated.

4.13 The contract default for elective activity will continue to pay unit prices for actual activity delivered. NHS England will allocate £3.2bn of elective recovery funding to ICBs on a fair shares' basis.

4.14 The national objectives for 2024/25 focus on reducing cancer waiting times and supporting faster diagnosis, including:

1. Improving performance against the 62-day standard to 70% by March 2025.

2. Improving performance against the 28-day Faster Diagnosis Standard to 77% by March 2025.

3. Increasing the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028. 4. Increasing the percentage of patients receiving a diagnostic test within 6 weeks towards the target of 95% by March 2025

4.15 The guidance reiterates that systems' allocations include an adjustment to weight resources to areas with higher avoidable mortality, and that £200m allocated specifically to address health inequalities was made recurrent in 2023/24. Systems are asked to demonstrate how they are using this funding to target the areas of highest need in line with the CORE20PLUS5 approach (for both adults and children and young people).

4.16 Systems are also asked to publish joined up action plans by the end of June 2024 to address health inequalities, outlining their delivery plans against the five strategic priorities for health inequalities and Core20PLUS5. The joined up plans should also consider NHSE's inclusion health framework, digital inclusion framework, and increasing understanding of health inequalities among the workforce.

4.17 As part of the plans, there should be 100% coverage of high intensity use services by December 2024. Systems are advised to update plans for the prevention of ill-health and incorporate these into their Joint Forward Plans. This should focus on:

- Providing a suite of lifestyle programmes and behavioural interventions to address inequalities in cardiovascular disease prevention; smoking and alcohol cessation; diabetes prevention and remission; and weight management.
- Supporting people to stop smoking through opt-out treatments for patients in hospital and as part of maternity pathways;
- Maximise vaccination uptake and increase uptake and coverage of NHS screening programmes.
- Collaborate with local authorities and family hubs to support the Healthy Child Programme framework and stronger parent-infant relationships

4.18 Systems are asked to improve retention and staff attendance by ensuring that plans embed a focus across all elements of the NHS People Promise, as well as implementing the actions set out in the retention hub and aligning with the latest Core Skills Training Framework by the end of June 2024.

4.19 Systems should implement actions focused on retention, including those in the Growing Occupational Health and Wellbeing Strategy. Systems must also embed the six high impact actions as stipulated in the NHS equality, diversity and inclusion improvement plan, and the 10 principles and actions from the sexual safety charter.

4.20 NHSE also expects systems to support workforce growth in line with the Long Term Workforce Plan by: delivering their share of increased education places for new roles, and work with NHSE to plan for the necessary workforce expansion. Systems must also develop multi-professional education and training investment plans, aligned with JFPs.

4.21 The planning guidance explicitly asks for a “significant reduction in temporary staffing costs” and a “reconciliation of staff increases since 2019/20”.

4.22 For digital, Providers should aim to have deployed their electronic health record system by March 2025. They are required to support and prioritise the implementation of the Federated Data Platform – this is due to be rolled out across 70 organisations in 2024/25 and continue to connect services to the NHS App.

4.23 Regarding system working, the planning guidance recognises the work systems have undertaken to consider the best model of delivery to implement their JFPs, including integrated neighbourhood teams, place partnerships, and provider collaboratives.

4.24 Systems are asked to develop their population health management capabilities via using joined up primary and secondary care data, to support proactive care.

4.25 The Trust is currently reviewing all the planning guidance and our 2024/2025 plan is required to be submitted by 2 May 2024. It is encouraging to see that the Trust is achieving many of the performance metrics required. I know that the team will continue to stretch our ambition and trajectories to further drive improvements for our patients and staff.

4.26 The full planning guidance can be found [2024/25 priorities and operational planning guidance (england.nhs.uk)]

5 POLICY APPROVAL

5.1 Since the Trust Board last sat, the following corporate policies have been approved by the Chief Executive on the advice of the Executive Team:

- Contractors policy (Health & Safety)
- Complaints and PALS policy

6 RECOMMENDATION(S)

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

Jo Williams

Chief Executive

3 April 2024

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Service Accreditation**
SPONSOR (EXECUTIVE DIRECTOR):	**Nikki Brockie, Chief Nurse**
AUTHOR:	**Emma Steele – Deputy Chief Nurse & Chidiebere Ukaegbu – Quality Improvement Nurse**
DATE OF MEETING:	**10 April 2024**

EXECUTIVE SUMMARY:

This presentation will provide the Trust Board with an overview of the services accreditation model being developed here at The Royal Orthopaedic Hospital.

Service Accreditation schemes are used to improve standards and quality of care on wards and in departments. The focus is on engaging and empowering staff to improve patient care by recognising, sharing and adhering to best practice. The Service Accreditation that we are developing at ROH will be used as a tool to encourage ownership of continuous quality improvement.

Developing a Service Accreditation programme at ROH is part of the Chief Nurse Nursing plan and Corporate Nursing Business plan for 24/25 with an aim to provide 'Outstanding Care Every time' and work has commenced by launching the programme and setting up a steering group.
The steering group will oversee, guide the design and implementation of the service accreditation programme at ROH.

REPORT RECOMMENDATION:

The Board is asked to note and receive this update

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

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

Continuous Improvement Project will follow QSIR and has been registered on AMaT

PREVIOUS CONSIDERATION:

None

Service Accreditation Project Presentation

(Outstanding Care Every Time)

SRO - Emma Steele

Service Accreditation Programme

- Service accreditation system is a quality assurance programme that follows a structured approach using a uniformed set of standards to measure quality of care delivered across clinical/ service units or areas. It is a key driver to improving patient care and celebrating good practice.
- Accreditation brings together key measures of nursing and clinical care into one overarching framework to enable a comprehensive assessment of the quality of care at ward, unit or team level (NHS England, 2019).

Opportunity Statement

- Currently The ROH does not have a formal local service accreditation system for nursing and allied health services which drives continuous improvement across the Trust
- The design and implementation of Service Accreditation program (**Outstanding Care Every Time**) will enable the Trust to deliver outstanding, safe and quality care to our patients and our communities. This aligns with the Trust's strategic ambitions and provides a local assurance system for the Trust
- Developing a Service Accreditation programme at ROH is part of the Chief Nurse Nursing plan and Corporate Nursing Business plan for 24/25

Vision

All wards, units and departments at ROH will achieve and sustain the highest level of accreditation rating to improve efficiency, productivity, patient outcomes and patient and staff experience.

Scope of the Accreditation Project

The Service Accreditation would cover the following areas in the phases:

Phase 1

- Wards 1,2,3,4,12
- ADCU
- HDU
- Discharge lounge

Phase 2

- Main Outpatients and Phlebotomy,
- CYP Outpatients and Topography
- POAC
- College Green

Phase 3

- Theatres
- Recovery
- ROCS

Objectives - Phase 1

Feb. 2024

To establish accreditation governance structure (Steering group) at ROH.

May. 2024

To develop service accreditation set standards and measures for ROH.

Aug. 2024

To train accreditation assessors.

Oct. 2024

To develop accreditation standard work/SOP

Dec. 2024

To have wards and units in Phase 1 accredited.

Accreditation Project Benefits

- Improve local and national audits compliance
- Improve ward/ unit efficiency
- Create sustainable continuous improvement platform
- Improve staff satisfaction/ morale
- Celebrate good and outstanding practices
- Improve patient experience
- Provide uniformed standards and measures for quality assurance
- Improve Trust CQC rating

Project Risks

- Operational pressure
- Poor stakeholders' engagement
- Leadership commitment
- Resistance to change
- Implementation and utilisation of AMaT
- Conflicting priorities

Who Has Done This Before!

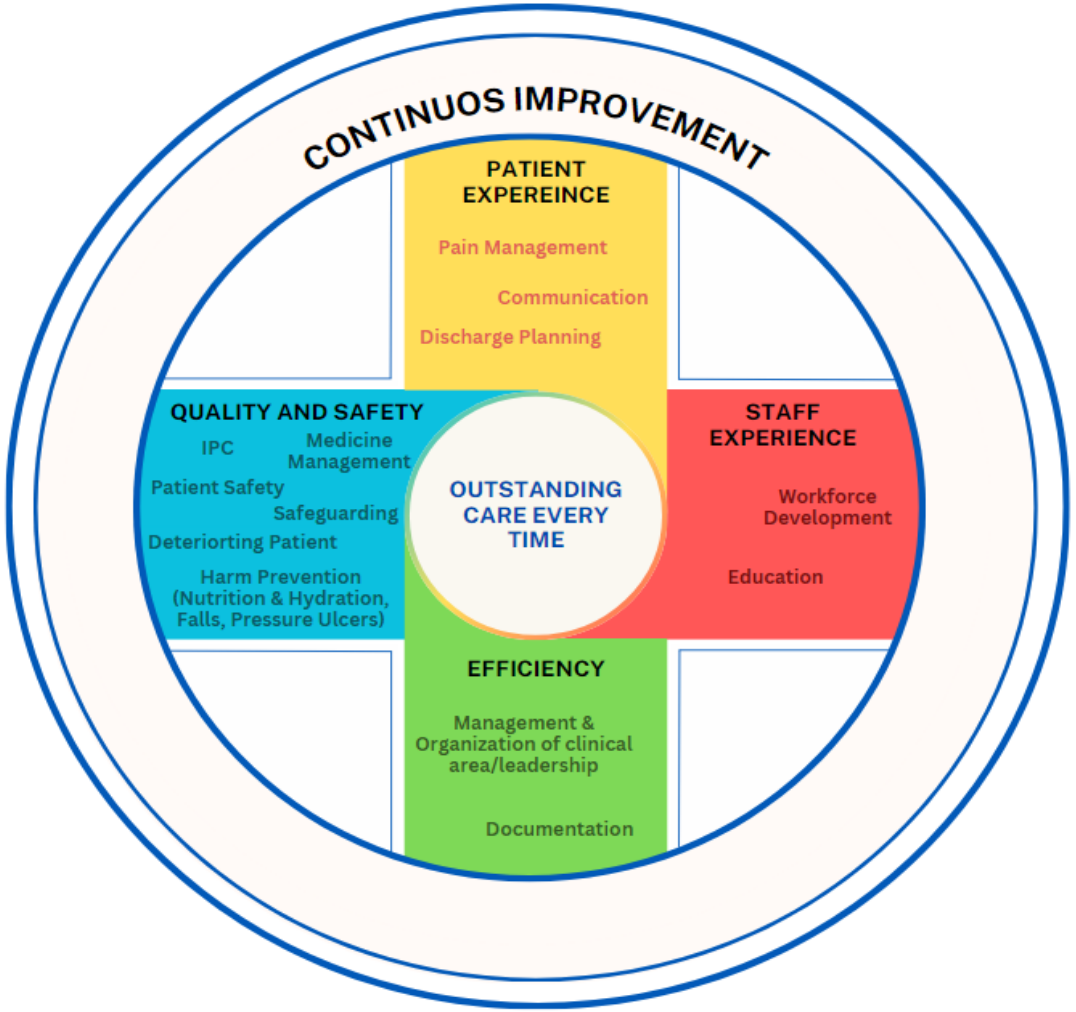
- United Lincolnshire Hospitals NHS Trust
- University College London Hospitals
- Royal National Orthopaedic Hospital
- University Hospitals Coventry & Warwickshire NHS Trust
- Salford Royal NHS Foundation Trust
- Gateshead Health NHS Foundation Trust

Current metrics/ Standards at ROH

Internal quality & safety reviews/report	Workforce establishment	Safeguarding reports	Patience experience reports	Tissue Viability Audits
IPC audits	Mandatory Training / PDR	Staff survey	FFT	Falls audit
Outstanding care every Time	Ward/unit condition report	Quality dashboard	Staff recognition award	PJ paralysis

Accreditation Steering Group

- Steering group formed with scheduled meetings once every month on a Wednesday to be chaired by Deputy Chief Nurse
- Made up of 14 core members and 10 identified subject matter experts
- Reports to Nursing council and Clinical Quality group


CONTINUOS IMPROVEMENT
PATIENT EXPEREINCE
Pain Management
Communication
Discharge Planning
QUALITY AND SAFETY
IPC
Medicine Management
Patient Safety
Safeguarding
Deteriorting Patient
Harm Prevention (Nutrition & Hydration, Falls, Pressure Ulcers)
OUTSTANDING CARE EVERY TIME
STAFF EXPERIENCE
Workforce Development
Education
EFFICIENCY
Management & Organization of clinical area/leadership
Documentation

Common Standards/ Measures across different Trusts

Pain management	Patient Safety	Documentation	Discharge planning	IPC	Patient experience
Safeguarding	Medicine Management	Nutrition & Hydration	Workforce Development	Deteriorating Patients	Management & Organisation of clinical area/ Leadership
	Communication	Falls Prevention	Pressure ulcer prevention	Culture of continuous improvement	

Accreditation Rating/Award system

The steering group adopted this rating/ award system and frequency of reassessment

Award system	Reassessment Frequency	Description
Platinum	15 months/18 months	TBC
Gold	Annually	TBC
Silver	Annually	TBC
Bronze	6 months	TBC
Haven't Achieved Accreditation	3 months	TBC • Crucial support

Service Accreditation Digital Platform

- The inspection module on AMaT is been explored by the project team after meeting with Clinical Effectiveness Manager

Test Ideas-Pilot

- Service accreditation tools (standards/metrics) to be tested in 2 inpatient areas before full implementation

REPORT REF: ROHTB (4/24) 007

TRUST BOARD

DOCUMENT TITLE:	**Flu Vaccination Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Executive Chief Nurse**
AUTHOR:	**Victoria Clewer, Lead IPCN**
PRESENTED BY:	**Nicola Brockie, Executive Chief Nurse**
DATE OF MEETING:	**10th April 2024**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Staff flu vaccinations are critical in reducing the spread of flu during winter months, protecting those in clinical risk groups and reducing the risk of contracting both flu and COVID-19 at the same time and the associated worse outcomes and reducing staff absence and the risk for the overall safe running of NHS services.

During 23/24 flu vaccination season at ROH 59.25% of Healthcare Workers with patient contact were vaccinated.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
• All Board Members were offered the vaccination during the first week of the campaign. • System wide approach taken across BSOL with all communication leads working together. • Peer vaccinators were trained & delivered vaccinations in a planned clinic and then offered a roaming vaccination service to staff in all areas	• 40.75% of healthcare workers with patient contact remain unvaccinated some reasons given are felt unwell on previous occasions, personal reasons & tired of vaccinations.

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to: receive the report.

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

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

ALIGNMENT TO TRUST STRATEGY, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Flu Vaccination CQUIN
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
System approach to vaccination
PREVIOUS CONSIDERATION
January meeting of Quality & Safety Committee

CQUIN01: Flu Vaccinations for Frontline Healthcare Workers

Commissioning for Quality and Improvement (CQUIN) 2023/24

1. INTRODUCTION

1.1. Staff flu vaccinations are critical in reducing the spread of flu during winter months; protecting those in clinical risk groups and reducing the risk of contracting both flu and COVID-19 at the same time and the associated worse outcomes and reducing staff absence and the risk for the overall safe running of NHS services.

1.2. CQUIN01: flu vaccinations for frontline healthcare workers ran for quarter 3 and 4 only, from 1st September 2023 to 29th February 2024.

1.3. The CQUIN lead is Victoria Clewer, Lead IPC Nurse and the Executive Lead is Nicola Brockie, Chief Nurse and DIPC.

2. CQUIN DETAILS

2.1. The aim was to achieve 80% uptake of flu vaccinations by frontline staff with patient contact. In line with the widened definition of frontline healthcare workers used during the 2021/22 flu season, eligible staff includes non-clinical staff who have contact with patients. The minimum uptake required to achieve the CQUIN was 75%. Payment is made based on the whole period (September 2023 to February 2024).

2.2. The Trust submit data monthly (between 1st September 2023 and 29th February 2024) to UKHSA via ImmForm.

2.3. At the start of the 2023/24 vaccination campaign NHS England implemented the new 'DAPB4075 - frontline healthcare worker COVID-19 and flu vaccination uptake collection'. This is a new automated data collection to monitor uptake of seasonal influenza and COVID-19 vaccinations to frontline healthcare workers as commissioned under the NHS Standard Contract (DAPB4075). This collection relaces previous manual collections (DAPB3146-02 and DAPB3146-01 COVID-19 vaccination SitReps) and is now the recognised source for all reporting of frontline healthcare worker vaccinations and the basis for the calculation of achievement against the 23/24 flu CQUIN indicator (CQUIN01).

2.4. The automated collection compares activity data reported through NHS England authorised Point of Care Systems (ROH use National Immunisation and Vaccination System – NIVS) and the NHS BSA Electronic Staff Record (ESR) data for frontline healthcare workers. The purpose of the collection was to remove the need for manual data collections and reduce the administrative burden on providers, however we are still

required to submit vaccination uptake data to UKHSA via ImmForm, this was undertaken monthly by the Lead IPC Nurse.

2.5. Access to the live DAPB4075 data has proven difficult as it is only accessible via Foundry, to which the vaccination programme leads did not have access, despite multiple attempts to gain access. Data held locally and submitted to UKHSA via ImmForm may differ from the data produced by the Data Processing Service (DPS) as it relies upon the accuracy of staff ESR and GP records. Therefore, data presented in this report may not reflect the data collected via DAPB4075 and may impact the calculation of ROH achievement against the 23/24 flu CQUIN indicator (CQUIN01).

3. VACCINATION UPDATE

3.1. An Influenza Campaign Management Group (ICMG) was set up and met regularly from May 2023 to plan and prioritise actions in preparation for delivering the programme. Engagement was initially good with an action plan developed to ensure an engaged and prepared workforce. However, proactive engagement was only received primarily from the nursing workforce.

3.2. The UKHSA best practice checklist was used to guide the group in prioritising actions to generate interest and increase uptake of vaccinations. The checklist was developed on the four key components (Committed leadership, Communications, Accessibility, and Incentives) of developing an effective influenza vaccination programme.

3.3. <u>Committed leadership</u>

3.3.1. The ICMG included:

- Board Champion – ICMG included both the Chief Nurse and Director of Finance.
- CQUIN Lead (responsible for supplying up to date information on vaccination progress and action plan)
- Divisional representation (Nursing)
- Pharmacy (responsible for ensuring the vaccine is available)
- Communications (responsible for delivering the Communications Plan)

3.3.2. All Board members were offered the influenza vaccination during the first week of the 2023-24 campaign. The CEO and Chairperson were photographed having their vaccinations which were shared on social media, the trust intranet etc.

3.3.3. Vaccination uptake progress was shared regularly with the ICMG by the campaign lead.

3.4. Communications Plan

3.4.1. The Trust communications team led the development of the 2023-24 Influenza Campaign Communication Plan. A system-wide approach had been taken across Birmingham and Solihull with all communication leads working together to deliver a joined-up seasonal influenza vaccination communications and engagement campaign for all health and social care workers in all settings.

3.5. Flexible accessibility

3.5.1. As seen in the previous year, plans to train and develop 'peer' vaccinators within clinical areas stalled with difficulties faced in gaining support for the campaign by clinical staff. However, the campaign was supported by a resolute team of 19 peer vaccinators (mostly made up of the senior nursing team and corporate nurses) who completed training and supported vaccine administration.

3.5.2. The previous outpatient physio services department was used as a base to provide a manned area for vaccinations for both influenza and COVID-19 for the first three weeks of the campaign. When attendance to the hub quietened, the vaccinators took on a 'roving' role and sought out individuals who wanted the flu vaccine within their own areas across the site.

3.5.3. Feedback received at the time of the campaign suggests that this location was not as accessible for all staff, which may have put some staff off receiving their vaccine. Access to suitable facilities to deliver both flu and COVID-19 vaccination suitable for all staff, time slots etc. is of great difficulty to achieve.

3.5.4. The vaccination hub was supported by the regional COVID-19 vaccination team for limited shifts for the first two weeks of the campaign to deliver COVID-19 booster vaccinations only.

3.5.5. Dedicated theatre sessions were provided to vaccinate those who were unable to leave the theatre area.

3.5.6. Reflections on the 2023/24 and previous year's campaign success suggest increased 'roving' within the initial two weeks of future campaigns may support increase uptake.

3.6. Incentives

3.6.1. Incentives for the 2023/24 vaccination programme were changed from the previous year's campaign with much commentary from staff suggesting this did not 'incentivise' them to obtain their vaccine.

Table 1: Vaccination programme incentives.

2022/23	2023/24
All staff who receive the flu vaccine received a free drink voucher. £5 café royale voucher. All staff who received the flu vaccine were entered into a prize draw to win: • X1 £100 voucher for a shop of their choice • X3 £50 vouchers for a shop of their choice All vaccinators who administer 75 vaccines received a £25 voucher for a shop of their choice.	All staff who received the flu vaccine received: • A free drink voucher • A sticker • A badge card

3.6.2. Executive decision on rewards for vaccinators is still yet to be agreed and communicated.

3.6.3. During the campaign, feedback was received which highlighted concern about the use of plastic badge cards. This was seen as an unnecessary waste of money and an inappropriate use of plastic as they cannot be reused (year printed on them). This feedback has been reflected on and will be considered when planning the 2024/45 campaign.

4. 2023/24 DATA

4.1. Data provided by the ESR team showed there were 1362 staff who were eligible to receive the influenza vaccine during the 2022/23 campaign. Of these, 962 were healthcare workers (clinical and non-clinical) who have patient contact. The remaining 400 staff were healthcare workers who have no patient contact.

4.2. Of the 962 frontline HCW with patient contact, 570 received a flu vaccination with at ROH or elsewhere. This is 59.23% of the eligible workforce. This falls short of the minimum threshold of CQUIN01 by 15.77% (152 staff).

Table 2: Percentage of all healthcare workers (patient contact and no patient contact) vaccinated with the influenza vaccine between 1st September 2023 and 29th February 2024.

Total Staff	No. HCWs vaccinated	% Vaccinated
1362	715	52.50%

Table 3: Percentage of healthcare workers who have patient contact vaccinated with the influenza vaccine between 1st September 2023 and 29th February 2024.

Occupation	No. Of HCWs involved with direct care	No. Vaccinated	% Vaccinated
All Doctors (inc. students and bank)	132	93	70.45%
Qualified Nurses (inc. students and bank)	316	190	60.13%
Other professionally qualified clinical staff (inc. students & bank)	164	98	59.76%
Support to clinical staff (inc. bank)	350	189	54.00%
TOTAL	**962**	**570**	**59.25%**

Table 4: Percentage of healthcare workers who do not have patient contact vaccinated with the influenza vaccine between 1st September 2023 and 29th February 2024.

No. Of HCWs NOT involved with direct care	No. of HCWs vaccinated	% Vaccinated
400	145	36.25%

Table 5: Percentage of healthcare workers who received the vaccine elsewhere or declined vaccination between 1st September 2023 and 29th February 2024.

Occupation	No. of HCWs received influenza vaccine elsewhere	No. of HCWs declined influenza vaccine
All Doctors (inc. students and bank)	5	1
Qualified Nurses (inc. students and bank)	7	2
Other professionally qualified clinical staff (inc. students & bank)	5	4
Support to clinical staff (inc. bank)	6	1
HCWs not involved with direct care	7	2
No information provided	2	2
TOTAL	**32***	**12**

*The HCWs who received vaccination elsewhere are included in the ROH total.

Figure 1: Location of vaccination if not at ROH.

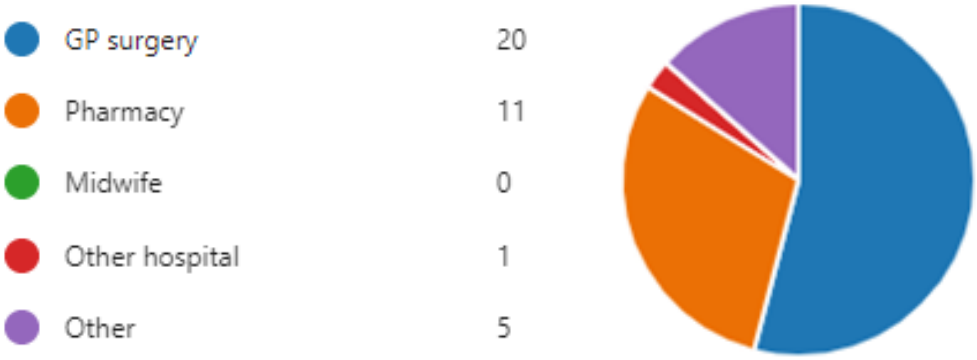
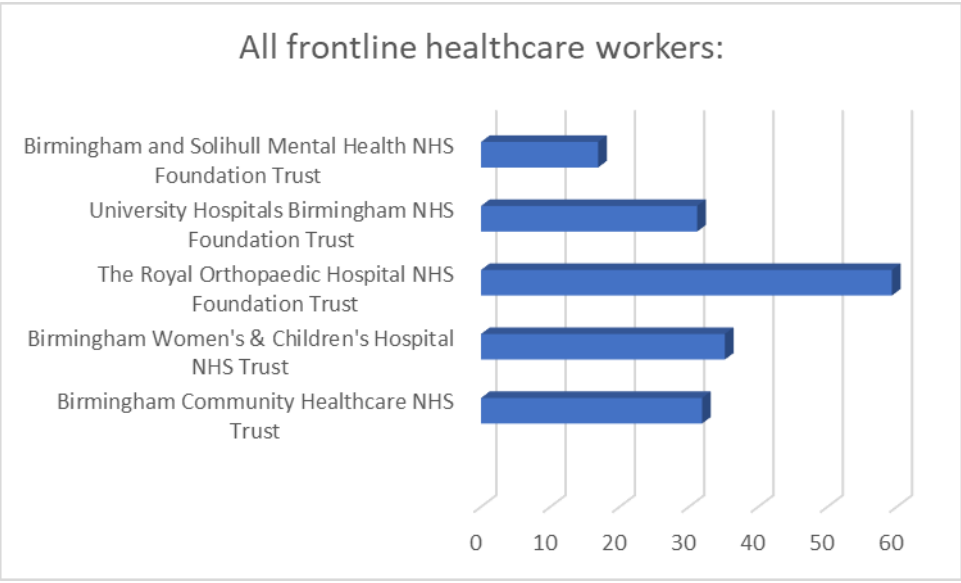


Figure 2: Reasons cited for declining the vaccination.

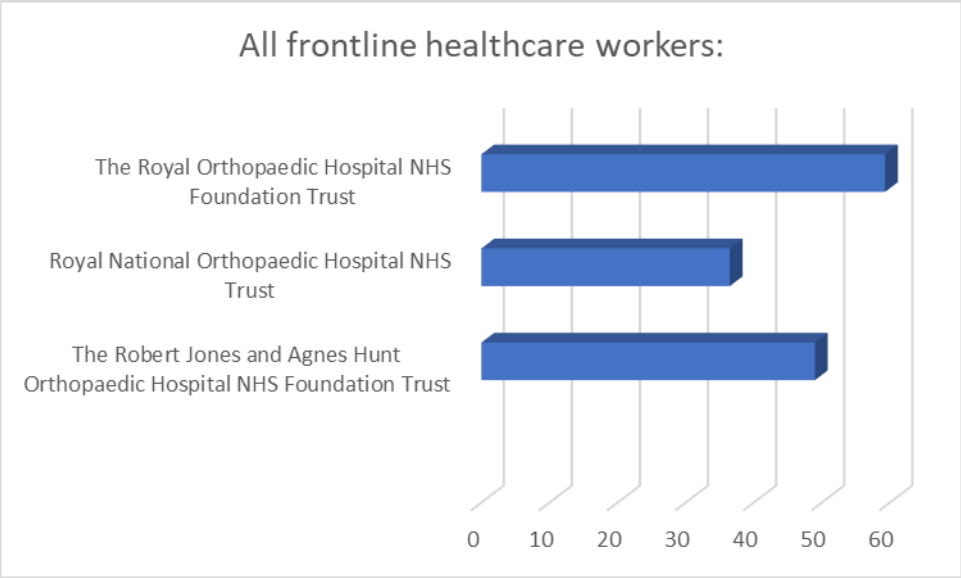
4.3

4.3 Comparison data (BSOL ICS)

Graph 1. Percentage of Healthcare workers who received vaccine in the five BSOL providers between 1st September 2023 and 29th February 2024.



Graph 2. Percentage of Healthcare workers who received vaccine in the peer providers between 1st September 2023 and 29th February 2024.



5. REFERENCES

NICE NG103 - Overview | Flu vaccination: increasing uptake | Guidance | NICE

REPORT REF: ROHTB (4/24) 008

TRUST BOARD

DOCUMENT TITLE:	**Fire Safety Annual Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Director of Governance**
AUTHOR:	**Paul Beech, Authorising Engineer (Fire), Fagus Fire Safety Consultancy Limited**
PRESENTED BY:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**10 April 24**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Consideration of an annual fire safety assurance is included within the workplan of the cycle of business for the Trust Board.

The report covers the following matters:

- Description of current fire safety advice/support
- Fire incidents
- Fire safety mandatory training and plans to improve the uptake of this
- Any national guidance around fire safety that the Committee needs to understand

An assessment of how the Trust measures up to fire safety legislation and regulatory standards, any gaps and what we are doing to address them

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
Good compliance overall with fire safety prevention and protective measures Policy for fire safety is in date and current	Poorer than desired performance against the fire safety mandatory training – 76% vs. 93% target

NOT APPLICABLE	

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Committee is asked to note and accept the report and agree to its onward transmission to Trust Board

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

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

ALIGNMENT TO TRUST STRATEGY, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Compliance with fire safety legislation.
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
None specifically.
PREVIOUS CONSIDERATION:
Executive Team on 26 March 2024 and Quality & Safety Committee on 27 March 2024.

FOR ASSURANCE

Annual Fire Safety Assurance Report 2024

REPORT TO THE TRUST BOARD ON 10 APRIL 2024

1.0 INTRODUCTION

1.1 Consideration of an annual fire safety assurance is included within the workplan of the cycle of business for the Trust Board.

1.2 The report covers the following matters:

- Description of current fire safety advice/support
- Fire incidents
- Fire safety mandatory training and plans to improve the uptake of this
- Any national guidance around fire safety that the Committee needs to understand
- An assessment of how the Trust measures up to fire safety legislation and regulatory standards, any gaps and what we are doing to address them

2.0 CURRENT FIRE SAFETY ADVICE AND SUPPORT

2.1 Fire safety advice and support continues to be provided by Fagus Fire Safety Consultancy Limited. Fagus acts in the capacity of both authorizing engineer (fire) and fire safety advisor to the Trust.

2.2 Fagus has conducted a detailed fire risk assessment of the premises occupied by the Trust and continues to conduct fire safety audits of all Trust occupied areas annually. In addition, Fagus provides further specialist fire safety training to fire response team leaders, porters (who form part of the fire response team), fire safety wardens, and training in the evacuation aids present in Trust occupied areas.

2.3 Advice is provided on request in respect of capital projects.

2.4 Fagus also reviews the local fire safety manuals issued to all wards and departments on the main site.

3.0 FIRE INCIDENTS

3.1 There have been 25 fire alarm activations during the (uncompleted) year 1 April 2023 to 31 March 2024 at the main site. All were 'unwanted' alarms; there were no actual fires in any of the Trust's premises.

3.2 While every effort must be made to reduce 'unwanted' fire alarms, the number that the Trust experiences is quite low. The causes are to a large extent predictable, many arising from poor cooking practices (especially in the accommodation halls) and the activity of contractors. Action to reduce the number of 'unwanted' fire alarms should continue.

4.0 FIRE SAFETY TRAINING

4.1 Fire safety training is separated into two categories: general fire awareness that should be attended annually by every member of staff, and specialist training for fire response team leaders and training in the use of evacuation aids.

4.2 General fire awareness training is available in a face-to-face session in the ROH lecture theatre or on-line. Presently, compliance with annual fire awareness training is at 76%. This is a disappointingly low percentage. The fire safety policy requires that line managers ensure that the staff for whom they are responsible attend fire safety training as required. Work has been undertaken to promote the need for staff to complete their mandatory fire safety training, most recently as part of the Director of Governance's slot on the all staff Team Brief.

4.3 Specialist training is provided annually for fire response team leaders. Training for fire safety wardens, porters, and on evacuation aids is provided as required.

4.4 The meetings of the Health and Safety Group provide oversight of compliance with the training and it is considered as part of the monthly Workforce performance reports, by both Trust Board and the Staff Experience & OD Committee when it meets.

5.0 NEW FIRE SAFETY GUIDANCE AND REGULATIONS AFFECTING THE TRUST

5.1 The Building Safety Act 2022 (the Act) applies to higher risk buildings, those in excess of 18 metres in height. (The height of a building is measured from the external ground to the height of the highest occupied floor.) In this respect, the Act has no immediate effect on ROH premises. However, the Act does amend the Regulatory Reform (Fire Safety) Order 2005 (the Order). While further amendments to the Order may arise from the Act, presently changes are made to section 9 – risk assessment. The amendments affect the detail that should be recorded following an assessment of the risks; this has little effect on the Trust as the level of detail recorded following an assessment of the risks was always greater than is commonly the case. However, the findings of the assessment are regularly reviewed, and will be reviewed during the year in order to ensure full compliance with the Order.

6.0 AN ASSESSMENT OF HOW THE TRUST MEASURES UP TO FIRE SAFETY LEGISLATION AND REGULATORY STANDARDS

6.1 Generally, Trust premises and fire safety management procedures meet the requirements of legislation; there are no compromises in the design of buildings.

6.2 The Trust is aware of the range of preventative and protective measures that must be implemented and maintained. It is important that the Trust responds to the recommendations resulting from fire safety audits and the Committee is asked to note that the Trust adopts these in a robust and timely manner.

6.3 To some degree, failures in general fire safety management result in a slightly higher risk than necessary, particularly around some aspects of housekeeping and the maintenance of fire doors. It is acknowledged that, due to the day-to-day pressures on a busy hospital, a perfect standard of fire safety will be difficult to achieve, although compliance overall is good.

6.4 Very recently, the West Midlands Fire and Rescue Service attend the main site to conduct a brief fire safety audit. Indeed, while generally satisfied with what they witnessed, they did comment on a small number of compromises – housekeeping and fire doors, in particular.

7.0 OTHER MATTERS

7.1 Review following the findings of the Grenfell Tower fire

The outcome of the Grenfell Tower fire was a result of a number of factors: primarily combustible external wall finishes and the failure of internal structural fire precautions. All NHS Trusts were required to identify if any taller buildings were clad in combustible materials; this is not the case at the ROH.

7.2 Fire Safety Policy

The fire safety policy, as with all Trust policies, is formally reviewed on a regular basis by the Estates Department. The policy imposes requirements on all staff according to their role and responsibility. Staff teams should be assessed so as to ensure that the requirements imposed of staff members are fully implemented. The policy is currently in date although a review date of April 2024 is set.

7.3 Governance reporting

Fire safety is a standing item on Health and Safety Group meetings, which reports upwards to the Quality and Safety Committee.

7.4 Key priorities for the year ahead

In addition to maintaining the auditing of the preventative and protective measures, the Trust should aim to improve attendance for the general fire safety awareness training and complete the transfer of its fire precautions drawings to CAD.

