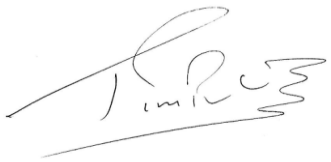
The Royal Orthopaedic Hospital NHS Foundation Trust

Notice of Trust Board Meeting in Public on Wednesday, 5th July 2023

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 5th July 2023, in the Boardroom, Trust HQ commencing at **09:00**.

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

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



Tim Pile
Chair

The Royal Orthopaedic Hospital NHS Foundation Trust

AGENDA
TRUST BOARD MEETING (IN PUBLIC)

Venue Boardroom, Trust Headquarters **Date** 5 July 2023: 09:00 – 14:15

Members attending

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

In attendance

Mrs Ali Sprason	Charity Manager	(AS)	[Item 9]
Ms Ruth Hughes	Charity Officer	(RH)	[Item 9]
Mrs Coralie Duff	Associate Director of Operations	(CD)	[Item 24]
Mr Naz Uddin	Associate Director of Operations	(NU)	[Item 24]
Miss Jane Dominese	Corporate Services Manager	(JDo)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
09:00	1	Apologies: Chris Fearns	Verbal	Chair
	2	Declarations of Interest. *Register available on request from the Director of Governance*	Verbal	Chair
	3	Minutes of Board Meeting held in Public on 7 June 2023: *for approval*	ROHTB (6/23) 003	Chair
	4	Actions from previous meetings in public: *for assurance*	ROHTB (6/23) 004	SGL
09:05	5	Questions from members of the public	Verbal	Chair
09:07	6	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (7/23) 006	TP/JW
09:20	7	Wellbeing update including childcare provision: *for assurance*	ROHTB (7/23) 007	SM
09:35	8	Turnover and retention plan update: *for assurance*	ROHTB (7/23) 008	SM

09:50	9	Charity update: *for assurance*	ROHTB (7/23) 009	AS/RH
10:10	10	Patient Pathway update: *for assurance*	ROHTB (7/23) 010	JW
10:25	11	Update on the ROH net zero strategy: *for assurance*	Verbal	SW
10:35	12	Annual complaints report: *for approval*	ROHTB (7/23) 012	NB
10:45	13	Gender pay gap: *for approval*	ROHTB (7/23) 013	SM
10:55	**BREAK**			
11:55	14	Annual declarations and changes to the licence for NHS foundations trusts: *for approval*	ROHTB (7/23) 014	SGL
12:05	15	Revisions to the Code of Governance for NHS foundation trusts: *for information*	ROHTB (7/23) 015	SGL
12:15	16	Upward reports from the Board Committees: a) Quality & Safety Committee b) Finance & Performance Committee c) Staff Experience & OD Committee d) Charitable Funds Committee	ROHTB (7/23) 016 (a) ROHTB (7/23) 016 (b) ROHTB (7/23) 016 (c) ROHTB (7/23) 016 (d)	Cttee Chairs
MATTERS TO BE TAKEN BY EXCEPTION ONLY				
12:35	17	Performance Reports: *for assurance* a) Finance & Performance b) Quality & Patient Safety c) Workforce overview	ROHTB (7/23) 017 (a) ROHTB (7/23) 017 (b) ROHTB (7/23) 017 (c)	
12:40	**CLOSE**			
Date of next meeting: Wednesday, 6 September 2023 @ 09:00 – 15:00				

Notes

Quorum:

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

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

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

ATTENDANCE REGISTER – FY 2023/24 UPDATED TO JULY 2023

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

KEY:

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

DRAFT PART ONE MINUTES - Trust Board Meeting in Public

7th June 2023, 09:00 – 13:00

Boardroom, Trust Headquarters

Members Present:

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

In attendance:

Prof Edward Davis	Head of Undergraduate Academy	(EDa)	[Item 11]
Mr Uzo Ehiogu	Clinical Teaching Fellow	(UEh)	[Item 11]
Mr Brett Ellis	Medical Education Manager	(BEl)	[Item 11]
Mr David Richardson	Head of Education & Training	(DRr)	[Item 11]
Miss Jane Dominese	Corporate Services Manager	(JDo)	[Secretariat]

Minutes		**Paper Reference**
1	**Patient Story (NBr)**	**Presentation**
1.1	The Chair called the meeting to order and opened the meeting at 09:04. He explained that the Board was due to receive a Patient Experience story however, due to an unexpected bereavement, NBr would be sharing the story on their behalf.	
1.2	NBr shared that the patient was a 57-year-old lady, a nurse, that had undergone a total ankle replacement in November 2022. In total, the referral to surgery had taken 13 months, due to various delays, including additional imaging requested and several unsuccessful attempts to contact the patient. The patient had stressed that it had, overall, been a positive experience; however, there had been the opportunity for some lessons to be learned, namely: • The Synopsis system was now live in the Pre-Operative Assessment Centre (POAC, whereby the patient was only required to input the information once and it was recorded. • The side room that the patient had been allocated to on Ward 12 had been assessed as too small based on the Department of Health guidance and, consequently, removed from the bed base.	

	• A 'sip to send' policy had been put in place in order to allow fasting patients to drink until a firm theatre slot was known. • Hot puddings were now served after a meal and not concurrently. The patient had been invited, and agreed, to become a Patient Safety Partner and support the Quality Walkabouts. She was also a member of the Patient Participation Group and was helping to establish the group and to ensure patient voice was heard.	
1.3	The 7 months imaging delay was queried, and the Board was advised that it had been partly due to the fact that the van only came twice a month and partly due to the fact that, in the first instance, some of the images had not included all of the information required. The second set of images was correct, and the Trust had attempted to contact the patient 6 times without success.	
1.4	A staggered admission time was now in place; however, some surgeons preferred to have two patients at a time ready for surgery.	
1.5	A service evaluation for the CT scan van was being undertaken and it would be brought back to the Board once completed.	
1.6	A decision would need to be taken on the use of Ward 12, as the facilities required upgrading.	
1.7	Despite the issues raised, due to the outcome, the patient had stated that it had been a positive experience and that she would be requesting to return to the ROH for the required surgery on her other ankle.	
1.8	It was requested that the patient be thanked for sharing her story and for agreeing to become an Expert Patient. **ACTION NBr**	
2	**Apologies (Chair)**	**Verbal**
2.1	Chris Fearns had given her apologies and they were accepted.	
3	**Declarations of Interest (Chair)**	**Verbal**
3.1	There were no declarations of interest in relation to the agenda. The Register was available, on request, from the Executive Director of Governance.	
4	**Minutes of Board Meeting held in Public on 3rd May 2023: (Chair)**	**ROHTB (3/23) 024**
4.1	The Board was asked to comment on the accuracy of the minutes from 3rd May 2023 meeting in public. It **WAS RESOLVED** that the minutes were a true and accurate record of discussions held.	
5	**Actions From Previous Meetings in Public (SGL)**	**ROHTB (6/23) 005**
5.1	SGL ran through the actions log and explained that a number of actions had been proposed for closure. He highlighted the amber actions, the first being the work being undertaken to refine some of the Risk statements, and the second one being the Childcare provision for staff. Discussions had not progressed as anticipated and an update would be provided at the July meeting. Action ROHTBACT.180 would need to be re-opened and had been re-timed for September.	

	The proposed closures were accepted.	
6	**Questions From Members of The Public (Chair)**	**Verbal**
6.1	No questions had been received.	
7	**Chair's and Chief Executive's update: (TPi/JWi)**	ROHTB (6/23) 007
7.1	MPe was asked to give a verbal update on the Junior Doctor's strike that was planned for the following month. She explained that there were 23 doctors eligible to strike. An on-call rota was largely in place, pending one Anesthetic registrar update; all wards were covered and safe, 136 patients were booked over the three days and no cancellations anticipated. There may be the need to move registrars into theatres to cover absences and 79 patient clinics would either be brought forward or reconvened. No unexpected, on-the-day, strike action had been experienced previously and the same was anticipated on this occasion. Emergency preparedness response meetings were taking place up to and post-strike action. All cancer activity would be maintained. There would be no strike activity on site.	
7.2	JWi highlighted the key items in the Chief Executive's report and shared that she and MRe were now invited to Integrated Care System workshops to contribute to discussions. She added that the Trust's representative hadn't been at the meeting, and she would address the issue, as representation was of paramount importance. A NHS England assurance checklist on elective care had been shared in the Board Pack, alongside a paper on 2023/24 turnaround priorities. Pathology turnaround would need to improve as it stood at 58%; however, it was understood that some of the reporting took slightly longer, and the target was not expected to be reached until March 2024. The Diagnostics and Imaging targets were already being met.	
7.2.1	Questions were invited on the Checklist and clarification was sought on how the 25% reduction, detailed on page 38, would be achieved. It was explained that the target would be to achieve a 25% reduction in follow-ups. This was likely to reduce backlogs created by Covid. It had been recognised, at System level, that the target would be impossible to achieve; however, discussions on non-payment for follow-ups had taken place and patients would be seen by alternative, most appropriate, pathways.	
7.2.2	The actual position to be reflected in the narrative. There were no further comments or questions on the checklist.	
7.3	The Chair shared that he and JWi would be attending a meeting at UHB the following day. A meeting with longstanding volunteers would be taking place to recognise their excellent work and invaluable contribution to the ROH.	

	The Chair had visited the new private ward. The facilities were excellent, and it had been a good development. The Chair had also visited the Pharmacy and observed the speed and accuracy that the robotics implementation offered. The equipment would also be tested in theatres. Barriers were links to other software, such as PICS.	
7.4	JWi gave an update on EPR and shared that she and SWa had attended several meetings with System partners and exchanged correspondence with NHSE. A business case would be submitted to the Investment Committee the following week and progress would be shared. She was confident that there would be a roll out of Order Comms across the System by the end of July. The Gap analysis illustrated that PICS did not talk to Omnicell and was part of the detail in the business case.	
8	**Update from Council of Governors (SGL)**	**Verbal**
8.1	The last Council of Governors meeting had taken place on 18th May and was well attended by Governors and NEDs. Key items discussed were: • The Annual Report and Accounts • The Elective Hub Accreditation • An update on the previous year's Quality Priorities and an outline of the new ones for the current year. Governors chose to sponsor the optimisation of patients prior to surgery. • The LD and Autism strategy was presented. An education programme detailing key competences and skills for Governors was being established. The programme offered some training sessions delivered by Trust staff and others delivered by NHS Providers. Governor walkabout and drop-in sessions had recommenced, and the first walkabout session would be taking place that afternoon.	
9	**Outline Wellbeing plan including childcare provision (SMa)**	**ROHTB (6/23) 008**
9.1	Papers had been provided for assurance. Key items were highlighted. A wellbeing diagnostic had been undertaken in consultation with stakeholders, the key areas identified had been included in the strategy outline and would form part of the future Wellbeing Plan. The diagnostic had identified that further work was required in relation to data insights.	
9.2	AAj congratulated SMa and the team for the large amount of work that had been undertaken. She had visited during the Wellbeing week, noted it had been well attended, and commended the offer to staff. It was felt that the wellbeing initiatives were well received. The Trust's approach had been very agile and responsive to staff's changing needs; however, there was further opportunity to expand the offer through partnering. She felt that a key weakness, which had also been identified in the toolkit, was to upskill managers to ensure that they integrated wellbeing activities in their working practice and allowed staff to attend sessions offered. The framework and gap analysis were commended as a good platform to inform the action plan.	

9.3	A robust plan and outline strategy, as a complement to the Trust Strategy, would be brought to the September Board meeting. **ACTION SMa/SGL**	
9.4	It was requested that "what success would look like" be defined, how it would be measured and the outcomes that would be measured. **ACTION SMa**	
9.5	SMa was asked how quickly the Wellbeing Champions would be established and how they would work with the other Champions in the Trust. She responded that Champions were already established but that there was a target set to establish a Champion in each department. Their roles would need to be formalised as they were currently voluntary. Mental Health was a recurring theme, and it was important to equip the Champions with the correct tools to carry out their roles.	
9.6	SMa shared that progress with the Co-op had been slow but a decision had been made that a tendering process for Childcare arrangements would be entered into in June and, contemporaneously, staff consultation would take place to determine requirements. It **WAS NOTED** that the Flexible Working arrangements that were being offered may mean there was a low uptake.	
10	**Outline turnover and retention plan (SMa)**	**ROHTB (6/23) 009**
10.1	It had been previously agreed that the item would remain a standing item given that turnover remained high. The Recruitment and Retention plan had been provided for assurance on the work being undertaken by the Workforce and OD team. The plan supported the work that was being undertaken on the Integrated Workforce Plan and the detail of the presentation showed progress against the action plan that was being developed.	
10.2	It had been recognised that further work was required on the retention of Bank staff and establishing if they were actively working with the ROH. The team was working on the data.	
10.3	The Interim Head of HR Operations (IHHRO) was working with the data team in ensuring the robustness of HR data.	
10.4	A slight drop in turnover had been observed. It was proposed to reduce it to 10% in the next five years.	
10.5	SMa was asked how the Trust presentation of data position would be maintained with the departure of the IHHRO. She responded that the IHHRO would be working with the Data team to ensure that the infrastructure was in place to continue producing the same standard of reports.	
10.6	The introduction of a probationary period had been suggested and it was observed that it was standard practice in the private sector.	
10.6.1	It was suggested that a good quality recruitment process negated the need for a probationary period.	
10.6.2	SMa shared that there was a low number of capability issues for new joiners and that a proposal would be discussed at the Executive meeting. **ACTION SMa**	

	17% of the total number of leavers were staff leaving within their first year. Substantial work was being completed on the "First 100 days"; however, more work was required on induction at local level. If a probationary period was introduced, it would not be in the current year.	
10.6.3	**IT WAS AGREED** that whilst the introduction of a probationary period would be an Executive decision to make, consideration of whether the recruitment process was appropriate, and what issue it was hoped the probationary period would rectify, to be examined.	
10.6.4	UHB was leading on the System Recruitment and Retention Plan; the Trust was determining which elements of it would add value to the Trust and it would collaborate on.	
10.6.5	Clarity on the role of the ICS in relation to Workforce Plans, what work they would do, and what elements individual providers would undertake, as each would also have their own plan, was discussed.	
10.6.6	Work was being completed to map the areas of higher Agency and Bank staff usage, in order to establish the areas in which there was a skills shortage, and to allow for future demands to be met appropriately. The Trust's competitive advantage to be considered in the work. The quick wins and progress to be brought back to the Board prior to the October meeting.	
10.6.7	**IT WAS AGREED** the Workforce Plan would be discussed in October. SGL to allocate 2 hours for discussion. **ACTION SMa** ***The meeting moved to agenda item 11 and EDa/UEh/BEl/DRi joined the meeting at 10:36***	
11	**Undergraduate academy report (EDa/UEh/BEl/DRi)**	**ROHTB (6/23) 011**
11.1	The Board received a presentation on the collaboration between the Trust, the University of Birmingham and Aston Medical School and the training provided by the ROH to their medical students.	
11.2	The number of placements had increased significantly since Aston had started placing students at the ROH and was likely to continue to do so as they utilized a different clinical placement model. There was also the opportunity to increase capacity by taking students from other medical schools outside of the West Midlands.	
11.3	Regular, formal, monitoring visits from the Universities, checked by the General Medical Council, were received. Feedback from students was also requested from all students prior to the end of their placement.	
11.4	Funding streams received for the training was illustrated. The income was based on actual attendance and top sliced to support staffing, the majority of funds were reinvested to support education and training. Significant investment in the knowledge hub had allowed increased intake capacity.	
11.5	The team were asked if they would be considering virtual learning environments for teaching and they responded that multiple options were being considered.	
11.6	The Board enquired if there was anything they could support with recruitment, and they were advised there was the need to change perceptions of Orthopaedics as it was very male dominated. It was hoped that some interventions would be produced to outline the equality of access. The importance of female role models was emphasised.	

	The team were thanked for their presentation and congratulated on their work. ***They left the meeting at 11:01***	
11.7	The Board were advised that it was intended for a workshop to take place, over the summer months, with the Educators in the Trust, to map-out the different offers with a view to obtaining accreditation. ***The meeting moved to agenda item 10***	
12	**NHS England Infection Prevention and Control (IPC) Board Assurance Framework (NBr)**	**ROHTB (6/23) 010**
12.1	NBr shared that the document was the abridged version of the IPC BAF. The 10 criteria had been detailed and the Trust had assurance on five and was working on the remaining five. Since the report had been prepared, work had been completed at pace. Antimicrobial Stewardship audit cycles were now in place and the Board could be fully assured that it was met. In house testing was now available and a training programme was being produced. It would also be added to ESR so that it could be tracked accurately. The document format had changed, once more, and the Board would be receiving it in a different format in future.	
12.2	NBr was asked if she was happy with the qualitative monitoring of infection. She responded that there had been some concern over some surgical sites, but that work had been completed on them. These were monitored stringently. Pre-operative screening was undertaken rigorously and served infection controls well. There had been some recent clusters of *C. Difficile*.	
13	**Finance & Performance Committee upward report (RPh)**	**ROHTB (6/23) 012**
13.1	RPh shared that the Committee had agreed the budgets that would be proposed for ratification later in the meeting. There had been some operational challenges in Month 1 and the variance in cash, of circa £600K, had been discussed. SWa explained that the value for the 20 cancelled elective surgeries had each related to circa £5K. The remainder of the monthly outturn was circa £500K of which £200K of patient activity and the remainder was not of material significance. Agency and Bank spend had also been discussed. Whilst there had not been pressure across pay at that time, pressures throughout the year were expected. The ROH had been the only trust in the System that had included an ERF adjustment. It would be a challenge at System level to return a balanced position. Formal notification from NHSE on the ERF position would likely not be received until July. The uncertainty and the consequent difficulty for planning processes was discussed.	
14	**Performance Reports: Finance & Performance, Quality & Patient Safety**	**ROHTB (6/23) 013 (a)** **ROHTB (6/23) 013 (b)**
14.1	The reports **WERE RECEIVED AND NOTED**	

15.	**Revised Board workplan**	**ROHTB (6/23) 014**
15.1	It was requested that a detailed session on productivity, in relation to Strategy KPIs, be included in the workplan. MPe to choose an appropriate time for the discussion. **ACTION SGL/MPe**	
16 Exclusion of the press and public (Chair)		**Verbal**
16.1	The matters recorded at minutes 17 to 27 **WERE AGREED** to be treated as confidential and excluded from the minutes to be made available for public inspection. They were minuted in Part 2 of these minutes.	

Notes

Quorum:

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

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ATTENDANCE REGISTER – FY 2023/24 UPDATED TO JUNE 2023

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

KEY:

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

Royal Orthopaedic Hospital NHS foundation Trust – Trust Board Actions from Meetings in Public

Updated 29/06/2023

Paper Reference: ROHTB (07/23) 005

Date	Reference	Agenda Item	Paper Ref	Action Description	Owner	Completion Date	Response Submitted / Progress Update	Status
05/04/2023	ROHTBACT.203	10. Update on Safeguarding – the System Approach	ROHTB (4/23) 004	It was suggested that the legal requirement to report Safeguarding issues would bring challenges to the ROH. It was requested that the item be discussed in more detail at the QSC Committee meeting. **ACTION JDo to add to the QSC agenda**	JDo	23/08/2023	ACTION NOT YET DUE	
05/04/2023	ROHTBACT.191	1. Guardian of Safe Working Hours	ROHTB (4/23) 001	LWi enquired if the two posts referred to in paragraph 3.2.2 of the report were part of a normal career progression and was advised that there were two tiers of graduate consultants. A structure would be shared with the SE & OD Committee. **ACTION MRe**	MRe	28/06/2023	The structure will be shared with the SE &OD Committee	**PROPOSE CLOSURE**
03/05/2023	ROHTBACT.235	13.1.5 Strategic Board & Development workplan	ROHTB (5/23) 013	**IT WAS AGREED** that the current Clinical Plan would be circulated. **ACTION MRe**	MRe	07/02/2024	A clinical strategy is on the Board schedule.	**PROPOSE CLOSURE**
05/04/2023	ROHTBACT.204	10. Update on Safeguarding – the System Approach	ROHTB (4/23) 004	CFe suggested that it would be important for the Board to discuss the shared cross-organisational risks, if they should be included in the ROH Risk Register and how they could be managed. NBr advised that the exercise was being conducted at System level and a report would be brought back to the Board once concluded. **ACTION NBr**	NBr	06/09/2023	ACTION NOT YET DUE	

Date	Reference	Agenda Item	Paper Ref	Action Description	Owner	Completion Date	Response Submitted / Progress Update	Status
03/05/2023	ROHTBACT.229	10.5 Summary of patient stories and lessons learned – 2022/23	ROHTB (5/23) 010	It was requested that stories from patients where English was not the first language also be included. **ACTION NBr**	NBr	06/09/2023	The team is looking for a story.	
03/05/2023	ROHTBACT.230	10.5 Summary of patient stories and lessons learned – 2022/23	ROHTB (5/23) 010	Patient experiences, in the interfaces across pathways, were also requested. **ACTION NBr**	NBr	07/06/2023	Will incorporate in the plan for Board stories.	**PROPOSE CLOSURE**
01/03/2023	ROHTBACT.178	Race Equality Code – key themes from discussions and next steps	Presentation	It was suggested that an additional collaborative relationship with the Co-Op could be achieved. Salary sacrifice schemes for charitable giving to be explored. It was requested that shift patterns and distance from the childcare provider to home addresses also be considered. Staff engagement, to determine specific requirements would also be needed. CFe countered that each organisation would have diverse and unique staffing issues and she urged SMa to conduct a short term, Trust focussed evaluation. **ACTION SWa/SMa**	SMa	5/07/2023	Update due at Board meeting in July	

Date	Reference	Agenda Item	Paper Ref	Action Description	Owner	Completion Date	Response Submitted / Progress Update	Status
03/05/2023	ROHTBACT.222	8.4 Wellbeing Update	ROHTB (5/23) 008	The Chair asked for an update on the Childcare arrangements' discussions with the Co-op. An alternative form of partnership was being considered. It would be discussed at Executives and brought back to the Board in June. **ACTION SMa**	SMa	03/07/2023	Co-op discussion have not progressed as anticipated – further update in July 23	
07.06.2023	ROHTBACT.242	9.3 Outline Wellbeing plan including childcare provision	ROHTB (6/23) 008	A robust plan and outline strategy, as a complement to the Trust Strategy, would be brought to the September Board meeting. It was requested that "what success would look like" be defined, how it would be measured and the outcomes that would be measured. **ACTION SMa**	SMa	06/09/2023	ACTION NOT YET DUE	
07.06.2023	ROHTBACT.245	10.6.6 Outline turnover and retention plan	ROHTB (6/23) 009	**IT WAS AGREED** the Workforce Plan would be discussed in October. SGL to allocate 2 hours for discussion. **ACTION SMa**	SMa	04/10/2023	ACTION COMPLETE. Inlcuded in the workplan. Session to be held in July.	**PROPOSE CLOSURE**
07.06.2023	ROHTBACT.246	15.1 Revised Board workplan	ROHTB (6/23) 014	It was requested that a detailed session on productivity, in relation to Strategy KPIs, be included in the workplan. MPe to choose an appropriate time for the discussion. **ACTION SGL/MPe**	SGL/Mpe	05/07/2023	Included in the workplan. Session to be held on 05/07/2023	**PROPOSE CLOSURE**

Date	Reference	Agenda Item	Paper Ref	Action Description	Owner	Completion Date	Response Submitted / Progress Update	Status
03/05/2023	ROHTBACT.231	11.2 Patient Experience and engagement update	ROHTB (5/23) 011	LWi observed that the Board was presented with a lot of positive and affirming stories but only a few instances of complaints. He requested that more instances of criticism be presented to the Board so as to evidence the learning and improvement in the organisation. ACTION NBr	NBr	05/07/2023	Patient story for the June meeting included points of learning and others where there are matters of improvement identified will be considered for the future.	PROPOSE CLOSURE
07/12/2022	(P)ROHTBACT.143	Osseointegration update	ROHTB (3/23) 008 ROHTB (3/23) 008 (a)	SGL added that the Risk Management Policy and how risk was articulated would also need to be considered. He would work with Managers on the subject. ACTION SGL	SGL	05/07/2023	This will be part of the BAF refresh to be considered by the Board in ~~June~~ July.	
01/03/2023	ROHTBACT.182	Board Assurance Framework update	ROHTB (3/23) 008 ROHTB (3/23) 008 (a)	It was suggested that a better discussion around risk appetite could take place if the risk categories were very clear. ACTION SGL to ensure there was clarity of risk categories.	SGL	04/10/2023	Completion by October 2023, based on the timings in the work plan.	
03/05/2023	ROHTBACT.234	13.1.1 Strategic Board & Development workplan	ROHTB (5/23) 013	Medicines management to be included in the Board reporting cycle. ACTION SGL	SGL	7/6/2023	Included in the revised Board workplan for 2024	PROPOSE CLOSURE
05/04/2023	ROHTBACT.196	9. Wellbeing Update &	Presentation	It was requested that evaluation questions be placed in the Wellbeing room. ACTION SMa	SMa	03/05/2023	Completed	PROPOSE CLOSURE

Date	Reference	Agenda Item	Paper Ref	Action Description	Owner	Completion Date	Response Submitted / Progress Update	Status
		Childcare Provision Plans						
05/04/2023	ROHTBACT.197	9. Wellbeing Update & Childcare Provision Plans	Presentation	A gap analysis of the wellbeing framework would be brought to the June Board meeting. ACTION SMa	SMa	07/06/2023	On the June meeting agenda	PROPOSE CLOSURE
05/04/2023	ROHTBACT.209	11. Retention & Recruitment – Mitigating the Risk	ROHTB (4/23) 005	JWi shared that it would require a mind-set change and critical posts would need to be identified and measures put in place to retain them. This may mean that pay, training, flexible working or other benefits may need to be considered further. The cost of recruitment was significantly higher than that of retention. The benefits of working for the ROH to be illustrated as part of the retention strategy. Clarity of what the Trust is trying to achieve, individual contributions and roles to be emphasised ACTION SMa	SMa	07/06/2023	Employer branding included in recruitment and retention plan	PROPOSE CLOSURE
03/05/2023	ROHTBACT.220	8.1 Wellbeing Update	ROHTB (5/23) 008	CFe countered that each organisation would have diverse and unique staffing issues and she urged SMa to conduct a short term, Trust focussed evaluation. ACTION SMa	SMa	01/09/2023	ACTION NOT YET DUE	
03/05/2023	ROHTBACT.226	9.10 Turnover and retention update	ROHTB (5/23) 009	The biggest groups of leavers were Admin, Clerical and Nursing of which 70 Admin had left in the last year. Detailed scrutiny of their reasons for leaving was being undertaken and would be presented at the June SE & OD Committee meeting. ACTION SMa	SMa	28/06/2023	Presented at SE&ODC in June	PROPOSE CLOSURE

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**5 July 2023**

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

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

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

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

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

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

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

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

PREVIOUS CONSIDERATION:

None

PAPER REFERENCE: ROHTB (7/23) 006

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Report to the Public Trust Board on 5th July 2023

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since the last Board on 7th June 2023 from the Chief Executive's position. This includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 Today we celebrate the 75th birthday of our wonderful NHS. 75 years ago, the then Health Secretary, Aneurin Bevan, announced to parliament the official launch date for the new NHS: 5th July 1948. Years on, it's difficult to imagine treatment not being free at the point of care.

This year has been another busy one and we have treated more orthopaedic patients than any other provider. As we recover from the effects of the pandemic, the ROH has supported colleagues in hospitals in Birmingham and Solihull with mutual aid projects, taking on patients from other trusts so they can be seen more quickly. This anniversary marks a point where we can honour our history, celebrate our accomplishments and look with hope to the future. Innovation is something that is in the roots of the ROH and we are lucky to be taking this forward in collaboration with partners including the local universities and though work in our on-site research laboratory, the Dubrowsky Lab.

I am exceptionally proud of my colleagues at the ROH, who work tirelessly every day for patients and to make our hospital the best it can be. Our staff achieve incredible things every day and provide compassionate care to patients despite facing challenges. Thank you to the ROH Charity for supporting our celebrations across the site and to everyone who has been involved over the last few months with the planning.

2.2 The British Medical Association (BMA) and the Hospital Consultants and Specialists Association (HCSA) have announced junior doctors' strikes on Thursday 13th July to 18th July 2023. On 27th June 2023 we received notification from the British Medical Association (BMA) that hospital consultants in England have voted in favour of taking strike action. They have advised that it would be to provide "Christmas Day" cover meaning it would work to keep minimal emergency services open but not elective care.

2.3 On Tuesday 20th June 2023 following a formal (and competitive) process, and successful interview panel, Steve Washbourne was appointed as the substantive Chief Finance Officer. Steve will continue to lead corporate functions including Finance, Estates, IT, Data and Digital Transformation and Emergency Preparedness. Steve has been in post at the ROH in an interim capacity since October 2017, has played a key role in supporting our growth and success. I would like to congratulate Steve on his appointment and wish him every success in the future.

2.4 On Thursday 29th June 2023 we welcomed to the Trust LT Col Charles Whitting to sign the Armed Forces Covenant jointly. The Armed forces Covenant is a promise by the nation that those who serve or have served, and their families are treated fairly. The Armed Forces Covenant is a part of the NHS Constitution. In relation to healthcare, the Covenant states that the Armed Forces Community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live, and that Veterans should receive priority treatment where it relates to a condition that results from their service in the Armed Forces. I am delighted and proud to support the covenant.

2.5 On Wednesday 28th June 2023 we received the sad news that Sandra Edwards had passed away surrounded by her family and close friends. Sandra worked at our Trust for an incredible 45 years. She was a housekeeper on the wards at the start of her career and she then moved to Outpatients. Sandra was someone who lived our values fully. She was compassionate with patients and would greet people with a smile and offer to help. Sandra was dedicated to care and was humorous and well-liked by all who knew her. Many of Sandra's family work at the Trust including Ann, Sandra's sister. I would like to offer my condolences to all who knew and worked with Sandra, she is in our thoughts and her contribution, and infectious smile are valued and will not be forgotten.

2.6 On Friday 21st July 2023 we welcome our shortlisted finalists to the Blue Heart Staff awards being held at the Botanical Gardens. Many congratulations to everyone who has been nominated for an award, it is a real pleasure to read all the fantastic nominations.

2.7 We are awaiting feedback, expected on 13th July 2023 from our Elective Hub accreditation site visit which took place on Friday 9th June 2023. I want to say huge thank you to the entire team, the accreditation panel were incredibly impressed with everything they heard and witnessed but what stood out for them was our kind, dedicated, friendly and compassionate staff – I am so proud of all the team thank you.

3. BSol ICS (Integrated Care System) Updates

3.1 The Birmingham and Solihull (BSol) Integrated Care Board (ICB) meets bimonthly, and next public meeting is being held on 10th July 2023.

4 NHS England/National updates

4.1 On the 23rd June 2023, NHS England issued information regarding the programme of work around Domestic Abuse and Sexual Violence (DASV) will it will undertake. In July 2022, NHS England established a DASV Programme to build on the robust safeguarding processes for protecting patients, improve victim support, and focus on early intervention and prevention. Detailed in **Appendix 1** is the letter requesting a nomination for an Executive Lead, which for the ROH will be Nikki Brockie, Chief Nurse. Nikki will provide updates to the Board as the work progresses including signing up to the platform and ongoing review of our policies.

5 POLICY APPROVAL

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

- Radiation Safety policy

6 RECOMMENDATION(S)

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

6.2 Note the contents of the report.

Jo Williams
Chief Executive

29th June 2023

ROHTB (7/23) 007

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Wellbeing update including childcare provision**
SPONSOR (EXECUTIVE DIRECTOR):	**Sharon Malhi, Chief People Officer**
AUTHOR:	**Clare Mair, Head of OD and Inclusion** **Laura Tilley-Hood, Wellbeing Officer**
DATE OF MEETING:	**5 July 2023**

EXECUTIVE SUMMARY:

The presentation gives an update on the work being completed on health and wellbeing, specifically around the Wellbeing Days held in May. It also highlights the work that has started to gain feedback from staff on childcare provision.

Positive assurance

- Good engagement with staff across the Trust for the Wellbeing Days in departments, and also at stands in the Knowledge Hub
- Increased number of external partners attending the Wellbeing Days to provide information and advice on a range of wellbeing areas
- Wellbeing champions encouraged staff to attend the Wellbeing sessions from their areas
- Work continues to signpost and support staff via weekly wellbeing email, wellbeing intranet pages, posters, comms emails and attendance at department meetings
- Questionnaire sent out to colleagues to gain feedback on childcare provision requirements

Current issues

- Staff understand a range of information available in wellbeing and are able to access the support specific to their needs.
- Ensuring all staff (who would wish to) have the opportunity to feedback about childcare provision

Next steps

Obtain feedback from external suppliers for planning of future events
Ensure staff feedback from suggestions box at the event is reviewed and actioned
Collate final results from childcare provision questionnaire

REPORT RECOMMENDATION:

To receive and note the report

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

Accept	Approve the recommendation	Discuss
X		**X**

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

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

Comments:

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

People Element of the ROH Strategy, ROH Inclusion strategy

PREVIOUS CONSIDERATION:

Trust Board meeting May 2023 and Staff Experience & OD Committee on 28 June 2023

Wellbeing Update including childcare provision

Trust Board

Laura Tilley-Hood
Engagement and Wellbeing Officer

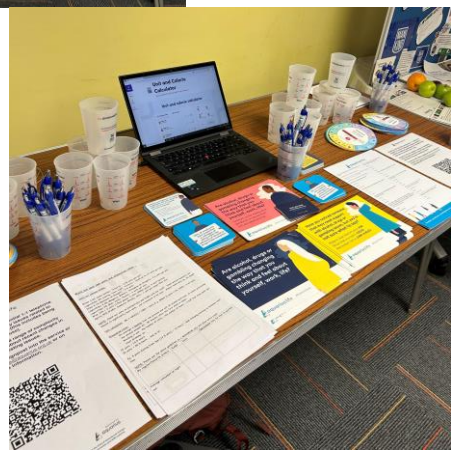
Clare Mair
Head of OD and Inclusion

July 5th 2023

ROH BE WELL STAFF WELLBEING

NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

Wellbeing Days



ROH BE WELL STAFF WELLBEING

Wellbeing Days in May

Each stand offered support for colleagues and also information to take away for future reference. There was also an opportunity for colleagues to give feedback. The event was supported by Ayodele Ajose, ROH Wellbeing Guardian

Departments that visited – Safeguarding, Estates, Ward 1,2,3,4, Physiotherapy, Oncology, Appointments, Research and Teaching, Learning and Development, Ward 12, Post Graduate Doctors, MRI, Bone Infection, Infection Control, ADCU, HDU, Pharmacy, Outpatients, X-ray, Consultants, Finance, Occupational Therapy, Theatres and HR

Departments information taken too – POAC, Ward 1, 2, 3, 4, 10 and 12, Spinal, Hydrotherapy, X-ray, MRI, Outpatients, Estates, Nurses Home, Orthotics, Medical Records, ADCU, Theatres, HDU, Pharmacy, Facilities, Café Royale, ROCS, Porters, CYPD, Infection Control and College Green.

Feedback – Stop, Start and Continue – Wellbeing at ROH

Staff were asked to post notes on feedback and ideas

Start

Paid 15-minute break x2

Focus more on positives/praise that we do x2

Providing more weight loss tips for colleagues

Walking class

Wellbeing hour for colleagues

Regular 1:1 wellbeing meeting

Social event for colleagues

Regular breaks

Allow more time for staff (ward) to attend wellbeing days/sessions x3

Ensuring appropriate PPE available to fit all shapes and sizes, appropriate X-ray protection and protection for email colleagues

Another free Wellbeing Days

Themed festival days on site

Holistic therapies

£1 meals – different dietary requirements

More wellbeing rooms

Area for colleagues to take a break

Zumba classes

Feedback Continued

Stop

Too many emails x2

Being judgemental and critical – stop focusing on negativities x2

Being critical on wards when things happen x3

Taking lunches – break at desks x2

3rd unplanned sessions in theatre

Ignoring the facts about wellbeing

Feedback Continued

Continue

Wellbeing days, activities and support x 26

£1 meals x6

Food Pantry

The free Wellbeing Day x3

Support with finances

Free vitamins

Blue Bag – Period Dignity x9

Recipes

Supporting each other

Support with counselling

Future plans

Wellbeing Dome – is now open, we will engage with colleagues about the use of the Dome.

Health and Wellbeing Strategy – outline completed.

Health and Wellbeing Conversations – Training slides completed, we are gaining feedback from colleagues before rolling out the training. Training sessions are in place for June and July.

Wellbeing Support – a session from Birmingham Arts Therapy for Theatres at TBALD and College Green. Also looking at other clinical areas.

Thrive at Work – Silver – First stage completed, we aim to complete this by October.

Mental Health First Aiders – new posters distributed to areas to replaced existing posters.

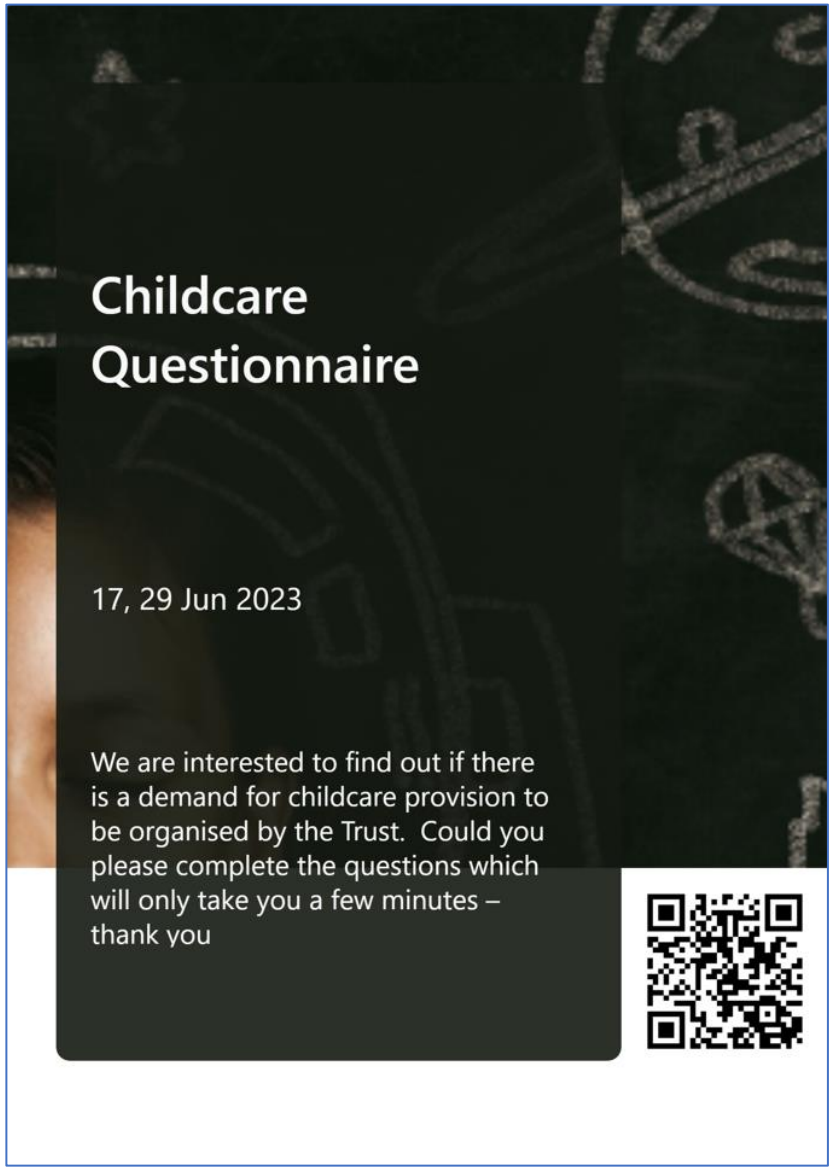
Continue linking in with national and regional – Working with the ICS, part of the steering group to share best practise. Linking in with regional colleagues on Future NHS and Health and Wellbeing fortnightly calls.

Childcare provision

Questionnaire

- A questionnaire has been sent out across the Trust for staff to complete
- The question areas included are:
  - Current childcare arrangements for parents, carers and guardians
  - Type of childcare currently accessed
  - Expenditure on childcare provision
  - Interest in accessing childcare organised offsite by the Trust
- The questionnaire has been sent out to all staff members via email and intranet
- The topic will be discussed at staff focus groups taking place in June and July with feedback collated
- Staff can also complete online or via QR code
- Results will be collated in July

Workforce and OD team and Finance will continue to work together on this project



The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Recruitment and Retention plan update**
SPONSOR (EXECUTIVE DIRECTOR):	**Sharon Malhi, Chief People Officer**
AUTHOR:	**Clare Mair, Head of OD and Inclusion** **Matt Dingle, Head of HR Operations and Business Partnering**
DATE OF MEETING:	**5th July 2023**

EXECUTIVE SUMMARY:

The paper gives a further update on the Recruitment and Retention work currently being undertaken by the Workforce and OD team.

Following the Trust Board June meeting, the plan to support this work has been reviewed and the actions streamlined.

Positive assurance

- The action plan has been streamlined to 37 actions
- There has been positive progress made on sections of the action plan
- The Listening session with staff members have provided important feedback on what is important to individuals

Current issues

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

Next steps

Work with nursing colleagues to ensure the plan integrates actions identified through the Nursing midwifery retention tool

REPORT RECOMMENDATION:

To review information and discuss

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

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		**X**

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

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

Comments:

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

People Element of the ROH Strategy, ROH Inclusion strategy

PREVIOUS CONSIDERATION:

Recruitment and Retention update Trust Board June 2023

PAPER REFERENCE: ROHTB (7/23) 008

Recruitment & Retention Action Plan update

Trust Board

July 2023

Key Points

Executive Summary

This presentation gives an update on the work being undertaken on the Recruitment and Retention action plan to support the Integrated Workforce Plan. The plan has been streamlined from 78 actions to 37 from a practicality perspective although some actions will be incorporated into each other.

Positive Assurances

- There has been positive progress made on sections of the action plan. Completed actions presented last month have been for the purposes of creating a shorter plan.
- The Listening sessions with staff members have provided important feedback on what is important to individuals

Key Risks

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

Next Steps

- Work with nursing colleagues to ensure the plan integrates actions identified through the Nursing & Midwifery Retention Tool
- Work with operational colleagues to translate some of the actions in the Nursing & Midwifery Retention Tool into other staff groups
- There is a need to ensure that this work impacts staff from top to bottom of the hierarchy and each action point should consider this as evaluation of effectiveness and sustainability.

A. Data Intelligence / Gathering

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jun-23	Jul-23	Aug-23	Sep-23
Data Intelligence / Gathering								
Design a consistent Retention & Recruitment Report using ESR data for assurance purposes	TH	A leaver survey for those who left in previous 12 months has been designed / sent out, but only 6 responses received so far.	There are too many 'unknowns' ticked on ESR and this needs to be discussed at managerial forums	Ongoing				Due
Provide new, informative data on turnover, including adjusted turnover and	MD / TH	This will form a part of the work to review the suite of monthly reports that get produced for various committees / meetings	Liaison with relevant stakeholders to take place	Ongoing				Due
Continue staff feedback events on a regular basis - See engagement section	MD/CM/JS	See engagement section		Ongoing				Due
Improve the exit feedback process	MD/DM	This is part of the Leaver Workshop workstream	Scoping of new feedback process	Ongoing				Due

B. Maximising Performance

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jun-23	Jul-23	Aug-23	Sep-23
Maximising Performance								
Overarching approach about managing the entire employee lifecycle	MD	Principles agreed at PODG & SE&OD	Project in scoping phase	Ongoing				Due
Reviewed and updated PDR/appraisal process and associated toolkit	CM	Principles agreed at PODG & SE&OD	Workshops with line managers / stakeholders to scope project	Ongoing				Due
Review all recruitment materials with a view to improving the attraction rate and clarifying the nature / location / benefits the ROH has to offer	MD	This will be an ongoing cycle of improvement	Work is ongoing with recruitment team around practices in place	Ongoing				Due
Develop, launch and implement the ROH Wellbeing plan	LTH CM	Paper presented at July Trust Board	Confirm final plan including comms plan					Due
Develop a Talent and Succession Strategy and accompanying delivery plan to ensure there is a clear approach to understanding colleagues' potential, performance requirements and skills requirements for all future roles across the Trust.	SM CM	Working with ICS Talent and Succession group	Due October 2023	Ongoing				Due
Career development tool is well embedded	DR CF			Ongoing				Due
Enhance opportunities for apprenticeship programmes	DR CF			Ongoing				Due

6. Recruitment Improvement Plan / Retention Steering Group

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jun-23	Jul-23	Aug-23	Sep-23
Recruitment Improvement Plan / Retention Steering Group								
Full set of documents that outline processes relating to medical recruitment	MD/DM	Standard Operating Procedures being developed for publication with a new Recruitment & Selection Policy	Testing of SOPs together with revisions where required	Ongoing				Due
Candidate survey to evaluate the experience of candidates using TRAC	MD/DM	Work has yet to be commenced	Another Trust has devised evaluation which we will review	Ongoing				Due
Improved time to hire and the experience of staff at pre-employment stage	MD/DM	Evaluation of time to hire has occurred and blockages established	Work ongoing with team around practices. SLA with Occupational Health reviewed.	Ongoing				Due
Improve the processes of staff on bank contracts but would prefer substantive employment	MD/DM	This task was identified from a survey of Bank Workers, the majority of whom expressed a desire for a substantive role.	This is also a system project and meetings are in place	Ongoing				Due
Review of recruitment practices from an inclusivity perspective	JS/DM	This is an activity that requires constant review and action to address	Further meetings TBA	Ongoing				Due
Increase in staff disability declaration rates	DM / CM	There has recently been an increase in declaration rates, but an increase would help us to offer reasonable adjustments		Ongoing				Due

C. Recruitment Improvement Plan / Retention Steering Group

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jun-23	Jul-23	Aug-23	Sep-23
Recruitment Improvement Plan / Retention Steering Group								
Close vacancy gap for HCSW's	MD/DM	Reporting currently takes place on a weekly basis		Ongoing				Due
Streamlining of all recruitment practices including international nursing	MD/DM	We are working on ways to streamline all international recruitment		Ongoing		Due		
Evaluate effectiveness of recruitment days/events	MD/DM	We have a calendar of events that take place and are tracking the number of contacts made at each one	Start logging and reporting on the number of conversions achieved at each event	Ongoing		Due		
Benefits booklet to inform staff what discounts / offers and employment related benefits are available to them	DM/TM	This needs to cover both financial and non-financial benefits available to staff	A first draft is nearly complete	Ongoing				Due
Promotion / education of retire / return options	DM/HR	Encourage people to return more flexibly to retain knowledge within the organisation		Ongoing				Due
Line manager education around supporting staff with flexible working	MD/HR	Improve on the awareness of the options available to the workforce, and upskill managers in handling requests	Scoping underway	Ongoing				Due

D. Digitisation

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jun-23	Jul-23	Aug-23	Sep-23
Digitisation								
Digitisation of personal files that are currently held in paper format	TH	The chosen option is to purchase a Document Management System to provide a cloud-based system for the storage of personal file	Work ongoing	Ongoing				Due

E. Introduction of KPIs

Workstream / Action	Lead	Updates/Comments	Next Steps	Status	Jun-23	Jul-23	Aug-23	Sep-23
Introduction of KPIs								
Review and adjust KPI's to suit business need for various forums	TH/MD/CM	Work in progress	Ongoing	Ongoing		Due		

F. System Working

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

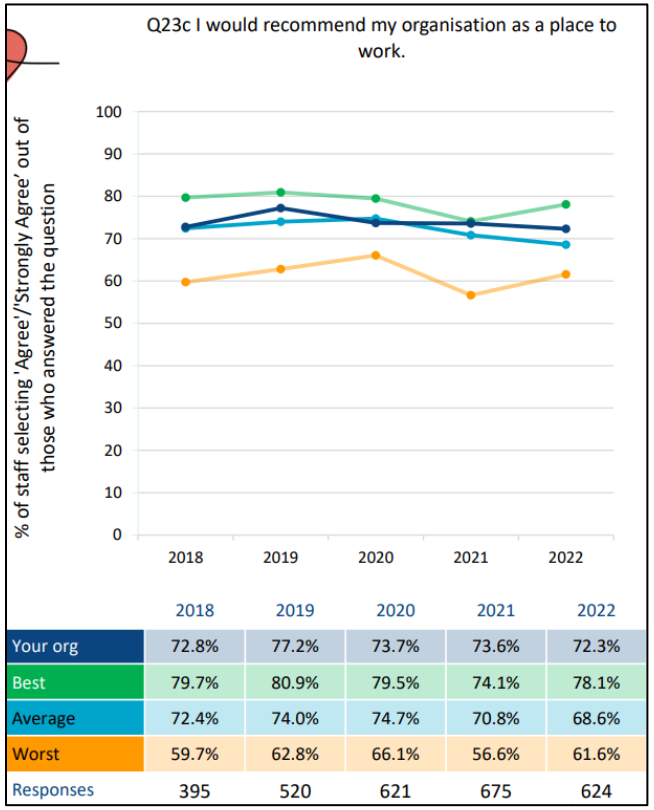
G. Employee Engagement 1/2

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

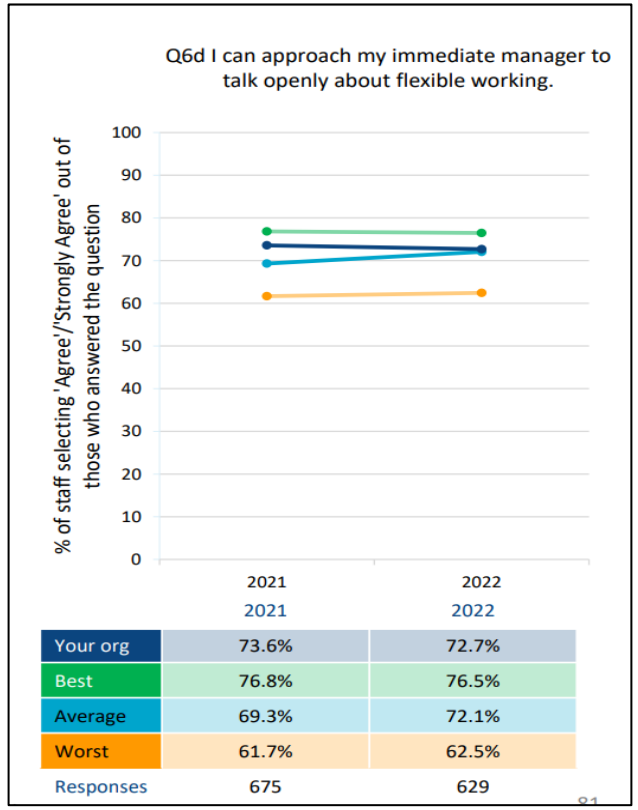
G. Employee Engagement

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

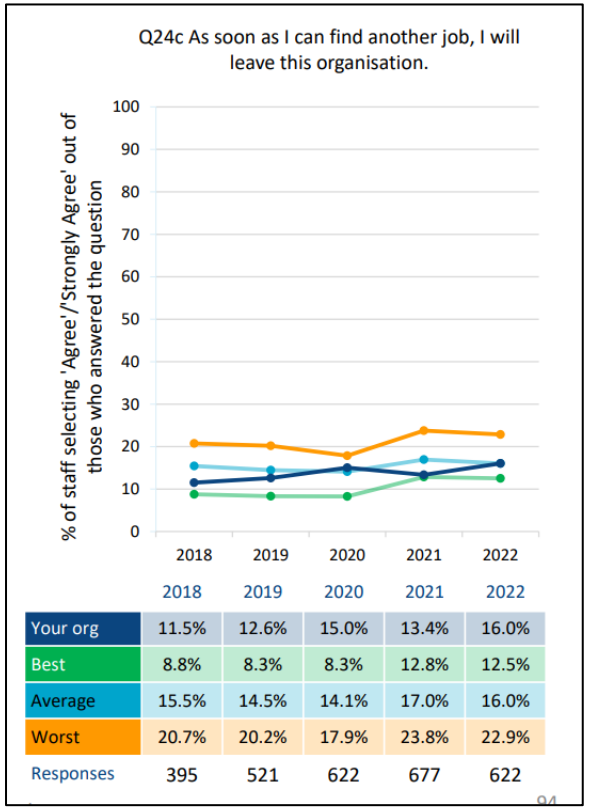
Key Staff survey results linked to recruitment and retention



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



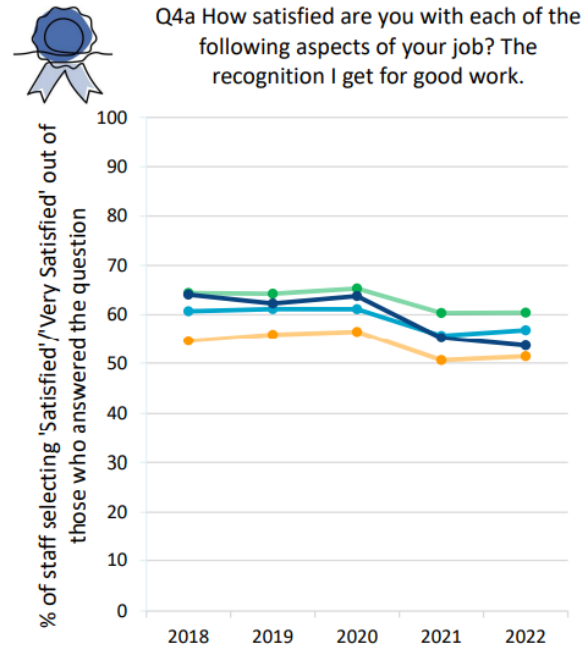
	2021	2022
Your org	73.6%	72.7%
Best	76.8%	76.5%
Average	69.3%	72.1%
Worst	61.7%	62.5%
Responses	675	629



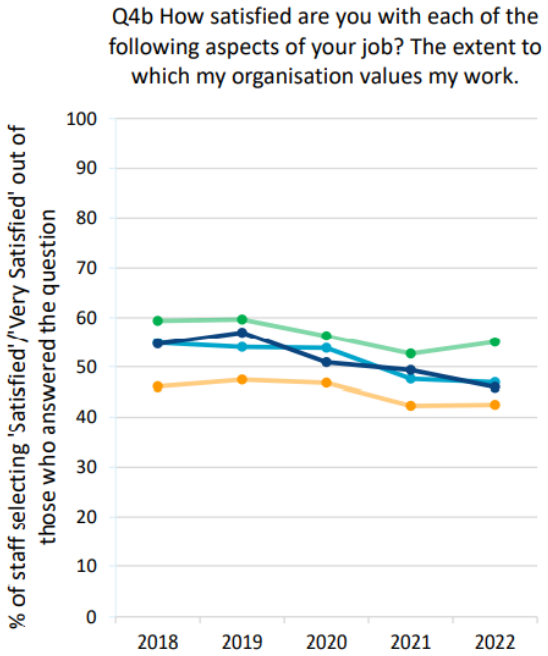
	2018	2019	2020	2021	2022
Your org	11.5%	12.6%	15.0%	13.4%	16.0%
Best	8.8%	8.3%	8.3%	12.8%	12.5%
Average	15.5%	14.5%	14.1%	17.0%	16.0%
Worst	20.7%	20.2%	17.9%	23.8%	22.9%
Responses	395	521	622	677	622

Recruitment & Retention Action Plan – July 2023

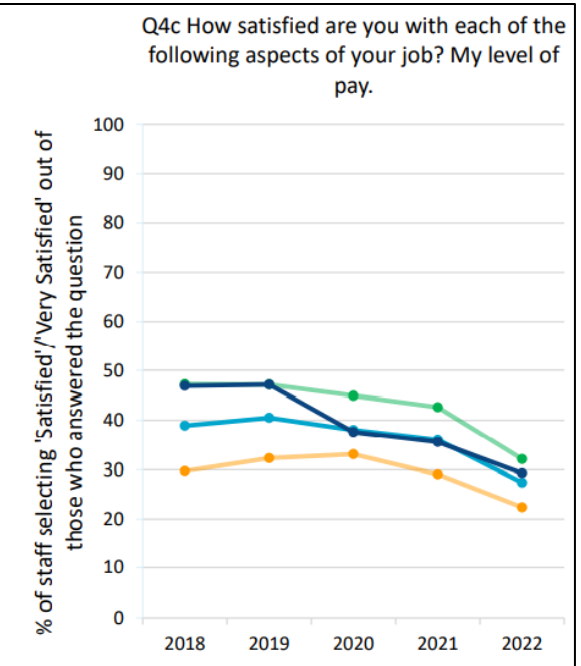
Key Staff survey results linked to recruitment and retention



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



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



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

ROYAL ORTHOPAEDIC CHARITY

PAPER REFERENCE: ROHTB (7/23) 009

Charity Strategy 2021 – 2024
Two years on…

Ali Sprason, Charity Manager
Ruth Hughes, Fundraiser

- Operational highlights
- Financial achievements
- Governance update
- Managing risk
- A new era
- Charity structure
- The next 12 months
- Request for your support
- The difference ROC makes

Operational Highlights

Priority 1; Establish a compelling case for support and programme of events to increase donor motivation and grow income:

- Donation income increase of 47%
- 85% increase in sponsorship from last year's Blue Heart Awards, 'Fundraiser of the Year' award
- Most successful Christmas Appeal, raising over £6700
- 83% of 'Digital Patient Information Service' devices installed

Priority 2; Raise the profile of the charity across Birmingham and Solihull, and beyond:

- Successful Charity re-brand
- Notable increase in Charity presence/awareness across the Trust
- Supported physio and podiatry relocation at College Green

Operational Highlights

Priority 3; Implement effective and efficient processes to ensure the charity operates to it's maximum potential:

- Governance
- Risk register

Priority 4; Identify new projects and partnerships to develop the charity and increase opportunities for income:

- MSK partnership with employers; supporting good MSK health
- Nuffield Health
- Fundraising events, campaigns and collaborations within community
- Staff recruitment

Proposing 4-5 non-restrictive funds

1. Clinical and quality improvement
2. Staff training and wellbeing
3. Research
4. General fund

Financial Achievements

Provided £33k worth of support to the Dubrowsky Regenerative Medicine Laboratory

Provided £59k worth of equipment to support patients

Supported £27k worth of research projects (17% increase from last year)

Enabled £45k worth of support for staff development and wellbeing (114% increase from last year)

Received £3k worth of ‘gifts in kind’ from our community

Donation Income target

- In 2021/22 we raised £36k **donation** income
- We agreed a target of 40% increase the next year
- In 2022/23 we raised £54k which is actually a 47% increase

Governance Update

General

- Changes to Standing Financial Instructions
- Current donation process
- The parameters around spending money/how we measure spend

How funds are structured

- Restricted and unrestricted
- Education for fund holders and expenditure
- Support/discussion around consolidation of funds

Expectation around Trustee engagement

- Trustee education
- Charitable Funds Committee; structure

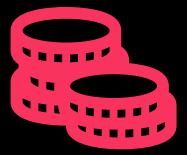
Risk register

Our risks and how we're managing them

Experimenting future fundraising initiatives (what we have learned)

Project involvement (level of investment, understanding the scope/investment, success story and enhancing the charity brand)

Public opinion - NHS Enquiries- NHS strikes – diverting focus



Financial Concern

- Grants and Trusts – new remits / not supporting NHS Charities, high income in restricted funds
- Community - cost of living crisis
- Investments – Brexit, Ukraine War

A New Era

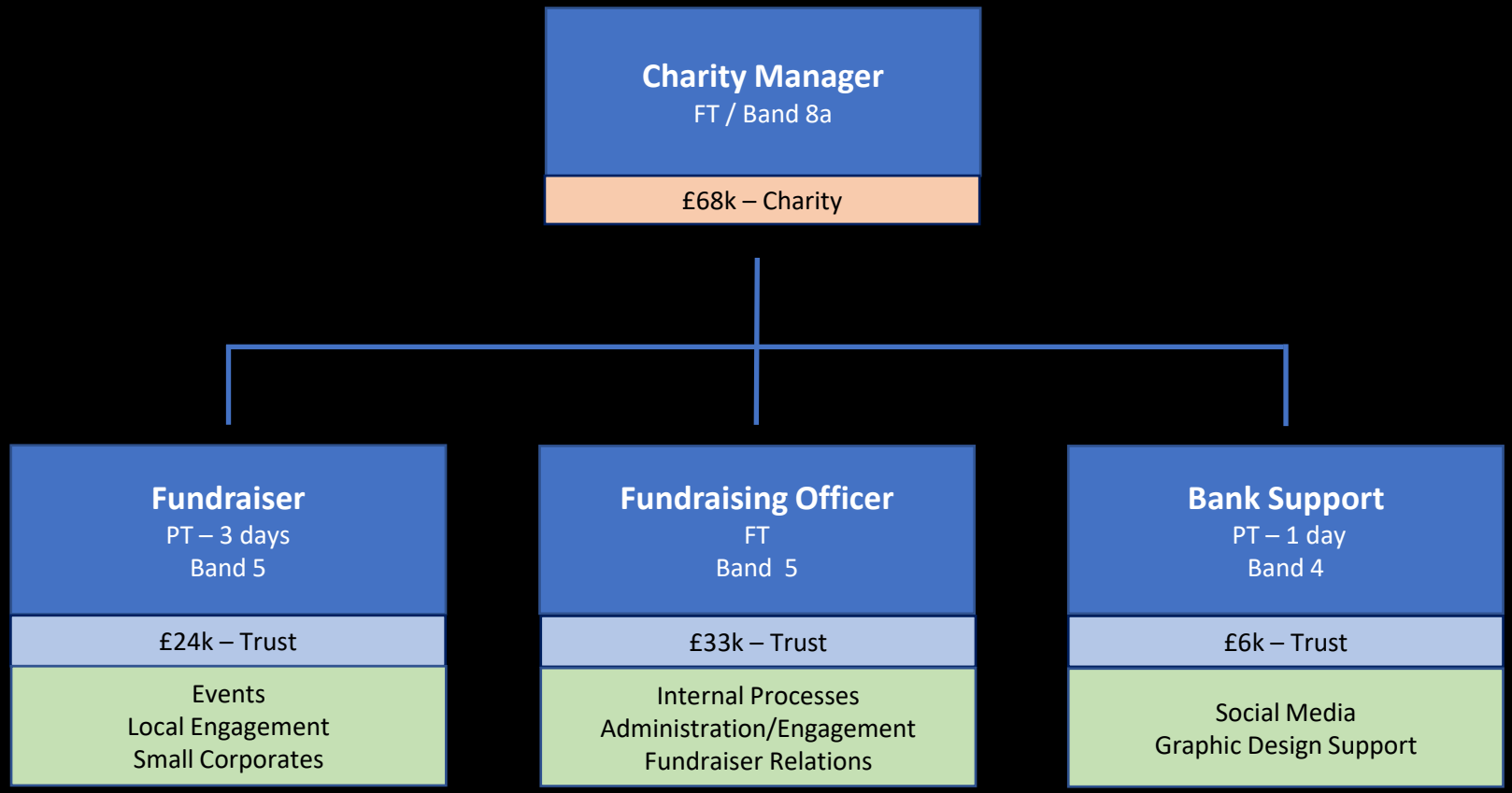
“My ambitions for the Charity are threefold: first - that we continue to explore new opportunities to broaden our reach within our community whilst not losing sight of our immediate priorities; second - to remain nimble-footed and responsive to the changing needs of our staff.

It's especially important that we fulfil our duty of care towards our staff during the cost-of-living crisis as the squeeze on incomes continues to bite; thirdly, at a time when financial pressures may have a negative impact upon the level of charitable giving, that we think creatively of how we remain effective in continuing to support both patients and our staff.”

Ayodele Ajose
ROC Chair 2023

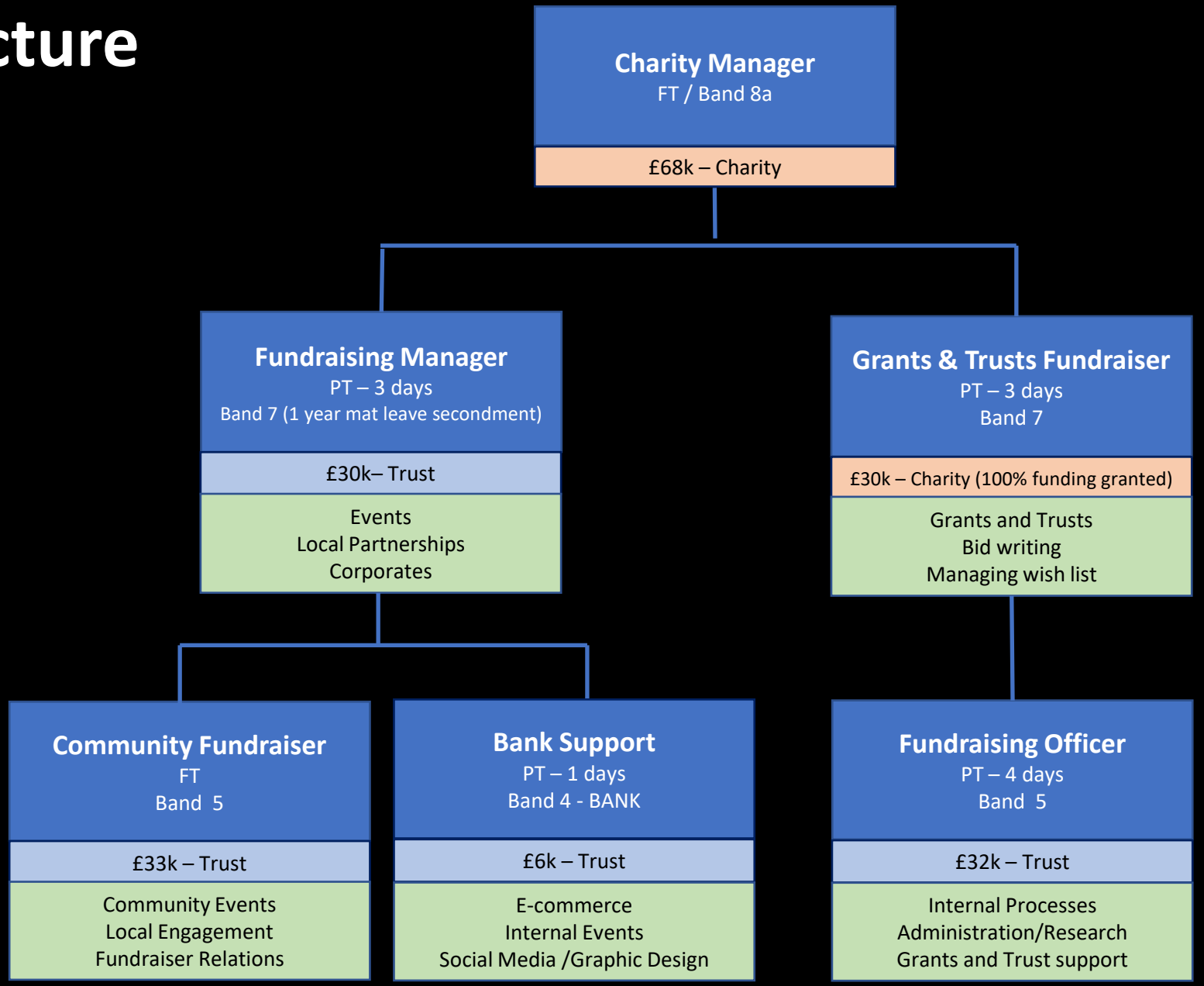
Charity Structure

Current



Charity Structure

Proposed



Our next 12 months

Delivering 'year 3' of the Charity Strategy

- Investment in recruitment
- Explore and launch 12-week Joint Pain management course
- Plan and deliver the Corporate Trustee Education Project
- Partner with / have a stronger affiliation with ROH suppliers/business contractors
- Continue partnership working within ICS – clinical, corporate and charity
- Explore a QSIR innovation award grant giving scheme
- Prioritise ‘legacy’ marketing and ‘grants and trust’ applications
- Consolidation of funds
- Community ‘fundraising in aid of’ support
- Internal and external ambassador programme
- Support ROH Projects/further development – Capital schemes, enhanced ROH facilities, ‘Joint Care’, Hardship Fund, MSK, Blue Heart Awards, Charity Hub Shop etc

Our next 12 months

What Does Success Look Like?

- Donation income increase of 40%
- Well recognised charity brand
- Increased Corporate Partners
- Established ambassador programme
- ROH direct patient information available in breadth of community locations, sponsored by ROH Charity

Our request for your support

- Expectation around Trustee engagement
- Support for recruitment investment
- Networking / contacts
- Support for consolidation of funds
- Education for fund holders and expenditure

The difference ROC makes

“For almost two years I was in terrible pain. I was told from my GP ‘nothing can be done’. I find it impossible to fully express my gratitude. The care I received from all staff has been fantastic. They always made time to be kind, friendly, supportive, and were happy to share their considerable knowledge. Thank you seems inadequate. Thank you for giving me my life back.”

Jane, former patient

“I just wanted to raise some money to give thanks back to the hospital after all they have done for me over the years, I have been a patient there. They have done so much for me, so I am able to keep on doing what I love. I am very grateful to everyone who has supported me over the years.”

Sophie, fundraiser

“Our donation is a gesture of our gratitude for the care I have received at the ROH this year. I was referred to you from Bristol with a suspicious bone lesion and had my first consultation with Professor Jeys. His calm and straightforward manner left me, and my husband reassured and confident that I was in the best hands at a very scary time in our lives. Vineet Kurisunkal took over my care and we want to say a big thank you, to him, his team and all the other staff that have looked after me through the biopsies and surgery to remove the tumour. I am recovering well and getting back to my usual daily life thanks to all these amazing people.”

Sarah and John, doners

The Royal Orthopaedic Hospital NHS Foundation Trust

LESS PAIN
MORE INDEPENDENCE
LIFE-CHANGING CARE

PAPER REFERENCE: ROHTB (7/23) 010

Pathways to Outstanding

Trust Board – 5 July 2023

Pathways to Outstanding

- We committed to produce a complete end-to-end pathway that covers the multiple ‘touchpoints’ that patients have with the ROH, from community through to tertiary care.
- We knew our challenge was to understand:-
  - What those entry routes are
  - Whether we are meeting patient expectations
  - How we collect patient feedback at each ‘touchpoint’
  - Where are our areas of improvement
  - What can we do to materially improve our patient experience and how can we measure this
- We have made good progress :-
  - Refreshed our Trust strategy
  - Ongoing service improvements projects
  - Accreditation for Elective hub helped to set the “standards”
  - Ongoing patient feedback – coffee catchup
- We have developed a stage on a page which we are now populating to ensure we have covered all the areas

Pathways to Outstanding

Patient experience
- How do patients experience ROH services and our specialist expertise?
- How and when can they provide feedback?

Patient information
- When do patients receive information?
- How is that information reflective of being a specialist hospital and the Orthopaedic Leader

Clinical contacts
- What are the consistent standards of care that we want to demonstrate across our whole patient pathway?

Administrative processes
- What are the patient facing administrative processes, as well as those which facilitate seamless transition between services?

Patient access and health inequalities
- How are patients given equitable access to ROH services/ information?

Physical environment
- What facilities are available and do they meet the ambition of the pathway (e.g. parking, wellness environment)
- How does it feel when entering the ROH site?

Workforce model
- Who do patients come into contact with, and when?
- What are our customer service standards?

Digital systems
- What are the digital solutions in place to facilitate efficient patient pathways?

Patient experience and feedback

- We undertook engagement sessions with Inpatients across the Trust
- We also reviewed historic patient experience data
- We invited in Patient Experience Network (PEN) and they reviewed our practice and feedback

- It confirmed what we know and what patients consistently feedback:
  i. Before surgery and appointments process could benefit from some improvement
  ii. The general experience while here is excellent

If it matters to you
- it matters to us.

