Notice of Trust Board Meeting in Public on Wednesday, 1 November 2023

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 1st November 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 Personal Assistant to the Director of Governance no later than 24hrs prior to the meeting, by post or e-mail, to Claire Kettle, at the Management Offices or via email to: claire.kettle@nhs.net

Tim Pile
Chair

The Royal Orthopaedic Hospital NHS Foundation Trust

AGENDA
TRUST BOARD

Venue Boardroom, Trust Headquarters **Date** 1 November 2023: 09:00h – 15:00h

Members attending

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

In attendance

Mr Luke Stanford	Housekeeper	(LS)	[Item 1]
Mrs Clare Mair	Head of OD & Inclusion	(CM)	[Item 10]
Mr Adam Roberts	Assistant Director of Governance & Risk	(AM)	[Item 11 & 12]
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Mrs Mandy Wilson	PA to the Chief Operating Officer	(MW)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
09:00	1	Staff story – my career pathway at the ROH	Presentation	LS
09:20	2	Apologies: Richard Phillips, Ayodele Ajose and Tammy Ferris	Verbal	Chair
	3	Declarations of Interest	ROHTB (11/23) 001	Chair
	4	Minutes of Board Meeting held in Public on 4 October 2023: *for approval*	ROHTB (10/23) 022	Chair
	5	Actions from previous meetings in public: *for assurance*	ROHTB (10/23) 022 (a)	SGL
	5.1	Board portal update	ROHTB (11/23) 002 ROHTB (11/23) 002 (a)	SGL
09:25	6	Questions from members of the public	Verbal	Chair
09:26	7	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (11/23) 003 ROHTB (12/23) 003 (a)	TP/JW

09:40	8	Wellbeing		
	8.1	Wellbeing & Cost of Living update: *for assurance*	ROHTB (11/23) 004 ROHTB (11/23) 004 (a)	SM
	8.2	Childcare Provision: *for information*	ROHTB (11/23) 005 ROHTB (11/23) 005 (a) ROHTB (11/23) 005 (b)	SM
09:55	9	Retention & recruitment update: *for assurance*	ROHTB (11/23) 006 ROHTB (11/23) 006 (a)	SM
10:05	10	Equality & Diversity annual report: *for assurance*	ROHTB (11/23) 007 ROHTB (11/23) 007 (a)	CM
10:20	11	Patient Safety Incident Response Framework (PSIRF) policy and plan: *for approval*	ROHTB (11/23) 008 ROHTB (11/23) 008 (a) ROHTB (11/23) 008 (b)	AR
10:40	12	Risk appetite: *for discussion*	ROHTB (11/23) 009 ROHTB (11/23) 009 (a)	AR
10:55	13	Board Assurance Framework: *for approval*	ROHTB (11/23) 010 ROHTB (11/23) 010 (a) ROHTB (11/23) 010 (b) ROHTB (11/23) 010 (c)	SGL
11:05	14	Vaccination programme update: *for assurance*	Verbal	NB
	UPWARD REPORTS FROM THE BOARD COMMITTEES			
11:10	15	Upward reports from the Board Committees: a) Finance & Performance Committee b) Quality & Safety Committee c) Staff Experience & OD Committee d) Audit Committee	ROHTB (11/23) 011 (to follow) ROHTB (11/23) 012 ROHTB (11/23) 013 ROHTB (11/23) 014/014 (a)	Cttee chairs
	MATTERS TO BE TAKEN BY EXCEPTION ONLY			
	16	Performance Reports: *for assurance* a) Finance & Performance b) Quality c) Workforce	ROHTB (11/23) 015 ROHTB (11/23) 016 ROHTB (11/23) 017	

11:30	**CONFIDENTIAL SESSION**			
	17	Exclusion of the press and public	Verbal	Chair
14:10	**CLOSE: Date of next meeting: Wednesday, 6 December 2023 @ 09:00**			

Notes

Quorum:

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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.

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Tim Pile (Ch)	✓	✓	✓	✓	✓	✓					
Christine Fearns	✓	✓	**A**	**A**	**A**						
Ian Reckless	**A**	✓	✓	✓	✓	✓					
Richard Phillips	✓	✓	✓	✓	✓	✓					
Simone Jordan	✓	✓	✓	✓	**A***	**A**					
Gianjeet Hunjan	**A**	✓	✓	✓	✓	✓					
Ayodele Ajose	✓	✓	✓	✓	✓	✓					
Les Williams	✓	✓	✓	**A**	✓	✓					
Jo Williams	✓	✓	✓	✓	✓	✓					
Matthew Revell	✓	✓	✓	✓	**A***	✓					
Nikki Brockie	✓	✓	✓	✓	✓	**A**					
Marie Peplow	✓	✓	✓	✓	✓	✓					
Stephen Washbourne	✓	✓	✓	✓	✓	**A**					
Sharon Malhi	✓	✓	✓	✓	✓	✓					
Simon Grainger-Lloyd	✓	**A**	✓	✓	✓	✓					

KEY:

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

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

The Royal Orthopaedic Hospital NHS Foundation Trust

AGENDA
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Mr Les Williams	Non Executive Director	(LW)
Dr Ian Reckless	Non Executive Director	(IR)
Mrs Jo Williams	Chief Executive	(JW)
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Mr Mathew Revell	Executive Medical Director	(MD)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance

Mr Luke Stanford	Housekeeper	(LS)	[Item 1]
Mrs Clare Mair	Head of OD & Inclusion	(CM)	[Item 10]
Mr Adam Roberts	Assistant Director of Governance & Risk	(AM)	[Item 11 & 12]
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Mrs Mandy Wilson	PA to the Chief Operating Officer	(MW)	[Secretariat]

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09:26	7	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (11/23) 003 ROHTB (12/23) 003 (a)	TP/JW

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	8.2	Childcare Provision: *for information*	ROHTB (11/23) 005 ROHTB (11/23) 005 (a) ROHTB (11/23) 005 (b)	SM
09:55	9	Retention & recruitment update: *for assurance*	ROHTB (11/23) 006 ROHTB (11/23) 006 (a)	SM
10:05	10	Equality & Diversity annual report: *for assurance*	ROHTB (11/23) 007 ROHTB (11/23) 007 (a)	CM
10:20	11	Patient Safety Incident Response Framework (PSIRF) policy and plan: *for approval*	ROHTB (11/23) 008 ROHTB (11/23) 008 (a) ROHTB (11/23) 008 (b)	AR
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11:05	14	Vaccination programme update: *for assurance*	Verbal	NB
	UPWARD REPORTS FROM THE BOARD COMMITTEES			
11:10	15	Upward reports from the Board Committees: a) Finance & Performance Committee b) Quality & Safety Committee c) Staff Experience & OD Committee d) Audit Committee	ROHTB (11/23) 011 (to follow) ROHTB (11/23) 012 ROHTB (11/23) 013 ROHTB (11/23) 014/014 (a)	Cttee chairs
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11:30	**CONFIDENTIAL SESSION**			
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14:10	**CLOSE: Date of next meeting: Wednesday, 6 December 2023 @ 09:00**			

Notes

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Tim Pile (Ch)	✓	✓	✓	✓	✓	✓					
Christine Fearns	✓	✓	**A**	**A**	**A**						
Ian Reckless	**A**	✓	✓	✓	✓	✓					
Richard Phillips	✓	✓	✓	✓	✓	✓					
Simone Jordan	✓	✓	✓	✓	**A***	**A**					
Gianjeet Hunjan	**A**	✓	✓	✓	✓	✓					
Ayodele Ajose	✓	✓	✓	✓	✓	✓					
Les Williams	✓	✓	✓	**A**	✓	✓					
Jo Williams	✓	✓	✓	✓	✓	✓					
Matthew Revell	✓	✓	✓	✓	**A***	✓					
Nikki Brockie	✓	✓	✓	✓	✓	**A**					
Marie Peplow	✓	✓	✓	✓	✓	✓					
Stephen Washbourne	✓	✓	✓	✓	✓	**A**					
Sharon Malhi	✓	✓	✓	✓	✓	✓					
Simon Grainger-Lloyd	✓	**A**	✓	✓	✓	✓					

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The Royal Orthopaedic Hospital NHS Foundation Trust

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In attendance

Mr Luke Stanford	Housekeeper	(LS)	[Item 1]
Mrs Clare Mair	Head of OD & Inclusion	(CM)	[Item 10]
Mr Adam Roberts	Assistant Director of Governance & Risk	(AM)	[Item 11 & 12]
Ms Rachel Richards	Private Patient Services Manager	(RR)	[Item 23]
Mr Amos Mallard	Head of Communications	(AM)	[Item 25]
Mrs Rebecca Lloyd	Deputy Director of Strategy	(RL)	
Mrs Mandy Wilson	PA to the Chief Operating Officer	(MW)	[Secretariat]

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11:30	**CONFIDENTIAL SESSION**			
	17	Exclusion of the press and public	Verbal	Chair
	18	Declarations of interest on any matters in the private session	Verbal	ALL
	19	Minutes of the previous meeting in private held on 6 September 2023: *for approval*	ROHTB (10/23) 022 (P)	Chair
	20	Actions from previous meetings in private: *for assurance*	ROHTB (10/23) 022 (a) (P)	SGL
11:35	21	Chair's and Chief Executive's update on any confidential matters: *for information and assurance*	Verbal	TP/JW
11:45	22	Financial Recovery planning update: for *assurance* • Agency Toolkit plan • Capital plan update	ROHTB (11/23) 019 (P) ROHTB (11/23) 019 (a) (P)	SW
12:00	**BREAK**			
13:00	23	Private Patient Update	ROHTB (11/23) 020 (P) ROHTB (11/23) 020 (a) (P)	RR
13:20	24	Final Workforce planning report: *for approval*	ROHTB (11/23) 021 (P) ROHTB (12/23) 021 (a) (P)	SM
13:40	25	Continuous Improvement methodology: *for discussion*	ROHTB (11/23) 022 (P) ROHTB (11/23) 022 (a) (P)	AM/RL
14:05	26	EPR update: *for information*	Verbal	SW
MATTERS FOR INFORMATION				
14:05	27	Committee Minutes a) Finance and Performance b) Quality & Safety c) Staff Experience & OD d) Audit	ROHTB (10/23) 023 (P) ROHTB (10/23) 024 (P) ROHTB (10/23) 025 (P) ROHTB (10/23) 026 (P)	
	28	Any Other Business	Verbal	All
	29	Meeting effectiveness	Verbal	All
14:10	**CLOSE: Date of next meeting: Wednesday, 6 December 2023 @ 09:00**			

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Tim Pile (Ch)	✓	✓	✓	✓	✓	✓					
Christine Fearns	✓	✓	**A**	**A**	**A**						
Ian Reckless	**A**	✓	✓	✓	✓	✓					
Richard Phillips	✓	✓	✓	✓	✓	✓					
Simone Jordan	✓	✓	✓	✓	**A***	**A**					
Gianjeet Hunjan	**A**	✓	✓	✓	✓	✓					
Ayodele Ajose	✓	✓	✓	✓	✓	✓					
Les Williams	✓	✓	✓	**A**	✓	✓					
Jo Williams	✓	✓	✓	✓	✓	✓					
Matthew Revell	✓	✓	✓	✓	**A***	✓					
Nikki Brockie	✓	✓	✓	✓	✓	**A**					
Marie Peplow	✓	✓	✓	✓	✓	✓					
Stephen Washbourne	✓	✓	✓	✓	✓	**A**					
Sharon Malhi	✓	✓	✓	✓	✓	✓					
Simon Grainger-Lloyd	✓	**A**	✓	✓	✓	✓					

KEY:

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TRUST BOARD DECLARATIONS OF INTEREST

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

Name	Interest	Voting Member
Gianjeet Hunjan **Non Executive Director**	• Non Executive Director, Black Country ICB • Lay Member, National Clinical Impact Awards - National Main Committee and West Midlands Committee • Governor, Oldbury Academy • Governor, Ferndale Primary School • Member of CIPFA • Member of IHSCM • Member of HFMA	Yes
Ayodele Ajose **Non Executive Director**	• None declared	Yes
Richard Phillips **Non Executive Director**	• Member, Longstanding member of the Institute of Healthcare Management • Director, Association of British Healthcare Industries Ltd	Yes
Ian Reckless **Non Executive Director**	• Executive Director (Medical Director and Deputy Chief Executive), Milton Keynes University Hospital NHS Foundation Trust • Director, ADMK Limited (wholly owned subsidiary of Milton Keynes University Hospital NHS Foundation Trust) • Director, JTER Trading Limited (company involved in property services and antiques trading) • Fellow, Royal College of Physicians • Fellow, Faculty of Medical Leadership and Management • Member of Congregation, University of Oxford	Yes

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

DRAFT PART ONE MINUTES – Trust Board Meeting Held in Public
4 October 2023, 09:00 - 12:45
Boardroom, Trust Headquarters

Members attending:

Mr Tim Pile	Chair	(TP)	
Mr Richard Phillips	Non-Executive Director	(RP)	
Mrs Gianjeet Hunjan	Non-Executive Director	(GH)	
Ms Ayodele Ajose	Non-Executive Director	(AA)	
Mr Les Williams	Non-Executive Director	(LW)	
Dr Ian Reckless	Non-Executive Director	(IR)	
Mrs Jo Williams	Chief Executive	(JW)	
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)	
Mr Matthew Revell	Executive Medical Director	(MR)	
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)	
Mrs Sharon Malhi	Executive Chief People Officer	(SM)	

In attendance:

Mrs Emma Steele	Deputy Chief Nurse (Deputising for Nikki Brockie)	(ES)	
Mrs Amanda Gaston	Deputy Director of Finance (Deputising for Steve Washbourne)	(AGa)	
Mrs Claudette Jones	Freedom to Speak Up Guardian	(CJ)	[item 7]
Mrs Tammy Ferris	Corporate Services Manager	(TF)	
Ms Becky Crowther	Deputy Chief People Officer	(BC)	[Observer]
Mrs Claire Kettle	Deputy Corporate Services Manager	(CK)	[Secretariat]

1 Apologies	**Verbal**
Apologies were received from Simone Jordan, Nikki Brockie and Steve Washbourne. TP welcomed to all the meeting with a particular warm welcome to Becky Crowther, Deputy Chief People Officer who joined the meeting as an observer, and to Tammy Ferris, Corporate Services Manager, both of whom have recently joined the Trust. TP thanked Emma Steele and Amanda Gaston for stepping in to deputise for absences and also thanked Claire Kettle for joining as secretariat. TP also welcomed Claudette Jones, Freedom to Speak Up Guardian, who joined at the start of the meeting to observe prior to presenting the Freedom to Speak Up update at Agenda Item 7.	
2 Declarations of Interest (Chair)	**ROHTB (10/23) 000 (a)**

It was noted there were no new declarations of interests to record.	
3 Minutes of Board Meeting held in Public on 6 September 2023: *for approval* (Chair)	**ROHTB (9/23) 027**
The minutes of the meeting held in Public on 6 September 2023 were agreed as a true record of the meeting. It was noted that GH had some comments she would like to address and would forward these to SGL/CK.	
4. Actions from previous meetings in public: *for assurance* (SGL)	**ROHTB (9/23) 027 (a)**
SGL reported the action log looked positive and commented there were a number of actions proposed for closure. Members of the Board were in agreement that these actions could be closed off. GH asked if the Clinical Excellence Awards process was going to be presented at Board. JW responded that this will be shared with the Trust Board once it has been presented at the Joint Local Negotiating Committee (JLNC).	
4.1 Board portal update (SGL)	**verbal**
SGL reported that Tammy (TF) will be leading on this piece of work going forward. SGL commented that the Board portal would be rolled out to the October and November meetings and the Trust Board meeting in December will be the first time using the Portal. SGL shared that meetings with the supplier are currently being scheduled and training will take place. AA asked by having the Portal in place what will this mean. SGL responded that the portal will take away the printing of paper copies and will provide electronic papers to members that can be annotated. TP commented that the system is very secure with password access to the portal. TP thanked SGL for this update.	
4.2 Stories for the Board (ES)	**ROHTB (10/23) 001** **ROHTB (10/23) 001 (a)**
ES shared that Dr Steven Beaumont (SB) is working on a Board story schedule. It was noted that patient and staff stories will provide feedback to the Trust Board on celebrating successes, positive feedback and experiences but would also share learning and focus on improvements. ES commented in order for these stories to be shared, consent from patients and staff will be required. ES commented that the schedule within the paper is documented until March 2024 and it was noted if there was not a suitable story to share, a themed	

presentation will be provided, TP commented he would encourage that the schedule is looked at beyond March. GH thanked everyone involved in this process and asked if a presentation from a Freedom To Speak Up (FTSU) Champion could be included within the schedule to allow them to explain their journey and share the issues they have challenged. LW commented on the excellent planning and asked if any thoughts had been given on how we bring together the learning from the stories on an annual basis. ES commented that she would feed this back into the process. **Action: ES to liaise with NB with regard to how we bring together the learning from the stories on an annual basis.** TP thanked ES for a clear and excellent paper and for presenting it so well.	
4.3 Assurance over RAAC (SGL)	**ROHTB (10/23) 002**
A copy of the response letter relating to 'Freedom of Information Act Request #4381' was shared with members of the Trust Board. SGL commented that this was provided as an assurance paper for the Board. It was noted and highlighted that an additional statement was added to the response stating that the Trust was not aware of RAAC being present, however, has commissioned an external review of the estate. JW commented that we are awaiting to receive the costs back and it was noted there was no immediate cause for concern. TP commented the Board would wait to see details from the external assessment to gauge assurance.	
5. Questions from members of the public (Chair)	**verbal**
No questions had been received from members of the public.	
6. Chair's and Chief Executive's update: *for information and assurance* (TP/JW)	**ROHTB (10/23) 003** **ROHTB (10/23) 003 (a)**
JW presented the Chief Executive's update and firstly shared the overall ROH update which included the following: • Royal College of Surgeons report around sexual harassment. JW commented that the report shared some stories that were a difficult read.	

JW commented the theme in the reports was around culture. It was noted there was no immediate response but was in the same line as the NHS Sexual Safety Charter. It was noted that over the coming weeks this Charter will be shared across the Trust and Nikki Brockie, Chief Nurse will lead on this within her safeguarding role.

- Notification has been received from the British Medical Association (BMA) that hospital consultants and junior doctors in England have voted in favour to take further co-ordinated strike action from 2 to 4 October 2023.

- It was noted that the month of October sees the launch of the Staff Survey which will be open from 2 October 2023 to 24 November 2023. JW commented that she encourages all departments and colleagues to participate and highlighted that this was anonymous.

- It was noted that Covid and Flu Vaccinations will be available from 9 October 2023.

- JW shared the ROH appears in the Top 6 Trusts for overall inpatient experience in the 2022 Care Quality Commission (CQC) Inpatient survey results which were released in September and commented we should celebrate this outcome.

- JW commented that she attended a session around 'Delivering the NHS Impact Framework: Creating and Leveraging a Management System' at Coventry & Warwickshire NHS Trust on 28 September 2023. JW shared that the conference featured Dr Gary Kaplan - CEO Emeritus, Virginia Mason of Franciscan Health and colleagues across health.

- JW shared that she was the Senior Responsible Officer (SRO) for Women's Heath Hub for BSol ICS. JW commented the £25 million investment had been equally distributed to Integrated Care Boards (ICBs) giving each ICB a total of £595,000 over two years non-currently. JW explained that a Women's Health Hub was required and she volunteered to be SRO and commented this would link in with the Trust's MSK work.

- JW highlighted that October is Freedom to Speak Up month and this will be a huge feature over the coming weeks along with Black History month.

TP presented the Chair's update as follows:

- TP highlighted what an incredible accolade it was for JW to be nominated CEO of the year for Inclusive Companies.

- TP commented that being in the Top 6 trusts for Inpatient experience was exceptional and recognised the work across the organisation. TP reiterated

this was an incredible achievement and testament to the leadership and the Board should recognise this and send their huge thanks of appreciation. • TP commented on the Royal College of Surgeons report around sexual harassment in the workplace and stated that the experienced shared within the report were distressing. • TP shared that he was continuing to attend external NHS meetings and had attended the NHS Providers Conference in London. TP also shared that he met with David Sallah, Chair of Birmingham Community Trust to visit the Dental Hospital and in return David is visiting the ROH during November 2023. TP attended the Integrated Care Partnership meeting, met with JW, MP and SW discussing the financial recovery and relayed thanks to them. • TP reported that the recruitment process for two Non Executive Directors had commenced. At this point TP recognised the input and impact Chris Fearns gave to the Trust and relayed his personal thanks. TP also, on behalf of the Board, expressed thanks for her major contribution she had given to the organisation. TP commented that he will report further on Non Executive Director recruitment at the next meeting. TP asked if there were any questions for JW. AA commented that she was interested in Black History Month and complimented JW on the work taking place around the Trust. AA asked if this is going to be circulated to everyone. JW responded that this is going to be refreshed at the MMEG Group and it is hoped that something will be produced similar to that of 'Beyond the Stigma'. Ian Reckless, Non Executive Director, joined the meeting at this point. TP thanked JW for her update report and commented on the vast amount of great work that was taking place.	
7 Freedom to Speak Up update: *for assurance* (CJ)	**ROHTB (10/23) 004** **ROHTB (10/23) 004 (a) – (d)**
TP welcomed to Claudette Jones, Freedom to Speak Up Guardian to present the Freedom to Speak Up update and thanked her for coming along to present this report to the Board as members were keen to see Freedom to Speak Up concerns raised at the Trust to see some benchmarking information and to understand if changes had been made as a result of the concerns being raised. CJ highlighted the concern categories under which we report to the National Guardian's Office (NGO) which are: • Element of inappropriate attitude and behaviour	

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

CJ reported NGO have recently introduced 'inappropriate behaviour' as a new category for reporting in 2022/23 and almost a third of cases were reported nationally against this category this year this being the most reported theme. CJ commented that the ROH is in line with this finding and this category continues to be the most common theme.

CJ commented that staff safety and wellbeing falls into high escalation areas.

CJ reported that the ROH have received very few concerns in the other categories listed above.

CJ highlighted some examples around inappropriate attitude and behaviour that the Trust are experiencing . It was noted that in response to the escalation of this Human Factor Training has been recommended for staff to attend and in more serious cases, disciplinary action has been taken.

In terms of concerns raised under the patient safety and quality category, CJ reported there were few issues raised that compromised patients' safety. However, some staff areas of staff reported that some of the issues being experienced were contributing factors that would potentially affect patient safety and examples were shared in the report.

CJ commented that concerns under staff safety and wellbeing highlighted the difference in salary between bank and agency staff. CJ commented the learning from this was that the contractual agreement was different and this has now been addressed.

CJ highlighted the improvement and changes as a result of Freedom to Speak Up concerns being raised and listed examples, including the work of the networks. It was noted that Champions were getting involved in setting up networks and last week and CJ reported a member of staff became a menopause champion.

The amount of development work was noted.

CJ highlighted that it was important to note that staff who seek support from her require a safe space to talk and in some cases staff approach her to seek guidance and signposting but do not wish discussion to go any further. It was noted that once signposting is received staff go back and deal with the concern themselves and CJ commented she was seeing a lot of this within the organisation.

CJ comment that the escalation process is important and shared that staff visit her to be supported whilst background work is being undertaken.

CJ commented that she is also the Chair of the ROH Equality & Diversity Network and highlighted the notable improvement from this network in the development of an open and honest culture across the Trust. As a result of raising awareness and signposting this has led to staff feeling more empowered, supported and valued. CJ commented that staff can bring anything along for discussion to the Equality & Diversity network and staff are feeling supported and empowered to progress things. CJ commented that she was very proud of that and this network is helping FTSU and CJ commented she is able to take the learning from this.

CJ highlighted the challenges addressed in this paper and commented the main theme was that staff want to come for guidance and support but feel reluctant to raise a concern. CJ commented staff were asking where they can meet the FTSU Guardian in their own time as there was no dedicated area for staff to visit. CJ commented to strengthen the Freedom to Speak Up commitment it would be helpful to have a designated space. JW thanked CJ for the work being undertaken and commented that she would address the issue of a FTSU designated area.

SGL commented on the changes to accommodation within the Governance Team and noted the need for safe spaces to undertake confidential conversations. GH raised concern that there is no dedicated area and the need to create an environment.

TP commented that a safe environment is required and that SGL will lead on this.

Action: SGL to lead on finding a designated area for the FTSU Guardian.

CJ highlighted the benchmarking data for FTSU concerns taken from the NHSE Model Health System. CJ commented that the Trust used to be measured around concerns raised but now is measured against staff survey. CJ commented that it was encouraging to see the ROH in the top 25 and shows we are progressing well.

CJ went through the next steps which included a comprehensive programme in October being the FTSU month. CJ explained this started on Monday 2 October 2023 and a request was made for colleagues to wear something green on 4 October to celebrate and raise awareness. CJ shared with members that she had visited most departments to deliver the Freedom to Speak Up awareness pack.

CJ commented that an agenda for the month has been communicated and a

FTSU flowchart have been provided in laminated format to support managers and staff. CJ also commented that Freedom to Speak Up posters have been launched. The FTSU stand will be outside Café Royale on 10 October 2023 and on 30 October 2023 the team will be visiting Theatres and raising awareness. TP thanked CJ for an excellent presentation. JW commented that she was aware that staff had raised with FTSU, the matter of the pay award for Bank staff. JW further commented that she knew that colleagues have found the decision which the Trust has taken difficult as the Trust has not paid the lump sum which substantive staff have received in the pay award. JW reiterated the message which she has given to staff directly that our Bank staff are valued and make an incredible contribution at the Trust. JW further explained that the decision to not pay the lump sum (non-consolidated award) to bank colleagues was difficult as we genuinely do recognise how much our bank colleagues contribute to the Trust. When taking the decision, we reviewed two things: the financial forecast for the Trust (the lump sum payment was not funded by government) and the impact for neighbouring Trusts should we have taken a decision which was at odds with that of other partner NHS Trusts within the BSOL Integrated Care System (BSOL ICS) and based on that, JW commented that this was the reason for the decision. JW highlighted and repeated that we do not take their support and flexibility for granted. SGL thanked CJ for all the work she had undertaken in supporting the Champions. GH thanked CJ and all of the Champions and comments that she would help support the FTSU month. AA thanked CJ for reassuring the Board what we are doing in the Trust with regard to FTSU. AA asked how many inappropriate attitude and behaviours have been received and how do we compare to compare with other Trusts. CJ commented that most Trusts have high numbers in this area and CJ agreed to obtain exact numbers for the Trust Board in her next update **Acton: CJ to provide exact numbers relating to inappropriate attitude and behaviour concerns in the next update** AA commented the flowchart mentions raising concerns formally with external bodies as a so called whistleblowing event and asked how would someone go about this and would the Trust be signposting this. CJ responded that walkabouts and training sessions take place and guidance relating to this is on the internet. SGL commented that this advice is contained within the Freedom to Speak Up Policy.	

RP commented on the need for a safe space for FTSU conversations and asked if there is anything else the Trust Board need to be aware of that can help. CJ commented that she feels this is a full-time role and people approach her because she well-known to them and feels she cannot turn them away. Therefore, CJ asked for support with this. It is national allocated time for Freedom to Speak Up. TP asked CJ if there was anything else the Board could provide support with. CJ commented that we have nine FTSU champions and it would be nice to have a team including admin support. SGL agreed to look into this. **Action: SGL to address Admin support for FTSU** TP referred to the benchmarking section of this report and asked under 5.2 what is the question behind this and what does the figure 6.8 refer to. The question was 'do you feel you are able to raise a concern'. It was noted that this is fed from an aggregate of scores from the staff survey. SM explained it is a series of questions which takes the aggregate score and takes an indicator. MP suggested that CJ attended the Model Hospital Club meetings to help with benchmarking.	
8 Wellbeing	
8.1 Wellbeing Plan: *for approval* (SM)	**ROHTB (10/23) 005** **ROHTB (10/23) 005 (a)**
SM commented that AA had been heavily involved in developing the Wellbeing Plan and thanked her for all of her support. SM commented that it was agreed that this be consolidated into an overarching plan. SM explained the plan shares success measures, frameworks used to measure wellbeing, and our vision for moving our wellbeing moving forward. SM commented there were 5 priority areas outlined to the plan which included objectives and critical success measurements. SM reported that consultation had taken place with NHSE in terms of their feedback and key elements working with partners as well. SM reported that the next steps once feedback had been captured from the Board, would be to take the Wellbeing Plan to the Staff Experience & Organisational (SE&OD) Committee for final sign-off. AA raised critical success metrics shown into people polices and asked which policies. SM commented that all policies will need a piece, including disciplinary, grievance and sickness and it was noted they do not feel as	

supportive as they can be at present. The practice of implementing policies was discussed and SM gave the Disciplinary Policy as a an example of showing little support on the individual going through the process.

Priority 3, entitled Leadership, was discussed and the measure in increasing the number of managers. The need to think about 360 feedback in terms of the teams was addressed. SM commented that conversations were taking place around upskilling managers and understanding what appraisals look like and SM commented the HR Team are currently working on this. SM commented that the new Appraisal Framework is going to the SE&OD Committee at the end of October 2023.

Action: SM to present the revised leadership framework to Staff Experience & OD Committee in October 2023

Stronger partnerships with national ICS events was touched on and who is going to do this. SM, commented that the Deputy Chief People Officer and Head of OD & Inclusion are developing and broadening these partnerships. It was noted that the Trust is 'ahead of game' in terms of its ambition to be the wellbeing hospital.

IR raised questions on Pages 63 to 65 and asked if the figures could be made clear. SM responded this was the baseline data and explained it was used through staff networks and diagnostic dashboard. SM agreed to provide a detailed explanation of the data in future reports.

JW commented on the NHSE framework and asked if NHSE had given any idea of any benchmarking. SM commented that she was in conversation with NHSE lead and that we were creating our own benchmarking and strengthening partnership with NHSE.

LW commented on the positive piece of work. LW referred to the statement on Page 4 at the end of the first paragraph and asked if the wording 'no option' could removed to reframe the sentence more positively.

ES commented on the leadership section and supported the point of improving our leaders in terms of wellbeing and commented this will also help signpost Freedom to Speak Up which is also important.

GH commented that she welcomes this plan. GH asked how we bring a cohort of champions together. How do we capture the data, what is our impact and understanding on how we measure these. SM commented on the mental health first aid champion and that there was a risk of diluting the champions and losing focus on what we are trying to achieve. She suggested that there was a need to train champions so there is one point of contact so that staff are clear who are the single points of contact.

AA congratulated SM and the team for producing this document and SM thanked AA for all of her support. TP commented where possible we should put numbers in, targets in what we are going to achieve, numbers against the increase in appraisals and how we are going to measure this and by whom, including dates. SM agreed to list metrics and timing. SGL asked if the plan was to reference this in the recruitment processes. SM commented it will go on recruitment site and on external website. It was suggested that this needed to be proactively included in recruitment materials however. MP suggested that staff testimonials should be shared and built in the plan if possible. TP congratulated all on their great work and the paper provided. TP commented this shows a real statement of what is excellent about this organisation.	
8.2 Cost of Living update: *for assurance* (SM)	**ROHTB (10/23) 006** **ROHTB (10/23) 006 (a)**
SM commented this was a paper for assurance and gives an update on Wellbeing work across the Trust and the continued Cost of Living support. SM commented that a number of hardship applications have been received and work continues on this. SM shared that more financial support from HSBC is now included. Bitesize Webinars will be available for the ROH and more details will follow in the next report. SM commented on the funding of the ROH pantry. A large donations and staff support for keeping this topped up had been received. SM highlighted the update on the wellbeing conversations within the report and more data will be provide in terms of an update in the next report. SM highlighted the positive feedback which included the nurse induction – welling being induction. JW commented on the hardship funds and that the people we have helped remain anonymous. JW asked about the four we had not supported and if the GP request was for staff or a patient. AGa responded the GP request was for a	

patient. AGa clarified that the four applications that were not supported are signposted to support afterwards. AA questioned the Health Kiosk and the cost of a loan and asked if we could do this in-house rather than spending money. SM commented that the wellbeing officer is collating information and getting quotes together and could possibly receive some sponsorship. SM commented that the issue is it will be a one-off and not sustainable. GH commented a lot of supermarkets were offering free testing and asked if this could be an alternative option. SM explained branding ourselves as a wellbeing hospital is important and also important in being available to staff and patients. JW commented this was a great idea and we would need to think about how someone can then signpost should any issues arise.	
8.3 Childcare Provision*: for information (SM)*	**ROHTB (10/23) 007** **ROHTB (10/23) 007 (a)**
SM commented this paper has been provided for information and in summary commented work was underway with a company looking at options. It was noted that there was still a procurement exercise to go through in terms of due diligence.	
9 Equality & Diversity Improvement Plan*: for assurance (SM)*	**ROHTB (10/23) 008** **ROHTB (10/23) 008 (a)**
SM commented that this paper has previously been presented at the Staff Experience & OD Committee meeting. SM reported that she has tried to consolidate the draft action plan within the inclusion plan. SM shared the first NHS Equality, Diversity and Inclusion (EDI) Improvement Plan was launched in June 2023 and this tied in with the Workforce Plan. The first area to report back is progress with Wellbeing conversations and needs to be with the National NHS Teams by the end of October 2023. SM commented on the key things to note including individual EDI objectives for each Board member, how we use data as a board to drive culture change in organisation. SM commented on the upskilling around the EDI agenda and providing regular assurance around EDI progress. SM stated that a lot of this is included in the inclusion work. JW suggested including this in the process when we undertake NED Recruitment.	

LW referred to Paragraph 6 with regard to the disciplinary process in terms of conversations about the process and content of policy around timing. LW also queried issues about training for staff in disciplinary processes. LW asked for this to be seen on the agenda at both the Staff Experience & OD Committee and Board. **Action: SM to ensure the disciplinary process appears on the SE&OD and Trust Board agenda with regular update and progress reports**	
10 CQC inpatient results: *for assurance* (NB)	**ROHTB (10/23) 009** **ROHTB (10/23) 009 (a)**
Steve Beaumont (SB), interim Deputy Chief Nurse, joined the meeting and reported the quantitative results from the CQC Adult Inpatient Survey 2022. It was noted that the feedback showed areas of improvement around communication with patients and the report in general showed positive feedback from patients. SB commented this is quantitatively written feedback and it was unknown who was providing this information. SB further commented it was hard to drill down this information as to how many patients the feedback was received from. SB commented that the ROH was in the Top 8 in the country and that the action plan is going to be light. SB highlighted the information around the pre and post operative cancer survey and commented that Division 1 was looking into this area. It was noted the area shows a very low number of responses. SB commented overall the results were very good and the ROH should be proud of the feedback received. JW commented that the CQC engagement lead had emailed her to congratulate the Trust and commented that the organisation should feel really proud. TP commented this was a huge testament to everyone involved, and highlighted these were a good set of results and accolade to this organisation. RP suggested that thought should be given to how we think about what our role in the system is around these results. RP commented this was a really strong message highlighting where we fit in a broad diverse system like BSol. JW highlighted this data as specialist hospitals and commented that this justifies and clarifies the role we can play. JW commented that she has asked FOSH (Foundation of Specialist Hospitals) to look at this piece of work and also for CQC, staff survey and ratings tables. JW commented that when this was carried out this hospital was treating 2,500 mutual aid patients and despite the wait,	

received great care at the ROH. TP commented that this reflects the excellent work done here at the hospital which gives our patients life changing experience. TP congratulated everyone. SM asked in terms of areas for improvement, what is being carried out and could this be improved. SB responded that quantitative results were awaited and plans are in place to speak to staff.	
11 Patient Safety Incident Response Framework (PSIRF) update: *for information* (SGL)	**ROHTB (10/23) 010**
SGL provided an update on the above. SGL commented that a draft policy and plan is in place and that the first draft of the PSIRF policy and plan will be presented at October's Quality & Safety Committee. SGL highlighted the close working relationship with the ICS and representatives of the Trust are due to attend a PSIRF Peer Review Workshop scheduled for 23 October 2023. SGL reported that final plans will be presented at November's Trust Board for Board approval and BSol ICB have set a 'go live' date of 4 November 2023. TP thanked SGL for this update.	
12 Responsible Officer's annual report: *for approval (MR)*	**ROHTB (10/23) 011** **ROHTB (10/23) 011 (a)**
MRev gave an update on the above and commented there were no major areas of concerns to report. IR commented on page 119 with regard to appraisal rates and mentioned within the GMC that Doctors should be given a month to receive an appraisal. MRev commented that there was three months flexibility in revalidation. MRev commented there were no issues of concern regarding this. MRev acknowledged the great engagement received and TP recognised this was a very positive report. GH asked about employment checks and if there was anything being done differently elsewhere. MRev responded that the Trust is comparable to what happens elsewhere. GH commented on talking to private practices. It was noted that the Responsible Officer is responsible for whole practice and also accountable if the	

GMC have concerns of anyone's practice. SM explained the agency for locum staff are obligated to provide assurance for employment and asked if additional checks take place. TP noted the good collaborative working.	
UPWARD REPORTS FROM THE BOARD COMMITTEES	
13 Upward reports from the Board Committees: **a) Finance & Performance Committee** RP commented that the Finance & Performance committed considered the self-assessment letter to NHS England and this was now completed. RP commented that activity was strong during the month despite the impact of industrial action. A financial deficit somewhere behind where we should have been was noted. Clinical coding was highlighted to be given focus in ensuring the correct code is allocated to the correct procedure. It was noted there are actions in place in respect of Better Payment Practice Code. Some uncertainly around elective recovery and the medium term financial plan was discussed. TP shared that RP is going to handover Chair of the Finance & Performance Committee to LW for October and November. LW registered his personal thanks to RP Chair of the F&P Committee and welcomed his perspective from a commercial sector. LW thanked RP for always being available. TP thanked RP for Chairing this committee and recognised his detail has been very impressive, his chairmanship has been exceptional and also thanked RP on behalf of the Trust Board.	**ROHTB (10/23) 012**
MATTERS TO BE TAKEN BY EXCEPTION ONLY	
14 Expanding elective capacity self-certification*: for information*	**ROHTB (10/23) 013** **ROHTB (10/23) 013 (a)**
The above paper was received and noted.	

15 Performance Reports: *for assurance* **a) Finance & Performance**	**ROHTB (10/23) 014**
The above report was received and noted.	
16 Internal Audit Plan 2023/24: *for information*	**ROHTB (10/23) 015**
TP commented that the Board was comfortable with the above and no further challenges were addressed in respect of the Internal Audit Plan.	

PUBLIC SESSION

Next Meeting: 6 December 2023, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 27 October 2023

Reference	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT.216	Net Zero progress update	ROHTB (9/23) 022 ROHTB (9/23) 022 (a)	06/09/2023	Present the Green Board update to FPC and a summary of any barriers to the achievement of the intentions to the Board at a later date	SW	~~1/11/2023~~ 6/12/2023	Green Board update presented to FPC in September and further update to Board in ~~November~~ December	
ROHTBACT.221	Wellbeing Plan	ROHTB (10/23) 005 ROHTB (10/23) 005 (a)	04/10/2023	Present the revised leadership framework to Staff Experience & OD Committee in October 2023	SM	25-Oct-23	Deferred to the January 2024 meeting	
ROHTBACT.217	Stories for the Board	ROHTB (10/23) 001 ROHTB (10/23) 001 (a)	04/10/2023	Liaise with NB with regard to how we bring together the learning from the stories on an annual basis	ES	03-Apr-24	Annual report on patient and staff stories to be presented in April 2024	
ROHTBACT.218	Freedom to Speak Up update	ROHTB (10/23) 004 ROHTB (10/23) 004 (a) – (d)	04/10/2023	Lead on finding a designated area for the FTSU Guardian	SGL	31-Dec-23	Will be part of the changes to the governance area in the nursing residency	
ROHTBACT.219	Freedom to Speak Up update	ROHTB (10/23) 004 ROHTB (10/23) 004 (a) – (d)	04/10/2023	Provide exact numbers relating to inappropriate attitude and behaviour concerns in the next update	CJ	07-Feb-24	ACTION NOT YET DUE	
ROHTBACT.222	Equality & Diversity Improvement Plan	ROHTB (10/23) 008 ROHTB (10/23) 008 (a)	04/10/2023	Ensure the disciplinary process appears on the SE&OD and Trust Board agenda with regular update and progress reports	SM	07-Feb-24	ACTION NOT YET DUE	

ROHTBACT.183	Patient Pathway update	ROHTB (7/23) 010	05/07/2023	Present an update on the Outstanding Pathways work at a future meeting	AM	~~6/09/2023~~ 4/10/2023	Discussed as part of the October private session	
ROHTBACT.184	Patient Pathway update	ROHTB (7/23) 010	05/07/2023	Arrange for a further update on the GP liaison work to be presented to the Board	MP	01-Nov-23	To be referenced as part of the private patient work discussed on the agenda of the November Trust Board meeting	
ROHTBACT.210	Turnover and retention plan update	ROHTB (9/23) 006 ROHTB (9/23) 006 (a)	06/09/2023	Staff turnover numbers to be reviewed at the Trust Board meeting in November	SM	01-Nov-23	Update included on the agenda of the November Public session	
ROHTBACT.214	Revised Board Assurance Framework	ROHTB (9/23) 014 ROHTB (9/23) 014 (a) – (f)	06/09/2023	Present the revised BAF in November 2023	SGL	01-Nov-23	Update included on the agenda of the November Public session	
ROHTBACT.220	Freedom to Speak Up update	ROHTB (10/23) 004 ROHTB (10/23) 004 (a) – (d)	04/10/2023	Lead on identifying administration resource for FTSU	SGL	01-Nov-23	To be provided by the Corporate Secretariat on an ad-hoc basis	

KEY:

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

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Portal Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Tammy Ferris, Corporate Services Manager**
DATE OF MEETING:	**1st November 2023**

EXECUTIVE SUMMARY:

The implementation of 'Board Effect' as a means of sharing Board and Committee papers has commenced; with a plan to roll out, and use, at Finance and Performance Committee in November followed by Trust Board in December.