Paul Beech
On behalf of Fagus Fire Safety Consultancy Limited
Authorising Engineer (Fire)

March 2024

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Board discussion areas 2024/25 - update**
SPONSOR (EXECUTIVE DIRECTOR):	**Tim Pile, Trust Chair**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**10 April 2024**

EXECUTIVE SUMMARY:

At the meeting in March 2024, the Board discussed some of the key topics for consideration during the coming year. These were over and over the routine cycle of business for the Board and items for which additional time for debate would be allowed on the agenda of the relevant meetings.

As mentioned at the meeting, the areas of Board interest align significantly with those for discussion as part of the financial sustainability development plans, drafted in response to the Board development session in late January.

Given the strategic, or in some cases, commercial nature of some of the plans, the Board should note that these would be considered under the confidential section of the Board agenda, however as discussed at the last meeting, the key highlights or progress with delivery would be built into the upward reports from the Board subcommittees where relevant.

The detail and progress of the proposed programmes will be considered in more detail later in the meeting, but the Board is asked to note that these are likely to be:

1. Increasing activity through improved productivity
2. Increasing Private Patient activity
3. Agency reduction and improved workforce design
4. Digitally optimised processes
5. High Performing Teams
6. Shared Services and Acute Integrator for Orthopaedics

Good progress has been made on the initiatives since the Board workshop in January and most recently a similar exercise has been undertaken with the Senior Leadership Team which has yielded a similar view of the priorities of focus. The timing for the discussion of these at the full Board meetings and subcommittees is yet to be finalised, until the scope and delivery plan for each is determined. Thought will be given to ensure that these are planned across the year 2024/25 and into 2025/26 to ensure adequate time for discussion and input at the appropriate time.

In terms of timing for the other substantial items for discussion, it is suggested that following timetable be proposed:

- Clinical plan – April 2024
- Estates – May 2024
- Continuous improvement – July 2024

The Royal Orthopaedic Hospital NHS Foundation Trust

The remainder items that the Board suggested would be of interest, but which may not require significant strategic debate are:

- Well led update – April 2024
- Service accreditation – April 2024
- CQC preparation plan update – September 2024
- Race Code gaps analysis/check and challenge – May 2024
- Charity update & Trustee training – July 2024
- Staff engagement (any items not covered by the High Performing Teams programme) – September 2024
- Research & Development – May 2024 and January 2025
- Divisional lookback and forward plan for 2023/24 – May 2024
- Health inequalities – November 2024

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:

March 2024

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Assurance Report from the Non Executive Champion for Freedom to Speak Up**
SPONSOR (EXECUTIVE DIRECTOR):	**Gianjeet Hunjan, Non Executive Director**
AUTHOR:	**Gianjeet Hunjan, Non Executive Director** **Claudette Jones, FTSU Guardian** **Veronica Thomas, FTSU Administrator** **Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**10 April 2024**

EXECUTIVE SUMMARY:

National guidance was received in 2022 which rationalised the number of Non Executive champion roles to five: Freedom to Speak Up; Security Management; Wellbeing; Doctors' Disciplinary; Maternity Safety (not relevant to ROH).

When the new guidance was presented to the Board, it was agreed that the assigned Non Executive champions would provide an assurance report to the Board by rotation.

Attached is the third of these reports, this being from the Non Executive Champion for Freedom to Speak Up, Gianjeet Hunjan.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- RECEIVE and NOTE the update and assurance within the report.

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

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

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

- NHS E guidance on Non Executive championships

PREVIOUS CONSIDERATION:

Report to Trust Board in June 2022.

ASSURANCE REPORT FROM THE NON- EXECUTIVE DIRECTOR

FOR FREEDOM TO SPEAK UP

Definitions and scope of responsibility	NHS England has committed to promoting Freedom to Speak Up, wanting all workers to feel valued and respected and to know that their views are welcomed, to enable them to provide the best possible care. NHS is committed to providing a working environment where FTSU is valued as an opportunity to learn and improve. FTSU statistics are reviewed regularly and fed back through the staff survey. The role of the Senior Lead for FTSU is defined as supporting the FTSU Guardian. This person should be considered: • A credible role model of the behaviours that encourage speaking up. • Clear about their role and responsibility. • Able to evidence that they help improve the organisation's speaking up culture. • They should be accountable for these aspects of the FTSU's guardian role: - Fair, inclusive recruitment - Capacity - Evaluating speaking up arrangements • They should also be able to explain to oversight bodies the rationale for decisions around: - Ringfenced time, as well as the checks and balances put in place to show this. - Time is sufficient and effective. - How the guardian was appointed. - How the organisation reviews its speaking-up arrangements. The role of the Non-Executive Director (NED) for FTSU in the NHS is defined as providing a senior, independent lead role specific to organisations with boards. In this context, the NED is predominantly a support for the guardian: a fresh pair of eyes to ensure that investigations are conducted with rigor and to help escalate issues, where needed.

	They should have an in-depth knowledge of FTSU and be able to readily articulate: • Why a healthy speaking-up culture is vital. • The indicators of a healthy speaking-up culture. • The indicators that there is sufficient support for speaking up and wider culture transformation. • The red flags that should trigger concern. They challenge the most senior people in the organisation to reflect on whether they could do more to create a healthy, effective speaking-up culture. This might involve constructively raising awareness about poor behaviours. Function responsibilities include: • Promoting an open and honest reporting culture within the NHS, where people can speak up and have their suggestions listened to and acted upon. • Raising concerns to support and encourage improvement. The role of the Guardian is defined as • Supporting colleagues, providing an alternative route for workers to speak up about issues that prevents them from providing good care – empowering them and breaking down barriers to speaking up. • Worker Experience – work to enhance the experience of workers. • Ensuring those who speak up are thanked. • Ensuring that issues raised are responded to. • Ensuring those speaking up receive feedback on the actions taken. • Patient safety and quality of care – contribute to protecting patient safety and improving quality of care. • Promoting learning and improvement – matters raised by staff are used as opportunities for learning and continuous improvement. • Contribute to the work of the National Guardian's Office by providing speaking up data, responding to surveys and passing on FTSU stories to share the impact of FTSU on health.

	• Complete the NGO's programme of training and maintain currency. • Recruit and support FTSU Champions. The role of the Champion is defined as • A voluntary role aiming to support colleagues to speak up. • Offer encouragement and signpost workers to avenues to speak up or receive support. • Raise awareness of the importance of speaking up. • Promote the value of speaking up. • Compliment the work of guardians by supporting a culture where open communication is encouraged.
Operational and Executive Leads with responsibility for Security Management	Simon Grainger Lloyd – Executive Lead for FTSU Gianjeet Hunjan – Non-Executive Lead for FTSU Claudette Jones – FTSU Guardian Champions: • Jane Bevan, Clinical Audit & Effectiveness Facilitator • Asif Kabala, Finance Assistant • Uzo Ehiogu, Senior Physiotherapist • Eunice Butler, Healthcare Assistant • Petros Mikalef, Consultant Surgeon • Symeon Hopkins, Oncology Admin Manager • Wilson Thomas, Consultant Anaesthetist • James Jones, Research Healthcare Technician
Activity this period (March 2023 – March 2024)	• Confirmed that the FTSU Plan is in line with the FTSU Strategy and NHS People Plan • Supported the development of triangulation document which will be shared at divisional level, providing information regarding number of cases raised and themes, to be used to promote shared learning, change and improvement. • Worked collaboratively with managers and colleagues across the Trust including: - Network Chairs - Engagements and Wellbeing Officer - Managers for reporting and following up of concerns. - Human Resources Manager - Regular 1:1 meetings with Director, senior leaders, managers and staff as appropriate.

	- Regional and National NHS FTSU meetings and conferences • Held training sessions for new starters and junior doctors in FTSU (in response to issues raised) • Attended meetings every 6 weeks with champions to share progress, discuss strategy and plans for associated events. • Undertook regular walkabouts to meet and support staff. • Participated in Awareness Events: - Awareness Day - Awareness Month • Supported the production and distribution of quarterly newsletters (provided updates across the Trust regarding FTSU activity) • Acted as a sounding board for the creation of resources around the site, maintenance and updating of associated publicity i.e. posting boxes (as a result of workers requests) • Supported the creation, update appropriately, and distribute leaflets and posters regarding Awareness of FTSU. • Collaborated with the Communications Team to provide avenues for FTSU responses via Intranet and regular awareness raising communications. • Supported the FTSUG to provide reports: - Monthly reports to the Safety Team - Quarterly reports to the National Guardians Office - Annual Report to the Executive Board • Sought assurance on the follow up of concerns raised and outcomes. • Supported the creation of Thank You cards to ensure those speaking up are thanked. • Collaborated with HR to develop Conflict Training in response to issues raised – currently in the piloting stage. • Supported the recruitment of champions from diverse backgrounds and roles across the organisation. • Had oversight to ensure that Champions completed bespoke training endorsed by NGO, delivered by FTSUG. • Participated in bespoke induction for FTSU Champions delivered by FTSU Guardian, Executive Director and Non-executive Director with certificate to induct Champions in their role.

	• Sought assurance that the FTSU page on the Intranet is updated regularly and when required. And that FTSU modules are currently on ESR for everyone to complete (not mandatory) - Freedom to speak up – all staff - Freedom to listen up – managers - Freedom to follow up – Boards member and senior managers. • Sought administrative support for the FTSU function which has been recently provided.
Status of relevant strategies and policies	• FTSU policy inline with FTSU template and NHSE was completed November 2022 (deadline was January 2024) and is not due to be updated until 2025. • FTSU – A guide for leaders in the NHS and organisations delivering NHS services: reflection tool (for the Board) is a task to be commenced. • Detriment document – currently being worked on. (Will be an appendix to the FTSU policy) • NGO FTSU new strategy will be coming out from NHS England in May 2024. At this point the above documents might need to be reviewed.
Matters of escalation/key points of assurance to the Board	• Identified room required for use by FTSU Guardian/Team. • Track completion of FTSU modules being completed on ESR. • Use ESR data to inform actions to promote completion of training, to aid learning and improvement of culture change. • Ensure awareness of FTSU is consistently at the forefront of meetings. • Share triangulation data at division level to foster training and development, so that senior managers are aware of themes and can develop or prioritise any necessary training. Training and outcome to be fed back to safety group • Mandate completion of FTSU module training for all staff.
Actions planned for next period	• FTSU – A guide for leaders in the NHS and organisations delivering NHS services: reflection tool, (for the Board) to be started. • FTSU handbook for ROH to be completed. • Complete recruitment and induction process for 2 additional champions.

	• Create a survey monkey asking if workers feel safe & confident to speak up and if they have experienced detriment following speaking up. • Arrange activities relating to the October FTSU Awareness month. • Complete triangulation document and build into FTSU process for sharing and learning from the issues raised. • Roll out FTSU thank you cards across the organisation. • FTSU Team 1:1 meeting with Executive and Non-Executive for team support • Continue recording and monitoring of worker concerns and providing feedback. • Continue formation of reports for Board, NGO and Safety Team.

Gianjeet Hunjan
Non Executive Director

March 2024

PAPER REFERENCE: ROHTB (4/24) 011

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 26 March 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Performance against the national 18-week Referral to Treatment Time was reported to have deteriorated slightly, which reflected the current focus on seeing patients who had waited significantly for a follow up appointment. • There continues to be uncertainty over the future use of ROH theatre space by surgeons from other System partners. • There remains some funding currently outstanding from NHS England and other Integrated Care Systems for work delivered, a matter which is being pursued by the Chief Finance Officer of the BSol ICB. • There was noted to remain below par completion rates for appraisals and mandatory training. The new appraisal process was highlighted which would assist with systematising the annual reviews. • The Committee was provided with an overview of the ROH and System's operational and financial plan for 2024/25, although the national guidance had not yet been released. There remains significant risk and uncertainty attached to the assumption around the Elective Recovery Fund (ERF), contract values and the efficiency requirement. • It was reported that a 'phishing' test had been organised across the Trust and a high number of people had opened unsolicited e-mails and links therein. More training and awareness are planned. • Attendance was noted to be poor at the Green Board and therefore work was underway to engage staff across the organisation with the work.	• Update on resourcing issues in the private patient team to be considered at the April 2024 meeting. • The Seamless Surgery initiative is planned for April and will include work on continuous improvement and the results of the staff survey. • Work continues to improve the position against the Better Payment Practice Code. • The final operational and financial plan is to be submitted by 2 May 2024 and delivery plans are being worked up. • The Committee will look in detail at the capital plan in April, as part of the Estates Plan, and at digital issues and the potential for further productivity from this source at the May meeting. • The Committee wished to see the revised cycle of business that had been updated based on amends suggested at the last meeting.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• The majority of specialities were approaching having eliminated any waiting times of 52 weeks and over. There was a specific focus on the spinal surgery patients where waiting times were longest. • The activity target had been exceeded in February 2024 and performance was above the System plan. • There had been a reduction in 'Did Not Attend' cases • There had been an increase in the take up of the Patient Initiated Follow Up pathway. • Performance against the diagnostics targets continues to be excellent. • Theatre session utilisation has increased to 84.8%. • Cancellations have reduced to 24 in month. • Cancer targets continue to be met apart from the 31-day standard, due to a single breach related to a complex case and the availability of a surgeon. • Bed occupancy has increased. • MSK waiting times for physiotherapy and back pain services have reduced. • Greater than planned activity had been handled through the private patient pathway. • A financial surplus was reported to have been delivered in February, although this largely reflected the receipt of additional funding to ameliorate the impact of Industrial Action. • Agency spend was reported to have reduced, with a further reduction down to 3.2% planned for 2024/25. • Delivery of the Cost Improvement Plan was reported to be progressing well, most of which was achieving recurrent savings. • Turnover was reported to have declined. • The 'GetUBetter' app was reported to be rolled out across the BSol system to improve absence rates associated with MusculoSkeletal conditions.	• None specifically.

• An update from the temporary workforce group was received, which highlighted the focus on physiotherapy and pharmacy to ensure that there was substantive recruitment into vacancies. The Trust remains an outlier in terms of temporary staffing usage to cover vacancies, out of hours work and sickness absence. • The Committee noted good progress against the actions arising from the effectiveness review undertaken at the end of 2023.	

Chair's comments on the effectiveness of the meeting: The Committee's time was agreed to have been spent on the areas requiring most focus and discussion.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 27 March 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Work continues to improve the gender pay gap, although there remain challenges with attracting female staff into senior medical roles. • It was noted that there was more work to do to improve staff declaration rates for disability and sexual orientation.	• Ensure that the clinical excellence awards process and outcome is presented to the Staff Experience & OD Committee. • Rigorous application of sexual safety principles to continue. • Work was reported to be underway through the data quality group to gather better ethnicity information for the Trust's patients.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
➢ A summary of the gender pay gap position was presented which showed an improvement in the median pay gap. An action plan is in place to address any inequalities identified, with the majority of work planned over 2024/25. ➢ The Committee considered an upward report into the protected characteristics of staff and patients which would form part of the annual equality and diversity update. ➢ The main section of the meeting was a workshop where the Committee considered the outcomes of the recent staff survey. The Committee discussed a number of questions: ➢ What do you see as our strengths? What should we be proud of? ➢ What could be better? What stands out as opportunities? ➢ In addition to the areas which IQVIA (survey provider) has highlighted for particular focus, what other high impact actions do you think we need to prioritise this year? ➢ What else should we be doing based on this feedback? ➢ Who will be responsible for owning the actions? The key themes for focus which emerged from the discussion, in addition to the three areas identified by IQVIA, were agreed by the Committee to be: ➢ Investment in line manager development which resonates and reflects our values	• None specifically.

➢ Engagement from across the Trust in a continuous improvement culture. Needing to be smart in aligning interventions from across the Trust with workforce at the heart of change and transformation so that people do not see staff engagement as separate from improving productivity, performance or sustainability – a single unifying narrative. Next step is for the Senior Leadership Team to engage in the staff survey focus groups so we can better understand what may have the greatest impact for staff in relation to those areas in the staff survey where we have opportunity for improvement.	
Chair's comments on the effectiveness of the meeting: The Committee enjoyed the workshop, as evidenced by the good engagement, as it allowed protected time to focus in detail on a single high priority issue. It was suggested that this could be a regular feature of the Committee's workplan going forward.	

PAPER REFERENCE: ROHTB (4/24) 013

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE QUALITY & SAFETY COMMITTEE

Date Group or Board met: 27 March 2024

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The extract of the Corporate Risk Register that detailed clinical risks was considered, which included concerns over the continued robustness of the provision of Speech & Language and Histopathology services. It was noted that these concerns had been raised through established escalation routes in the Birmingham and Solihull Integrated Care System and would continue to be highlighted given the potential for delivery of adverse quality of care. The national shortage of pathologists was noted to be a key factor comprising resilience in the histology service. • The was reported to have been a slight increase in falls – these would be reviewed thematically and work was underway to continuously improve the patient environment to prevent risks of falling. • There has been an increase in complaints and PALS enquiries. There was some delay in responding to PALS in a timely way therefore additional Executive oversight was now in place through the Executive Governance forum. Some of the outstanding enquiries related to spinal services, an area that was currently focussing on the challenges with handling long waiting times for surgery. • It was noted that a Patient Safety (CAS) alert concerning bedrails was overdue for closure, specifically due the need to develop a training plan for staff. An action plan was in place and there was confidence that the action plan would ensure this was addressed by the end of April 2024. • The 'flu uptake target had not been met and measles vaccination uptake was also low across the Birmingham and Solihull System. • It was noted that fire safety training uptake needed to be improved across the Trust. • The Endoscopic Spinal surgery service remained suspended. Some external support was being sourced to undertake an assessment of the cases which would inform the timing of resuming the service.	• Refine the overarching risk concerning equity of patient access to better highlight the ROH's contribution to the mitigations to this. • Provide local benchmarking data for readmissions in the next Quality Report. • Within the new PSIRF Quality Report include the rationale for when different methods of investigation were used – Patient Safety Incident Investigation (PSII), After Action Review (AAR), Structured Judgement Review (SJR) and Hot Debriefs. The report should also provide benchmarked data and detail about how lessons learned from the investigations is embedded. • A final 'go live' date for full implementation of PSIRF was requested. • It was suggested that the WHO checklist process could be considered as part of the Internal Audit into pre-operative assessment that is planned.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• It was highlighted that the nursing recruitment gap had reduced and agency usage was also reducing as a consequence. • It was noted that in nearly every speciality, all 52-week waiting times had been addressed. • An update on the National Joint Registry was provided. It was noted that there had been two outliers reported previously, both of which had been investigated and addressed. The good return rates were noted to be particularly positive. • The Committee received a detailed report on clinical audit which provided good assurance that there was additional rigour in terms of registering and structuring audits. Credit was offered for this to the new Head of Clinical Audit & Outcomes. • The Committee received a suggested Annual Report to the Board to provide an overview of its work over the last year and to signal where it would direct its focus for next year. • The Fire Safety annual report was presented which offered good assurance that the Trust was compliant with relevant legislation. • The Research and Development annual report was received which showcased the breadth of the work and innovation covered by the Trust. • Work was reported to be underway to comply with the requirements set out in relation to Martha's Rule. This includes the expansion of the Critical Care Outreach Team. A 'Call4Concern' model was also being explored. • An update on the compliance with the Human Tissue Authority requirements was received. It was noted that the Trust was preparing for an inspection by the HTA shorty.	• The Committee approved revisions to the terms of reference for the Safeguarding Group • The Committee approved the Fire Safety annual report for presentation to the Trust Board. • The Committee supported the proposed revision to its Terms of Reference.

Chair's comments on the effectiveness of the meeting: It was agreed that there had been an appropriate focus on key risks and assurances to offer the Board.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Quality & Safety Committee annual report 2023/24**
SPONSOR:	**Dr Ian Reckless, Chair of Quality & Safety Committee**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**10 April 2024**

EXECUTIVE SUMMARY:

Attached is the annual report from the Quality & Safety Committee, which outlines the Committee's key areas of focus during the year, the coverage of its workplan and the plans for future developing the operation of the Committee over the next period.

REPORT RECOMMENDATION:

The Trust Board is asked to note the contents of this report and accept the assurance offered as to the Committee's effectiveness.

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

Note and accept	Approve the recommendation	Discuss
x		

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

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

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

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

Good governance

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 27 March 2024.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ANNUAL REPORT 2023/24

1.0 Introduction

1.1 The purpose of the report is to formally report to the Board of Directors on the work of the Quality & Safety Committee during 2023/24 and update the Board on the plans for its work in 2024/25.

1.2 The Quality & Safety Committee reviewed its Terms of Reference in December 2022 and will revisit them again in March 2024. These will be presented for approval by the Board of Directors in April 2024. The changes are largely cosmetic but reflect some changes in titles and names of national bodies. The changes also reflect some amendment to the list of groups reporting up to the Quality & Safety Committee, including the creation of the Quality & Safety Executive which now accepts upward reports from a number of the operational bodies that have historically reported to the Quality & Safety Committee. The Terms of Reference also reflect the changes to the secretariat for the Committee.

1.3 During the year, the Chair of the Quality & Safety Committee was undertaken by Chris Fearns and then by Ian Reckless when Mrs Fearns stood down as a Non Executive member of the Board in September 2023. Gianjeet Hunjan is also a member of the Committee creating a close link with the work of the Audit Committee. Jenny Belza, a Non Executive with a clinical background, who started with the Trust from 1 February 2024, has joined the membership of the Quality & Safety Committee and will also provide updates to the Audit Committee as part of its membership.

2.0 Meetings

2.1 During 2023/24 the Quality & Safety Committee met on six occasions, following the decision in early 2023 to move the mode of operation to meeting on alternate months. This reflected the confidence in the work of the Quality & Safety Executive in relation to more operational quality matters and the scope of the quality & safety agenda in a small specialist organisation.

2.2 The attendance at these meetings is shown overleaf.

MEMBER	MEETING DATE						TOTAL
	26/04/23	28/06/23	23/08/23	18/10/23	31/01/24	27/03/24	
Christine Fearns (Ch)	✓	A	A				**1/3**
Ian Reckless (Ch)	✓	✓	✓	✓	✓	✓	**6/6**
Gianjeet Hunjan	✓	✓	✓	✓	✓	✓	**6/6**
Jenny Belza						✓	**1/1**
Jo Williams	✓	✓	✓	✓	✓	✓	**6/6**
Nikki Brockie	✓	✓	✓	✓	✓	✓	**6/6**
Matthew Revell	✓	✓	✓	✓	✓	✓	**6/6**
Marie Peplow	✓	✓	✓	✓	A*	A*	**4/6**
Simon Grainger-Lloyd	A	✓	✓	✓	✓	✓	**5/6**

KEY:

✓	Attended	A	Apologies tendered
	Not in post/not required	*	Michelle Hubbard, Deputy COO, attended for Marie Peplow in an acting up capacity

2.3 Meetings are also attended routinely by the Deputy Medical Director who offers an operational perspective when required.

2.4 The Secretariat to the Committee is the Corporate Services Manager who organises the minutes to be taken by the Executive Personal Assistant team.

2.5 The Quality & Safety Committee's minutes are submitted to the Board of Directors for consideration as part of the private Board sessions, supported by a full assurance report in public, detailing the key points of discussions, risks noted & matters to escalate and decisions taken by the Committee.

3.0 Work undertaken 2023/24

The Committee dealt with the following key matters:

Routine Work

The Committee received upward reports from the Trust's Clinical and Corporate Governance Committees, namely:

- Quality & Safety Executive
- The Audit, Quality Improvement, Learning & Assurance panel (AQILA)
- Cancer Board
- Infection Control Committee

- Safeguarding Committee
- Patient Experience & Engagement Group
- Children's Board
- Health & Safety Group
- Human Tissue Authority Advisory Group
- Research & Development Group

In year the Committee continued to receive the upwards reports using the standard assurance template used by the Board Committees who report upwardly to the Trust Board.

The Committee during the year, has received routine reports on:

- Quality & Patient Safety performance
- Litigation and claims
- Preparation for and implementation of the Patient Safety Incident Response Framework (PSIRF)
- Progress with Quality Priorities
- Performance against CQUINs
- Patient Reported Outcome Measures (PROMS) and the National Joint Register (NJR)
- Controlled Drugs
- Learning from Deaths
- Nurse staffing
- 'Flu vaccination
- CQC engagement work
- Compliance with the IPC Board Assurance Framework
- Patient Experience
- Updates from the ICB Quality Committee
- Quality & Safety risks on the corporate risk register

The following annual reports were received, in accordance with the Committee's routine cycle of business:

- Medicines Safety Officer
- Complaints
- Safeguarding
- Vulnerabilities
- Accountable Officer for Controlled Drugs
- Infection Prevention & Control
- Fire safety

Single issue or non-routine reports

During the year, the Committee received some specific reports providing assurance on particular key issues or single-issue updates, these being:

- Wound infections
- Legionalla
- *C.difficile* themed review

- R & D strategy
- Virtual clinic plans
- Falls themed review
- Lessons learned framework
- Appointments incidents themed review
- Update on stroke incident following spinal surgery
- Surgical site infections
- Endoscopic spinal surgery service
- Accreditation as an elective hub
- Oversight and governance of joint pathways
- Violence Prevention and Reduction Standards compliance
- Quality Assurance walkabouts
- New complaints process
- A proposed approach to Excellent in Quality at ROH
- Proposed change to the reporting of clinical audit matters to the Committee
- Deprivation of Liberty Safeguards/Mental Capacity Act update
- 'Martha's Rules' update

4.0 2024/25 Work Plan

4.1 For 2024/25, the Quality & Safety Committee will continue with its routine work as well dealing with ad hoc requirements that will emerge from time to time or remitted from the Board and/or Audit Committee.

4.2 A key piece of work for the Committee will be the oversight of the work to reshape the routine Quality & Patient Safety report, particularly the realignment to the requirements of the new Patient Safety Incident Response Framework (PSIRF) and the focus on lessons learned.

4.3 As discussed at the January 2024 meeting, reporting of Clinical Audit matters will be considered as a standalone item as part of the Committee's workplan rather than as part of the upward report from AQILA.

4.4 Several discussions have been held at meetings of the Committee during 2023/24 around the need to ensure that benchmarking information is provided for key performance metrics and so this will be an area of development for the Committee's reports for the coming year.

4.5 The Committee has an appetite to see further collaboration with peers, including those from the National Orthopaedic Alliance, during the coming year and will expect to see reports to the Committee outlining progress with this work.

4.6 The Committee has discussed the need for defining some key performance indicators around excellence in quality related to some of the Trust's clinical pathways and there is an ambition for these to be developed during the coming year.

4.7 The revised workplan was presented to the Quality & Safety Committee for its approval in October 2023 which is not likely to change significantly for the coming year.

4.8 There will remain a focus on improving the effectiveness of the Committee during 2024/25, with particular focus on seeking appropriate assurance on matters within its remit and understanding how lessons learned from incidents, complaints, litigation and clinical audit are disseminated & acted upon and the linkages to the Trust's Quality Improvement work.

5.0 Quality & Safety Committee Effectiveness

5.1 An item is included on the agenda of each meeting to review the effectiveness of the meeting and of the Committee in general.

In addition, a specific piece of work was undertaken at the beginning of 2023 to consider the effectiveness of the Committee, canvassing the views of its members using a standard questionnaire. The outcome of thew survey was an overall positive assessment of effectiveness, with some recommendations or improvement required around the following:

- Better use of SPC charts to highlight any variations or trends of significance
- Wider oversight of Research & Development matters
- Improved use of benchmarking information
- Use of an 'At a Glance' summary of performance against quality and operational metrics
- Better induction for new members to the Committee
- A move to meeting on alternate rather than every month
- Mapping of the workplan to regulatory requirements

The Committee has received regular updates on progress with these actions during the year, with the majority now addressed. The actions around benchmarking and SPC charts have been partially addressed, with full achievement expected when the reshaped Quality & Patient Safety report is presented.

6.0 Conclusion

6.1 The Quality & Safety Committee has functioned well during 2023/24 and is operating effectively, providing clear and adequate assurance upwards to the Trust Board across a comprehensive range of matters of a quality & patient safety nature.

Ian Reckless
Chair of the Quality & Safety Committee

March 2024

TRUST BOARD

DOCUMENT TITLE:	**Proposed revisions to the terms of reference of the Quality & Safety Committee**
SPONSOR:	**Ian Reckless, Chair of the Quality & Safety Committee & Non Executive Director**
AUTHOR:	**Simon Grainger-Lloyd, Executive Director of Governance**
DATE OF MEETING:	**10 April 2024**

EXECUTIVE SUMMARY:

The attached presents a suggested revision to the terms of reference of the Quality & Safety Committee in line with the requirement for them to be reviewed annually.

The changes proposed are predominately minor in nature, reflecting:

- The secretariat support to be provided by the Corporate Services Manager and relevant Executive PAs
- The frequency of meetings of 6 per annum instead of 8 per annum
- The change in the title of the NHS oversight body from NHS Improvement to NHS England
- Key personnel changes
- The addition of the Director of Governance into the membership
- Removal of the need for an annual report from the Medical Director, given that this work is covered by all other routine reports
- Typographical errors amended

REPORT RECOMMENDATION:

The Board is asked to consider and approve the proposed revisions to the terms of reference.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

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

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

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

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

None specifically

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 27 March 2024

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Quality & Safety Committee
Terms of Reference

1 Constitution

The Constitution of the Trust provides that the committees and sub-committees established by the Board of Directors are:

(i) Nominations & Remuneration Committee;
(ii) Quality & Safety Committee; and
(iii) Audit Committee
(iv) Staff Experience & OD Committee
(v) Finance & Performance Committee

The Constitution states that "Quality & Safety Committee" means a committee whose functions are concerned with the arrangements for scrutiny and monitoring and improving the quality of healthcare for which the Trust has responsibility.

2 Delegated Authority

The Committee has the following delegated authority:

2.1.1 The authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee;

2.1.2 The authority to establish Sub-committees. The Committee shall determine the membership and terms of reference of those Sub-committees.

2.1.3 The authority to establish Advisory Groups including forums. The Committee shall determine the membership and terms of reference of those Advisory Groups including forums.

3 Accountability

The Trust Board

4 Reporting Line

The Trust Board

5 Objective

Oversight and scrutiny of all aspects of quality, patient safety, clinical

outcomes, effectiveness and experience

To assure the board that robust systems, clinical policies and processes are in place to enable the Trust to:

5.1.1 Fulfil its statutory duty to act with a view to securing continuous improvement in the quality of services provided to individuals; and,

5.1.2 Identify and effectively manage any quality or clinical risks associated with performing statutory and non-statutory functions

6 Duties

The Committee will deliver its Objectives by seeking assurance across the following areas:

6.1 **Contract management & Commissioning**

6.1.1 The Committee will oversee, by appropriate monitoring of actions taken by responsible officers, the provision of evidence of trust performance in line with contractual requirements ~~commissioners~~.

6.2 **Leadership for quality**

6.2.1 Provide oversight to maintain a focus on quality by the Trust's leadership provide assurance to the Board regarding the adequacy of skills to lead efforts across the organisation to drive continuous quality improvement.

6.2.2 The C~~c~~ommittee will review the Trust's quality reports and approve the annual Quality Account for ~~inclusion in the Annual Report~~publication.

6.3 **Regulatory Assurance** – NHS ~~Improvement~~ England and CQC (review of guidance, CQC and inspection outcome reports) ~~outcome assurance report,)~~

6.3.1 The C~~c~~ommittee will oversee, by appropriate monitoring of actions taken by responsible officers, compliance with standards set by the Care Quality Commission and, insofar as they relate to clinical matters, those set by NHS ~~Improvement~~England.

6.3.2 The Committee will seek assurance that there are robust systems and processes in place for monitoring and assuring the quality of services and for driving continuous quality improvement.

6.3.3 The Committee will review performance against constitutional targets on a monthly basis from the perspective of impact on quality and patient experience as part of the routine consideration of the Quality & Patient Safety report.

6.4 **Clinical Audit of outcomes and effectiveness**

6.4.1 The committee will oversee the annual programme of clinical effectiveness and audit – this will include surgical audit, anaesthetic audit, histopathology audit, radiology audit, participation in national audits and locally determined audits

6.5 **Risk management**

6.5.1 The Ccommittee will regularly review clinical risk - in particular, Board Assurance Framework clinical risks, Corporate Risk Register and those risks owned by executive governance committees providing assurance to the Quality & Safety Committee.

6.6 **Upward governance reports**

The Ccommittee will review reports from other committees as outlined below:

6.6.1. Committee reports at agreed intervals from infection control, Safeguarding Committee, Children's Board, Research & Development Committee, Cancer Board, Audit Quality Improvement Learning & Analysis panel (AQILA), Radiation Safety Advisory Group, Human Tissue Act Group and Health & Safety Group.

6.6.2 The Committee will receive annual reports from the covering the following areas:

- Health & Safety
- Fire Safety
- Radiation Safety
- Lessons learned
- ~~Medical Directors portfolio~~
- Medicines Safety
- Controlled Drugs Accountable Officer
- Complaints
- Infection Prevention and Control
- Safeguarding

The Committee will review these reports prior to them being sent to the Trust Board for formal approval.

6.6.3 The Committee will consider feedback from the Trust's patient groups through a routine upward report from the Patient Experience & Engagement Group and from peer reviews.

6.6.4 The Committee will receive updates on cases which are dealt with by the ~~NHSLA~~ NHS Resolution or any successor body and will seek to monitor lessons learnt.

6.7 **Other**

6.7.1 The Committee will assure the Board that the Trust's research activity complies with necessary regulations and supports the Trust's strategy.

6.7.2 The Ccommittee will assure the Board that the Trust's medical and clinical education meets the required standards.

6.7.3 The Committee will review the adequacy of the clinical governance frameworks for services being delivered jointly with partner organisations.

7 Permanency

The Committee is permanent

8 Membership

The Committee membership will comprise no fewer than three Non Executive Directors and the Chair of the Committee will be a Non Executive holding a clinical background.

The Vice Chair of the Committee will be a Non Executive with a clinical background and will take on the Chair's duties in their capacity as chairman of the Quality & Safety Committee if the Chair is absent for any reason.

Executive members

- Chief Nurse
- Medical Director
- Chief Executive
- Chief Operating Officer
- Director of Governance

9 Quorum

At least two NEDs ~~(including an Associate Non Executive Director if required)~~ and one from Executive Medical Director or Executive Chief Nurse.

10 Secretariat

The Executive PA to the Executive Chief Nurse, Executive Medical Director and Executive Chief Operating Officer shall rotate the role secretary to the Committee and the Corporate Services Manager will provide administrative support and advice. The duties of the Corporate Services Manager in this regard are:

- Agreement of the agenda with the Chair of the Committee and attendees with the collation of connected papers
- Organise taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee as appropriate

11 In attendance, by invitation

Deputy ~~Director of Nursing~~ Chief Nurse
Deputy Medical Director
Others relevant to the agenda of the meeting such as chairs of advisory groups, Heads of Nursing, the ~~Head of Clinical Governance~~Assistant Director of Governance & Risk and~~,~~ Clinical Service Leads ~~and the Corporate Governance Manager .~~

~~A representative from the Council of Governors may attend in a non-participative, observatory capacity.~~

12 Internal Executive Lead

Executive Chief Nurse

13 Frequency of meetings

At least ~~8~~ 6 meetings per annum

14 Work programme

The Committee will prepare an annual work programme covering at least 12 months. The Work Programme is to be a living document which steers the agenda for the committee.