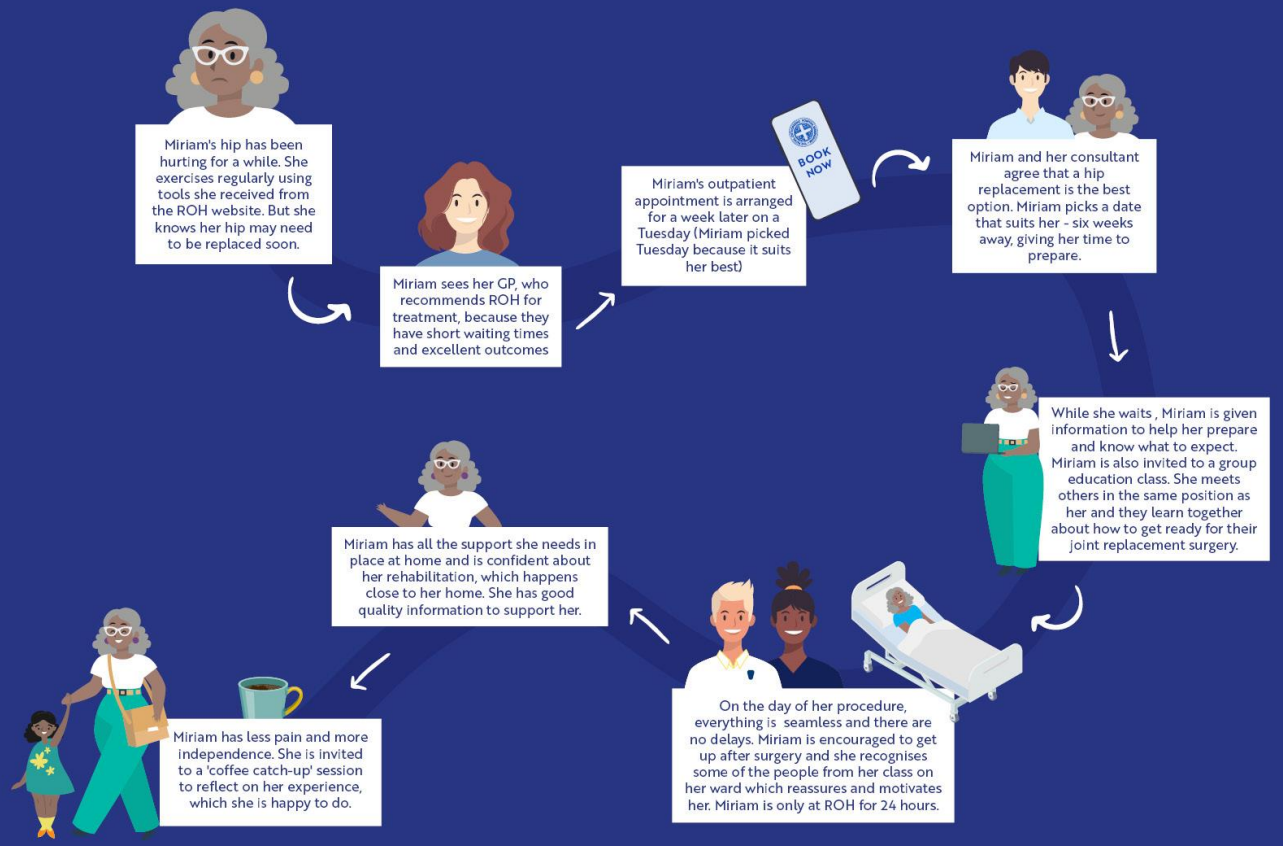
NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

LESS PAIN
MORE INDEPENDENCE
LIFE-CHANGING CARE

Outstanding pathways

There are eight steps on our pathway

- Step 1: Access to healthcare in the community
- Step 2: First contact with a community healthcare provider
- Step 3: First appointment at the ROH
- Step 4: Decision to treat
- Step 5: Waiting well for treatment
- Step 5: Waiting for treatment
- Step 7: Recovery and follow-up care
- Step 8: Return to independence and improved quality of life



Stage on a page -examples

Step 1: Access to healthcare in the community

Measures	Enablers
•Analytics of Comms channels •% uptake of resources •Primary Care coverage (engagement)	•Trust website
Current Projects/Service Improvements	**Project/Resource Gaps**
• Health Hacks – MSK schools initiative • Embed marketing / ROH brand	

Miriam's hip has been hurting for a while. She exercises regularly using tools she received from the ROH website. But she knows her hip may need to be replaced soon.

Stage on a page

Step 2: First contact with a community healthcare provider

Measures	Enablers
•Number of referrals •Primary Care coverage (engagement)	•Orthopathways •Single PTL
Current Projects/Service Improvements	**Project/Resource Gaps**
•MSK triage Hub •Primary Care engagement	•NHS App/Wayfinder

Miriam sees her GP, who recommends ROH for treatment, because they have short waiting times and excellent outcomes

Stage on a page

Step 3: First appointment at the ROH

Measures	Enablers
•% of patients using Dr Doctor or Synertec •DNA rate •Time from receiving referral, to appointment generation •Time from appointment generation, to appointment date	•Patient-led booking •Electronic appointment letters •SMS and digital opening of letters •Bi-directional digital notifications •EPROMS •PIFU •
Current Projects/Service Improvements	**Project/Resource Gaps**
•Appointments process review •DrDoctor rollout & Phase 2 •EPR •Virtual consultation roll out	

Stage on a page

Step 4: Decision to treat

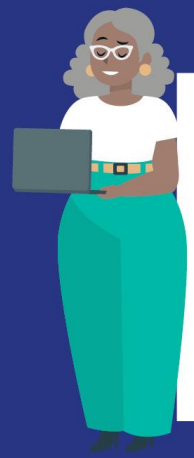
Measures	Enablers
•SDM/Consent •Conversion rates •Research uptake	•SDM – consent (part of EPR/EPROMS) •PIFU •Myrecovery – pathway support Apps
Current Projects/Service Improvements	**Project/Resource Gaps**
•Speech recognition roll out •DrDoctor rollout & Phase 2 •EPR •Clinical Portal	

Miriam and her consultant agree that a hip replacement is the best option. Miriam picks a date that suits her - six weeks away, giving her time to prepare.

Stage on a page

Step 5: Waiting well for treatment

Measures	Enablers
•Wait time from listing to treatment •Engagement in waiting well tools •% PROMS completion	•Get U Better
Current Projects/Service Improvements	**Project/Resource Gaps**
•Preop anaemia pathway •Myrecovery App •Mymobility App	•EPR with patient portal

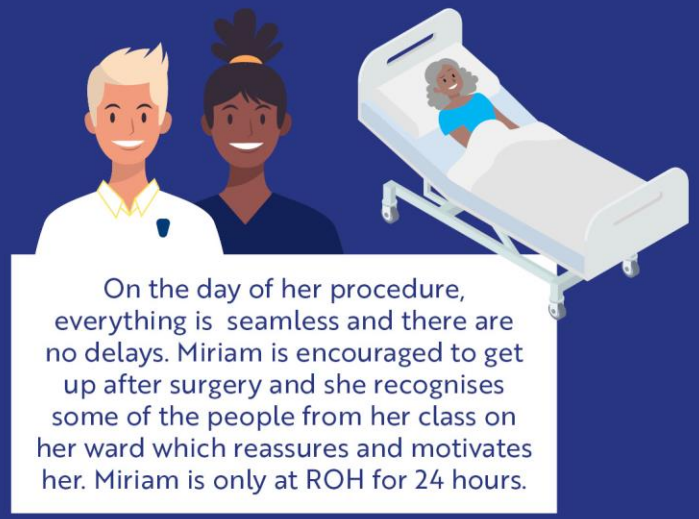


While she waits , Miriam is given information to help her prepare and know what to expect. Miriam is also invited to a group education class. She meets others in the same position as her and they learn together about how to get ready for their joint replacement surgery.

Stage on a page

Step 6: Receiving treatment

Measures	Enablers
•Length of Stay •Clinical outcomes – readmission and complication rates •Discharge delays – TTOs, equipment, social needs	•Order Comms •PICS •Robotics/tech •Electronic Outcomes •EPIS •Synopsis
Current Projects/Service Improvements	**Project/Resource Gaps**
•Optimised pathways – JointCare •Day case roll out •Theatre Efficiency Programme •POAC productivity programme •EPR	•Day Case Unit •Service Improvement ward huddles



Stage on a page

Step 7: Recovery and follow up care

Measures	Enablers
•% PROMS completion •Patient experience •App metrics •ROH wait for OP Physio	•Coffee Catch Up •PIFU •Virtual Consultation •
Current Projects/Service Improvements	**Project/Resource Gaps**
•Myrecovery App •Mymobility App •Postop outpatient arthroplasty VTE management	•Electronic wearables

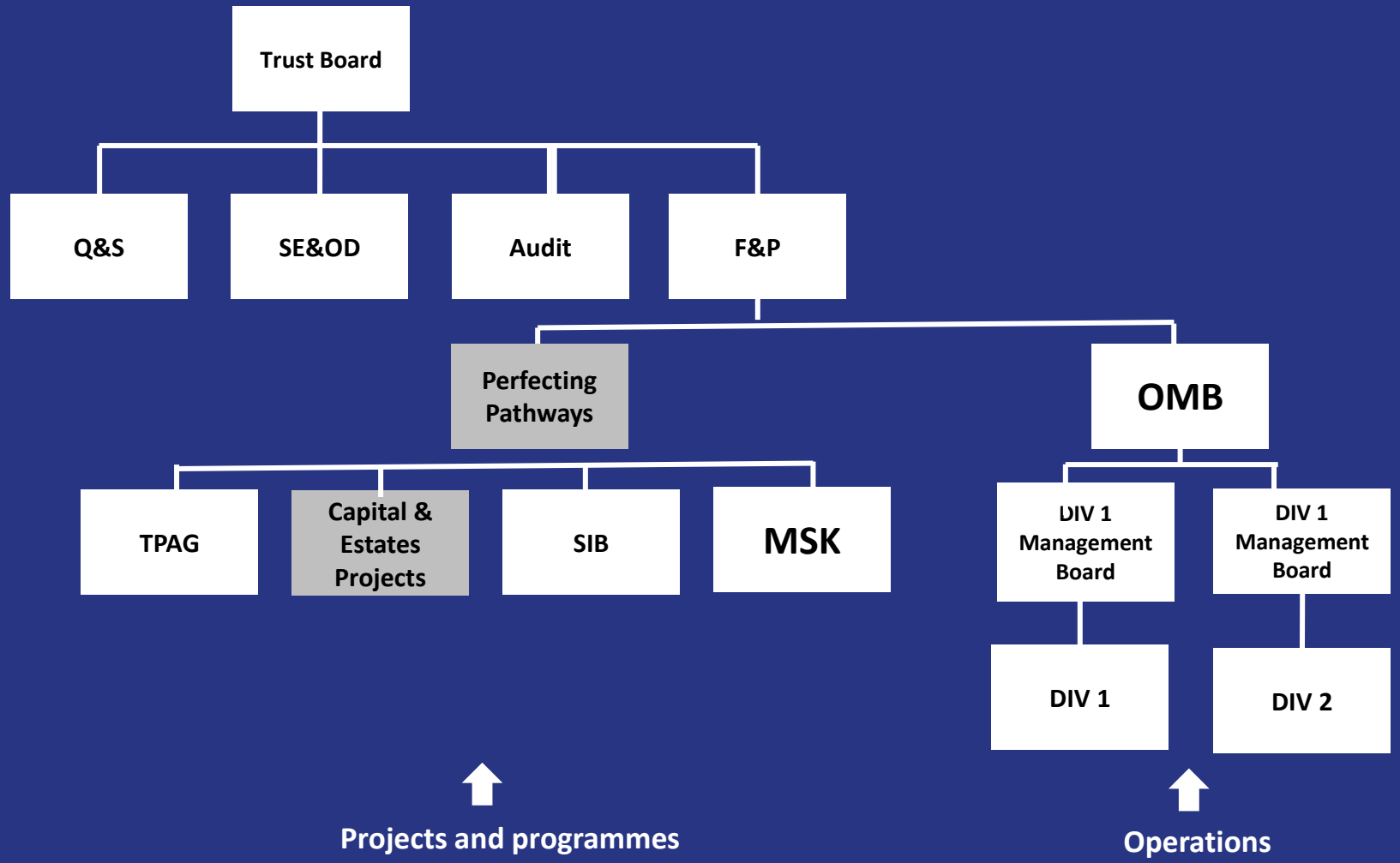
Miriam has all the support she needs in place at home and is confident about her rehabilitation, which happens close to her home. She has good quality information to support her.

Stage on a page

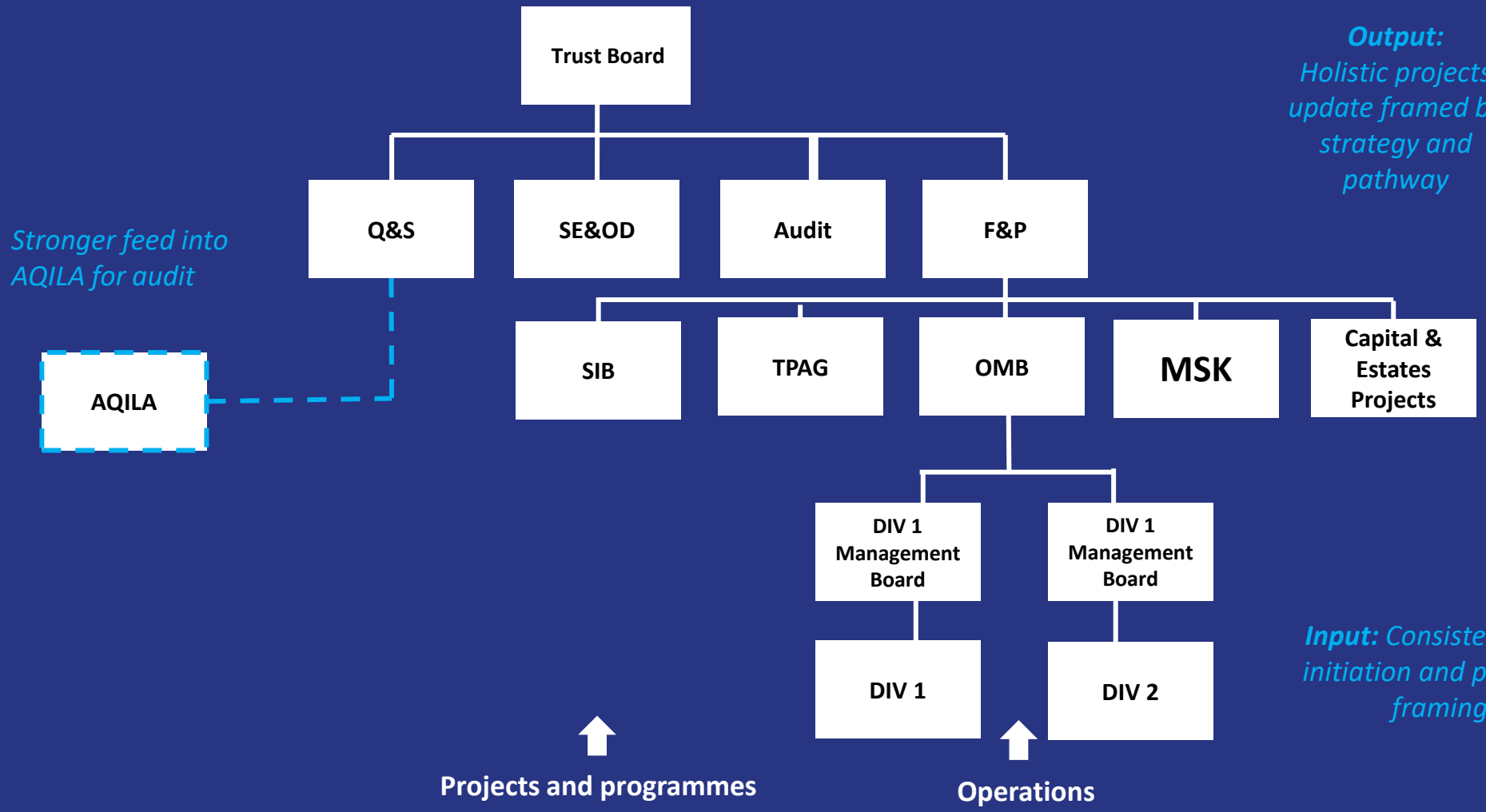
Step 8: Return to independence

Measures	Enablers
•% PROMS completion •Engagement with ‘staying well’ tools	•Trust website
Current Projects/Service Improvements	**Project/Resource Gaps**

Governance of improvement



Governance of improvement



Next phase:-

- Imperative that the Access to Healthcare pathways aligns with patient choice agenda (Sept 23)
- Produce and display end to end pathway with overlays so that everyone can see their role
- We know we need to make improvements to the physical environment (e.g. parking) in line with an estates plan – 3 year capital plan to develop
- Define ambition for each of the eight steps ensuring it meets patient need and expectation and in line with Trust strategy
- Ensure patient co-production by building this into governance – patient experience group
- Confirm and implement new governance model
- Overlay health inequalities work
- Develop standards of care /customer service standards at each stage
- Alignment to People Plan
- Reporting progress updates for each stage on a page to Trust Board

REPORT REF: ROHTB (7/23) 012

TRUST BOARD

DOCUMENT TITLE:	**Annual Complaint and Patient Experience Report 2022/23**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Chief Nurse**
AUTHOR:	**Roko Skocic, Head of Patient Experience**
PRESENTED BY:	**Nicola Brockie, Chief Nurse**
DATE OF MEETING:	**5 July 2023**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Under the Local Authority Social Service and National Health Service Complaints (England) Regulations (2009), the Trust must prepare an annual learning from complaints report each year. The Trust treated a total of 50,104 patients, and they used our services 127,283 times between 1st April 2022 to the 31st March 2023 (2022/2023). The percentage of formal complaints, compared to the activity, was 0.035% (45) complaints for the year, Patient Advice & Liaison Service (PALS) concerns, compared to the activity, was 0.38% (488) and PALS enquiries, compared to the activity, was 0.14% (175).

In 2022/2023, the Trust was measured against two contractual complaint key performance indicators (KPIs) which were reported to the Trust Board and commissioners via the Quality Report as part of the monthly reporting cycle. In 2022/2023, the Trust acknowledged 100% of all complaint letters received within 3 working days. In addition, 90% of all formal complaints were responded to within the timescale agreed with the complainant (KPI target 80%, the contractual requirement).

The top four themes of formal complaints received in 2022/2023 were:

➢ Clinical query; including clinical treatment, delay to be seen by doctor, delays with treatment and dispute over diagnosis.

➢ Appointments: including cancellation, delay, error, failure to provide follow up, letter not issued.

➢ Communication: including failure to communicate between departments and information given to patients.

➢ Values and behaviour; including attitude of medical, nursing or admin staff.

Actions taken:

In the year 2022/2023, Division 1, in collaboration with the analysed data by the Head of Patient Experience, made substantial improvements in the spirit of passion and determination to enhance the Patient Experience.

Following a thorough review of the top 4 main themes of the contacts received in the Patient Experience Department, we took a focused approach to address concerns related to appointments. Through a themed review that involved analysing incidents, Patient Advice and Liaison Service (PALS) contacts, and formal complaints, we identified key areas for improvement. This comprehensive analysis has further

drove our commitment to improving patient experience.

We value patient feedback, which we actively collected through surveys, resulting in a decrease in the number of PALS contacts and formal complaints. Over the last 4 years, we have implemented responsive improvement action plans, leveraging the insights gained from these surveys. The Trust has diligently rolled out surveys in various formats, and we are proud to have received a very good response rate. This collective effort has allowed us to make significant strides in our ongoing mission to provide exceptional patient care and satisfaction.

Additionally, the Trust is committed to further improving the Patient Experience in the coming years. Building upon the progress made, we will continue to prioritize enhancing the quality of care and satisfaction for all patients. By leveraging the valuable insights gained from patient feedback, we will develop and implement targeted strategies to address any remaining areas of concern. The Trust firmly believes in the importance of continuous improvement and will dedicate resources and efforts to ensure that patients receive the highest level of care and support. Our unwavering commitment to improving the Patient Experience will drive us to set new benchmarks and achieve even greater outcomes in the future.

ASSURANCE PROVIDED BY THE REPORT:	
POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
In 2022/2023 2 formal complaints were referred to the PHSO. Both complaints were closed by the PHSO, and no further action was required by the Trust.	The Trust reported 5 reopened complaints in 2022/2023.

NOT APPLICABLE	

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Board is asked to: APPROVE publication of the Annual Report.

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

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

Comments:

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

Local Authority Social Service and National Health Service Complaints (England) Regulations (2009). Trust Strategy.

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

Update and discussion with by BSOL ICB on a monthly basis

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 28 June 2023

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

PAPER REFERENCE: ROHTB (7/23) 012

Annual Complaints and patient Experience Report 2022/2023

Author: Roko Skocic, Head of Patient Experience
Executive Sponsor: Nicola Brockie, Chief Nurse

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Preface from Nicola Brockie, Chief Nurse

The Royal Orthopaedic Hospital is committed to delivering the best possible patient experience. I'm very proud of the experience patients have at our Trust which, according to our patient feedback, is consistently positive and among the best in the whole NHS. However, sometimes we get things wrong or fail to meet expectation - and this may result in a complaint. One of our core Trust values is openness, and it is this value which guides how we manage complaints at The Royal Orthopaedic Hospital.

Complaints are always an opportunity to learn, and I believe this report demonstrates that we are an organisation who learn and focus on continuous improvement. Complaints are a valuable source of feedback and help inform how we develop and deliver our services and support the mitigation of risk. We have undertaken work in the past year to help embed learning from complaints and continue to refine our processes to be as efficient as possible.

I'm proud of the work our complaints department do; providing people with support throughout the process, ensuring they have a clear understanding of the process and possible outcomes, and helping them understand where to seek help and advice. Good complaints handling is essential, and I believe we have robust processes in place to expedite resolution wherever possible.

While we have achieved much, there is still work to do. Ultimately, our ambition is to give people confidence that they will be fully supported when making a complaint and that there will be a constructive outcome. This relies as much on process as it does on culture and values. As interim Chief Nurse, I'm pleased to report that our Trust is focussed on both and people who directly or indirectly use our services should be reassured that we are here to work with them and provide the best experience possible.

Nicola Brockie, Chief Nurse

Preface from Roko Skocic, Head of Patient Experience

It is with great pleasure that I present to you the Annual Complaints and Patient Experience Report for 2022/2023. As Head of Patient Experience for the Royal Orthopaedic Hospital, I am delighted to share the fantastic news that our hospital has performed exceptionally well in terms of patient experience this year.

I am proud that the Trust have received fewer complaints than last year, it is worth noting that the hospital's activity was much higher. Furthermore, we are proud to report that the less of our patients complained to the Trust this year, which we attribute to our early prevention approach and acting on patient experience surveys data and PALS contacts. I am pleased to confirm that the KPIs for Formal Complaints and PALS cases have been met for the year.

Our success in improving patient experience was achieved through a collaborative effort between my team and all divisions of the hospital. Together, we have implemented a range of initiatives aimed at enhancing patient experience, and I am grateful for the dedication and support from my team and staff in delivering these improvements.

I am excited to announce that we are planning to roll out new PHSO complaints standards at the Royal Orthopaedic Hospital in the upcoming year. This initiative will further strengthen our commitment to providing excellent patient experience.

I am delighted to share that the average positive patient experience rating from the Friends and Family test for inpatient areas was an impressive 99%, surpassing the national average of 94%. We have also rolled out in-depth surveys and Smiley Faces devices to the outpatient areas, which have been warmly welcomed by our patients and visitors.

As much as I am excited about the progress we have made in the past year, I would like to take this opportunity to announce that I will be leaving the Trust at the end of quarter 1, 2023/2024. However, I have no doubt that the team will continue to build on the successes of the past years and further improve patient experience.

In closing, I would like to express my sincere appreciation to my team, staff, and everyone involved in the Royal Orthopaedic Hospital's journey towards providing excellent patient experience. Your hard work, dedication, and support have been instrumental in achieving this year's successes.

Roko Skocic, Head of Patient Experience

1.0. Executive Summary

The Royal Orthopaedic Hospital NHS Foundation Trust (Trust) is committed to improving our services and learning from complaints, feedback, comments, and compliments raised by our patients, their carers their family & friends and members of public. The Trust is dedicated to continuously improving our services by listening to concerns, enquiries, feedback, comments, and compliments. Whilst ensuring we are acting from the feedback we receive.

Complaints made to the Trust are managed and dealt with in accordance with the PALS and Complaints Policy, NHS Complaints Policy and the Local Authority Social Service and National Health Service Complaints (England) Regulations (2009). The fundamental objective is to resolve each complaint with the complainant through discussion, explanation, or a written response to their satisfaction within the agreed timescale.

Under the Local Authority Social Service and National Health Service Complaints (England) Regulations (2009), the Trust must prepare an annual learning from complaints report each year. The report must specify the number of complaints received and number of complaints that the Trust decided were well-founded. It must also summarise the subject matter of complaints and any matters of general importance arising from those complaints. It must include the way in which the complaints have been managed and any actions that have been taken to improve services because of those complaints. This report will be publicly available on the Trust web site https://www.roh.nhs.uk/ . Section 6.0. of this document outlines the statutory requirement that the Trust is measured against.

The Trust treated a total of 50,104 patients, and they used our services 127,283 times between 1st April 2022 to the 31st March 2023 (2022/2023). The percentage of formal complaints, compared to the activity, was 0.035% (45) complaints for the year, Patient Advice & Liaison Service (PALS) concerns, compared to the activity, was 0.38% (488) and PALS enquiries, compared to the activity, was 0.14% (175).

Overall, The Trust has received fewer formal complaints and PALS contacts in 2022/2023 compared to the last 6 years.

In 2022/2023, the Trust was measured against two contractual complaint key performance indicators (KPIs) which were reported to the Trust Board and commissioners via the Quality Report as part of the monthly reporting cycle. In 2022/2023, the Trust acknowledged 100% of all complaint letters received within 3 working days. In addition, 90% of all formal complaints were responded to within the timescale agreed with the complainant (KPI target 80%, the contractual requirement). Compliance against these KPIs is outlined in section 6.0.

With the strengthening of the Patient Experience Team, we have seen a decrease of formal complaints, PALS concerns, PALS enquiry and strengthened Patient experience across the Trust, including rebranding of department and making sure that the Governance structure is in place for other departments to include patients in the decision making.

1.1. Definitions Within this Report

1.1.1. Type of Complaint

1. **Formal Complaint**: Any expression of dissatisfaction, where the complainant wishes to have a fully investigated response in writing. These are likely to take longer than 25 working days to resolve, but may also include issues that are resolvable quickly, where the complainant expresses a wish for the complaint to be dealt with formally.

2. **Informal Complaint:** A concern that is raised by the complainant where the issue can be resolved either immediately or to the complainant's satisfaction within 48 hours. It also applies to issues raised verbally through the Patient Advice and Liaison Service, or the Complaints Department where the complainant indicates he/she does not require a written response from the Trust or does not wish to proceed with a formal complaint, once resolved to their satisfaction. These are not formally reported via the complaints data to NHS England.

3. **PALS Enquiry:** A general enquiry that does not raise any matters of concern, but the individual merely requires information. These are not formally reported to NHS England and are resolved within 3 working days.

4. **PALS Concern:** An enquiry that requires contact with other members of staff to resolve and a response is required verbally or in writing to the individual providing answers to specified questions. These are not formally reported to NHS England and are resolved within 7 working days.

5. **Complaint Resolution Meeting-** A meeting in which is organised upon complainants' request. A member of the complaints team, lead on complaint and complainant is present within the meeting. Questions or concerns are agreed with the complainant and are resolved within the meeting. A letter is formulated and sent 10 working days after the meeting outlining any actions agreed and outstanding questions or concerns are answered.

1.1.2. Formal Complaint Outcome Decision

- **Upheld:** If a complaint is received which relates to one specific issue, and substantive evidence is found to support the complaint, then the complaint should be recorded as upheld.
- **Partially upheld**: If a complaint is made regarding more than one issue, and one or more of these issues (but not all) are upheld, the complaint should be recorded as partially upheld.
- **Not upheld:** Where there is no evidence to support any aspects of a complaint made, the complaint should be recorded as not upheld.

2.0. The Patient Experience Team

The structure for the department stayed the same as the year before. The Patient Experience department has 5 different services that are managed by the Head of Patient Experience, and they are as follows:

- Patient Experience
- Patient Advice and Liaison Service
- Complaints
- Volunteer Service
- Chaplaincy Service

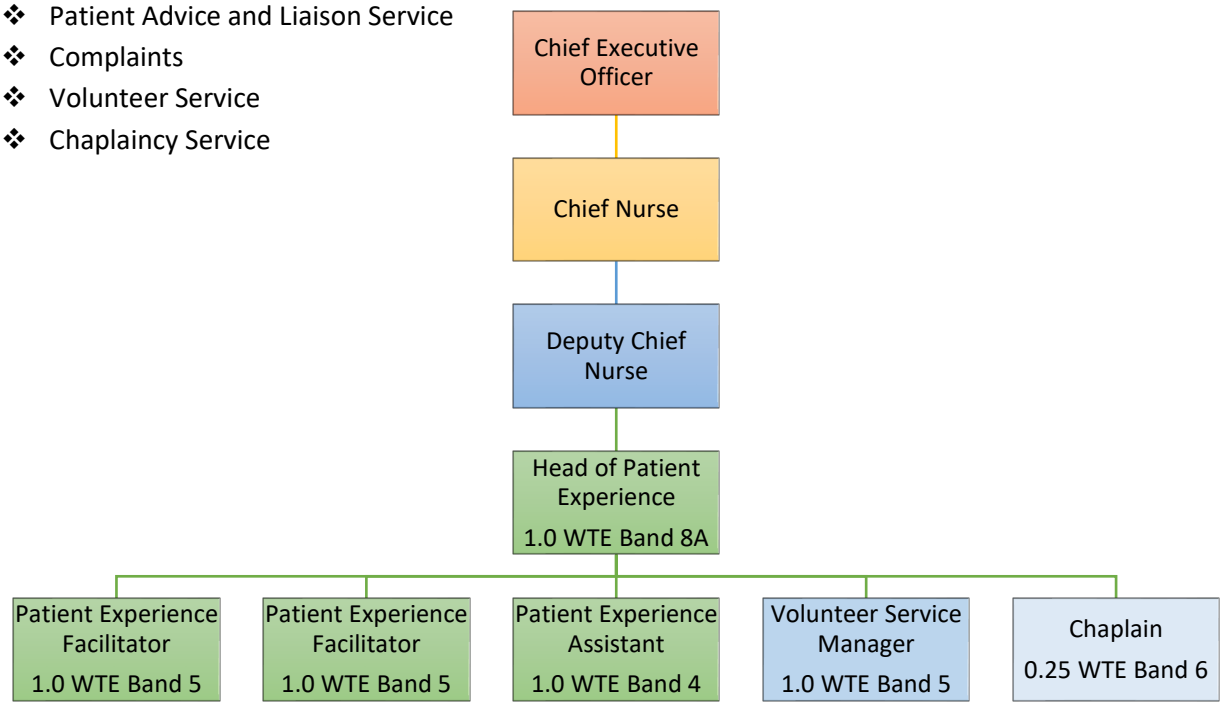


Figure 1: Patient Experience Team Structure

2.1. Roles and Responsibilities Within Structural Tree for the Complaints

2.1.1. Chief Executive Officer

- Named officer with responsibility for ensuring that the Trust complies with statutory obligations made under the Local Authority Social Services and National Health Services Complaints (England) Regulations 2009. Ensuring that actions are taken depending on the outcome of complaints.
- The CEO or nominated deputy in his/her absence will read and review all complaint responses and provide a signed cover letter.

2.1.2. Chief Nurse

- Has overall responsibility, delegated from the CEO, for ensuring that effective systems and processes are in place to deal with patient and service users' feedback and to ensure that this is shared and acted upon in order to continually improve the quality of care.

2.1.3. Deputy Chief Nurse

Is responsible for

- Providing the Quality and Safety Committee with a quarterly report regarding complaints activity, the actions taken and an evaluation of the effectiveness of the action.
- Agreeing actions to be taken when complaints are presented after the statutory 12-month period.
- Ensuring detailed procedures are developed, agreed, and implemented.
- Ensuring key performance indicators (KPIs) are monitored and reported to Divisions, Clinical Quality Group and Quality and Safety Committee.

2.1.4. Head of Patient Experience

Is responsible for

- Day-to-day management and provision of a patient advice and support service in relation to feedback and complaints.
- Managing the procedures for handling and considering complaints and acts as a 'complaints manager' under The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009.
- Interpretation of NHS Complaints Procedure and developing and reviewing associated local policy and procedures.
- Execution his/her duties as described in the associated procedural documents.
- Providing quality assurance of complaint responses for complaints risk rated amber, yellow, or green.
- Managing the administrative process for Parliamentary Health Service Ombudsman investigations.
- Providing training in relation to the management of Complaints and PALS.
- Monitoring concerns and complaints key performance indicators (KPIs) analysing complaints information and provide data and information for Divisional. Governance Board, Clinical Quality Group, Quality and Safety Committee and the annual complaints report to Trust Board.
- Informing the Communications Manager of any potential media interest.
- Providing support to the Divisional leads as required.
- Development of an Annual Complaints Report for presentation to the Board of Directors by the Chief Nurse.
- Responsible for improving the Patient Advice and Liaison Service (PALS) and complaint services on a regular basis.
- Presentation of an Annual Complaints Report to the Board of Directors.

2.1.5. Patient Experience Team- Patient Experience Facilitators

- Is designated by the Trust to listen and to facilitate the handling of complaints appropriately and in a timely manner.
- Is responsible for maintaining accurate PALS records of contacts and outcomes that can be used for the identification of trends and for sharing learning across the Trust.
- Will report any issues of concern to the Head of Patient Experience.
- Is responsible for providing written reports detailing PALS activity and outcomes to the Head of Patient Experience monthly in order to enable production of monthly quality report

3.0. Governance Structure

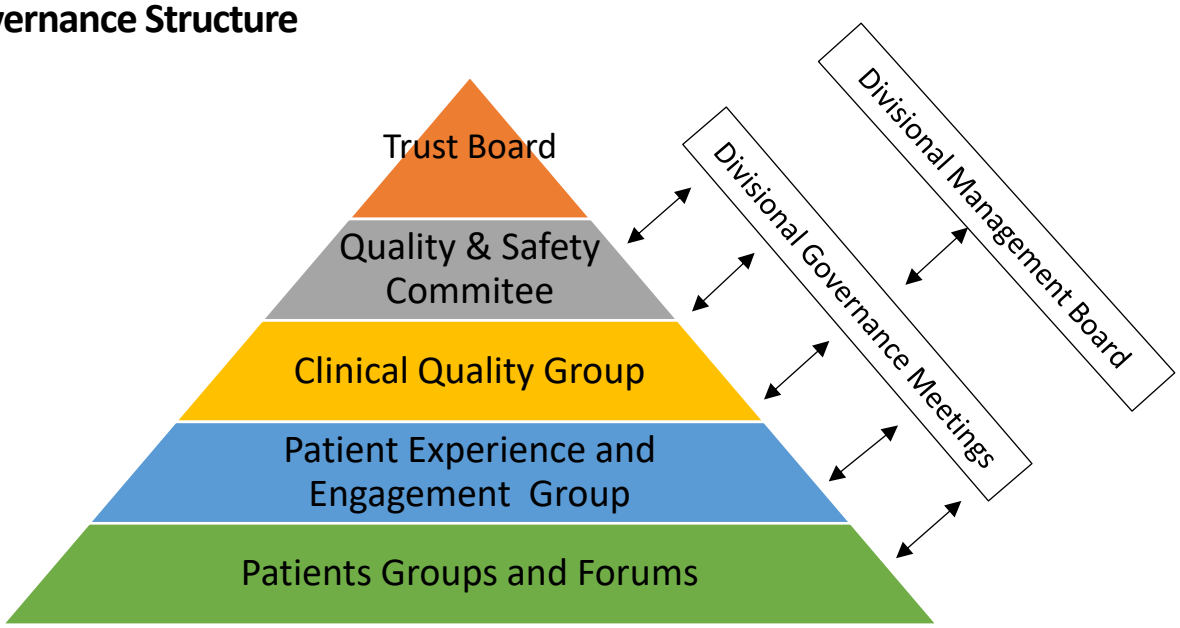


Figure 2: PALS and Complaints Governance Structure for reporting

3.1. Roles and Responsibilities within Governance Structure

3.1.1. Trust Board

- Receives assurance that robust systems are in place that enables feedback to be heard, actioned and lessons learned in order to provide the best possible care and experience to patients and service users.
- The Trust Board will receive information on the number of complaints and timeliness of response in the Integrated Performance Report.
- The Trust Board will receive and approve the Annual Complaints Report.

3.1.2. Quality and Safety Committee

- Will receive quarterly assurance reports about complaint numbers, timeliness of responses, themes and trends, risk grading of initial complaint, number upheld, partially upheld, or not upheld.
- Number and percentage responded to in time agreed with complainant, complaint outcomes and learning identified, evidence of how learning has been shared across the Trust, number referred to Parliamentary Health Services Ombudsman (PHSO) and outcome, number, and percentage of re-opened and criteria for re-opening, details of measure of complaint satisfaction sought via survey or proactive feedback process and summary of training undertaken in respect of learning from complaints. This report will also include details of concerns and compliments received by the Trust

3.1.3. Clinical Quality Group

- Will receive monthly assurance reports about complaint and PALS numbers, timeliness of response, themes and trends, risk grading of initial complaint, number upheld, partially upheld, or not upheld.
- Number and percentage responded to in time agreed with complainant, complaint outcomes and learning identified, evidence of how learning has been shared across the Trust, number referred to Parliamentary and Health Service Ombudsman (PHSO) and outcome, number, and percentage of re-opened and criteria for re-opening, details of measure of complaint satisfaction sought via survey or proactive feedback process, summary of training undertaken in respect of learning from complaints. This report will also include details of concerns and compliments received by the Trust.
- Has overall responsibility for ensuring that complaint action plans are monitored and closed at Divisional level.
- Has responsibility for ensuring that learning from complaints is shared across the Trust.

3.1.4. Patient Experience and Engagement Group

- The purpose of this group is to provide assurance to the Quality and Safety Committee of patient, public and carer involvement, and experience within the Trust.
- The Patient Engagement and Experience Group is responsible for setting its own annual work plan in agreement with the Quality and Safety Committee and be accountable for delivering and evaluating its key tasks and responsibilities.
- Is responsible to ensure there is a clear Involvement, Experience and Volunteering Strategy in place with a work plan aligned to ensure implementation.
- Is responsible to oversee compliance with standards set by the Care Quality Commission and NHS.

3.1.5. Patient Experience Forums and Groups

- The Patient Experience Groups and Forums helps the Trust look at ways to improve patient experience. The groups and forums will discuss issues that patients and carers raise and consider actions that need to be taken to resolve them.
- The Patients Groups and Forums are used to help us gain a better understanding of the priorities and concerns of service users.

3.1.6. Divisional Governance Meeting

- Are responsible for ensuring that all complaints and patient feedback are investigated and responded to in line with the policy.
- Will monitor and oversee closure of complaint action plans and ensure that learning is widely shared across the Division.

- Will receive Bi-monthly reports with trends of PALS contacts (enquiries, comments, or concerns) and Formal complaints covering the whole year from April to March, together with main trends from the month before.

3.1.7. Divisional Management Board

- Are responsible for ensuring that all complaints and patient feedback are investigated and responded to in line with the policy.
- Will review an open Formal complaints tracker, PALS contacts and PALS trends for that month.
- Ensuring that all divisional complaints or concern actions are closed and track their process.

4.0. Data Collection and Analysis

All data from the PALS concerns, PALS enquiries, compliments and formal complaints are entered and collected via the Customer Service Module within Ulysses Safeguard System. This has enabled more accurate and responsive trend and theme analysis across all Patient Experience data and allowed the team to work closely with the Divisional teams to improve the recording of actions and learning taken because of complaints.

The PALS and Complaints department produce reports on weekly, monthly, and quarterly basis to ensure that Divisions are aware of any issues and themes within their departments.

5.0. Formal Complaints Process

Complaints are a rich source of patient feedback, and this should be regarded as such by all staff members. From time to time, the experience of our service users is not as good as it should be and therefore there is an opportunity for us to learn from our mistakes.

The PALS & Complaints process gives the Divisions full ownership and oversight of the formal complaints that are connected to their division. The Triumvirate has full oversight of all complaints that are received by the Trust; identify the lead and provide divisional sign off complaint before it goes to the Executive Director and Chief Executive Officer approval.

Figure 3: Formal Complaints Process Hierarchy

5.1. Roles and Responsibilities within Formal Complaints Process

5.1.1. Patient Experience Facilitator

- Will receive complaint and act as a first point of contact to the complainant.
- Is responsible for reading and extracting the questions from the complaint, to allow timely review, responding and reading of the complainant.
- Facilitates all processes for the formal complaint and makes sure that the complaint response is sent within the agreed timescale with the complainant.

5.1.2. Head of Patient Experience

- Is named Complaints Manager which is responsible for managing the procedures for handling and considering complaints in accordance with the arrangements made under the Local Authority Social Services and National Health Services Complaints (England) Regulations 2009

5.1.3. Triumvirate

- Triumvirate is made of Head of Nursing, Deputy Medical Director, and Deputy Chief Operating Officer
- Are responsible for identifying a named individual to lead the complaint response.
- Are responsible for identifying a lead and identification of an immediate action.
- Are responsible for approving the draft response for a formal complaint before it goes to a director.
- Quality assures all complaint responses and ensures all aspects of the complaint have been addressed and the response has been written in line with the guidance on writing response letters.
- Review and approve any changes within PALS and Complaints processes or system.

5.1.4. Response Lead

- Undertake local investigation into complaints as requested.
- Meet with complainants as required to enable local resolution of concerns/complaints
- Ensures that all identified staff within the complaint have received relevant training and understand their responsibilities when responding to the specific needs/requests of patients and service users. Staff should aim to resolve issues locally wherever possible.

5.1.5. Executive Director

- Is responsible for approval of the final complaint response before CEO approval.
- Executive Director will sign off all complaints within their portfolio.

5.1.6. Chief Executive Officer

- Is named officer with responsibility for ensuring that the Trust complies with statutory obligations made under The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009, and in particular ensuring that action is taken, if necessary, in the light of the outcome of a complaint.
- The CEO or nominated deputy in his/her absence will read, review, and approve all complaint responses and provide a signed cover letter.

5.2. Governance Structure for Approval of the Formal Complaints

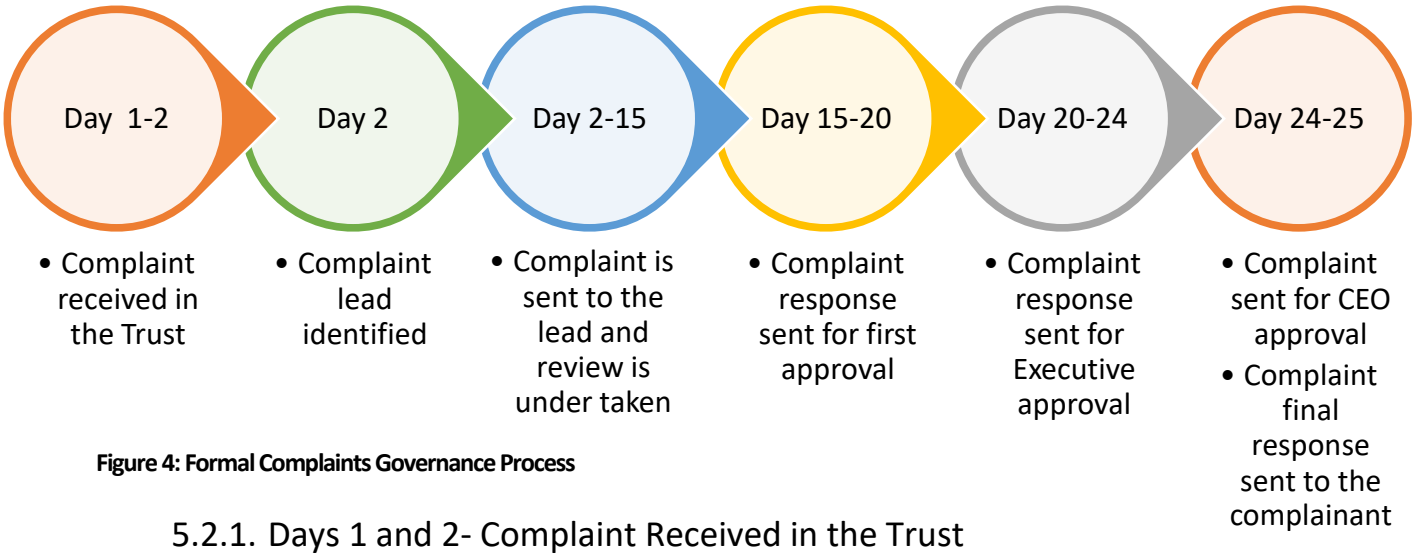


Figure 4: Formal Complaints Governance Process

5.2.1. Days 1 and 2- Complaint Received in the Trust

- Complaints team will read the complaint letter and extract key elements.
- Complaints team phone the complainant to discuss key elements of the complaint and discuss complaint letter and extracted questions with complainant.
- Complaints team offer the complainant a telephone call and meeting with an investigation lead.
- Complaints team will email the Triumvirate requesting that they identify a lead for the complaint, provide the questions that the complainant would like to answer and advise the method of response requested.

5.2.2. Day 2- Complaint Lead identified

- Triumvirate to complete an immediate action plan, initial risk rating and identifies lead for the complaint.
- Complaints department will forward the complaint to the response lead (the following will also be copied into the correspondence: the patient's Consultant, Clinical Service Manager and Clinical Service Lead who will contribute to the response if applicable) asking them to respond as per instructions.

5.2.3. Day 2 to 15- Complaint Sent for Investigation

- Response lead to phone the complainant if instructed to do so, within 5 working days and notify Complaints team of the outcome of that conversation. Telephone response must be followed up with a written response, outlining the discussion with complainant.
- Complaint's lead has 15 working days to respond in the format of a letter.

5.2.4. Day 15 to 20- Complaint Response sent for First Approval

- Complaint version 1 draft response created and sent to Complaints team, together with final risk rating and final Action plan.
- Complaints team will proofread complaint version 1 response letter.
- Complaints team will notify Triumvirate that version 1 draft response has been created and it is ready for them to review, make comments/amendments or approve.
- Once a complaint draft response is approved by Triumvirate it will be sent for Director approval.

5.2.5. Day 20 to 24- Complaint sent for Executive Director Approval

- Complaints team will send a draft version of the response and final action plan to the Executive Director to review, make comments or approve.
- Executive Director approves draft response, and it is then sent for CEO approval.

5.2.6. Day 24 and 25- Complaint sent for CEO approval and to the Complainant

- CEO reviews draft response for the complaint and once it has been approved it becomes a final response.
- In the cover letter, the CEO will offer the complainant an opportunity to meet with key managers to discuss the outcome of the complaint.
- Final response letter and CEO cover letter is then scanned, and a copy saved on Ulysses.
- Complaint final letter sent to the complainant and complaint closed.

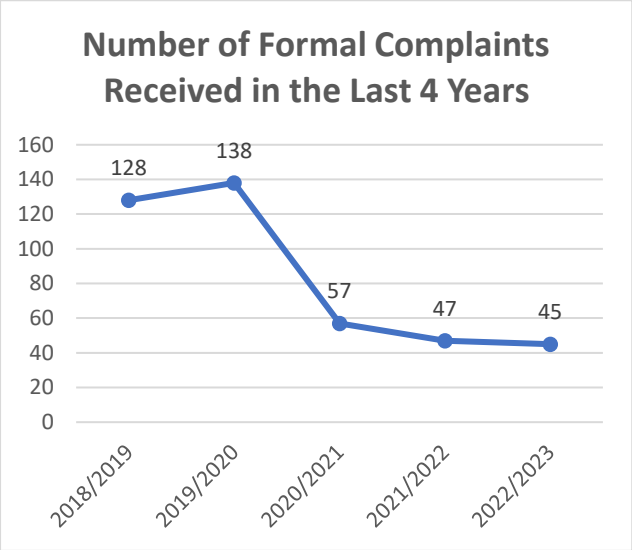
6.0. Formal Complaints Received

This section is a statutory requirement for the Trust under the Local Authority Social Service and National Health Service Complaints (England) Regulations 2009.

From 1 April 2022 to 31 March 2023 (2022/2023), the Trust had a footfall of 127,283 patients throughout all services. We received 53 formal complaints. However, 6 complaints were withdrawn, and 2 complaints have been investigated trough the Root Cause Analysis investigation led by the Governance Department, leaving a total of 45 complaints which were formally responded. Although, 6 complaints have been withdrawn, for different reasons the Trust have reviewed them to see if there was any learning from them.

For comparison, in 2021/2022 the Trust had a footfall of 146,416 patients throughout all services. The Trust received 50 formal complaints. Four were withdrawn, leaving a total of 46 complaints which were responded to.

In 2022/2023, 0.01% less service users have raised a formal complaint to the Trust compared to 2021/2022 when 0.04% of all patients raised a formal complaint. The Trust saw a 0.01% decrease in the formal complaints raised compared to the year before, this is an overall drop of 0.77% decrease in the last 5 years.



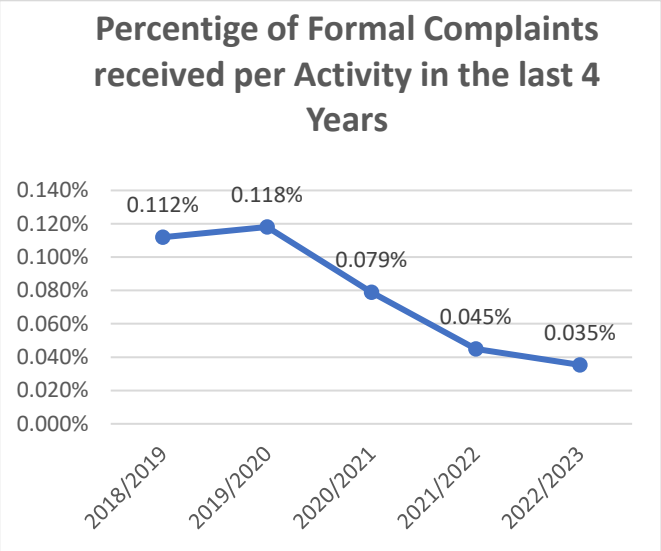


Figure 5 and 6: Number and Percentage of Formal Complaints Received over the Last 5 Years

The data above shows that the Trust has had a decrease in the formal complaints received in the last 4 years. The Trust has had more contacts and cases open in the Patient Advice and Liaison Service (PALS) over last 4 years and it is believed that early prevention, intervention, and resolution has avoided our service users deciding to proceed to a formal complaint; this is outlined in the section 7.0. of this document.

6.1. Complaints received per Quarter

Figure 7 below details the number of complaints received by quarter in 2022/2023 compared with the previous year's data.

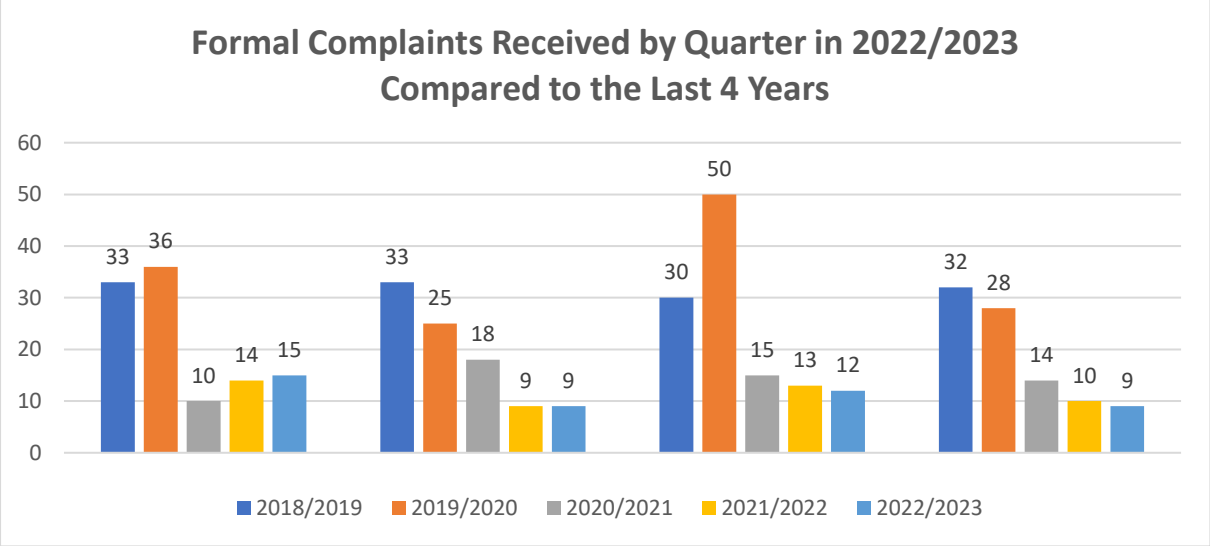


Figure 7: Formal Complaints received by Quarter

6.1.1. Benchmarking Against our Peers

In 2022/2023 the Trust strengthen connections with our peers, other orthopaedic Trust, this includes The Royal National Orthopaedic Hospital (RNOH) and Robert Jones and Agnus Orthopaedic Hospital (RJAHH).

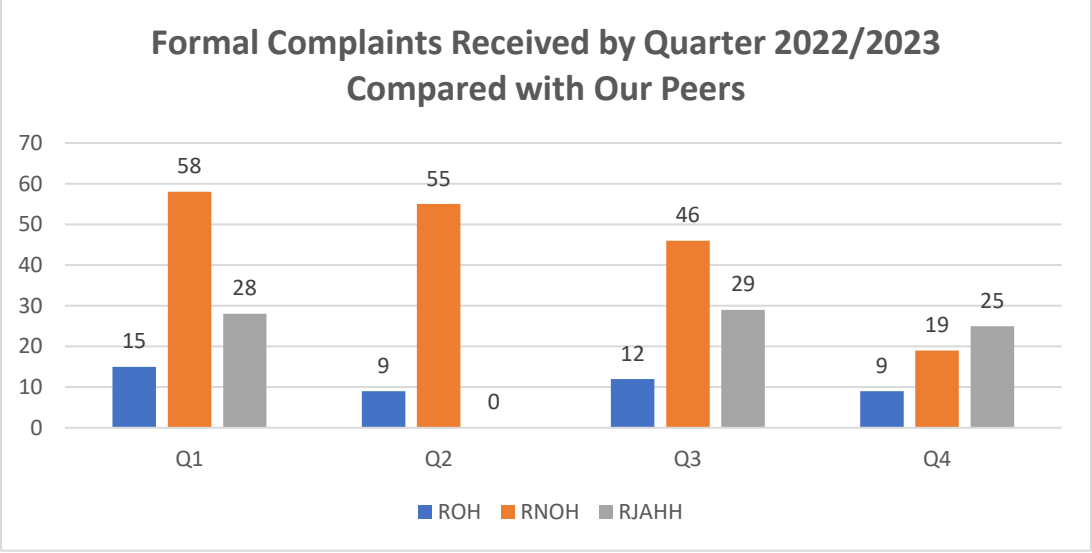


Figure 8: Formal Complaints received and compared with orthopaedic hospital

6.1.2. Withdrawn Complaints

In 2022/2023 the Trust received 53 complaints of which 6 was withdrawn by the complainants. Some of the reasons that complaints were withdrawn are as follows:

1. Complaint was responded within first 24 hours of receipt by the phone call and the complainant was happy with the response
2. Complaint was referred to the Root Cause Analysis (RCA)
3. Complaint accepted a meeting with the senior manager
4. Complaint was happy with the PALS process

6.2. Number of Complaints per 1000 Beds

The table below details number of the complaints per 1000 occupied bed days (OBD) in 2022/2023 compared to the last 2 years.

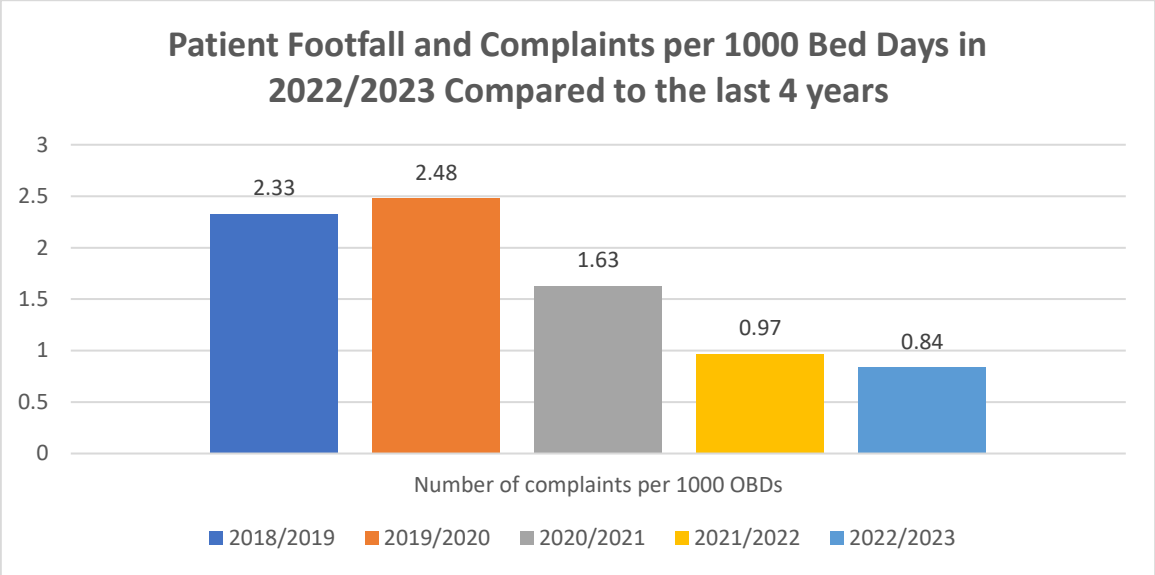


Figure 9: Complaints per 1000 Bed Days

6.3. Acknowledgement of Complaints

The Local Authority Social Service and National Health Service Complaints (England) Regulations 2009 and the Trust PALS and Complaints Policy states that an acknowledgement should be made within three working days of receipt by any method.

The Trust's Policy states that all attempts should be made to contact the complainant by telephone within the first two days of receipt and this conversation informs the acknowledgement letter sent out by day three. If there is no telephone number available, or the complainant does not answer/return the calls, then the letter is sent within the same timescale.

In, 2022/2023 the Trust responded to 100% of complaint letters within the correct timescale, thereby meeting the standard. This is the third year a 100% completion rate has been achieved.

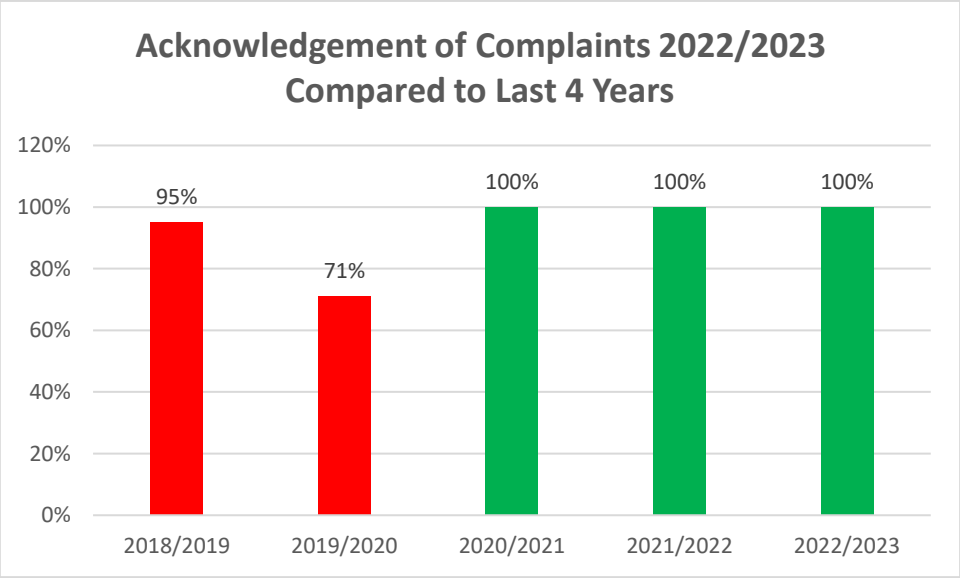


Figure 10: Acknowledgement of Formal Complaints in 2022/2023 Compared to the Last 4 Years

6.4. Responding to Complaints Within the Agreed Timescale

The PALS and Complaints Policy states that the timescale for response should be agreed with the complainant. However, in the event of not being able to contact the complainant and speak to them directly, the Trust sets a provisional response date of 25 working days for routine/lower risk complaints and 40 working days for complex/higher risk complaints (dependent on discussion with the Deputy Chief Nurse, the Designated Complaint Manager, and the Complainant as to the complexity of work required).

In line with the Policy, it is permissible to discuss an extension with the complainant, particularly if there is significant delay with review, such as due to the unavailability of staff that are crucial in giving their statements or based on the complexity of case. If they agree with the extension, the complaint will be deemed to have been completed within agreed timescales. Any complaint timescale can only be extended once. The complaint extension must be approved by the Executive Director following advice form the Head of Patient Experience.

During 2022/2023 the Trust extended 3 of Formal Complaints. During 2022/2023 the Trust extended the highest number of complaints compared to the years before. The majority of the complaints that were extended the response lead was a clinician. Some of the reasons for extending were:

1. Complaint response lead was on annual leave
2. Complaint lead could not properly investigate complaint due to the staff absence
3. Complaint lead could not complete complaint investigation in time due to the other commitments

Annual compliance with the contractual reporting requirement of 80% for the year has been met at 90%, however the internal KPI of 90% was met in 10 months and on average the response rate was 27 working days. 5 formal complaints breached the agreed date with the complainant; however, this have been communicated with the complainant.

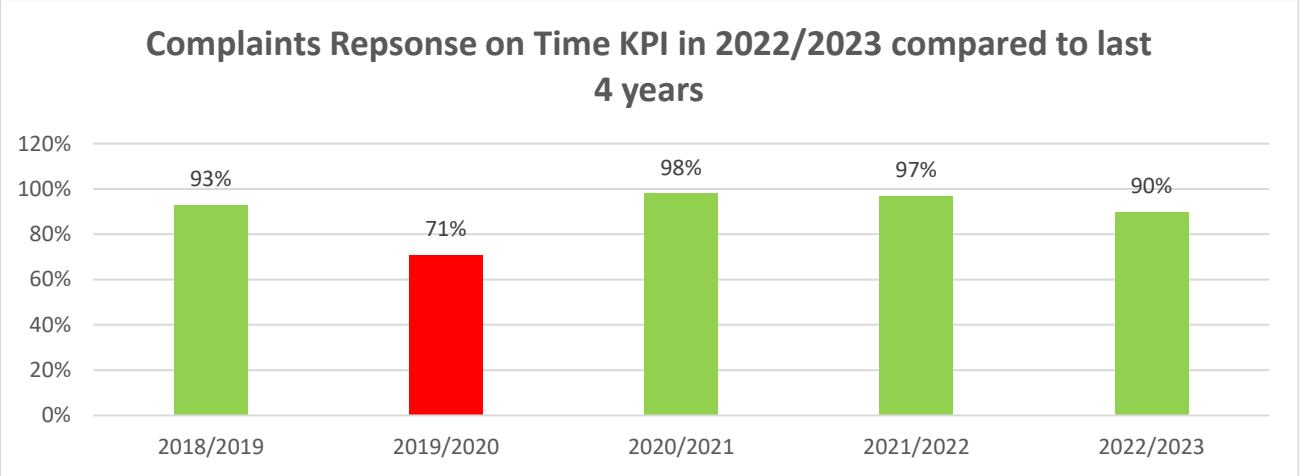


Figure 11. Formal Complaints Response on Time KPI in 2022/2023 Compared to the last 4 years

6.5. Risk Ratings of Formal Complaints

The Trust has a robust system of tracking and monitoring complaints. Part of this tracking involves the logging of an initial risk rating. The Head of Patient Experience monitors these risk ratings, and the Triumvirate reviews all complaints, to ensure Duty of Candour requirements have been discussed and met where required.

	SEVERITY				
LIKELIHOOD	**Insignificant 1**	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

Green = LOW risk **Yellow = MODERATE risk** **Amber = MEDIUM risk** **Red = HIGH risk**

Figure 12. Trust Risk Rating Matrix

The results of this monitoring clearly show that most of the complaints that represent a lower risk to the Trust are handled via different processes within the Trust, such as PALS or informally, as the number of complaints assessed as green or low risk are few. A review of the formal complaints assessed in the lower risk categories shows that in each case, the complainant had expressed a preference for their concerns to be made formal. This is indicative that the Trust is handling complaints in accordance with the Department of Health Complaint Regulations 2012 – that the complainant is able to determine how their concerns are managed.

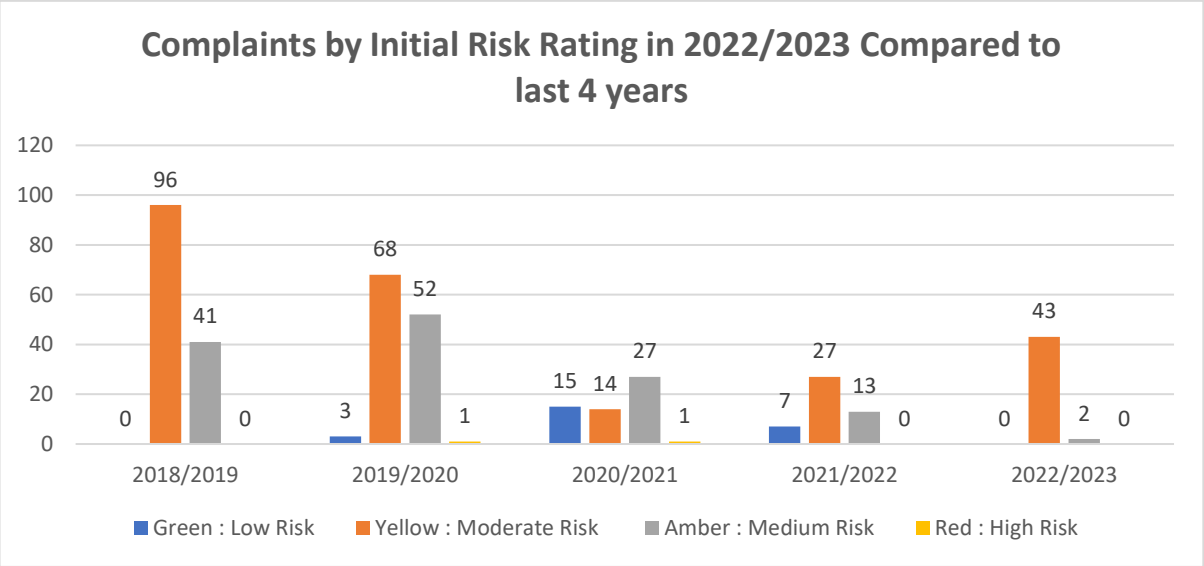


Figure 13. Complaints by Risk rating in 2022/2023 compared to the last 4 years

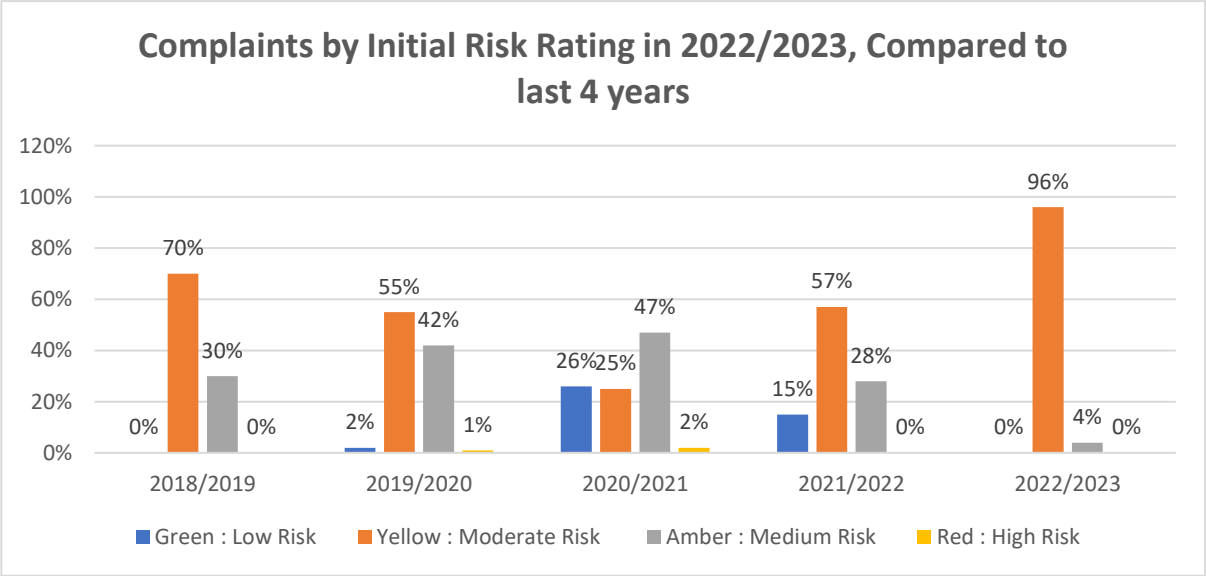


Figure 14. Percentage of Complaints by Initial Risk Rating in 2022/2023 compared to the last 4 years

The percentage of initial risk rating for low-risk complaints went down by 15% for moderate risk went up by 39% for medium risk went down for 24% and for High Risk stayed the same at 0% in the last 4 years.

6.6. Themes of Formal Complaints

Listed below are the themes arising out of the formal complaints received during 2022/2023 compared to 2021/2022, 2020/2021, 2018/2019 and 2019/2020.

