The Royal Orthopaedic Hospital NHS Foundation Trust

12th May 2023

Notice of a meeting of the Council of Governors

Notice is hereby given to all members of the Council of Governors of the Royal Orthopaedic Hospital NHS Foundation Trust that a meeting of the Council of Governors will be held on Thursday, 18th May 2023, at 14:00, to transact the business detailed on the attached agenda.

The meeting will be held in the Boardroom, Trust Headquarters of The Royal Orthopaedic Hospital, Bristol Road, Birmingham, B31 2AP.

Members of the press and public are welcome to attend.

Questions for the Council of Governors should be received by the Corporate Services Manager no later than 24hrs prior to the meeting, by post to: Jane Dominese, Trust Headquarters or via email to: jane.dominese@nhs.net

Tim Pile
Chair

Public Bodies (Admissions to Meetings) Act 1960

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

The Royal Orthopaedic Hospital NHS Foundation Trust

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Notice is hereby given to all members of the Council of Governors of the Royal Orthopaedic Hospital NHS Foundation Trust that the following meeting of the Governors will be held in the Boardroom, Trust HQ, on Thursday 18th May 2023. The plan for the session is as follows:

Meeting	**Timing**
Pre-meet and lunch, including the opportunity for governor photographs for the Trust website. Boardroom, Trust HQ	13:00 – 14:00
Meeting in Private	14:00 – 14:35
Meeting in Public	14:35 – 16:00

The business to be transacted is provided on the agenda enclosed.

Tim Pile
Chair

The Royal Orthopaedic Hospital NHS Foundation Trust

AGENDA
COUNCIL OF GOVERNORS

Venue: Boardroom **Date:** 18th May 2023 14:00 – 16:00

TIME	ITEM	TITLE	PAPER REF	LEAD
14:00	1	Exclusion of the press and public	Verbal	Chair
14:02	2	Non Executive appraisals	Verbal	Chair
14:20	3[#1]	DRAFT Annual Governance Statement and Accounts	ROHGO (5/22) 003	SGL/ SWa
14:35	4	Apologies and welcome	Verbal	Chair
14:37	5	Declarations of interest	Verbal	ALL
	6	Minutes of previous meetings on 19 January 2023	ROHGO (01/23) 006	Chair
	7	Update on actions arising from previous meetings	Verbal	SGL
14:40	8	Chair and Chief Executive's update	Presentation	TPi/JWi
15:00	9	Elective Hub Accreditation	ROHGO (5/23) 009	MHu
15:15	10	Quality Account Priorities a) 2022/23 Progress b) Proposed 2023/24	 ROHGO (5/23) 010 (a) ROHGO (5/23) 010 (b)	NBr
15:30	11	Learning & Disability Autistic Strategy	Presentation	Florence Dowling
15:40	12	Updates from the Board and Board Committees a) Finance & Performance Committee b) Quality and Safety Committee c) Staff Exeprience & OD Committee d) Audit Committee e) Trust Board	 ROHGO (5/23) 012 (a) ROHGO (5/23) 012 (b) ROHGO (5/23) 012 (c) Verbal ROHGO (5/23) 012 (d)	Chair & NEDs
15:50	13	Governor updates: a) Governor Walkabout Plans b) Governor elections update	 Verbal Verbal	JDo SGl
	14	For information: a) Finance & Performance update b) Quality & Patient Safety update c) Workforce update d) Board Assurance Framework	 ROHGO (5/23) 014 (a) ROHGO (5/23) 014 (b) ROHGO (5/23) 014 (c) ROHGO (5/23) 014 (d)	Chair
16:00	**Close**			
	Date of next meeting: Thursday 23rd November @ 1400h – 1600h at Trust Headquarters			

[#1] Public, CEO and Non Executives join meeting

MINUTES

Council of Governors - Version

Venue Board Room, Trust Headquarters **Date** 19 January 2023 @ 1400 - 1530h

Members present

Tim Pile	Trust Chair	TP
Brian Toner	Lead Governor	BT
Petro Nicolaides	Public Governor	PN
Tony Thomas	Public Governor	TT
Rheya Dole	Public Governor	RD
Anne Waller	Public Governor	AW
Arthur Hughes	Public Governor	AH
Robert Rowberry	Public Governor	RR
Gavin Newman	Staff Governor	GN
David Robinson	Stakeholder Governor	PS
Hannah Abbott	Stakeholder Governor	HA
Dr Dagmar Scheel-Toellner	Stakeholder Governor	DS-T

In attendance

Simone Jordan	Non Executive Director	SJ	
David Gourevitch	Non Executive Director	DG	
Richard Phillips	Non Executive Director	RP	
Gianjeet Hunjan	Non Executive Director	GH	
Ayodele Ajose	Non Executive Director	AO	
Les Williams	Non Executive Director	LW	
Chris Fearns	Non Executive Director	CF	
Jo Williams	Chief Executive	JW	
Simon Grainger-Lloyd	Director of Governance	SGL	[Secretariat]

Minutes	**Paper Ref**
1 Apologies and welcome	**Verbal**
Apologies were received from Rob Talboys, Pat Clarke, Julia Liddle, Petro Nicolaides, Wilson Thomas, Gianjeet Hunjan and Ian Reckless.	
2 Declarations of interest	**Verbal**
There were none.	

3 Minutes of previous meeting on 21 November 2022	**ROHGO (11/22) 015**
The minutes of the meeting held on 21 November 2022 were accepted as a true and accurate reflection of discussions held.	
4 Update on actions arising from previous meetings	**Verbal**
The Director of Governance reported that the two key actions concerned re-engaging the governors following the lull created by the pandemic and secondly to present a gap analysis against the new requirements on governors as a result of the recent change in the Health and Social Care Act. Both updates were noted to be included on the agenda of the meeting.	
5 Chair & Chief Executive's update	**ROHGO (1/23) 001** **ROHGO (1/23) 001 (a)**
The Chief Executive reported that in terms of support for the Birmingham and Solihull system (BSol ICS), the Trust was accepting spinal emergency and ambulatory trauma patients. It was noted that there was further industrial action by the Royal College of Nursing planned for 6 & 7 February 2023. As a result of the recent industrial action, 47 inpatients and 73 outpatient procedures had needed to be cancelled but there were good processes in place to reschedule these patients where they had been cancelled. JointCare was noted to have been a very positive pathway prior to the COVID pandemic and this had been relaunched and reinvigorated. This was being widened out to other specialities including shoulders, knees and spinal. An app was also to be implemented. The Trust was reported to be in the top 9 specialist trusts for the adult impatient survey results, with some scores being much better than expected or better than expected. There were good engagement scores for the medics. The action plan as a result of this would return to the Quality & Safety Committee. The 100-day induction programme was reported to have restarted. Work was planned with managers to ensure that staff had a good staff experience and local induction was positive. There was a reunion event after 100 days. The reunion events were noted to be poorly attended at present so work was underway to ensure that staff were released. It was reported that the Trust had invested in two new satellite locations: Griffinsbrook and College Green. It was anticipated that the College Green facilities would be operational from beginning of March 2023 and would offer outpatient physiotherapy and treatment for MSK conditions.	

Café Royale was noted to be being refurbished and the range of food offered would be expanded. It was noted that there had been some new videos created to use as part of recruitment and attract staff. It was reported that there were some portfolio changes that had occurred and were planned for the Executive Team, particularly from 1 April 2023 when the Director of Strategy & Delivery was to retire. Brian Toner noted that there was considerable work on communication and staff wellbeing and suggested that this should be celebrated. It was suggested that the CQC needed to be reminded to include the views of the governors when an inspection was planned. The increasing portfolio of the Director of Governance was questioned in terms of resilience. He offered assurance that additional staff were being recruited to support these changes including the recruitment of a Corporate Services Manager who would take on the administration for the Board and its Committees which would alleviate some of the burden of this work from the Director of Governance. In terms of Café Royale, it was questioned whether food was available out of hours. The Chief Executive confirmed that there would continue to be significant provision out of hours including a frozen meal offering which was priced in line with the current Cost of Living offerings. The Chair advised that 2022/23 continued to be a difficult year and there continued to be focus on efficiency and productivity following the impact of the pandemic. There was a review of ICSs that was being undertaken by the Rt Hon Patricia Hewitt. Considering the national backlog of cases that had been paused during the pandemic, this would be a challenging year with much scrutiny on the NHS. This meant that the ICSs were equally under scrutiny as to how services should be commissioned. There was reported to be considerable change nationally and the Chair of the local Mental Health Trust had stepped down and the leadership of the ICS and University Hospitals Birmingham NHSFT had changed, with Dame Yve Buckland appointed on an interim basis as Chair. The Vice Chair of the ICS Patrick Vernon was acting into the role vacated by Dame Yve. It was noted that there needed to be more work to embrace the use of digital technology to help deliver services. The role of the ROH in the system was the key area of focus at the moment. It was noted to be a key aim to offer MSK and Orthopaedic leadership to the	

system. This was being set out in a statement to the ICS.	
6 Wellbeing & Cost of Living update	**ROHGO (1/23) 002** **ROHGO (1/23) 002 (a)**
The Chief Executive advised that the Health and Wellbeing offering had been embedded and the work to improve this was evolutionary. There had been focus groups held around wellbeing which had supported the work. The £1 food menu was continuing which had received national interest. Out of hours provision was discussed which as highlighted earlier was also £1 per portion. The money would be collected by an honesty box. There had been money given to the ROH to support a food bank provision. Period dignity was also being considered and patients would also be supported. The Real Living Wage had been adopted at the ROH although it had not been agreed at System level. This had been a decision made quickly by the Board. This had received mixed reception for those that were already at the top of a Band 2 pay band. There was noted to be no other provider in Birmingham and Solihull that had adopted this approach. It was noted that there was a need to consider this in terms of retention and recruitment expense. David Robinson noted that there had been some implications and complexities in terms of equality of pay. It was reported that a hardship fund was being set up and a confidential process would be arranged for the award of grants for bills or food. This would be launched at the end of January 2023. The team was to be thanked for this work.	
7 ROH strategic plan	**Presentation**
The Governors welcomed Amos Mallard, Acting Deputy Director of Strategy. He provided an overview of the plans to refresh the Trust's strategy. This incorporated the relationship with the ICB and optimising patient experience. This would move to a more overt leadership role. It would retain the '5Ps' which was now supplemented by a sixth, 'Population'. Simone Jordan suggested that spend on health and social care needed to be included in the strategy. It was also suggested that numbers needed to be included in the strategy to be able to define deliverables and progress. The Chief Executive noted that there was work to ensure that staff felt connected with the strategy. The whole pathway was being mapped and this would be included in the main corridor of the hospital to show how individual roles contributed to the delivery of the strategy. It was noted that a critical part of the four objectives was productivity. It should be a requirement of the strategy to be the best in terms of outcomes, productivity and innovation. The Chief Executive noted that the strategy was the journey to 'Outstanding'. Arthur Hughes asked how this work reported to the Executive Team. He was	

advised that the work was reported directly to the Chief Executive.	
8 Statutory duties of governors – gap analysis and action plan	**ROHGO (1/23) 003** **ROHGO (1/23) 003 (a)** **ROHGO (1/23) 003 (b)**
The Director of Governance presented a gap analysis against the new requirements for governors as part of the refresh of the new Health and Social Care Act. It was reported that compliance was good overall but there were some additional actions that could be taken to ensure there was full or retained compliance over coming months. It was noted that a lead governor's council was to be established which reported into the ICB or ICP. It was noted that this needed to be promoted further and raised at the next lead governor meeting. The governors approved the action plan to achieve full compliance with the new statutory duties and agreed that a further update be provided at the autumn meeting.	
9 Updates from the Board and Board Committees	**ROHGO (1/23) 004 - ROHGO (1/23) 008**
In terms of the update from the Board, the Chair noted that most of the information had already been covered. He advised that the patient story that had been presented was powerful. There had been a presentation on the Osseointegration work which was organised in partnership with the Ministry of Defence. Child care had also been discussed at the meeting to understand where this may be provided for staff. Thanks had been given to David Gourevitch, Non Executive Director who had now left the organisation. Richard Phillips reported that the finances and activity were behind plan and there was a forward look to the end of year. There had been some hard work undertaken operationally including JointCare and to maximise the use of theatres. Productivity was noted to be better when the ROH surgeons were reusing their own facilities so this needed to be addressed. The financial landscape was opaque which was an ongoing challenge. Agency spend and the forward trajectory was higher than planned, although this was common across the country. Sickness absence was noted to be high. COVID-19 related sickness remained high. National productivity targets had been set. A good Cost Improvement Programme was in place for the current year, although this would be challenging next year due to the efficiencies required. Tony Thomas asked what the difference was between bank and agency contracts. He was advised that bank staff could work across the system on zero hour contracts. Agency staff worked for a private company. Banks staff were treated as part of the ROH team, especially given that a number of them were the Trust's own staff undertaking additional hours. Chris Fearns advised that the last meeting of the Quality & Safety Committee	

was on 30 November 2022. It was a well engaged and organised Committee. There were noted to be no major issues however there were areas of focus for improvement. In terms of Infection Prevention & Control, *C. difficile* rates were higher than the target number but this reflected community transference. There appeared to be no lapses of care. There had been a cohort of wound infections and this was being investigated. The Chief Executive advised that this looked as though it was not from the theatres that were closed but a deep clean would be organised for all theatres. In terms of the WHO checklist, compliance was just short of the required position and the improvement trajectory for this was required. Every NHS Trust would need to build in a new Patient Safety Incident Response Framework. A report had been received to show that there was a clear plan that the implementation would occur. There was also some effectiveness work planned and some work to realign the quality dashboard. There was also a plan to test out the patient voice in the Committee. Brian Toner asked if mutual aid patients were treated in line with ROH patients. He was advised that a harm review was undertaken for all those waiting excessive times for treatment. The 1800 patients were being reported as part of a separate cohort however all received equity of care. The CQC noted that the mutual aid plans were an innovation to be celebrated. Simone Jordan advised that the last meeting of the Staff Experience & OD Committee had been held on 30 November 2022. It was noted that the workforce agenda was taken as seriously as the financial and operational performance. There was not a significant pool from which to recruit at present so retention mechanisms were important. People, processes and systems needed to be changed together. The Charitable Funds Committee report was taken as read. A charity cricket match had been held. There was £2.3m in the fund to be used.	
10 Governor updates	
10.1 Governor re-engagement and upskilling	**ROHGO (1/23) 009** **ROHGO (1/23) 009 (b)**
The Director of Governance presented a plan to re-engage the governors with the operation of the Trust after the period of remote working during the pandemic. An education programme would be arranged which would complement and supplement the formal meetings via a set of 'Sizzle Sessions' and the proposed topics were noted to be included in the paper. Governors were asked if they felt that the list of topics was sufficiently comprehensive and they agreed that it was. It was agreed that the governors be formally invited to the July Board meeting and would also receive an invitation to the Staff Awards.	
11 For information:	

• **Finance and performance update** • **Quality & Patient Safety update** • **Workforce update**	**ROHGO (1/23) 010** **ROHGO (1/23) 011** **ROHGO (1/23) 012** **ROHGO (1/23) 014**
The reports were presented for information.	
12 Date of next meeting: The next meeting is planned for Thursday 11 May 2023, 1400h to 1600h in Trust Headquarters.	
13 Any other business	**Verbal**
It was noted to have been announced via social media that the Chief Executive had been appointed to the Board of Arthritis UK. She had been supported by the ROH to join the organisation given that its work aligned to the work of the ROH. The Chief Executive was congratulated. Dagmar Scheel-Toellner noted that she was affiliated to the Charity through her current role. Robert Rowberry offered to help the Trust as much as he could. Brian Toner wished to thank the departments visited as part of the tour.	

First choice for orthopaedic care
roh.nhs.uk

welcome

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

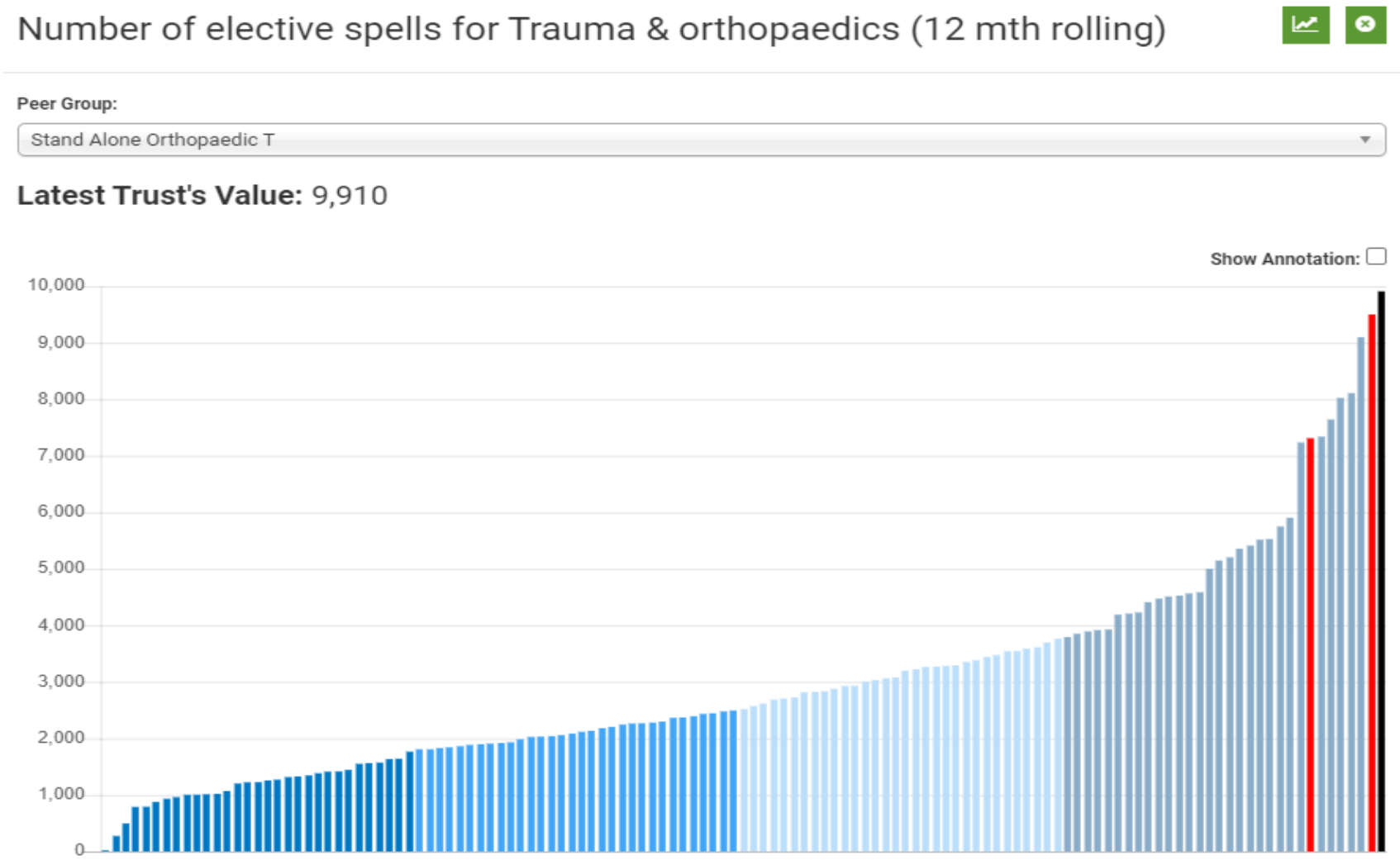
Council of Governors meeting

May 2023

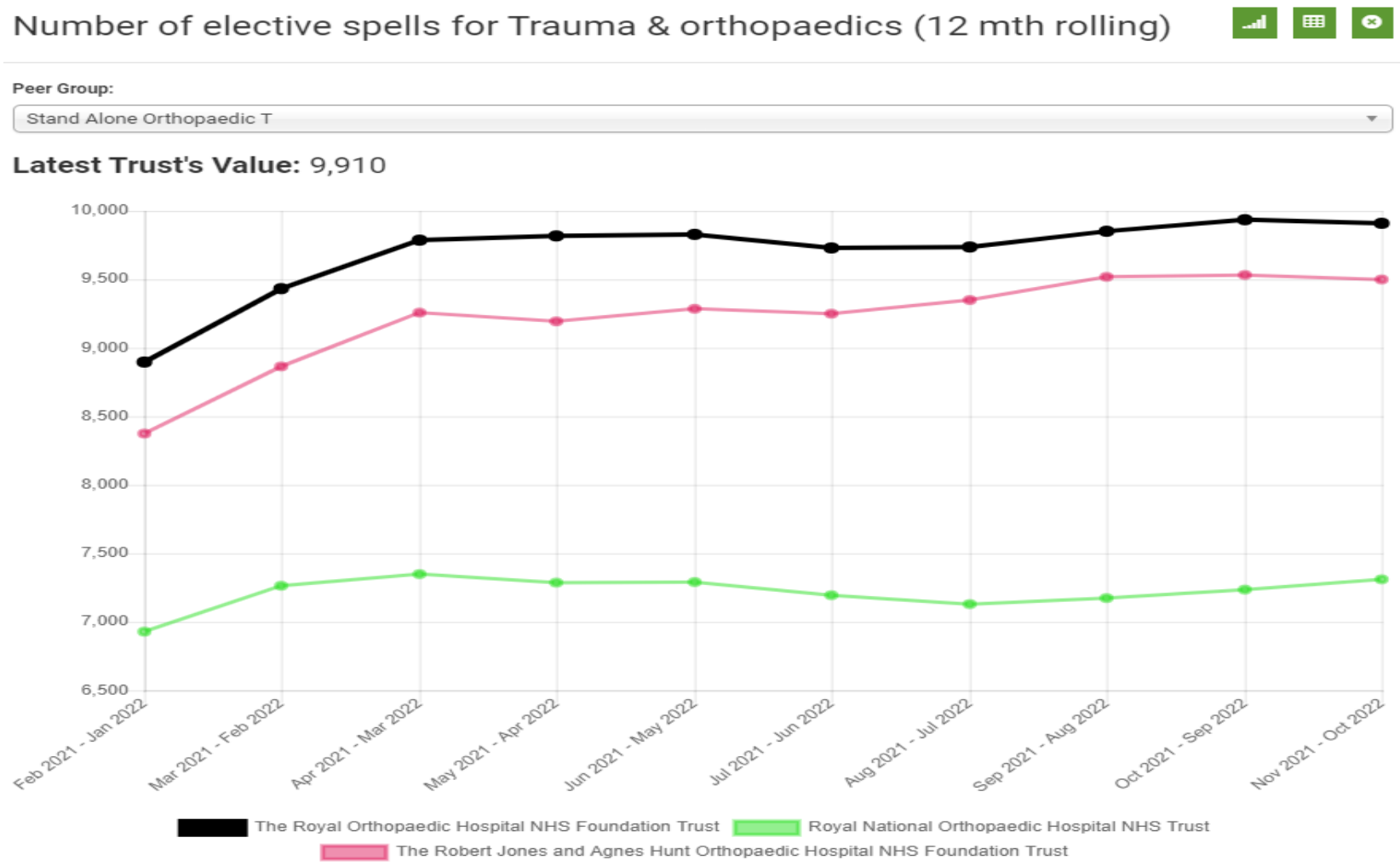
ROH: THE WELLBEING HOSPITAL

CareQuality Commission
Good

National activity



National activity



Integrated Care System

What is an Integrated Care System?
And Integrated Care System (ICS) is a partnership of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. In our case, Birmingham and Solihull.

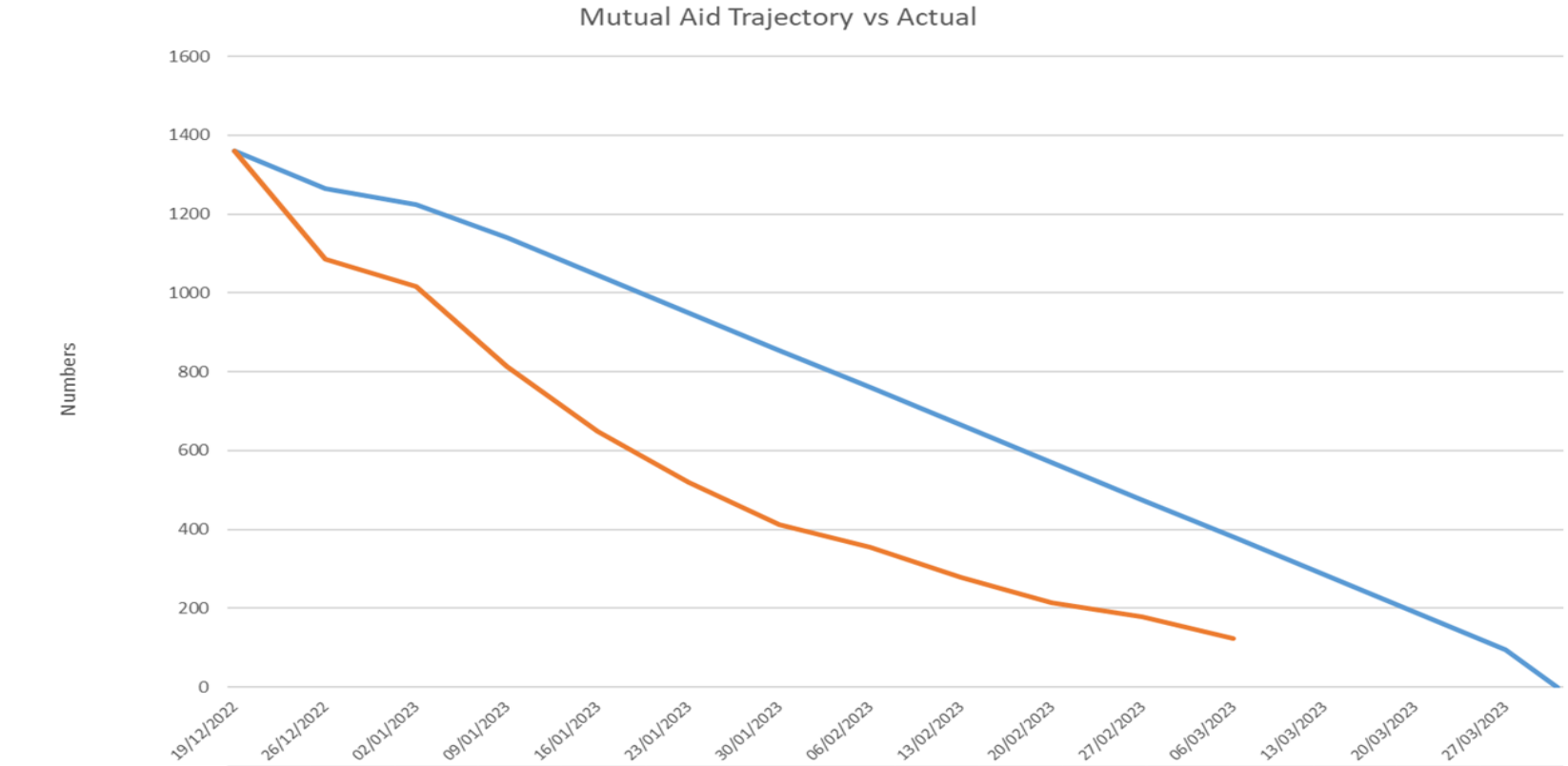
Who is in Birmingham and Solihull ICS?
- All of the NHS hospitals and community services
- All of the GPs, pharmacists, dentists and opticians
- Birmingham City Council and Solihull Metropolitan Borough Council
- The voluntary, faith and community sector
- Healthwatch Birmingham and Healthwatch Solihull

What is the purpose of an ICS?
- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money

Key areas for ROH already ongoing :-

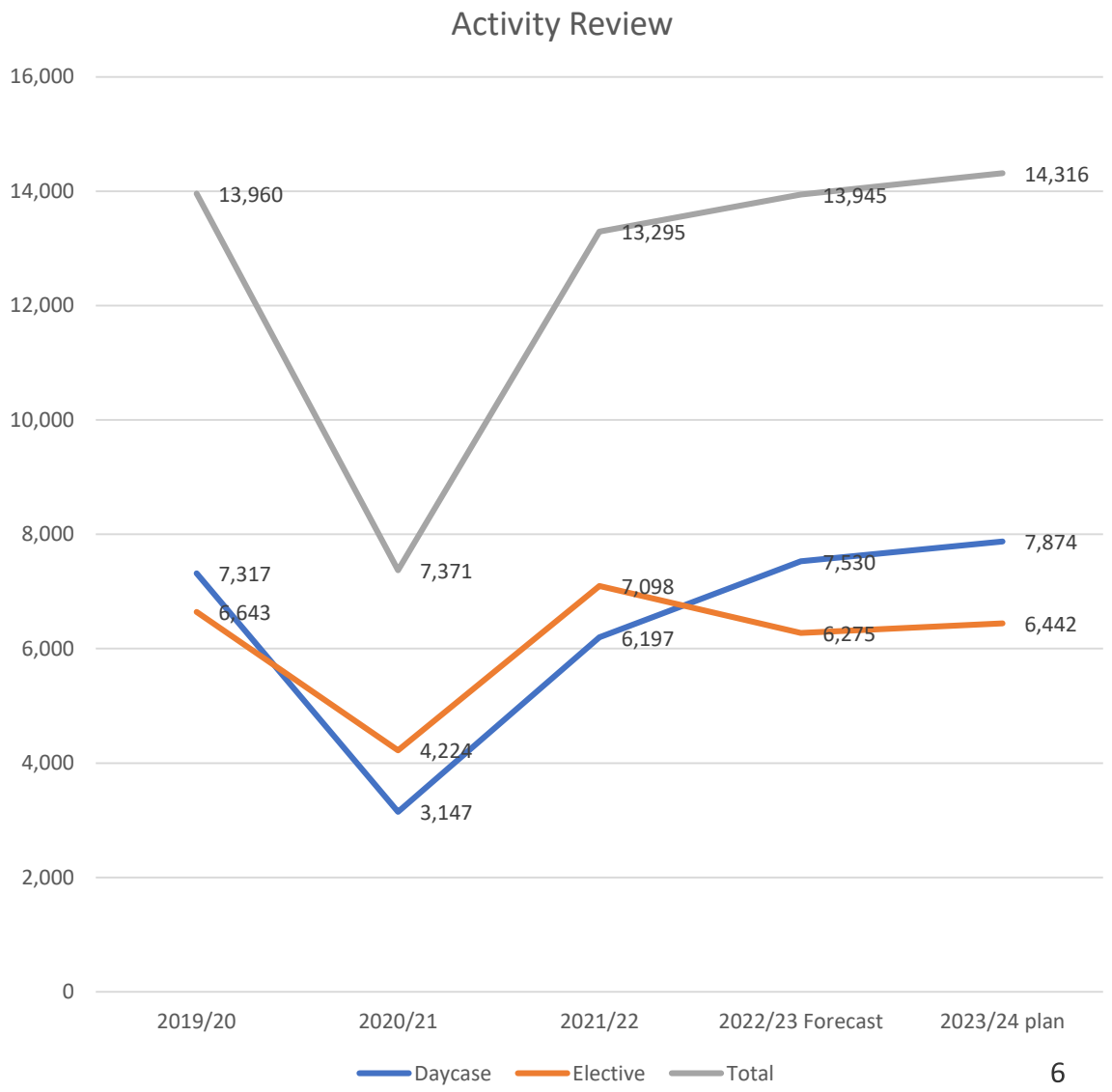
- Mutual aid
- EPR electronic patient record
- Productivity & efficiency

Mutual Aid Updated Trajectory vs. Actual

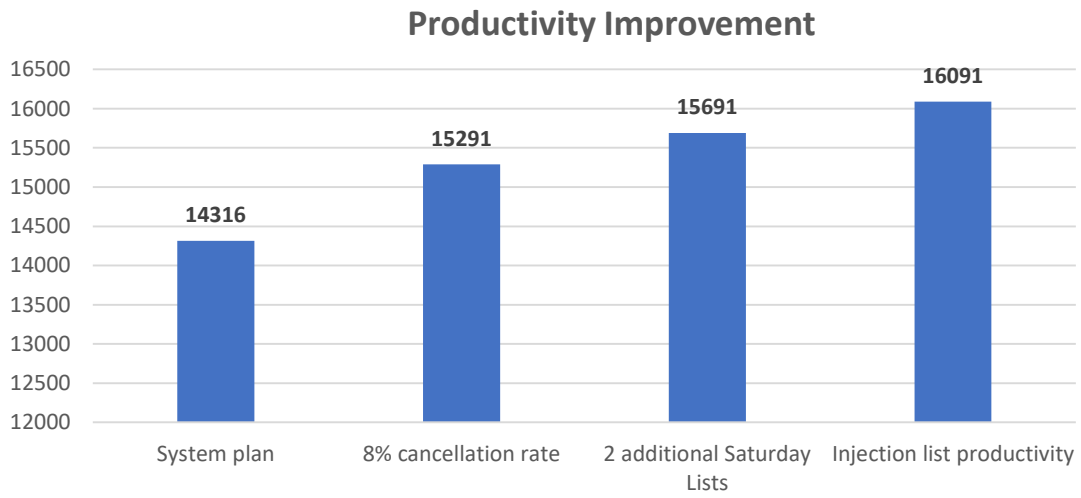


	19/12/2022	26/12/2022	02/01/2023	09/01/2023	16/01/2023	23/01/2023	30/01/2023	06/02/2023	13/02/2023	20/02/2023	27/02/2023	06/03/2023	13/03/2023	20/03/2023	27/03/2023	31/03/2023
Mutual Aid Trajectory	1359	1264	1223	1140	1045	950	855	760	665	570	475	380	285	190	95	0
Actual Mutal Aid Position	1359	1085	1017	814	649	520	411	354	279	215	177	124				

Review of activity delivered over 4 financial years including 2019-2024

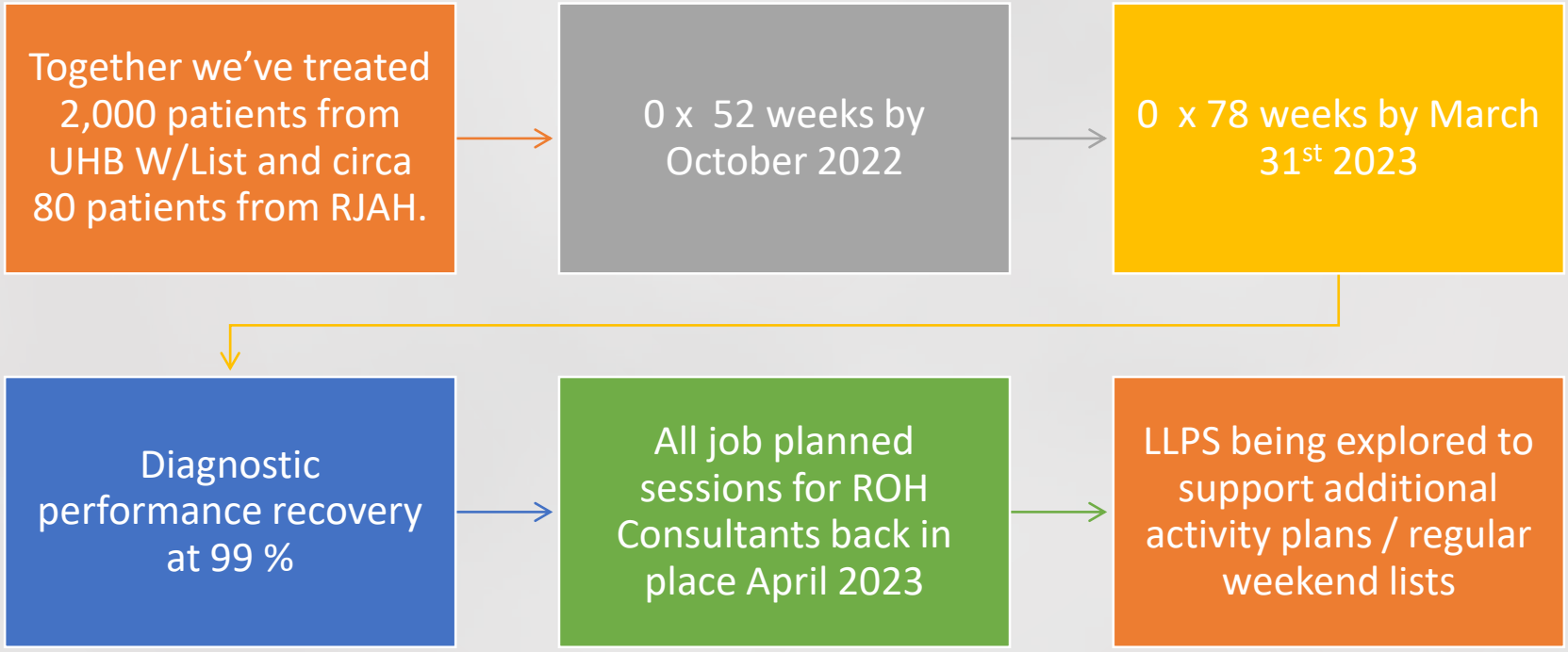


Activity aspirations

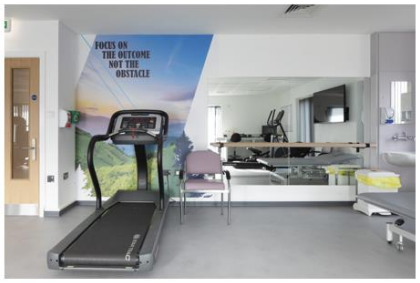


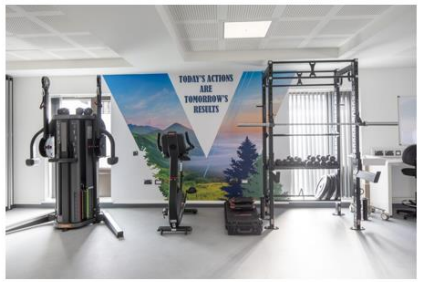
- To deliver the system target of 14,316 procedures
- Improve cancellation rates from 12% to 8% - 15,291
- 2 additional NHS Saturday lists (6 in total) – 400 – 15,691
- Improve productivity on injection lists increasing from 8 to 9 – 400 - 16,091

Performance Highlights



College Green opened
April 2023 - £3.5m





Collaborating with GPs

Community Links – Ramblers / Versus Arthritis

New specialist equipment

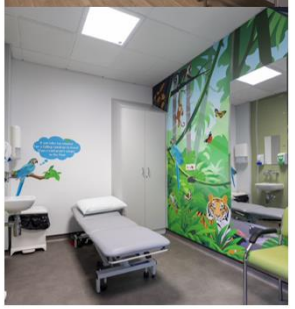
21 classes per week

2202 patients attendances in our first month

Dedicated Paediatric Facilities

Charity funded wall art

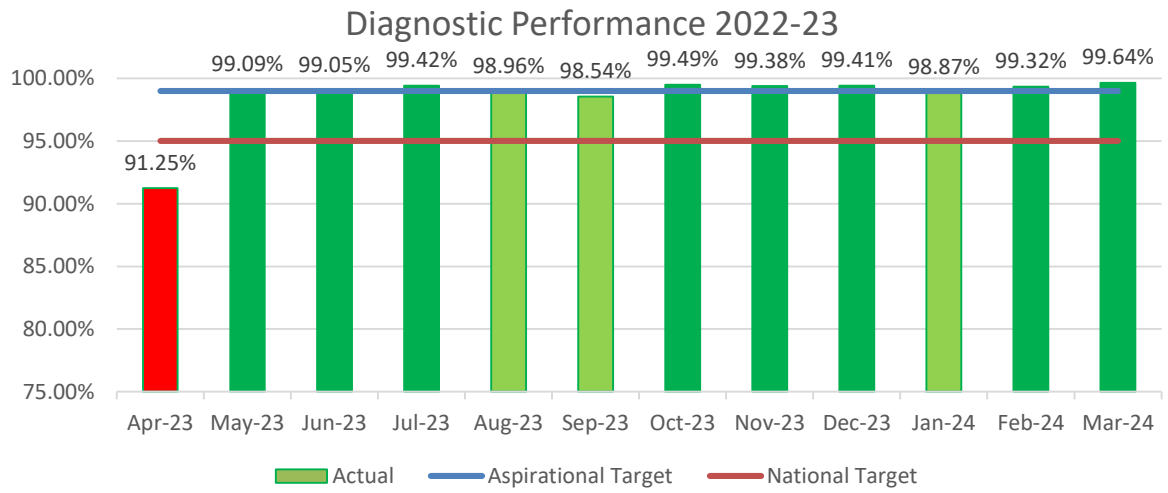
200 Paediatric appointments per month



Consistent high cancer performance

Key Performance Indicators Cancer Services 022/23	Target	Q1	Q2	Q3	Q4
% Urgent cancer referrals seen within 2 weeks wait	93%	89.40%	94.80%	97.00%	97.40%
% Patients treated within 31 days of decision to treat	96%	83.90%	100.00%	100.00%	97.20%
% Patients receiving subsequent treatment within 31 days (surgery)	94%	100.00%	100.00%	96.40%	100.00%
% Cancer patients treated within 62 days of urgent GP referral	85%	51.70%	51.40%	65.50%	56.50%
Faster Diagnostic standard	75%	80.30%	77.90%	80.50%	84.70%

Imaging performance



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Aspirational Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
National Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Actual	91.25%	99.09%	99.05%	99.42%	98.96%	98.54%	99.49%	99.38%	99.41%	98.87%	99.32%	99.64%

Summary of KPIs associated with Operational planning guidance – ROH position

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Elective care : *Eliminate waits of over 65 weeks for elective care by March 2024*

- Trajectory in place to deliver 65 weeks by March 2024 with an aspirational target to deliver under 52 weeks
- System working and mutual aid included (joint PTL)

Cancer

Continue to reduce the number of patients waiting over 62 days

- Trajectory in place to manage a maximum of 2 patients monthly, reflecting the high number of tertiary referrals and low treatment numbers
- We will continue to work with the Cancer Alliance to improve pathways

Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days

- The ROH already achieves an average of 79% turnaround consistently, above the national standard of 75%

Increase the percentage of cancers diagnosed at stages 1 and 2 *in line with the 75% early diagnosis ambition by 2028 Diagnostics*

- Joint working with GPs and the Cancer Alliance to deliver

Summary of KPIs associated with Operational planning guidance – ROH position

Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% *Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition*

- The ROH has achieved over the 95% target since June 2022
- The aspiration is to meet 99% consistently over 2023/24

Theatre Productivity:

Meet the 85% day case target (GIRFT)

- Current performance is on 79.5%

85% theatre utilisation expectations

- Uncapped Intouch utilisation is at 85%

Outpatients & Access:

Deliver an appropriate reduction in outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024

- Drive use of PIFU , support reduction of follow ups for new and existing FU backlog . On track to deliver 5% PIFU target by end March 2023

Offer meaningful choice at point of referral and at subsequent points in the pathway, and use alternative providers if people have been waiting a long time for treatment including through the Digital Mutual Aid System (DMAS) need to state position on DMAS

- ROH is registered as a provider on DMAS

Our refreshed strategy – Extracts planned work

Our vision
Less pain.
More independence.
Life-changing care

Our mission
We will reduce pain and restore independence to help people lead healthy, fulfilling lives

Our values
Compassion, Openness, Pride, Innovation, Excellence, Respect

Our heritage
Established in 1817, we have been at the forefront of orthopaedics for over 200 years

Our team
1,600 people

Our turn-over
£130m

Inpatients
12,000 per year

Outpatients
55,000 per year

We deliver the most elective orthopaedic proceudres in the NHS

Our CQC rating
Good

Our culture
- Rated the most inclusive employer in the NHS
- Rated 7th most inclusive UK employer
- Accredited a Disability Confident Leader
- Thriving Staff Networks to empower an open culture
- A Real Living Wage employer
- A full programme of health and wellbeing support

Our core services
- Arthroplasty and arthroscopy
- Young Adult Hip
- Foot and Ankle
- Hands
- Orthopaedic Oncology
- Orthotics
- Spinal Services
- Musculoskeletal Therapies
- Radiology
- Musculoskeletal
- Anaesthetics
- Paediatric Outpatient

Our staff survey results
Top 15% in the country

Our inpatient survey results
Top 15% in the country

The six Ps: our strategic framework

Patients | People | Population | Process | Performance | Partnership

Our care

Safe care: our highest priority

Our highest priority is providing safe care. We are proud of our safety record which indicates that The Royal Orthopaedic Hospital is a very safe place for treatment. We are committed to continuously improving patient safety, our systems and sustaining a safe culture where the environment is collaboratively crafted, created, and nurtured so that everybody can flourish and deliver safe care by:

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork and understanding Human Factors
- Enabling and empowering speaking up by all
- Embedding knowledge around the Patient Safety Incident Response Framework (PSIRF)

We will continue to invest in building and sustaining our culture to enable the safety and highest quality care for patients.

The future of care: creating outstanding pathways

Imagine a hospital with the shortest waiting times, where you choose your own appointment. Imagine feeling supported and prepared before you even arrive. Imagine the best surgeons using the best technology to give you the best clinical outcome. Imagine being on a ward that didn't feel like a ward because it was designed to support you to move and improve. Imagine a seamless care journey with you at the centre, delivered by an expert team who really care about reducing your pain, restoring your independence, and providing life-changing care.

The Outstanding Pathways Programme

We are ambitious about the future of care. We will transform care pathways through our 'Outstanding pathway programme'. This programme will improve each stage of the patient pathway. It will give patients more choice and provides the very best experience and outcome. We will use the latest technology to make the pathway as seamless and efficient as possible. This is the future of care at The Royal Orthopaedic Hospital.