15 Review of terms of reference

This should be undertaken annually.

Date of adoption ~~**October 2021**~~ **March 2024~~3~~**
Date of next review ~~**October 2022**~~ **March 2025~~3~~**

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Gender Pay Gap report**
SPONSOR (NON EXECUTIVE DIRECTOR):	**Sharon Malhi, Chief People Officer**
AUTHOR:	**Clare Mair, Head of OD and Inclusion** **David Morris, Workforce Information & Recruitment Manager**
DATE OF MEETING:	**10th April 2024**

EXECUTIVE SUMMARY:

Background:
The presentation gives an update on the ROH Gender Pay Gap reporting. Any employer with 250 or more employees on a specific date each year (the 'snapshot date') must report their gender pay gap data. The information in this report covers data collection as on 31st March 2023. The statutory requirements is to publish this information along with an action plan on the ROH Trust website by March 30th 2024.

Positive assurance
The data from the report highlights that:

- The mean gender pay gap has stayed steady since 2018 and has seen a positive decrease from 33.8% in 2022 to 32.54% in 2023
- Since 2022 there has been a further **positive decrease** in the median gender pay gap of 1.5% to 21.1%
- The number of female consultants which is six in total has stayed consistent since 2022

Based on the comparisons to previous years, the trends would suggest that the Trust is making progress with closing the Gender Pay Gap in some areas.

In addition, there has been good engagement with colleagues across the Trust (including female medical colleagues) to highlight areas to focus on and progress, as part of the Gender Pay Gap Action Plan. This work is supported by Women's network and the Wellbeing agenda.

Following approval at the Staff Experience and OD Committee March 2024, this report has been published on the ROH website. The data has also been submitted to the National Government Equalities Office.

Current issues

- There has been a marked increase in the mean bonus pay gap since 2022. However for assurance, it is important to highlight that this calculation only includes data for the Consultant Clinical Excellence Awards (CEA). For the ROH, with the current diversity of the consultant population, the distribution of CEAs has predominantly been amongst male consultants. The Medical Director is currently reviewing the CEA process, with support from the Joining Local Negotiating Committee (JLNC), to ensure future awards are equitable for the diversity of the medical consultant workforce

Next steps

- Confirm progress dates with Gender Pay Gap action plan leads

- Gender Pay gap action plan integrated into the Inclusion action plan and supported by work being undertaken within the Women's network

REPORT RECOMMENDATION

To review and accept the information in the report for assurance

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

People Element of the ROH Trust Strategy, ROH Inclusion strategy

PREVIOUS CONSIDERATION:

Staff Experience and OD Committee March 2024
Trust Board – July 2023
Women's network – February and April 2024

The Royal Orthopaedic Hospital

Gender Pay Gap Report

March 2024

Introduction

- Government legislation means employers with 250 or more employees are required to publish their figures comparing men and women's average pay across the organisation.
- The gender pay gap is the difference between the average earnings of men and women.
- The first report was published in March 2018, which provided gender pay data as at 31 March 2017
- The gender pay gap report must include:
  - Mean gender pay gap
  - Median gender pay gap
  - Mean bonus gender pay gap
  - Median bonus gender pay gap
  - Proportion of men in the organisation receiving a bonus payment
  - Proportion of women the organisation receiving a bonus payment
  - Proportion of men and women in each quartile pay band
- This report shows gender pay data as at 31 March 2023

Difference between Gender Pay and Equal Pay

Equal Pay

- Equal pay deals with pay differences between men and women, who carry out the same jobs, similar jobs or work of equal value

Gender Pay

- Gender pay gap shows the differences in the average pay between men and women

Using the results of the Gender Pay Gap Report

Although we continue to develop an environment where people feel we provide equal opportunities and take action against any discrimination, we are not complacent and set priorities around our Public Sector Equality Duties

We can use the results of this report to address:

- The levels of gender equality at the ROH
- The balance of male and females at different levels
- How effectively talent is being maximised and rewarded
- A clear set of actions to promote change

Definitions and Scope

- **Mean**

  The mean hourly rate is the average hourly wage across the entire organisation so the mean gender pay gap is a measure of the difference between women's mean hourly wage and men's mean hourly wage.

- **Median**

  The median hourly rate is calculated by ranking all employees from the highest paid to the lowest paid, and taking the hourly wage of the person in the middle; so the median gender pay gap is the difference between women's median hourly wage (the middle paid woman) and men's median hourly wage (the middle paid man).

- **Pay Quartiles**

  Pay quartiles are calculated by splitting all employees in an organisation into four even groups according to their level of pay. Looking at the proportion of women in each quartile gives an indication of women's representation at different levels of the organisation.

- This report is based on pay rates for the following year:
  - Pay as at 31 March 2023 and covers any bonuses paid within the year 1 April 2022 to 31 March 2023.

- It covers all employees under contract to The Royal Orthopaedic Hospital NHS Foundation Trust (the ROH) , including Agenda for Change and Medical terms and conditions. It includes those employed under Temporary Staffing but does not include Non-Exec Directors.

- All data has been collated from the Electronic Staff Record (ESR) system.

Median and Mean Gender Pay Gap

MEDIAN GENDER PAY GAP AT ROH

- The median hourly wage for men: £19.42
- The median hourly wage for women: £15.33 (2023)
- This equates to a difference of £4.09
- The median hourly rate: **21.06% (2023)** lower for women than it is for men
- **In 2023 there had been a slight improvement for every £1 earnt by men, women earnt 78.94**

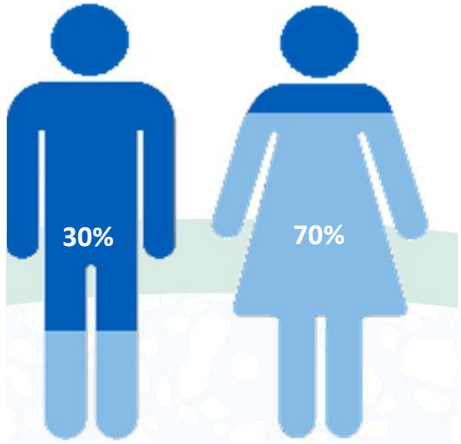
MEAN GENDER PAY GAP AT ROH

- The mean hourly rate for men: **£25.58**
- The mean hourly rate for women: **£17.26**
- **When comparing mean hourly wages, women's mean hourly wage was 32.54% lower in 2023**
- This was a difference of £**8.32** in the average hourly rates between men and women in 2023

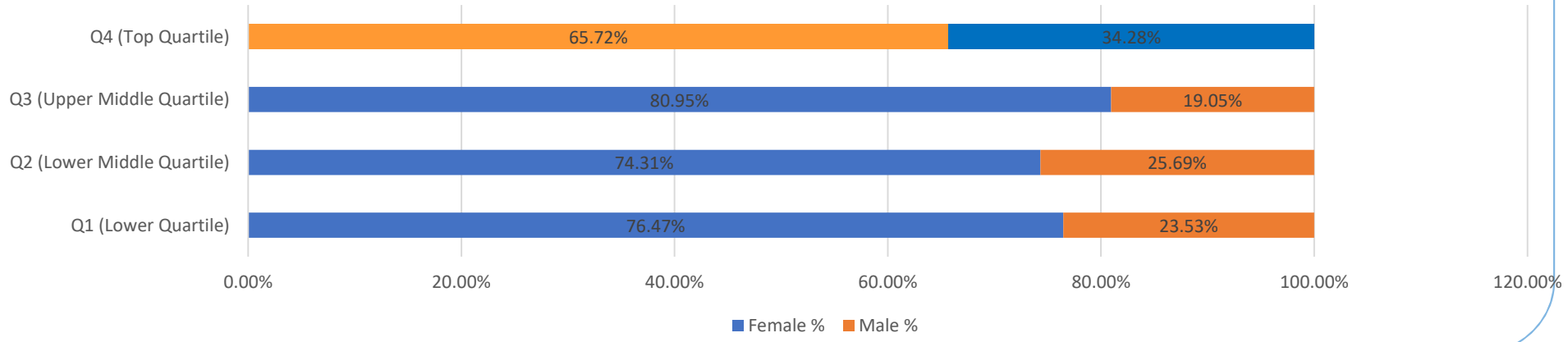
Pay Quartiles

- The gender profile of the ROH have not changed significantly overall. 70.2% female to 29.8% male in 2022 compared to **70.35 to 29.65 in 2023**. This is a common workforce profile across NHS Trusts.
- The Trust employ significantly more women in Quartiles 1, 2 and 3, (**accounting for approximately 78% of the total**), however there is a smaller proportion within the top quartile (Q4) at 34%.
- Consultant medical staff was **123 in 2023** of which 6 were women

Trust Gender Profile



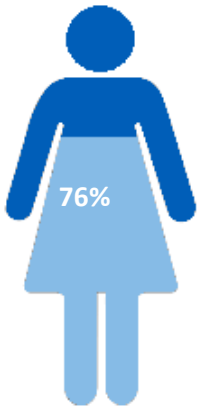
Gender Pay - Ordinary Pay Comparison 2023



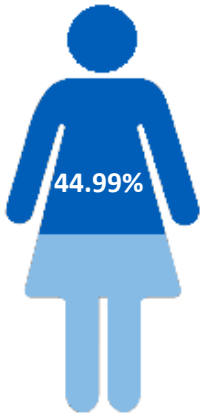
Gender Pay Gap Bonus Pay

- For the purposes of the gender pay gap, bonus pay is classed as any rewards that related to profit- sharing, productivity, performance, incentive and commission that were actually paid within the reporting period. In ROH the only payment that qualifies as a bonus payment is the Clinical Excellence Award that applies to substantive consultant medical staff with more than 12 months service.
- At the ROH, the women's median bonus pay is 59% lower than men's. This means that women earn 41p for every £1 that men earn when comparing median bonus pay.
- When comparing the mean bonus pay gap, women's mean bonus pay was **76.11% in 2023** lower than men's**.**

Mean Bonus Gender Pay Gap



Median Bonus Gender Pay Gap



Who received bonus pay at the ROH

- **0.1%** of women
- **5.05%** of men

Excluding Consultants

Gender 2023	Avg. Hourly Rate 2023	Median Hourly Rate 2023
Male	18.9325	15.9973
Female	17.0423	15.1839
Difference	1.8902	0.8135
Pay Gap %	9.9841	5.0850

Excluding all Medical Staff

Gender 2023	Avg. Hourly Rate 2023	Median Hourly Rate 2023
Male	17.6818	14.3767
Female	16.8418	15.0753
Difference	0.8490	-0.6986
Pay Gap %	4.7510	-4.8592

Comparison to Previous Years

ORDINARY PAY			
MEAN		MEDIAN	
Year	Pay Gap %	Year	Pay Gap %
2018	36.2%	2018	27.8%
2019	34.3%	2019	23.1%
2020	36.9%	2020	29.5%
2021	36.3%	2021	28.6%
2022	33.8%	2022	22.6%
2023	32.54%	2023	21.06%

BONUS PAY			
MEAN		MEDIAN	
Year	Pay Gap %	Year	Pay Gap %
2018	53.9%	2018	62.2%
2019	46.9%	2019	53.3%
2020	63.5%	2020	55.5%
2021	61.4%	2021	42.5%
2022	62.9%	2022	45.0%
2023	76.11%	2023	59.09%

- **The mean pay gap has decreased from 2022.**
- The Trust's gender pay and bonus pay gap is primarily driven by the gender split in the consultant body which is approximately 90% male and 10% female.
- The mean gender pay gap has stayed steady since 2018 and decreased from 33.8% in 2022 to 32.54% in 2023
- Since 2022 we have seen a further decrease in the median gender pay gap of 1%
- There has been a marked increase in the mean bonus pay gap since 2022
- The gap for median bonus pay has increased but is still lower than 2018.
- Based on the comparisons to previous years, the trends would suggest that the Trust is making progress with closing the Gender Pay Gap in some areas.

Action Plan (Integrated into the Inclusion Action Plan)

Key Actions	Lead	Completion
Continue the work to actively promote flexible working opportunities/ shared parental leave in the advertising of new roles	Recruitment Team	July 2024
Recruitment and establishment of Women's network chair Further development of the Women's network to highlight specific areas for improvement with involvement from female colleagues in all departments	OD and Inclusion Team (CM) Women's network	December 2024
Implementation of Sexual Safety Charter across the Trust	Nursing Directorate (NB) Medical Directorate (JT) Freedom to Speak up Guardian	December 2024
Development of Talent and Succession strategy to include work on talent pipelines in line with EDI Improvement plan	OD and Inclusion Team (CM)	March 2025
Delivery of the EDI Improvement plan objectives aligned with Gender Pay gap	EDI Improvement plan Leads OD and Inclusion Team	March 2025

Action Plan (Integrated into the Inclusion Action Plan)

Action	Lead	Completion
Project to ensure that full functionality for flexible working options on E rostering is documented, and training is provided to Managers	ROH Bank Team Finance Team	December 2024
Develop work experience programme for pre medical schools (diversity in orthopaedics to be included as an element in programme)	Education and Training (DR)	March 2025
Review of Medical Trainee rotation programme to ensure correct level of support is available	Medical Directorate (AM)	March 2025
Scoping exercise to review criteria of Clinical Excellence Awards for Medical staff	Medical Directorate (MR)	October 2024
Undergraduate Academy to explore development of a research project around perception of orthopaedics within medical students including outcomes.	Education and Training (ED)	September 2025
Curriculum map for Inclusion to be developed as part of all Medical Education work streams.	Education and Training (DR)	September 2025

REPORT REF: ROHTB (4/24) 015

TRUST BOARD

DOCUMENT TITLE:	**Progress Report on The RACE Equality Code Adoption**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, CEO**
AUTHOR:	**Sharon Malhi, Chief People Officer**
PRESENTED BY:	**Sharon Malhi, Chief People Officer**
DATE OF MEETING:	**10th April 2024**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This report provides the Trust Board with assurance on progress to date with regards to adoption of the RACE code at the Royal Orthopaedic Hospital NHS Foundation Trust.

Background

The Board approved adoption of the RACE Equality Code in February 2024.

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

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

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

An initial meeting has taken place between Karl George, Jo Williams (CEO) and Sharon Malhi (Chief People Officer). The purpose of the meeting was to register the Trusts intent to adopt the Code and to understand the key steps involved in adoption and implementation.

The initial step will be for a Board Development ('DRIVERS') workshop to take place which is scheduled for May Board. The DRIVERS workshop, delivered by Karl George, will be a facilitated group discussion on diversity using the RACE Equality Code ('Code') methodology to lead the narrative.

The Code uniquely provides one set of standards applicable to every organisation irrespective of size or sector. By reporting, tracking, educating and creating accountability at the top, its purpose is to create practical change. Note that although the Code focuses on ethnic representation in the leadership of an organisation, this workshop (and the underlying methodology) covers wider aspects of inequality.

The session will cover why it is important for an organisation to adopt approaches that will impact positive change / lead to impact in promoting inclusion for all protected characteristics. The workshop will cover the development of the Code and consider together why developing a systemic business-led approach to equality, diversity and inclusion ('EDI') is critical to moving the dial on race inequality.

The session will move on to examine broader EDI issues of which the Board should be aware, using the 'DRIVERS' model:

Diversity – getting the focus right.
Responsibility – addressing inequality from the top.
Integrity – holding to account and accountability.
Values – zero tolerance and what that means.
Equity – recognising inclusive practice.
Realty – being proactive.
Society – allyship.

There is a fee for the work which covers a diagnostic process and action plan which will involve a steering group, a workshop with the Board and/or Senior Leadership Team, a review of our current documentation and conducting a survey of our leadership and resultant report.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
• An introductory meeting has taken place with Karl George and the CEO and Chief People Officer. • Further meeting scheduled for April 2024 to scope the outline for the Board workshop. • Board development session confirmed for May 2024.	• There is not system funding allocated to adoption of the RACE code and this will need to be locally funded by each provider organisation who adopts the Code

NOT APPLICABLE	

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Trust Board is asked to NOTE the assurance provided in this report.

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial	**x**	Environmental/Net Zero		Communications & Media	x
Business and market share	**x**	Legal, Policy & Governance		Patient Experience	**x**
Clinical		Equality and Diversity	**x**	Workforce	**x**
Inequalities	**x**	Integrated care	**x**	Continuous Improvement	**x**
Comments:					

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

People Plan
Health Inequalities Plan
WRES Indicators

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

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

PREVIOUS CONSIDERATION:

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

Finance and Performance Report

Month 11

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.

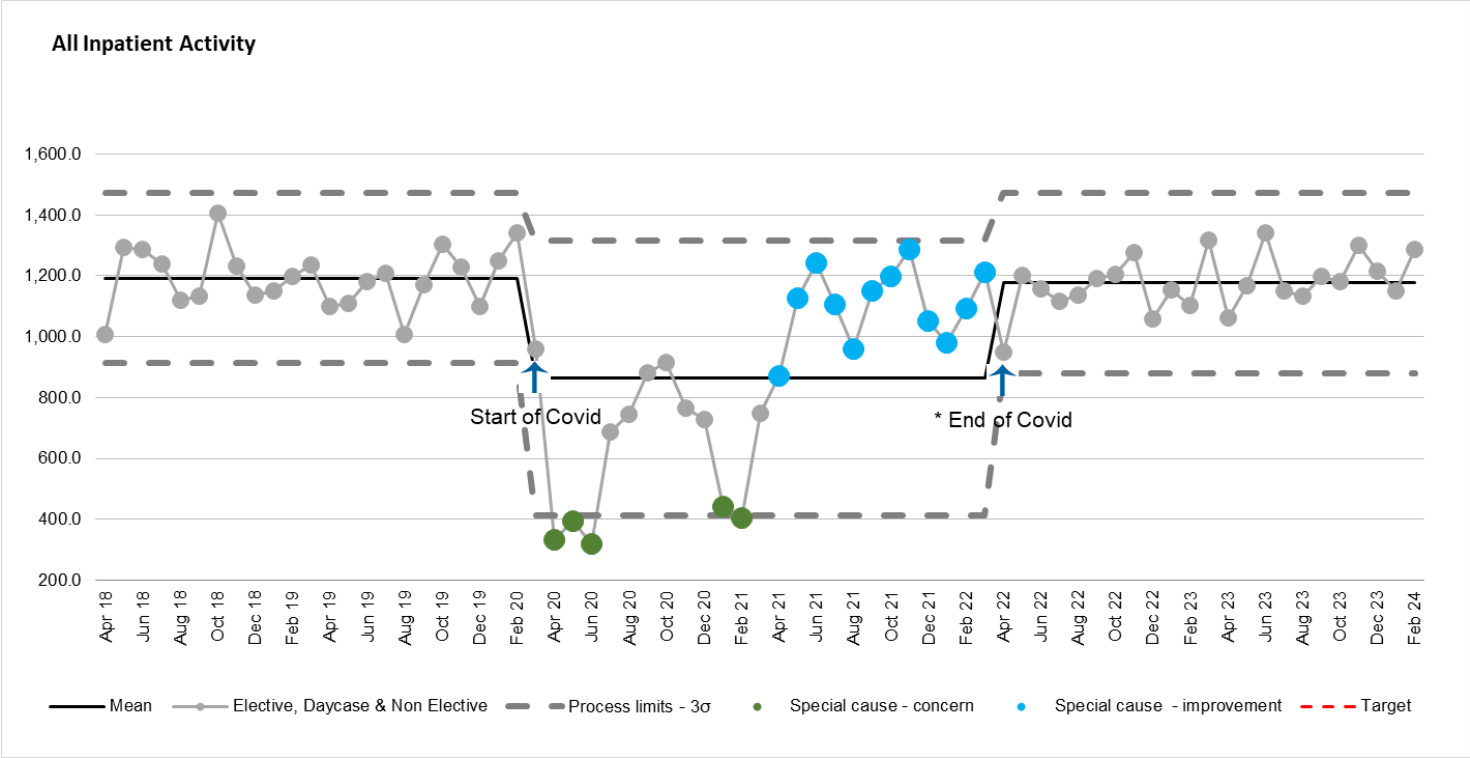
Operational Performance Summary

Performance to end February 24	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	49.77%	50.65%	92%		F
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	68	83	0	L	F
52 week waits (52 – 64 Weeks)	414	428	0	H	F
All activity YTD (compared to plan)	13,190	11,902	13,005		P
Outpatient activity YTD (compared to plan)	60,545 100.7% Cumulative	55,304 100.9% Cumulative	60,111 YTD Target		P
Outpatient Did Not Attend (YTD)	7.0%	7.6%	8%		P
PIFU (trajectory to 5% target)	447 8.8%	490 8.6%	184 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	10.7%	10.5%	19%		F
FUP attendances(compared to 19/20)	90.4%	90.5%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	110.0%	109.5%	120%		F
Diagnostics volume YTD (compared to plan)	23,144 Cumulative	20,660 Cumulative	17,222 YTD Target		P
Diagnostics 6 week target	99.9%	99.3%	99%		P

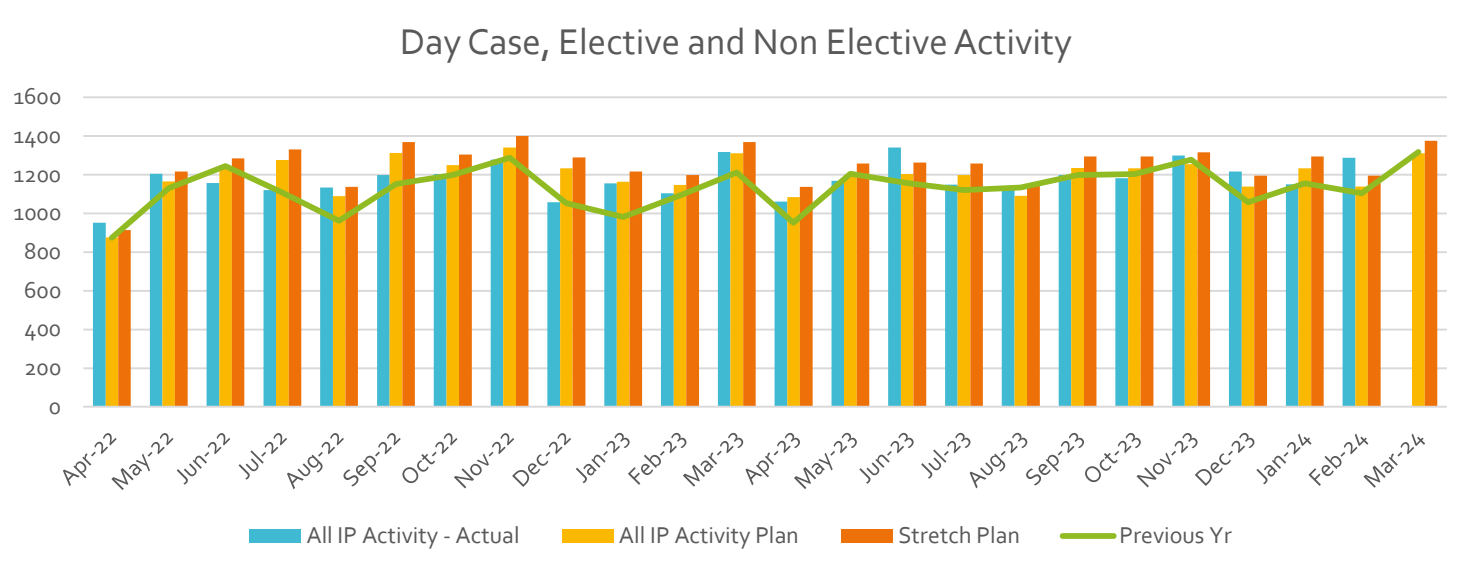
Operational Performance Summary

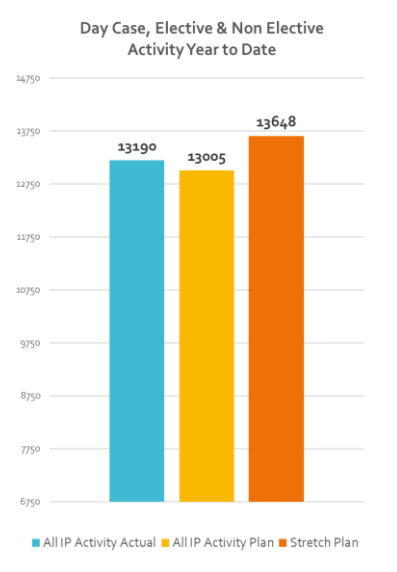
Performance to end February 24	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (Uncapped)	92.5%	82.0%	85%		
Cancer - 31 day first treatment	93.7%	100%	96%		
Cancer - 62 day (traditional)	85.7%	85.7%	85%		
28 day FDS	87.9%	75.3%	75%		
Patients over 104 days (62 day standard)	0	0	0		No Target
POAC activity volume (YTD)	23,415 Cumulative	21,257 Cumulative	21,184 Cumulative		
Bed Occupancy (excluding CYP and HDU)	73.7%	62.6%	82-85%		
LOS - excluding Oncology, Paeds,YAH, Spinal	3.37	3.16	n/a		No Target
LOS - elective primary hip	3.10	2.90	2.7		
LOS - elective primary knee	3.10	2.80	2.7		
BADS Daycase rate (Note: due to time lag in month is Nov'23)	74.0%	77.0%	85%		

1. Activity Summary



1. Activity Summary



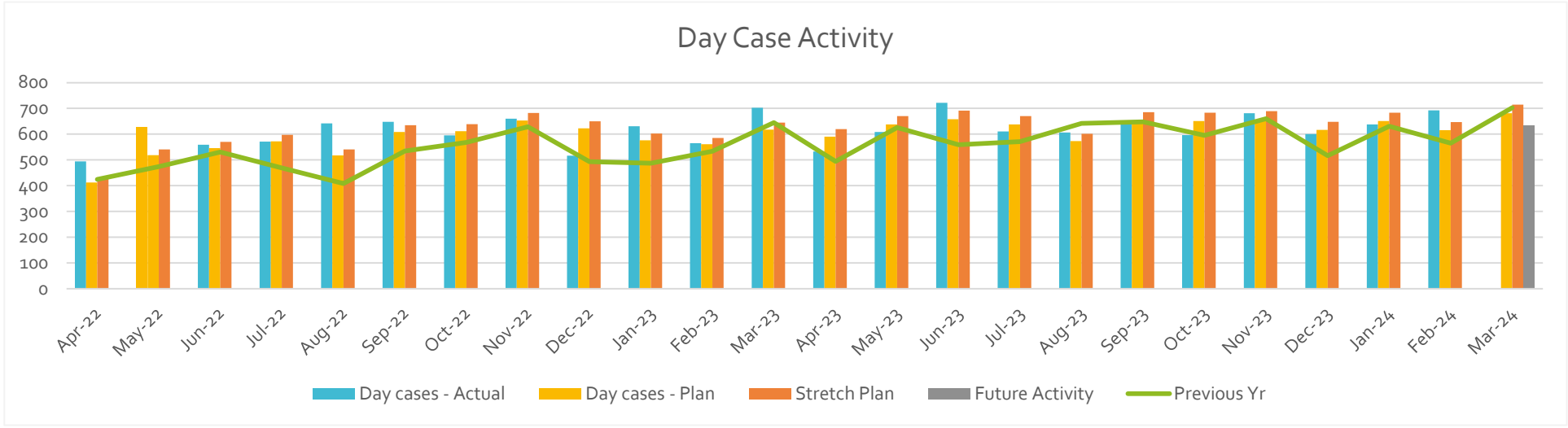


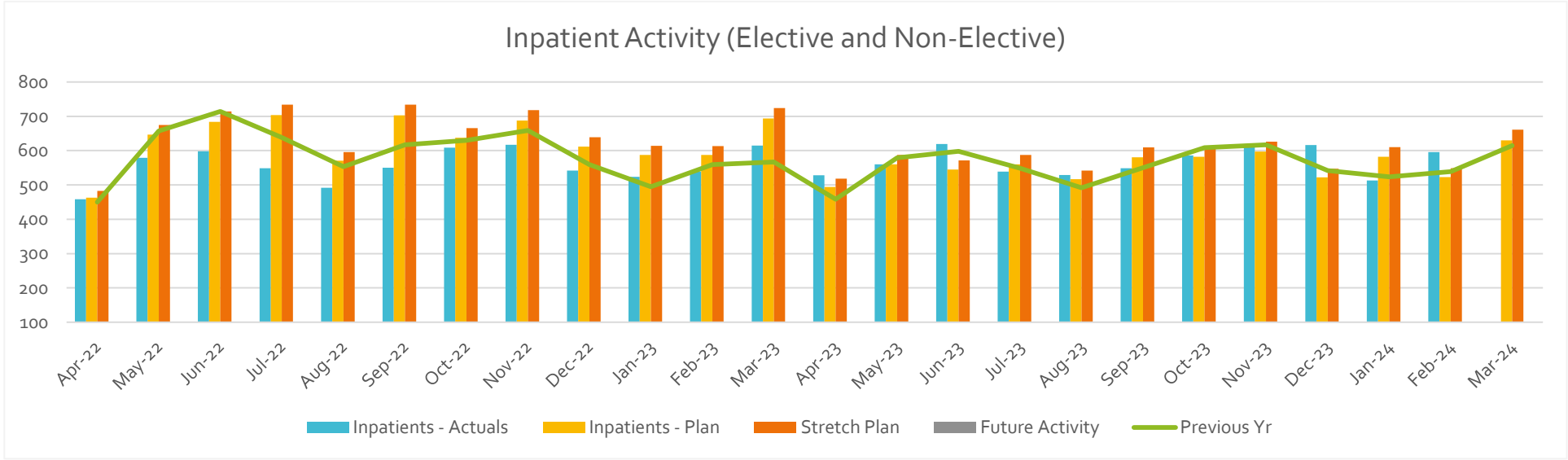
		Plan												Plan	Actual	% Achieved	Variance
	Activity Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Year to Date	Year to Date	against plan	Year to Date
Trust Plan	Inpatient	483	547	533	547	505	568	569	584	510	569	511	616	5926	5992	101%	66
	Daycase	590	638	658	638	573	653	651	657	617	651	616	681	6942	6936	100%	-6
	NEL	11	13	12	13	12	13	13	13	12	13	12	14	137	262	191%	125
	All Activity	**1084**	**1198**	**1203**	**1198**	**1090**	**1234**	**1233**	**1254**	**1139**	**1233**	**1139**	**1311**	**13005**	**13190**	**101.4%**	**185**
Stretch Plan	Inpatient	507	574	560	574	530	596	597	613	536	597	537	647	6222	5992	96%	-230
	Daycase	620	670	691	670	602	686	684	690	648	684	647	715	7289	6936	95%	-353
	NEL	11	13	12	13	12	13	13	13	12	13	12	14	137	262	191%	125
	All Activity	**1138**	**1257**	**1263**	**1257**	**1144**	**1295**	**1294**	**1316**	**1195**	**1294**	**1195**	**1376**	**13648**	**13190**	**97%**	**-458**

February 2024

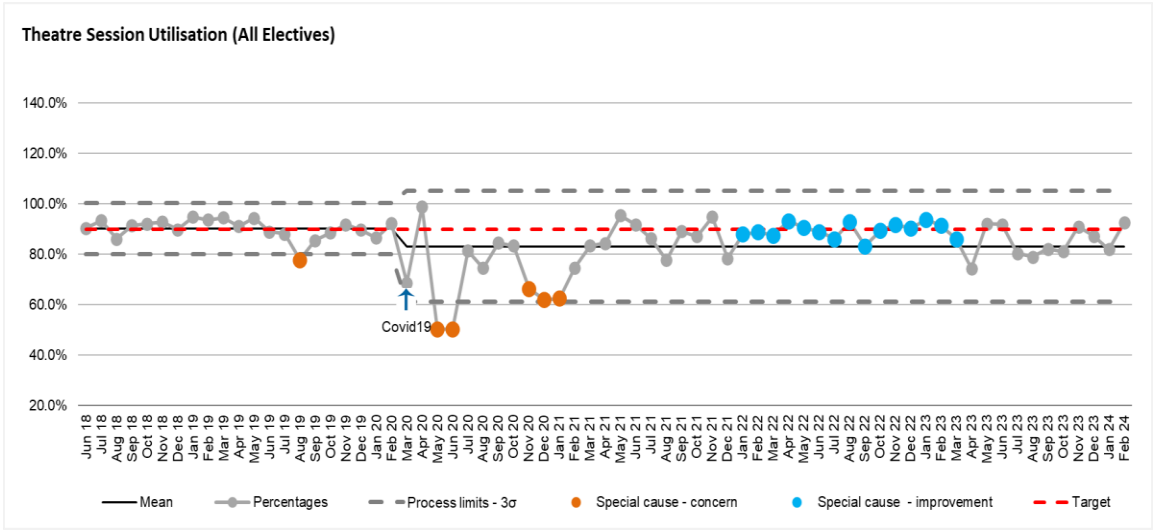
Actual Monthly 1288 vs 1139 System Monthly Plan (Variance +149)
YTD position against Actual vs System plan is 101.4% (Variance +185)

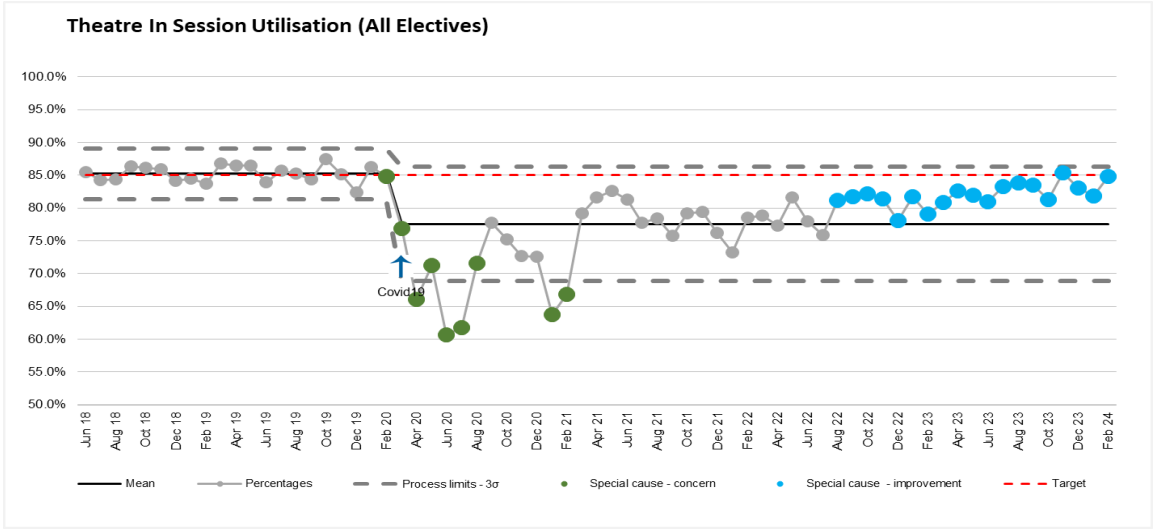
1. Activity Summary





2. Theatre Utilisation





Elective Session Utilisation (February 2024)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	466	427	39	91.63%
UHB	81	79	2	97.53%
Totals	**547**	**506**	**41**	**92.50%**

Elective In Session Utilisation (February 2024)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1834	1562	272	85.16%
UHB	346	288	58	83.29%
Totals	**2180**	**1850**	**330**	**84.86%**

2. Theatre Utilisation

SUMMARY

Overall theatre session utilisation for February was **92.50%** which was above the Trust target of **85%.**

The overall in-session utilisation for February 24 was **84.86%**.