Training on using the system will be completed by two 'super users' (Claire Kettle, Deputy Corporate Services Manager and Tammy Ferris, Corporate Services Manager). A bespoke training session will then be completed by Simon Grainger-Lloyd, Executive Director of Governance.

Further back-office training will be completed by the Executive Assistants, followed by an End User training session for the Executive Team on 21st November 2023. A virtual guide will be created for Non-Executive Directors to use, but support will be available if required.

All log in details and instructions will be circulated after 21st November.

REPORT RECOMMENDATION:

The Board is asked to note the contents of the report.

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

Note and accept	Approve the recommendation	Discuss
X		

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

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

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

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

Aligned to the Trust Strategy and NHS Long Term Plan of using digital technology.

PREVIOUS CONSIDERATION:

Discussed at October Board 2023

First choice for orthopaedic care
roh.nhs.uk

Board Effect Roll Out Plan

Key:
- Planned
- Complete
- In Progress
- Delayed

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Last updated: 26.10.23 v2.0

2023/24

	Oct	Nov	Dec	Jan
System Set Up	Kick Off Meeting Identify 40 users Add 40 users to Board Effect	Email Users Log in details Set up Events/Meetings	Roll out of Board Effect to all Board Committee Meetings	
System Training Plan	Identify dates for training	Admin Training 1 – 8th Nov Workroom Administrator Training Admin Training 2 – 9th Nov End User Training		
Board/Committee Meeting Dates		Finance & Performance 28th November	Trust Board 6th December Need End User Training to be Completed Charitable Funds 14th December	Audit Committee 19th January Finance & Performance 30th January SE & OD Committee 31st January Q&S Committee 31st January

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:	**1 November 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

The Royal Orthopaedic Hospital NHS Foundation Trust

Chief Executive's Report to the Trust Board (in Public)

1 November 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 4 October from the Chief Executive's position. This includes an overall update, ROH news and wider NHS updates.

2. OVERALL ROH UPDATE

2.1 November sees the continuation of the annual staff survey and I have encouraged all our colleagues to participate. Their voice matters. Their insights, feedback, and suggestions help shape the future of our hospital. Whether they work in a clinical area, in administration, research, or any other department, their perspective is invaluable.

The Staff Survey is an opportunity to make a difference, to influence positive change, and to ensure that we continue to provide the best possible care to our patients. The survey is one way to hear everyone's collective voice. It's important that everyone feels they can be heard and can share.

The survey runs till 24th November, and sharing thoughts, experiences, and suggestions are anonymous. We are committed to maintaining the confidentiality of the responses received, and honest feedback is encouraged.

2.2 Planning is ongoing in preparation for our Annual General Meeting on 23 November 2023 where we will share highlights from the 2022/2023 financial year with a look ahead to this year.

2.3 On Wednesday 1 November, we are expected to hear from Inclusive Companies who will confirm if the Trust has retained a place in the Top 50 Inclusive Companies awards. Thank you to all the team who have developed a great submission for the judging panel.

2.4 Congratulations to Jennifer Pearson who has been ranked in the HSJ *'50 most influential Black, Asian and minority ethnic people in health: The bubbling unders'*. We're incredibly proud of Jennifer and the work she is doing as Head of Nursing and to address inequality in our Trust and across the NHS

2.5 I'm also very proud to say that at the annual NOA awards, we won two awards, firstly the 'Partnership and Integration Initiative' award for our Mutual Aid project with UHB. We also won a 'Workforce Retention Initiative' award for our work on developing a hardship fund for staff and patients. Huge congratulations to all involved, it's a testament to their commitment, skill, and compassion.

2.6 Thank you to the BMA for asking me to support a webinar supporting colleagues with the Menopause. We had over 500 people join us for the session which reflects that we need to continue to listen, educate and support colleagues.

2.7 To commemorate Remembrance week on Friday 10 November, we are unveiling our war horse/poppy display which will be an incredible spectacle on site. The display will include 1000 handmade poppies which will be available to purchase with the money being donated to the Royal British Legion. The event which will be supported by a press release will be attend by the knit and natter group and our Veteran's Awareness group.

2.8 On 2 November, we launch our Trust strategy. Sessions are being held in the Lecture Theatre and Knowledge Hub between 10am-1pm with an initial event to brief all our managers and team leaders. This will be first of many engagements sessions as we now bring the strategy to life where everyone can connect with their role and see their valued contribution.

2.9 As November approaches it's a useful time to highlight the "Movember" campaign which seeks to raise awareness regarding three of the biggest health issues affecting men: mental health and suicide prevention, prostate cancer and testicular cancer. The "grow a moustache" throughout November campaign is the symbol for better men's health and a show of support.

The ManKind Staff Network at ROH seeks to support health and wellbeing initiatives, encourage awareness raising and support community building at the ROH. On November 21st there will be a ManKind network stall outside Café Royale providing information around the network and various awareness campaigns that the network will be promoting – Prostate Cancer, Mental Health and suicide prevention, Alcohol, Drug and Gambling support to name but a few.

2.10 Congratulations to the elective hub accreditation team for a successful review meeting where great progress and improved metrics were highlighted. Thank you to Marie Peplow, Chief Operating Officer and the whole team for the momentum and good progress to date.

2.11 On 18 October the Chair and I welcomed Jonathan Pearson who is the new Chair of Birmingham Health Partners (BHP). We look forward to continuing to contribute into the strategic direction for BHP as it further evolves across clinical trials capabilities, early detection, health inequalities and experimental

medicine. This would include showcasing some exemplars of existing activity in these areas.

2.12 At the start of November we will unveil our new exhibition, 'Many Cultures, One NHS', which is an exhibition about inclusion and supporting staff wellbeing. I want to thank all the staff who have contributed to the beautiful photography and I look forward to seeing the response to the exhibition.

2.13 During the month, the governor election process concluded and we are delighted to welcome some new and existing governors to serve on our Council of Governors. From the public governor elections, Tony Thomas and Lyndsey Hughes were elected. Lyndsey served as a governor some time ago, so it is great to welcome her back. In terms of staff governors, Petros Mikalef, Consultant Surgeon and Pete Law, Graphics Officer, have been elected as clinical and non-clinical staff governors respectively. We look forward to working with our new governors over the coming months.

3. BSol ICS (Integrated Care System) Updates

3.1 The Birmingham and Solihull (BSol) Integrated Care Board (ICB) meets bimonthly, and next public meeting is being held on 13 November 2023.

3.2 The CQC has confirmed two systems where they are piloting new system-wide assessments, one of which is Birmingham and Solihull. The process began earlier this year, when the ICS received a series of requests for information which provided the CQC with appropriate evidence which they needed to review. Inspectors will be speaking directly with people using our services, and with staff across our system about their experience. Specialist advisors and executive reviewers will also be carrying out on-site interviews throughout November.

During the pilot, they will be testing their assessment methods which includes how they work with partners and stakeholders, use feedback, involve experts effectively, use tools and methods including information returns and enable efficient ways of working. They will be looking at how leadership works, how systems are integrated, progress being made towards reducing inequalities and how quality and safety is managed across local services.

Colleagues, including myself and the Chair will be interviewed as part of the pilot assessment, as they look to get a wide range of comments, views and experiences from across all corners of our system. The CQC will use their new assessment framework which is centred around 17 quality statements.

4 NHS England/National updates

4.1 The next 6-monthly NHS Leadership event for CEOs with the NHSE leadership team will be held on 8 November 2023.

5 POLICY APPROVAL

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

6 RECOMMENDATION(S)

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

6.2 Note the contents of the report.

Jo Williams
Chief Executive

26 October 2023

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Wellbeing Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Sharon Malhi, Chief People Officer**
AUTHOR:	**Laura Tilley-Hood, Wellbeing Officer**
DATE OF MEETING:	**1st November 2023**

EXECUTIVE SUMMARY:

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

Positive assurance

- Colleagues are able to access the hardship fund and there is a quick turnaround for them to receive the funds
- Wellbeing Week plans are in place, ensuring the team visit different departments
- Continuing to provide financial support for colleagues as we move into the winter months; using support from Finance, Salary Finance, Barclays, HSBC, regional and national support

Current issues

Ensuring everyone has access to the Wellbeing Week.
Ensuring all managers attend the Wellbeing Conversation Training

Next steps

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

REPORT RECOMMENDATION:

To review information

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

Accept	Approve the recommendation	Discuss
X		

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

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

Comments:

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

People Element of the ROH Strategy, ROH Inclusion strategy

PREVIOUS CONSIDERATION:

Cost of Living and Wellbeing update Trust Board – October 2023

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

Trust Board – November 2023

Monthly Update on Wellbeing and Cost of Living

1. Wellbeing Update

1.1 Wellbeing Days

The week is 27th November – 30th November. There will be stands outside Café Royale. The stands will also be set up in Theatres and wards during TBALD. Support will be available from Barclays, HSBC, Birmingham Mind, ROH Charity, Knit and Natter, ROH Networks, CAB and Aquarius.

The Executive Team are supporting a Tea Trolley which will be taken to different areas. The trolley will be stocked with tea, coffee, juice, water, fruit and snacks and will be funded by the Birmingham Winter Funds Grant.

1.2 Packs for students

The team are continuing to support students with toiletry packs, we are using the Winter Funding for this.

1.3 Wellbeing support

There has been an increase for one to one wellbeing support over the last month, the themes have been bereavement and general wellbeing support.

1.4 Wellbeing Conversation Training

Training continues for managers with evaluations and feedback received from each sessions. Monthly sessions are booked up to March 2024.

1.5 Screen – Wellbeing Room

A Charities application has been submitted for the remaining funds for the Wellbeing Room. The screen in the room will display all the wellbeing information and colleagues can also access different apps with support, mindfulness sessions and signposting.

1.6 West Midlands Combined Authority (WMCA)

West Midlands Combined Authority and Andy Street will be visiting the Trust on 1st November. Andy Street will visit different areas including, Outpatients for the new MMEG exhibition, Theatres Department to view surgical robots, the Wellbeing Room and Café Royale to meet the catering team. The visit will be hosted by the Executive Team.

1.7 Menopause

A stand for World Menopause Day was run to share lots of signposting and support available, including a new booklet which prepares colleagues on how to talk to their health care practitioner about menopausal symptoms. There are three Menopause Champion; one has received their training through partners Talking Menopause and two other colleagues who are booked for training in November. Menopause Training – dates are being booked for awareness sessions for colleagues, specifically for managers.

1.8 Health Kiosk

The Trust has secured the loan of a Health Kiosk free of charge for a month. This will be situated outside Café Royale and can be used by patients and colleagues. They can check their BMI, temperature, height, weight and blood pressure. We will be able to gain feedback from colleagues as the machine has a survey inbuilt into the questions.

2. Cost of Living

2.1 Royal Orthopaedic Charities initiative: The ROC Hardship Fund

The Workforce and OD team continue to work with colleagues to deliver the ROH Hardship Fund. The Hardship Fund panel runs weekly to review applications and is made up of representatives from: Charities, HR and Wellbeing.

- Since launching the fund in June 2023, the Trust have received a total of 27 application. 25 have been assessed and 2 applications are awaiting review (26th October).

Based on the 25 applications which have been reviewed:

- The Trust has supported 80% of these applications through £8815 of financial support – 5 patients and 15 staff.
- To date, the Trust have supported 15 staff applications through £7400 of support. 14 of these staff applications received the full £500 grant and the other received £400.
- To date, the Trust has supported 5 patients through £1415 of support. The amount requested varies, however, *on average* the patients have received £283 each

The Trust won an award at the National Orthopaedic Alliance (NOA) conference for the work being undertaken on the Hardship Fund.

2.2 HSBC Financial Support

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

1) **Always on** – this is a schedule of different daily webinars that provide colleagues with the knowledge and tools to look after their financial needs no matter who they bank with. This is updated monthly. It has been shared on the Weekly Wellbeing email (this is also shared on Loop) and has been distributed via posters.

Topics include:

- Making the most of your money
- Discover practical steps to optimise your everyday finances and gain financial confidence.
- My family Gain insights on childcare, family savings and how money can work harder for your family.

- Managing debt Get back on track financially and discover what debt support systems are available and many more.

2) Bitesize Webinars for ROH

The Bitesize sessions are 45-minute sessions, these will be delivered via MS Teams. They offer signposting and financial wellbeing support and a time for questions at the end. The first webinar was about Coping with the Rising Cost of Living, we had 16 colleagues attend. Space has been booked out in the Lecture Theatre for colleagues to attend as well as on MS Teams. We are also running a bespoke session in Theatres at the Clinical audit meeting on Monday 30th October, the theme is Spending your income and Budgeting. Further dates are booked for November with different topics being covered.

3) 1:1 Financial Health Check

HSBC will be joining the Trust in Wellbeing Week to offer support. They will have a stand and also the Wellbeing Room will be available for a quiet and private space. Colleagues can also book a free financial health check via a QR code or be emailing directly. This has been shared in the Wellbeing Weekly email and posters will also be distributed.

The HSBC Bitesize Webinars and 1-1 Financial Health Checks are free, confidential and open to all.

2.3 Other Cost of Living initiatives include:

1 ROH Pantry

Continuing to keep it fully stocked with supplies to restock. The Trust has been successful in securing the Winter Funding Grant to keep the pantry restocked over the winter months. We also have stock to keep it topped up.

2 Out of hours food

Frozen ready meals have continue to be used from the freezer, we will be using the Grant to keep freezer fully stocked.

3 Blue Bag Project

These bags are kept fully stocked across the Trust, we have also added a bag to the Griffins Brook site.

4 Salary Finance

New material and information from SF, this will be distributed to colleagues across the trust, this had been added to the Weekly Wellbeing email and the Wellbeing Hub.

FOR ASSURANCE

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

5 Stands at Wellbeing Week

The finance team will be holding a stand during the week to help with the Cost of Living. We also have financial support from HSBC and Barclays.

Laura Tilley-Hood

Engagement and Wellbeing Officer

November 2023

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Provision of Childcare Services for Employees**
SPONSOR (EXECUTIVE DIRECTOR):	**Sharon Malhi, Chief People Officer**
AUTHOR:	**Alex Gilder, Deputy Director of Finance** **Clare Mair, Head of OD and Inclusion**
DATE OF MEETING:	**1st November 2023**

EXECUTIVE SUMMARY:

Background

This report provides an overview of the work completed to date with regards to a review into the potential of provision of childcare services for employees, some of the key risks being investigated, and next steps.

As a reminder to members of the Board, the combination of the people who said they either were interested, or might be interested in childcare provision was 63, including people currently on maternity leave. It is considered likely that there would be a slow initial uptake of places due to the administrative burden of moving children from their existing childcare provision, followed by a growth in uptake over time.

Since the last meeting, RSM have been engaged to provide the ROH with a technical summary regarding salary sacrifice arrangements and Section 318, in addition to the implications for those on lower wages and the salary sacrifice arrangements which would need to be put in place. This technical note is DRAFT, in that the ROH have requested further detail is included regarding other local arrangements, and some more details in Appendix A, but given the timing of the Board it was considered worthwhile sharing.

Information reviewed from third party nursery supplier

As part of the technical summary RSM were also asked to look at a financial model provided by potential third party nursery supplier to establish if the suggested arrangement would meet the requirements of Section 318. As previously noted, it is important to state that a supplier has not be formalised – it would be important to use an appropriate procurement route to secure an offsite nursery facility, and therefore the final financial impact may differ from the values included in this note.

The model proposed included a c.£100k first year investment, and then a variable future year investment based on 15% of the relevant employment costs of the nursery based on the ratios required for the number of employees signed up to the nursery.

Key risks

The main point of risk here is that the 15% future investment needs to be sufficiently large to meet HMRC's requirement of a 'substantial financial commitment'. RSM have confirmed that one way of achieving this might be to have a minimum core investment of c.£30k-£50k each year irrespective of staff numbers. RSM have concluded that this investment, plus the requirements regarding attendance at the Management Committee, would meet the requirements of Section 318.

RSM have noted that there is a risk with regards to National Minimum Wage (NMW), which would need to be managed. In short, the Trust are not allowed to permit members of staff to make salary sacrifice payments which would take them below minimum wage.

Managing risks

Ways this could be managed would include;

1. uplifting the salaries of those members of staff to a level which would no longer breach NMW
2. not offering salary sacrifice to those members of staff who would be taken below NMW. Instead, the Trust could ask the successful supplier to provide a discount to those staff, who would then pay the supplier directly and not through salary sacrifice.

The latter option is that proposed as it is considered the least problematic and divisive, as the former option would result in an additional financial impact for the ROH and would also result in a difference in treatment of staff depending on whether they did or did not have children of nursery age. A hospital approached in the ROH's research used the latter model successfully.

Financial overview

Appendix A to the RSM report shows a simplistic calculation which suggests on an assumption of an average full time nursery placement costing in the region of £8k a year, employees could save between £213-£280 a month for basic and higher rate earners respectively through salary sacrifice (£2.5k-£3.4k a year). The ROH savings of £90 a month for each employee would be netted against the investment made, but ROH must always make sure that the investment made substantially outweighs any savings on NI to remain in line with Section 318.

In terms of disinvestment risk, disinvestment from a tax point of view is considered simple – there would need to be a notice period to ensure employees had time to make alternative arrangements, but there is no minimum number of years that the nursery would need to run if uptake were poor. There would of course be a potential risk to staff retention to those staff using the facility if the provision were removed at a later date which would need to be considered.

Next steps

In summary, the technical note provides the ROH with sufficient guidance to suggest that an offsite nursery that meets the requirements of NMW and Section 318 is possible, and if there is support from the Trust Board, it could be progressed to specification procurement stage.

On the basis of the technical note provided, and a likely financial impact being in the region of £100k for the first year and then £50k each year going forward (dependent on the uptake in terms of places), the Board are asked to APPROVE the decision for the ROH to progress to drafting a procurement specification to test the market for an offsite nursery.

REPORT RECOMMENDATION:

The Board is asked to NOTE the work performed to date and APPROVE the suggestion to proceed to procurement for an off-site nursery facility.

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		Communications & Media	
Business and market share		Legal & Policy	x	Patient Experience	
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:

Strategic Objective – Rated as among the best NHS hospitals to work for by our team

- Increased retention
- Improved morale
- Reduced vacancies

PREVIOUS CONSIDERATION:

Verbal consideration at previous Trust Board meetings and initial paper at October 23 Trust Board.

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Workplace Nursey Provision – Technical Summary Note

25 October 2023

INTRODUCTION

Scope of engagement

RSM ('us' or 'we') have been engaged by the Royal Orthopaedic Hospital NHS Foundation Trust ('ROH') to provide employment tax advice in relation to the proposed workplace nursery provision by the commercial provider with a view to preparing a technical summary report outlining the technical position in terms of the exemption relating to employer-provided childcare and the requirements that must be satisfied.

As part of this summary report, we have also included commentary around wider considerations such as the effectiveness of any salary sacrifice from a tax perspective alongside the implications of National Minimum Wage ('NMW') to give ROH a wider awareness of the risk areas to consider as part of any arrangements.

This summary report is prepared in accordance with the signed Call off Schedule dated 10 October 2023.

Basis of the memorandum

This summary report is intended solely for use by the management of ROH for the specific purpose set out in the Introduction and Scope of this report.

RSM takes no responsibility for any other use of this report and specifically has no duty of care or responsibility to any third party. We are not obliged to update this report for changes in tax law, subsequent to the date of this report, which may affect the conclusions set out in this report. We would, therefore, recommend that the report is subject to regular review to reflect such changes should they occur.

Please be advised that our comments are based solely on the information provided, if the proposed workplace nursery arrangements change or differ to the information provided; our technical comments may not be applicable. If any information is incorrect or incomplete, please confirm as this may materially change our advice.

TECHNICAL POSITION

Background

Effective employer provided childcare potentially can benefit employees significant personal and tax savings as it allows all or part of the childcare costs to be funded by the employer free of Income Tax and National Insurance Contributions ('NIC'). Broadly speaking, the legislation covers two forms of exemption: childcare provided at the workplace and other childcare.

From 6 April 2017, there was changes to the operation of tax efficient childcare. While many of the historic arrangements continue, there are transitional arrangements for previous childcare vouchers which were closed to new entrants from 4 October 2018.

Workplace Nurseries

Section 318 of the Income Tax (Earnings and Pensions) Act ('ITEPA') 2003 provides an exemption from tax and NIC for employer-provided childcare, where all the qualifying conditions from A to D are met:

- Condition A: The care must be for a qualifying child under the age of 16. This a child or stepchild that the employee either lives with or for who the employee has parental responsibility.
- Condition B: The premises on which the care is provided must qualify. Broadly, this requires the premises to meet registration requirements (defined in legislation under the Childcare Act 2006 within England), and for the premises not to be wholly or mainly a private dwelling.
- Condition C: The premises on which the care is provided must either be made available by the scheme employer, or the partnership requirements must be met. See further on this below - it is the joint provision and the partnership requirements that are the focus of HMRC's updated guidance.
- Condition D: The arrangement under which care is provided must generally be open to all employees or, if the scheme employer has premises at more than one location, the scheme must be open generally to employees at the location at which the scheme operates.

Condition C – Partnership Requirements

Condition C allows employers who do not make a workplace nursery available on their own premises to jointly run a childcare facility. The partnership requirements must then be met for the exemption to apply, the conditions being that:

- the employer must be included in the arrangements for providing the care; and
- the premises where the care is provided must be on one of the employer's sites or on the premises of a commercial childcare provider involved in the partnership; and
- the employer must, at least in part, contribute to both the financial and management elements of the care provision.

HMRC Guidance

On 8 March 2023, HM Revenue and Customs ('HMRC') updated their guidance in relation to jointly run childcare facilities. HMRC's concern was primarily around employers entering into partnership arrangements with commercial nursery providers, where the employer does not engage with the commercial provider in such a way that it is wholly or partly responsible for financing and managing the provision of the care.

What happens if the Exemption does not apply?

The benefit will be regarded as liable to tax and Class 1A NIC. The benefit in kind value (liable to tax and Class 1A NIC) for each employee will be based on the higher of the cost to ROH (for each employee) and (if it is provided under a salary sacrifice arrangement) the amount of earnings forgone by the employee for the benefit.

If HMRC successfully challenges an arrangement that has been treated as exempt in the past, and concludes that the exemption does not apply, it could go back six tax years to collect the underpaid Class 1A NIC and charge late payment interest and penalties. HMRC may also invite ROH as the employer to settle any underpaid tax due on a grossed-up basis, normally for the previous four tax years.

PROPOSED ARRANGEMENT

Background

ROH has held initial discussions with potential commercial providers to understand the potential arrangements and commercial considerations to determine whether they are appropriate alongside whether it will be beneficial from a commercial perspective in terms of achieving the aim of using the arrangement as an effective recruitment and retention tool.

Proposed Arrangement

Based on the information provided, it is our understanding that the current proposed arrangement by the commercial provider which they consider meeting the exemption requirements and HMRC's guidance is as follows:

- An initial ROH financial contribution of £50,000 to fund required works in the identified existing childcare setting to ensure the required facilities are available within the premises;
- Year one commitment for ROH to fund the salaries and relevant employment costs, such as pension contributions and Class 1 National Insurance Contributions ('NIC'), of at least two qualified early years practitioners (depending on uptake).
- Year two onwards this would reduce to a commitment for ROH to fund 15% of the nursery's relevant employment costs;
- A commitment for a representative of ROH to be appointed onto the nursery's Management Committee. The appointed member will commit to attend all management committee meetings where key policies involving the childcare and education settings will be taken alongside having a vote on all management decisions.

The commercial provider and their advisors consider the above proposal satisfies the requirements for the exemption under Section 318 ITEPA 2003 enabling ROH employees to settle their nursery fees via salary sacrifice. Within the proposal the provider and their advisors have commented that the proposed financial commitment is considered to satisfy the requirements of HMRC's new guidance.

It is understood that the overall financial contribution from ROH in Year 1 is likely to be c.£98,000. The financial contribution in following years Is likely to be at least c.£51,000. Please see our comments in this regard below.

PRACTICAL APPLICATION

Section 318 ITEPA Exemption

Based on our discussions and the proposal information shared we have outlined our considerations below in terms of the exemption.

Condition A

- Whilst the arrangements are not finalised, it is understood that the care would cover a child or stepchild that the employee either lives with or for who the employee has parental responsibility and therefore qualifying children for the purposes of the exemption. On this basis it is considered that Condition A is satisfied.

Condition B

- On the basis that the proposed childcare setting will be located within England, the premises must be meet the registration requirements set out in Part 3 of the Childcare Act 2006. Given the proposed setting is currently a childcare premises it is reasonable to assume that the requirements are met. For the avoidance of doubt, we would however recommend that further confirmation is sought in this regard to validate that Condition B is met.

Condition C

- The premises on which the care is provided must either be made available by the scheme employer, or the partnership requirements must be met. Please see our below section with further comments in this regard.

Condition D

- Based on our understanding, the majority of ROH staff are based out of the main ROH site or the nearby ROH site at College Green, both are within vicinity of each other (approximately 1 mile). With the proposed arrangement being open to all employees with no specific criteria or bias towards groups of employees. On this basis it is considered that Condition D is satisfied.

Condition C – Application

As the proposed premises is not being made available by ROH within its own capacity the partnership requirements test must be considered. To satisfy the test the following must be met under Section 318(7) ITEPA 2003:

a) Conditions A, B and D are satisfied – please see our comments above which based on our understanding of the proposed arrangements would be the case;

b) The care is provided under arrangements made by persons who include the scheme employer – for the purposes of the rules the “scheme employer” means the employer operating the scheme under which care is provided. In this case this would be ROH alongside the commercial provider and therefore satisfied.

c) The premises in which care is provided is made available by one or more of those persons – the commercial provider and ROH “partnership” includes ROH as the employer whose employees would be eligible to benefit from the childcare provision and therefore satisfied.

d) Under the arrangements the scheme employer is wholly or partly responsible for financing and managing the provision of the care.

Responsibility for financing the provision of childcare test

HMRC considers that the “responsibility” for financing under Section 318(7)(c) for jointly run workplace nurseries requires significantly more than merely purchasing places from a commercial nursery. HMRC’s view is that there must be some real and substantial commitment to funding the facility and the risks associated with operating a childcare facility.

In the case of newly established facilities there is an assumed risk of viability by HMRC and consequently an expectation of financial commitments in terms of contributions to ensure overall financial viability of the facility. On the basis that within year one, the proposal includes a capital sum of £50,000 to “set-up” the facility alongside the commitment to fund the relevant salaries and employment costs of a minimum of two qualified practitioners would satisfy the test.

We note that it is not confirmed within the summary the position in terms of number of places available/expansions depending on uptake. It is reasonable to assume these costs will increase accordingly where more practitioners are required and ROH would be committed to cover any associated costs, where this is the case again this would also support meeting the financial responsibility requirements.

One final comment would be in terms of ongoing costs in years two onwards and whether ROH would be responsible for any additional capital amounts for the upkeep of the facility or whether this is included within the 15% overall contribution. Where this is not the case, we would recommend further consideration into the overall cost(s) to ensure that ROH are still meeting the financial responsibility test and the amounts would not be open to challenge by HMRC.

Responsibility for managing the provision of childcare

The responsibility for management test does not necessarily require day-to-day management or direct responsibility for the care of the children. The test instead requires involvement further than giving ad-hoc advice or being consulted from time to time about general policies or having a right to a place on a committee which has no power or influence in the way in which the care is provided.

On the basis that the proposal includes the provision of a member of ROH joining the Management Committee who must attend all committee meetings where key policies involving the childcare and education settings will be taken alongside having a vote on all management decisions. This would satisfy the test provided in practice this does happen and ROH are involved in playing a part in the management of the facility.

Summary

Based on the proposal information provided it is considered that the exemption under Section 318 ITEPA 2003 would be met. We would however recommend further consideration or confirmation is sought in the following areas:

- Consideration of the year two position going forwards in terms of what the 15% amount entails to ensure the financial responsibility test can be met;
- Confirmation of the voting rights / scope for the management committee to ensure that ROH has sufficient involvement in the management of the facility;
- Consideration as to who would be the ROH committee member and ensuring that they are able to fulfil the role and responsibilities fully to mitigate any risk of HMRC challenge that ROH are not meeting the management test in circumstances where ROH is not actively participating in any votes/decisions.
- Confirmation of the number of places/potential costs depending on uptake so ROH are informed from a commercial perspective.
- Confirmation of any liability for loses or additional costs ROH may be responsible for if the nursery is not viable.

RSM would be happy to review any proposed contractual documentation (where available) to consider the above comments and the exemption applicability remains.

SALARY SACRIFICE

Background

A salary sacrifice happens when an employee gives up the right to part of the cash remuneration due under their contract of employment. Usually, the sacrifice is made in return for the employer's agreement to provide the employee with some form of non-cash benefit. The sacrifice is achieved by varying the employee's terms and conditions of employment relating to remuneration.

From 6 April 2017, the Income Tax and NICs advantages where benefits in kind are provided through salary sacrifice arrangements, described in the legislation as Optional Remuneration Arrangement rules ('OpRA') were largely withdrawn. However, it is important to note that a qualifying workplace nursery scheme under the exemption outlined above is excluded from the OpRA rules and therefore employees can utilise salary sacrifice to give up an amount of pay equal to the cost of the nursery place and receive Income Tax and NIC savings in the process. Where effective, this can also provide ROH with employers NIC savings too.

It is important to note that where a salary sacrifice is not effective, the amount of pay 'sacrificed' could be considered as normal pay which is liable to tax and NIC via PAYE (despite it not being received or paid).

How salary sacrifice is implemented

Changes to employment contract

The terms of an employment are generally set out in the contract between the employer and employee. The contract or agreement will usually specify among other things:

- the obligations and responsibilities of the employee (hours of attendance at the workplace; standards of work; dress code, etc.)
- the remuneration package to be paid and provided (this may include cash wages/salary, non-cash benefits, pension rights, etc.)

In a salary sacrifice arrangement the contract is changed or varied with the employee agreeing to a smaller salary in return for a non-cash benefit. This change in the entitlement should be reflected in the contract. Where the contract is not effectively varied, the employee remains entitled to the elements of the remuneration package previously specified (and therefore subject to PAYE).

Varying the contract can be achieved in several ways but within the circumstances of the proposed arrangements the most practical options are either (it may be more practical to apply the second point):

- rewriting the document in part or whole; or
- setting out agreed changes in a separate document that is attached to the main contract. This may be letter or pro-forma.

The first two points on the bulleted list are easily recognised as effective changes as the employee will usually signify their agreement by signing the document which should be retained to demonstrate the sacrifice.

When these conditions have been satisfied, the employees have indicated their agreement to the variation by their conduct and the revised agreement is legally binding on both parties. It is important to note that generally the salary sacrifice side is not covered by commercial nursery providers and therefore an area in which ROH must ensure is addressed to manage any potential risk.

Salary Sacrifice Risk Factors

Employees participating in a salary sacrifice arrangement during maternity leave must also continue to have the benefits provided.

Any agreement that involves giving up taxable salary to cover the nursery costs may affect other work-related benefits that depend on the rate of pay, such as holiday pay, overtime rates and pension contributions. Also, by sacrificing pay, an employee's entitlement to certain contributory state benefits may be reduced or even removed altogether. Such benefits include the State Second Pension, Tax Credits, Incapacity Benefit and Jobseeker's Allowance. Furthermore, employees who are entitled to statutory minimum payments such as paid leave for ill health, maternity / paternity and where parents adopt a child. Such statutory payments are

calculated by reference to the employees' gross pay and a salary sacrifice would reduce their gross pay, possibly to the statutory minimum, whereupon they would not be able to sacrifice any further pay without losing these payments.

In practice, loss of the statutory benefits outlined above are unlikely to occur, as to trigger loss of entitlements the vast majority of employees would have to earn less than the National Minimum Wage ('NMW'). A salary sacrifice arrangement must not reduce the level of pay below the NMW. Where this is the case, this would be considered a legislative breach which HMRC would enforce (see below for more information).

If the salary sacrifice has not been correctly carried out and is not successful, e.g., the employee is able to easily revert to the pre-sacrifice salary, it is HMRC's view that the employee has still received the pay they have sacrificed. Therefore, tax and NIC is due on that pay element which could cause both a reputational and financial impact to ROH where any liabilities are identified.

Salary Sacrifice and National Minimum Wage ('NMW')

NMW is calculated after considering any salary sacrifices on the basis that contractually the amount has been given up before it ever belongs to the employee and therefore cannot count for NMW purposes.

In short, salary sacrifice must not reduce an employee's salary below the NMW, there is no exemption or exclusion for this. For example, an employee aged 29 who is earning £10.50 an hour (which for the purposes of this example is above the minimum hourly rate) and working a 35-hour week enters a salary sacrifice arrangement as part of an employer provided nursery for £50 per week. Their post-salary sacrifice pay will be £317.50 a week: £9.07 an hour, which is below NMW.

The tax / NIC exemption for employer-provided childcare outlined above is predicated on the benefit being made available to all employees. In circumstances where the employer requires all employees involved in such arrangements to participate via salary sacrifice but some employees would not be able to participate due to NMW compliance, HMRC accepts that the restriction by reason of the NMW does not mean the benefits are no longer available to all and does not therefore remove the tax / NIC exempt status.

It is however noted that workers who may be excluded may also be those who would benefit the most from the proposed childcare arrangements, therefore we recommend further review and consideration into the proposals from a NMW perspective considering the commercial implications in this regard.

Example Savings

We have provided a high-level indication of potential savings for an effective salary sacrifice as part of Appendix A for information purposes.

RECOMMENDATIONS

We have outlined below our recommendations in terms of areas to consider and next steps which ROH should consider as part of the decision-making process around whether to adopt the scheme:

- Consideration of the process in terms of implementation and management of the salary sacrifice arrangements to ensure they are effective for tax purposes and documented;
- Consideration of potential NMW impacts for salary sacrifice alongside the interaction with any other salary sacrifice arrangements such as pension, cars, cycle to work etc;
- Employee communications for those who are considering entering the proposed scheme to ensure they can make informed decisions;
- We would also recommend further consultation with the commercial provider around the points raised earlier within our analysis of the technical position to ensure that all areas are addressed, and ongoing monitoring is applied to ensure that the exemption continues to be satisfied.

Next Steps

Once you have had the opportunity to consider the contents of this initial drat report, we would be pleased to arrange a follow-up meeting to discuss any queries alongside how RSM can support ROH in terms of the implementation as outlined previously. As a minimum, we would recommend support or review in terms of the effectiveness of any salary sacrifice from a tax perspective.

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EXAMPLE PAYSLIP – BASIC RATE - PRE–SALARY SACRIFICE

ROH					
PAYMENTS	**HOURS**	**RATE**	**AMOUNT**	**DEDUCTIONS**	**AMOUNT**
Basic pay			3,000.00	TAX	600.00
				NI	360.00
		TOTAL PAY	**3,000.00**	**NET PAY**	**2,040.00**

From the net salary the employee would then have to fund £666.67 per month for nursery fees. Leaving them with £1,373.33.

* Please note in this high-level example we have not factored in any personal allowance and applied the tax/NI at the marginal rates for ease.

EXAMPLE PAYSLIP – BASIC RATE - POST SALARY SACRIFICE

"Pre-exchange Salary" is a record of pay before the salary sacrifice adjustment. This is kept for all pay related benefits (i.e. bonus/overtime payments)

Lower employee tax and NIC

ROH

PAYMENTS	HOURS	RATE	AMOUNT	DEDUCTIONS	AMOUNT
Pre-exchange Salary			3,000.00	TAX	466.66
Salary Sacrifice			666.67	NI	279.99
				TOTAL DEDUCTIONS	746.65
		TOTAL PAY	**2,333.33**	**NET PAY**	**1,586.68**

Gross contractual pay is reduced by the nursery fees. ROH will instead pay this as part of the arrangement. ROH only pay Employers NIC on the reduced amount.

Take-home pay is lower but already has nursery costs paid so overall net the employee has saved.

Net employee (less childcare) saving = £213.35 per month – ROH Saving = £92.01 per month

EXAMPLE PAYSLIP – HIGHER RATE - PRE–SALARY SACRIFICE

ROH					
PAYMENTS	**HOURS**	**RATE**	**AMOUNT**	**DEDUCTIONS**	**AMOUNT**
Basic pay			6,000.00	TAX	2,400.00
				NI	120.00
		TOTAL PAY	**6,000.00**	**NET PAY**	**3,480.00**

From the net salary the employee would then have to fund £666.67 per month for nursery fees. Leaving them with £2,813.33.

* Please note in this high-level example we have not factored in any personal allowance and applied the tax/NI at the marginal rates for ease.

EXAMPLE PAYSLIP – HIGHER RATE - POST SALARY SACRIFICE

"Pre-exchange Salary" is a record of pay before the salary sacrifice adjustment. This is kept for all pay related benefits (i.e. bonus/overtime payments)

Lower employee tax and NIC

ROH

PAYMENTS	HOURS	RATE	AMOUNT	DEDUCTIONS	AMOUNT
Pre-exchange Salary			6,000.00	TAX	2,133.33
Salary Sacrifice			666.67	NI	106.66
				TOTAL DEDUCTIONS	2,239.99
		TOTAL PAY	**5,333.33**	**NET PAY**	**3,093.34**

Gross contractual pay is reduced by the nursery fees. ROH will instead pay this as part of the arrangement. ROH only pay Employers NIC on the reduced amount.

Take-home pay is lower but already has nursery costs paid so overall net the employee has saved.

Net employee (less childcare) saving = £280.01 per month – ROH Saving = £93.00 per month

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Recruitment and Retention Action Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Sharon Malhi, Chief People Officer**
AUTHOR:	**Matt Dingle, Head of HR**
DATE OF MEETING:	**1 November 2023**

EXECUTIVE SUMMARY:

This paper aims to provide the Trust Board with assurance in relation to the Trusts improvement in performance in relation to recruitment and retention.

The Trust Board and the Staff Experience and OD Committee have previously been sighted and appraised of the Trusts Recruitment and Retention action plan which was devised as a response to high levels of turnover within the Trust.

The paper will also highlight the final outstanding actions of the Recruitment and Retention action plan and provide next steps.

REPORT RECOMMENDATION:

The Board is asked to note and accept the report.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		

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

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

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

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

Workforce performance metrics.

PREVIOUS CONSIDERATION:

September 2023

The Royal Orthopaedic Hospital NHS Foundation Trust

Recruitment and Retention Action Plan

1. Introduction

This paper aims to provide the Trust Board with assurance in relation to the Trusts improvement in performance in relation to recruitment and retention.

The Trust Board and the Staff Experience and OD Committee have previously been sighted and appraised of the Trusts Recruitment and Retention action plan which was devised as a response to high levels of turnover within the Trust.

The paper will also highlight the final outstanding actions of the Recruitment and Retention action plan and provide next steps.

2. Background information

Turnover in the organisation has been a concern due to high percentages of adjusted turnover, beyond Trust target of 11.5%, reaching it's highest point of 15.88% over a rolling 12 months in December 2022.

Many areas have their own informal action plans around supporting and retaining staff.

The HR team established a retention workstream to understand how the HR function could support retention in the organisation. An action plan was created in May 2023 with the aim of positively addressing areas where improvements could be made which would have a positive impact recruitment and retention.

3. Recruitment and Retention Action Plan

There were 40 key action points and areas of focus, each with varying degrees of complexity and effort required to improve. Out of the 40, 33 are completed although it is recognised that continuous action is required for some areas of priority. An update is included below for outstanding actions.

4. Positive assurances

On the following pages, analysis will indicate an improvement in Trust performance as follows:

Performance area	Change
Turnover (adjusted)	Month on month improvement since Jan 23
Establishment	Increased by over 100 staff in one year
% WTE employed as % of establishment	1.6% improvement in September 23
Time to clear	Improved to be within 30 day KPI

Next steps

The following next steps are proposed:

1. We will continue to monitor and report on this data and stay close to narrative around why staff are leaving, taking necessary action as matters arise.
2. We will be focussing on finalising the remaining actions of the action plan and ensuring actions taken have a meaningful impact.