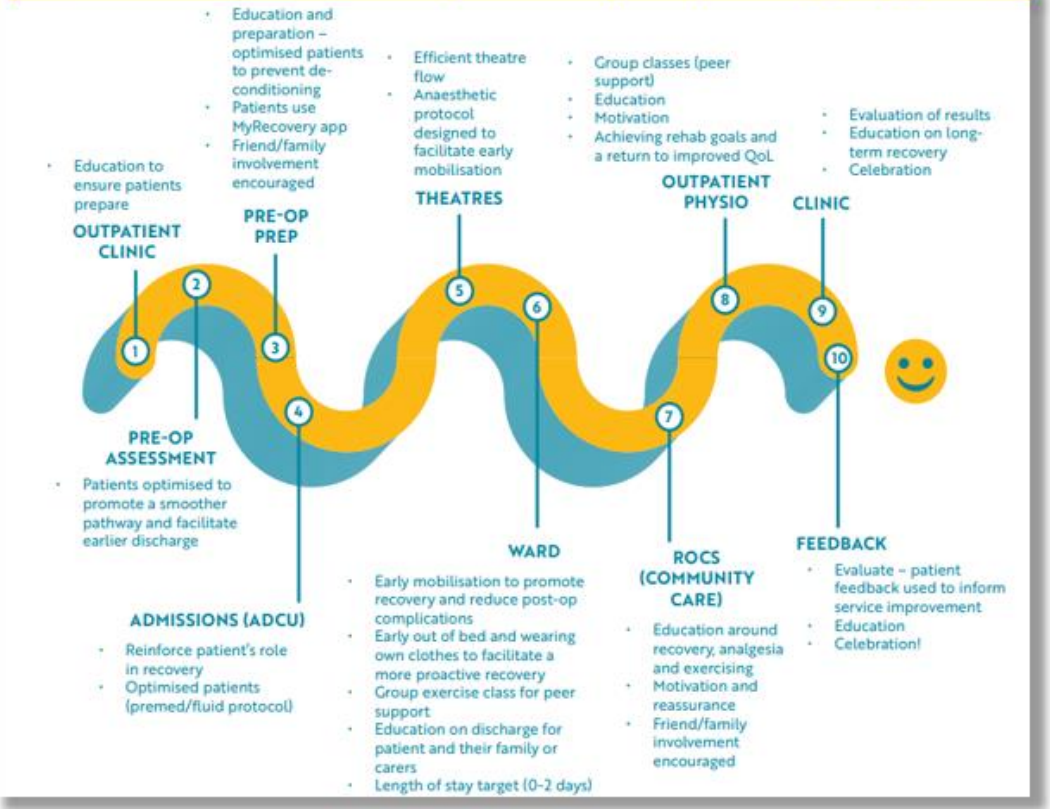
Jointcare

JOINTCARE

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

The JointCare Pathway

The JointCare pathway has ten key steps - and almost every team is involved directly in making this pathway happen!



myrecovery: the mobile app which follows your joint replacement journey and helps you recover

Benefits of the myrecovery app

- Track and monitor your progress
- Understand your condition and how to recover
- An interactive physiotherapy experience

★★★★★

myrecovery has really helped, it's easy to use and has all the information I need

How to access and use the app

1. Please wait for 7 days after your appointment for us to set you up on the app
2. Scan the QR code or visit **nhs.auth.msk.ai** to register your account
3. Download the myrecovery app via the app store
4. Start your recovery journey!

Scan to register for the app

Questions about the app?
help@appsupport.team

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

myrecovery

Data protection statement: *Information gathered by the app may be used to help us better understand your progress as well as to monitor and help improve the quality of care for you and other patients. Your identifiable information will be not be shared with third parties. You can remove the app and any associated communication at any time.*

Scan me for a step-by-step guide on getting started with the app

Our progress & ambition

JointCare

JointCare is an optimised pathway for all primary hip and knee replacement patients. It provides:

- Improved patient experience
- Improved staff experience
- Improved efficiency
- Reduced length of stay

We will expand the provision of JointCare across other clinical specialities so that more people can experience optimised care that reduces their pain and restores their independence.

The MyRecovery app will support patients throughout their journey

Shared decision-making (SDM)

Shared decision making (SDM) is a process which ensures that individuals are supported to make decisions that are right for them. It is a collaborative process through which a clinician supports a patient to reach a decision about their treatment.

Our patients will have access to high quality information at all stages of their journey. They will know what to expect and will understand how to support their own recovery. The information they receive will meet their needs.

All of our clinicians will understand the benefit of SDM and will support patients by helping them access information and ask questions.

Developing a Day Case service

There are a significant number of procedures we perform that can be delivered as day cases. This is excellent for patient experience and outcomes and productive for the Trust.

We will continue to develop our day case service across specialities. This may include:

- ACL reconstruction
- Partial knee replacement
- Total knee replacement
- Total hip replacement
- Shoulder arthroscopy
- Shoulder replacement
- Bunion surgery
- Discectomies

We will also build a day case unit which provides bespoke facilities for supporting our day case service.

- ❑ Design and plan 23 hour unit – ADCU/ward 12
- ❑ Define and scope dedicated Day Case Unit (long-term)

- ❑ Day Case Hips – 1st patient February 2023
- ❑ Day Case Knees
  - ➢ UKR rollout to more surgeons
  - ➢ Start TKR patients Mar 2023
- ❑ Day Case Shoulders – complete 10 patient pilot
- ❑ External comms plan – awareness in primary care and JointCare across the system

- ❑ Internal comms plan
  - ➢ Promotion in departments & Trust Newsletters
  - ➢ New starter packs
- ❑ Theatre Efficiency Programme
  - ➢ List utilisation
  - ➢ ADCU flow
- ❑ Handover & sustain – planning for business as usual

Our People

Our people plan

Our People Vision is to build a healthy, resilient, flexible and capable workforce who are enabled to learn, lead and innovate. One team, which will thrive in a supportive, inclusive, wellbeing focussed culture, with investment in training and development, and excellent management. Our People Plan will help us to deliver this vision. There are four key themes in our People Plan:

Looking after people

We will support the health and wellbeing of our people. This includes creating a positive working environment and proactively supporting mental and physical health. We will take a whole-person approach.

Belonging in the NHS

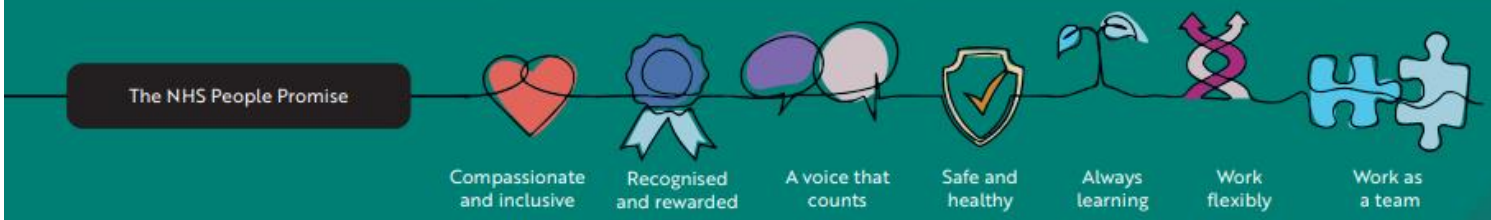
We will support our people by creating a more equal and inclusive environment where diversity is celebrated, and people can be authentically themselves. We will reduce and eliminate discrimination.

New ways of working

We will support our people to embrace new ways of working and empower them to continually improve. We will use new technologies and focus on training and to enable our workforce to innovate.

Growing for the future

We will grow our workforce through excellent recruitment and retention. We will plan for the future and we will meet the needs of our communities with a resilient, agile, and dynamic workforce.



Equality reporting

We will continue to work to the regulatory NHS measures and look beyond the data and national benchmarking to understand the key actions that are required to have the best impact for inclusion at the Trust.

- Workforce Race Equality standards (WRES)
- Workforce Disability Equality standards (WDES) standards
- Gender Pay gap
- Equality data for staff and patients
- EDS 2 framework

Our inclusion vision

Our vision is to nurture a connected culture of belonging where we bring our authentic selves to work and visitors experience an inclusive environment, ready to meet their needs.

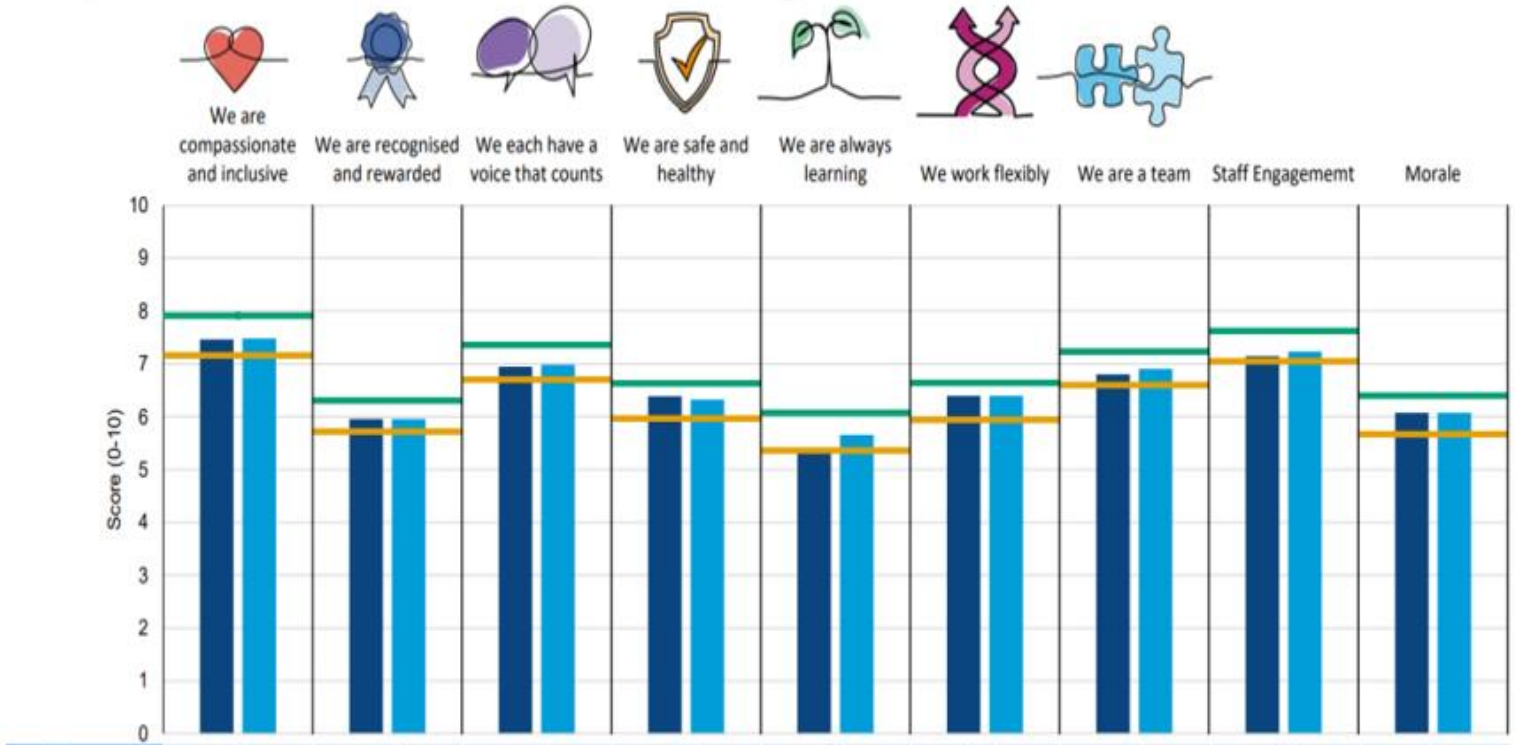
Our People

ROH Themes Overview

People Promise Elements and Themes: Overview

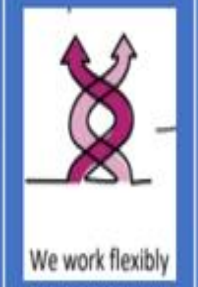
Survey Coordination Centre NHS

All of the People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	7.5	6.0	6.9	6.4	5.4	6.4	6.8	7.1	6.1
Best	7.9	6.3	7.4	6.6	6.1	6.6	7.2	7.6	6.4
Average	7.5	6.0	7.0	6.3	5.7	6.4	6.9	7.2	6.1
Worst	7.2	5.7	6.7	6.0	5.4	5.9	6.6	7.1	5.7
Responses	629	628	616	620	584	626	628	628	629

Our People - comparisons

Themes	 We are compassionate and inclusive	 We are recognised and rewarded	 We each have a voice that counts	 We are safe and healthy	 We are always learning	 We work flexibly	 We are a team	Staff Engagement
ROH	7.5	6.0	6.9	6.4	5.4	6.4	6.8	7.1
BWCH	7.3	5.7	6.8	5.7	5.2	6.1	6.7	6.9
BMHT	7.1	6.0	6.7	6.1	5.7	6.4	6.9	6.9
BCHC	7.2	5.8	6.7	5.9	5.4	6.4	6.7	6.7
UHB	6.9	5.4	6.4	5.8	5.0	5.7	6.4	6.5

Our Organisation

Investing in our estate

We will continue to invest in our estate enabling us to treat more patients and provide our team with modern facilities in which to work. We will develop clinical environments which are conducive to recovery and empower our team to deliver outstanding care. We will continue to refurbish our existing estate and build new facilities with greener credentials and the latest technology. We will work with our ICS partners and industry to continually develop world-class facilities.

Our green agenda

We will reduce the environmental impact of the services we offer through reducing our reliance on non-renewable fuels and gasses, using cleaner energy sources, reducing our use of non-recyclables and recycling wherever possible. In doing so we will support public health and the environment, save money and reach net carbon zero.

Inclusion matters

INCLUSIVE TOP50 UK EMPLOYERS

The Royal Orthopaedic Hospital is currently ranked by Inclusive Companies as the most inclusive NHS organisation, and 7th overall most inclusive employer in the UK. While this is positive progress, inclusion is not a static state. We are committed to creating a culture where everyone can be authentically themselves.

Our six equality objectives for the future:

- Objective 1: Tackling and removing all forms of discrimination in order to promote equality for all
- Objective 2: Creating an inclusive and healthy ROH culture through Trust values
- Objective 3: Giving colleagues and patients a voice to speak up and ask for access to opportunities
- Objective 4: Ensuring our leaders, managers and colleagues role model in a compassionate and inclusive way
- Objective 5: Being recognised as a Top Inclusive Employer externally through best practice approach in order to demonstrate continuous improvement
- Objective 6: Ensure the Equality and Diversity work plan delivers on the required objectives

In conclusion

Our six Ps: the strategic framework

Our strategy is simple. We will excel in six important areas. We call them the six Ps...

Patients
Providing the highest quality orthopaedic care with an excellent experience and positive clinical outcomes.

People
Building and sustaining a talented, dynamic, and inclusive workforce who are motivated to care and empowered to continuously improve.

Population
Reducing health inequality by offering our expertise, improving access and transforming our healthcare system.

Process
Creating efficient healthcare pathways and processes which support the best experience and outcomes for patients.

Performance
Delivering excellent performance which supports the best experience and outcomes for patients.

Partnership
Collaborating with partners across all sectors to innovate, coordinate, learn and improve in everything we do.

If we make progress in these six areas, we will achieve some really important benefits:

- Consistently safe and high-quality services
- Outstanding patient experience
- Outstanding clinical outcomes
- Improved access and reduced waiting times
- Earlier support with resources and tools
- Reduced health inequalities
- A better working experience for our team
- More research, development and innovation

Questions

THANK YOU

REPORT REF: ROHGO (5/23) 009

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Elective Hub Accreditation - Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Marie Peplow- Chief Operating officer**
AUTHOR:	**Michelle Hubbard- Deputy Chief Operating Officer**
PRESENTED BY:	**Marie Peplow- Chief Operating officer**
DATE OF MEETING:	**18 May 2023**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Trust submitted a bid to be considered in the 1ST Cohort for elective hub accreditation and has been successfully chosen as 1 of 8 sites to be evaluated by Getting it Right First Time (GIRFT) for accreditation. This report provides an update on progress to date.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Oversight Group Set Up • Domain Leads in place • Data gathering process agreed • Action plans for each domain with leads for each action and deadlines • Site visit agreed – 9th June 2023 AM	• Policies may need amendments to fulfil some essential and desirable criteria. • New Standard Operating Procedures may need to be produced in short timescales to meet accreditation standards.

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to:
Note progress towards obtaining elective hub accreditation and to be assured that the Trust is on target to provide evidence against all 105 criteria within the required timescales.

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

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

Comments: Data will be useful for future audits and CQC inspections

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

The accreditation is fully aligned with the Trust Strategy and achievement of performance metrics in line with GIRFT.

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

Achieving elective hub theatre accreditation will have a positive reputational impact both for the ROH and for the Birmingham and Solihull ICS. ROH will be an exemplar in the system and can support other Trust's to achieve accreditation in the future.

PREVIOUS CONSIDERATION:

The Theatre Accreditation progress update has been tabled at the executive committee meeting on 25th April 2023

Elective Hub Accreditation Update briefing paper
Trust Board – 3rd May 2023

1.0 Situation

The ROH has been selected by GIRFT for Cohort 1 of elective hub accreditation. The deadline for gathering data for submission is 2 weeks prior to the planned site visit that is scheduled to take place on Friday 9th June 2023, 9am to 12 noon.

2.0 Background

GIRFT conducted a pilot study to review a group of trusts for elective hub accreditation. The pilot was a success and GIRFT requested expressions of interest for Trusts to take part in the 1st full cohort. To be considered for accreditation, a hub needs to be able to demonstrate the following:

- Elective Hub able to operate as a distinct self-contained unit.
- Exclusively perform planned surgery in at least one of the High-Volume Low Complexity (HVLC) specialties.
- Have dedicated facilities & staff (meeting the definition of ringfencing) who are not used to support operational pressures elsewhere (unless in exceptional circumstances and with decision required at Executive level).
- Have embedded - or are working towards - the HVLC principles of 6-day operating, 48 weeks per year, 2.5 session days and 85% theatre utilisation

The Trust submitted a successful bid and ROH along with 8 other Trusts will be measured against an agreed published set of criteria, developed following the successful pilot programme. Please refer to **Appendix 1** List of trusts participating in cohort 1. On successful completion the Trust will be presented with an accreditation badge that can be added to all hub and patient documentation. Please refer to **Appendix 2** for a picture of the accreditation badge that will be awarded following successful accreditation.

Benefits of being accredited as articulated by GIRFT include:

- A measurable marker of high standards that results in better uptake of treatment offers.
- A measurable marker of high standards that can be communicated to staff resulting in enhanced retention and recruitment.
- Visibility of accreditation standards and the requirement to maintain and improve levels of quality.
- Demonstrates the service is optimised, efficient and delivering best possible care and value.
- A centre for surgical training opportunities and to grow and develop all clinical and non-clinical staff.

3.0 Analysis

The criterion for accreditation is split into the following 5 domains:

Domain 1 - Patient Pathway
Domain 2 - Staff Training & Well-Being
Domain 3 - Clinical Governance and Outcomes
Domain 4 - Facilities & Ring-Fencing
Domain 5 - Utilisation & Productivity

Each domain contains a set of criteria that the Trust will be assessed against. The criteria is colour coded as follows:

Red – Essential criteria
Black - Desirable criteria
Green - New criteria introduced post pilot stage.

4. Progress to date

The Project has been aligned to Quality Service Improvement Redesign (QSIR) methodology.

Progress made to date is as follows:

- Senior Responsible Officer and Operational Lead assigned.
- Weekly Executive oversight.
- An operational oversight group has been established to meet weekly to monitor overall progress including a medic and nursing lead. Please refer to **Appendix 3** for project structure.
- A communications representative has been nominated to facilitate Internal and External communication.
- Operational and/or Clinical leads have been assigned to each domain.
- Patients to be engaged via the next Patient Experience Group.
- Individual action plans have been created for each domain.
- Criteria have been assessed and RAG rated.
- A high-level gap analysis has been conducted.
- Sufficient evidence is available for most of the criteria.
- In total 7 out of 105 criteria require additional work to ensure sufficient evidence can be provided.

  This is relevant to the following criteria:

  - 1 x Red Essential Criteria

Criteria	Work to be undertaken
Passporting process & rotational models fully embedded *Induction processes are in place for all staff, including those from other sites & visiting clinicians. (Only underlined part requires further work)	Confirm aspirations of system workforce group for the development of hospital passports for staff and include in documentation.

- 5 x Black Desirable Criteria

Criteria	Work to be undertaken
Electronic Consent - Digital approach in place, or a plan for this, with alternatives available for patients without digital access.	Create a project plan and schedule electronic consent into EPR programme. Review new consent policy and Synopsis options.
Where hub is receiving referrals from across a wider geographic footprint, there are options for patients to attend pre-op appointments locally.	Some aspects of pre op can be completed at home. Virtual POAC options. For patients that travel the team facilitate a 1 stop service. An action plan will be developed to determine how we will offer further opportunities for local pre op options to be considered.
All staff (inc. Booking staff) are aware of key information about benefits of hub referral, such as waiting time and clinical benefits	Re-educate staff and circulate policies
Hubs without enhanced care provision treat ASA 1, 2 and stable ASA 3 patients. In addition, all ASA 3 patients are treated at hubs that can provide enhanced care. Reference enhanced care documents.	Patient mitigation is to transfer to UHB. Further discussion required with Matt Revell and the clinical teams.
Fair access to training lists for staff from all hospitals who use the hubs.	Working with Matt Revell and clinical teams to understand what training is currently offered and what needs to be developed?

- 1 x Green New Criteria

Criteria	Work to be undertaken
There is an awareness of and a plan to move towards The Green Theatre Checklist.	A copy has been obtained and the team is assessing the capability to rollout. **This is a new criteria and Trust's are not expected to have this in place.**

4.0 Next Steps

Below is a summary of the next steps:

Next Step	Frequency / Date
Executive Meeting oversight	Weekly
Operational Oversight Meetings to review status of evidence gathering.	Weekly
Individual Domain Project Meetings	As and when required
GIRFT Process and Visit Information Call with all Cohort 1 Sites	Wednesday 3rd May 2023.
GIRFT Pre-Visit Site Briefing meeting	Tuesday 23rd May 2023.
Operational Oversight Group final review of evidence	Friday 19th May 2023
Final upward report for Executive team	Tuesday 23rd May 2023
SRO Final Sign Off	By Wednesday 24th May 2023
Upload of evidence	Wednesday 24th to Friday 26th May 2023
Mock Inspection	Between Friday 26th May 2023 and Tuesday 6th June 2023
GiRFT Team Site Visit	Friday 9th June 2023 – 9am to 12 noon

5.0 Summary

The Board is requested to:

Note progress towards obtaining elective hub accreditation and to be assured that the Trust is on target to provide evidence against all 105 criteria within the required timescales.

Next update to board will be to confirm that evidence was submitted on time and that the site is ready for the elective hub accreditation visit on Friday 9th June 2023. Please refer to **Appendix 4** for the GIRFT team members undertaking the site.

Appendix 1 – Cohort 1 Sites

Hub Name	Region
Sulis Hospital	South-West
Heatherwood Hospital, Frimley	South-East
The Royal Orthopaedic Hospital	Midlands
Warwick Hospital DSU	Midlands
SWELOC	London
Chase Farm	London
University of Hartlepool	North-East and Yorkshire
Chapel Allerton Hospital	North-East and Yorkshire
Rochdale	North-West

Appendix 2 – Accreditation Badge

Appendix 3 – Project Structure

Senior Responsible Office – Marie Peplow, Chief Operating Officer

Operational Lead – Michelle Hubbard – Deputy Chief Operating Officer

Members of Operational Oversight Group

Name	Role
Michelle Hubbard	Meeting Chair – Deputy Chief Operating Officer
Dr Ben Smith	Associate Medical Director Division 2
Jennifer Pearson	Head of Nursing – Division 2
Karen Hughes	Head of Nursing – Division 1
Kirstie Owens	Clinical Service Manager
Coralie Duff	Associate Director of Operations
Alicia Stanton	Clinical Service Improvement Lead
Tracey Littlehales	Matron
Yasmin Brown	Communications Officer

Domain Leads

Domain	Project Lead
1	Coralie Duff
2	Coralie Duff
3	Michelle Hubbard
4	Kirstie Owens
5	Kirstie Owens / Marie Raftery

Appendix 4 – GiRFT Team Members for Site Visit

Date: Friday June 9th 2023
Time: 09.00-12.00hrs

The planned visiting team will be as follows:

Professor Tim Briggs- National Director for Clinical Improvement and SRO for elective hubs (Clinical Lead)

Stuart Smith- Consultant anaesthetist at Sheffield Hospital(Anaesthetist)

Vel Sakthivel- Consultant Orthopaedic surgeon at Grantham Hospital (Surgeon)

Deb Millington- GIRFT Implementation Manager, RGN (Nurse)

Rebecca Anderton- GIRFT Implementation Manager (Manager)

Helen Wilkinson- Senior Programme Manager, Accreditation Programme (Observer)

Jane Rooney- Elective Hub Accreditation Programme Lead, NHS England (Visit Lead)

FOR DECISION

FOR INFORMATION

FOR DISCUSSION

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NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Proposed Quality Priorities 22/23 (Final report)

Report to Board of Governors on May 2023

1 EXECUTIVE SUMMARY

1.1 The purpose of this paper is to provide the final overview of the quality priorities for the Royal Orthopaedic Hospital (ROH) in 2022/23.

2 Background

2.1 Providers of National Health Service (NHS) healthcare are required to publish a quality account each year. These are required by the Health Act 2009, and the Health and Social Care Act 2012 in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended ('the Quality Accounts Regulations').

2.2 Our vision is '*Less pain, more independence, life-changing care*' and we are committed to delivering world leading outcomes and excellent patient experience in line with our values: *respect, openness, compassion, excellence, pride, and innovation*.

3 Our Quality Priorities for 2023/24

3.1 During 2022/23 we continued to focus on quality improvement. We have developed the capability of our staff within the organisation through Quality Service Improvement and Redesign (QSIR) training, enabling them to improve the quality of care they offer. We have continued to foster the links between hospitals IN BSOL and other organisations to work together to improve the quality of care to patients across the community.

3.2 Last year we identified five priority areas for improvement as follows: achievement against each of these priorities is set out below:

Safe	**Embedding the Patient Safety Strategy across the ROH**
Caring	**Bereavement Services and Multi-Faith Provision**
Effectiveness	**Learning Disability – implement the learning disability improvement standards for the ROH.**
Responsive	**Timely assessment and management of pain.**

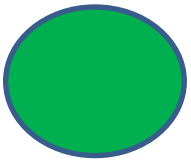
Well-led	**Implement shared decision making -achieve 65% in monitoring and publish 10 + Major pathways.**

3.3 The quality improvement priorities have been part of the Clinical Quality Group (CQG) work plan and have been individually scrutinised within the CQG chaired by the Chief Nurse and Clinical Governance. The CQG took the decision based on delivery and ongoing scrutiny within a governance forum within the Trust to close four of the five priorities. This decision was supported by the Trust's Quality and Safety Committee and further accepted by the Audit Committee.

4.0 Performance on 2022/23 Quality Priorities and the Quality priorities for 2023/2024

Priority 1: Embedding the Patient Safety Strategy across the ROH

Background: The National Patient Safety Strategy sits alongside the NHS long term plan; the aim is to build a patient safety culture and a patient safety system. A key element is patient safety huddles; A safety huddle is a short multidisciplinary briefing, held at a predictable time and place, and focused on the patients most at risk. When effective, safety huddles provide the opportunity to reduce harm and celebrate success.



Performance: Complete

How was progress monitored? Progress was reported into the Clinical Quality Group monthly and Quality & Safety Committee quarterly.

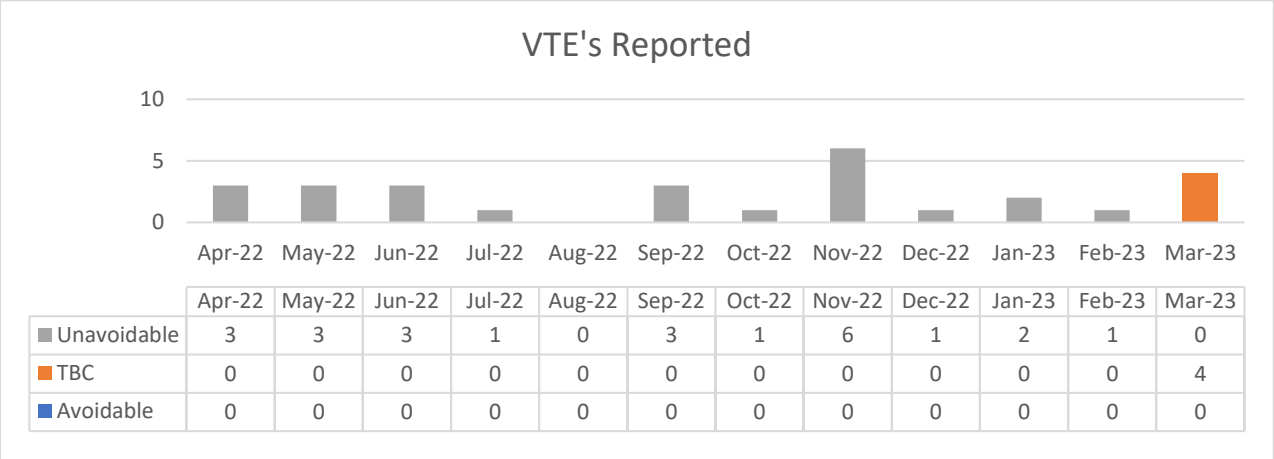
Initiatives to be carried out in 2022/23:

- A standardised method of running and recording safety huddles has been developed and in being implemented across the ROH focusing on in-patient and theatre areas in the first year.
- A review of our current Safer Surgery training, recording, and monitoring processes has been carried out to ensure they are following the spirit of the WHO Safer Surgery Standards.
- Continue to monitor and maintain our good VTE.
- Introduce Human Factors training across the trust to support a safety culture.

How was success measured in 2022/23?

- VTE thematic review completed. No themes identified. Compliance dropped for a short period over the year due to a change in coding, but this was addressed quickly and did not affect patient safety. The Trust has submitted application to maintain '*Exemplary Site*' status. Figure x. Show the overall performance reported VTE against avoidable v's unavoidable.

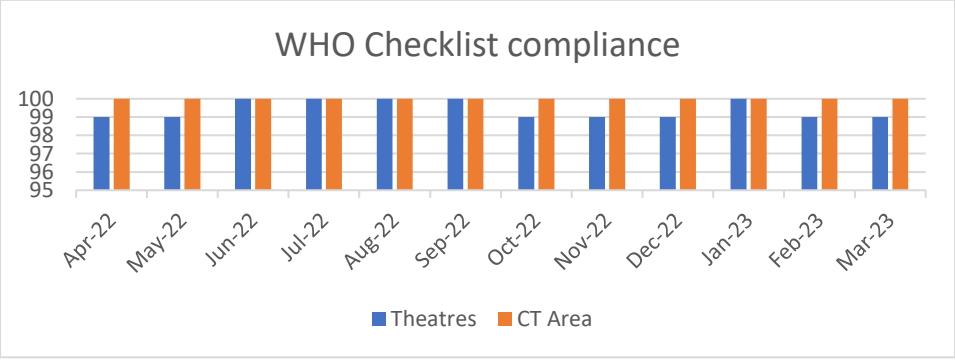
VTE reported over the year:



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Unavoidable	3	3	3	1	0	3	1	6	1	2	1	0
TBC	0	0	0	0	0	0	0	0	0	0	0	4
Avoidable	0	0	0	0	0	0	0	0	0	0	0	0

WHO Surgical Safety Checklist:

- Visual WHO check list compliance has improved over the year and is consistently >99%. Work continues within Theatre led by the Matron to ensure learning from excellence, lessons learned, and compliance remains high.



Human Factors:
Human Factors training has been launched and rolled out under the Patient safety strategy. Impact will be monitored using key metrics: near misses, incident reporting and staff survey data. This work will continue however the QP has been achieved.

Safety Huddles:

- Theatre and OPD successful embedded the practice. The wards will audit effectiveness in the first week of May while moving to continuous cycle of improvement under QSIR methodology and business as usual.

Initiatives carried out in 2023/24:

We recognise the importance of the Patient Safety Strategy and the planned roll out of the Patient Safety Incident Response Framework. Therefore, while the key elements of this priority have been achieved and moved to business as usual, under caring we will move this quality priority forward and focus on the next step.

Sponsored by our Council of Governors

Priority 2: Bereavement Services and Multi-Faith Provision

Background: Establishing a Bereavement Service for the families of our patients. Building on work in 2020/2021 related to end-of-life care, specifically end-of-life education, working with UHB and participating in the Faith Advocacy Group with a view to expand multi-faith provision at ROH. We will seek to explore managing our Bereavement Services under the UHB team provision and update our End-of-Life Care Policy to reflect these changes.

Performance: Partially Achieved

How was progress monitored? Progress was reported into the Clinical Quality Group monthly and Quality & Safety Committee quarterly.

Initiatives carried out in 2022/23:

- An SLA and moving care under UHB provision has been scoped, however in Q4 UHB has withdrawn their bereavement services in its current format. Work is underway to understand how ROH and UHB can move the services over with the new model.
- Expanding the multi-faith presentation through volunteers and the Faith Advocacy Group at the ROH.
- Review service against Chaplaincy gap analysis.
- Use charitable funds to address faith in the organisation including a review of the Faith Room to ensure it is inviting to all faiths.
- Develop a Multi Faith education booklet to be shared with patients and staff.

How was success measured in 2022/23?

- Deceased patient pathway is being mapped out – on hold due to changes at UHB, within the bereavement services. Meeting are planned to explore how ROH and UHB can implement in the new climate to ensure families are supported.
- The Trust has been actively recruiting to Chaplaincy volunteer with limited success.
- The Multi-Faith religious booklet has been developed and is being launched in World religion month.
- Multifaith room working group – meeting held. Chaired by the Head of Patient Experience January 2023. Good attendance with excellent multi-faith representation. Agreement gained to access Multifaith charity funds to refresh the room; work being planned.
- The communication team have been focusing acknowledging and celebrating the multi-faith holiday.
- Multi-faith and the faith room are to be advertised on the Patient Information System. Increase access for patients and staff as per the Chaplaincy guidance recommendation.

Priority 3: Learning Disability – implement the learning disability improvement standards for the ROH.

Background: Ensure that children, young people, and adults with learning disabilities can access our services and explore opportunities at the ROH.

Performance: Partially Achieved

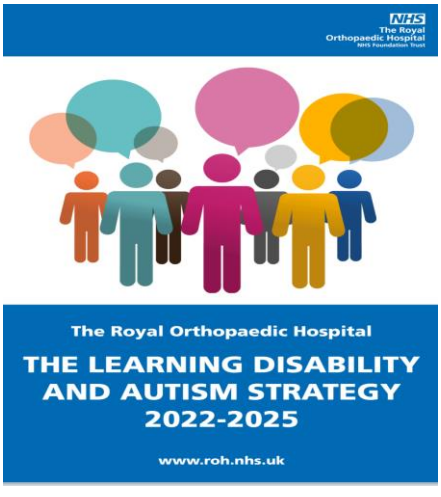
How was progress monitored? Progress was reported into the Clinical Quality Group monthly and Quality & Safety Committee quarterly.

Initiatives carried out in 2022/23:

- To establish a learning disabilities forum in 2022/23.
- To conduct a baseline assessment of our performance against national standards, agree and action plan to lead improvements.
- Develop and launch a Learning Disabilities and Autism Strategy.
- Establishing LD & Autism forum has remained difficult, work will continue.

How was success measured in 2022/23?

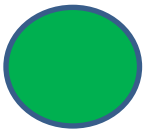
- The strategy was launched in late 2022.
- Benchmarking data entry completed.



Priority 4: Timely assessment and management of pain.

Background: There is evidence that our performance regarding pain management requires improvement, this is from a range of sources including complaints and the CQC annual inpatient survey

Performance: Achieved



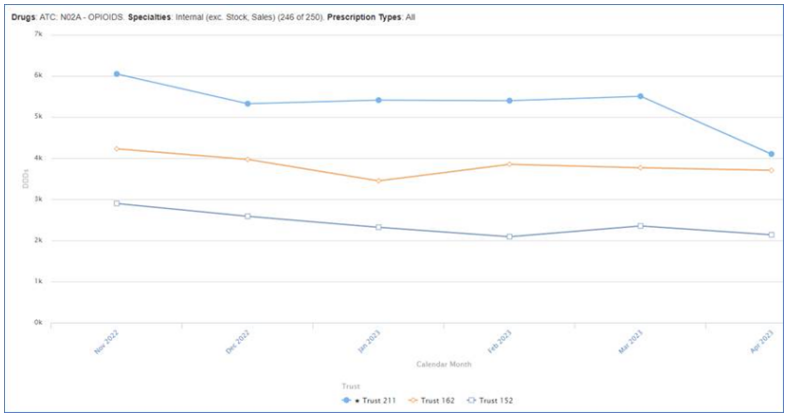
How was progress monitored: Progress was reported into the Clinical Quality Group monthly and Quality & Safety Committee quarterly.

Initiatives carried out in 2022/23:

- A gap analysis of the provision of pain management within ROH against national standards.
- Review the Rapid Response Teams skills gaps around pain and develop a plan.
- Review pain management, accessing the PICS and reviewing opiate use in the trust.

How was success measured in 2022/23?

- It was identified that the Rapid Response Team has no clinical expertise within the team as part of the gap analysis. As a result of this finding, recruitment is underway to recruit a part-time acute pain nurse to support the pain rounds and provide advice and guidance.
- Opiate use in the Trust has been reviewed by the pharmacy team and changes to prescribed pain relief have been introduced in-line with the national plan to reduce opioid use.
    - As a result of benchmarking ROH Oral Morphine usage in 2022, a decision was made by pharmacy and medical leads to switch from oral solution to oral tablets on discharge. This would enable a smaller quantity to be dispensed at discharge compared to a whole 100mls bottle, thus reducing the overall opioid prescribing burden. This has led to a significant reduction in the use of morphine as demonstrated in the graph below. ROH is now in line with other Specialist orthopaedic organisations. There is ongoing work around identifying further strategies to reduce opioids in line with the national MEDSIP program which is incorporated into the national patient safety strategy.



Overall Opioid use has also declined in April 2023.

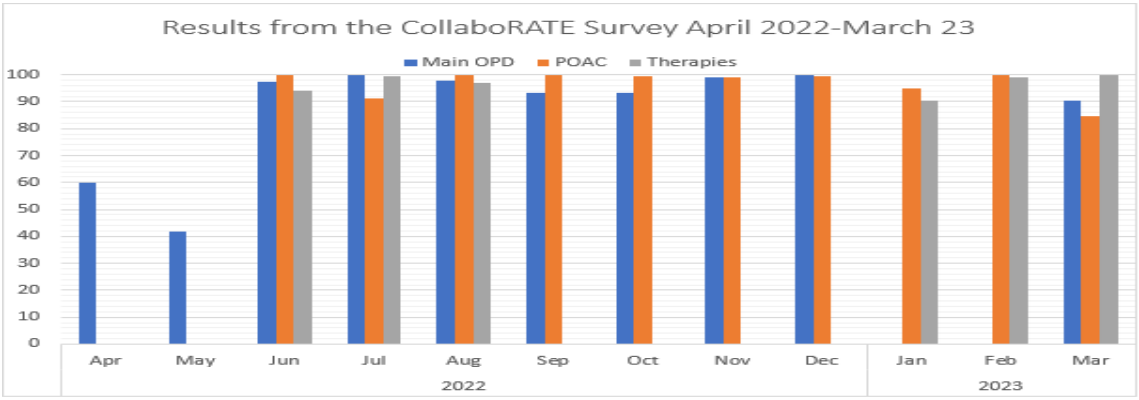
Priority 5: Implement shared decision making -achieve 65% in monitoring

Background: In June 2021 NICE published a guideline on Shared Decision Making. The guidance makes recommendations that 'shared decisions', "Should be embedded in healthcare".
It includes recommendations on training, communicating risks, benefits, and consequences, using decision aids, and how to embed shared decision making in organisational culture and practices.

Performance: Achieved

How was progress monitored: Progress was reported into the Clinical Quality Group monthly and Quality & Safety Committee quarterly.

Initiatives carried out in 2022/23:



How was success measured in 2022/23?

- Embedding the CollaboRATE survey into the outpatient questionnaire. The April and May results were collected whilst the survey was in implementation and there was initially confusion regarding the Likert 1-5 scale about if 1 was positive or 5. The wording was strengthened for the June data collection.
- Identifies and trained 2 members of staff to work with the ICS to learn how to deliver the Shared Decision-Making Training within ROH. These Senior Physiotherapy trainers attended the training and have been included into the Shared Decision-Making Steering Group
- The ROH has achieved the first milestone of the CQUIN, implementing a methodology to capture the patient perspective on SDM, then collecting data for quarter 2. Due to our positive results the target will be to maintain 75% or above in quarter 4.
- Funding secured to create a 90 second patient informational video to explain the Shared decision-making concept
- Trust web pages redesigned, and the patient information section has been strengthened and streamlined. Patient information is quicker to access and presented in a uniform layout

5.0 Next steps

5.1 The proposed quality prioritises FY 23/24 have been represented in a separate paper for consideration.

Nicola Brockie
Chief Nurse
May 2023

FOR DECISION

FOR INFORMATION

FOR DISCUSSION

The Royal Orthopaedic Hospital NHS Foundation Trust

Proposed Quality Priorities 23/24

Report to Board of Governors on May 2023

1 EXECUTIVE SUMMARY

1.1 The purpose of this paper is to provide an overview of the proposed quality priorities for the Royal Orthopaedic Hospital (ROH) IN 2023/24.

2 Background

2.1 Providers of National Health Service (NHS) healthcare are required to publish a quality account each year. These are required by the Health Act 2009, and the Health and Social Care Act 2012 in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended ('the Quality Accounts Regulations').

2.2 Our vision is '*Less pain, more independence, life-changing care*' and we are committed to delivering world leading outcomes and excellent patient experience in line with our values: *respect, openness, compassion, excellence, pride, and innovation*.

3 Our Quality Priorities for 2023/24

3.1 The Trust values the views of our key stakeholders and as in previous years has sought their involvement and feedback to ensure our plans accurately reflect the needs of our patients and the communities we serve. We have done this by consulting with staff, key stakeholders, patients, and members of the pubic using various methods including complaints, PALS and NHS CQC In-patient feedback. The consultation process took place during April and May 2023. Six specific areas to focus our attention in 2023/24 were identified. These priorities link directly to those set out in our refreshed Trust Strategy for 2023 to 2028.

Six specific areas to focus on attention in 2023/24 have been identified.

Safe	Improving the quality and accessibility of communication with patient's, including patient information leaflets, letters, and use of the interpretation service.
Safe	The roll out and implementation of the Patient Safety Incident Response Framework.

Caring	Improving the accessibility of services for patients.
Effectiveness	Antimicrobial Stewardship
Responsive	Optimisation of patient's health prior to surgery.
Well-led	Ensuring gaps are identified and addressed to ensure our work force are culturally responsive to the needs of the people we serve.

3.2 Oversight of the performance will be provided by the Clinical Quality Group, ensuring early escalation of complications by way of regular progress reports. Allowing for early escalation to the Quality & Safety Committee.

Priority 1: Improving the quality and accessibility of communication with patient's, including patient information leaflets, letters, and use of the interpretation service.

Executive lead: Marie Peplow, Chief Operating Officer / Nikki Brockie, Chief Nurse

Why we chose this Quality Priority: Medical and healthcare information can be complex, if people don't get clear and understandable information, they may make decisions that aren't right for them or not be able to access services at all.

Healthwatch UK reports that since the start of the Covid 19 pandemic there has been a national increase in people contacting them due to not being able to obtain information in a way that meets their needs.

How was progress monitored: Progress was reported into the Clinical Quality Group monthly and Quality & Safety Committee quarterly.

How will we evaluate success?

- To Incidents reported relating to patient communication will decrease by 20%
- Reduction in DNA rates
- Friends and Family Feedback will reduce related to communication.

Priority 2: The roll out and implementation of the Patient Safety Incident Response Framework.

Executive lead: Nikki Brockie, Chief Nurse / Simon Grainger-Lloyd, Director of Governance

Why we chose this Quality Priority:

How was progress monitored: Progress was reported into the Clinical Quality Group monthly and Quality & Safety Committee quarterly.

How will we evaluate success?

- Implementation of PSIRF

- Improve themes and triangulation of data

Priority 3: Improving the accessibility of services for patients

Executive lead: Marie Peplow, Chief Operating Officer / Nikki Brockie, Chief Nurse

Why we chose this Quality Priority: To meet and exceed the requirements of the 2010 Equality Act. NHS Services are for everyone. We have a duty to consider everyone's needs when designing and delivering services.

To ensure that everyone can access the services they need regardless of their background, identity, or circumstance.

How was progress monitored: Progress was reported into the Clinical Quality Group monthly and Quality & Safety Committee quarterly.

How will we evaluate success?

- Reduction in DNA rates.
- Increase involvement of users and communities.
- Analysis of protected characteristics of people who use our services.

Priority 4: Antimicrobial Stewardship

Executive lead: Nikki Brockie, Chief Nurse, Matt Revell, Medical Director

Why we chose this Quality Priority: NICE recommendations: Antimicrobial resistance (AMR) in the loss of antimicrobial effectiveness and although it evolves naturally this process in accelerated by the incorrect use of antimicrobials. Direct consequences of infection with resistant microorganisms can be severe and affect all areas of health, such as prolonged illness and hospital stays, increased costs and mortality, and reduced protection for patients undergoing operations or procedures.

How was progress monitored: Progress was reported into the Clinical Quality Group monthly and Quality & Safety Committee quarterly.

How will we evaluate success?

- Audits on the use of antimicrobials across the Trust.
- Prescribers' compliance with PHE and Health Education England's e-learning All Our Health: Antimicrobial Resistance.

Priority 5: Optimisation of patient's health prior to surgery

Executive lead: Nikki Brockie, Chief Nurse, Marie Peplow, Chief Operating Officer

Why we chose this Quality Priority: To reduce health inequalities amongst the community we serve. It is recognised on the day cancellations for surgery occurs and as such the priority seeks to support patients to pre-optimisation prior to surgery. Patients who are not fully

ready for treatment are at a greater risk of significant complications after surgery, which can result in extended hospital admissions, lead to longer term health issues and reduced mortality.

How was progress monitored: Progress was reported into the Clinical Quality Group monthly and Quality & Safety Committee quarterly.

How will we evaluate success?

- Patient outcomes.
- Reduction of patient cancellations on the day of surgery.
- Reduction in delayed discharges.

Priority 6: Ensuring clinical knowledge gaps are identified and addressed to ensure our workforce are culturally responsive to the needs of the people we serve.

Executive lead: Nikki Brockie, Chief Nurse

Why we chose this Quality Priority: To reduce health inequalities amongst the community we serve. To ensure safety of all patients we serve, whilst recognising differing needs due to ethnicity. We must have the ability to recognise risk factors amongst specific groups and be able to take actions to improve their healthcare outcomes.

How was progress monitored: Progress was reported into the Clinical Quality Group monthly and Quality & Safety Committee quarterly.

How will we evaluate success?

- Patient outcomes for patients with condition specifically related to their race i.e., Sickle cell.
- Analysis of protected characteristics of people who use our services.
- Review of the training available to staff and the uptake of relevant training.

4. Recommendations

4.1 The committee is recommended to support quality priority 5, *Optimisation of patient's health prior to surgery.* This priority is in line with the national drive to reduce waiting list.