Complaint Category types	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Access To Treatment	14	8	6	1	0
Admissions & Discharges	7	5	3	9	0
Appointments	14	27	11	4	2
Cancellation Of Surgery	0	0	1	1	1
Clinical Query	34	36	20	12	21
Communication	5	9	4	4	3
COVID-19	0	0	2	2	0
Nursing	0	0	0	0	5
Patient Care Including Nutrition/Hydration	10	8	1	0	0
Privacy, Dignity and Wellbeing	3	2	2	0	0
Trust Administration	5	9	3	0	1
Values & Behaviours	20	17	3	9	9
Waiting Times	9	13	1	0	0
Facilities	0	1	0	2	0
Consent to treatment	1	0	0	0	0
Transport	1	0	0	0	0
Other	1	1	0	0	8

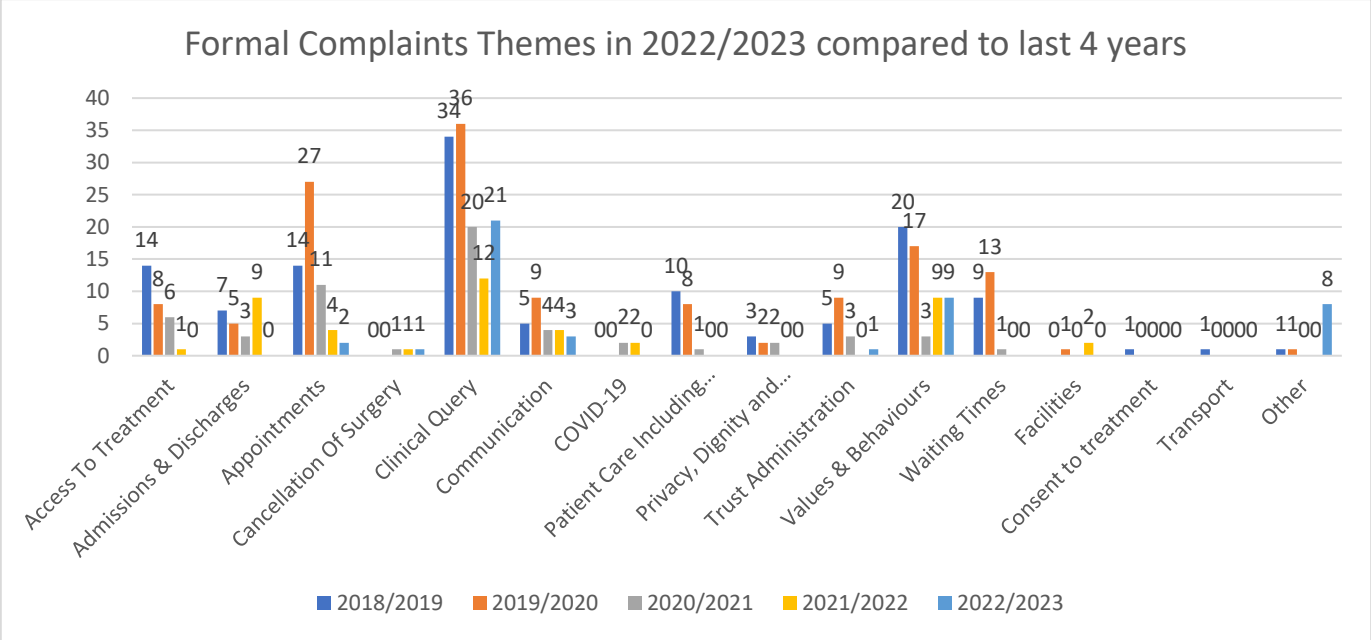


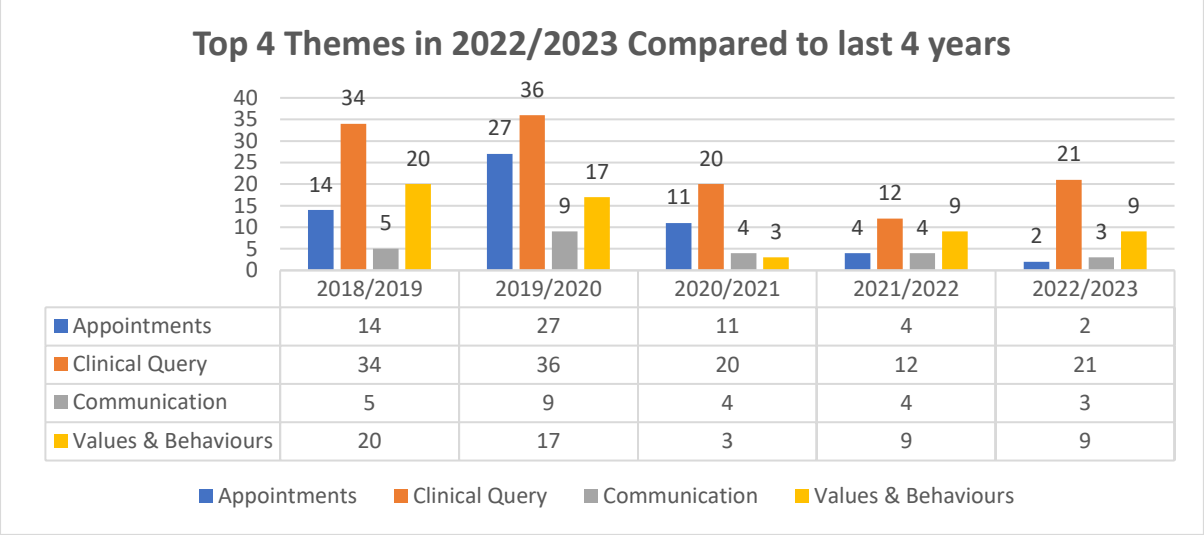
Figure 15. Formal Complaint's Themes Compared to the Last 4 Years

6.6.1. Top 4 Themes of Formal Complaints

The top four themes of formal complaints received in 2022/2023 were:

- Clinical query; including clinical treatment, delay to be seen by doctor, delays with treatment and dispute over diagnosis.
- Appointments: including cancellation, delay, error, failure to provide follow up, letter not issued.
- Communication: including failure to communicate between departments and information given to patients.
- Values and behaviour; including attitude of medical, nursing or admin staff.

The Trust saw an increase in the clinical query Category in 2022/2023



	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Appointments	14	27	11	4	2
Clinical Query	34	36	20	12	21
Communication	5	9	4	4	3
Values & Behaviours	20	17	3	9	9

Figure 16. Top Four Themes in 2022/2023 Compared to the last 4 years

The top four themes for 2022/2023 have been the same top four for the past 4 years. We have seen a decrease in appointments, decrease in communication. Increase in clinical query and Values & behaviours has remained the same.

The Trust have received more complaints about Clinical Query 2022/2023 than the previous year at 21. Access to treatment theme has been removed as we have received 0 formal complaints in 2022/2023 about this and 1 the previous year. This is due to the actions that have been set in place following the complaints.

6.6.2. Theme: Appointments SPc Chart

As you can see the Trust has seen a steady decrease from October 2022 and has remained at 0 complaints for 5 months.

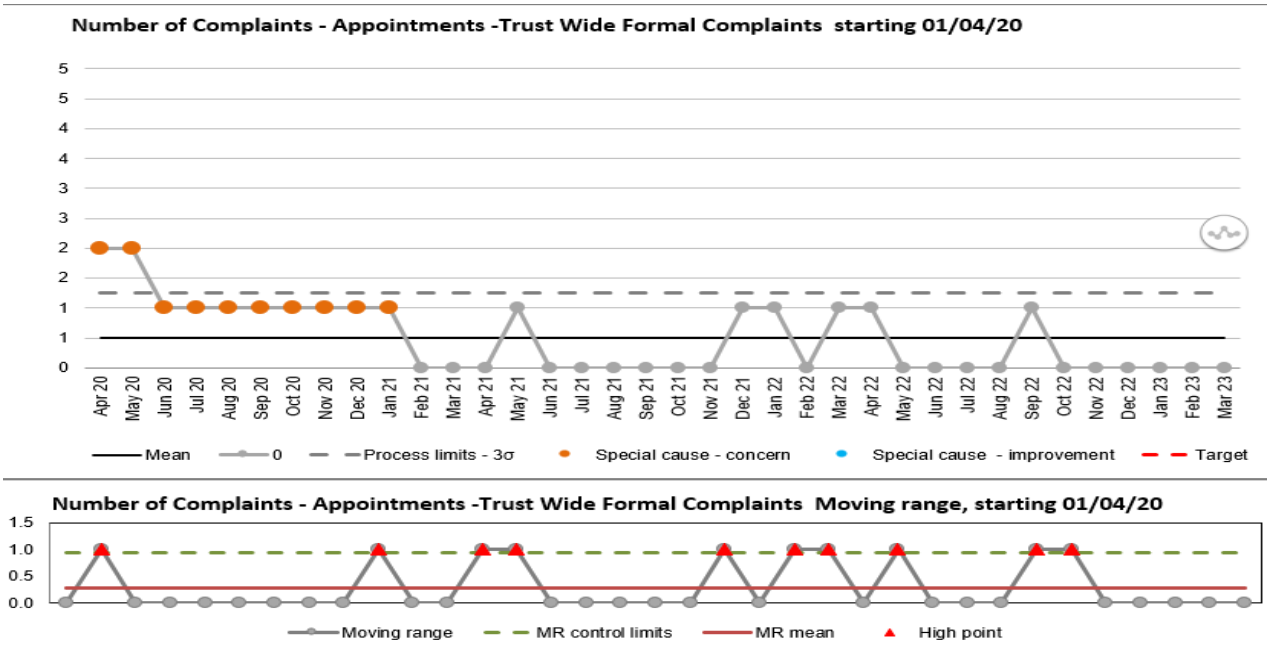


Figure 17. SPc Chart

6.6.3 Theme: Clinical Query SPc Chart

The Trust has seen a significant decrease in complaints by clinical query since March 2021.

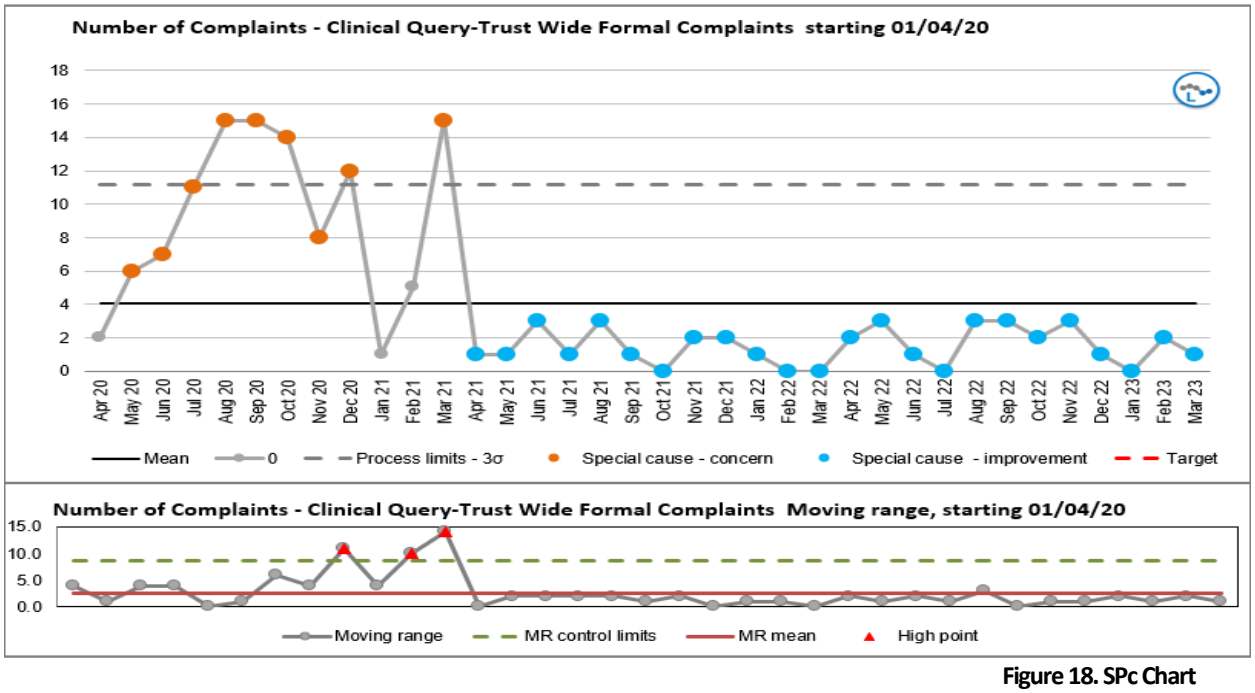


Figure 18. SPc Chart

6.6.4 Theme: Communication SPc Chart

Communication has remained under 2 per month since January 2021.

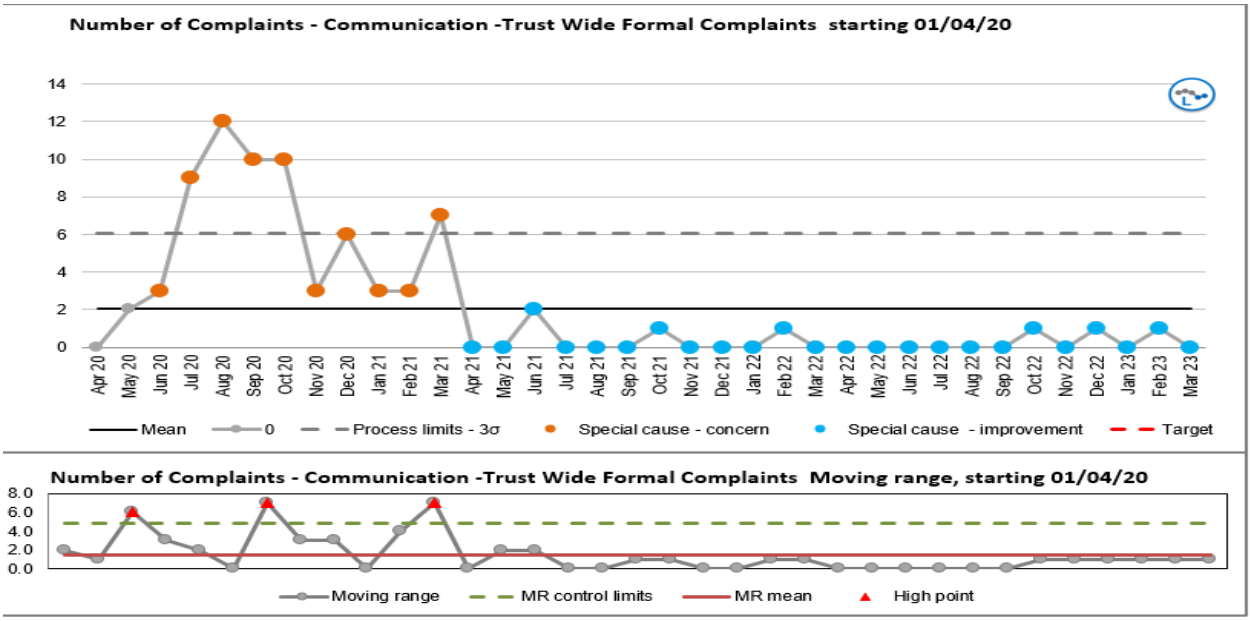


Figure 19. SPc Chart

6.6.3. Theme: Values and Behaviours SPc Chart

Values & Behaviours has remained under 2 per month from December 2022 and we will review and ensure this stays the same through 2023/2024

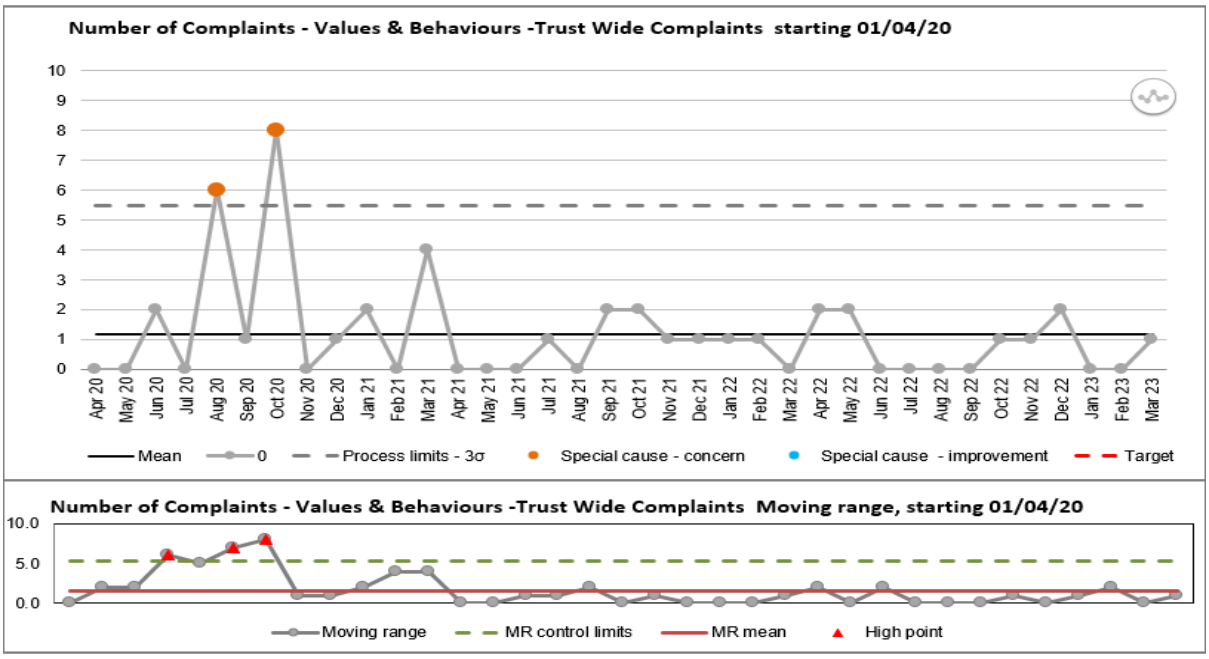


Figure 20. SPc Chart

6.7. Formal Complaints by Areas

The Trust consist of 3 Divisions. Division 1 oversees the Ward areas, Main Outpatient department, Spinal Services, Large and Small Joints Services, Oncology Services, Patient access, Discharge lounge, ROCS, CYP OPD and phlebotomy.

Division 2 oversees Therapy Services, Theatres, Preoperative Assessment, Admission and Day-Case Unit, Imaging and Pharmacy, HDU and rapid response.

Division 4 oversees Estates and Facilities

6.7.1. Formal Complaints by Directorate

The largest number of complaints received relates to concerns about Spinal and Paediatrics Services at 32% Large and Small Joints at 23% and Nursing (Inpatient & discharge) also at 23%.

Spinal & Paediatrics complaints related to concerns such as Clinical Treatment, Delays with Treatment and Attitude of Medical Staff.

Large & Small Joints complaints related to concerns such as, Attitude of Medical Staff, Delays with Treatment and Appointment not satisfactory

Nursing complaints related to concerns such as, Care needs not adequately met, nursing care and Attitude of Nursing staff.

Directorate	2020/2021	2021/2022	2022/2023
Large and small Joints	22	12	10
Spinal and paediatrics	13	9	14
Patient access	2	2	1
Oncology	6	7	3
Nursing (Inpatient and discharge)	6	9	10
Corporate	3	1	1
Therapy Services	5	3	1
Estates	0	2	2
Theatres and anaesthetics	0	1	2

Figure 21: Directorate Formal Complaints compared to the last 2 years

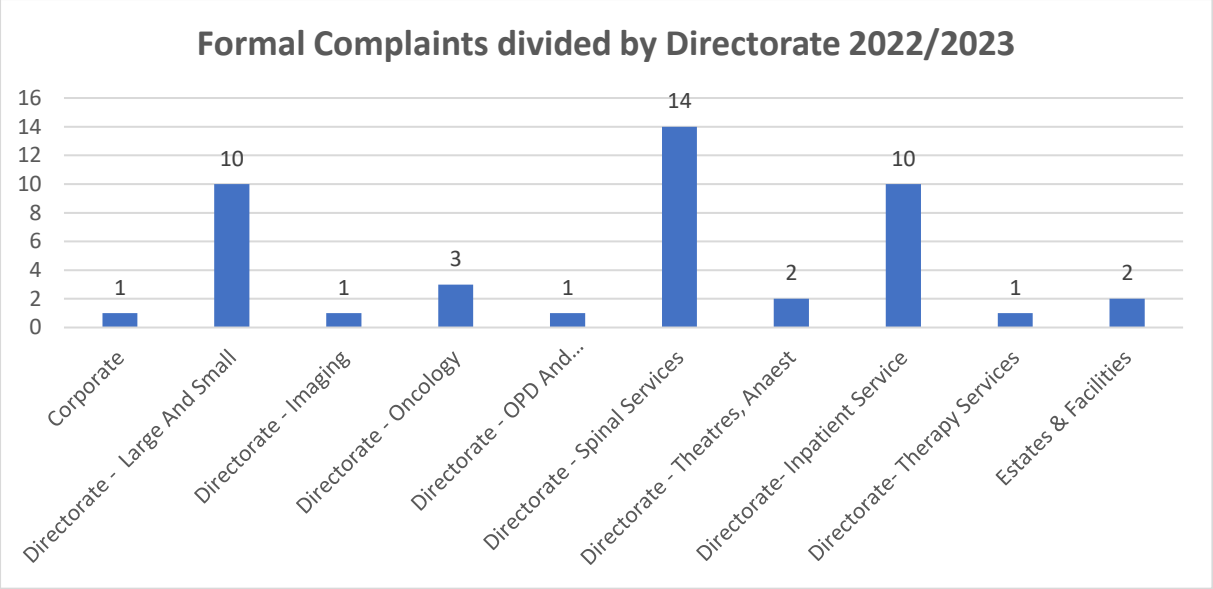


Figure 22: Percentage of Formal Complaints Divided by Directorate in 2022/2023

6.7.2. Formal Complaints by Speciality

Spinal & Paediatrics received the majority of formal complaints in 2022/2023. At 14 out of 45 complaints. The majority have been under Spinal Degen which is 12 out of 14 complaints received. 10 have been consultant lead investigations and 3 have breached and 2 extensions.

Top 3 Directorate/Speciality	Count
Directorate - Large and Small	**10**
Arthroplasty	4
Arthroscopy	4
Foot & Ankle	1
Hands	1
Directorate - Spinal Services	**14**
Spinal Deformity	1
Spinal Deformity- Paediatrics	1
Spinal Degen	12
Directorate- Inpatient Service	**10**
Arthroplasty	4
Foot & Ankle	1
Oncology	1
Spinal Degen	3
Spinal Degen - Paediatrics	1
Grand Total	**34**

Figure 23: Formal Complaints by Speciality in 2022/2023

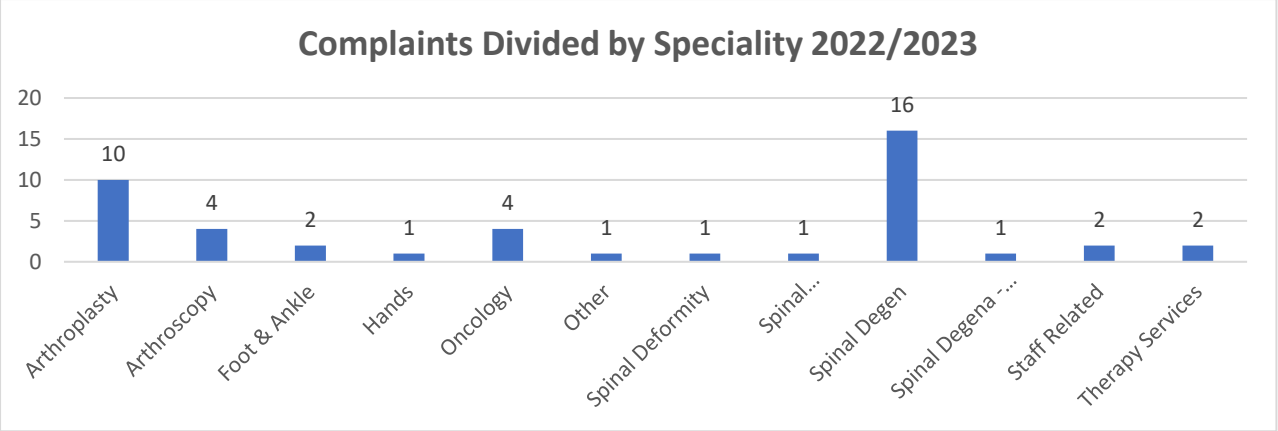


Figure 24. Formal Complaints Divided by Speciality in 2022/2023

6.7.3. Formal Complaints by Ward

10 formal complaints were received into the department relating to Inpatient Services (wards) The majority of formal complaints received were for Ward 1. As you can see below 50% of formal complaints received for Inpatient services were for Ward 1. Specifically Nursing at 3/5 received.

Complaints divided by Department (Ward) and Category Type	
Ward 1	**5**
Clinical Query	1
Nursing	3
Values & Behaviours	1
Ward 12	**1**
Values & Behaviours	1
Ward 2	**3**
Clinical Query	2
Prescribing	1
Ward 3	**1**
Nursing	1
Grand Total	**10**

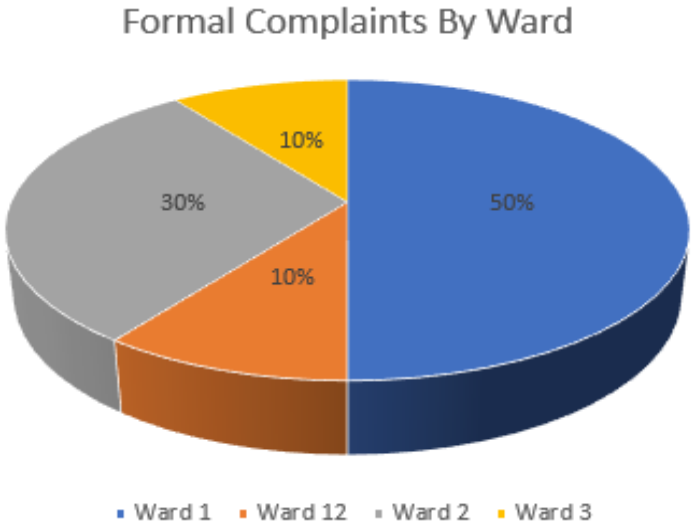


Figure 25. Formal Complaints Divided by Ward in 2022/2023

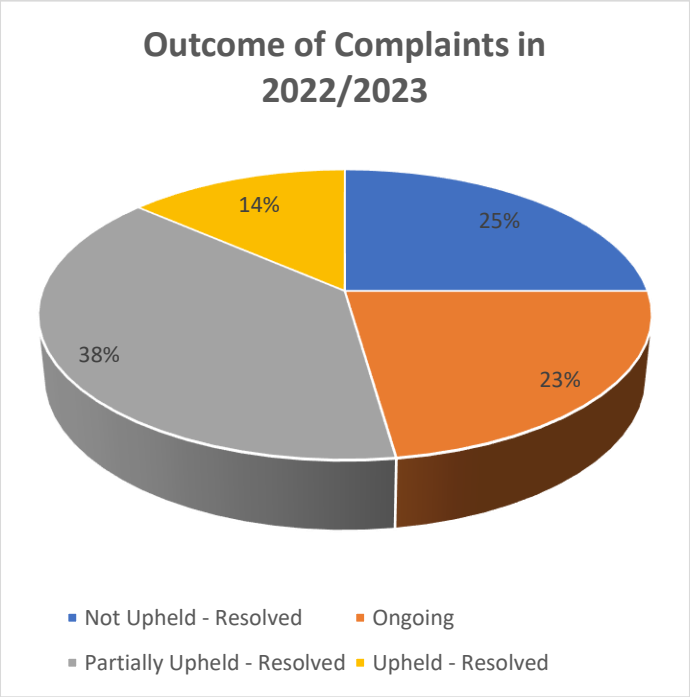
6.8. Complaints Referred to the Parliamentary Health Service Ombudsman (PHSO)

In 2022/2023 2 formal complaints were referred to the PHSO. The PHSO contacted us on 2 occasions to request more information on the formal complaint, and for copies of complainant's records. Both complaints were closed by the PHSO, and no further action was required by the Trust.

6.9. Outcome of Complaints

The majority of formal complaints received (45) in 2022/2023 were partially upheld 38% which was 25 formal complaints. 11 Formal complaints were decided Not Upheld and 8 were upheld.

Partially upheld is if a complaint is made regarding more than one issue, and one or more of these issues (but not all) are upheld.



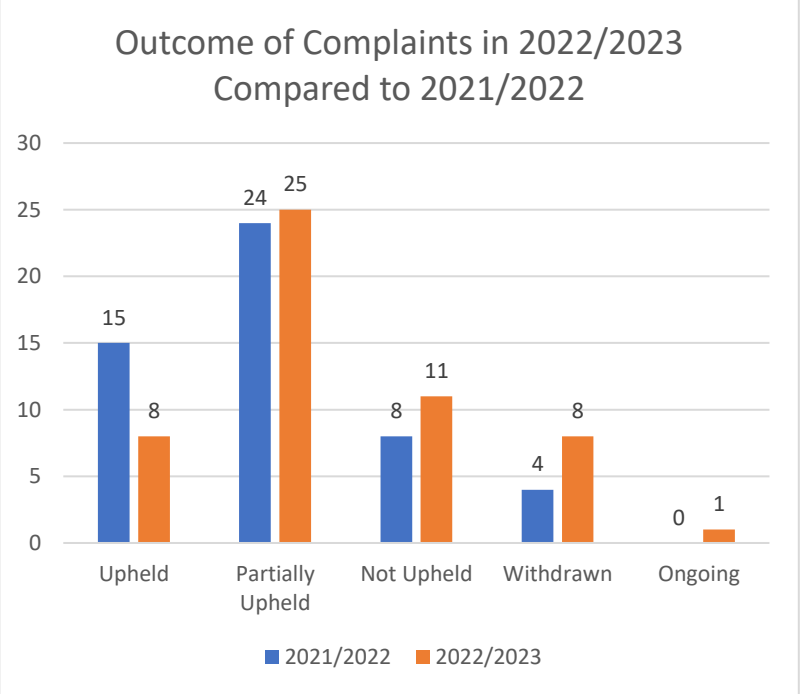


Figure 26. Outcome of Complaints in 2022/2023

Complaints are coded in line with the guidance from NHS Digital and there may be more than one aspect in each complaint

6.10. Performance Against Key Performance Indicators

Key Performance Indicators (KPI's) are measured on PALS Cases, Formal Complaints, Acknowledgement of PALS/Complaints

Formal Complaints - 25 working days. **Target 90%**

Months	Complaints %
Apr-22	100%
May-22	100%
Jun-22	100%
Jul-22	100%
Aug-22	100%
Sep-22	100%
Oct-22	75%
Nov-22	100%
Dec-22	100%
Jan-23	100%
Feb-23	50%
Mar-23	100%
	Average: 90%

Figure 27. Performance against KPI for Complaints in 2022/2023

6.11. Reopened Complaints

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.

The Trust received 5 reopened complaints in 2022/2023. 4 out of 5 reopened complaints were for Division 1 for the following departments:

- Inpatient Services (x2)
- Spinal Services
- Large Joints

Some of the reasons we received for the reopened complaints were as follows:

- Not satisfied with complaint response
- Request for further investigation
- Further questions raised following complaint response

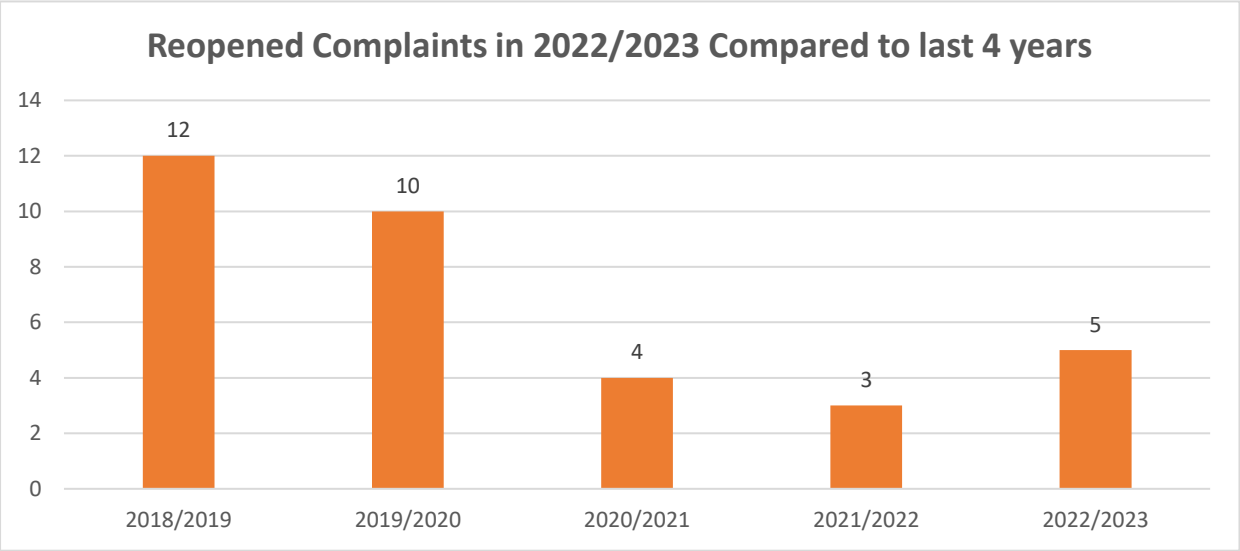


Figure 28. Reopened Formal Complaints in 2022/2023

6.12. Actions Taken to Improve Patient Experience

Individual action plans are created for any actions that are specific to an individual complaint or PALS Case. Where actions form part of a larger work plan; complainants or enquirers are informed of this in their response.

Actions are now created for PALS cases, this may be in the instance where the enquirer/complainant is happy with the outcome received, but the lead will need to follow up again in a few days or weeks' time. Actions are then created to remind the lead of this agreement.

In 2022/2023 100 individual action plans were created for PALS and Formal Complaints. 51 were actions created for formal complaints and 49 were for PALS Cases. In comparison to last year (2021/2022) This is 27 more actions as a whole

The Trust learns from complaints and action plans are required to be completed by the complaint lead.

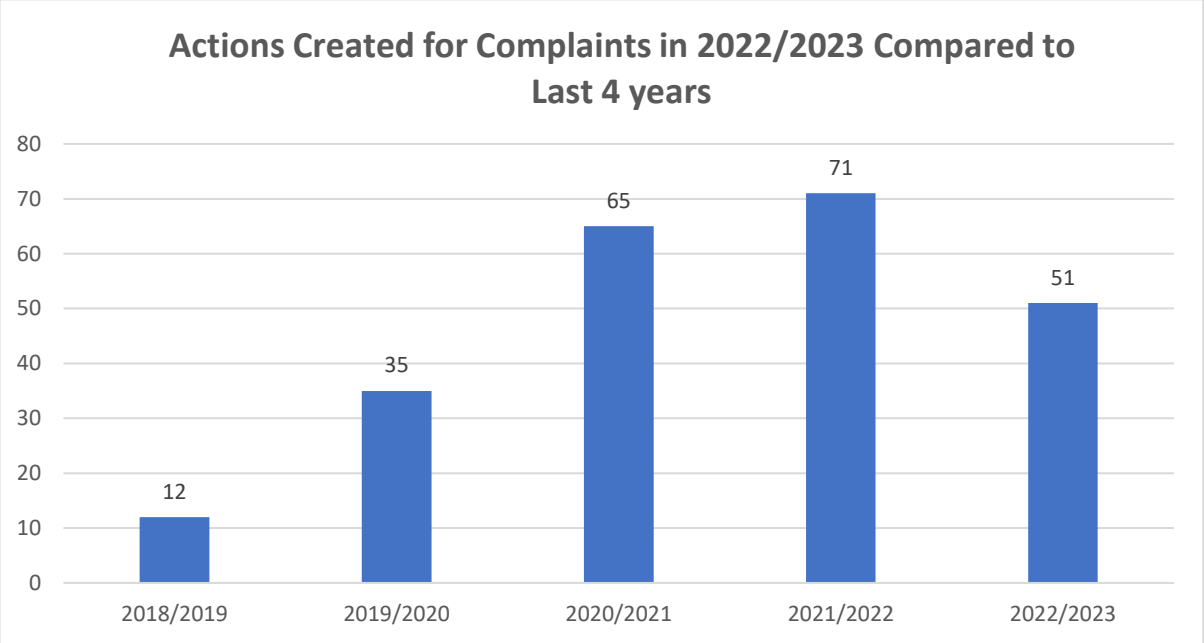


Figure 29. Actions Created in 2022/2023 Compared to Last 4 years

In the year 2022/2023, Division 1, in collaboration with the analysed data by the Head of Patient Experience, made substantial improvements in the spirit of passion and determination to enhance the Patient Experience.

Following a thorough review of the top 4 main themes of the contacts received in the Patient Experience Department, we took a focused approach to address concerns related to appointments.

Through a themed review that involved analysing incidents, Patient Advice and Liaison Service (PALS) contacts, and formal complaints, we identified key areas for improvement. This comprehensive analysis has further drove our commitment to improving patient experience.

We value patient feedback, which we actively collected through surveys, resulting in a decrease in the number of PALS contacts and formal complaints. Over the last 4 years, we have implemented responsive improvement action plans, leveraging the insights gained from these surveys. The Trust has diligently rolled out surveys in various formats, and we are proud to have received a very good response rate. This collective effort has allowed us to make significant strides in our ongoing mission to provide exceptional patient care and satisfaction.

Additionally, the Trust is committed to further improving the Patient Experience in the coming years. Building upon the progress made, we will continue to prioritize enhancing the quality of care and satisfaction for all patients. By leveraging the valuable insights gained from patient feedback, we will develop and implement targeted strategies to address any remaining areas of concern. The Trust firmly believes in the importance of continuous improvement and will dedicate resources and efforts to ensure that patients receive the highest level of care and support. Our unwavering commitment to improving the Patient Experience will drive us to set new benchmarks and achieve even greater outcomes in the future.

7.0. Patient Advice and Liaison Service (PALS)

The Patient Advice and Liaison Service (PALS) offers confidential advice, support, guidance, and provide a point of contact for patients, families, and carers. The Trust's main focus is improving the service which is provided to the patient.

The PALS department has handled 663 individual contacts in 2022/2023 which is as increase of 49 contacts compared to 2021/2022 (614). We believe this is due to the activity increase throughout the Trust, which is an additional 22,767 patients compared to last year.

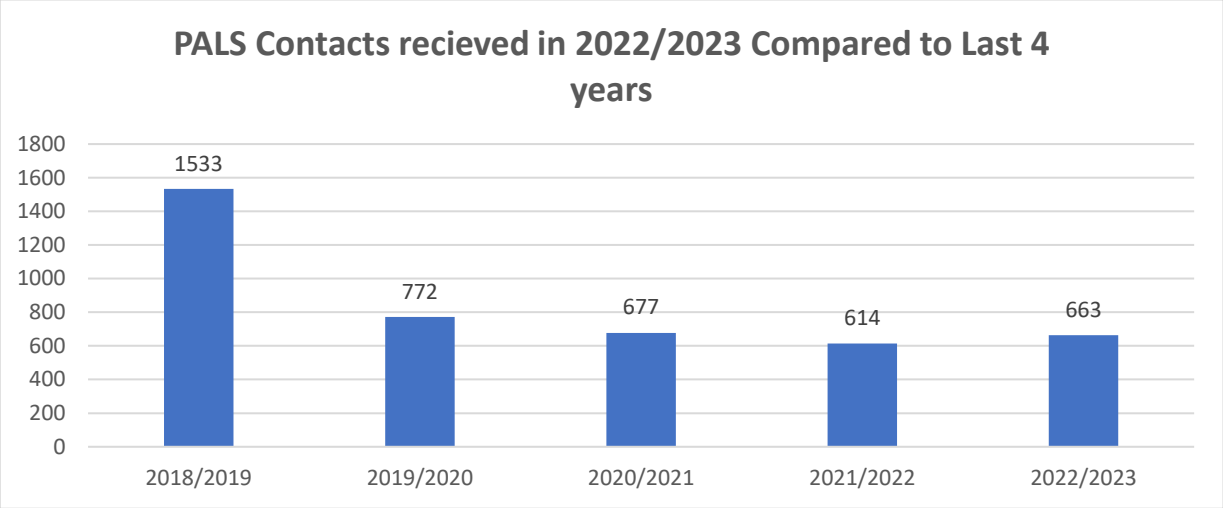


Figure 30. PALS received compared to last 4 years in 2022/2023

7.1. Contact Type

In 2022/2023 the Trust received 175 PALS contacts that were classed as an enquiry, 488 Concerns and 0 informal complaints. This is an additional of 49 contacts compared to last year

7.1.1. Themes of PALS Contacts

Below are the top themes of PALS Contacts received during 2022/2023 compared to last 4 years. In 2022/2023 the PALS and Complaints department have enhanced and improved category types on the Ulysses system for easier identifying issues arising.

Themes	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Access To Treatment or Drugs	9	28	30	3	0
Admissions & Discharge	27	27	48	84	38
Appointments	145	304	312	197	235
Clinical Query	82	124	91	123	157
Communication	18	44	64	55	90
Transport	2	2	4	1	0

Trust Administration	55	46	45	8	0
Values & Behaviours	22	20	21	47	38
Cancellation of Surgery	N/A	N/A	N/A	14	7
Referral	N/A	N/A	N/A	37	61

Figure 31. Themes of PALS in 2022/2023 Compared to Last 4 Years

The top 4 themes in PALS during 2022/2023 were as follows:

- Clinical Query: including clinical treatment, delay to be seen, delays with treatment and dispute over diagnosis
- Appointments: cancellation, appointment request, appointment rescheduled and availability
- Communication: info to patients, communication failure and conflicting information
- Referral: referral not actioned, disagreement with referral and referral letter not sent

7.2. PALS Contacts by Department

The Top 4 Department that received the most amount of PALS cases in 2022 /2023 were as follows:

- Appointments Department
- Large Joints
- Spinal
- Oncology

Below is a comparison of the top 4 departments in the past 4 years. There has been a slight increase in 2022/2023 due to activity increase within the Trust. However, the top 4 themes remain the same throughout all years.

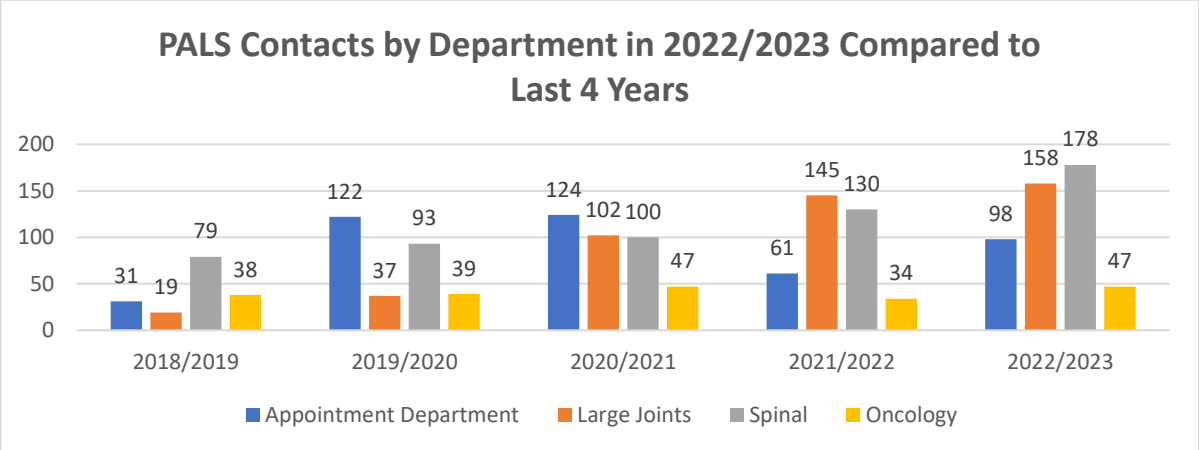


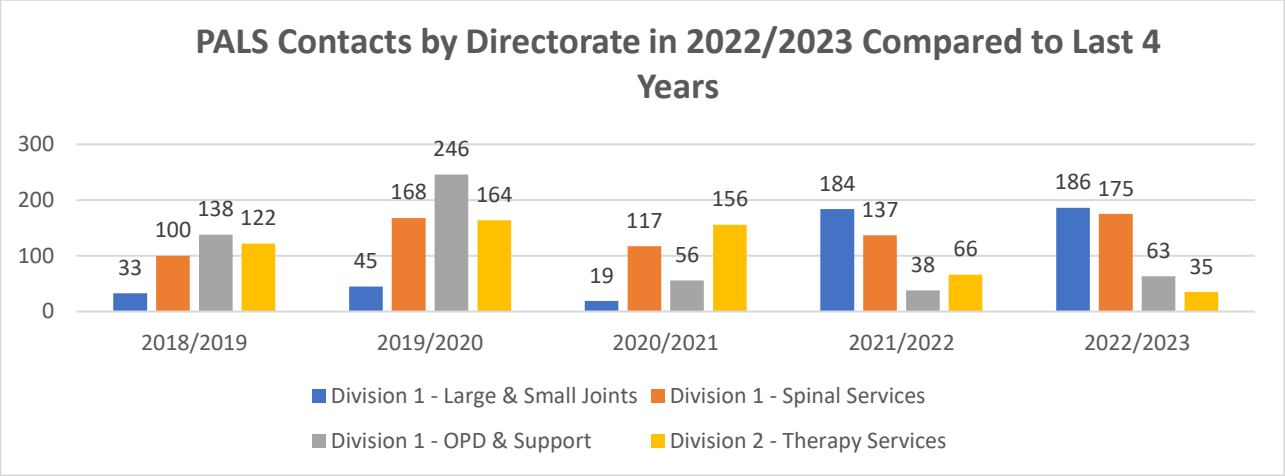
Figure 32. PALS by Department compared to last 4 years

7.2.1. PALS Contacts by Directorate

The top 4 directorates that received the highest numbers of PALS contacts are as follows:

- Division 1 - OPD and Support
- Division 1 – Spinal Services
- Division 1 – Large and Small Joints
- Division 2 – Therapy Services

There has been a decrease in contacts for therapy services and they have continued to decrease in PALS Contacts since 2019/2020. However, the others remain to fluctuate throughout the years, however, they remain to be the top 4 in all years.



7.2.2. PALS Contacts by Speciality

The Top 4 specialities have been recorded over the last 2 years (2021/2022, 2022/2023) This is due to the change in speciality options on Ulysses. From 2021, the speciality option has become more detailed and therefore cannot be compared to previous years.

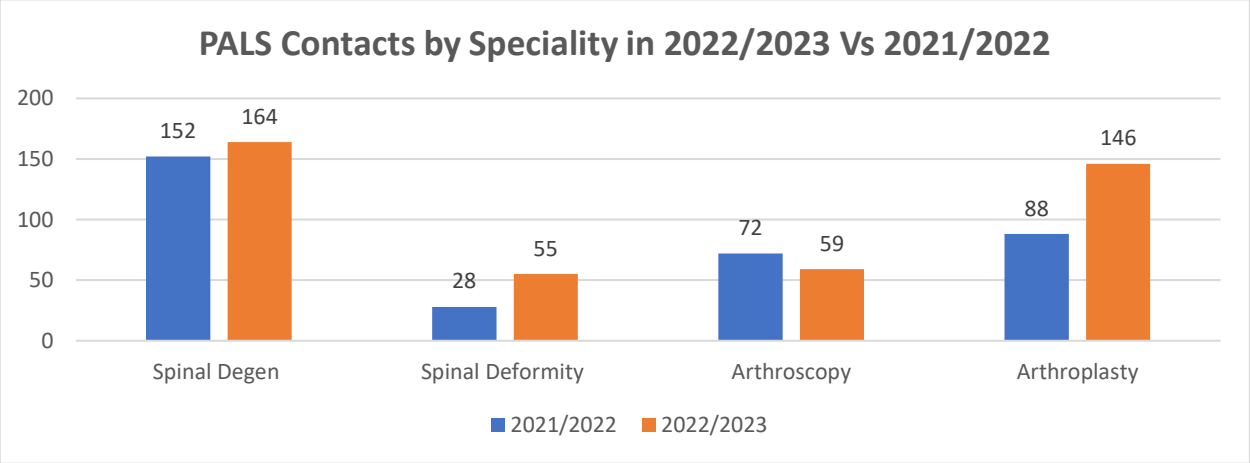


Figure 34. PALS by Speciality compared to last 4 years

7.3. Performance Against Key Performance Indicators

Key Performance Indicators (KPI's) are measured on PALS Cases, Formal Complaints, Acknowledgement of PALS/Complaints

PALS Enquiries - 3 working days. **Target: 80%**

PALS Concerns – 7 working days. **Target 80%**

The Trust have met KPI for PALS contacts in 11 months, which mean that the Trust met KPI for the year at 92%

Months	PALS Concerns %	PALS Enquiry %	Acknowledgement of PALS & Complaints
Apr-22	95%	89%	100%
May-22	94%	85%	100%
Jun-22	94%	85%	100%
Jul-22	87%	100%	100%
Aug-22	86%	100%	100%
Sep-22	88%	95%	100%
Oct-22	93%	100%	100%
Nov-22	96%	100%	100%
Dec-22	90%	88%	100%
Jan-23	72%	100%	100%
Feb-23	90%	100%	100%
Mar-23	84%	74%	100%
	Average: 89%	Average: 93%	Average: 100%

Figure 35. Performance Against KPIs for PALS in 2022/2023

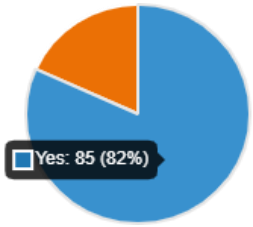
8.0. PALS and Complaints Satisfaction Survey

PALS and Complaints Satisfaction Surveys are a great way to gain anonymous feedback from patients or their carers/families who have raised either a PALS Contact or formal complaint through the department. A satisfaction survey is sent via post or via email monthly with a QR code to give people the access to submit it online.

PALS and Complaints Satisfaction Survey Results

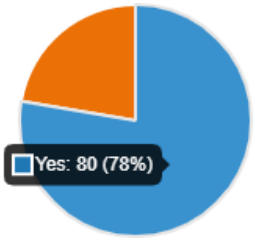
Do you feel that our team listened to and/or handled your concerns sympathetic?

Yes	No
80	19



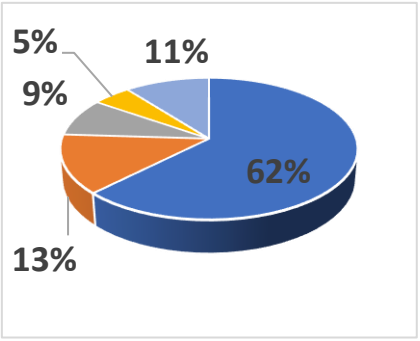
Do you feel satisfied with our response?

Yes	No
80	23



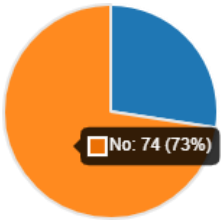
2.1.3 How satisfied were you with the time it took us to respond to you?

Very Satisfied	Somewhat satisfied	Neither	Somewhat dissatisfied	Very dissatisfied
65	14	9	5	11



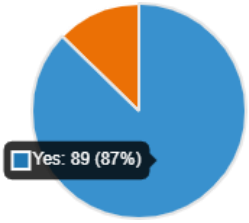
Were you concerned that by contacting our team, your care or treatment may have been affected?

Yes	No
28	74



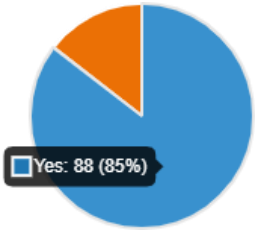
Would you use the PALS service again?

Yes	No
28	74



Would you recommend the PALS service to your friends or family?

Yes	No
88	15



Is there anything else you want to tell us?

Some of the responses we received to this question are as follows:

- Excellent Service
- It was a pleasure talking to PALS, they listened and sympathised and responded quickly
- They were very helpful

Demographics

<u>Are you</u>

Male	Female
31	62

Sexuality

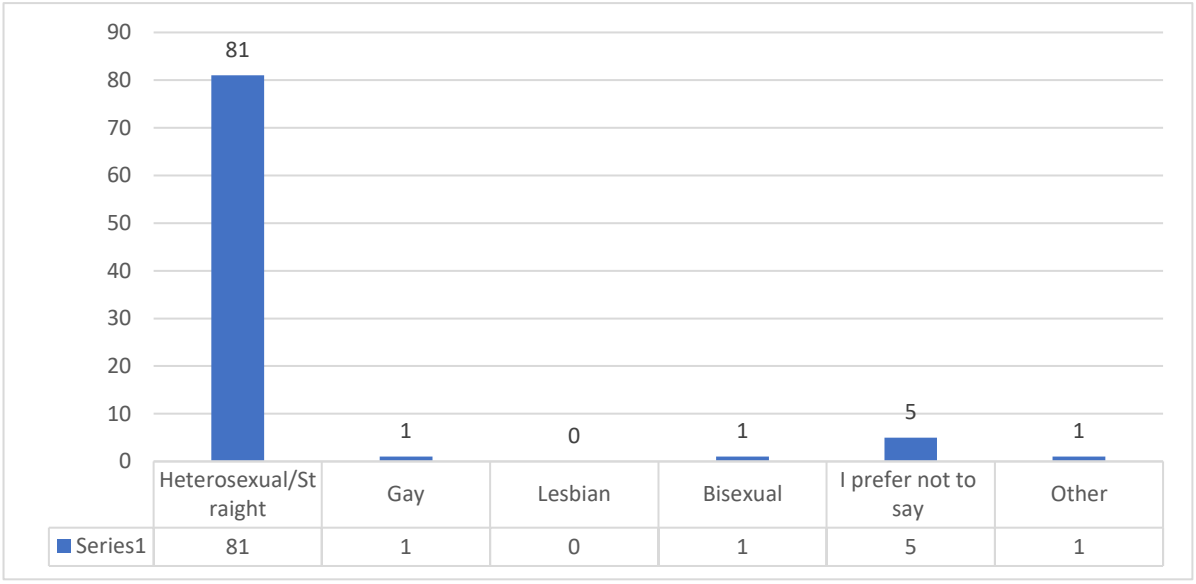


Figure 36. PALS Satisfaction Survey by Sexuality in 2022/2023

Ethnicity

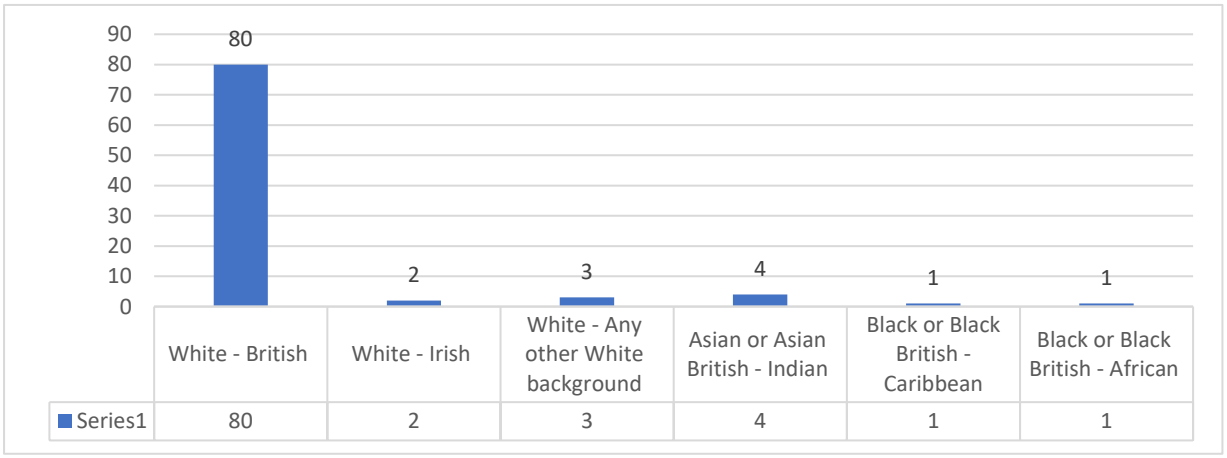


Figure 37. PALS Satisfaction Survey by Ethnicity in 2022/2023

9.0. Demographics of Formal Complaints and PALS Contacts

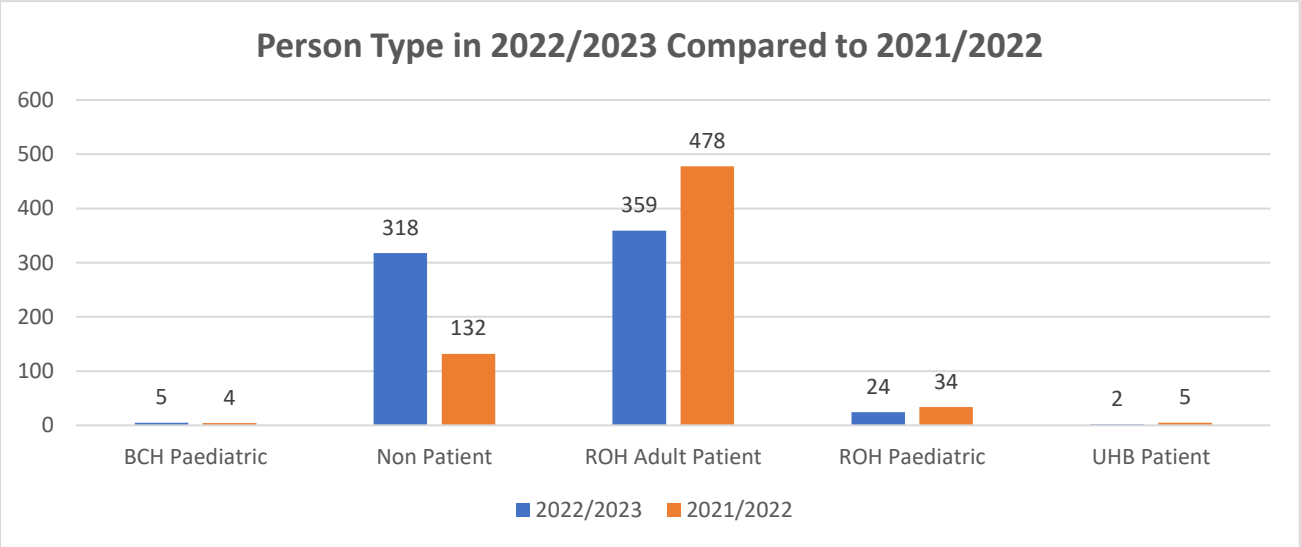
The main priority of the Trust is to provide the best care and services to the patients. To do that, the Trust first needs to understand who the community is that it serves. The information that the Trust collects regarding patients and complainants' demographics tells us a lot about their needs, allowing better care and a better patient experience to be provided.

Collecting sex, age and ethnicity data can help improve the quality of care for all patients because it helps to identify and address differences in care for specific populations and distinguishes which populations do not achieve optimal interventions.

The Trust started to collect demographics of complainants in 2020/2021, therefore there are not compared with 2018/2019 or 2019/2020.

9.1. Complainant Type

Using this data, the Trust can understand who has raised more complaints, concerns, or enquiries. In 2022/2023, 51% of all PALS contacts and complaints received were submitted by ROH adult patients, 45% were non patient, meaning the patient raising the concern or enquiry is doing it on behalf of the patient.



9.2. Age

The top three age groups with the most complaints in 2022/2023 were 36-50 (134 contacts), 51-70 (244 contacts) and 71-85 (101 contacts) The PALS Department did not have the age recorded for 44 people. This could be due to the case being raised on behalf of the patient and the complainant / enquirer has not given their details.

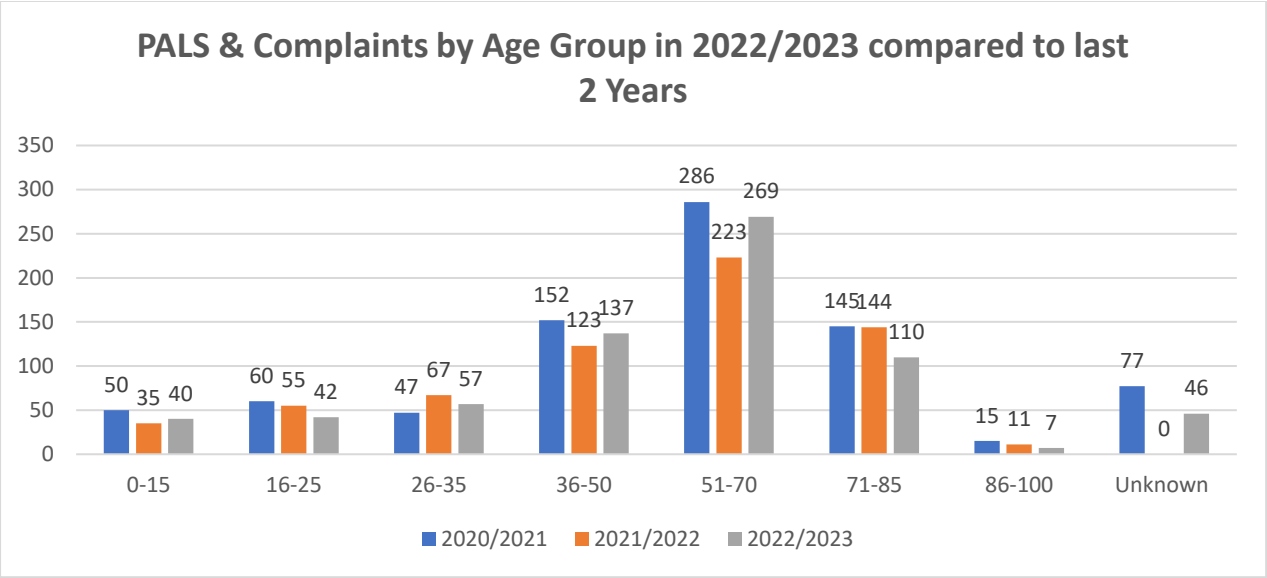
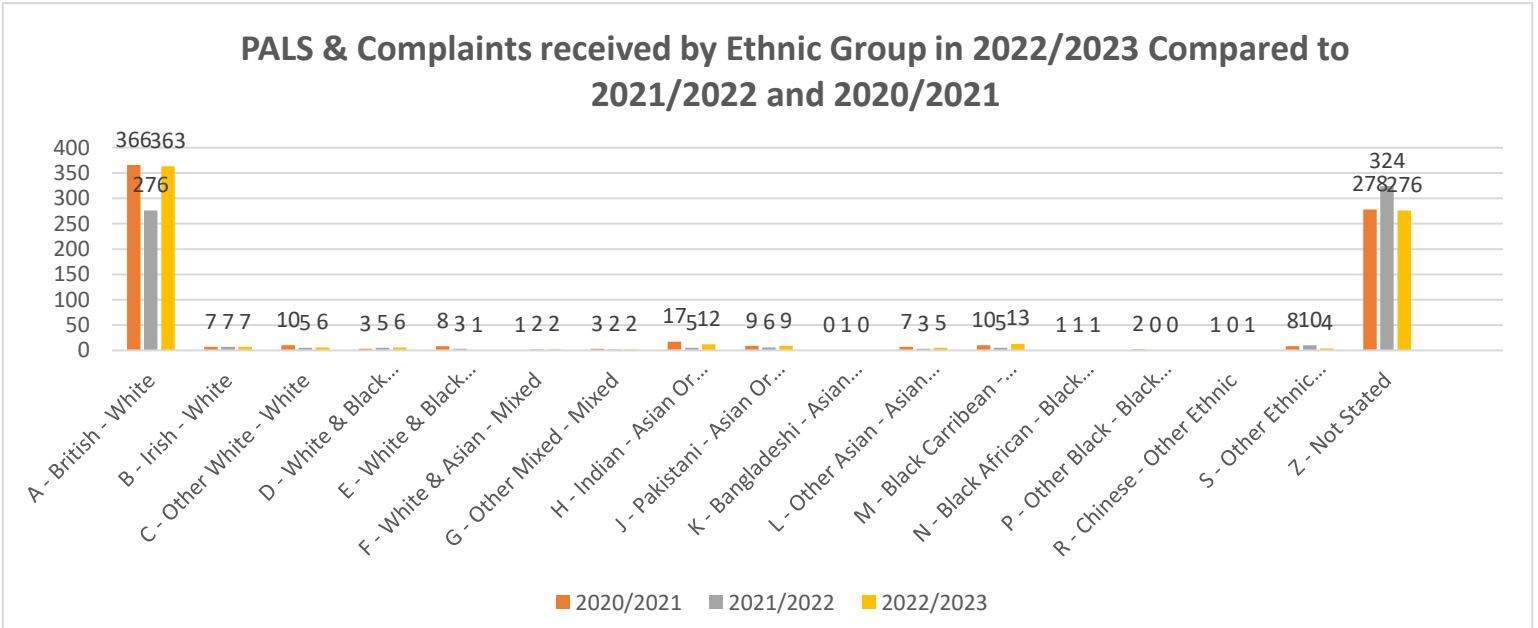


Figure 38. PALS & Complaints by Age Group in 2022/2023 Compared to last 2 years

9.3. Ethnicity

Ethnic monitoring is important to the Trust as it provides services to a diverse and multicultural community. The Trust collect this information so that it can better meet patients cultural, religious and language needs. It is important to collect ethnicity data to understand the needs of patients from different groups and provide better and more appropriate services and identifies patients at risk – some groups are more at risk of specific diseases or conditions

The top three ethnic groups with the most complaints in 2022/2023 were White British (363 contacts), Indian- Asian (12 contacts) and Irish- white (7 contacts)



9.4. Sex

As you can see below, the number of female complainants/enquirers has increased by 7, and the number of male complainants/enquirers has also increased by 37.

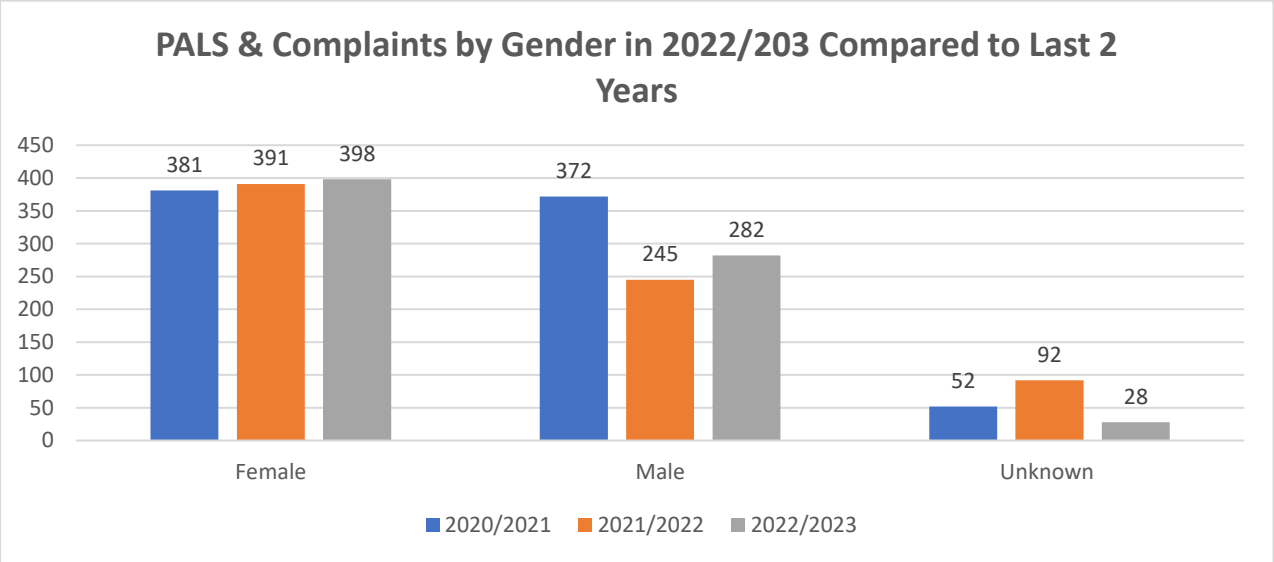


Figure 40. PALS & Complaints by Gender in 2022/2023 Compared to Last 2 years

10.0. Patient Experience Surveys

At the Royal Orthopaedic Hospital, we are dedicated to providing excellent patient experience, and to achieve this, we undertake various surveys throughout the year. The purpose of these surveys is to improve patient experience and demonstrate to our patients and visitors that we listen to their comments and feedback, which is essential to our Trust.

We are proud to announce that we have different surveys that are live throughout the year, such as the Friends and Family tests for inpatients, In-depth surveys, and Smiley Faces surveys in all outpatient departments. We also have a Theatre survey for patients that have undergone surgery. These surveys provide us with valuable feedback and insights that help us to improve the overall patient experience.

This year, we have introduced new surveys such as Patient falls, Patient food on the wards, Fifteen steps Walkabout, and ROCS survey. We have worked closely with departmental managers to ensure that anyone can do surveys for their patients, and we have a robust governance structure to monitor surveys and improvements made following patient feedback.

Improving patient experience is crucial to our Trust, and we are dedicated to listening to our patients and visitors. We believe that through our surveys and patient feedback, we can continually improve the services we provide and deliver the best possible experience for our patients

10.1. Friends and Family Test (FFT)

The NHS Friends and Family Test (FFT) was created to help service providers and Commissioners understand whether patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for the service users to provide views after receiving NHS care or treatment.

In the FFT we ask our patients to rate us on the following:

1. Was the location clean?
2. Did you feel involved enough in decisions made about you?
3. Were you treated with dignity and respect?
4. Were you treated with kindness and compassion by the staff looking after you?
5. Did you receive timely information about your care?
6. How was your experience?

The patients receive FFT form at the point of their discharge form the hospital. Following review of the results for each question, there is no issues or decrease in the patient experience in the 2022/2023.

SPC- Was the location clean?

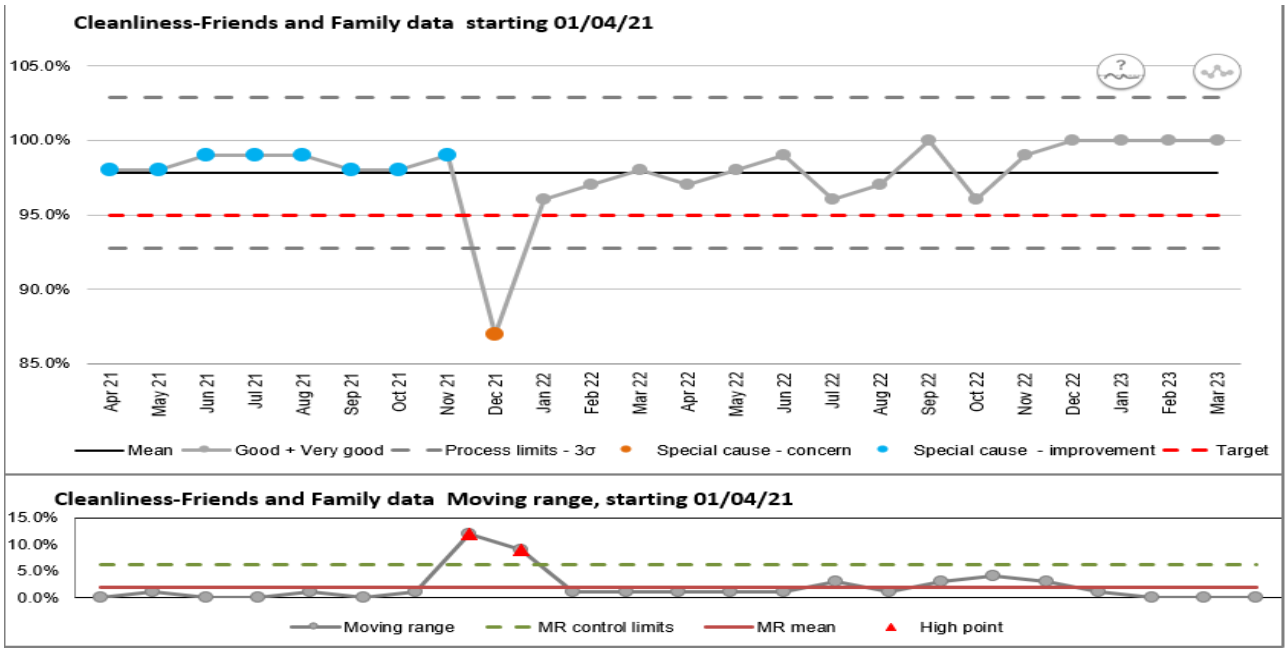


Figure 41. SPC Chart for Cleanliness

SPC - Did you feel involved enough in decisions made about you?