3. We will take a key focus on retirement and leavers processes as priority. For example:

- Anything we can do to ensure staff return when they retire will be a positive in attaining experienced staff. Pensions are providing information around Flexible Retirements in the coming months and a retirement intranet page will be devised to provide as much information as possible and to accompany a retirement policy.
- A framework for encouraging staff to approach management when they are thinking of leaving or need a new challenge would likely have a positive impact on retention.

4. We will work to ensure sustainability and measure that interventions are having an impact from top to bottom of the organisation.

Matt Dingle – Head of HR
26 October 2023

Remaining Actions of the Recruitment and Retention Action Plan

Action	Lead	Progress	Proposal/Due By
Improve the exit feedback process	MD	An evaluation of our current exit process was tabled for SE&OD Committee on 24/10	To be concluded by Q4 2023.
Overarching approach about managing the entire employee lifecycle	MD	None – although work on different areas of the lifecycle have occurred	In light of other work identified as priority, this task should be abandoned for now and potentially recommenced in future.
Digitalisation of personal files that are currently held in paper format	MD	Sharepoint is live but no action around digitalisation of files has occurred	There is a substantial cost and resource implication associated with this project. It is proposed that we review this in the new financial year.
Reviewed and updated PDR/Appraisal processes and associated toolkit	CM	A new concept has been drafted and engagement is being sought	This will be concluded in November 23
Deliver a revised Staff Engagement Strategy	CM	This will be transferred to Becky Crowther and requires collaboration with key stakeholders	Completion by April 2024
Review and refresh values behaviours framework to be incorporated in all ROH work and enhance a sense of belonging	CM	This will be reviewed in line with work associated with performance management.	Completion by April 2024
Review and adjust KPI's to suit business need for various forums	MD/CM	We have recruitment KPI’s but more work is needed on reviewing all KPI’s. A change in KPI’s will also need a	Completion by April 2024

Turnover Data

How Turnover is measured:

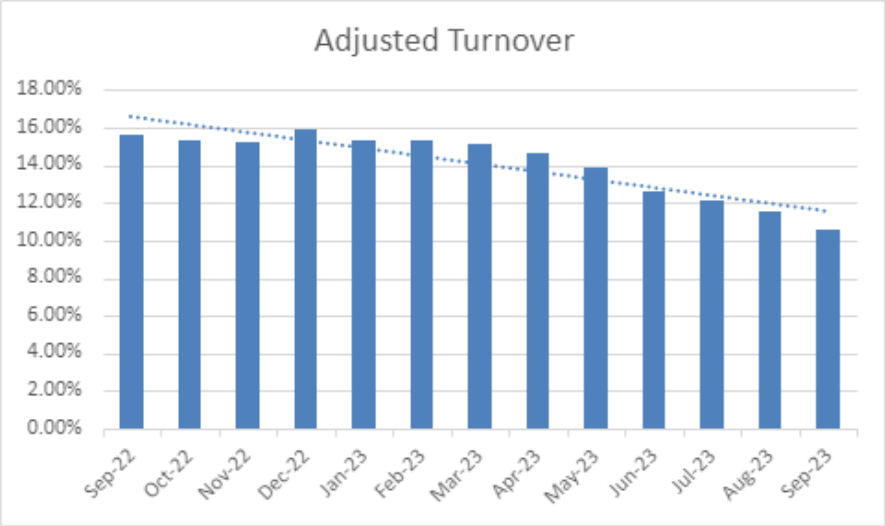
There are two main ways of approaching how we measure turnover:

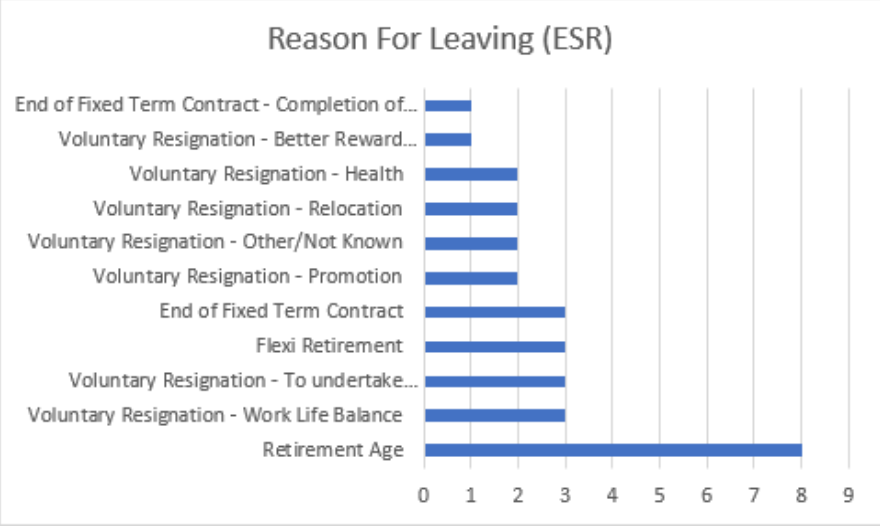
1. **Unadjusted turnover** – a measure of all leavers in the organisation.
2. **Adjusted turnover** – a measure of all leavers in the organisation minus junior doctor rotation, dismissals and endings of fixed term contracts.

Adjusted turnover is traditionally used as a measure of how the Trust performs in retaining staff. Both are measured over a rolling 12 months. The data is captured from Electronic System Records (ESR).

A report has been taken to SE&OD showing how turnover will be monitored going forwards.

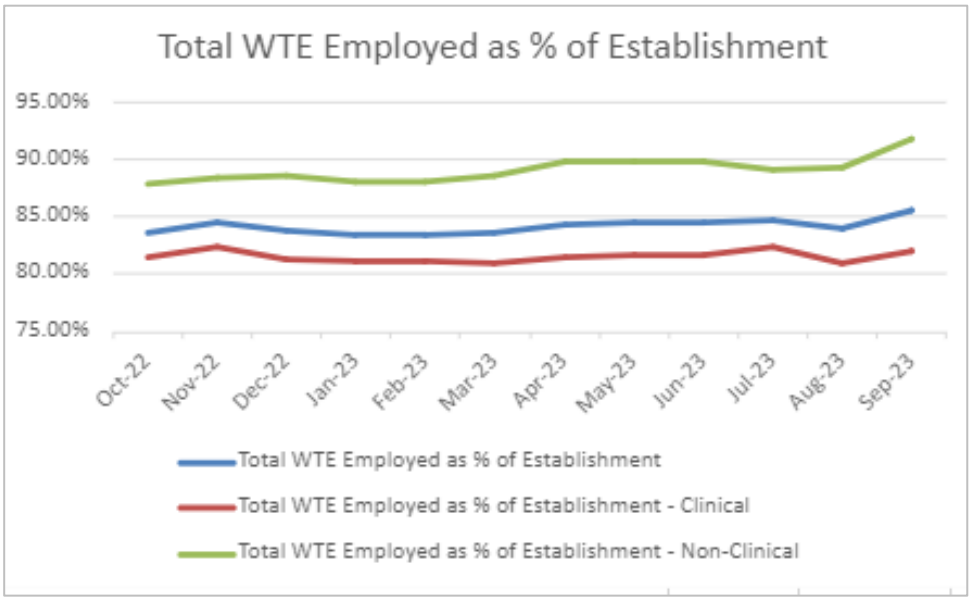
Month	Percentage	Change
Sep-23	10.56%	-0.98%
Aug-23	11.54%	-0.58%
Jul-23	12.12%	-0.45%
Jun-23	12.57%	-1.33%
May-23	13.90%	-0.74%
Apr-23	14.64%	-0.50%
Mar-23	15.14%	-0.15%
Feb-23	15.29%	-0.06%
Jan-23	15.35%	-0.53%
Dec-22	15.88%	0.63%
Nov-22	15.25%	-0.12%
Oct-22	15.37%	



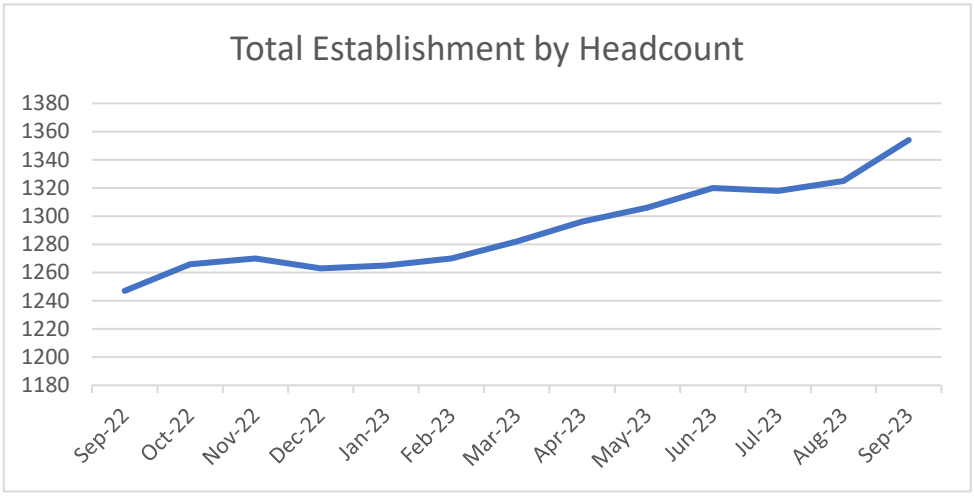


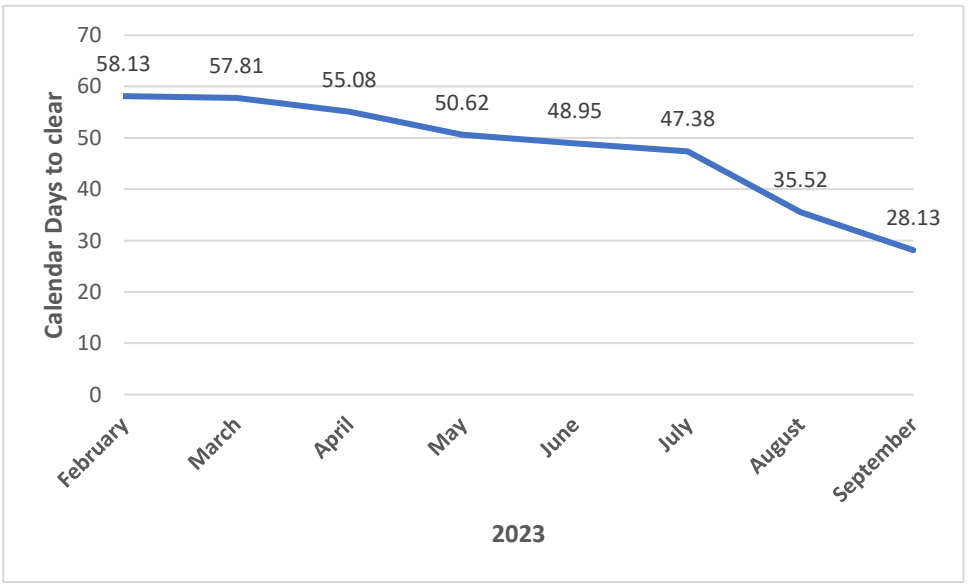
Recruitment/vacancy data

Month	Percentage	Change
Sep-23	85.59%	1.60%
Aug-23	83.99%	-0.82%
Jul-23	84.81%	0.31%
Jun-23	84.50%	0.00%
May-23	84.50%	0.07%
Apr-23	84.43%	0.75%
Mar-23	83.68%	0.12%
Feb-23	83.56%	0.00%
Jan-23	83.56%	-0.32%
Dec-22	83.89%	



Month	Headcount
Sep-22	1247
Oct-22	1266
Nov-22	1270
Dec-22	1263
Jan-23	1265
Feb-23	1270
Mar-23	1282
Apr-23	1296
ay-23	1306
Jun-23	1320
Jul-23	1318
Aug-23	1325
Sep-23	1354





Recruitment and Retention Action Plan

Workstream / Action	Lead
Data Intelligence / Gathering	
Design a consistent Retention & Recruitment Report using ESR data for assurance purposes	TH
Provide new, informative data on turnover, including adjusted turnover and	MD / TH
Continue staff feedback events on a regular basis	MD/CM/JS
Improve the exit feedback process	MD/DM
Maximising Performance	
Overarching approach about managing the entire employee lifecycle	MD
Reviewed and updated PDR/appraisal process and associated toolkit	CM
Review all recruitment materials with a view to improving the attraction rate and clarifying the nature / location / benefits the ROH has to offer	MD
Develop, launch and implement the ROH Wellbeing strategy as defined in the Maximising performance work to include engagement plan	LTH CM
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
Career development tool is well embedded	DR CF
Enhance opportunities for apprenticeship programmes	DR CF
Recruitment Improvement Plan / Retention Steering Group	
Full set of documents that outline processes relating to medical recruitment	MD/DM
Candidate survey to evaluate the experience of candidates using TRAC	MD/DM
Improved time to hire and the experience of staff at pre-employment stage	MD/DM
Improve the processes of staff on bank contracts but would prefer substantive employment	MD/DM
Review of recruitment practices from an inclusivity perspective	JS/DM
Increase in staff disability declaration rates	DM / CM
Close vacancy gap for HCSW's	MD/DM
Streamlining of all recruitment practices including international nursing	MD/DM
Evaluate effectiveness of recruitment days/events	MD/DM
Benefits booklet to inform staff what discounts / offers and employment related benefits are available to them	DM/TM
Promotion / education of retire / return options	DM/HR
Line manager education around supporting staff with flexible working	MD/HR
Digitisation	
Digitisation of personal files that are currently held in paper format	TH
Introduction of KPIs	
Review and adjust KPI's to suit business need for various forums	TH/MD/CM

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
Continue working with ICS Talent Development group to identify best practice and work with Talent diagnostic tool. To include work on career conversations and succession planning	CM
Continue work with ICS colleagues on Inclusion and OD groups to identify best practice	CM SM
Continue work with ICS colleagues on staff engagement and Wellbeing groups to access best practice and ICS funded initiative available to ROH	LYH CM
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
Employee engagement	
Good levels of TED implementation to enable teams to discuss and feedback on positives and improvements	JS
Good attendance and actions completed for monthly 'Be Involved' staff engagement sessions	JS LTH
Feedback from initial retention listening sessions shared with colleagues including actions completed	TH
Review and refresh values behaviours framework to be incorporated in all ROH work and enhance sense of belonging	CM JS SJ
Deliver training for managers to enable them to support team members through TED and Me as Manager	JS
Deliver a revised Staff Engagement Strategy	SM CM
Staff network meeting to discuss current topics and potential actions to improve engagement	JS Network chairs
Awareness days organised by staff networks and other professional groups including Wellbeing Awareness Days	CM
Focus group for staff survey results to engage with staff an understand key priorities for action planning	JS LTH SM
New programme of Schwartz Round dates to cover key areas of interest from staff members	CM AMcG

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Equality and Diversity Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Sharon Malhi, Chief People Officer**
AUTHOR:	**Clare Mair, Head of OD and Inclusion**
DATE OF MEETING:	**1st November 2023**

EXECUTIVE SUMMARY:

As part of the Public Sector Equality Duty (PSED), there is a requirement for every public organisation to achieve the following objectives:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

As part of these objectives, the Trust is required, and has published a report on the ROH website with key EDI information on staff and patient data for 2022/23. This report is attached and also includes:

- An overview of the ROH Inclusion strategy (which is currently being reviewed for 2024)
- Information on progress made in the Inclusion agenda for 2022/2023
- Key project undertaken by teams and networks across the Trust
- Information on key partners who provide support and assessment frameworks to help advance Equality, Diversity and Inclusion work at the Trust
- Workforce Race Equality Standard (WRES) metrics for 2022
- Workforce Disability Equality Standard (WDES) metrics for 2022

Positive assurance

- The report highlights key progress made in 2022/23 linked to the ROH Inclusion strategy.
- Colleagues from across the Trust have been involved in compiling this report.

Gaps in assurance

- Ensuring the information is accessed by colleagues at the Trust in an informative way, alongside the ROH Inclusion strategy.

Next steps

Future reports will incorporate the EDI Improvement plan that was launched in June 2023

REPORT RECOMMENDATION:

The Board is asked to receive and accept the report which will be published on the Trust's internet site.

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		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:
People Plan ROH Inclusion strategy
PREVIOUS CONSIDERATION:
Staff Experience & OD Committee on 25 October 2023

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Report update

Equality & Diversity Report 2022/ 23

Royal Orthopaedic Hospital

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

Contents

Summary

This Equality and Diversity (E&D) report gives an overview of key information and achievements in line with the ROH Inclusion strategy and Inclusion action plan for 2022/2023.

There is a requirement for every NHS organisation to compile and publish information linked to Equality and Diversity for colleagues and patients in the form of an annual report. This document will be published on the ROH website alongside other equality, diversity and inclusion documents.

In 2022/23 key areas to note are:

- Significant progress has been made to hear colleague voice through the development of the staff networks particularly for the Multi Minority Ethnic Group (MMEG) network and the BeMyself LGBTQ+ group. The Mankind network was also formed in this year and listening session started to hear from female staff. The networks chairs work together to promoting diversity and inclusion in a number of ways across the Trust

- The Freedom to Speak up (FTSU) Guardian has continued to recruit and develop a network of FTSU champions to help embed a culture of openness and speaking up. This work is reported back to the National Guardian's office – Freedom to Speak up

- The AccessAble project was implemented at the Trust which allows colleagues, patients and visitors with both visible and hidden disabilities to review up to date useful information for the hospital site e.g. ramps, sound levels in restaurants and changing facilities

- Highlighted in NHS Workforce Race Equality Standard (WRES) annual report 2022. Progress on reducing bullying and harassment. Placed in the top 10 for improvement across NHS organisations and for sustained improvement since 2018.

- The Trust has continued to be recognised for the progress on their Inclusion journey with a ranking of 7 in the Inclusive Companies Top 50 UK Employers in the UK 2021.

- Disability Confident Employer accreditation with the Trust now supporting other organisations on the Disability Confident journey
-
- The NHS Staff Survey results 2022 highlighted that the Trust has maintained a positive score in the engagement score which concentrates on 'how it feels to work at the ROH'.
-
- CEO (Chief Executive Officer) presented Menopause work at Institute of Government and Public Policy (IGPP) 2022 national conference

- Chief People Officer is the Senior Responsible Officer (SRO) for EDI (Equality, Diversity and Inclusion) and Talent across the NHS region, and also chairs the regional BAME (Black, Asian and Minority Ethnic) Network

Work must continue to promote equal opportunities for all staff members. The workforce data in this report highlights the difference in representation across our diverse groups. The Trust is aware from colleague feedback that diversity in some areas is impacting the experience of individuals at the Trust. With support from the staff networks and colleague listening sessions, the Trust will continue to implement OD (Organization Development) and Inclusion programmes to close these inequality gaps.

Glossary

- Access Information Standard (AIS)
- Black, Asian and Minority Ethnic (BAME)
- Black & Minority Ethnic (BME)Birmingham Race Action Partnership (BRAP)
- British Medical Association (BMA)
- Care Quality Commission (CQC)
- Chartered Institute of Personnel and Development (CIPD)
- Clinical Commissioning Groups (CCG)
- Equality Delivery System (EDS)
- Equality & Diversity (E&D)
- Enabling a Productive & Inclusive Culture (EPIC)
- Learning Disability (LD)
- Lesbian, Gay, Bisexual, Transgender & Queer (LGBTQ+)
- Managed Service Provider (MSP)
- Multi Minority Ethnic Group (MMEG)
- National Staff survey (NSS)
- NHS Employers/Improvement (NHS/I)
- Royal Orthopaedic Hospital (ROH)
- Staff Experience & Organisational Development (SE&OD)
- Sustainability and Transformation Partnership (STP)
- Very Senior Manager (VSM)
- Workforce Disability Equality Standard (WDES)
- Workforce Race Equality Standard (WRES)

Links

- AccessAble https://www.accessable.co.uk/
- British Medical Association (BMA) https://www.bma.org.uk/
- Chartered Institute of Personnel and Development https://www.cipd.co.uk/#gref
- Disability Confident Employer https://disabilityconfident.campaign.gov.uk/
- Diverse Inclusive Together https://www.nhsemployers.org/EDI
- Inclusive Companies https://www.inclusivecompanies.co.uk/
- The Point of Care Foundation https://www.pointofcarefoundation.org.uk/
- Royal College of Nursing https://www.rcn.org.uk/
- Schwartz Rounds https://www.pointofcarefoundation.org.uk/our-programmes/schwartz-rounds/
- Stonewall https://www.stonewall.org.uk/
- Unison https://join.unison.org.uk/

Equality and Diversity at the Royal Orthopaedic Hospital

Strategy

The Trust

The Trust has been at the forefront of orthopaedic care, pioneering new surgical techniques and advancing treatment for people with bone and joint disorders from across the world. That heritage of innovation and excellence still drives the Trust today as boundaries continue to be pushed to deliver the best care possible.

Introduction on Equality and Diversity at ROH

Led by the Trust Board, the Royal Orthopaedic Hospital (ROH) is committed to ensuring equality, diversity and human rights are central to the way healthcare services are delivered to our patients and how we support our staff. We recognise the right of all our patients, visitors, and employees to be treated fairly and considerably irrespective of age, gender, marital status, religious belief, ethnic background, nationality, sexual orientation, disability, and social status.

We are committed to promoting equality and diversity in everything we do; we strive for the Trust to be a safe place where people can be their true and authentic selves.

We make every effort to ensure staff and patients are treated in an inclusive way by encouraging everyone to role model the values, create equal opportunities, treat people fairly and develop good working relationships at the ROH. The Trust works to ensure that patients, staff and other stakeholders have a voice to put forward suggestions, concerns and ideas. There is a dedicated team to co-ordinate and drive the Inclusion Strategy, agenda and action plan across the Trust. There is also a Patient Liaison team to support any patients who has concerns.

The Trust aims for a zero-tolerance approach to all forms of harassment including sexual and racial harassment and will take all complaints of this nature extremely seriously.

The General Equality Duty

The Trust is required to work to Section 149(1) of the Equality Act 2010 as part of the various requirements on NHS organisations when exercising their functions. The general duty requires NHS organisations to have due regard to:

- Eliminate discrimination, harassment and victimisation and other conduct prohibited under the Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Summary

The Royal Orthopaedic Hospital NHS Foundation Trust is one of the largest specialist orthopaedic units in Europe, with approximately 1200 permanent employees. We offer planned orthopaedic surgery to people locally, nationally, and internationally. The Trust has a 200-year history and a strong culture of tradition and loyalty. The aim at the Royal Orthopaedic Hospital (ROH) is to offer an inclusive and fair patient service and employment which meet the diverse and personal needs of our patients, staff, and visitors.

This report reviews relevant diversity and equality data for patients and staff highlighting key areas of interest. Additional information in the report includes staff survey data, the Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES).

The Trust works to the EDS 2 system, as recommended by commissioners to ensure all areas of the Trust are evaluated for effectiveness of an equality and diversity. Consultation with key stakeholders continues to enable the Inclusion actions to be reviewed and updated on an ongoing basis providing assurance the Board and stakeholders. All the actions are aligned to the Trust Inclusion Strategy and ROH Inclusion action plan

Our Inclusion Vision and Values

Our values

Our values are more than words, they define how we treat one another and how we deliver care. Positive values are the bedrock of our culture. Our values inform how we understand and practice inclusion at ROH.

- ***Respect*** *and listen to everyone*
- *Have* ***compassion*** *for all*
- *Work together and deliver* ***excellence***
- *Have* ***pride*** *in and contribute fully to patient care*
- *Be* ***open****, honest and challenge ourselves to deliver the best*
- *Learn,* ***innovate****, and improve to continually develop orthopaedic care*

Inclusion Strategy

The ROH Inclusion strategy was refreshed and launched in 2021 during the pandemic to support the increased focus required to support staff to provide the best patient care. This strategy is due to be reviewed and refreshed at the end of 2023. This will come into effect in 2024 and will be aligned to the ROH People Plan and Trust Strategy.

The key elements of the strategy are the Inclusion Vision, Equality objectives and Six High Impact Areas. There is an ROH Inclusion Action Plan which is aligned to the Inclusion strategy and includes actions from all EDI reporting including Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).

Our Inclusion Vision

Nurturing a connected culture of belonging where our colleagues can bring their authentic selves to work and visitors experience a supportive and inclusive environment, ready to meet their needs.

Equality Objectives

We continue to achieve our ambition to be an inclusive organisation (in line with the NHS People Plan) through a clear set of strategic objectives and an action plan which will work across all areas of the Trust.

Overall, the strategic objectives are to create a truly inclusive environment at the ROH which will continue to improve the patient and colleague experience through:

• **Objective 1:** Tackling and removing all forms of discrimination in order to promote equality for all

• **Objective 2:** Creating an inclusive and healthy ROH culture through Trust values

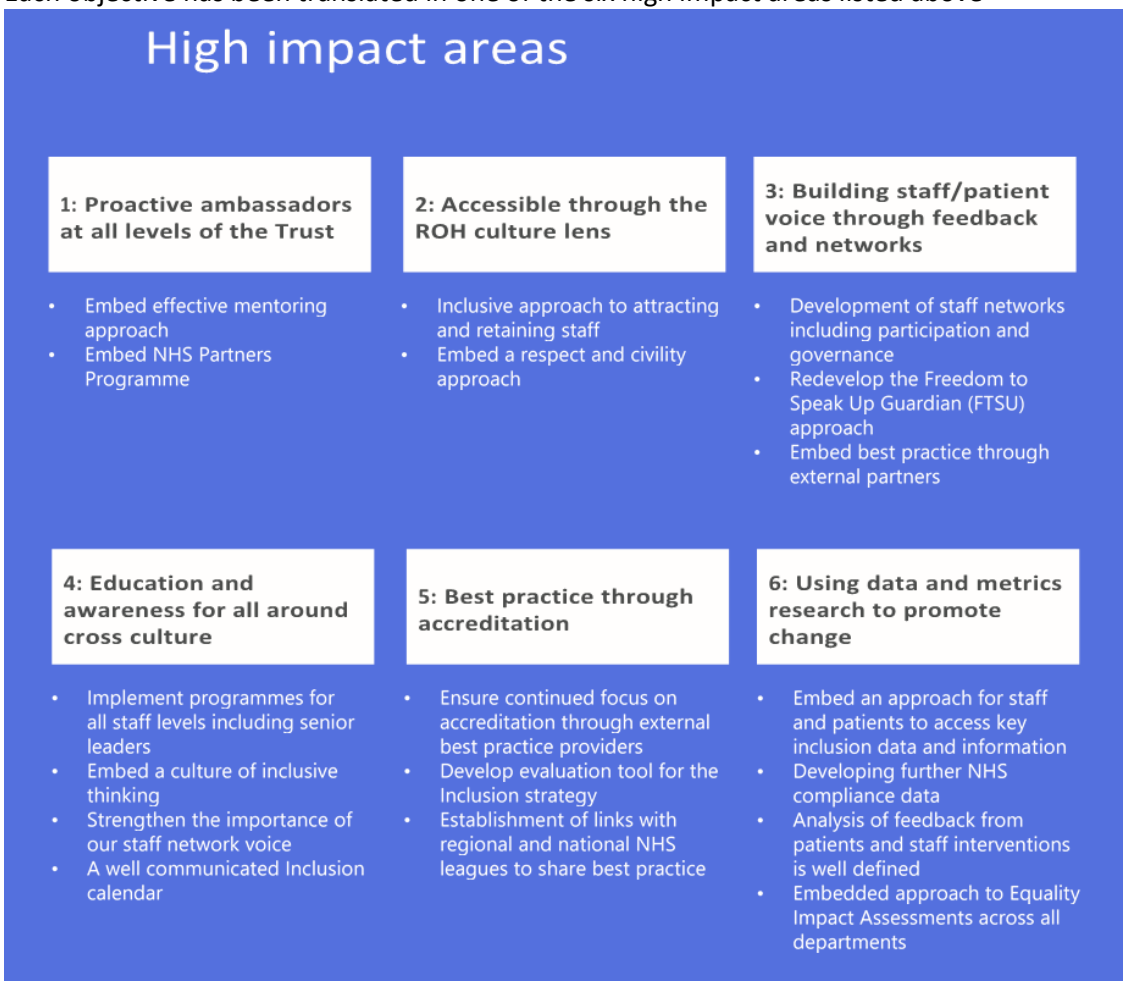
• **Objective 3:** Giving colleagues and patients a voice to speak up and ask for access to opportunities

• **Objective 4:** Ensuring our leaders, managers, and colleagues role model in a compassionate and inclusive way

• **Objective 5**: Being recognised as a Top Inclusive Employer externally through best practice approach to demonstrate continuous improvement

• **Objective 6:** Ensure the Equality and Diversity work plan (Inclusion Action plan) delivers on the required objectives

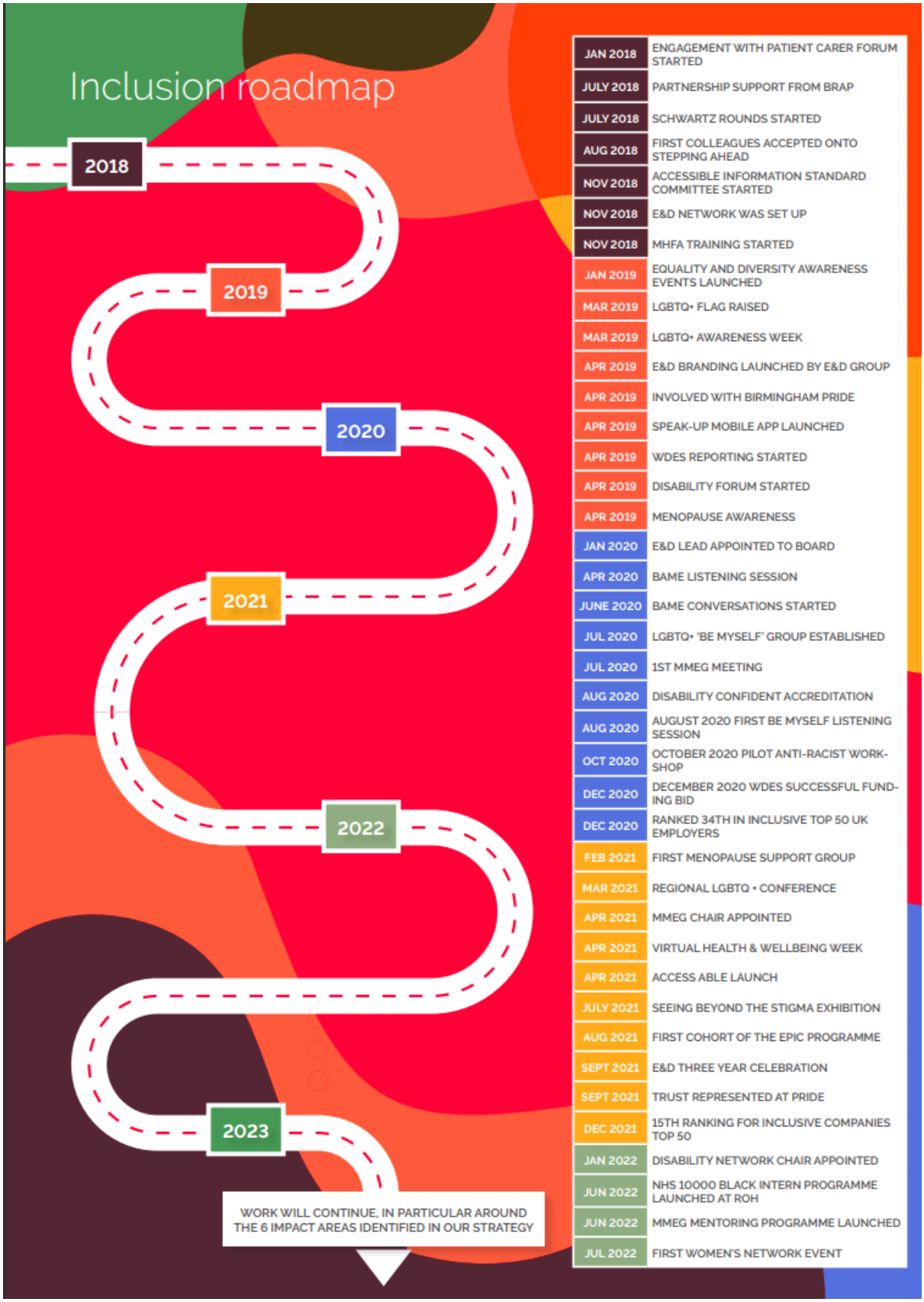
Each objective has been translated in one of the six high impact areas listed above



Key Highlights in 2022 / 2023

- Continued progress with Inclusion Action plan with all updates reported to Trust Board
- Completed first Stonewall Workplace Equality Index application
- Second cohort of Enabling Productive Inclusive Culture (EPIC) workshop was completed for colleagues across different disciplines
- "Seeing Beyond the Stigma" Exhibition has been extended to allow staff and patients to understand the stories of colleagues with hidden and visible disabilities
- Ranked number 7 in the Inclusive Top 50 UK Employers in the UK 2021
- Worked with regional NHS team to support Birmingham Pride
- Maintained Level 3 Disability Confident Employer accreditation
- Continued work following the Bronze accreditation from the Thrive at Work Workplace Wellbeing programme – next steps are to achieve Silver
- Research project started with Canterbury Christ Church University
- MMEG mentoring programme delivered
- Co production with colleagues on ways to support staff and the community during the Cost of Living crisis
- Session with senior female leaders to highlight the need to support diversity into senior roles
- Improvement in the declaration rate for staff with a disability through joint work with the ABLE network and the ESR (Electronic Staff Record) team
- Trust participated in the 10000 Black Intern programme with an intern undertaking a placement in a number of areas at the Trust
- The recruitment team participated in a number of recruitment fairs in the community to promote opportunities for everyone
- Oliver McGowan training introduced as mandatory to educate; designed with help from people with learning disabilities and autism

ROH Inclusion Road Map



Key Ambassadors

To deliver the Inclusion strategy, it is important that the Trust supports and promotes the involvement of ambassador groups at different levels. These groups include involvement from staff, senior leaders, unions, staff networks, Foundation Trust members and patients. More information about these networks is shared below:

Staff involvement

All staff are given the opportunity to learn more about the importance of equality, diversity, and inclusion. This is done through mandatory training, learning opportunities and regular feedback sessions to capture staff thoughts. Sessions are run across the Trust and also in specific departments. Future interventions will continue to balance the advantages of using online medium and classroom formats.

Senior Leaders

Our Executive Directors and Non-Executive Directors (NEDs) are very involved in the Inclusion work undertaken at the Trust with Richard Phillips being appointed as E&D Lead in January 2020. Through Trust Board meeting and sub board committees, members are given updates on progress and future plans. In addition, Trust Board members from the sub board committee of Staff Experience and Organisational Development (SE&OD) are active participants in interventions including Inclusion sessions, listening sessions and network meetings. In addition, members of our SE&OD Board members regularly meet with departments during 'staff walk-abouts'.

ROH Networks – Staff Voice

At the ROH, we are hoping in the future to have full engagement from our colleagues on a number of initiatives, programmes and networks that help to promote the importance equality and diversity for staff, to enhance the experience for patients and visitors. The Trust will continue to work towards the ROH Inclusion approach supporting our work in delivering continuous improvement and working in partnership with local and national stakeholders.

The Trust has a growing number of networks run by colleagues to promote the voice of our diverse staff groups. The Trust recognises the strength of supporting our network groups. Equality and Diversity was the first network formed in November 2018, with the remit of raising awareness and promoting Inclusion across the Trust. Following on from the success of the E&D Network, other diverse networks have formed, as shown below. These networks have their own identity and focus and are aligned to the overall Inclusion plan. The ambition is for the diversity of staff voices to be increased over the coming years as either standalone networks, or as part of the Equality and Diversity Network. The following networks have clear Terms of Reference with the overarching aims to provide support, awareness, education, and positive action. All the networks are supported by our Executive Team. We are looking to expand our networks in the future.

Equality & Diversity Network (E&D Network)

The Equality & Diversity Network was set up in 2018, to create the opportunity for employees to discuss matters surrounding diversity, inclusion and to raise awareness within the Trust. The network has gone on to hold numerous awareness sessions surrounding diverse topics and have drawn together a wide range of information about all aspects of equality, diversity, inclusion, and human rights.
Chair: Claudette Jones

Multi Minority Ethnic Group (MMEG)

The Multi Minority Ethnic Group (MMEG) was set up in summer 2020 following a series of listening sessions with colleagues at the Trust during the rise of the Black Lives Matter movement. The group provides a space for colleagues to talk about issues important to staff from ethnic minority backgrounds with an aim of creating positive change. Any member of ROH staff, including allies, are welcome to attend meetings and get involved. Activity for the group during 2022/2023 included Trust wide celebratory and educational activity for Black History Month as well commencing work in setting up the MMEG Mentoring Programme which is due to launch during 22/2023. The group was also instrumental in supporting the facilitation of a CQC focus group for colleagues from ethnic minority backgrounds – agreeing actions following the session and incorporating them into the Trust wide inclusion agenda and action plan.
Chair: Falon Paris-Caines

Disability Network

The Disability Network was set up in April 2019. Their purpose is to promote and celebrate the diversity of our Disabled staff, patients, and allies. A key element of the network is to engage and educate staff around the different disabilities that our colleagues live with, including those who may have invisible disabilities, such as mental health conditions, or long-term conditions following on from an illness.
Chair: Alex Gilder

LGBTQ+ Network (BeMyself)

BeMyself, The Trust's LGBTQIA+ Network, is an inclusive and open group of colleagues. The group was set up in 2020 to provide a safe space for members of staff to come together and celebrate diversity and inclusion, and to discuss any concerns they may have surrounding the representation of LGBTQIA+ staff in the Trust. They welcome allies and celebrate the diversity of the group. Listening sessions are set up by a member of the group, to provide a safe environment for staff to discuss their issues and concerns, or if they are just looking for other staff members to talk to.
Representative: Group Led

Menopause Support Network

In July 2020, a Menopause Support Group was set up; the group offers peer to peer support and has been a great opportunity for colleagues to be open and discuss how they are feeling and also share any support. The network continues to offer guidance, signposting and support for all our colleagues around the menopause.
Chair: Group Led

Mankind Support Group In February 2023 the ManKind support group was set up to help support men's health and wellbeing initiatives, encourage awareness raising and support the male staff community here at the Royal Orthopaedic Hospital. The network continues to offer guidance, signposting and support for all our colleagues around the menopause.
Chair: Gavin Newman

Women's Network

This group is in the early stages of creating a network. There have already been positive discussions at the initial meetings including women's health and career in the NHS for senior female leaders.
Chair: (Stand in chair at present) - Clare Mair

Safe spaces

With support from the Tom's Fund, the Trust has set up a Wellbeing room in the heart of the hospital. The space is accessible to all network members for wellbeing and supportive conversations.

Key Projects

Schwartz Rounds

Schwartz Rounds are group reflective practice forums giving staff from all disciplines an opportunity to reflect on the emotional and social aspects of working in healthcare.

Enabling a Productive & Inclusive Culture (EPIC) Programme

The Enabling a Productive & Inclusive Culture (EPIC) Leadership Programmes approach is to drive enabling and establishing improved inclusive culture within the Royal Orthopaedic Hospital Trust (ROH).

The EPIC programme provides participants with practical resources to apply in their working environments to enable an inclusive culture to flourish. It is open to everyone. It is inclusive at its core. The EPIC programme influences participants to become inclusive leaders through exploration

of the following: exploring inclusive thinking and how it improves performance and culture, inclusive conversations, inclusive talent, and inclusive improvement.

Learners gain a deeper understanding of themselves, their impact on others, tools to engage individuals and teams through a coaching approach, how to give effective feedback, how to identify and nurture individuals, tools to develop succession plans and techniques to support improvement and change plus much more.

The programme is made up of 6 modules attended over a period of 6 months focussing on key elements each day to become an inclusive leader within the workplace.

The modules are:

- **Values Discovery** (*Gain a deeper understanding of your values, the impact they have on your decision, making relationships and goal achievement)*
- **Inclusion & Unconscious Bias** (*Identifying that the concept of inclusion is not a tick box exercise and requires a different mind-set, thinking skills and new perspectives)*
- **Inclusive Conversations** (*Identifying practical coaching practices, what coaching is and when a coaching style is appropriate. Additionally, looking at foundation skills such as Active Listening, Building Rapport & Questioning)*
- **Inclusive Talent** (*Understand what is talent and talent management)*
- **Inclusive Improvement** (*Underpinning knowledge, resources and support to make you think, plan and do things differently. Additionally, look at the fundamentals required to enable and support innovation)*
- **Inclusive Leadership, Going Beyond the Conversation & Next Steps** (*Focussing on inclusive leadership behaviours, including a Synopsis Quiz and your next steps for Organisational Impact)*

All learners are required to attend all the modules and work on a project. There are also opportunities for buddying up with peers on the programme, becoming a member of our proactive Inclusion network of colleagues and be part of influencing the future design of new ROH services and models for an improved inclusive culture.