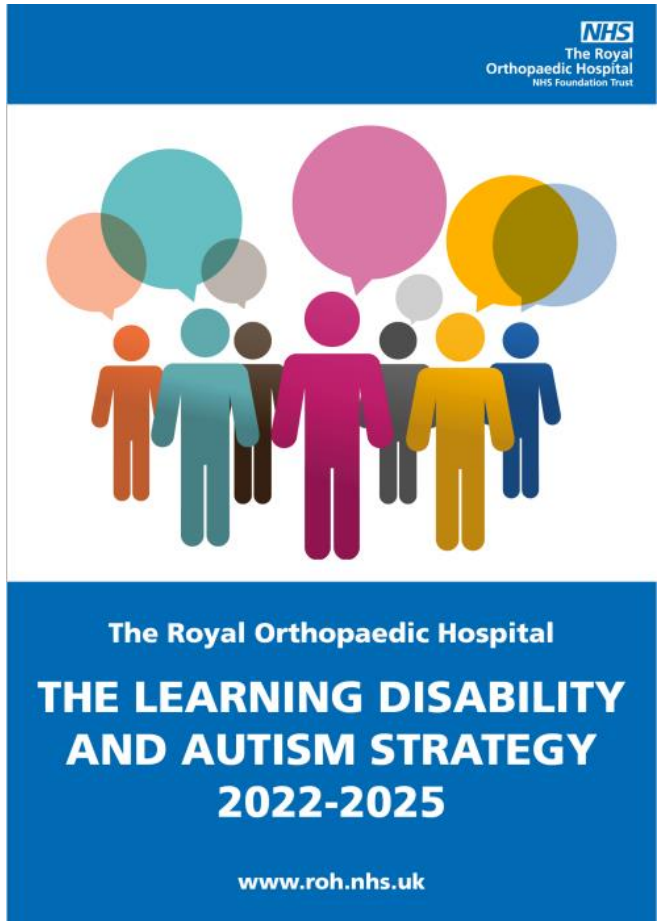
Nicola Brockie
Chief Nurse
May 2023

Learning Disability & Autism Strategy

The Learning Disability Strategy 2017-2020

Since the learning disability strategy was implemented in 2017 there have been several improvements in learning disability care across the Trust, which was echoed by the 2018 CQC report.

- Mandatory awareness training was introduced, both online and face to face with 78% of staff attending learning disability and autism awareness training by 2022
- The Trust signed up to the annual benchmarking project in conjunction with NHS England (NHSE) and NHS Improvement (NHSI) to measure Trusts performance against the Learning Disability Improvement Standards with an action plan developed to implement the standards
- Introduction of hospital passports
- Introduction of the internal learning disability notification system for staff to submit following contact with a patient
- Specialist support given for appointments and admissions
- Introduction of a basic recording system with the view to develop a database
- Implementation of reasonable adjustments e.g. first appointments



Development of The Learning Disability and Autism Strategy

To update the strategy, a staff audit was carried out in April 2021 in a questionnaire format which was completed by 82 members of ROH staff. As well as this, during learning disability week 2022 staff were asked to make suggestions regarding changes they would like to see within the service. Data collated from these inform the priorities and actions laid out in this strategy.

Examples that ROH staff identified as reasonable adjustments they provide daily from the Learning Disability Strategy Audit, April 2021.

To ensure the patient voice was heard and implemented throughout the strategy, a survey was sent out to patients to complete. The responses were analysed and reflected within the priorities and actions.

Data was also used from the annual benchmarking report published by NHS England and NHS Improvement showing how the Trust performs against the Learning Disability Standards. This includes a patient and a staff survey as well as organisational level data collection.

Goal	How will it be achieved	How will it be monitored
We will provide outstanding care	- Ensure the patient is at the centre of every decision regarding their care - Involve important people around the individual in decision making - Increase awareness and use of hospital passports - Increase awareness, understanding and implementation of reasonable adjustments - Communication strategies and appropriate assessments will be used - Learning disability notifications will be submitted following contact - Forward-looking document used to proactively plan - Development of a 'reasonable adjustments flag' by NHS Digital - Smooth detailed handover and discharge - Development of a learning disability database - Ensure effective safeguarding arrangements are in place to ensure any restrictions placed on a patient are proportionate, necessary and regularly reviewed	Bimonthly Safeguarding Committee Annual learning disability audit Annual benchmarking project Patient Engagement and Experience Group Equality Delivery System (EDS) 2 action plan
We will listen	- Face to face learning disability and autism forum to be launched - Patient and parent/carer feedback to be gathered proactively - Involvement of experts by experience in training delivery - Information leaflets about the learning disability service to be developed - Easier access to easy read information - Learn from excellence and best practice	Bimonthly Safeguarding Committee Patient Engagement and Experience Group Annual benchmarking project
We will have the skills	- All staff to attend mandatory learning disability and autism training sessions - Mandatory autism e-learning to be added on ESR - Training to be regularly reviewed and updated to reflect new guidance and best practice - The ROH is committed to rolling out the Oliver McGowan Mandatory Training in Learning Disability and Autism once it has been developed - Staff to utilise the ROH Hub and access information, support and 'how to' guides	Bimonthly Safeguarding Committee Annual benchmarking project Annual learning disability audit
We will have positive partnerships	- Appropriate sharing of information between departments - Partnership working between services - Tailor relationships with patients to support them effectively - Collaboratively work as part of a multidisciplinary team - Appropriate support available for staff	Annual learning disability audit

Less pain. More independence. Life-changing care.
roh.nhs.uk

Welcome

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Learning Disability and Autism Strategy

We will give the very best care to people with learning disabilities and autism.

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

THE GOALS OF OUR STRATEGY

We will provide outstanding care
By putting the patient at the centre of every decision made about their care

We will always listen
By listening to the people we care for and ensuring their voices are heard by everyone

We will have the right skills to help
By providing excellent training and resources to our team to help them deliver the best care

We will build positive partnerships
By working in our Trust and with patients, families and carers and with other agencies

MAKING OUR STRATEGY WORK

Alignment	Engagement	Outcomes	Review
This strategy will align with the Learning Disability Improvement Standards and the wider Trust Strategy.	We will work with our teams to help them understand their roles and we will help patients understand what to expect from us.	We will measure outcomes through an annual benchmarking project, which feeds recommendations back into the service.	We will review our strategy every year to ensure it reflects patient and staff feedback and helps to meet people's needs.

FIND OUT MORE

Florence Dowling
Learning Disabilities Nurse
f.dowling1@nhs.net
07341123385

Ask a question

Resources to support you

Read the full strategy

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

We will give the very best care to people with learning disabilities and autism.

- We will provide the best care by making decisions with you.
- We will always listen to you.
- We will make sure our team know how to care for people with learning disabilities or autism.
- We will work with your family, your carer and other people who look after you.

If you want to ask a question about your care, please visit roh.nhs.uk or scan the QR code.
You can also call 07341123385

How to find support

Florence Dowling, Learning Disabilities Nurse
f.dowling1@nhs.net
EXT: 55721 Bleep: 2688 Mob: 07341123385

PAPER REFERENCE: ROHGO (5/23) 014 (a)

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 25th April 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The Committee noted that there were 106 new starters that had completed the recruitment process and were awaiting start dates from line managers. • Increasing Covid and seasonal illness rates, impacting patients and staff, and resulting in short notice cancellations, were noted. • The Referral to treatment position was below the National Constitutional Target. All patients over 52 weeks were being reviewed by the relevant clinical teams on a monthly basis. • The lack of an electronic referral system in Diagnostics and the potential risk of paper referral forms being lost/delayed and the consequent impact on performance was noted. • Non recurrent funding had been received in 2022/23, generating an underlying financial risk for 2023/24 and beyond. Agency spend continued to remain above plan and causing a significant cost pressure during the year. Above inflationary pressures continued to be a concern.	• ESR and ledger work was being completed in order to reconcile data.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee had received a presentation on the new Trust Data Quality Strategy. It was noted that Data quality, an action from the KPMG audit, had improved. • It was also noted that despite industrial action, activity was at its highest with theatre utilisation above the Trust target. • A number of clinics were being moved from in person to virtual to aid with industrial action. • A Standby system for patients was being piloted for Hands at the end of April. • Two years of patient files had been transported off site and incidents of missing notes had been significantly reduced as a consequence. • A final surplus financial position was reported of £338K • The Month 12 position was actual 1318 vs Plan 1311	• It had been agreed that a decision would be taken outside of the meeting as to whether to maintain the meeting frequency on a monthly basis.

Chair's comments on the effectiveness of the meeting: It was agreed to have been a productive meeting with a good balance of discussions.

UPWARD REPORT FROM THE QUALITY & SAFETY COMMITTEE

Date Group or Board met: 26th April 2023

The Royal Orthopaedic Hospital NHS Foundation Trust

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- There is no improvement in Safeguarding training rates and Committee requested assurance on the plan to secure compliance including interim solutions for electronic training other than ESR.
- A thematic review report of *C difficile* infections was received with 5 of 10 criteria fully assured.
- The Committee received an update on the in-depth work programme related to a previously reported cluster of reportable infections - with no reported patterns and no issues for urgent action. The Trust has resumed its participation in the UKHSS SSIS from Jan 2023. Committee noted the short-term theatre ventilation system failure in March. The risk is on the BAF and Committee requested early discussion at Board on the strategic resolution of this risk.
- There was an increase in moderate harm incidents reported with the majority linked to delays, all undergoing investigation. Committee discussed the reported increase in deaths within 30 days of discharge and requested improved reporting format.
- Committee noted the ongoing issue regarding suboptimal turnaround times for pathology via an SLA. It welcomed the executive oversight and escalation management.
- Committee received a verbal update on the CNO planned quality review of night shift staffing levels.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- The BAF IPC had been received and was noted. The Committee were advised that a new version of the BAF had been issued by NHSE and would be presented to the Committee when available.
- Risk Register. Committee requested improvements to the Risk Descriptors and to ensure that mitigations were clear and up to date at each meeting
- Committee requested the development of the Safer Staffing Report to include other staffing groups which were pertinent to the assurance of safe staffing.
- Quality Priorities 2023/2024. Committee requested consideration of Safety in the finalisation of priorities for circulation and agreement in principle prior to approval.
- Committee requested a report on outcomes, learning and recommendations for improvement in connection with the *C difficile* infections be reported to the next meeting
- Update on night shift staffing required for the next meeting

POSITIVE ASSURANCES TO PROVIDE

- The Committee received a comprehensive presentation on the Trust's Research and Development planning detailing research portfolio, research capabilities, partnerships, and the emergent strategic

DECISIONS MADE

- The Medicines Safety Officer Annual Report had been received and approved. A report on the timeline for Omnicell implementation in all outstanding areas was requested.

direction of travel. Recommended further work on five year objectives and success metrics. Consideration to be given to reporting lines and wider review by Board. • A water safety report was received, for assurance and closure, on the Legionella cases identified in the hospital and it was accepted. • Committee received the Medicines Safety Officer Annual Report 2022. Positive improvement in CD incidents aligned to the Omnicell roll-out. Assurance on safety improvement, thematic analysis and learning. Examples of innovation and excellence. • Committee received a presentation on the Patient Safety Incident Response Framework (PSIRF) providing assurance on the plan and processes underway in the organisation to ensure effective implementation, adoption, and ownership.	

Chair's comments on the effectiveness of the meeting: Length of papers to be reduced and clear recommendations, and greater assurance focus to be considered further. Agenda setting to be reviewed. Effectiveness review action plan to be reported to the next meeting. Good engagement, open, constructive discussions.

PAPER REFERENCE: ROHTB (5/23) 014 (c)

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 26th April 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Further industrial action was scheduled to take place between 30th April and 2nd May. The Committee had been advised that DHSC had asked for the second day of industrial action to be classed as unlawful. Guidance had been to plan for strike action and the team were working through the mitigations.
- The Committee received a workforce update and noted that there continued to be a high number of working days lost to MSK, stress and anxiety.
- The Committee noted that the timelines proposed for work on workforce planning seemed too lengthy, given its urgency.
- The number of paper personnel files retained in the organisation was of concern and a robust record management system was required. The work was being led by THi.
- The incidents of verbal abuse the HR and administration teams were subjected to would be added to the risk register. Resilience training would also be implemented as part of the mandatory training. Clear reporting of incidents was also required. The matter would be raised at Trust Board.
- A turnover and retention report, with cleansed data, had been received and key risks and next steps highlighted.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- The Committee were advised that a Pregnancy Loss Policy would be launched imminently.
- A second meeting with Managers would be taking place in May to discuss the action plan for the Staff Survey.
- An Annual Leave policy had been drafted and would be submitted to Executives in the coming weeks.
- It was noted that there continued to be a high level of spend on Bank and Agency staff. The committee requested that an agency reduction plan be developed and brought back to the Committee, showing plans for reducing usage, trajectories, and timelines.

POSITIVE ASSURANCES TO PROVIDE

- The Committee received the story of a member of staff who had taken part in the EPIC (Enabling a Productive & Inclusive Culture) Programme.

DECISIONS MADE

- The Committee had received and accepted the recommendations in the Workforce Planning Audit.

The member of staff, an advanced nurse practitioner, had previously worked at the Trust in 2006, left in 2009 and subsequently returned in 2016. She had taken part in the second cohort of the programme and, as an output, intended to establish a forum for international nurses. She was also very active in the Trust's MME Group. She explained that, whilst nursing was an international profession, some difficulties were experienced in the volume of paperwork, policies and procedures in the UK. Her collaboration was requested on developing the service recruitment plan. • The ROH had been commended for ranking 7th in the top 50 inclusive employers and encouraged to enter the Recruitment Industry Disability Initiative Awards the following year.	

Chair's comments on the effectiveness of the meeting: The meeting frequency change was commented on and it was felt that the additional time between meetings was useful. It would continue to be monitored.

UPWARD REPORT FROM TRUST BOARD

Date Board met: 3rd May 2023

MATTERS OF CONCERN OR KEY RISKS CONSIDERED	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Strike action and mitigations had been discussed and assurance that plans were in place had been received. • Staff turnover was being scrutinised and data analysed. Retention strategies were being designed.	• Patient Safety Incident Response: a presentation was received. The work was being implemented using QSIR methodology and was on track to be delivered on time. • Childcare provision was being researched. Tax implications were also being considered.
POSITIVE ASSURANCES RECEIVED	**DECISIONS MADE**
• Patient Story: Safeguarding. Candy and Jenny, nurses from Children and Young People Outpatient Department, gave a presentation on a young patient who had been missing appointments. The team followed the *Was Not Brought Policy* and safeguarding procedures. Their actions prevented a vulnerable patient from facing further harm. • Blue Hearts: 580 nominations had been received. Shortlisting had taken place and the awards would be taking place on 21st June. • CQC routine engagement visit had taken place and positive feedback was received. • A summary on Patient Stories and Patient Experiences was received. A number of initiatives had taken place to receive feedback from patients so as to learn from positive and negative feedback.	• It had previously been decided that the Committee meeting frequency would be changed, and Committees would now meet on alternate months. It had been agreed that it would be kept under review.

Finance and Performance Report

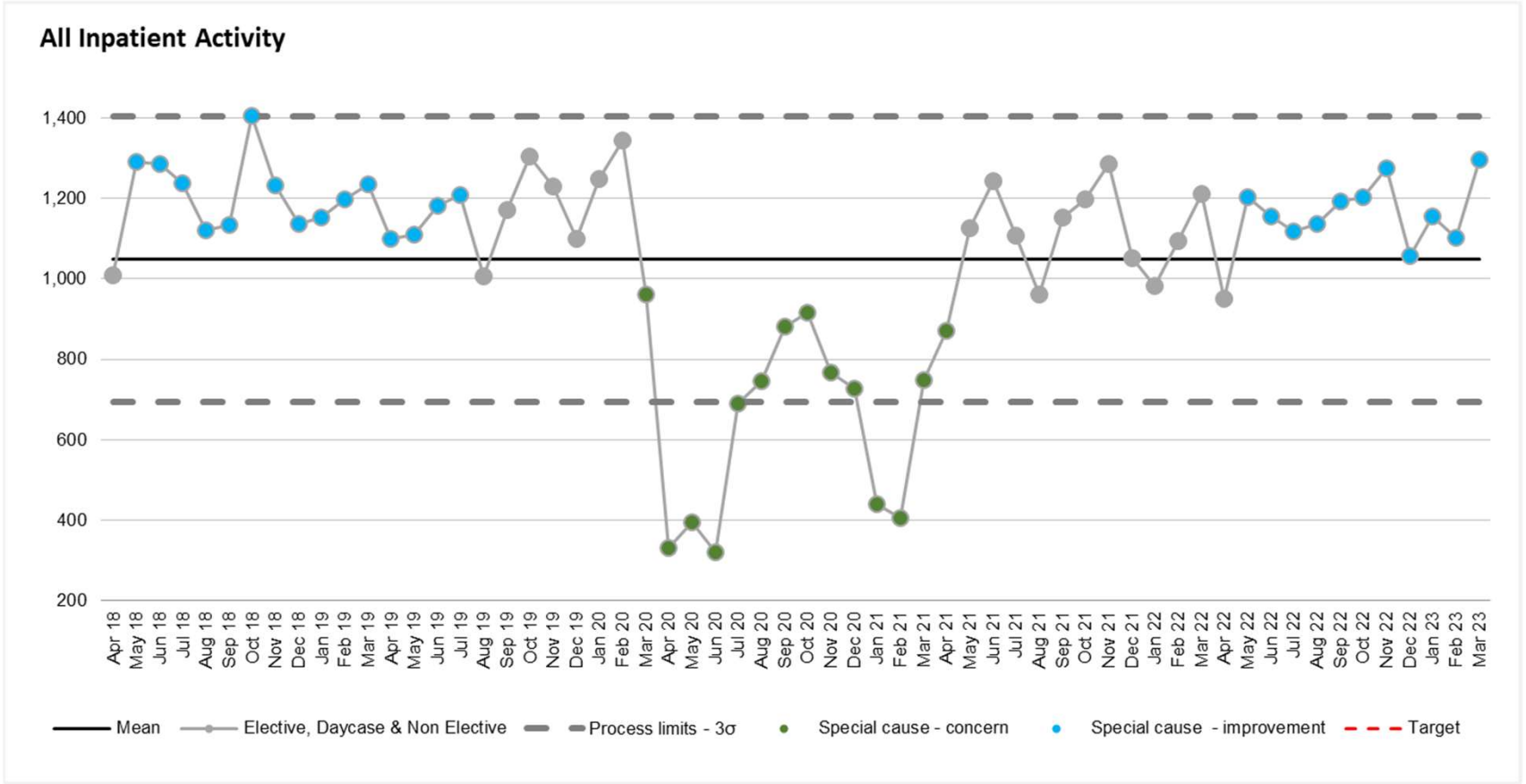
Month 12

Introduction

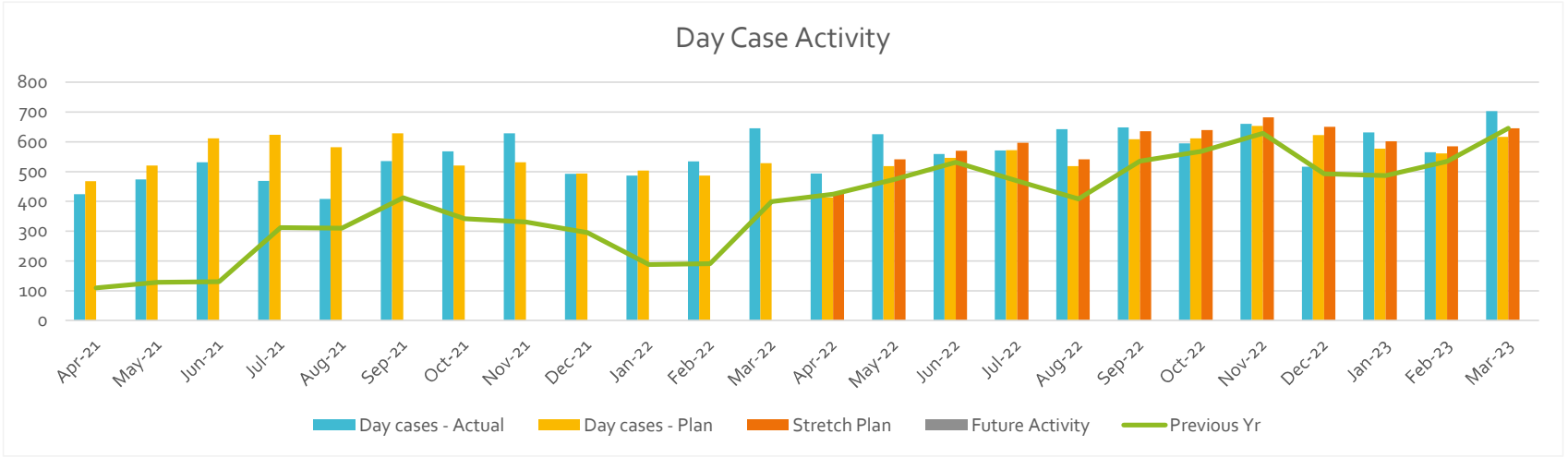
The Finance & Performance Report provides an overview of the Trust's performance against Key Performance Indicators (KPIs) that support the delivery of the Trust's Strategic Objectives.

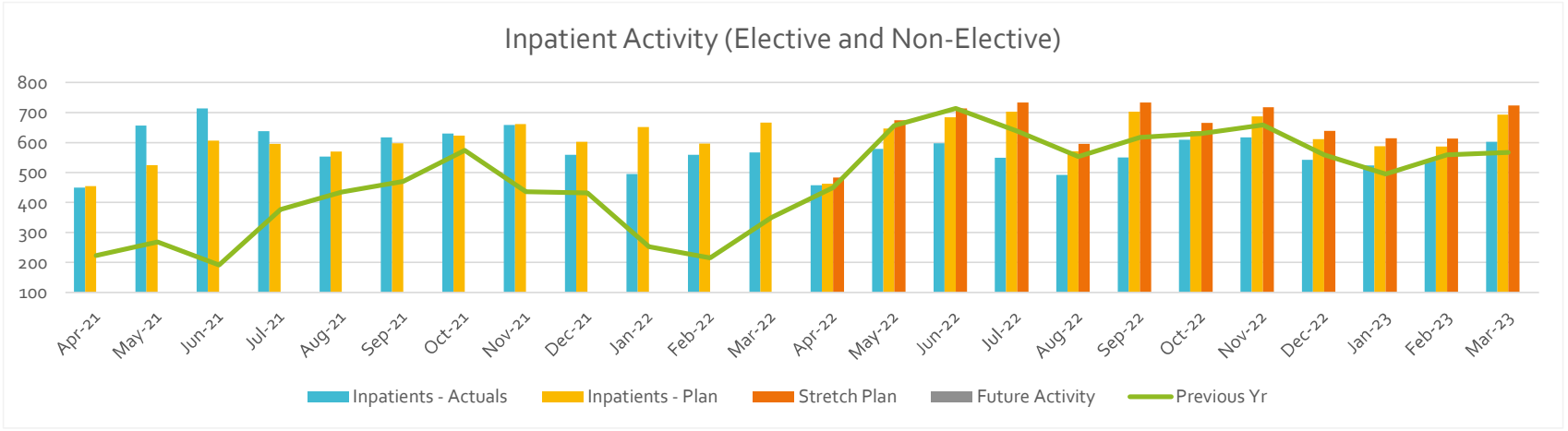
A range of metrics will be assessed to give assurance of performance related to; finance, activity, operational and workforce requirements. In month and annual performance will be assessed with a clear explanation around any findings, including actions for improvement, learning and any risks and/or issues that are being highlighted.

1. Activity Summary



1. Activity Summary





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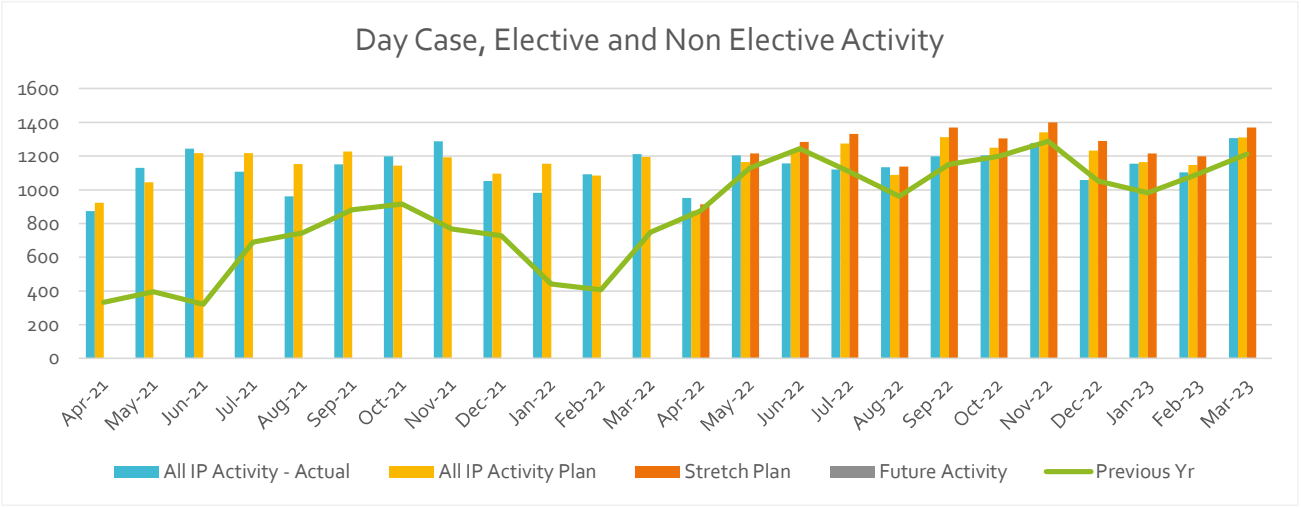
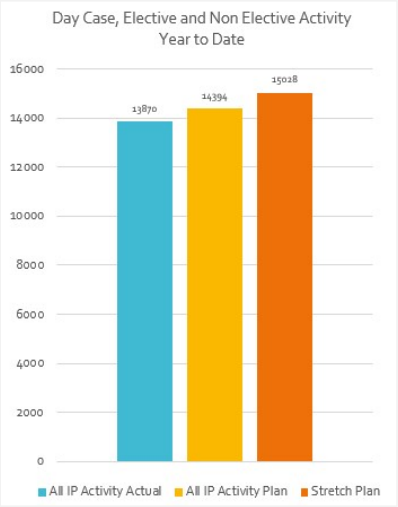
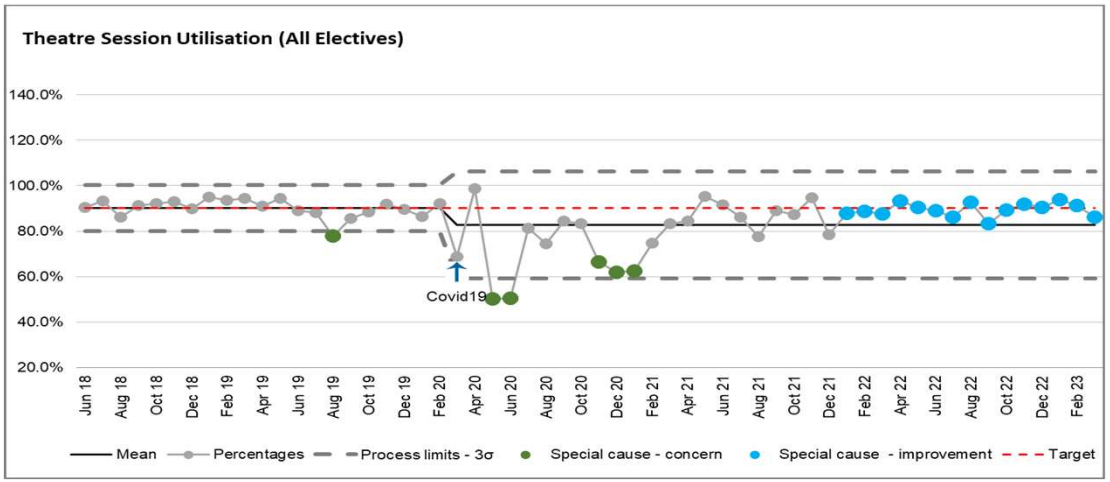


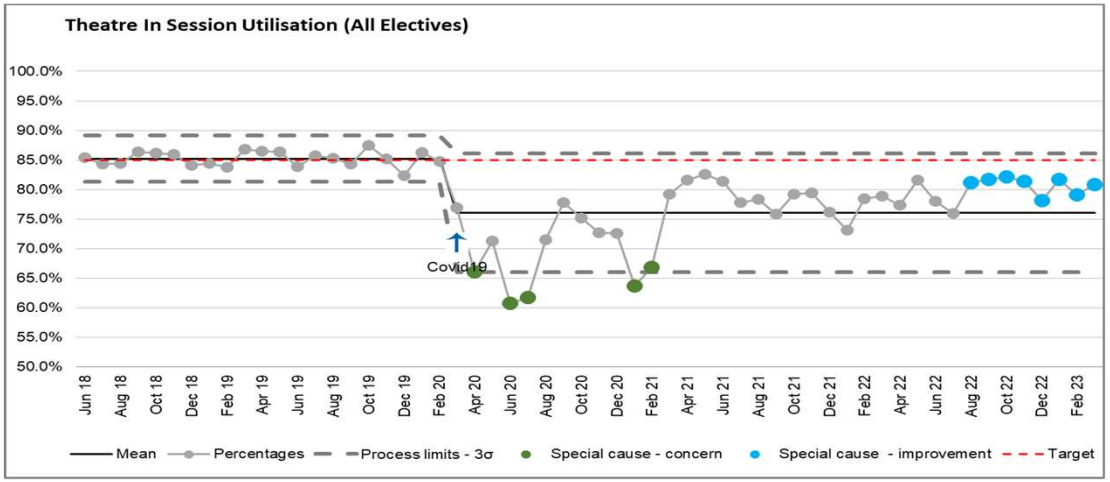


		Plan												Plan	Actual	% Achieved	Variance
	Activity Type	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Year to Date	Year to Date	against plan	Year to Date
Trust Plan	Inpatient	439	623	660	679	547	679	614	664	588	564	563	670	7289	6341	87%	-948
	Daycase	413	519	546	572	518	608	612	653	622	577	561	617	6817	7210	106%	393
	NEL	24	24	24	24	24	24	24	24	24	24	24	24	288	319	111%	31
	All Activity	**876**	**1165**	**1230**	**1276**	**1089**	**1312**	**1250**	**1340**	**1234**	**1164**	**1148**	**1311**	**14394**	**13870**	**96.4%**	**-524**
Stretch Plan	Inpatient	459	651	690	710	572	710	642	694	615	590	589	700	7622	6341	83%	-1281
	Daycase	431	541	570	597	541	635	639	682	650	602	585	645	7118	7210	101%	92
	NEL	24	24	24	24	24	24	24	24	24	24	24	24	288	319	111%	31
	All Activity	**914**	**1216**	**1284**	**1331**	**1137**	**1369**	**1305**	**1400**	**1289**	**1216**	**1198**	**1369**	**15028**	**13870**	**92%**	**-1158**

March 2023
Trust / system plan – Actual 1318 v Plan 1311
Stretch Plan – Actual 1318 v Plan 1369
NB : plan against actual +7
YTD position against Trust/ system plan is 96.4%

2. Theatre Utilisation





Elective Session Utilisation (March 2023)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	499	443	56	88.78%
UHB	103	75	28	72.82%
Totals	602	518	84	**86.05%**

Elective In Session Utilisation (March 2023)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1960	1620	339	82.68%
UHB	339	238	101	70.22%
Totals	2298	1858	440	**80.84%**

2. Theatre Utilisation

SUMMARY

Overall theatre session utilisation for March was **86.05% which was above the Trust target of 85% .**

However, the total in-session utilisation was **80.84**%; the main driver for this was the loss of capacity due to the industrial actions (IA) on the 13th – 15th March 2023. The Trust lost 12 theatre lists in March (24 sessions0 due to IA.

AREAS FOR IMPROVEMENT

At the end Apr 23, theatres are piloting a Surgical 'Stand-by' patient process in the Hands / Arthroplasty May service to improve theatre in-session utilisation.

May 2023 a deep dive into early finishes supported by the clinical teams is planned , supported by the power BI dashboard metrics with a focus on key specialties where early finishes are more prevalent. The aim is to help reduce the number of early finishes. The team will feed back on progress in May 23.

A soft launch of the theatre efficiency BI dashboard is underway. The aim will be to provide access and tool kits to our heads of services to help identify bottlenecks within individual services to drive improved efficiency. Training is being arranged for all staff including sharing with clinical colleagues via the specialty triumvirates , with the aim of sharing current position to drive productivity going forward .

On-going engagement with operational teams is taking place to agree and introduce speciality level utilisation targets that will feed into the theatre dashboard to help streamline service level improvements. Each specialty will have a monthly activity plan and stretch plan, which will be monitored at divisional board and Operational management Board .
6 day theatre working group established as part of Elective Hub accreditation programme

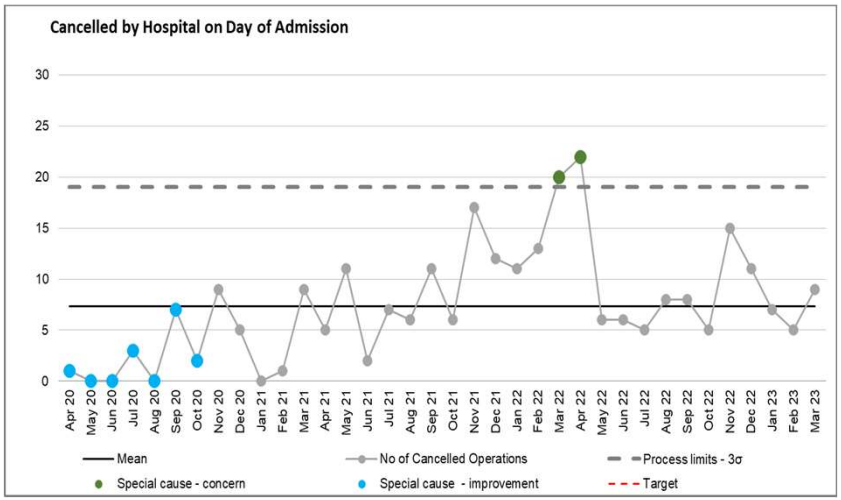
RISKS / ISSUES

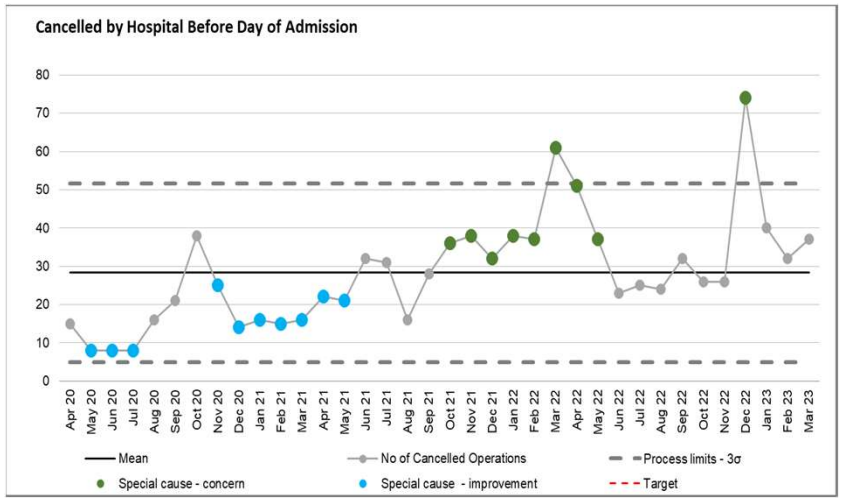
Risk of continued Impact of trends of increasing Covid rates impacting on both patients and staff.

Theatre Recruitment is ongoing , current vacancies are 34.53 WTE, Recruitment drive is being supported by Communications team.

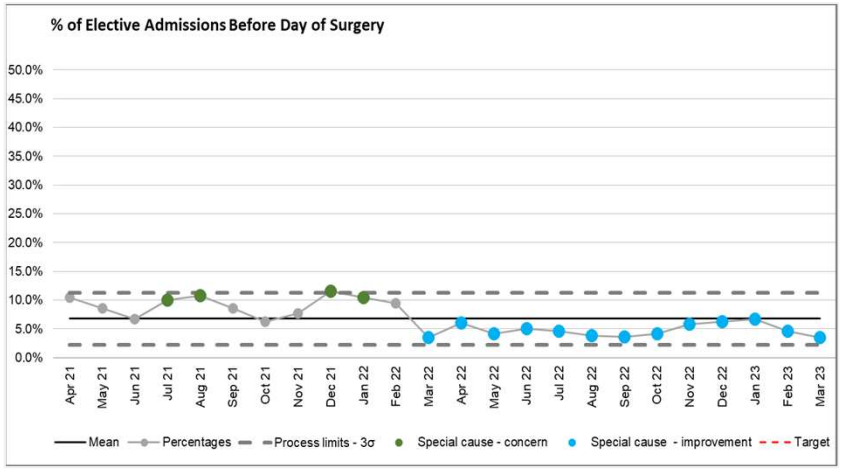
LLP 's being developed by sub specialties – currently being reviewed by DOF and COO to support additional activity out with job planned sessions.

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
Mar-22	20	28	61	109	0
Apr-22	22	25	51	98	2
May-22	6	40	37	83	1
Jun-22	6	28	23	57	1
Jul-22	5	28	25	58	0
Aug-22	9	28	23	60	0
Sep-22	8	29	32	69	0
Oct-22	5	35	26	66	0
Nov-22	15	18	26	59	0
Dec-22	11	24	74	109	0
Jan-23	7	25	40	72	0
Feb-23	7	29	33	69	0
Mar-23	9	31	37	77	0
Total	**130**	**368**	**488**	**986**	**4**



2. Theatre Utilisation/ Hospital Led Cancellations

SUMMARY

The number of cancellations / deferrals detailed on the previous slide does not include patients who were either emergency or urgent cases as these are more difficult to avoid due to the very short notice booking:

There were 9 patients cancelled on the day in March 2023 with reasons detailed as follows:
4 x Staffing related sickness
4 x Theatre equipment / kit related issues
1 x Patient not fit

There were 31 patients admitted and treatment was deferred, with the reasons detailed as follows:
25 x Medically unfit / Clinical change in condition / covid / flu related
1 x Patient choice
2 x Theatre plant failure
3 x Lack of theatre time

There were 37 patients cancelled by the hospital the day before the date of admission.
12 x Medically unfit / Covid/Flu related
7 x Staffing related sickness
2 x Industrial Action
3 x Replaced by medically urgent cases
4 x Consultant decision
9 x Patient choice / Surgical choice

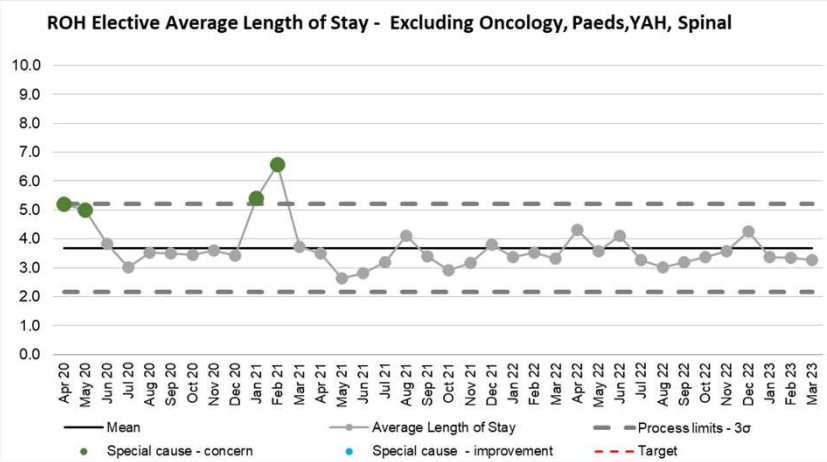
AREAS FOR IMPROVEMENT

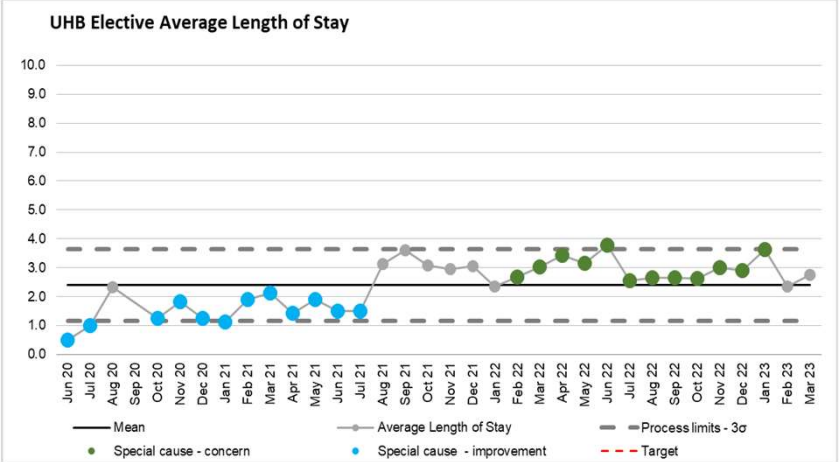
- As detailed on the previous slide and in line with the Recover and Deliver programme monitored at the Service Improvement board.
- Progress is being made on the introduction of stand by patients, pilot due to start for Hands by end April 23 and to then roll out to Arthroplasty .
- Deep dive into the patients cancelled due to no longer requiring surgery or patients changing their mind about surgery to take place, The deep dive is to establish if there is any learning / process changes required to prevent / reduce the risk of this continuing..

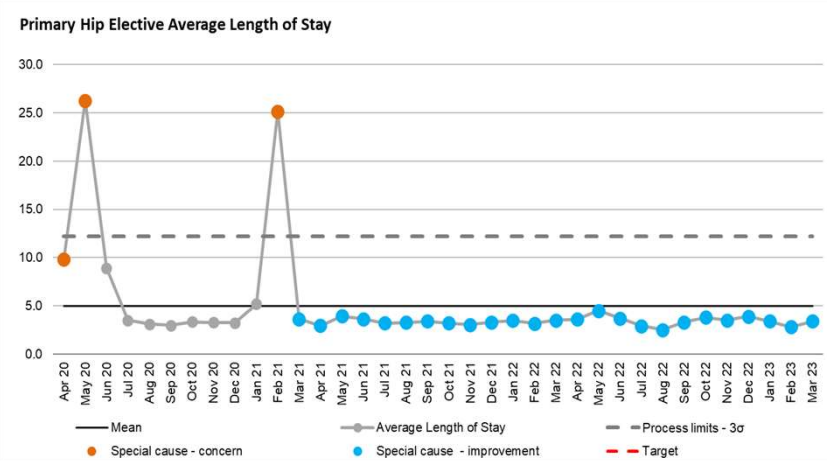
RISKS / ISSUES

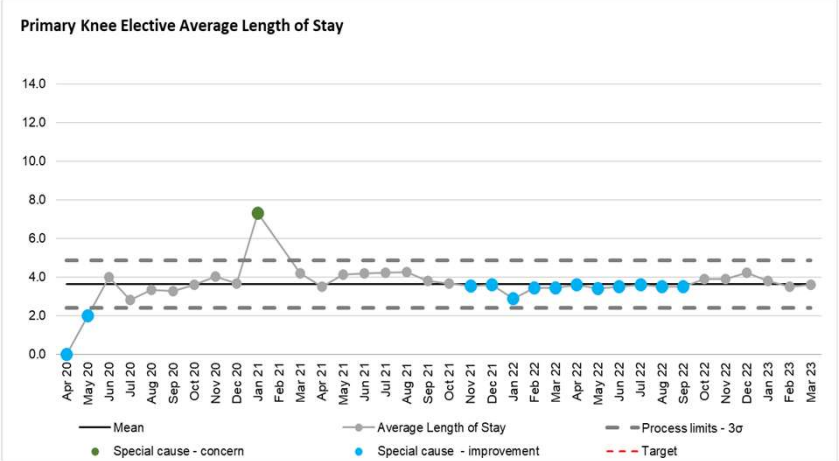
Covid is continuing to have an impact on both patients and staff.
March 23 saw a rise in seasonal illnesses generating a high number of short notice cancellations due to patients and staff becoming unwell with flu, colds, COVID

3. Length of Stay









3. Length of Stay

SUMMARY

The average length of stay for ROH patients excluding Oncology, Young Adult Hip and spinal is **3.28** (3.34 February).

The average length of stay for ROH primary Hips is at 3.4 days (2.8 days February 23) and primary Knees 3.6 days (3.5 February 23).

March 2023 length of stay data produced for UHB and ROH, has been reviewed and the following observations made:

- 6 (8 Feb) UHB arthroplasty patients with LOS greater than 3 days. 4 (5 Feb) with a length of stay greater than 5 days and 1 (4 Feb) with a stay greater than 7 days. (excludes Rehab). It should be noted that UHB had a total of 15 patients within the data.

- 59 (65 Feb) ROH patients, arthroplasty and oncology arthroplasty, with a LOS greater than 3 days. 35 (17 Feb) with a length of stay greater than 5 days, 13 (10 Feb) with a length of stay greater than 7 days.

In summary 13 ROH arthroplasty and 1 UHB arthroplasty patient had a length of stay greater than 7 days.
On review of the 13 ROH patients: 8 were primary hip/knees, 5 were revisions or other complex arthroplasty procedures. All had medical or social care needs.

In February 169 patients went home via the discharge lounge (170 Jan). Number of patients discharged home before lunch 36% in February,**35%** January , (March data not yet available).