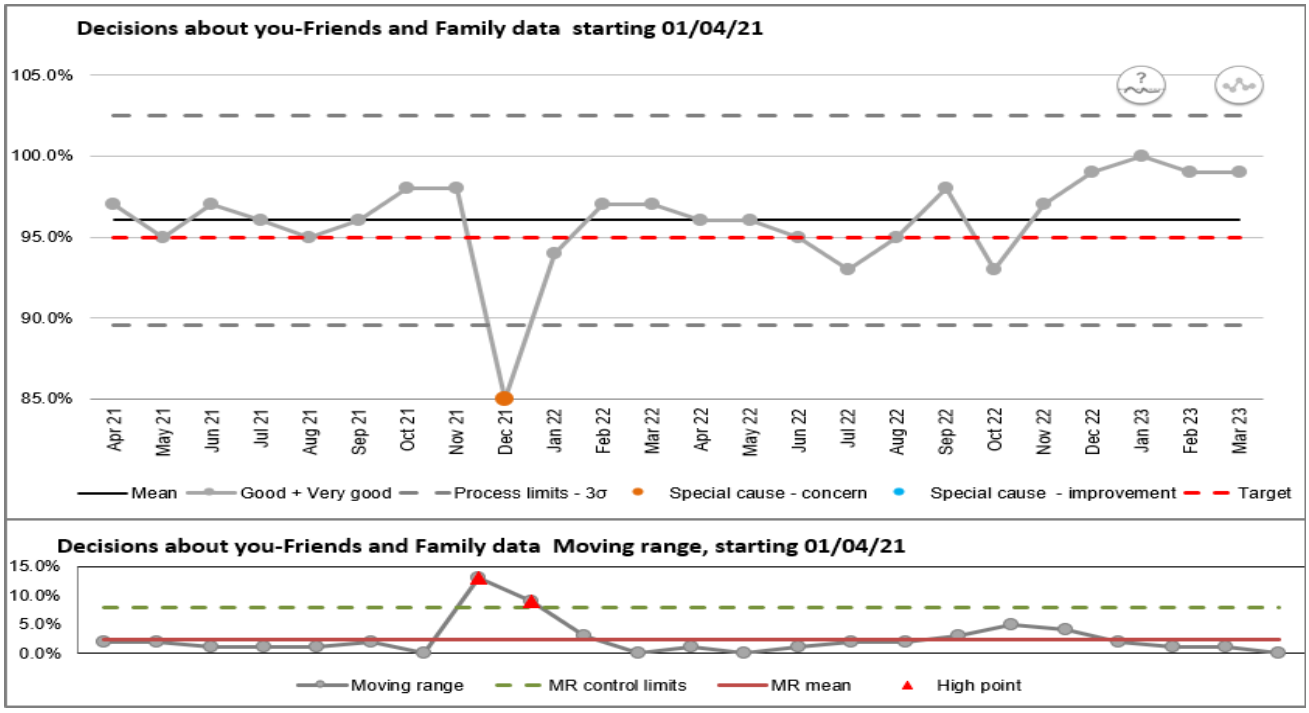


Figure 42. SPC Chart for Decisions about you

SPC - Were you treated with dignity and respect?

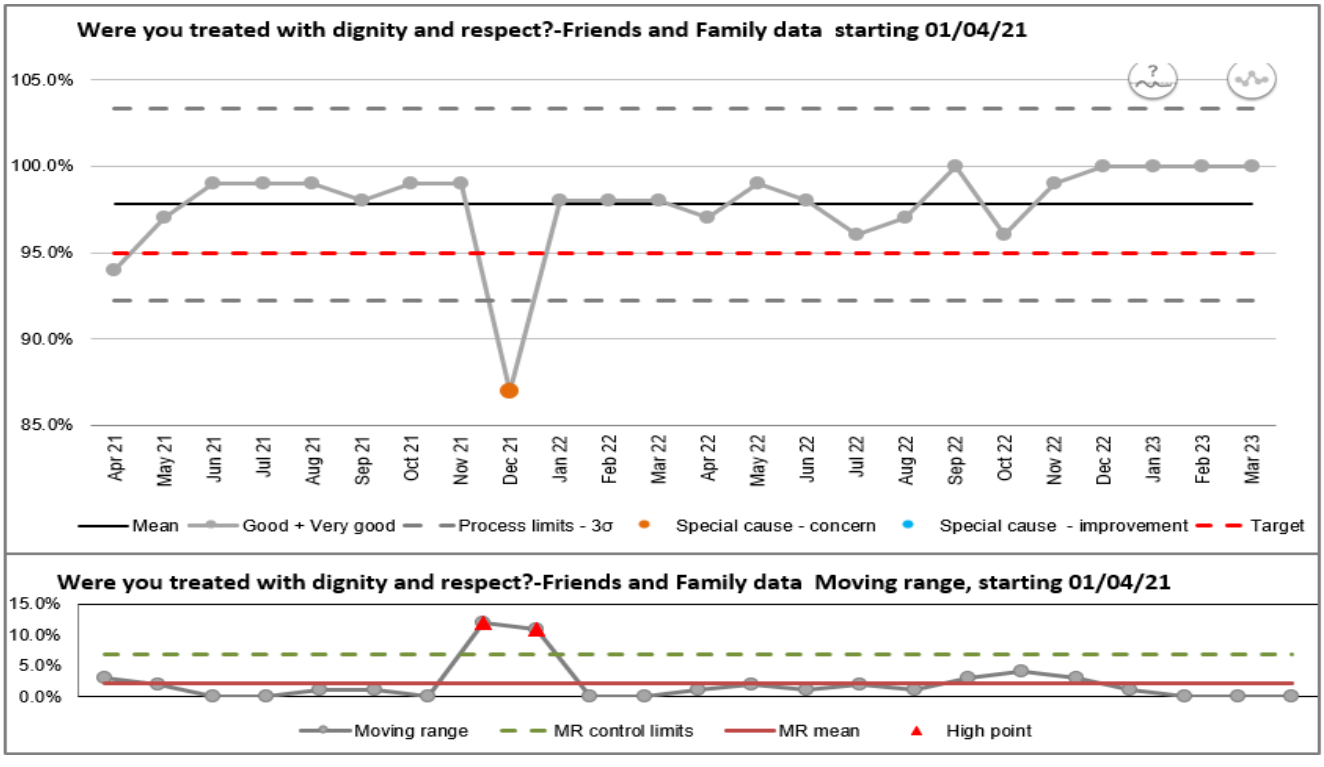


Figure 43. SPC Chart for Dignity & Respect

SPC- How was your experience?

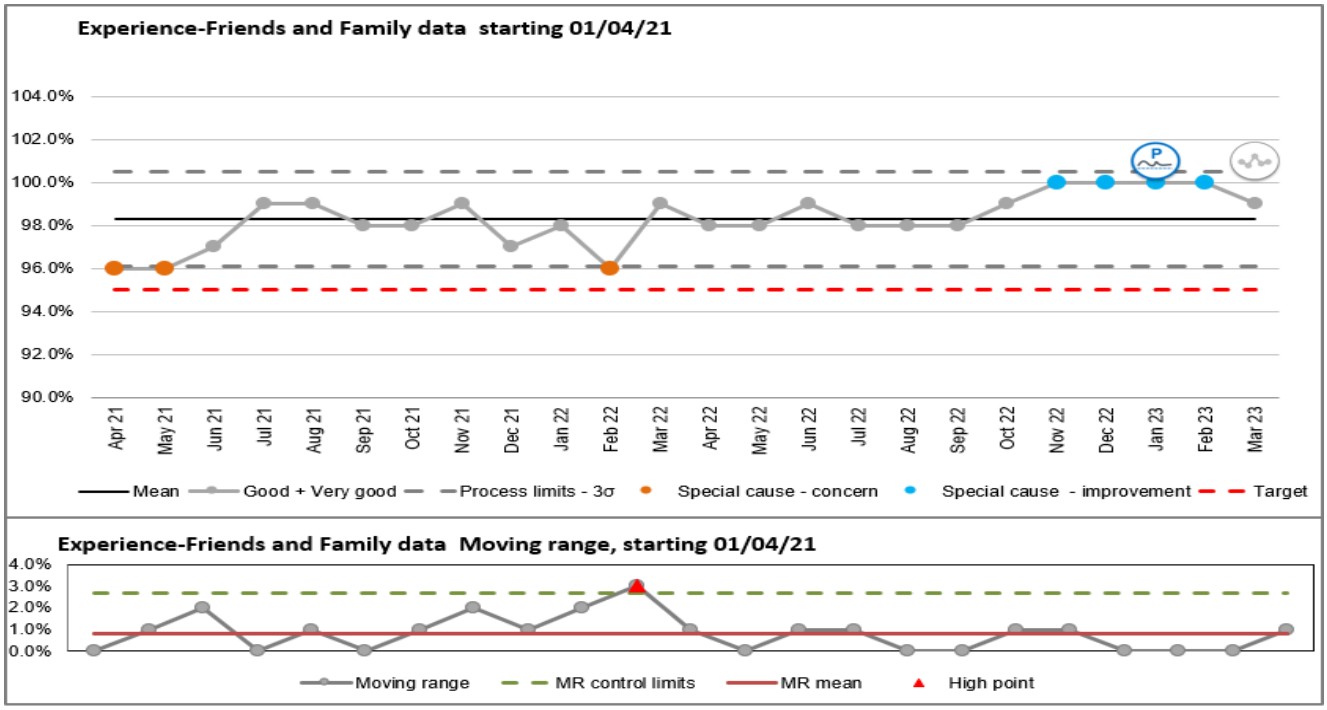


Figure 44. SPC Chart for Experience

SPC- Were you treated with kindness and compassion by the staff looking after you?

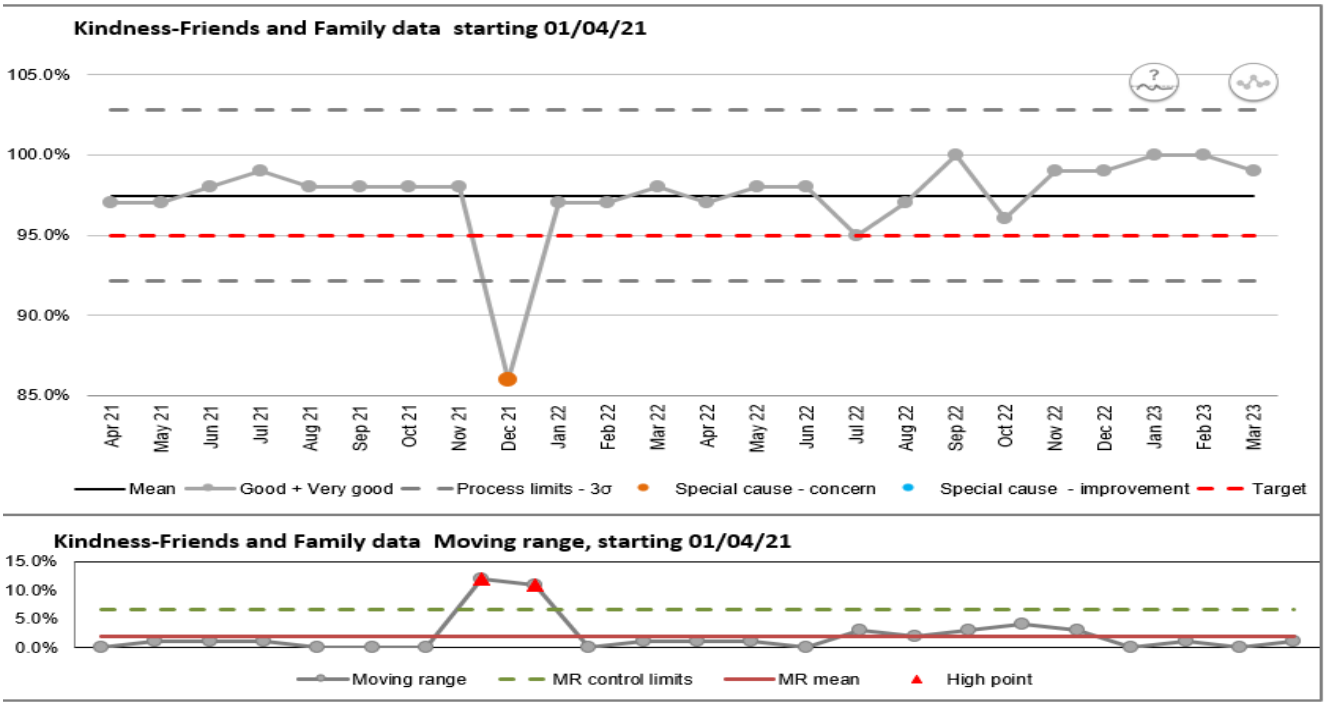


Figure 45. SPC Chart for Kindness

SPC- Did you receive timely information about your care?

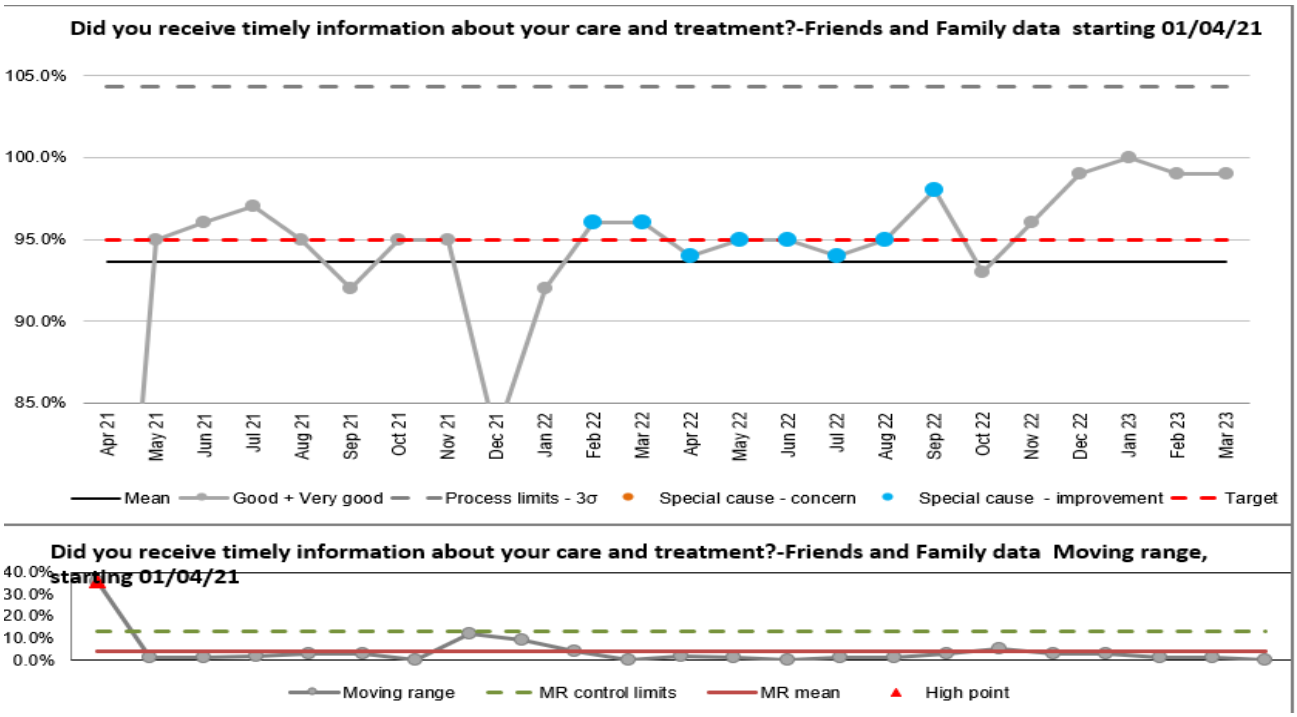
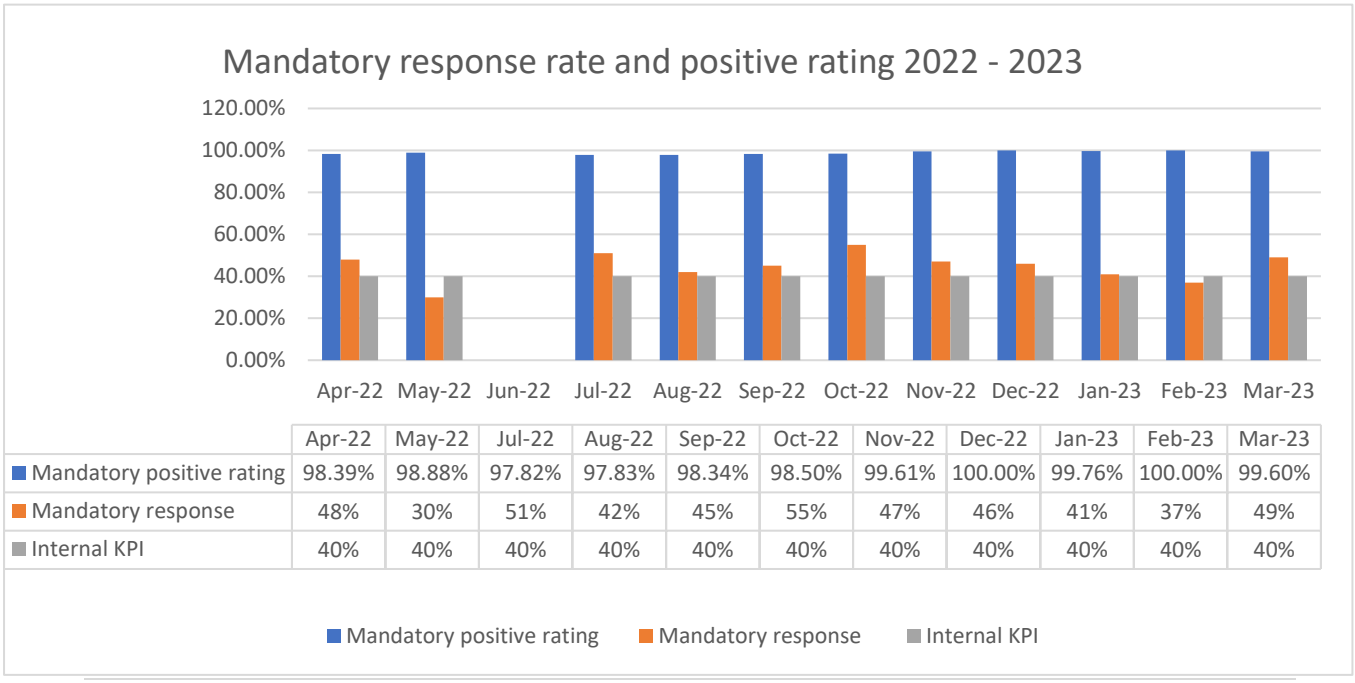


Figure 46. SPC Chart for Information

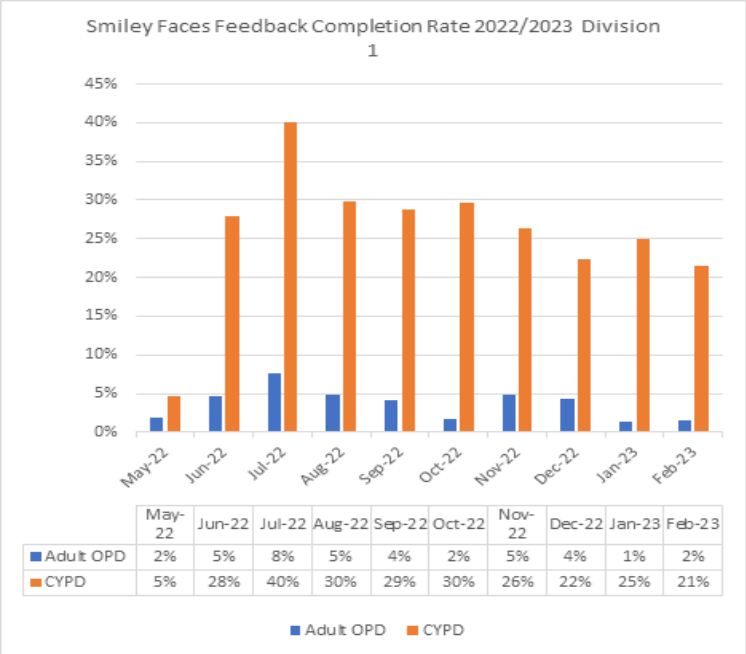
Below is the mandatory and positive rating in 2022/2023 for Friends and Family Tests. In May 2022 and February 2023 were the only months that did not meet the internal KPI of 40%



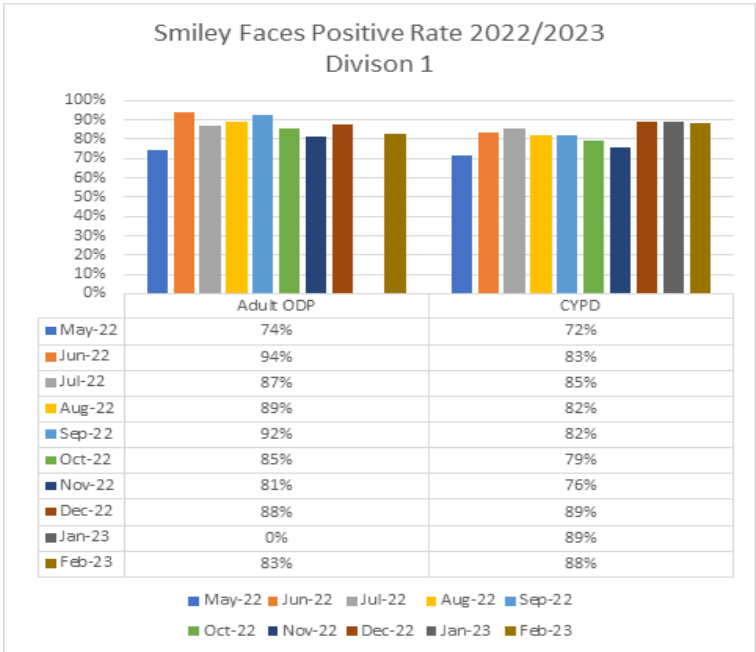
	Apr-22	May-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Mandatory positive rating	98.39%	98.88%	97.82%	97.83%	98.34%	98.50%	99.61%	100.00%	99.76%	100.00%	99.60%
Mandatory response	48%	30%	51%	42%	45%	55%	47%	46%	41%	37%	49%
Internal KPI	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%	40%

10.2. Smiley Faces Feedback

From May 2022 the Trust stopped Friends and Family Tests in all outpatient areas. They have been replaced with Smiley Faces Devices. There are currently no KPI's sent for the decides however will be agreed in 2023/2024. The smiley faces data is recorded on positive rating received and cmpletion rates. Please see below data compared from 2022 to 2023



	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
Adult OPD	2%	5%	8%	5%	4%	2%	5%	4%	1%	2%
CYPD	5%	28%	40%	30%	29%	30%	26%	22%	25%	21%



	Adult ODP	CYPD
May-22	74%	72%
Jun-22	94%	83%
Jul-22	87%	85%
Aug-22	89%	82%
Sep-22	92%	82%
Oct-22	85%	79%
Nov-22	81%	76%
Dec-22	88%	89%
Jan-23	0%	89%
Feb-23	83%	88%

10.3. In- Depth Surveys

At the heart of The Royal Orthopaedic Hospital (Trust) is its commitment to offering the highest quality care for patients and service users.

The views of patients (both children and adults), carers and members of the public are highly valued by the Trust and for developing services, recognising priorities and addressing concerns.

In April 2022 the Trust have rolled out the In-Depth Surveys for all outpatient departments which received Smiley Faces feedback devices in May 2022. In depth surveys were developed in partnership with all departmental managers and are undertaken by our volunteers. These reports include data for quarter 1 and quarter 2 of the 2022/2023 financial year.

For each department, Head of Patient Experience sent an email with the comments and reports to Managers to celebrate positive results and great work that their staff are doing and to ask them to focus on some areas that need to improve.

In all areas the positive patients experience was above 97% and the number of the patients that have had this survey answered across the Trust was 323. First 15 questions are the standard questions or all departments and on majority of the questions, the Trust got positive response. There were some questions that needed clarification and actions for improvement form the service managers.

Summary of the patient experience and full reports:

Main Outpatient Department

Response rate: 201
Positive rating: 96%
https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=4n3KUqDBWTMpGSONpBQCa17wqFaliB3s&id=slTDN7CF9UeyIge0jXdO4_TxseiCinpPk5EKPUXvV0hUNTJRREJDQzZQUllRVVRSNklMSkhCTjVaViQlQCN0PWcu - link for the survey

Therapy Services

Response rate: 96
Positive rating: 100%
https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=RcgF4NjFwjNiBrlrSQDgwdGNswKF3ZC4&id=slTDN7CF9UeyIge0jXdO4_TxseiCinpPk5EKPUXvV0hUMlFaTEpGTkVPN04xTlU3NjlVTEVQQUZXTiQlQCN0PWcu -link for the survey

Imaging

Response rate: 103
Positive rating: 98%
https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=6WMztisDb6abVBizMGS2LkkoO7Yw2iqg&id=slTDN7CF9UeyIge0jXdO4_TxseiCinpPk5EKPUXvV0hUREYwSFhZUTRHMDkxMjRGOVJaVktZOUhLQSQlQCN0PWcu -link for the survey

POAC

Response rate: 101
Positive rating: 99%
https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=6gG03vHKNO4WCGcvmOCO7TvAgJr6c81Q&id=slTDN7CF9UeyIge0jXdO4_TxseiCinpPk5EKPUXvV0hUQk5WRVcySjNFS1cxUzNWWFYxNlBCSTFKTyQlQCN0PWcu - link for the survey

11.0. Patient Experience Groups and Forums

11.1. Patient Experience and Engagement Group

The purpose of PEEG is to provide assurance to the Quality and Safety Committee of patient, public and carer involvement, and experience within the Trust.

The Patient Engagement and Experience Group is responsible for setting its own annual work plan in agreement with the Quality and Safety Committee and be accountable for delivering and evaluating its key tasks and responsibilities.

PEEG meetings are held every 6 weeks and action plans are formulated following the meeting. Patients, staff and third parties such as Healthwatch Birmingham are all invited and are encouraged to be involved.

11.2. Patient Participation Group

The PPG Group helps look at ways to improve patient experience at the hospital. The group will discuss issues that patients and carers raise and consider actions that need to be taken to resolve them.

We also use this group to help us gain a better understanding of the priorities and concerns of service users. Members of the group will include patients, carers, relatives, and members of the patient experience department. The relaxed friendly environment takes place every six weeks and are currently held on an online forum via MS Teams. If the number of attendees increases, the Patient Experience Team would like to look into converting this group to a face-to- face meeting in either the Trust or a local community hub.

11.3. Coffee Catch Up

Our virtual coffee catch-up is an opportunity for patients to share their feedback, ask questions about recovery and connect with other patients who have been through surgery. The session will involve asking questions and discussing things like how well-prepared patients felt there were before surgery, how their discharge was, what could have been done better and gives them an opportunity to discuss and compare to other patients within the group who have had the same or similar surgical procedures. Following the coffee catch-up meeting. An action plan is then formulated, inputting opinions of those who have used our services and have ideas on how to make it better. This is then discussed and shared within the Patient Experience and Engagement Group and the necessary departmental managers.

11.4. Youth Forum

The Youth Forum is a way to provide young people the opportunity to have a voice, discuss issues and be involved in decision making. Involvement of young people will help to contribute towards the improvement and development of services for young people within the Trust. The Trust would like to offer representing the voice and views of young people who can then contribute towards the hospital, i.e interview panels, youth worker within the Trust, and a chance to enhance their CV's.

11.5. Fifteen Steps Walkabout

15 Steps Walkabout are arranged monthly in different departments. The aim of the walkabout is to focus on seeing healthcare and ROH services through a patient's eyes. Visits are organised to identify if there are any areas of improvements within the various departments.

The walkabout is managed by the Volunteer Services Manager who recruits a small team of individuals from various backgrounds to conduct the walk around. The group then meet following the walkabout to discuss their findings and to share feedback amongst themselves. The group are also given a booklet to use to have questions to prompt them to think about how a patient might see or feel, for example, smells, atmosphere, information displays ect.

The volunteer manager then identifies areas for improvement and formulates an action plan, which is sent to the departmental manager to review and improve. The departmental managers are not currently given a set timeframe to complete actions however, these are closely monitored and checked by the volunteer manager.

The action plan and findings are then taken to the Divisional Governance meeting to discuss. The departmental managers are all given access to the action plan to update and close accordingly.

12.0. Working with Partners and Patients to Improve our services

12.1. Patient Engagement During the Year

- Patient Experience Department Celebrated Patient Experience Week in April 2022. Patient Experience Week in an innovative way to bring staff and patients together to support and celebrate the most important thing in a patients care, patient experience.
- The Department is actively sending PALS and Complaints Satisfaction Surveys out monthly to patients/families/carers who have raised a PALS or Formal Complaint with us. Currently we have received 105 results.
- Fifteen Steps Walkabout was commenced and the first department it was rolled out in was Ward 4 in May 2022. It was proven to be successful and are now held every month across the Trust.
- Smiley Faces Roll out. In May 2022 the Smiley Face Machines were fitted throughout the Trust in all Outpatient Areas. From May 2022-March 2023. The Trust received over 8000 responses Trust wide. Which are reported on and sent out monthly to all departmental managers.
- The Patient Experience Department received fewer formal complaints in 2022/2023 compared to last year 2021/2022. This is due to the Patient Experience Team appropriately categorising them.
- Over 100 Actions have been created for PALS and Formal Complaints this year. In which all are reported on weekly in the divisional governance meetings. Actions are created to learn from the complaints receive and improve our services where necessary.
- In-depth Surveys were rolled out in 2022/2023. Our Volunteers kindly spoke to our inpatients and outpatients to fill in the survey. They were created for POAC, OPD, Therapies, Theatres, and Imaging. Overall, we received 700 completed surveys.
- Youth Forum and Learning Disability & Autism Forum has been rolled out

9.0. Improvements made

The PALS and Complaints team has continued to work with the nursing and operational colleagues to identify more effective ways of working that benefit all and improve patient experience.

If it matters to you, It matters to us. We're listening.

Annual Complaints and Patient Experience Report- Action plan for Priorities

NHS The Royal Orthopaedic Hospital NHS Foundation Trust

			Not Achieved	In progress	Achieved	Ongoing
Financial Year	**Priority**	**Progress Made**	**Status Update**			
2021/2022	The patient experience and engagement strategy 2019 to 2021 will be enhanced with a new strategy for the next 4 years and the associated action plan will be refreshed 2022/2023- The Patient Experience and Engagement Strategy 2019 to 2021 will be enhanced with a new strategy for the next 4 years and the associated action plan will be refreshed.	November 2021- Action plan updated- majority of actions were completed as per strategy, actions that have been started will be carried forward to new start edgy December 2021- action plan was presented on Patient Experience and Engagement Group- members of group did not make any comments on the action plan	**November 2021**- Meeting with Deputy Director of Strategy to start with new strategy **November 2021/December 2021**- 2019-2021 strategy workplan have been made into the action plan and actions have been reviewed. Following review actions were closed where appropriate (with evidence) and updated strategy will need to be created and planned roll out will be in 2022/2023 **March 2022-** Strategy will be completed following Patient Participation Group Meeting, taking into the consideration patient views **August 2022**- Decision made to add Patient Experience strategy within the Main Trust Action. Patients have been asked to give us their views of what Trust need to be focused on. Strategy should be rolled out in Q4 of 2022/2023 **November 2022-** HoPE met with the Deputy Director of Strategy to discuss engagement with the patients. Roll out of the main Trust strategy set for 1/4/2023 **March 2023**- Chief Nurse requested Strategy to be ready by the June 2023			

2021/2022	The PALS and Complaints department will have a meeting room to meet with complainants and patients that wish to give us feedback.	**October 2021-** Request for space have been completed and submitted to Estates department	Awaiting Estates department to confirm new office if appropriate
2022/2023	The Trust will roll out the Coffee Catch-Up patient engagement methodology to the Oncology Services.	**May 2022- Meeting was held between Head of Patient Experience, Improvement team and Oncology team to start and roll out Oncology Coffee catch up in Q3** **September 2022- this has been postponed due to the staff shortages within the Oncology department** **March 2023- Oncology Department cancelled meeting- staff shortages within department**	Ongoing
2022/2023	The Trust will continue engage with diverse groups of the community that the ROH serve, to understand their views and to improve their experience.	**May 2022-**The Trust rolled out Patient Participation Group. **August 2022-** Youth Forum will engage Youth form our community to help us shape our services **November 2022-** the Trust have rolled out the Youth Forum, Patient Participation Group, PEEG, variety of the surveys to engage patients from different backgrounds	Achieved
2022/2023	A responsive action plan will be produced off the back of this annual report to look more closely into themes of the complaints and PALS contacts, demography of the complainants and departments.	**June 2022-** Annual Complaints and Patient Report 2021/2022 has been shared with Divisions **September 2022-** Division did not give any feedback **November 2022**- The Patient Experience team have produced themed reports following the AC&PE report 2021/22 and sent it to division 1 for review. Division 1 have an action plan as how to address issues raised by the complainants	Achieved

2022/2023	#CallMe campaign to be introduced within the Trust	**May 2022-** All agreed for the project to be rolled out by IT in September 2022 **August 2022-** IT changed their processes and HoPE will need to do another project. Date of delivery not known **December 2022-** Project request submitted to the IT team **March 2023**- HoPE presented project to the IT team	Ongoing
2022/2023	Smiley Faces Feedback Devices will be rolled out.	**May 2022-** Smiley Faces Feedback system rolled out	Achieved
2022/2023	In-Depth Survey for Outpatient and Inpatient departments will be rolled out.	**May 2022-** In depth Surveys rolled out	Completed
2022/2023	Youth Forum and Learning Disability & Autism Forum will be rolled out.	**September 2022-** Both Groups are set to have first meeting at the end of the month	Completed
2022/2023	The Trust will have at least one patient in a quarter sharing their story to the Trust Board Members.	**June 2022-** Annual Work plan for the Patient stories has been formatted by the Head of Patient Experience and Trust board is received Pt story on monthly basis delivered by the member of staff.	Ongoing
2022/2023	Fifteen Step Challenge will be introduced and rolled out.	**May 2022-** 15 steps challenge has been rolled out	Completed
2022/2023	The Trust will celebrate Patient Experience Week.	**April 2022-** Patient Experience week was celebrated	Completed
2022/2023	New PHSO NHS Complaints standards will be fully rolled out in the Trust.	**July 2022-** agreed with Comms team re training sessions around PHSO standards and PALS to	Ongoing

2022/2023	The PALS and Complaints team will roll out training on PALS, Complaints and Patient Experience.	start in Q3 together with the roll out of the New standards which will be rolled out in April 2023 **August 2022-** Meeting with the PHSO, the Trust got complimented for work we are doing and our process will be used in their roll out **October 2022** training delivered to the clinical Band 6 **November and December 2022-** The first phase of the roll out for the standards has begun with training rolled out to the staff about awareness of the standards. **March 2023:** Rolled out to staff and patients. The PHSO standards will go live on 1/4/23	
2022/2023	The Healthwatch Birmingham will be on site at least once a month undertaking patient experience surveys July.	**May 2022**- Healthwatch Birmingham has set schedule to come in the ROH every 2 weeks	Completed

14.0. Looking Ahead to 2023 / 2024

The Trust will continue to improve the PALS and Complaints services and the Patient Experience in the 2023/2024. Improvements planned for the next financial year are as follows:

- New PHSO Complaints Standards to be rolled out in 2023/2024.
- #CallMe Campaign to be introduced within the Trust
- The Trust will continue engage with diverse groups of the community that the ROH serve, to understand their views and to improve their experience.
- Inpatient In-depth Surveys to be rolled out
- Coffee Catch Up for Oncology to be rolled out
- To source a suitable area for the whole Patient Experience Team to be situated. With appropriate office and meeting spaces.
- To continue to celebrate Patient Experience Week
- To continue to celebrate Volunteer Week
- The PALS and Complaints team will roll out training on PALS, Complaints and Patient Experience.
- The Patient Experience and Engagement Strategy 2019 to 2021 will be enhanced with a new strategy for the next 4 years and the associated action plan will be refreshed.

ROHTB (7/23) 013

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD	
DOCUMENT TITLE:	**Gender Pay Gap**
SPONSOR (EXECUTIVE DIRECTOR):	**Sharon Malhi, Chief People Officer**
AUTHOR:	**Clare Mair, Head of OD and Inclusion** **David Morris, Workforce Information & Systems Manager** **David Richardson, Head of Education and Training**
DATE OF MEETING:	**5th July 2023**

EXECUTIVE SUMMARY:

The presentation gives an update on the ROH Gender Pay Gap work. Any employer with 250 or more employees on a specific date each year (the 'snapshot date') must report their gender pay gap data.

The committee has previously received an update on data collection as on 31st March 2022 in line with statutory requirements to publish the information and action plan on the Trust website by March 30th 2023.

In order to continue progress in the Gender Pay Gap work, in line with the Inclusion agenda, this presentation reports further data as at 31st March 2023 (which must be reported on the Trust website by March 30th 2024).

Positive assurance

The data from the report highlights that:

- The mean pay gap has decreased from 2022.
- The mean gender pay gap has stayed steady since 2018 and decreased from 33.8% in 2022 to 32.54% in 2023
- Since 2022 there has been a further decrease in the median gender pay gap of 1%
- There has been an increase in female consultants since 2022 from 6 to 19
- Based on the comparisons to previous years, the trends would suggest that the Trust is making progress with closing the Gender Pay Gap in some areas.

In addition, there has been good engagement with female medical colleagues to start to highlight areas to be progressed through the work of the newly formed Women's network and the Wellbeing agenda

Current issues

- There has been a marked increase in the mean bonus pay gap since 2022

Next steps

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

REPORT RECOMMENDATION:

To review the information and comment

The Royal Orthopaedic Hospital NHS Foundation Trust

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

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***					
Financial	x	Environmental	x	Communications & Media	x
Business and market share		Legal & Policy		Patient Experience	
Clinical	x	Equality and Diversity	x	Workforce	X
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
People Element of the ROH Strategy, ROH Inclusion strategy
PREVIOUS CONSIDERATION:
Gender Pay Gap Report 2022 and Staff Experience & OD Committee on 28 June 2023

Gender Pay Gap Report
Comparison data for 2022 and 2023

Trust Board July 2023

Sharon Malhi, Chief People Officer
Clare Mair, Head of OD and Inclusion
David Morris, Workforce Information & Systems Manager
David Richardson, Head of Education and Training

Introduction

- Government legislation means employers with 250 or more employees are required to publish their figures comparing men and women's average pay across the organisation.
- The gender pay gap is the difference between the average earnings of men and women.
- The first report was published in March 2018, which provided gender pay data as at 31 March 2017
- The gender pay gap report must include:
  - Mean gender pay gap
  - Median gender pay gap
  - Mean bonus gender pay gap
  - Median bonus gender pay gap
  - Proportion of men in the organisation receiving a bonus payment
  - Proportion of women the organisation receiving a bonus payment
  - Proportion of men and women in each quartile pay band
- This report shows gender pay data as at 31 March 2022 and 31 March 2023

Overall the report shows positive progress in the gender pay gap work particularly around mean gender pay gap

Difference between Gender Pay and Equal Pay

Equal Pay

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

Gender Pay

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

Using the results of the Gender Pay Gap Report

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

We can use the results of this report to address:

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

Definitions and Scope

- **Mean**

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

- **Median**

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

- **Pay Quartiles**

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

- This report is based on pay rates for two comparison years:
  - Pay as at 31 March 2022 and covers any bonuses paid within the year 1 April 2021 to 31 March 2022.
  - Pay as at 31 March 2023 and covers any bonuses paid within the year 1 April 2022 to 31 March 2023.

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

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

Median and Mean Gender Pay Gap

MEDIAN GENDER PAY GAP AT ROH

- The median hourly wage for men: £17.63 (2022) and £19.42 (2023)
- The median hourly wage for women: £13.65 (2022) and **£15.33 (2023)**
- This equates to a £3.98 difference (2022) and £4.09 (2023)
- The median hourly rate: 22.6% (2022) and **21.06% (2023)** lower for women than it is for men
- In 2022 this meant that for every £1 earnt by men, women earn 77.4p. In **2023** there had been a slight improvement for every £1 earnt by men, **women earnt 78.94**

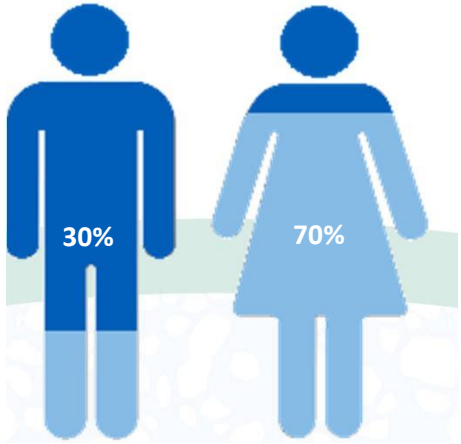
MEAN GENDER PAY GAP AT ROH

- The mean hourly rate for men was £24.24 (2022) and **£25.58 (2023)**
- The mean hourly rate for women is £16.05 and **£17.26 (2023)**
- When comparing mean hourly wages, women's mean hourly wage was 33.8% lower than men's in 2022 and **32.54% lower in 2023**
- **This was a difference of £8.19 in the average hourly rates between men and women in 2022 and 8.32% lower in 2023**

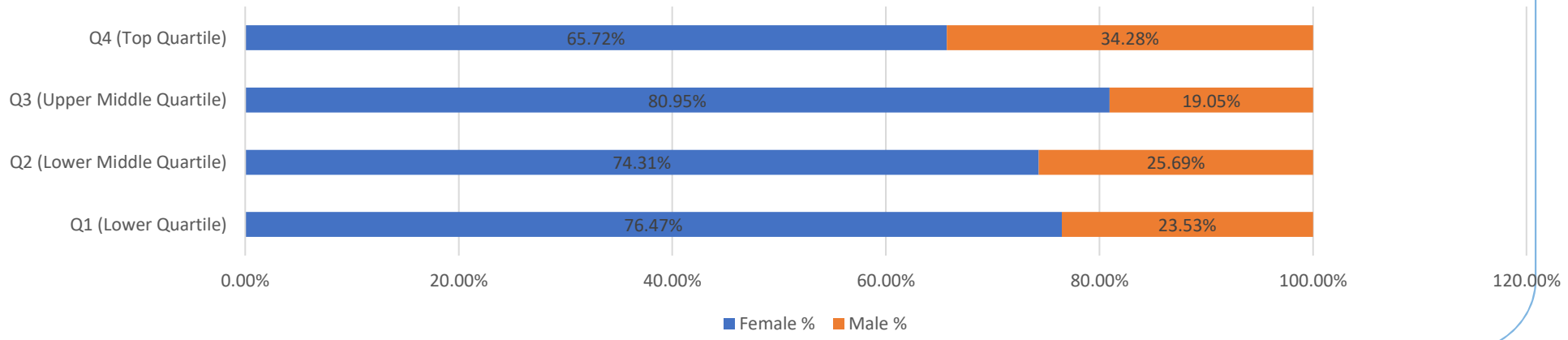
Pay Quartiles

- The gender profile of the ROH have not changed significantly overall. 70.2% female to 29.8% male in 2022 compared to **70.35 to 29.65 in 2023**. This is a common workforce profile across NHS Trusts.
- The Trust employ significantly more women in Quartiles 1, 2 and 3, (accounting for approximately 78% of the total), however there is a smaller proportion within the top quartile (4) at 34%.
- Consultant medical staff was 90 in 2022 and **123 in 2023** of which 6 were women in 2022 and **19 were women in 2023**

Trust Gender Profile



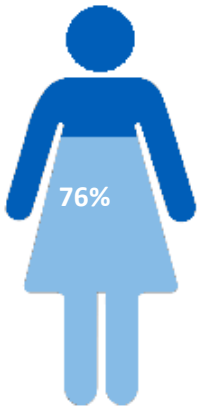
Gender Pay - Ordinary Pay Comparison 2023



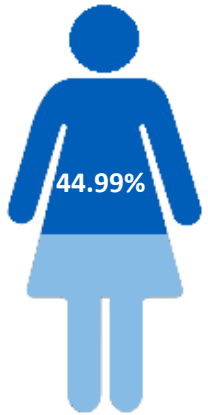
Gender Pay Gap Bonus Pay

- For the purposes of the gender pay gap, bonus pay is classed as any rewards that related to profit- sharing, productivity, performance, incentive and commission that were actually paid within the reporting period. In ROH the only payment that qualifies as a bonus payment is the Clinical Excellence Award that applies to substantive consultant medical staff with more than 12 months service.
- At the ROH, the women's median bonus pay is 59% lower than men's. This means that women earn 41p for every £1 that men earn when comparing median bonus pay.
- When comparing the mean bonus pay gap, women's mean bonus pay was 62.88% in 2022 and **76.11% in 2023** lower than men's**.**

Mean Bonus Gender Pay Gap



Median Bonus Gender Pay Gap



Who received bonus pay at the ROH

- **0.1%** (0.2% in 2022) of women
- **5.05%** (6.06% in 2022) of men

Excluding Consultants

Gender 2023	Avg. Hourly Rate 2022	Avg. Hourly Rate 2023	Median Hourly Rate 2022	Median Hourly Rate 2023
Male	16.9393	18.9325	14.3263	15.9973
Female	15.6972	17.0423	13.4445	15.1839
Difference	1.2422	1.8902	0.8818	0.8135
Pay Gap %	7.3329	9.9841	6.1555	5.0850

Excluding all Medical Staff

Gender 2023	Avg. Hourly Rate 2022	Avg. Hourly Rate 2023	Median Hourly Rate 2022	Median Hourly Rate 2023
Male	16.9393	17.6818	13.8185	14.3767
Female	15.6693	16.8418	13.3814	15.0753
Difference	0.6968	0.8490	0.4371	-0.6986
Pay Gap %	4.3	4.7510	3.2000	-4.8592

Comparison to Previous Years

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

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

Positive assurance for Gender Pay Gap 2023 includes:

- The mean pay gap has decreased from 2022.
- The mean gender pay gap has stayed steady since 2018 and decreased from 33.8% in 2022 to **32.54%** in 2023
- Since 2022 there has been a further decrease in the median gender pay gap of **1%**
- There has been an increase in female consultants since 2022 from 6 to **19**
- Based on the comparisons to previous years, the trends would suggest that the Trust is making progress with closing the Gender Pay Gap

Other information

- There has been an increase in the mean bonus pay gap since 2022
- The gap for median bonus pay has increased but is still lower than 2018.

Action Plan (Integrated into the Inclusion Action Plan)

Action	Lead	Completion
Continue the work to actively promote flexible working opportunities/ shared parental leave in the advertising of new roles	Recruitment Team	Ongoing
Widen participation on the current MMEG career mentoring programmes to include support for women in career conversations	OD and Inclusion Team	September 2023
Development of the Women's network to highlight specific areas for improvement with involvement from female medical colleagues	OD and Inclusion Team Women's network	Ongoing
Development of Talent and Succession strategy to include work on talent pipelines	Clare Mair	October 2023
Undertake an annual review of gender split across all pay bands and take action on outcomes	Clare Mair	March 2024
Develop work experience programme for pre medical schools (diversity in orthopaedics to be included as an element in programme)	David Richardson	March 2024
Undergraduate Academy to explore development of a research project around perception of orthopaedics within medical students including outcomes.	Prof Ed Davis	September 2024
Curriculum map for Inclusion to be developed as part of all Medical Education work streams.	David Richardson	Ongoing

Additional work

Other initiatives currently being undertaken and aligned to Gender Pay Gap work include:

- A number of positive actions to increase successful female applicants into consultant and senior leadership roles and more men into clinical support to include recruitment training for panel members, interview panels with an equal gender split and diversity
- Continuing the work to actively promote flexible working opportunities/ shared parental leave in the advertising of these roles
- Ensure people policies consider the needs of carers to enable agile working and contributing to a good work life balance
- Continued partnership working with National Orthopaedic Alliance (NOA) and British Orthopaedic Association (BOA)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual declarations and changes to the NHS Provider licence**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive & Tim Pile, Chair**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**5 July 2023**

EXECUTIVE SUMMARY:

The Board of Directors is required to make a set of declarations on an annual basis.

The attached paper outlines the proposed declarations of compliance with the terms of the Trust's licence for 2022/23, the Governance licence condition (General Condition F4) and the duty to ensure governors are adequately trained to discharge their duties. Appendices are attached to provide the evidence base to support the declarations.

The declarations are required to be made with regard to the views of the governors, therefore these proposed declarations have been circulated and received the support of a quorum of the Council of Governors.

The paper also sets out the changes to the Foundation Trust provider licence that came into force from 1 April 2023.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- APPROVE the proposed declarations of compliance against:
  - Conditions of the Provider Licence in effect during 2022/23
  - Terms of the Corporate Governance licence condition (Condition FT4 (8))
  - Requirement to train governors
- NOTE the changes to the NHS Providers licence from April 2023
- APPROVE the proposal to continue making these annual declarations, subject to ongoing capacity to enable this

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

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

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

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

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

Compliance with the Self-certification: guidance for NHS FTs and specifically compliance with the Trust's

licence to operate.
PREVIOUS CONSIDERATION:
Circulated to the Council of Governors for comments. Annual declaration.

FOR APPROVAL

Annual Declarations

REPORT TO THE TRUST BOARD – 5 JULY 2023

1.0 Introduction

1.1 The Board of Directors has to date been mandatorily required to make a set of declarations on an annual basis, these being as follows:

- Systems in place to enable the Trust to conform to the terms of its Provider licence;
- Compliance with the governance condition (General Condition F4) at the date of the statement; and
- Forward compliance with the governance condition for the current financial year, specifying (i) risks to compliance and (ii) any actions proposed to manage such risks
- The provision of necessary training to governors, pursuant to Section 151(5) of the Health & Social Care Act.

1.2 This paper, specifically with reference to the attached appendices, sets out the basis behind the proposed declarations of compliance with these requirements.

1.3 The paper also details the changes to the NHS Provider licence that came into effect from April 2023.

2.0 Compliance with the terms of the Trust's FT Provider licence

2.1 **Appendix A** presents the proposed declaration to confirm, or otherwise, that the Trust has in place systems to enable compliance with its licence conditions.

2.2 On this basis of the commentary and evidence base behind the statement of compliance for each condition, it is proposed that the Trust states 'CONFIRMED' to the following:

'***Following a review for the purpose of Paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in order the financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and had regard for the NHS Constitution***'

2.3 The Board is asked to note that the changes to the NHS Provider licence, described in a later section of this report) remove the requirement set out in General Condition G6 for foundation trusts to annually declare compliance with the licence going forward, noting the burdensome nature of the declarations process. It is however recommended to the Board that while there remains capacity to do so, this process continues at the ROH, given that it represents sound evidence of a good governance framework at the Trust, should this be needed.

3.0 Changes to the NHS Provider licence

3.1 The NHS provider licence was introduced in 2013 for foundation trusts and independent providers of NHS-funded services. The licence forms part of and supports the operation of NHS oversight arrangements by providing the legal basis for NHS England to provide mandated support to its most challenged providers in line with the principles and procedures outlined in the NHS Oversight Framework and operating framework.

3.2 Much has changed since 2013, therefore NHS England wrote to the sector in October 2022 setting out proposals to update the licence conditions and align them with current statutory and policy requirements, including new legislation requiring NHS trusts (as well as NHSFTs) to hold a licence from 1 April 2023.

3.2 These changes were designed to support the development of effective system working, enhance the oversight of key services provided by the independent sector and help address climate change. NHSE also proposed a number of technical changes to align the licence with its regulatory framework and reduce burden.

3.3 The proposed changes were subject to a statutory consultation from 28 October to 9 December 2022. The modified licence came into effect from 1 April 2023.

3.4 Key changes to the licence are:

- Introduce a new section into the licence – Trusts Working in Systems (WS) and specifically within this:

  - Introduce a new condition: **WS1 Cooperation** – which requires NHS trusts, foundation trusts and NHS controlled providers to consistently cooperate with ICBs, Local Authorities and other organisations that deliver NHS care when developing and delivering system plans, delivering NHS services, improving NHS services, delivering system financial plans and delivering system workforce plans. The condition notes that: 'For the purposes of this condition, cooperation is considered synonymous to collaboration'.

  - Introduce a new condition: **WS3 Digital Transformation** – which requires NHS trusts, foundation trusts and NHS controlled providers to comply with the information standards of section 250 of the Health and Social Care Act 2012 and with guidance related to digital maturity as they pertain to cooperation and the Triple Aim.

- Introduce a new requirement in **NHS2**: Governance arrangements paragraph 3(c) and **CP1: Governance arrangements for NHS controlled providers** paragraph 3(c) to have systems and processes in place to meet guidance on digital maturity

- Reframed condition: **IC1 Provision of Integrated Care** – as a positive obligation that all providers take steps to integrate services and enable cooperation with other services to improve quality and reduce inequalities of access and outcomes.

- Expansion of condition: **IC2 Personalised care and Patient Choice** – to require providers to support the implementation and delivery of personalised care by having regard for relevant guidance and legislation, offering people control to manage their own health and wellbeing.

- Removal of **Choice and Competition Condition 2: Competition Oversight**.

- Removal of redundant clauses from **General Condition 9 (now G8)**

➢ To allow NHS England to determine and apply continuity of service conditions to Hard to Replace Providers

- Amended relevant **CoS** conditions to reference Hard to Replace Providers.

➢ This includes a mechanism added to G8 (Application of section 6 (Continuity of Service)) which sets out that the Continuity of Service conditions shall apply to licensees subject to a contractual obligation as CRS, or as determined by NHS England to be a Hard to Replace provider. CoS3 (Standards of corporate governance and financial management), Cos6 (Cooperation in the event of financial stress) and CoS7 (Availability of resources) will also be amended to refer to Hard to Replace Providers

- Amended condition **CoS 3** and **CoS 6** to include standards of Quality Governance for Commissioner Requested services and Hard to Replace Providers and provide reasonable safeguards against the licensee being unable to deliver services when standards of quality governance have fallen below expectations.

- Introduction of a new requirement in: **NHS2** Governance arrangements paragraph 3(b) and **CP1** Governance arrangements for NHS controlled providers paragraph 3(b) – to ensure NHS trusts, foundation trusts and NHS Controlled Providers have regard to guidance on tackling climate change.

- Replacement of **Pricing Condition 1** with new Costing Condition 1: Submission of costing information

- Replacement of **Pricing Condition 2** with new Costing Condition 2: Provision of costing and costing related information

- Replacement of **Pricing Condition 3** with new Costing Condition 3: Assuring the accuracy of pricing and costing information

- Updated **Pricing Condition 4** (renamed as Pricing Condition 1) – to apply the rules and methods of charging for the provision of NHS services as set out in the NHS Payment Scheme.

- Removal of **Pricing Condition 5** (local modifications) from the licence

- Removal of the reporting requirements from **General Condition 6** (Systems for compliance), which requires licensees to self-certify against the licence, and Foundation Trust Condition 4/Controlled Provider condition 1, which requires foundation trusts to report on past and future compliance with the licence and to prepare a Corporate Governance Statement.

- Amendment of the licence to **apply relevant existing conditions to NHS trusts** and to extend the existing foundation trust conditions to NHS trusts, excluding specific legislative requirements which relate only to foundation trusts

- **Removal of all references to Monitor or NHS Commissioning Board** and replace them with 'NHS England', and to amend references to commissioning to reflect the new role of Integrated Care Boards and of bodies which may hold delegated commissioning functions

- Removal of the following conditions:
  - **General Condition 3**: Payment of fees to Monitor
  - **Foundation Trust Condition 2**: Payment to Monitor in respect of registration and related costs
  - **Foundation Trust Condition 3**: Provision of information to advisory panel

- To include the changes to licence condition **G4: Fit and Proper Persons** as per the consultation run by Monitor in February-March 2021

4.0 Corporate Governance Licence Condition and Training of Governors

4.1 As with the assessment against the overall Provider Licence conditions, it has historically been a requirement of the governance condition of the Trust's licence that the Trust publishes a statement within three months of the end of the financial year setting out whether it believes it has complied with the required governance arrangements of its licence (Condition FT4 (8)).

4.2 The governance condition requires the Trust Board to confirm:

- Compliance with the governance condition at the date of the statement; and
- Forward compliance with the governance condition for the current financial year, specifying (i) risks to compliance and (ii) any actions proposed to manage such risks

4.3 Appendix B outlines the rationale and core evidence that the Board can rely on in order to confirm or otherwise the statements relating to the Corporate Governance statement and other declaration.

4.4 It is proposed to declare '**Confirmed**' to the statement that the provider has complied with required governance arrangements.

4.5 NHS England also requires the Board to make a declaration regarding:

- The provision of necessary training to governors, pursuant to Section 151(5) of the Health & Social Care Act. The Board is recommended to make a declaration of '**Confirmed**' in respect of Governor training. Again, the evidence base behind this declaration is detailed in **Appendix B**.

4.6 Again, as detailed in Section 3, above, the requirement to mandatorily make a declaration against the corporate governance licence condition has been removed from the modified Provider Licence. It is again, however recommended that subject to availability of capacity to do so, that the Trust continues to make these declarations of compliance as evidence of the sound corporate governance framework in the ROH.

5 Recommendation

5.1 The Trust Board is asked to:

- APPROVE the proposed declarations of compliance against:
  - Conditions of the Provider Licence in effect during 2022/23
  - Terms of the Corporate Governance licence condition (Condition FT4 (8))
  - Requirement to train governors

- NOTE the changes to the NHS Providers licence from April 2023
- APPROVE the proposal to continue making these annual declarations, subject to ongoing capacity to enable this

Simon Grainger-Lloyd
Director of Governance
30 June 2023

ROHTB (7/23) 014 (b) - Evidence for ROH Compliance with Monitor Licence Conditions 2022-23 – Appendix A

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1 Section 1 – General Conditions

1.1 *Condition G1 – Provision of information*

1. Subject to paragraph 3, and in addition to obligations under other Conditions of this Licence, the Licensee shall furnish to NHS Improvement such information and documents, and shall prepare or procure and furnish to NHS Improvement such reports, as NHS Improvement may require for any of the purposes set out in section 96(2) of the 2012 Act.

2. Information, documents and reports required to be furnished under this Condition shall be furnished in such manner, in such form, at such place and at such times as NHS Improvement may require.

3. In furnishing information documents and reports pursuant to paragraphs 1 and 2 the Licensee shall take all reasonable steps to ensure that:

   (a) in the case of information or a report, it is accurate, complete and not misleading;

   (b) in the case of a document, it is a true copy of the document requested; and

4. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

Lead Exec	Compliant	Comment	Evidence
SW/SGL	Y	All NHS England returns have been prepared in the required format and delivered on time. There has been no adverse comment from NHS England re late or incomplete returns. A copy of the audited annual reports and accounts for 2021/22 was submitted by the required deadline. All returns are reviewed buy at least one other person than the author.	• NHS England monthly performance reports • Confirmation receipts of declarations & AR & Accts from NHS portal

1.2 *Condition G2 – Publication of information*

1. The Licensee shall comply with any direction from NHS Improvement for any of the purposes set out in section 96(2) of the 2012 Act to publish information about health care services provided for the purposes of the NHS and as to the manner in which such information should be published.

2. For the purposes of this condition "publish" includes making available to the public, to any section of the public or to individuals.

Lead Exec	Compliant	Comment	Evidence
SW/SGL	Y	FT Code of Governance requirements to publish on the website have been complied with, largely in the form of the Trust's annual report	• Screen shot of licence included on the Trust's internet • Screen shot of annual report on website

1.3 *Condition G3 – Payment of fees to NHS Improvement*

1. The Licensee shall pay fees to NHS Improvement in each financial year of such amount as NHS Improvement may determine for each such year or part thereof in respect of the exercise by NHS Improvement of its functions for the purposes set out in section 96(2) of the 2012 Act.

2. The Licensee shall pay the fees required to be paid by a determination by NHS Improvement for the purpose of paragraph 1 no later than the 28th day after they become payable in accordance with that determination.

Lead Exec	Compliant	Comment	Evidence
SW	Y	No fees have been levied by NHS Improvement during 2022/23.	None

1.4 *Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)*

1. The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor, except with the approval in writing of NHS Improvement.

2. The Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of NHS Improvement.

3. The Licensee shall ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee shall ensure that it enforces that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of NHS Improvement.

4. If NHS Improvement has given approval in relation to any person in accordance with paragraph 1, 2, or 3 of this condition the Licensee shall notify NHS Improvement promptly in writing of any material change in the role required of or performed by that person.

5. In this Condition an unfit person is: (a)

an individual;

(i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

(ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

(iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or

(iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

(b) a body corporate, or a body corporate with a parent body corporate

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub- paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or

(v) which passes any resolution for winding up, or

(vi) which becomes subject to an order of a Court for winding up.

Lead Exec	Compliant	Comment	Evidence
SGL	Y	The Trust has continued the annual review of those who are required to meet the FPPT, and to apply the Trust policy. All required members of the Board completed a self-declaration in 2021 and new starters Chris Fearns and Ian Reckless completed pre-employment checks and the self-declaration in regard to FPPT. The annual round of self-declarations is underway as of June 2023. DBS checks for Board members remain current.	• FPPT policy • FPPT declarations • DBS list • Personal files

1.5 *Condition G5 – NHS Improvement guidance*

1 Without prejudice to any obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by NHS Improvement for any of the purposes set out in section 96(2) of the 2012 Act.

2 In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform NHS Improvement of the reasons for that decision.

Lead Exec	Compliant	Comment	Evidence
SW/SGL	Y	FT Code of Governance requirements have been complied with as detailed in the annual report under the "comply or explain" section. The Trust adheres to the requirements of the NHS Oversight Framework (ROH is Rated 2) and has participated in a System segmentation process this year, which resulted in the BSol ICS being graded as 3. New guidance came into force from 1 July 2022 placing a duty on Providers to collaborate.	• Annual report 2022/23 • Finance & Performance Report, and Quality & Safety Report • Agency staffing information included in Finance & Performance papers and the Workforce Overview • Published Health and Social Care Act requirements around collaboration and establishment of Integrated Care Systems

1.6 *Condition G6 – Systems for compliance with licence conditions and related obligations*

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   (a) the Conditions of this Licence,

   (b) any requirements imposed on it under the NHS Acts, and

   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

(a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

(b) regular review of whether those processes and systems have been implemented and of their effectiveness.

3. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to NHS Improvement a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

4. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to NHS Improvement in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

Lead Exec	Compliant	Comment	Evidence
PART 1			
SW/SGL/NB re (a) and (b)	Y	(A) Controls relating to this are described in the whole of this appendix (B) The Trust is registered with the CQC and the HTA as per the NHS Acts. The Chief Nurse holds the post of HTA designated individual. (C) The Board is not aware of any other significant requirements under the NHS Acts.	• This appendix • CQC registration certificate • HTA registration certificate
CEO	Y	The NHS constitution establishes the principles and values of the NHS in England. The constitution can be broken down into 6 key areas, 4 of which apply to requirements for the organisation: guiding principles, NHS values, rights of patients & public and rights for staff. The Trust's five year strategy, which was approved in Autumn 2019 and applied through the 2022/23 year, echoed the guiding principles in the NHS constitution including putting the patient at the heart of everything the organisation does, working across organisational boundaries and aspiring to achieve the highest standards of excellence & professionalism. The strategy also provides a set of values that are	• Strategy Powerpoint from Board session held in October 2022. • Finance & Performance overview • Quality & Patient Safety report • Workforce overview • Annual complaints report • National Staff Survey results • Quality Account

Lead Exec	Compliant	Comment	Evidence
		consistent with those in the NHS constitution including promoting respect & dignity, commitment to quality of care and being compassionate. The measurement of the outcomes of these indicators is through consideration of a suite of reports received by the Board and its Committees and at an Executive level by reports to the weekly Executive meeting. During the year, a refreshed Trust strategy was developed and although approval of this sits outside of the year covered by these declarations, it is important to reflect that the majority of discussions leading to its creation took place in 2022/23. In terms of compliance with the constitutional requirements relating to the rights of the public and patients, compliance is demonstrated through performance against the range of nationally commissioned targets set out in the Quality Account & Annual Report. The specific relating to confidentiality & consent are monitored respectively by an IG Group and by the Quality & Safety Committee. In terms of complaints and redress, the Trust has made improvements to its processes for complaints handling during the year and maintained adherence to Regulation 20: Duty of Candour guidance. The right to drugs and treatments can be demonstrated by the Joint Formulary available on the internet. The Trust was inspected by the CQC in Quarter 3 2019/20 and maintained its regulatory rating as 'Good' across all domains. Discussions have continued with the CQC during 2022/23 and no concerns have been raised. The Trust has seen a deterioration in the performance against the national Referral to Treatment Time standards as a result of the need to support system partners with elective recovery through the application of a mutual aid arrangement. The Trust has worked with AccessAble to ensure that the estate of the Trust assists those requiring additional support with navigating the	• Quality & Safety Committee meeting papers • Finance & Performance Committee meeting papers • Staff Experience & OD Committee papers • Quality Account 2021/22 • Annual Report 2021/22 • Data security toolkit toolkit submission and internal audit report • Minutes of Quality & Safety Committee • Annual complaints reports to Quality & Safety Committee and Trust Board • Duty of Candour updates as part of Quality & Patient Safety report Quality & Safety Committee • CQC report and CQC action plan • Screenshot of joint formulary • Duty of Candour audit • NICE guidance internal audit and action plan • Performance against access targets included in the Finance and Performance report

Lead Exec	Compliant	Comment	Evidence
		hospital to be provided with visuals and a step by step guide to accessing the hospital. There has been no regulatory enforcement action during the year or any undertakings imposed. Regarding the rights of staff, the Trust has policies and procedures in place to support staff and ensure that their needs are met appropriately. The Trust has a Freedom to Speak Up policy in place and has undertaken an assessment against the WRES and WDES standards which has flagged some work to do to improve the Trust's regard for equality & diversity matters. An equality and diversity network and a Multi Minority Ethnic Group (MMEG) are in place in addition to a 'BeMySelf' forum, a Disability forum (Able) and a ManKind forum. The Trust has in place a Freedom to Speak Up Guardian who reports to the Director of Governance. A set of nine FTSU champions have been recruited during the year The Trust Board is supported by a Committee, the Staff Experience &OD Committee, which seeks assurance on the Trust's adherence to staff-related policies, workforce matters and organisational development. The Committee also received regular updates from staff where they are able to describe the experience of working at the ROH and air any concerns they have around their employment circumstances and environment. The Health and Safety Group reviews any issues likely to impact on the staff's working environment from a legal perspective.	• AccessAble narrative in workforce reports. • Workforce policies, including Freedom to Speak Up • Terms of Reference for the staff networks • Schwartz Round information • WRES assessment to Staff Experience & OD Committee • Freedom to Speak Up presentation to Trust Board • Freedom to Speak Up Guardian and Champion role description • Staff Experience & OD Committee terms of reference • National staff survey results • Health and Safety Group minutes.
PART 2			
SGL	Y	The Trust has continued to improve its risk management processes over 2022/23, including a refresh of some of the risk registers of the Trust's major committees and groups. Further work is underway to improve the framework further and address the actions raised in the annual internal audit review of the BAF and Risk Management framework. The Annual Governance Statement for 2022/23 sets out the framework of risk management	• Annual Governance Statement • Board Assurance Framework • Corporate Risk Register • Risk improvement plan • Internal audit review of BAF and risk management

Lead Exec	Compliant	Comment	Evidence
		within the Trust and provides an assessment of the effectiveness of these systems and processes. The Head of Internal Audit Opinion for 2022/23 confirms that the Trust has adequate internal control mechanisms, however there is further work to do. The CQC inspection and the external well led inspections in 2019 did not highlight any weaknesses in the Trust's risk management framework.	• Risk management policy • HOIA 2021/22
PART 3			
SGL	Y	Notification was received during the year that the requirement to undertake the annual declaration process was discretionary however the decision was to continue with the process given that it was sound evidence of good governance	• Trust Board paper which is published on the Trust's website

1.7 *Condition G7 – Registration with the Care Quality Commission*

1. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able lawfully to provide the services authorised to be provided by this Licence.

2. The Licensee shall notify NHS Improvement promptly of:

   (a) any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or

   (b) the cancellation by the Care Quality Commission for any reason of its registration by that Commission.

3. A notification given by the Licensee for the purposes of paragraph 2 shall: (a)

   be made within 7 days of:

   (i) the making of an application in the case of paragraph (a), or

   (ii) becoming aware of the cancellation in the case of paragraph (b), and

   (b) contain an explanation of the reasons (in so far as they are known to the Licensee) for:

(i) the making of an application in the case of paragraph (a), or

(ii) the cancellation in the case of paragraph (b).

Lead Exec	Compliant	Comment	Evidence
GM	Y	The ROH was registered with CQC throughout the financial year. The ROH is registered without conditions currently. The Executive Lead for the CQC is the Director of Governance. The Nominated Individual for the CQC is the CEO.	• Screenshot of CQC website • CQC acute insight reports • CQC inspection reports from 2019 • Meeting notes from the CQC relationship meetings

1.8 *Condition G8 - Patient eligibility and Selection criteria*

1. The Licensee shall:

(a) set transparent eligibility and selection criteria,

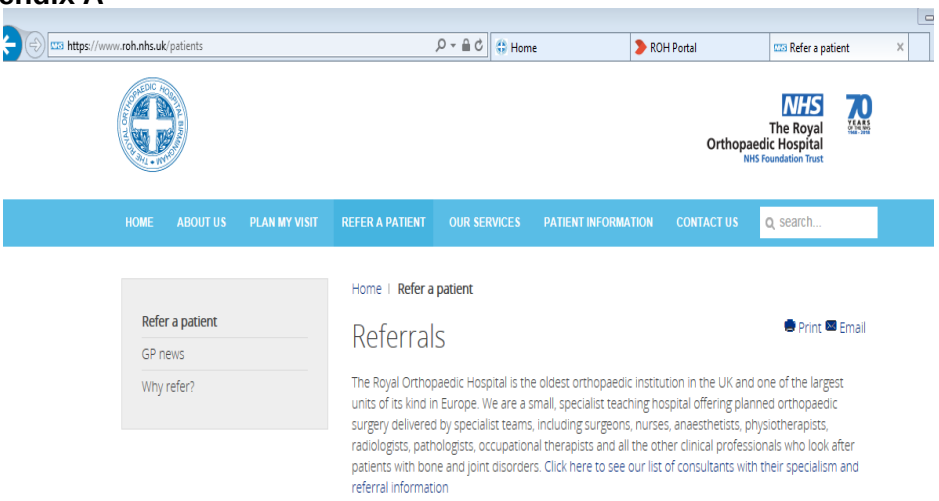
(b) apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and

(c) publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.

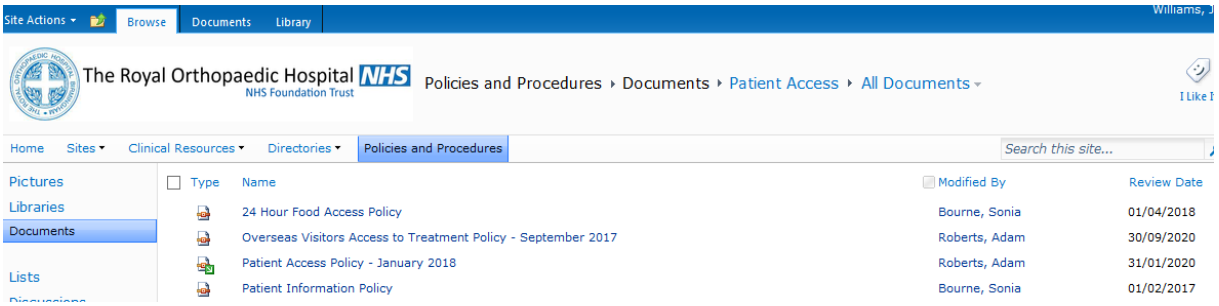
2. "Eligibility and selection criteria" means criteria for determining:

(a) whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and

(b) if the person is selected, the manner in which the services are provided to the person.



Lead Exec	Compliant	Comment	Evidence
MP	Y	The Trust has in place a policy for patient access. Application of this policy is overseen by the Clinical Services Manager (Patient Access, Performance and Outpatients Department) who reports directly to the Associate Chief Operating Officer (COO).	• Patient Access policy • Screen shot of patient access policy on intranet • Screens shot of referral page on internet site



1.9 *Condition G9 – Application of Section 5 (Continuity of Services)*

1. The Conditions in Section 5 shall apply:

(a) whenever the Licensee is subject to a contractual or other legally enforceable obligation to provide a service which is a Commissioner Requested Service, and

(b) from the commencement of this Licence until the Licensee becomes subject to an obligation of the type described in sub-paragraph (a), if the Licensee is an NHS foundation trust which:

(i) was not subject to such an obligation on commencement of this Licence, and

(ii) was required to provide services, or was party to an NHS contract to provide services, as described in paragraph 2(a) or 2(b);

for the avoidance of doubt, where Section 5 applies by virtue of this subparagraph, the words "Commissioner Requested Service" shall be read to include any service of a description falling within paragraph 2(a) or 2(b).