Further industrial action took place in February, however, the team managed to support UHB lists with first assistants to avoid a loss of activity.

AREAS FOR IMPROVEMENT

A 'theatre first' approach continues with a positive improvement on theatre utilisation and an over achievement on the activity target for February.

A review of POAC processes/pathways is to be undertaken, supported by the GIRFT Pre-operative Lead who attended site W/C 18.03.24.

Plans are being developed to deliver another 'seamless surgery week' that is scheduled to take place w/c 29th April. This will include a perfect week from Monday through to Saturday.

Ongoing close monitoring of UHB theatre utilisation continues with Acting COO oversight.

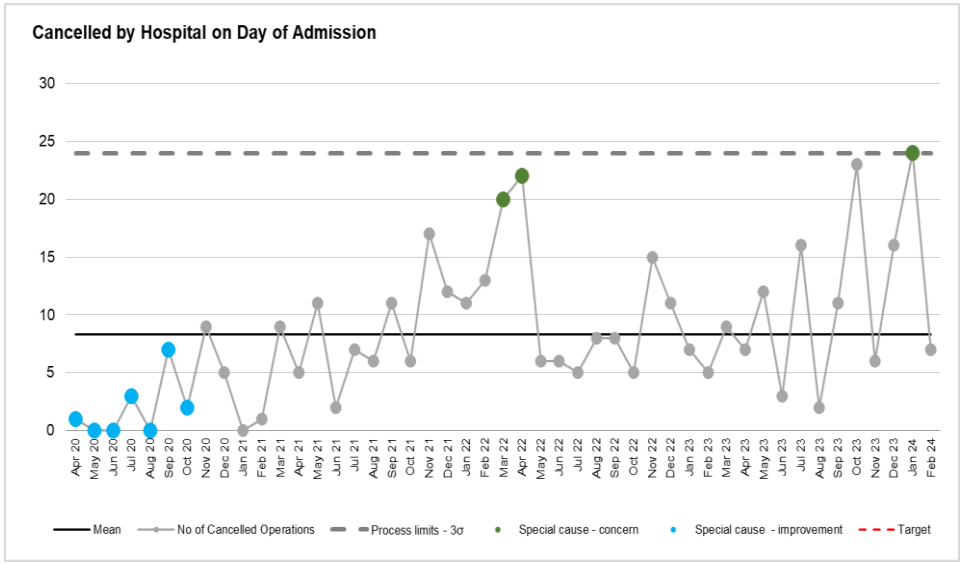
RISKS / ISSUES

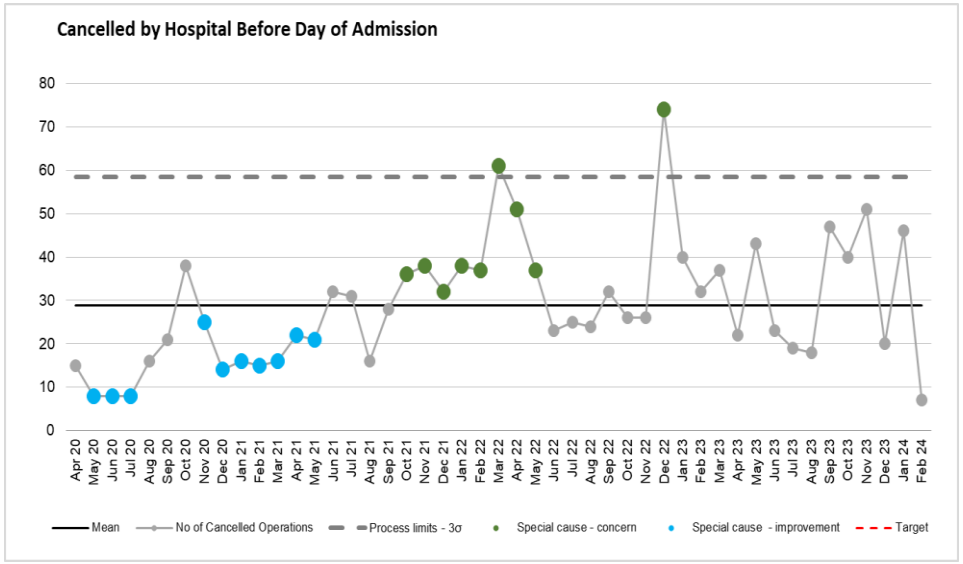
Ongoing uncertainty regarding the capacity required by UHB surgeons. Options being progressed on the assumption that UHB will vacate in July 24, for instance, increase private patient operating in week, implementation of regional block area, allocation of lists to displaced surgeons and recruiting to vacancies.

Reviewing demand and capacity data to ensure that consultant recruitment delivers 50 weeks in line with specialty backlogs.

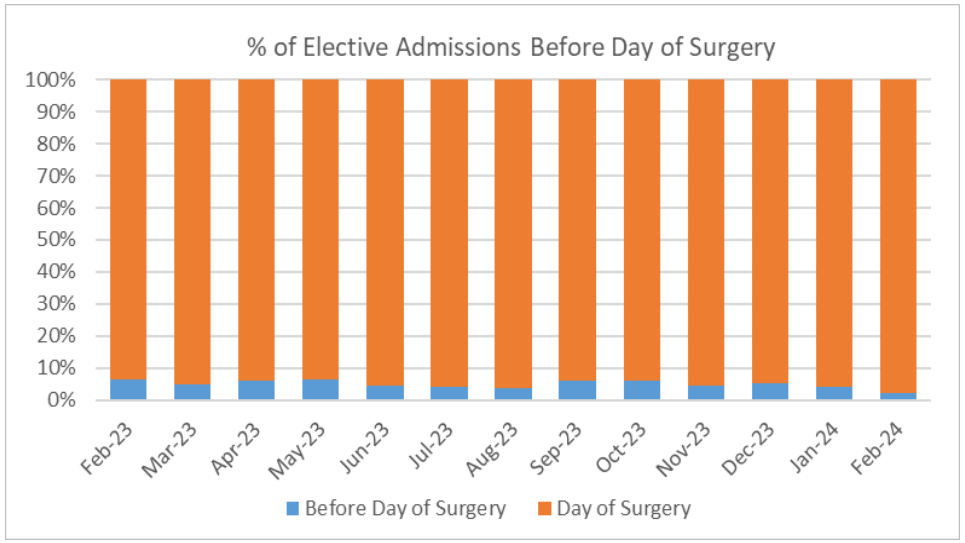
Agreeing a cap by specialty on LLP Lists.

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
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
Feb-24	7	26	7	40	0
Total	143	323	407	873	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 February 24:

Patients cancelled on the day x 7	Patients admitted and had treatment deferred x 26	Patients cancelled by the hospital the day before the date of admission x 7
3 x Medically unfit /change in clinical condition / further tests required 2 x Lack of theatre time due to complex cases overrunning. 1 x IT/PACS unavailable 1 x patient notes unavailable	15 x Medically unfit / Covid/Flu related/change in clinical condition / not stopped meds 2 x Clinician unavailable/unwell 5x Change in plan / pt no longer wanted the procedure 1 x Equipment unavailable – kit needed for an emergency case 3 x Lack of theatre time – due to complex cases	6 x Medically unfit / Covid/Flu related/change in clinical condition / not stopped meds 1 x Patient not aware of their TCI date (UHB).

AREAS FOR IMPROVEMENT/ RISKS/ISSUES

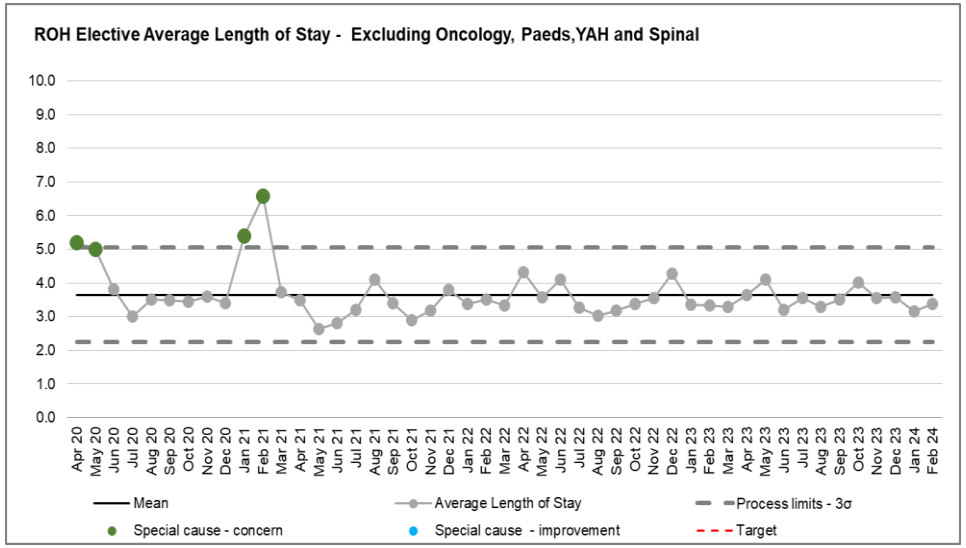
Daily monitoring of cancellations for non-clinical reasons that must be approved by Deputy COO, COO or Exec on call.

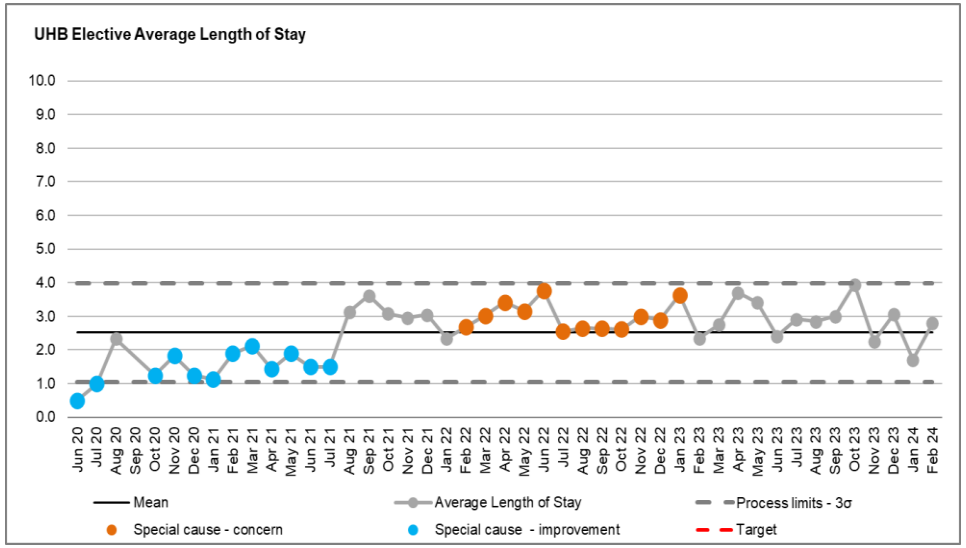
February performance has improved and has offset the capacity lost in January 24.

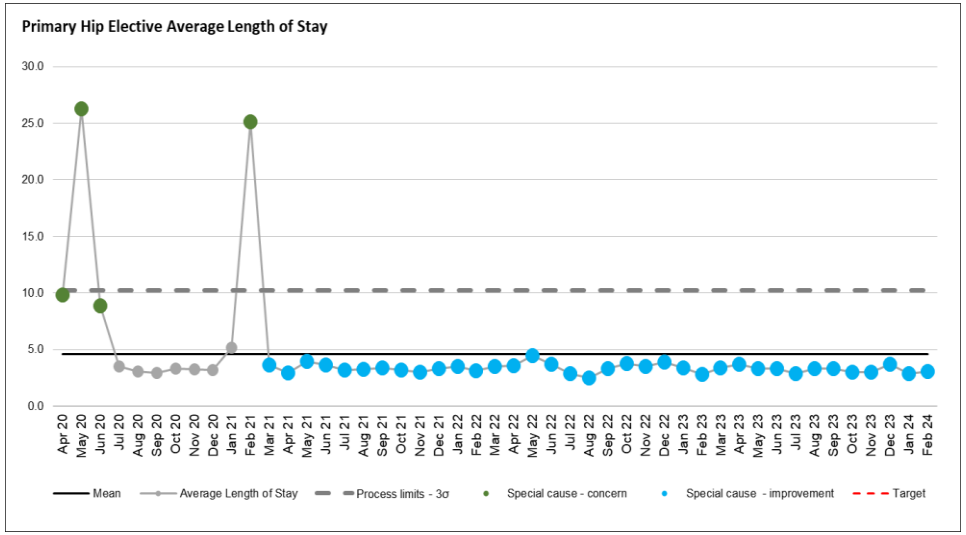
Theatre lookback meeting continues to review short notice cancellations with a view to identify opportunities to improve.

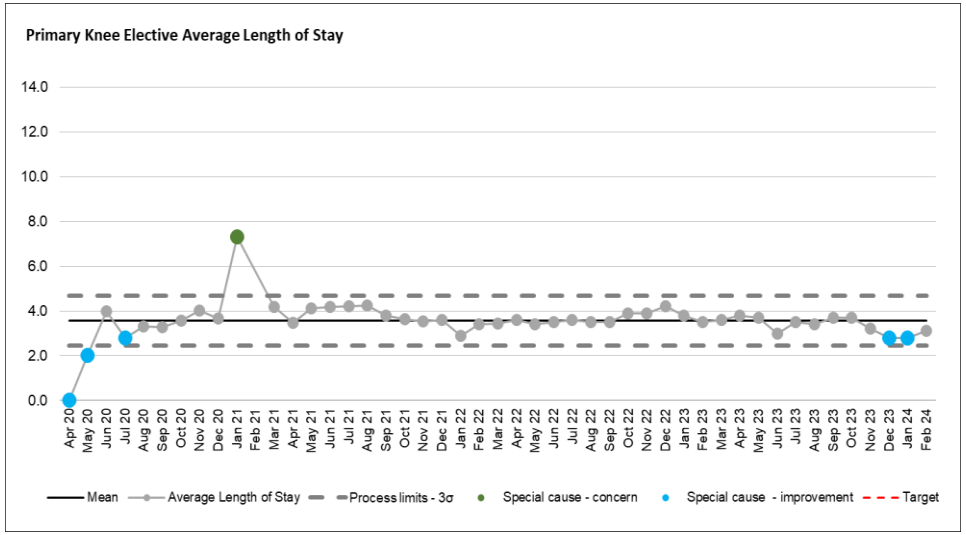
Seamless Surgery week is being scheduled for W/C 29th April 24.
GIRFT supporting with the standby patient process and will share evidence of good practice from other Trusts.
SOPs from other organisations have also been sourced and are being reviewed by the teams.

3. Length of Stay









3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips increased slightly to 3.1 days (2.9 days January 24) and primary Knees has increased to 3.1 days (2.8 days January 24).

The average length of stay for ROH patients excluding Oncology, Young Adult Hip and spinal has increased to **3.37 days** (3.16 January).

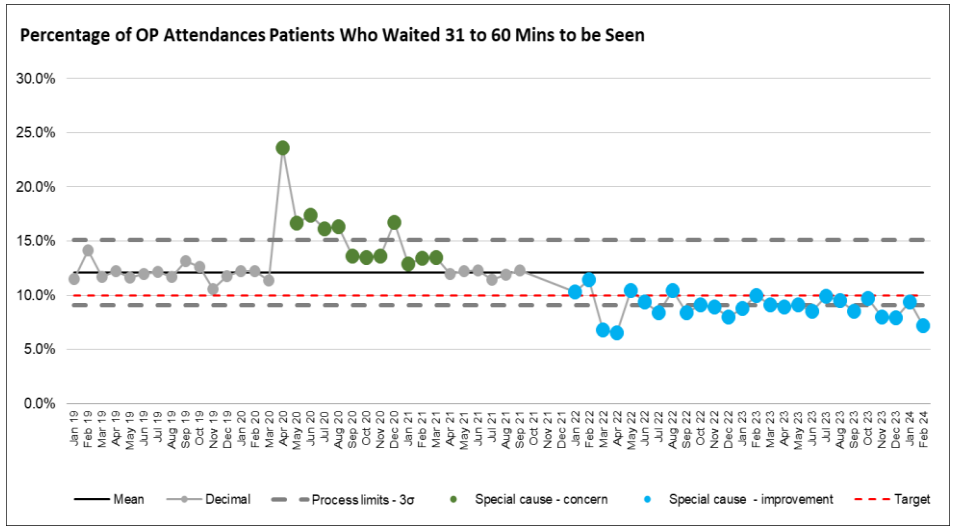
A review of the ROH data for primary arthroplasty and oncology arthroplasty patients, identifies the number of patients with LOS >/= to 8 days. 10 patients stayed >/= to 8 days compared to 11 in January 2024. 4 were Oncology arthroplasty, other 6 were arthroplasty.

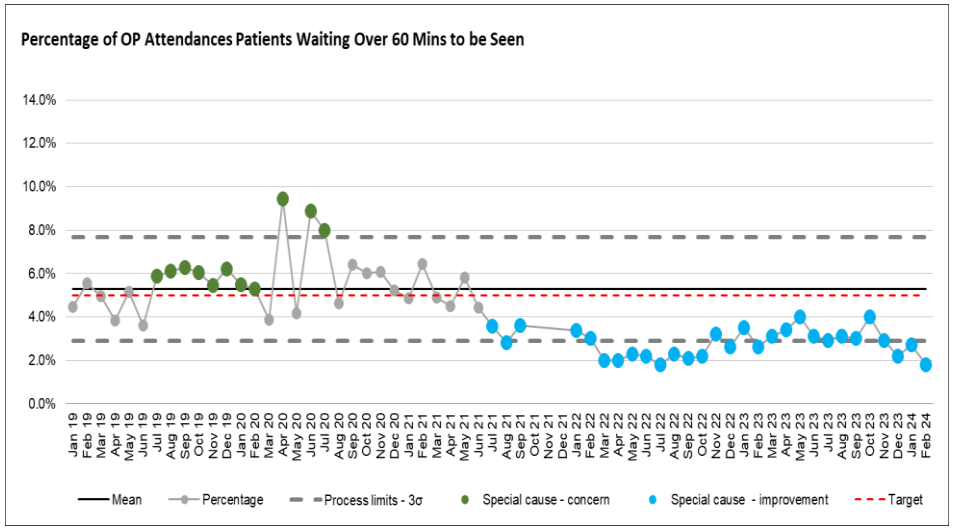
Review of records identifies that there was no theme with regards to surgeon. 3 had an ASA score of 3 (severe systemic disease), 6 an ASA score of 2 (mild systemic disease)
9 had extended length of stay due to ongoing clinical, therapy needs or complex discharge needs . 1 repatriation delay due to availability of beds at receiving Trust.

AREAS FOR IMPROVEMENT / ACTION PLAN

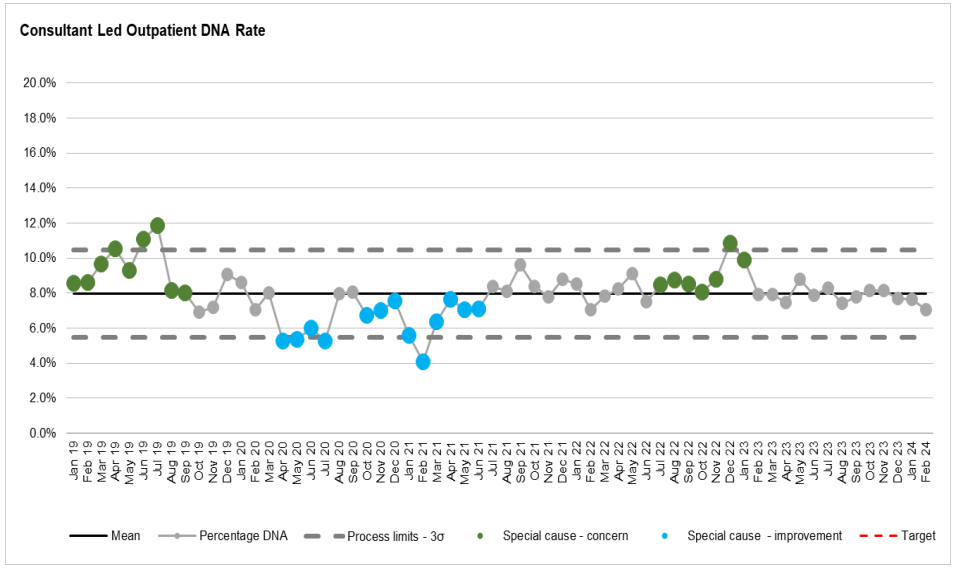
- Review and develop documented process/pathway for default to day case primary hip/knee procedure and how information is captured.
- MDT discussion involving medical, nursing and therapy colleagues to identify barriers to day case procedures and reducing length of stay for primary hips and knees.
-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

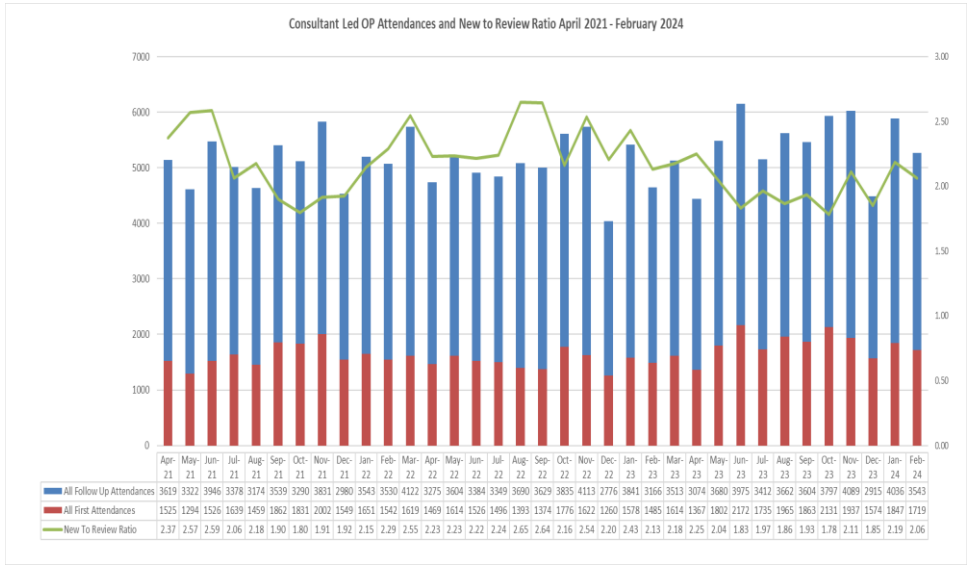
4. Outpatient efficiency

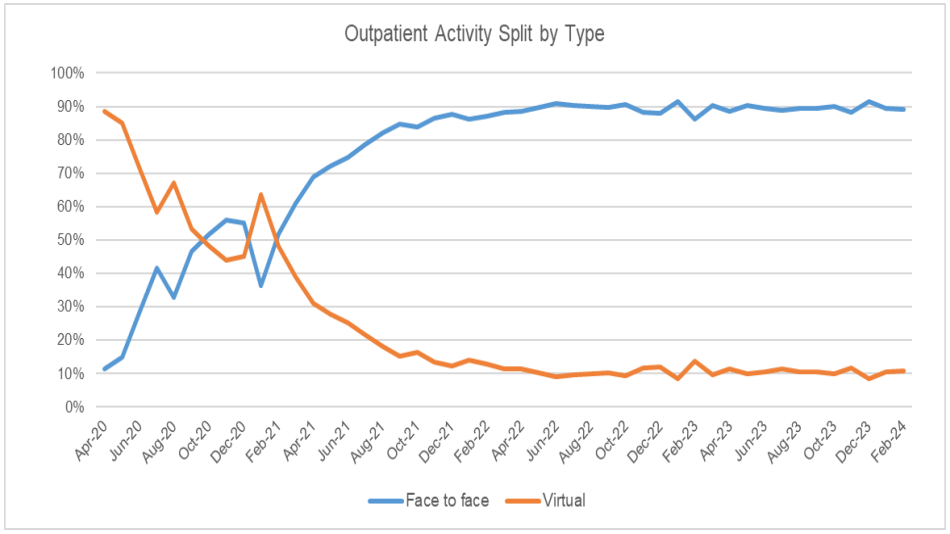


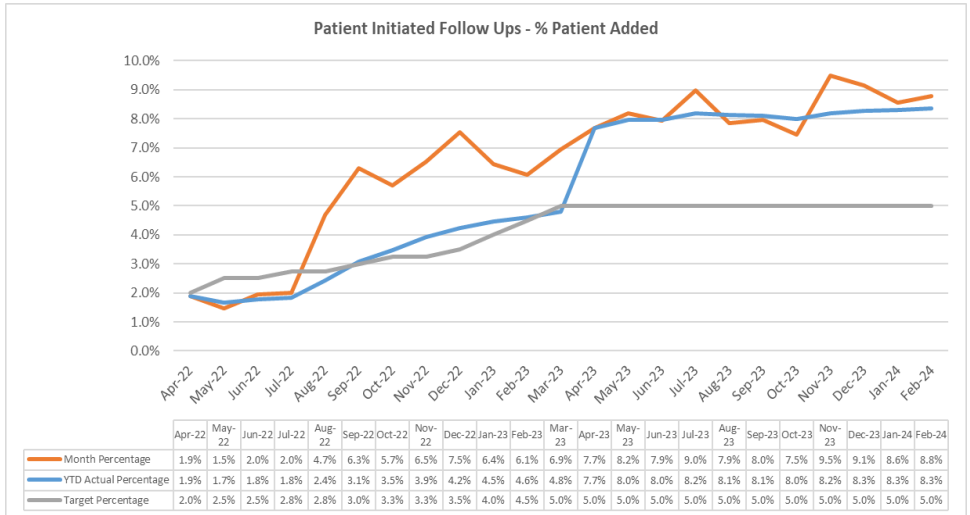


4. Outpatient efficiency









	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
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%	8.8%
YTD Actual Percentage	1.9%	1.7%	1.8%	1.8%	2.4%	3.1%	3.5%	3.9%	4.2%	4.5%	4.6%	4.8%	7.7%	8.0%	8.0%	8.2%	8.1%	8.1%	8.0%	8.2%	8.3%	8.3%	8.3%
Target Percentage	2.0%	2.5%	2.5%	2.8%	2.8%	3.0%	3.3%	3.3%	3.5%	4.0%	4.5%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

4. Outpatient efficiency

SUMMARY

February 2024 performance is as follows:

Overall Outpatient activity was –5% variance against the Trust trajectory with February delivering 5,280 (New and Review) episodes. The deficit was within the non-face to face activity.

- 4,700 face to face and 594 virtual appointments
- 11.6% virtual in total.
- 8.6% of outpatient attendances moved to the PIFU waiting list. The overall YTD position is 8.3%.
- 7.2% Missed Appointment (DNA) rate – lower than the Trust target of 8% and higher than the national standard of 6%

- **Clinic Waiting Times**
- 30-minute delays **– within trust target at 8.1% (Target 10%)**
- 60-minute delays – **within trust target at 2.27% (Target 5%)**

AREAS OF IMPROVEMENT

Missed Appointments
The Outpatients CSM is now chairing a Missed Appointments Group which is held on a monthly basis and feeds into the Outpatient Transformation Project Group.

Appointments
Outpatient and Appointment KPIs are monitored with weekly oversight to the Acting Chief Operating Officer.

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 missed appointment rate by having a targeted approach to ensure that all patients on a review waiting list are appointed accordingly.

ROH is represented clinically and operationally at the ICB Outpatient Transformation Group and Task & Finish groups.

4. Outpatient Transformation

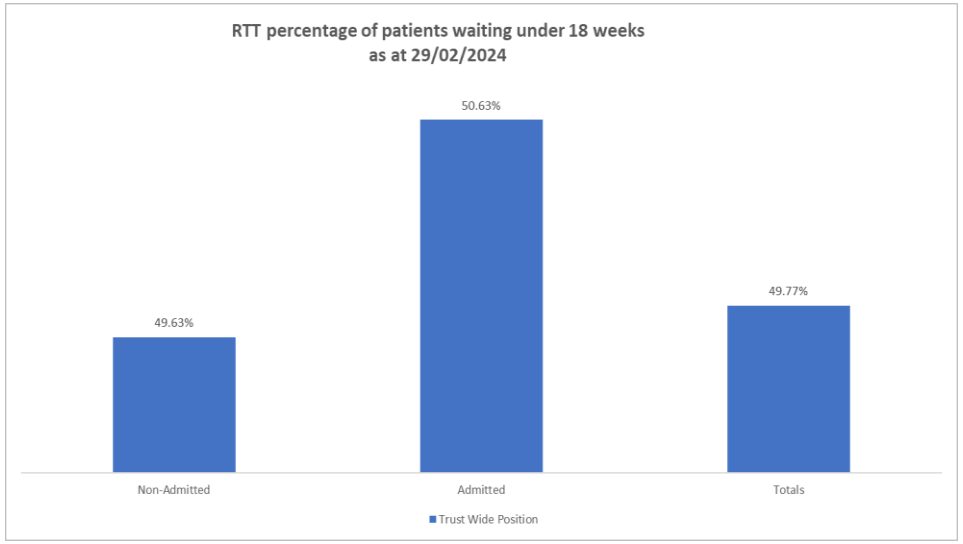
Specialty Priority Updates / Highlights

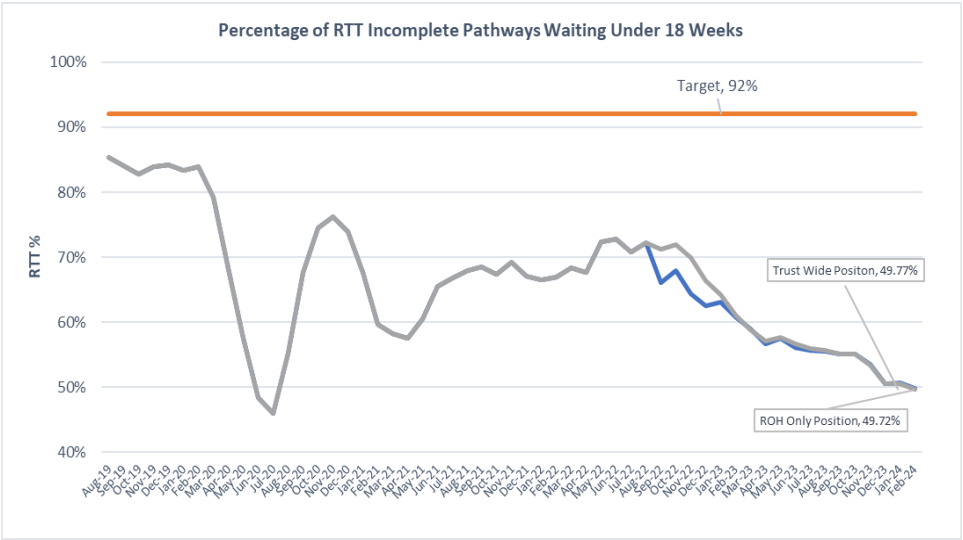
PIFU	Reduction in Missed Appointments (MA)	Reduction in Follow Ups	Clinical Pathways (e.g. Specialist Advice)	Productivity & Efficiency
Dr Doctor PIFU module delayed until TIARA configuration complete. Communications are being prepared for April 2024 for PIFU. GIRFT Further Faster handbooks have been disseminated to specialties including a PIFU checklist and recommendations for standardisation.	Following significant improvements in Imaging MAs due to Dr Doctor text reminders going live, a case study is being worked on to highlight Imaging as an area of good practice. Outstanding clinics are being reviewed to go live with reminders and TIARA coding has commenced to send reminder texts to patients due to attend Therapy appointments. Following the successful funding bid for missed appointment management, additional functionality in Dr Doctor is being confirmed.	Supported by other workstreams. Some challenges in areas with overdue follow ups. GIRFT recommendations have been circulated to the teams.	Clinical Pathways ICB programme is underway with engagement from YAH and Arthroplasty. Contact has also been made in respect to optimising Spinal referrals. Advice & refer is under review in parallel with referral mapping exercise with Appointments. System Wide Access Policy is progressing with the ICB.	Outpatients CSM has replicated 6-4-3, check and challenge and lookback process to closely monitor utilisation in outpatients. The first GIRFT Further Faster meeting has taken place.