AREAS FOR IMPROVEMENT

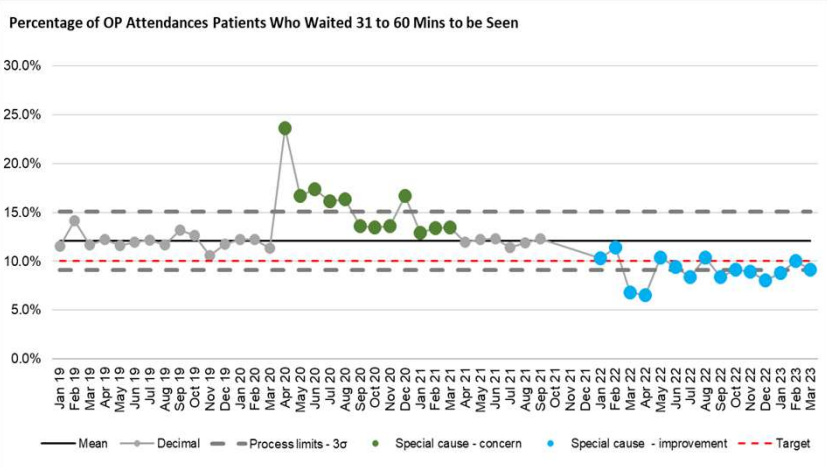
Updates against previous actions:

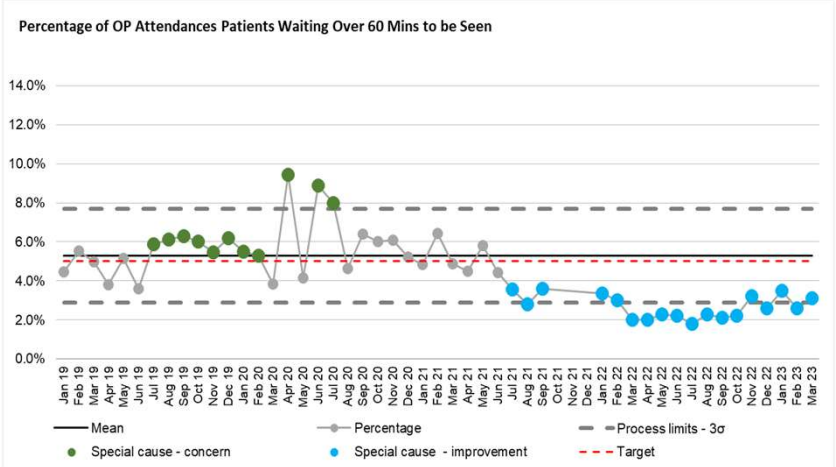
- Aspiration for overall Average LOS for primary arthroplasty patients of 2 days. This is in place for uni-knees and planning is being undertaken for TKR and shoulder cases

RISKS/ISSUES

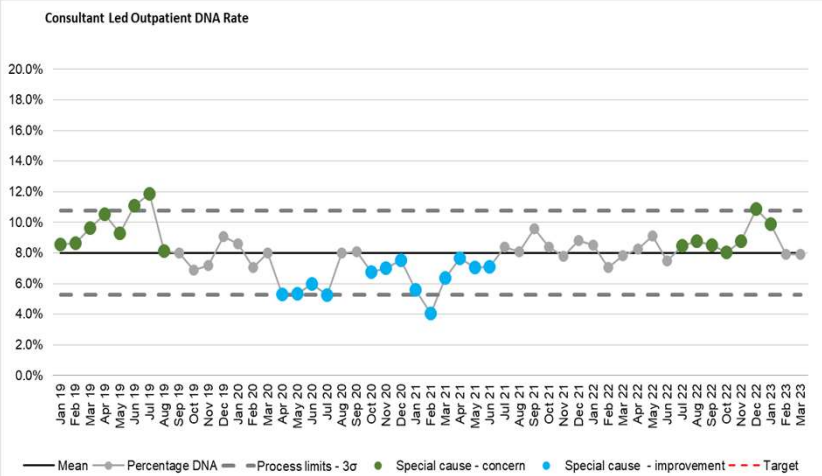
Major Revision Centre/BIS work . A service framework is currently in development, in association, with the clinical teams and the national programme.
Social care and other medical needs of primary arthroplasty patients will need to be taken into account when aspiring to 2 day LOS. Process for monitoring and escalating any delays in accessing POC or Rehab.

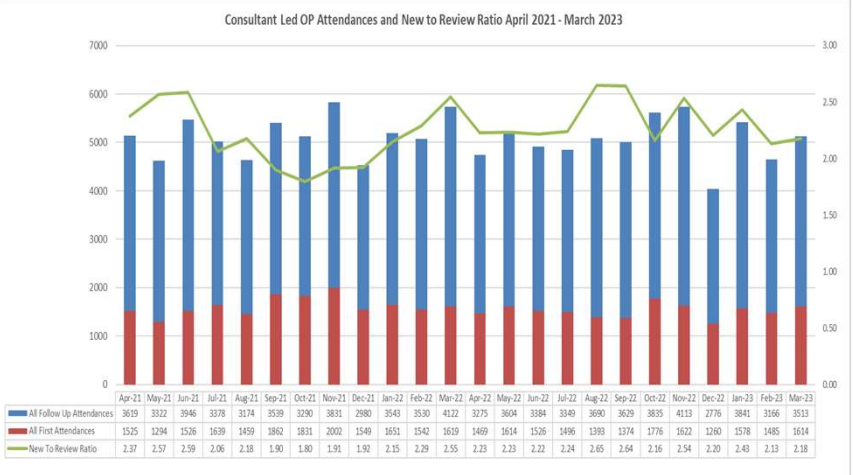
4. Outpatient efficiency

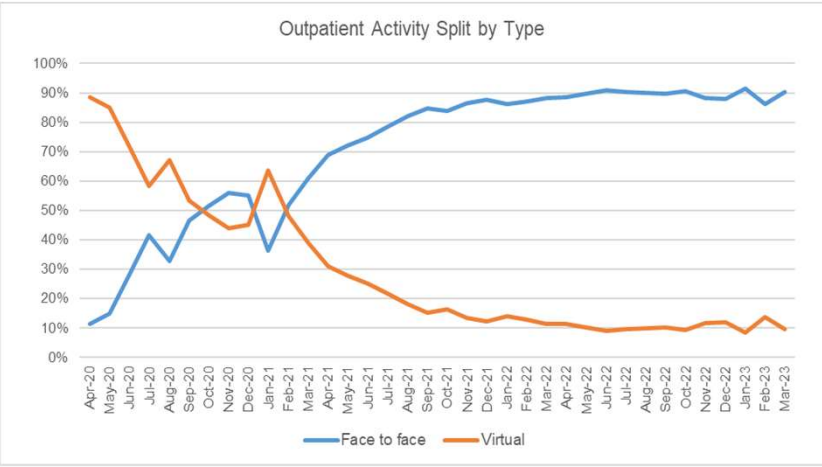


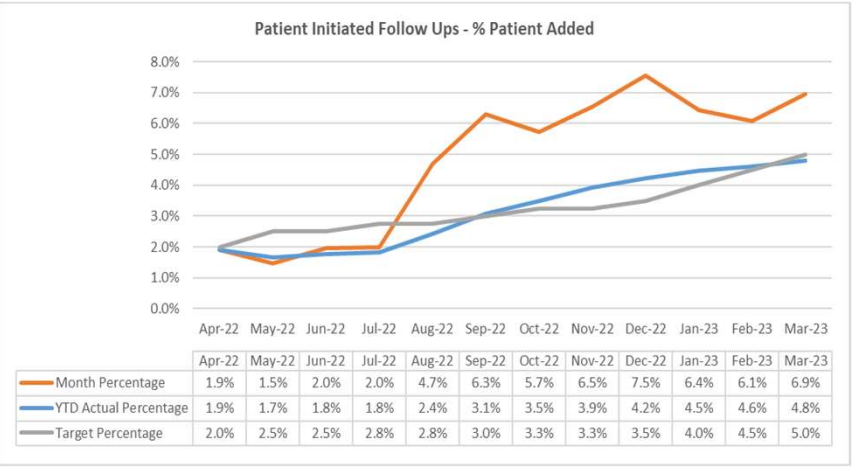


4. Outpatient efficiency









4. Outpatient efficiency

SUMMARY

There were 4,639 face to face and 496 virtual appointments carried out in March 23 (**9.6 % virtual**).

The electronic referral management system (RMS) has now gone live in all adult services. Paediatrics will go live shortly and the system has significantly improved the tracking of referrals , however the visibility of referral progression when compared to the paper process is highlighting milestones where referrals progressing to the appointment stage can be delayed e.g. triage by specialty, awaiting images from external organisations etc , therefore refreshed KPIS are being agreed for the referral management process and a daily report to monitor performance is currently in development .
This month **6.9%** of outpatient attendances moved to the PIFU waiting list. The overall YTD position is **4.8%.** In total there are 3,447 patients on a PIFU waiting list. Work to validate the PIFU list is ongoing and digital solutions via Dr Doctor for PIFU management are being explored.

AREAS OF IMPROVEMENT

Clinic Delays:
30 minute delays **– within trust target at 9.1% (Target 10%)**
60 minute delays – **within trust target at 3.1% (Target 5%)**

The DNA rate for March has remained stable at **7.92** % and is within the Trust target of 8%. The aspirational Operational target for 23/24 is 6%. A reduction of DNAs is confirmed as one of the key Divisional quality improvement schemes for 2023/24 with a plan to extend the use of the Dr Doctor system, and continue to audit via the patient experience team to ascertain the reasons behind patient DNAs and patient not brought outcomes as part of the wider access and inequalities agenda
DNA rates are monitored on a regular basis and the Dr Doctor system is due to be rolled out further across the Trust in Radiology and then Therapies as part of the 23/23 Operational productivity plan.
Clinic templates are being reviewed again to ensure accuracy against job plans as we enter the new financial year. This is a large project which is being overseen by the Clinical Service Manager for Performance. The revised templates will ensure that clinic capacity is optimised to make the best use of resource and further reduce clinic delays
Electronic outcomes project is underway and this will be trialled in Young Adult Hips and Therapies (Podiatry).

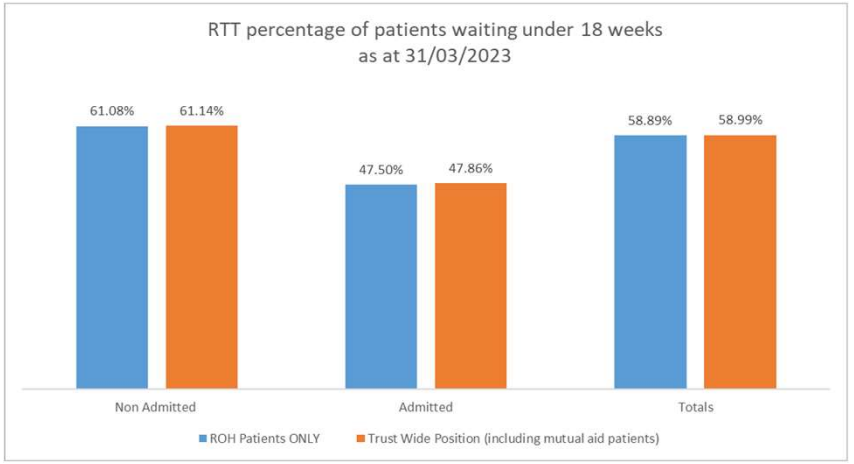
RISKS / ISSUES

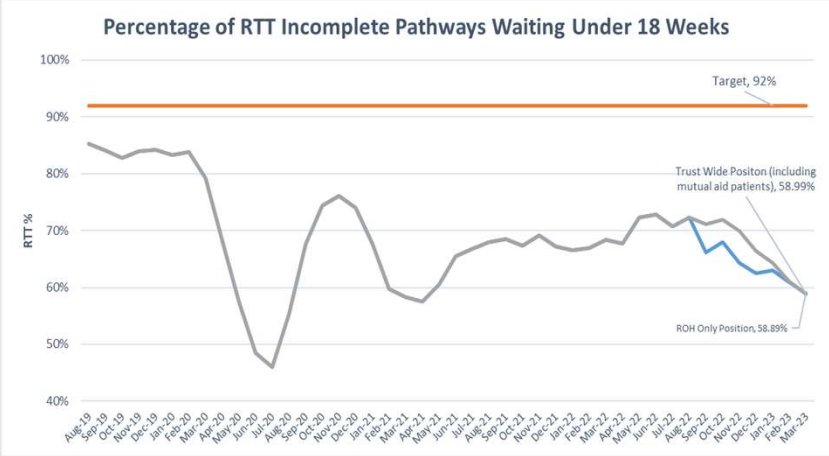
- 2 years of notes transported off site, freeing up space in the library. Incidents of missing notes have been significantly reduced and notes from offices around the Trust have been repatriated to the Medical Records department.
- The team continue to work to improve Appointments KPI performance following a period of recruitment and retention challenges. KPIs are monitored daily with Divisional oversight and the team have made substantial progress in this area. The appointments team are due to move to new office space in the old therapies area which will allow further planned expansion of the team to ensure KPIs continue to be met..(Date TBC)
- There is a regular task and finish group, which has cross divisional and clinical representation. Incident reports relating to the visibility of referrals enabled by the roll out of electronic referrals are being actively managed and investigated, ensuring feedback has been given to the reporters. A thematic review will be monitored at the executive governance meeting for assurance and included in the QSC upward report once finalised.(May 2023)

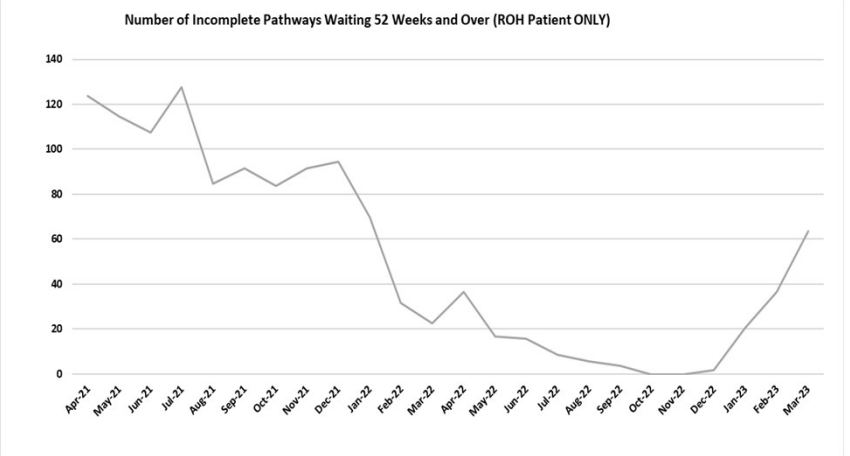
5. Referral to Treatment

	ROH Patients ONLY			Trust Wide Position (including mutual aid patients)		
Weeks Waiting	Non Admitted	Admitted	Totals	Non-Admitted	Admitted	Totals
0-6	3,503	498	4,001	3,520	512	4,032
7-13	2,497	410	2,907	2,512	415	2,927
14-17	1,413	205	1,618	1,419	205	1,624
18-26	2,490	482	2,972	2,498	482	2,980
27-39	1,742	524	2,266	1,742	524	2,266
40-47	381	153	534	381	153	534
48-51	70	47	117	70	47	117
52 weeks and over	40	24	64	44	27	71
Total	12,136	2,343	14,479	12,186	2,365	14,551

Weeks Waiting	Non Admitted	Admitted	Totals	Non-Admitted	Admitted	Totals
Under 18	7,413	1,113	8,526	7,451	1,132	8,583
18 and over	4,723	1,230	5,953	4,735	1,233	5,968
Month End RTT %	**61.08%**	**47.50%**	**58.89%**	**61.14%**	**47.86%**	**58.99%**







5. Referral to Treatment

SUMMARY

The Referral To Treatment (RTT) position for March was **58.99%** against the National Constitutional Target of 92%. This represents a 1.87% decrease compared to February reported position at **60.86%** which relates to inclusion of the mutual aid patents **.**

There were **71** patients waiting over 52 weeks in March, a decrease from the trust wide position in January which was **105.**

All patients over 52 weeks are being reviewed through the harm review process. No harm has been concluded on any of these patients to date. The team have **651** ROH patients who are currently waiting over 40-51 weeks. All patients in this category are being regularly reviewed by the relevant clinical teams on a monthly basis and the services meet weekly for an in-depth review of the PTL.

The Team continue to work in partnership with UHB and RJAH to support with the Mutual aid.. There are 68 patients of the original 2000 cases transferred in Quarter 3 of 2022/23 and we have agreed to support an additional 170 cases at UHB.

During Mar 23, ROH received 2,731 referrals (101%) when compared to pre covid levels. 2,704 is the average monthly referrals received Pre-Covid. The team continues to work closely with the system and GP's to restore pre COVID referral levels and continued growth patterns. Regular meetings are in place to ensure the team keep in contact and update the ICB and GP's on the current position and mutual aid support being provided.

AREAS FOR IMPROVEMENT

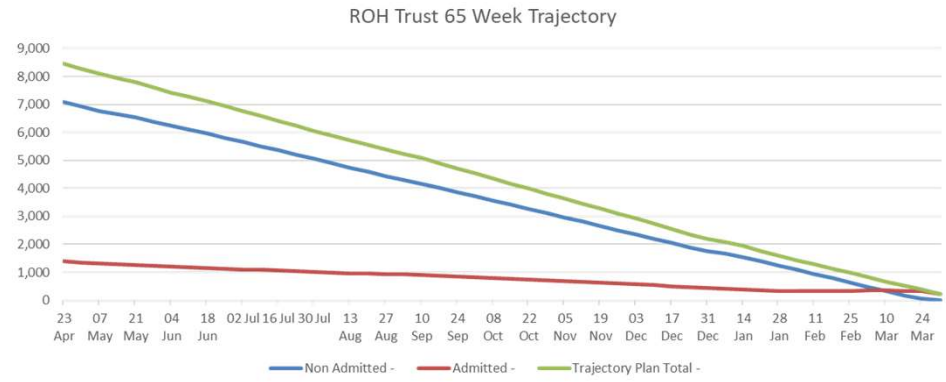
Newly appointed Associate Director of Operations for system integration and oversight – will be overseeing all mutual aid to ensure compliance with targets and minimise impact on ROH performance. PTL meetings are in place with RJAH to review the PTL 3 times per week. Deputy COO has overall oversight of mutual aid plans and delivery.

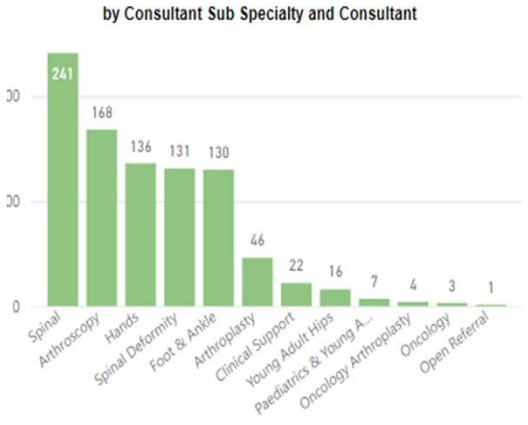
RISKS / ISSUES

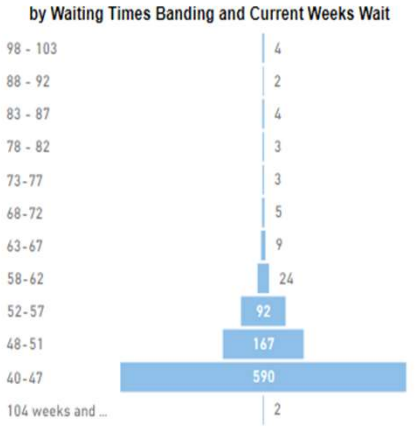
Due to a combination of the Mutual aid and industrial action there continue to be risks around Internal 52 weeks for ROH. This is being monitored closely by the Operational/ performance teams.

5. Referral to Treatment

Elective Recovery: Trajectory to eliminate 65 week waits and Mutual Aid Assurance

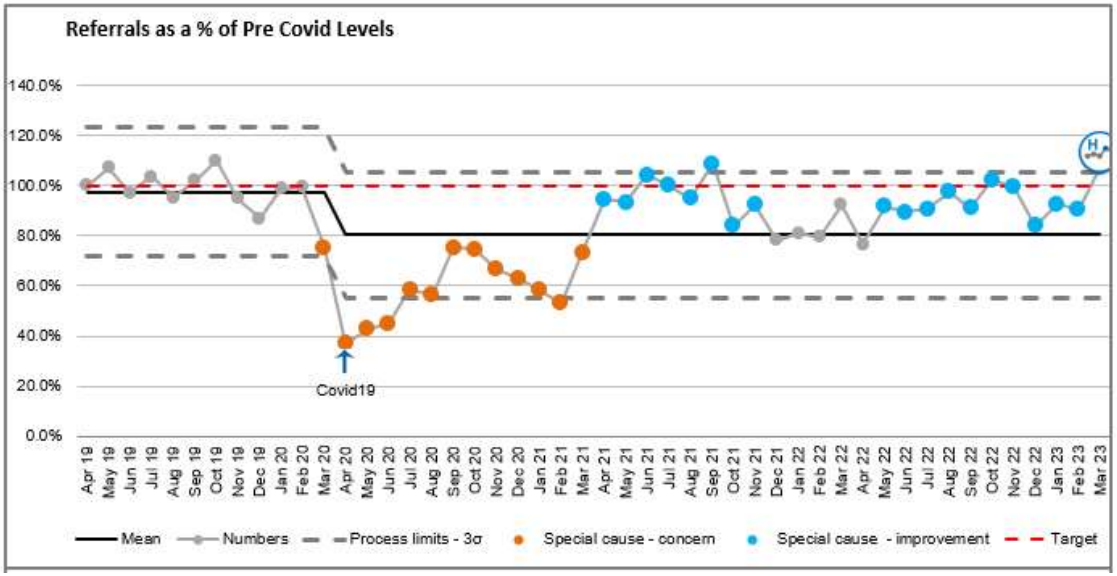






- Ddelivered national mandate for zero 78 week wait patients by the end of March 2023.
- Trajectory produced for the delivery of elimination of patients waiting over 65 weeks by March 24
- We are providing mutual aid support for RJAH patients in Spinal Services. There are currently 48 patients on the ROH PTL who were transferred from RJAH, a proportion have already waited longer than 78 weeks.
- We continue to work with UHB and the system to support this year's 65 week wait focus as a system.
- The team continue to work in partnership with UHB and the system on shared PTL oversight. There are 68 patients of the original 2,000 cases transferred in Quarter 3 of 2022/23 and we have agreed to support an additional 170 cases with a waiting profile of between 59-71 weeks in Quarter 1 of 2023/24.

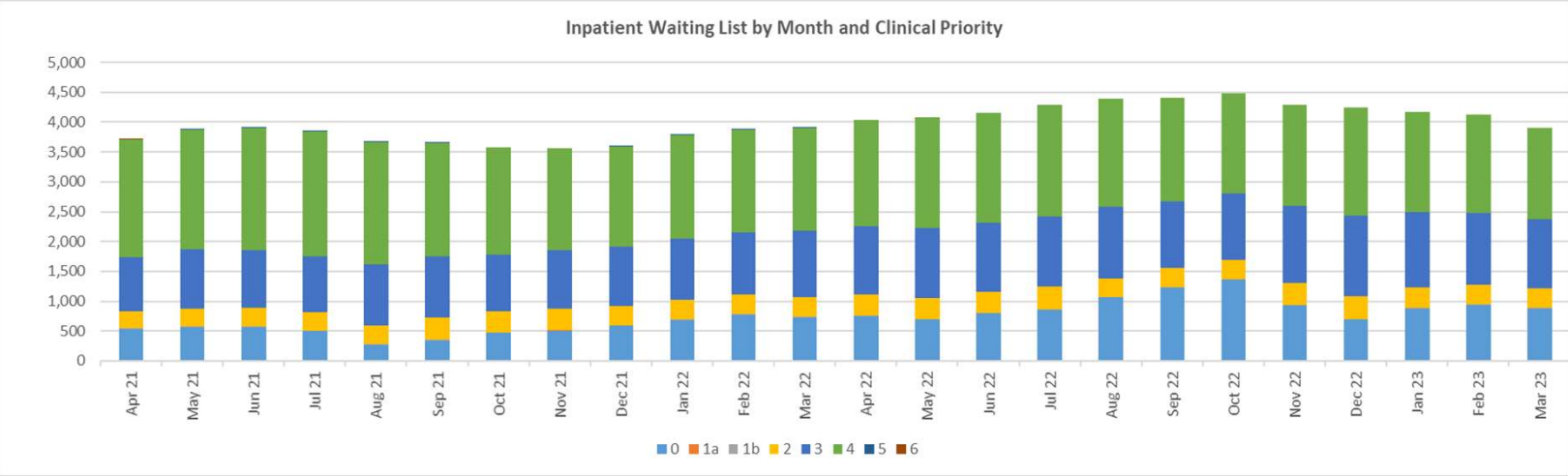
5. Referral to Treatment



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	2065	2480	2417	2450	2632	2462	2769	2686	2267	2501	2444	2896
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%	76.37%	91.72%	89.39%	90.61%	97.34%	91.05%	102.40%	99.33%	83.84%	92.49%	90.38%	107.10%

5. Referral to Treatment



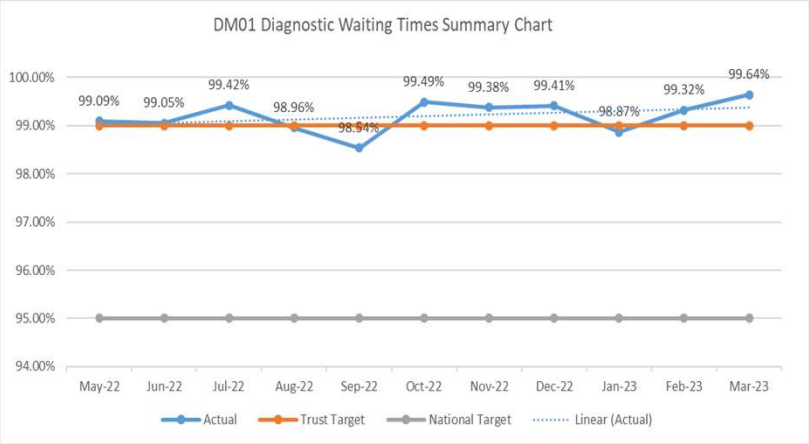
	Number of IP waiting as at	% of IP waiting as at
Priority	31/03/23	31/03/23
0	881	23%
1a		0%
1b	3	0%
2	327	8%
3	1161	30%
4	1526	39%
5		0%
6		0%
Total	3898	100%

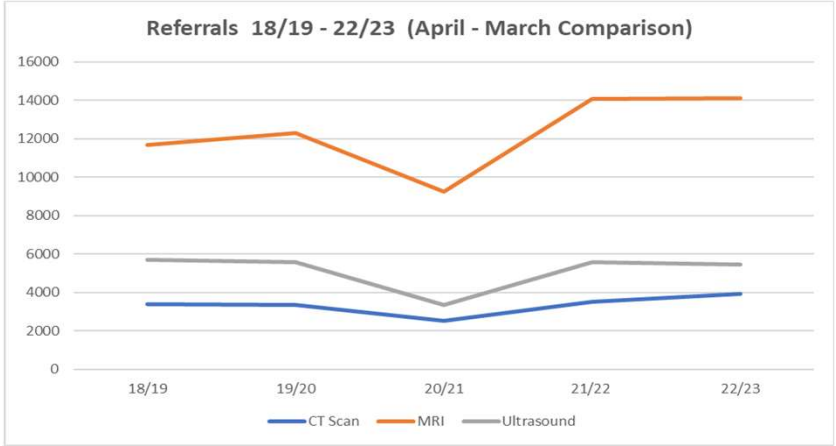
All specialities review and update admitted patients without a priority status. Regular review meetings are held to ensure that all patients are given a priority before being added to an Inpatient waiting list. In addition, an ongoing clinical audit is underway, reviewing all patients who have breached their priority score.

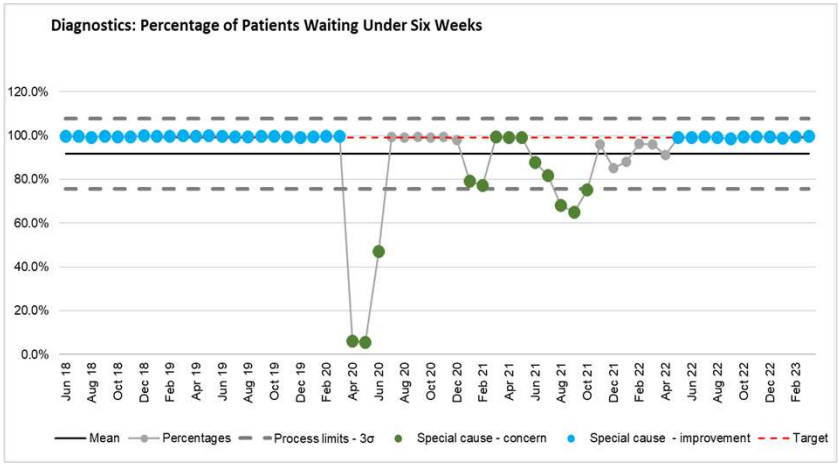
Figures show total inpatient waiting list including planned patients and patients with a TCI date.

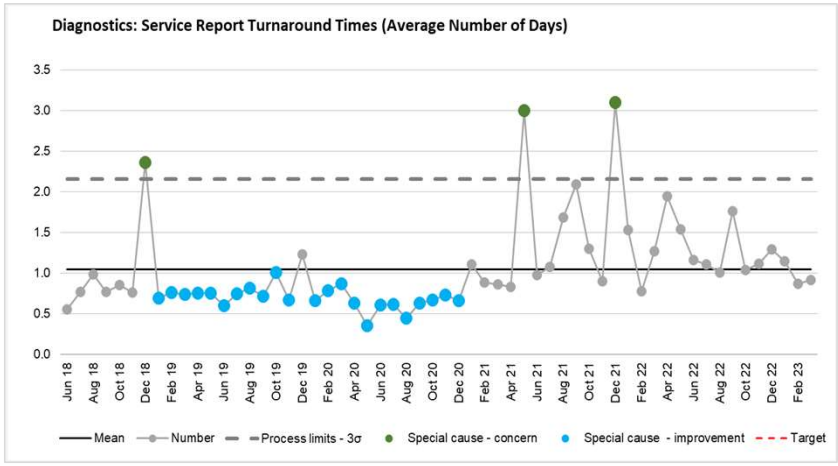
6. Diagnostic Performance

% of Patients Waiting <6 Weeks for Diagnostic Test - National Standard is 99%









6. Diagnostic Performance

SUMMARY

The Imaging service achieved the 99% DM01 target in March 2023 closing the month at 99.64%. The main area of challenge remains with paper based referrals being received late into the Imaging Department resulting in breaches. Order Comms (e-requesting) will be with the Trust soon and will help eliminate any delays.

The National 22/23 operational target remains at 95% which ROH are achieving; however, we have retained reporting against the traditional 6 week diagnostic target locally as our aspirational target and is within our constitution.

March 23 reporting times remain on target; however, typing is an issue with a vacancy out to advert – an external company has been used to support this service.

New DR room is being installed with a go live date of mid May 2023 – this will increase x-ray capacity and reduce patient waiting times in X-ray

AREAS FOR IMPROVEMENT

To continue to ensure all capacity is fully utilised and minimise DNA's.

Utilisation of diagnostics capacity will be maximised with the introduction of Dr Doctor within the imaging service that will also help reduce DNAs. Dr Doctor will be an added form of digital patient engagement to support patient communication and appointment management. The initiative will allow patients to receive text messages to inform them of their appointments to allow patients to access the patient portal remotely.

Order Comms is due to be implemented in April 2023 to help streamline imaging referrals.

RISKS / ISSUES

The lack of an electronic referral system (order comms) potential impact on performance. In addition, there is an increased risk of paper referral forms potentially being lost/delayed. Ongoing discussions are underway with system partners around the implementation of e- referrals in Imaging to help mitigate this risk.

7. Cancer Performance

Summary Performance Figures – Feb 2022 (March Submission)

Metric	Patients	Compliant	Breach	Total Accountable	%	Target
2WW	60	58	2*	60	95.5%	93%
31 day 1st	9	9	0	9	100%	96%
31 day sub	8	8	0	8	100%	94%
62 days	2	1	1	2	50%	85%
62 day upgrade	4	2.5	1	3.5	71.40%	90%
28 day FDS	57	49	8	57	86%	75%
104 days treated at ROH	0	0	0	0		

Performance

All cancer performance standards were met in February 2023, excepting 62 days with x 1 patient breach .

There was 1 breach against the 62 day traditional standard. As there were only two patients treated in February against this standard it shows as 50% compliant. This breach was due to complex diagnostic requirements – CT chest and a CT guided biopsy under GA, with a 20 day wait for histology to come back (bone biopsies take longer so this was still within SLA).

There was also one breach against the upgrade target – which we are not held accountable to but has been shared at cancer board for assurance. The root causes were an initial delay due to patient infection, then some complications around safeguarding, patient capacity and a language barrier.

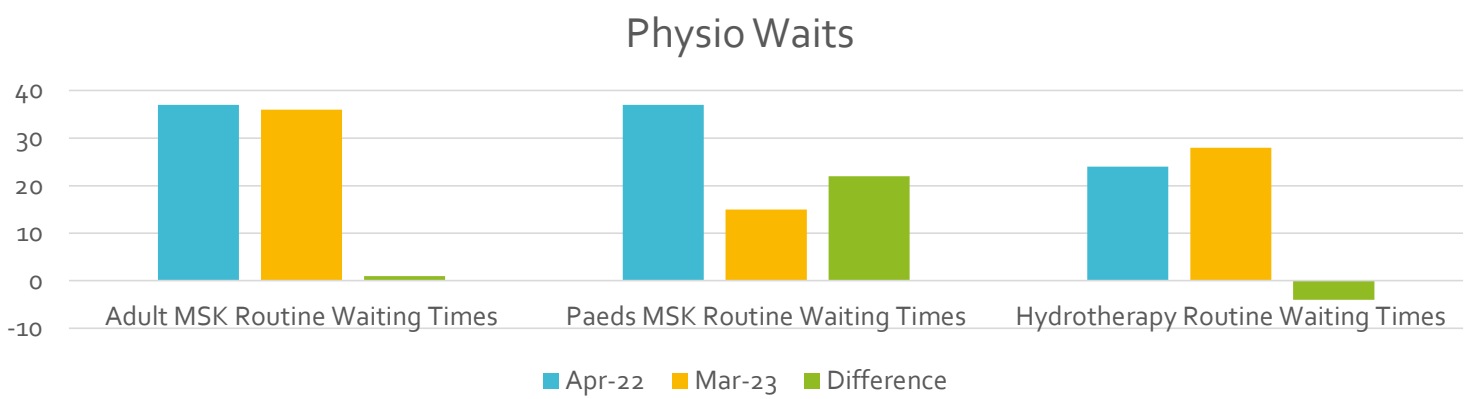
The other standards were all compliant. It has been noted and escalated that over 50% of the FDS breaches were a result of delays in pathology reporting – notably more than previous months.

Risks /actions ongoing

ROH are actively participating and engaging with the weekly System Oversight Group for cancer recovery and receive positive feedback against overall performance standards.
A meeting to discuss pathology reporting delays has been set up with the UHB senior team led by the COO and medical director at ROH in April to scope an action plan for reducing waiting times in pathology, however this is a national challenge . Feedback will be shared at FPC and QSC following this meeting.

8. Physio Waits

Physio Wait Comparison April 22 vs March 23



Summary

Physio Adult MSK waits continue to be a challenge with waits of 37 weeks for a routine appointment. Workforce is the main contributory factor to the limited progress; however the team have successfully offered 6.5wte Band 6 posts that are working their way through the recruitment process. Paediatric waits have improved from 37 weeks to 15 weeks and the team are working towards the 12 week aspirational target. Hydrotherapy waits have increased by 4 weeks to 28 weeks; however, resource has been re-allocated and we expect this wait to reduce over the next couple of months.

For future FPCs a trajectory and waiting list profile will be provided. An update on progress against the agreed trajectory to reduce waits to 12 weeks in line with potential future national targets, will be included in the performance pack for assurance .

Risks /actions ongoing

A comprehensive action plan has been produced to address the long waits associated with Adult MSK Routine appointments. A copy has been circulated with the Physio wait update paper.(April FPC meeting)

8. Overall Financial Performance

SUMMARY

The Trust delivered a surplus in month of £2,340k against a planned deficit of £16k. This is contributing towards a year to date surplus of £368k, £368k better than plan.

Income year to date is £10,257k better than plan, as a result of recognising additional inflationary income allocation and higher than planned private patient income.

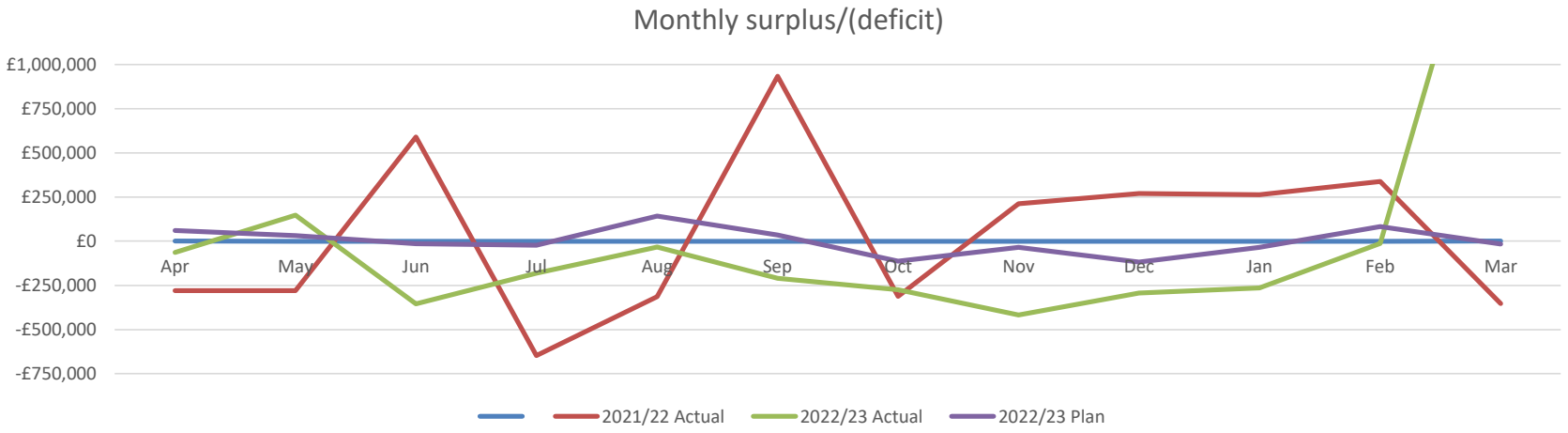
Pay and non pay expenditure remain overspent year to date by £8,459k and £671k respectively.

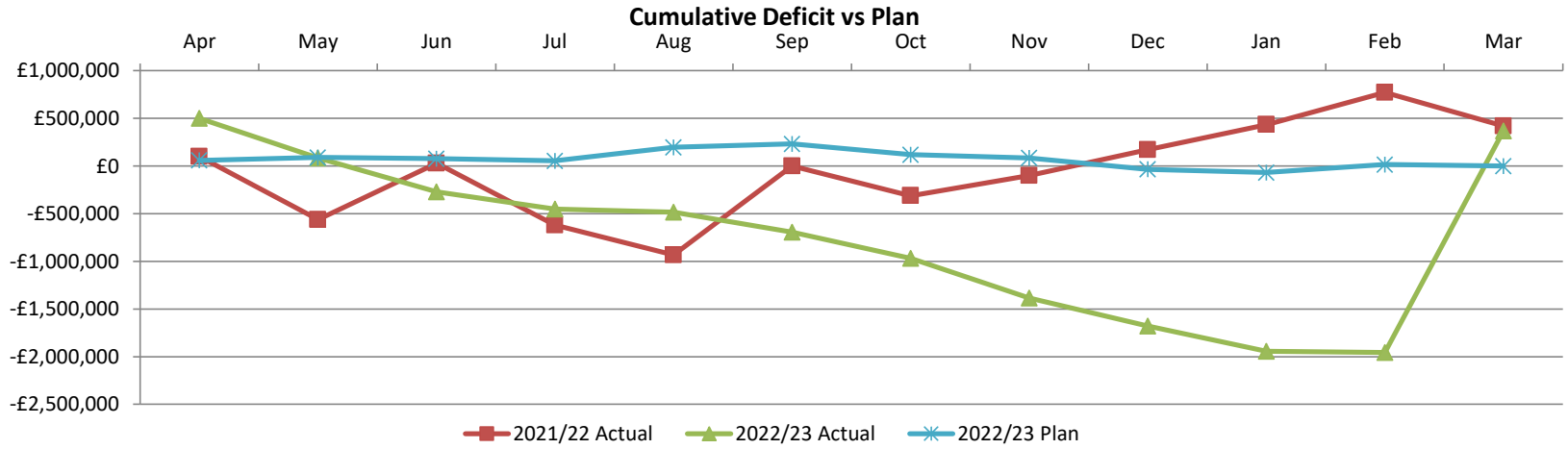
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	10,257	(8,459)	(671)	(759)	368
Year to date plan	117,253	(66,530)	(49,423)	(1,300)	0
Year to date actual	127,510	(74,989)	(50,094)	(2,059)	368
Variance compared previous month	↑ 6,089	↓ (5,741)	↑ 2,978	→ (985)	↑ 2,341
Forecast Variance					

8. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	112,844	121,824	8,980
Other Operating Income (Excluding top up)	4,409	5,686	1,277
Employee Expenses (inc. Agency)	(66,530)	(74,989)	(8,459)
Other operating expenses	(48,561)	(50,094)	(1,533)
Operating Surplus	**1,220**	**2,427**	**1,207**
Net Finance Costs	(1,300)	(1,479)	(180)
Net surplus/(deficit)	**(80)**	**948**	**1,028**
Remove donated asset I&E impact	(80)	(580)	(500)
Adjusted financial performance	**0**	**368**	**368**
Non recurrent funding	16,159	16,159	0
Underlying surplus/(deficit)	**(16,159)**	**(15,791)**	**368**

8. Overall Financial Performance





9. Income

SUMMARY

Income year to date is £10,257k better than plan, as a result of recognising additional inflationary income allocation during Mth1-11.

An adjustment in month has been included to accrue for a potential back dated pay award with funding of £2,189k funding anticipated to fund this. In addition there is a an adjustment for pension funding of £2,602k.

The year to date position now excludes income provision for ERF clawback for underperformance against target following guidance from NHS England. The assumption that no clawback will be enacted during the year.

Private patient income continues to overperform and is now at £3.35m, almost £1.4m better than plan.

AREAS FOR IMPROVEMENT

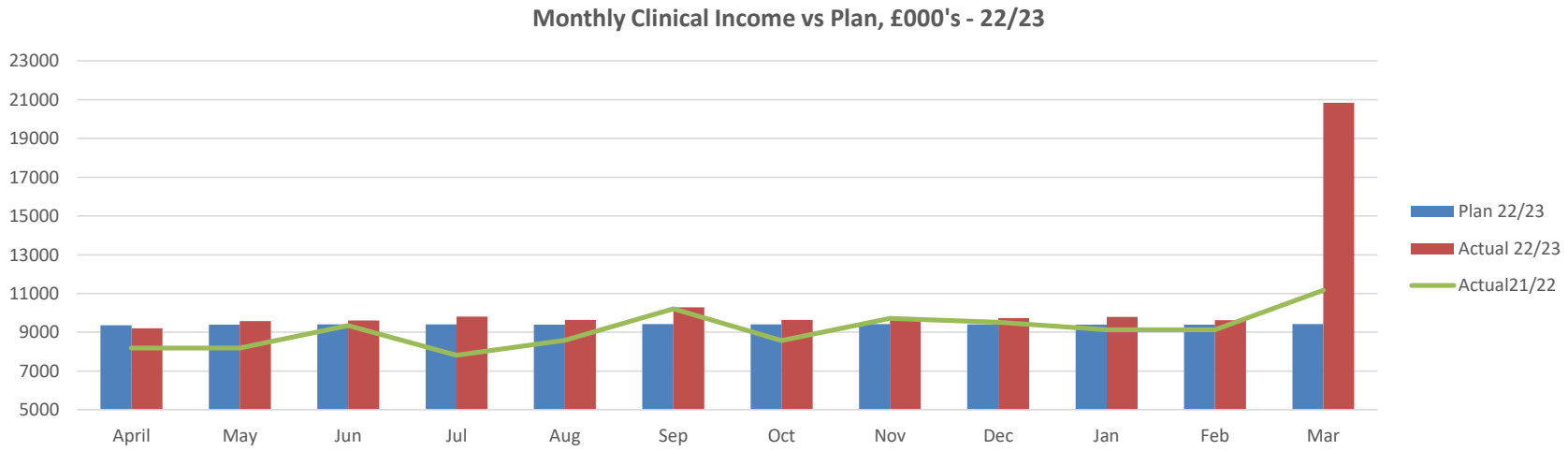
Other income is above plan by £391k year to date. This category of income includes car parking, catering and accommodation.

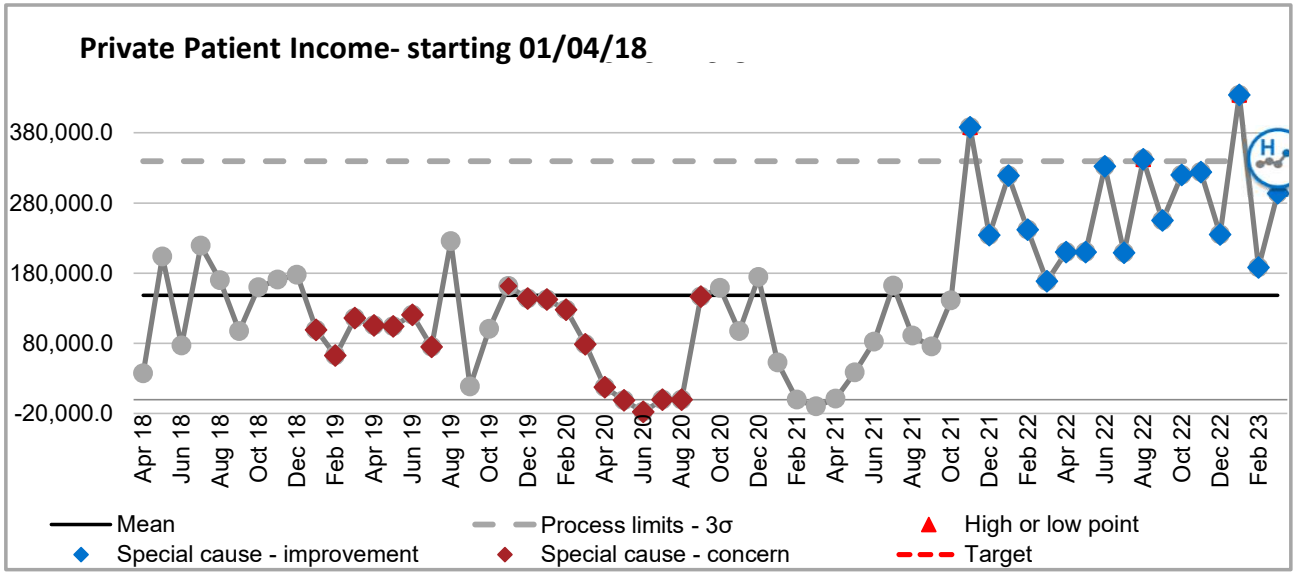
RISKS / ISSUES

Uncertainty remains as we enter into 2023/24 around the implementation of the elective recovery funding (ESRF) clawback mechanism. The system are performing significantly below target against ESRF. The system have not yet agreed how internal performance against ERF will be managed, and how overperformance against a provider target could be incentivised, within a system break-even or underperformance position.

Non recurrent funding has been received in 2022/23, generating an underlying financial risk for 2023/24 and beyond.

9. Income


Monthly Clinical Income vs Plan, £000's - 22/23
23000
21000
19000
17000
15000
13000
11000
9000
7000
5000
April
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Plan 22/23
Actual 22/23
Actual21/22


Private Patient Income- starting 01/04/18
380,000.0
280,000.0
180,000.0
80,000.0
-20,000.0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
Dec 19
Feb 20
Apr 20
Jun 20
Aug 20
Oct 20
Dec 20
Feb 21
Apr 21
Jun 21
Aug 21
Oct 21
Dec 21
Feb 22
Apr 22
Jun 22
Aug 22
Oct 22
Dec 22
Feb 23
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target

9. Expenditure

SUMMARY

Pay and non pay expenditure remain overspent year to date by £8,459k and £671k respectively.

There are two adjustments within Month 12 that has inflated the pay costs. Firstly, an adjustment has taken place in month to accrue for a potential back dated pay award which totals £2,645k. An income accrual of £2,189k off sets the majority of this but there is an anticipated cost pressure of £456k. Secondly, pension costs totalling £2,602k which is also offset by an income adjustment.