2. A service is a Commissioner Requested Service if, and to the extent that, it is:

(a) any service of a description which the Licensee, being an NHS foundation trust with an authorisation date on or before 31 March 2013, was required to provide in accordance with condition 7(1) and Schedule 2 in the terms of its authorisation by NHS Improvement immediately prior to the commencement of this Licence, or

(b) any service of a description which the Licensee, being an NHS foundation trust with an authorisation date on or after 1 April 2013, was required to provide pursuant to an NHS contract immediately before its authorisation date, or

(c) any other service which the Licensee has contracted with a Commissioner to provide as a Commissioner Requested Service.

3. A service is also a Commissioner Requested Service if, and to the extent that, not being a service within paragraph 2:

(a) it is a service which the Licensee may be required to provide to a Commissioner under the terms of a contract which has been entered into between them, and

(b) the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either

(c) the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or

(d) the Commissioner, not earlier than the expiry of the [28th] day after making that request to the Licensee, has given to NHS Improvement and to the Licensee a notice in

accordance with paragraph 4, and NHS Improvement, after giving the Licensee the opportunity to make representations, has issued a direction in writing in accordance with paragraph 5.

4. A notice in accordance with this paragraph is a notice:

   (a) in writing,

   (b) stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and

   (c) setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service

5. A direction in accordance with this paragraph is a direction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 3(b) is unreasonable.

6. The Licensee shall give NHS Improvement not less than [28] days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.

7. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested Service, for the period from the expiry of the contractual obligation until NHS Improvement issues either:

   (a) a direction of the sort referred to in paragraph 8, or

   (b) a notice in writing to the Licensee stating that it has decided not to issue such a direction.

8. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, NHS Improvement issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then for that period the service shall continue to be a Commissioner Requested Service.

9. No service which the Licensee is subject to a contractual or other legally enforceable obligation to provide shall be regarded as a Commissioner Requested Service and, as a consequence, no Condition in Section 5 shall be of any application, during any period for which there is in force a direction in writing by NHS Improvement given for the purposes of this condition and of any equivalent condition in any other current licence issued under the 2012 Act stating that no health care service provided for the purposes of the NHS is to be regarded as a Commissioner Requested Service.

10. A service shall cease to be a Commissioner Requested Service if:

(a) all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and NHS Improvement has issued a determination in writing that the service is no longer a Commissioner Requested Service, or

(b) NHS Improvement has issued a determination in writing that the service is no longer a Commissioner Requested Service; or

(c) it is a Commissioner Requested Service by virtue only of paragraph 2(a) above and 3 years have elapsed since the commencement of this Licence; or

(d) it is a Commissioner Requested Service by virtue only of paragraph 2(b) above and either 3 years have elapsed since 1 April 2013 or 1 year has elapsed since the commencement of this Licence, whichever is the later; or

(e) the contractual obligation pursuant to which the service is provided has expired and NHS Improvement has issued a notice pursuant to paragraph 7(b) in relation to the service; or

(f) the period specified in a direction by NHS Improvement of the sort referred to in paragraph 8 in relation to the service has expired.

11. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.

12. Within [28] days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to NHS

Improvement in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.

13. Unless it is proposes to cease providing the service, the Licensee shall not make any application to NHS Improvement for a determination in accordance with paragraph 10(b):

(a) in the case of a service which is a Commissioner Requested Service by virtue only of paragraph 2(a) above, in the period of 3 years since the commencement of this Licence or

(b) in the case of a service which is a Commissioner Requested Service by virtue only of paragraph 2(b), in the period until the later of 1 April 2016 or 1 year from the commencement of this Licence.

14. In this Condition "NHS contract" has the meaning given to that term in Section 9 of the 2006 Act.

Lead Exec	Compliant	Comment	Evidence
SW	Y	No application was made to NHS England to cease any service, including any Commissioner Requested Services	• Not Applicable

2 Section 2 – Pricing

2.1 *Condition P1 – Recording of information*

1. If required in writing by NHS Improvement, and only in relation to periods from the date of that requirement, the Licensee shall:

   (a) obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, and

   (b) establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information,

   as are necessary to enable it to comply with the following paragraphs of this Condition.

2. From the time of publication by NHS Improvement of Approved Reporting Currencies the Licensee shall maintain records of its costs and of other relevant information broken down in accordance with those Currencies by allocating to a record for each such Currency all costs expended by the Licensee in providing health care services for the purposes of the NHS within that Currency and by similarly treating other relevant information.

3. In the allocation of costs and other relevant information to Approved Reporting Currencies in accordance with paragraph 2 the Licensee shall use the cost allocation methodology and procedures relating to other relevant information set out in the Approved Guidance.

4. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by NHS Improvement the Licensee shall procure that each of those sub-contractors:

   (a) obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and

   (b) provides that information to NHS Improvement in a timely manner.

5. Records required to be maintained by this Condition shall be kept for not less than six years.

6. In this Condition:

"the Approved Guidance"	means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs by reference to Approved Reporting Currencies as may be published by NHS Improvement;
"Approved Reporting Currencies"	means such categories of cost and other relevant information as may be published by NHS Improvement;
"other relevant information"	means such information, which may include quality and outcomes data, as may be required by NHS Improvement for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The annual National Cost Collection (NCC) is now embedded across the Acute sector of the NHS and has mandated the patient level data collection for Community and Mental Health providers. The Trust continues to adhere to the national costing guidance and is providing detailed Patient level information to NHSE/I, The Trust has maintained the overall NHSI's costing assurance tool score of 100% ensuring the Trust is fully compliant. The direction of travel from NHSE/I is to implement quarterly collections to understand the complex costs of services within the NHS during the Covid-19 pandemic and future state. The Trust continues to develop and improve the way in which costs are being reported and allocated in conjunction with Clinicians.	• NCC return

2.2 *Condition P2 – Provision of information*

1. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall furnish to NHS Improvement such information and documents, and shall prepare or procure and furnish to NHS Improvement such reports, as NHS Improvement may require for the purpose of performing its functions under Chapter 4 in Part 3 of the 2012 Act.

2. Information, documents and reports required to be furnished under this Condition shall be furnished in such manner, in such form, at such place and at such times as NHS Improvement may require.

3. In furnishing information documents and reports pursuant to paragraphs 1 and 2 the Licensee shall take all reasonable steps to ensure that:

   (a) in the case of information or a report, it is accurate, complete and not misleading;

   (b) in the case of a document, it is a true copy of the document requested; and

4. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust has completed all required information with regards to monthly, quarterly and annual performance data. In addition, the Trust has provided ad-hoc information as requested.	• Confirmatory emails from NHS England

2.3 *Condition P3 – Assurance report on submissions to NHS Improvement*

1. If required in writing by NHS Improvement the Licensee shall, as soon as reasonably practicable, obtain and submit to NHS Improvement an assurance report in relation to a submission of the sort described in paragraph 2 which complies with the requirements of paragraph 3.

2. The descriptions of submissions in relation to which a report may be required under paragraph 1 are:

   (a) submissions of information furnished to NHS Improvement pursuant to Condition P2, and

   (b) submissions of information to third parties designated by NHS Improvement as persons from or through whom cost information may be obtained for the purposes of setting or verifying the National Tariff or of developing non-tariff pricing guidance.

3. An assurance report shall meet the requirements of this paragraph if all of the following conditions are met:

(a) it is prepared by a person approved in writing by NHS Improvement or qualified to act as auditor of an NHS foundation trust in accordance with paragraph 23(4) in Schedule 7 to the 2006 Act;

(b) it expresses a view on whether the submission to which it relates:

(i) is based on cost records which have been maintained in a manner which complies with paragraph 2 in Condition P1;

(ii) is based on costs which have been analysed in a manner which complies with paragraph 3 in Condition P1, and

(iii) provides a true and fair assessment of the information it contains.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust has complied fully with an externally commissioned audit of our costing and coding systems and outputs that took place in January / February 2015. No similar reviews since.	• Audit report • E-mail exchanges confirming externally commissioned audit occurred

2.4 *Condition P4 – Compliance with the National Tariff*

1. Except as approved in writing by NHS Improvement, the Licensee shall only provide health care services for the purpose of the NHS at prices which comply with, or are determined in accordance with, the national tariff published by NHS Improvement, in accordance with section 116 of the 2012 Act.

2. Without prejudice to the generality of paragraph 1, except as approved in writing by NHS Improvement, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the national tariff published by NHS Improvement in accordance with, section 116 of the 2012 Act, wherever applicable.

Lead Exec	Compliant	Comment	Evidence
SW	Y	Due to Covid the NHS introduced block payments for all Trusts to provide certainty for all organisations providing NHS-funded services under the NHS Standard Contract. This minimised the burden of formal contract documentation and contract management processes, so that staff could focus fully on the COVID-19 response. This continued during 2022/23. The Trust has also continued to submit accurate activity and tariff submissions to Commissioners.	• Standard contract

2.5 *Condition P5 – Constructive engagement concerning local tariff modifications*

1. The Licensee shall engage constructively with Commissioners, with a view to reaching agreement as provided in section 124 of the 2012 Act, in any case in which it is of the view that the price payable for the provision of a service for the purposes of the NHS in certain circumstances or areas should be the price determined in accordance with the national tariff for that service subject to modifications.

Lead Exec	Compliant	Comment	Evidence
SW	Y	No additional changes have been requested locally for 2022/23	• Standard contract • NHSE contract for specialised services

3 Section 3 – Choice and Competition

3.1 *Condition C1- The right of patients to make choices*

1. Subsequent to a person becoming a patient of the Licensee and for as long as he or she remains such a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, he or she is notified of that choice and told where information about that choice can be found.

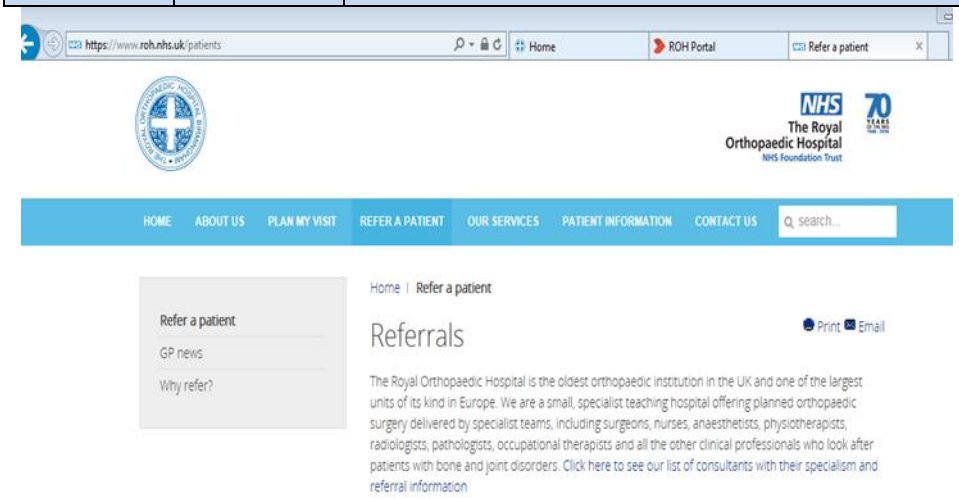
2. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.

3. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.

4. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.

Lead Exec	Compliant	Comment	Evidence
MP	Y	All patients accessing services are offered two reasonable dates with three weeks' notice as part of their referral process, and subsequently a choice of operation date where applicable. As a routine part of our consenting documentation a record of clinical procedural options is made and narrative discussion recorded, determined by consultant. Post Covid, processes have been developed to offer a blended model of face to face & virtual appointments (via telephone and/or via the attend anywhere digital platform) with the aim of ensuring those patients who are not digitally enabled remain able to choose how to access Trust services in a way that suits their preferences and personal requirements.	• Referral page on internet • Consent policy • Access policy

		The Trust will offer virtual appointment via telephone or its video platform, Dr Doctor. This means that virtual appointments are available even to patients who are not digitally enabled to undertake video consultation. There is work underway to see if old IT equipment held by the Trust could be used to bridge any gaps created by digital poverty. Virtual appointments are the default consultation media wherever clinically appropriate. This is to ensure the Trust is working towards the Department of Health target of virtual appointments. If a patient would rather be seen face to face for whatever reason their needs would be accommodated by the Trust wherever possible.	



3.2 *Condition C2 – Competition oversight*

1. The Licensee shall not:

   (a) enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS, or

   (b) engage in any other conduct which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS,

   to the extent that it is against the interests of people who use health care services.

Lead Exec	Compliant	Comment	Evidence
MP	Y	The ROH has never knowingly done anything anti-competitive.	• Standing Financial Instructions

4 Section 4 – Integrated care

4.1 *Condition IC1 – Provision of integrated care*

1. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of such services by others with a view to achieving one or more of the objectives referred to in paragraph 4.

2. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of health-related services or social care services by others with a view to achieving one or more of the objectives referred to in paragraph 4.

3. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling it to co-operate with other providers of health care services for the purposes of the NHS with a view to achieving one or more of the objectives referred to in paragraph 4.

4. The objectives referred to in paragraphs 1, 2 and 3 are:

   (a) improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision,

   (b) reducing inequalities between persons with respect to their ability to access those services, and

   (c) reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

5. The Licensee shall have regard to such guidance as may have been issued by NHS Improvement from time to time concerning actions or behaviours that might reasonably be regarded as against the interests of people who use health care services for the purposes of paragraphs 1, 2 or 3 of this Condition.

Lead Exec	Compliant	Comment	Evidence
MP/NB	Y	The Trust has an Accessible Information Standard policy and has a forum that monitors its ongoing compliance with the standard, There is an Accessible Information Standard internet page for patients to obtain information about how to request communications in different formats and inform them what the Trusts obligations are. The interactive text messaging service makes it easier for patients to request a reschedule or cancellation of appointment and this is being expanded to an interactive patient-led booking. Data on which patients are and are not accessing these services will be used to identify areas of potential digital exclusion. Appointment letters are now available electronically which allows patients to be able to increase font size as well as us read aloud software and potentially internet based translation software The Trust has worked with Synertec to enable sending letters in other formats such as braille, large print, extra large print and easy read. The Trust has access to interpreting services 24/7 via telephone and can be face to face if required At our outpatient desks the Trust has the loop up system for individuals with hearing loss For patients with complex needs the Trust has; A dementia strategy; A Learning Disability strategy; A Mental health policy Staff are trained in a range of forums to ensure compliance against theses polices The Trust has in place a Patient Engagement & Experience Group and regularly holds 'Coffee Catch Up' events to aid patient engagement, for which the scope, which currently includes joint care services, is to be expanded to include all orthopaedic specialties. The Trust has also	• Accessible Information Standard • AccessAble • Dr Doctor interactive text messaging system • Electronic letters • Synertec • Learning Disabilities Strategy • Dementia Strategy • Mental Health policy • Patient Experience & Engagement Group minutes • ICB Board papers • Governance documents supporting the UHB elective recovery mutual aid arrangement

		introduce 'Smiley Face' around the hospital in key areas to encourage feedback. In addition, work was undertaken to relaunch the Patient Participation Forum meetings. The Trust has in place a Learning Disability Group. The Trust has worked in partnership with AccessAble to create Detailed Access Guides to facilities, wards and departments at the ROH. The Guides are 100% facts, figures and photographs and give patients useful information to plan their visit to the hospital and assure them that we are accessible and have considered their needs. The free Accessibility Guide is for staff and visitors and is available at www.roh.nhs.uk and www.AccessAble.co.uk and on the AccessAble App. As the country emerged from the pandemic there was a return to face to face appointments although there remained a key focus on ensuring that virtual clinic appointments were used when appropriate. The Trust is a key member of the Integrated Care System to allow the shaping of seamless services within the City and is working collaboratively particularly with University Hospitals Birmingham NHSFT to deliver the national elective recovery imperatives. The Trust has a joint governance forum with BWCH to oversee patients cared on pathway between the two providers. Inequalities metrics regarding waiting lists are currently included in the sub board / board committee papers to support the monitoring of inequalities and explore the patient waiting list (PTL) across a range of measures.	

5 Section 5 – Continuity of Services

5.1 *Condition CoS1 – Continuing provision of Commissioner Requested Services*

1. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.

2. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G9(1)(b), NHS Improvement issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.

3. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except:

   (a) with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or

   (b) at any time when this condition applies by virtue of Condition G9(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or

   (c) if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by NHS Improvement for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.

4. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within [28] days of the alteration, shall give to NHS Improvement notice in writing of the occurrence of the alteration with a summary of its nature.

5. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery

or provision of that service in a manner which differs from the manner specified and described in:

(a) the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or

(b) if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or

(c) at any time when this Condition applies by virtue of Condition G9(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust has not had cause to cease to provide, or materially alter the specification or means of delivery of any Commissioner Requested Services.	• Schedule of commissioning meetings • Minutes of commissioning meetings

5.2 *Condition CoS2 – Restriction on the disposal of assets*

1. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")

2. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.

3. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.

4. The obligations in paragraphs 5 to 8 shall apply to the Licensee if NHS Improvement has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.

5. The Licensee shall not dispose of, or relinquish control over, any relevant asset except:

   (a) with the consent in writing of NHS Improvement, and

   (b) in accordance with the paragraphs 6 to 8 of this Condition.

6. The Licensee shall furnish NHS Improvement with such information as NHS Improvement may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.

7. Where consent by NHS Improvement for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.

8. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:

   (a) NHS Improvement has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to:

      (i) transactions of a specified description; or

      (ii) the disposal of or relinquishment of control over relevant assets of a specified description, and

   the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or the Licensee is required by the Care Quality Commission to dispose of a relevant asset.

9. In this Condition:

"disposal"	means any of the following: (a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or (b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or (c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or (d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered, and references to "dispose" are to be read accordingly;
"relevant asset"	means any item of property, including buildings, interests in land, equipment (including rights, licences and consents relating to its use), without which the Licensee's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced;
"relinquishment of control"	includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and "relinquish" and related expressions are to be read accordingly.

10. The Licensee shall have regard to such guidance as may be issued from time to time by NHS Improvement regarding:

(a) the manner in which asset registers should be established, maintained and updated, and

(b) property, including buildings, interests in land, intellectual property rights and equipment, without which a licence holder's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust maintains an up-to-date asset register, which is audited as part of the annual audit of the accounts. The Trust has a policy in place regarding the disposal of all assets, which includes the process for the disposal of relevant assets. Asset disposal forms are completed and authorised for any asset disposals.	• Asset register • Asset disposal policy • Asset disposal forms • Annual accounts – asset disposal

5.3 *Condition CoS3 – Standards of corporate governance and financial management*

1. The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:

   (a) suitable for a provider of the Commissioner Requested Services provided by the Licensee, and

   (b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.

2. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to:

   (a) such guidance as NHS Improvement may issue from time to time concerning systems and standards of corporate governance and financial management;

   (b) the Licensee's rating using the risk rating methodology published by NHS Improvement from time to time, and

   (c) the desirability of that rating being not less than the level regarded by NHS Improvement as acceptable under the provisions of that methodology.

Lead Exec	Compliant	Comment	Evidence
SW for financial management	Y	The Trust has a range of financial policies and controls in place to meet this licence condition. These policies and controls are audited annually by our Internal Auditors	• Financial policies • Internal audit reviews of

		and recommendations and actions are monitored by Audit Committee. A plan was agreed at the start of the year within the ICS and contracts agreed which reflected this. Whilst essentially these remained a block payment through the year, an Elective Recovery Scheme was introduced to incentivise elective recovery. However due to ongoing pressure across urgent and emergency care, and industrial action, and the corresponding impact on elective recovery, under-recovery against these elective targets were never actioned.	financial management • Audit Committee minutes • Annual Report
SGL for corporate governance	Y	The Trust's segmental rating remained at 2 during the year.	• NHS Oversight Framework segment correspondence from NHS E and the BSol ICB • Annual Governance Statement

5.4 *Condition CoS4 – Undertaking from the ultimate controller*

1. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by NHS Improvement, that the ultimate controller ("the Covenantor"):

   (a) will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the 2012 Act or this Licence, and

   (b) will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS Improvement.

2. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.

3. The Licensee shall:

(a) deliver to NHS Improvement a copy of each such undertaking within seven days of obtaining it;

(b) inform NHS Improvement immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and

(c) comply with any request which may be made by NHS Improvement to enforce any such undertaking.

4. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:

(a) directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and

(b) that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.

5. A person is not an ultimate controller if they are:

(a) a health service body, within the meaning of section 9 of the 2006 Act;

(b) a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;

(c) any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or

(d) a trustee of the Licensee and the Licensee is a charity.

Lead Exec	Compliant	Comment	Evidence
SW/SGL	Y	The ROH is a health service body so this is not applicable	• None

5.5 *Condition CoS5 – Risk pool levy*

1. The Licensee shall pay to NHS Improvement any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.

2. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by NHS Improvement.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust has not been required to make any risk pool levies during 2022/23	• None

5.6 *Condition CoS6 – Co-operation in the event of financial stress*

1. The obligations in paragraph 2 shall apply if NHS Improvement has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.

2. When this paragraph applies the Licensee shall:

   (a) provide such information as NHS Improvement may direct to Commissioners and to such other persons as NHS Improvement may direct;

   (b) allow such persons as NHS Improvement may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and

   (c) co-operate with such persons as NHS Improvement may appoint to assist in the management of the Licensee's affairs, business and property.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust has not received any such notice from NHS Improvement during the financial year.	• Finance and performance overview

5.7 *Condition CoS7 – Availability of resources*

1. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

2. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

3. The Licensee, not later than two months from the end of each Financial Year, shall submit to NHS Improvement a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

   (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

   (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".

   (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

4. The Licensee shall submit to NHS Improvement with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

5. The statement submitted to NHS Improvement in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

6. The Licensee shall inform NHS Improvement immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

7. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

8. In this Condition:

"distribution"	includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital;
"Financial Year"	means the period of twelve months over which the Licensee normally prepares its accounts;
"Required Resources"	means such: (a) management resources, (b) financial resources and financial facilities, (c) personnel, (d) physical and other assets including rights, licences and consents relating to their use, and (e) working capital as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services.

Lead Exec	Compliant	Comment	Evidence
SW	Y	The Trust Board has approved the Trust's financial and operational plan for 2022/23 that evidences that the financial resources and working capital required to deliver sustainable services are in place. The Board also approved the 2022/23 capital plan which reviewed the physical assets required for this purpose. With regard to the availability of sufficient personnel there remain some risks in relation to sufficient clinical staffing, although this is an improving position, and this risk is not believed to be sufficiently serious to impact upon NHS Improvement's license requirements as arrangements are in place to ensure sufficient safe staffing.	• Planning slides considered at Finance & Performance Committee and Trust Board • Workforce overview and recruitment and retention updates

6 Section 6 – NHS Foundation Trust Conditions

6.1 *Condition FT1 – Information to update the register of NHS foundation trusts*

1. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall ensure that NHS Improvement has available to it written and electronic copies of the following documents:

   (a) the current version of Licensee's constitution;

   (b) the Licensee's most recently published annual accounts and any report of the auditor on them, and

   (c) the Licensee's most recently published annual report,

   and for that purpose shall provide to NHS Improvement written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.

3. Subject to paragraph 4, the Licensee shall provide to NHS Improvement written and electronic copies of any document that is required by NHS Improvement for the purpose of Section 39 of the
   2006 Act within 28 days of the receipt of the original document by the Licensee.

4. The obligation in paragraph 3 shall not apply to:

   (a) any document provided pursuant to paragraph 2; (b)

   any document originating from NHS Improvement; or

   (c) any document required by law to be provided to NHS Improvement by another person.

5. The Licensee shall comply with any direction issued by NHS Improvement concerning the format in which electronic copies of documents are to be made available or provided.

6. When submitting a document to NHS Improvement for the purposes of this Condition, the Licensee shall provide to NHS Improvement a short written statement describing the document and specifying its electronic format and advising NHS Improvement that the document is being sent for the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act.

Lead Exec	Compliant	Comment	Evidence
SGL	Y	There were some amendments to the Constitution proposed to the Council of Governors in relation to the public constituencies and the latest version has been provided to NHSE. The audited annual report and accounts for 2021/22 were provided to NHSI according to the required timetable.	• Annual report & accounts • Paper to Council of Governors proposing changes to the Constitution.

6.2 *Condition FT2 – Payment to NHS Improvement in respect of registration and related costs*

1. The obligations in the following paragraph of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. Whenever NHS Improvement determines in accordance with section 50 of the 2006 Act that the Licensee must pay to NHS Improvement a fee in respect of NHS Improvement's exercise of its functions under sections 39 and 39A of that Act the Licensee shall pay that fee to NHS Improvement within
28 days of the fee being notified to the Licensee by NHS Improvement in writing.

Lead Exec	Compliant	Comment	Evidence
SW	Y	No fees have been levied by NHS England during 2022/23	• None

6.3 *Condition FT3 – Provision of information to advisory panel*

1. The obligation in the following paragraph of this Condition applies if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall comply with any request for information or advice made of it under

Section 39A(5) of the 2006 Act.

Lead Exec	Compliant	Comment	Evidence
SGL	Y	No request for a referral to the advisory panel was received from members of the Council in the financial year.	• None

6.4 *Condition FT4 – NHS foundation trust governance arrangements*

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

   (a) have regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time; and

   (b) comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:

   (a) effective board and committee structures;

   (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and

   (c) clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:

   (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

   (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;

(c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions

(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8. The Licensee shall submit to NHS Improvement within three months of the end of each financial year:

(a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and

(b) if required in writing by NHS Improvement, a statement from its auditors either:

(i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or

(ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

Lead Exec	Compliant	Comment	Evidence
SGL	Y	The corporate governance framework is set out within the Trust's annual report and specifically within the Annual Governance Statement. The Director's report within the Accountability Report outlines the Board composition and skills and also references the architecture of the Board & its committees. The Performance report section outlines the performance against a range of quality metrics.	• Annual Report • Safe staffing reports • Presentations to the CQC and meeting notes from the engagement events • Head of Internal Audit opinion

		The safe staffing report seen at Quality & Safety Committee provides assurance to the Board that there is adequate nurse staffing cover to maintain a safe level of care for patients. The Corporate Governance Declaration will be presented at the Board meeting on 5 July for approval and publication. The Trust has not received any regulatory enforcement action or undertakings applied during the year. The end of year assessment from the Head of Internal Audit was that there were no matters of significance to include within the section of the annual report concerning lapses in internal control.	

7 Section 7 – Interpretation and Definitions

7.1 *Condition D1 – Interpretation and Definitions*

1. In this Licence, except where the context requires otherwise, words or expressions set out in the left hand column of the following table have the meaning set out next to them in the right hand column of the table.

"the 2006 Act"	the National Health Service Act 2006 c.41;
"the 2008 Act"	the Health and Social Care Act 2008 c.14;
"the 2009 Act"	the Health Act 2009 c.21;
"the 2012 Act"	the Health and Social Care Act 2012 c.7;
"the Care Quality Commission"	the Care Quality Commission established under section 1 of the 2008 Act;
"clinical commissioning group"	a body corporate established pursuant to section 1F and Chapter A of Part 2 of the 2006 Act;
"Commissioner Requested Service"	a service of the sort described in paragraph 2 or 3 of condition G9 which has not ceased to be such a service in accordance with paragraph 9 of that condition;
"Commissioners"	includes the NHS Commissioning Board and any clinical commissioning group;
"Director"	includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of: (i) an NHS foundation trust, or (ii) a company constituted under the Companies Act 2006;
"Governor"	includes any person who, in any organisation, performs the functions of, or functions equivalent or

	similar to those of, a Governor of an NHS foundation trust as specified by statute;
"the NHS Acts"	the 2006 Act, the 2008 Act, the 2009 Act and the 2012 Act;
"NHS Commissioning Board"	the body corporate established under section 1E of, and Schedule A1 to, the 2006 Act;
"NHS foundation trust"	a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act.

2. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.

3. Unless the context requires otherwise, words or expressions which are defined in the 2012 Act shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.

4. Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.

The Royal Orthopaedic Hospital NHS Foundation Trust

ANNUAL STATEMENTS & SELF-CERTIFICATION – EVIDENCE FOR STATEMENT OF COMPLIANCE WITH CORPORATE GOVERNANCE CONDITION & DUTY TO TRAIN GOVERNORS

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
CORPORATE GOVERNANCE STATEMENT			
The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	None	• **Annual Governance Statement which outlines the key controls in place to ensure that the Trust's governance arrangements are sound and effective.** • **Annual Report contents in 'Accountability Report' summarises how the Trust complies with the Code of Governance.** • **Judgements under the Oversight Framework by NHS England and discussion with the ICB during the year; correspondence from NHSE to ICB outlining judgement of segmentation.** Currently Segment 2 • **Head of Internal Audit Opinion 2022/23** which concludes that there is '**significant assurance with minor improvements required**' regarding the Trust's Internal control and risk management framework • Further progress during the year with strengthening the use of the Board Assurance Framework and risk management systems & processes. **Trust Board agendas showing BAF is considered routinely and the BAF showing it is organised to be in line with the Trust's strategic priorities. Internal audit into Risk Management and BAF (Quarter 4 2022/23). Reports to Audit Committee on the BAF.**	DoG

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time		• **CEO reports to Board highlighting new guidance issued. Reports from the Director of Governance around specific new pieces of legislation and guidance – new Code of Governance including guidance on role of governors. Reports on Ockenden; Fuller report.** • **Plethora of guidance received during the year in response to elective recovery following the pandemic and the operational requirements throughout the year.** • **Annual report 2022/23 which outlines the Trust's response to the later phases of the pandemic in terms of clinical prioritisation and internal governance adaptations.** • Routine bulletins from NHS England and NHS Providers 'On the Day' briefings are received and reviewed by the Executive Team and Trust Board – **bulletins**	DoG
The Board is satisfied that the Trust implements:	(a) Effective board and committee structures;	• The Committee structure has remained static during the year. **Committee structure in the Annual Governance Statement.** • An effectiveness review has been completed for the Quality & Safety Committee during the year and the Staff Experience & OD Committee and Finance & Performance Committee process has also commenced. **Papers to the Committees around effectiveness reviews and action plans where developed.** • The **terms of reference for the Committees** have been reviewed and amended during the year • All Committees report back at each Board meeting on key highlights and matters needing to be escalated via an **assurance report or briefing note**. • **Annual Governance Statement** 2022/23 outlines the Board & Committee structure. • The Board and Committees have **annual workplans and Board topics schedules**.	DoG

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
		• The **meetings structure chart** has been revised during the year to include Quality & Safety Executive, a new development to enhance the oversight of the quality agenda • **Committee agendas and minutes** showing where items have been remitted to the Board or other committees.	
	(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees;	• The Trust has a **Scheme of Delegation** in place which sets out the matters reserved to the Board. • The **terms of reference for the Committees** have been reviewed and amended during the year. • **External well led assessment** in 2019/20 presented a positive view of the Trust's internal control and governance arrangements. This remains current and another external review is not yet required. • **CQC report** highlights that the governance arrangements in respect of the Board and its Committees are overall sound. • The **Quality & Safety Committee and Quality & Safety Executive workplans** include reports from the clinical governance committees that present by rotation. • Executive Team weekly meeting is the main advisory group to the Chief Executive. **Agendas of Executive Team business meetings** • Guests of the Board and Committees undergo a briefing session with the Director of Governance when not familiar with the forum. **A Guide to presenting to the Board** and its Committees is in place.	DoG

	(c) Clear reporting lines and accountabilities throughout its organisation.	• The structure of the Executive team and the portfolios of the Executive Directors have remained static during the year, although the proposed changes post 31 March 2023 were approved by the Nominations & Remuneration Committee in March 2023. The recruitment of a Chief Nurse took place during 2022/23, with the final outcome in December 22. **Job descriptions for Executive Directors. Objectives of the Executive Directors. Minutes of the Nominations and Remuneration Committee. Job Description for the Chief Nurse.** • The Director of Governance holds responsibility for risk management and policy governance as well as more traditional elements of support to the Board & Chairman. A change to the portfolio of this role was effected during the year to subsume the responsibilities for Clinical Governance, oversight of which previously sat with the Chief Nurse **Job description for Director of Governance. Objectives of the Director of Governance.** • The Trust has an established divisional structure in place for clear accountability and this is supported by a Deputy Chief Operating Officer, a Deputy Medical Director, Heads of Nursing and an Associate Medical Director and Associate Chief Operating Officers. **Job descriptions and divisional management structures may be used to evidence compliance with this requirement.** • **Corporate governance framework** • **Board and committee workplans.** • **Team brief slides** providing updates on the responsibilities between the Executive portfolios	CE
The Board is satisfied that the Trust effectively implements	(a) To ensure compliance with the Licensee's duty	• **Internal and External Audit opinions considered by Audit Committee** • **Going Concern statement in Annual Report and paper to Audit Committee on Going Concern.**	CFO/CE

systems and/or processes:	to operate efficiently, economically and effectively;	• **Finance & Performance Committee meeting papers** demonstrating the detail considered to assess efficiency and effectiveness. • **Papers on partnership working, mutual aid and ICB updates.** • **Elective Hub Accreditation updates** • **Cost Improvement Programme updates.** • **Litigation updates** demonstrating a reduction in CNST premia year on year • **Model Hospital** updates • **Annual Report and Accounts 2022/23 showing that the Trust ended the year achieving a surplus**	
	(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	• **Board cycle of business** and the **workplans of the Board Committees** ensure that there is comprehensive oversight of key matters. • **Board meeting agendas.**	Ch/ DoG

	(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	• **CQC:** Assurance is obtained routinely on compliance with CQC registration requirements through Directors and Senior Managers of the Trust having specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems to support those standards. The Trust last underwent a full inspection in 2019, where it remained rated as 'Good' overall, with a 'Good' rating in each of the five CQC domains. There has been some good engagement with the CQC during the year, with regular relationship meetings and an onsite visit. **CQC insight reports and engagement meeting notes**. • **NHS Commissioning Board**: The Trust works in partnership with the Commissioners Groups and NHS England. Assurance of compliance with Quality Standards and Constitutional Imperatives is measured and gained through the **Patient Safety & Quality Report and Finance & Performance report** scrutinised at Quality & Safety Committee and Finance & Performance Committee. • **Board and Statutory Regulators of health care professionals**: All registered NHS professionals are bound to their code of conduct and the rules and requirements of their registration therein. Failure to comply with their expected professional standards would lead to disciplinary action via the Trust's disciplinary policy and in some cases removal from their professional register. Assurance is obtained routinely on compliance with professional member registration requirements through Directors and Senior Managers of the Trust having specific responsibilities in respect to members of staff working within their specific areas and more generally in maintaining internal control systems such as annual PDR, and re-validation processes. **Appraisal and revalidation reports to Trust Board and Nurse staffing updates to Quality & Safety Committee. Workforce overview to Staff Experience & OD Committee.**	CE/CN/ COO
	(d) For effective financial decision-making,	• The Trust Board approves the **annual budget and operational plan.** • Budget meetings are held with Divisions and Corporate areas. **Diary invites of these meetings may be used to evidence this.**	CFO

	management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	• Financial performance is discussed and challenged at every Board meeting and in detail by the Finance & Performance Committee. **Minutes of Board & Finance & Performance Committee and Trust Board.** • The Audit Committee considers Going Concern status and recommends statements for the annual report and accounts. **Going Concern paper to Audit Committee.** • The Trust has **Standing Financial Instructions** in place and any breaches of these are reported to the Audit Committee as part of its annual workplan**. Papers to Audit Committee.** • Governors are required to approve 'significant transactions' although have not been required to do so during the year. **Governor induction handbook** and **NHS England Guide to the Responsibilities of Governors.** • The Trust uses the services of a Counter Fraud specialist to monitor and investigate any potential fraudulent practice and report back to the Audit Committee. **Updates to Audit Committee.**	
	(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	• The Board makes every effort to ensure that reports to both the Board and its Committees contain relevant timely and accurate information. • The Board met formally on eleven occasions during the year. **Board minutes** and **agendas** • The sequencing of Board Committees is configured such that they meet prior to the Trust Board and can provide appropriate upwards assurance on matters of detail considered. **Meeting schedule. Assurance reports.** • **Workplans for the Board & its Board Committees** ensure that there is a forward view of matters needing to be considered several months ahead.	Ch

	(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	• **Declaration approved by the Board on 1 June 2022, confirming how the Trust operates to meet the conditions of its licence. Update to the Board on 5 July 2023.** • Material risks are considered through the **Board Assurance Framework** which has been refreshed a number of times during the year. • The Corporate Risk Register is considered by the Executive Team and the elements of this relevant to each Board committee are also considered monthly, the most serious of which are included on the Board Assurance Framework. **Corporate Risk Register.**	Ch/ DoG
	(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	• Trust Board approves the **annual budget and operational plan**. • Performance discussed and challenged at every Board meeting and in detail by the Finance & Performance Committee. **Minutes from Board and Finance & Performance Committee.** • Business planning process has been strengthened this year with all areas presenting to the Executive Team. **Presentations to Executive Team** • Internal Audit review key areas of interest and report findings to Audit Committee. **Internal Audit plan. Internal Audit progress reports.** • Delivery of audit recommendations is monitored at Audit Committee via **recommendation tracking reports.** The process to ensure timely closure of recommendations has been revisited this year in conjunction with the Internal Audit function. • A summary of the internal audit plan and the level of assurance that the reviews have found is considered at the May meeting of the Audit Committee as part of the Head of	ALL

		Internal Audit's opinion. **Paper to the May 2023 meeting. Annual Governance Statement covering 2022/23.**	
	(h) To ensure compliance with all applicable legal requirements.	• The Trust uses the services of an established law firm to provide legal advice on request. • The **Trust's constitution** reflects the legal requirements governing the operation of the foundation trust. • The Board is not aware of any other material issues that would place it in contravention of any legal requirements. • **A quarterly report on open claims and related litigation** is received by the Quality & Safety Committee.	ALL
"The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:	(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	• The Board keeps the balance of its skills and competencies under review to ensure completeness and appropriateness for the requirements of the Trust. Within the year, the Trust Board's membership has been refreshed and was joined by two new Non Executives, each offering a clinical skills set and experience. The Chief Nurse recruitment process took place in 2022/23. **Board member profiles in annual report.** • The Board's composition includes a Medical Director who is a practicing clinician, a registered nurse and two Non Executives with a clinical background. The process for succession planning for the clinical element of the Non Executive cadre concluded within the 2022/23 year, with the recruitment of two new Non Executives holding a clinical background. The process was supported by an external recruitment agency. **Board structure in annual report.**	Ch
	(b) That the Board's planning and decision-making processes take	• Most public Board meetings include a Patient Story. **Minutes and agendas of Board meetings.** • Quality Impact Assessments have been undertaken for any pathway introduced into the organisation, including mutual aid and ambulatory trauma services. **EQIA updates to Trust Board and Quality & Safety Committee.**	CN/COO/ CFO

	timely and appropriate account of quality of care considerations;	• The Quality & Safety Committee provides a written update on its work at each Board meeting. **Assurance reports from Quality & Safety Committee.** • CIP schemes are quality impact assessed, and the process has been strengthened during the year under the remit of the Deputy Director of Finance. **CIP QIA register** and **minutes of the CIP Programme Board.** • Quality Service Improvement and Redesign (QSIR) methodology is now embedded into the organisation which systematises a review of quality considerations for projects and initiatives within the organisation. **QSIR and 'Perfecting Pathways' Programme Board papers.** • The **Quality Account** includes a set of quality priorities, delivery of which will be monitored by the Clinical Quality Group and Quality & Safety Committee on a quarterly basis.	
	(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;	• The Quality & Safety Committee receives a **Patient Safety & Quality report**, the highlights of which are reported up to the Board as part of the assurance report from the Committee. • Detailed reports into specific quality indicators are considered by the Quality & Safety Committee. **WHO compliance, VTE reports, infection prevention and control, mortality reports and falls** • The Board considers a monthly **Finance & Performance Overview**, which includes a set of metrics including key constitutional standards and regulatory requirements. • A **Workforce Overview** which provides a suite of information is scrutinised by the Staff Experience & OD Committee when it meets on alternate months. • Further work has been undertaken to ensure that the quality of data considered is sound. **Data Quality policy. Minutes of Data Quality Group.**	CN/COO

		• The suite of information considered by the Board and its committees has been enhanced this year by the development of sets of data which provide a demographic analysis which supports discussions around Health Inequalities. **Demographic information in the Finance & Performance packs.**	
	(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	• The Quality & Safety Committee receives a monthly **Patient Safety & Quality report,** the highlights of which are reported up to the Board as part of the assurance report from the Committee. • Detailed reports into specific quality indicators are considered by the Quality & Safety Committee. • The Quality & safety Committee's workplan includes service presentations, where key clinical leads provide an update on the work of their service. **Updates to Quality & Safety Committee and Committee minutes.** • The Board has received an update from the Freedom to Speak Up Guardian during the year which has outlined some key areas of concern over patient care and the actions planned to address them. **Presentation to Trust Board in February 2023.**	CN/DoG
	(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into	• Data is reported through into the **Patient Safety & Quality Report** which includes PALS contacts, friends and family test results, compliments and complaints. • Patient stories are shared at the Board. **Minutes from Board meetings**. • Governors and patient representatives are included on some of the Trust's corporate meetings and groups. **Patient Experience and Engagement Group, Patient Participation Forum, Charitable Funds Committee minutes.** • Key members of the medical and nursing teams meet with patients who have registered dissatisfaction with their care. **Diary invites.**	CN

	account as appropriate views and information from these sources; and	• The Quality Assurance walkabouts framework has been refreshed during the year with the intention to relaunch these in 2023/24. • There is a robust complaints process in place which meets the required regulatory standards. **Annual complaints report.** • 'Smiley Faces' technology has been introduced during the year to provide a real time sense of patient satisfaction. **Patient Safety and Quality Report inclusion of this information.** • The work to implement the new PSIRF framework will require engagement with patients and the public to ensure that the offering meets their needs as well as that of the Trust. **PSIRF presentations to Board and Quality & Safety Committee.** • A Patient Experience & Engagement Group and Patient Participation Forum provides a strategic focus on matters which involve patients. **Terms of reference.** • 'Coffee Catch Up' initiatives have provided a rich source of patient feedback and opportunities for engagement. **Presentation to the Board on JointCare.** • The 'Chat and Check' initiative had provided closer connection between the Executive Team and the various functions of the organisation. **Feedback in 'Team Brief' and Chief Executive's public report to Trust Board.**	
	(f) That there is clear accountability for quality of care throughout the Trust including	• As described within the **Annual Governance Statement**. • The Board receives assurance on the Quality of Care through the oversight of the Quality & Safety Committee which is chaired by a Non Executive with a clinical background and attended by the Executive Chief Nurse, the Medical Director, the Chief Operating Officer, Director of Governance and the Chief Executive. **Terms of Reference for Quality & Safety Committee.**	CN/DoG/ MD

	but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate	• Biweekly meetings chaired by the Director of Governance and attended by the Medical Director, Chief Operating Officer, Chief Nurse and divisional representatives are in place to provide additional oversight of incidents and Root Cause Analyses at a divisional and corporate level. **Papers from Executive Governance meetings** • The Trust has in place a Clinical Quality Group, chaired by the Deputy Chief Nurse (Chief Nurse for the most part this year) which is attended by a range of clinical and non-clinical senior staff from across the Trust. **Agendas and terms of reference for Clinical Quality Group.** • The Quality & Safety Committee in turn receives more detailed reports from subgroups covering particular aspects of quality. This supports the process of escalation of risk related to quality throughout the Trust. **Quality & Safety Committee workplan.** • During the year the Quality & Safety Executive met to strengthen the underlying quality oversight by the Executive Team and this upwardly reports to the Quality & Safety Committee on a monthly basis. This forum will be refreshed for 2023/24. **Upward reports from Quality & Safety Executive. Terms of Reference.** • The Executive Team holds monthly briefings with Heads of Department & other senior managers for dissemination to teams. **Team Brief.** • The AQILA panel has gathered together a number of clinically focused processes, including Outcomes, Effectiveness and Audit. **Upward reports to Quality & Safety Committee from AQILA and terms of reference.**	
The Board is satisfied that there are systems to ensure that the Trust has in place		• The Board keeps the balance of its skills and competencies under review to ensure completeness and appropriateness for the requirements of the Trust. • Further work has been undertaken to devise and review the succession planning for the Board and to keep the skill set under review. **Board skills matrix.**	Ch/CE

personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.		• Some portfolio changes were effected during the year, including the transfer of the clinical governance portfolio to the Director of Governance. The Nominations and Remuneration Committee approved some further changes which took effect from 1 April 2023 when the Director of Strategy & Delivery retired. **Minutes from the Nominations & Remuneration Committee.** • The Board includes a Non Executive Director with specific skills in workforce and improvement. The processes to recruit a Chief Nurse occurred during 2022/23. **Board structure in annual report. Chief Nurse Job Description.** • The Quality & Safety Committee has considered during the year a nurse staffing update which shows where there have been gaps in nurse staffing, the mitigations that have been applied to address these. Any incidents associated with nurse staffing are also reviewed in the same report. **Safer staffing papers.** • Further work has been undertaken this year to underpin the resources and skill set below the Executive Team including the recruitment of a Deputy Chief Operating Officer, Associate Chief Operating Officers, a Deputy Chief Nurse, a Deputy Chief People Officer and a plan is in place to recruit an Assistant Director of Governance. **Structure charts.**	

GOVERNOR TRAINING			
The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.		New governors receive induction during which any specific training issues are identified and addressed. Bespoke training is provided in-house each year for all Governors on topics identified by them as the norm. During the year, an education programme was developed which was approved by the Council of Governors at the January 2023 meeting. The first sessions commenced in June 2023. Two papers were presented during the year setting out the implications for governors of the introduction of the new annex to the Code of Governance, particularly around the need to represent the public as a whole, rather than individual constituencies and to embrace System working. Governors during the year were offered and participated in a tour of the site to offer an insight into the working of the organisation which is designed to support their duty to hold to account and represent the interests of the public at large. New governors appointed or elected during the year have been offered and participated in an induction meeting with the Chair, Director of Governance and Lead Governor. Further work is planned during 2022/23 to strengthen the partnerships with governors of other peer organisations and within the Integrated Care System and to further embed the formal training programme. **Minutes from Council of Governors meetings. Papers on the changes to the annex to the Code of Governance for FTs. Details of the Governor 'Sizzle Sessions' and engagement plans.**	Ch/DoG

KEY:

Abbreviation	Job Title
Ch	Chair
CEO	Chief Executive Officer
COO	Chief Operating Officer
CFO	Chief Finance Officer
CN	Chief Nurse
DoG	Director of Governance
Emboldened text indicates evidence available to confirm compliance	

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Changes to NHS Governance Guidance**
SPONSOR (EXECUTIVE DIRECTOR):	**Tim Pile, Trust Chair and Jo Williams, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**5 July 2023**

EXECUTIVE SUMMARY:

In May 2022, NHS England announced that given the introduction of the Integrated Care Systems as a result of the revisions to the Health and Social Care Act, it was planning to propose some changes to the 'Code of Governance for NHS Provider trusts' and to also set out some recommended amendments to its guide 'Your Statutory Duties – A Guide for NHS Foundation Trust governors'. Finally, NHS England published 'draft guidance on good governance and collaboration'.

This paper summarises the changes to the Code of Governance which came into effect from April 2023 and the summary of the guidance on good governance and collaboration.

REPORT RECOMMENDATION:

The Trust Board is asked to:

- RECEIVE and ACCEPT the update on the new national guidance on governance of Provider organisations
- SUPPORT the proposal to receive an annual update on compliance

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		

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

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

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

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

Requirement to adhere to the legal obligations under the terms of the Health and Social Care Act 2022.

PREVIOUS CONSIDERATION:

The proposed changes were outlined at the September 2022 meeting.

FOR INFORMATION

Changes to NHS England National Governance Guidance

BRIEFING TO THE TRUST BOARD – 5 JULY 2023

1.0 Introduction

1.1 In May 2022, NHS England announced that given the introduction of the Integrated Care Systems as a result of the revisions to the Health and Social Care Act, it was planning to propose some changes to the 'Code of Governance for NHS Provider trusts' and to also set out some recommended amendments to its guide 'Your Statutory Duties – A Guide for NHS Foundation Trust governors'. Finally, NHS England published 'draft guidance on good governance and publication'.

1.2 A period of consultation was undertaken between 27 May 2022 – 8 July 2022. NHS England worked closely with stakeholders in the development of the proposals, and also held a series of national and regional engagement events attended by trust and system leaders as part of the consultation process.

1.3 The new Code of Governance came into force from 1 April 2023. This paper summarises the key changes.

2.0 Code of Governance for NHS Providers – introduction and summary

2.1 The purpose of the code of governance (the code) is to help NHS provider boards deliver effective corporate governance, contribute to better organisational and system performance and improvement, and ultimately discharge their duties in the best interests of patients, service users and the public.

2.2 The code is built around a series of high-level organisational principles backed by specific provisions that translate these into corporate governance processes. These are divided into five areas:

- board leadership and purpose
- division of board responsibilities
- board composition, succession and evaluation
- audit, risk and internal control
- board remuneration.

2.3 The code is based on the Financial Reporting Council's UK Corporate Governance Code, and was last updated in 2014

2.4 Following the consultation exercise, the proposed amendments and key requirements were largely implemented unaltered, these being:

- The code remains on a 'comply or explain' basis.
- The code is extended to NHS trusts.
- Updates and positions corporate governance processes in the context of system working and meeting the triple aim covering quality of care, use of resources and health and wellbeing.
- Reflecting the latest NHS England policy in the appointment, appraisal and pay of trust directors, including specific points regarding recruitment to board positions:
  - Selection panels for board appointments should – as best practice – include at least one assessor from NHS England and/or an integrated care board (ICB) representative. Appointments will remain within the power of nominations committees, but this will ensure that the wider NHS has a say in the process.
  - The selection process for board members should, in addition to other criteria, consider ability and willingness to co-operate with the wider system.
  - Chairs should generally only remain in post on the board for up to six years – trusts extending this period should only do so with the agreement of NHS England.
- Embedding equality, diversity and inclusivity considerations in corporate governance processes.

2.5 NHSE did, however, seek to create some points of clarity based on the consultation feedback, as follows:

- Clarifying the link between principles and provisions in the code (each section contains a set of high-level principles; the provisions that follow translate these into governance processes).
- Stressing the need to spread responsibilities across the whole board to ensure that individual chairs, non-executive directors and executive directors have enough capacity to carry out their roles effectively.
- Referencing links between quality of care and operational governance where appropriate – though it should be noted that the code is concerned with setting effective corporate governance practices, rather than well-led criteria supporting day-to-day operations.
- Clarifying that an individual who serves three years as a non-executive director can go on to spend up to six years as chair without requiring NHS England agreement.

3.0 Code of Governance for NHS Providers - Addendum to 'Your Statutory Duties – A Guide for NHS Foundation Trust governors'

3.1 NHS foundation trust governors have a formal role to hold the chair and non-executives to account for the overall performance of their trust's board. With the move to system working, the Code seeks to make clear that they should now also assess how their trust's board is supporting the system(s) it is a partner of and considering how its decisions affect the system(s). To support this, NHSE developed

and consulted on an addendum to the existing guide for foundation trust governors, which:

- Explains how the duties of foundation trust councils of governors can support system working and collaboration.
- Highlights the importance of considering the impact of the board's decisions on the wider public inside and outside the ICS.
- Gives examples of how councils of governors and boards can work well together.
- Sets out further considerations of the duty of councils of governors in respect of corporate activity

3.2 Given the support for the proposed addendum, NHSE generally limited any changes to points of clarification to address some of the issues that may be underpinning some respondents' concerns, including:

- A reference to appointed governors, to ensure that the guidance is understood to be applicable to all types of foundation trust governor.
- Additional clarity on the scope and intentions for system working and implications for providers.
- Stressing that the present arrangements and nature of the governor role remain the same – there is no expectation that the governor role should increase materially in response to the establishment of ICBs. Working in a system means providers are now expected to collaborate with other organisations to support their systems, as well as deliver high-quality NHS care in an efficient manner. Governors should work through their boards to assess how the trust is collaborating to support their system – eg by requesting information on this from the trust board rather than reaching out to other organisations or the ICB itself. Governors do not have a formal role regarding other providers or the ICB.
- Where a trust sits near a system boundary and has material numbers of patients from multiple ICSs, governors should work with their board to consider how to represent patients in ICSs that the trust is not a partner of. The addendum now suggests governors – with support from their board – should be aware of how the trust's services are used and accessed, and be assured that the trust's board has considered the impact of any changes or decisions on the public using its services, irrespective of what system they are from.

4.0 Guidance on good governance and collaboration

4.1 To help providers collaborate and work effectively in systems to deliver system objectives, NHSE developed and consulted on guidance practically setting out what collaborative behaviour looks like in practice, framed around three areas of behaviour:

- Engaging consistently in shared planning and decision-making.

- Taking collective responsibility with partners for delivery of services across various footprints including system and place.
- Taking responsibility for delivery of improvements and decisions agreed through system and place-based partnerships, provider collaboratives or any other relevant forums.

With five supporting characteristics:

- developing and sustaining strong working relationships with partners
- ensuring decisions are taken at the right level
- setting out clear and system-minded rationale for decisions
- establishing clear lines of accountability for decisions
- ensuring delivery of improvements and decisions.

4.2 To help providers understand how internal processes may need to change to facilitate better collaboration, NHSE developed a series of key lines of enquiry (KLOEs), articulating expectations more clearly and providing organisations with a means to assess their behaviours. This guidance links these expectations regarding collaboration between trusts and their partners in systems with FT4, the governance condition in NHS foundation trusts' licence. If foundation trusts are not co-operating, this can ultimately lead to regulatory action by NHS England.

4.3 Given the high level of support from respondents for the guidance NHSE did not made substantial changes in the final guidance. However, there were some changes to:

- More explicitly link governance and collaboration to oversight of care quality and cross-reference other publications in this regard.
- Align the content with the powers in the Health and Care Act 2022, which were not finalised at the time of developing the draft guidance, eg with reference to financial obligations.

4.4 In addition to issuing the final guidance, NHSE also published its consultation on proposed changes to the provider licence, which includes incorporating the system working expectations in the guidance directly into the provider licence itself. The new provider licence was issued earlier in the year and is the subject of a separate item on today's agenda.

5 Next steps

5.1 Having reviewed the guidance, there are no immediate concerns around whether the Trust would meet its obligations under both the revised Code of Governance and the supplementary guidance for governors suggests that the Trust is well placed to comply. The Board, Committees and Council activities, agendas and discussions already address a number of the additional or changed requirements, in particular around:

- Non Executive and Chair appointments, where discussions and plans around succession for those Board members is being worked through at present;

- The refocus of the Council of Governors on the Trust's work within the Integrated Care System;
- The arrangements in place to allow the Board to collaborate with others.

5.2 It is proposed that an annual update be considered by the Board to provide assurance that there is due compliance with the terms of the Code of Governance for FTs and other related national guidance.

6 Recommendation

6.1 The Trust Board is asked to:

- RECEIVE and ACCEPT the update updates on national guidance on governance of Provider organisations

- SUPPORT the proposal to receive an annual assessment detailing the Trust's position against the guidance.

Simon Grainger-Lloyd
Director of Governance
30 June 2023

PAPER REFERENCE: ROHTB (7/23) 016a

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE QUALITY & SAFETY COMMITTEE

Date Group or Board met: 28 June 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Themed reviews were being organised into neurological deficit incidents and skin damage cases. The outcomes would be reported to the Quality & Safety Committee when concluded. • One serious incident had been declared which concerned a fall resulting in harm. The incident was undergoing investigation. • It was noted that there had been some thefts in the organisation and so enhanced communications around tailgating and security were being organised. Improved CCTV was also being arranged.	• Discussions underway with colleagues from other Orthopaedic organisations to determine benchmarking information for some quality indicators and incidents which would be included in future quality reports. • On the Quality report: Statistical Process Chart to be provided for incident numbers; deaths to be removed from the incident graphics; revised Friends and Family Test information to more clearly articulate response rate and positive feedback. • Update on investigation of appointment incidents to be received at the next meeting. • Update on the position against the Violence & Aggression Prevention and Reduction standards to be presented at a future meeting. • Agreed to review the medical staffing data included in the safer staffing report to ensure that it provides a meaningful picture. • Consider streamlining the annual complaints report. • Update on governance of joint pathways to be presented in August. • Establish the trends in CNST premia at other specialist orthopaedic trusts
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• A risk 'summit' was reported to be being organised to review all clinical risks to ensure that they were accurately recorded, scored and were entered onto the appropriate risk register. This process was designed to ensure that the Committees and groups across the Trust were focussed on the most appropriate level of risk. • Additional narrative was noted to be included in the Quality Report around lessons learned. Some historic and obsolete data was noted to have been removed to provide better focus. • Work was being undertaken to improve Safeguarding training rates. • Assurance was sought and provided on the implementation of learning from VTEs and it was highlighted that the Trust had recently been awarded VTE exemplar status. • Relatively good performance compared to peers across the range of operational and constitutional standards was outlined.	• None specifically.

• An assurance report was received describing the investigation of the 46 provisional moderate harm incidents associated with Outpatients reported in a previous version of the Quality Report. No harm had been identified associated these incidents. The work to address process inefficiencies and to ensure that there was sufficient skilled resource to manage the referral processes was described. • The work to prevent falls in the hospital was described including the audit of bathrooms and the adoption of a 'call, don't fall' initiative. • An overview of the lessons learned framework in the organisation was described, together with the plans to strengthen this further. The adoption of a Learning on One Page (LOOP) initiative was welcomed. It was suggested that this approach be implemented for corporate areas including workforce. • The work to strengthen the governance of the Health & Safety framework in the organisation was outlined, including better consideration of risks and the reinvigoration of the Health & Safety Group which now would report into the Quality & Safety Committee. • The Committee considered the Annual Complaints report and agreed to its onward transmission to the Trust Board for approval. • An update on open claims was presented, which highlighted that a number of the cases had settled at considerably less than the estimated cost. The overall number of claims was reported to be reducing. It was reported that the CNST premia for 2023/24 had reduced for the sixth year in a row, attributable to improved clinical practice and better medical engagement with handling cases. • The introduction of an electronic platform for the management of clinical audits was reported. The audit programme for 2023/24 was outlined.	
Chair's comments on the effectiveness of the meeting: It was noted that the pace of the meeting had been good, the challenge had been balanced and constructive and the meeting agenda had been more manageable. Thanks were offered to the guests presenting updates.	

PAPER REFERENCE: ROHTB (7/23) 016b

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 27 June 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The activity position was noted to be below plan, largely as a consequence of recent industrial activity. The further industrial action in July may potentially impact further. • It was noted that there had been some operations cancelled as a result of missing equipment. Assurance was provided that these incidents were rare and lessons learned were harnessed when they were reviewed by the theatre look back process. • It was noted that the Trust had delivered a £383k deficit in month against a planned surplus of £120k. Income year to date is £208k below plan. Non pay expenditure was reported to be overspent against plan with an adverse variance of £622k. It was reported that the detail behind the overspend would be tested as part of the divisional performance discussions. • The challenges with meeting the nationally set activity levels to ensure that a breakeven financial position was achieved by the end of the year were highlighted. • Agency pay was noted to remain high and above the agency cap. • Sickness absence remained high and particularly in theatres. • It was highlighted that the unadjusted turnover rate had increased, although the adjusted position had reduced. • The poor outcome of the recent recruitment days was highlighted given that the resources targeted appear to be from a common pool being accessed by other providers. • The Trust was not fully compliant with the requirements of the Data Security and Protection Toolkit, although action plans to achieve compliance with the three areas of non-compliance were in place. Overall, the Trust met 110 out of the 113 standards. Further work was particularly required around achieving the 95% training target. • It was noted that there was a shortfall in compliance with the Freedom of Information and Subject Access Request standards. A recovery	• It was suggested that two key matters be considered for presentation to the Trust Board at a future meeting: the operation of the Limited Liability Partnerships (LLPs) for clinical services; and an update on the GP engagement work. • Circulate the CIP workbook. • Committee effectiveness review to be presented at the July 2023 meeting. • Deep dive into length of stay to be presented at the July 2023 meeting. • Update on the implementation of a ‘standby’ patient at the July 2023 meeting. • Work planned by the Executive Team to understand the controls that could be implemented to reduce expenditure. The same discussions are planned at System level. • Discussions are underway with the Occupational Health teams to establish how the time to onboard could be reduced.

plans was being developed to address this which was reliant in changing practice and consideration around resourcing required.	
POSITIVE ASSURANCES TO PROVIDE • There had been a slight improvement on performance against the 18 weeks Referral to Treatment Time target to 57.5%. • There continued to be no patients waiting in excess of 104 or 78 weeks for treatment. The number of patients waiting 52 weeks or more for treatment was noted to be reducing. • There continued to be good focus on virtual consultations, with the level at present being 8.9%. • Theatre utilisation was reported to be strong for the month and reflected the position tested as part of the recent Elective Hub accreditation work. • The performance of the PreOperative Assessment Centre (POAC) was noted to have improved, this being supported by the introduction of the Synopsis system. • The positive joint working with University Hospitals Birmingham NHSFT to ensure that theatres are adequately staffed was noted. • Congratulations were extended to the team on the achievement of a level of referrals from GPs that was in excess of that prior to the COVID pandemic. • Delivery of the Cost Improvement Plan was reported to be sound at present, although it would be challenging to deliver the full quantum required by the year end. Across the System it was noted that there was a concerning shortfall in delivery. • It was reported that there had been good progress with moving forward the plans for the implementation of an Electronic Patient Record for the ROH. • The positive feedback from the Elective Accreditation Hub visit was shared.	**DECISIONS MADE** • None specifically.
Chair's comments on the effectiveness o the meeting: It was agreed to have been a productive meeting with a good balance of discussions. The dashboard of operational metrics was particularly welcomed. The Committee congratulated Steve Washbourne on his recent appointment as the Chief Finance Officer.	

PAPER REFERENCE: ROHTB (7/23) 016c

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE STAFF EXPERIENCE & ORGANISATIONAL DEVELOPMENT COMMITTEE

Date Group or Board met: 28 June 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• The potential impact of the forthcoming industrial action by Medical staff was discussed. • The intention to continue to operate without a Chief People Officer (CPO) for the Integrated Care Board was highlighted. This was noted to have a potential impact on the capacity of CPOs in provider organisations with the System. • Unadjusted turnover was reported to remain high, although the adjusted figure had dropped slightly. • Appraisal rates were reported to be lower than desired and the analysis of this by age group and contract position was reported. • Time to hire remained lengthy, with more work to do with the Occupational Health team to ensure that the onboarding process could be reduced.	• The position statement and action plans to achieve compliance with the Violence & Aggression reduction & Prevention Standards to be presented to the Committee in August. • Verbal aggression against the HR team to be included on the workforce risk register. • Ensure there is a deep dive on the workforce risks at the next meeting. • All to comment on the set of proposed HR metrics to be used to judge effectiveness and efficiency. • Meeting to be organised to discuss the outcome of the recent effectiveness review of the Staff Experience & OD Committee.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee heard a positive story from the Head of Undergraduate Academy & Consultant Surgeon about his experience of working at the ROH. He particularly celebrated the success he had achieved in developing the Research & Development function. The story also outlined the challenges and impact of System working on colleagues at the ROH. The hindrance of some of the bureaucracy associated with the existing governance framework was also described. The ambition to be part of the work to achieve greater productivity at the Trust was outlined. • The Committee welcomed Matt Dingle, new Head of HR Operations & Business Partnering. • The improved response rate to the People Pulse was highlighted. The results around advocacy, motivation and involvement were particularly positive. • The recent pay uplift for those staff on Agenda for Change was noted to be positive for those experiencing difficulties with the Cost of Living crisis.	• None specifically.

• The declaration rate for those living with a disability was reported to have increased. • Attendance at the staff networks had improved. • The work to improve the position in terms of the gender pay gap was described, including the activity by the Women's Network and the focus on attracting females into orthopaedic medical positions. • There was noted to be some good progress to improve mandatory training rates for some modules concerning life support. The plans for the recruitment of a new Resuscitation Officer were outlined which would have a positive impact on Resuscitation training. • A detailed analysis into the leavers from an administration & clerical background was presented, which showed that the main group of staff were those in the age range of 21-35 and that there was a high proportion who left to join other NHS organisations. A key reason for leaving was for higher salaries or a promotional opportunity. The actions that may alleviate this situation were described, including reviewing the structures at the Trust and considering where internal opportunities for development may be identified. • An update on the recent staff survey results for the Medical directorate was outlined. The results were positive particularly around learning. It was noted that appraisal rates were high for medics. The triumvirate approach to managing the medical workforce was described. • The work to engage an external agent to support the development of a workforce plan was outlined. This would be presented to the Board in October. • The Committee welcomed sight of the draft ROH People Plan. • A positive report on the work to use the apprenticeship levy was considered. The Trust was on course to recruit the full complement of apprentices for the coming year. • An update on the high impact actions to achieve nursing workforce retention was provided. • It was noted that the Veteran's Covenant would be signed on 29 June 2023. • The successful recruitment into the Deputy Chief People Officer was celebrated.	
Chair's comments on the effectiveness of the meeting: The quality of meeting papers was agreed to be high. The agenda included several items requiring significant discussion which it was noted added pressure to the timings of the meeting.	

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM CHARITABLE FUNDS COMMITTEE

Date Group or Board met: 29 June 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• A conversation took place with regard to the Contactless Payment Units and it was noted that donations were not providing significant revenue to date. It was agreed that a separate meeting would take place with J Williams, S Washbourne and A Sprason to discuss further and a proposal would be presented at the next meeting. • The return on funds held in investment were highlighted and the Chief Finance Officer asked the Committee to consider the risk appetite to ensure best value could be demonstrated. It was discussed this could be via a more traditional route through a high-streek bank, or a comparison of investment funds. Following discussion SW would present a set of options for the Trustees to consider at the next meeting.	• NHS 75th Birthday Celebrations will be taking place around the Trust for patients and staff Wednesday 5 July 2023 which will include various 1940's themed games, Bluebird Belles, a close harmony trio passionate about keeping vintage sound alive, the Rock Choir and a Vintage Gramophone Performance by DJ Adam Wareham. • The Charity has received two entries for 'Posters that Pay' (Poster Competition) which have been submitted with public voting taking place on Wednesday 5 July 2023 (where public voting takes place) and the winner will be announced on Friday 14th July. • The Charity is hosting a Football Match and Family Fun Day (Nightingale Football Club VS Matt's Legends Football Club) on Saturday 15 July 2023, at Shenley Lane Community Sports Centre, Northfield. • The Blue Heart Awards was highlighted and this event will be taking place on Friday 21 July 2023 at the Botanical Gardens. • A Charity Cricket Match and Family Fun Day on Saturday 23 September is being planned and further details on this will be communicated. • The ROH Charity Christmas Party event is currently under review and a survey has been circulated to all colleagues for their feedback, ideas and preference for this event in the future. • The Charity has been awarded a development grant of £30,000 from NHS Charities Together. The Charity is looking to invest in a Grants and Trusts Officer. The post will be advertised as a Band 7 role, three days per week. In addition to the Grants and Trusts Officer role, a new Community Fundraiser post is proposed within the structure. It was noted that the Charity Structure will be presented to the Trust Board on 5 July 2023. AA commented that she has been fully appraised of the plan and gave her support for the proposal.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• The Blue Heart Awards event received a lot of sponsorship with thanks to Matt Maycock in IT. A sponsorship brochure was prepared in advance and sent out to various contractors. Good sponsorship was also received for Steve Washbourne in respect of the London Marathon. An increase in sponsorship of 85% was noted compared to last year. • The reputational impact, along with the excellent work and achievements were noted in respect of the Dubrowsky Lab. • The Hardship Fund was launched on 12 June 2023 and the first meeting has taken place which was noted as positive. Seven applications have been received to date of which one was from a patient and six from staff members. Four applications were assessed at the first panel meeting. • It was noted that the bequest money in the sum of £556,323 has now been received.	• The following six bids were approved by the Committee: #208 Dubrowsky Lab Manager #214 Development and Optimisation of Anti-Microbial Bioactive Materials for Orthopaedics and Bone Cancer Therapy #219 Dubrowsky Lab Intern #225 Dubrowsky Regenerative Medicine Laboratory, annual operational budget 2023/2024 #220 ChondrOx (Exploring new therapeutic opportunities based on replication stress and hydroxylase biology in next-generation chondrosarcoma models) #222 – Café Royale Refurb • The Committee agreed that an additional £5,000 be added to the original £10,000 Hardship Fund limit to enhance funds whilst consideration is given to propose moving this from a pilot to a more continuous cycle of fundraising and grant giving.