MMEG Mentoring Programme

This bespoke course was designed to inspire mentees from ethnic minority backgrounds to develop their careers positively in a working environment where they may be under-represented or disadvantaged. The course aimed to equipped mentors to be intentional about supporting inclusive talent management, succession planning and retention at the ROH. Addressing unconscious bias and championing the huge productive benefits of diverse talent.

Seeing Beyond the Stigma Exhibition

A powerful and remarkable exhibition that shares the stories of members of staff and their experience of disability and long-term conditions, both visible and unseen. Eight people from the Royal Orthopaedic Hospital took part in this project to share their experiences to help others see beyond the stigma. https://www.roh.nhs.uk/beyondstigma

TED (Team Engagement Development) OD Development Tool

The Trust has been selected on the pilot programme through Lancashire Teaching Hospital to roll out the TED toolkit. This is a tool which is linked closely to the NHS National staff survey and enables to managers and team to reflective on team working and inclusion in departments. It consists of a support tool for managers, an online survey tool and a suite of development options to run with teams

Apprenticeship programme

The Trust continues to run a comprehensive programme of apprenticeships across the Trust for a number of disciplines including Team Leader and clinical qualifications

Key Meetings

There are several meetings to support the Inclusion work at the Trust. These include
Network meetings
Trust Wellbeing Implementation Group (TWIG)
People & Organisational Development Group (POD Group)

The outcomes of these meetings are reported at the Staff Experience & Organisational Development Committee (SE&OD) for Trust Board members.

National measurements

As a Trust we will continue to work to the regulatory NHS measures required. Each of these is highlighted below with a brief overview. We will also ensure that we look beyond the data and national benchmarking to understand the key actions that are required to have the best impact for Inclusion at the Trust.

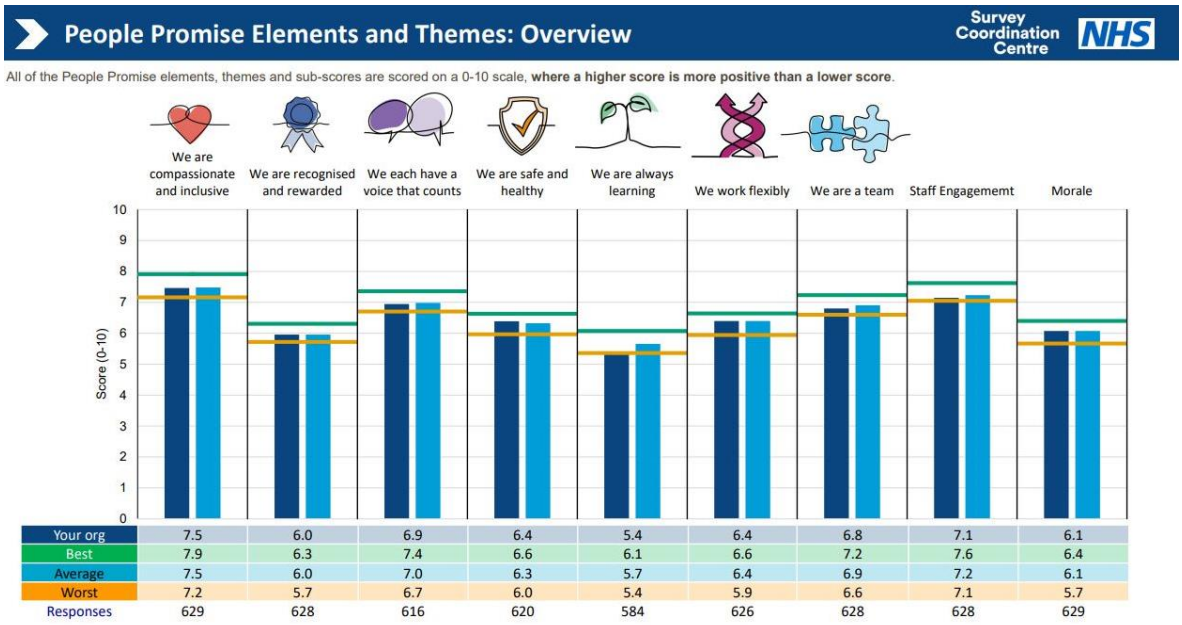
NHS Staff survey results

People Pulse Survey

The People Pulse is a national pulse survey, developed for all NHS provider and commissioner organisations, to support local listening and engagement activities. Results provide a regular national, regional and local view of employee experience and wellbeing. Following the pandemic, the first People pulse (previously called Staff Survey FFT (Friends and Family Test)) was started in January 2022. The questions are based around the nine engagement questions in the National NHS survey. The Trust has seen a steady increase in the three reporting areas of Advocacy, Motivation and Improvement. These results are reported to Trust Board on a quarterly basis.

National NHS staff survey

All Trusts are required to undertake the staff survey which is completed during October and November on an annual basis. Key information can highlight issues and opportunities not just in different departments or directorates but also in diverse groups. There is an annual organisational action plan, as well as directorate plans. The staff survey information is used across the Trust. The completion rate for 2022 was 54% which was a slight decline from the previous year at 57%. The data is valid and gives good representation across the Trust. The table below shows the results for the ROH compared to twelve other Trusts in the Specialist Acute Trust group. In all areas the ROH results are towards the higher end of the results in this Group. The ROH was the highest score in most areas when compared against Trusts in the BSol region. The Trust's score is average or above in all areas except 'We are Learning' at 5.4 and 'Engagement' at 7.1. Work continues to focus on ways to improve these two areas



Workforce Race Equality Standards (WRES)

The Workforce Race Equality Standard (WRES) is to improve the experience of ethnic minority staff in the workplace. This includes employment, promotion and training opportunities. It also applies to people from ethnic minorities whose ambition is to work in the NHS. See separate information in Appendix I.

Workforce Disability Equality Standards (WDES)

The NHS Workforce Disability Equality Standard (WDES) came into force on 1 April 2019. See separate information in Appendix I.

It is a set of specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information is used by the Trust to develop a local action plan and enable them to demonstrate progress against the indicators of disability equality.

Equality data for staff and patients

This information is included annually in this Equality and Diversity annual report which is published on the internet.

Access Information Standard (AIS)

Work continues to further secure the Trust's compliance with the Accessible Information Standard (AIS). The Trust has an up-to-date AIS policy and information in relation to the standard is included in the Trust mandatory training. Part of the work is through AccessAble to carry out a complete survey of the ROH site and provide patients, visitors and staff with internet-based access guides that help all visitors to the ROH site plan their journey, regardless accessibility issues they may or may not have.

Gender Pay Gap Reporting

Gender pay reporting is different to equal pay which deals with the right for men and women to be paid the same when doing the same, or equivalent, work. The gender pay gap shows the difference in average pay of all men and average pay of all women within one organisation. It is therefore possible to have genuine equality of pay but still have a pay gap between genders. As a trust ROH, uses the Agenda for Change job evaluation framework to benchmark appropriate pay bandings to our roles, this in turn provides a process for paying staff equally for the same or equivalent work. Progression through pay steps under the Agenda for Change framework is based on time in post and satisfactory performance irrespective of gender. There has been a positive improvement in this reporting with the latest data (2022) showing there has been a further decrease in the mean pay gap to 33.8% and median pay gap to 22.6%.

The Equality Delivery System (EDS)

The Equality Delivery System 23 (EDS 2) is designed to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. A full explanation of EDS can be found at the weblink below

EDS 2023 Framework

The EDS framework has changed in 2023 including the action plan. This is now split into 3 areas (previously four) which focus under the four following outcomes:

- Patient
- Staff
- Leadership

Delivery of the action plan is achieved by colleagues working across the Trust. An Inclusive culture needs to be everyone's business and there is strong support and guidance from the Trust Board and stakeholders.

Implementation of EDS 2023 at ROH

This is the seventh year that ROH have developed an annual equality and diversity plan (Inclusion action plan) working with the key EDS 2023 criteria. The actions in the EDS2 (Equality Delivery System 2) framework are developed taking into account staff and patient data.

There is now a requirement for Trust to work across the ICS (Integrated Care System) to complete the patient element of the framework. Following discussion with the NHS National Team, in the first year of the new frameworks, Trust can still complete the patient element independently but with 'check and challenge' from regional EDI colleagues. The Trust work with Birmingham Women's and Children's and University Hospitals Birmingham to complete this exercise

Monitoring and reviewing

Monitoring and reviewing of the ROH Inclusion Action plan is a continuous process achieved in conjunction with the EDS 2 action plan in the following ways:

- Sign off and bi annual update at the People Committee

- Sign off and bi annual update at the Staff Experience and OD Committee meeting
- Annual update at operational meetings
- Updates to Executive Directors and Trust Board as requested
- Progress updates to Chief People Officer
- Discussion at staff networks

Outstanding through External partners

The Trust works with a number of external partner organisations which enables ROH to be assessed and accredited against independent standards. It also gives the Trust access to national and international support, advice, networking, and resources.

The Trust has been awarded Level 3 Disability Confident Leader accreditation, a positive increase from our Level 2 accreditation. This means ROH is recognised as being actively committed to attracting, recruiting, and retaining disabled people. There is a paragraph on the NHS Jobs website for our Trust which welcomes applicants with Disabilities "The ROH is an equal opportunities employer. We employ people of difference and are committed to growing an inclusive culture, where difference is celebrated, and people feel able to bring their whole and authentic self to work. We are a Disability Confident Leader and offer a range of inclusive, family friendly and flexible working arrangements and policies, to support our people in the workplace. The Trust is committed to the 'Disability Confident Interview Scheme' and will offer an interview to disabled applicants who meet the minimum criteria for a vacancy and consider them on their abilities".

We have a paragraph on the NHS Jobs website for out Trust which welcomes applicants with Disabilities "Our organisation is disability confident; we are committed to offering equal opportunities for all. We welcome applications from disabled people and value their life experience"

The Inclusive Top 50 UK Employers is a definitive list of UK based organisations that promote inclusion across all protected characteristics, throughout each level of employment within their organisation. The Trust submits an application annually to be assessed for the top 50 ranking. The Trust is currently ranked at No 7

The HSJ Awards continue to be the most esteemed accolade of healthcare service excellence in the UK. The Awards do not only adhere values of sharing best practice, improving patient outcomes, and innovating drivers of better service, but most importantly provide a well-deserved thanks to the sector.

tered Institute of Personnel and Development set professional standards for HR and people development

The Point of Care Foundation helps to deliver their vision by providing evidence and resources to support health and care staff in the valuable work of caring for patients.

Stonewall empowers LGBTQ+ People to be their authentic selves, enabling them to realise and achieve their full potential, and empower LGBTQ+ People and allies to create positive change.

BRAP (Birmingham Race Action Partnership) is a charity transforming the way we think and do equality.

Mental Health First Aiders have the skills they need to support their own and others' wellbeing.

Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical come together regularly to discuss emotional and social aspects of working in healthcare.

Thrive at Work Thrive at Work is a workplace commitment from West Midlands Combined Authority with criteria and guidelines on creating a workplace that promotes employee health and wellbeing. There are four accreditation levels for Thrive at Work, Foundation, Bronze, Silver and Gold, each have commitment themes. The themes are Enablers of Health, Mental Health, Musculoskeletal Health, Lifestyles and External Risks to Health which we use alongside ROH's five ways to wellbeing Connect, Be Active, Mindfulness, Give and Keep Learning. Using this framework, promoting and reinforcing wellbeing will help with a happier, more productive and healthier workforce.

Union Partnerships

The Royal College of Nursing represent nurses, midwives, student nurses, and health care assistants, assistant practitioners, nursing degree apprentices and trainee nursing associates across the UK.

UNISON represents and acts for members working in a range of public sector services and utilities.

The BMA is the trade union and professional body for doctors in UK.

Links to other ROH Strategies

The Inclusion strategy does not sit independently and is linked most importantly to the following strategies:

- The ROH five-year strategy for excellence
- The ROH Clinical Strategy
- The Education and Training strategy
- The Patient Engagement strategy

Integrated Care System (ICS) partners

The Trust works collaboratively with ICS partners to develop the Equality, Diversity and Inclusion work across all local Trusts.

ROH staff also have access to numerous EDI development opportunities from system work including network, mentoring, coaching and learning programmes.

Learning Disabilities support

The work of the Learning Disability (LD) nurse is well embedded. The Learning Disability Strategy has launched, and a suite of training sessions are available on the subjects of Learning Disabilities, Dementia and Mental Health. The LD nurse is available to offer support and advice.

Recruitment and Selection

The Trust implements Value Based Recruitment (VBR) with standard documentation and interview panels consisting of at least one VBR trained interview panellist. Training courses will continue to be provided once 'trac' is introduced to further upskill interviewers to recruit fairly as well as recognising the nine protected characteristics.

Following feedback from the staff survey around opportunities as well as equality data for recruitment, the Trust will concentrate on creating a stronger employer brand, improve attraction from all sectors of society to ensure the workforce accurately reflects the community the Trust serves, and implementing best practice for a fair and equitable recruitment and selection approach.

Bullying and Harassment

There is union representation at the Trust for staff and a good working relationship between HR (Human Resources) and Staff Side.

The Freedom to Speak up (FTSU) Guardian also works closely with key colleagues to offer support on staff issues and patient safety concerns. Freedom to Speak up champions will be recruited in 2022.

Inclusion training continues to be delivered at mandatory session and material has been updated in 2022 to reflect current information, survey results and national trends. Inclusion awareness is timetabled on all internal Leadership programmes run at the Trust. Staff are also made aware of funded regional Inclusion training workshops open to all staff members.

Policy updates

Policies linked to Equality and Diversity are regularly reviewed and updated. With the introduction of the "trac" candidate management system, the Recruitment and Selection Policy will be updated to reflect a different way of working in future.

The Staff side representative review and approve all changes to policies. The representative is also kept fully informed by the HR Team on any issues or changes that may impact staff members.

Impact on Equality

All individuals submitting policies must complete and include an Equality Impact Assessment. Completion is monitored by the Director of Governance and Data Protection Officer (DPO).

Workforce and Patient Information

The following sections include data information for staff and patients. This information is collected and reported by the ROH ESR and Informatics Teams on an annual basis. There is a requirement for the data to be published on the ROH website.

The data is reviewed and used in a number of ways including:

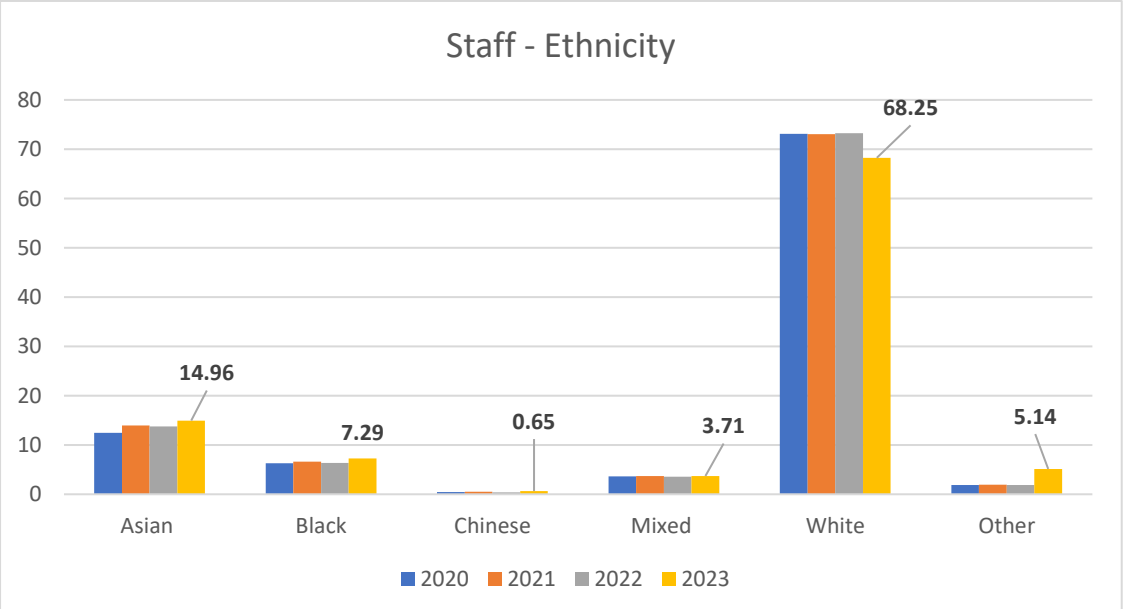
- Discussion at the Staff Experience and OD (SE&OD) Trust Board sub committees
- Discussions at Operational meetings
- Review and discussion at staff network meetings
- Review by Patient Liaison team to support the patient experience
- Used to inform on the key priority areas as part of the ROH Inclusion plan
- Presentations to external organisations on the ROH Inclusion strategy
- Analysis of data as part of the NHS WRES and WDES standards

Workforce information

In this section, staff data is presented for the six of the protected characteristics: Ethnicity, Religion Belief, Gender, Disability, Sexual Orientation and Marital Status. There is no detailed information recorded for Transgender staff members, Marriage and Civil Partnership, Pregnancy and Maternity. The data has been collated from the NHS workforce ESR database as at January 2023.

Ethnicity

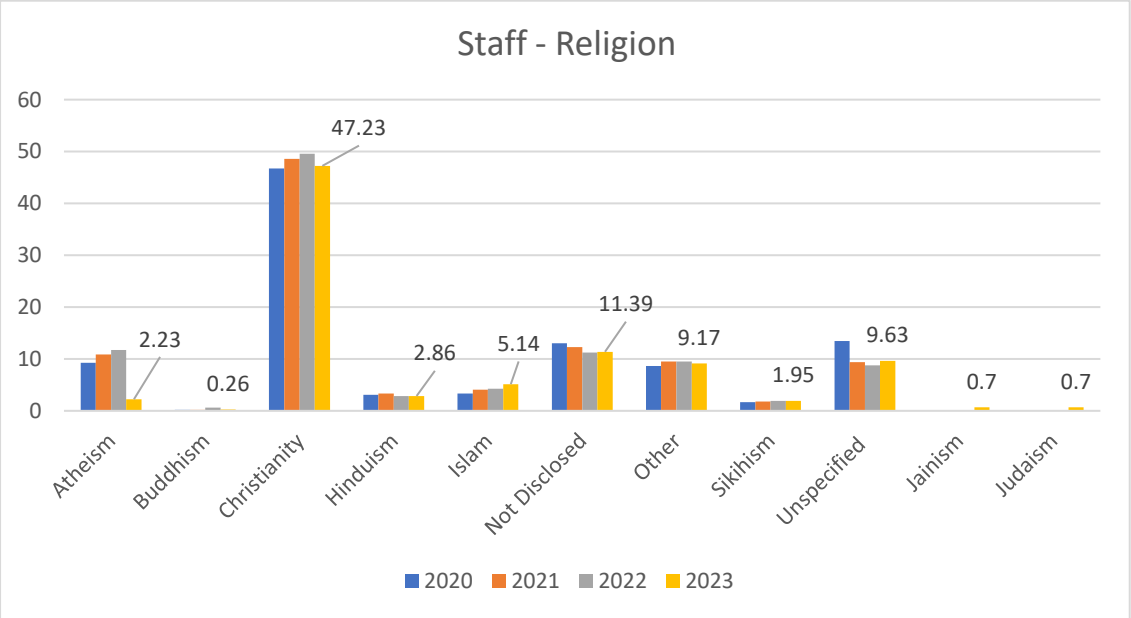
The data has not changed significantly over the last twelve months however for the first time there has



been a larger decline in White staff members. Work continues through the Inclusion plan to ensure that recruitment and career opportunities are a key focus for our diverse colleagues.

Religious Belief

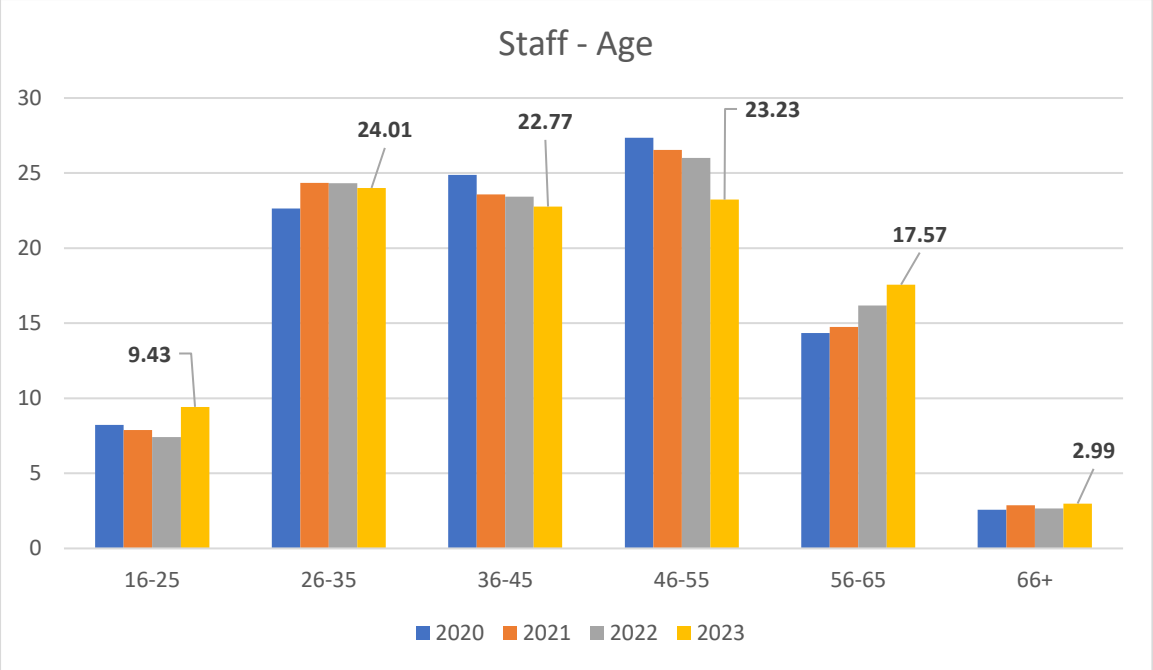
Through the different staff networks, the Trust has continued to support and highlight the different religious celebrations and festivals that are important to colleagues. This includes education on how staff will need to be supported during working hours for religious festival.



Staff networks have produced a religious booklet to be used by both staff and visitors to highlight different religions and support available

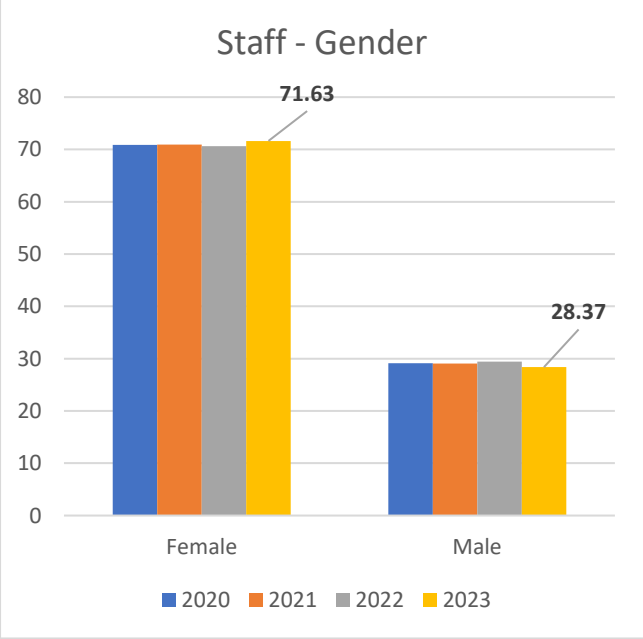
Age

Again, there are no significant changes to this data however the information has helped to focus on key initiatives including supporting a Menopause programme and recognising Long Service.
As part of the retention programme at the Trust it is recognised that approximately 43% of staff are 46 years or older.

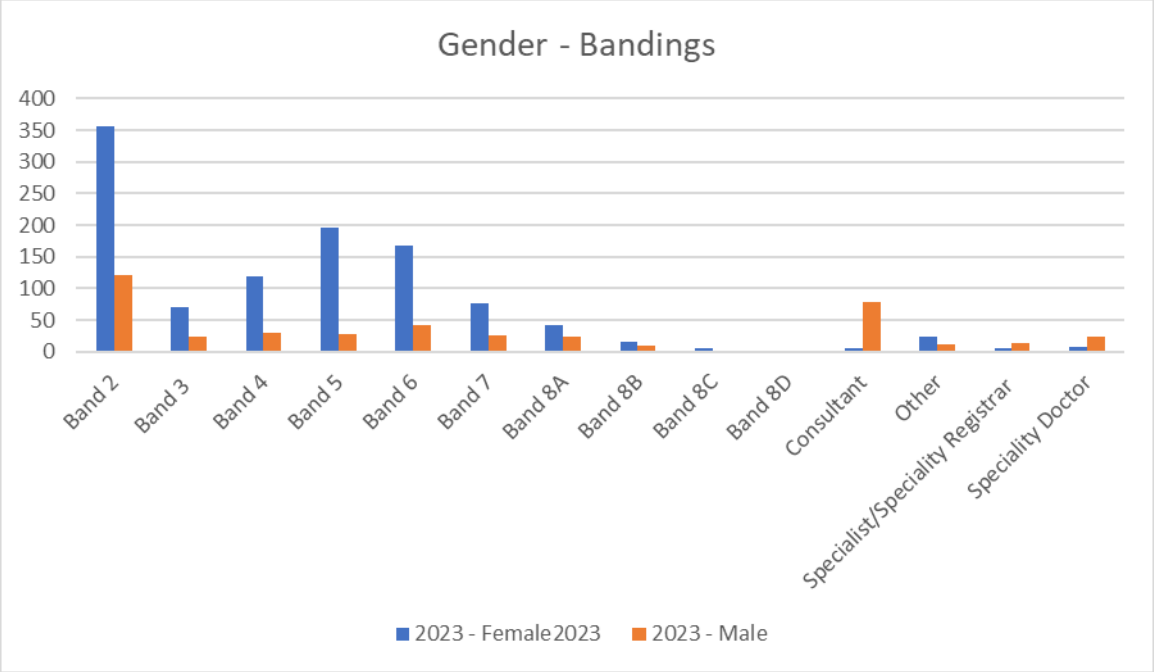


Gender

The second table gives key information on gender across the different levels in the Trust. Work continues to ensure there is equal access to job opportunities and promotion for all colleagues with key focus on the future workforce.

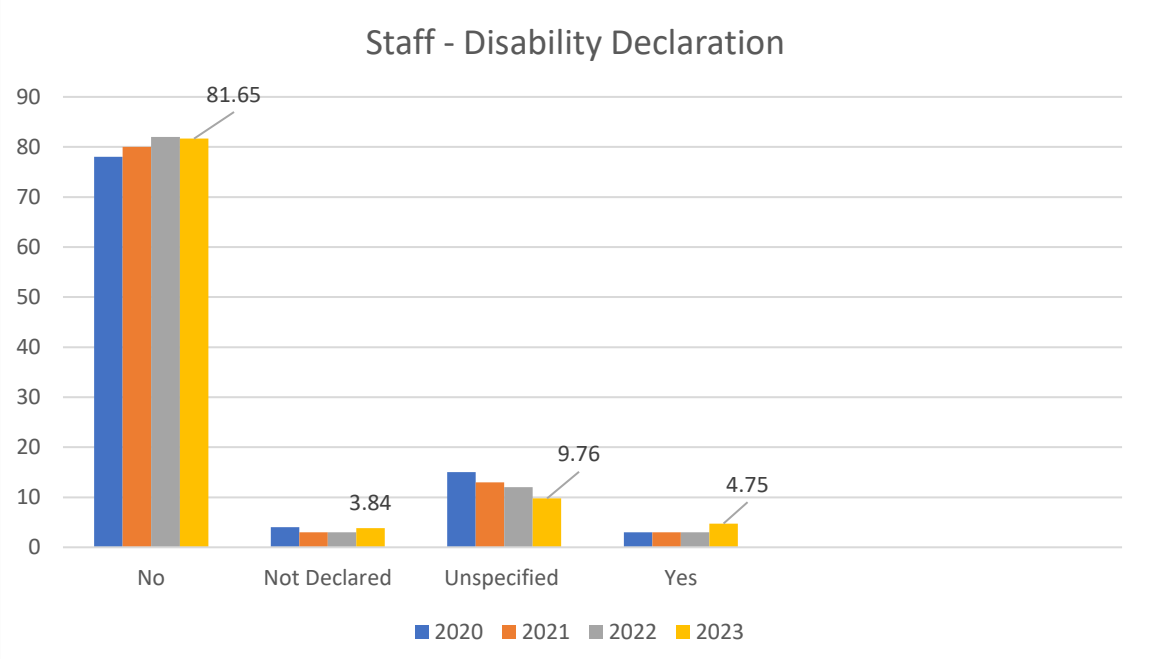


The Banding information shows the largest differences at lower bands shift at higher bands. Work continues to address this including Gender Pay Gap reporting



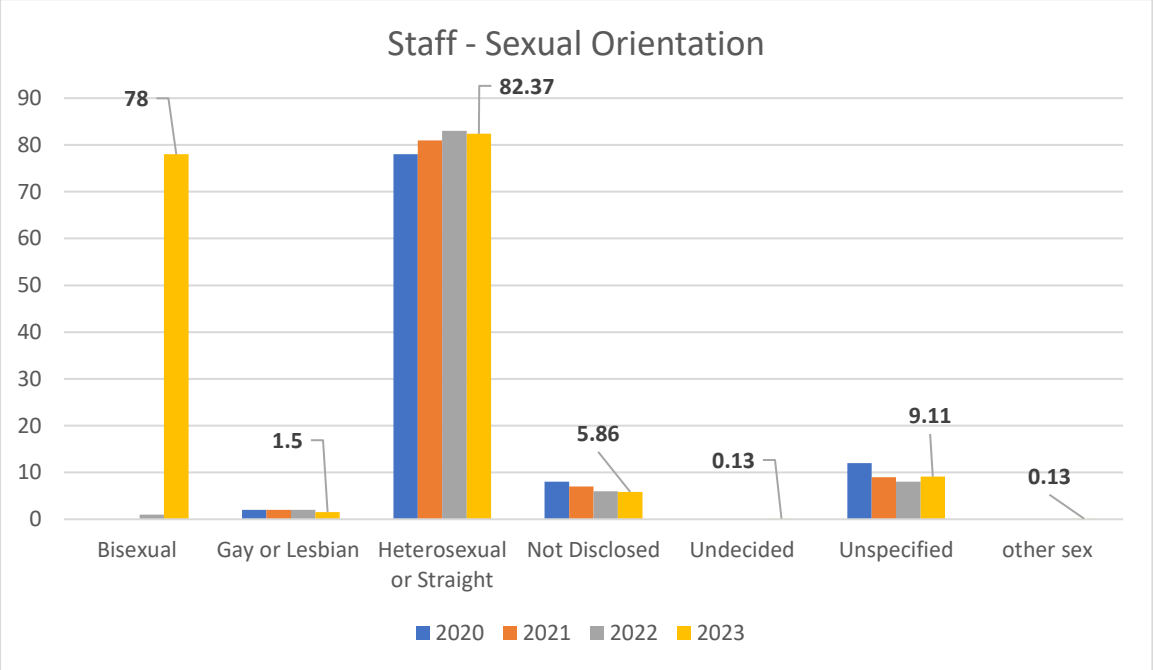
Disability

This data highlights that more work still needs to be done to ensure staff are encouraged to confirm their status in a safe way. A project is underway to improve declaration rates that is supported by the Disability network, other staff networks, the OD and Inclusion team and ESR Team.



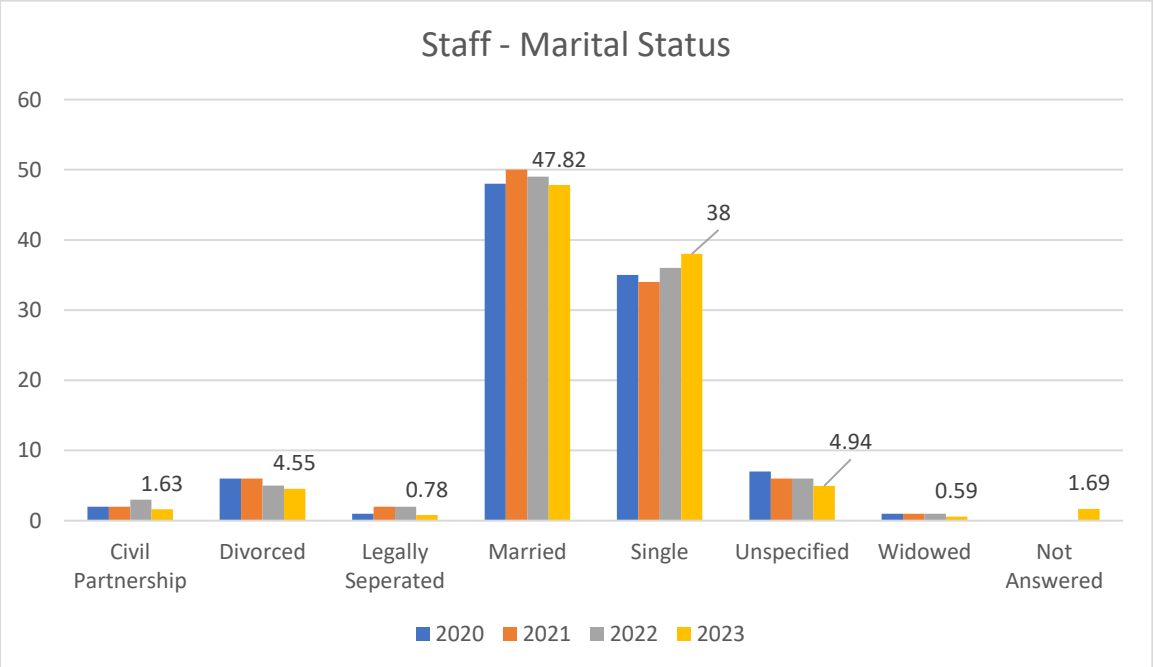
Sexual Orientation

Again, this data highlights that more work needs to take place to ensure staff are comfortable to declare sexual orientation. The number of not 'disclosed' and 'unspecified' has not declined to level hoped and work will concentrate on understanding the reasons behind this.



Marital Status

The data again has stayed consistent from previous years**.** However there has been an increase in 'Not Answered' which will be addressed.

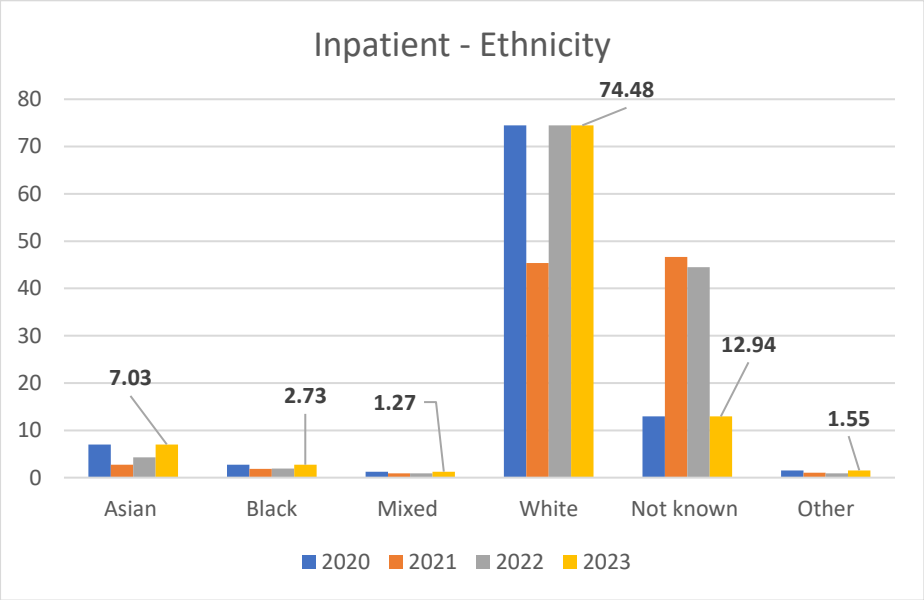


Patient data

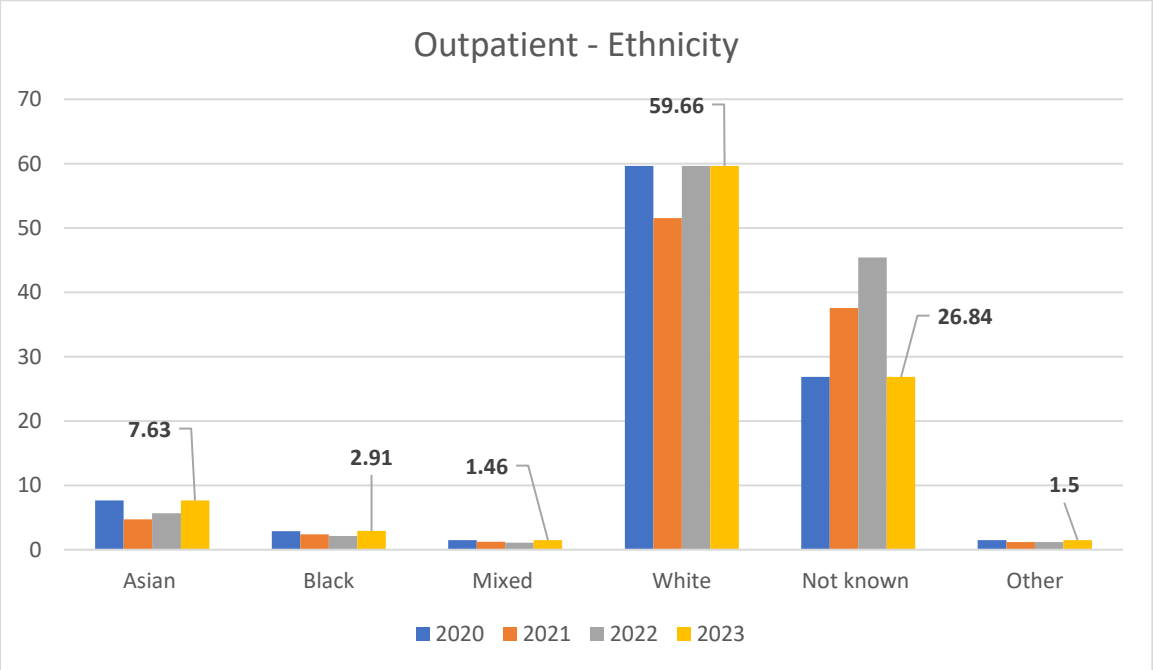
In this section, patient data is presented for the five of the protected characteristics: Ethnicity, Religion Belief, Gender, Sexual Orientation and Marital Status. The data has been collated from the Informatics team as at January 2023.

The data shown below for patients is taken from January 2021 to January 2022.

Ethnicity

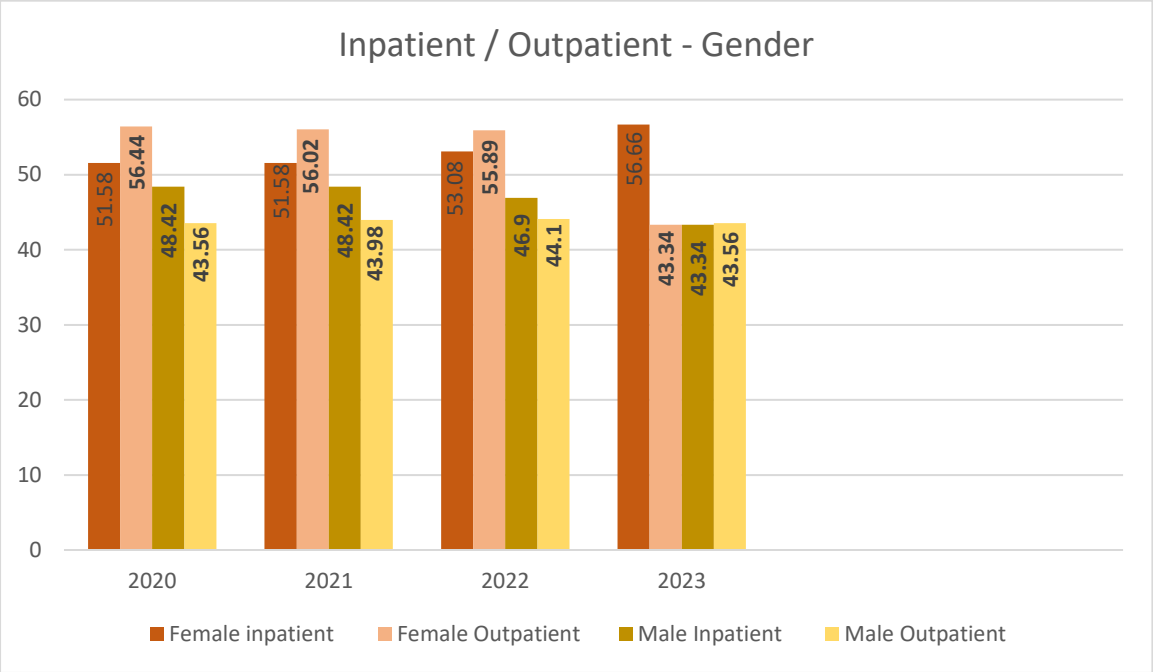


There is a difference between inpatient and outpatient data. For latest data there was 74.5% inpatient from a white background compared to 60% for outpatients. It should also be noted that for both inpatients and outpatients, a large number of patients did not declare ethnicity.