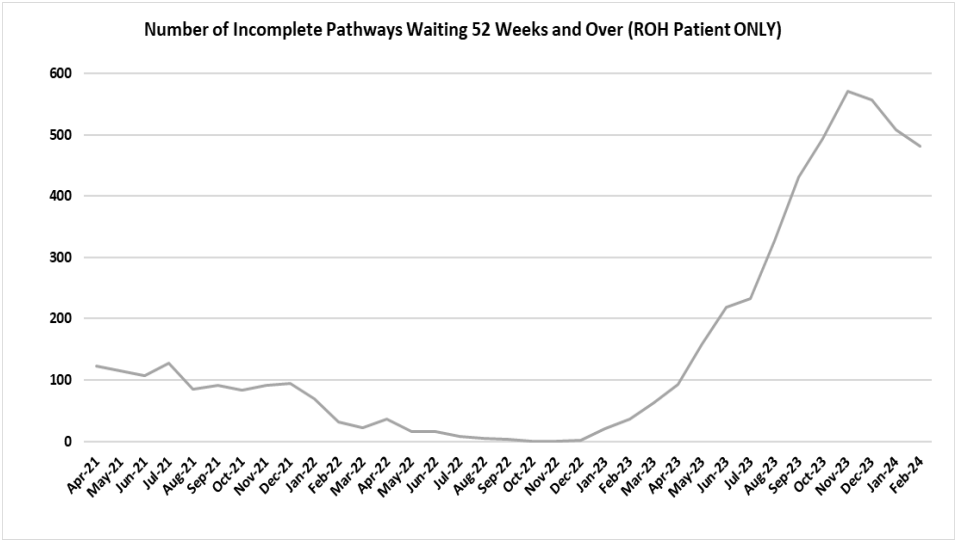
5. Referral to Treatment

	Trust Wide Position		
Weeks Waiting	Non-Admitted	Admitted	Totals
0-6	3,276	573	3,849
7-13	2,123	371	2,494
14-17	1,332	219	1,551
18-26	2,491	417	2,908
27-39	2,798	413	3,211
40-47	860	129	989
48-51	315	61	376
52 weeks and over	368	114	482
Total	13,563	2,297	15,860

Weeks Waiting	Non Admitted	Admitted	Totals
Under 18	6,731	1,163	7,894
18 and over	6,832	1,134	7,966
Month End RTT %	**49.63%**	**50.63%**	**49.77%**



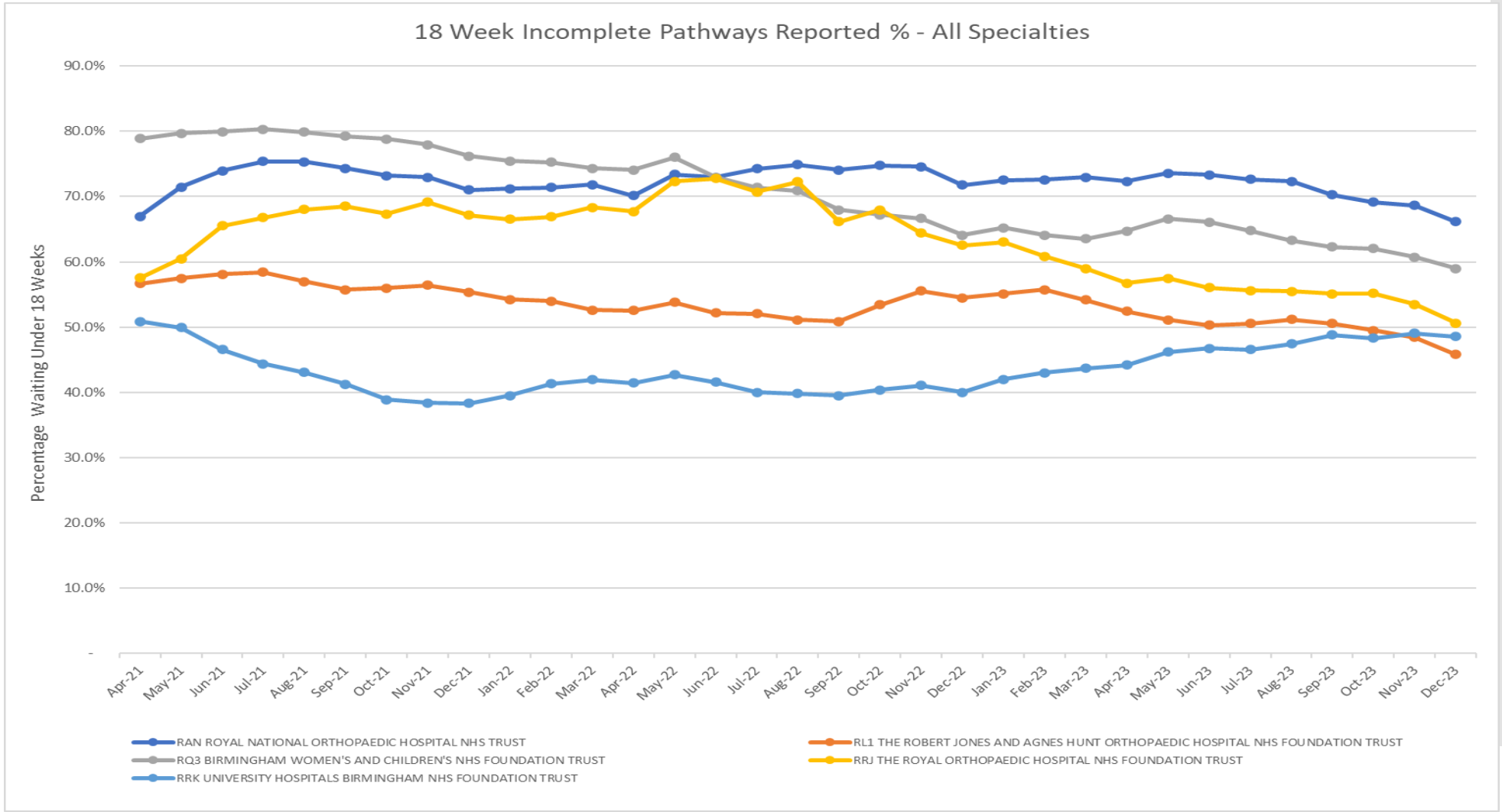




5. Referral to Treatment

18 Week Incomplete Pathways Benchmarking

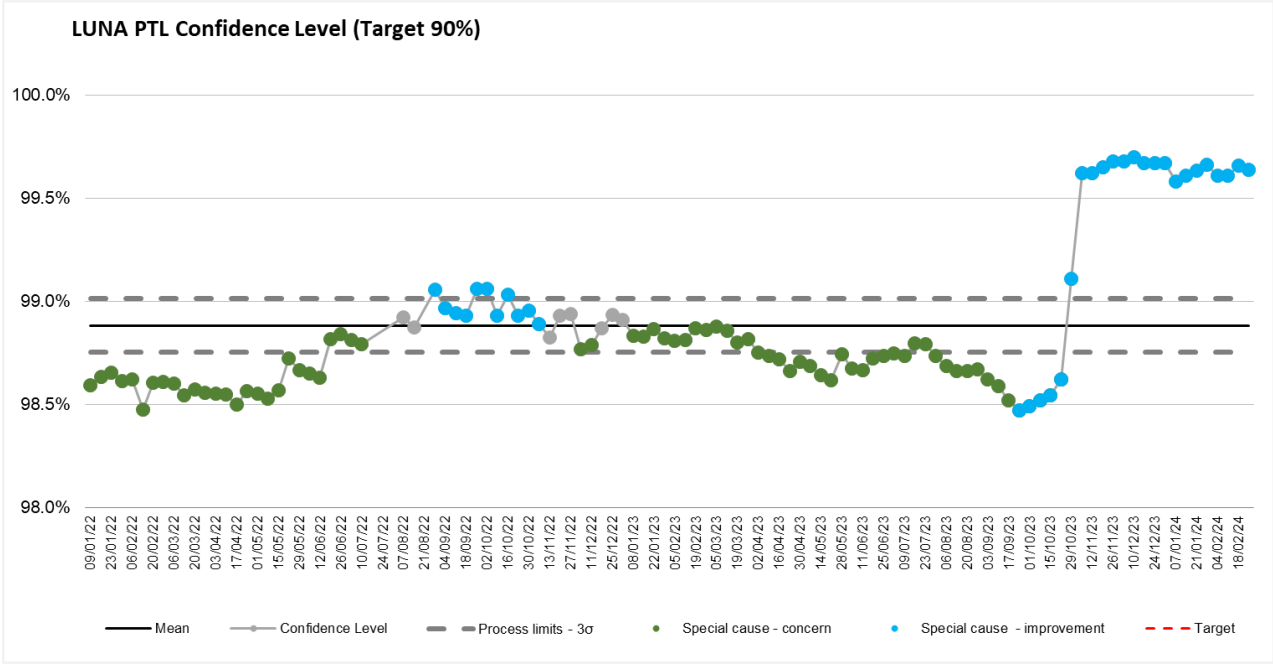
18 weeks Incomplete pathways Benchmarking against other providers:



5. Referral to Treatment

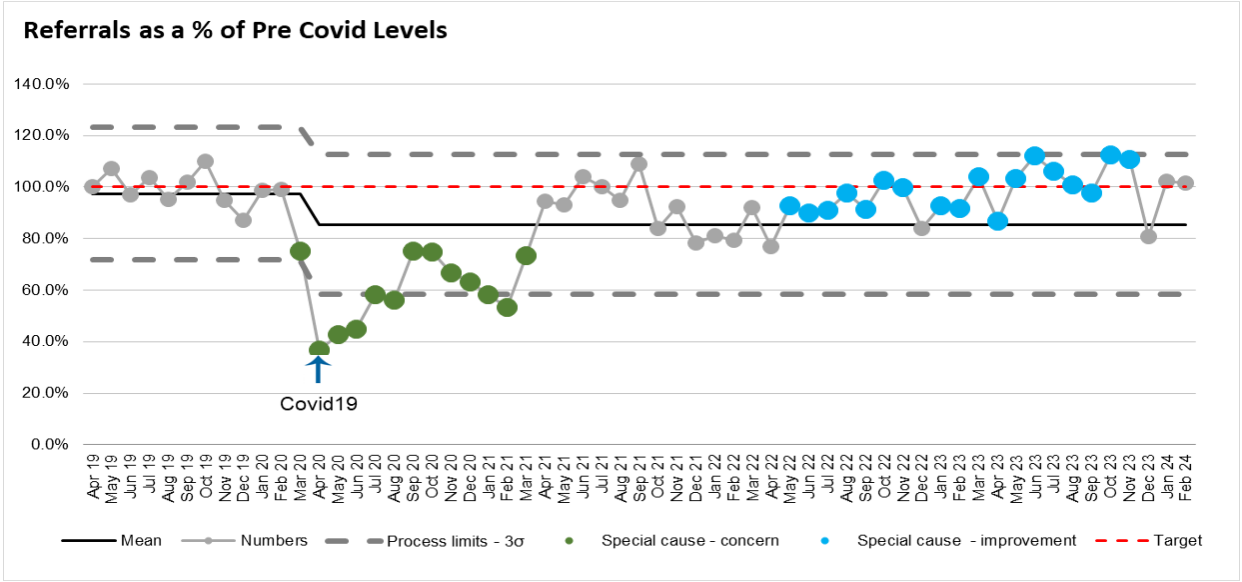
Luna Data

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	2347	2793	3029	2871	2722	2645	3045	2990	2188	2767	2743													
Referrals as a % of Pre Covid Levels	86.80%	103.29%	112.02%	106.18%	100.67%	97.82%	112.61%	110.58%	80.92%	102.33%	101.44%													

5. Referral to Treatment

SUMMARY

The Referral To Treatment (RTT) position for January was **49.77%** against the National Constitutional Target of 92%. This represents a 0.88% decrease compared to the January reported position of **50.65%** that includes patients transferred from other providers**.** The LUNA report for data quality validation is consistently above 98%.

There were **482** patients waiting over 52 weeks in February, a decrease from the trust wide position in January which was **511** 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 February 24, ROH received 2,743 referrals (101.44%) compared to pre covid levels. 2,704 is the average monthly referrals received Pre-Covid.

AREAS FOR IMPROVEMENT

RTT training has been rolled out within Division 1 and continues to focus on Appointments and Outpatients Reception for Phase 1.

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. NHSE is extending the deadline to 30.09.24, however, the system is still pushing for achievement by 31.03.24. There are complex patients currently within the spinal service that will not meet the target of 31.03.24. The number is expected to be between 20 and 50 patients. The team are confident that this will be delivered by 30.04.24. All other specialities will meet the target and most specialities are working on 0 x 52 week waits.

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

Spinal backlog continues to be a concern with the team focussing on managing all patients currently over 65 weeks and preventing tip ins. A restriction in LLP will reduce the opportunities to get ahead and appoint patients further down the waiting lists. Spinal is to be prioritised with the roll out of GIRFT follow up recommendations. The Validation team continue to provide extra support to spinal services to help manage patients through their pathway.

5. Referral to Treatment

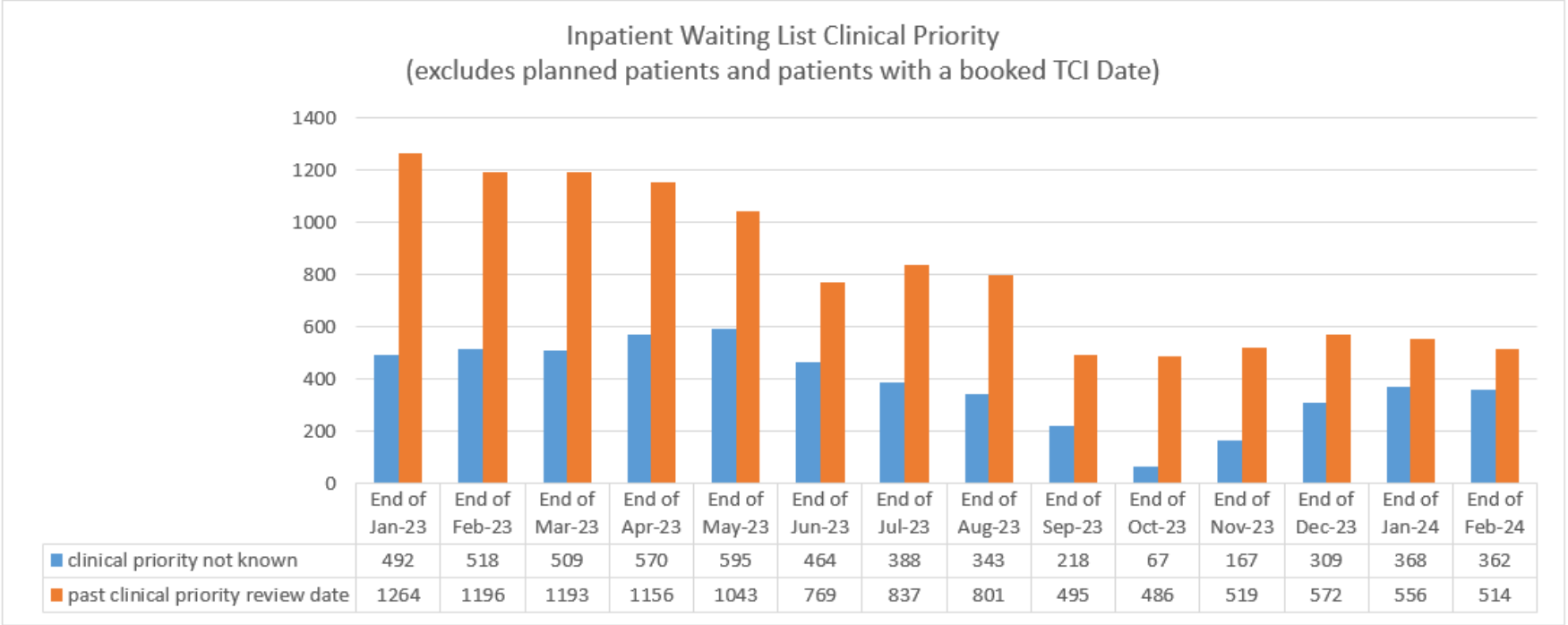
Specialty Breakdown

The national RTT target is for 92% of patients to be treated within 18 weeks. The table below highlights the current performance against this target by specialty. It also includes the number of patients currently waiting over 52 weeks prior to any tip ins. This will be used to support focussed intervention going forward:

Specialty	Number of patients over 52 weeks with an incomplete RTT pathway	RTT % as of 18.03.24
Arthroplasty	2	68.6%
Arthroscopy	41	43.7%
Clinical Support	6	54.0%
Foot and Ankle	2	39.2%
Hands	30	38.3%
Oncology	0	78.8%
Oncology Arthroplasty	4	40.6%
Paediatrics	3	60.7%
Spinal	267	29%
Spinal Deformity	158	32.4%
Young Adult Hips	1	62.6%

5. Referral to Treatment

Overdue Clinical Priority:

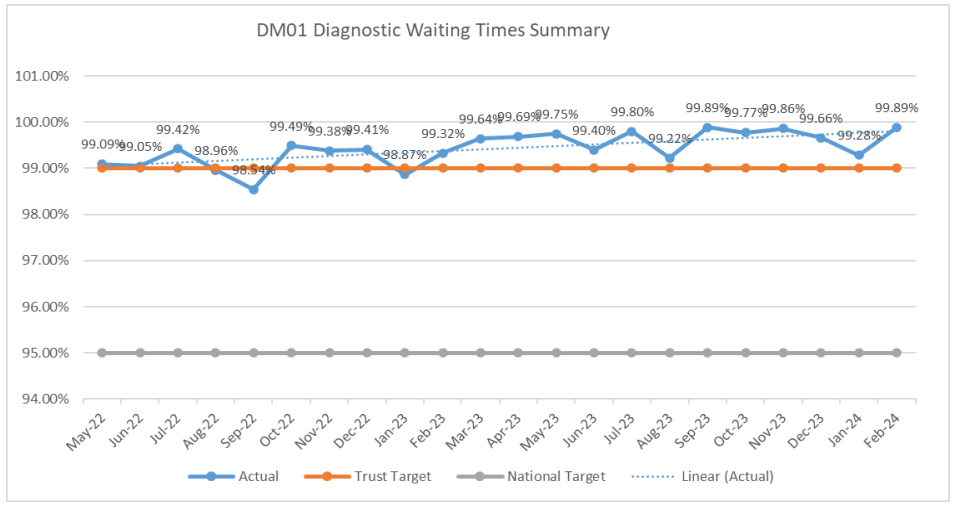


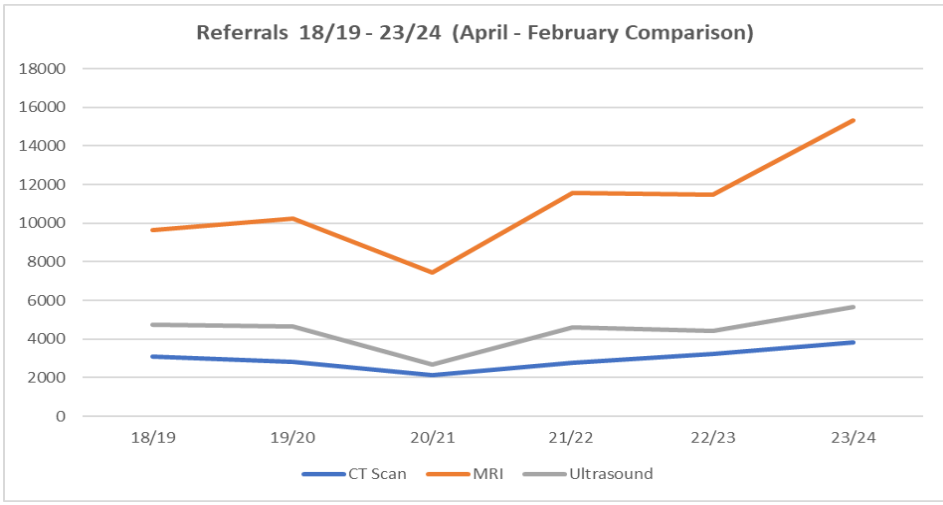
	End of Jan-23	End of Feb-23	End of Mar-23	End of Apr-23	End of May-23	End of Jun-23	End of Jul-23	End of Aug-23	End of Sep-23	End of Oct-23	End of Nov-23	End of Dec-23	End of Jan-24	End of Feb-24
clinical priority not known	492	518	509	570	595	464	388	343	218	67	167	309	368	362
past clinical priority review date	1264	1196	1193	1156	1043	769	837	801	495	486	519	572	556	514

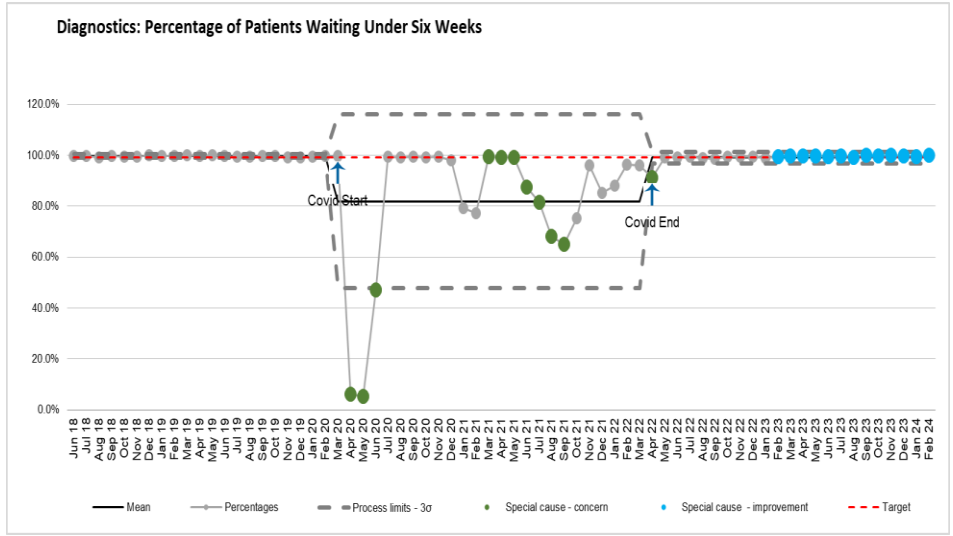
The numbers have reduced slightly during February and have been shared with all CSLs to review and make improvements for next month. Clinical priority unknown is linked to some of the UHB patients. The new Service Manager for UHB will ensure the priority is entered onto theatre man going forward.

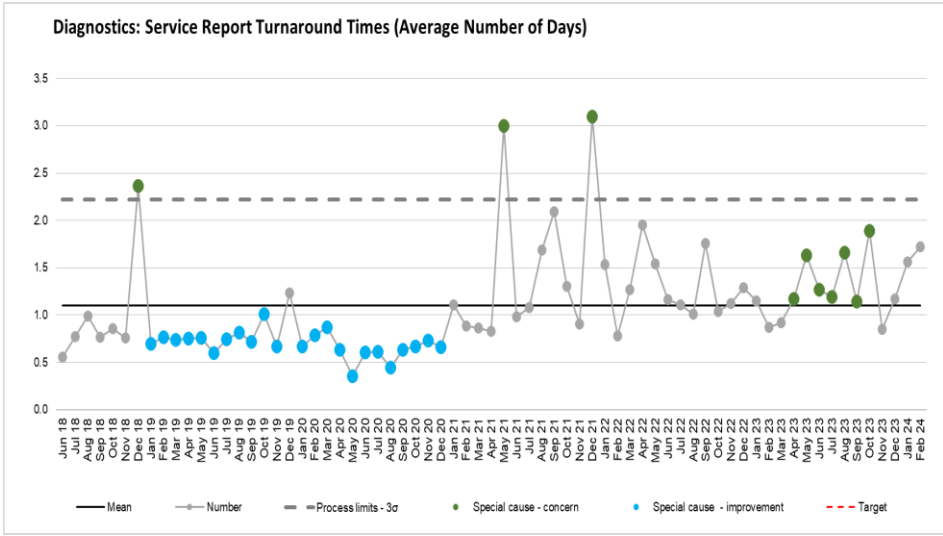
6. Diagnostic Performance

% 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 February 2024 closing the month at 99.89% despite a reduction 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 7weeks. The 3T MRI scanner upgrade completed. 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 – January 2024 (March 2024 Submission)

		January 24 (complete)			
Target Name	National Standard	%	In target	Breach	Total
31 DTTD to Treatment	96%	93.7%	15.0	1.0	16.0
62 day RTT to treatment	85%	85.7%	6	1	7
28 day FDS REPORTED	75%	87.9%	58	8	66
Patients over 104 days (62 day standard)					

		January 2024 (Old Standards		
Target Name	National Standard	%	In target	Breach
2 WW	93%	97.0%	88.0	5.0
31 First	96%	100%	9.0	0.0
31 day subsequent	94%	85.7%	6.0	1.0
62 day Standard	85%	66.7%	2.0	1.0
62 day (Cons Upgrade)	n/a	100.00%	4.0	0.0
28 day FDS REPORTED	75%	87.9%	58.0	8.0
Patients over 104 days (62 day standard)				

Performance

The trust was compliant against the 62 day standard and the faster diagnosis standards for January 2024. The 62-day target was achieved with a compliance rate of 85.7%. Unfortunately, the 31-day metric was not achieved due to 1 x Spinal Oncology patient that missed the target due to surgeon availability over the xmas period. The PTL denominator is so small that 1 patient is the difference between hitting and failing the target.

We were compliant with the 28 days FDS standard achieving 87.9%% against a target of 75%. A significant improvement has been seen from pathway improvements arising from the new reporting standards.

The root cause of the delay for the 1 x 62-day breach was:

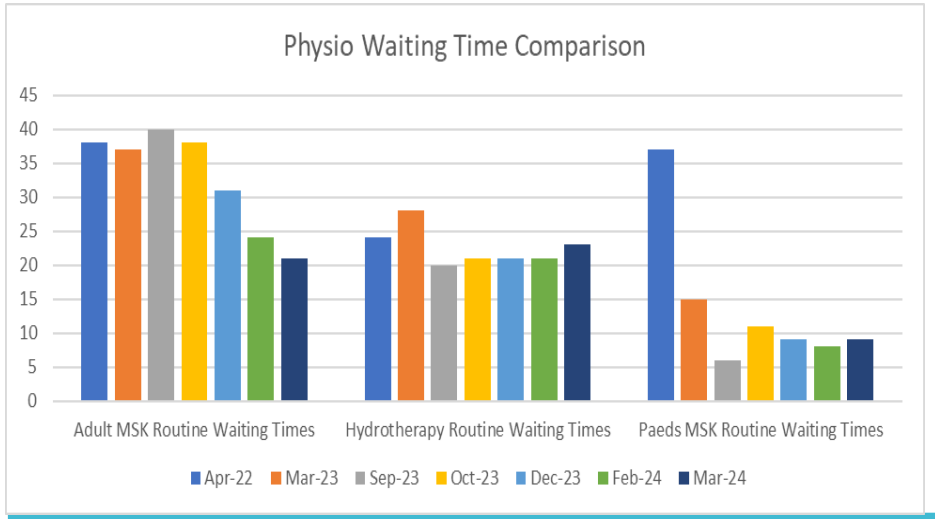
- 1 x full breach – Patient was directly referred into the ROH on a 2ww pathway. Root cause of delay was due to complex diagnostics. Patient required MRI and MDT discussion prior to biopsy which took place on day 24. Additional tests were requested before a diagnosis was confirmed on day 53.

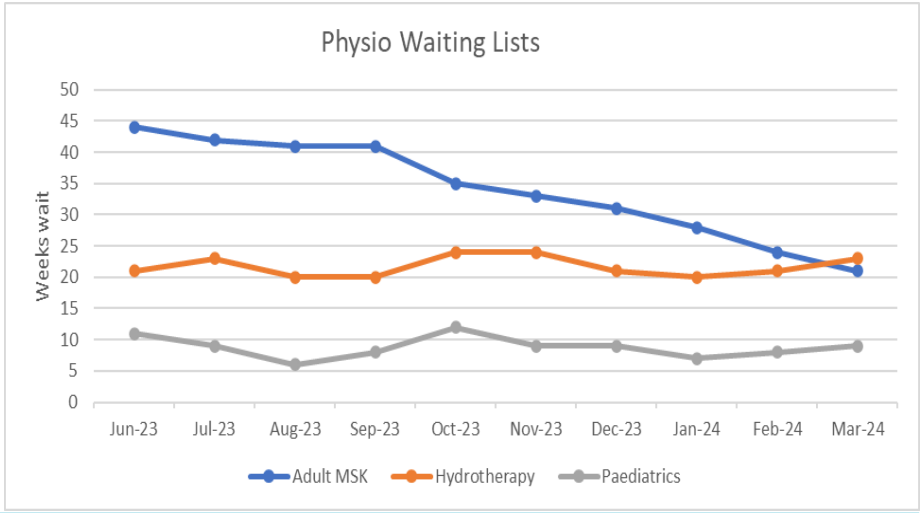
Risks /actions ongoing

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. There has been some improvements to the Faster diagnosis standards this month through continued escalation and improved collaborative working.

9. MSK Waits

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





Summary – data as per 18/03/24

Paediatric Physio waits continue to be maintained below 12 weeks with the March position currently at 9 weeks.
Hydrotherapy waits are at 23 weeks.
Adult physio waiting times have reduced from 44 weeks in June/July to 21 weeks as of 18th March 24.
Back Pain waiting times reduced from 39 weeks in Sept 23 to 19 weeks as of 18th March 24.
Plans being developed to support the hydrotherapy waiting times with resources from the adult MSK team
A planning meeting for the Community Appointment Day has been scheduled for 2nd April 24 including QE and College Green Medical Practice colleagues.

Risks /actions ongoing

- A comprehensive action plan had been produced to address the long waits associated with Adult MSK Routine appointments and as a result the Trust has seen a positive reduction in the waiting list
- A number of new starters have also helped with the improved position

10. Private Patients

SUMMARY

- There were 53 inpatients treated privately in February 24
- The service has exceeded its inpatient activity plan in month by 41 patients and YTD by 219 patients.
- There is no outpatient target, however there were 119 private outpatient appointments, and the service has booked 1,216 outpatient appointments YTD.
- The service overachieved against its income target in February by £51k and is over its YTD position by £300k.

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	YTD
Income Plan £000	306	306	306	306	255	253	325	361	209	289	346	3262
Activity Plan	9	24	35	24	37	28	29	36	11	29	12	274
Income to be collected £000	353	229	254	397	255	314	347	354	308	388	397	3596
Activity actual	47	37	41	55	38	39	46	48	39	50	53	493

AREAS FOR IMPROVEMENT

To aid 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:

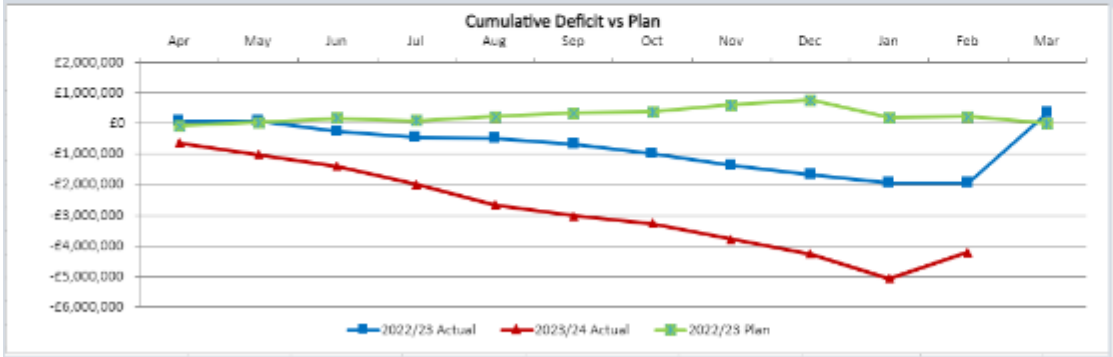
A) 3-year strategic plan submitted and agreed at the Trust Board in March 2024.
B) Renegotiation with AXA and subsequently BUPA to agree tariff pricing for the new financial year – negotiations have begun with AXA
C) Uplift on self-funding package pricing – in place for 1st April with a 6-month review planned.
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 11

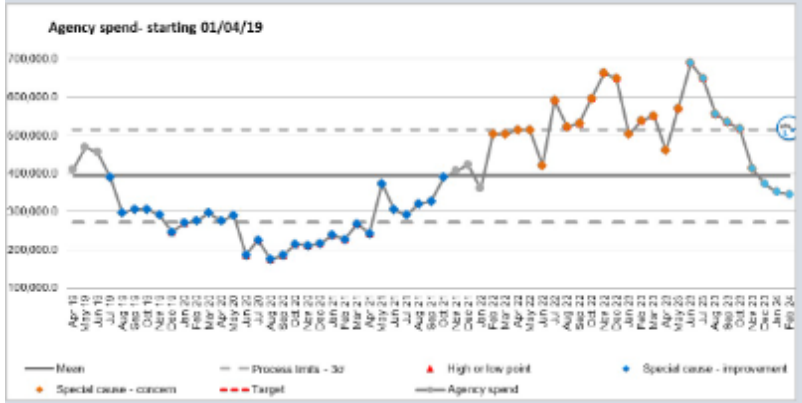
FINANCIAL PERFORMANCE

Income and Expenditure category	£'000s								
	In Month			Year to date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Pay	-£6,236	-£6,467	-£231	-£68,512	-£69,235	-£723	-£74,746	-£75,189	-£443
Non Pay	-£4,224	-£4,936	-£712	-£47,257	-£53,368	-£6,111	-£51,756	-£54,039	-£2,283
Income from patient care activities	£10,199	£11,815	£1,616	£112,612	£113,829	£1,217	£122,811	£124,167	£1,356
Other income	£422	£569	£147	£4,642	£5,658	£1,016	£5,064	£6,140	£1,076
Non operating costs	-£121	-£130	-£9	-£1,331	-£1,168	£163	-£1,455	-£1,339	£116
Remove capital donations	£7	£7	£0	£77	£84	£7	£82	£91	£9
TOTAL	£48	£857	£809	£231	-£4,200	-£4,431	£0	-£169	-£169



Agency as a % of paybill = 7.9%

Recurrent efficiency % of forecast = 100%



Efficiencies	YTD	Forecast
Plan	£4,607	£5,076
Actual	£4,636	£5,076
Variance	£29	£0

Capital	YTD	Forecast
Plan	£3,512	£3,909
Actual	£2,384	£3,499
IFRS 16	£756	£756
Variance	£372	-£346

Better Payment practice code	YTD	% move't prev month
Non-NHS		
By number	88.8%	0.2%
By Value	90.8%	0.7%
NHS		
By number	46.2%	1.5%
By number	10.0%	0.0%
Total		
By number	87.8%	0.2%
By Value	80.4%	0.8%

9. Overall Financial Performance

SUMMARY

The Trust delivered a surplus in month of £857k against a planned surplus of £48k, generating a £809k positive variance, resulting in a year to date deficit of £4,200k against a surplus plan of £231k, generating an adverse variance of £4,431k.
An in month income adjustment to account of industrial action impact of £1,326k was made. The underlying position with this non recurrent adjustment removed was a deficit in month of £469k against a planned surplus of £48k, generating a £517k adverse variance, resulting in a year to date deficit of £5,526k against a surplus plan of £231k, generating an adverse variance of £5,757k.

Income year to date is £2,,233k ahead of plan.

Pay expenditure is overspent by £723k. Non pay expenditure overspent against plan with an adverse variance of £6,111k.

Agency spend, although reduced, remains a concern – the spend year to date is 7.9%.

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

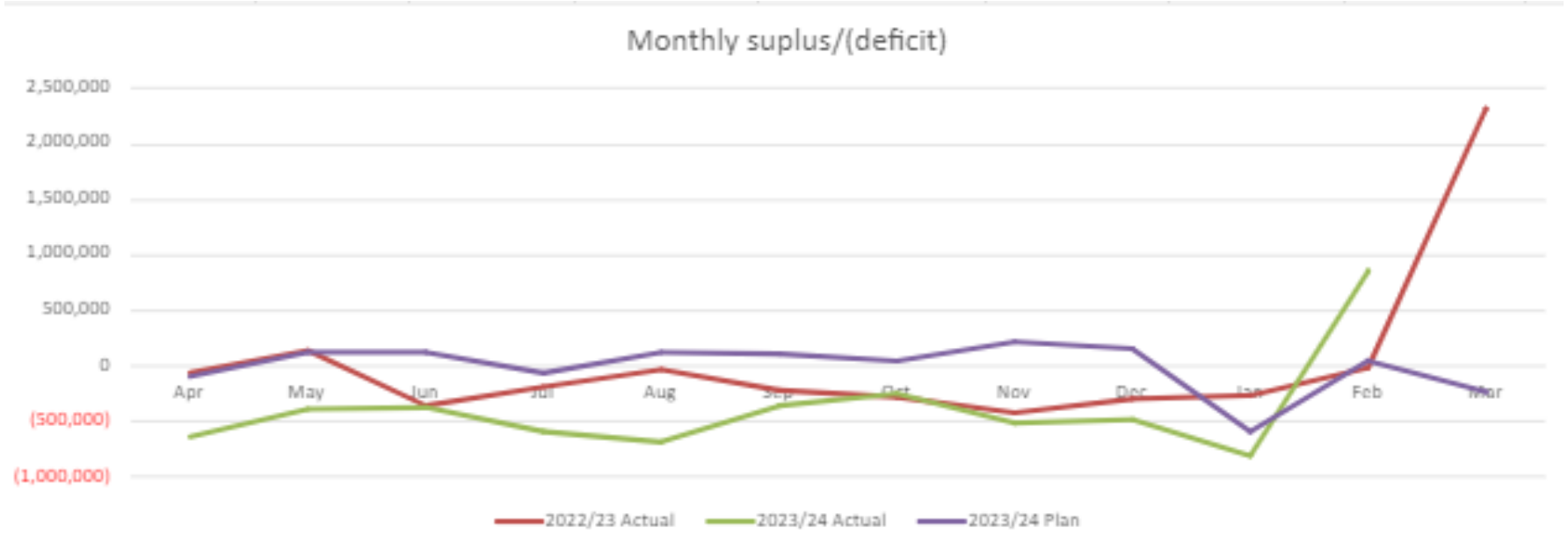
The forecast variance has improved to £169k.