Chair's comments on the effectiveness of the meeting: The meeting was noted to have been extremely positive and thoroughly enjoyed by the new Chair. The Chair commented that the lay breakdowns of the clinical bids provided by the presenters were very much appreciated**.**

PAPER REFERENCE: ROHB (7/23) 017 (a)

Finance and Performance Report

Month 02

Introduction

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

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

Icons reading guide

Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

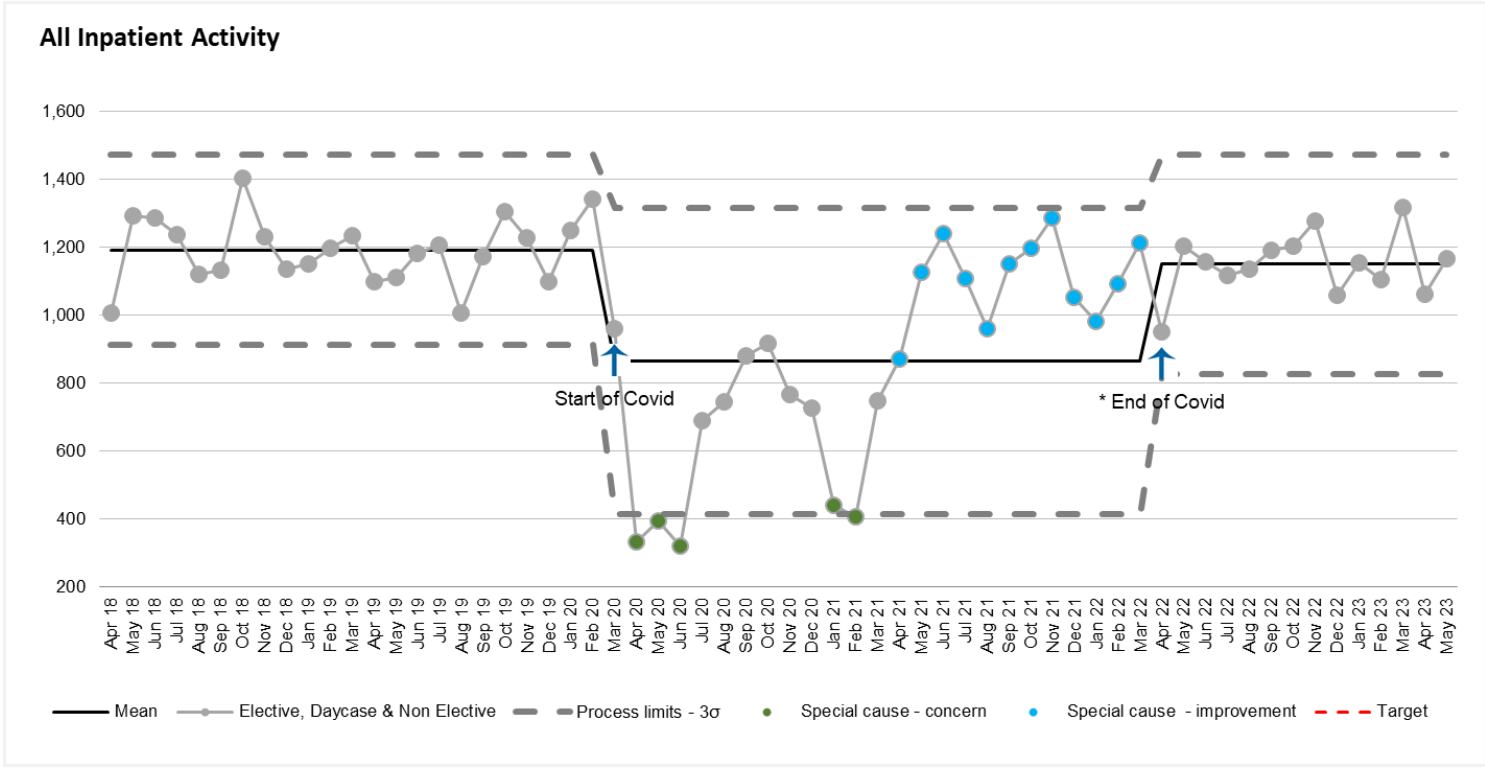
Operational Performance Summary

Performance to end May 23	In month	Previous month	Target	Variation	Assurance
RTT – combined (constitutional target remains 92%)	57.50%	56.73%	92%		
104 week waits	0	0	0		
78+ week waits	0	0	0		
65 Week waits (65-77 weeks)	46	63	0		
52 week waits (52 – 64 Weeks)	161	179	0		
All elective activity YTD (compared to 19/20)	99.0%	103.4%	110%		
All elective activity YTD (compared to plan)	2,230 Cumulative	1,062	2,282 YTD Target		
Outpatient activity YTD (compared to plan)	10,112 Cumulative	4,576	10,545 YTD Target		
Outpatient Did Not Attend (YTD)	8.80%	7.44%	8%		
PIFU (trajectory to 5% target)	430 8.3%	325 7.7%	193 5%		
Virtual Consultations (target is plan, operational planning guidance is 25%)	9.8%	11.5%	19%		
Diagnostics volume YTD (compared to plan)	3,965 Cumulative	1,953	3,065 YTD Target		
Diagnostics 6 week target	99.8%	99.7%	99%		

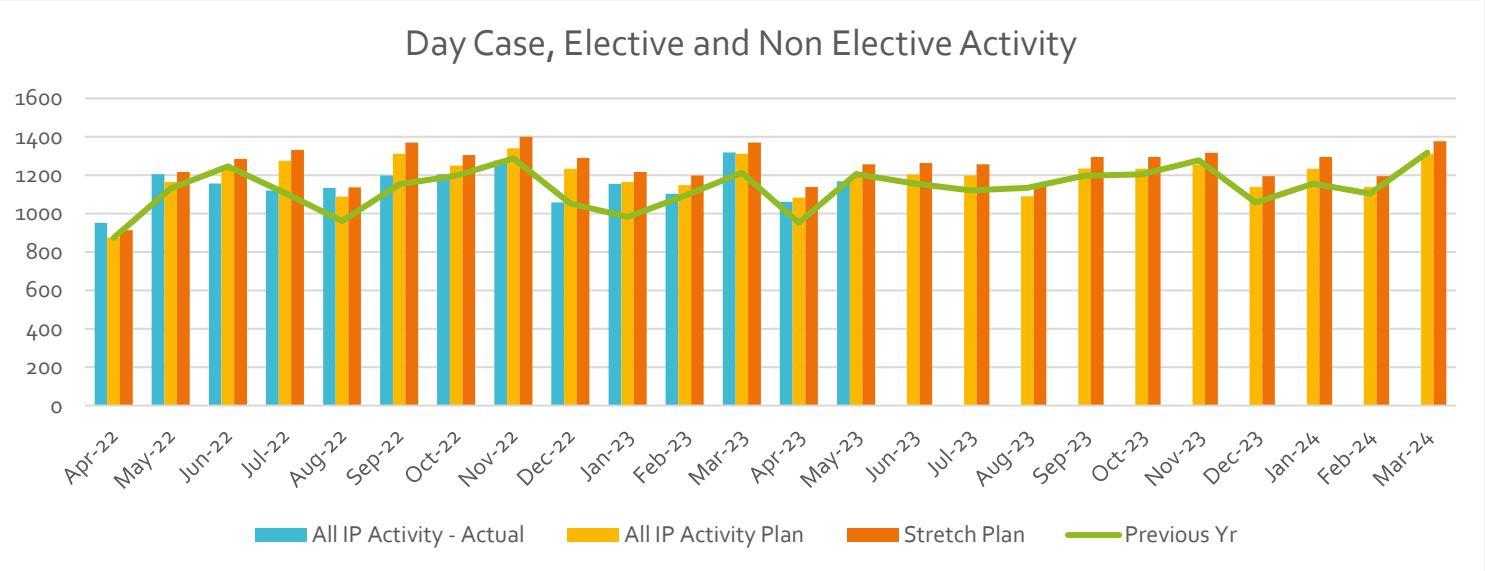
Operational Performance Summary

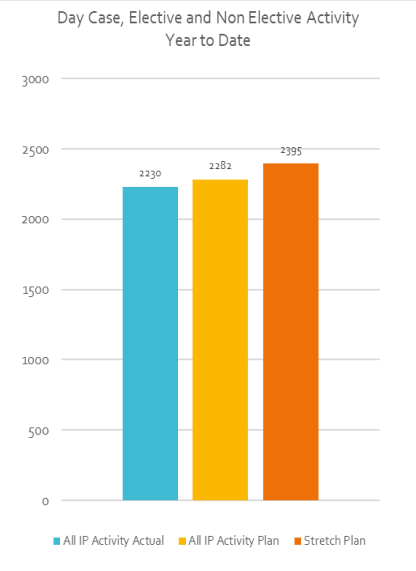
	In month	Previous month	Target	Variation	Assurance
Theatre In session utilisation	81.96%	82.58%	85%		
Theatre Session Utilisation	92.13%	74.41%	90%		
Cancer - 2 week wait (Mar – Feb)	96.8%	100%	93%		
Cancer – 31-day first treatment	84.6%	100%	96%		
Cancer - 31 day subsequent (surgery)	100%	100%	94%		
Cancer - 62 day (traditional) April 23 confirmed	20.0%	50%	85%		
Cancer - 62 day (Cons upgrade)	100%	100%	n/a		
28-day FDS	80%	78.2%	75%		
Patients over 104 days (62-day standard)	0	1	0		
POAC activity volume (YTD)	3,615 cumulative	1,578	3,530 YTD Target		
LOS - excluding Oncology, Paeds, YAH, Spinal	4.11	3.65	n/a		
LOS - elective primary hip	3.30	3.70	2.0		
LOS - elective primary knee	3.70	3.80	2.0		
BADS Day case rate (Note: due to time lag in month is Feb'23)	78%	79%	85%		

1. Activity Summary



1. Activity Summary



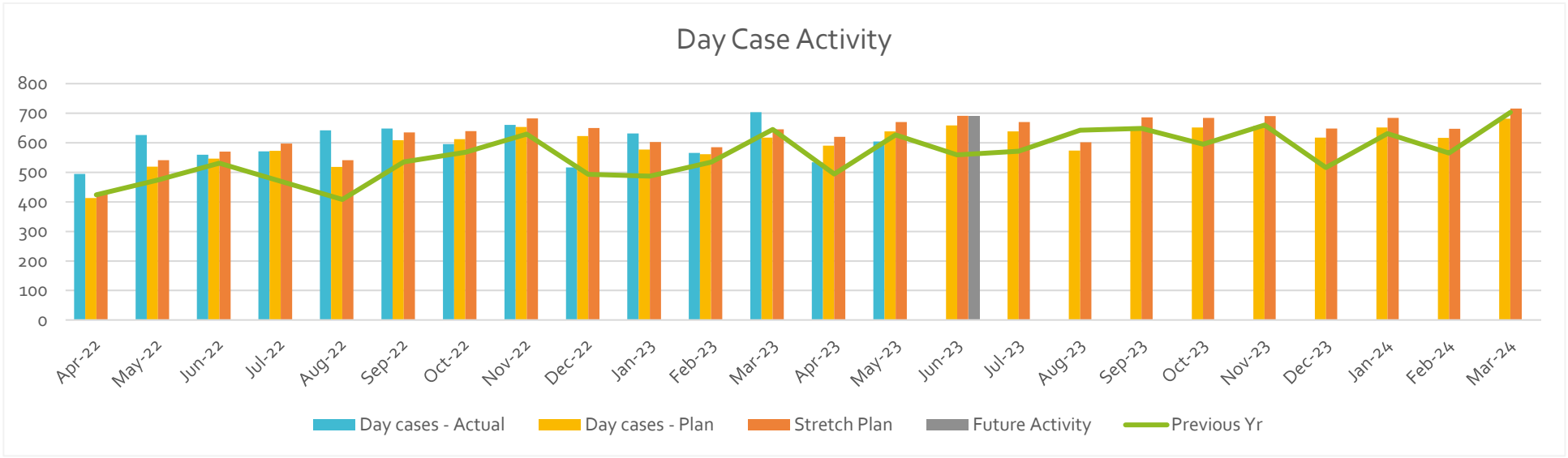


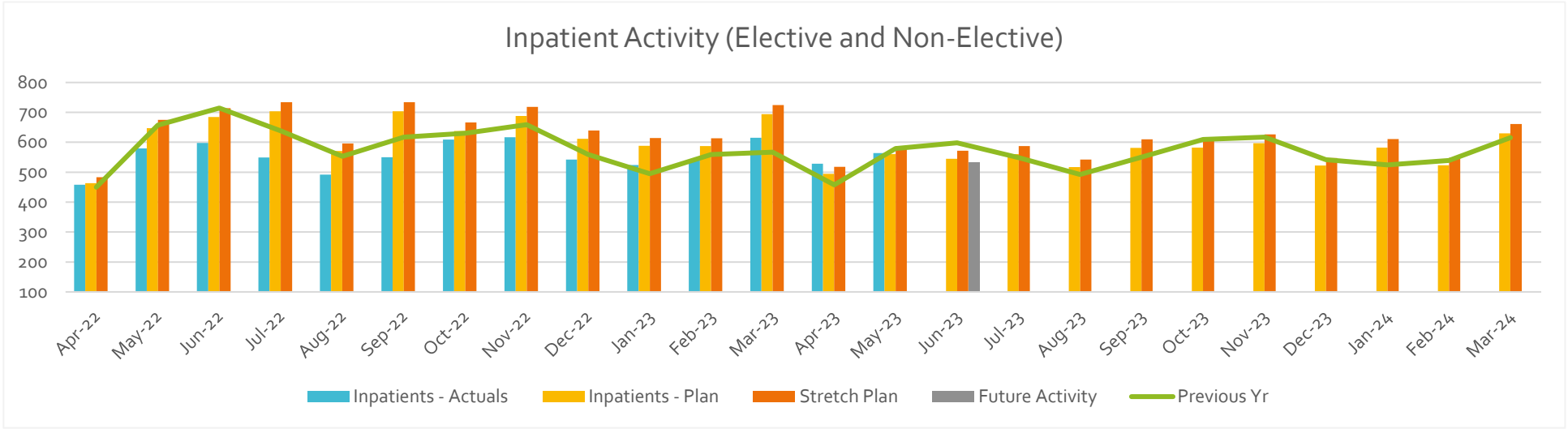
		Plan												Plan	Actual	% Achieved	Variance
	Activity Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Year to Date	Year to Date	against plan	Year to Date
Trust Plan	Inpatient	483	547	533	547	505	568	569	584	510	569	511	616	1030	1033	100%	3
	Daycase	590	638	658	638	573	653	651	657	617	651	616	681	1228	1138	93%	-90
	NEL	11	13	12	13	12	13	13	13	12	13	12	14	24	59	246%	35
	All Activity	**1084**	**1198**	**1203**	**1198**	**1090**	**1234**	**1233**	**1254**	**1139**	**1233**	**1139**	**1311**	**2282**	**2230**	**97.7%**	**-52**
Stretch Plan	Inpatient	507	574	560	574	530	596	597	613	536	597	537	647	1082	1033	96%	-49
	Daycase	620	670	691	670	602	686	684	690	648	684	647	715	1289	1138	88%	-151
	NEL	11	13	12	13	12	13	13	13	12	13	12	14	24	59	246%	35
	All Activity	**1138**	**1257**	**1263**	**1257**	**1144**	**1295**	**1294**	**1316**	**1195**	**1294**	**1195**	**1376**	**2395**	**2230**	**93%**	**-165**

May 2023

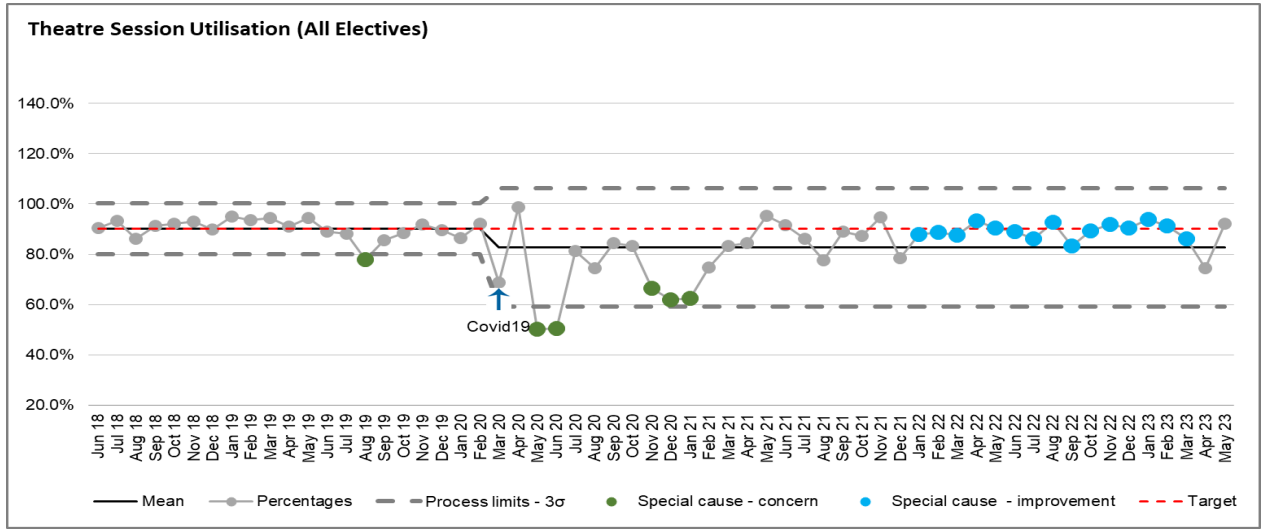
Actual 1168 vs 1198 System Plan (Variance -30)
YTD position against Actual vs System plan is 97.7%
For M1 and M2, we are -52 behind the system plan, however we are forecasting an over achievement in June inpatient activity, which will result in being ahead of the System plan for Q1.

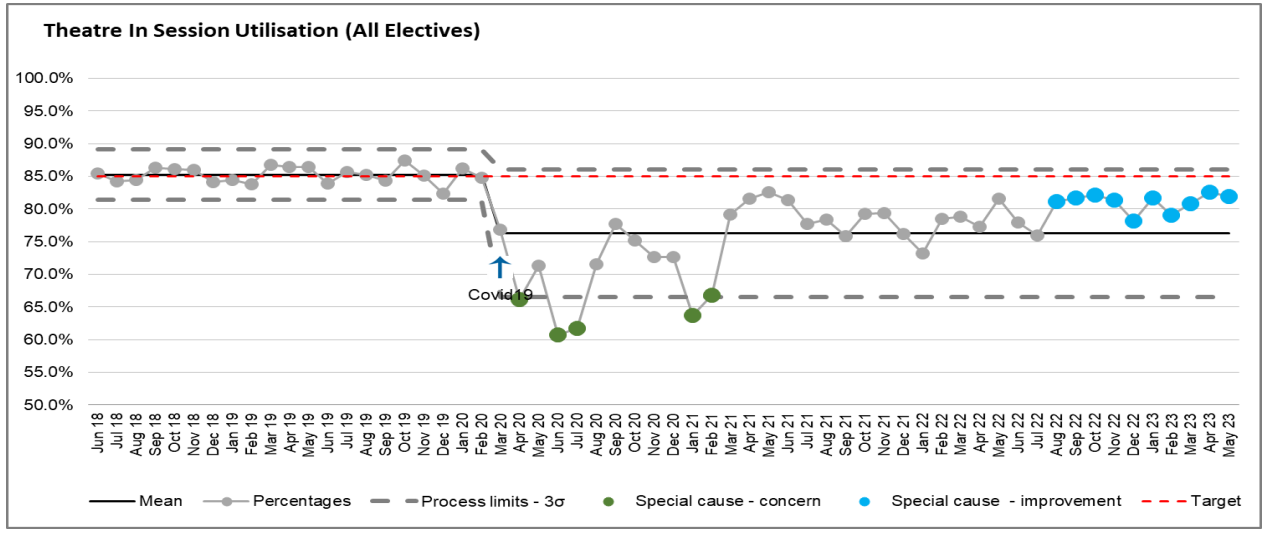
1. Activity Summary





2. Theatre Utilisation





Elective Session Utilisation (May 2023)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	438	400	38	91.32%
UHB	83	80	3	96.39%
Totals	521	480	41	**92.13%**

Elective In Session Utilisation (May 2023)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1773	1471	302	82.98%
UHB	356	273	82	76.86%
Totals	2129	1745	384	**81.96%**

2. Theatre Utilisation

SUMMARY

Overall theatre session utilisation for May was **92.13%** which was above the Trust target of **85%,**

The in-session utilisation of the ROH lists was **82.98%** and the utilisation of UHB lists was **76.85%** resulting in an overall **t**otal in-session utilisation of **81.96**%. The main driver behind this is the short notice submission of the patient lists impacting on the time available to pre-optimise patients and ensure they are passed fit for surgery. Following escalated discussions with UHB, led by the Deputy COO administration arrangements and oversight processes have been embedded and protected pre-operative clinic slots have been allocated to ensure that lists are populated with at least 4 weeks' notice.

AREAS FOR IMPROVEMENT

The Surgical 'Stand-by' patient process went live on 05.06.2023. It is proposed that a bi-monthly update will be provided detailing how many patients were willing to bring forward their operation and backfill a short notice

The proposed deep dive into early finishes supported by the clinical teams and by the power BI dashboard metrics can now commence following the positive conclusion of the GIRFT Accreditation visit held on 09.06.23. It has been proposed that this deep dive will commence starting with spinal services. Further updates will be provided on a monthly basis .

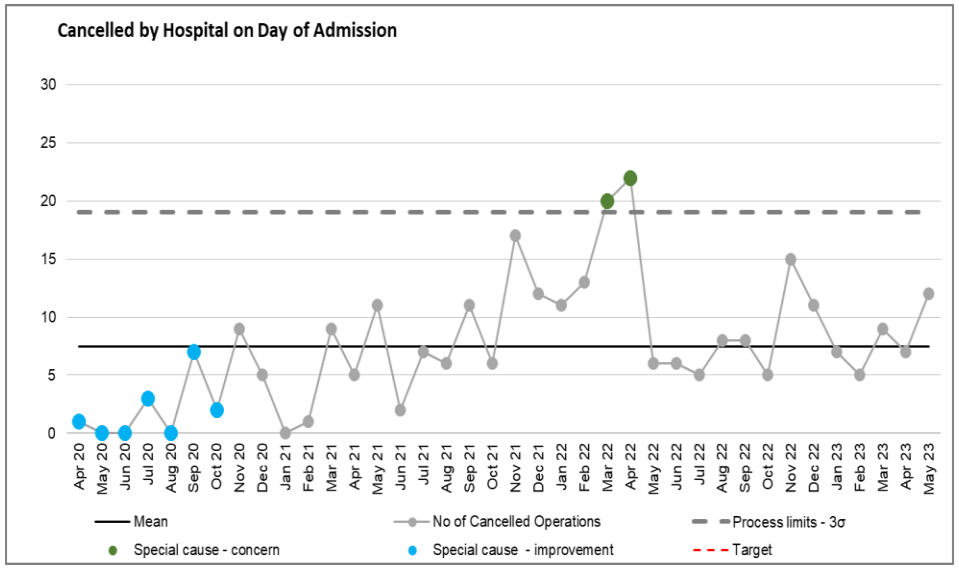
Speciality specific targets to support theatre service level improvements are being agreed at the next round of speciality meetings. Once approved, these will be monitored at Divisional Management Board and Operational Management Board.

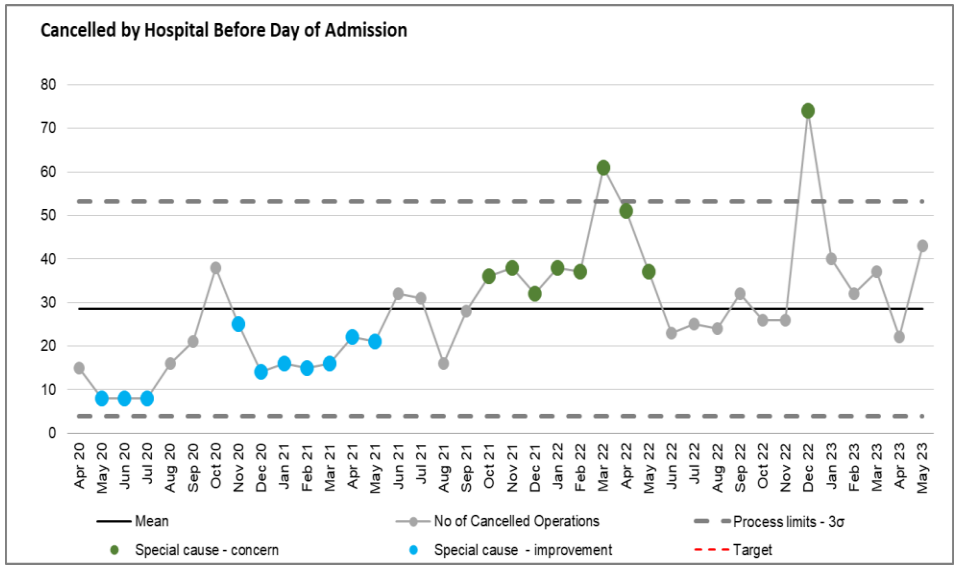
RISKS / ISSUES

Theatre Recruitment is ongoing, current vacancies are 34.53 WTE across all grades, 9 candidates are progressing through the HR process and a further 3 new starters have dates in May, June and August 2023.

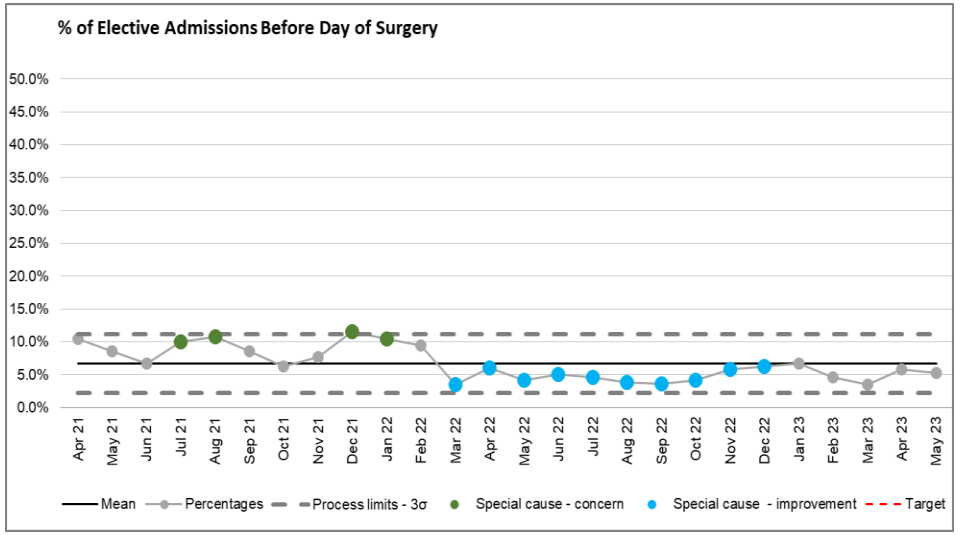
LLP arrangements are being developed by sub-specialties – currently being reviewed by DOF and COO to support additional activity outside of job planned sessions.

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
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
Apr-23	7	24	22	53	0
May-23	12	16	43	71	0
Total	**117**	**364**	**449**	**930**	**4**



2. Theatre Utilisation/ Hospital Led Cancellations

SUMMARY

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

12 patients were cancelled on the day in May 2023 with reasons detailed as follows:
4 x lack of equipment – (UHB related)
3 x replaced by emergency – inconvenienced patients were treated the next day.
2 x Lack of theatre time
2 x Patients not fit-
1 x HDU bed not available

16 patients admitted and had treatment deferred, with the reasons detailed as follows:
13 x Medically unfit / Clinical change in condition / Covid / Flu related
2 x procedure no longer required
1 x patient choice

43 patients cancelled by the hospital the day before the date of admission
17 x Medically unfit / Covid/Flu related
16 x Surgeon availability (Industrial Action for UHB)
1 x Replaced by medically urgent cases
8 x Patient choice / Surgical choice
1 x Equipment unavailable

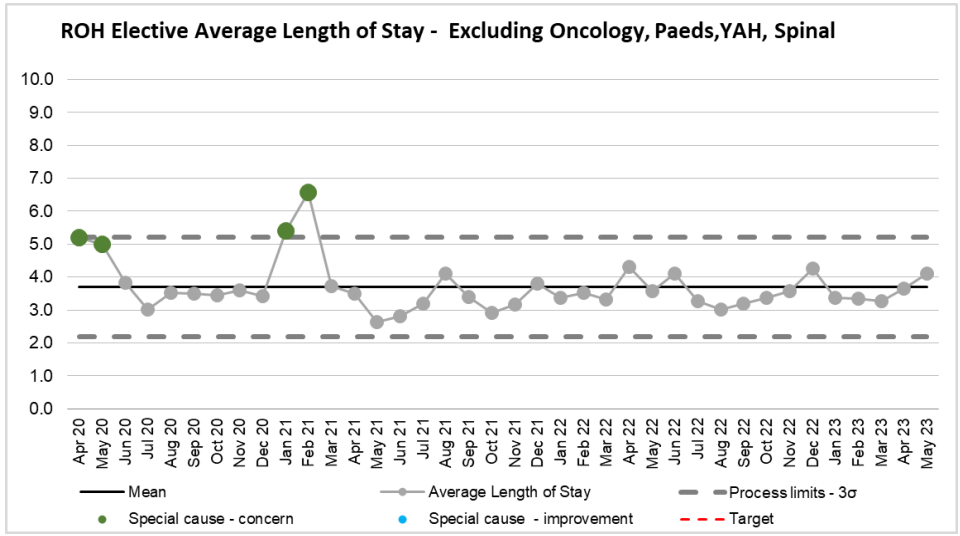
AREAS FOR IMPROVEMENT

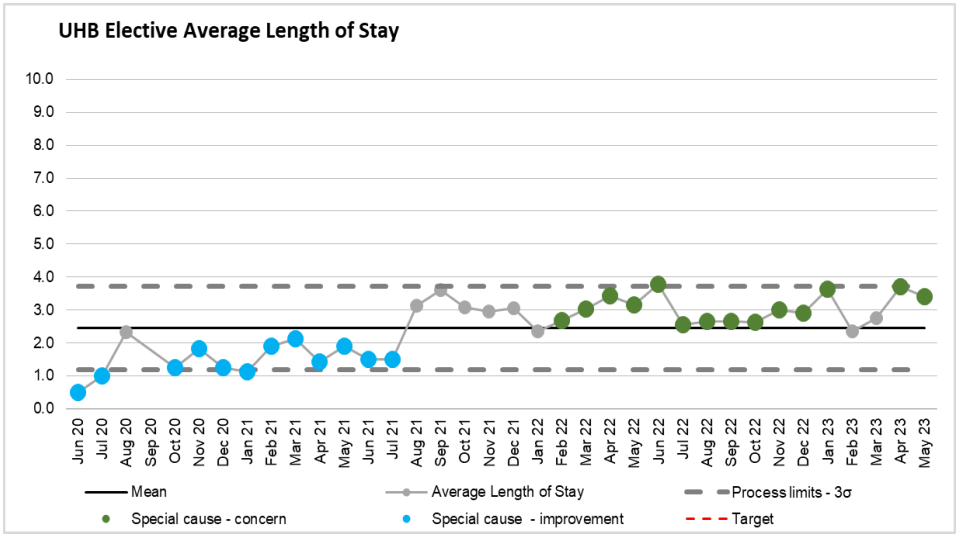
- Progress is being made on the introduction of stand by patients, pilot commenced 5th June 23.
- Deep dive to investigate why patients cancelled due to them no longer requiring surgery or patients changing their mind about surgery to take place, The deep dive will focus on any learning / process changes required to prevent / reduce the risk of this continuing.
- UHB list utilisation – action plan in place monitored by Deputy COO at ROH and Managing Director at UHB

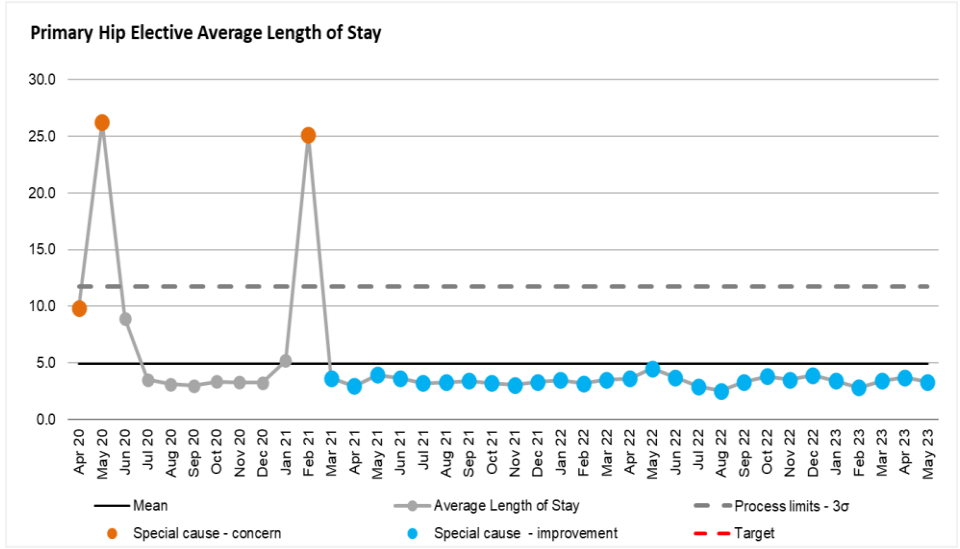
RISKS / ISSUES

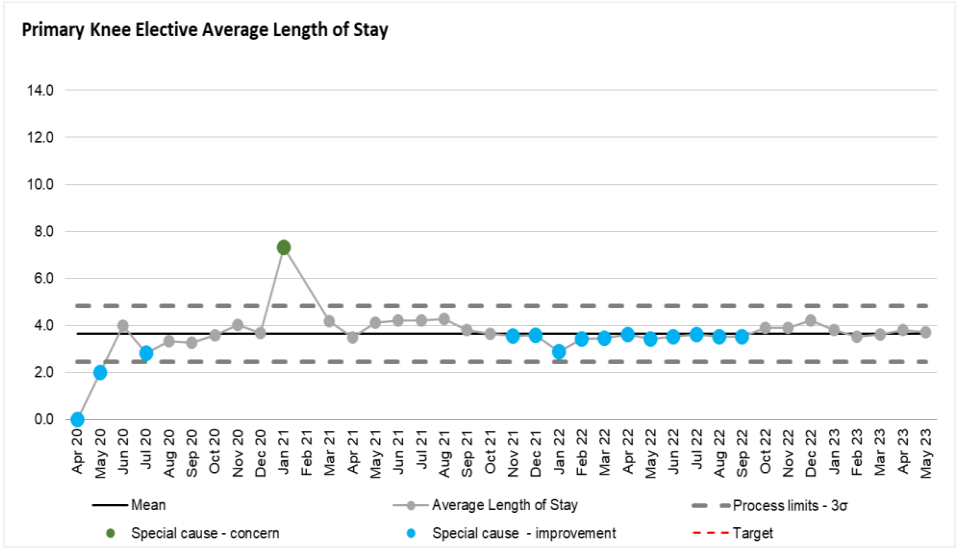
UHB has had some challenges with admin resulting in lists being sent over outside of the 6-4-2 principles. This has led to an increase in short notice cancellations and early finishes. Escalation plan in place implemented by the Deputy COO to mitigate future occurrences.

3. Length of Stay









3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips is at 3.3 days (3.4 days April 23) and primary Knees 3.7 days (3.8 April 23).

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

- 27 patients within primary hip data had a length of stay >3 days; 10>5 days and 5>7days.
- 31 patients within primary knee data had length of stay> 3 days; 10>5days and 7>7days.

A review of the patients with a longer LOS had clinical reasons identified. Some had more than primary surgery documented in the notes e.g. removal of metal work, complex

The average length of stay for ROH patients excluding Oncology, Young Adult Hip and spinal is **4.11 days** (3.65 April).

- 66 (65 April) ROH patients, arthroplasty and oncology arthroplasty, with a LOS greater than 3 days. 32 (42 April) with a length of stay greater than 5 days, 22 (25 April) with a length of stay greater than 7 days.

UHB patients-23 had primary hip or knee replacement.

- 8 (3 April) UHB arthroplasty patients with LOS greater than 3 days. 6 (2 April) with a length of stay greater than 5 days and 1 (0 April) with a stay greater than 7 days.

In summary 22 ROH arthroplasty and 1 UHB arthroplasty patient had a length of stay greater than 7 days.
14 of the ROH patients were Oncology Arthroplasty patients that included above knee /hindquarter amputations and EPR's. All ROH patients reviewed on PICS had a greater LOS due to complex clinical or social needs.

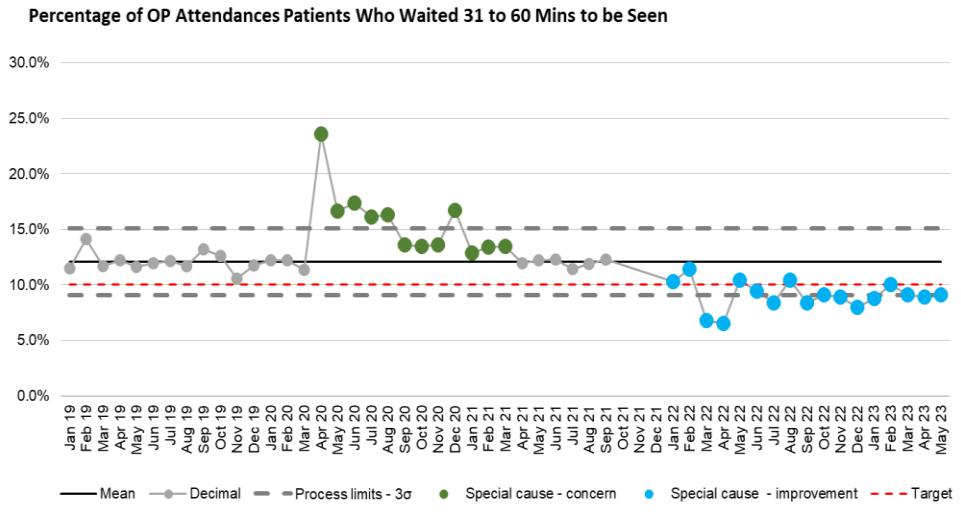
AREAS FOR IMPROVEMENT

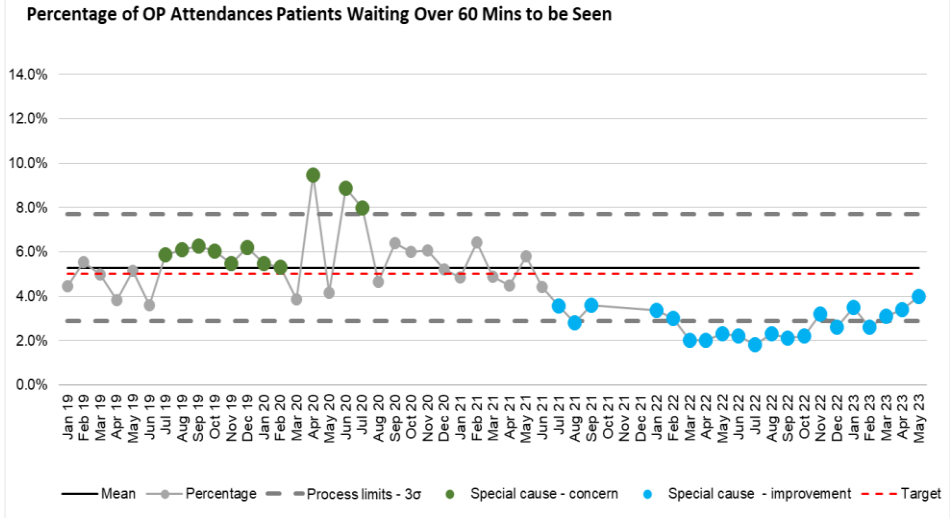
Following a recent Model Hospital Club presentation by spinal services, SIB is reviewing opportunities to increase day case options for spinal. The Deputy COO, AMD and Head of Nursing – Division 1 are reviewing data quality and ensuring processes for escalation are being followed for patient staying longer than the average LoS. ROH is ahead of comparable peers such as RJAH and RNOH on most Orthopaedic Model Hospital metrics. The aspiration for overall Average LOS for primary arthroplasty patients is 2 days. This is in place for Uni-knees and planning is being undertaken for TKR and shoulder cases. Further benchmarking will be undertaken and conversations with peers that are achieving 2 days for hip and knee primaries.

RISKS/ISSUES

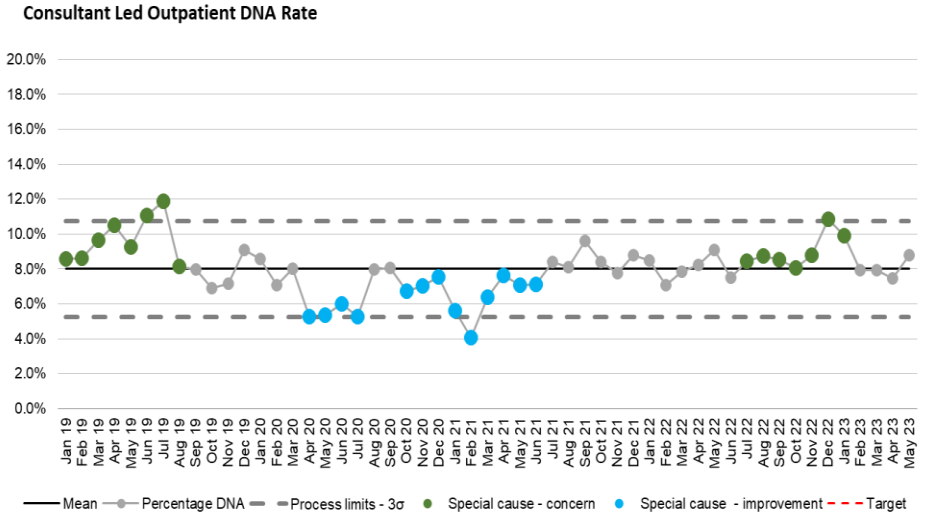
Major Revision Centre/BIS work. A service framework is in development, in association, with the clinical teams and the national programme.
Pre-existing social care and medical needs of primary arthroplasty patients need to be considered when aspiring for 2-day LOS.

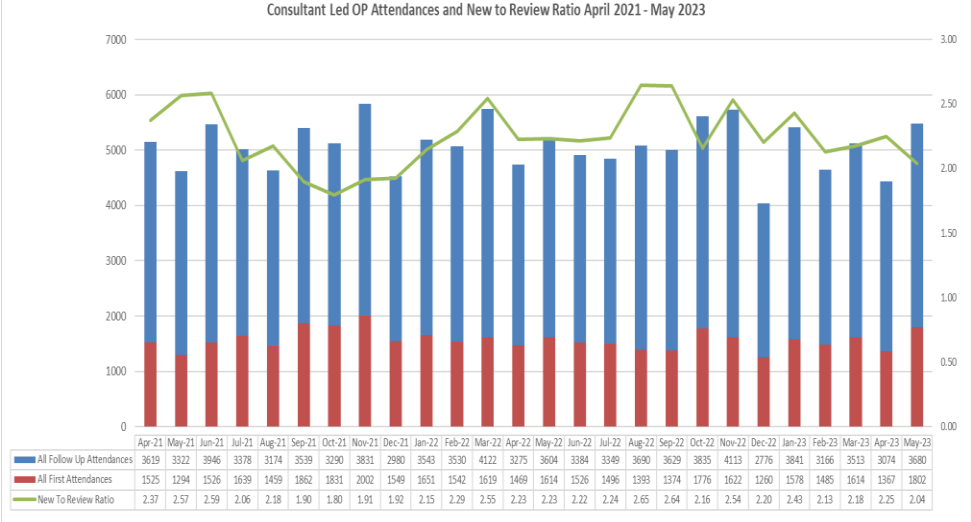
4. Outpatient efficiency

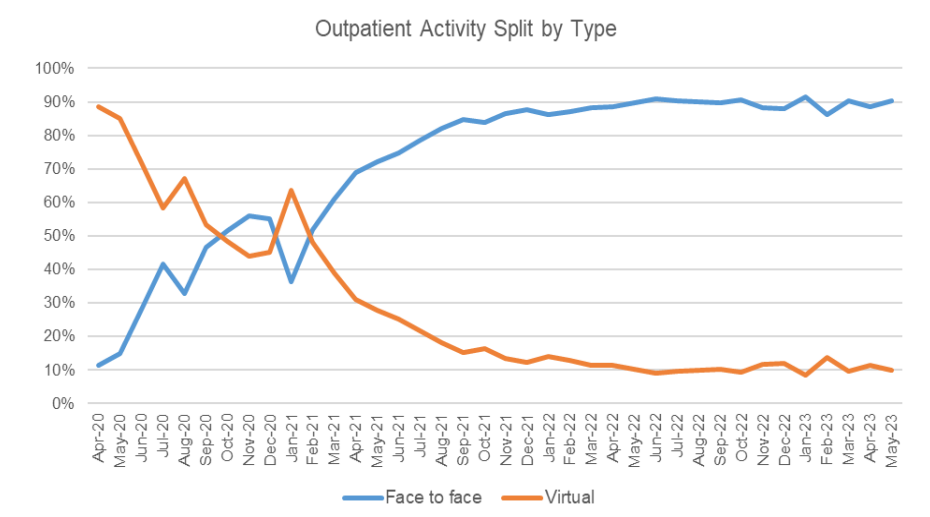


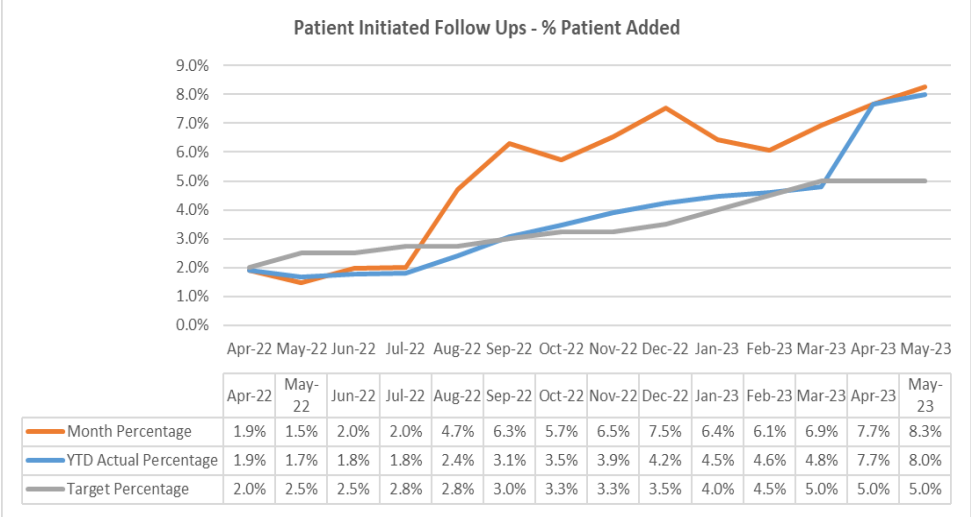


4. Outpatient efficiency









	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Month Percentage	1.9%	1.5%	2.0%	2.0%	4.7%	6.3%	5.7%	6.5%	7.5%	6.4%	6.1%	6.9%	7.7%	8.3%
YTD Actual Percentage	1.9%	1.7%	1.8%	1.8%	2.4%	3.1%	3.5%	3.9%	4.2%	4.5%	4.6%	4.8%	7.7%	8.0%
Target Percentage	2.0%	2.5%	2.5%	2.8%	2.8%	3.0%	3.3%	3.3%	3.5%	4.0%	4.5%	5.0%	5.0%	5.0%

4. Outpatient efficiency

SUMMARY

There were 4,945 face to face and 537 virtual appointments carried out in May 23 (**9.8% virtual**).

This month **8.3%** of outpatient attendances moved to the PIFU waiting list. The overall YTD position is **8.0%.** In total there are 3,993 patients on a PIFU waiting list. The PIFU waiting list is being validated to confirm that patients wish to remain on the list. The Trust intends to use the Dr Doctor Quick Question function to validate waiting lists. This is part of the wider ROH Outpatient Transformation programme.

AREAS OF IMPROVEMENT

Clinic Delays:
30-minute delays **– within trust target at 9.1% (Target 10%)**
60-minute delays – **within trust target at 4.0% (Target 5%)**

The DNA rate for May has increased from April and is currently **8.80**%, slightly above 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. Audits are also being set up via the patient experience team using text messaging and web-based questionnaires. The audit aims to ascertain the reasons behind patient DNAs and patient not brought outcomes, as part of the wider access and inequalities agenda. An update will be provided at July 2023.

Appointments
Following the delays discovered with the implementation of the referral management system there are now daily KPIs.
The appointments team are due to move to a new office space in the old therapies area that will allow further planned expansion of the team to ensure KPIs continue to be met.
Recruitment of an additional 3 members of staff is underway to create the OP call centre delivery model.

Medical Records
Over 1000 boxes of notes have now been moved off site which has freed up sufficient space in the library to repatriate notes from around the Trust. 2 years of Medical notes have been transferred to external storage facilities.

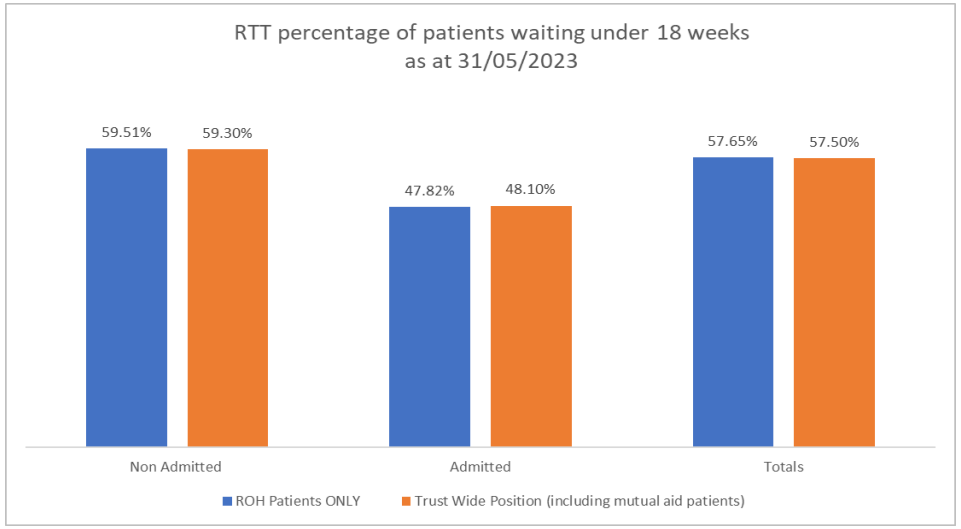
RISKS / ISSUES

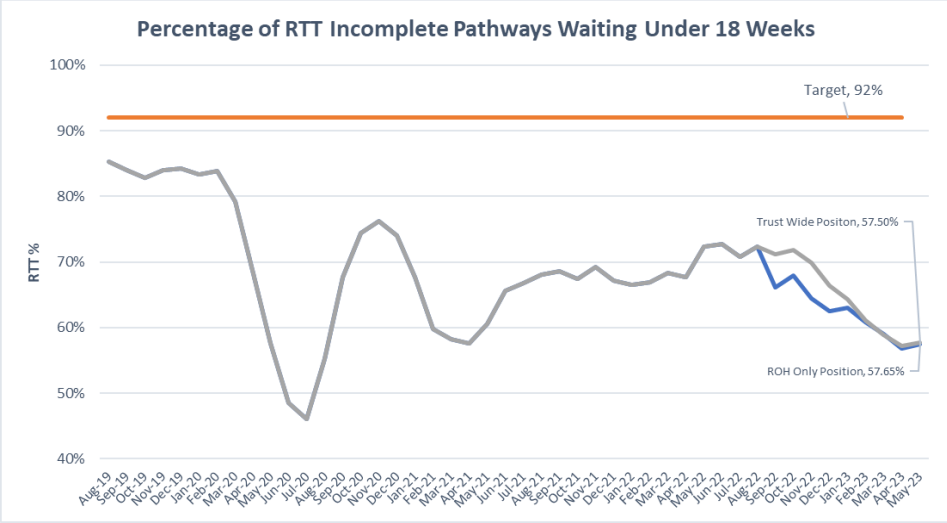
- Outpatient Incident reports continue to be actively managed and investigated, ensuring feedback has been provided to the reporters.

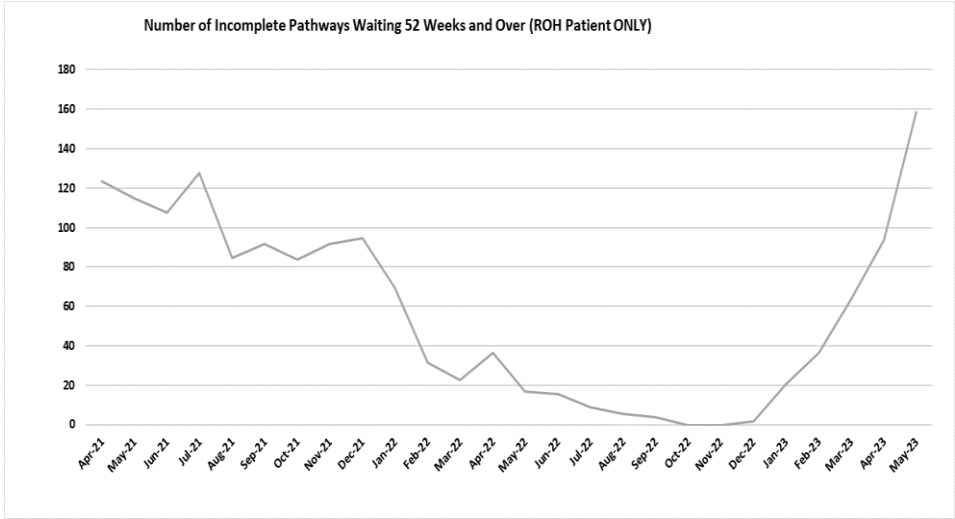
5. Referral to Treatment

	ROH Patients ONLY			Trust Wide Position (including mutual aid patients)		
Weeks Waiting	Non Admitted	Admitted	Totals	Non-Admitted	Admitted	Totals
0-6	3,443	540	3,983	3,452	555	4,007
7-13	2,719	424	3,143	2,725	430	3,155
14-17	1,483	200	1,683	1,495	204	1,699
18-26	2,174	422	2,596	2,182	423	2,605
27-39	2,280	530	2,810	2,284	531	2,815
40-47	508	193	701	520	193	713
48-51	141	65	206	144	65	209
52 weeks and over	99	60	159	136	71	207
Total	12,847	2,434	15,281	12,938	2,472	15,410

Weeks Waiting	Non Admitted	Admitted	Totals	Non-Admitted	Admitted	Totals
Under 18	7,645	1,164	8,809	7,672	1,189	8,861
18 and over	5,202	1,270	6,472	5,266	1,283	6,549
Month End RTT %	**59.51%**	**47.82%**	**57.65%**	**59.30%**	**48.10%**	**57.50%**







5. Referral to Treatment

SUMMARY

The Referral To Treatment (RTT) position for May was **57.50%** against the National Constitutional Target of 92%. This represents a 0.77% improvement compared to the April reported position of **56.73%** that includes mutual aid patents**.**

There were **207** patients waiting over 52 weeks in May, a decrease from the trust wide position in April which was **242** patients.

The Team continue to work in partnership with UHB,RJAH and UHNM to support with Mutual aid. More recently a request has been received from Shrewsbury and Telford and we have agreed to support with 20 elective Hips.

During May 23, ROH received 2,775 referrals (102.63%) compared to pre covid levels. 2,704 is the average monthly referrals received Pre-Covid. The team continues to work closely with the system and GPs to restore pre COVID referral levels and continued growth patterns. Regular meetings are in place to ensure the team stay connected and update the ICB and GPs on the current position and ongoing mutual aid support being provided.

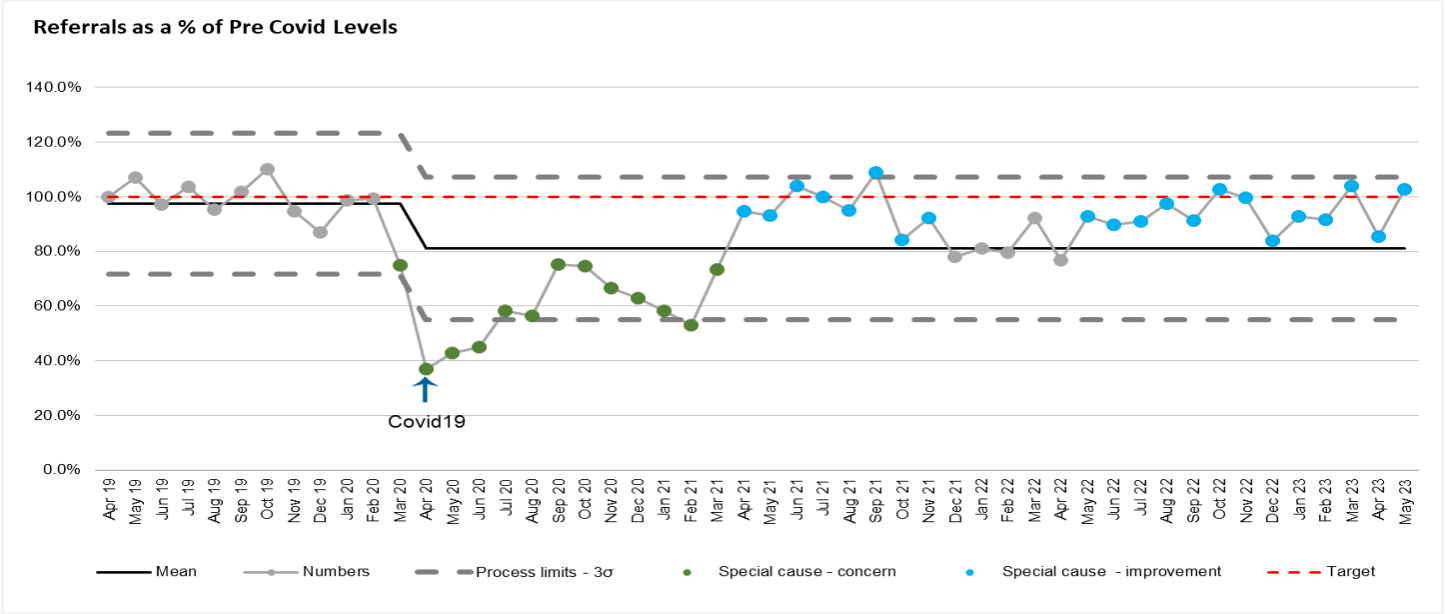
AREAS FOR IMPROVEMENT

The newly appointed Associate Director of Operations – Operational lead for system integration is leading on agreeing terms of engagement with new organisations requesting mutual aid. This is to ensure that the process remains streamlined and concise. Prior to accepting mutual aid patients an assessment is undertaken on the ROH position and delivery of its own 65-week trajectory. Patients waiting over 65 weeks requiring mutual aid must be agreed by the Deputy COO or COO. All mutual aid patients are formally IPT'd onto the ROH PTL and the patients once received are ROH patients under the care of ROH. PTL meetings are in place with RJAH and UHB. The Deputy COO has overall oversight of mutual aid plans and delivery.

RISKS / ISSUES

Due to the continued success of the ROH's management of the existing mutual aid requests, further requests have been received from NHSE, GIRFT and the system for help with long waiting patients across England. These requests will need to be considered and monitored closely to ensure ROH continues to meet its own trajectory. Industrial action continues to be risk for 65 weeks delivery, and this is being monitored closely by the Operational/performance teams and the Deputy COO.

5. Referral to Treatment

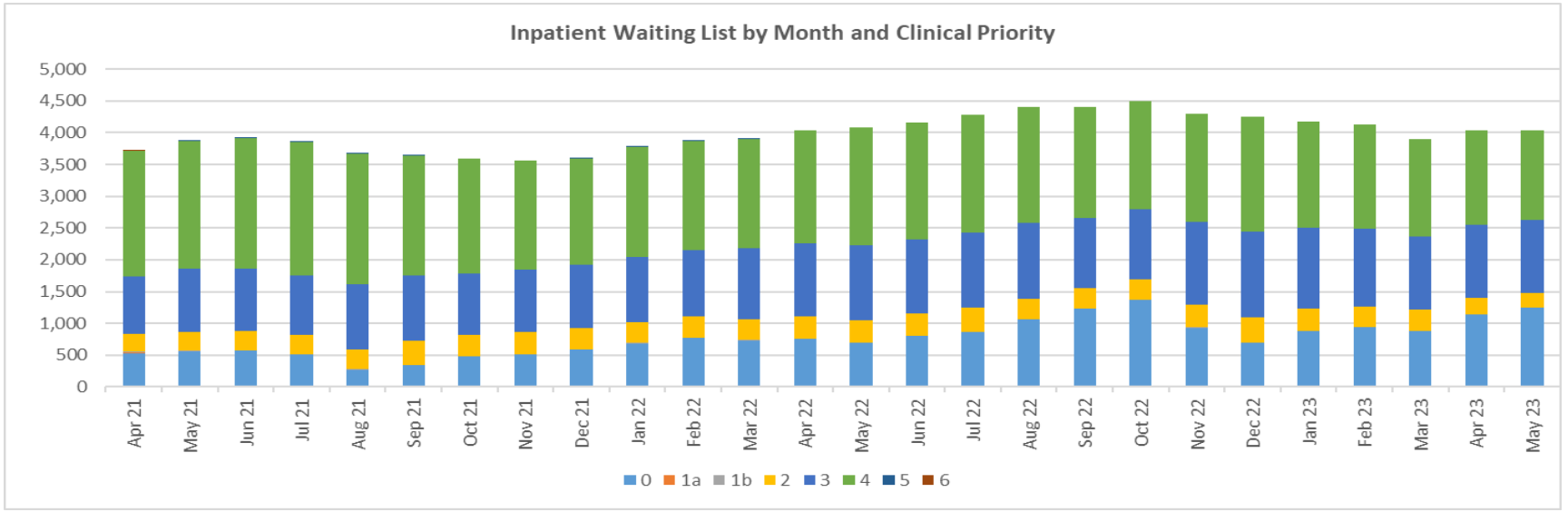


Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of Referrals	2706	2895	2626	2801	2574	2752	2976	2561	2351	2667	2683	2030	996	1154	1213	1578	1522	2034	2019	1803	1704	1574	1437	1983
Referrals as a % of Pre Covid Levels	100.07%	107.06%	97.12%	103.59%	95.19%	101.78%	110.06%	94.71%	86.95%	98.63%	99.22%	75.07%	36.83%	42.68%	44.86%	58.36%	56.29%	75.22%	74.67%	66.68%	63.02%	58.21%	53.14%	73.34%

Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Number of Referrals	2557	2521	2815	2704	2567	2941	2273	2495	2113	2193	2148	2492	2076	2508	2431	2461	2639	2467	2777	2696	2267	2510	2480	2812
Referrals as a % of Pre Covid Levels	94.56%	93.23%	104.11%	100.00%	94.93%	108.76%	84.06%	92.27%	78.14%	81.10%	79.44%	92.16%	76.78%	92.75%	89.90%	91.01%	97.60%	91.24%	102.70%	99.70%	83.84%	92.83%	91.72%	103.99%

Month	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of Referrals	2344	2775																						
Referrals as a % of Pre Covid Levels	86.69%	102.63%																						

5. Referral to Treatment



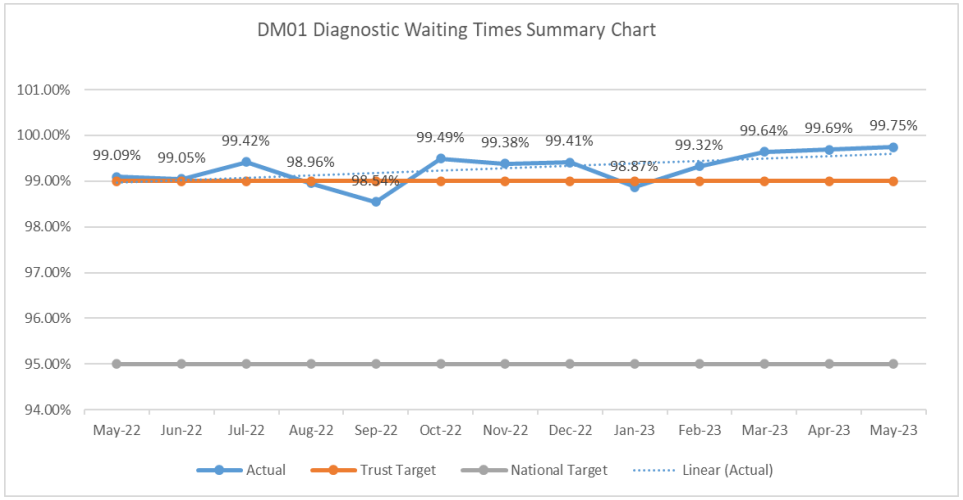
	Number of IP waiting as at	% of IP waiting as at
Priority	31/05/23	31/05/23
0	1243	30.8%
1a		0.0%
1b	6	0.1%
2	228	5.7%
3	1148	28.5%
4	1410	34.9%
5		0.0%
6		0.0%
Total	4035	100.0%

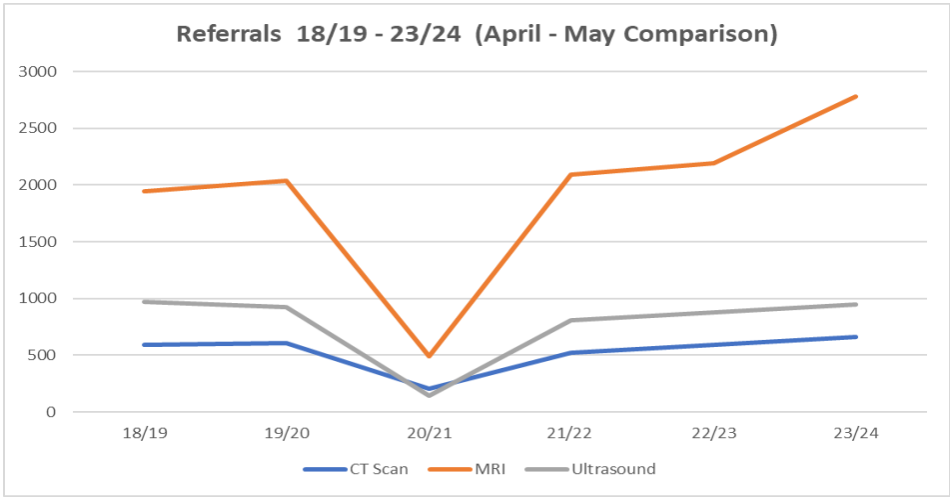
All specialities review and update admitted patients without a priority status. Regular review meetings are held to ensure that all patients are given a priority score. This data is reviewed monthly at the CSLs meeting in conjunction with the Medical Director

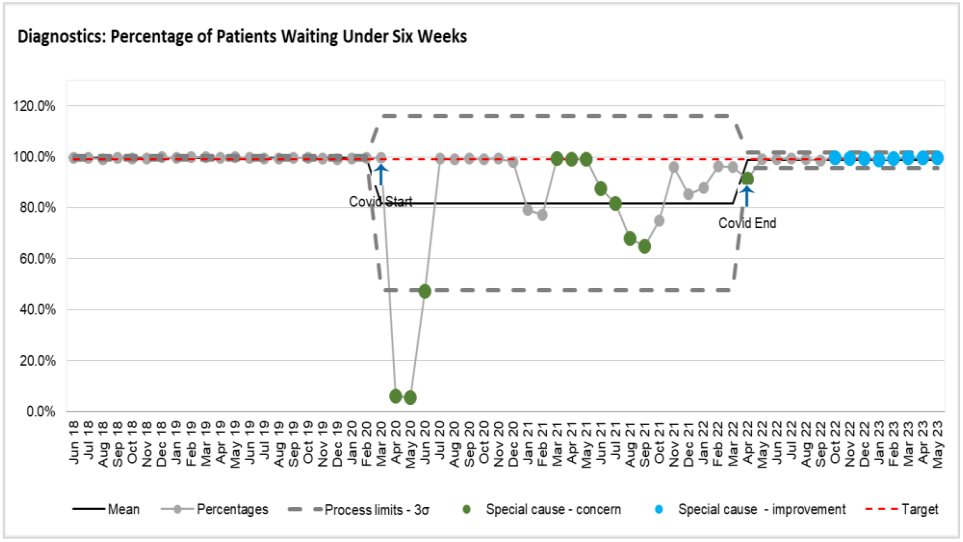
Figures show total inpatient waiting list including planned patients and patients with a TCI date.

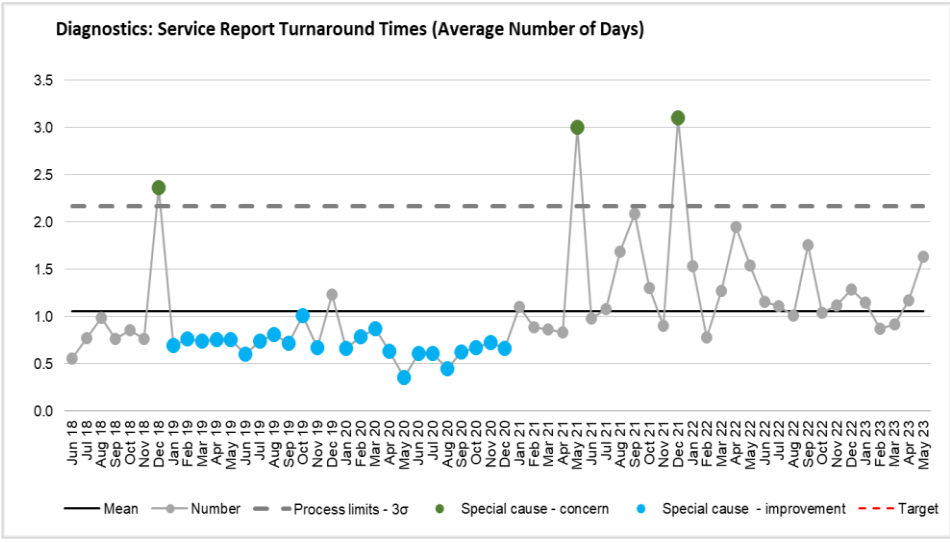
6. Diagnostic Performance

% 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 May 2023 closing the month at 99.75%. The main area of challenge is paper referrals being received late into the Imaging Department resulting in breaches. Testing for the PICS based electronic requesting is due to start in the next few weeks with the potential go live toward the end of July/ early August if testing goes well.

The National 23/24 operational target remains at 95% which ROH are achieving; however, we have retained reporting against the traditional 6-week diagnostic target locally as our aspirational target and is within our constitution.

May 23 reporting times remain on target; however, typing is an issue with a vacancy that is being re-advertised – an external company is continuing to be used to support this service.

The new Digital x-ray room (room 3) was handed over on 5th June 2023 and is now in use. 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 Summer 2023 to help streamline imaging referrals.

RISKS / ISSUES

The lack of an electronic referral system (order comms) could have a potential impact on performance. In addition, there is an increased risk of paper referral forms 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 – April 2023 (May 2023 Submission)

Metric	Patients	Compliant	Breach	Total Accountable	%	Target
2WW	63	61	2	63	96.8%	93%
31 day 1st	13	11	2	13	84.6%	96%
31 day sub	6	6	0	6	100.0%	94%
62 days	3	0.5	2	2.5	20%	85%
62 day upgrade	10	7.5	0	7.5	100%	90%
28 day FDS	75	60	15	75	80%	75%
104 days treated at ROH	0	0	0	0	0.0%	0

Performance

Cancer performance standards were met in April 2023, apart from the 62-day traditional and the 31-day 1st metric. One patient breached both the 31-day 1st and the 62-day traditional.

The root cause of the delays were:

31-day 1st – Complex pelvic patient, consultant annual leave, required 2 Surgeons.
Both pelvic cases were planned to be listed on the same day, however the first 31 breach was very complex, as it went into the spinal canal so they couldn't put two pelvic cases on the list with a 3rd session so complex patient was listed first due to clinical priority

62 day traditional – Patient fitness for surgery – 95 years old, had 43-day local admission for delirium/dehydration (would have met target if they had not been admitted locally)

The 2 week wait compliance standard was met overall, the 2 breaches were – 1x ultrasound capacity, 1x patient holiday.

Risks /actions ongoing

ROH are actively participating and engaging with the weekly System Oversight Group for cancer recovery and receive positive feedback against overall performance standards.

8. Overall Financial Performance

SUMMARY

The Trust delivered a deficit in month of £383k against a planned surplus of £120k, being a £503k adverse variance, resulting in a year to date deficit of £1,020k against a surplus plan of £35k.

Income year to date is £208k below plan.

Pay expenditure is behind plan by £272k. Non pay expenditure is overspent against plan with an adverse variance of £622k.

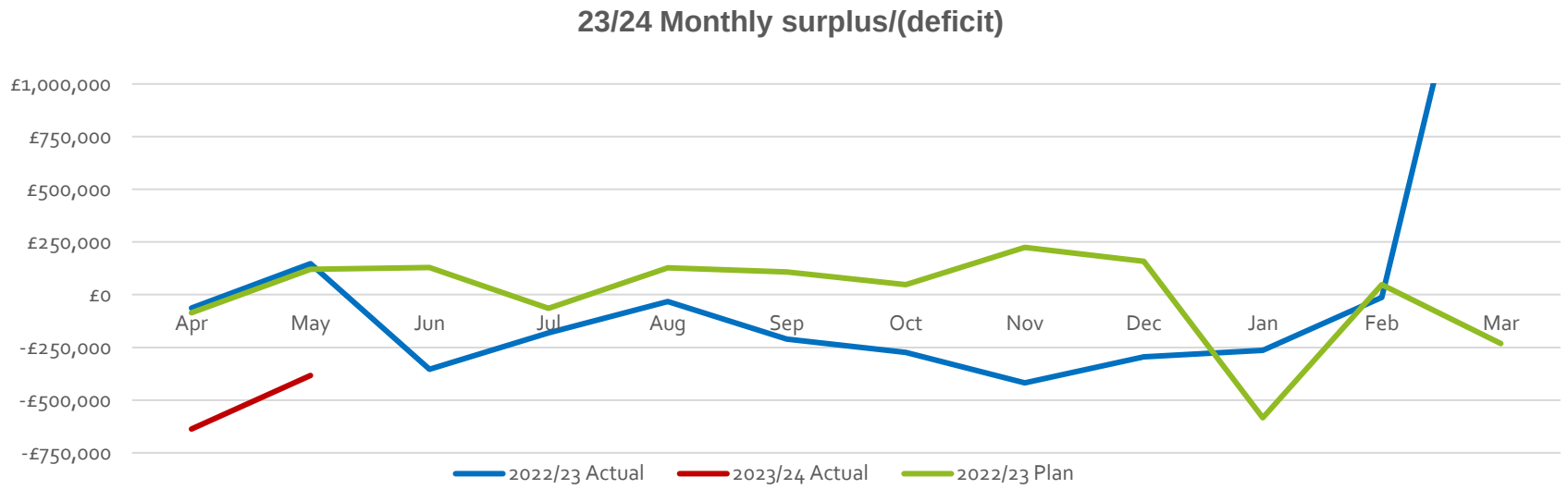
Forecast remains as breakeven against plan.