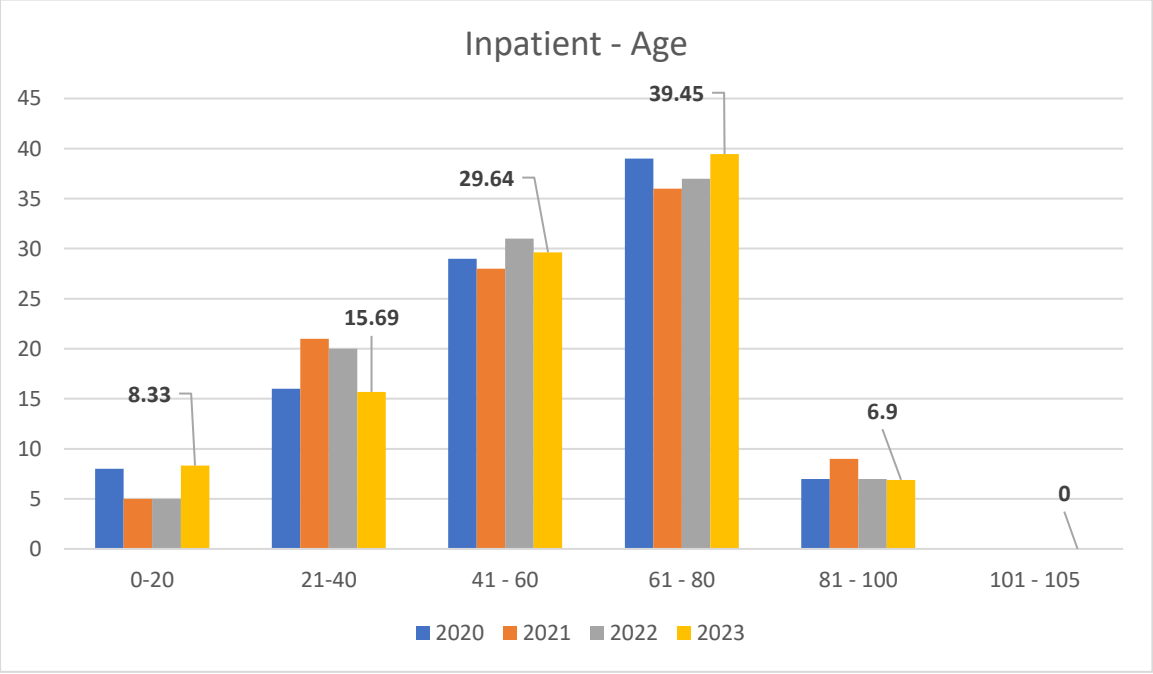
Gender

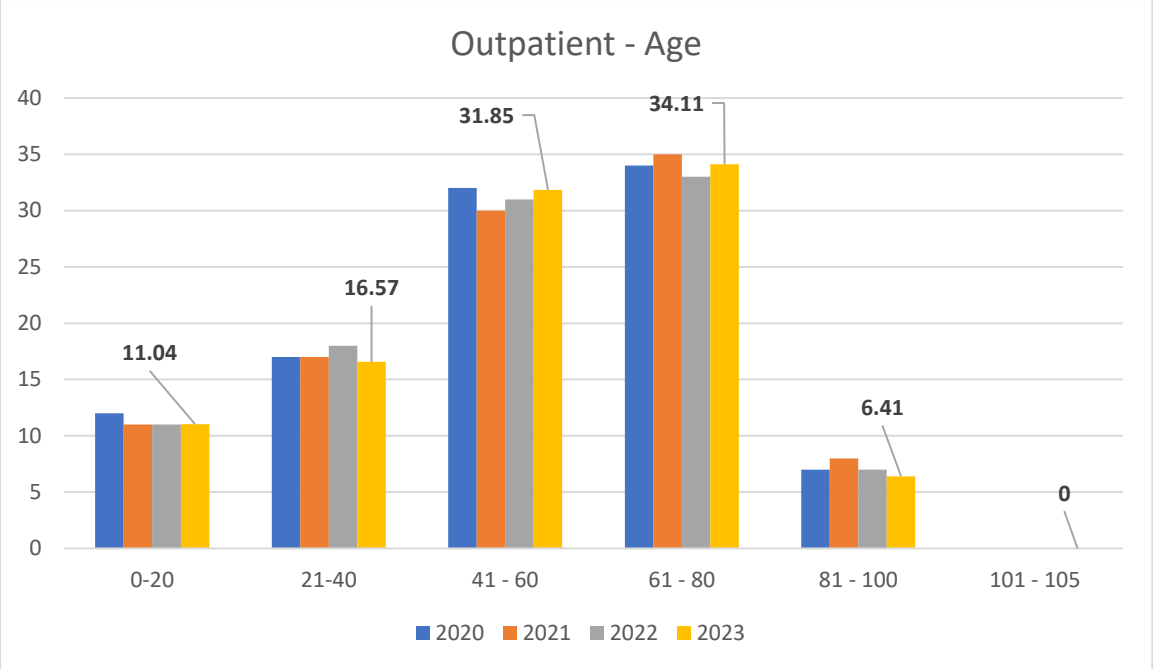
This data remains largely unchanged from 2022



Age

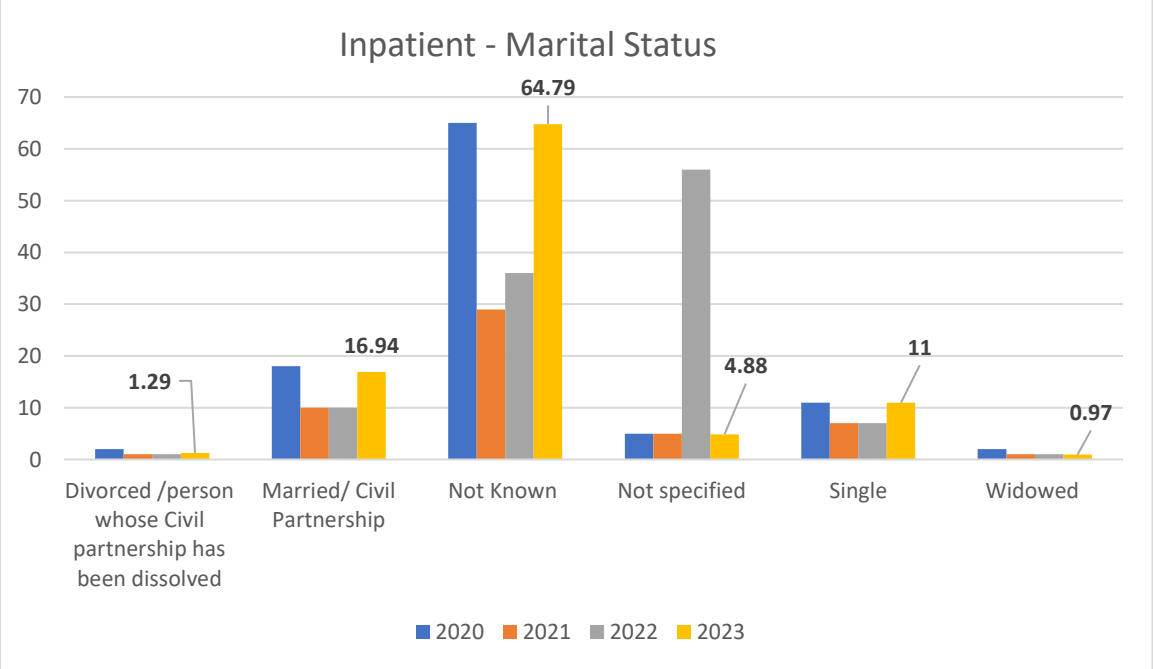
The data show little change from the previous years. However, it is useful to note the age profile of our patients is concentrated between the age groups of 41-80 years.

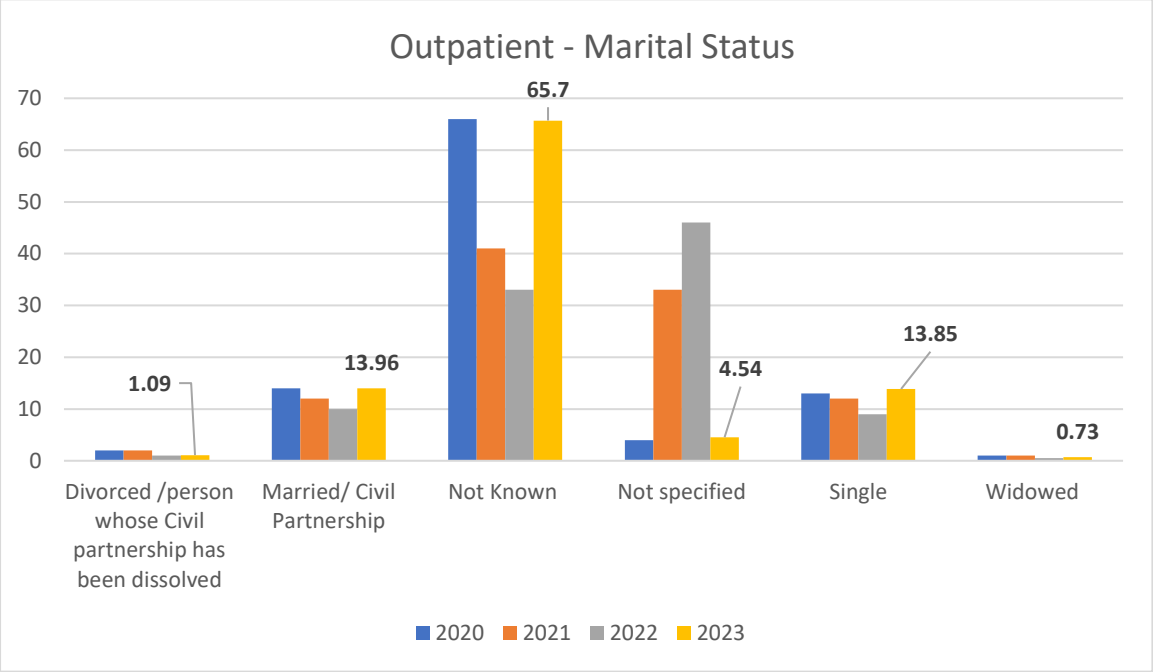




Marital Status

There has not been any significant changes in this data.





Patient Languages spoken

The PALS team continue to work with patients and carers to ensure information can be well understood. This includes a translation service.

Inpatient -Spoken Language	2020	2021	2022
Arabic	0.12%	0.22%	0.16%
Bengali	0.15%	0.11%	0.13%
English	88.35%	86.26%	91.30%
Hindi	N/A	N/A	0.01%
Kurdish	0.11%	0.08%	0.08%
Not Specified	9.13%	10.88%	5.85%
Panjabi; Punjabi	0.44%	0.53%	0.36%
Persian	0.08%	0.08%	0.04%
Polish	0.27%	0.33%	0.34%
Urdu	0.56%	0.68%	0.72%

Religious Beliefs

Inpatient Religious Belief	2020	2021	2022	2023
Agnostic	0.35%	0.56%	0.40%	0.56%
Arya Samaj Hindu	0.23%		0.22%	0.30%
Atheist	0.62%	0.80%	0.46%	0.80%
Baptist	0.11%		0.10%	0.17%
Celtic Christian	5.49%	8.73%	6.01%	8.73%
Church of England	4.44%	7.70%	5.17%	7.70%
Jewish	0.12%	0.11%	0.16%	0.11%
Methodist	0.15%	0.29%	0.19%	0.29%
Muslim	1.15%	1.88%	1.12%	1.88%
Not Religious	0.73%	0.89%	0.68%	0.89%
Patient religion unknown	83.02%	72.58%	82.08%	72.58%
Religion not given –PATIENT refused	0.24%	0.50%		0.50%
Roman Catholic	2.62%	4.15%	2.92%	4.15%
Sikh	0.27%	0.66%	0.32%	0.66%

Registered Disabled

Based on Patient data for registered disabilities in 2019 and 2020, the Trust was able to implement Access Able which is a resource to help patients and visitors with visible and hidden disabilities.

Further information

The information in this report gives an overview of the Equality, Diversity and Inclusion progress at the The Royal Orthopaedic Hospital in 2022/23.

For more information, please go to our website Home (roh.nhs.uk) or contact Clare Mair, Head of OD and Inclusion claremair@nhs.net

Appendix I

The information below shows the data for the Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES). There are annual action plans for each standard to address areas that need improvement for further progress. These action plans are reported to NHS England and also form part of the ROH Inclusion Action Plan.

WDES Data

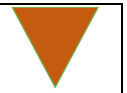
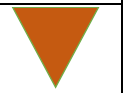
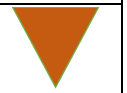
Staff data and national staff survey data was collected and submitted to NHS England in August 2022. The data period is 1st April 2021 to 31st March 2022 and is formulated into ten WDES Indicators. The Trust implements an WRES action plan based on the outcome of the metrics to ensure progress is made.

An additional question is included for WDES (compared to WDES) around reasonable adjustments for staff members. All NHS Trusts are required to collate and publish this information on their website.

In Table One data for Indicators 4 – 8 is collated from the National Staff Survey (NSS) results which staff completed between 8th October and 30th November 2022.

Table One: Summary of ROH WDES Indicators (2019 -2022)

WDES Indicator	Indicator Definition	2019	2020	2021	2022	
1	% of disabled staff	3.3	3.5	3.3	5.2	▲
2	Relative likelihood of disabled staff being appointed from shortlisted candidates compared to non-disabled staff	1.30	1.06	1.45	1.29	▼
3	Relative likelihood of disabled staff entering formal capability	0.0	0.0	0.0	0.00	=

4	% of disabled staff experiencing harassment, bullying or abuse from patients or public in last 12 months	20.8 (19.8)	28.4 (19.2)	23.4 (13.3)	26.3 (17.2)	
4a	% of disabled staff experiencing harassment, bullying or abuse from staff in last 12 months	31.3 (15.4)	22.0 (15.4)	29.0 (13.2)	28.9% (14.8)	
5	% of disabled staff believing the trust provides equal opportunities for Career progression or promotion from staff in the last 12 months	52.1 (63.1)	63.2 (63.4)	61.1 61.2)	52.3 (61.7)	
6	% of disabled staff have felt pressure from their managers to come to work, despite not feeling well enough to perform duties	25.8 (21.2)	26.7 (19.0)	20.3 (16.6)	31.2 (18.2)	
7	% of staff saying they are satisfied with the extent to which the organisation values their work	60.4 (56.1)	53.7 (58.3)	36.5 (54.4)	37.3 (53.9%)	
8	% of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	75.0 (75.2)	80.9 (76.5)	74.0 (77.0)	77.5 (71.4)	
9	The staff engagement score for disabled staff compared to non-disabled staff and the overall engagement score for the organisation	7.2	7.2	6.7	6.9	
10	Total Board members % by Disability	0	0	0	6.25	

WRES Data

Staff data was collected and submitted to NHS England in August 2022. The data period is 1st April 2021 to 31st March 2022 and is formulating into nine WRES Indicators.

All NHS Trusts are required to collate and publish this information on their website.

Table One below shows ROH WRES Performance Data for all indicators comparing 2016, 2017, 2018, 2019 and 2020. National data is currently not available as a comparison. This information with national comparisons will be presented at a future Staff Experience and OD (SE&OD) meeting.

Data for Indicators 5 – 8 is collated from the National Staff Survey (NSS) results which staff completed between 4th October and 27thNovember 2022.

Table One: Summary of ROH WRES Indicators (2019 -2022)

WRES Indicator	Indicator Definition	2019	2020	2021	2022	
1	% of staff BME	23.7	24.5	27.6	25.9	▼
2	Relative likelihood of White staff being appointed from shortlisted candidates compared to BME staff	1.70	1.36	1.55	1.62	▼
3	Relative likelihood of BME staff entering formal disciplinary	1.83	2.84	1.44	2.84	▼
4	Relative likelihood of BME staff accessing non mandatory CPD	1.12	1.08	1.13	1.03	=

5	% of BME staff experiencing harassment, bullying or abuse from patients or public in last 12 months	13.7 (22.0)	16.5 (21.9)	15.6 (15.6)	15.9 (20.3)	
6	% of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months	31.5 (26.7)	25.0 (22.9)	24.8 (22.1)	27.8 (20.6)	
7	% of BME staff believing the trust provides equal opportunities for career progression or promotion	49.3 (61.4)	51.9 (59.7)	43.1 (62.2)	41.1 (61.1)	
8	% of BME staff personally experienced discrimination at work from a manager /team leader or other colleague member of staff	18.3 (7.0)	16.7 (7.6)	14.5 (6.3)	12.2 (5.4)	
9	% of the full board identifying as BME	0	11	28.6	25	

The Royal Orthopaedic Hospital NHS

NHS Foundation Trust

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Patient Safety Incident Response Framework – Update on Implementation – November 2023**
SPONSOR (EXECUTIVE DIRECTOR):	**Nikki Brockie, Executive Chief Nurse & Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Rebecca Hipwood, Patient Safety Lead and Adam Roberts, Assistant Director of Governance & Risk**
DATE OF MEETING:	**1st November 2023**

EXECUTIVE SUMMARY:

Overview of PSIRF

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approaches to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and improvement.

PSIRF Policy and Plan

Please see the enclosed PSIRF policy and accompanying plan for your views, comment and approval.

Our patient safety incident response policy describes our overall approach to responding to and learning from patient safety incidents for improvement and identifies the systems and processes we will utilise to integrate the four key aims of PSIRF.

It details how those affected by a patient safety incident will be engaged, what governance processes for oversight are in place and how learning responses are translated into improvement and integrated into wider improvement work across the organisation.

The policy also outlines how patient safety incident responses will integrate with other activities such as clinical governance, HR and complaints management, and underlines that the remits of different

response types are distinct and must be kept so.

Our patient safety incident response plan sets out how we will respond to the specific themed and profiled patient safety incidents identified as part of the data analysis process of PSIRF implementation. The plan contains a guide that details what form of patient safety incident response will be conducted in relation to the different identified incident types.

Both documents – our policy and plan – align with and will be integral to the Trust's wider approach to safety improvement and will be published on our website. Both the policy and the plan have followed nationally prescribed templates and format but have been localised to the Trust.

Going forward, our policy and plan will be regularly reviewed and updated based on new learning, will be adaptive to any changes in our risk and incident profile and reflective of ongoing improvements.

Summary of Key Changes/Differences

Current Approach	PSIRF Approach	Alignment to PSIRF Aims
Incident by incident approach based on definitions of harm	Focus and priority on the patient safety incidents set out in PSIRF Plan	• Considered and proportionate responses to patient safety incidents. • Application of a range of system-based approaches to learning from patient safety incidents. • Supportive oversight focused on strengthening response system functioning.
Large volumes of lengthy and often siloed SIs, RCAs & SNR investigations that focus on identification of 'root cause'.	Less volume of investigations and more focus on linking into wider already on-going QI work/projects and/or less resource intensive methods of patient safety incident response that allow better focus on quicker identification and implementation of learning.	• Application of a range of system-based approaches to learning from patient safety incidents. • Considered and proportionate responses to patient safety incidents. • Supportive oversight focused on strengthening response system functioning and improvement.

Limited patient engagement with investigation process	More focus on engagement of patient in patient safety incident response, utilising Duty of Candour process to seek direct involvement and also via involvement of Patient Safety Partners in management of patient safety incidents	• Compassionate engagement and involvement of those affected by patient safety incidents

Next Steps

Consultation on the enclosed Draft PSIRF Policy and Plan has closed with comments and feedback incorporated into this version. The drafts were also discussed at the October Q&S Committee meeting and Exec Team Meeting on the 17th October 2023.

Copies of the drafts have also been shared with BSOL ICB and again feedback and comment has been incorporated.

In addition, representatives of the Trust attended a PSRIF Peer Review Workshop on the 23rd October 2023. The purpose of the meeting was to provide an opportunity for representatives from each trust within the BSOL system to meet and go through each other's PSIRF Plans and Policies and provide feedback and share learning and experiences from the implementation of PSIRF. The peer review meeting was attended by the Executive Director of Governance, the Executive Medical Director, the Assistant Director of Governance & Risk, the Deputy Chief Nurse and the Patient Safety Lead Nurse.

'Go live' date still remains planned for the 4th November 2023.

An implementation plan is currently being drafted and will include a comms/engagement plan, which is being developed in conjunction with the Trust's Communications Team. A further update on the implementation plan will follow.

REPORT RECOMMENDATION:

The Board is asked to approve the PSIRF Plan and Policy

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

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

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

PSIRF is a national framework for the management of patient safety incidents with the intent to better

identify and embed learning and improvement across the Trust, therefore it aligns to the Trust's strategic objectives, its BAF and the standard of service provided
PREVIOUS CONSIDERATION:
PSIRF update presented to the Board in October 2023. The policy and plan were considered by the Quality & Safety Committee on 18 October 2023. The policy and plan were also subject to a 'check and challenge' session with BSol colleagues on 23 October 2023.

Patient Safety Incident Response Policy

Effective date: 04/11/2023

Estimated refresh date: 11/2024

	NAME	TITLE	SIGNATURE	DATE
Authors	**Rebecca Hipwood**	**Patient Safety Specialist**		
	Adam Roberts	**Assistant Director of Governance & Risk**		
Reviewer				
Authoriser				

Contents

Purpose

This policy, along with the accompanying plan, supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out The Royal Orthopaedic Hospital NHS Foundation Trust (ROHNFT) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

A patient safety incident or event is any unintended or unexpected incident or event which could have, or did, lead to harm for one or more patients receiving healthcare, and can result in no harm or contribute to a fatal outcome. This policy requires all staff to take responsibility for reporting any incident or adverse event or near miss that they become aware of and review them as detailed within this policy.

The Trust acknowledges that adverse events usually reflect a breakdown in systems within the organisation and that people are trying to do their best to do their job safely and well. Experience shows that although staff actions may contribute to an adverse incident there are often underlying causes for these actions. Consequently, the Trust is committed to exploring how these system failures occurred and how they can be improved using a range of learning response tools.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents and safety issues.
- Supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across The Royal Orthopaedic Hospital NHS Foundation Trust (ROHNFT).

The Patient Safety Incident Response Framework (PSIRF, 2020) provides the NHS with guidance on how to respond to patient safety incidents; with no distinction between incidents and 'serious incidents' for the purpose of learning. As such, it is relevant to all bodies involved in providing; commissioning, supporting, overseeing and regulating NHS-funded care.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principal aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Where there are legitimate concerns about individual and/or organisational accountability including criminal or civil proceedings, disciplinary procedures, employment law, or professional standards and organisational or professional regulators need to be involved, they must be informed, and their relevant protocols followed.

This policy applies to all permanent and temporary staff employed, or those working under contract for services or under service level agreement, within the Trust. The policy also describes the arrangements for the management of incidents where more than one provider is involved.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Our Patient Safety Culture

PSIRF heralds a significant cultural shift. Like all cultural shifts, it will not be easy and will take time. But the potential gains for patients and families, for staff and ultimately for safety are significant. There could be no bigger incentive.

At the ROHNFT, we are committed to working towards the move from a retribution approach to types of incidents, such as patient safety incidents, to establishing a just culture within the organisation. Leaders across the ROHNFT are required to proactively embrace this approach and support from staff side colleagues will be instrumental in supporting the organisation to a just culture.

The goals of a just culture include:

- Moral engagement
- Fairness
- Reintegration of the practitioner
- Organisational Learning

Further information about the NHS Just Culture Guide can be found here:

NHS England » A just culture guide

PSIRF will enhance these by creating stronger links between patient safety events and learning for improvement.

Our safety culture within the ROHNFT continues to make progress: we have programmes of work in place to improve this, including:

- A Just Culture Project Group
- Development and implementation of safety data/dashboards
- Human Factors and Civility and Respect Programmes
- Focused work on Freedom to Speak Up and raising concerns.
- Leadership Development Programme
- Equality and Diversity/Inclusion Agenda
- Wellbeing Programme
- Embedding of Values and Behaviours
- Policy development and revisions
- Utilisation of resources to monitor improvement work across the organisation
- Implementation of a lessons learned framework

Patient Safety Partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across the NHS.

At the ROHNFT, we are excited to welcome PSPs, who will offer support alongside our people, patients, families, and carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and offer great opportunities to share experiences and skills and provide an additional level of scrutiny. This exciting new role will evolve over time with the main purpose of the role being to act as the voice for our patients and community who utilise our services, ensuring patient safety is at the forefront of all that we do.

PSPs will provide objective feedback focusing on maintaining safety and improvement. This may include attendance at our patient safety and quality governance meetings and involvement with the production and review of relatable policies and procedures. The information may be complex, and partners will provide feedback to ensure patient safety is our priority.

PSPs will be supported in their voluntary role by the Patient Safety Specialist who will provide expectations and guidance for the role. They will have regular reviews and training needs will be agreed together, based on the experience and knowledge of each partner.

The PSP role will be reviewed annually to ensure the role is aligned to the patient safety agenda as it continues to develop and expanded to ensure we are represented by the diverse communities we serve, including population groups who may sometimes experience challenges in accessing our services.

Addressing Health Inequalities

Health inequalities refers to the differences in care that people receive and the opportunities they have to lead healthy lives. Typically, in England health inequalities are often addressed across four types of factors:

- Socio-economic factors, for example, income.
- Geography or location.
- Specific characteristics, including protected characteristics.
- Socially excluded groups, for example, people experiencing homelessness.

The PSIRF has been developed to provide a mechanism to help address inequalities in patient safety through the following:

- Its flexible approach makes it easier to address concerns specific to health inequalities, and it provides the opportunity to learn from PSIs that did not meet the definition of a ‘serious incident’.
- It prompts consideration of inequalities in the development and maintenance of patient safety incident response policies and plans, and in the learning response process it describes.
- It gives guidance on engaging those with diverse needs.
- The framework endorses a system-based approach (instead of a ‘person focused’ approach). This will support the development of a just culture and aims to reduce gaps in rates of disciplinary action between ethnic groups across the NHS workforce.

The NHS has a duty to reduce inequalities in health by improving access to services and tailoring those around the needs of the local population in an inclusive way. The Trust is committed to delivering on its statutory obligations under the Equality Act, (2010) and will use data intelligently to assess any disproportionate patient safety risk to patients from across the range of protected characteristics. This data can be captured via our Electronic Patient Records (EPR) and Ulysses incident reporting system.

In our response toolkit, we will directly address any features of an event which indicate health inequalities, that may have contributed to harm or demonstrate an ongoing risk to any population group, including all protected characteristics.

When constructing safety improvement actions in our patient safety learning responses we will consider inequalities. We will look to address health inequalities as part of our safety improvement work. In establishing our future policy and plan we will work to identify variations of inequality by using our population and patient safety data to ensure it is considered as part of the development process for the future.

Engagement of those involved (patients, families/carers, and our people) following a patient safety event, is crucial to our patient safety learning responses. We will ensure that we use available tools to include easy read, translation, and interpretation services alongside any other method appropriate to meet their needs and maximise the potential of being involved.

Information resources produced by the ROHNFT can be made available in alternative formats, such as easy read or large print and may be available in alternatives languages upon request. These requests can be made to our internal communications team.

ROHNFT endorses a zero tolerance of racism, discrimination, and unacceptable behaviours from and towards our people, our patients, carers, and families.

Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.
The term engagement describes everything an organisation does to communicate with and involve people affected by a patient safety incident in a learning response. This may include the Duty of Candour notification or discussion, and actively engaging patients, families, and healthcare staff to seek their input to the response and develop a shared understanding of what happened.

Compassionate engagement describes an approach that prioritises and respects the needs of people who have been affected by a patient safety incident.

Involvement is part of wider engagement activity but specifically describes the process that enables patients, families, and healthcare staff to contribute to a learning response.

Those affected by a patient safety incident must have clear information about the purpose of a learning response, and what to expect from the process. Organisations will need to provide this information to those affected. Any information should ideally contain:

1. What a patient safety incident is.
2. What a learning response is, and what the different types of response are.
3. Definitions of key words and phrases.
4. Ways to involve those affected, and how they can prepare for this involvement.
5. Support resources (local and national).

Correspondence or information should be made available in both digital and physical formats, recognising that not everyone will have access to an electronic device. Special attention should be paid to how the information is presented, its tone, the reading age it is pitched at, its understandability by those whose first language is not English.

Patient Safety Incident Response Planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The ROHNFT will take a proportionate approach to its response to patient safety events, ensuring the focus is on maximising improvement. To fulfil this, we will proactively undertake planning of our current resources for patient safety learning responses and our existing safety improvement workstreams. Our Patient Safety Incident Response Plan (PSIRP) will detail how this will be achieved, alongside how we intend to meet both the National requirements and our ROHNFT local priorities for patient safety incident responses.

Resources and Training to Support Patient Safety Incident Response.

Training requirements for those involved in producing Patient Safety Incident Responses PSIRF oversight:

Topic	**Minimum duration**	**Content**
Systems approach to learning from patient safety Incidents	2 days or 12 hours	● Introduction to complex systems, systems thinking and human factors ● Learning response methods: including interviewing, and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews ● Safety action development, measurement, and monitoring
Involving those affected by patient safety incidents in the learning process	1 day or 6 hours	● Duty of Candour ● Just Culture ● Being open and apologising ● Effective communication ● Effective involvement ● Sharing findings ● Signposting and support
Patient safety syllabus level 1: essentials for patient safety	E-Learning	● Listening to patients and raising concerns ● The systems approach to safety, where instead of focusing on the performance

		of individual members of staff, we try to improve the way we work ● Avoiding inappropriate blame when things don't go well ● Creating a just culture that prioritises safety and is open to learning about risk and safety
Patient safety syllabus level 2: access to practice	E-Learning	● Introduction to systems thinking and risk expertise ● Human factors ● Safety culture
Continuing professional development	At least annually	● To stay up to date with best practice (for example through conferences, webinars.)

We will have governance arrangements in place to ensure patient safety learning responses are not led by ROHNFT staff who were involved in the patient safety event itself. Responsibility for patient safety learning responses from our locally agreed ROHNFT priorities sits with the Divisional governance teams and our Divisional Triumvirates.

Patient Safety Learning Responses (PSLRs) sitting outside of our priorities will be led by a suitable senior leader within the relevant service line. Patient Safety Incident Learning Response Leads will have an appropriate level of seniority to influence within the Trust; this may depend on the nature and complexity of the patient safety event and the learning response required.

The Trust's governance arrangements will ensure patient safety learning responses are not undertaken by staff working in isolation. The Divisional governance team and core governance team will support patient safety learning responses wherever possible and can provide advice on cross-system and cross-area working where this is required.

Our people affected by patient safety events will be afforded the necessary support and given time to participate in patient safety learning responses. All ROHNFT leaders will work within our just culture principles and utilise other teams to ensure our people are supported.

We will utilise both internal and (where necessary) external subject matter experts with relevant experience, knowledge, and skills.

Our Patient Safety Incident Response Plan

Our accompanying plan sets out how the ROHNFT intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

The process to create our patient safety incident response plan has been collaborative.

To define the ROHNFT patient safety risk and responses for 2023/24 the following stakeholders were involved*:

- Staff – through the incidents reported on the ROHNFT Local Incident Management System
- Senior leaders across the divisions
- Partner organisations from across the Integrated Care System (ICS), through partnership working with the ICS patient safety and quality leads

*The ROHNFT aims to incorporate wider patient perspective into future PSIRF planning through the introduction of Patient Safety Partners (PSPs). More information can be found on the National PSP programme on the NHS England website NHS England » Framework for involving patients in patient safety

The ROHNFT patient safety risks were identified through the following data sources:

- Trend analysis of five years of Ulysses incident data
- Thematic analysis of Ulysses incident data
- Key themes from complaints/PALS/claims/inquests
- Key themes from specialist safety and quality groups (e.g. falls, VTE and pressure ulcers)
- Output of stakeholder discussions

Reviewing Our Patient Safety Incident Response Policy and Plan

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to Patient Safety Incidents

Patient Safety Incident Reporting and Decision-Making Arrangements

The Trust is responsible for the safety of everyone who uses or works within its services and must ensure robust systems are in place to recognise, report, investigate and respond to patient safety incidents and to improving the quality of care to patients and the safety of staff and members of the public, through the consistent monitoring and review of incidents which result, or had the potential to result in harm, damage or other loss.

Organisational learning and remedial action are central to a good patient safety incident response and the reporting of all incidents is a key factor in enabling this. Staff have a right, and a duty, to raise with their employer any matters of concern they may have about health service issues associated with the organisation and delivery of care.

Our aims and objectives are to:

- Promote an open, honest and fair approach to the identification, management and learning from patient safety incidents.
- Provide staff with an agreed method of reporting, investigation and management of patient safety incidents in line with our PSIRF Plan and development of quality improvement plans.
- Enable collection and use of robust data to inform and promote organisational learning and improvement, providing appropriate assurance to internal and external stakeholders as required.
- Use patient safety incident responses to identify any deficiencies in care or service, learning from these findings through the development of safer practices and environments for the benefit of patients, staff and visitors.
- Establish a patient safety incident response and management framework which is proportionate to the incident being reported and fulfils statutory and contractual requirements in line with national best practice.
- Support openness and transparency and assure patients / their representatives that appropriate review, investigation and learning from patient safety incidents are embedded within the organisation.

The Trust's arrangements for the reporting of and management of patient safety incidents are set out below:-

<u>Incident Reporting</u>

All staff are required to report and manage patient safety incidents. Where a patient safety incident occurs, staff must take appropriate immediate remedial action at the

time of an incident to prevent further harm to patients; staff; general public and Trust assets.

All patient safety incidents are reported by staff via our Local Incident Management System (LIMS), which is currently Ulysses. Through induction and mandatory training all staff receive training on how to report incidents and those members of staff specifically involved in the management and investigation of incidents are provided with further, more specialist training on how to utilise the system.

Divisional Triumvirate & Governance Arrangements

Each of the two Divisions within the Trust have delegated responsibility for the quality and safety of the clinical services that are within their remit.

The Divisional Governance groups/triumvirates, which hold a divisional governance meeting on a bi-weekly basis, are responsible for:

- Ensuring appropriate and timely patient safety incident identification, reporting, management and response arrangements are in place for all areas within their responsibility.
- Ensuring patient safety incident responses are conducted in line with the Trust's PSIRF Plan and takes into consideration wider on-going or planned quality improvement projects or plans when making decisions on the necessity and/or type of response to patient safety incidents.
- Monitoring the implementation of recommendations from incident investigations and quality improvement plans relevant to their division.
- Escalating assurance/exceptions to appropriate Trust level Committees / individuals.

Reporting to the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS)

Until NRLS and StEIS are replaced by the Learn From Patient Safety Events service (LFPSE), all patient safety incidents must be reported to NRLS via the trust's local incident management system, and all patient safety incidents for which an independent or provider led PSII is undertaken must be reported to StEIS.

Once an independent PSII report is finalised and shared with the provider, the provider can complete the uploading of investigation findings to StEIS for sharing and learning purposes, ahead of closure of the incident.

Reporting to the Learn From Patient Safety Events service (LFPSE)

The LFPSE service will replace NRLS and StEIS.

Reporting to LFPSE is the equivalent of reporting to NRLS and StEIS but once an organisation starts reporting to LFPSE, it only needs to make one incident report – that is, it no longer needs to report to NRLS or StEIS.

Responding to Cross-System Incidents/Issues

The Trust will continue to follow current governance processes in regard to cross system patient safety incidents.

Where patient safety incidents involve other trusts, the governance team communicates and liaises with the other Trust's respective governance team to co-ordinate and facilitate timely investigation and feedback.

In addition, the Trust currently holds monthly joint governance meetings with University Hospital Birmingham NHS Foundation Trust and Birmingham Women's and Children's Hospital NHS Foundation Trust, which provides the forum for discussion of joint pathway patient safety incidents and operational risks and issues. Similar arrangements are currently being established with Robert Jones and Agnes Hunt NHS Foundation Trust.

Timeframes for Learning Responses

Response Type	Expected time to gather information	Expected timeframe to produce response report
Patient Safety Incident Investigation (PSII)	20 – 80 hours over several weeks.	3 months from date of incident, can be extended to up to 6 months in extenuating circumstances, to be agreed by divisional governance group.
After Action Review (AAR)	Likely to take 45 – 90 minutes.	Within 2-4 weeks of AAR.
Multidisciplinary Team (MDT) Review	Likely to take 2 – 3 hours.	Within 2-4 weeks of MDT Review.
Thematic Reviews	Dependent on complexity and data set to be reviewed.	Within 4 weeks of need for thematic analysis identified and investigator allocated.

Safety Action Development and Monitoring Improvement.

Learning response methods enable the collection of information to acquire knowledge. This is important, but it is only the beginning. A thorough human factors analysis of a patient safety incident does not always translate into better safety actions to reduce risk. We must move from identifying the learning to implementation of the lessons. Without an integrated process for designing, implementing, and monitoring safety actions, attempts to reduce risk and potential for harm will be limited.

The process starts by identifying and agreeing those aspects of the work system where change could reduce risk and potential for harm (i.e., 'areas for improvement' or system issues). Actions to reduce risk (i.e., safety actions) are then generated in relation to each defined area for improvement. Following this, measures to monitor safety actions and the review steps are defined.

The term 'areas for improvement' is used instead of 'recommendations' to reduce the likelihood of solutionising at an early stage of the safety action development process. Understanding contributory factors and work as done should not be confused with developing safety actions. Areas for improvement set out where improvement is needed without defining how that improvement is to be achieved. Safety actions in response to a defined area for improvement depend on factors and constraints outside the scope of a learning response.

The process emphasises a collaborative approach throughout, including involvement of those beyond the 'immediate and obvious' professional groups and working closely with those with improvement expertise. Imposed solutions often fail to engage staff and lack sustainability as a result.

Work is ongoing to ensure our quality and safety improvement methodology is aligned to the PSIRF and that all improvement work is registered on one platform so that improvements required can be designed, implemented and monitored using an integrated approach of reducing risk and limit the potential for future harm.

Safety Improvement Plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The ROHNFT will have several improvement plans in place which will be adapted to respond to outcomes of improvement efforts and other influences such as national safety improvement programmes.

The ROHNFT Patient Safety Incident Response Plan has outlined local priorities for focus or response under the PSIRF. These were developed due to the opportunity they offer for learning and improvement where improvement efforts have not been accompanied by reduction in risk or harm.

The Trust will implement a platform where all improvement plans and improvement work will be logged in one place to give an overview of where we were, what actions have been completed, what the impact of interventions and improvements has been and ongoing monitoring can continue to ensure that improvements are fully embedded.

Oversight Roles and Responsibilities

Key staff and internal stakeholders/groups

All Staff

All staff are required to report and manage incidents in line with this policy. Where an incident occurs staff must take appropriate immediate remedial action at the time of an incident to prevent further harm to patients; staff; general public and Trust assets.

Chief Executive

The Chief Executive is responsible for ensuring the infrastructure is in place to identify, report, manage, investigate and analyse patient safety incidents in order to learn lessons. The Chief Executive delegates responsibility to the Director of Governance.

Executive Director of Governance

The Director of Governance is responsible to the Trust Board and the Chief Executive in relation to patient safety incident management and the implementation of learning and improvement that stems from the investigation of patient safety events.

Executive Chief Nurse

The Executive Chief Nurse is responsible to the Trust Board and the Chief Executive and is the Executive Lead in relation to patient safety.

All Executive Directors

All Executive Directors have a role to encourage patient safety incident reporting, support patient safety incident responses and share lessons and themes from incidents across their areas of responsibility.

Assistant Director of Governance & Risk

The assistant Director of Governance & Risk, as well as the wider governance team, are responsible for:-

- Oversight of the development and management of the PSIRP within the Trust
- Developing strategies, designing and implementing systems to raise awareness of and improvement of incident reporting, risk assessment, risk registers, investigation processes including training in learning response tools
- Organisation wide trend analysis to identify cross cutting themes including the identification of health inequalities.