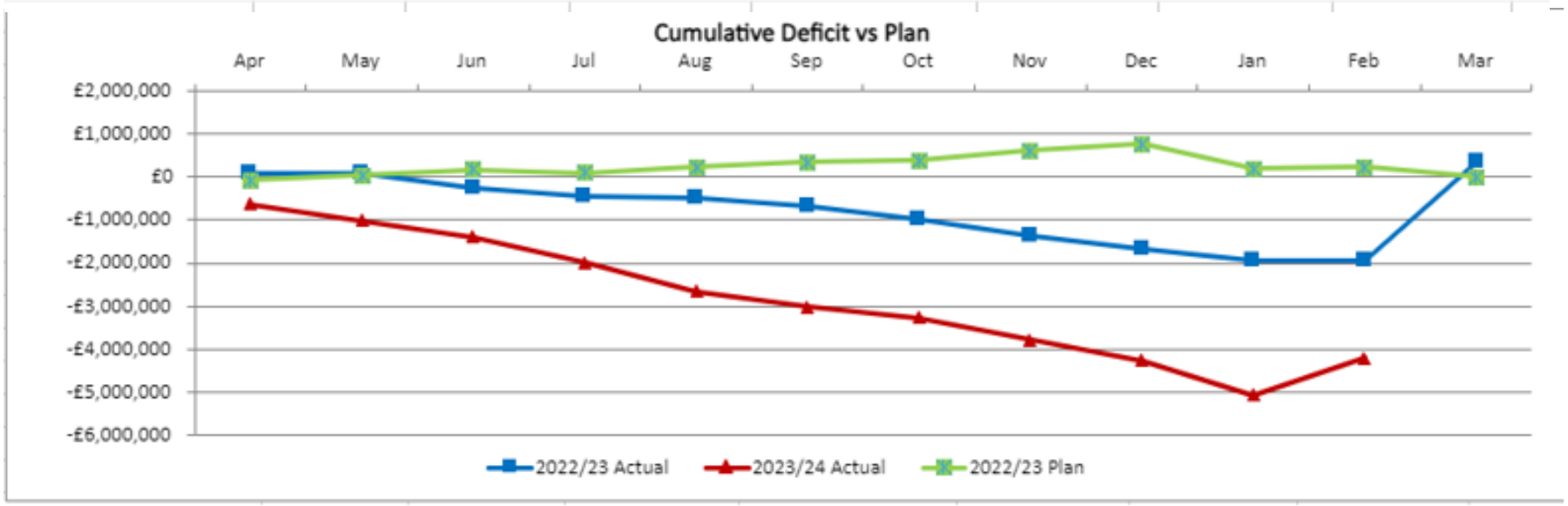
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	2,233	(723)	(6,111)	170	(4,431)
Year to date plan	117,254	(68,512)	(47,257)	(1,254)	231
Year to date actual	119,487	(69,235)	(53,368)	(1,084)	(4,200)
Variance compared previous month		(232)	(712)	(10)	()
Forecast Variance	2,432	(443)	(2,283)	125	(169)

9. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	112,612	1113,829	1,217
Other Operating Income (Excluding top up)	4,642	5,658	1,016
Employee Expenses (inc. Agency)	(68,512)	(69,235)	(723)
Other operating expenses	(47,257)	(53,367)	(6,111)
Operating Surplus	**1,485**	**(3,116)**	**(4,601)**
Net Finance Costs	(1,331)	(1,168)	163
Net surplus/(deficit)	**154**	**(4,284)**	**(4,438)**
Remove donated asset I&E impact	77	83	7
Adjusted financial performance	**231**	**(4,200)**	**(4,431)**

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)**	**857**	
Monthly Variance to revised trajectory			**36**	**0**	**(68)**	**(527)**	**(979)**	**679**	**(3,438)**
Cumulative Variance to revised trajectory			**(2,628)**	**(2,628)**	**(2,696)**	**(3,223)**	**(4,202)**	**(3,523)**	

10. Income

SUMMARY

Income year to date is £2,233k ahead of plan. An in month non recuurrent income adjustment to account of industrial action impact of £1,326k was made. We have also, received a £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 convergence 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

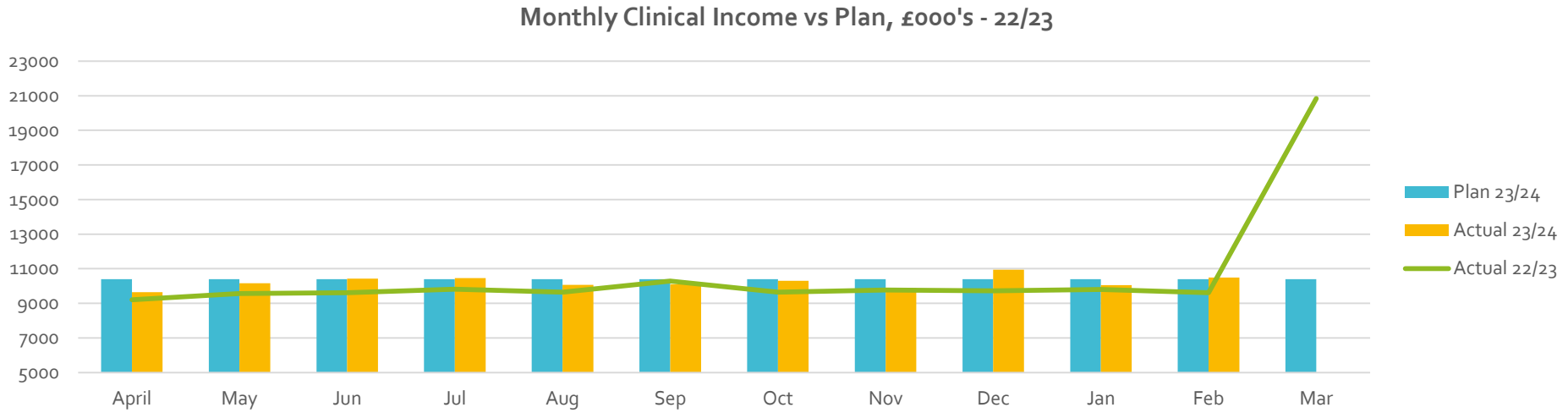
Elective recovery target delivery during the year to maximise income generation.

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



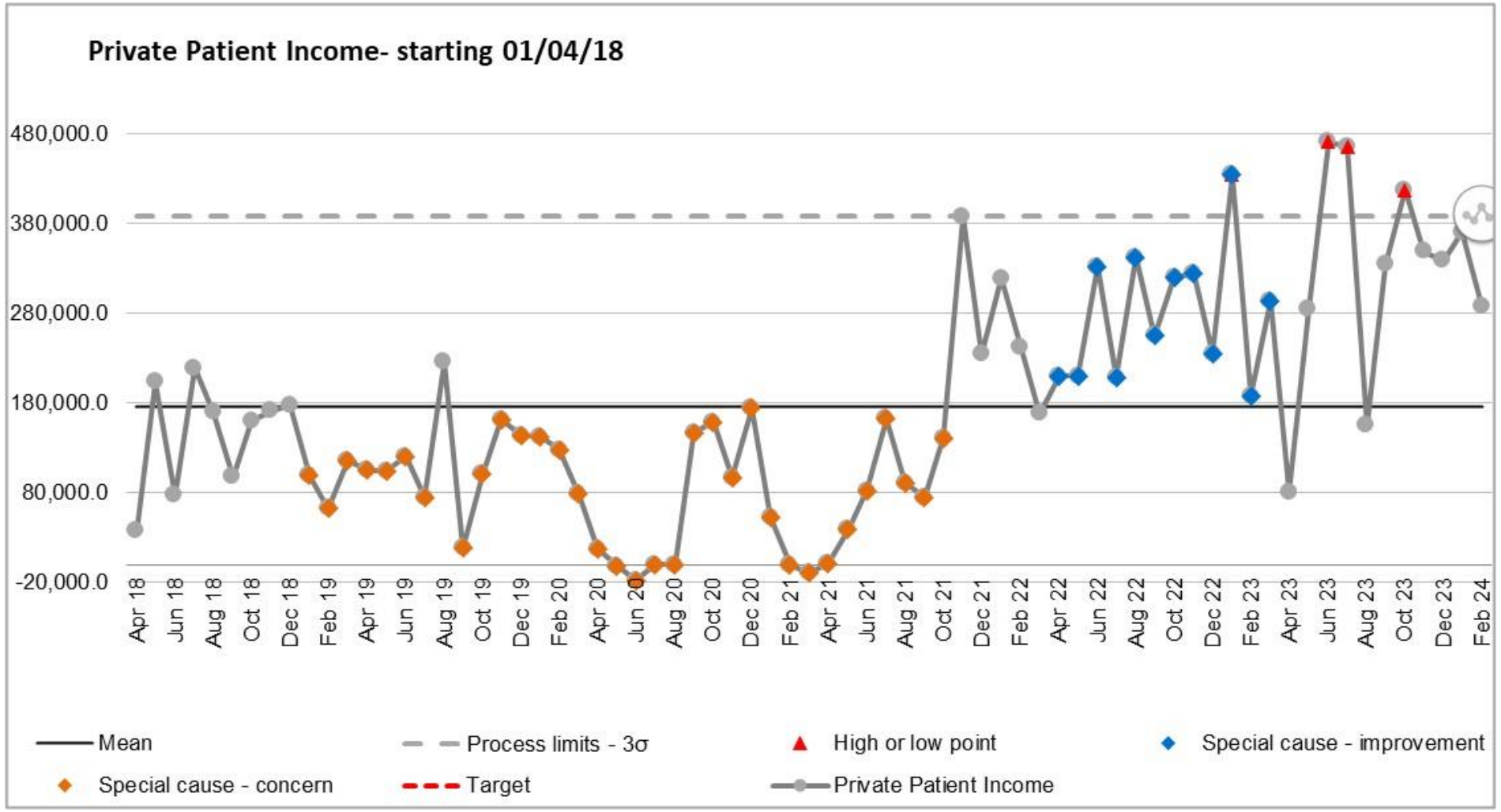
Confirmed performance by NHE England for Months 1-7 is an underperformance against revised target, with the largest variance against specialised commissioning. Work is ongoing to understand variances between internal performance calculations and NHS England performance, therefore the year to date position 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) pe rformance	% 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 £723k. Non pay expenditure is overspent against plan with an adverse variance of £6,111k.

Agency spend continues to improve, although the year to date spend as a percentage of paybill at 7.9%, is above the target of 3.7%.

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%.

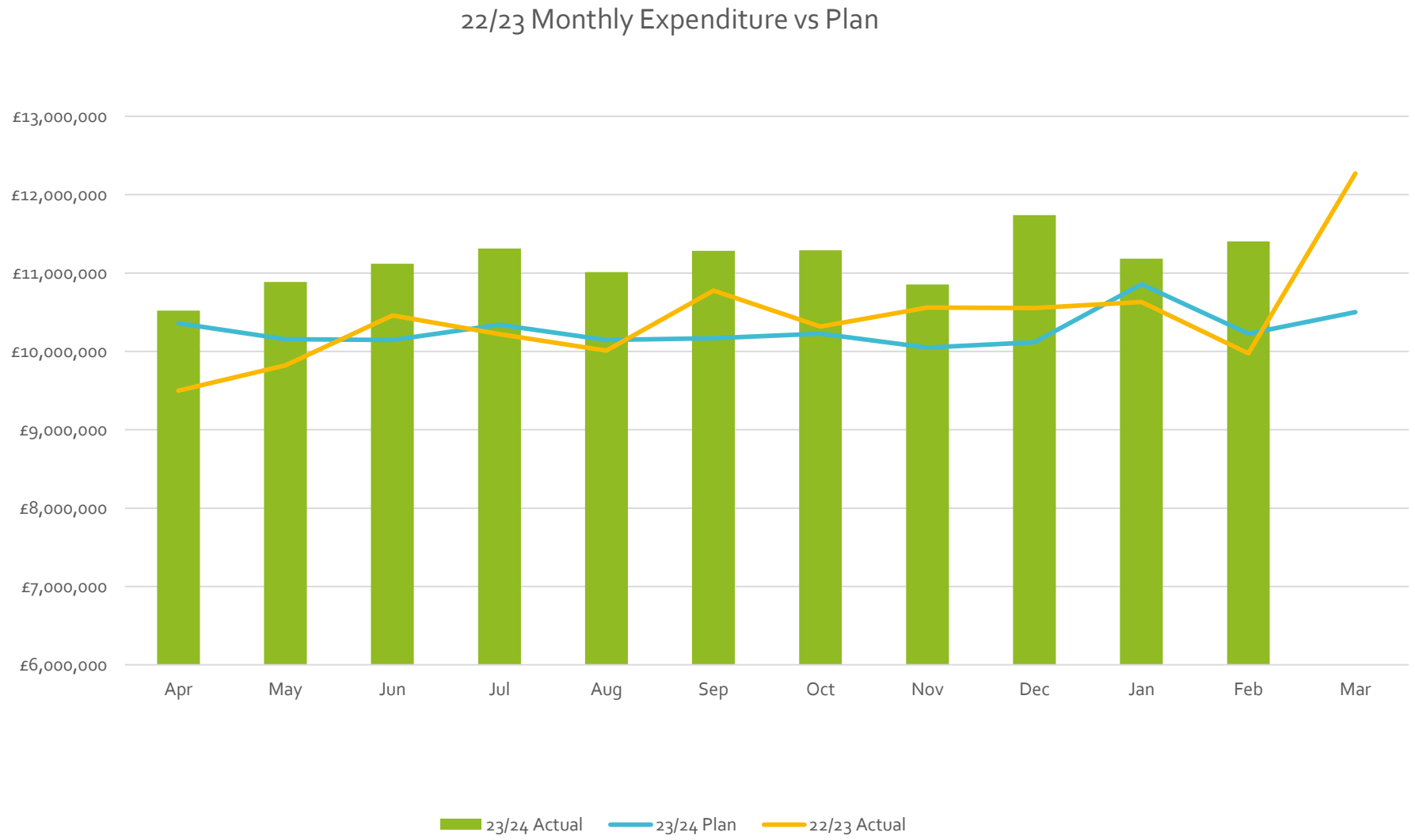
Theatre consumable spend reducing to planned levels.

LLP expenditure reduction.

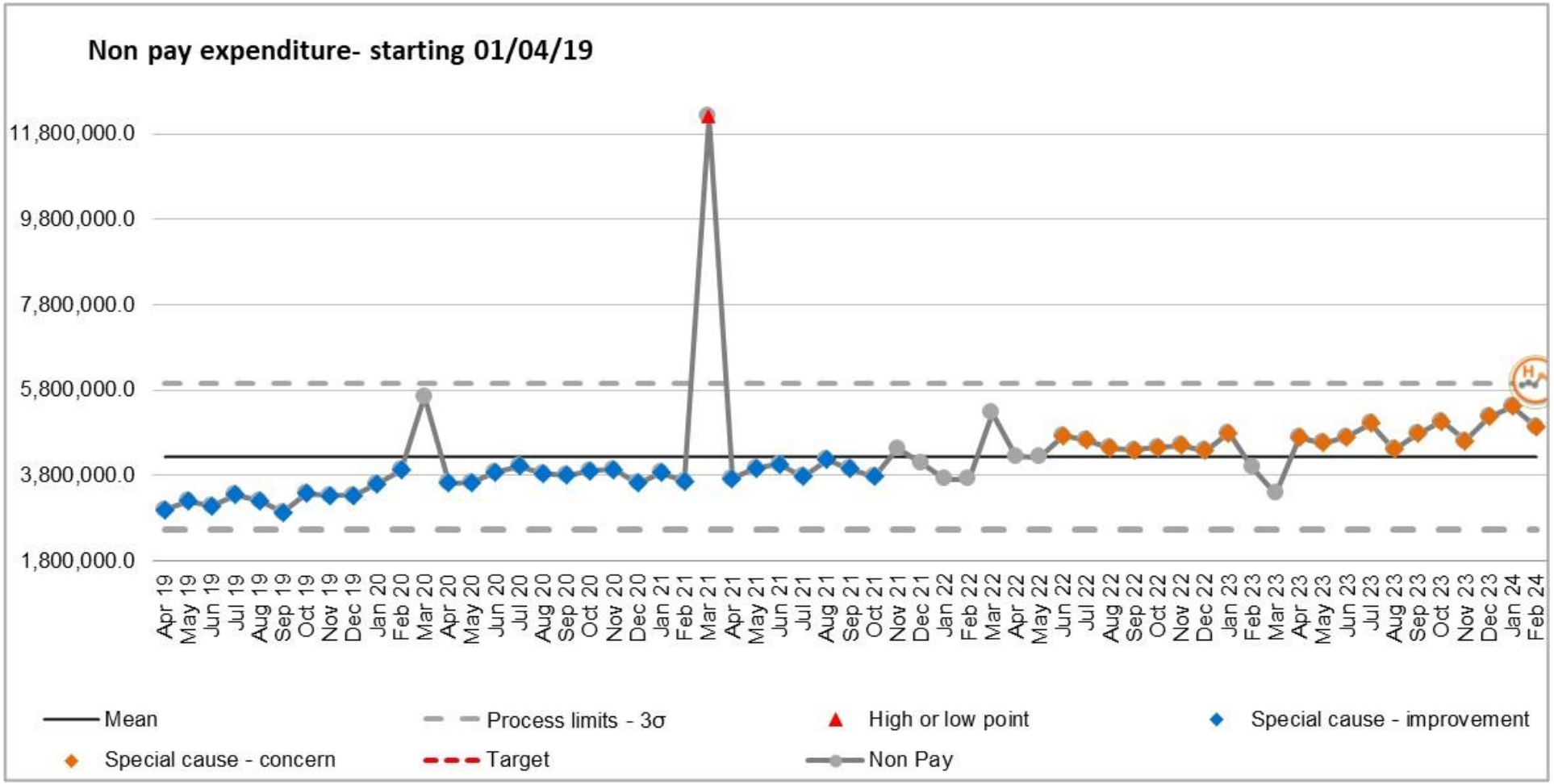
RISKS / ISSUES

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

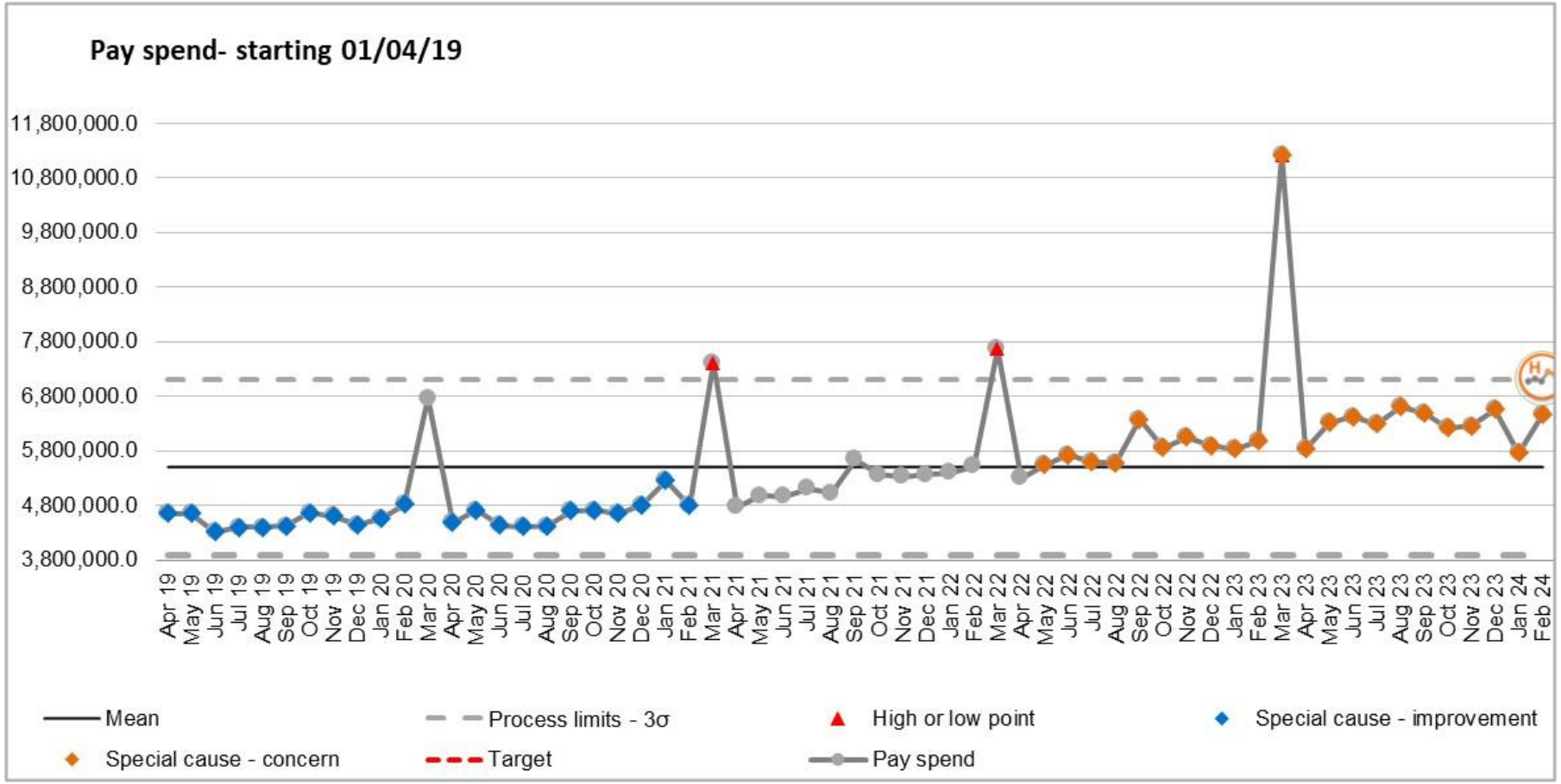
11. Expenditure



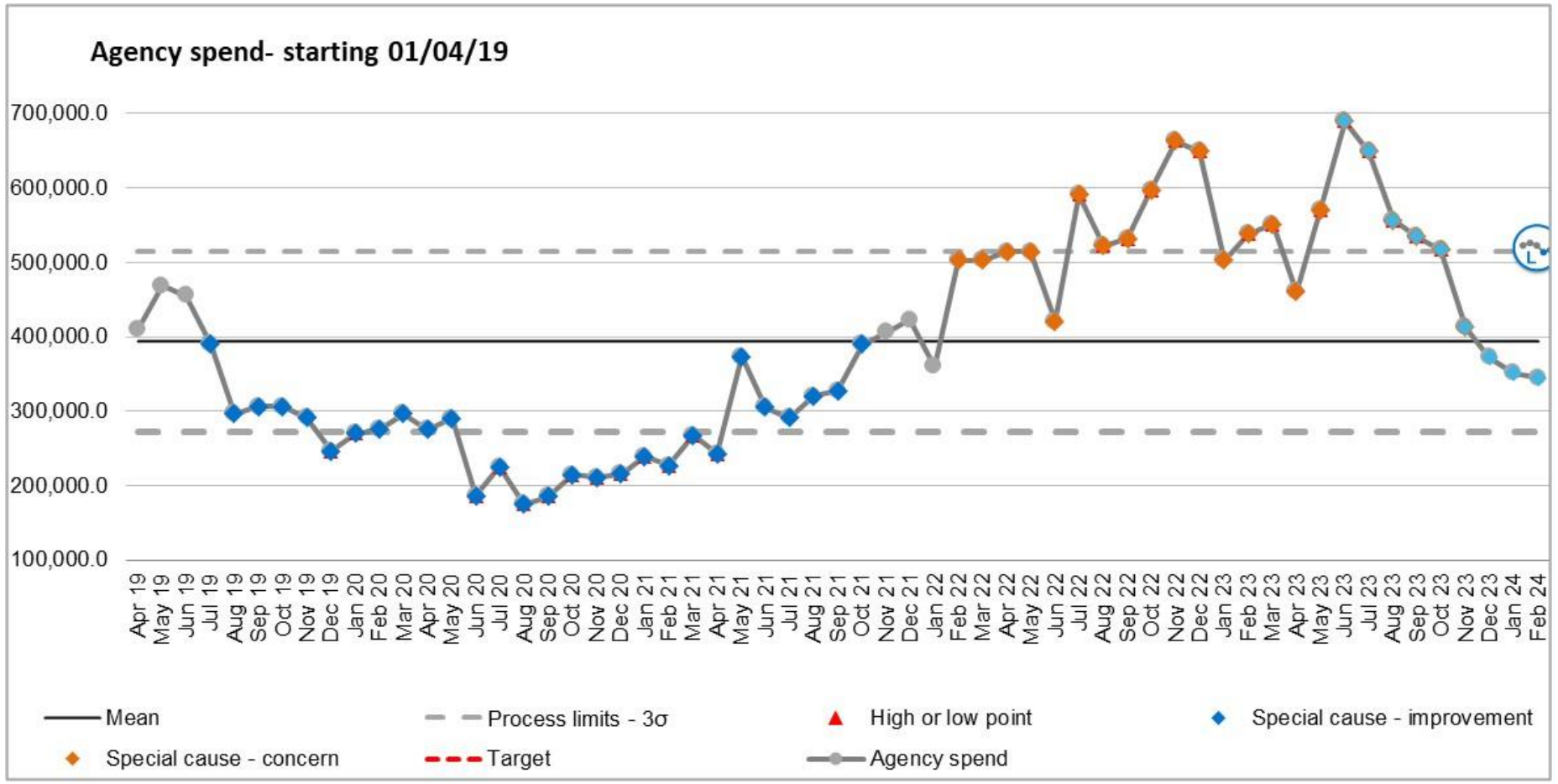
12. Non Pay Expenditure



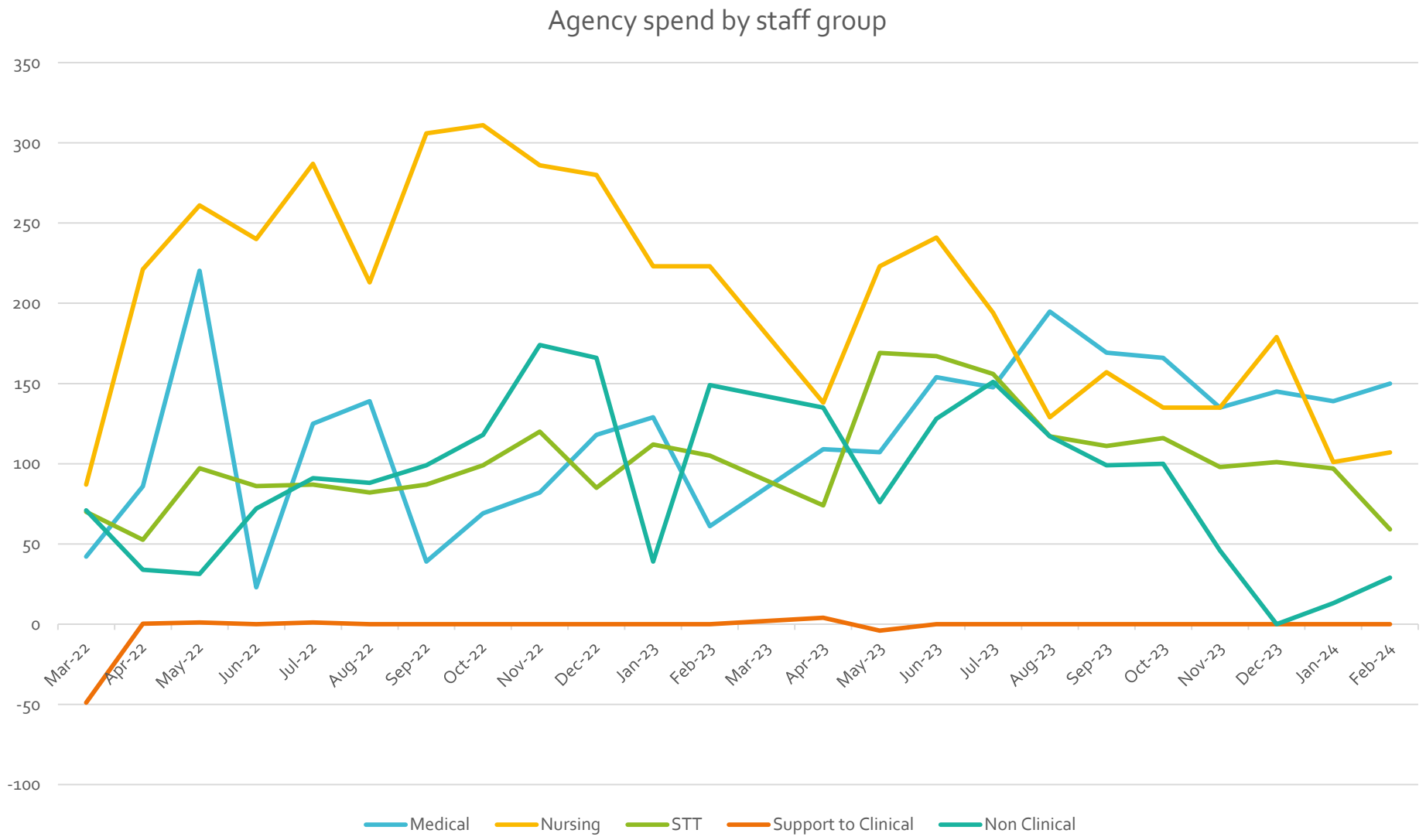
13. Pay Expenditure



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	Mth 11	Total
Nursing	138	223	241	194	129	157	135	135	179	101	107	1,739
STT	75	150	138	140	91	202	116	98	101	97	59	1,265
Medical	60	70	123	133	138	361	166	135	145	139	150	1,617
Non-Clinical	135	76	128	151	117	99	100	46	-53	13	29	841
	408	**518**	**630**	**618**	**475**	**818**	**517**	**413**	**372**	**350**	**345**	**5,462**

Actual	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	Mth 10	Mth 11	Total
Nursing	138	223	241	194	129	157	135	135	179	101	107	1,632
STT	79	165	167	157	117	111	116	98	101	97	59	1,206
Medical	110	109	155	148	194	169	166	135	145	139	150	1,467
Non-Clinical	135	76	128	151	117	99	100	46	-53	13	29	812
	462	**572**	**691**	**650**	**557**	**535**	**517**	**413**	**372**	**350**	**345**	**5,117**

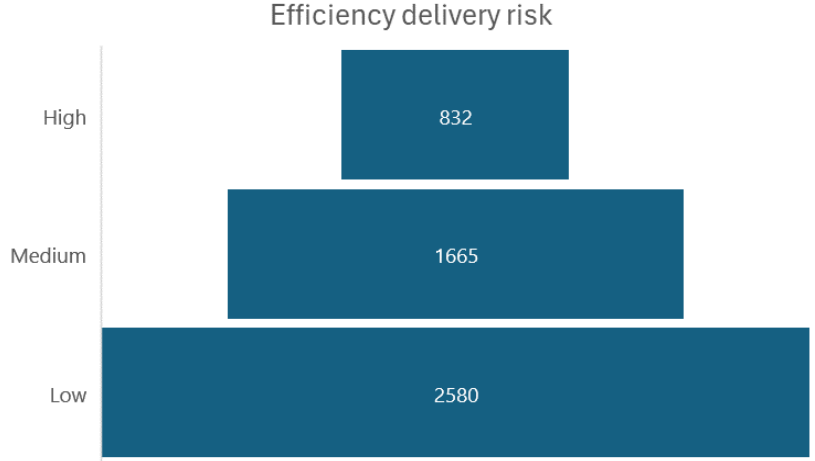
Variance	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Mth 7	Mth 8	Mth 9	Mth 10	Mth 11	Total
Nursing	-	-	-	-	-	-	-	-	-	-	-	-
STT	-4	-15	-29	-17	-26	91	-	-	-	-	-	-
Medical	-50	-39	-32	-15	-56	192	-	-	-	-	-	-
Non-Clinical	-	-	-	-	-	-	-	-	-	-	-	-
	-54	**-54**	**-61**	**-32**	**-82**	**283**	**-**	**-**	**-**	**-**	**-**	**-**

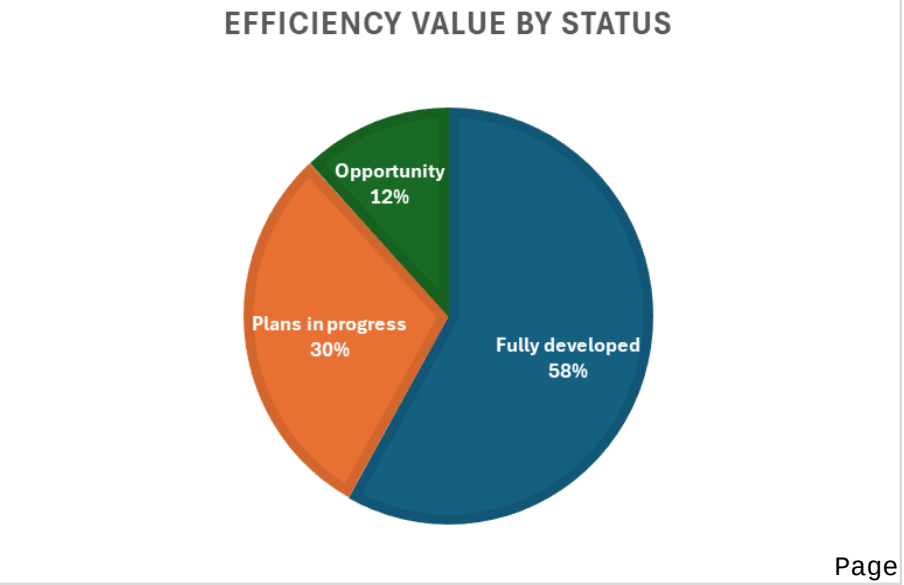
15. Cost Improvement Programme Summary

SUMMARY

Year to date savings totalling £4,636k have been delivered, against a plan of £4,607k, delivering a positive variance of £29k. 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	£605	£25	(580)	25
Non pay	£3,544	£4,488	944	4,928
Income	£458	£123	(335)	123
Grand Total	**£4,607**	**£4,636**	**29**	**5,076**





16. Statement of Financial Position

SUMMARY

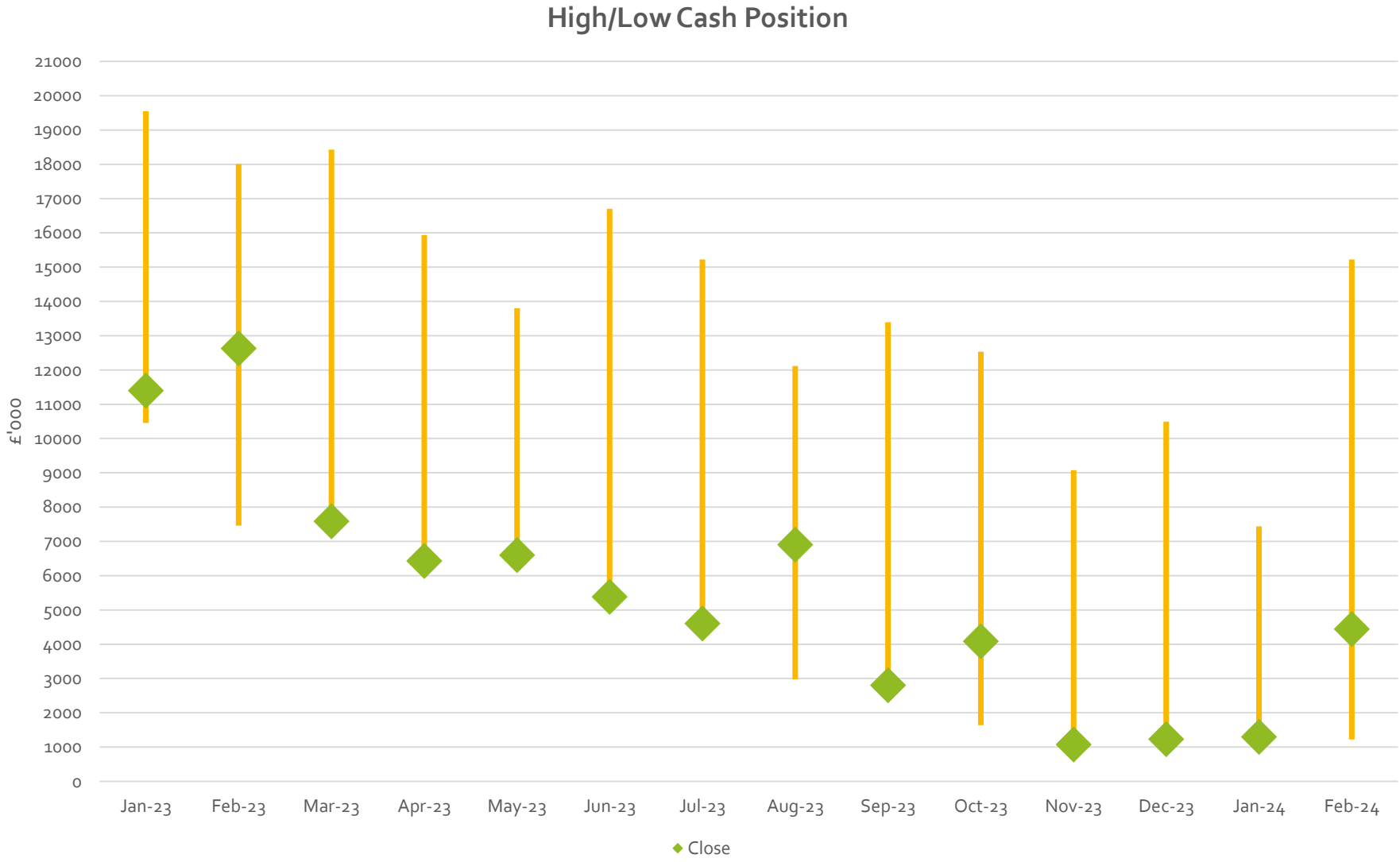
The main movements in the balance sheet have been in relation to the reduction in cash and an increase in deferred income (within other liabilities) due to some of the Trust's funding for the full year being received at the start of the year and utilised throughout 23/24.