Agency spend remains high in month totalling £3.1m overspent year to date. Key drivers remain continued high sickness, and high vacancy levels. This equates to 9.0% in month and 9.5% of pay year to date. The Agency Cap for 23/24 will be 3.7%.

Bank expenditure for the year is £6.03m against a plan of £5.2m causing an adverse variance of £837k.

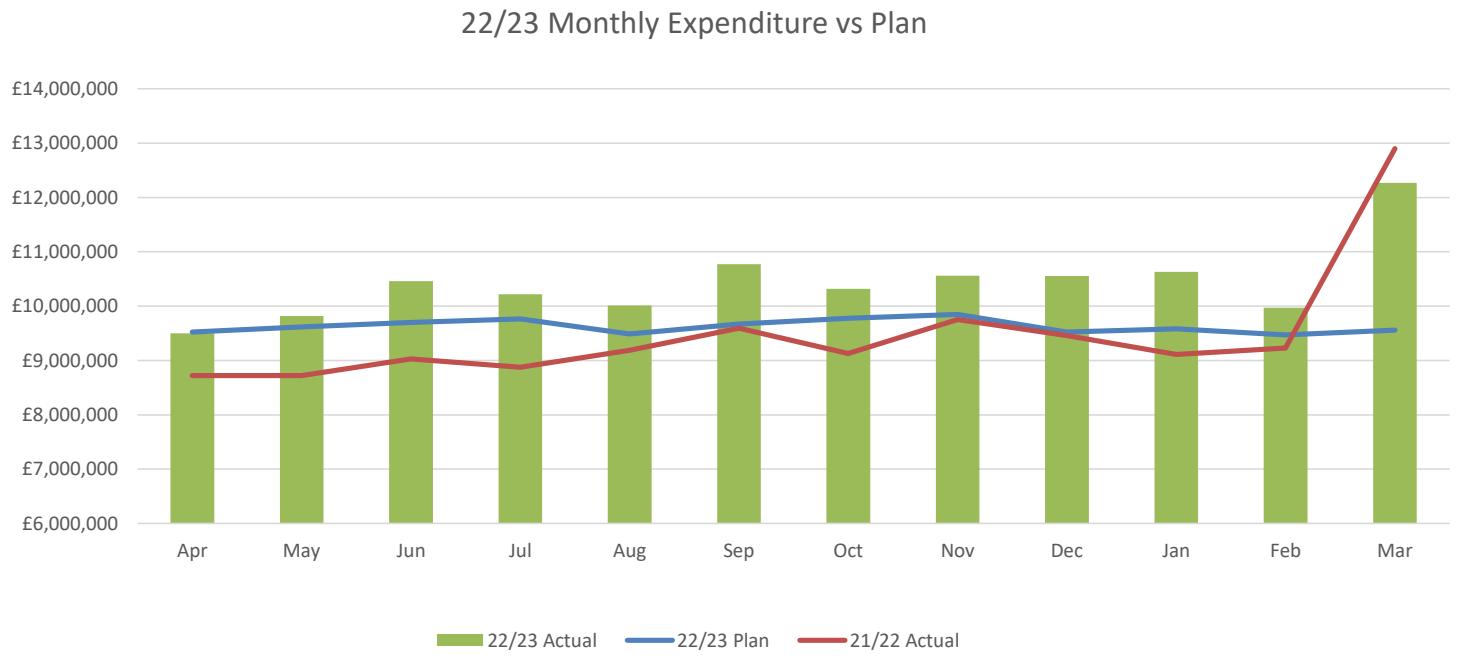
AREAS FOR IMPROVEMENT

Agency spend is above plan year to date by £3.2m. A greater focus by NHS England on agency controls is leading to greater scrutiny in this area of expenditure. The Agency Cap for 23/24 will be 3.7%.

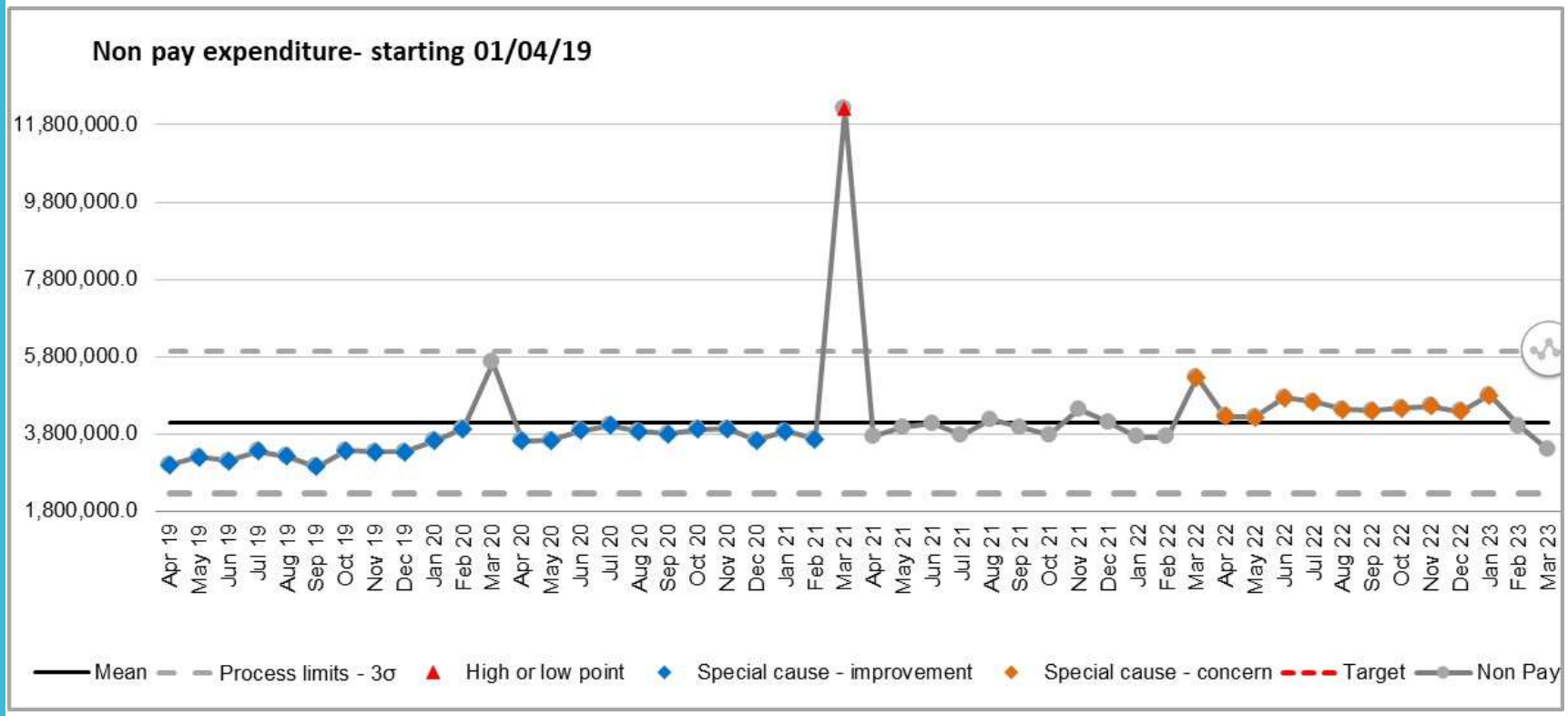
RISKS / ISSUES

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

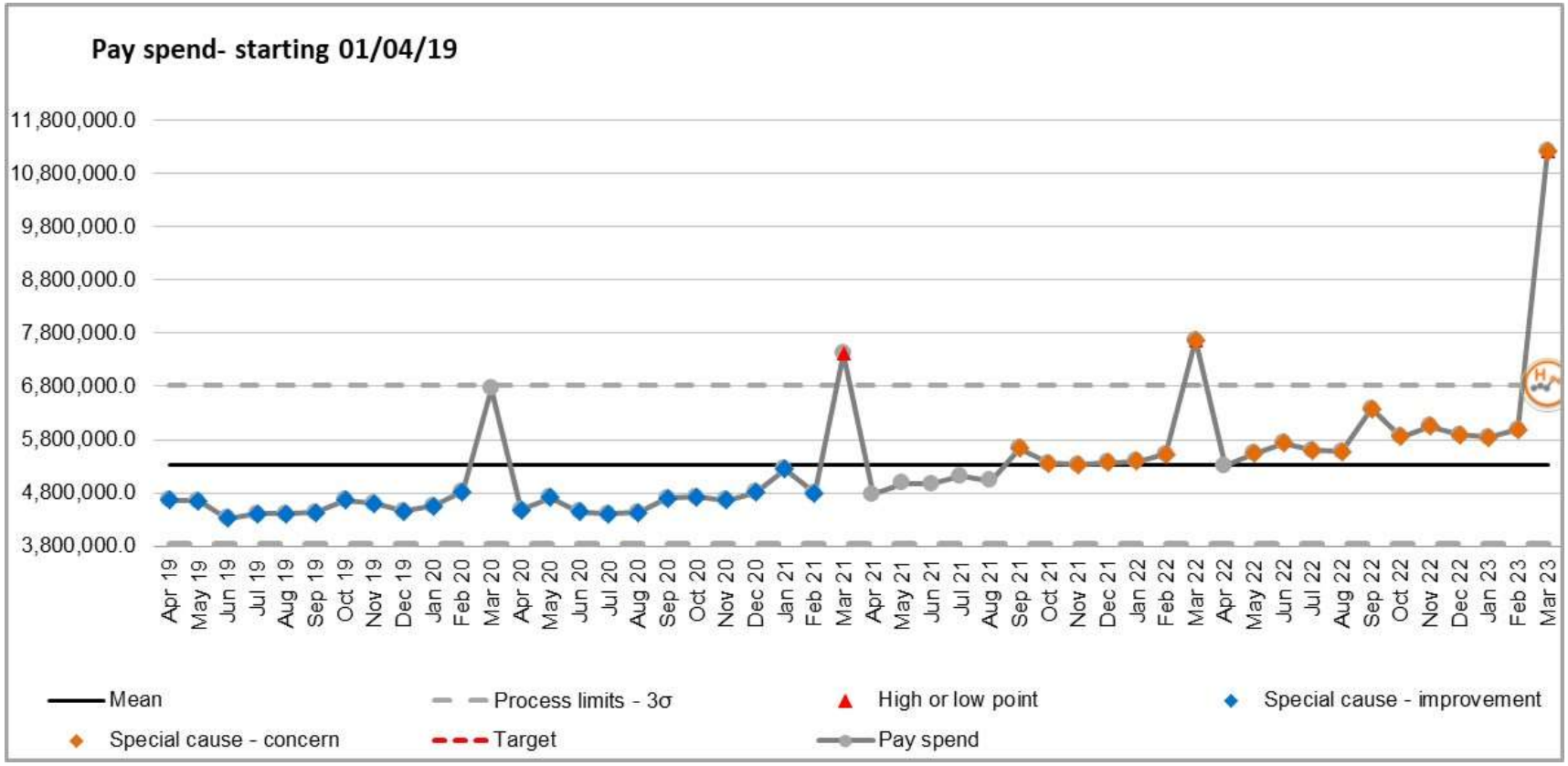
9. Expenditure



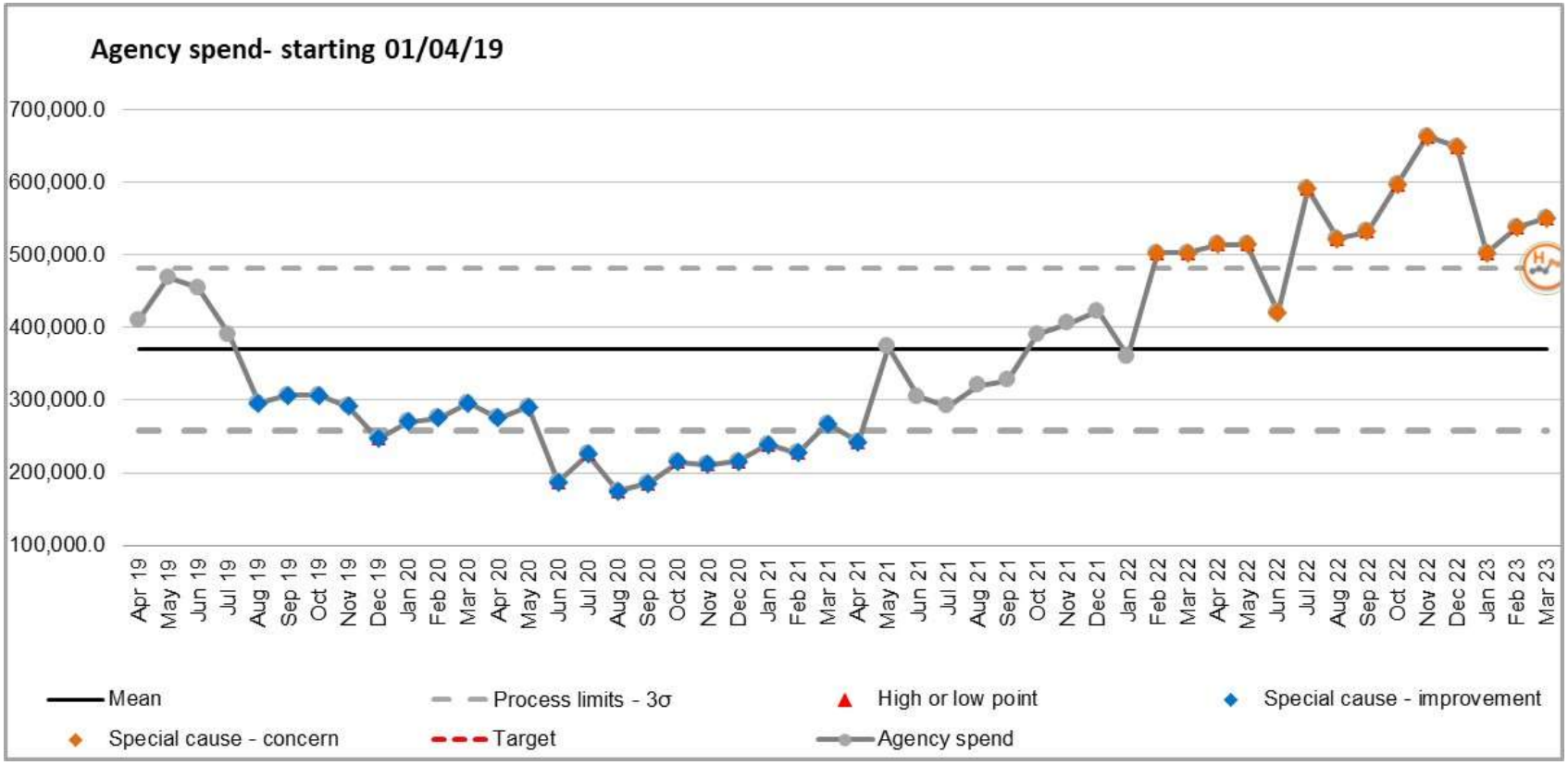
9. Non Pay Expenditure



9. Pay Expenditure



11. Agency Expenditure



12. Cost Improvement Programme Summary

SUMMARY

Year to date savings of £2.7m have been delivered, with only £84k delivered non recurrently. CIP schemes for 2023/24 have identified schemes c.£2.1m, with over 100 schemes already identified at varying stages of the planning process.

CIP Category	Year to date Plan	Year to date Actual	Variance	Forecast
Pay	£508	£105	-£403	
Non pay	£1,906	£1,463	-£443	
Income	£353	£1,199	£846	
Grand Total	**£2,767**	**£2,767**	**£0**	

Scheme	Confidence	Plan	Actual	Forecast
Private patient service expansion	High	£120	£995	
Procurement - Birmingham Hospital Alliance Collaborative	High	£1,309	£683	
Hips & Knees Implant Rationalisation / contract negotiation	High	£306	£371	
Medical Agency Reduction - Direct Engagement	High	£190	£77	
Enhanced Voice Recognition - Digital Dictation	High	£60	£0	
DNA Rate Reduction - Outpatients	High	£50	£0	
Substantive Nursing recruitment	High	£109	£0	
Minimisation of medical agency spend - Agency commission rates	High	£12	£1	
Managed Patient Communications via Synertec	High	£12	£2	
Pharmacy drug savings	High	£11	£11	
Energy efficiency schemes	High	£6	£6	
Microsoft 365 Licence review	High	£10	£6	
Daycase Joint Replacement	High	£75	£0	
Substantive Nursing recruitment	High	£95	£0	
Robotic Process Automation (RPA) - Review manual process to automate	High	£40	£0	
Enhanced Voice Recognition - Digital Dictation	Med	£55	£0	
In-house printing for patient communications	High	£25	£0	
DNA Rate Reduction - Outpatients	High	£46	£0	
Diagnostics and Therapies - Synertec paperless	Med	£10	£0	
Interpreting via telephone	Low	£12	£0	
Minimisation of medical agency spend - Agency commission rates	High	£11	£0	

13. Statement of Financial Position

SUMMARY

The most significant movement on the balance sheet is the implementation of IFRS 16 which has resulted in a substantial uplift in tangible assets and an offsetting increase in borrowings, having an overall limited impact on net assets employed.

The remaining movement in tangible assets is as a result of both the investment in the estate in the year, and a substantial uplift in the valuation of the estate as a result of the year end valuation process.

Inventories has reduced and prepayments have increased (included under trade and other current assets) as a result of the year end stock count and the continued expected transition of inventories to prepayments as the trust stock balance is utilised and replaced by the managed service provider.

Provisions has also reduced as a result of the release of the letter received from HMRC as previously described to members of the committee.

	2021/22 M12	2022/23 M12	Movement
	(£'000)		
Intangible Assets	1,536	1,340	(196)
Tangible Assets	45,448	72,232	26,784
Total Non Current Assets	**46,984**	**73,572**	**26,588**
Inventories	359	18	(341)
Trade and other current assets	9,946	10,816	870
Cash	11,147	7,591	(3,556)
Total Current Assets	**21,452**	**18,425**	**(3,027)**
Trade and other payables	(13,323)	(16,585)	(3,262)
Borrowings	(1,057)	(20,879)	(19,822)
Provisions	(7,818)	(1,328)	6,490
Other Liabilities	(744)	(2,471)	(1,727)
Total Liabilities	**(22,942)**	**(41,263)**	**(18,321)**
Total Net Assets Employed	**45,494**	**50,734**	**5,240**
Total Taxpayers' and Others' Equity	**45,494**	**50,734**	**5,240**

14. Workforce metrics

Trust Workforce Metrics	Feb-23	Mar-23	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1270	1282	12	-	-
Staff In Post - Full Time Equivalent	1122.80	1134.03	11.22879	-	-
Staf Turnover % - Unadjusted	17.34%	17.06%	-0.28%	↓	<=11.5%
Staf Turnover % - Adjusted	15.29%	15.14%	-0.15%	↓	<=11.5%
Total WTE Employed as % of Establishment	83.56%	83.68%	0.12%	↑	>=93%
Total WTE Employed as % of Establishment - Clinical	81.17%	81.06%	-0.10%	↓	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	88.14%	88.64%	0.50%	↑	>=96%
% Of Attendance	94.34%	94.47%	0.13%	↑	>=96.3%
% Of 12 mth MAA Attendance	93.94%	93.96%	0.02%	↑	>=96.3%
% Staff received mandatory training last 12 months	87.59%	86.38%	-1.21%	↓	>=93%
% Staff received formal PDR/appraisal last 12 months	65.46%	65.41%	-0.04%	↓	>=95%
% of Sickness - Trust wide Long-term	3.07%	2.75%	-0.32%	↓	-
% of Sickness - Trust wide Short-term	2.59%	2.78%	0.18%	↑	-
Return To Work Completion %	52.98%	58.17%	5.19%	↑	>=80%

14. Workforce metrics

Summary / Highlights

In March, 86.38% of staff had completed their mandatory training within the last 12 months which is a slight decrease on February. Staff have been completing their mandatory training through e-Learning over the last year, with new starters supported to complete their mandatory training prior to starting. Classroom sessions have now started back up.

Turnover (both Unadjusted and Adjusted) have been increasing over the last months but at the moment we have seen a slight decrease. Turnover unadjusted stands at 17.06% which is a decrease from February.

The percentage of staff attendance in the month has increased to 94.47%.

The Establishment of WTE is still below target and has increased to 83.68% from 83.56% in February.
Clinical staff are currently 81.06% established in terms of WTE.
Non-Clinical staff are currently 88.64% established in terms of WTE.

Risks / Issues

Cost of living seems to be affecting the NHS as a whole, the Trust is doing it's upmost to alleviate the impact.

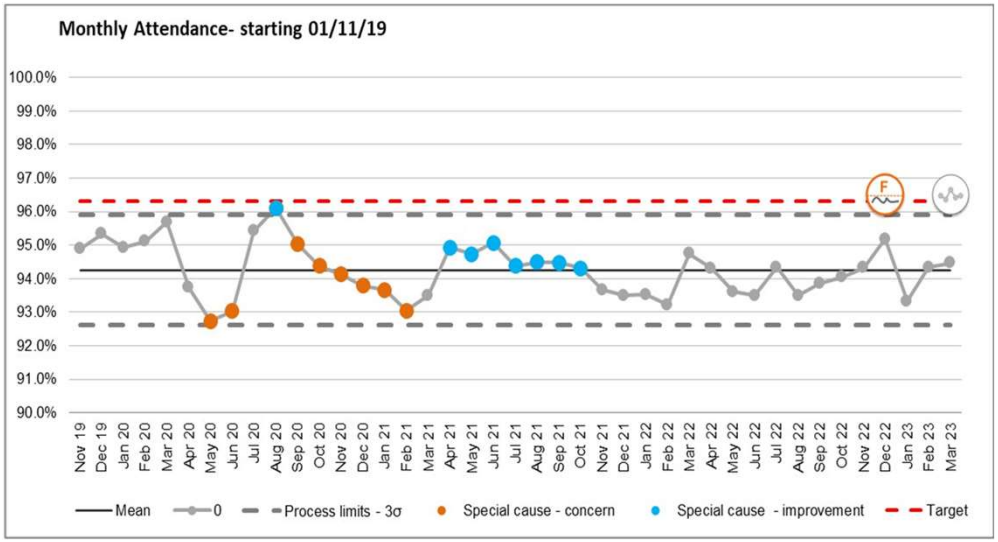
Other Trusts seem to be able to offer higher bands, this has seen some employees move on.

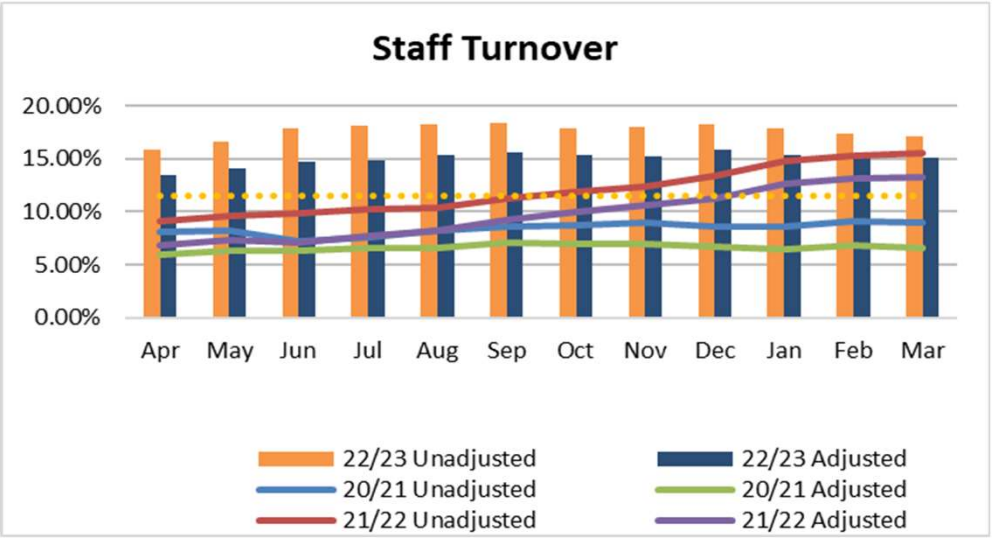
Staff with no PDR/Appraisal will have no way of been appraised and will have no personal goals.
Return To Work meetings if these aren't carried out there is a potential for further sickness and opportunities to support employees will be missed.

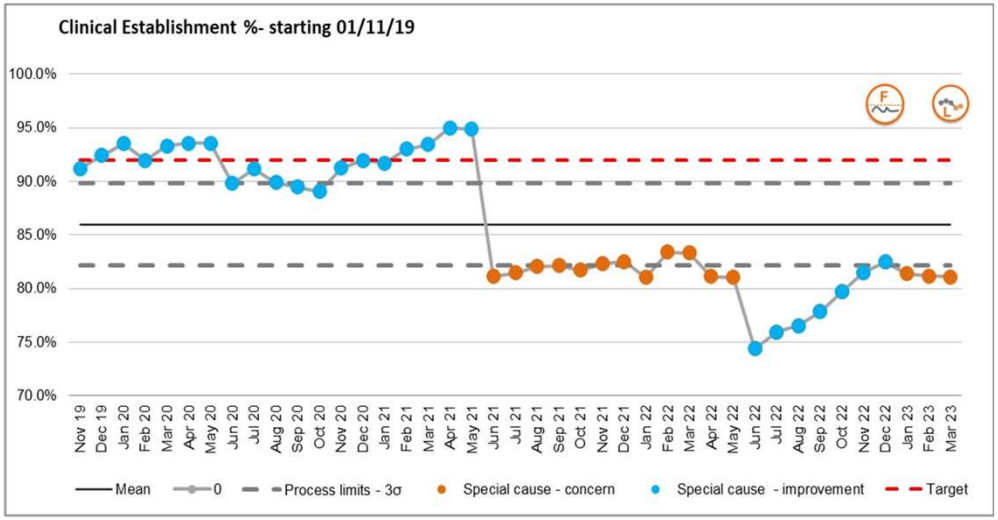
We anticipate that over the next few months, attendance may drop as we come through the summer months. Staff are being encouraged to have their Annual Leave which should hopefully help with minimising the impact of this.

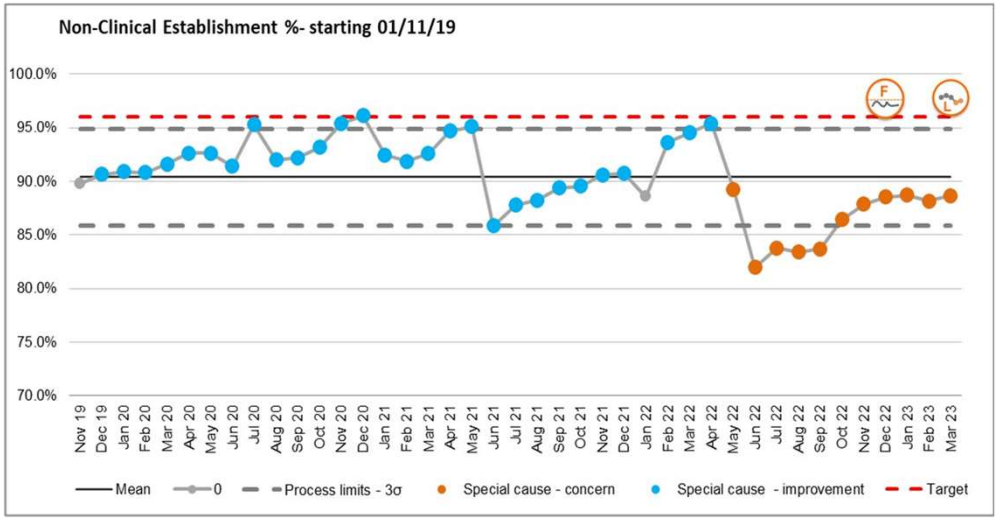
Actions

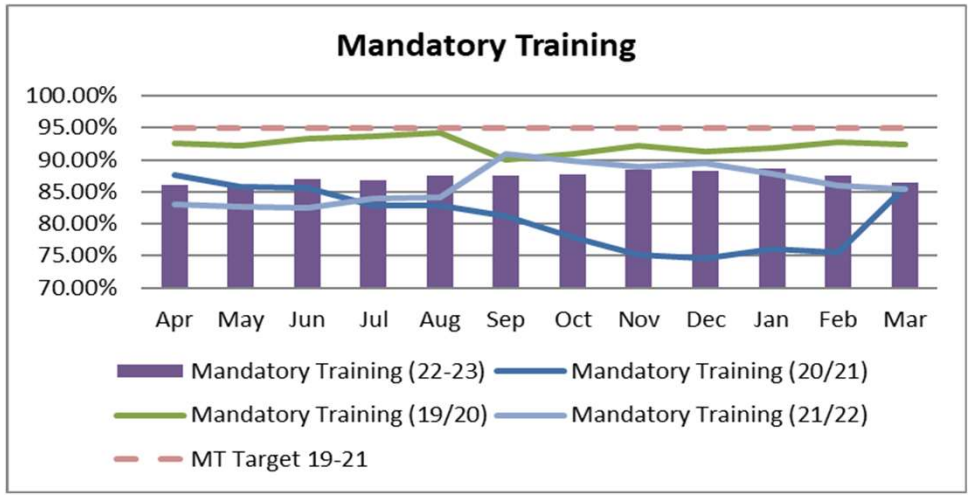
HR and E-Roster team to look into the issues around Return To Work meetings, Sophie Beavon, Paddy Coen and Jade Johnson are running drop in sessions for managers.
HR to review the Staff Turnover and look into the reasons and dig deeper into them, Terrie Hillier provides a deeper dive into the data and will be running a Leavers Process working group to tackle some of the themes.

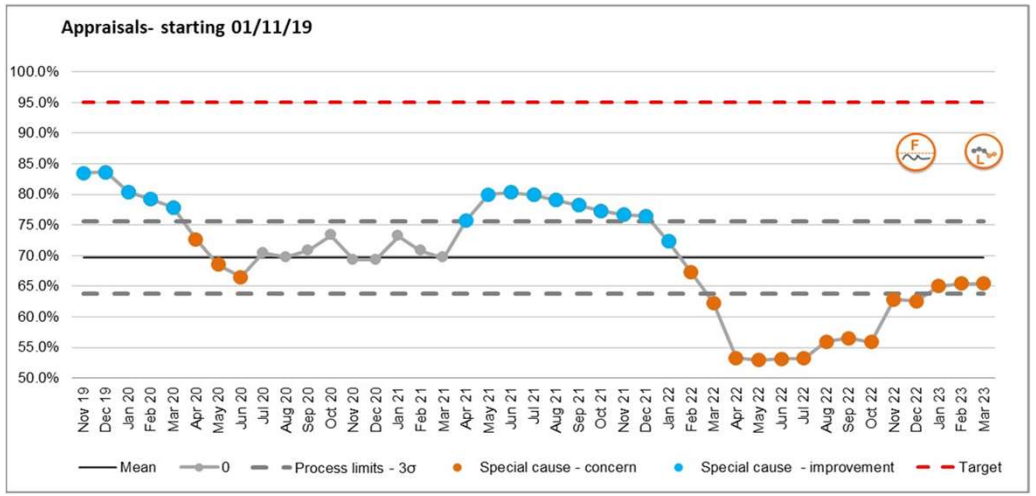

Monthly Attendance- starting 01/11/19
100.0%
99.0%
98.0%
97.0%
96.0%
95.0%
94.0%
93.0%
92.0%
91.0%
90.0%
Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 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
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

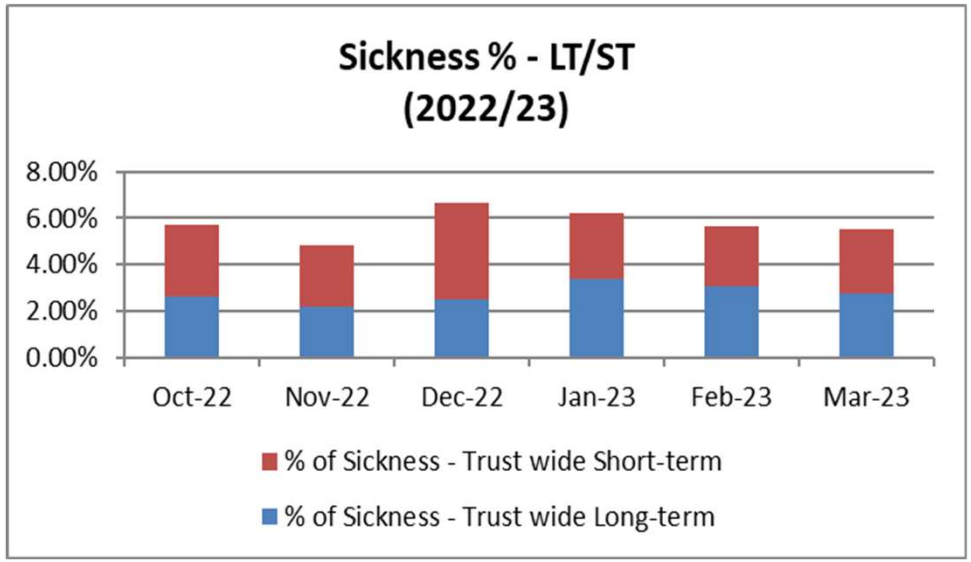

Staff Turnover
20.00%
15.00%
10.00%
5.00%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
22/23 Unadjusted
22/23 Adjusted
20/21 Unadjusted
20/21 Adjusted
21/22 Unadjusted
21/22 Adjusted

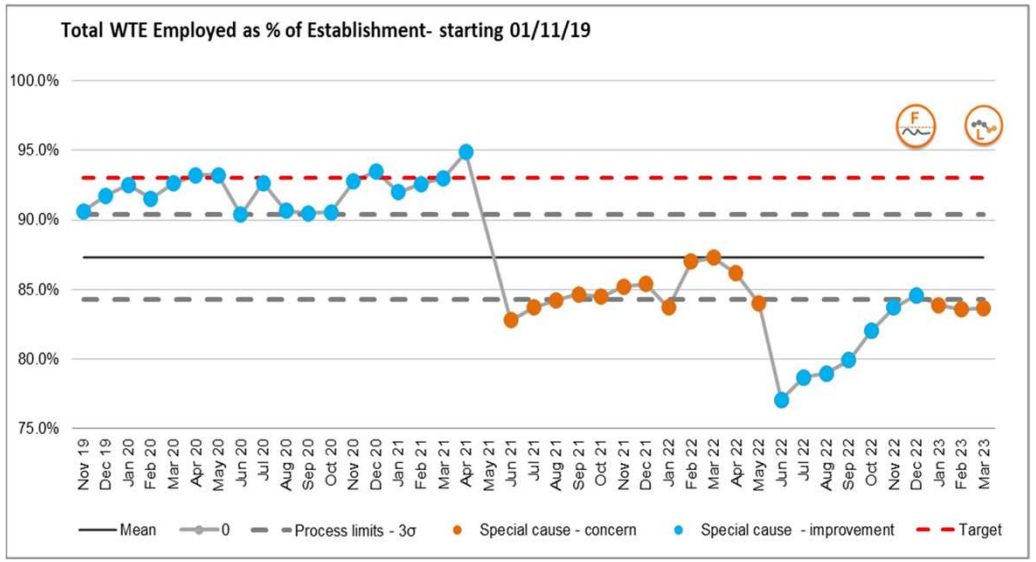

Clinical Establishment %- starting 01/11/19
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Non-Clinical Establishment %- starting 01/11/19
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 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
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Mandatory Training
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Mandatory Training (22-23)
Mandatory Training (20/21)
Mandatory Training (19/20)
Mandatory Training (21/22)
MT Target 19-21


Appraisals- starting 01/11/19
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%
Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 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
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Sickness % - LT/ST
(2022/23)
8.00%
6.00%
4.00%
2.00%
0.00%
Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23
% of Sickness - Trust wide Short-term
% of Sickness - Trust wide Long-term


Total WTE Employed as % of Establishment- starting 01/11/19
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 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
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY AND SAFETY REPORT

April 2023(March 2023 Data)

EXECUTIVE DIRECTOR:	Simon Grainger Lloyd	Director of Governance
	Nikki Brockie	Chief Nurse
	Marie Peplow	Chief Operating Officer
AUTHOR:	Adam Roberts	Acting Head of Governance and Assurance

Quality Report – April 2023 (March 2023 Data) – Summary Dashboard

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	2021/2022	2022/2023	
Incidents	308	387	304	289	280	296	308	329	310 (↓)	283 (↓)	292 (↑)	374 (↑)			
Serious Incidents	1	0	1	2	0	1	0	0	1	0 (↓)	2 (↑)	0 (↓)	13 (Total)	8	
Internal RCA investigations	3	4	6	2	1	6	2	6	2 (↓)	4(↑)	4	3 (↓)			
VTEs (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0 (0	2 (Avoidable)	0	
Falls	9	10	4	3	5	3	10	5	9 (↑)	3 (↓)	7 (↑)	5 (↓)	91 (Total)	79	
Pressure Ulcers: Cat 2 (Avoidable)	0	3	0	0	0	0	0	2 (↑)	0	0	0	0 (0	3 (Avoidable)	5	
Pressure Ulcers: Cat 3 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0 (0	0 (Avoidable)	0	
Complaints	6	5	4	1	2	6	4	4	3	2	4 (↑)	1 (↓)	52 (Total)	35	
PALS	57	54	42	51	57	62	42	59	41(↓)	51 (↑)	50 (↓)	57 (↑)	64 (↑)		
Compliments	3	1	4	4	3	2	3	4	TBC	TBC	TBC	TBC	TBC		
FFT Score %	99.39	98.88	98.68	97.82	97.93	98.34	98.50	99.61	100 (↑)	99.8 (↓)	100 (↑)	99.6 (↓)			
FFT Response %	48	30	38	51	42	45	55	47	46(↓)	41 (↓)	37 (↓)	49 (↑)			
Duty of Candour	12	10	16	16	12	10	10	12 (↑)	12	16(↑)	14 (↓)	10 (↓)			
Litigation (New)	0	0	0	1	2	0	0	3	0	0	2 (↑)	2			
Coroners	0	0	0	0	0	0	0	0	0	0	0	0			
WHO %	99	99	100	100	100	100	99	99	99	100 (↑)	99 (↓)	99 (↓)			
Infections	1	1	2	0	0	1	1	1	1	0	1 (↑)	0 (↓)	7 (Total)	9	

CONTENTS

1. INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Integrated Care System and the CQC for routine engagement and assurance meetings.

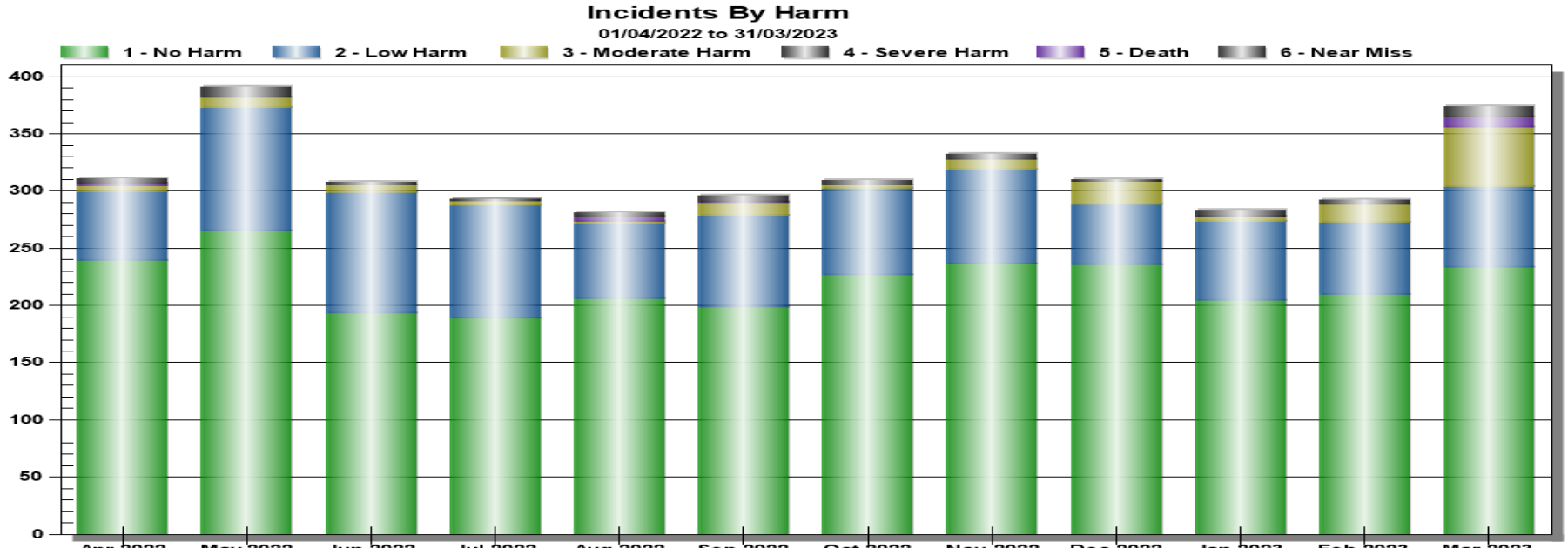
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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

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

Tel: **0121 685 4000 (ext. 55216)**

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



Month and Year	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
1 - No Harm	239	265	193	188	205	198	226	236	235	204	209	233
2 - Low Harm	60	107	105	99	66	80	76	82	53	69	63	70
3 - Moderate Harm	5	9	7	4	2	11	3	9	20	4	16	52
4 - Severe Harm	0	0	0	1	0	0	0	0	0	0	0	0
5 - Death	2	0	0	0	4	1	0	0	0	0	0	9
6 - Near Miss	5	10	3	1	4	6	4	5	2	6	4	10

In the month of March 2023, there were a total of 374 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is as follows;

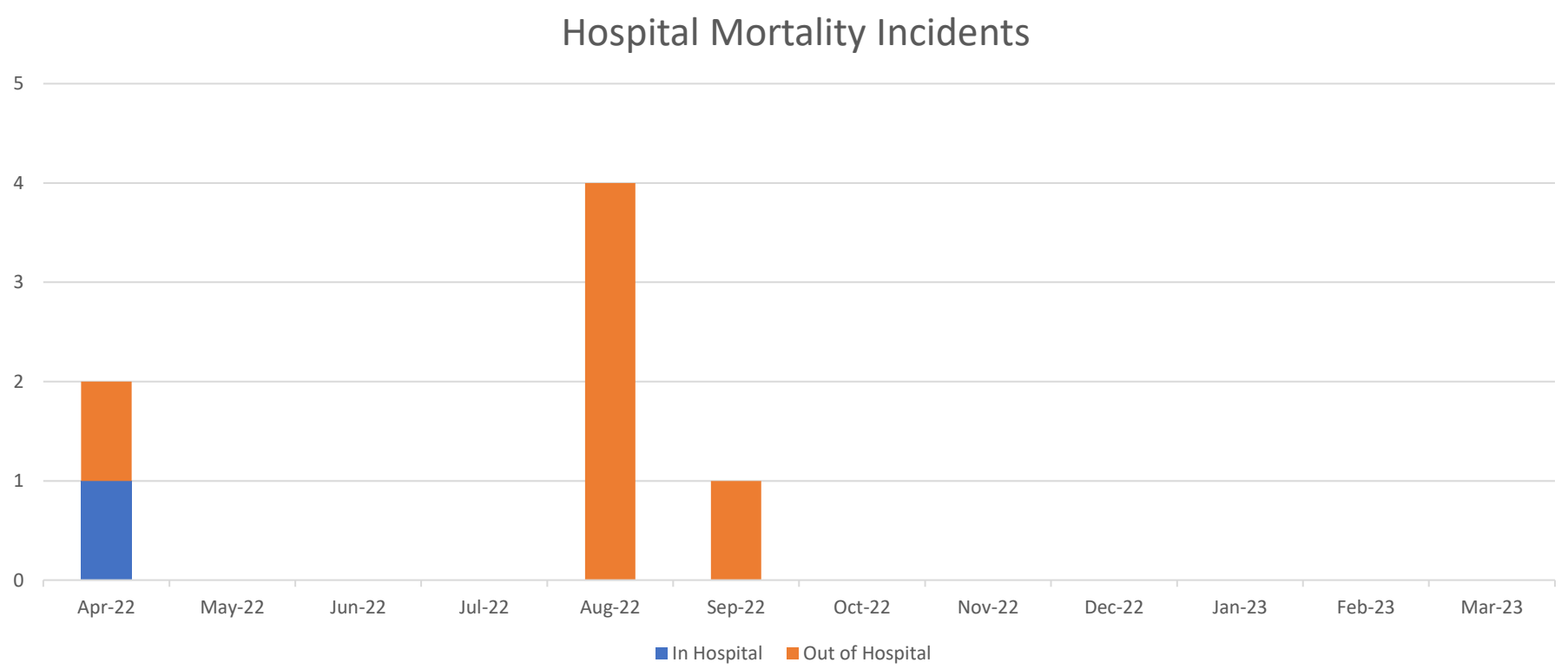
233 – No Harm
70 - Low Harm
52 - Moderate Harms
0 - Severe Harm
10 - Near Miss
9 – Death

There were 52 potential moderate harm incidents reported in March 2023.

All are currently going through the governance process to confirm actual level of harm

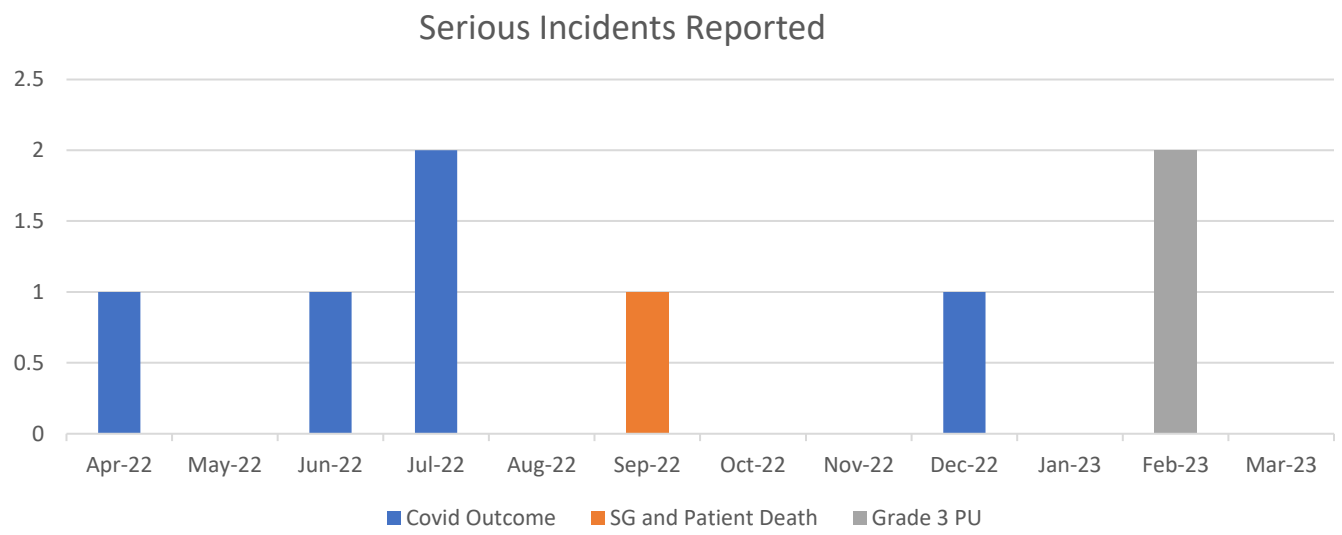
0 of the 16 potential moderate harms reported within the March 2023 Quality Report were downgraded – all remain under investigation.