- Ensuring that learning from adverse events and incidents is shared across the Trust and where relevant the health system.
- Ensuring appropriate notification of incidents to relevant internal and external stakeholders, agencies and regulatory bodies.
- Notifying the Chief Executive, Executive Directors, Non-Executive Directors and all other relevant stakeholders, of unexpected deaths or other serious incidents that may attract media attention.
- Providing appropriate advice and support to the Chief Nurse and Medical Director to enable the accurate identification, reporting and investigation of incidents.
- Ensuring an effective quality assurance process is in place to monitor the quality of investigations, associated reports and action plans.
- Ensuring an effective tracking system is in place so that investigation and learning response data and progress against action plans can be monitored and reported on to the Trust Board and Sub Committees.
- Ensuring that evidence is collected and appropriately stored to validate the implementation of recommendations and actions arising from PSII's.
- Ensuring assurance evidence can be retrieved in a timely way when required by the Trust Board or other internal or external stakeholders, as appropriate.

Patient Safety Lead

The Trust's Patient Safety Lead is responsible for: -

- Oversight of the development and implementation of the PSIRF Plan and Policy within the Trust.
- Development and implementation of the Trust's Patient Safety Strategy and implementation of the NHS Patient Safety Strategy within the Trust.
- To ensure that the ROHNFT patient safety incident response system and investigations integrates the four key aims of PSIRF:
- Compassionate engagement and involvement of those effected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement.
- Oversight of safety improvement workstreams, ensuring that these are logged appropriately and accessible to relevant staff and teams.
- Working with HR and other relevant stakeholders to ensure a just culture, systems thinking and human factors awareness is embedded across the Trust.

Patient Safety Partner

The Patient Safety Partner (PSP) will be actively involved in the design of safer healthcare at all levels in the organisation. PSPs will provide objective feedback focusing on maintaining safety and improvement. This may include attendance at our patient safety and quality governance meetings and involvement with the production and review of relatable policies and procedures. The information may be complex, and partners will provide feedback to ensure patient safety is our priority.

Divisional Triumvirate & Governance Team

The respective Divisional Triumvirates and the governance team are responsible within their areas and remit for:-

- Ensuring arrangements are in place at a ward or departmental level to enable appropriate and timely patient safety incident identification, reporting, management and investigation for all areas within their responsibility.
- To inform the Governance team immediately of any serious incidents and ensure that an incident report is completed via the Trust's Local Incident Management System
- To make decisions on and undertake investigation into patient safety incidents by utilising and following the PSIRF Plan
- To produce a quality improvement plan outlining the required actions to be implemented to ensure lessons are learned.
- Sharing of any relevant patient safety incident response reports, quality improvement plans/action plans, and copies of any Duty of Candour correspondence with the patient / family.
- To feedback the outcome of patient safety incident responses to staff as appropriate.
- Governance team to provide assurance reports on patient safety incident responses to Divisional Management Board.
- Ensure that staff involved in patient safety incidents, or the management and investigation of patient safety incidents, receive appropriate support.
- Ensure that the patients, relatives or carers are informed about the incident in a timely manner in accordance with the Duty of Candour and document this discussion on the Trust's LIMS.
- To support and formally monitor, at Division meetings, progress against quality improvement plans/action plans produced as a result of patient safety incident investigations and responses.

Patient Safety Incident Investigators

Patent Safety Incident Investigators are responsible for conducting the types of patient Safety incident responses as set out in the PSIRF Plan and as decided upon by the divisional triumvirate under the governance processes outlined in this policy. They are responsible for:-

- Ensuring that they are competent to undertake the PSIIs assigned to them and if not or there is a conflict of interest, request it is reassigned.
- Developing clear terms of reference in conjunction with the Divisional Triumvirate, governance team, clinical teams, patients/relatives (those affected) and relevant Executive Directors
- Ensure that they undertake PSIIs in line with the national PSII standards.
- Undertake PSIIs and PSII-related duties in line with latest national guidance and training.
- Identify those affected by patient safety incidents, both patients, families, carers and staff and support their needs, including signposting to support services and provide them with timely and accessible information and advice.
- Provide documentary evidence in support of the investigation findings and conclusions for safekeeping by the Patient Safety Team. This will include copies of evidence, statements and completed analysis tools. Following executive approval of the report, the report findings will be fed back to the Divisional Triumvirate and Governance Team

Key Board and Committee Responsibilities

Board of Directors

The Board of Directors is responsible for ensuring that appropriate systems are in place to enable the organisation to deliver its objectives in relation to PSIRF. It delegates this responsibility to the Quality & Safety Committee.

Quality and Safety Committee

The Quality and Safety Committee is responsible for assuring the Board of Directors that:

- The Trust has a strong patient safety incident reporting culture in which patient safety incidents are promptly identified reported and investigated.
- PSIIs are being appropriately identified, managed and investigated and any resulting actions and learning are being addressed and embedded.
- Trends in patient safety incidents are being reviewed and managed on a Trust-wide basis.
- Quality improvement and learning from patient safety incidents is being identified and implemented.

In collaboration with the Divisions and the Governance Team, the Quality and Safety Committee will also ensure that divisions are:

- Reporting, managing and investigating patient safety incidents in line with this policy and the accompanying plan.
- Ensuring implementation of recommendations and quality improvement plans from serious incident investigations.

They also have a role in the analysis of patient safety incident data, triangulating this information with other sources to identify trends and request assurance and improvement where required.

Executive Governance Meeting

The Executive Governance meeting is a forum for assurance and oversight as well as sign off on PSIIs and patient safety incidents and their responses that are deemed suitable for escalation to Executive Director level.

Key External Stakeholders

Birmingham and Solihull Integrated Care Board (BSOL ICB)

BSOL ICB will seek assurance on PSIIs and any other patient safety incident matters and provide scrutiny and oversight via regular monthly contracting and patient safety oversight meetings.

Complaints and Appeals

All complaints add/or appeals relating to the Trust's response to patient safety incidents are to be communicated to our Patient Experience Team and managed in accordance with the Trust's Complaints and PALS policy.

The contact details for our Patient Experience Team can be accessed via the below link:-

Royal Orthopaedic Hospital - Patient experience (roh.nhs.uk)

Other Policies to which this Policy Relates

- Complaints and PALS Policy
- Incident Reporting and Management Policy
- Risk Management Policy

Further Information

For further advice and information please contact the governance team on:-

Ext: 55292 or Ext: 55432

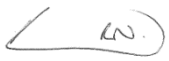
Or email:-

roh-tr.governance-mail@nhs.net

Patient Safety Incident Response Plan

Effective date: 04/11/2023

Estimated refresh date: 11/2024

	NAME	TITLE	SIGNATURE	DATE
Author	**Rebecca Hipwood**	**Patient Safety Specialist**		
	Adam Roberts	**Assistant Director of Governance & Risk**		
Reviewer				
Authoriser				

Contents

Introduction

This plan, along with the accompanying policy, supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out The Royal Orthopaedic Hospital NHS Foundation Trust (ROHNFT) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

A patient safety incident or event is any unintended or unexpected incident or event which could have, or did, lead to harm for one or more patient's receiving healthcare, and can result in no harm or contribute to a fatal outcome. This policy requires all staff to take responsibility for reporting any incident or adverse event or near miss that they become aware of and review them as detailed within this policy.

The Trust acknowledges that adverse events usually reflect a breakdown in systems within the organisation and that people are trying to do their best to do their job safely and well. Experience shows that although staff actions may contribute to an adverse incident there are often underlying causes for these actions. Consequently, the Trust is committed to exploring how these system failures occurred and how they can be improved using a range of learning response tools.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents and safety issues.
- Supportive oversight focused on strengthening response system functioning and improvement.

This Patient Safety Incident Response Plan sets out how The Royal Orthopaedic Hospital NHS Foundation Trust (ROHNHSFT) intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. The purpose is to continually improve the quality and safety of the care we provide.

One of the underpinning principles of PSIRF is to do fewer “investigations” but to do them better. Better means taking the time to conduct systems-based investigations by people that have been trained to do them. This plan and associate policies and guidelines will describe how it all works. The NHS Patient Safety Strategy challenges us to think differently about learning and what it means for a healthcare organisation. A risk to successfully implementing PSIRF is continuing to investigate and review incidents as we did before, but simply giving the process a new label. The challenge is to embed an approach to investigating that forms part of the wider response to patient safety incidents, whilst allowing time to learn thematically from the other patient safety insights.

Our Services

The Royal Orthopaedic Hospital NHS Foundation Trust (ROHNFT) is registered with the Care Quality Commission to provide services in the following locations:

- The Royal Orthopaedic Hospital
- College Green (Outpatient physiotherapy services)
- Lordswood Musculoskeletal Clinic
- ROH Community Health Hub
- The Royal Orthopaedics Community Scheme (delivering care in patients’ homes)

We provide a variety of services across the organisation in the following departments:

- Admissions and Day Case Unit (ADCU)
- In patient wards, including a private ward (109 beds - predominantly used by elective surgical patients)
- Main Outpatients Department
- Children and Young Persons Outpatient Department
- Theatres (14 theatres)
- Pre-Operative Assessment Unit (POAC)

- High Dependency Unit (HDU)
- Physiotherapists – inpatient, outpatient and hydrotherapy
- Orthotics
- Pain Management
- Imaging (X Ray and MRI)
- Discharge Lounge
- Safeguarding
- The Royal Orthopaedic Community Scheme

We also have a variety of specialities which include:

- Foot and Ankle
- Hands and Forearms
- Hips
- Knees
- Musculoskeletal
- Shoulder and Elbow
- Spines
- Oncology
- Anaesthetics
- Critical Care
- Chronic Pain
- Perioperative Medicine
- Musculoskeletal Medicine
- Radiology

Defining Our Patient Safety Incident Profile

The process to define our patient safety incident profile has been collaborative. To define the ROHNFT patient safety risk and responses for 2023/24 the following stakeholders were involved:

- Staff – through the incidents reported on the ROHNFT Local Incident Management System (LIMS)
- Senior leaders across the divisions.
- ICS partner organisations through partnership working with the ICS patient safety and quality leads.

*The ROHNFT aims to incorporate wider patient perspective into future PSIRF planning through the introduction of Patient Safety Partners (PSP's). More information can be found on the National PSP programme on the NHS England website NHS England » Framework for involving patients in patient safety

The ROHNFT patient safety risks were identified through the following data sources:

- Analysis of five years of ROH LIMS incident data
- Thematic analysis of ROH LIMS incident data
- Key themes from complaints/PALS/claims/inquests
- Key themes from specialist safety and quality committees (e.g. falls, VTE and pressure ulcers)
- Output of stakeholder discussions

National priorities for investigation or referral to other bodies have been defined by NHS England, please see below for a full list of the current priorities and mandated response required.

Defining our patient safety improvement profile

Throughout the ROHNFT improvement work is a key thread that is woven throughout all that we do. However, this improvement work is most often undertaken in silo, there is a lack of oversight of improvement work and a lack of assurances that improvements have been successful, meaningful and fully embedded as “work as done”. Work has commenced to ensure this oversight and assurance is visible and continuing.

There are many groups, networks and committee’s that implement improvement works and these include, but are not limited to:

- The Falls and Dementia Working Group
- Cancer Board
- Safeguarding Committee
- Medical Device Assurance Group
- Divisional Management Boards
- Divisional Governance Groups
- Infection Prevention and Control Groups, including a Theatre Focus Group
- AQILA
- Resuscitation Group (responsible for National Managing Deterioration Safety Improvement Program (ManDetSIP))
- The Human Tissue Authority Group
- Specialty Meetings – ADCU, POAC, Theatres, RRT, HDU
- Harm Reviews
- Clinical Audit
- Venous Thromboembolism Group
- Blood Safety Group
- Nutrition and Hydration Steering Group
- Medication Safety Group (responsible for National Medicines Safety Improvement Programme (MH-SIP))
- Drugs and Therapeutics Committee

Work is ongoing to ensure our quality and safety improvement methodology is aligned to the PSIRF and that all improvement work is registered on one platform so that improvements required can be designed, implemented and monitored using an integrated approach of reducing risk and limit the potential for future harm.

Our Patient Safety Incident Response Plan: National Requirements Applicable to ROHNFT

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria 2018 (or it's replacement)	Locally led Patient Safety Incident Investigation (PSII)	Create local organisational actions and feed these into the quality improvement strategy
Deaths thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	Locally led PSII	Create local organisational actions and feed these into the quality improvement strategy
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR.	Create local organisational actions and feed these into the quality improvement strategy
Safeguarding incidents in which: • Babies, children, or young people are on a child protection plan; Children in Care or a victim of wilful neglect. • People above the age of 16 experience domestic abuse. • Adults (over 18 years old) are in receipt of care and support needs from their local authority. • The incident relates to other forms of abuse and/or neglect where safeguarding has been identified as a factor.	Refer to local authority safeguarding lead Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews, adult safeguarding reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding children's partnership and local safeguarding adults boards.	Create local organisational actions and feed these into the quality improvement strategy

Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response See: Guidance for managing incidents in NHS screening programmes	Create local organisational actions and feed these into the quality improvement strategy

A full list of the national incident response requirements is available on the NHS England website or by the following link:

B1465-3.-Guide-to-responding-proportionately-to-patient-safety-incidents-v1.1.pdf (england.nhs.uk)

Our Patient Safety Incident Response Plan: Local Focus

In line with the Patient Safety Incident Response Framework the Trust will utilise 4 differing methods of investigating incidents. Please see Appendix 1 for further information on these response types.

Response Type	Report Template	Is report template mandatory?
Patient Safety Incident Investigation (PSII)	Patient Safety Incident Investigation (PSII) Report Template	Yes – recommended by NHSE
After Action Review (AAR)	AAR Response Template	No – other report templates can be used depending on findings e.g., Learning on One Page (LOOP)
Multidisciplinary Team (MDT) Review	MDT Response Template	No – other report templates can be used depending on findings e.g., LOOP
Thematic Reviews	Thematic Review Response Template	No – other report templates can be used depending on findings e.g., LOOP or a written report.

Patient Safety Incident Type	Patient safety incident issue	Planned response	Anticipated improvement route
Infection Prevention and Control (IPC) *This is provisional – currently under review by NHSE Midlands IPC Group, awaiting finalisation. Where a death occurs National Requirements to be followed.	• Surgical Site Infections • HCAI Outbreak • Bacteraemia • Clostridioides Difficile • Increase of Catheter related and UTI incidents	Thematic Review	Create local safety actions and feed these into existing quality improvement workstreams: • IPCC Meetings • Theatre Focus Group • Safety Huddles
	Reportable IPC outbreaks	Divisional Governance group to decide required response with advice from IPC Lead.	

Tissue Viability	Category 3 and 4 pressure sores (acquired or deteriorated under ROHNFT care)	AAR	Create local safety actions and feed these into existing quality improvement workstreams: • Safety Huddles • Tissue Viability Mandatory Training
	All category pressure sores, acquired or deteriorated under ROHNFT care, in patients with darker skin tones	AAR	
	An increase of tissue viability related incidents	Thematic review	
Slips, Trips and falls	Where serious harm occurs as a result of the incident	Divisional Governance or Medication Safety Group to decide, either: • AAR • MDT	Create local safety actions and feed these into existing quality improvement workstreams: • Safety Huddles • Falls and Dementia Working Group
	An increase of slip, trip and fall related incidents	Thematic Review	
Venous Thrombo-embolism	Following completion of positive VTE questionnaire if there is any question over avoidability of VTE.	AAR	Create local safety actions and feed these into existing quality improvement workstreams: • Safety Huddles • VTE Advisory Group
	An increase in occurrence or severity of VTE related incidents.	Thematic Review	
Medication Error	Error in prescribing, dispensing or administering medication where moderate or severe	Divisional Governance or Medication Safety Group to decide, either: • MDT • AAR	Create local safety actions and feed these into existing quality improvement workstreams:

	harm has occurred (or near miss)		• Medication Safety Group • Drugs and Therapeutic Committee • Safety Huddles
	An increase in occurrence or severity of medication related incidents	Thematic Review	
Clinical Assessment/Care	Incident led to moderate harm or above	Divisional Governance group to decide either: • AAR • MDT Review • PSII *depending on complexity of incident	Create local safety actions and feed these into existing quality improvement workstreams: • Clinical Quality Group • Safety Huddles • TBALD
	An increase in occurrence or severity of incidents	Thematic Review	
Deteriorating patient	Potential delay in diagnosis or care leading to moderate harm or above	Divisional governance to decide, either: • PSII • AAR • MDT review	Create local safety actions and feed these into existing quality improvement workstreams: • Deteriorating Patient Group • Resuscitation Committee
Emergency Transfers Out	All	Divisional governance to decide if response required, either: • PSII • AAR • MDT review	Create local safety actions and feed these into existing quality improvement workstreams: • Deteriorating Patient Group • Resuscitation Committee
New and emergent issues	All	Review by divisional governance group and response type to be decided.	Create local safety actions and feed these into quality improvement workstreams relevant to the incident type.

For any incident not listed above, we will use a specific patient safety review tool to enable a learning response. For lesser harm incidents we propose to manage these at a local level with ongoing thematic analysis via our existing Trust assurance processes which may lead to new or supplement existing improvement work.

Appendix 1 – Overview of response types

Patient Safety Incident Investigation (PSII)

What is it?	When would you use it?	Time required to complete.	Who leads it?	Who is involved?
An in-depth review of a single patient safety incident or cluster of events to understand what happened and how.	When there has been serious harm to a patient or patients.	20 – 80 hours over several weeks.	Undertaken by a trained patient safety investigator who collates data, conducts interviews, undertakes analysis and writes the recommendations report.	People directly involved in the incident and senior clinicians.

Strengths	Weaknesses
•It is a well-established approach which is widely recognised and valued by patients and their families. •PSIIs provide a thorough analysis of an event where harm happened and ensure specific causes are identified •Responsibility for the investigation and the completion of the actions arising is clearly articulated in the governance arrangements in each provider.	•Investigations take a long time to complete and actions arising in the PSII report can take many more months to be completed. •Outcomes are less system focused than other tools. •The quality of PSIIs varied before PSIRF mandated training for investigators. • Staff are only involved when they are interviewed, and this can feel very stressful.

After Action Review (AAR)

What is it?	When would you use it?	Time required to complete?	Who leads it?	Who is involved?
A structured, facilitated discussion of an event, the outcome of which gives the individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT	After any event, where patient care or service was not as effective or safe as expected, or when events turned out better than expected	Likely to take 45 minutes to 90 mins depending on complexity of the issue and the numbers participating	Led by a trained AAR Conductor -this could be anyone from within the MDT, local or remote to the participants	Those directly involved in the event and others connected to them or the patient pathway. Patients and family members may be included

Strengths	Weaknesses
• The individuals learn for themselves what was happening and identify similarities and differences between themselves and others. • Learning during the AAR is the main focus, not the report, with those participating positioned as the agents of change and improvement. • It's a group learning process, so the interactions between members of the team are available to learn from and improve. This has a strong effect on team performance and patient safety. • It is highly adaptable, suitable for a wide range of events. • Psychological safety is actively created and maintained throughout. • Provides a safe reflective environment which staff experience as supportive, reducing isolation and rumination after events.	• Whilst lessons learned and actions arising are shared outwards and upwards, primary responsibility for change rests with those involved reducing central authority. • There are limited ways to track if individuals have changed their behaviour or completed actions as a result of the AAR. • Governance processes for tracking AAR activity and outputs are not established in many providers. This means the value of collated learning may not be available.

Multidisciplinary Team Review (MDT)

What is it?	When would you use it?	Time required to complete?	Who leads it?	Who is involved?
An in-depth process of review, with input from different disciplines, to identify learning from patient safety incidents, and to explore a safety theme, pathway, or process. To understand how care is delivered in the real world i.e. work as done	After several similar events have occurred, when it's more difficult to collate staff recollections of events, either because of the passage of time or staff availability	No defined time allocated. Likely to include a workshop lasting 2 to 3 hours	Likely to be led by a patient safety facilitator who will use the MDT review as one source of data for learning about a series of events or a theme	Those directly involved in these events from the MDT, plus patient safety experts, other senior clinicians

Strengths	Weaknesses
• The participation of many members of the MDT without the spotlight on a single adverse event enables a broad and deep discussion to take place and a system view to be gathered. • Can be adapted to incorporate the systems engineering initiative for patient safety (SEIPS) framework to structure the review.	• Responsibility for learning and acting on the learning primarily rests with the person/s who set up the MDT review reducing the sphere of influence. • Whilst participants will contribute and learn, it is not the specific purpose of the activity. • It is a planned event, and it may take many weeks to set up and ensure full MDT representation is available. • Resource intensive to undertake.

Thematic Review

What is it?	When would you use it?	Time required to complete?	Who leads it?	Who is involved?
A way of identifying patterns in data to help answer questions, show links or identify issues	Developing or revising an improvement plan; aggregating information from many sources of data; gathering insights into gaps/safety issues to direct further analysis; aggregating findings from multiple incidents to identify interlinked contributory factors; presenting summary data to show the impact of improvement work	Dependent on complexity and data sets to be reviewed - can be lengthy.	Led by an individual who understands how to conduct the review.	Those directly involved in the events and others connected to the patient pathway.

Strengths	Weaknesses
• As there is no single measure of safety – insights might come different forms - qualitative or quantitative; What is seen, heard and perceived is as important as hard data. Allows for exploration and triangulation of insights from different type of data and gives structure to this. • Allows for curiosity and a willingness to explore and being open to what the data is saying. • Allows for scoping of the questions(s) you want the review to answer, for example what factors contributed to this incident or safety theme? • Allows for collation and triangulation of data from different sources and transparency of evidence. • Allows the opportunity to seek out and include multiple perspectives that may bring out innovative ideas to find something you didn't know.	• Need to choose an approach to the analysis that best suits the question /theme – deductive or inductive. • Thematic analysis may be time consuming – requires immersion and resources. • Making assumptions too early can bias findings, be wary of drawing conclusions to soon and be open to the data. • Need to plan how the analysis will be written up to bring the findings to life – summarising is key, • Need to think about the analysis can lead to safety actions can lead to improvements

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Risk Appetite Presentation**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Adam Roberts, Assistant Director of Governance & Risk**
DATE OF MEETING:	**1st November 2023**

EXECUTIVE SUMMARY:

Please see the enclosed Risk Appetite presentation.

The aim and objectives of the session are to receive an overview of:-

1. An introduction to theory and key principles of risk appetite and risk tolerance
2. How risk appetite and tolerance should work in practice
3. Proposed Trust Board application of risk appetite and tolerance and the next steps

REPORT RECOMMENDATION:

The Board is asked to note the presentation and support the approach to considering risk appetite outlined.

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	
Business and market share		Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity	x	Workforce	x

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

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

Aligns directly to the management and oversight of the Trust's Board Assurance Framework and links to the wider BAF improvement work that is ongoing

PREVIOUS CONSIDERATION:

2 October 2019

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RISK APPETITE

Risk appetite session for the Royal Orthopaedic Hospital Trust Board – November 2023

Adam Roberts, Assistant Director of Governance & Risk and Simon Grainger-Lloyd, Executive Director of Governance

Objectives

1. Introduction to theory and key principles of risk appetite and risk tolerance
2. How risk appetite and tolerance should work in practice
3. Trust Board application of risk appetite and tolerance and the next steps

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Introduction to theory and key principles of risk appetite and risk tolerance

The Royal Orthopaedic Hospital NHS Foundation Trust

Risk Appetite

- Risk appetite can be defined *as 'the amount and type of risk that an organisation is willing to take in order to meet their strategic objectives'.*
- The word “appetite” is somewhat misleading and not always helpful in understanding the term ‘risk appetite’. It brings connotations of food, hunger and satisfying one’s needs. Easier to understand if you think in terms of ‘flight’ or ‘fight’
- Risk appetite is aspirational and linked to our goals – how much risk are we willing to take in order to achieve our strategic objectives

Introduction to theory and key principles of risk appetite and risk tolerance

The Royal Orthopaedic Hospital NHS Foundation Trust

Risk Tolerance

- Risk tolerance is about what level of risk an organisation can actually cope with
- Have to take and accept some risks and avoid others. To do so, we need to be clear about what successful performance looks like
- Risk tolerance is a performance measure, a tool for a Board to judge how well we are managing and controlling the current level of risk?
- Key question a Board needs to ask is whether performance in terms of the tolerance (control) of a risk is trending towards and aligned with our appetite (target) for that risk?

How risk appetite and risk tolerance work in practice

Key Principles

- Risk appetite and tolerance are essentially about risk and control.
- Risk appetite and risk tolerance are inextricably linked to performance over time
- Risk appetite and tolerance need to be high on any board's agenda and are a core element of good risk management of a Board Assurance Framework.
- A risk appetite statement needs to be considered and written on a risk by risk basis
- A risk appetite statement is not a tick box exercise – it is a valuable tool used to measure how good our performance is towards the control and mitigation of a risk to the achievement of each of our strategic objectives.
- A risk appetite statement needs to be flexible and adaptable to change
- Risk appetite and tolerance need to be measurable

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Trust application of risk appetite and tolerance – next steps

- First task is that the Risk appetite statement for each strategic risk should be agreed upon by the Board
- Following agreement of risk appetite statement there should be a review of, and discussion around, the following at each meeting:-
  - key current controls and future proposed actions
  - current risk score
  - risk tolerance rating

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REPORT REF: ROHTB (11/23) 010

TRUST BOARD

DOCUMENT TITLE:	**Revised Board Assurance Framework (BAF) Report – November 2023**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Adam Roberts, Assistant Director of Governance & Risk**
PRESENTED BY:	**Adam Roberts, Assistant Director of Governance & Risk**
DATE OF MEETING:	**1st November 2023**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

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

The purpose of a Board Assurance Framework

Assurance goes to the heart of the work of any NHS board of directors. The provision of healthcare involves risk and being assured is a major factor in successfully controlling risk. Assurance is the bedrock of evidence that gives confidence that risk is being controlled effectively, or conversely, highlights that certain controls are ineffective or there are gaps that need to be addressed.

The simplest purpose of the BAF is to bring together in one place all of the relevant information on the risks to the board's strategic objectives. It provides an effective methodology for boards to help them use their BAF productively so that they have real confidence that they are providing thorough oversight of strategic risk.

The BAF is also of vital regulatory importance. The well led framework requires the boards of all provider organisations to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. It extends to include a board assurance framework being in place, which is assessed by the board, reflecting risks to the initiatives in the strategic plan.

The requirement to have a BAF forms part of the relevant governance codes and frameworks and is applicable to all providers of health and social care services in England whether the entity is private, public sector, not-for-profit or charitable.

There is some ambiguity and differences of opinion around whether a BAF should be used, quite literally, as a wider mechanism for managing a Trust's assurances to the Board; or whether the BAF should be used as the key document used to record and report on an Trust's risks, controls and actions that drive towards its achievement of its strategic aims and objectives.

Guidance from NHS Providers suggests that the correct approach for Trust boards should be to align their BAF to their strategy and/or strategic objectives.

The Revised ROH Board Assurance Framework

New Strategic Risks

The drafting and publication of the Trust's new strategy for 2023/2028 provided the ideal opportunity to review and reflect upon the current iteration of the Trust's BAF.

Upon review of the 'current' BAF it was apparent that the risks populating it were more akin to high level current operational risks that were not sufficiently clearly, nor adequately aligned to the specific strategic objectives of the Trust.

In essence, the risks were of clear strategic relevance and significance in terms of their impact but were not framed or worded in a way that reflected the actual risk to delivery and implementation of each of the specific objectives set out in the Trust Strategy. There were no overarching high level risks that directly correlated with the actual aims and objectives of the strategy and the risk to its delivery.

Based on the review and based on the new Trust Strategy we proposed at the October Trust Board meeting that the Trust adopts a BAF that carries 6 overarching, high level risks that correlate and align directly to each of the 6 new strategic objectives (Our Care, Our Expertise, Our People, Our Community, Our Services and Our Collaboration).

In the enclosed revised BAF example you will see that further work to improve the presentation of the BAF has been undertaken. This version contains a newly proposed risk layout that summarises the risk to achievement of one of the specific objectives, with the potential causes and consequences set out within the narrative of each risk.

If this approach is approved then all 6 of the BAF risks will be presented in this way going forward.

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

Risk Appetite Statements

A Risk Appetite Presentation is on the agenda for the November Trust Board meeting.

Next Steps

It is proposed that a session at an upcoming Trust Board meeting is scheduled, with the aim of agreeing and approving the risk appetite statements for all 6 of the BAF risks and rating the assurance of the controls of those risks.

ASSURANCE PROVIDED BY THE REPORT:	
POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
• Alignment of BAF to strategic objectives is in line with true purpose of BAF and follows relevant risk management guidance and best practice. • Proposed new strategic risks have risk appetite statements • Action plans are aligned to the wider Trust Strategy and Plan • Revised BAF incorporates comments and feedback from KPMG external audit lead	• Mapping of current high-level risks to new strategic risks is a work in progress
NOT APPLICABLE	
REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:	
The Board is asked to: consider and discuss the proposed changes to the Board Assurance Framework	

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

ALIGNMENT TO TRUST STRATEGY, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Direct alignment to Trust's strategy
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
PREVIOUS CONSIDERATION:
Previously considered at October Trust Board

BOARD ASSURANCE FRAMEWORK SUMMARY

REF	STRATEGIC RISK	DATE OF ENTRY	LAST UPDATE	LEAD EXEC	LEAD COMMITTEE	TARGET RISK SCORE	CURRENT RISK SCORE
SR1	**OUR CARE**	Sept 23		Chief Nurse	Trust Board Q&SC	4 (1LX4C)	12 (3Lx4C)
SR2	**OUR EXPERTISE**	Sept 23		Medical Director	Trust Board Q&SC SE&OD	6 (2Lx3C)	9 (3Lx3C)
SR3	**OUR PEOPLE**	Sept 23		Chief People Officer	Trust Board SE&OD	10 (4Lx5C)	20 (4Lx5C)
SR4	**OUR COMMUNITY**	Sept 23		Chief Executive Officer	Trust Board	8 (2Lx4C)	12 (3Lx4C)
SR5	**OUR SERVICES**	Sept 23		Chief Operations Officer	Trust Board, FPC	5 (1Lx5C)	15 (3Lx5C)
SR6	**OUR COLLABORATION**	Sept 23		Chief Executive Officer	Trust Board	8 (2Lx4C)	12 (3Lx4C)

QUARTERLY RISK SCORE MOVEMENT

	October 2023	January 2024	April 2024	July 2024	October 2024	January 2025	`April 2025	July 2025	October 2025
SR1	12 (3Lx4C)								
SR2	9 (3Lx3C)								
SR3	20 (4Lx5C)								
SR4	12 (3Lx4C)								
SR5	15 (3Lx5C)								
SR6	12 (3Lx4C)								

Board Assurance Framework (BAF): SR1 - OUR CARE - November 2023

Risk Reference: SR1 - Our Care	Strategic Risk: There is a risk that the Trust will fail to meet its objective of being rated as 'outstanding' by the CQC by 2028.	**Causes**	As a result of the Trust:- Not being able to maintain current standards of service and patient care; Not being able to optimise pathways to ensure they are seamless and patient centred; Not being enabling patient-led booking via implementation of innovative digital technologies; Not having enough staff and resources Not having a suitable physical estate or environment	**Consequence**	With the consequence of detriment to:- Patient safety, The quality of service we provide; and Our reputation and rating as a Trust.	**Priorities**	Workforce Estates Digital Transformation Operational performance	**Strategic objective:**	**CARE - By 2028, we will be rated as 'outstanding overall' by our regulators, the Care Quality Commission. This will indicate that we are achieving the highest levels of care and quality.**
Lead Committees	Trust Board, Q&SC	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	4		4			**October 2023**	12 (3IX4c)
Executive Lead:	Chief Nurse	**Likelihood**	3		1			**January 2024**	
Initial Date of Assessment	September 2023	**Risk Rating**	12		4	TBC		**April 2024**	
Risk appetite Statement	The Trust has a low/no tolerance to risks that have the potential to negatively impact the quality of care we provide and the safety of our patients							**July 2024**	
								October 2024	

SUMMARY OF KEY CONTROLS AND MITIGATIONS	ACTIONS PLANNED
Good oversight of current clinical and operational performance at sub-board committees	Delivery of our People Plan
Maintenance schedule	Delivery of our Operational Delivery Plan
Quality & Safety walkabouts	Delivery of our Clinical Plan
GIRFT accreditation	Delivery of our Nursing Plan
	Delivery of our Patient Safety Plan
	Delivery of our Patient Experience Plan
	Implementation of PSIRF
	Implementation of actions in our Good to Outstanding Plan

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

Aligned Clinical Risks	Target Score	Current Score
Risk MD1 - If a patient develops a clinical condition that is outside the scope or level of organ system support they need, there may be harm as a result of delay or a ceiling on the care offered at the ROH site. The impact will be clinical and may be financial, reputational, and legal.	5 (1Lx5C)	10 (2Lx5C)
Risk MD3 (also see CE2) - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required in the context of mutual aid. The wait may be due to intrinsic factors within the Trust or the Trust may inherit a risk transferred from other providers as part of mutual aid arrangements. This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	10 (2Lx5C)	15 (5Lx3C)
1918 - Risk relating to patients no longer having access to specialist speech and language assessment and support	4 (1Lx4C)	16 (4Lx4C)
Risk 1759 - risk relating to abilty to meet the national standard of having access to a senior children's nurse for advice at all times throughout the 24 hour period.	4 (1Lx4C)	8 (2Lx4C)
Risk No 1919 - Risk relating to potential patient harm due to possible failure of current blood glucose meters which could result in insufficient monitoring devices within the Trust	4 (1Lx4C)	12 (3Lx4C)
Risk 1467 - Risk relating to non-compliance with blood transfusion standards as a result of no Transfusion Practitioner dedicated to ROH.	5 (1Lx5C)	10 (2Lx5C)
Risk 1573 - risk relating to patient outcomes and consequent risk of harm due to ongoing backlog and increased waiting times for physiotherapy.	3 (1Lx3C)	9 (3Lx3C)

Risk 1938 & MD4 - risk of patient harm when novel techniques and devices are used in care provision, as happens in research and in service evaluation of a new technology. The cause is that all procedures and devices carry a risk of harm; in the case of new technology the level of uncertainty about the outcome is higher and there is a possibility of a cohort of patients experiencing harm before a pattern is identified. The consequences of patient harm would be clinical, reputational, and financial.	10 (2Lx5C)	15 (3Lx5C)

Aligned Operational Risks	Target Score	Current Score
Risk CE2 - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required. The wait may be due to intrinsic factors within the Trust or inherited as part of mutual aid . This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	8 (2Lx4C)	12 (3Lx4C)
1089 - risk relating to failure to meet national 52 week waiting time targets	9 3Lx3C)	20 5Lx4C)
656 - risk relating to delayed or missing imaging referals due to reliance on a paper based referral system posing a risk to patient safety, diagnostic standards, cancer target performance and overall compliance with national RTT targets	3 (1Lx3C)	16 (4Lx4C)
Risk 1893 - Risk of patient harm due to delays in receiving histology results which may impact patients treatment and/or outcomes Turnaround times as described in the Service Level Agreement with UHB are not being met and result in Cancer target breaches and poor patient experience	8 (2Lx4C)	16 (4Lx4C)

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

Risk 1917 Risk relating to patients not having their dietary needs assessed and met as a result of lack of suitabilty skilled and trained staff employed by the Trust	4 (1Lx4C)	12 (3Lx4C)
Risk 27 - risk relating to Inability to control the use of unfunded temporary/agency staffing. Reduced availability of suitably qualified junior doctors in training posts either GP trainees or FY2.	4 (1Lx4C)	12 (3Lx4C)
Risk 1425 - risk relating to high number of days lost due to stress, anxiety and MSK	6 (2Lx3C)	12 (4Lx3C)
Risk 1809 - Risk relating to potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	6 (2Lx3C)	9 3Lx3C)
Risk 1710 -risk relating to patient safety and quality of care risks due to ongoing challenges associated with nursing workforce gaps	6 (2Lx3C)	9 3Lx3C)
Risk 1895 - Risk of regulatory non compliance as a result of the Trust being unable to recruit a resuscitation officer. With this post vacant the trust is at risk of not remaining up to date with legislation/ guidance and changes in practice	6 (2Lx3C)	9 3Lx3C)
Risk MD2 - There is a risk of a shortfall of ward doctors due to the Deanery do not send the agreed number of GP trainees to rotate into the Trust. This may lead to gaps in the ward cover rota, clinical risk, reduced contact with the GP community or financial cost.	4 (1Lx4C)	12 (4Lx3C)
CL1 - There is a risk that poor staff retention will lead to higher use of temporary staffing which has the potential to compromise the delivery of consistent high quality of care to our patients.	4 (1Lx4C)	12 (3Lx4C)
Risk CL6 - There is a risk that poor mechanisms for staff engagement will limit the Trust's ability to demonstrate the linkage between the work of staff in all disciplines to the delivery of excellent patient care.	tbc	tbc

Aligned Estates Risks	Target Score	Current Score
Risk 770 - risk relating to aged theatre plant	5 (1Lx5C)	12 (3Lx4C)
Risk CL8 - There is a risk that as a result of insufficient capital funding to replace parts of the ageing Estate, there is limited capacity to treat additional cohorts of patients and increase productivity.	4 (1Lx4C)	12 (3Lx4C)

Aligned Digital/IT Risks	Target Score	Current Score
Risk 1648 - Risk of non-delivery of Quality Improvement Projects due to problems with clinical informatics projects	3 (1Lx3C)	12 (4Lx3C)
Risk 1181 - risk relating to lack of abilty for IT systems to flag safeguarding alerts	6 (2Lx3C)	12 (4Lx3C)
Risk 1089 - There is a risk that a fully integrated and fully interoperable electronic patient record (EPR) will not be achieved in the required timelines. This will impact on an ability to meet the national Healthcare Information and Management Systems Society required level 5 be met, and we will fail to achieve Digital Capable Framework Compliance. This would put at risk the financial sustainability by restricting our ability to transform processes and deliver efficiencies.	9 3Lx3C)	20 5Lx4C)
Risk CL2 - There is a risk that the lack of suitable technology to automate the assessment of the Trust's delivery of care against the CQC key lines of enquiry that areas of poor compliance may not be visible.	3 (1Lx3C)	12 (4Lx3C)

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

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

Aligned risk
Estates: [3]

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

PAPER REFERENCE: ROHTB (11/23) 012

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE QUALITY & SAFETY COMMITTEE

Date Group or Board met: 18 October 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There were reported to be continuing risks associated with the resilience of some of the Trust's clinical Service Level Agreements although work was underway with System partners to ensure that there was adequate service provision when needed. • It was noted that in terms of wellbeing concerns raised via the FTSU route, some issues had been raised in connection with availability of refreshments out of hours; this related to the disruption caused by the refurbishment of the canteen which had now been largely resolved. • It was noted that the endoscopic spinal pathway remained paused pending further review. • It was noted that vaccination uptake was lower at present than in previous years.	• Update on the two deaths after discharge for the next meeting. • Provide an explanation of the visual WHO check at the next meeting. • Pathway approach to excellence in quality to be presented at the January and subsequent meetings. • Recommendation to be presented to the Quality & Safety Committee around the plan to resume the endoscopic spinal surgery pathway at the January 2024 meeting. • Arrange a Committee briefing for December 2023.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Risk summits have continued to revise and refresh the clinical risks. • The Quality Report was noted to have evolved to include a focus on key themes – this was in line with the intentions of the new Patient Safety Incident Response Framework (PSIRF). • The Committee was joined by the Associate Director of Operations for Outpatients & Transformation who presented an overview of the work to investigate the cluster of incidents raised in connection with Outpatient appointments. The issues related to staffing levels some months ago which had been resolved and the review of the incidents did not identify any harm that had arisen as a result of the delays. • The Committee received an update on the proposed PSIRF policy and plan. The work and actions arising would feed into the Continuous Improvement framework. The team was invited to a check and challenge session with other BSol partners on 23 October 2023. The plans included the introduction of Patient Safety Partners.	• The Committee approved its revised workplan.

• An update on patient experience was presented which provided good assurance around the process for managing complaints and PALS contacts. It was noted that the PALS contacts at ROH were significantly lower than those of the other specialist orthopaedic trusts and the reasons for this were being reviewed. It was noted that the complaints process had been refreshed in cognisance of the revised guidance issued by the Public Health Service Ombudsman (PHSO). • An update on surgical site infections was considered which did not indicate any risks or matters of concern. • An update on the quality safety walkabouts was given which described the approach to assessing the clinical areas using a CQC inspection methodology. Action plans were developed in response to the outcome of the inspections which were monitored through the divisional governance routes. It was noted alongside this work, ward accreditation was being worked up. • The Committee chair shared a proposed approach to reviewing pathways and establishing a set of metrics which could be monitored to provide a view on quality improvement. It was agreed that this approach would be applied and presented back at a future meeting. It was suggested that the same methodology could be used for the staff journey through the Trust. • An update on the Patient Reported Outcome Measures (PROMS) was presented which showed overall, the Trust's position for most procedures compared to other providers as better. It was noted that the results would be used to promote the clinical excellence of services at the ROH. • An interim report on Controlled Drugs was presented which described sound management of the framework for the management of these medications. • The work to provide grip and control around temporary nurse staffing was described, including the establishment of a vacancy control forum. It was noted that there had been a reduction in the vacancy factor in nursing.	