Debtors have appeared to reduce in month due to BSOL paying us Month 12's cash in Month 11.

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 M11	Movement
		(£'000)	
Intangible Assets	1,339	1,013	(326)
Tangible Assets	69,123	67,029	(2,094)
Total Non Current Assets	**70,462**	**68,042**	**(2,420)**
Inventories	19	2	(17)
Trade and other current assets	12,839	7,302	(5,537)
Cash	7,591	4,437	(3,154)
Total Current Assets	**20,449**	**11,741**	**(8,708)**
Trade and other payables	(20,229)	(14,076)	6,153
Borrowings	(18,339)	(16,366)	1,973
Provisions	(1,329)	(1,292)	37
Other Liabilities	(273)	(2,917)	(2,644)
Total Liabilities	**(40,170)**	**(34,651)**	**5,519**
Total Net Assets Employed	**50,741**	**45,132**	**(5,609)**
Total Taxpayers' and Others' Equity	**50,741**	**45,132**	**(5,609)**

17. Cash


High/Low Cash Position
£'000
21000
20000
19000
18000
17000
16000
15000
14000
13000
12000
11000
10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
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 M11 system position and planned trajectory are shown below. This is shown prior to the receipt of IA funding. Instead adjustments to forecasts were made to account for the impact of industrial action are shown below. The adjustments to forecast allow for expected lost income in addition to the additional expenditure incurred.

M11

Organisation	Surplus / (Deficit) - Adjusted Financial Position					
	Plan YTD	Actual YTD	Variance YTD	Plan Year Ending	Forecast Year Ending	Variance Year Ending
	£000	£000	£000	£000	£000	£000
Birmingham and Solihull ICB	1,188	13,160	11,972	0	16,402	16,402
Birmingham And Solihull Mental Health NHS Foundation Trust	-	1,990	1,990	0	4,001	4,001
Birmingham Community Healthcare NHS Foundation Trust	94	567	473	0	663	663
Birmingham Women'S And Children'S NHS Foundation Trust	0	(59)	(59)	0	3,614	3,614
The Royal Orthopaedic Hospital NHS Foundation Trust	231	(5,526)	(5,757)	0	-961	(961)
University Hospitals Birmingham NHS Foundation Trust	(1,300)	(58,163)	(56,863)	0	-44,200	(44,200)
ICS Total	213	(48,032)	(48,245)	0	-20,481	-20,482

Trajectory		Better/(worse) than trajectory	
Trajectory YTD	Trajectory FOT	YTD	FOT
£000s	£000s	£000s	£000s
12,145	16,402	1,014	1
1,884	4,001	106	0
356	663	211	(0)
(1,016)	4,415	957	(801)
(3,582)	(170)	(1,944)	(791)
(32,602)	(25,312)	(25,561)	(18,888)
(22,815)	(1)	(25,216)	(20,481)

20. Workforce

Summary / Highlights

- There were plenty of positives to report in February 2024:
- We are retaining staff well with only 10 leavers in February 2024 (excluding rotation) and the majority appeared to be due to
- The establishment has made significant improvements in the last two months.

Risks / Issues

- In the most recent available benchmarking data for sickness absence in the system, we were the highest in January. Given February improved performance, it is hoped this was an outlier month.

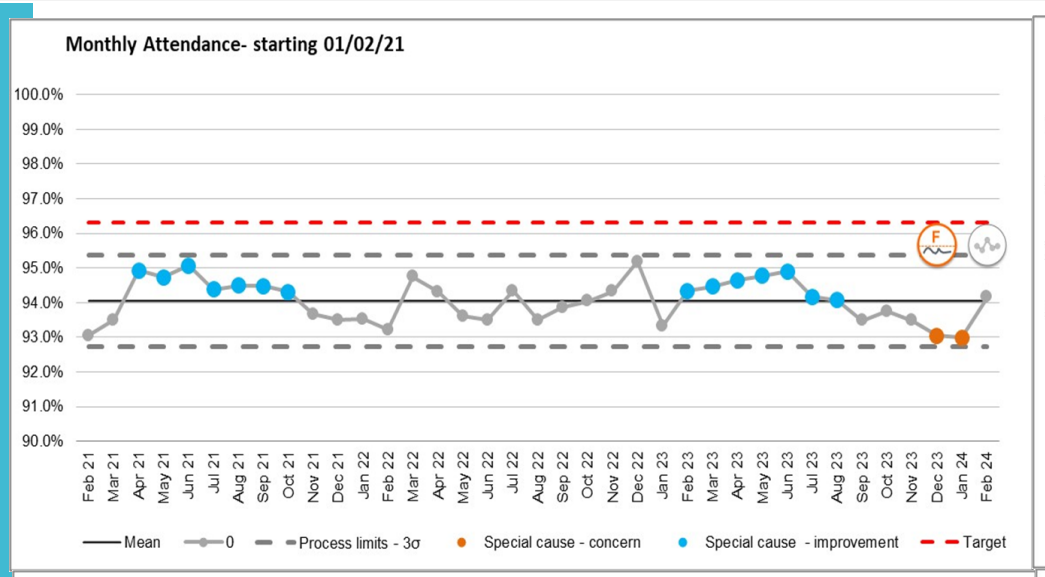
Actions

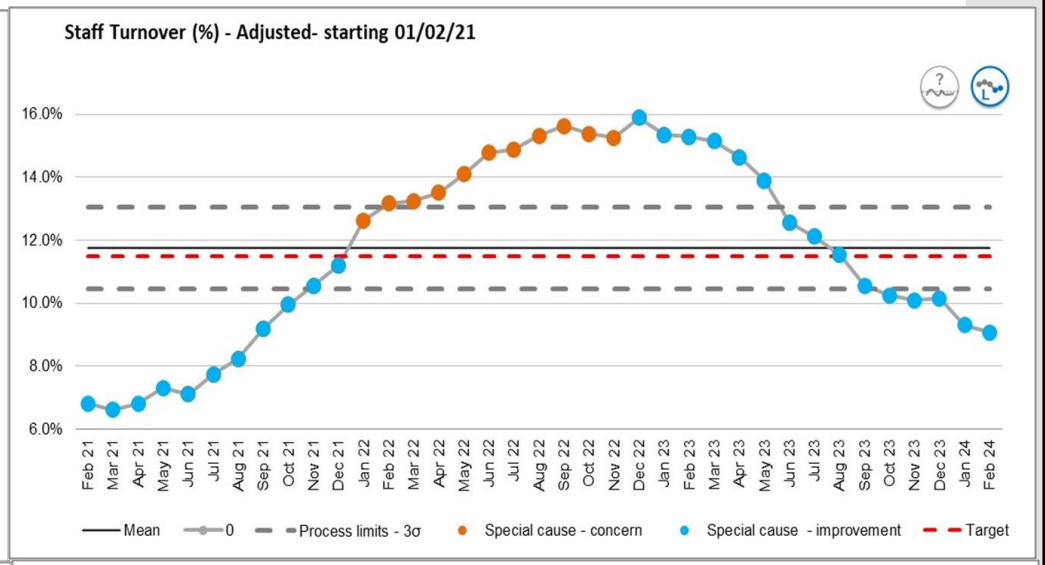
- Meetings with occupational health are fortnightly and assurances have been provided around improving their turnaround times which will support both time to hire figures and support staff with their health.
- New Medical Staffing Advisor will support the recruitment process for medical staff.

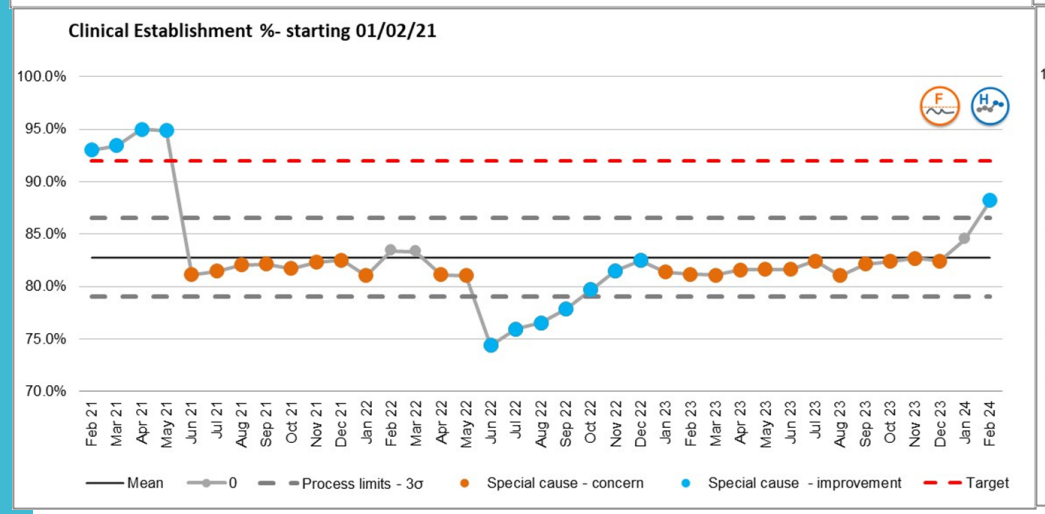
20. Workforce

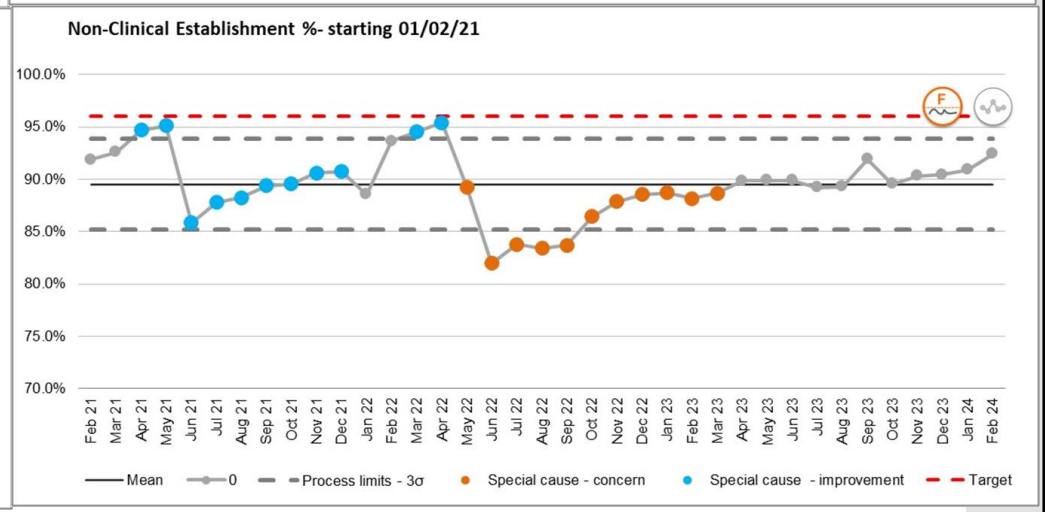
Trust Workforce Metrics	Jan-24	Feb-24	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1398	1417	19	-	-
Staff In Post - Full Time Equivalent	1235.39	1253.30	17.90973	-	-
Staf Turnover % - Unadjusted	10.81%	10.59%	-0.22%	↓	<=11.5%
Staf Turnover % - Adjusted	9.31%	9.07%	-0.24%	↓	<=11.5%
Total WTE Employed as % of Establishment	86.79%	89.74%	2.95%	↑	>=93%
Total WTE Employed as % of Establishment - Clinical	84.47%	88.21%	3.74%	↑	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	90.91%	92.43%	1.52%	↑	>=96%
% Of Attendance	92.99%	94.16%	1.17%	↑	>=96.3%
% Of 12 mth MAA Attendance	93.81%	93.85%	0.04%	↑	>=96.3%
% Staff received mandatory training last 12 months	88.12%	87.69%	-0.43%	↓	>=93%
% Staff received formal PDR/appraisal last 12 months	71.00%	68.90%	-2.10%	↓	>=95%
% of Sickness - Trust wide Long-term	4.34%	3.48%	-0.86%	↓	-
% of Sickness - Trust wide Short-term	2.68%	2.81%	0.13%	↑	-
Return To Work Completion %	69.85%	63.21%	-6.64%	↓	>=80%

20. Workforce

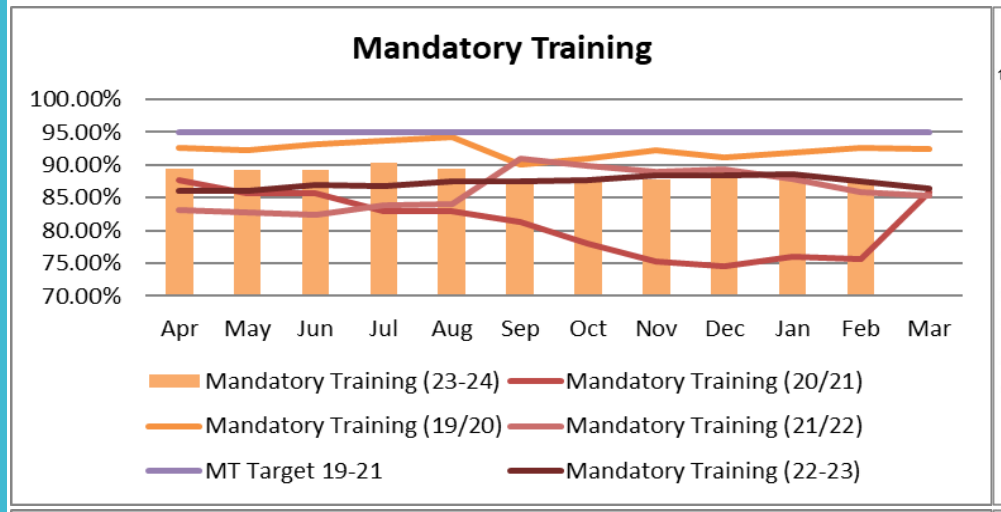


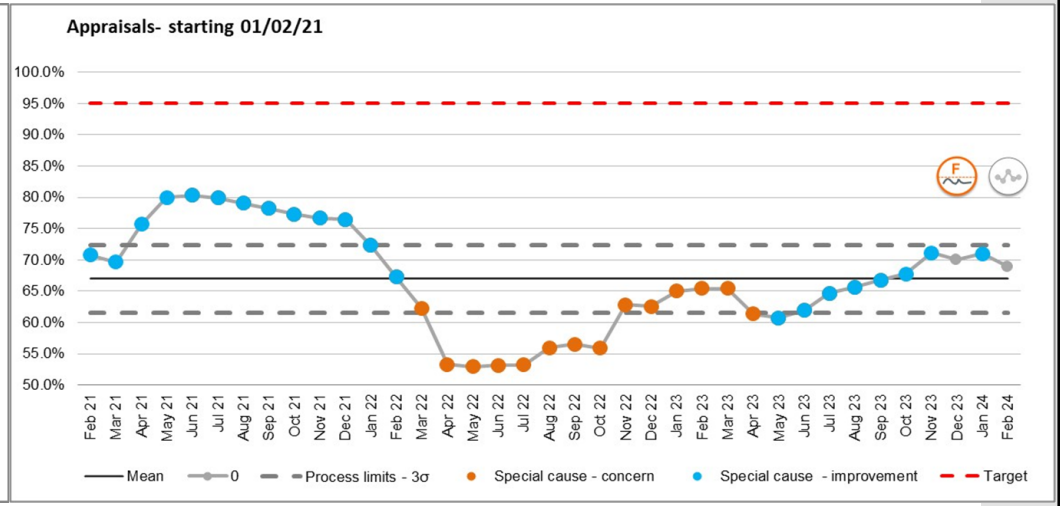


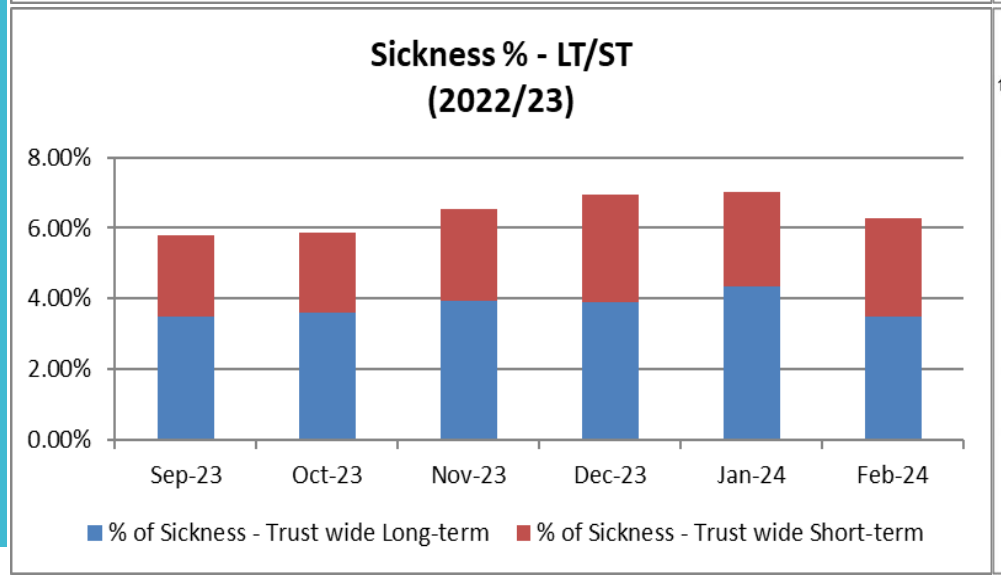


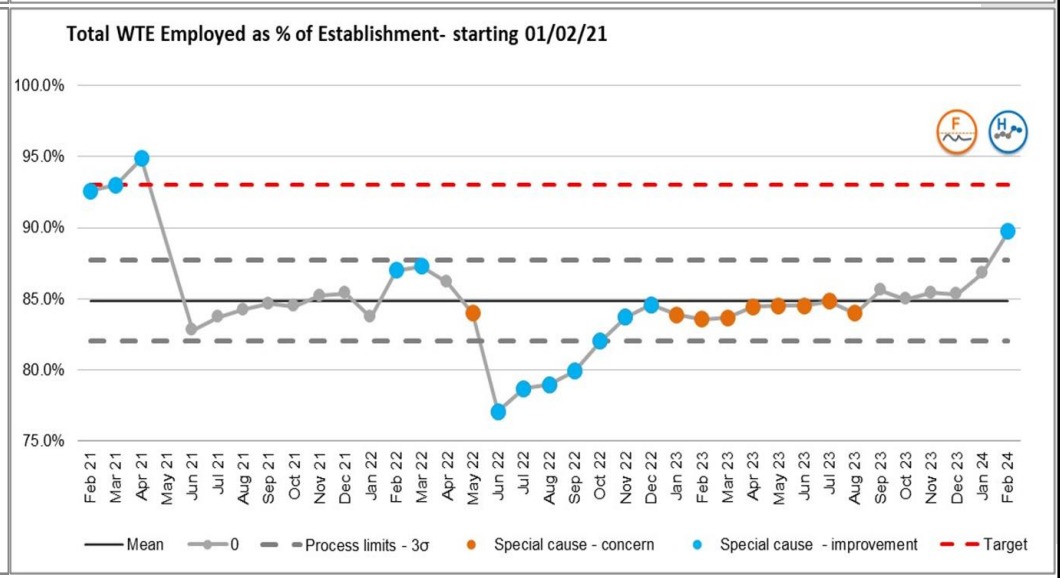


20. Workforce









The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY AND SAFETY REPORT

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

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	2022/2023	2023/24
Incidents	292 (↑)	374 (↑)	269(↓)	378 (↑)	341 (↓)	323 (↓)	297 (↓)	411 (↑)	354 (↓)	354	303 (↓)	297 (↓)	356 (↑)		
Serious Incidents	2 (↑)	0	1(↑)	1	0	0	0	0	0	0	0	1 (↑)	0	8	3
Inpatient Deaths	0	0	0	1 (↑)	0	1 (↑)	0	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	7 (↑)	5 (↓)	12(↑)	9 (↓)	7 (↓)	7	8 (↑)	8	7 (↓)	8 (↑)	6 (↓)	6	10 (↑)	79	88
Pressure Ulcers: Cat 2 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	5	0
Pressure Ulcers: Cat 3 (Avoidable)	1	0	0	0	0	0	0	0	0	0	0	0	0	2	0
Infections	1 (↑)	0	0	0	1 (↑)	1	2	1	0	1	1	1	0 (↓)	9	8
Complaints	4 (↑)	1 (↓)	3(↑)	2 (↓)	2	5 (↑)	1	3	3	3	1 (↓)	4 (↑)	7 (↑)	45	34
Litigation	2 (↑)	2	0	0	0	3 (↑)	0	0	1 (↑)	0	0	0	0	9	4
Coroners	0	0	0	1 (↑)	0	1 (↑)	0	0	0	1	0 (↓)	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 February 2024, there were a total of **356** Incidents reported on the Ulysses Incident Management System. The breakdown of those incidents is as follows;

No Harm = 271
Low Harm = 75
Moderate Harms = 6
Severe Harm = 0
Near Miss = 4

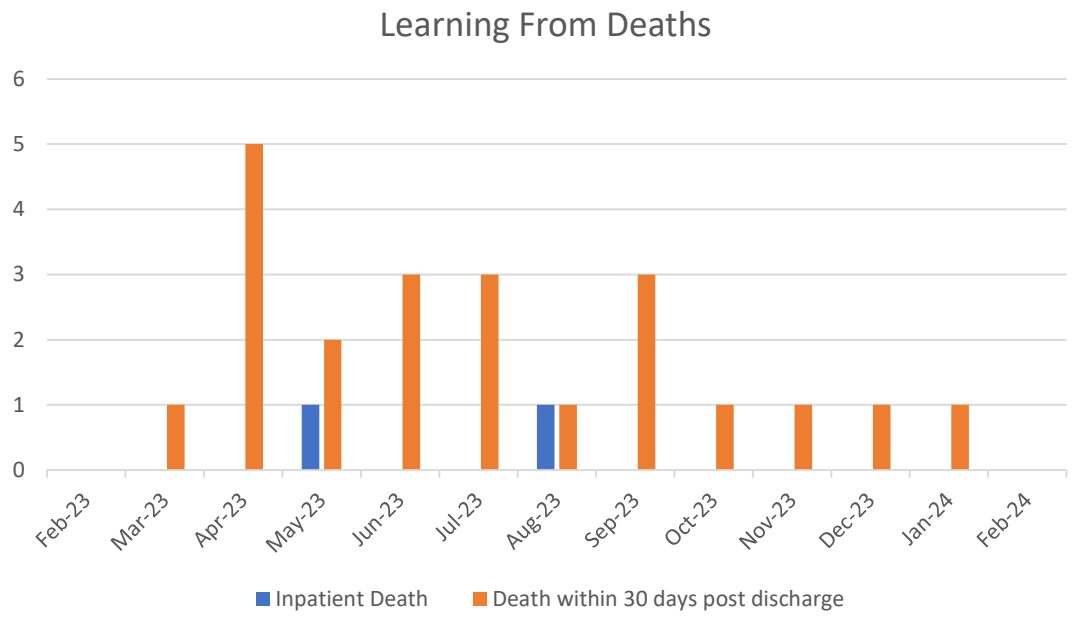
3. Patient Deaths

Inpatient Deaths

There were 0 inpatient deaths reported during February 2024

Deaths within 30 days post discharge

There were 0 patient deaths that occurred within 30 days post discharge during February 2024.



4. Serious Incidents

There were 0 Serious Incidents reported in February 2024.

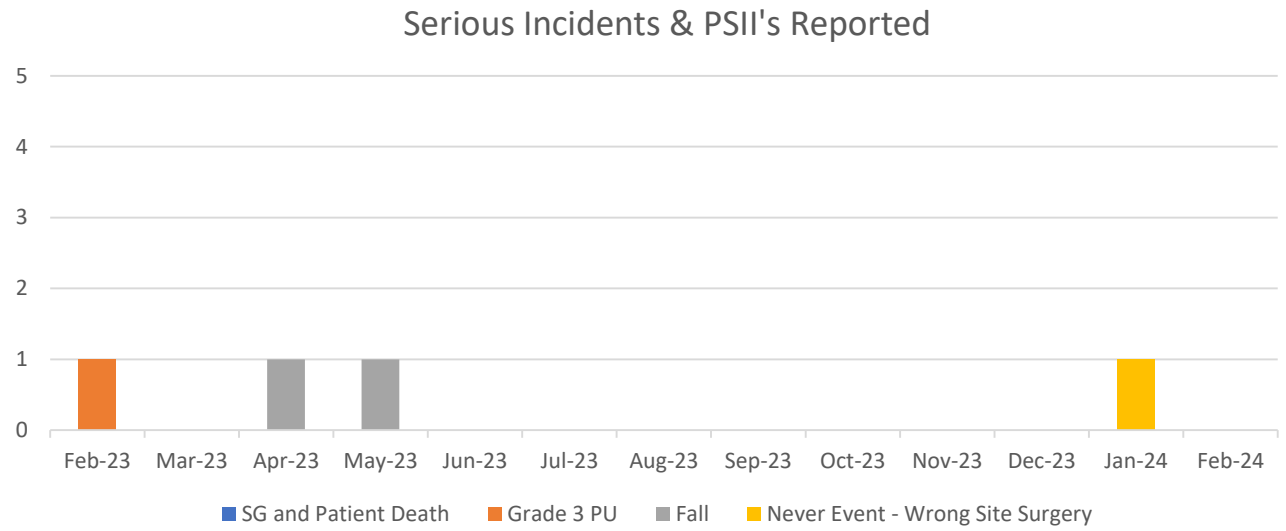
Update:

Wrong Site Surgery Never Event

Reported on 24.01.2024 - Joint ROH /UHB Pathway patient.

In line with Trust PSIRF Plan a PSII investigation is in progress. The final draft has been received and is on the division 2 governance agenda for discussion and sign off.

Incident has been reported to BSOL ICB as per usual STEIS process



5. Potential Moderate Harm & Severe Harm Incidents

There were **6 potential Moderate Harm** incidents and **0 potential Severe Harm** incident reported in February 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 12** – SSI related Incident
- **1 x Ward 2 –** SSI related Incident
- **1 x Large Joints –** Delay in Appointment
- **1 x Appointments –** Delay in Appointment
- **1 x Ward 2** – Medical Emergency
- **1 x Recovery** – Transfer within Trust/Failure/Delay

6. Update on Moderate Harm Incidents from January 2024

There were 8 potential Moderate Harm incidents reported in January 2024. An update on each of these incidents can be found below:

- **1 x Ward 1** – SSI related Incident - **Remains as Moderate Harm**. IPC, using new IPC PSIRF Framework, have completed review. No further action required.
- **1 x Ward 3 –** SSI related Incident - **Remains as Moderate Harm**. IPC, using new IPC PSIRF Framework, have completed review. No further action required.
- **1 x Spasticity –** Medication - **Remains as Moderate Harm and under review**. Clinic outcome and decision-making documentation has been requested for review.
- **1 x Spinal –** Potential Wrong side block - **Remains as a Moderate Harm**. MDT Meeting has taken place, confirmed not to a Never Event. Awaiting minutes and actions to add to Ulysses.
- **1 x OPD** – VTE - **Remains as a Moderate Harm**. VTE RCA is in progress.
- **1 x OPD** – Emergency Transfer into Trust - **Remains as a Moderate Harm**. All actions taken were appropriate and managed well. No further action required.
- **2 x Ward 3** – VTE - 2nd incident is a duplicate Incident - **Remains as a Moderate Harm.** Patient was a transfer elsewhere, where they had acquired the VTE. VTE diagnosed within 24 hours of transfer therefore being investigated by other hospital.

Summary of Potential Severe Harm Incidents

- **1 x Emergency Transfer Out -** Cardiac arrest & subsequent death - **Remains as Severe Harm.** Final draft of AAR received and added to division 2 governance agenda for discussion and sign off. Report will then be provided to the Coroner.

7. Near Miss Incidents

There were 4 Near Miss incidents reported in February 2024

All incidents have been tabled at Divisional Governance Meetings.

Summary of Incidents

- **1 x Discharge Lounge** – Medication (Wrong Drug) - Incident remains under review.
- **1 x Large Joints** –Clinical Documentation And Health Records (Patient ID Issue) - Incident remains under review.
- **1 x Large Joints** – Clinical Assess/care (Diag, Scans, Tests) - Incident remains under review.
- **1 x Oncology** – Communication Issues (Not Meeting Patients Communication Needs) - Incident remains under review.

8. Learning from Incidents

There were **2** RCAs closed in February 2024**.**

Ward 2 VTE - Outcome - Unavoidable

Actions / Recommendations: To Continue to adhere to trust VTE guidelines, training staff as necessary, sharing the learning from the incidents with all staff on the departments as routine

Ward 2 VTE - Outcome - Unavoidable.

Actions / Recommendations: None present on this occasion. Patient was increased risk of Pulmonary Embolism due to Plaster of Paris and limited mobility pre-operatively and post-operatively, these were unavoidable factors.

9. Venous Thromboembolism (VTE) Incidents

There was **1 VTE incident** reported in February 2024. The incident is under investigation using the new PSIRF Framework template.

<u>Update on Previously Reported VTE Incidents:</u>

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

The 3rd January VTE incident remains under investigation by ROH, Provisional conclusion pending sign off at Divisional Governance is that it was unavoidable VTE.

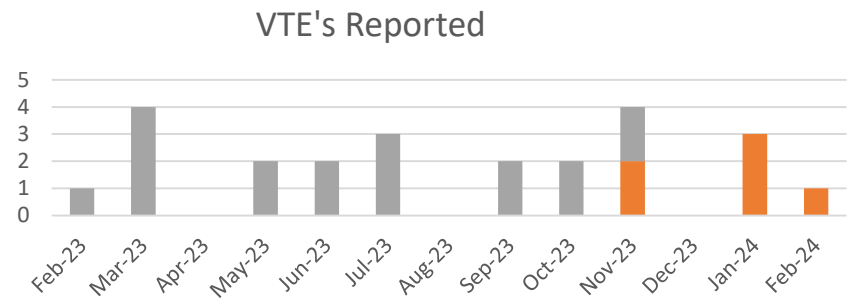
Of the 4 VTE incidents reported in November 2023 2 remain under investigation. Provisional conclusion pending sign off at Divisional Governance is that they were both unavoidable.