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



INFORMATION
No inpatient deaths were reported in March 2023. 9 patient deaths, where we were notified of the death occurring within 30 days of discharge, were reported in March 2023. The date of death in regards to these incidents did not occur in March 2023. We were notified of the deaths in March 2023 via national data sources and they were incident reported in March 2023, hence the increase in number. These deaths are incident reported for the purposes of our learning from deaths review, under which we review all inpatient deaths and all deaths that occur within 30 days of discharge from ROH. Further amendment to the way deaths within 30 days of discharge are reported within the Quality Report will be undertaken to give a better indication of when the deaths actually occurred.
ACTIONS FOR IMPROVEMENT AND LEARNING
The learning from deaths tracker is a standing agenda item on the Executive Governance oversight meeting both divisional governance meetings and forms part of the routine mortality update
RISK AND ISSUES
None

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

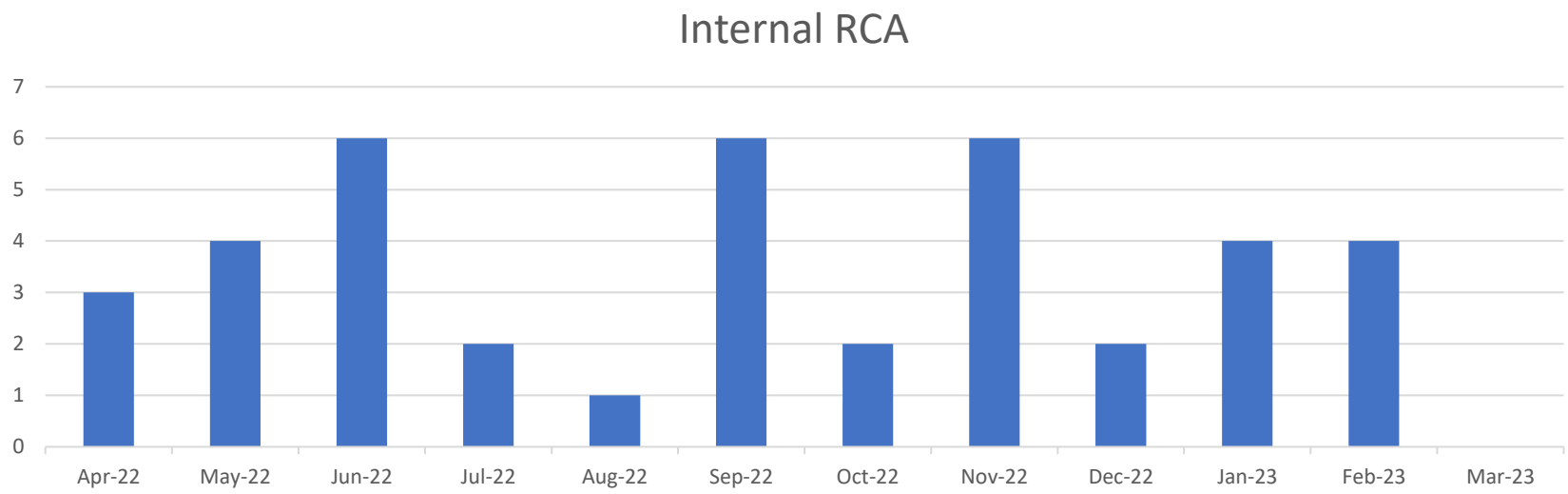


Year Totals	
20/21	11
21/22	13
22/23	8

Data Source – STEIS

INFORMATION
0 Serious Incidents were reported in March 2023
ACTIONS FOR IMPROVEMENT AND LEARNING
N/A – Still pending outcome of RCA investigations into the 2 x grade 3 pressure sores reported in Feb 23
RISK AND ISSUES
None

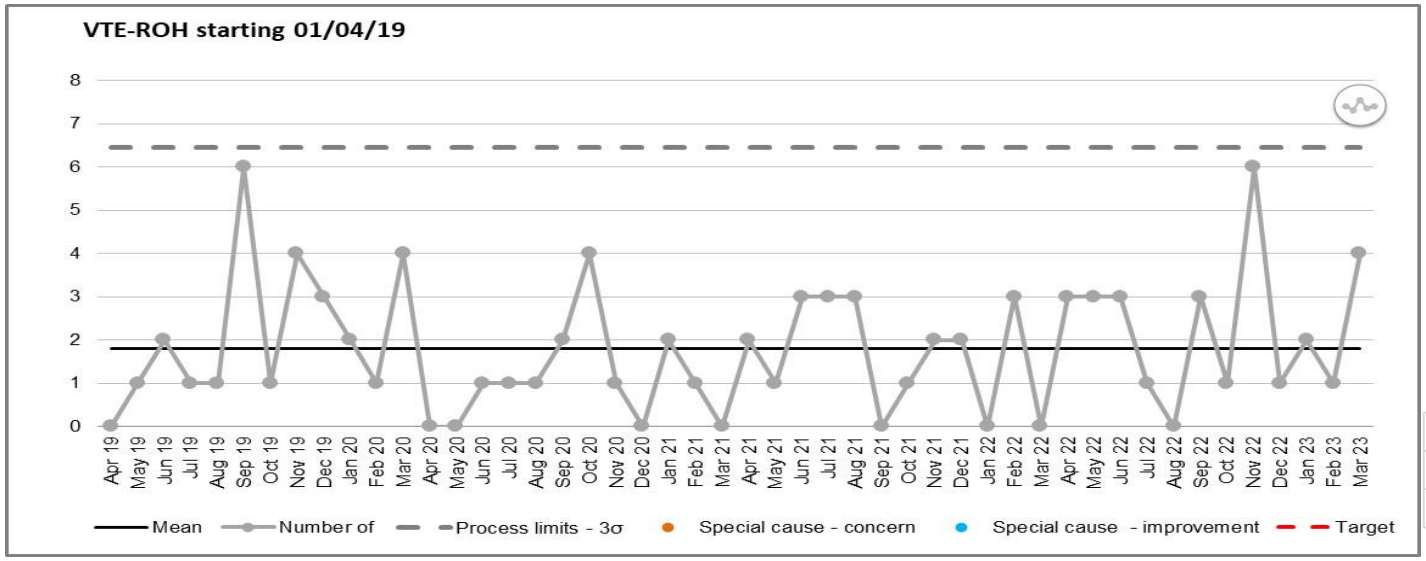
4. Internal Root Cause Analyses (RCAs) - These are incidents that are not declared on STEiS to the Commissioners as they do not meet the serious incident framework. If there is still a potential for learning, the divisions decide that a heightened level of response is needed for these incidents. All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

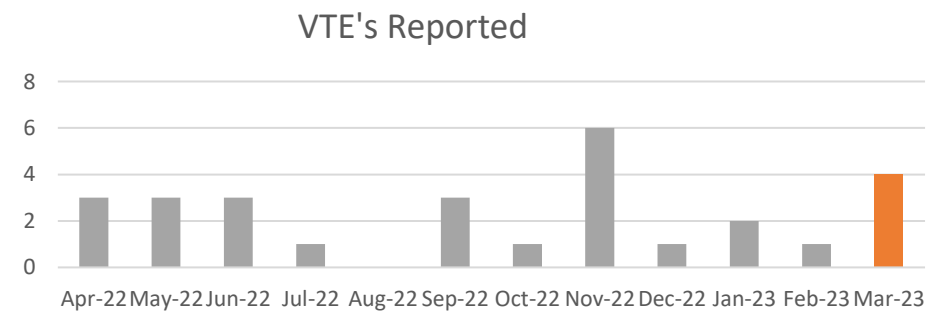


Data Source – Internal RCA tracker

3 RCAs were commenced in March 2023

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





	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Unavoidable	3	3	3	1	0	3	1	6	1	2	1	0
TBC	0	0	0	0	0	0	0	0	0	0	0	4
Avoidable	0	0	0	0	0	0	0	0	0	0	0	0

Data Source – Ulysses and VTE leads

Year	Avoidable Year Totals	Total including unavoidable
20/21	1	13
21/22	2	20
22/23	0	28

INFORMATION

4 x ROH associated VTE incidents were reported in March 2023. 3 were recorded as low harm and 1 as potential moderate harm – RCA's currently underway to scope avoidability

Provisional figures for admission assessment

Total possible	**1248**
Total assessed	1142
%	91.51%

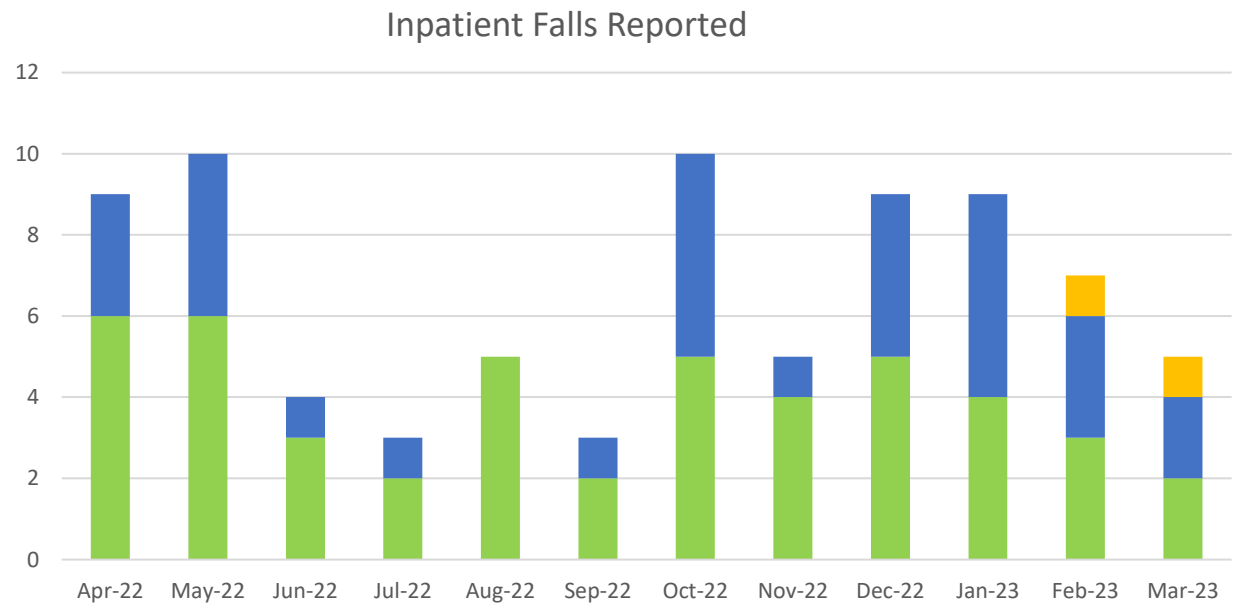
ACTIONS FOR IMPROVEMENT AND LEARNING (CLOSED RCA'S FOR SHARED LEARNING)

- VTE RCA template reviewed and updated
- Re-assessment re-audit to be undertaken by Medical VTE lead – paper due for Q&S
- Exemplar site submission was completed by end of March 2023 deadline – awaiting outcome

RISK AND ISSUES

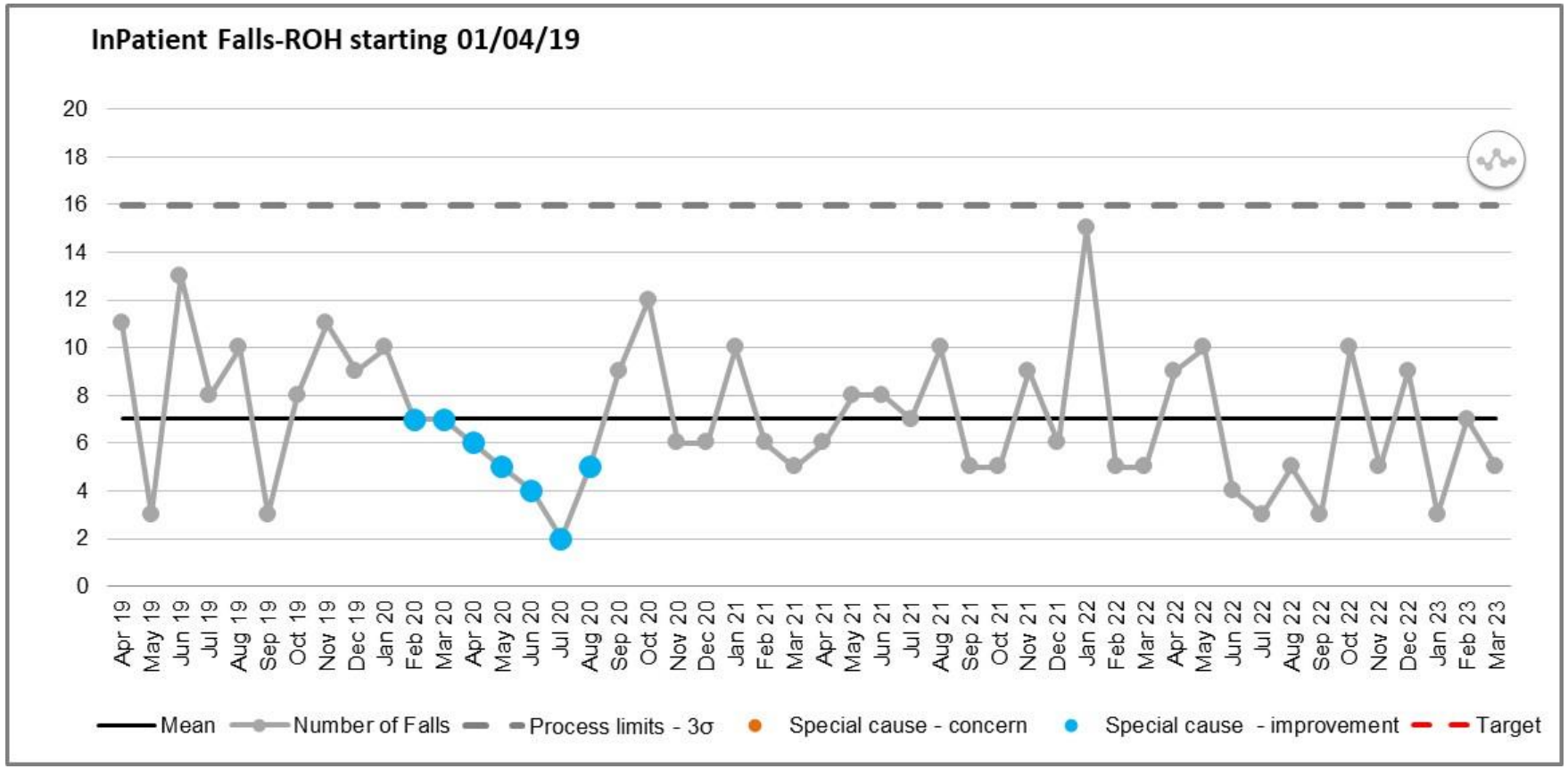
None

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



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	0	0	0	0	0	1	1
Low Harm	3	4	1	1	0	1	5	1	4	5	3	2
No Harm	6	6	3	2	5	2	5	4	5	4	3	2

Year Totals	
20/21	76
21/22	91
22/23	79


InPatient Falls-ROH starting 01/04/19
20
18
16
14
12
10
8
6
4
2
0
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
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Oct 21
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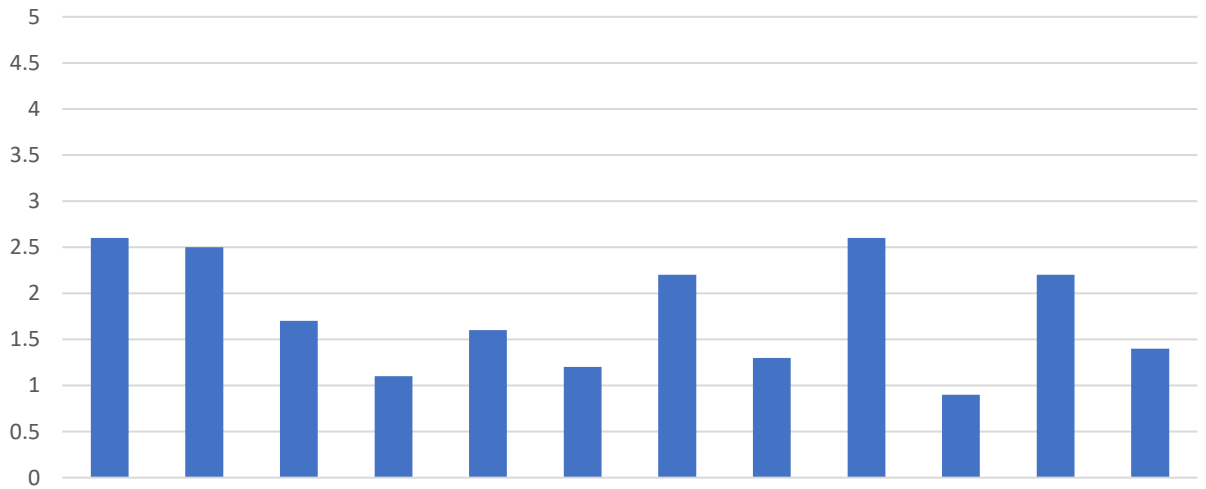
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Mean
Number of Falls
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Falls per 1000 Bed Days



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Falls per 1000 BD	2.6	2.5	1.7	1.1	1.6	1.2	2.2	1.3	2.6	0.9	2.2	1.4

INFORMATION

There were 7 incidents reported across the Trust in March 2023 relating to Falls, note 1 incident was not actually a fall:

5 x In-Patient Incidents

1 x ROCS Incidents

1 x Staff Incident (non-fall)

There is a consistently low number of in-patient falls this month, with no identifiable themes. One incident resulted in moderate harm, whereby a patient was found in the bathroom, this is subject to an ongoing review.

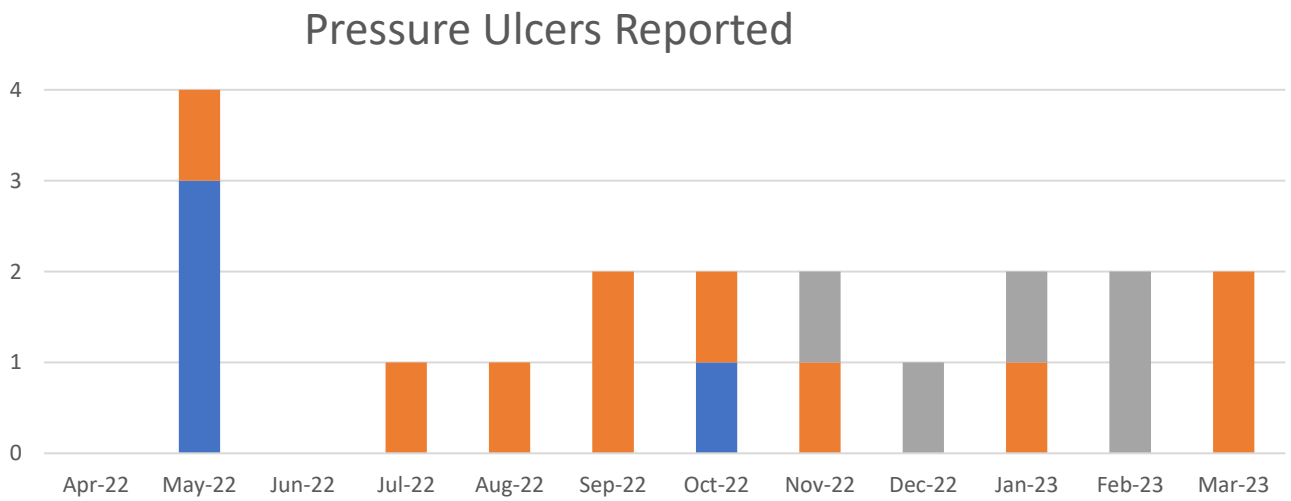
ACTIONS FOR IMPROVEMENT AND LEARNING

- Drafted new criteria for falling leaves campaign to highlight in-patient's at higher risk of falls, to be submitted to falls/dementia working group for review.
- New falls/dementia information boards for out-patient areas designed, still waiting on communications team for production

RISK AND ISSUES

Resolved issue from last month, now only have one Hoverjack in the Trust that is broken, the remaining three Hoverjacks are now all available for use

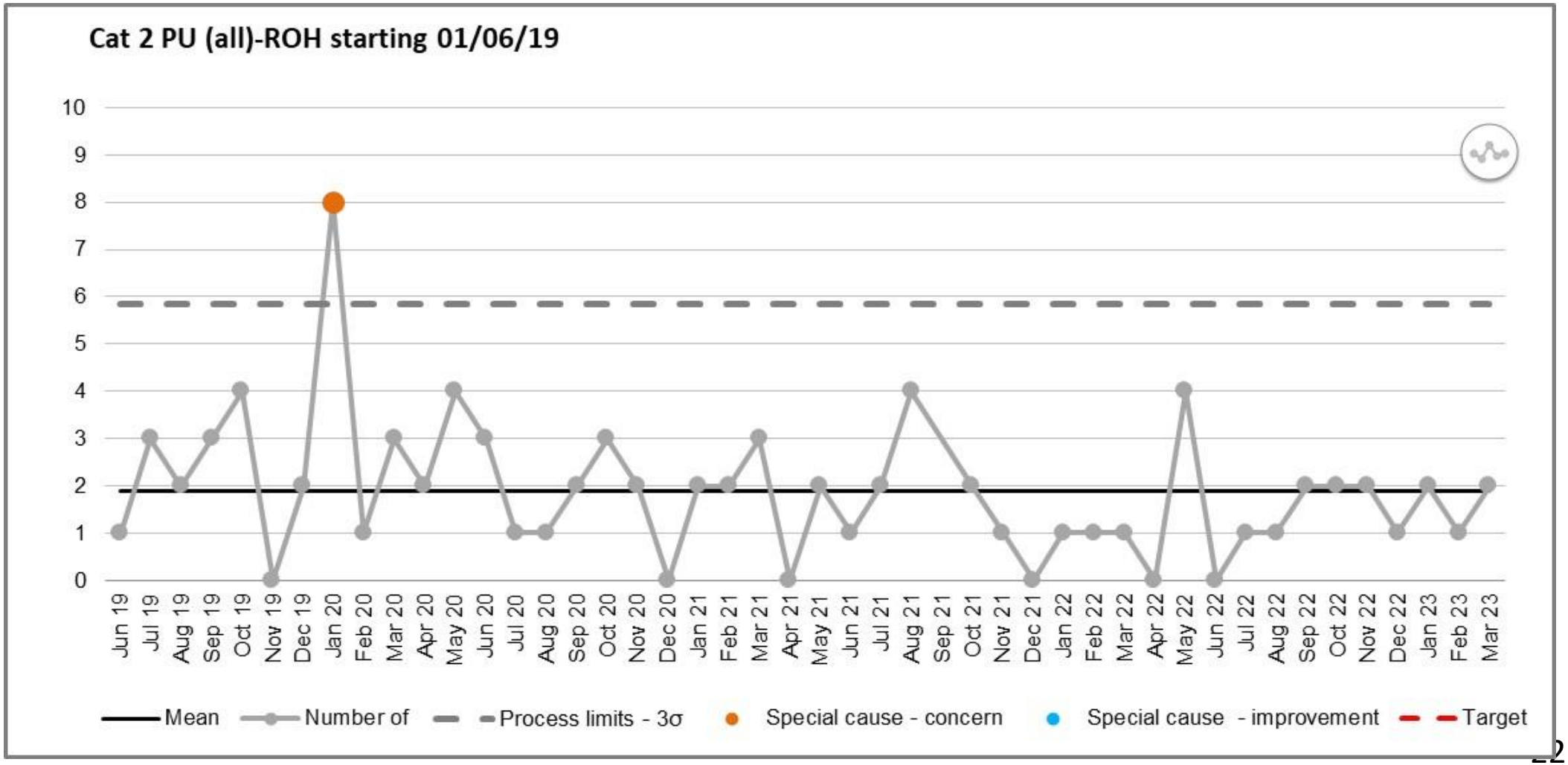
7. Pressure Ulcers - "A pressure ulcer is localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a medical or another device), resulting from sustained pressure (including pressure associated with shear). The damage can be present as intact skin or an open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



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Sum of TBC	0	0	0	0	0	0	0	1	1	1	2	0
Sum of Unavoidable	0	1	0	1	1	2	1	1	0	1	0	2
Sum of Avoidable	0	3	0	0	0	0	1	0	0	0	0	0

Number of PU reported total

Year Total	Cat 2	Cat 3
20/21	25	1
21/22	14	0
22/23	17	2


Cat 2 PU (all)-ROH starting 01/06/19
10
9
8
7
6
5
4
3
2
1
0
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
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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
Mean
Number of
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

INFORMATION

March 2023 Incidents

Category – 4	**0**
Category – 3	0
Category – 2 (Non-Device)	2
Category – 2 (Device)	0
Category – 1	1
Suspected Deep Tissue Injury	0
ROH Moisture Associated Skin Damage (MASD)	MASD ROH Incontinence – 1 MASD ROH Intertriginous dermatitis – 0 MASD ROH Periwound - 1 MASD admitted with Incontinence - 1 MASD admitted with Intertriginous dermatitis - 1

INFORMATION

Patients admitted with PUs	**PU admitted with Cat 1 – Nil** **PU admitted with Cat 2 x 1 pts home 1 Royal Preston Hospital** **PU admitted with Cat 3 – Nil** **PU admitted with SDTI – Nil** **PU admitted with DTI – 1 (at least a Cat 3) pt's own home**

Avoidable only Pressure Ulcer CCG Contracts KPI2021/2022 – Contract to be confirmed.	
2021/2022	
Avoidable Grade 2 pressure Ulcers	3
Avoidable Grade 3 pressure Ulcers	0
Avoidable Grade 4 pressure Ulcers	0
2022/2023	
Avoidable Grade 2 pressure Ulcers limit of 12	4
Avoidable Grade 3 pressure Ulcers limit of 0	2
Avoidable Grade 4 pressure Ulcers limit of 0	0

ACTIONS FOR IMPROVEMENT AND LEARNING

The National Wound Care Strategy Programme – have issued a Consultation document re :-Pressure Ulcer Clinical Recommendations and Pathway

Section 2:10 Categorise - "Deep tissue injuries (DTI's) should not be recorded as pressure ulcers unless they result in broken skin at which point, they should immediately be categorised and reported.

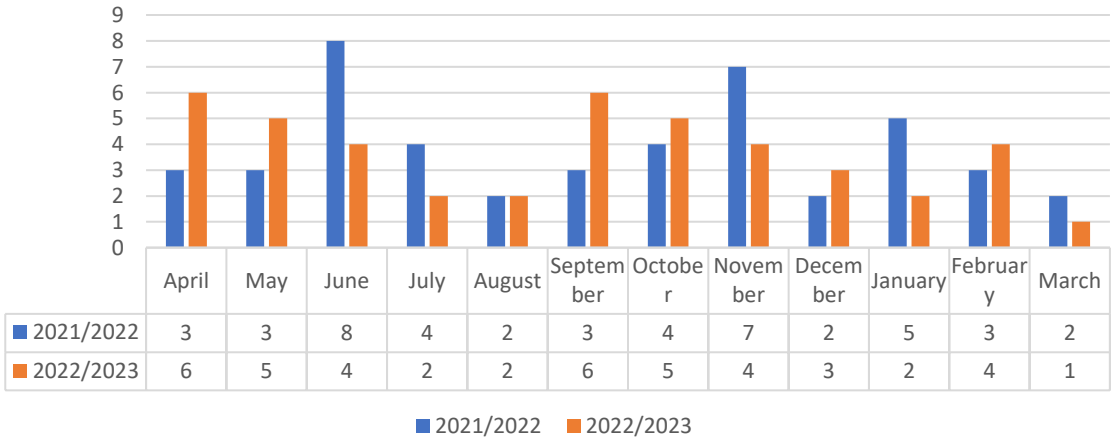
TV Lead Nurse has responded on behalf of the Trust. Consultation period has been extended to Mid April 2023

RISK AND ISSUES

None

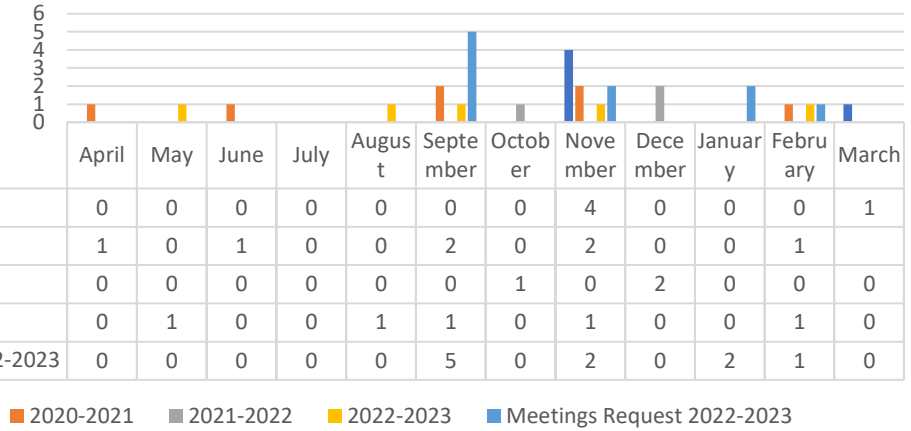
Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.

Formal Complaints received 2021/2022 Vs 2022/2023



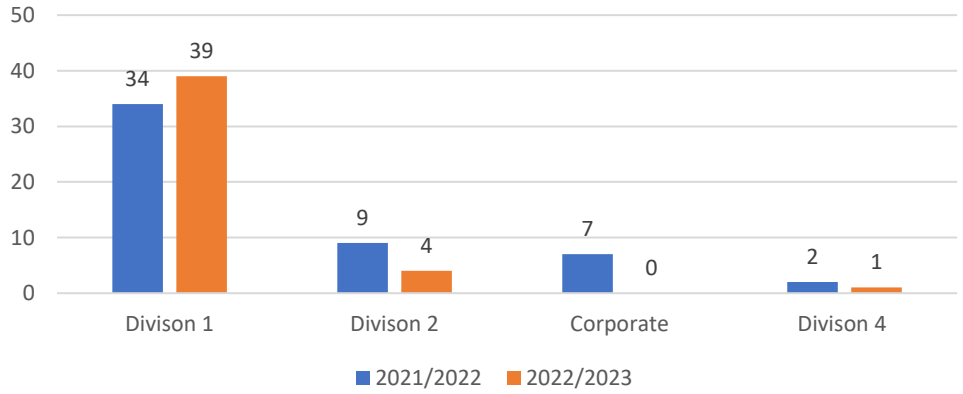
	April	May	June	July	August	September	October	November	December	January	February	March
2021/2022	3	3	8	4	2	3	4	7	2	5	3	2
2022/2023	6	5	4	2	2	6	5	4	3	2	4	1

Reopended Complaints 2022/2023 Compared to the Last 3 years



	April	May	June	July	August	September	October	November	December	January	February	March
2019-2020	0	0	0	0	0	0	0	4	0	0	0	1
2020-2021	1	0	1	0	0	2	0	2	0	0	1	
2021-2022	0	0	0	0	0	0	1	0	2	0	0	0
2022-2023	0	1	0	0	1	1	0	1	0	0	1	0
Meetings Request 2022-2023	0	0	0	0	0	5	0	2	0	2	1	0

Formal Complaints Received per Division 2022/2023 Compared to 2021/2022



Complaint Year Totals	
April 2021 – March 2022	47
April 2022 – March 2023	47

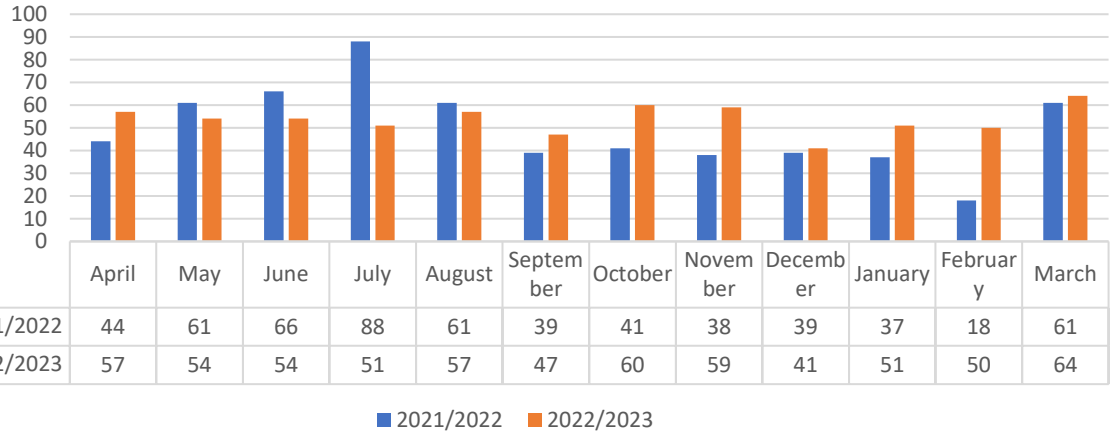
Data Source – Patient Experience team

INFORMATION
The Trust received 1 formal complaint in March 2023 Below is the category for the formal complaint received. 1. Clinical Query – Dispute over Diagnosis / Treatment In March 2023 the Trust closed 2 formal complaints within the agreed timeframe with the complainant. Meaning KPI's for complaints have been met this month. At the time of producing this report (04th April 2023) we currently have 5 open formal complaints. 2 for Division 2 and 3 for Division 1.
1
The Trust offers meetings to the complainant in the verbal and written acknowledgement and in the response letter. Often complainants will wait for the first written response before arranging a meeting as they then have a clearer picture of what has happened with the concerns raised within their complaint. Where the Trust did not meet the complainant's expectation in the first response or meeting, the Trust encourages complainants to write to us with any additional comments, questions or recommendations that will satisfy the complainant. During a period of four years, it is evident that the Trust has received less reopened complaints. It is believed that this is due to the offer to meet with each complainant and a better quality of response letter In March 2023 the Trust received 0 reopened complaints. In March 2023 we received 0 meeting requests
RISK AND ISSUES

Patient Advice and Liaison Service – PALS

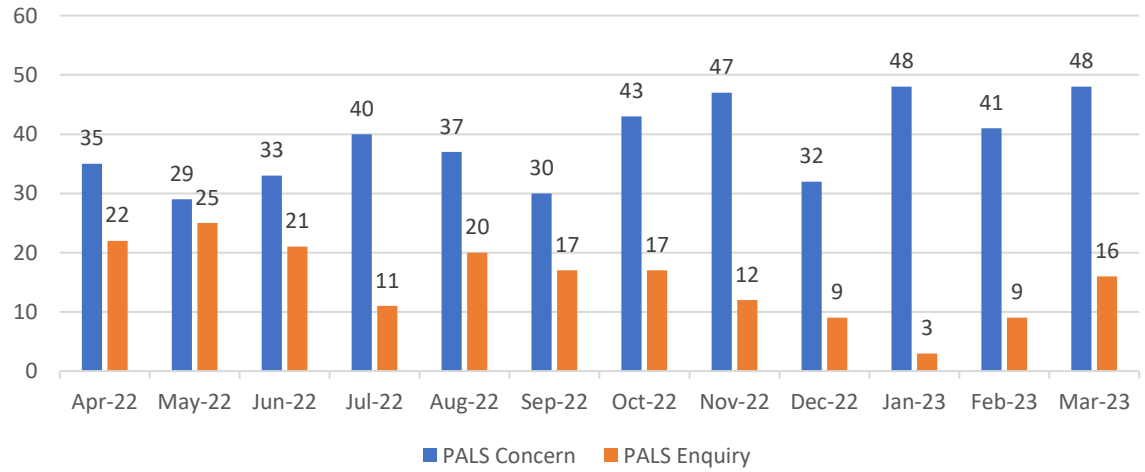
Below is the comparison of PALS contacts received in 2021/2022 and 2022/2023

PALS contacts received 2021/2022 Vs 2022/2023



	April	May	June	July	August	September	October	November	December	January	February	March
2021/2022	44	61	66	88	61	39	41	38	39	37	18	61
2022/2023	57	54	54	51	57	47	60	59	41	51	50	64

PALS Contacts Divided by Contact Type 2022/2023



INFORMATION

The main themes in the PALS data related to Appointments (27), Clinical Query (15) and Communication (8)
The Trust has set an internal target of 3 working days to respond to enquiries and 7 working days to respond to concerns in 80% of cases.
In March 2023, 83% of enquiries and concerns were met, meaning 9 PALS cases breached in March, meaning the KPI's were met for this month

Appointments	**27**
Appointment Cancelled	6
Appointment Request	3
Appointment Rescheduled	2
Availability	2
Confirmation Of Appointment	1
Delay	1
Delay To Be Seen In Hospital	5
Failure To Provide Follow Up	2
Letter Not Issued	4
Virtual Clinic - Call Received	1
Clinical Query	**15**
Appointment Not Satisfactory	2
Appointment Request	1
Delay Or Failure To Diagnose	2
Delays With Treatment	9
Operation - Outcome Not As Exp	1
Communication	**8**
Communication/Info To Patients	8

ACTIONS FOR IMPROVEMENT AND LEARNING (CLOSED RCA'S FOR SHARED LEARNING)

RISK AND ISSUES

9 PALS Cases breached in March 2023

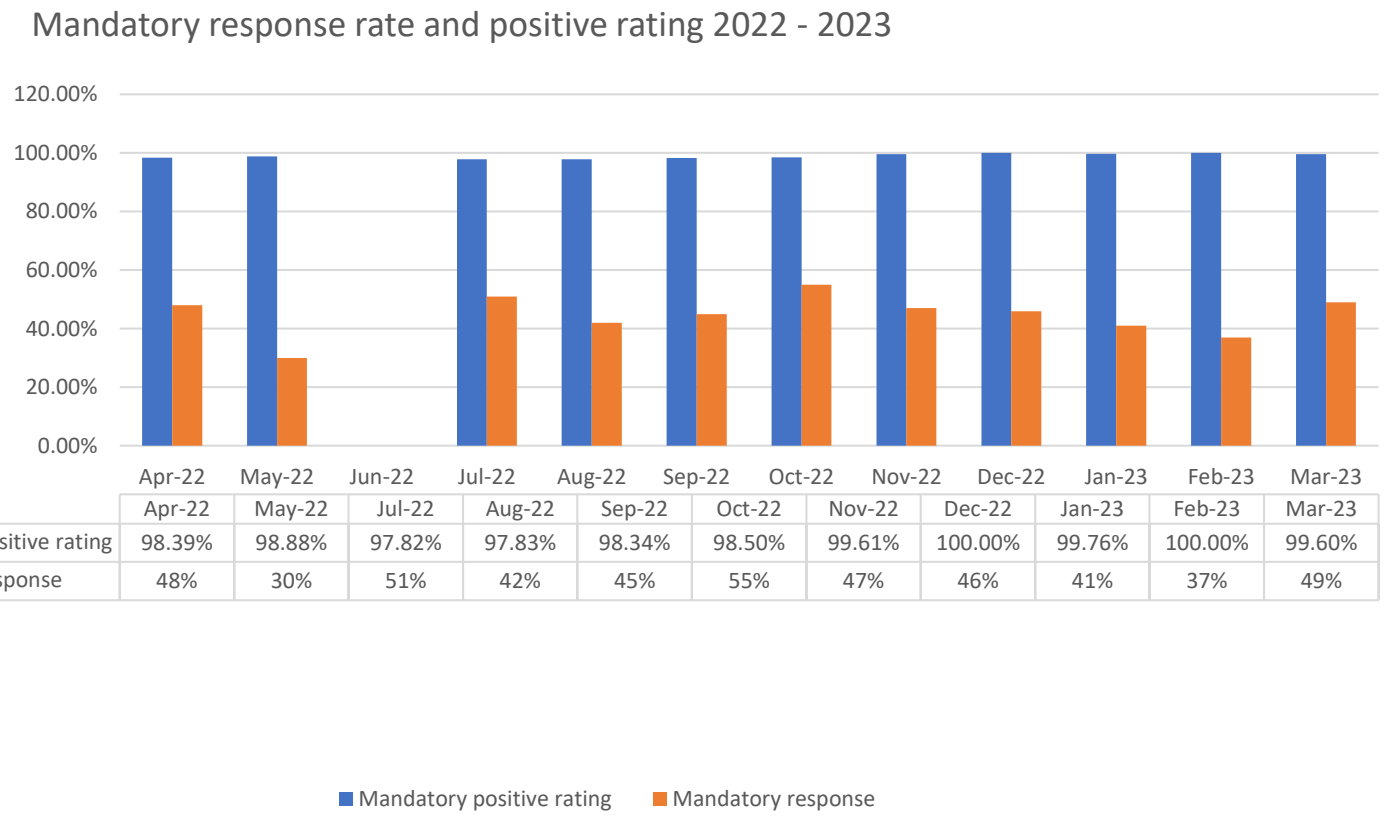
Patient Experience KPI's from April 2022 – February 2023

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

KPI	Complaints %	PALS Concerns %	PALS Enquiries %
April -22	100	95	89
May - 22	100	94	85
June - 22	100	94	100
July – 22	100	87	100
August -22	100	86	100
Sept – 22	100	88	95
Oct - 22	75	93	100
Nov-22	100	96	100
Dec-22	100	90	88
Jan- 23	100	72	100
Feb- 23	50	90	100
Mar-23	100	82	90

2 formal complaints were closed in February 2023, 1 complaint breached the agreed timeframe with the complainant due to lead not working within the Trust.

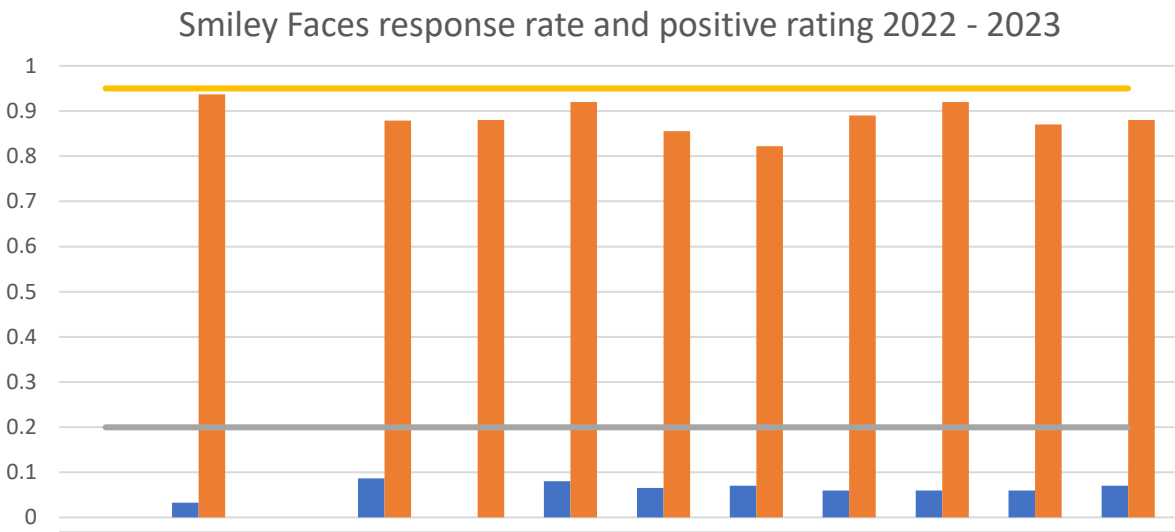
Friends and Family Test Results. FFT Mandatory Reporting FFT Mandatory (inpatient areas) Reporting



	Apr-22	May-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Mandatory positive rating	98.39%	98.88%	97.82%	97.83%	98.34%	98.50%	99.61%	100.00%	99.76%	100.00%	99.60%
Mandatory response	48%	30%	51%	42%	45%	55%	47%	46%	41%	37%	49%

Smiley Faces Report

The Trust has 10 smiley faces devices in all outpatient areas. Below are the results collected through May 2022 – March 2023 . The devices were rolled out in May 2022



	Apr-22	May-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Response Rate	0	3%	9%	0%	8%	7%	7%	6%	6%	6%	7%
Positive Experience	0	94%	88%	88%	92%	86%	82%	89%	92%	87%	88%
Positive Experience Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Response Rate Target	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%

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

There are currently 10 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

11. Litigation and Coroners

New claims

2 new claims against the Trust were received in March 2023.