• The Committee action plan was considered which showed further progress with delivery including the revised workplan.	
Chair's comments on the effectiveness of the meeting: It was agreed to have been a productive meeting which had been well chaired.	

PAPER REFERENCE: ROHTB (11/23) 013

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 25 October 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that the risk around the recruitment into the estates workforce related primarily to being able to offer competitive terms and conditions to equivalent roles in the private sector. The Committee was assured that the use of apprenticeships was being used to attract individuals into the ROH where possible. • It was noted that the implementation of a new Learning Management System (LMS) was deferred to the next financial year although the work to prepare for the procurement exercise remained ongoing. • It was highlighted that two out of four of the BSol system workforce workstreams were being led by ROH Executives, which potentially created a risk in terms of capacity. The situation would be monitored closely. • An increase in absences due to mental health reasons was reported.	• Detailed overview of sickness absences to be presented at the Committee in January 2024. • Present the final audit report into Mandatory Training data at the January 2024 meeting. • Present an update on bank and agency usage at each meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee heard the story of the Deputy Head of Estates who described his journey through the ROH. It was noted that he had been given good opportunities in terms of training and education and was now undertaking a degree course related to his area of expertise. • A positive movement in the completion of the national staff survey was highlighted. • The current leaver process was outlined, together with the improvements planned to this, including enhanced training for staff undertaking exit interviews. • Time to hire was reported to have reduced and the workforce establishment was noted to be improving. There were plans to focus on retirements to ensure that those wishing to work after formal retirement were able to do so more easily. • A new format for the workforce report was presented. It was suggested that an 'At a Glance' summary page would be useful.	• Approved the Equality & Diversity annual report - this would be provided to the Trust Board for assurance.

• Improvements in training rates for Information Governance, Cyber security and resuscitation were highlighted. It was noted that Oliver McGowan learning disabilities training would be introduced. • A draft audit report into the data around Mandatory Training was noted to have provided 'Significant Assurance with minor improvements needed'. • There has been an increase in the rate of appraisals and the new methodology is due to be rolled out shortly. • The recent People Pulse survey shows improvements in terms of engagement and staff recommending the ROH as a place to be treated and at which to work. • The Committee endorsed the integrated workforce plan which had been supported by Midlands and Lancashire Clinical Support Unit (CSU). It was noted that the priorities arising from this should be aligned to the Trust's overall strategy. This included building in the necessary skill sets to 'future proof' the ROH. • The self-assessment against the national Long Term Workforce Plan provided a positive view of progress. • An update on apprenticeships was provided which showed that in 2023/24 to date, 18 apprenticeships had been filled and the Trust was on track to recruit into 26 of the 29 roles by the year end. • It was noted that good progress had been made on the equality and diversity agenda, including championing the staff voice through the networks. • Good progress was noted against the Workforce Race Equality System (WRES) and Workforce Disability Equality System (WDES). Both action plans had been developed jointly with the network leads. • Work to support the Equality & Diversity System (II) was reported to be on track for delivery with a focus on PALS contacts, End of Life Care and accessibility. • The Trust was noted to have been successful in securing an award for 'Workforce Retention Initiative' in the recent National Orthopaedic Alliance awards to reflect the hardship fund that had been established.	

Chair's comments on the effectiveness of the meeting: It was agreed to have been a productive meeting which had been well chaired with a more concise agenda.

PAPER REFERENCE: ROHTB (11/23) 014

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE AUDIT COMMITTEE

Date Group or Board met: 20 October 2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There remain a number of instances of breaches to SFIs or waivers which the Committee noted was disappointing and encouraged further work to make it clear in some cases, that these were unacceptable. It was noted that in a number of cases however, the instances reflected an extension to current contracts which using the new contracting management solution, would be addressed more robustly in future. • The poorer than desired performance against the Better Payment Practice Code was noted and an action plan had been prepared and submitted to NHS England. The Committee would take a key role in oversight of this work.	• The declarations process remains manually driven at the moment but it is anticipated that the new corporate governance solution planned to be introduced in 2024 will help with automation of the process. • Demonstration of the new contract management software to be provided at the next meeting, together with a summary of the contracts and their respective values. • Final Mandatory Training audit to be presented with action plan at the January 2024 meeting. • An analysis of themes associated with breaches and waivers to be presented at the next meeting. • Update the self-assessment questionnaire to ensure that the questions are devoid of technical language.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The internal audit plan for 2024/25 is being drafted earlier in the year than previously to allow more time and debate prior to final agreement. • The strengthened process for contracts management was outlined and welcomed by the Committee. • The Committee noted the 'Positive Assurance' opinions in respect of the Theatres Utilisation and draft Mandatory Training Information reviews. In respect of the first of these audits, improvement in the use of the information from Theatreman was a key recommendation. The theatres utilisation audit findings support the work ongoing to reduce early finishes and efforts to improve productivity. • The outline plans for the 2023/24 external audit were discussed and there had been a debrief from the 2022/23 process which would feed into next year's work.	• The Committee supported the changes to its terms of reference and these are attached for the Board's approval.

• The progress report from Counterfraud was considered, which highlighted good work over the last quarter, including delivery of a number of training sessions and some reactive work. • There was reported to have been no losses or special payments made during the period. • The Committee was pleased at the work to refine the Board Assurance Framework and realign it to the new strategic objectives. It was noted that there was effort to ensure that there was a balance between minimal and excessive information and to clarify the risks to the delivery of the Trust's strategic objectives. • The Committee received an update on risk improvement, which included procurement of a new risk management solution and creating a focus on the risk registers held by the corporate areas. A session on risk appetite was noted to be planned for delivery at the Board session in November 2023. • The Committee noted the plan for self-assessing its effectiveness and that of the audit functions over the next period. • It was noted that the standards within the Data Protection and Security Toolkit (DPST) had changed, with one of the most significant being a move away from 95% completion rate for cybersecurity training to a level that the organisation feels is appropriate. The new standards would be audited as part of the internal audit workplan.	

Chair's comments on the effectiveness of the meeting: It was agreed that the agenda included enough space for the opportunity to seek assurance from colleague on key pieces of work. The Committee agreed that the balance of good humour and serious debate made for a productive meeting. The Committee members invited the auditors to a private meeting after the main meeting.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust

Audit Committee

1 Constitution

The Board hereby resolves to establish a Committee of the Board to be known as Audit Committee. The Committee is a non-executive Committee and as such has no delegated authority other than that specified in these Terms of Reference.

2 Delegated Authority

The Committee has the following delegated authority:

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

2.1.2 The authority to take decisions on behalf of The Trust Board on matters relevant to the objective of the Committee; and,

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

2.1.4 The authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3 Accountability

The Committee is accountable to the Trust Board.

4 Reporting Line

The Trust Board and Council of Governors (for specific matters)

5 Objective

To provide independent oversight and scrutiny of compliance and effectiveness across the whole organisation and all its functions. Internal and external auditors are a key means to providing that assurance**.**

6 Duties

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

6.1 <u>Internal control and risk management</u>

6.1.1 To ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance.

6.1.2 To maintain an oversight of the foundation trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements.

6.1.3 To review the adequacy of the policies and procedures in respect of all counter-fraud work.

6.1.4 To review the adequacy of the foundation trust's arrangements by which foundation trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

6.1.5 To review the adequacy of underlying assurance processes that indicate the degree of

achievement of corporate objectives and the effectiveness of the management of principal risks.

6.1.6 To review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

6.2 Internal audit & counter fraud

6.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

6.2.2 To oversee on an on-going basis the effective operation of internal audit in respect of:

- Adequate resourcing
- Its co-ordination with external audit
- Meeting mandatory Public Sector Internal Auditing Standards.
- Providing adequate independent assurances;
- Meeting the internal audit needs of the foundation trust.
- Delivering the agreed internal audit programme.

6.2.3 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.2.4 To consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.

6.2.5 To conduct an annual review of the internal audit function and market test at least every 5 years.

6.2.6 To ensure that appropriate processes and resources are in place to support the detection and prevention of fraud.

6.2.7 To consider the major findings of counter fraud investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.3 External audit

6.3.1 To make recommendations to the Council of Governors in respect of external auditors covering:

- Appointment
- Reappointment
- Removal

To the extent that recommendations are not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendations were not adopted.

In support of the above the Audit Committee will make a report to the Council of Governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable the Council of Governors to consider whether or not to re-appoint them.

The Audit Committee will approve the remuneration and terms of engagement of the external auditor. Consideration should be given to assessing the auditors work and fees on an annual basis, and there should be a market testing exercise at least once every 5 years.

6.3.2 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

6.3.3 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

6.3.4 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

6.4 **Review of Annual Report & Accounts~~, incorporating the Quality Account~~**

6.4.1 To review the annual statutory accounts, before they are presented to the board of directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is

not limited to:

- The meaning and significance of the figures, notes and significant changes
- Areas where judgment has been exercised
- Adherence to accounting policies and practices
- Explanation of estimates or provisions having material effect
- The schedule of losses and special payments
- Any unadjusted statements
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
- The Trust's going concern status and any disclosures associated with this

6.4.2 To review the annual report and ~~statement of internal control~~Annual Governance Statement (AGS) before they are submitted to the board of directors to determine completeness, objectivity, integrity and accuracy.

6.4.3 To receive the Annual report and associated annual opinion from the HOIA and to consider the AGS is consistent with this opinion.

~~6.4.4 To review the annual quality account before it is submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.~~

6.5 Standing orders, standing financial instructions and standards of business conduct

6.5.1 To review on behalf of the board of directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

6.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

6.5.3 To review the scheme of delegation.

6.6 Other

6.6.1 To review performance indicators relevant to the remit of the audit committee.

6.6.2 To examine any other matter referred to the audit committee by the board of directors and to initiate investigation as determined by the audit committee.

6.6.3 To annually review the accounting policies of the foundation trust and make appropriate recommendations to the board of directors.

6.6.4 To develop and use an effective assurance framework to guide the audit committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.

6.6.5 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health (and social care) sector and professional bodies with responsibilities that relate to staff performance and functions.

6.6.6 To review the work of all other foundation trust committees in connection with the audit committee's assurance function.

6.6.7 As part of the annual report,~~To~~ produce an annual report for Trust Board covering the activity and effectiveness of the Audit Committee.

6.6.8 To report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

7 Permanency

The Committee is permanent.

8 Membership

Chair
A suitably qualified non-executive Director. Members of the committee have the power to elect one of their members as Vice Chairman to act as the Chairman in the absence of the substantive Chairman.

Other members
At least two other ~~NEDs~~Non Executives.

9 Quorum
The Chair and one other ~~NED.~~Non Executive.

10 Secretariat
~~Director of Corporate Affairs & Company Secretary~~Arranged through the office of the Director of Governance.

11 In attendance, by invitation
Regular attendance
~~Director of Finance and Performance~~Chief Finance Officer
Medical Director
Internal Auditors
External Auditors

Occasional attendance
Chief Executive
Chairman

The Committee may request the attendance of any director or manager to seek assurance on progress of key pieces of work or plans to address audit recommendations.

12 Internal Executive Lead
~~Director of Finance & Performance~~Chief Finance Officer.

13 Frequency of meetings
Not less than five times per annum

14 Work programme
The Committee will prepare an annual work programme covering at least 12 months. The Work Programme is to be a living document which steers the agenda for the committee. Progress should be updated for each meeting via rolling action notes.

15 Review of terms of reference
This should be undertaken annually.

16 Date of adoption
October 2023~~2~~.

17 Date of next review

October 2024~~3~~.

Finance and Performance Report

Month 06

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.

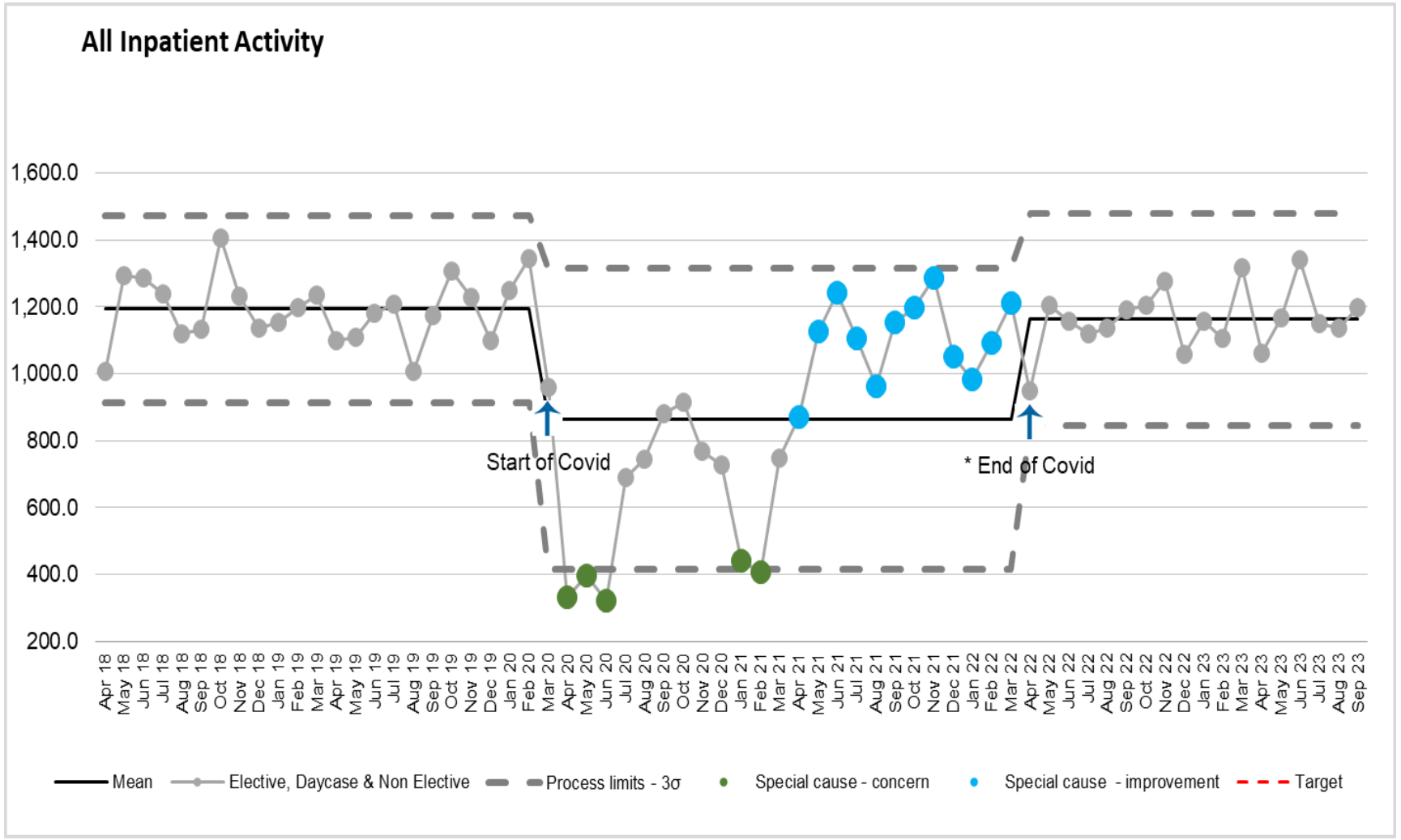
Operational Performance Summary

Performance to end September 23	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	55.10%	55.48%	92%		F
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	37	30	0	L	F
52 week waits (52 – 64 Weeks)	421	358	0	H	F
Elective activity YTD (compared to plan)	7,053	5,856	7,007 46 ahead		P
Outpatient activity YTD (compared to plan)	32,661 110.2% Cumulative	27,248 100.7% Cumulative	32,591 YTD Target 70 ahead		P
Outpatient Did Not Attend (YTD)	7.8%	7.4%	8%		P
PIFU (trajectory to 5% target)	412 8.0	425 7.9%	193 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	10.6%	10.5%	19%		F
FUP attendances(compared to 19/20)	90.2%	91.0%	75%		P
Diagnostics volume YTD (compared to plan)	11,754 Cumulative	9,703 Cumulative	9,253 YTD Target		P
Diagnostics 6 weeks target 9253	99.9%	99.2%	99%		P

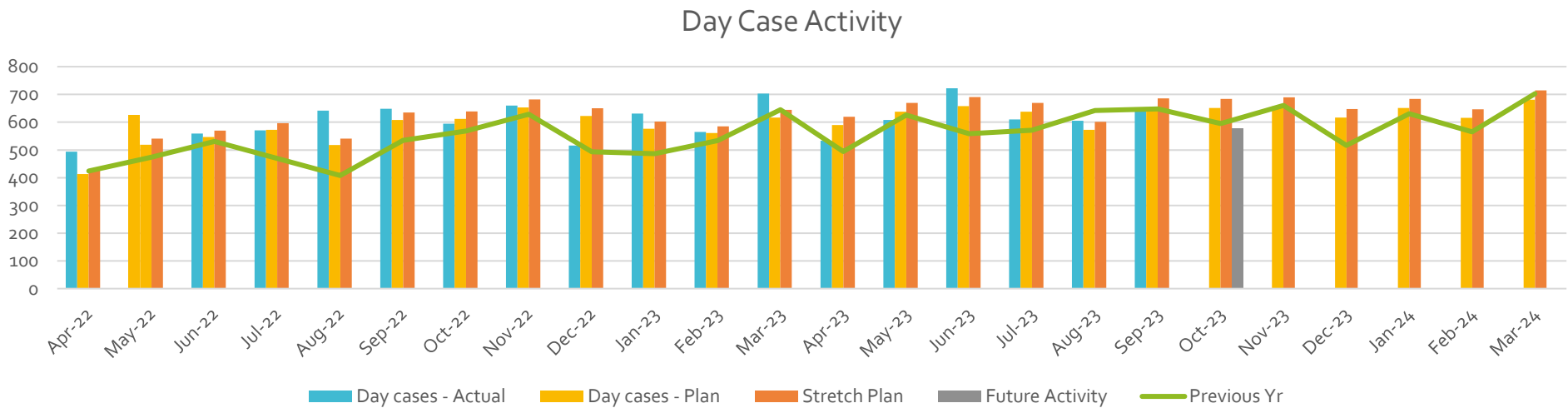
Operational Performance Summary

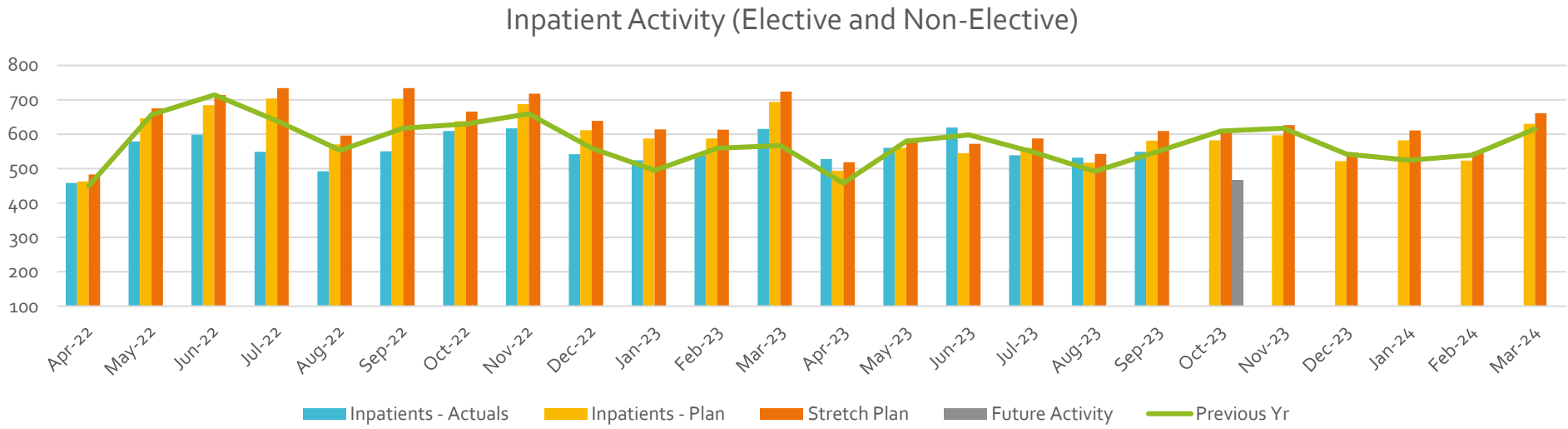
	In month	Previous month	Target	Variation	Assurance
In theatre session utilisation	83.6 %	79.0%	85%		
Cancer - 2 week wait (May – Apr)	97%	98%	93%		
Cancer - 31 days first treatment	100%	100%	96%		
Cancer - 31 days subsequent (surgery)	100%	100%	94%		
Cancer - 62 days (traditional)	80%	80%	85%		
Cancer - 62 days (Cons upgrade)	74.1%	100%	n/a		No Target
28 days FDS	80 %	77%	75%		
Patients over 104 days (62 days standard)	0	1	0		
POAC activity volume (YTD)	12,385 Cumulative	10,360 Cumulative	11,335 Cumulative		
Bed Occupancy (excluding CYP and HDU)	69.8%	72.8%	82-85%		
LOS - excluding Oncology, Paeds, YAH, Spinal	3.51	3.31	n/a		No Target
LOS - elective primary hip	3.30	3.30	2.7		
LOS - elective primary knee	3.70	3.40	2.7		
BADS Daycase rate (Note: due to time lag in month is June'23)	74%	75%	85%		

1. Activity Summary

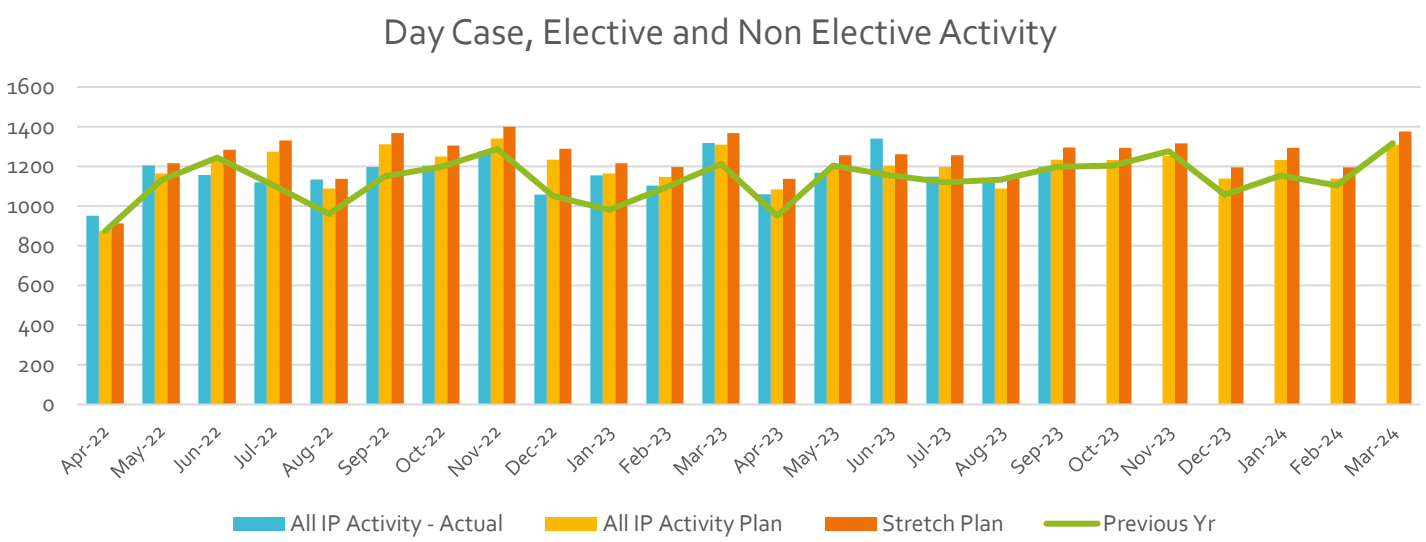


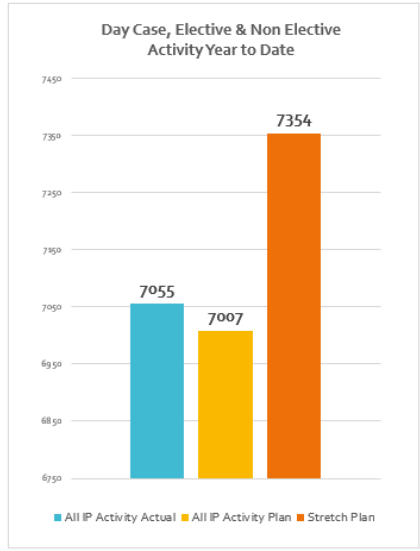
1. Activity Summary





1. Activity Summary



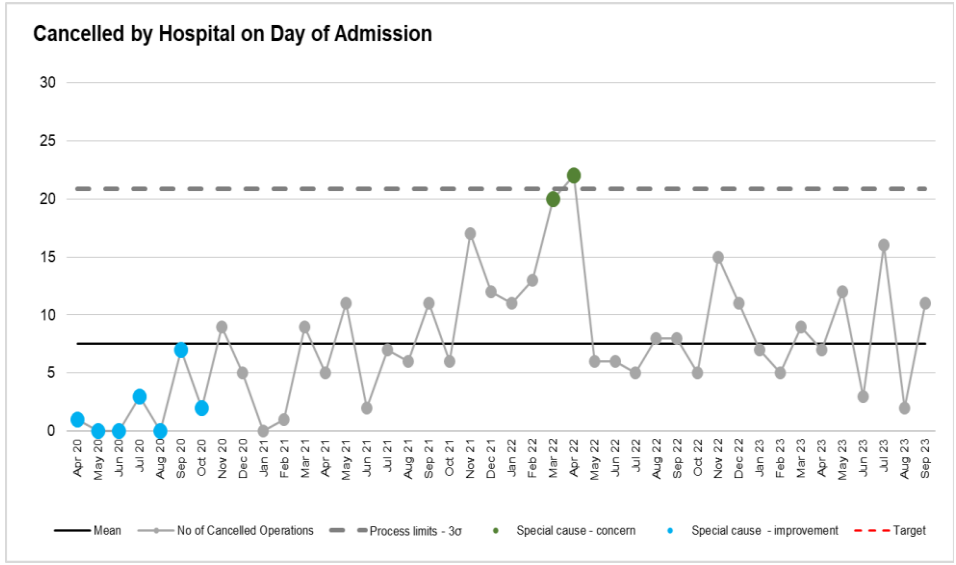


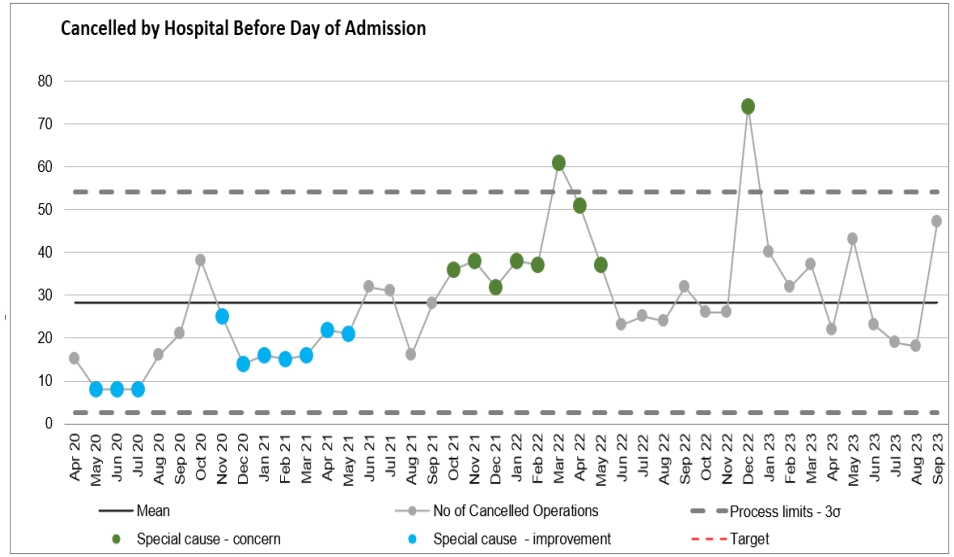
		Plan												Plan	Actual	% Achieved	Variance
	Activity Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Year to Date	Year to Date	against plan	Year to Date
Trust Plan	Inpatient	483	547	533	547	505	568	569	584	510	569	511	616	3183	3168	100%	-15
	Daycase	590	638	658	638	573	653	651	657	617	651	616	681	3750	3728	99%	-22
	NEL	11	13	12	13	12	13	13	13	12	13	12	14	74	159	215%	85
	All Activity	**1084**	**1198**	**1203**	**1198**	**1090**	**1234**	**1233**	**1254**	**1139**	**1233**	**1139**	**1311**	**7007**	**7055**	**100.7%**	**48**
Stretch Plan	Inpatient	507	574	560	574	530	596	597	613	536	597	537	647	3342	3168	95%	-174
	Daycase	620	670	691	670	602	686	684	690	648	684	647	715	3938	3728	95%	-210
	NEL	11	13	12	13	12	13	13	13	12	13	12	14	74	159	215%	85
	All Activity	**1138**	**1257**	**1263**	**1257**	**1144**	**1295**	**1294**	**1316**	**1195**	**1294**	**1195**	**1376**	**7354**	**7055**	**96%**	**-299**

September 2023

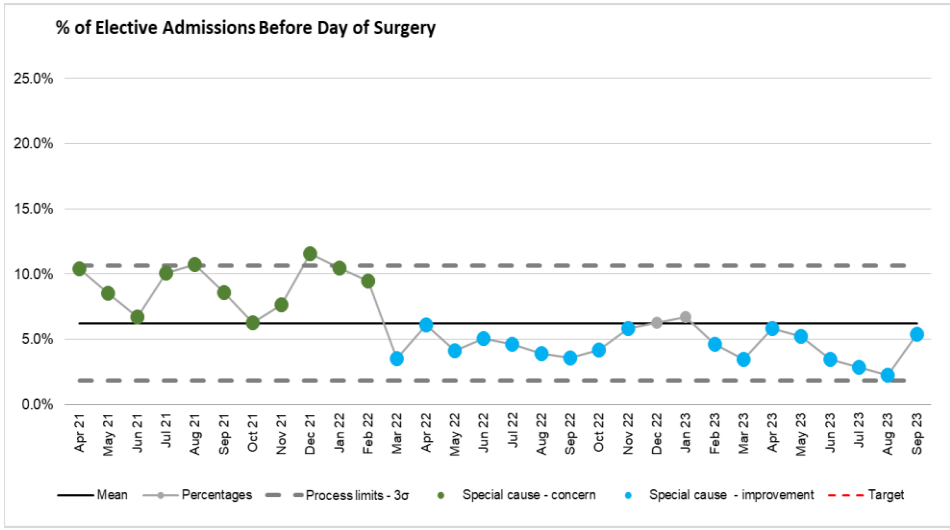
Actual in month 1199 vs 1234 System Plan (Variance -35)
YTD position against Actual vs System plan is 100.7% (Variance +48)
Overall impact of the industrial action in September is estimated at 65 cases therefore delivery against target is better than predicted

2. Theatre Utilisation/ Hospital Led Cancellations

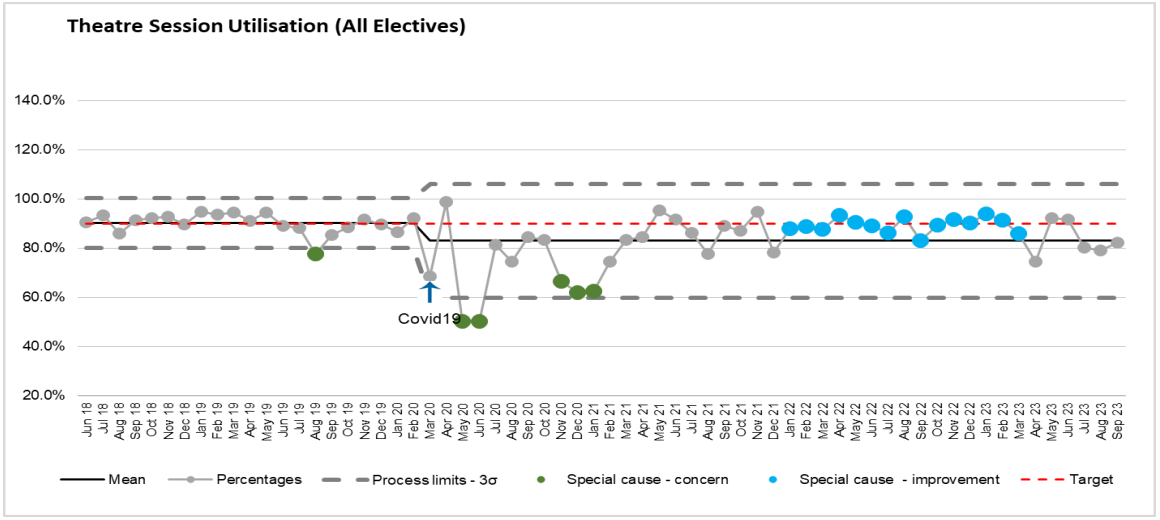


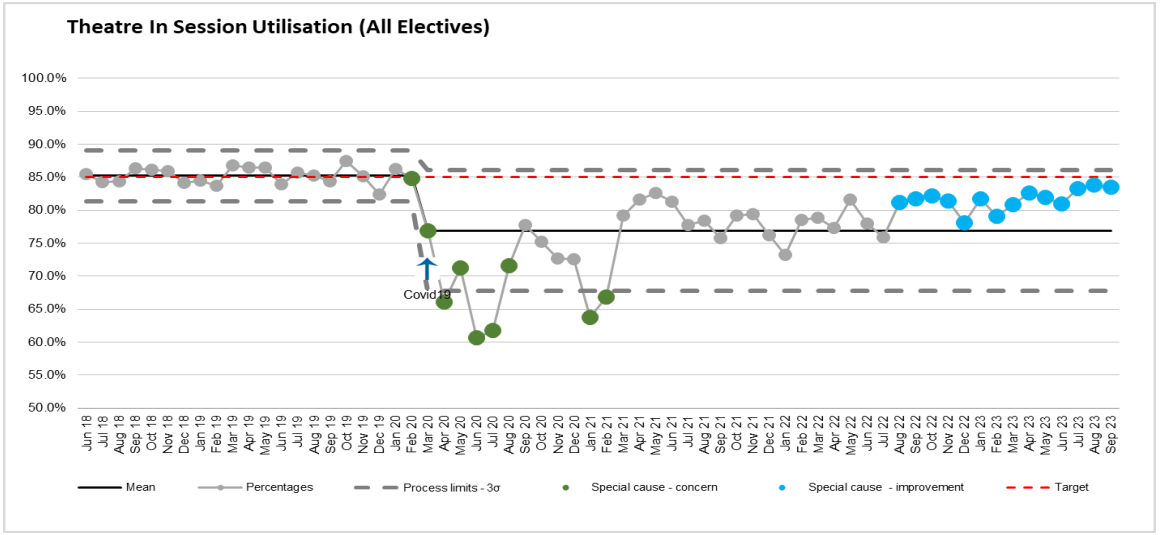


Year - Month	Cancelled by Hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by Hosp. Before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
Sep-22	8	29	32	69	0
Oct-22	5	35	26	66	0
Nov-22	15	18	26	59	0
Dec-22	11	24	74	109	0
Jan-23	7	25	40	72	0
Feb-23	7	29	33	69	0
Mar-23	9	31	37	77	0
Apr-23	7	24	22	53	0
May-23	12	16	43	71	0
Jun-23	3	27	23	53	0
Jul-23	16	20	19	55	0
Aug-23	2	27	18	47	0
Sep-23	11	22	47	80	0
Total	**113**	**327**	**440**	**880**	**0**



2. Theatre Utilisation





Elective Session Utilisation (September 2023)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	464	384	80	82.76%
UHB	84	66	18	78.57%
Totals	**548**	**450**	**98**	**82.12%**

Elective In Session Utilisation (September 2023)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1670	1400	269	83.87%
UHB	288	235	53	81.57%
Totals	**1958**	**1635**	**322**	**83.53%**

2. Theatre Utilisation

SUMMARY

Overall theatre session utilisation for September was **82.12%** which was slightly below the Trust target of **85%,**

The in-session utilisation of the ROH lists improved in month at **83.87%** and the utilisation of UHB lists was **81.57%** resulting in an overall **t**otal in-session utilisation of **83.57**%.

The consultant and junior doctor industrial action resulted in all elective theatres being cancelled with cover in place for emergency patients and CT guided biopsies. 2 periods of industrial action were held over 4 days resulting in a loss of 24 days of theatre. It is estimated that the session utilisation without industrial action would have exceeded the Trust target at 87%. It is not possible to estimate the in-session utilisation.

AREAS FOR IMPROVEMENT

Specialty theatre performance packs have been produced and shared with CSL's and CSM's The theatre triumvirates are meeting with the specialty CSMs and CSLs to review the data and provide opportunities to theatres for improvements in productivity and efficiency.

In line with the Trust's financial position, the operations team have re-visited processes and escalations for request for new kit. An additional approval process has been put in place to ensure new requests are clinically agreed at MDT prior to submission to Medical Devices Advisory Group. Tighter controls are in place for UHB surgeons requesting kit that is not on the ROH shelves with sign off required by the Associate Director of Operations. Consignment kit for limb reconstruction will be available to avoid loan kit expenditure.

A theatre 6 day working group has been established, which is led by the Divisional Head of Nursing and supported by the Associate Director of Operations, with an update briefing paper due to Execs in November 2023.

RISKS / ISSUES

There is currently no B Braun decontamination service on a Sunday, this will be added to the service specification for the new BSOL system led contract.to support 6 day working as business as usual from April 2024. The LLP lists are being carefully managed to mitigate any risks to ensure this doesn't impact on weekday activity.

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:

11 patients were cancelled on the day with reasons detailed as follows:
6 x Surgeon emergency leave / illness
2 x Lack of theatre time due to complex patients running over
2 x lack of equipment due to clinical need
1 x Medically unfit / Clinical change in condition

22 patients admitted and had treatment deferred, with the reasons detailed as follows:
21 x Medically unfit / Clinical change in condition / Covid / Flu related
1 x patient choice

47 patients cancelled by the hospital the day before the date of admission
13 x Medically unfit / Covid/Flu related
11 x replaced by more urgent case
8 x Industrial action
6 x shortage of external provider (NPP / Interpreter)
4 x Surgeon unavailable/unwell
2 x Pt admitted day before TCI date
1 x lack of theatre staff
1 x not suitable for weekend list
1 x Patient choice

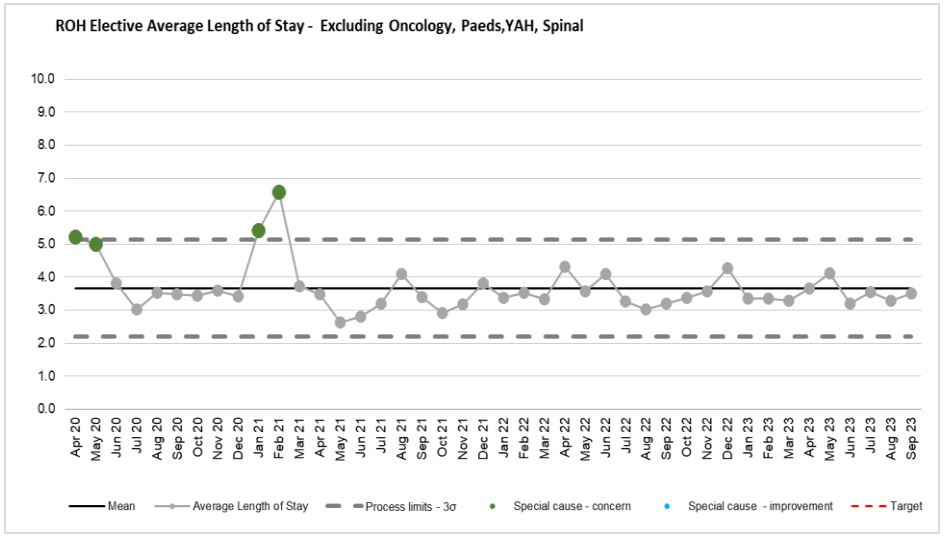
AREAS FOR IMPROVEMENT

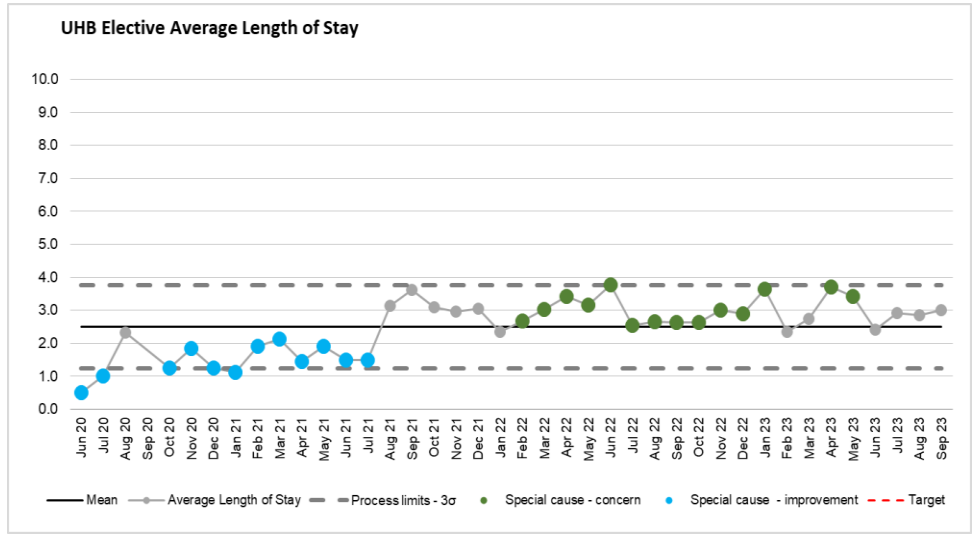
A deep dive to investigate why patients are cancelled due to them no longer requiring surgery or patients changing their mind about surgery to take place, The deep dive will focus on any learning / process changes required to prevent / reduce the risk of this continuing. Work commenced in September and report will be provided at November F&P.