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

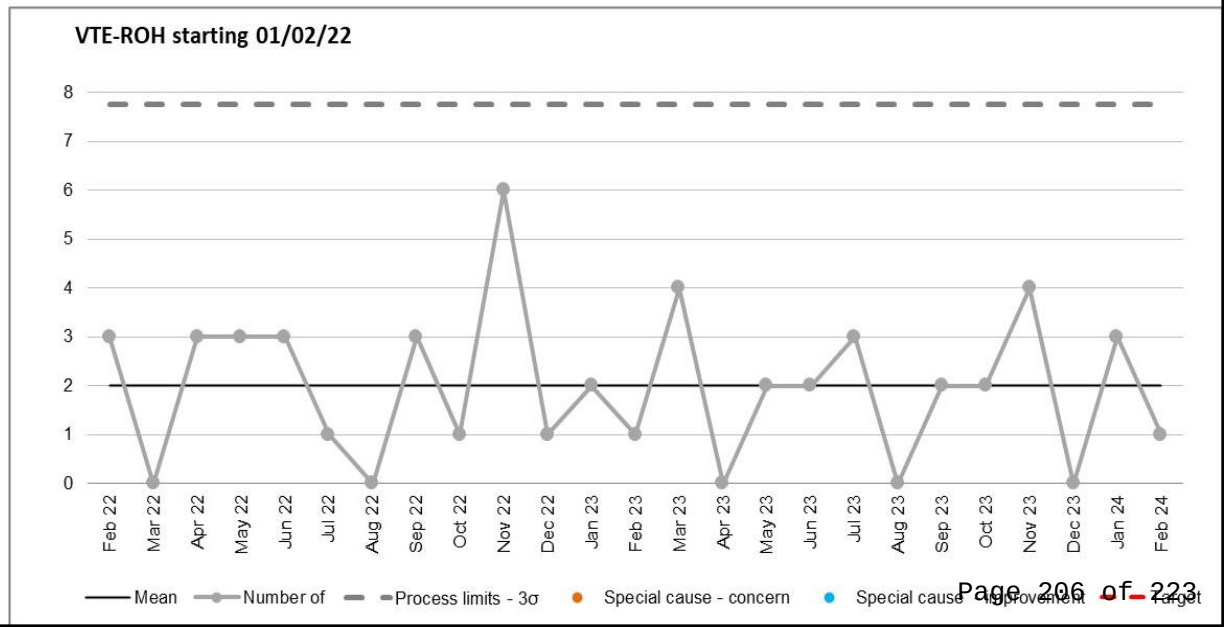
Compliance figure for February 2024 = **98.97%**

<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.



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



10. Falls

10 Inpatient falls incidents reported in February 2024

No Harm = 10

Trends

8 of the falls involved patients deemed safe to mobilise however became unstable.

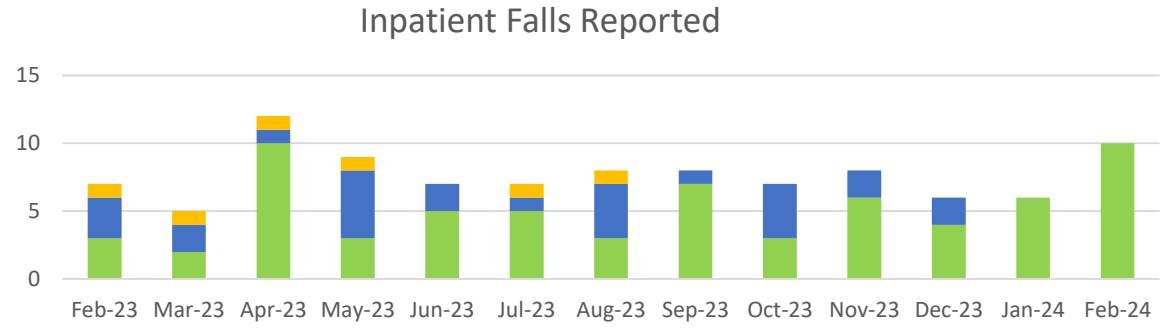
2 of the falls involved patients mobilising against advice.

6 were unwitnessed falls.
1 was a witnessed fall when patient slipped on wet floor after washing hands.
1 was a patient fall when attempting to transfer from wheelchair to car.

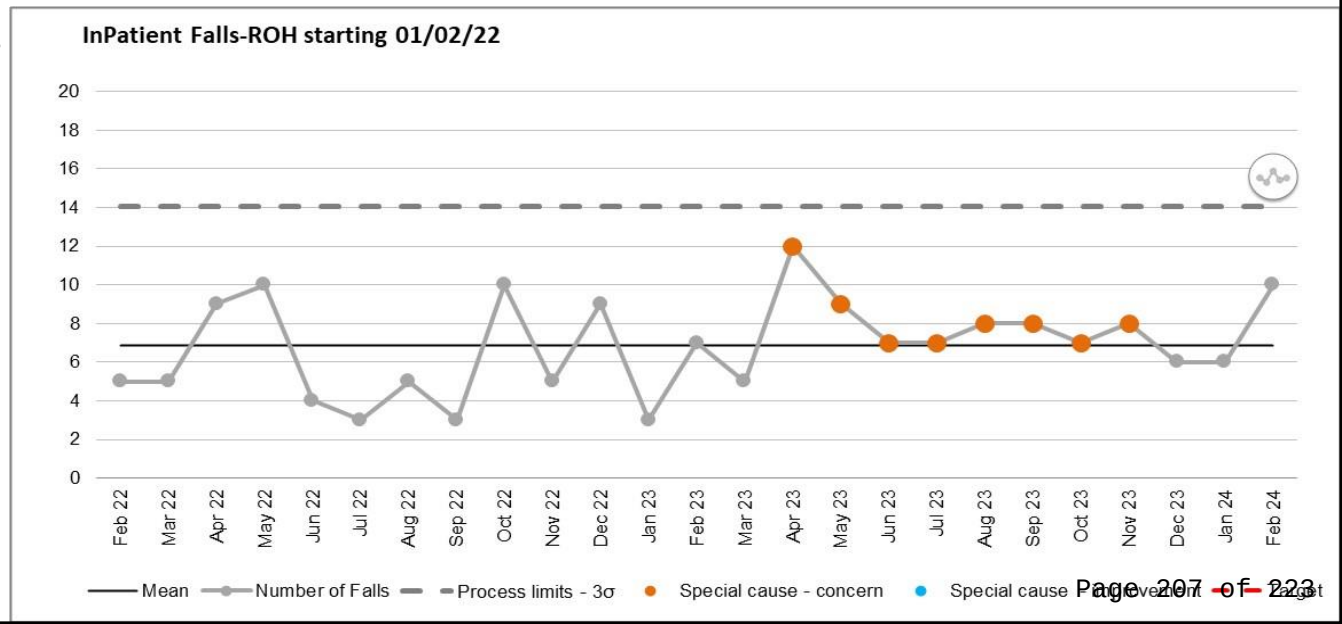
There is a slight increase in falls this month, however there are no significant themes to these falls.

Quality Improvement Work Underway

- Reviewing bed rails risk assessment in conjunction with Rebecca Hipwood, Patient Safety Lead
- Planned walk round with Estates team to identify outstanding work needed in relation to falls & dementia



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



11. Pressure Ulcers

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

1 Category 2 PU incidents reported in February 2024.

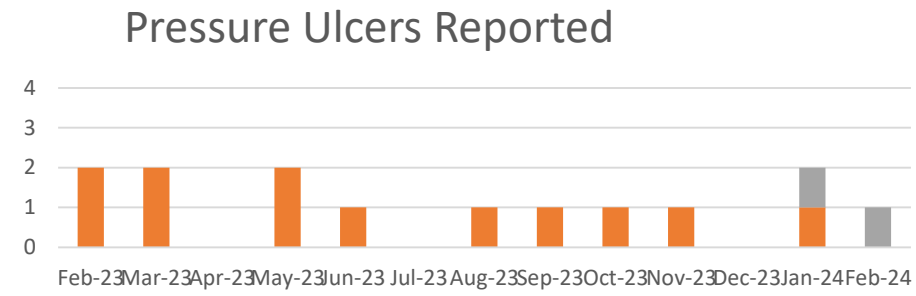
1 x Ward 1 – Remains under review

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

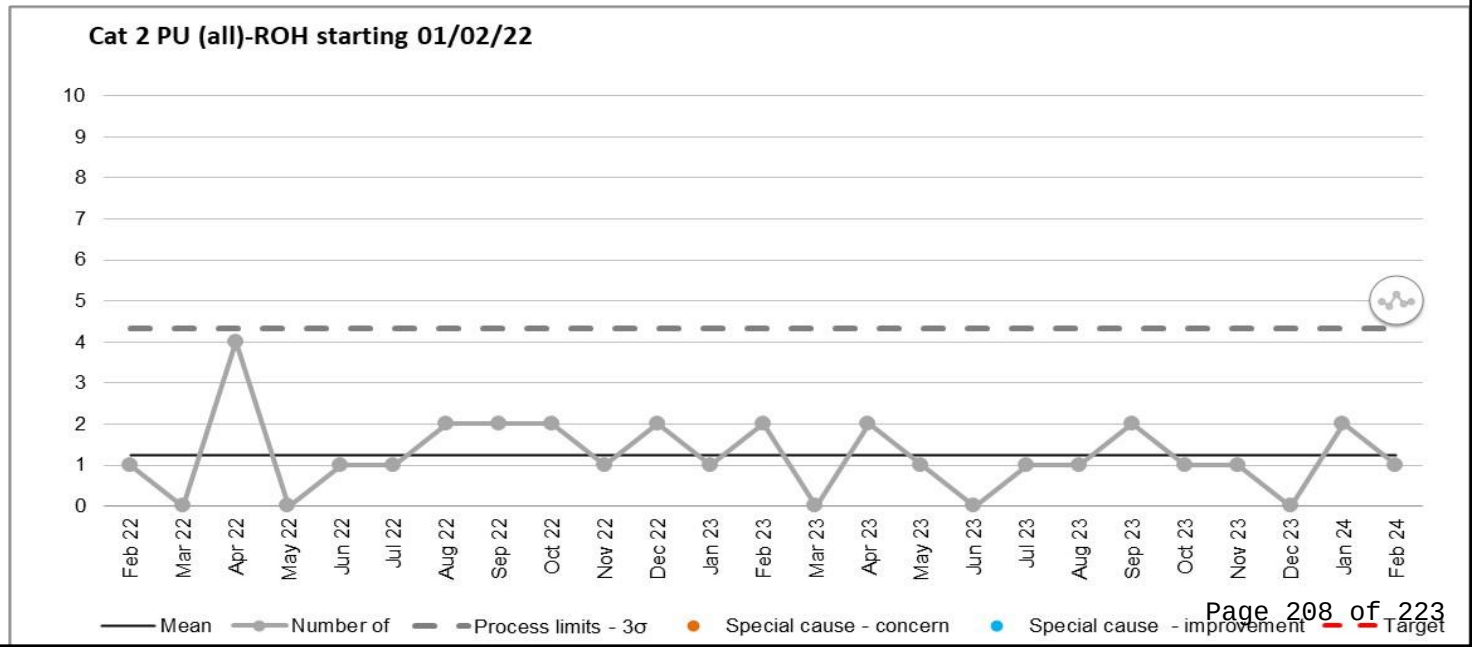
New NWCSP "Pressure Ulcer Recommendations and Clinical Pathway" have been released. Changes will need to be made to the PU categorisation and reporting process. TVN Lead undertook a gap analysis and sent summary report to Clinical Quality Group on 05/02/24. Task and finish group to be arranged to discuss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

Post-op dressing collaborative (TV and ROCS) work discussed at Board on 6/3/24 and well received.



	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Sum of TBC	0	0	0	0	0	0	0	0	0	0	0	1	1
Sum of Unavoidable	2	2	0	2	1	0	1	1	1	1	0	1	0
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)	February 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	0	3
Klebsiella spp. bloodstream infection	0	0
Pseudomonas aeruginosa bloodstream infection	0	0

Actions underway:

- Theatre focus group has changed into Surgical Site Prevention Group – focusing on the ‘one together’ approach to reducing SSI’s and infections.
- IPC lead has been leading improvement work around high impact audits and refreshing local education. Documentation was flagged as an area for improvement. Specific work in recovery to address gaps.

Complaint Information

The Trust received **7** complaints in February 2024

Complaints by department in February 2024

- Spinal x3
- Ward 1 x2
- Large Joints x1
- Paediatrics x 1

In February 2024, the complaints team closed **2** formal complaints on time.
At the time of producing this report there are **11** open formal complaints. (1 complaint is being managed under the 'resolution meeting' request and 1 complaint relates to private patient.
Extended complaint agreed via Triumvirate : 1 due to complexity. Patient made aware.

Complaints open by department:

- Spinal x 4
- Paediatrics x 1
- Large Joints x 2
- Ward 1 x 2
- Private Suite x 1

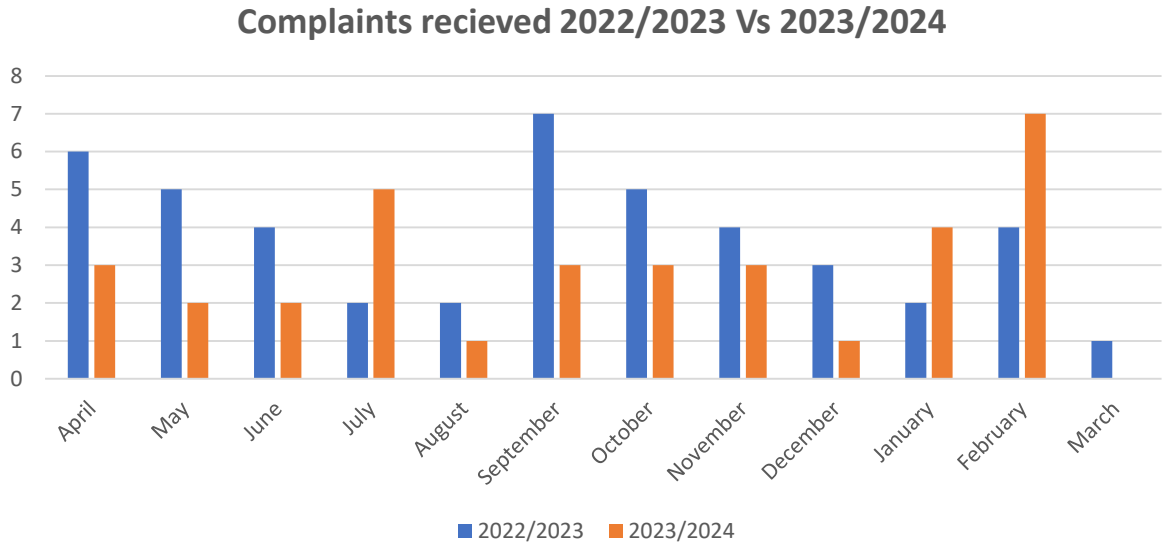
No complaints received where the complainant disclosed that they or their close family were Veterans or Current members of the Armed Forces.

Complaint Resolution Meetings

The Trust offers resolution meetings to all complainant in both the verbal and written acknowledgement correspondence. 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 an improved quality of response letter

In February, the Trust received **0 reopened complaints.**
In February 2024, the Trust received **1 request for a resolution meeting.** This case is currently still ongoing

Complaints



The above table shows that so far this year, overall we have received fewer formal complaints compared to 2022/2023.

Complaint Year Totals	
April 2022- March 2023	45
April 2023 – February 2024	34

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%
February 2024	100%

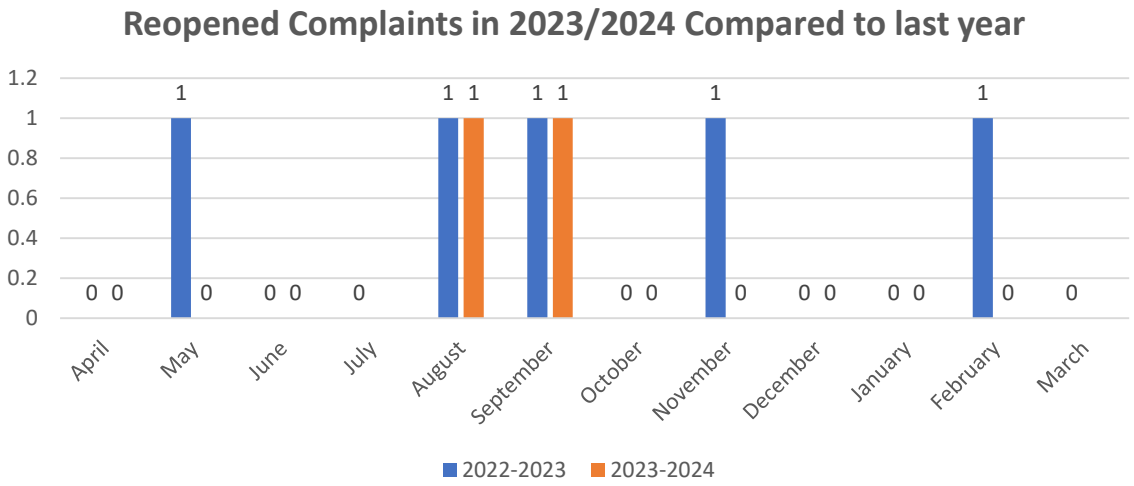
0%-79%
80%-90%
91%-100%

100% of KPI's were met. 2 complaints were received and closed on time. In one complaint information was collated and completed by the complaints team

Actions from Complaints

- In February 2024 - 2 actions were identified, both of which remain open
- No Immediate action plans were completed by the triumvirate for any of the complaints received in February.
- In total, we currently have 5 open actions for 3 different complaints. 2 are for OPD, 2 are for Oncology and 1 is for Paediatrics. These are reviewed in the bi-weekly governance meetings.

Complaint Themes



Reopened complaints

The Trust received no requests to reopen complaints in February 2024. This can be attributed to the complaints previously resolved being managed to the complainant's satisfaction.

PHSO Cases

The Trust currently has no PHSO complaints cases open.
The previously open case was closed in March 2024 following the PHSO advising The Trust that they will not be taking any further action.

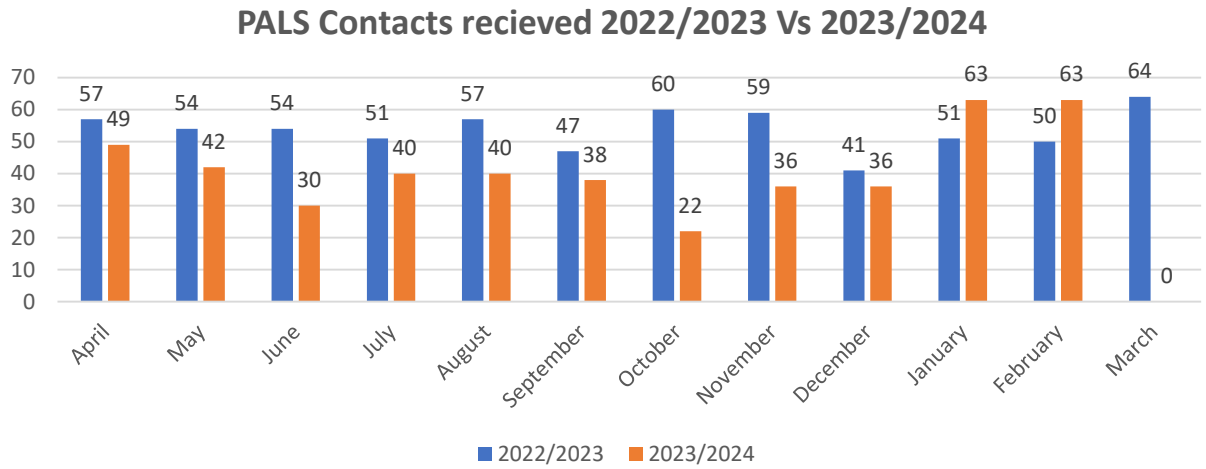
Themes

1. Values and Behaviours
2. Clinical Query

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. Requesting updates on outstanding actions in bi-weekly governance meetings

Patient Advice and Liaison Service – PALS



The above graph shows that so far this year overall The Trust has received less PALS contacts in comparison to last year. This is due to the PALS department practicing early resolution where possible and dealing with concerns within the PALS Department before escalating to the specialities. However, it should be noted that there has been a marked increase in concerns raised over the last 2 months.

PALS KPI's

KPI	PALS Contacts %
April 2023	85%
May 2023	93%
June 2023	90%
July 2023	88%
August 2023	50%
September 2023	36%
October 2023	50%
November 2023	56%
December 2023	82%
January 2024	68%
February 2024	64%

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

The KPI for PALS Contacts have not been met (90%) since May 2023.
This is primarily due to the lack of, or delayed responses from the specialities.

PALS Themes

- Clinical Query- 17 out of 63 received
- **Specifically: Request for second opinion**
- Appointments – 16 out 63 received
- **Specifically: Appointment cancelled**

What we have done

- Tracked in Executive Governance Meetings
- Raised in Governance meetings and with departmental managers.
- Escalation to ensure PALS cases are responded too.
- Head of Patient Experience sending out individual reminders on outstanding PALS

No PALS Cases were received where the complainant disclosed that they or their close family were Veterans or Current members of the Armed Forces.

15. Litigation and Coroners

New claims

0 new claims were received in February 2024.

Pre-Application Disclosure

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

Coroner's Inquests

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

16. WHO Surgical Safety Checklist

Theatre Audit

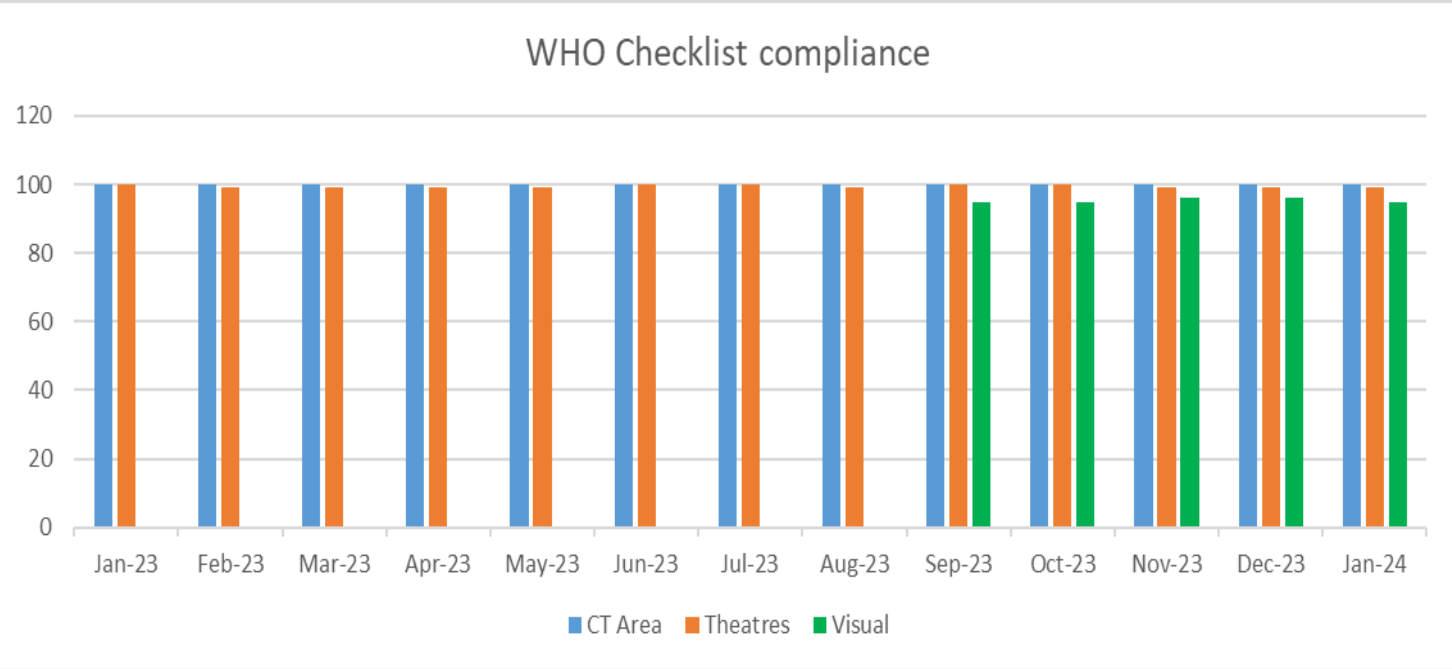
	Scores	Percentages
Team Brief	895/895	100%
Sign In	895/895	100%
Time Out	895/895	100%
Sign Out	895/895	100%
Team Debrief	893/895	99%
Total	895/895	99%

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%



Actions:

- Visual audit continue to ensure compliance.
- Risk identified : Theatreman Aqua update has been stalled. Plans are been worked up to review how improvements can be made without the update.

17. CAS Alerts

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

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2024/003/DHSC_MVA	Shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials. A Medicines Supply Notification (MSN) issued on 14 February 2024, detailed a shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid. The resolution date is to be confirmed. The supply issues have been caused by a combination of manufacturing issues resulting in increased demand on other suppliers. Terbutaline, salbutamol with ipratropium, and ipratropium nebuliser liquids remain available, however, they cannot support an increase in demand. Ventolin (salbutamol) 5mg/ml nebuliser liquid (20ml) is out of stock until mid-April 2024 and cannot support an increased demand after this date. This National Patient Safety Alert provides further background and clinical information and actions for providers.	National Patient Safety Alert – DHSC	26-Feb-24	Action Completed **Email from Chief Pharmacist:** *'have ordered more stock to get through shortage period. Alert forwarded to MSO'.*	8 Mar 203 Actions completed.
CEM/CMO/2024/001	Valproate: important new regulatory measures for oversight of prescribing to new patients and existing female patients The harmful effects of prenatal exposure to valproate are well documented. Following a review, the Commission on Human Medicines has recommended further restrictions to valproate use to reduce avoidable harm which were introduced by the MHRA in January.	CMO Messaging	21-Feb-24	Forwarded to Chief Pharmacist.	Response not required

17. Cas Alerts Continued - Outstanding Alerts from Previous Month

Paper attached with action plan.

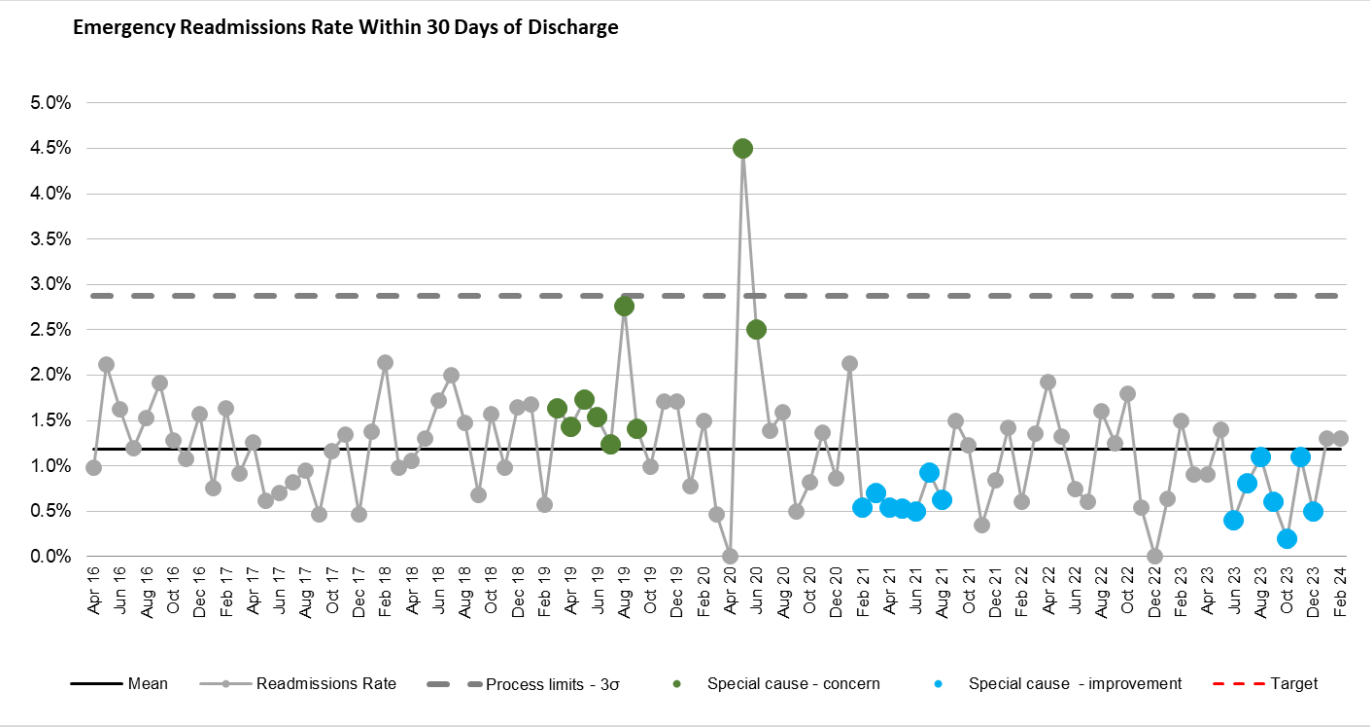
Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2023/010/MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls. The MHRA continues to receive reports of deaths and serious injuries from entrapment or 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. On-going…

18. Safeguarding

KPI	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Safeguarding Adult Notifications	35	17	43	21	44	43	47	37	47	58	65		72
Safeguarding Children Notifications	76	23	37	29	55	51	42	25	35	40	45		45
Adult Level 2 - 85%	80.28% (↓)	80.19% (↓)	82.27% (↑)	83.12% (↑)	84.68% (↑)	86.22% (↑)	86.22%	85.48% (↓)	86.86% (↑)	88.7% (↑)	88.97% (↑)		89.03% (↑)
Adult Level 3 - 85%	75.2% (↓)	76.37% (↓)	77.84% (↑)	80.15% (↑)	83.02% (↑)	83.11% (↑)	82.06% (↓)	83.15% (↑)	83.83% (↑)	86.03% (↑)	84.11% (↓)		83.99% (↓)
Level 4 - 90%	60% (↓)	80.0% (↑)	80.00%	80.00%	80.00%	100% (↑)	100% (↑)	100.00%	80% (↓)	80.00%	80.00%		60% (↓)
Child Level 2 - 85%	79.93% (↓)	79.85% (↓)	82.18% (↑)	82.86% (↑)	84.68% (↑)	86.14% (↑)	86.12% (↓)	85.23% (↓)	86.7% (↑)	88.46%(↑)	88.89% (↑)		88.89%
Child Level 3 - 85%	75.2% (↓)	76.37% (↑)	78.03% (↑)	80.15% (↑)	82.82% (↑)	83.11% (↑)	81.68 (↓)	82.8% (↑)	83.46% (↑)	85.84% (↑)	83.96% (↓)		83.99% (↑)
Mental Capacity Act MCA - 85%	80.19% (↓)	80.36% (↑)	82.44% (↑)	83.21% (↑)	84.85% (↑)	86.39% (↑)	86.35% (↓)	85.88% (↓)	87.11% (↑)	88.62% (↑)	88.97% (↑)		89.19% (↑)
Deprivation of Liberty Safeguards DoLs - 85%	79.93% (↓)	79.93%	82.09% (↑)	82.95% (↑)	84.68% (↑)	86.22% (↑)	86.27% (↑)	85.63% (↓)	86.95% (↑)	88.54%	88.89% (↑)		89.12% (↑)
Prevent Awareness - 90%	89.40%	88.96%	90.14%	89.86%	90.49%	91.24% (↑)	91.32% (↑)	89.98% (↓)	94.48% (↑)	91.38%	90.33% (↓)		89.35% (↓)
WRAP (prevent level 3) - 85%	78.55% (↓)	80.2% (↑)	82.19% (↑)	83.89% (↑)	85.68% (↑)	87.89% (↑)	87.41% (↓)	86.15% (↓)	85.51% (↓)	86.25% (↑)	85.22% (↓)		81.21% (↓)
FGM	2	1	3	0	1	0	5	2	3	1	1		2
DOLS	4	0	7	0	6	4	4	2	5	3	6		5
MCA	0	1	3	4	1	4	2	7	5	6	7		13
PIPOT cases	1	0	0	0	0	1	0	0	0	0	1		0
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0	0		0

Actions underway: Level 4- drop relates to new staff within the SG team requiring training.
Level 3- HON's managing team to ensure compliance improves.

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



Actions underway:

	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
No of Readmissions	5	4	7	2	4	5	3	1	6	3	6	7
Denominator	546	465	494	554	482	469	492	543	553	559	462	545
% Readmissions	0.9%	0.9%	1.4%	0.4%	0.8%	1.1%	0.6%	0.2%	1.1%	0.5%	1.3%	1.3%

20. Freedom to Speak Up Update

Concerns Raised

There were 14 concerns raised February 2024; there were in relation to the following:

Worker safety and wellbeing - concerns regarding long term illness and staff retention, there is a perception that this is influencing worker wellbeing, stress level and feeling overworked.

Learning and Outcome: Reported to the relevant department manager and awaiting outcome.

Attitude and Behaviour - poor communication and support between manager and staff, negative behaviour between colleagues, perception of racial discrimination.

Learning and Outcomes:

Attitude and behaviour issues escalated to relevant managers, issues resolved through discussion, clarification, and apologies.
Wider on-going collaborative work with HR to review how Conflict Resolution Training could be tailored to improve attitude and behaviour in the organisation. Waiting for this to be rolled out.

Operational Performance

February 24

Operational Performance Summary

Performance to end February 24	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	49.77%	50.65%	92%		
104 week waits	0	0	0		
78+ week waits	0	0	0		
65 Week waits (65-77 weeks)	68	83	0		
52 week waits (52 – 64 Weeks)	414	428	0		
All activity YTD (compared to plan)	13,190	11,902	13,005		
Outpatient activity YTD (compared to plan)	60,545 100.7% Cumulative	55,304 100.9% Cumulative	60,111 YTD Target		
Outpatient Did Not Attend (YTD)	7.0%	7.6%	8%		
PIFU (trajectory to 5% target)	447 8.8%	490 8.6%	184 5%		
Virtual Consultations (target is plan, operational planning guidance is 25%)	10.7%	10.5%	19%		
FUP attendances(compared to 19/20)	90.4%	90.5%	75%		
Diagnostics volume YTD (compared to 19/20) – All Modalities	110.0%	109.5%	120%		
Diagnostics volume YTD (compared to plan)	23,144 Cumulative	20,660 Cumulative	17,222 YTD Target		
Diagnostics 6 week target	99.9%	99.3%	99%		

Operational Performance Summary

Performance to end February 24	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (Uncapped)	92.5%	82.0%	85%		
Cancer - 31 day first treatment	93.7%	100%	96%		
Cancer - 62 day (traditional)	85.7%	85.7%	85%		
28 day FDS	87.9%	75.3%	75%		
Patients over 104 days (62 day standard)	0	0	0		No Target
POAC activity volume (YTD)	23,415 Cumulative	21,257 Cumulative	21,184 Cumulative		
Bed Occupancy (excluding CYP and HDU)	73.7%	62.6%	82-85%		
LOS - excluding Oncology, Paeds,YAH, Spinal	3.37	3.16	n/a		No Target
LOS - elective primary hip	3.10	2.90	2.7		
LOS - elective primary knee	3.10	2.80	2.7		
BADS Daycase rate (Note: due to time lag in month is Nov'23)	74.0%	77.0%	85%		