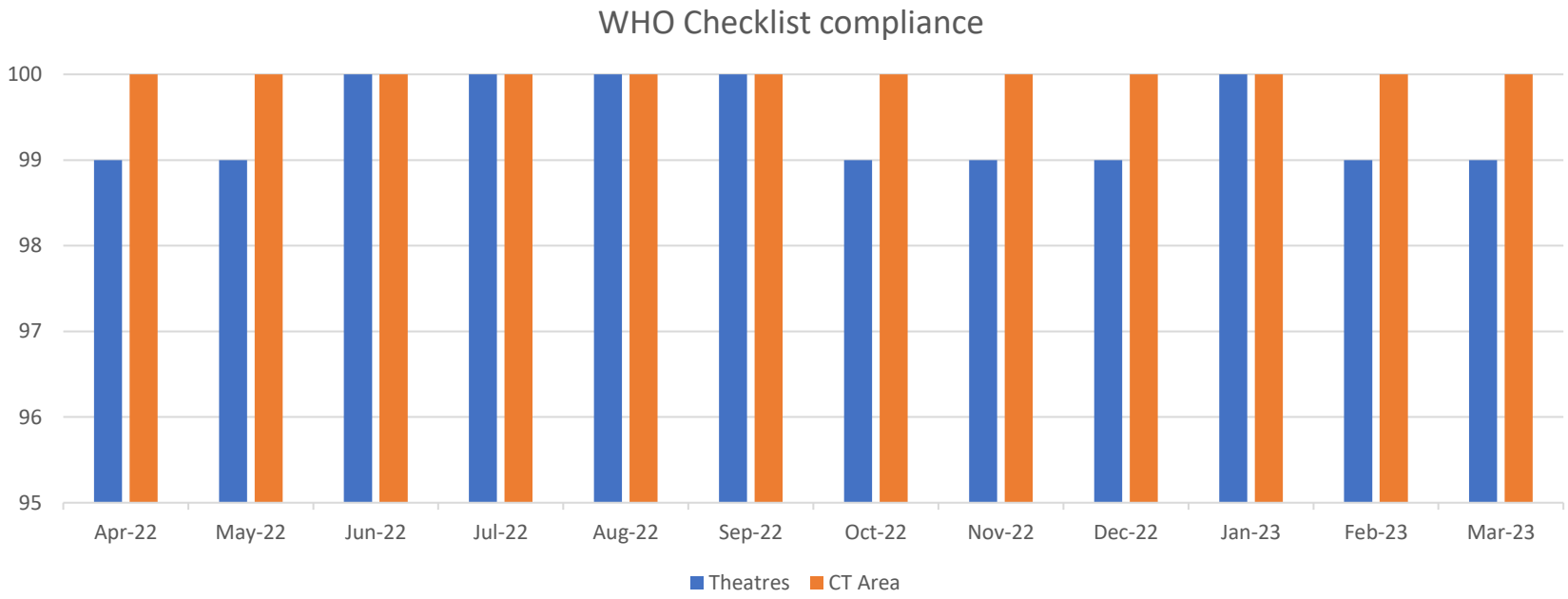
Pre-Application Disclosure

3 new requests for Pre-Application Disclosure of medical records were received in March 2023

Coroner's Inquests

0 Inquests in which the Trust was an 'interested person' were held in March 2023

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



Data Source – Theatreman and local audits

INFORMATION

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

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

Theatres

Total Number of Patients = 871

Notes accessed = Yes

Non-compliance = 1

Compliance = 99%

CT area

Total cases = 94

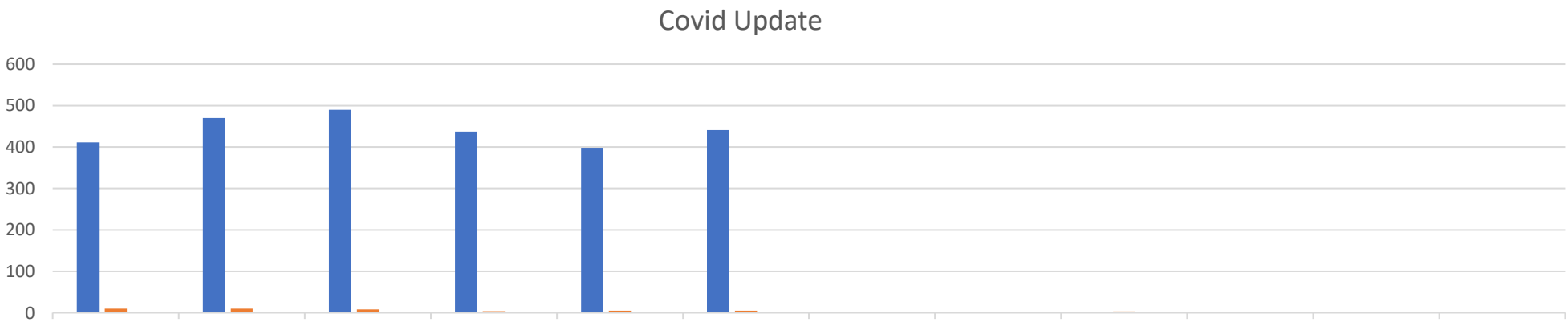
WHO Compliance for CT area = **100%**

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)	March 2023 Total	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72-hour Clostridium difficile infection (CDI)	0	8
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	0
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	1
Pseudomonas aeruginosa BSI cases	0	0

INFORMATION

The graph below details the reportable infections reported in month and year to date.
The graph below details the number of tests, positives and deaths for Covid-19.



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Covid Tests	411	470	490	437	398	441	0	0	0	0	0	0
Covid Positive	10	10	8	4	5	5	0	0	3	0	0	0
Covid Deaths	0	0	0	0	0	0	0	0	0	0	0	0

ACTIONS FOR IMPROVEMENT AND LEARNING (CLOSED RCA'S FOR SHARED LEARNING)

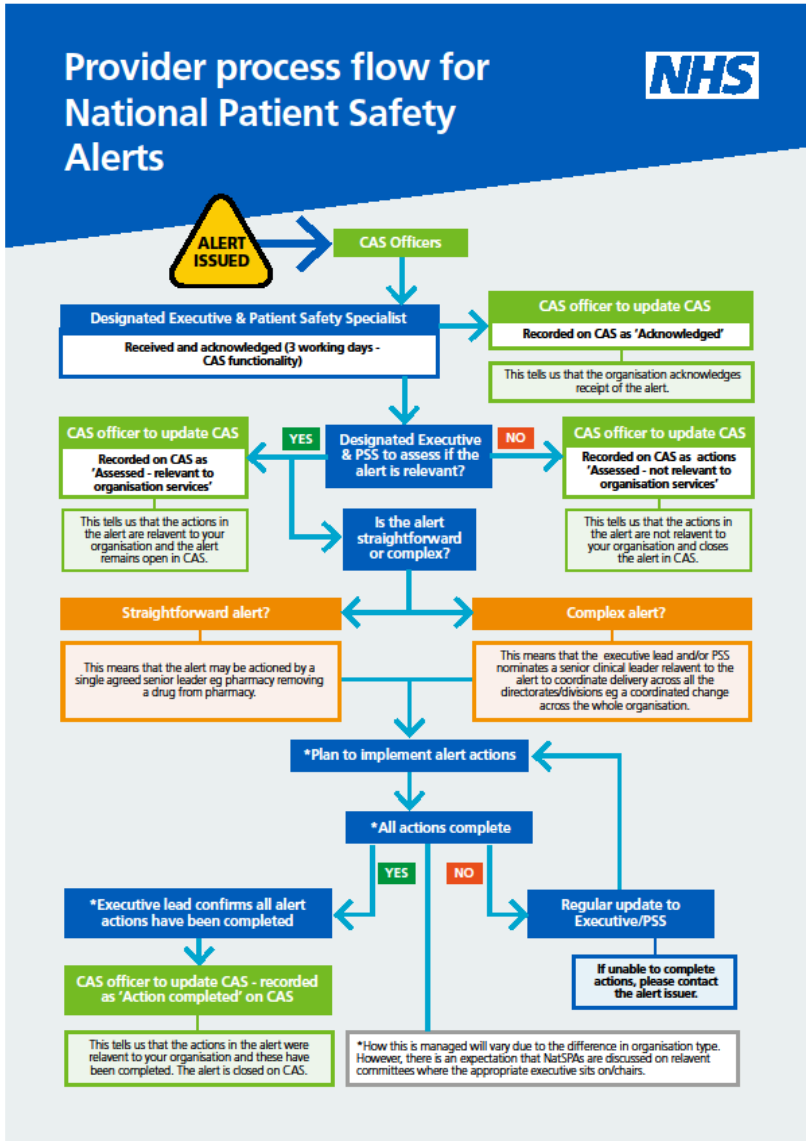
The Trust are no longer reporting and routinely testing for Covid-19 as per the national guidance. The Trust will continue to monitor positive cases and any deaths or outbreaks in relation to Covid-19

RISK AND ISSUES

None

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

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
CHT/2023/002	Management of National Patient Safety Alerts. Describes the process for the management of National Patient Safety Alerts. This has been designed in conjunction with Patient Safety Specialists, Patient Safety Partners, and Alert Originators. Please ensure that the Designated Safety Executive/Board Member, Patient Safety Specialist, and those involved in the governance of the National Patient Safety Alerts in your organisation are aware of and support the implementation of this process.	CAS Helpdesk Team	22-Mar-23	Trust adheres to process. Action Completed.	11 Apr 23


Provider process flow for National Patient Safety Alerts
NHS
ALERT ISSUED
CAS Officers
Designated Executive & Patient Safety Specialist
Received and acknowledged (3 working days - CAS functionality)
CAS officer to update CAS
Recorded on CAS as 'Acknowledged'
This tells us that the organisation acknowledges receipt of the alert.
Designated Executive & PSS to assess if the alert is relevant?
YES
NO
CAS officer to update CAS
Recorded on CAS as 'Assessed - relevant to organisation services'
This tells us that the actions in the alert are relavent to your organisation and the alert remains open in CAS.
CAS officer to update CAS
Recorded on CAS as actions 'Assessed - not relevant to organisation services'
This tells us that the actions in the alert are not relavent to your organisation and closes the alert in CAS.
Is the alert straightforward or complex?
Straightforward alert?
This means that the alert may be actioned by a single agreed senior leader eg pharmacy removing a drug from pharmacy.
Complex alert?
This means that the executive lead and/or PSS nominates a senior clinical leader relavent to the alert to coordinate delivery across all the directorates/divisions eg a coordinated change across the whole organisation.
*Plan to implement alert actions
*All actions complete
YES
NO
*Executive lead confirms all alert actions have been completed
Regular update to Executive/PSS
If unable to complete actions, please contact the alert issuer.
CAS officer to update CAS - recorded as 'Action completed' on CAS
This tells us that the actions in the alert were relavent to your organisation and these have been completed. The alert is closed on CAS.
*How this is managed will vary due to the difference in organisation type. However, there is an expectation that NatSPAs are discussed on relavent committees where the appropriate executive sits on/chairs.

15. Safeguarding – Below details the Key performance indicators and metrics in relation to Safeguarding compliance within the Trust.

KPI	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sept 2022	Oct-22	Nov-22	Dec-22	Jan-22	Feb-23	March 2023
Safeguarding Adult Notifications	26	44	29	33	44	36	27	51	31	31	35	17
Safeguarding Children Notifications	49	40	43	44	57	43	44	42	26	26	76	23
Adult Level 2	91.90%	91.06%	89.98%	87.99%	87.26%	86.01%	84.53%	85.14%	81.83%	81.83%	80.28%	80.19% (↓)
Adult Level 3	88.63%	88.84%	88.71%	87.97%	88.41%	86.52%	83.30%	80.31%	75.68%	75.68%	75.2%	76.37% (↓)
Level 4	80%	80%	75%	75%	75%	66.67%	66.67%	75.00%	75.00%	75.00%	60%	80.0% (↑)
Child Level 2	91.64%	90.81%	89.65%	87.66%	87.02%	85.87%	84.12%	84.54%	81.16%	81.16%	79.93%	79.85% (↓)
Child Level 3	88.57%	88.84%	88.21%	87.97%	88.41%	84.52%	83.10%	80.12%	75.29%	75.29%	75.2%	76.37% (↑)
Mental Capacity Act MCA	91.47%	90.27%	88.97%	87.58%	88.84%	85.78%	84.48%	84.97%	81.67%	81.67%	80.19%	80.36% (↑)
Deprivation of Liberty Safeguards DoLs	91.39%	90.27%	88.97%	87.58%	86.84%	85.87%	84.48%	85.05%	81.58%	81.58%	79.93%	79.93% (↔)
Prevent Awareness	93.22	93.71	93.34%	98.92%	92.44%	91.70%	90.04%	91.01%	89.88%	89.88%	89.40%	88.96% (↓)
WRAP (prevent level 3)	83.98	84.71	85.36%	83.84%	82.51	82.86%	80.15%	81.80%	81.06%	81.06%	78.55%	80.20% (↑)
FGM	0	0	1	0	1	0	3	1	1	1	2	1
DOLS	1	6	2	5	3	11	5	7	6	6	4	
MCA	2	4	3	6	7	4	7	4	4	4	0	1
PIPOT cases	0	0	0	0	2	1	1	0	0	0	1	0
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0	0	0

INFORMATION

Trust Safeguarding Quality report is discussed in detail at each meeting, which are held bimonthly with good attendance.

The statutory KPI's above are discussed in detail at the Safeguarding Committee via the Safeguarding Quality Report

The Safeguarding Team continue to see an increase in staff referring safeguarding concerns via their individual emails or over the phone. Staff have been reminded to follow internal safeguarding procedures using the safeguarding notification system and team email generic not the alerts email, to ensure all concerns are reported and monitored appropriately.

SG Quality Report

The team are revising the format of the committee quality report. The Senior Named Nurse is updating the content format.

Going forward we will have a SG report and a Vulnerabilities report which will include LD and Autism, Mental Health and Dementia and Transition to Adult Services. Data will include age and gender graphs. The intention to help in providing more robust internal and external data reporting for both Safeguarding and Vulnerability. These will be presented at next Safeguarding committee.

Transition to Adult Services

National Transition Network-The expected Transition Framework documents are still awaited. There has been a delay with NHSE publishing the documents. The Framework will be a National deliverable policy and the Trust will need to acknowledge Statutory requirements.

Transition CNS had a meeting with Regional Transition Nurse Advisor and ROH Chief Nurse to discuss the possible implications of the Framework for the Trust. This will impact on training and education for all staff. The framework will be used by inspectors such as CQC to monitor services.

The Burdett National Transition Network announced that the Network in its current form will come to an end in May 2023 due to lack of funding support for the Regional Nurse Advisors from NHSE. The Midlands is currently the only region that has secured funding for continuation of the Regional Nurse Advisor.

Champions meeting – next due to held 18.05.2023- Being led by the Clinical Nurse Specialist, agenda and workplan for the group being formulated.

Section 11 Audit and Care Act Compliance tool

Regional self assessment audit tool work has commenced by the SG Lead and Senior Named Nurse for the Trust. This is a new regional audit within the West Midlands. Deadline for submission is the 11th May 2023. The areas for improvement identified for children and adults safeguarding will be presented to the Trust Committee and upwardly to Quality and Safety Committee.

Mental Health

Mental Health & Dementia Practitioner work currently underway :-

- **Updating the current dementia package**
- **Will also be updating the mental health package**
- **Providing supervision as necessary to staff**
- **Contributing to the vulnerabilities folder that once approved will be placed on the wards outlining the pathway re referrals for MH & Dementia.**
- **Scoping Tier 2 training and costing which will meet the 13 defined Tier 2 outcomes.**

Mental Health First Aid England – Youth

Training was held on 23rd and 24th March 2023 (2-day course), 14 delegates attended from a range of areas including Wards, ROCs, CYP, OPD and Patient Experience. Two further dates to be planned for this year, scoping possibly June & October 2023.

Mental Health First Aiders Adults (MHFA)

Trust does not currently have any trainers for this course – Risk number 1758, remains static. Practitioner scoping other training and current staff MHFA , and Chief Nurse scoping a peer review for mental health with external provider.

Learning Disabilities

A part-time band 6 learning disability liaison nurse will be starting on 3rd April 2023.

Training:-Oliver McGowan Training This will replace the current e-learning available for ROH staff on ESR from 1st April 2023. Consists of two Tiers 1 and Tier 2.

- **Tier 1- is a combination of e-learning (90 minutes) part a; plus a follow up online discussion with experts by experience part b. This is all staff who will have minimal support contact. For example, admin staff. Only part a is currently nationally available.**
- **Tier 2- is a full day's training co delivered by people with a learning disability and autistic people plus the e-learning section. For all staff who support or have contact with patients with learning disabilities and or autism. For example, all ward staff, clinical staff.**

The Trust is awaiting confirmation on how the remaining parts of the rollout will take place.

Child Exploitation Awareness

Child exploitation is a form of abuse that involves the manipulation and/or coercion of young people under the age of 18. The Named Nurse for Safeguarding Children and Adults put together a display stand in the CYP department. Rapid Read 7 min briefing – produced by new Named Nurse on Exploitation aimed to help everyone to think, spot and speak out against child exploitation, all year round. 7-minute briefing

ACTIONS FOR IMPROVEMENT AND LEARNING (CLOSED RCA'S FOR SHARED LEARNING)

- Bank staff - SG and Prevent training that is outstanding, further work is required to ensure that the data is accurate and plan to improve current compliance by the Bank Team and
- Training session capacity has now been increased for Level 3; due to a long waiting list for delegates to attend. All SG training dates have been uploaded onto training calendar and are on ESR to book onto. Managers and staff have been updated via comms and the safeguarding committee.
- The next Youth Forum is planned for 9th May 18:00 – 20:00 hrs aimed at 13-25 year olds
- Interviews for the part time Band 6 Transition Nurse was undertaken 16th March 2023, successfully appointed to staff member due to commence in post mid May 2023.
- Well Infant in adult ward guidance for the Trust is being further developed by the Senior Named Nurse, following a previous incident, this was one of the agreed actions.
- At the March Committee findings of the annual internal audit of children and adults safeguarding documentation were presented with recommendations and learning and required actions. These included
  - All staff to ensure they follow record keeping and documentation principles which include signing and printing name, using stamp and date and time within documentation on purple records.
  - Follow internal safeguarding processes by reporting safeguarding concerns via internal safeguarding notifications, staff must update purple records with outcomes and actions taken, review alerts on PAS and other electronic systems.
  - Departments that use electronic systems only are not creating a set of paper records as per safeguarding policies to document all actions on purple paper to ensure all department within the Trust are aware of the safeguarding concerns.

RISKS AND ISSUES

Safeguarding database (internal) - Risk number- 1817 (score 12) Lack of robust database to record and store safeguarding, learning disability / autism, transition, and mental health data. Work has commenced on this in March This will be in two phases, phase one – SG database which will be cloud based. Phase 2 will be the Learning Disability & Autism and Mental Health & Dementia and Transition to Adult Services. Initial meetings held mapping the pathway, and requirements document being produced.

Training compliance Safeguarding- Again this month the Trust is below the contractual target and national target required, as noted above in red. Training for Level 3 continues to be delivered off site due to lack of room availability at ROH. The ICS have requested trajectory for delivery of required training compliance and escalation. All managers are requested to take action and ensure staff are booked onto and attend and complete the required outstanding training.

Trust Prevent Quarter 4 return to DOH -This has been submitted in March as required, Unify return. Both awareness and WRAP training were below the required level of compliance. Prevent training compliance is on risk register , risk number 1816 remains static.

Both awareness and WRAP can be done on line eLearning ESR or attend face to face WRAP training. SG Lead Nurse has sent out reminders to all CSM and Division regarding outstanding staff members and the action required.

Please note compliance targets:-

National Target is 95%- Local is 85% for Awareness Training

National Target 90%, Local is 85% for WRAP L3 Training

Safeguarding team office accommodation /environment –Risk number -1863 the risk remains static. No accommodation for new starters who started with us in March 2023. The team are working a roster around available desk rotation. Team members remain working /based over 3 areas in the Trust. Chief Nurse working with Facilities and Estates to address this. This impacts on team effectiveness and resilience.

Mental Health - Risk register number -1758- Psychiatric Liaison Support. Trust continues to have no agreed support from BSMHFT, this continues to be scoped further by the Trusts Medical Director and Chief Nurse.

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

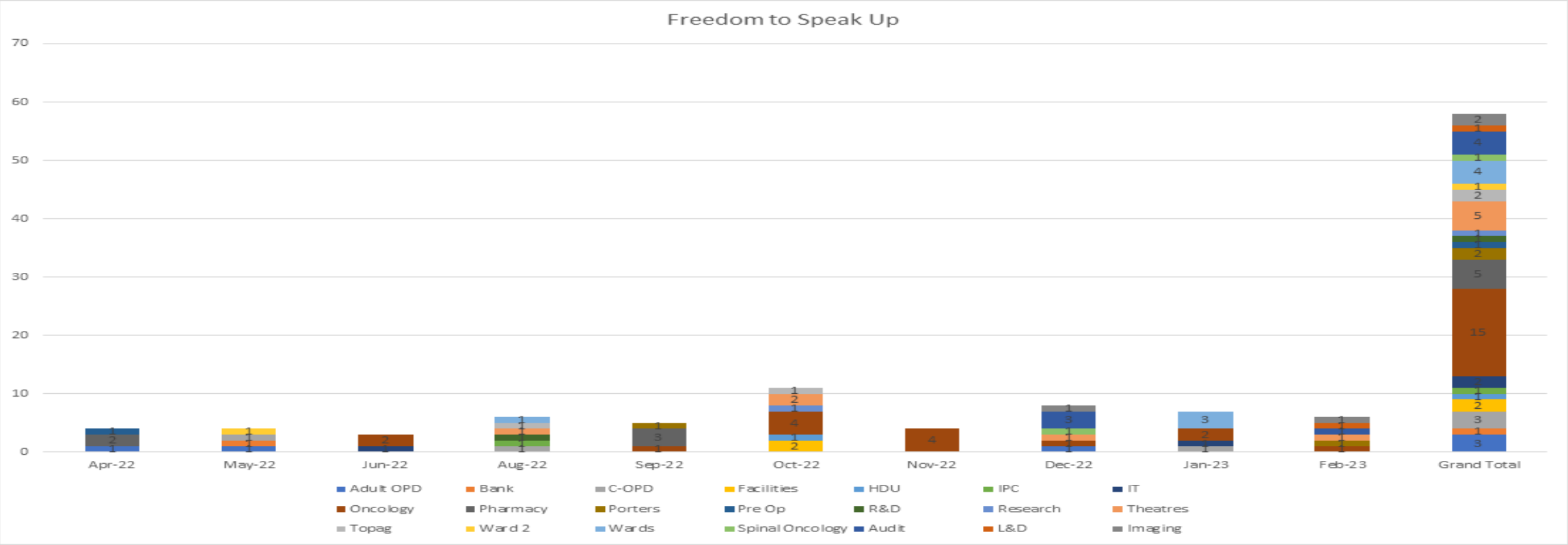
The 30 day readmissions as defined by Monitor for the Quality Accounts

The percentage of patients aged who are readmitted to a hospital which forms part of the trust within 30 days of being discharged during the reporting period.

	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
No of Readmissions	8	7	4	3	7	6	9	3	0	3	7	5
Denominator	415	531	544	495	437	484	557	556	486	468	468	534
% Readmissions	1.9%	1.3%	0.7%	0.6%	1.6%	1.2%	1.6%	0.5%	0.0%	0.6%	1.5%	0.9%

17. Freedom to Speak Up Update

The safety of patients/service and colleagues are a top priority for the Trust. Our endeavour is to ensure that they feel able to speak up about anything which prevent them from doing a good job or improve our service.



INFORMATION
4 concerns raised in March 2023; these were all in relation to the following theme Poor attitude and behaviour – This remains a common theme

ACTIONS FOR IMPROVEMENT AND LEARNING
• Ensuring breaks are taken • Well-being support at all levels • Protected time to complete mandatory training • Delivery of Management Skills Programme and scoping of leadership training • Delivery of civility and respect training • Embedding of Freedom to Speak Up champions to signpost to routes to raise concerns • Retention of staff & staffing levels • Team building sessions • Equality and Inclusion awareness at all levels

RISK AND ISSUES
• Retention of staff & staffing levels

Operational Performance

March 2023

Icons reading guide

Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

For KPIs that are not applicable to SPC; to identify exceptions we look at performance against target over the last 3 months - automatically assigning measures as an exception if the last 3 months have been falling short of the target in line with how we're calculating the assurance icon for non-SPC measures.

Variation Icons

Are we showing improvement, a cause for concern, or staying within expected variation?

Orange variation icons indicate special cause of concerning nature or high pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

Blue variation icons indicate special cause of improving nature or lower pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

A grey graph icon tells us the variation is common cause, and there has been no significant change.

For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

The special cause mentioned above is directly linked to the rules of SPC; for variation icons this is if the latest point is outside of the control range, or part of a run of consecutively improving or declining points.

Assurance Icons

Can we expect to reliably hit the target?

An orange assurance icon indicates consistently (F)alling short of the target.

A blue assurance icon indicates consistently (P)assing the target.

A grey assurance icon indicates inconsistently passing and falling short of the target.

For measures without a target you will instead see the "No Target" icon.

Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months in comparison to the target, showing F or P icons if consistently passing of falling short.

Operational Performance Summary

Performance to end Mar 23	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	58.99%	60.86%	92%		
104 week waits	0	0	0		
78+ week waits	0	19	0		
52 week waits (52 – 77 Weeks)	71	86	0		
All activity YTD (compared to 19/20)	99.2%	96.5%	110%		
All activity YTD (compared to plan)	13,844	12,549	14,394		
Outpatient activity YTD (compared to plan)	89.9%	90.8%	69,024		
Outpatient Did Not Attend (YTD)	7.92%	7.92%	8%		
PIFU (trajectory to 5% target)	6.90%	6.10%	5%		
Virtual Consultations (target is plan, operational planning guidance is 25%)	9.7%	13.7%	19%		
FUP attendances(compared to 19/20)	92.5%	90.2%	75%		
Diagnostics volume YTD (compared to 19/20) – All Modalities	98.5%	98.4%	120%		
Diagnostics volume YTD (compared to plan)	18,088	16,179	21,760		
Diagnostics 6 week target	99.6%	99.3%	99%		
Theatre utilisation (Uncapped)	86.1%	91.4%	85%		

Operational Performance Summary

	In month	Previous month	Target	Variation	Assurance
Cancer - 2 week wait (Feb – Jan)	95.5%	95.5%	93%		
Cancer – 31 day first treatment	100%	93.3%	96%		
Cancer – 31 day subsequent (surgery)	100%	100%	94%		
Cancer – 62 day (traditional)	50%	70%	85%		
Cancer – 62 day (Cons upgrade)	71.4%	90%	n/a		No Target
28 day FDS	86.0%	87.1%	75%		
Patients over 104 days (62 day standard)	0	0	0		
POAC activity volume (YTD) (target set is average monthly 19/20 activity)	19,600	17,717	13,704		
Bed Occupancy (excluding CYP and HDU)	64.3%	61.3%	82-85%		
LOS - Excluding Oncology, Paeds,YAH, Spinal	3.28	3.34	n/a		No Target
LOS – elective primary hip	3.40	2.80	2.7		
LOS – elective primary knee	3.60	3.50	2.7		
BADS Day case rate (Note: due to time lag in month is Nov'22)	79%	79%	85%		

Glossary of terms

VTE	Venous thromboembolism (VTE)
UHB	University Hospitals Birmingham
PIR	Post Infection Review
ADCU	Admissions and Daycase Unit
BBRAUN	Medical manufacturer B. Braun Medical Ltd
CQC	Care Quality Commission
DAIR	The DAIR (debridement, antibiotics and implant retention) procedure for infected total knee replacement
STEIS	STEIS
RCA	Root Cause Analyses
OPD	Outpatient Department
CAS	Central Alerting System (CAS)

PAPER REFERENCE: ROHGO (5/23) 014c

Monthly Workforce & OD Report

March 2023

CONTENTS

Introduction

This report shows the Workforce and OD information for the months of March 2023 compared with the previous month(s).

This information is at the point of when the reports are taken in ESRBI and relies on the updates from managers and members of staff to keep the data up to date.

Key Points

Executive Summary

- Overall 83.68% of WTE employed against the Establishment
- Staff Turnover remains high at 17.1%
- PDR/Appraisals are still well below what we should be doing as a Trust currently at 65.41%
- Return To Work meetings are still not being recorded fully currently 58.17%

Positive Assurances

- Work to tackle the Return To Work meetings recording is currently being planned
- Work to understand the reasons for employees leaving is being undertaken
- With Trac implemented we hope this will help with recruitment
- There has been an increase in membership for staff networks and work continues to encourage attendance at meeting
- Wellbeing spaces continued to be well used by staff members and attendance at events has increased

Key Risks

- Cost of living seems to be affecting the NHS as a whole, the Trust is doing it's upmost to alleviate the impact.
- Other Trusts seem to be able to offer higher bands, this has seen some employees move on.
- Staff with no PDR/Appraisal will have no way of been appraised and will have no personal goals.
- Return To Work meetings if these aren't carried out there is a potential for further sickness and opportunities to support employees will be missed.

Next Steps

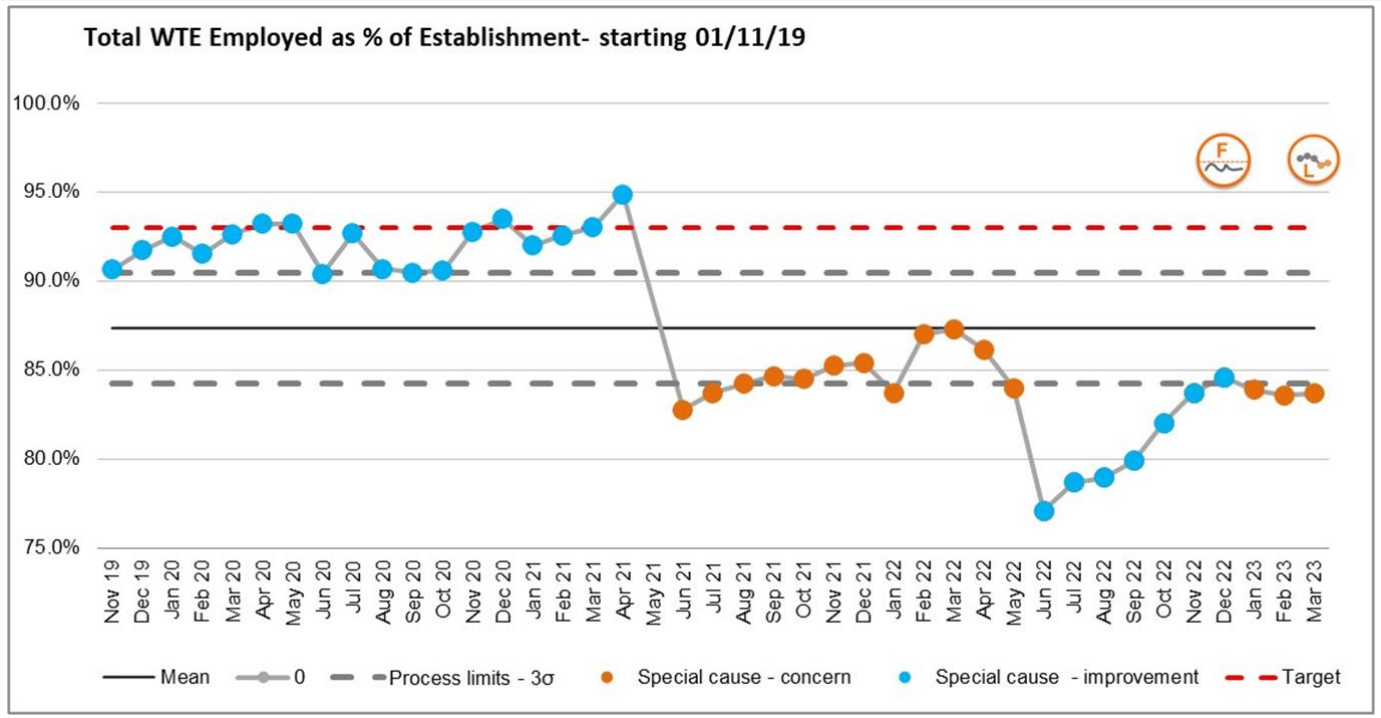
- HR and E-Roster team to look into the issues around Return To Work meetings, Sophie Beavon, Paddy Coen and Jade Johnson are running drop in sessions for managers.
- HR to review the Staff Turnover and look into the reasons and dig deeper into them, Terrie Hillier provides a deeper dive into the data and will be running a Leavers Process working group to tackle some of the themes.

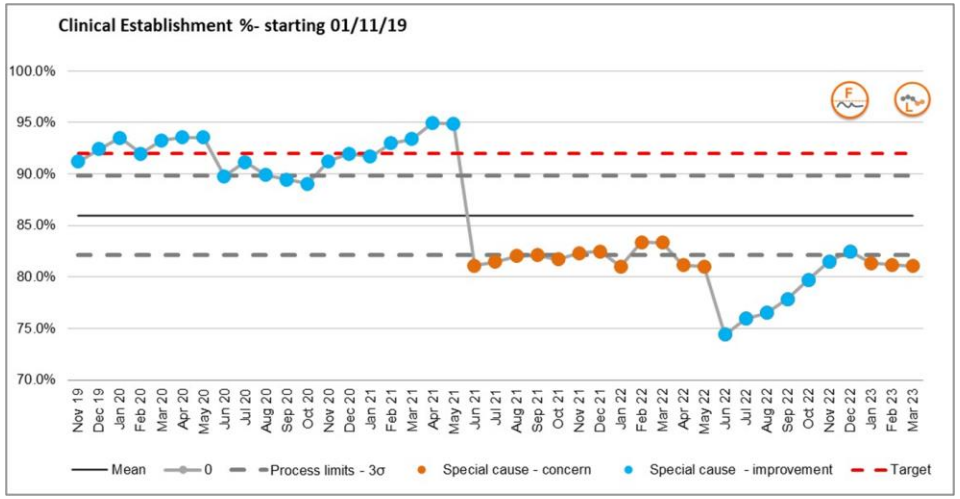
1. Workforce Overview

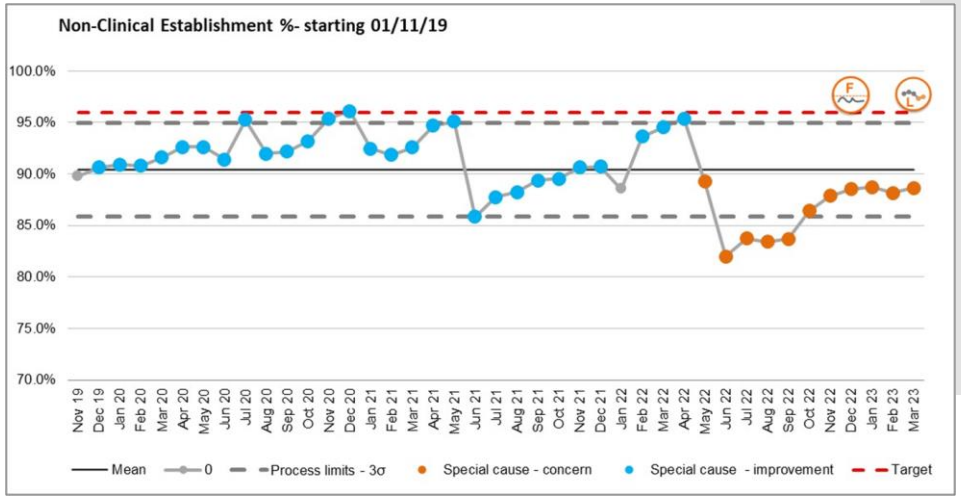
Trust Workforce Metrics	Feb-23	Mar-23	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1270	1282	12	-	-
Staff In Post - Full Time Equivalent	1122.80	1134.03	11.22879	-	-
Staf Turnover % - Unadjusted	17.34%	17.06%	-0.28%	↓	<=11.5%
Staf Turnover % - Adjusted	15.29%	15.14%	-0.15%	↓	<=11.5%
Total WTE Employed as % of Establishment	83.56%	83.68%	0.12%	↑	>=93%
Total WTE Employed as % of Establishment - Clinical	81.17%	81.06%	-0.10%	↓	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	88.14%	88.64%	0.50%	↑	>=96%
% Of Attendance	94.34%	94.47%	0.13%	↑	>=96.3%
% Of 12 mth MAA Attendance	93.94%	93.96%	0.02%	↑	>=96.3%
% Staff received mandatory training last 12 months	87.59%	86.38%	-1.21%	↓	>=93%
% Staff received formal PDR/appraisal last 12 months	65.46%	65.41%	-0.04%	↓	>=95%
% of Sickness - Trust wide Long-term	3.07%	2.75%	-0.32%	↓	-
% of Sickness - Trust wide Short-term	2.59%	2.78%	0.18%	↑	-
Return To Work Completion %	52.98%	58.17%	5.19%	↑	>=80%

2. Establishment

At the end of March, the number of staff on payroll stood at 1282 (WTE 1134.03) which is a increase of 11.22 WTE from February.
The Total WTE Employed as a % of the Establishment this month was 83.68% which rests well below the Trust Target 93%.



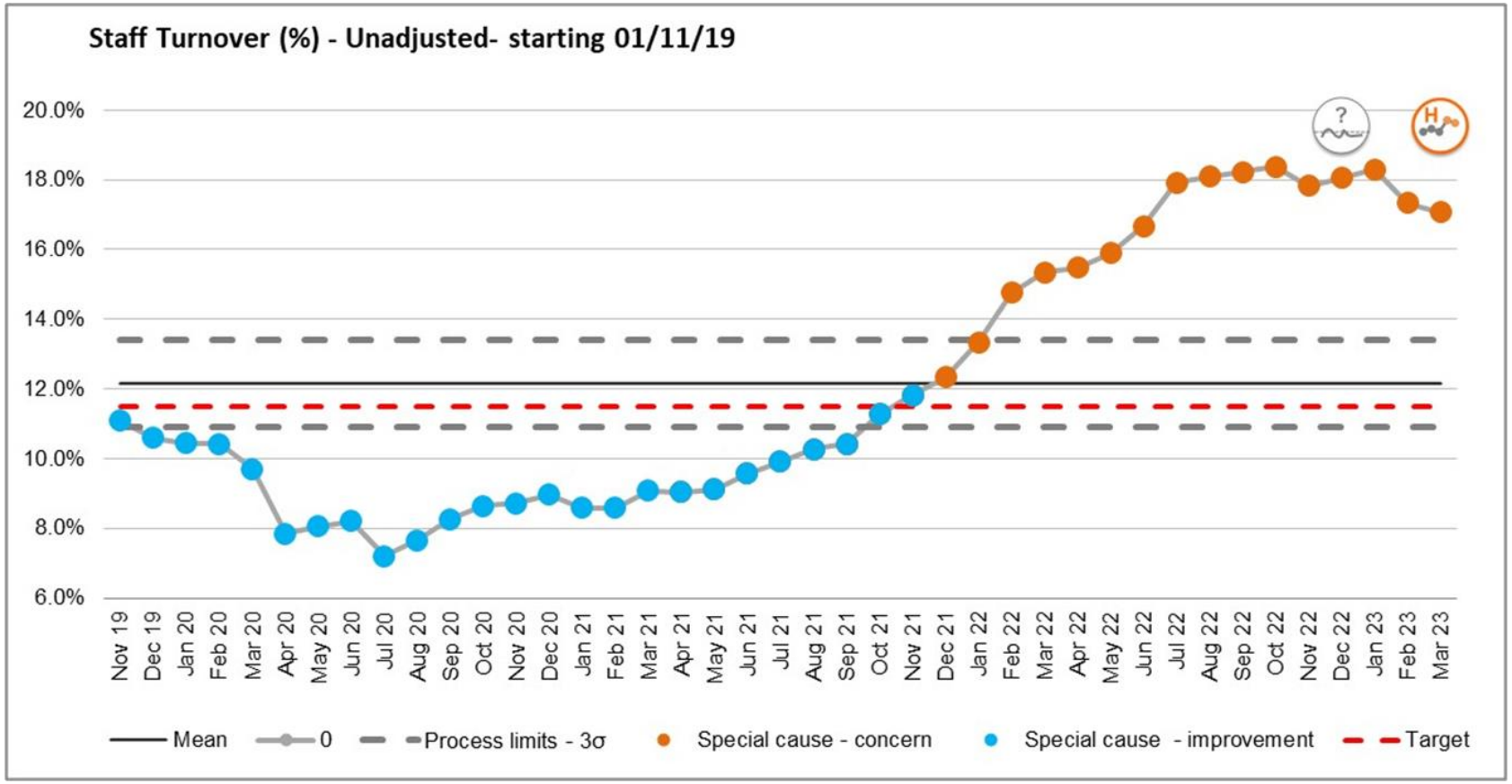




3. Turnover & Retention

Unadjusted turnover for this month was 17.06% which is well above the Trust target of 11.5%.
For unadjusted turnover by staff group, over the last 12 months, turnover was the highest in the Add Prof Scientific and Tech, closely followed by Admin & Clerical and Nursing & Midwifery which are all in the red category against the Trust target.

Work continues to look into the Recruitment & Retention of staff within the Trust. HR continue to work with Managers to review reasons why employees are leaving.



Staff Group	FTE
Medical and Dental	11.94%
Allied Health Professionals	14.02%
Additional Clinical Services	15.24%
Estates and Ancillary	17.62%
Nursing and Midwifery Registered	17.82%
Administrative and Clerical	18.33%
Add Prof Scientific and Technic	23.97%

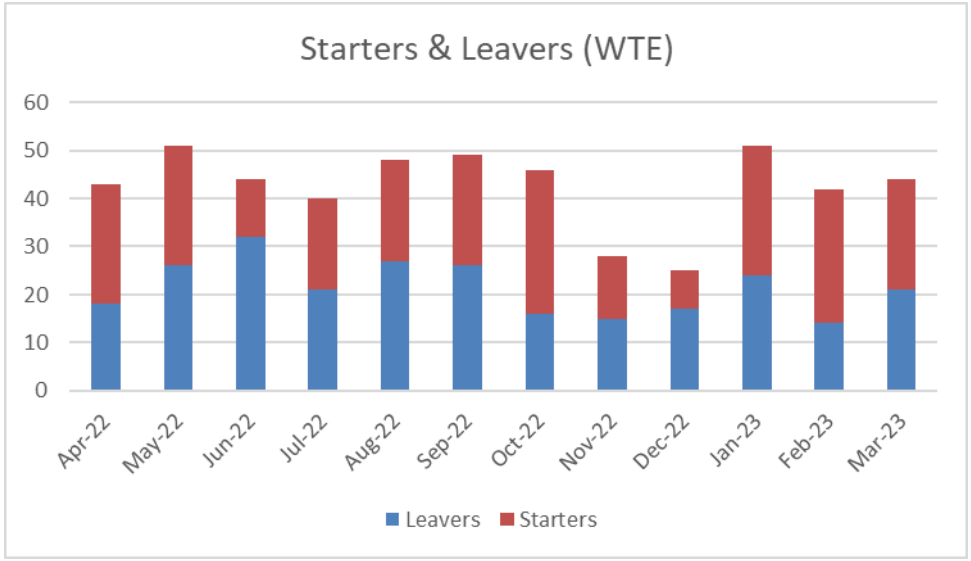
Org L4	FTE
303 Division 4 - Estates and Facilities	8.30%
303 Division 2 - Patient Support	14.43%
303 Division 1 - Patient Services	18.02%
303 Corporate Directorate	23.74%

4. Starters & Leavers

Over the last 2 months, the main reasons for staff leaving (according to ESR data) were other not known, Retirement and To undertake further education or Training, which is different to previous months.

Managers need to gauge the reason why employees are leaving, Other/Not known should not be used.

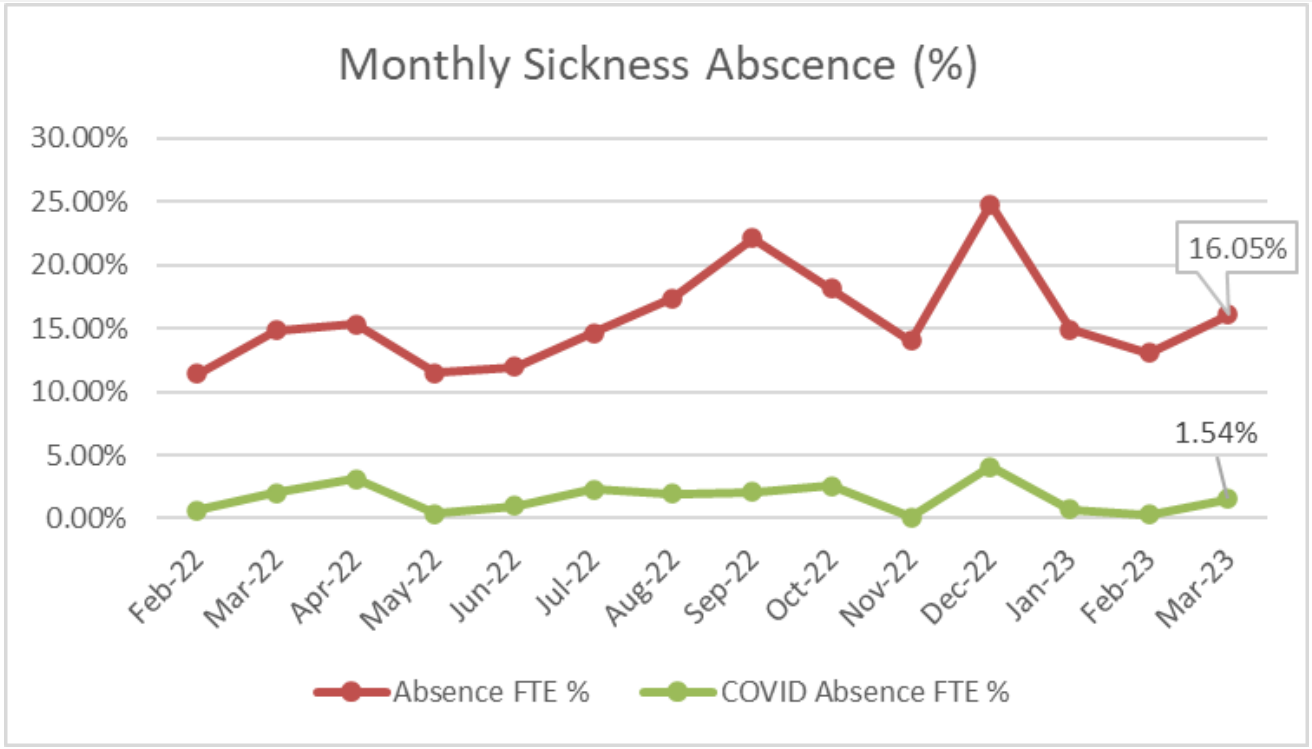
As a Trust we need to find out why people are leaving for To undertake further education or Training and not securing them with our education offering.



5. Attendance & Sickness

Attendance for this month was 94.47% (sickness absence % = 5.53) and Attendance for the rolling past 12 months was 93.96%. This currently sits below the Trust target of 96.3% and has remained fairly consistent over the past few months.

The top reasons for sickness absence included Anxiety/stress, cold cough or flu like symptoms (including COVID-19), gastrointestinal problems and musculoskeletal problems. This month sees Chest & respiratory stay in the top 5 reasons.