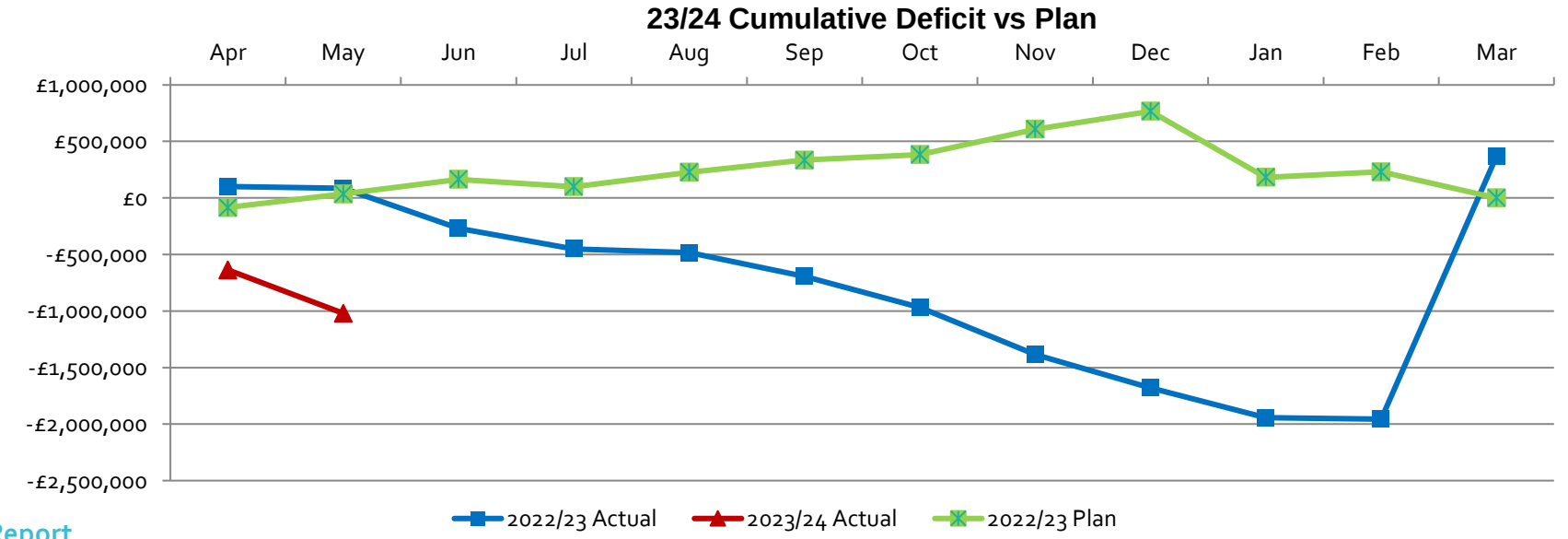
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	(208)	(272)	(622)	46	(1,056)
Year to date plan	20,778	(11,882)	(8,633)	(242)	21
Year to date actual	20,570	(12,154)	(9,255)	(196)	(1,035)
Variance compared previous month	↑ 211	↓ (378)	↓ (354)	↑ 60	↓ (461)
Forecast Variance	0	0	0	0	0

8. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	19,934	19,797	(137)
Other Operating Income (Excluding top up)	844	773	(71)
Employee Expenses (inc. Agency)	(11,882)	(12,154)	(272)
Other operating expenses	(8,633)	(9,255)	(622)
Operating Surplus	**263**	**(839)**	**(1,102)**
Net Finance Costs	(242)	(196)	45
Net surplus/(deficit)	**21**	**(1,035)**	**(1,056)**
Remove donated asset I&E impact	14	15	1
Adjusted financial performance	**35**	**(1,020)**	**(1,055)**

8. Overall Financial Performance





9. Income

SUMMARY

Income achieved during Month 1 and 2 is performing £208k below plan.

The elective recovery fund (ERF) Communications from NHS England has requested no adjustment is applied for ERF clawback, therefore the adjustment previously made in Month 1 has been removed.

Private patient income is underperforming year to date with an adverse variance against plan of £246k which shows recovery in month 2 performance following the underperformance in month 1.

AREAS FOR IMPROVEMENT

Elective income delivery is below plan during Month 1 and 2.

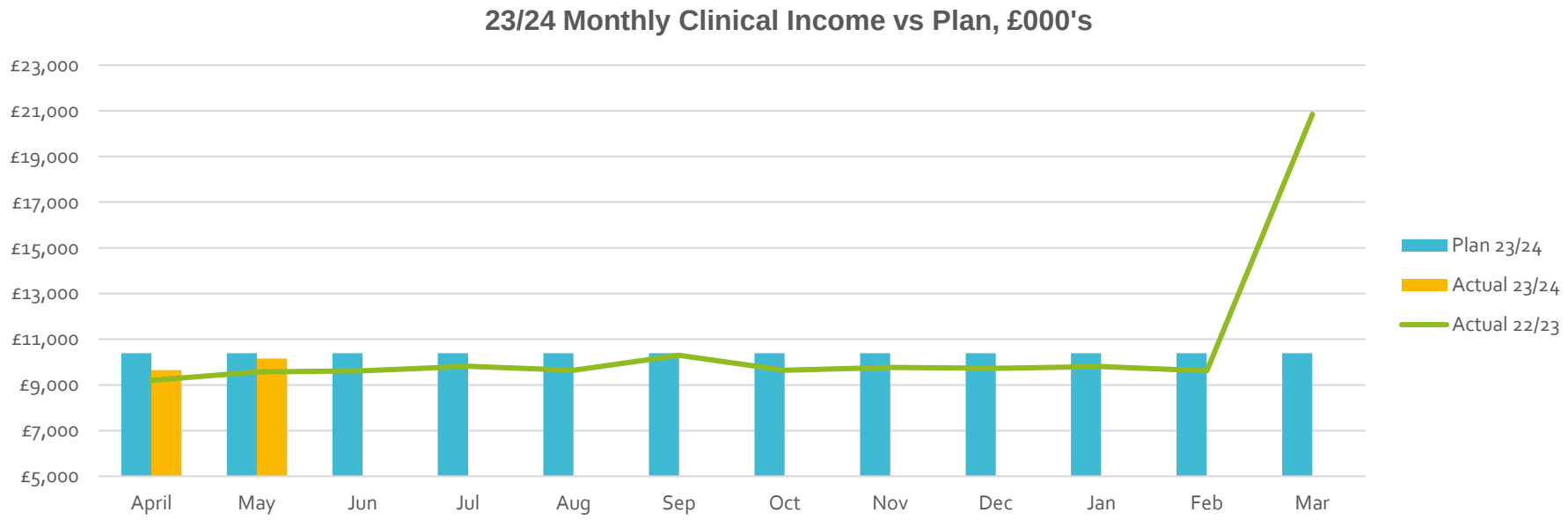
Private patient income requires recovery against year to date plan.

RISKS / ISSUES

Elective recovery target delivery during the year remains a risk.

Non recurrent funding has been included within plans for 2023/24, generating an underlying financial risk for 2024/25 and beyond.

9. Income

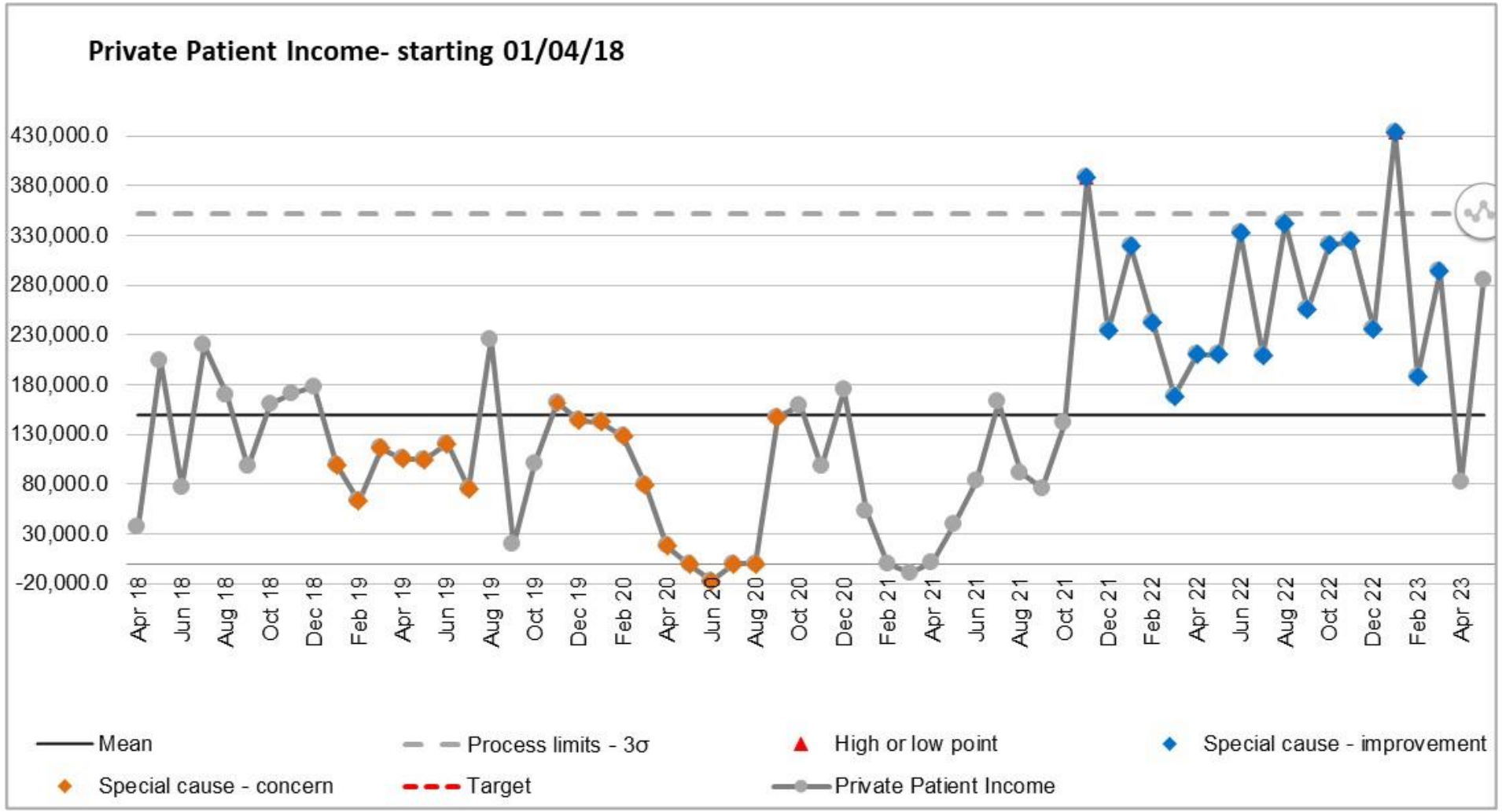


Elective recovery fund (ERF) value weighted activity (VWA) performance

Elective Recovery Income Performance	1	2 Year to Date	
Day Cases	£689,352.76	£885,962.10	£1,575,314.86
Elective	£2,594,708.90	£3,171,437.51	£5,766,146.41
Outpatient FA Single Professional Consultant Led	£274,164.50	£341,788.25	£615,952.75
Outpatient FA Single Professional Consultant Led Non Face to Face	£8,964.22	£7,681.03	£16,645.25
	£3,567,190.38	**£4,406,868.89**	**£7,974,059.27**
ERF Plan	**£4,251,755**	**£4,315,265**	**£8,567,020**
Variance	**-£684,565**	**£91,604**	**-£592,961**

Please note this ERF Value weighted activity (VWA) performance is subject to change as agreements on performance against target are ongoing.

9. Income


Private Patient Income- starting 01/04/18
430,000.0
380,000.0
330,000.0
280,000.0
230,000.0
180,000.0
130,000.0
80,000.0
30,000.0
-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
Apr 23
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Private Patient Income

9. Expenditure

SUMMARY

Pay expenditure is overspent against plan by £272k, when the pay award impact is removed there is a small underspend against plan year to date. Note that the pay award impact is in offset by a corresponding increase in income. Non pay expenditure is overspent against plan with an adverse variance of £622k.

Agency spend remains above price cap with 7.6% overall pay spent on agency year to date against an agency cap of 3.7%. Key drivers for high agency spend remain continued high sickness, high turnover rate and high vacancy levels.

Non pay spend has also remained high in month generating an adverse variance of £622k. Key drivers for this include high consumable spend in theatres which is being investigated to understand the drivers, and above inflationary pressures particularly with regards to estates spend.

AREAS FOR IMPROVEMENT

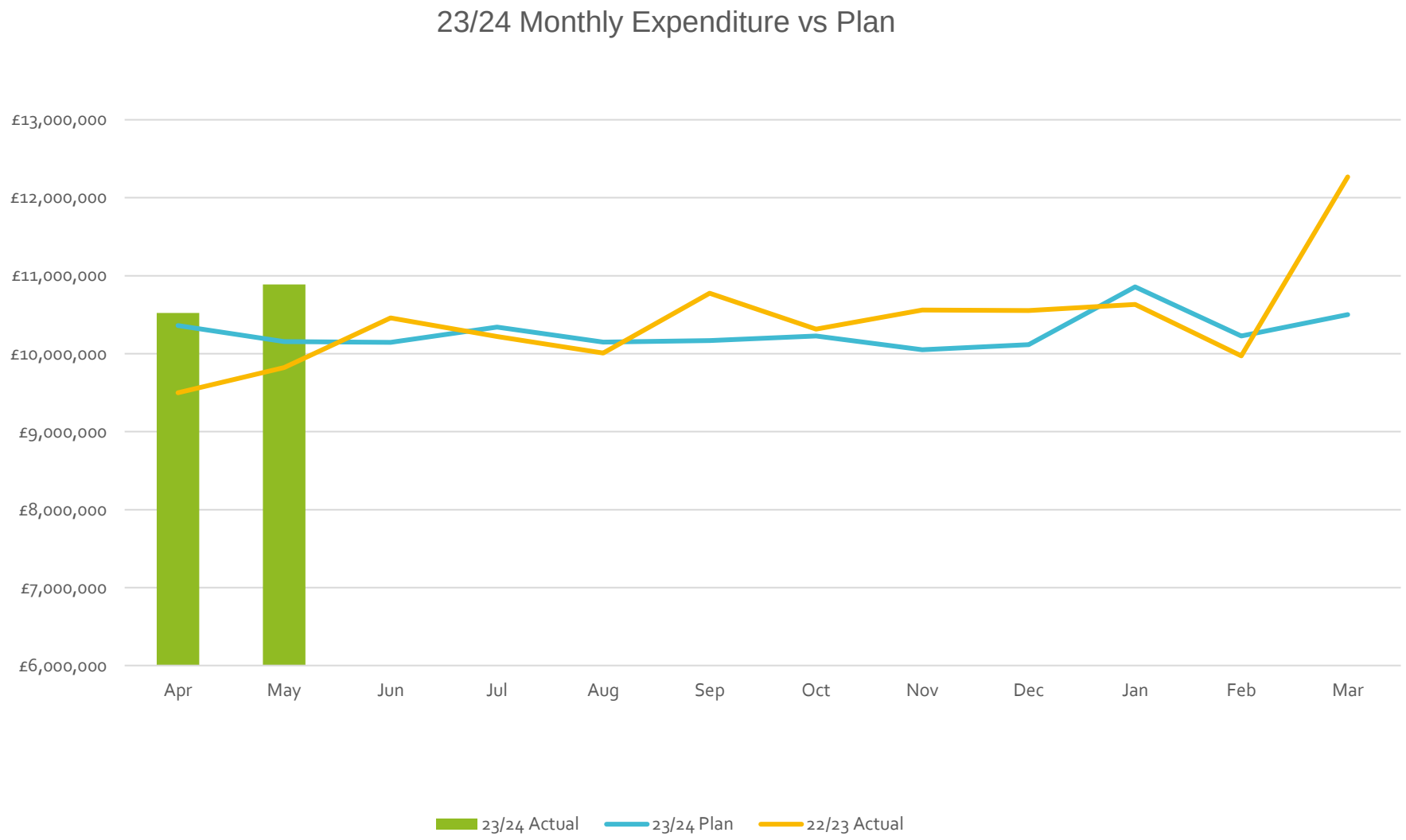
Agency spend is above agency Cap of 3.7%.

Theatre consumable spend reducing to planned levels.

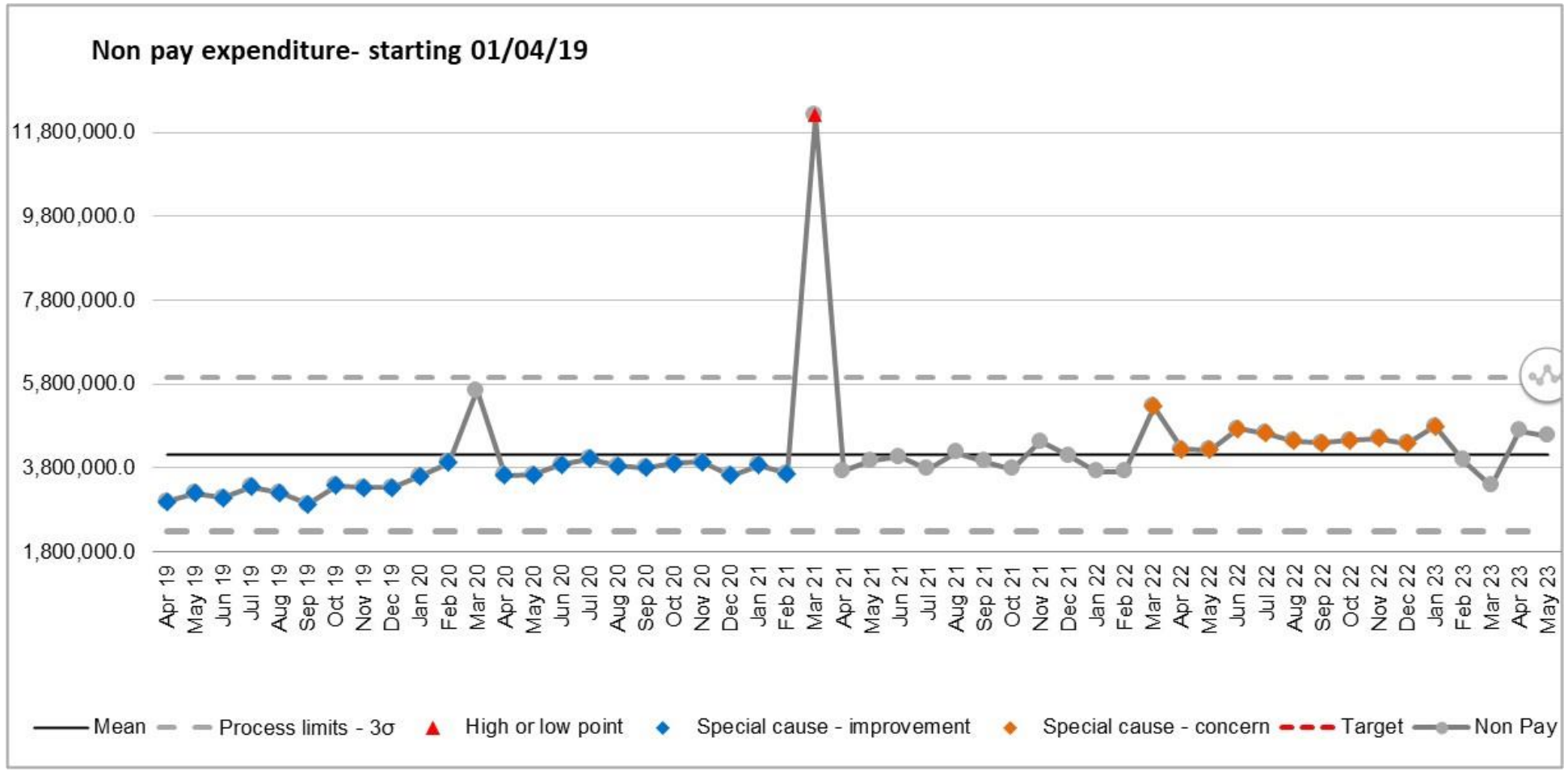
RISKS / ISSUES

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

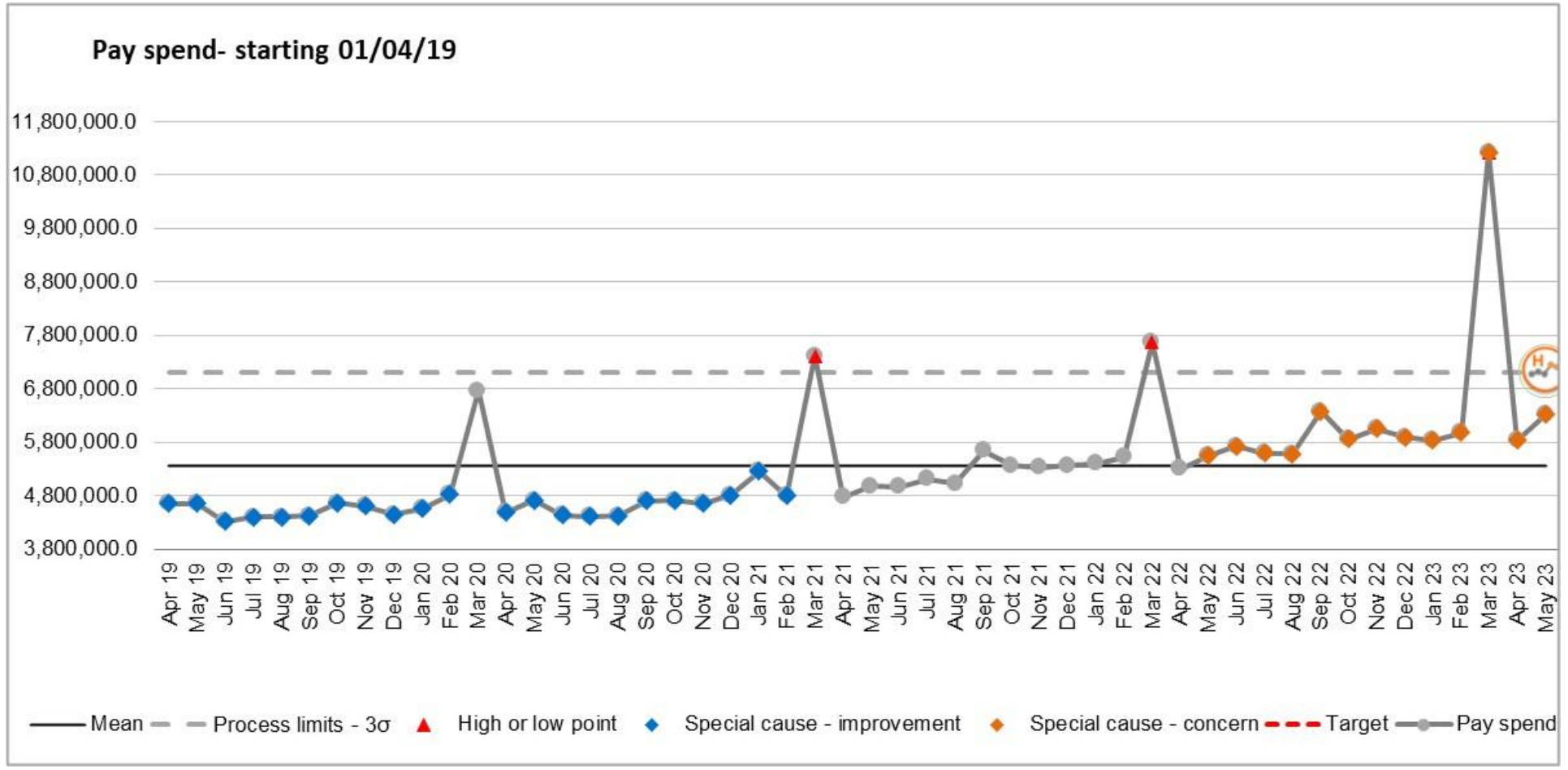
9. Expenditure



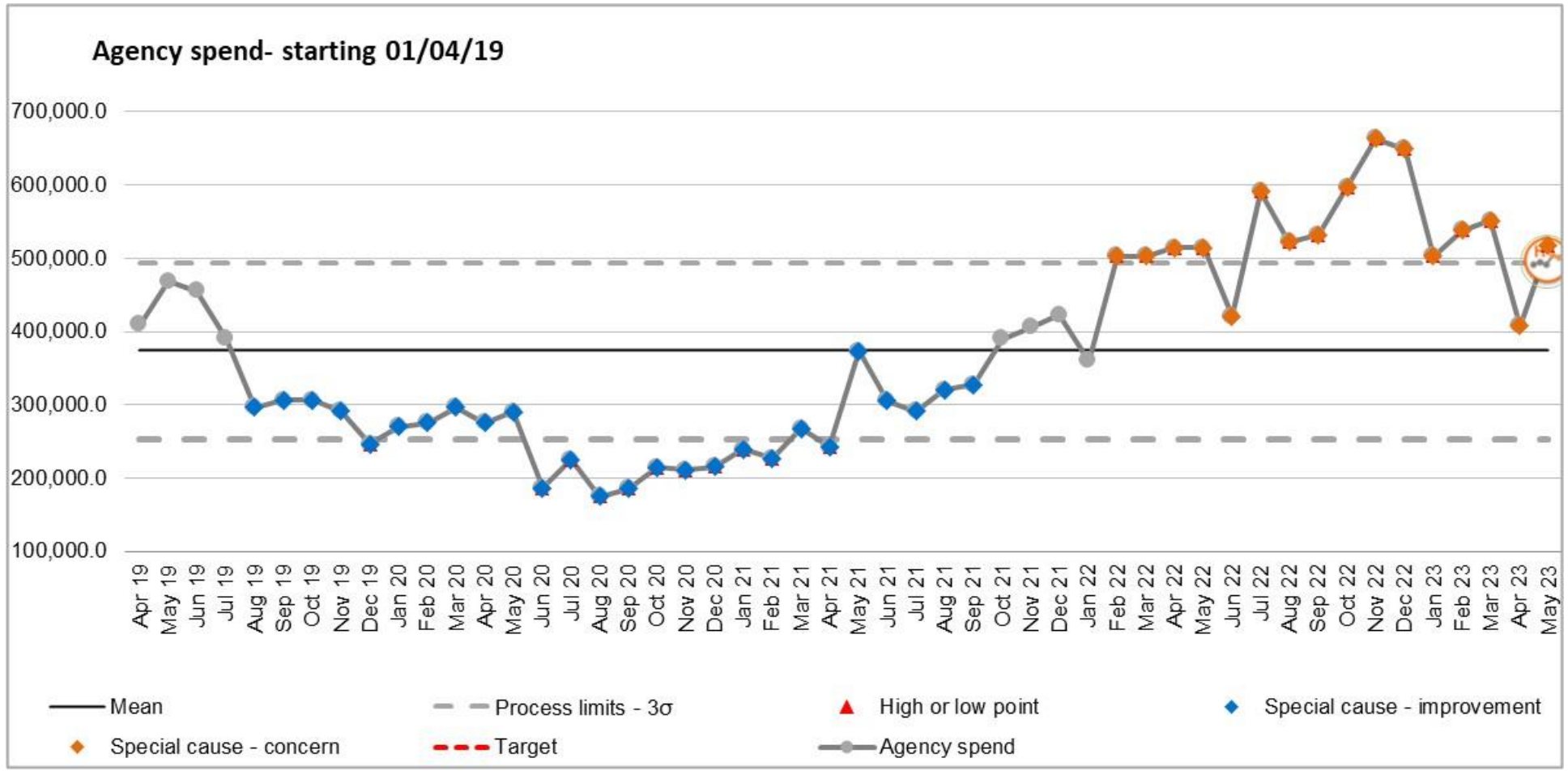
9. Non Pay Expenditure



9. Pay Expenditure



11. Agency Expenditure

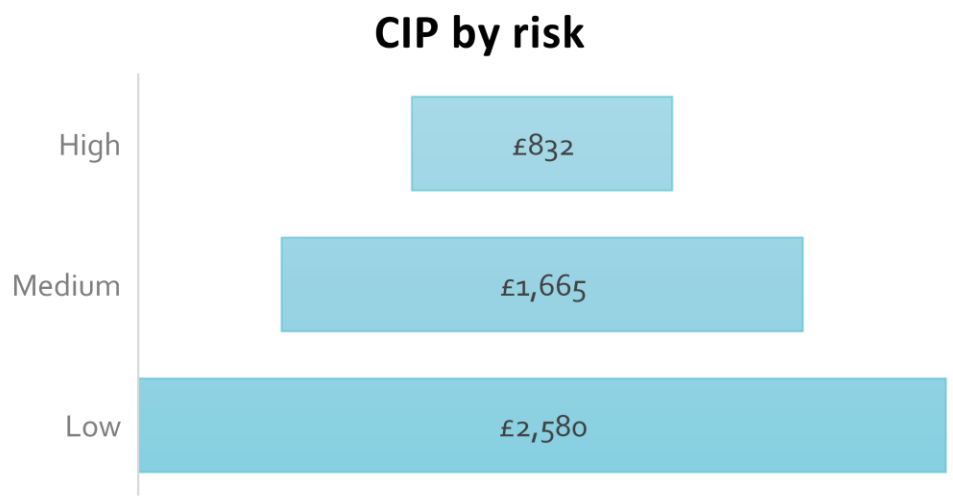


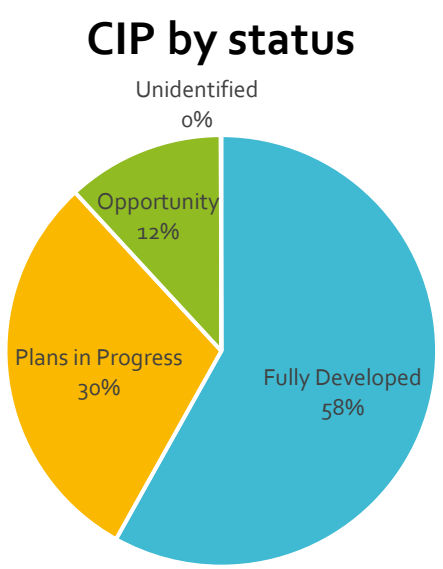
12. Cost Improvement Programme Summary

SUMMARY

Year to date savings totalling £660k have been delivered, against a plan of £619k, delivering a positive variance of £41k. CIP schemes have been identified totalling £5 million, with over 100 schemes identified at varying stages of the planning process.

£000s				
CIP Category	Year to date Plan	Year to date Actual	Variance	Forecast
Pay	£0	0	0	£679
Non pay	£536	£621	£85	£3,897
Income	£83	£39	(£44)	£500
Grand Total	**£619**	**£250**	**£41**	**£5,076**





13. Statement of Financial Position

SUMMARY

There have been limited balance sheet movements since year end, with the main movement being a reduction in cash, largely due to a the ongoing investment in the Trust's estate, particularly with regards to Café Royale and improved accommodations for the facilities staff.

	2022/23 M12	2023/24 M2	Movement
	(£'000)		
Intangible Assets	1,339	1,293	(46)
Tangible Assets	68,977	68,616	(361)
Total Non Current Assets	**70,316**	**69,909**	**(407)**
Inventories	19	19	-
Trade and other current assets	10,541	11,824	1,283
Cash	7,591	6,601	(990)
Total Current Assets	**18,151**	**18,443**	**292**
Trade and other payables	(17,820)	(19,672)	(1,852)
Borrowings	(18,327)	(17,826)	501
Provisions	(1,328)	(1,328)	-
Other Liabilities	(250)	(504)	(254)
Total Liabilities	**(37,726)**	**(39,330)**	**(1,604)**
Total Net Assets Employed	**50,741**	**49,023**	**(1,718)**
Total Taxpayers' and Others' Equity	**50,741**	**49,023**	**(1,718)**

14. System

SUMMARY

It has been a challenging start across the ICB due to a mix of continuing industrial action, and the signifanct level of CIP that needs to be delivered on a monthly basis

Organisation	Surplus / (Deficit) - Adjusted Financial Position							
	Plan YTD £000	Actual YTD £000	Variance YTD £000	Variance YTD %	Plan Year Ending £000	Forecast Year Ending £000	Variance Year Ending £000	Variance Year Ending %
Birmingham And Solihull ICB	6,028	6,101	73	0.0%	-	(0)	(0)	(0.0%)
Birmingham And Solihull Mental Health NHS Foundation Trust	-	(410)	(410)	(0.4%)	-	-	-	0.0%
Birmingham Community Healthcare NHS Foundation Trust	88	(663)	(751)	(1.3%)	-	-	-	0.0%
Birmingham Women'S And Children'S NHS Foundation Trust	-	(314)	(314)	(0.3%)	-	-	-	0.0%
The Royal Orthopaedic Hospital NHS Foundation Trust	35	(1,020)	(1,055)	(5.1%)	-	-	-	0.0%
University Hospitals Birmingham NHS Foundation Trust	(7,400)	(11,831)	(4,431)	(1.2%)	-	-	-	0.0%
ICS Total	(1,249)	(8,136)	(6,887)	(1.4%)	-	(0)	(0)	(0.0%)

Trust Workforce Metrics	Apr-23	May-23	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1296	1306	10	-	-
Staff In Post - Full Time Equivalent	1144.60	1152.31	7.71418	-	-
Staf Turnover % - Unadjusted	16.74%	19.44%	2.70%		<=11.5%
Staf Turnover % - Adjusted	14.64%	13.90%	-0.74%		<=11.5%
Total WTE Employed as % of Establishment	84.43%	84.50%	0.07%		>=93%
Total WTE Employed as % of Establishment - Clinical	81.57%	81.61%	0.04%		>=92%
Total WTE Employed as % of Establishment - Non-Clinical	89.82%	89.89%	0.07%		>=96%
% Of Attendance	94.65%	94.77%	0.12%		>=96.3%
% Of 12 mth MAA Attendance	94.04%	94.07%	0.03%		>=96.3%
% Staff received mandatory training last 12 months	89.48%	89.26%	-0.22%		>=93%
% Staff received formal PDR/appraisal last 12 months	61.36%	60.70%	-0.66%		>=95%
% of Sickness - Trust wide Long-term	2.70%	2.59%	-0.11%		-
% of Sickness - Trust wide Short-term	2.65%	2.64%	-0.01%		-
Return To Work Completion %	57.58%	57.32%	-0.26%		>=80%

Summary / Highlights

In May, 89.26 of staff had completed their mandatory training within the last 12 months which is a slight decrease on April. Staff have been completing their mandatory training through e-Learning over the last year, with new starters supported to complete their mandatory training prior to starting. Classroom sessions have now started back up.

Turnover (both Unadjusted and Adjusted) have been increasing over the last months this trend continues. Turnover unadjusted stands at 19.44% which is an increase from April which was 16.74%.

The percentage of staff attendance in the month has increased to 94.77%.

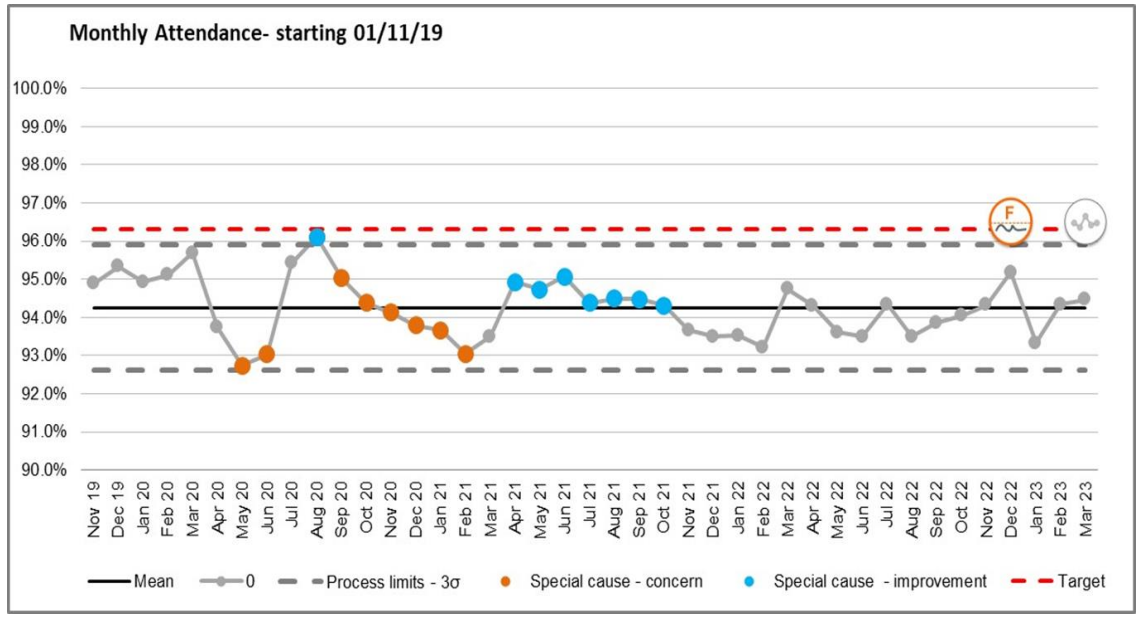
The Establishment of WTE is still below target and has increased to 84.5% from 84.43% in April.
Clinical staff are currently 81.6% established in terms of WTE.
Non-Clinical staff are currently 89.89% established in terms of WTE.

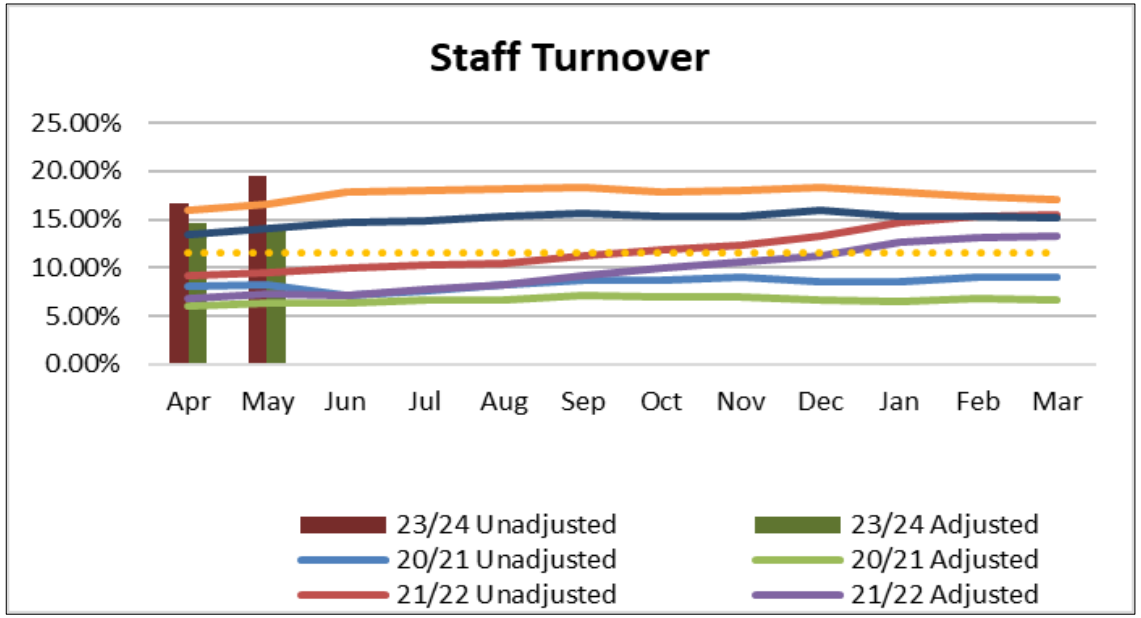
Risks / Issues

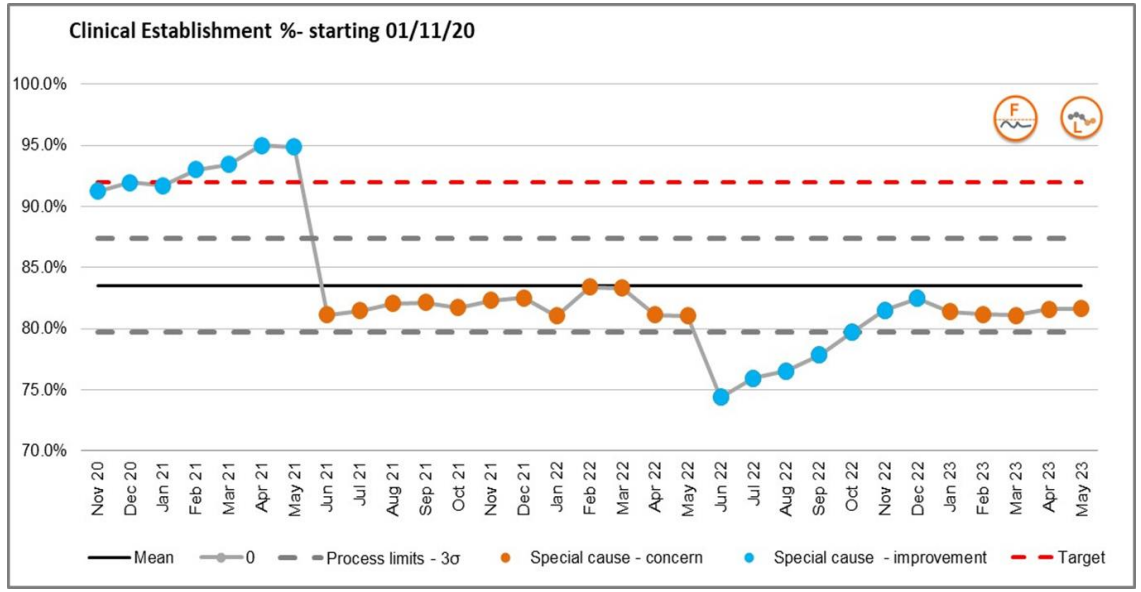
Cost of living seems to be affecting the NHS as a whole, the Trust is doing it's upmost to alleviate the impact. Other Trusts seem to be able to offer higher bands, this has seen some employees move on.
Staff with no PDR/Appraisal will have no way of been appraised and will have no personal goals.
Return To Work meetings if these aren't carried out there is a potential for further sickness and opportunities to support employees will be missed.
We anticipate that over the next few months, attendance may drop as we come to the summer months. Staff are being encouraged to have their Annual Leave which should hopefully help with minimising the impact of this.

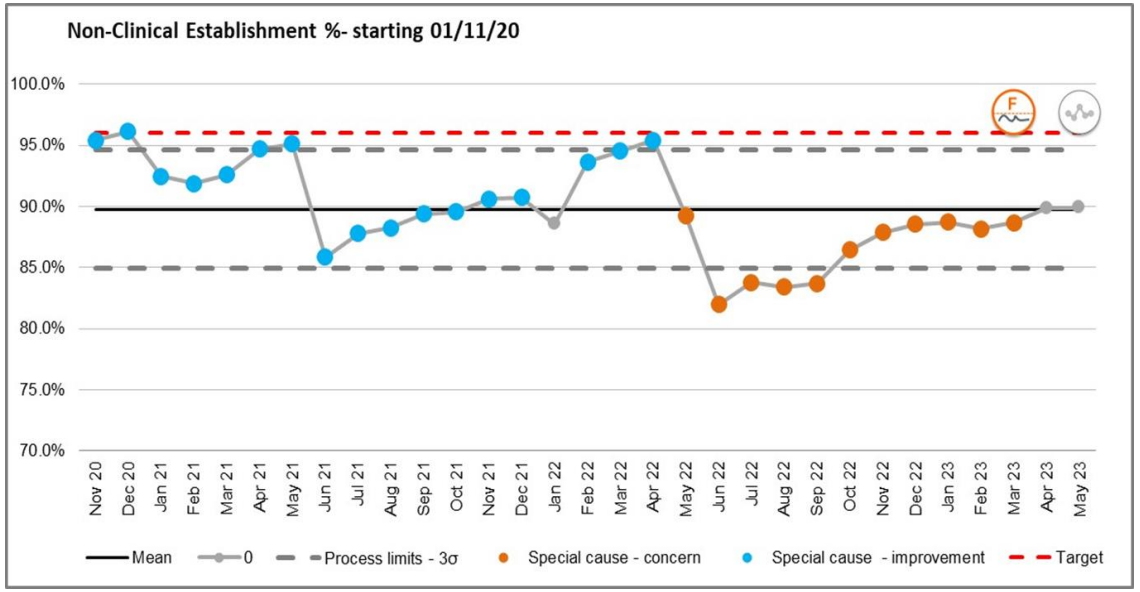
Actions

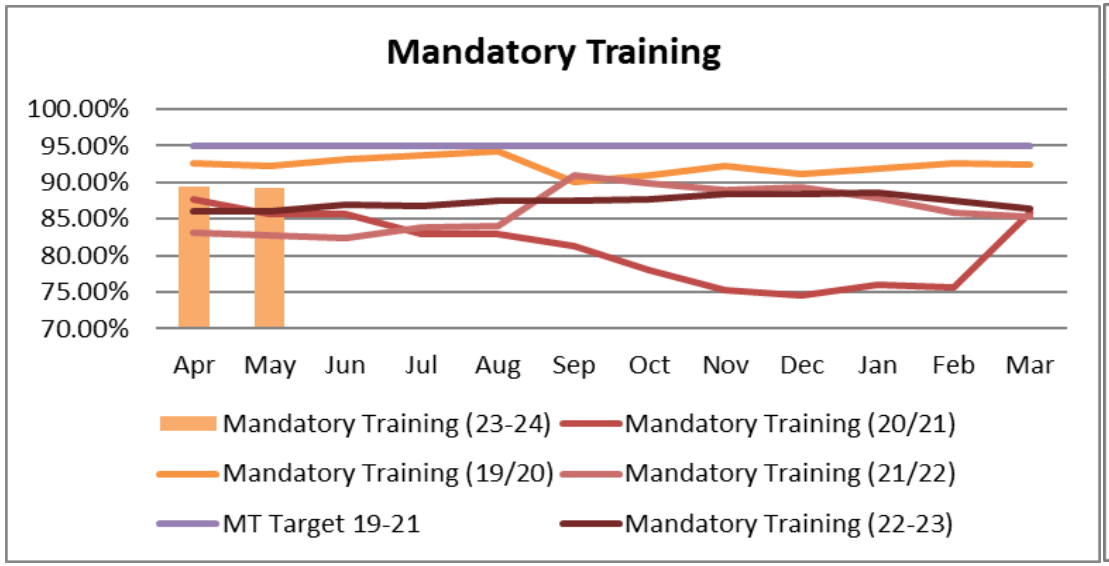
HR and E-Roster team to look into the issues around Return To Work meetings, Sophie Beavon, Paddy Coen and Jade Johnson are running drop in sessions for managers.
HR to review the Staff Turnover and look into the reasons and dig deeper into them, Terrie Hillier provides a deeper dive into the data and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

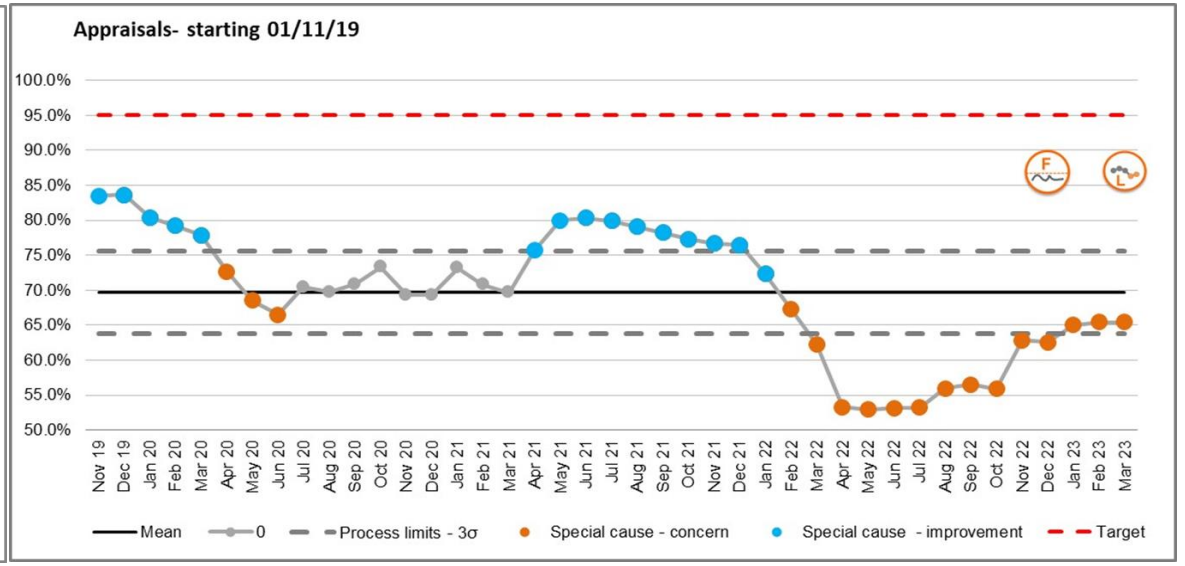

Monthly Attendance- starting 01/11/19
100.0%
99.0%
98.0%
97.0%
96.0%
95.0%
94.0%
93.0%
92.0%
91.0%
90.0%
Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 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

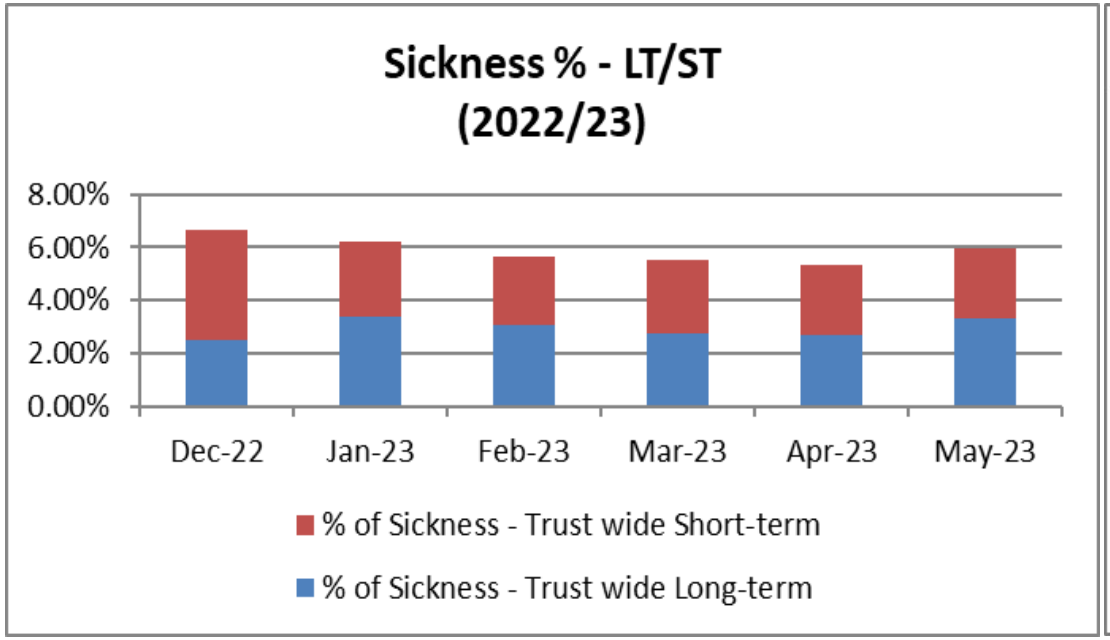

Staff Turnover
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
23/24 Unadjusted
23/24 Adjusted
20/21 Unadjusted
20/21 Adjusted
21/22 Unadjusted
21/22 Adjusted

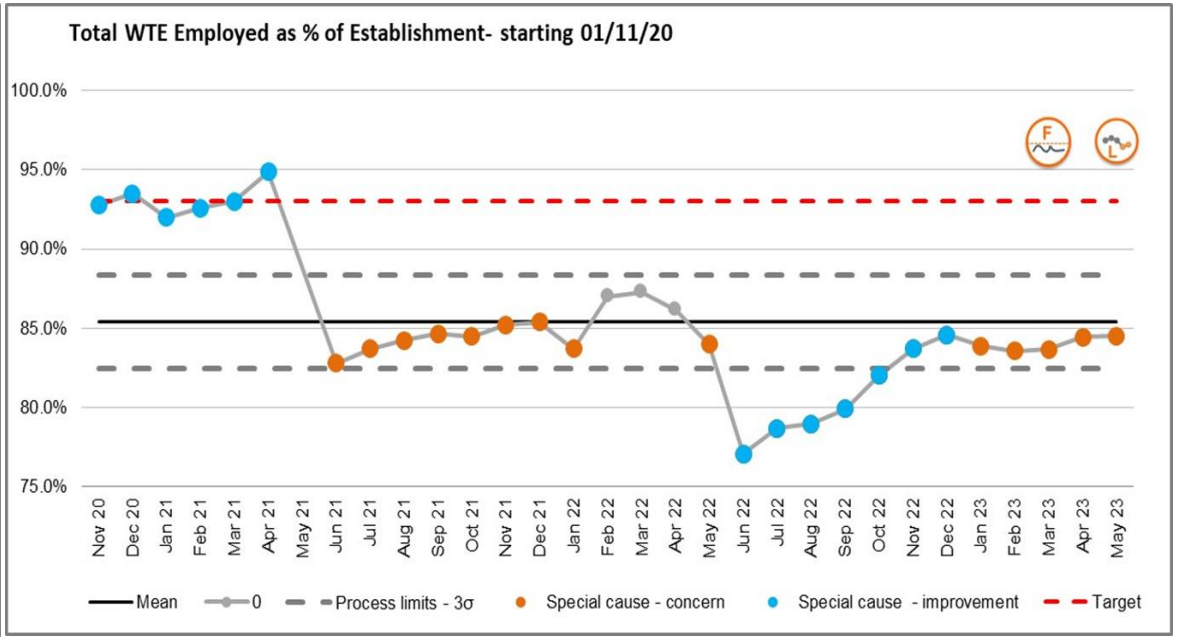

Clinical Establishment %- starting 01/11/20
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May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


Non-Clinical Establishment %- starting 01/11/20
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
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 Apr 23 May 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 (23-24)
Mandatory Training (20/21)
Mandatory Training (19/20)
Mandatory Training (21/22)
MT Target 19-21
Mandatory Training (22-23)


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%
Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23
% of Sickness - Trust wide Short-term
% of Sickness - Trust wide Long-term


Total WTE Employed as % of Establishment- starting 01/11/20
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
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 Apr 23 May 23
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY AND SAFETY REPORT

June 2023 (May 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 & Assurance

Quality Report – June 2023 (May 2023 Data) – Summary Dashboard

	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	2022/2023	2023/24
Incidents	387	304	289	280	296	308	329	310 (↓)	283 (↓)	292 (↑)	374 (↑)	269(↓)	378 (↑)		
Serious Incidents	0	1	2	0	1	0	0	1	0 (↓)	2 (↑)	0 (↓)	1(↑)	1	8	2
Inpatient Deaths	0	0	0	0	0	0	0	0	0	0	0	0	1 (↑)	1	1
VTEs (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Falls	10	4	3	5	3	10	5	9 (↑)	3 (↓)	7 (↑)	5 (↓)	12(↑)	9 (↓)	79	12
Pressure Ulcers: Cat 2 (Avoidable)	3	0	0	0	0	0	2 (↑)	0	0	0	0 (0	0	0	5	0
Pressure Ulcers: Cat 3 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0 (0	0	0	0	0
Infections	1	2	0	0	1	1	1	1	0	1 (↑)	0 (↓)	0 (↓)	0	9	0
Complaints	5	4	1	2	6	4	4	3	2	4 (↑)	1 (↓)	3(↑)	2 (↓)	45	3
Litigation	0	0	1	2	0	0	3	0	0	2 (↑)	2	0(↓)	0	9	0
Coroners	0	0	0	0	0	0	0	0	0	0	0	0(↓)	1 (↑)	0	1

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.

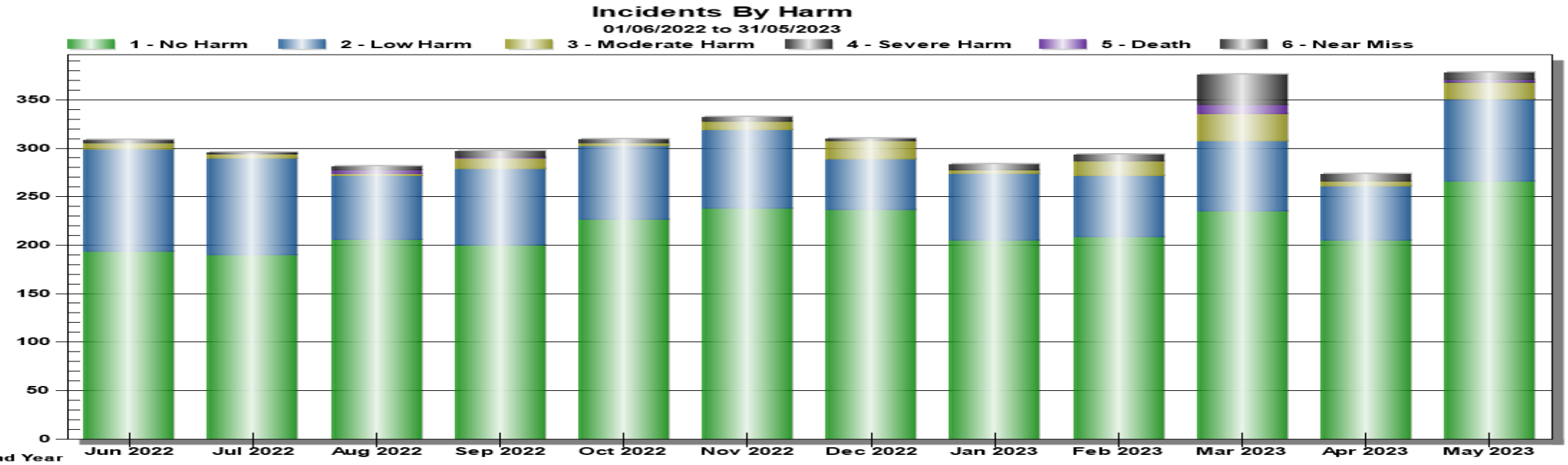
The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

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	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023
1 - No Harm	193	189	205	199	226	237	236	204	208	234	204	265
2 - Low Harm	105	100	66	79	76	81	52	69	63	73	56	85
3 - Moderate Harm	7	4	2	11	3	9	19	4	15	28	5	17
4 - Severe Harm	0	1	0	0	0	0	0	0	0	0	0	1
5 - Death	0	0	4	1	0	0	0	0	0	9	0	2
6 - Near Miss	3	1	4	7	4	5	3	6	7	32	8	8

In the month of May 2023, there were a total of 378 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is as follows;

265 – No Harm
85 - Low Harm
17 - Moderate Harms
1 - Severe Harm
8 - Near Miss
2 – Death * actual figure is 1. Same death was reported twice on Ulysses

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

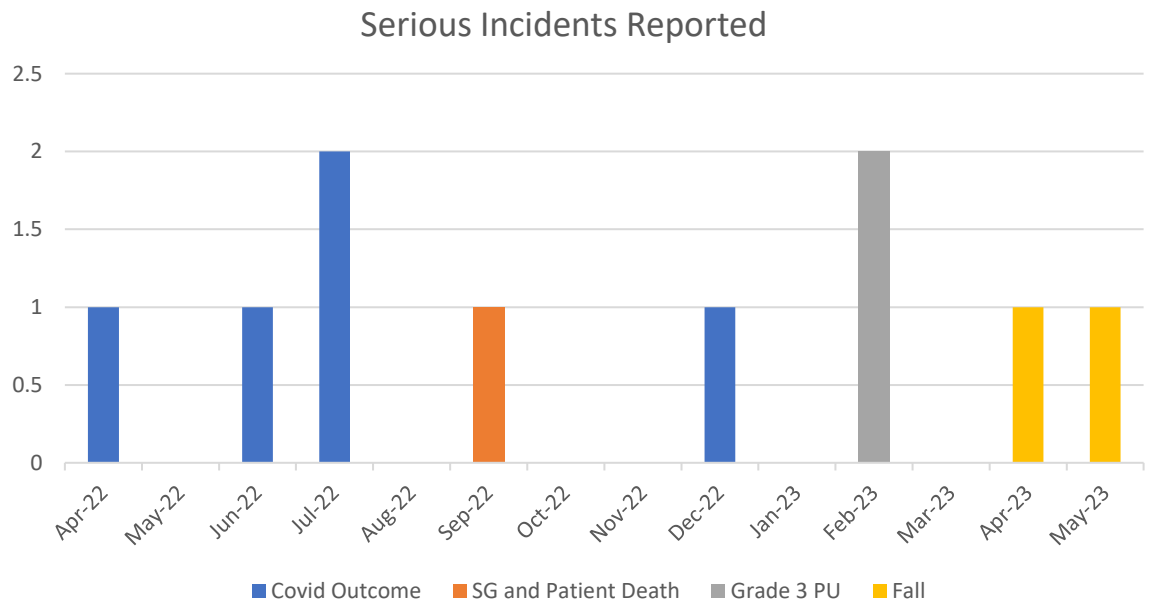
1 Serious Incident (SI) reported in May 2023

Patient Fall on Ward 2

Potential Moderate Harm

RCA underway - 1st Draft of RCA out for comment.

Update to follow in next report



4. Patient Deaths – All inpatient deaths and deaths within 30 days of discharge will be incident reported and will be reviewed as part of the learning from deaths process.

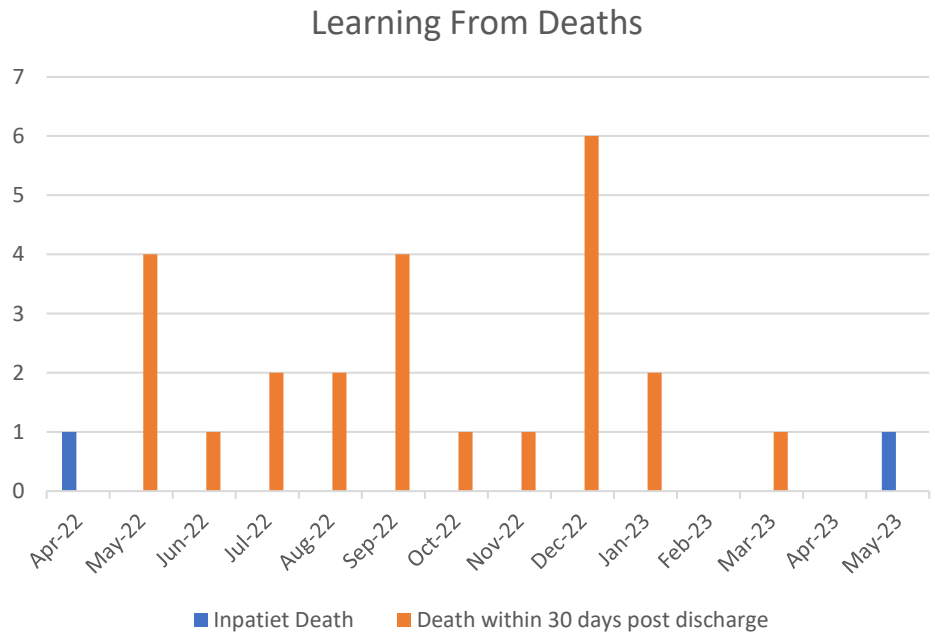
1 inpatient death was reported in May 2023

Coroner ruled that no inquest is to be held into the death

RCA and Learning from Death review underway – update to follow in next report

<u>Immediate Learning Implemented</u>

Improved communication around the location of Interosseous needles. Learning shared with teams during resus huddles.



5. Potential Moderate Harm & Severe Harm Incidents

There were **17** potential Moderate Harm incidents and **1** potential severe harm incident reported in May 2023

All incidents have been tabled at Divisional Governance meetings and are currently under investigation

Summary of Incidents

- 1 x Severe Harm – Spinal Department Incident – post-operative neurological deficit
- 8 x Appointments Department Incidents
- 4 x Surgical Site Infections (SSIs)
- 1 x Spinal Department Incident – Neurological deterioration of patient following spinal decompression surgery
- 1 x Theatres Incident – Skin damage to patient's thigh
- 1 x Ward 12 Incident – Retained Cannula tip
- 1 x Ward 2 incident – Emergency Transfer out of
- 1 x Ward 2 Incident – Fall

6. Near Miss Incidents

There were 8 Near Miss incidents reported in May 2023

All incidents have been tabled at Divisional Governance Meetings and are currently under investigation

<u>Summary of Incidents</u>

6 x Appointments Department Incidents
1 x Cancer Waiting Time incident
1 x Medication Error

7. Learning from Serious Incidents, Never Events and RCAs

There were 5 RCA investigations closed in May 2023. The incidents and the key learning from these RCA reports is summarised below:-

1. Bone Infection Service (BIS) Incident

Summary

Duplication of blood tests and prescription. No harm to patient. Duplicate medication not taken. Blood tests were repeated but caused no harm

Key Learning

- Improve Junior Doctors Awareness about information required on PICS discharge letter regarding BIU input and outcomes to ensure GP's have increased awareness
- Existing PICS discharge letter to have specific BIU prompts to improve BIU information given to patients and GP's.
- UHB Microbiology and Infectious Disease Consultants to have ROH PICS access
- BIS MDT review of GP letters
- Primary Care formulary to be reviewed re classification of Linezolid
- BIS patients to be given safety notification card on discharge

2. VTE incidents x 4

Summary

1 x Ward 12
1 x Ward 4
2 x Ward 2

Key Learning

- Ensure that clear documentation is in place and when signing for AES to ensure checks are commenced as not always clear as to what AES was in place.
- Ensure that if only one AES is in place to make sure that the prescription is changed on PICS and assessed by a doctor if AES has been removed for long periods of time.
- Ensure nursing care plans are up to date and the front of the VTE care plan is completed correctly.
- Ensure that the 24 VTE reassessment is reviewed and completed if any changes occur.
- Ensure that if SCD or AES are not in place that a doctor is informed and the VTE assessment is re assessed
- Ensure that clear documentation is in place and when signing for anti-embolic stockings to ensure actual physical checks are undertaken and not presumed.
- Be clear as to what anti embolic stocking is in place.
- Ensure that if only one anti embolic stocking is in place, make sure that the prescription is changed accordingly and assessed by the medical staff.
- Ensure nursing care plans are up to date and the front of the care plans are completed correctly. Ensure that the 24-hour venous thrombolytic event re-assessment is reviewed and completed if any changes occur.
- Ensure that if anti venous thrombolytic devices are not in place as prescribed that a doctor is informed and the assessment is re-assessed.