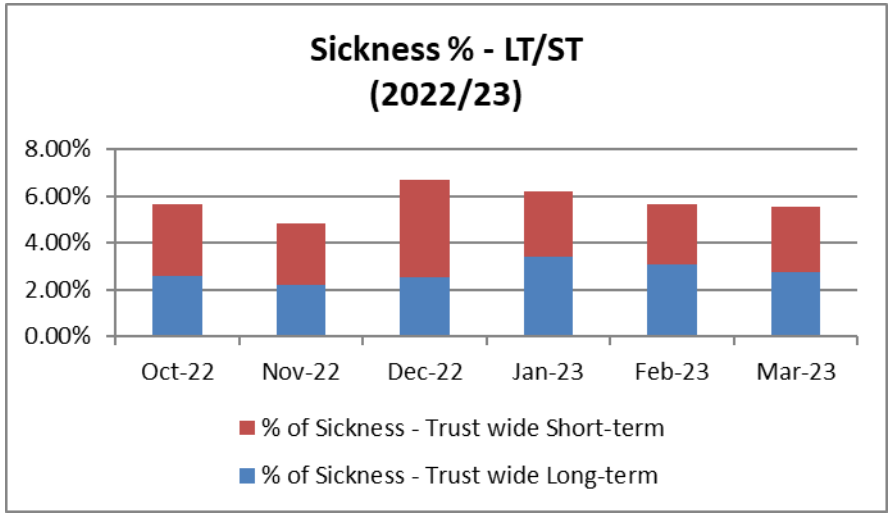
This chart shows that 16% of the WTE were off with sickness which started in March 2023 (not inc Long Term Sickness) and of that sickness 1.54% is attributed to Covid, this against the WTE figure of 1134.032

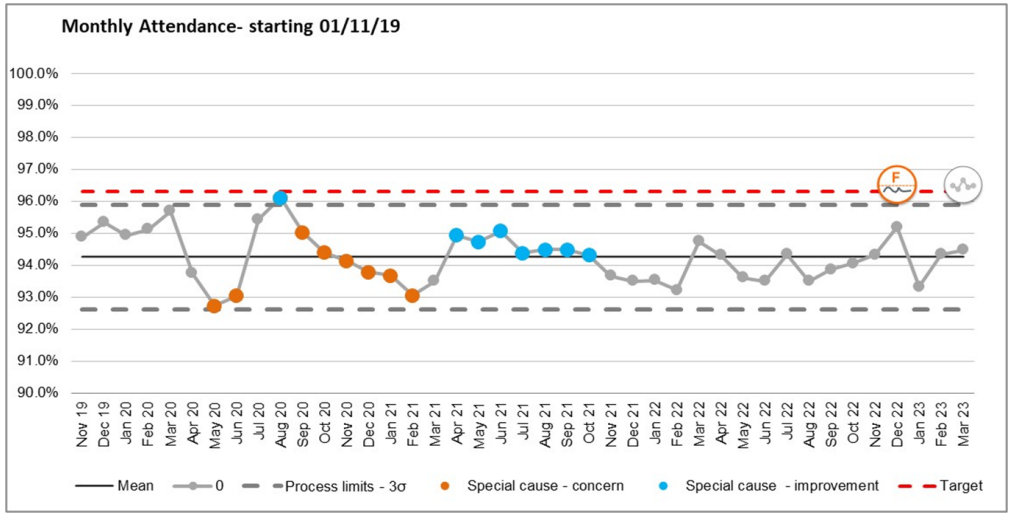
Top Absence Reasons In the Last 12 Months by FTE Days Lost	Count of Episodes	FTE Days Lost	Estimated Cost Of Absence
Cold, Cough, Flu - Influenza	952	5784.87297	£ 587,517.93
Anxiety/stress/depression	212	4950.05386	£ 486,465.78
Musculoskeletal problems	145	2403.69341	£ 250,797.48
Gastrointestinal problems	482	1642.30339	£ 149,895.19
Chest & respiratory problems	114	1245.45415	£ 138,370.29

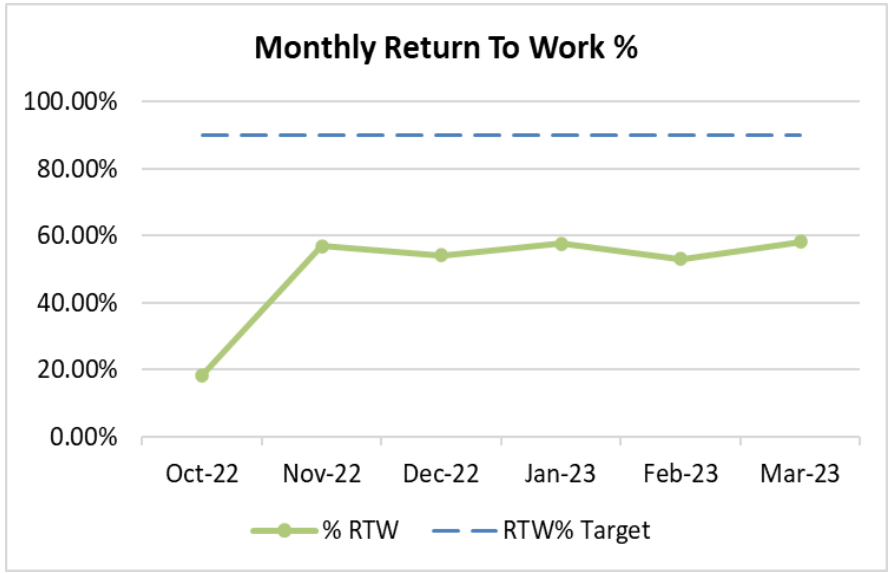
5. Attendance & Sickness

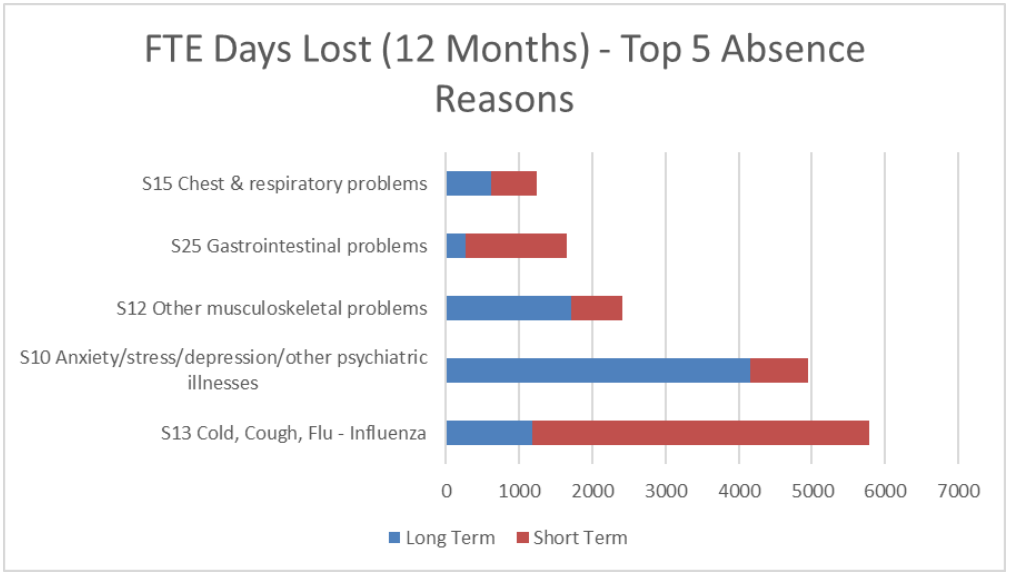
Return To Work Discussion Meetings Following Sickness Absence

Trust wide Return To Work (RTW) interviews increased to 58.17% in March, compared to 52.98% in February. This still remains below the Trust Target of 80%.



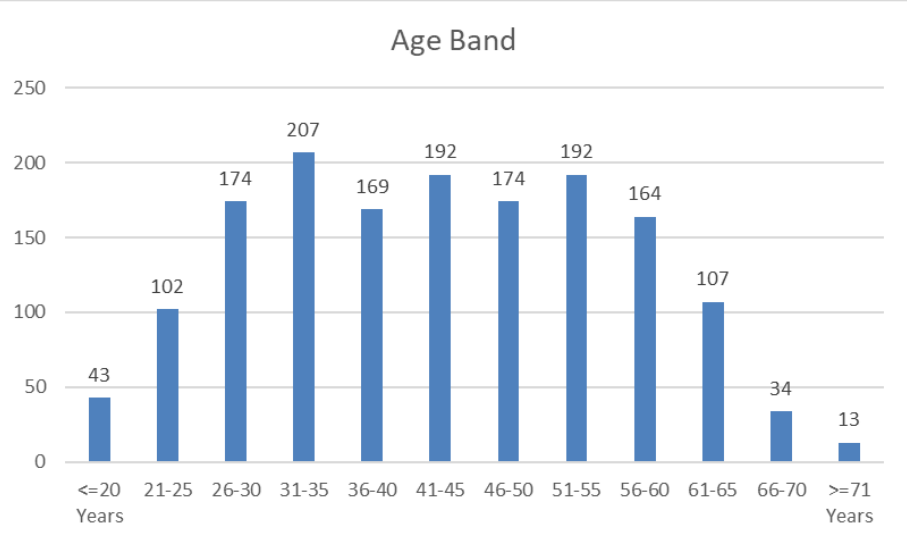


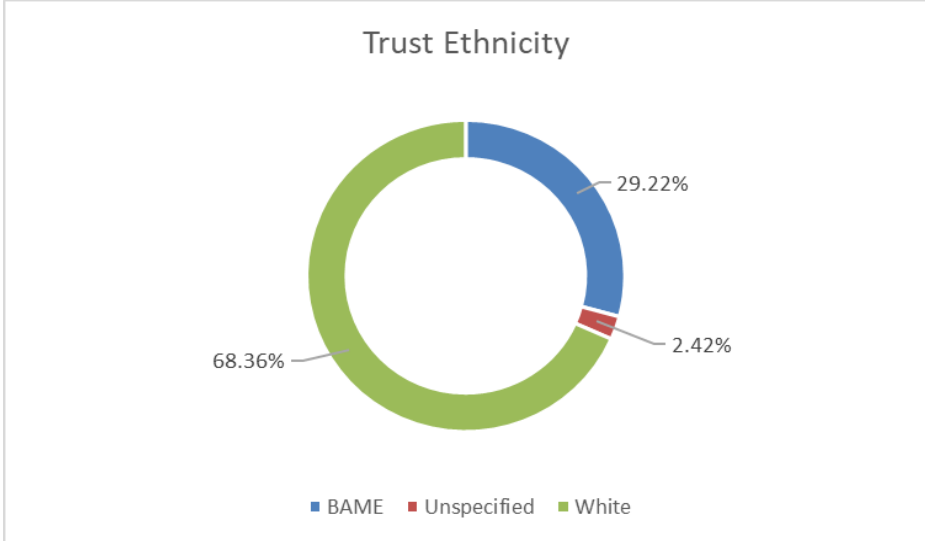


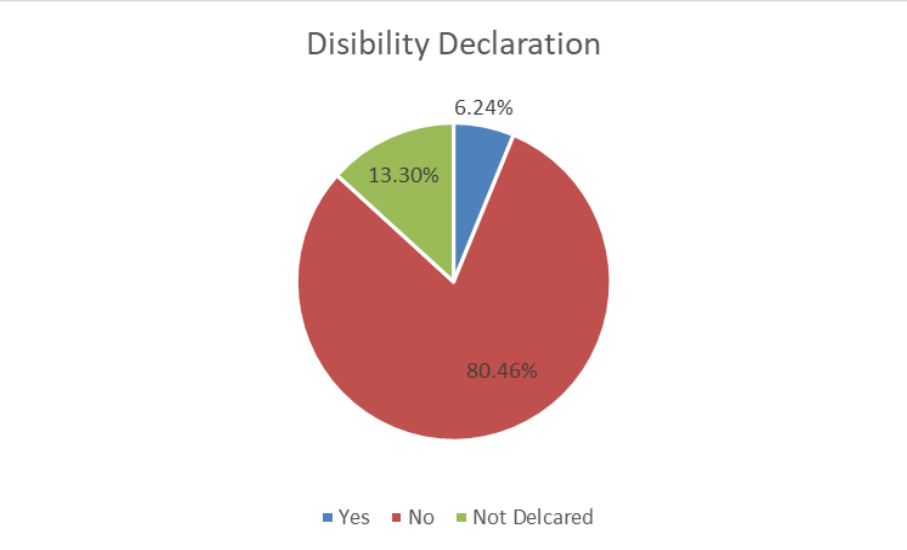


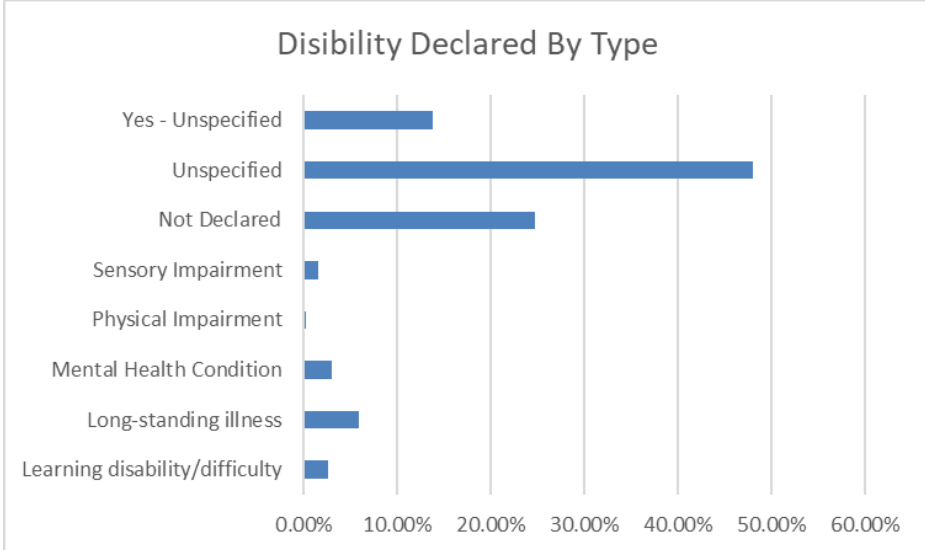
6. Workforce Demographics

The Trust is made up of 71.61% female and 28.39% male staff
Our current status of staff with a disability is 6.24% with 13.3% of staff still to declare their disability status, this has decreased slightly due to a new members of staff joining without declaring. Staff are being encouraged to update their equality and diversity details through Electronic Staff Record.



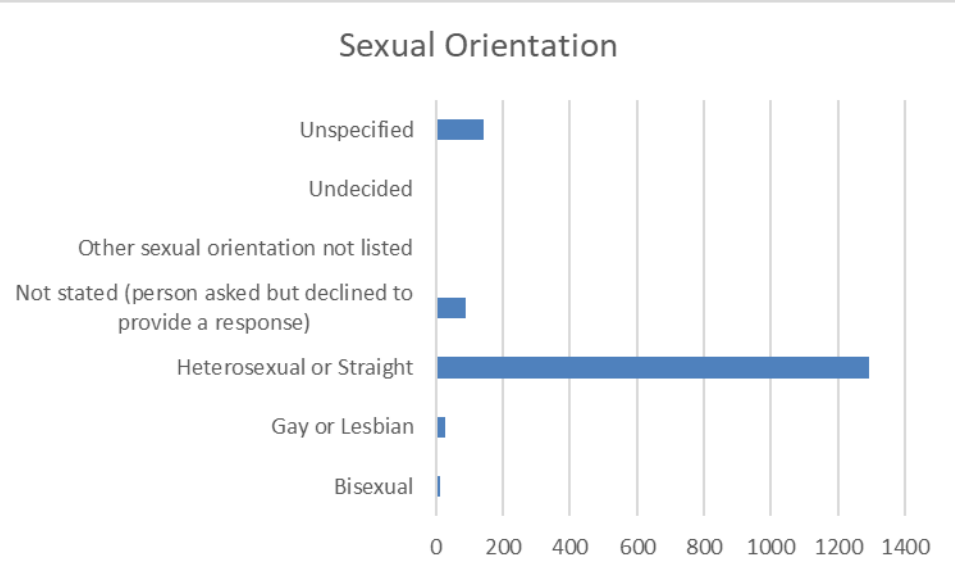


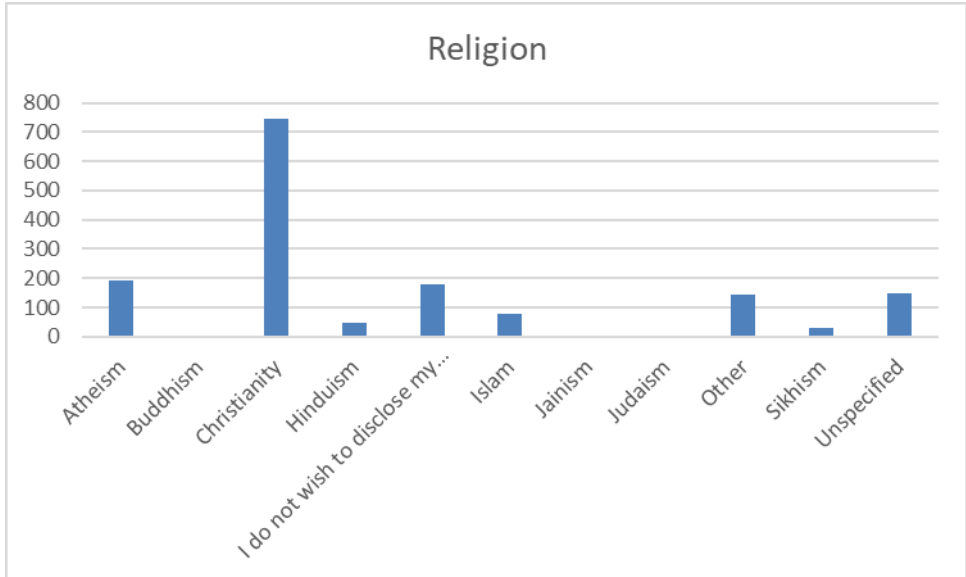


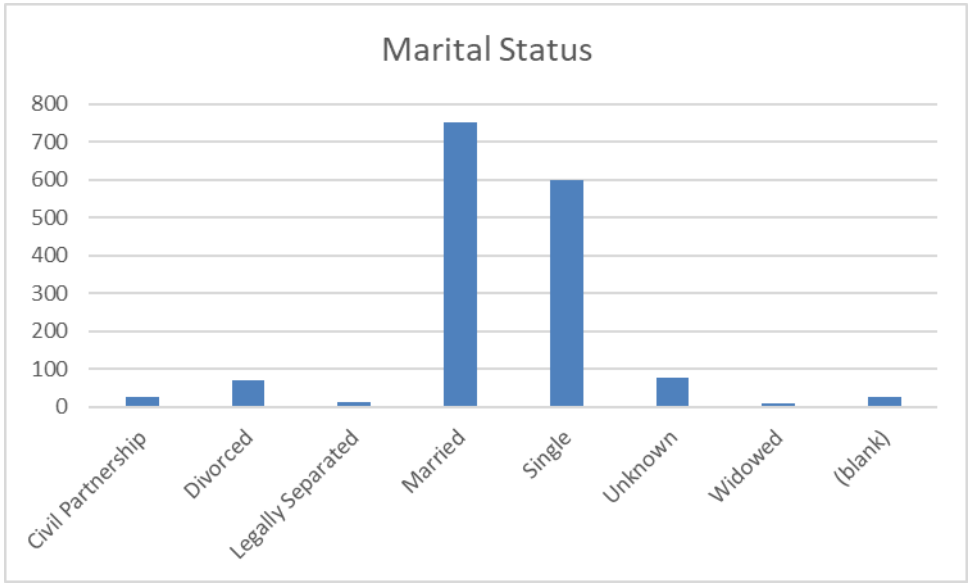


6. Workforce Demographics cont.

Currently in the Trust we have 26 staff members on Maternity or Adoption Leave







7. Workforce Wellbeing – Annual Leave

Annual Leave

At the end of Q4 (Mar 23) for the financial year, AfC staff have taken 97.19% of their annual leave entitlement. At this point in the year, staff are expected to have taken at least 100% of their annual leave entitlement, to support staff in having regular rest breaks. This is better than the previous year when only 95% was taken.

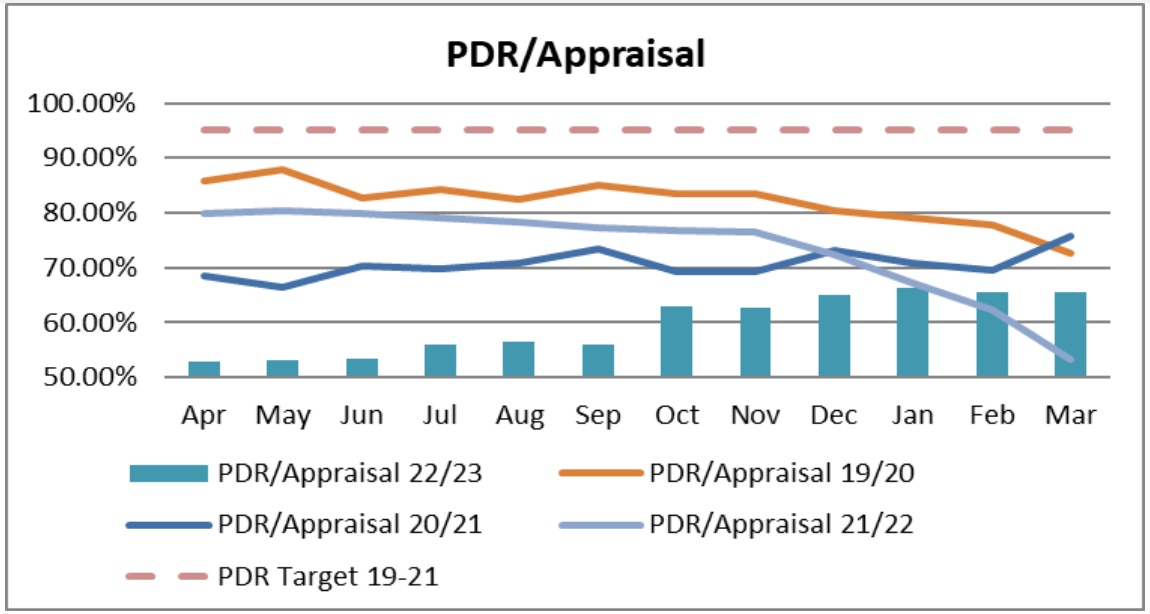
Division	% Annual Leave Taken
303 Corporate Directorate	91.97%
303 Division 1 - Patient Services	96.07%
303 Division 2 - Patient Support	98.88%
303 Division 4 - Estates and Facilities	101.56%
Trust Total	**97.19%**

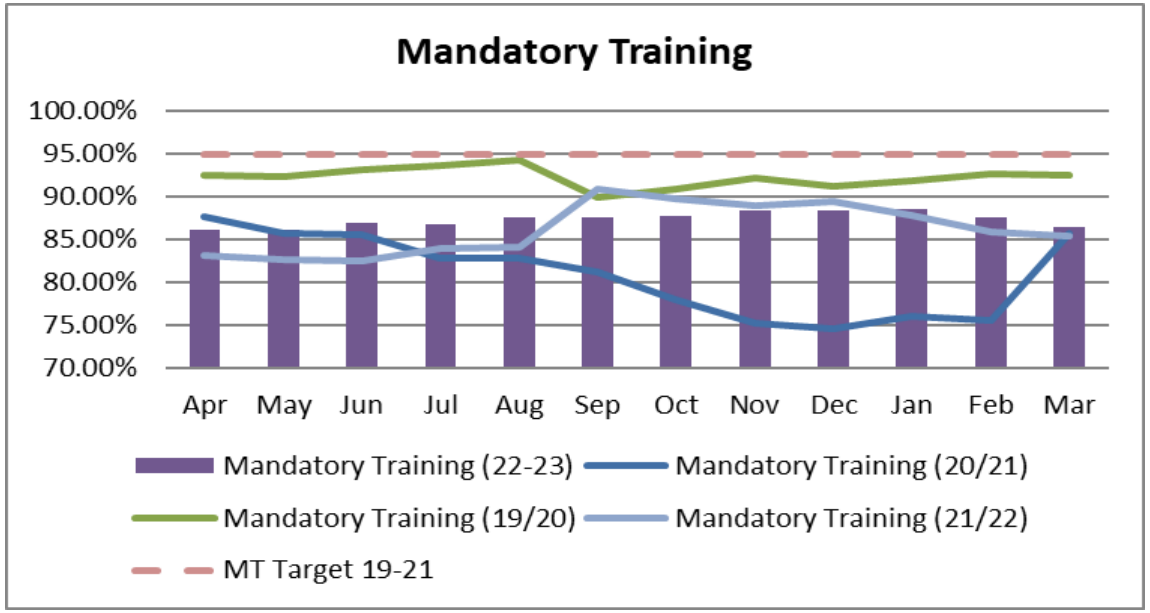
Staff Group	% Annual Leave Taken
Add Prof Scientific and Technic	90.32%
Additional Clinical Services	101.05%
Administrative and Clerical	95.15%
Allied Health Professionals	98.10%
Estates and Ancillary	101.22%
Nursing and Midwifery Registered	101.44%

8. Training & Education

Appraisals completions decreased by 0.04% to 65.41% in March and retains it's red status against the Trust target of 95%

Mandatory training decreased by 1.21% to 86.38% in March, staying in the amber status against the Trust's target of 95%. This has stayed steady since January 2022 that staff have been more than 85% compliant in this.





Workforce Experience and Engagement

Disability Declaration rate

DDR 2022						
Jan	Mar	June	Sept	Dec	Feb	March
4.0	5.2	5.3	4.3	5.7	6.39	6.2

Activity metrics

Initiative	Jan	Feb	March
Number of members of staff network meetings	177	189	244
Number of attendees at staff network meetings	26	42	29
Number of hits on Staff Networks intranet site	85	90	86
Number of hits on Health & wellbeing intranet site	N/A	N/A	262
Workshop attendance Health & wellbeing	54	126	116
Entrance swipe to Wellbeing room	409	302	361

Staff engagement
(Respondents 630)

Positive improvement in 8 out of 9 areas

Over staff engagemer maintained at 7.1

Results							
	People Pulse Quarter 4 2022/2023	**People Pulse** Quarter 2, 2022/2023	**People Pulse** Quarter 1, 2022/2023	**People Pulse** Quarter 4, 2021/2022	**ROH National Survey (NSS)** October – November 2021	**NSS National Results** October-November 2021	**NSS National Results** October-November 2022
Overall Staff Engagement	**7.03**	**7.04**	**7.00**	**6.94**	**7.40**	**6.8**	**6.8**
Q1. I often/always look forward to going to work.	52%	55%	54%	52%	58%	53%	54%
Q2. I am often/always enthusiastic about my job.	66%	**68%**	67%	65%	73%	67%	70%
Q3. Time often/always passes quickly when I am working.	69%	**68%**	68%	66%	70%	73%	71%
Q4. There are frequent opportunities for me to show initiative in my role.	66%	63%	66%	69%	76%	72%	74%
Q5. I am able to make suggestions to improve the work team/department.	69%	**67%**	66%	65%	75%	70%	73%
Q6. I am able to make improvements happen in my area of work.	62%	**59%**	59%	57%	58%	53%	57%
Q7. Care of patients/service users is my organisations top priority.	80%	**81%**	78%	79%	84%	76%	83%
Q8. I would recommend my organisation as a place to work.	70%	**68%**	66%	71%	74%	59%	72%
Q9. If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation.	86%	**87%**	86%	87%	90%	68%	85%

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Board Assurance Framework (BAF): February 2023

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level)

- Risk ratings – current (residual), tolerable and target levels

- Clear identification of primary strategic threats and opportunities that are considered likely to increase or reduce the Principal Risk, within which they are expected to materialise

- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board (Averse = aim to avoid the risk entirely; Minimal = insistence on low risk options; Cautious = preference for low risk options; Open = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)

- Key elements of the risk treatment strategy identified for each threat and opportunity, each assigned to an executive lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)

- Sources of assurance incorporate the three lines of defence: (1) Management (those responsible for the area reported on); (2) Risk and compliance functions (internal but independent of the area reported on); and (3) Independent assurance (Internal audit and other external assurance providers)

- Clearly identified gaps in the primary control framework, with details of planned responses each assigned to a member of the Senior Leadership Team (SLT) with agreed timescales

Key to lead committee assurance ratings:

Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity - no gaps in assurance or control AND current exposure risk rating = target

OR - gaps in control and assurance are being addressed

Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy

Red = Negative assurance: the Committee is satisfied that there is sufficient reliable evidence that the current risk treatment strategy is not appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

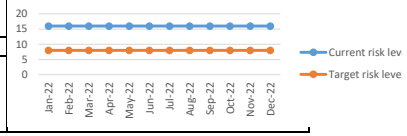
This BAF includes the following Principal Risks to the Trust's strategic priorities:

Reference	Principal Risk	Lead Committee	Initial date of assessment	Last reviewed	Target risk score	Previous risk score (at last review)	Current risk score	Risk Movement
1298	Malicious attempts to disrupt IT systems	Trust Board	Dec 2018	Feb 2023	8 (2Lx4C)	16 (4Lx4C)	16 (4Lx4C)	↔
CE1	Run rate pressure	Trust Board	Pre Feb 2021	Dec 2022	12 (3Lx4C)	16 (4Lx4C)	16 (4Lx4C)	↔
CE2	Longer waiting times following Covid pandemic	Trust Board	May 2022	Dec 2022	8 (2Lx4C)	12 (3Lx4C)	12 (3Lx4C)	↔
OP6	Insufficient capacity to handle the activity as part of restoration and recovery phase	Trust Board	Pre Feb 2021	Dec 2022	8 (2Lx4C)	16 (4Lx4C)	20 (5Lx4C)	↑
770	Theatres' engineering plant beyond it's normal life expectancy	Trust Board	Nov 2014	Jan 2023	5 (1Lx5C)	16 (4Lx4C)	12 (3Lx4C)	↓

1089	Failure to meet national target of treating 92% and patients waiting 52 weeks increases		Dec 2016	Dec 2022	9 (3Lx3C)	20 (5Lx4C)	20 (5Lx4C)	↔
HR11	Challenges with workforce gaps.	Trust Board	Dec 2021	Dec 2022	6 (2Lx3C)	9 (3Lx3C)	9 (3Lx3C)	↔
1902	Digital Capable Framework Compliance	Trust Board	April 2023	April 2023	8 (2Lx4C)	20 (5Lx4C)	20 (5Lx4C)	Newly escalated

Board Assurance Framework (BAF): January 2023

Principal risk (what could prevent us achieving the strategic priority)	**1298** BAF AND CRR There is a large and increasing growth in the number and type of malicious attempts to disrupt IT systems and hold organisations to ransom. The Trust is vulnerable to a cyber attack due to the following:- 1.Lack of patching and monitoring 2.Presence of unsupported Systems 3.Poor access and password audit and management 4.Inadequate and untested incident management and disaster recovery processes 5.Poor cyber security user awareness and training.							**Risk Category**	**Strategic priority:** **Safe and efficient processes that are patient-centred**
Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk type**	Finance and Performance		
Executive Lead	Executive Director F&P	**Consequence**	4	4	4	**Risk appetite**			
Initial Date of Assessment	Dec-18	**Likelihood**	5	4	2				
Last reviewed	Feb-23	**Risk Rating**	20	16	8				
Last changed	Dec-22								

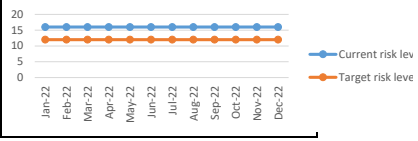


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Risk Control Assurance rating**
Malicious attempts to disrupt IT systems.	The number of risks notified by CareCert each week means that significant effort is required across servers, networking and project teams. Many of these activities are not being actioned due to other priorities. Only High risk items from CareCert will be actioned from now on. Contractor Cyber Security Officer just been appointed at Band 6 for 3 months, so some progress to be made shortly with outstanding tasks. Process implemented to patch corporate windows servers monthly. Further work planned to extend the type of patches installed and the range of operating systems patched (IOS, Cisco, Intel, Linux etc.). Currently talking with 3rd party suppliers (GE, Philips, Siemens, Omnicell) to agree a process for patching their servers and/or isolating them from the corporate network. Full update on Cyber Security prepared and submitted to Finance & Performance Committee on March 26th. Improving Cyber Security Resilience Report has been prepared to provide assurances on critical controls to reduce the risks of ransomware and denial of service attacks as recommended by NCSC. Cyber Security Consultant has been employed to develop Trust's plans.	DSPT status is still Approaching Standards, with some standards still not met	Move of infrastructue to cloud with AWS to improve security and resiliance of compliance. DSPT Action plan has been accepted by NHSD	IM&T programme board papers Presentation from CORS team to Audit Committee Audit Committee minutes Information Governance Group minutes DSPT Action plan has been accepted by NHSD who have confimed that the ROH remain at Approaching Standards		Positive

RISK CATEGORIES

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

Board Assurance Framework (BAF): January 2023

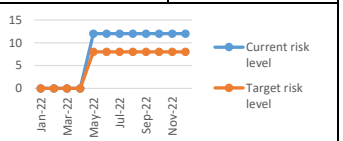
Principal risk (what could prevent us achieving the strategic priority)	**CE1** Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.							**Risk Category**  **Strategic priority:** **Safe and efficient processes that are patient centred**
Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk type**	Finance and Performance	
Executive Lead	Chief Executive	**Consequence**	4	4	4	**Risk appetite**		
Initial Date of Assessment	Pre Feb 21	**Likelihood**	5	4	3			
Last reviewed	Dec-22	**Risk Rating**	20	16	12			
Last changed	Dec-22							

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Risk Control Assurance rating**
Risk of significant run-rate pressure over next four years	The ICS has identified a signifiacnt run-rate pressure from 2022 onwards Further work is being undertaken by each Provider to understand the nature of their individual pressure, and the degree to which this is being generated by an expected reduction in Income post COVID, an increase in the cost base of delivering services post COVID, increased costs of service restoration and backlog reduction, or a combination of all of these things. Additionally the ROH is leading system work on the MSK pathway in prepartion for the production of a case-for change document. Further detailed planning work is being undertaken by each provider and is cooridnated through the ICS. A system Investment Committee is being stood up to review investment decisions across providers, and further work around producutivity , efficiency an sustainablity, as well as service transformation is planned The ICS CFOs have commissioned PWC to undertake some intial work for the creation of a unit to spefically support Trusts in reducing the current identified gap.	Planning guidance has recently been issued for 2023/24. This creates an additional delivery risk as financial and contract frmework move to Aligned Incentive Payments relating to a predetermined activity target	Additional work targeted at opportunity to release further productivity gains, and further development of integrated performance dashboard	FPC reports; Board approval for cash borrowing; Finance & Performance overview; 'Perfecting Pathways' update. Will be picked up as part of 2023/24 financial planning process that has just started.		Positive

RISK CATEGORIES

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

Board Assurance Framework (BAF): January 2023

Principal risk (what could prevent us achieving the strategic priority)	**CE2** Risk of clinical harm due to longer waiting times for treatment following the Covid pandemic resulting in sub-optimal clinical outcomes, reputational and financial loss.							**Risk Category**	**Strategic priority:** **Safe and efficient processes that are patient-centred**
Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk type**	Patient harm		
Executive Lead	Medical Director	**Consequence**	4	4	4	**Risk appetite**	Moderate/High		
Initial Date of Assessment	May-22	**Likelihood**	3	3	2				
Last reviewed	Dec-22	**Risk Rating**	12	12	8				
Last changed	May-22								

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Risk Control Assurance rating**
Longer waiting times for treatment following the Covid pandemic	Harm Prevention Framework designed Summer 2021 Harm Prevention Tracker in use from January 2022 > mitigates risk by identifying clinical priority of patients listed for surgery	Whilst we have made good progress bringing down our own longest waits we are also accepting patients from regional and specialty partners and the longer waits potentially add to clinical risk from delays in surgery and regulatory risks or reputational risks from adding more long waiter patients. Harm reporting can be done through normal incident management or a harm assessment form. Balancing logistics and risks the system relies on reporting and escalating harm by exception.	In terms of accepting patients the Trust will accept and manage the risk as we feel we have controls in place and there is a wider population risk around access to care that means that the opportunity to do wider good outweighs the mitigated risk of accepting long waiters. The tracker continues to mature and be improved. An audit of high priority cases is underway.	Harm prevention tracker continues to be fedback to CSLs and clinicians on a regular basis. 1000 patients from UHB have been transferred with a defined Harm Assessment to be carried out on each patient – escalation to the corporate harm review if any moderate or severe harm anticipated or actulaised. December 2022 Medical Director update: Priority status feedback to clinicians continues. Jan/Feb 23. The patients have been integrated into the ROH prioritiy tracker. Further transfers of patients are anticipated as we make progress with cohort 1 and therefore the risk is unlikely to move significantly towards targer in the short term.	Backlogs have increased post pandemic. Whilst Covid 19 may have been a significant causal factor it is also largely historical as a risk factor.	Positive

RISK CATEGORIES

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- Reputation and brand

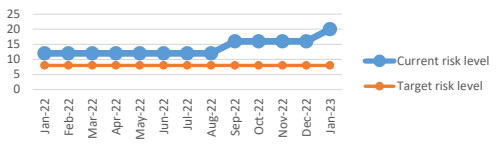
Board Assurance Framework (BAF): January 2023

Principal risk (what could prevent us achieving the strategic priority)	**OP6** There is a risk that there will be insufficient capacity to handle the activity from the new services being handled by the Trust as part of the restoration and recovery phase						
Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk type**	Restoration and Recovery
Executive Lead	Chief Operating Officer	**Consequence**	4	4	4	**Risk appetite**	
Initial Date of Assessment	Pre February 2021	**Likelihood**	4	5	2		
Last reviewed	Dec-22	**Risk Rating**	16	20	8		
Last changed	Dec-22						

Risk Category

Strategic priority:

Safe and efficient processes that are patient-centred



Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Risk Control Assurance rating**
Risk of insufficient capacity to handle the activity from the new services being handled by the Trust as part of the restoration and recovery phase	All 14 theatres operational. Bid for second MRI scanner to support Trust/System wide diagnostics approved and planning permission received. Enabling works commenced to increase ultrasound capacity in the imaging department. Additional mobile MRI 'van days' have been secured to maintain MRI activity and an increase in interventional/ CT capacity by providing extra lists Theatre look back meeting to monitor any incident raised on a weekly basis. Theatre allocation reviewed monthly to monitor the delivery of the level 2/3 patients. 642 meeting will monitor theatre utilisation weekly.	Additional digital xray move in place April 2023.	Improved theatre utilisation through surgery initiative. As part of Trust Strategy in development to delivery fully equipped 4 theatre day case unit. Estimated timescale for approval of system investment 2023/24.	Divisional performance meeting commencing April 2023. Weekly Executive Finance and Performance Committee. Weekly meeting to assess activity against agreeed trajectory.		Positive

RISK CATEGORIES

- Financial health and sustainability
- Clinical excellence
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- Systems, information and processes
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- Strategy and system alignment
- Reputation and brand

Board Assurance Framework (BAF): January 2023

Principal risk (what could prevent us achieving the strategic priority)	**770** BAF and CRR Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure, with significant impact on clinical services.						
Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk type**	Equipment and Estates
Executive Lead	Chief Operating Officer	**Consequence**	5	4	5	**Risk appetite**	
Initial Date of Assessment	Nov-14	**Likelihood**	4	3	1		
Last reviewed	Dec-22	**Risk Rating**	20	12	5		
Last changed	Dec-22						

Risk Category

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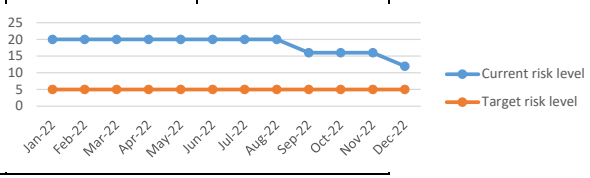
Strategic priority:

Safe and efficient processes that are patient-centred



Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Risk Control Assurance rating**
Due to age of equipment, high risk of failure, with significant impact on clinical services.	1st phase of Theatre maintenance was successfully completed in April 2022 (Theatres 5, 6 and 7 and Ward 2). Second phase was successfully completed in August 2022 (Theatres 9 and 10 and Ward 1). Further work scheduled for April 2023 (Theatres 11 and 12), August 2023 (Theatres 3 and 8 and Ward 4) and November 2023 (Theatres 1, 2 and 4 and Ward 10/12). Full maintenance programme in place, agreed Board Maintenance Plan currently in development for 2023-2025.	Environmental monitoring currently being undertaken - awaiting results.	As part of Trust Strategy in development to delivery fully equipped 4 theatre day case unit. Estimated timescale for approval of system investment 2023/24.	Feedback following maintenance work carried out, being reviewed by Director of Estates once work completed. Robust maintenance contract in place. Robust contract for management of estate in place (review due April 2023). Regular reports to Finance and Performance Committee in relation to activity delivery and any associated downtime.		Positive

RISK CATEGORIES

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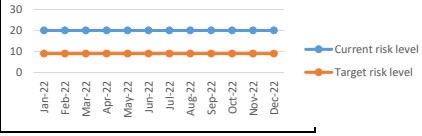
Financial health and sustainability
Clinical excellence
Patient safety
Patient experience
Workforce capacity, capability and engagement
Systems, information and processes
Regulatory compliance and national targets
Equipment & estates
Strategy and system alignment
Reputation and brand

Board Assurance Framework (BAF): January 2023

Principal risk (what could prevent us achieving the strategic priority)	**1089** BAF and CRR The Trust fails to meet the national target of treating 92% and patients waiting 52 weeks increases creating significant delays in patient treatment and as a result of cessation of elective activity mandated as part of the national response to the Covid-19 pandemic							**Risk Category**  **Strategic priority:** **Delivering exceptional patient experience and world class outcomes**
Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk type**	Finance and Performance	
Executive Lead	Chief Operating Officer	**Consequence**	5	4	3	**Risk appetite**		
Initial Date of Assessment	Dec-16	**Likelihood**	5	5	3			
Last reviewed	Dec-22	**Risk Rating**	25	20	9			
Last changed	Dec-22							

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Risk Control Assurance rating**
Risk of failing to meet the national target of treating 92% of patients and increase in patients waiting 52 weeks.	Patients waiting in excess of 52 weeks are all going through the Trust harm review process. All patients in this category are regularly reviewed by their clinical teams on a monthly basis. Refreshed post-Covid Trajectory is being developed in line with the system backlog reduction working group is monitored by the Finance & Performance Committee monthly. Delivery of restoration and recovery plans as part of the wider system for P2 and P3 elective operating. Second MRI Scanner operational August 2021. Module build of additional theatres. Continued transformation of Outpatients services maximising the digital opportunities. Ongoing system working for elective orthopaedics for P2, P3 Weekly Elective Care Board in place to monitor and track performance. Restoration and recovery plans now business as usual.	Development of a single system orthopaedic PTL currently being developed.	As part of Trust Strategy in development to delivery fully equipped 4 theatre day case unit. Estimated timescale for approval of system investment 2023/24. Development of PICU (in line with 2023/24 operational guidance) Regular oversight and support by Exec Team at Divisional Performance Committee commencing April 2023.	Weekly update to Exec Team & Ops Board; monthly finance overview. All 14 theatres operational and scoping three session days and weekend working. Jan 23 as part of 2023/24 operational plan continued monitoring of PTL to ensure delivery of P2/3 procedures in line with RCS guidance and specialty level /harm review process instigated where appropriate	Challenging to deliver accurate RTT trajectory due to system reconfiguration of orthopaedic waiting lists.	Positive

RISK CATEGORIES

- Financial health and sustainability
- Clinical excellence
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- Workforce capacity, capability and engagement
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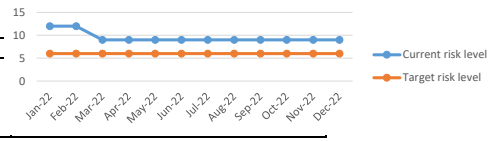
Board Assurance Framework (BAF): January 2023

Principal risk (what could prevent us achieving the strategic priority)	**HR11** BAF and CRR There is a risk to patient safety and quality of care due to ongoing challenges with workforce gaps. Nationally and regionally there are significant gaps in nurse workforce, impacting on our ability to recruit and retain.							**Risk Category**  **Strategic priority:** **Safe and efficient processes that are patient-centred**
Lead Committee	Staff Experience & OD Committee	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk type**	Workforce	
Executive Lead	Chief People Officer	**Consequence**	4	3	3	**Risk appetite**		
Initial Date of Assessment	Dec-21	**Likelihood**	4	3	2			
Last reviewed	Dec-22	**Risk Rating**	16	9	6			
Last changed	Dec-22							



Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Risk Control Assurance rating**
Patient safety and risk to Trust reputation	6 High Impact Inclusive Actions being developed and will roll out upon appointment of resourcing manager. Feedback to the Trust 6-4-2 process on any gaps in the nursing workforce to allow amendments to the Trust activity plans where appropriate Continue active recruitment process to vacant posts though multiple workstreams engaging fully in the BSOL workforce meetings. Sustain three time daily staffing meeting to ensure allocation of available staff to areas requiring support Ensure Business continuity plans are regularly reviewed Upwardly report within finance and performance committee the impact of cancellations ensuring rescheduling of any cancelled patient in the agreed timeframes Harm review and harm prevention processes in place to indentify any patients at risk of harm ICS business plan- International recruitment workforce being presented to Investment committee on 20/1/22. Aim to establish a IR workforce hub.	It apears that a significant number of line managers have a tendency to record reasons for leaving with insufficient detail to make analysis meaningful. The most often recorded reason until recently was 'Voluntary Resignation - Other / Unknown', but recently the HR / ESR teams have been challenging terminations that come through for that reason and asking line managers to record a mores specific reason. ESR has a lot of reasons to choose from that cover the vast majority of the reasons that people leave an organisation.	The next Retention Steering Group meeting (date TBC) will examine the feedback obtained from the Listening Events and determine workstreams. Responsibility for each workstream will be allocated with deadlines and PIDs in place. Additional workstreams include the survey of leavers from 2022, with possible incentives for those participating; a review of the leaver process to ensure it is fit for purpose; and a review of the exit questionnaires we currently employ and how they are used by line managers.	On a monthly basis, data from ESR is used to create assurance reports that are presented at both SE&OD and PODG. Reasons for staff leaving the ROH are scrutinised and analysis produced that can inform future interventions to address the exodus of staff and encourage 'stay' conversations. ESR contains the details of staff who leave the ROH and their reasons for leaving so that is a vital source of information. ESR also collects information about the exit interviews, which is currently under-utilised.	It is currently not mandatory that managers conduct the exit interviews which is a rich source of data about the real reasons for people who leave the Trust.	Positive

RISK CATEGORIES

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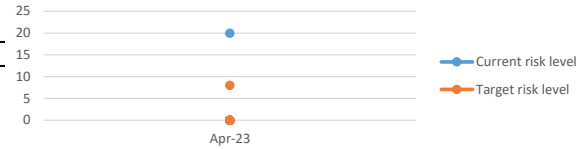
Board Assurance Framework (BAF): April 2023

Principal risk (what could prevent us achieving the strategic priority)	**1902** There is a risk that the national Healthcare Information and Management Systems Society required level 5 will not be met, Digital Capable Framework Compliance. Unable to achieve financial sustainability by being unable to meet contract data expectations. Data Quality							**Risk Category**  **Strategic priority:** **Delivering exceptional patient experience and world class outcomes**
Lead Committee	Trust Board	**Risk Rating**	Initial Risk Score	Current Risk Score	Target Risk Score	**Risk type**	Digital	
Executive Lead	Finance Director	**Consequence**	4	4	4	**Risk appetite**		
Initial Date of Assessment	Apr-23	**Likelihood**	5	5	2			
Last reviewed	Apr-23	**Risk Rating**	20	20	8			
Last changed	Apr-23							



Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we already have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Risk Control Assurance rating**
Risk that we won't meet national requirements due to electronic systems	Roll out PICS ROCS Portal AQUA - Theatreman Upgrade	Order Comms in diagnostics Work ongoing for Safeguarding database Digital pre-op Electronic outcomes pilot (podiatry and hands) by end of May 2023	Solution to fulfil ROH requirements to be identified by end of October 2024 with a 2025 delivery.	Data Quality group sighted on risks.		Positive

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