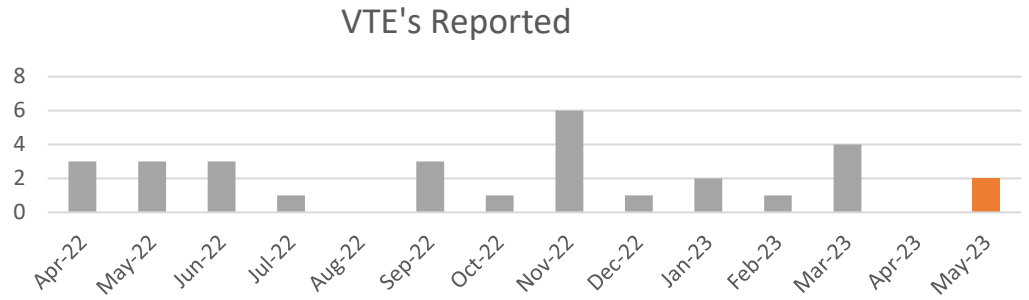
8. Venous thromboembolism (VTE) Incidents

There were 2 VTE incidents reported in May 2023

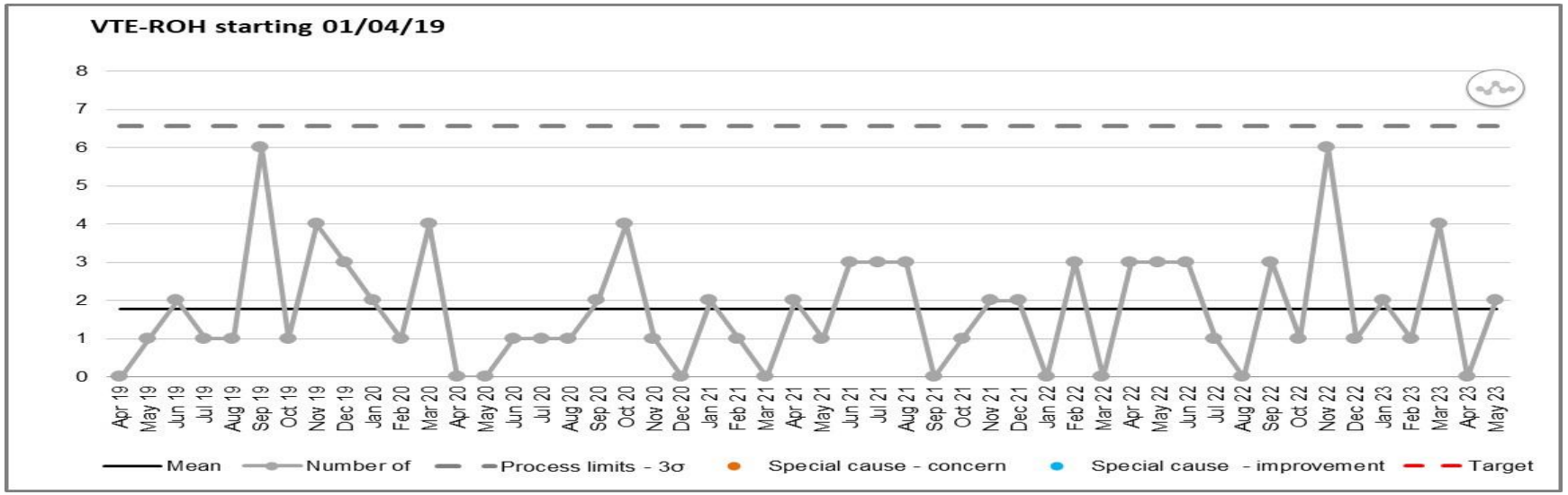
Both incidents were reported as Low Harm and are currently undergoing an RCA investigation to determine avoidably as per Trust practice and process

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

May 2023 = **97.11%**



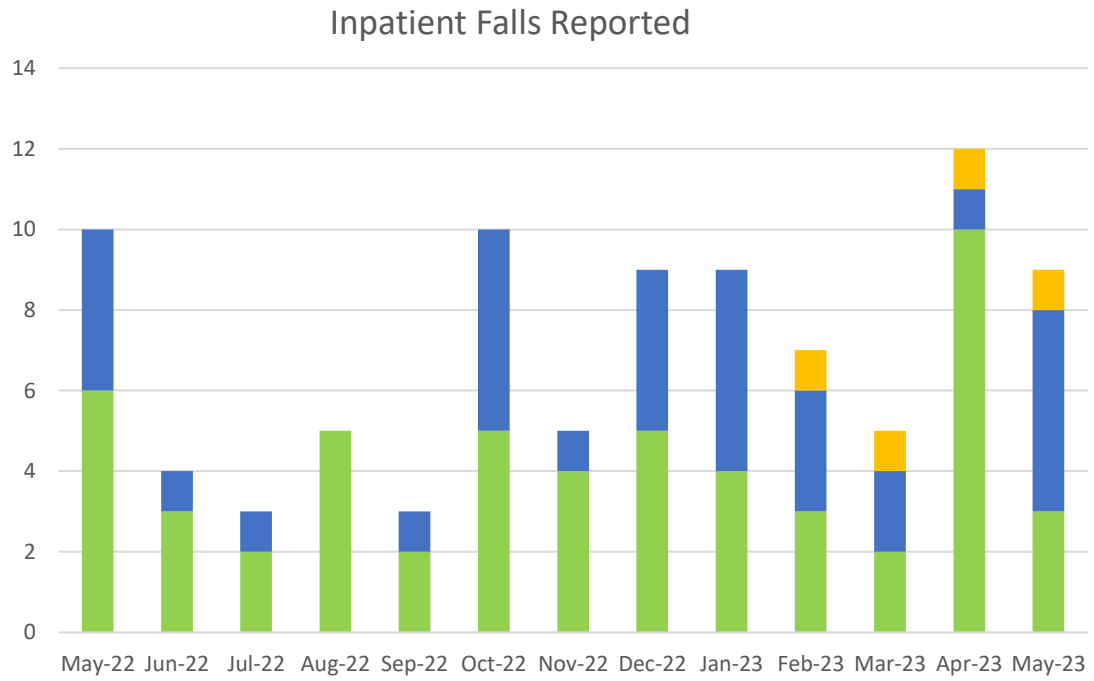
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Unavoidable	3	3	3	1	0	3	1	6	1	2	1	4	0	
TBC	0	0	0	0	0	0	0	0	0	0	0	0	0	2
Avoidable	0	0	0	0	0	0	0	0	0	0	0	0	0	0



9. Falls –

9 falls incidents reported in May 2023 – reduction on last month

No Harm = 3
Low Harm = 5
Moderate Harm = 1



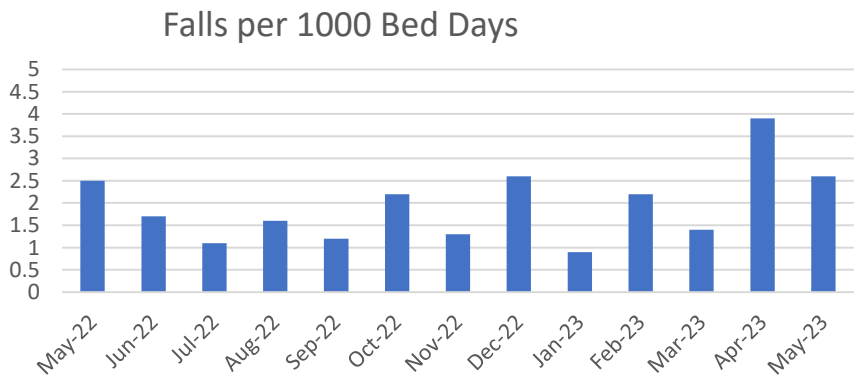
	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	0	0	0	0	1	1	1	1
Low Harm	4	1	1	0	1	5	1	4	5	3	2	1	5
No Harm	6	3	2	5	2	5	4	5	4	3	2	10	3

Trends

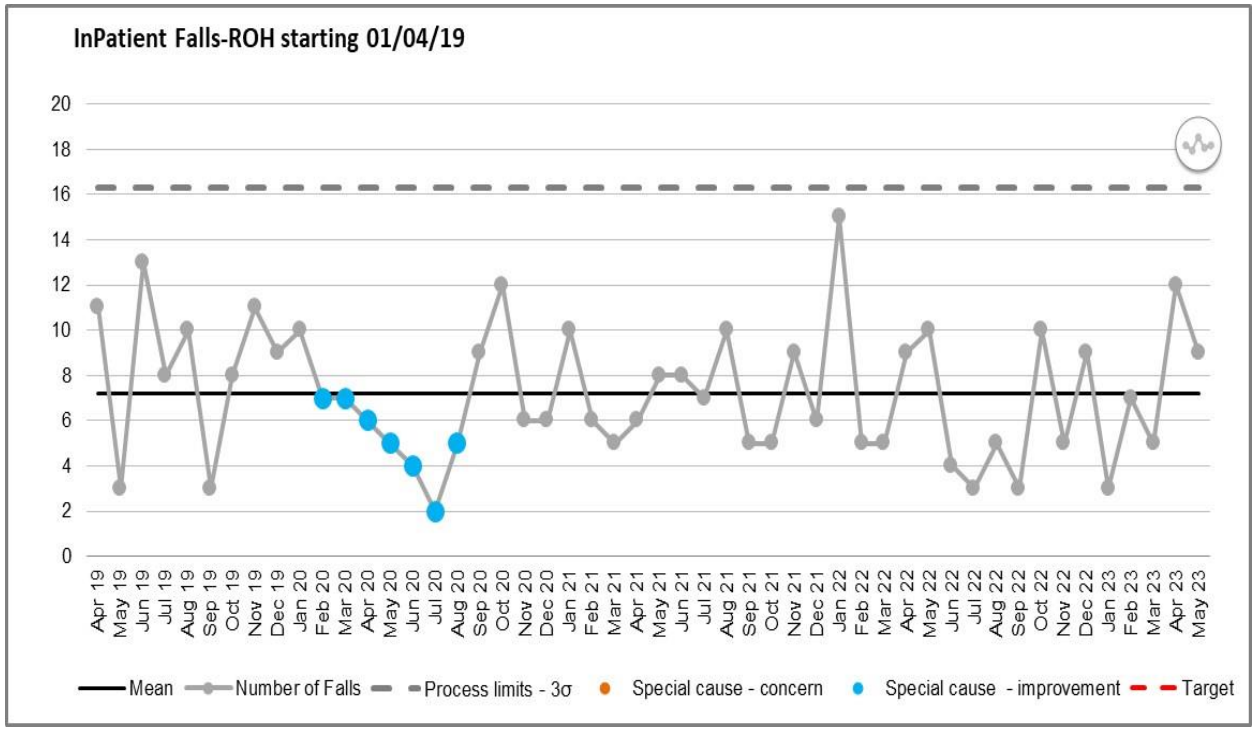
7 of the 9 were unwitnessed falls – 2 of which were bathroom related and 3 related to falls off bed or out of bed

Quality Improvement Work Underway

- Bathroom audit carried. Equipment is being streamlined to ensure consistency and to reduce clutter in the space.
- Increased awareness of ‘call don’t fall’ campaign is underway, the sign appears in bedspaces and bathroom, planned to go on Patient Information System.
- Patient survey highlighted patients don’t want to ask for help as they’re concerned nurses a busy. Team aware re-enforcing the message with patient and carers.
- Safety huddles are in place and used to identify patient at risk to the whole ward team.
- Falls board have been redesign to update learning and will be replaced.



	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Falls per 1000 BD	2.5	1.7	1.1	1.6	1.2	2.2	1.3	2.6	0.9	2.2	1.4	3.9	2.6



10. Pressure Ulcers

No Grade 3 PU reported in May 2023

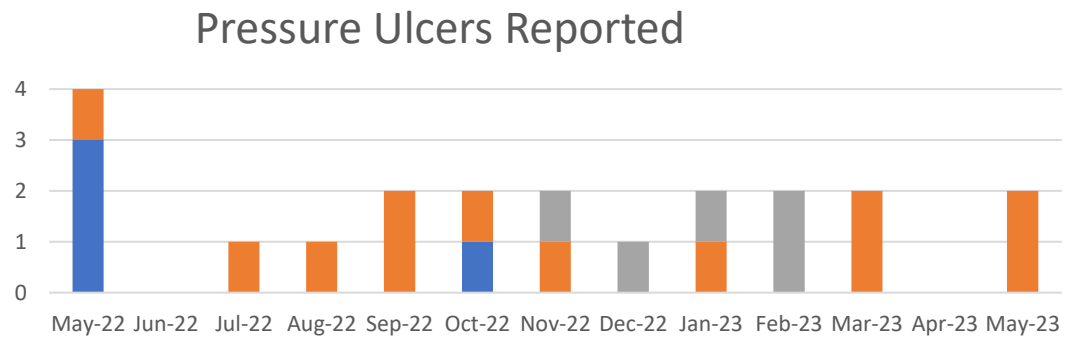
2 x Grade 2 ROH acquired PU incidents reported in May 2023 – Tissue Viability questionnaires completed – no lapses in care found

<u>Quality Improvement work underway</u>

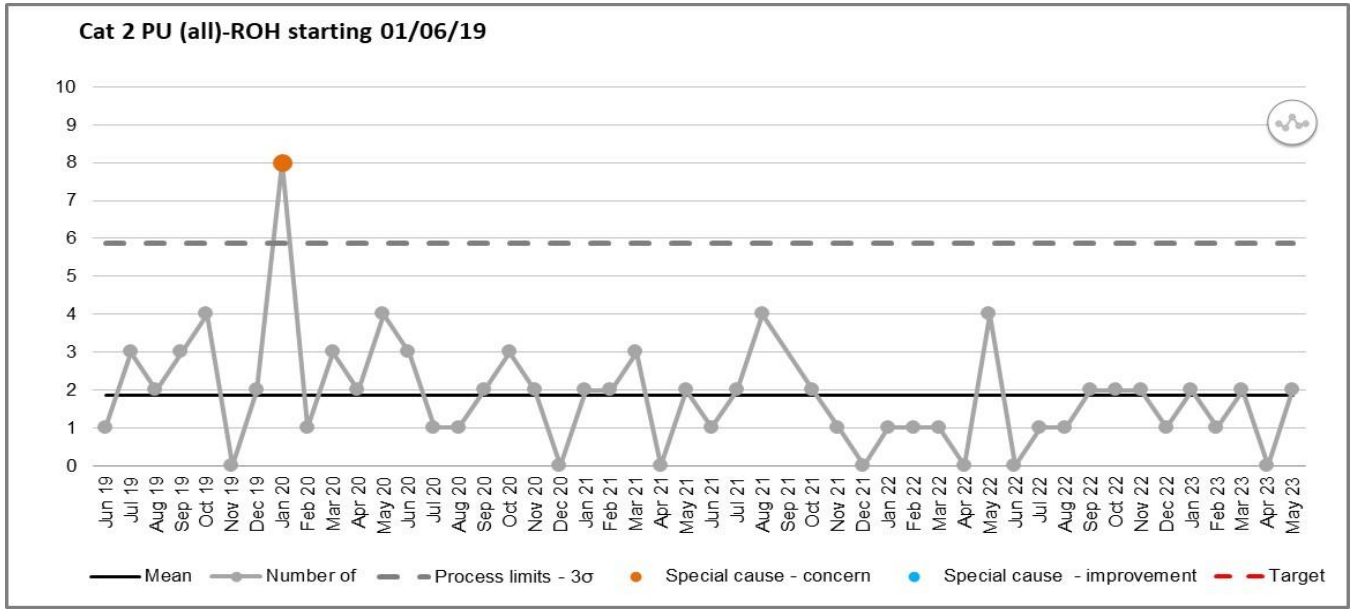
- Newsletter developed and published focusing on all skin issues (shared with all clinical staff).
- 'What's under the dressing?' Campaign is being rolled out, to remind staff to review and check skin under dressing.
- PDSA cycle approach has been introduced to skin damage reduction (not just pressure damage). Focusing on raising awareness and outcome will be monitored.

<u>Risks/Issues</u>

- **Skin tears**- A thematic review is underway following an increase in skin tears noted in Division 2 governance. Focusing on theatres, specifically drapes removal. Interventions in place to reduce risk and training being rolled out.
- **Aqua cell dressing skin damage** – 9 patient affected reported by ROCS team, reported to MHRA and company (Some indication of other issues). Training issues addressed, communication and change in practice, however issues continued. Consultants have now agreed to trial Mepilex Border Post-op dressing.



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



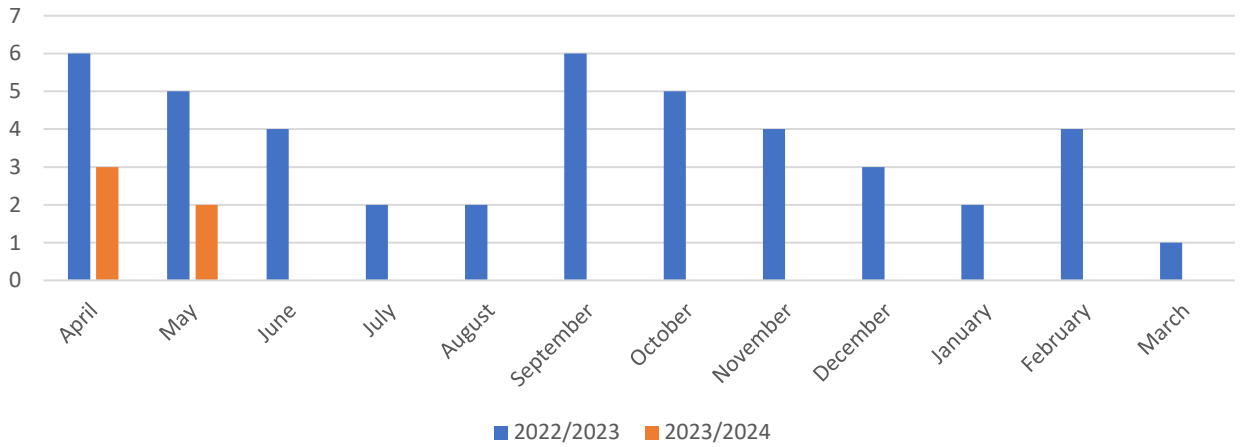
11. Infection Prevention Control

Below are the Statutory requirement/Reportable Infections and are included within this report for awareness. A detailed IPCC report is submitted to Quality and Safety quarterly. All infections are reported and scrutinised at the IPCC committee.

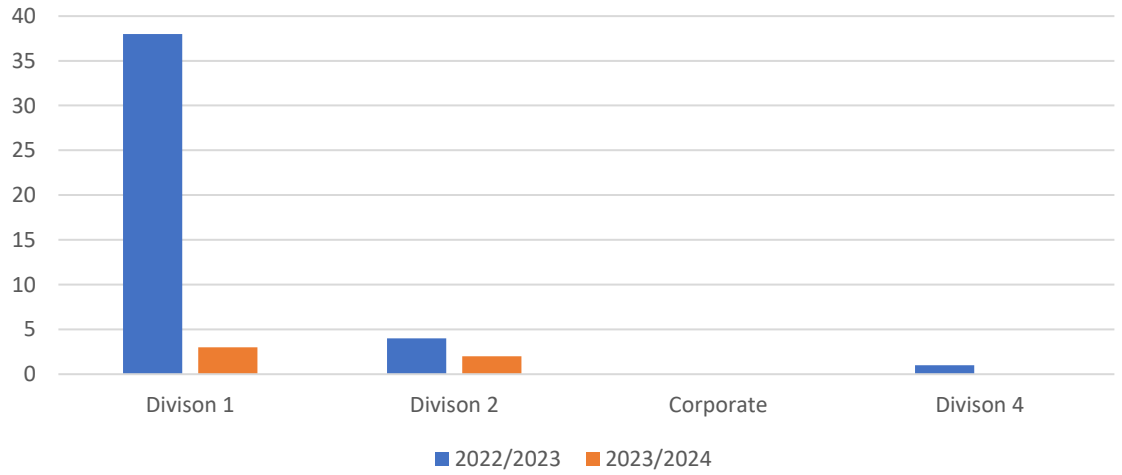
Infections Recorded in month and Year to Date (YTD)	May 2023	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72-hour Clostridium difficile infection (CDI)	0	0
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	0
E.coli BSI	0	0
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

12. 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.

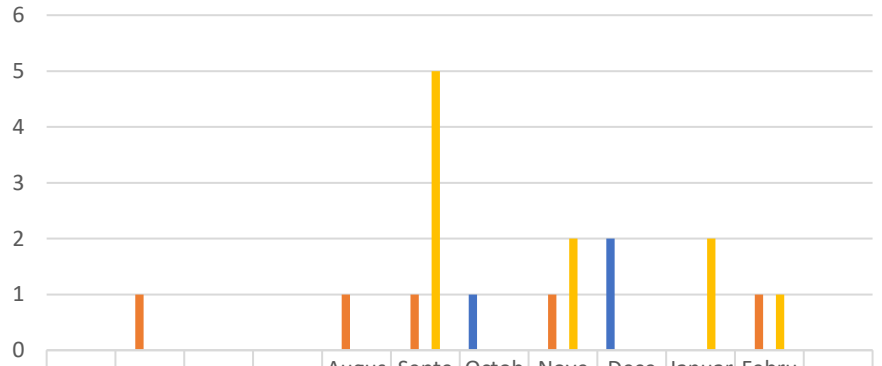
Complaints received 2022/2023 Vs 2023/2024



Complaints Per Division 2022/2023 Vs 2023/2024



Reopened Complaints 2023/2024 Compared to last 3 years



	April	May	June	July	August	September	October	November	December	January	February	March
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
2023-2024	0	0										
Complaint Resolution Meeting 2022-2023	0	0	0	0	0	5	0	2	0	2	1	0
Complaint Resolution Meeting 2023-2024	0											

Complaint Year Totals	
April 2022- March 2023	45
April 2023-March 2024	5

Data Source – Patient Experience team

INFORMATION

The Trust received 2 complaints in May 2023
Below are the summaries for complaints received.

1. Lack of Treatment and Communication
2. In competencies

In May 2023 the Trust closed 0 complaints

At the time of producing this report we currently have 2 open formal complaints. Both of which are for Division 1

Learning & Improvement

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 May 2023 the Trust received 0 reopened complaints.

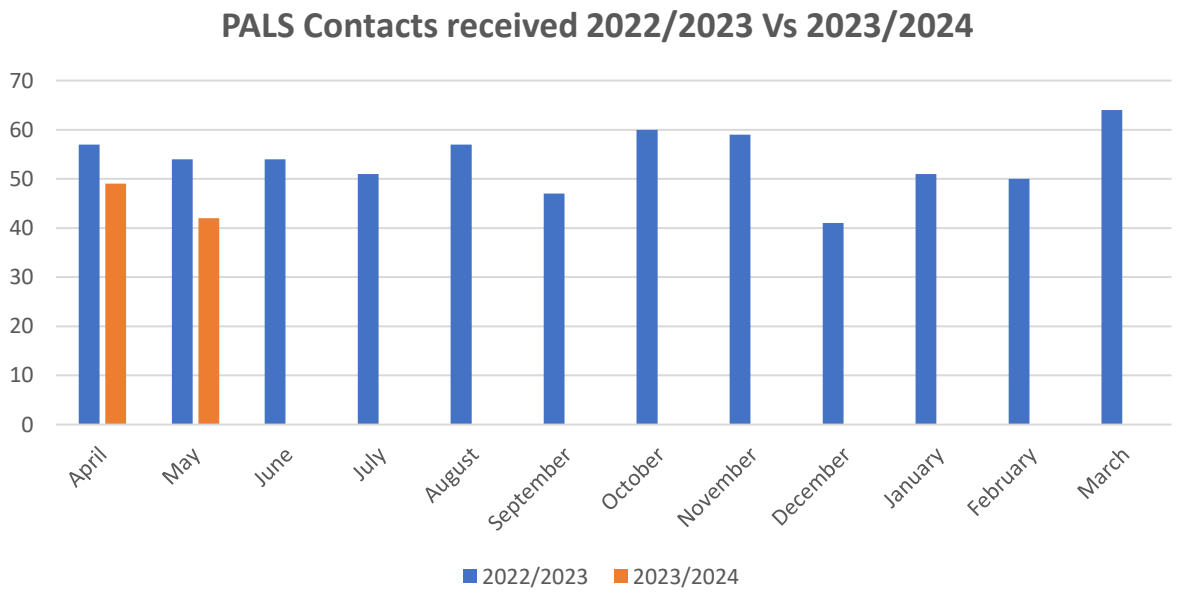
In May 2023 we received 0 meeting requests

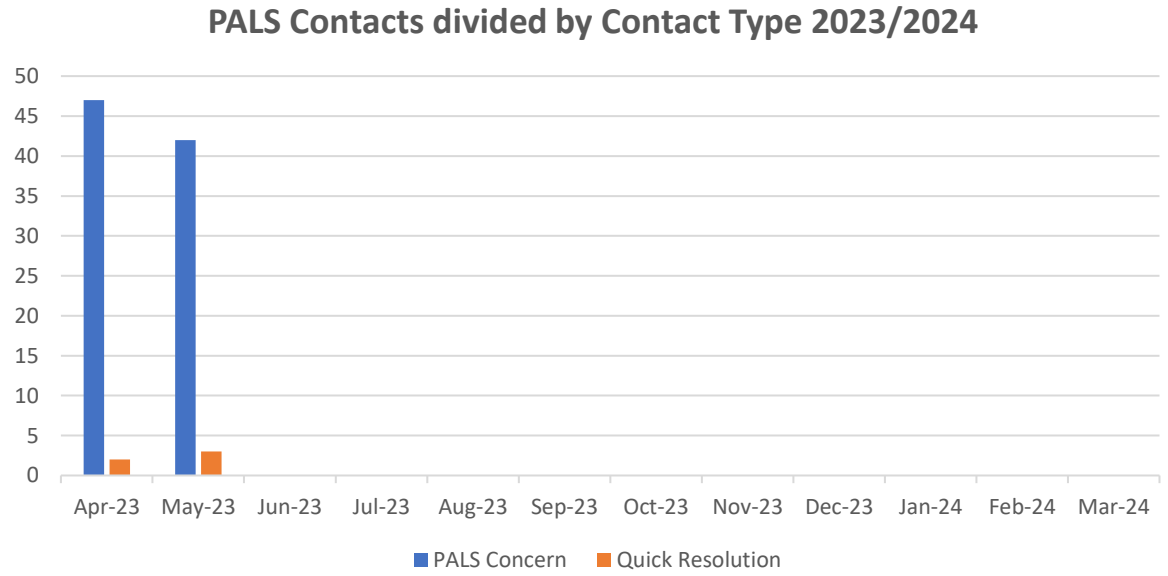
RISK AND ISSUES

- Head of Patient Experience post is vacant. New HOPE will start in August 23. Chief Nurse and Patient Experience lead is overseeing to team.
- Plan to create a deputy post within the team to build resilience.

Patient Advice and Liaison Service – PALS

Below is the comparison of PALS contacts received in 2022/2023 Vs 2023/2024





The main themes in the PALS data related to Appointments (9), Clinical Query (9) and Referral (7) The Trust has set an internal target of 5 working days to respond to concerns in 80% of cases. In May 2023, 93% of contacts were met, 3 PALS cases breached however the KPI's were met for this month

Risks and Issues

3 PALS Cases breached in May 2023 but KPI still met.

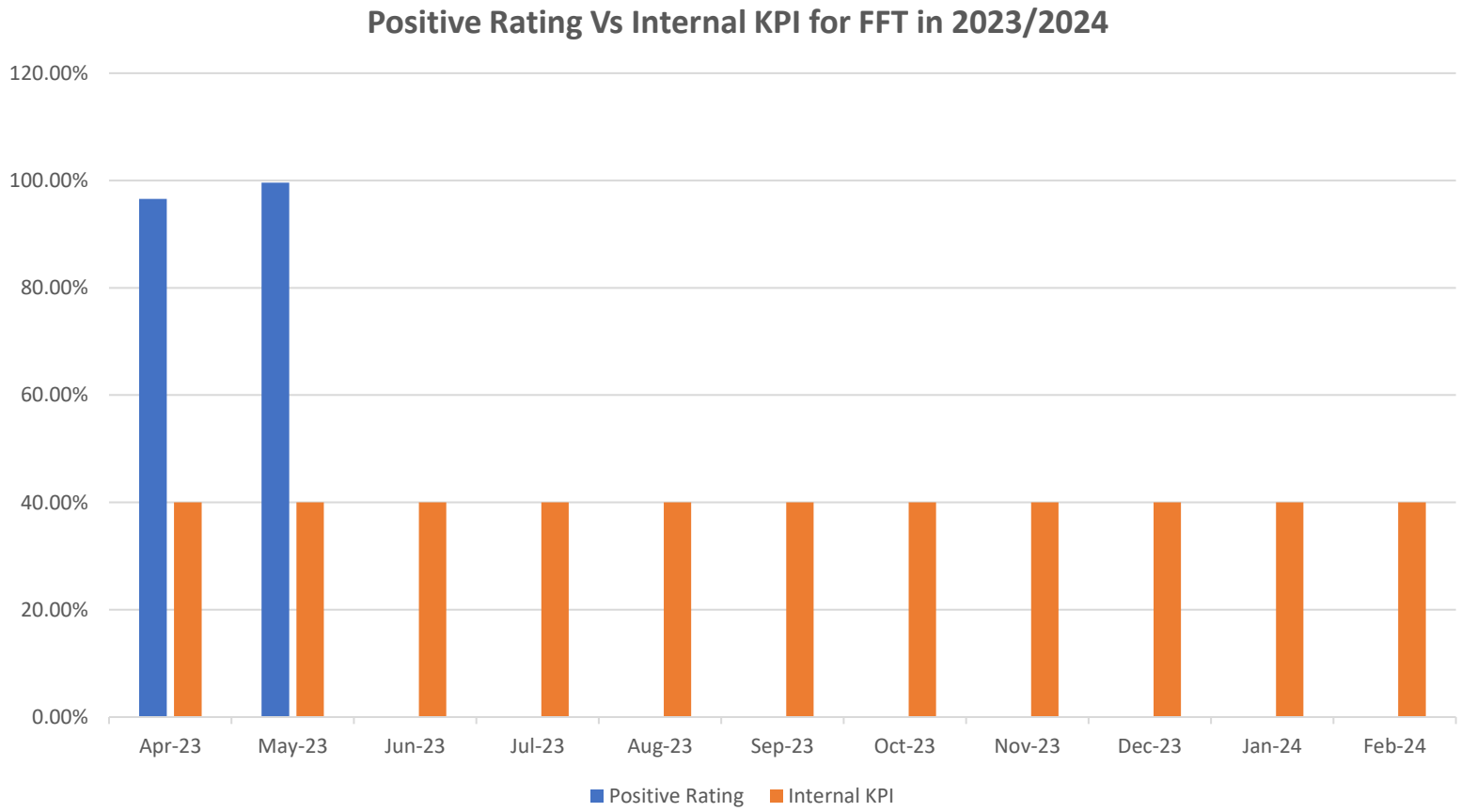
Patient Experience KPI's from April 2023 – May 2023

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

KPI	Complaints %	PALS Concerns %
April -23	100%	85%
May-23	67%	93%

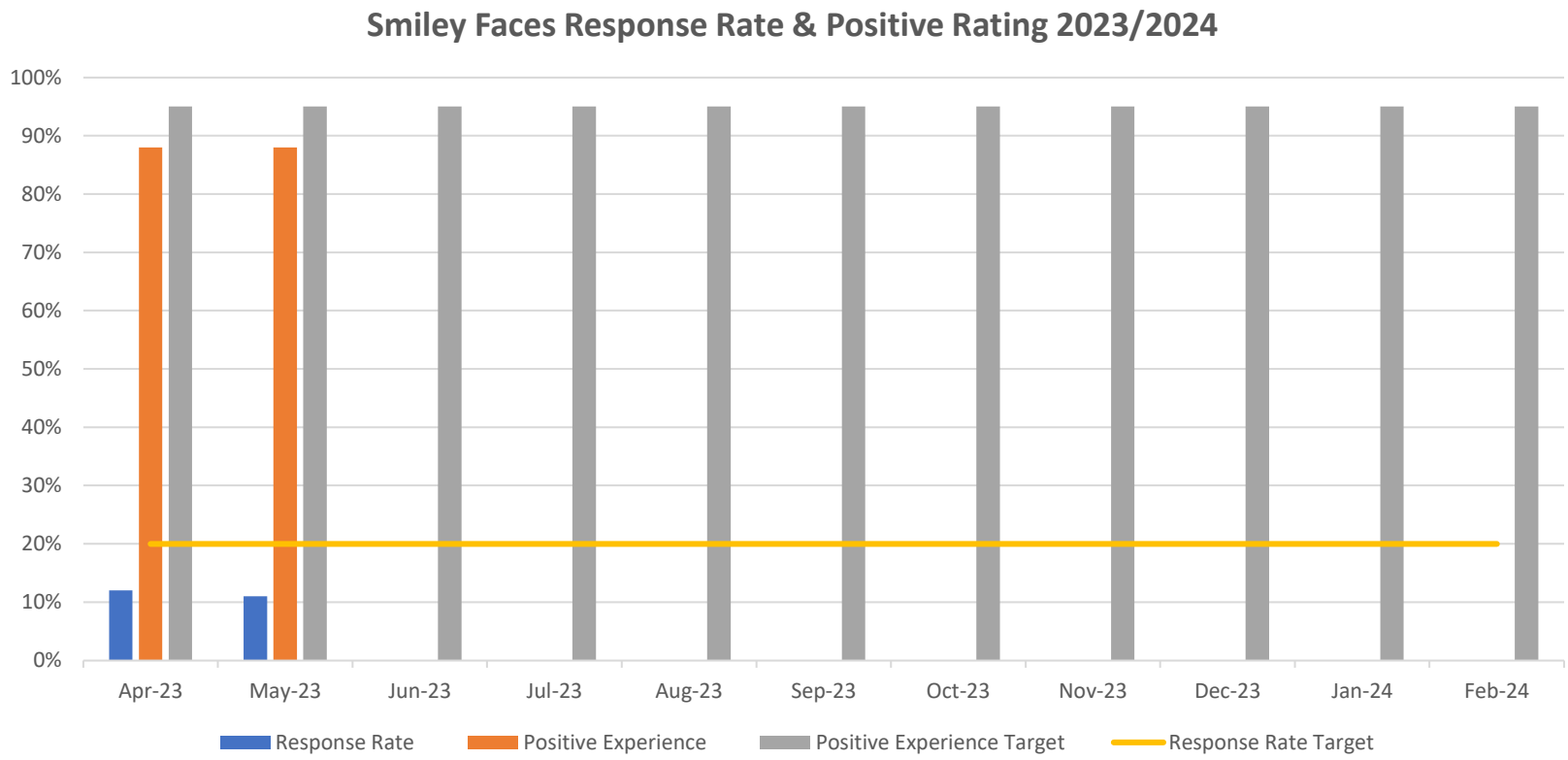
1 complaint breached in May 2023, which is why the KPI has not been met

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



Smiley Faces Report

The Trust has 10 smiley faces devices in all outpatient areas and the devices were rolled out in May 2022. Below is the smiley faces data in May 2023.



13. Litigation and Coroners

New claims

0 new claims against the Trust were received in May 2023.

Pre-Application Disclosure

2 new requests for Pre-Application Disclosure of medical records were received in May 2023

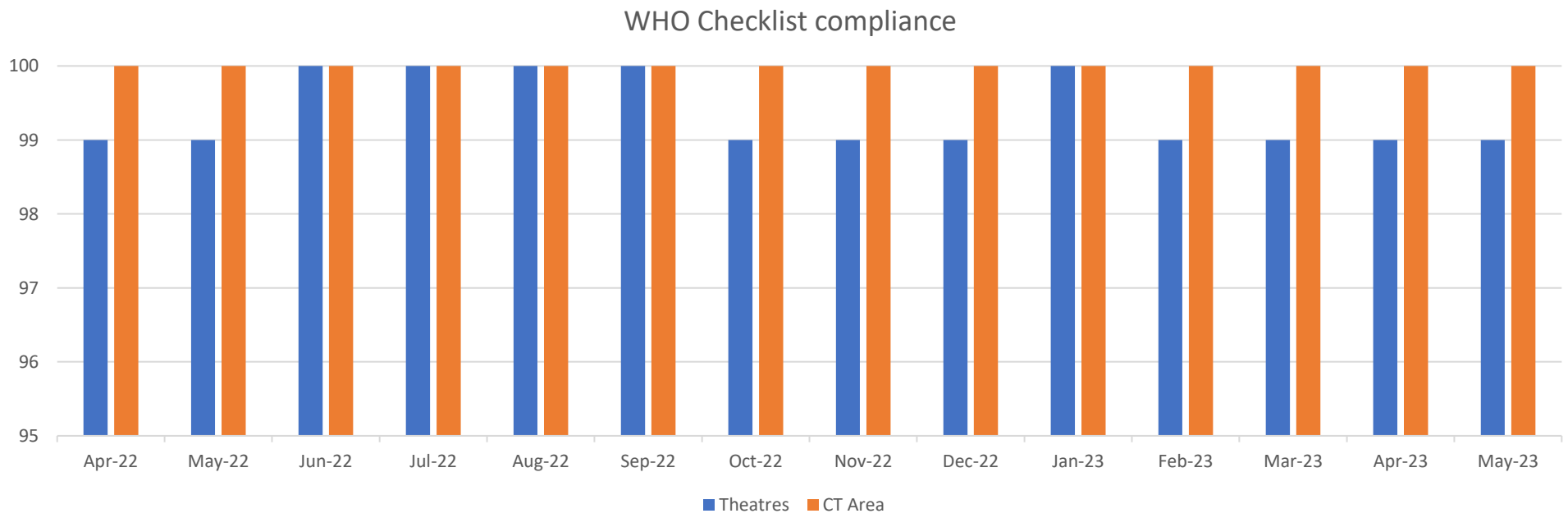
Coroner's Inquests

1 Inquest in which the Trust was an 'interested person' was held in May 2023.

No concerns or questions at Inquest around the care provided by ROH. At the Inquest Hearing the family were highly complimentary of care whilst at ROH.

14. WHO Surgical Safety Checklist

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



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15. CAS Alerts

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

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2023/006/DHSC	Shortage of pyridostigmine 60mg tablets. Pyridostigmine 60mg tablets are out of stock, resupply is expected week commencing 12 June 2023. There are three suppliers of pyridostigmine 60mg tablets: Viatris, Teva and Flynn Pharma. The supply issue is caused by a combination of manufacturing issues and a resulting increase in demand to other suppliers.	National Patient Safety Alert - DHSC	24-May-23	Assessed - not relevant to organisation's services Issued	26 May 23

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2023/005/MHRA	Removal of Philips Health Systems V60 and V60 Plus ventilators from service - potential unexpected shutdown leading to complete loss of ventilation This alert concerns all Philips Respironics V60 and V60 Plus non-invasive ventilators. The MHRA is issuing updated advice that these ventilators must be permanently removed from use. This advice is issued following further in-depth review of additional safety evidence and recent regulatory issues in consultation with a number of external stakeholders and the MHRA's independent Interim Devices Working Group. It has been concluded that the benefits of these devices no longer outweigh the potential risks.	National Patient Safety Alert - MHRA	18-May-23	Assessed - not relevant to organisation's services	02 Oct 23
NatPSA/2023/004/MHRA	Recall of Emerade 500 micrograms and Emerade 300 micrograms auto-injectors, due to the potential for device failure Pharmaswiss Česka republika s.r.o. and distributor Bausch & Lomb UK Limited is recalling all unexpired batches of Emerade 500 micrograms and Emerade 300 micrograms adrenaline auto-injectors (also referred to as pens) from patients. This is due to an issue identified during an ISO 11608 Design Assessment study where some auto-injectors failed to deliver the product or activated prematurely.	National Patient Safety Alert - MHRA	09-May-23	Assessed - not relevant to organisation's services	09 May 23

16. Safeguarding

Below details the Key performance indicators and metrics in relation to Safeguarding Training compliance within the Trust. The Trust training compliance remains below target but has maintained a continual upward trend towards meeting the required standards.

KPI	May-22	Jun-22	Jul-22	Aug-22	Sept 2022	Oct-22	Nov-22	Dec-22	Jan-22	Feb-23	Mar-23	Apr-23	May-23
Safeguarding Adult Notifications	44	29	33	44	36	27	51	31	31	35	17	43	21
Safeguarding Children Notifications	40	43	44	57	43	44	42	26	26	76	23	37	29
Adult Level 2	91.06%	89.98%	87.99%	87.26%	86.01%	84.53%	85.14%	81.83%	81.83%	80.28% (↓)	80.19% (↓)	82.27% (↑)	83.12% (↑)
Adult Level 3	88.84%	88.71%	87.97%	88.41%	86.52%	83.30%	80.31%	75.68%	75.68%	75.2% (↓)	76.37% (↓)	77.84% (↑)	80.15% (↑)
Level 4	80%	75%	75%	75%	66.67%	66.67%	75.00%	75.00%	75.00%	60% (↓)	80.0% (↑)	80.00%	80.00%
Child Level 2	90.81%	89.65%	87.66%	87.02%	85.87%	84.12%	84.54%	81.16%	81.16%	79.93% (↓)	79.85% (↓)	82.18% (↑)	82.86% (↑)
Child Level 3	88.84%	88.21%	87.97%	88.41%	84.52%	83.10%	80.12%	75.29%	75.29%	75.2% (↓)	76.37% (↑)	78.03% (↑)	80.15% (↑)
Mental Capacity Act MCA	90.27%	88.97%	87.58%	88.84%	85.78%	84.48%	84.97%	81.67%	81.67%	80.19% (↓)	80.36% (↑)	82.44% (↑)	83.21% (↑)
Deprivation of Liberty Safeguards DoLs	90.27%	88.97%	87.58%	86.84%	85.87%	84.48%	85.05%	81.58%	81.58%	79.93% (↓)	79.93%	82.09% (↑)	82.95% (↑)
Prevent Awareness	93.71	93.34%	98.92%	92.44%	91.70%	90.04%	91.01%	89.88%	89.88%	89.40%	88.96%	90.14%	89.86%
WRAP (prevent level 3)	84.71	85.36%	83.84%	82.51	82.86%	80.15%	81.80%	81.06%	81.06%	78.55% (↓)	80.2% (↑)	82.19% (↑)	83.89% (↑)
FGM	0	1	0	1	0	3	1	1	1	2	1	3	0
DOLS	6	2	5	3	11	5	7	6	6	4	0	7	0
MCA	4	3	6	7	4	7	4	4	4	0	1	3	4
PIPOT cases	0	0	0	2	1	1	0	0	0	1	0	0	0
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0	0	0	0

Actions underway to recover position:

- Safeguarding team are providing two additional super session over and above normal programme, with capacity for up to 100 staff during July and August.
- Executive and Divisional leads have been written to by the Executive for Safeguarding seeking support to recovery and compliance at training.
- All non-medical clinical staff seeking to access additional training outside of mandatory training will have to provide evidence 100% mandatory compliance prior to approval

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

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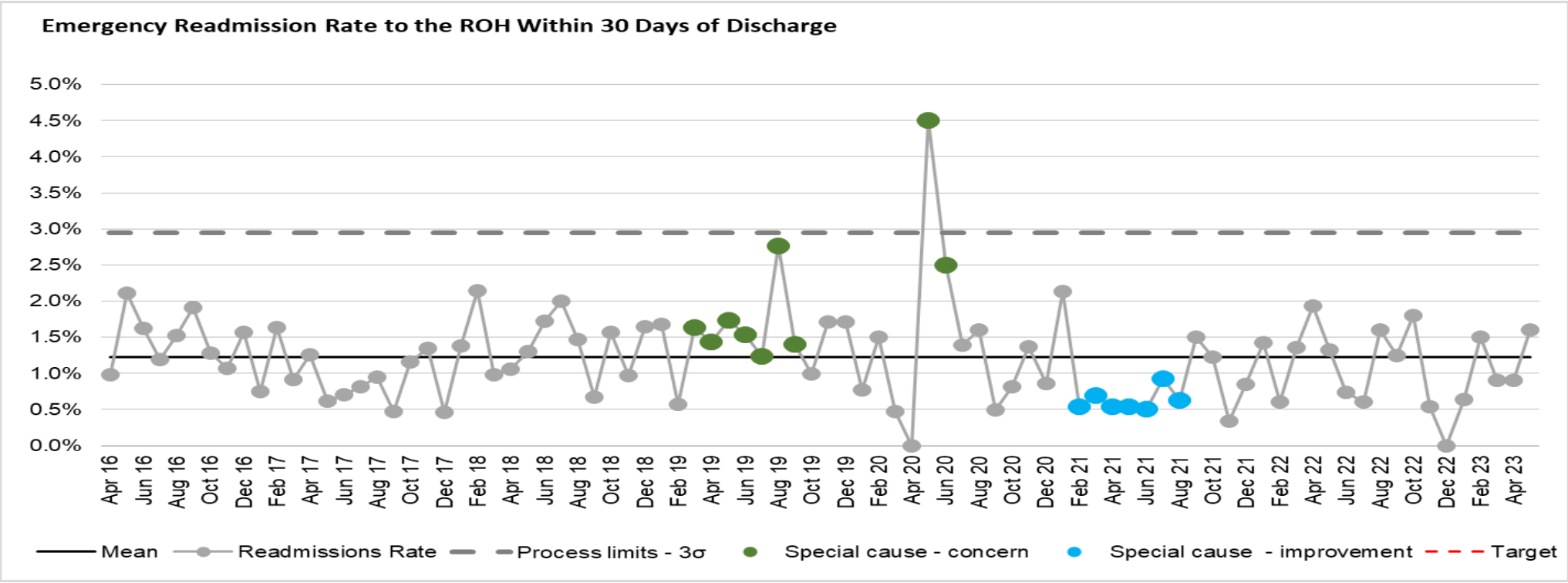


	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
No of Readmissions	4	3	7	6	9	3	0	3	7	5	4	8
Denominator	543	495	435	484	556	556	486	468	468	546	465	494
% Readmissions	0.7%	0.6%	1.6%	1.2%	1.6%	0.5%	0.0%	0.6%	1.5%	0.9%	0.9%	1.6%

18. Freedom to Speak Up Update

Concerns Raised

There were 4 concerns raised in May 2023; these were in relation to the following themes:-

- Low Staffing levels
- Lack of support from managers
- Stress

Employee safety and wellbeing

Concerns raised regarding a lack of support from managers, which appears to have a knock on effect on other areas, such as stress and low staffing levels, which in turn could have a negative impact on patient safety and quality if not addressed.

Learning and Improvement Work Underway

- Implementation of TED Tool across the organisation to improve team engagement and development
- Improvement of culture and inclusivity within the organisation, staff feel more empowered to speak up without fear of negative consequences with the support of the Freedom to Speak up Team
- Working with the HR department to support, empower and educate managers on how to use Trust policy to help make informed decisions
- Feedback received from workers regarding improvements within their local areas following speaking up about issues that are causing them stress and preventing them from doing a good job.
- Roll out of FTSU ‘Green Boxes’, where staff can register concerns/issues confidentially
- Issue No 1 of FTSU Newsletter planned for July 2023
- FTSU team to consider branding

Operational Performance

May 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 May 23	In month	Previous month	Target	Variation	Assurance
RTT – combined (constitutional target remains 92%)	57.50%	56.73%	92%		
104 week waits	0	0	0		
78+ week waits	0	0	0		
65 Week waits (65-77 weeks)	46	63	0		
52 week waits (52 – 64 Weeks)	161	179	0		
All elective activity YTD (compared to 19/20)	99.0%	103.4%	110%		
All elective activity YTD (compared to plan)	2,230 Cumulative	1,062	2,282 YTD Target		
Outpatient activity YTD (compared to plan)	10,112 Cumulative	4,576	10,545 YTD Target		
Outpatient Did Not Attend (YTD)	8.80%	7.44%	8%		
PIFU (trajectory to 5% target)	430 8.3%	325 7.7%	193 5%		
Virtual Consultations (target is plan, operational planning guidance is 25%)	9.8%	11.5%	19%		
Diagnostics volume YTD (compared to plan)	3,965 Cumulative	1,953	3,065 YTD Target		
Diagnostics 6 week target	99.8%	99.7%	99%		

Operational Performance Summary

	In month	Previous month	Target	Variation	Assurance
Theatre In session utilisation	81.96%	82.58%	85%		
Theatre Session Utilisation	92.13%	74.41%	90%		
Cancer - 2 week wait (Mar – Feb)	96.8%	100%	93%		
Cancer – 31-day first treatment	84.6%	100%	96%		
Cancer - 31 day subsequent (surgery)	100%	100%	94%		
Cancer - 62 day (traditional) April 23 confirmed	20.0%	50%	85%		
Cancer - 62 day (Cons upgrade)	100%	100%	n/a		
28-day FDS	80%	78.2%	75%		
Patients over 104 days (62-day standard)	0	1	0		
POAC activity volume (YTD)	3,615 cumulative	1,578	3,530 YTD Target		
LOS - excluding Oncology, Paeds, YAH, Spinal	4.11	3.65	n/a		
LOS - elective primary hip	3.30	3.70	2.0		
LOS - elective primary knee	3.70	3.80	2.0		
BADS Day case rate (Note: due to time lag in month is Feb'23)	78%	79%	85%		

PAPER REFERENCE: ROHTB (7/23) 017 (c)

Monthly Workforce Report

May 2023

CONTENTS

	Introduction
1	Workforce Overview
2	Establishment
3	Turnover & Retention
4	Starters and Leavers Data
5	Attendance & Sickness Absence
6	Workforce Demographics
7	Workforce Wellbeing – Annual Leave
8	Training & Education
9	Workforce Experience & Engagement

Introduction

This report shows the Workforce and OD information for the months of May 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 84.5% of WTE employed against the Establishment
- Staff Turnover remains high at 19.44%
- PDR/Appraisals are still well below what we should be doing as a Trust currently at 60.7%
- Return To Work meetings are still not being recorded fully currently 57.32%

Positive Assurances

- Return to work meeting compliance is regularly reviewed and escalated to leads. Drop in sessions took place in the last quarter will help managers with technical issues and managerial responsibility
- Work to understand the reasons for employees leaving is being undertaken via focus groups. Staff Survey Focus Groups will also support our understanding of engagement and turnover.
- Financial Hardship Panels have commenced and are in place on a weekly basis.
- The NHS Pay Award will provide staff with a timely non-consolidated bonus and a pay increase which will support staff suffering with rising costs.

Key Risks

- Cost of living continues to impact the NHS workforce as a whole, the Trust is doing it's upmost to alleviate the impact.
- PDR/Appraisals are essential for staff development and performance. Underutilisation could lead to lower staff engagement and may impact retention.
- Return To Work meetings are key for supporting staff and preventing further sickness absence. Low compliance may have an impact on workforce performance.

Next Steps

- The HR Team will continue regular workshops with directorates where HR metrics will be reviewed and support put in place where required.
- Time to recruit is a priority piece of work with the aim of improving how quickly we get replacement staff into the organisation.
- Key policies are in their final stages for approval; these includes the Flexible Working Policy, Annual Leave Policy and the Attendance Management Policy which are seen as highly utilised by staff and managers.

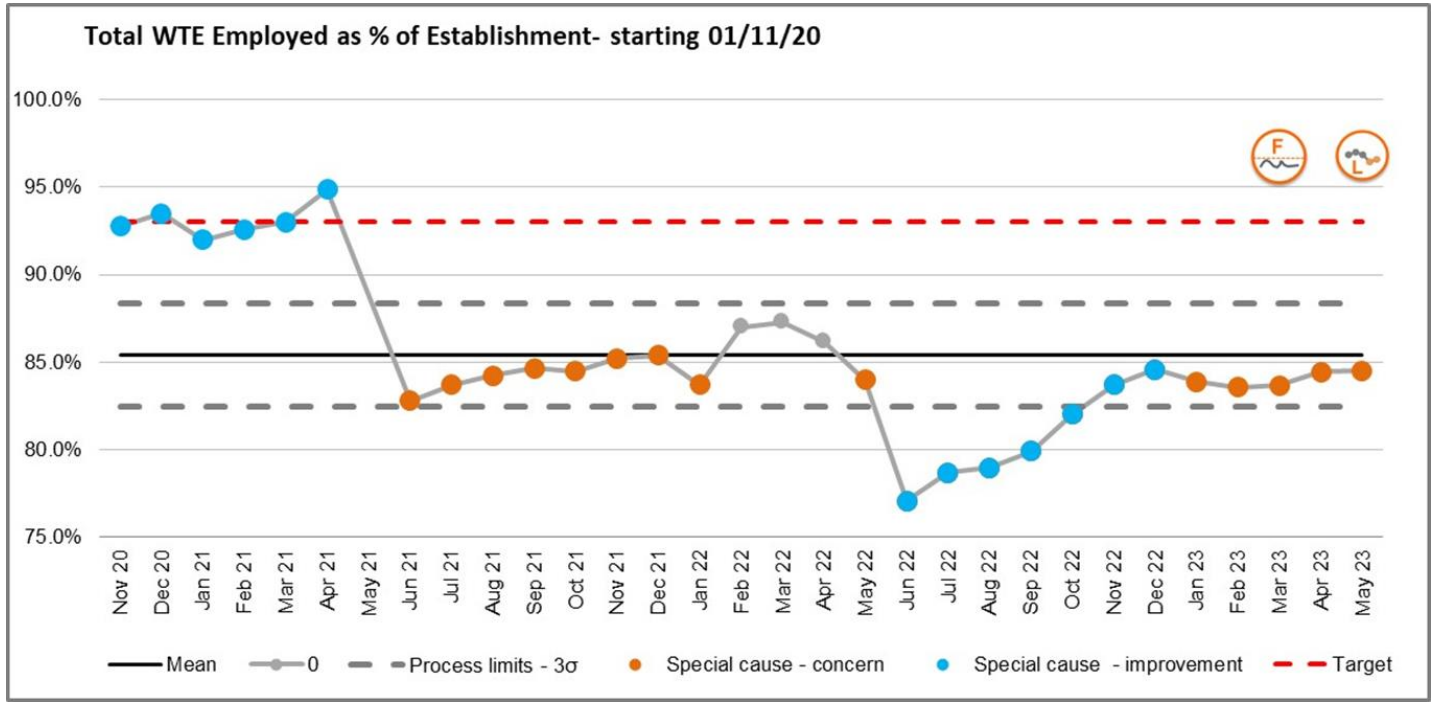
1. Workforce Overview

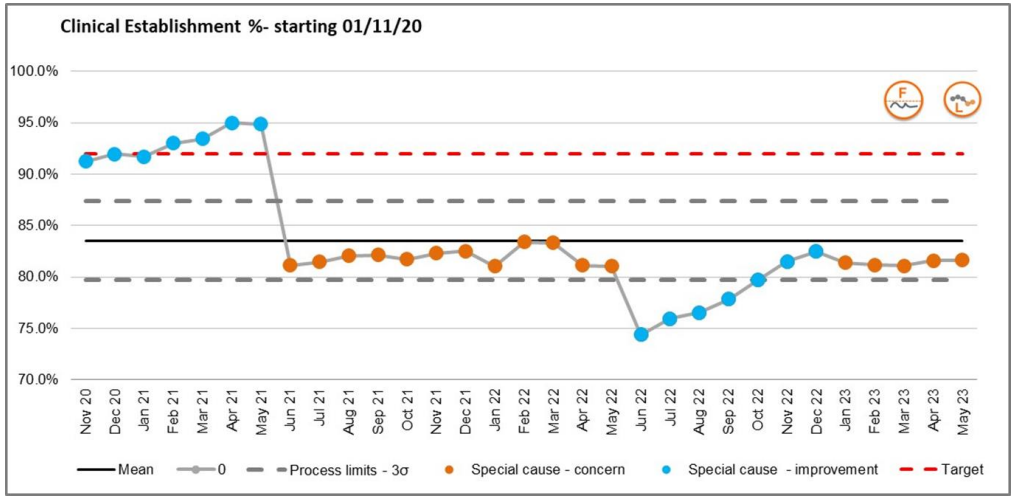
Trust Workforce Metrics	Apr-23	May-23	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1296	1306	10	-	-
Staff In Post - Full Time Equivalent	1144.60	1152.31	7.71418	-	-
Staf Turnover % - Unadjusted	16.74%	19.44%	2.70%	↑	<=11.5%
Staf Turnover % - Adjusted	14.64%	13.90%	-0.74%	↓	<=11.5%
Total WTE Employed as % of Establishment	84.43%	84.50%	0.07%	↑	>=93%
Total WTE Employed as % of Establishment - Clinical	81.57%	81.61%	0.04%	↑	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	89.82%	89.89%	0.07%	↑	>=96%
% Of Attendance	94.65%	94.77%	0.12%	↑	>=96.3%
% Of 12 mth MAA Attendance	94.04%	94.07%	0.03%	↑	>=96.3%
% Staff received mandatory training last 12 months	89.48%	89.26%	-0.22%	↓	>=93%
% Staff received formal PDR/appraisal last 12 months	61.36%	60.70%	-0.66%	↓	>=95%
% of Sickness - Trust wide Long-term	2.70%	2.59%	-0.11%	↓	-
% of Sickness - Trust wide Short-term	2.65%	2.64%	-0.01%	↓	-
Return To Work Completion %	57.58%	57.32%	-0.26%	↓	>=80%

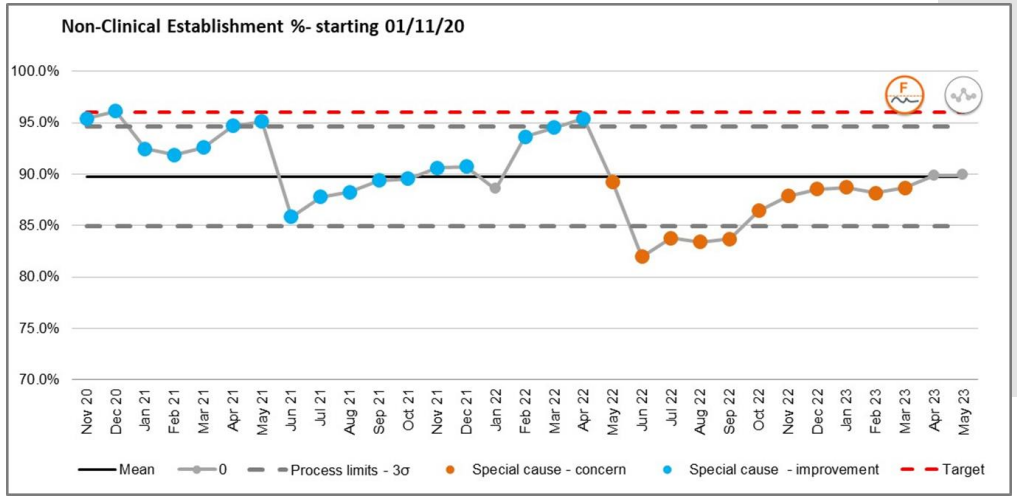
2. Establishment

At the end of May, the number of staff on payroll stood at 1306 (WTE 1152.31) which is a increase of 7.71 WTE from April.

The Total WTE Employed as a % of the Establishment this month was 84.5% which rests well below the Trust Target 93%.





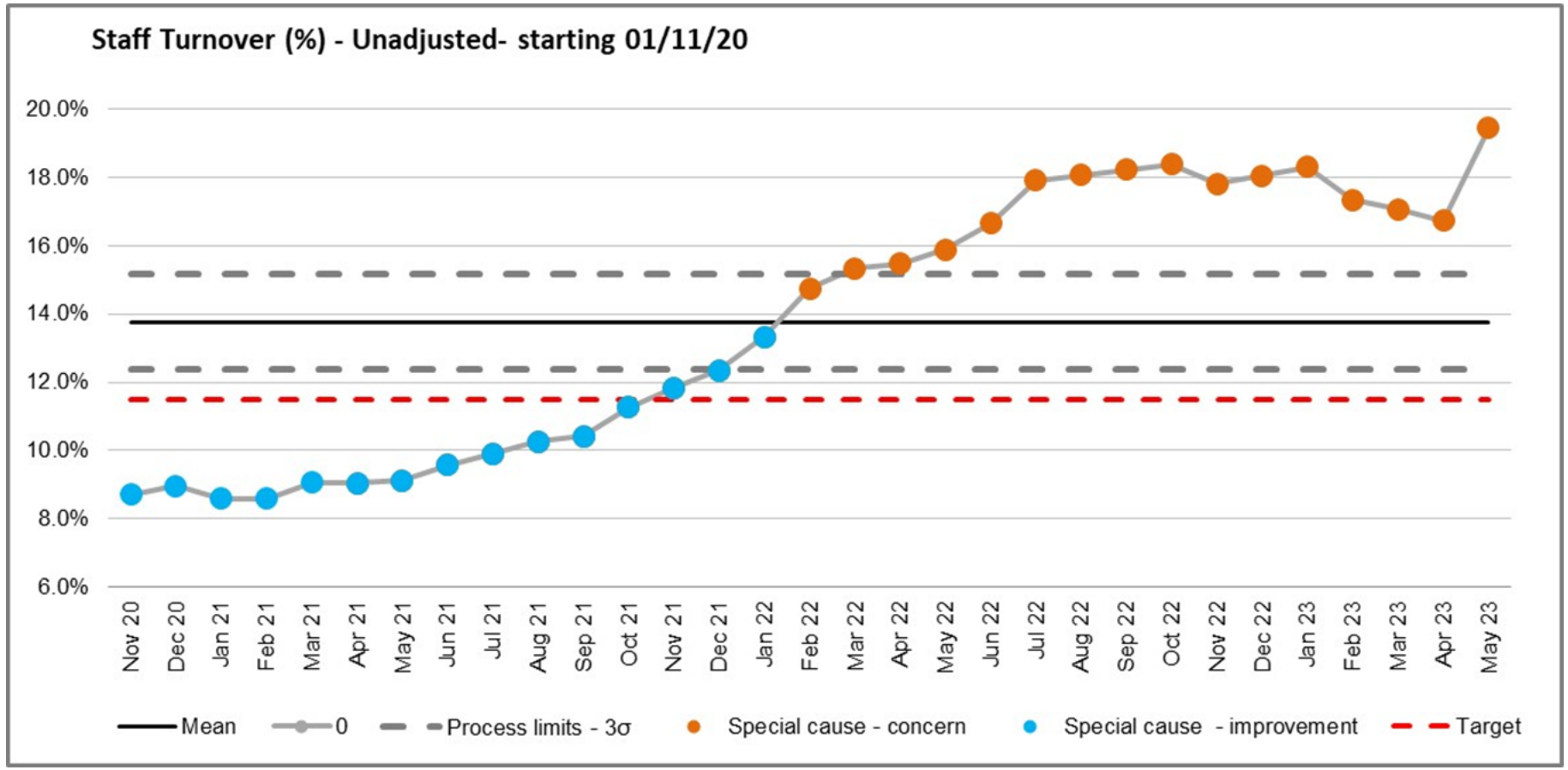


3. Turnover & Retention

Unadjusted turnover for this month was 19.44% 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 Estates and Anc, Admin & Clerical and Nursing & Midwifery which are all in the red category against the Trust target.

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



Staff Group	FTE
Additional Clinical Services	13.72%
Allied Health Professionals	15.02%
Administrative and Clerical	15.95%
Estates and Ancillary	16.44%
Nursing and Midwifery Registered	17.21%
Add Prof Scientific and Technic	26.53%

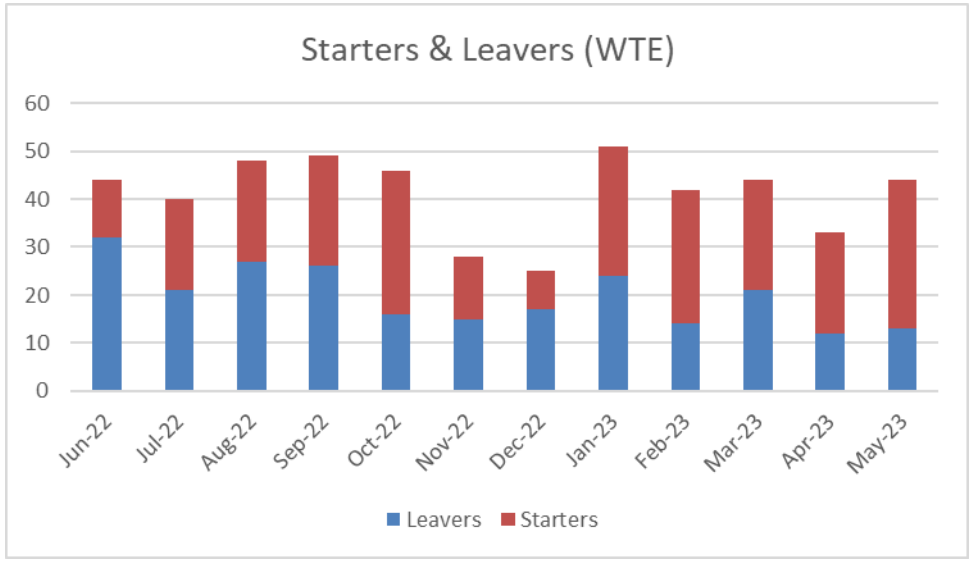
Org L4	FTE
303 Division 4 - Estates and Facilities	8.22%
303 Division 2 - Patient Support	17.42%
303 Corporate Directorate	19.90%
303 Division 1 - Patient Services	22.70%

4. Starters & Leavers

Over the last 2 months, the main reasons for staff leaving (according to ESR data) were 'other not known', 'Retirement' and 'Better Reward Package', which differs 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 us to understand if our employment package (i.e. training/development) is suitable.

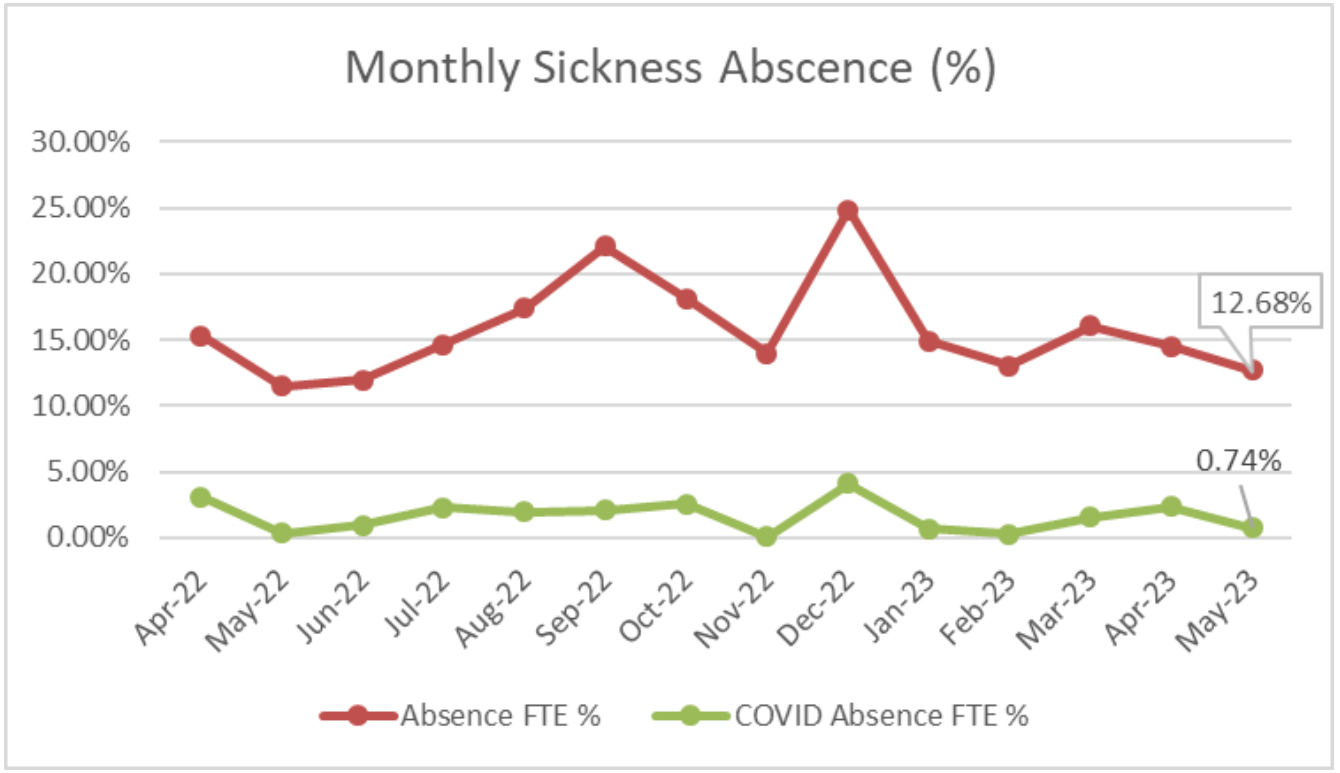


Note: starters and leavers data is reported over a rolling 12 month period. High turnover in May 22 has impacted on May 23's figures.

5. Attendance & Sickness

Attendance for this month was 94.77% (sickness absence % = 5.23%) and Attendance for the rolling past 12 months was 94.07%. 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.



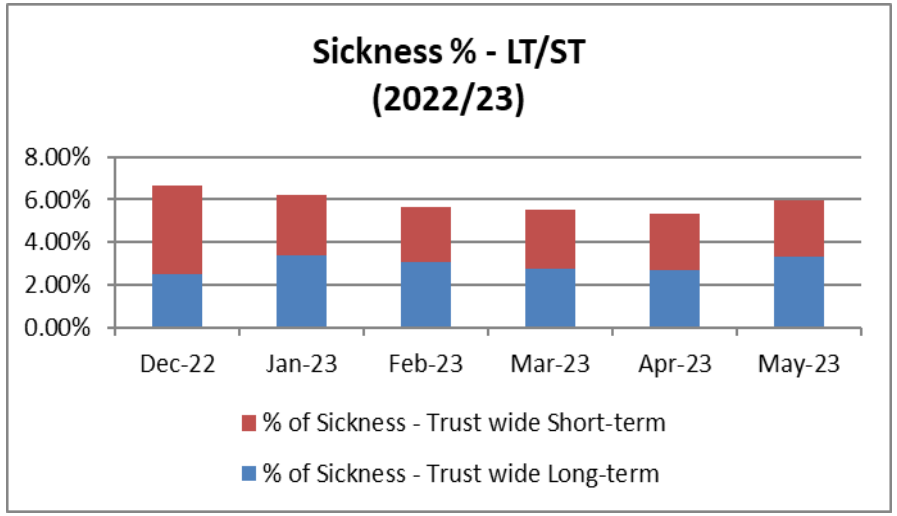
Top Absence Reasons In the Last 12 Months by FTE Days Lost	Count of Episodes	FTE Days Lost	Estimated Cost Of Absence
Cold, Cough, Flu - Influenza	912	5583.84504	£560,806.57
Anxiety/stress/depression	186	4929.20088	£479,035.79
Musculoskeletal problems	151	2097.64414	£221,518.03
Gastrointestinal problems	478	1813.95669	£167,873.10
Chest & respiratory problems	111	1261.49405	£140,468.19

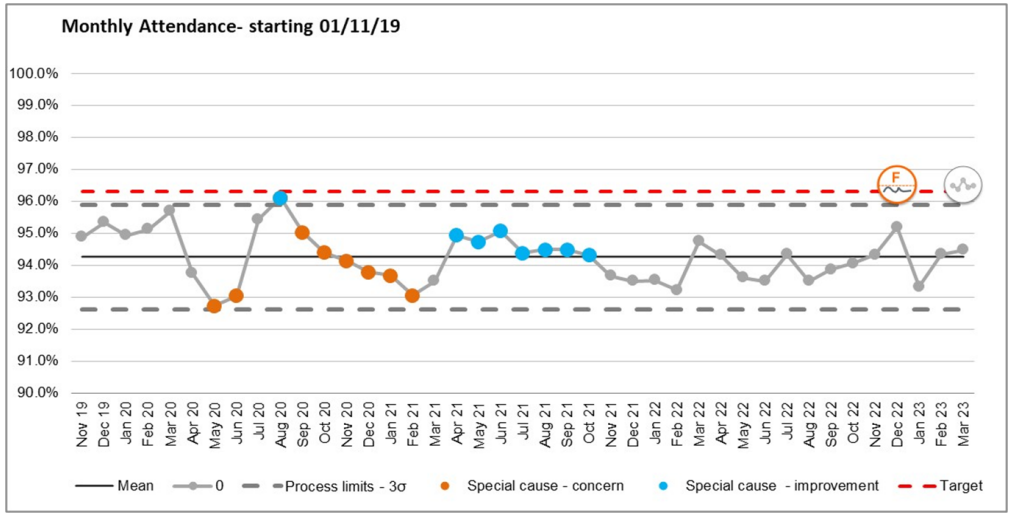
This chart shows that 12% of the WTE were off with sickness which started in May 2023 (not inc Long Term Sickness) and of that sickness 0.74% is attributed to Covid, this against the WTE figure of 1152.31

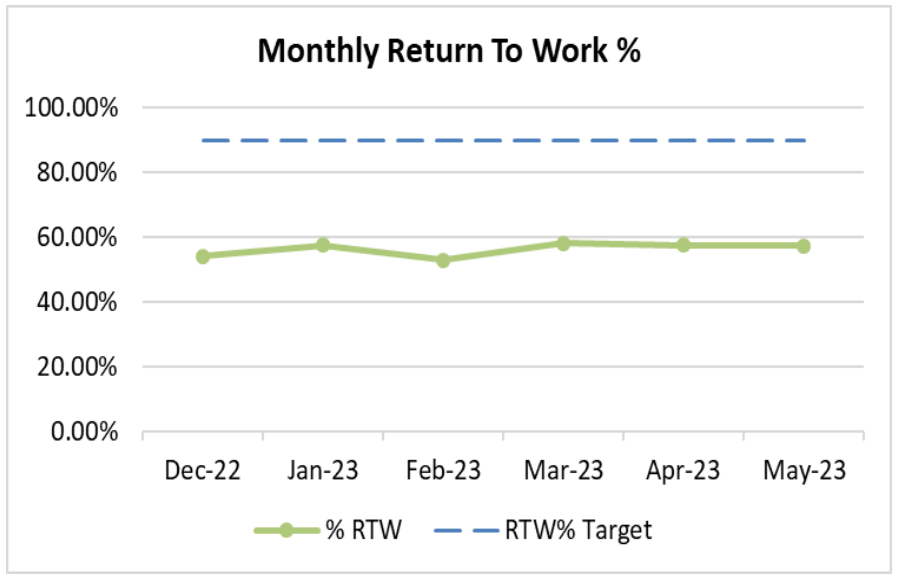
5. Attendance & Sickness

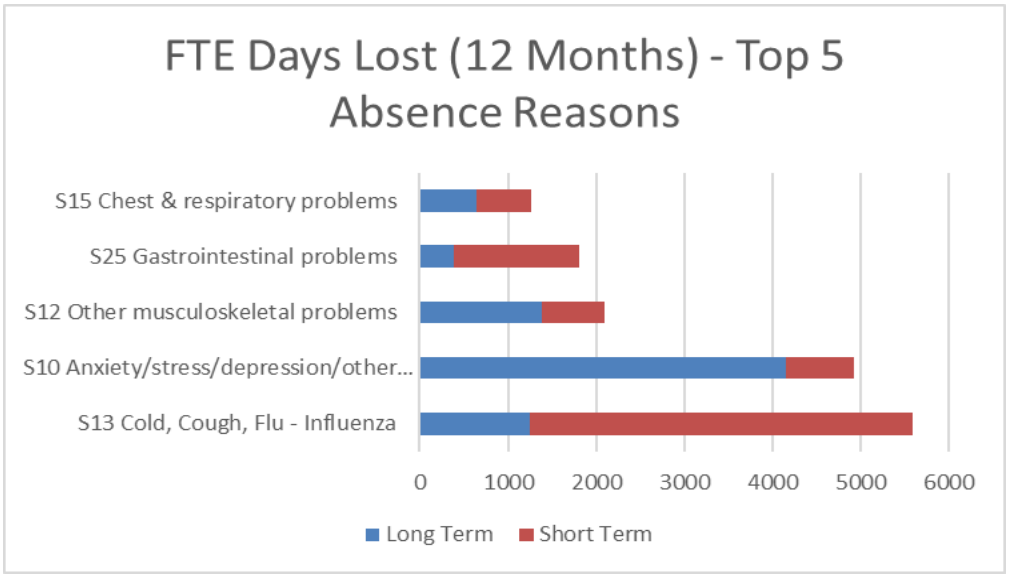
Return To Work Discussion Meetings Following Sickness Absence

Trust wide Return To Work (RTW) interviews decreased to 57.32% in May, compared to 57.58% in April. This still remains below the Trust Target of 80%.









The Royal Orthopaedic Hospital NHS Foundation Trust

30th June 2023

Notice of a meeting of the Board of Directors

Notice is hereby given to all the members of the Board of the Royal Orthopaedic Hospital NHS Foundation Trust that the following meetings of the Trust Board will be held in the Boardroom, Trust HQ on Wednesday, 5th July 2023:

Meeting	**Timing**
Non-Executives pre-meet – Director of Finance's Office	08:00 – 08:45
Public Board meeting – Boardroom, Trust HQ	09:00 – 10:45
BREAK	
Public Board meeting – Boardroom, Trust HQ	11:55 – 12:35
Private Board meeting – Boardroom, Trust HQ	12:40 – 13:50

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

Tim Pile
Chair

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