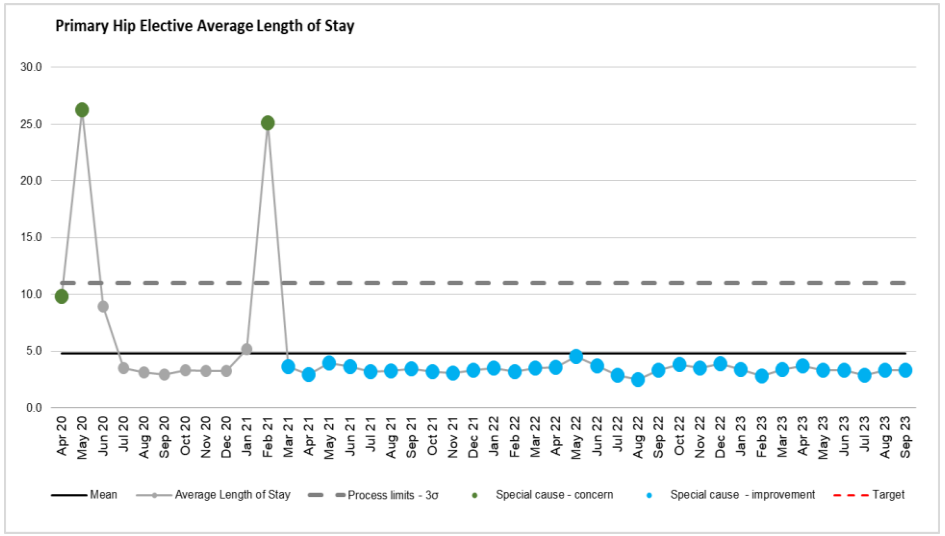
RISKS / ISSUES

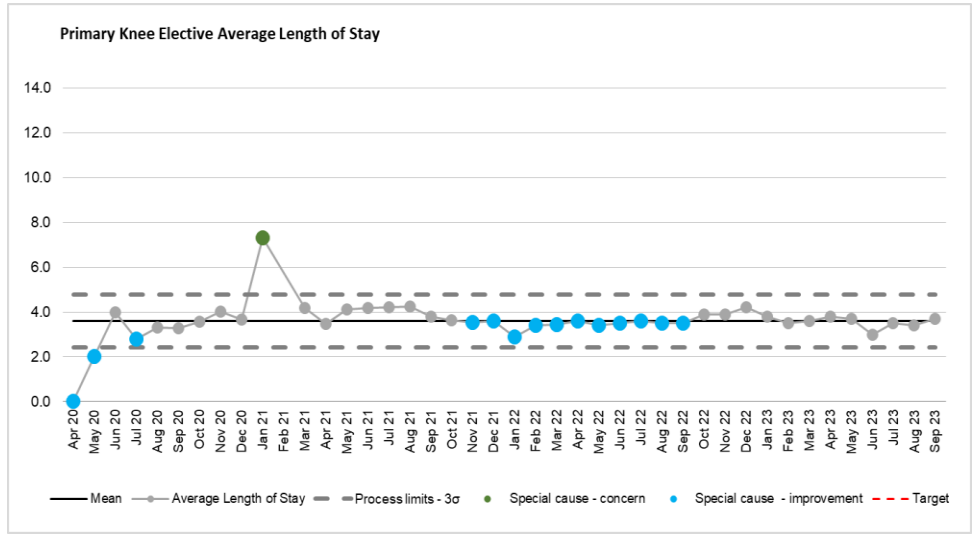
Increase in number of patient led cancellations to be mitigated by short notice cancellations patients. Reinstated standby lists for UHB patients to mitigate last minute cancellations. Division 2 triumvirate reviewing POAC capacity in line with specialty need.

3. Length of Stay









3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips is at 3.3 days (3.3 days August 23) and primary Knees 3.7 days (3.4 August 23).

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

The average length of stay for ROH patients excluding Oncology, Young Adult Hip and spinal is **3.51 days** (3.31 August).

ROH patients- 199 (248 August) Arthroplasty/Oncology Arthroplasty. The data includes revisions, aspirations and excisions of muscle or bone.
Review of data provided specific to primary hip and knees shows all patients with a LOS>7 days had an ASA score of 2, mild or 3 severe, systemic disease.

- 79 (98 August) ROH patients, arthroplasty and oncology arthroplasty, with a LOS greater than 3 days. 37 (41 August) with a length of stay greater than 5 days, 19 (24 August) with a length of stay greater than 7 days.

UHB patients- 6 (33 August) arthroplasty (includes various OPCS4 descriptions including shoulder and foot).

- 2 (10 August) UHB arthroplasty patients with LOS greater than 3 days. 1 (7 August) with a length of stay greater than 5 days and 1 (3 August) with a stay greater than 7 days.

In summary 19 ROH arthroplasty and 1 UHB arthroplasty patient had a length of stay greater than 7 days.
6 ROH patients were Oncology arthroplasty. Review of patients with LOS >7 days shows 9 TKR, 2 THR, 2 excision of muscle and 3 NULL (no surgery included). Primary hip and knees shows all patients with a LOS>7 days had an ASA score of 2, mild or 3 severe, systemic disease.
In addition, patients with unexpected post-operative complications or clinical needs and those with complex social discharge needs account for extended LOS on review of PICS records.

AREAS FOR IMPROVEMENT

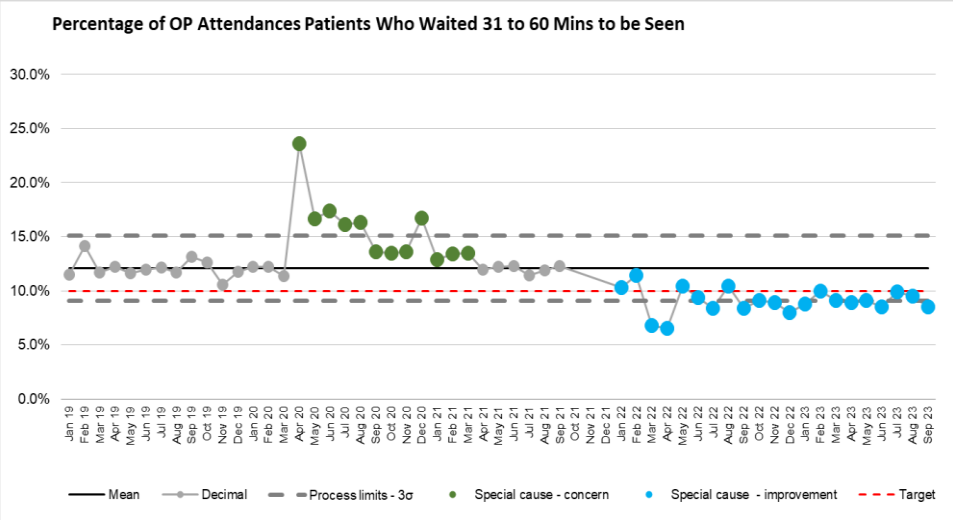
Head of Nursing Division 1 and Deputy COO to continue to work with BI, Model Hospital and GIRFT leads to ensure data collected and shared is comparable and enables focus on any actual areas for improvement and safe reduction in LOS.

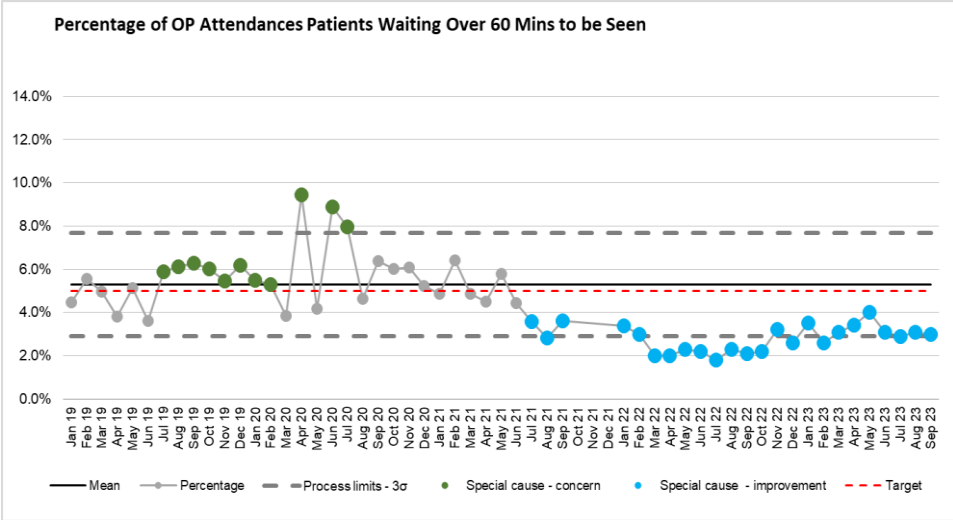
Continued focus on identifying any potential complex discharge/ social care needs at Pre-operative Assessment stage supported by additional physician sessions.

Ongoing promotion of day case Arthroplasty

Continuing to refine the data to ensure the length of stay for primary hip and knees is accurately presented.

4. Outpatient efficiency





4. Outpatient efficiency

SUMMARY

September 2023 performance is as follows:

5,413 face to face and 573 virtual appointments
10.59% virtual in total.
8.0% of outpatient attendances moved to the PIFU waiting list. The overall YTD position is 8.1%..
7.78% DNA rate, meets Trust target of 8%
Clinic Waiting Times
30-minute delays **– within trust target at 8.5% (Target 10%)**
60-minute delays – **within trust target at 3.0% (Target 5%)**

AREAS OF IMPROVEMENT

Appointments
Daily Outpatient KPIs have now been agreed and monitored by the Division 1 triumvirate with escalation to the Deputy COO, as required. The Division are having a specific focus on referral processes to maximise the use of outpatients.

DNAs
The Trust' has an aspirational 6% target that will be facilitated through the use of Dr Doctor text messaging for appointments and reminders being extended to other areas. Oncology went live in September 23, followed by imaging W/C the 23rd October. Next steps for text messaging will be Therapies patients recorded on the Tiara system will be rolled out during November 23. Pre op assessment will follow Therapies.

In addition, patients can now view their appointment date and time on the NHS app, as well as on Dr Doctor.
70% of patients are accessing their appointment letters on the Dr Doctor app preventing the need for a paper letter to be sent in the post.

Clinical Portal is scheduled to go live in December 23 that will allow the roll out of interactive patient led booking via Dr Doctor

ROH is represented clinically and operationally at the ICB Outpatient Transformation Group and Task & Finish groups.
The focus is on remote consultations, PIFU, and development of Clinical Pathways for ‘Advice and Refer’.

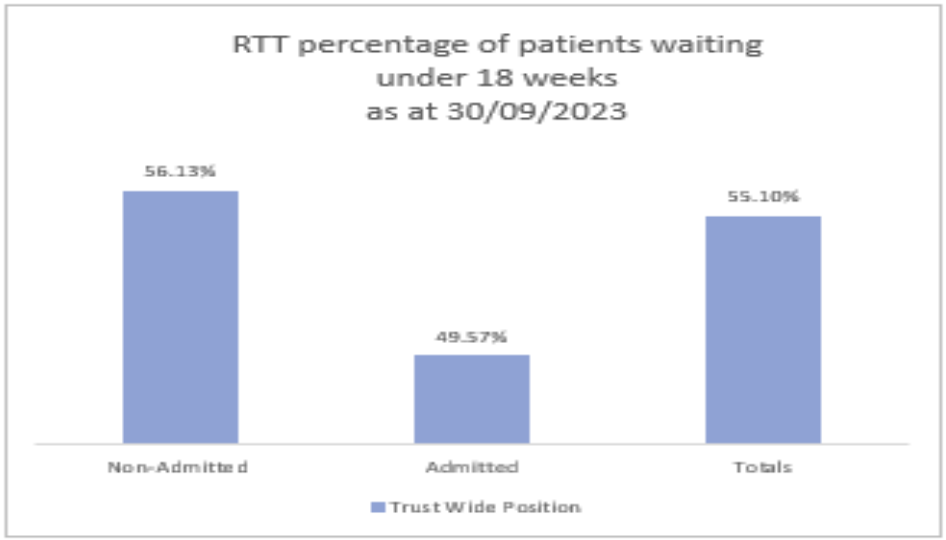
RISKS / ISSUES

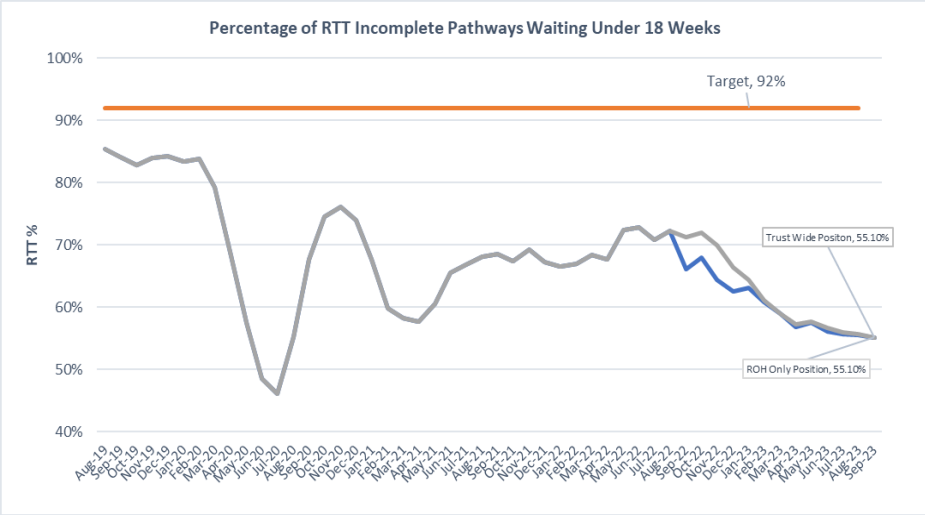
Outpatient Incident reports continue to be actively managed and investigated, ensuring feedback has been provided to the reporters

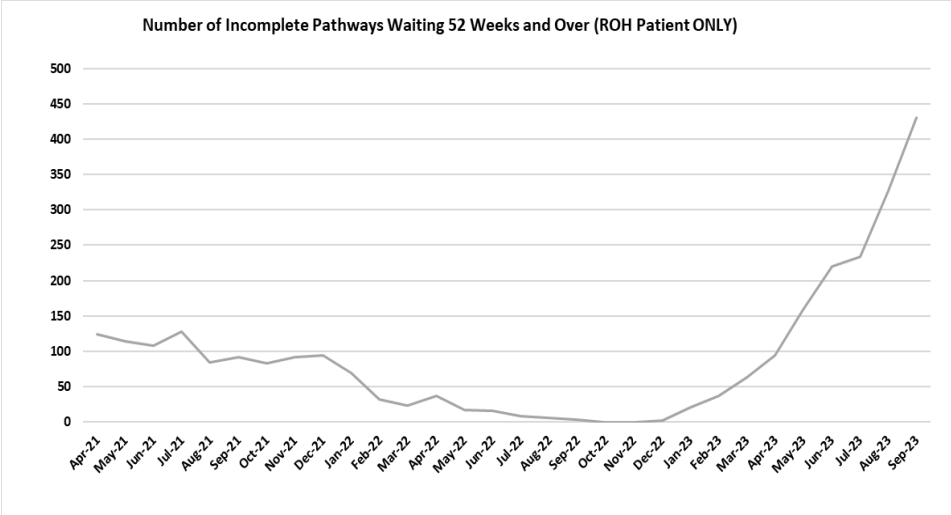
5. Referral to Treatment

Weeks Waiting	Trust Wide Position		
	Non-Admitted	Admitted	Totals
0-6	3,241	608	3,849
7-13	3,119	432	3,551
14-17	1,390	240	1,630
18-26	2,269	494	2,763
27-39	2,325	413	2,738
40-47	867	189	1,056
48-51	273	71	344
52 weeks and over	323	135	458
Total	13,807	2,582	16,389

Weeks Waiting	Non-Admitted	Admitted	Totals
Under 18	7,750	1,280	9,030
18 and over	6,057	1,302	7,359
Month End RTT %	**56.13%**	**49.57%**	**55.10%**



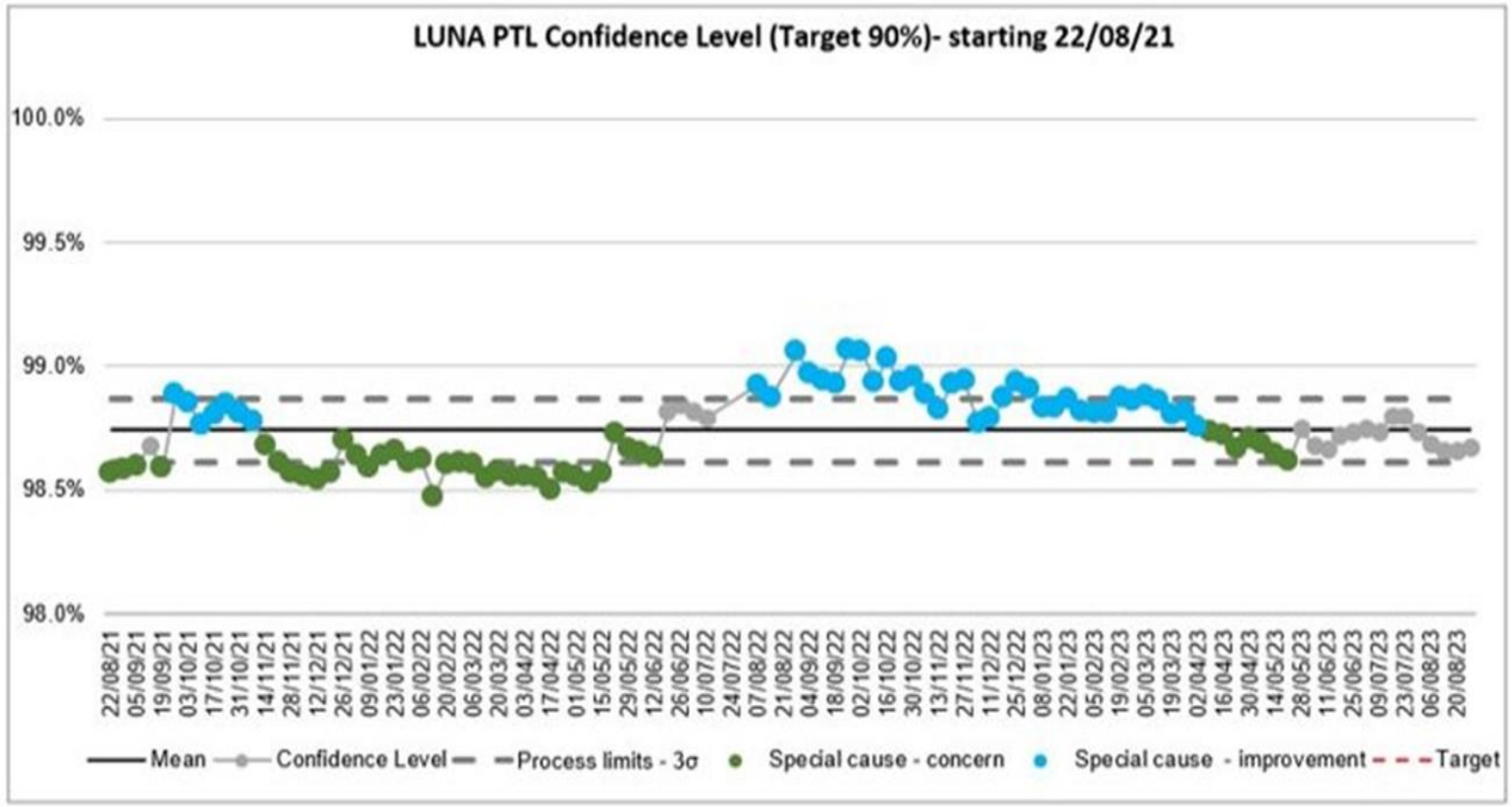




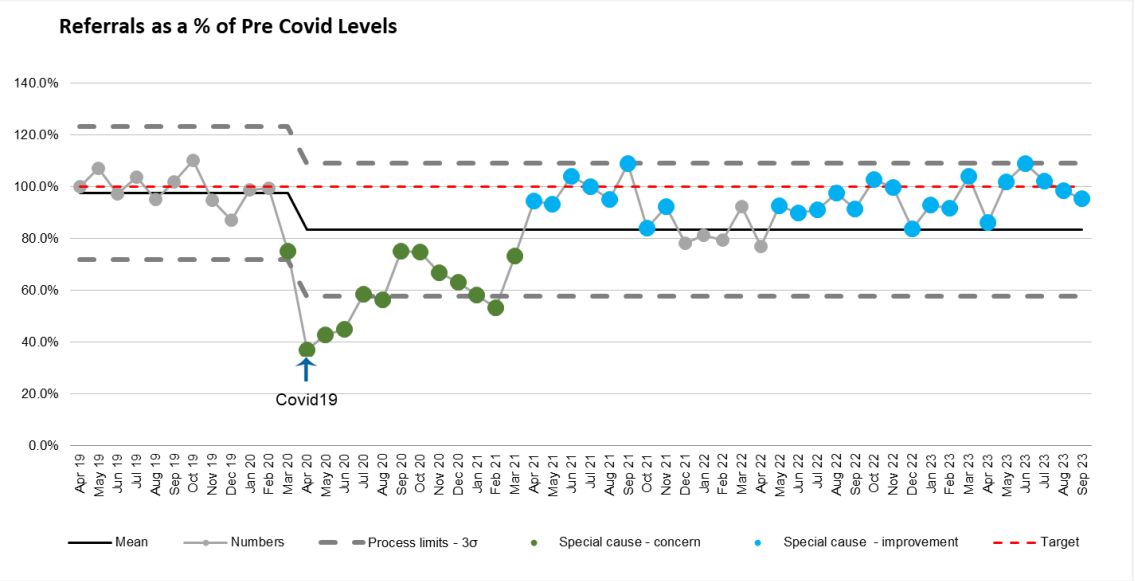
5. Referral to Treatment

Luna Data

The chart below shows LUNA National Data Quality report data for the Trust, and our average confidence levels for our RTT data has consistently remained above 98% against a target of 90%. Over the last 24 months, the average confidence levels in our weekly data submissions have remained above 98%, with no areas of concern highlighted.



5. Referral to Treatment



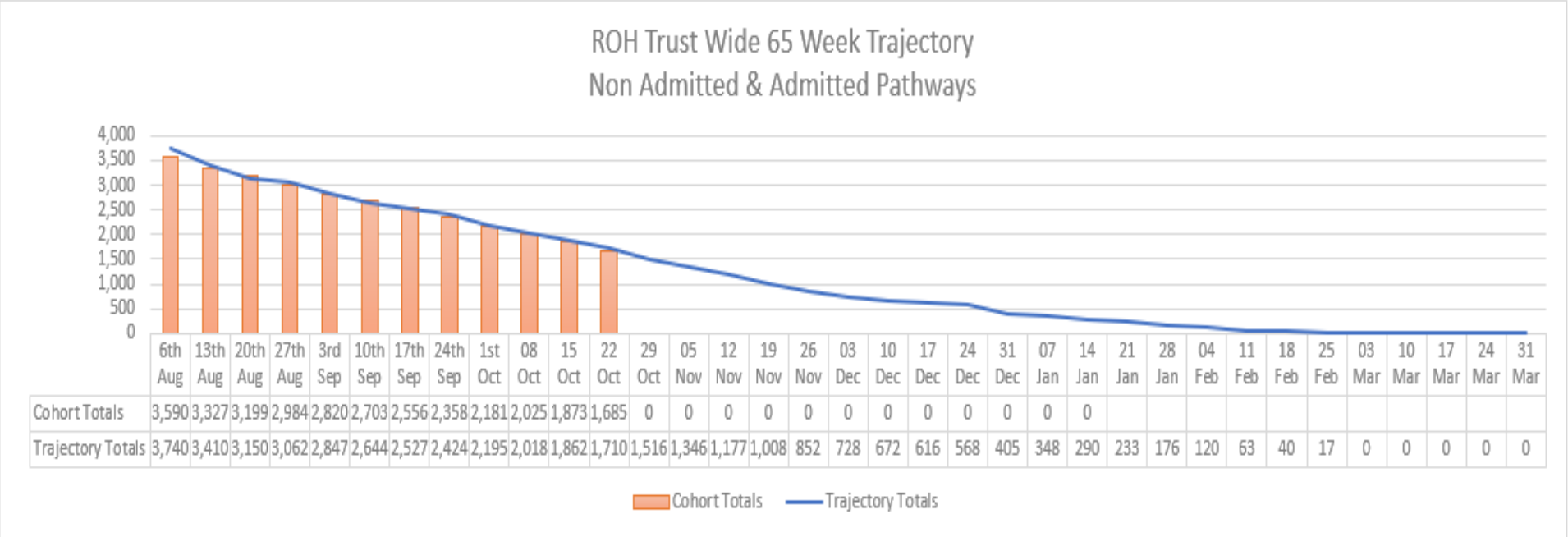
Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of Referrals	2706	2895	2626	2801	2574	2752	2976	2561	2351	2667	2683	2030	996	1154	1213	1578	1522	2034	2019	1803	1704	1574	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	2331	2752	2946	2760	2662	2580																		
Referrals as a % of Pre Covid Levels	86.21%	101.78%	108.95%	102.07%	98.45%	95.41%																		

5. Referral to Treatment

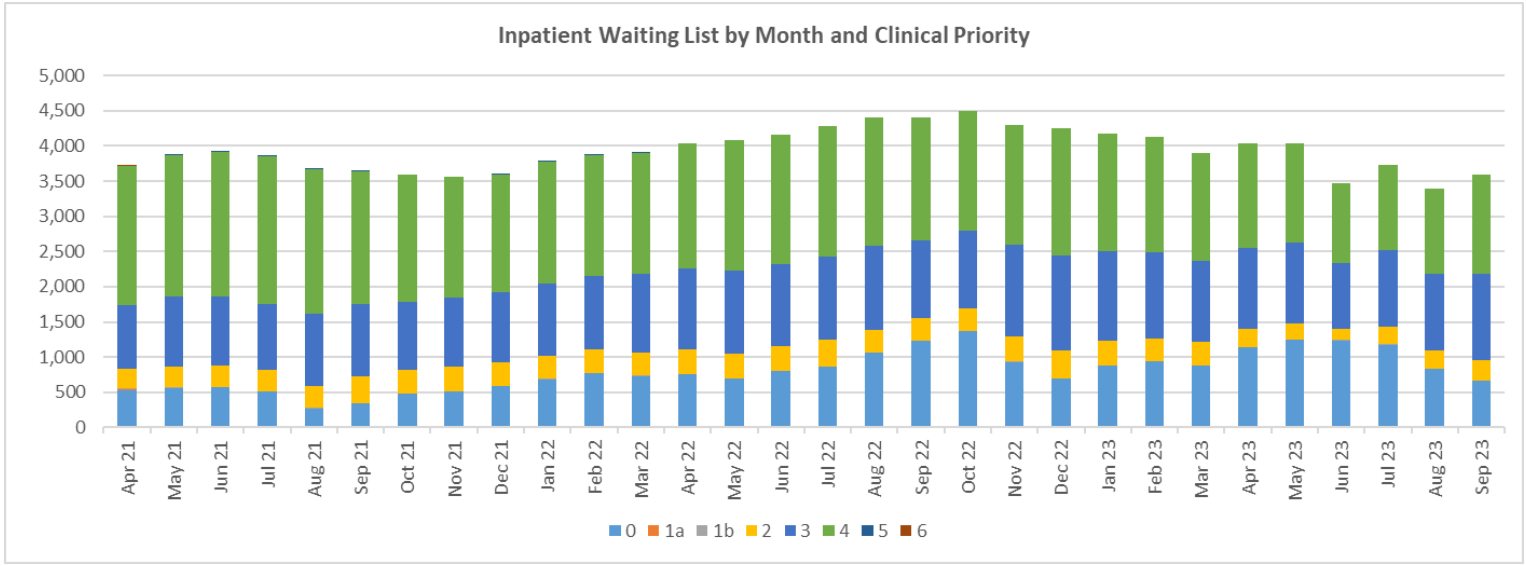
Below is the current Trust trajectory for the delivery of 0 x 65 week waits in line with the NHSE and system targets:



	6th Aug	13th Aug	20th Aug	27th Aug	3rd Sep	10th Sep	17th Sep	24th Sep	1st Oct	08 Oct	15 Oct	22 Oct	29 Oct	05 Nov	12 Nov	19 Nov	26 Nov	03 Dec	10 Dec	17 Dec	24 Dec	31 Dec	07 Jan	14 Jan	21 Jan	28 Jan	04 Feb	11 Feb	18 Feb	25 Feb	03 Mar	10 Mar	17 Mar	24 Mar	31 Mar
Cohort Totals	3,590	3,327	3,199	2,984	2,820	2,703	2,556	2,358	2,181	2,025	1,873	1,685	0	0	0	0	0	0	0	0	0	0	0	0										
Trajectory Totals	3,740	3,410	3,150	3,062	2,847	2,644	2,527	2,424	2,195	2,018	1,862	1,710	1,516	1,346	1,177	1,008	852	728	672	616	568	405	348	290	233	176	120	63	40	17	0	0	0	0	0

The Trust is currently ahead of trajectory to deliver the NHSE requirement to have 0 patients waiting over 65 weeks by 31.03.2024.
It is currently predicted that the Trust will have 0 patients in the 65 weeks cohort by W/C 03.03.2024 for Spinal.
The system target is 0 x 65 weeks wait by 31.12.2023 and we are on track to deliver this for Orthopaedics.

5. Referral to Treatment



	Number of IP waiting as at	% of IP waiting as at
Priority	30/09/23	30/09/23
0	662	18.4%
1a		0.0%
1b	3	0.1%
2	288	8.0%
3	1234	34.3%
4	1409	39.2%
5		0.0%
6		0.0%
Total	3596	100.0%

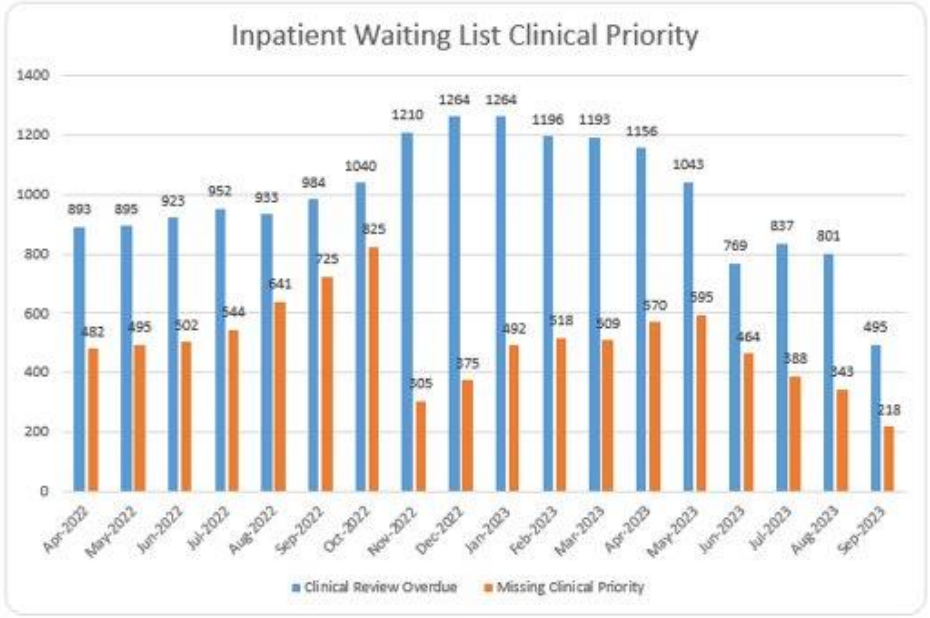
All specialities review and update admitted patients without a priority status. Regular review meetings are held to ensure that all patients are given a priority score. This data is reviewed monthly at the CSLs meeting in conjunction with the Medical Director.

Ongoing work to ensure the P score is being recorded in the right place to feed the PTL to pull through to the BI report. Reviewing whether this can be made a mandatory field and automated. An improvement has been demonstrated in month.

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

5. Referral to Treatment

Overdue Clinical Priority:



Latest Position as at 30/09/2023 by Specialty

Consultant Sub Speciality	Clinical Priority				Totals
	P1	P2	P3	P4	
Arthroplasty	0	12	42	14	68
Arthroscopy	1	14	126	88	229
Clinical Support	0	0	3	24	27
Foot & Ankle	0	0	6	21	27
Hands	0	8	5	5	18
Oncology	0	9	9	3	21
Oncology Arthroplasty	0	5	8	3	16
Paediatrics & Young Adults	0	0	0	0	0
Spinal	0	19	13	2	34
Spinal Deformity	0	10	10	5	25
Young Adult Hips	0	1	8	16	25
UHB	0	4	1	0	5
Grand Total	1	82	231	181	495

The data above is reviewed monthly at the CSLs meeting in conjunction with the Medical Director.

We has seen this number reduce from 800 to 495 compared to the previous month.

An action plan is in place for Arthroscopy service to review the clinical priority status with a view to reducing the numbers overdue. An update will be provided in the October F&P pack.

5. Referral to Treatment

SUMMARY

The Referral To Treatment (RTT) position for September was **55.10%** against the National Constitutional Target of 92%. This represents a 0.38% decrease compared to the August reported position of **55.66%** that includes patients transferred from other providers**.** The LUNA report for data quality validation is consistently above 98%.

There were **458** patients waiting over 52 weeks in September, an increase from the trust wide position in August which was **388** patients.

The Team continue to work in partnership with UHB,RJAH,UHNM and SATH to support with orthopaedic recovery. Long waiters added to the PTL have been prioritised leading to the number of shorter waits growing impacting on the overall RTT position, as well as the reduction in capacity due to industrial action.

During September 23, ROH received 2,580 referrals (95.41%) compared to pre covid levels. 2,704 is the average monthly referrals received Pre-Covid.

AREAS FOR IMPROVEMENT

We are now scoping the RTT training need's role specific to all admin areas and will commence training early January. This will support the ongoing PAS data quality issues that arise.

Additional meetings have been implemented and led by the DCOO to focus on our longest waiting patients and achieving the 0 x 65 weeks target for Orthopaedics by 31.12.23 and Spinal by 28.02.24. Trajectories are being developed to achieve 0 x 52 weeks waits. This will be available in the October 2023 pack.

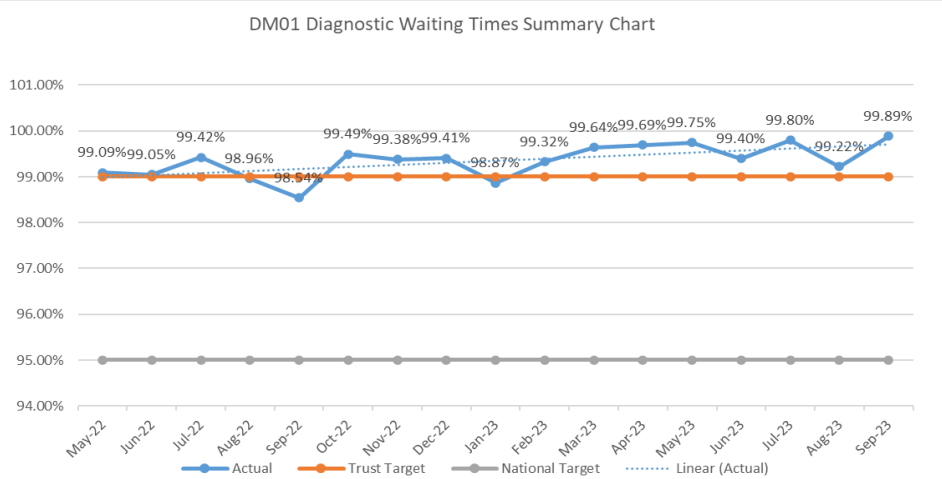
The Validation team are providing extra support to spinal service to help manage patients through the pathway and all patients down to 12 weeks have been sent a text message to determine whether they wish to remain on the waiting list in line with national guidance.

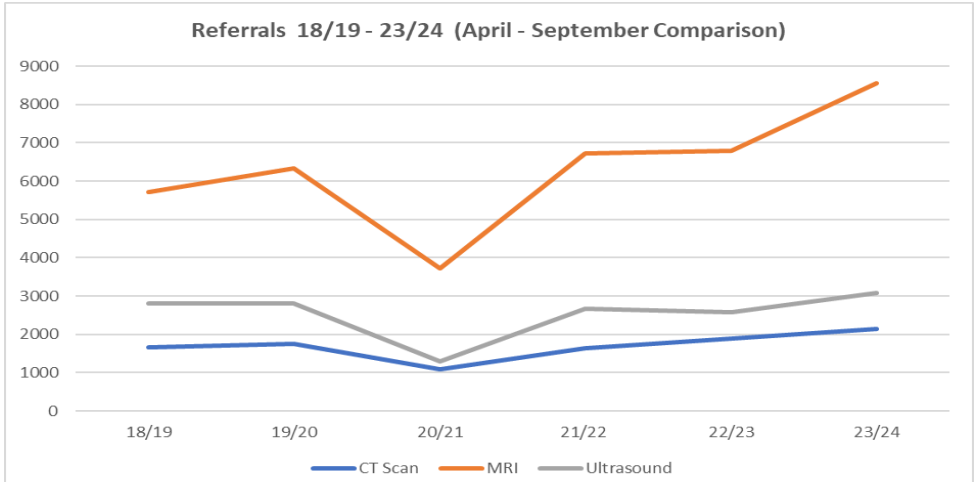
RISKS / ISSUES

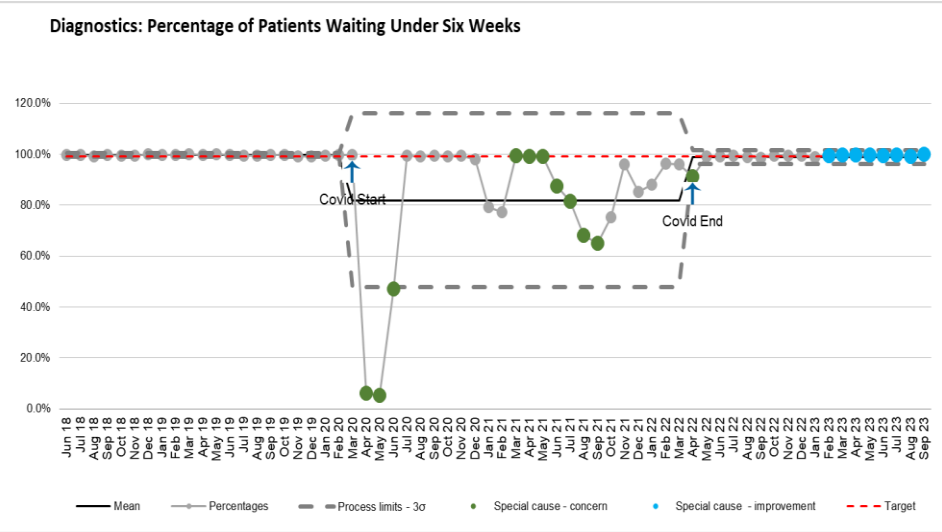
Due to the continued success of the ROH's management of long waiters from other providers, further requests have been received from NHSE, GIRFT and the system for help with long waiting patients across England. These requests will need to be considered and monitored closely to ensure ROH continues to meet its own trajectory..
Industrial action continues to be a risk for 65 weeks delivery, and this is being monitored closely by the Operational/performance teams and the Deputy COO.

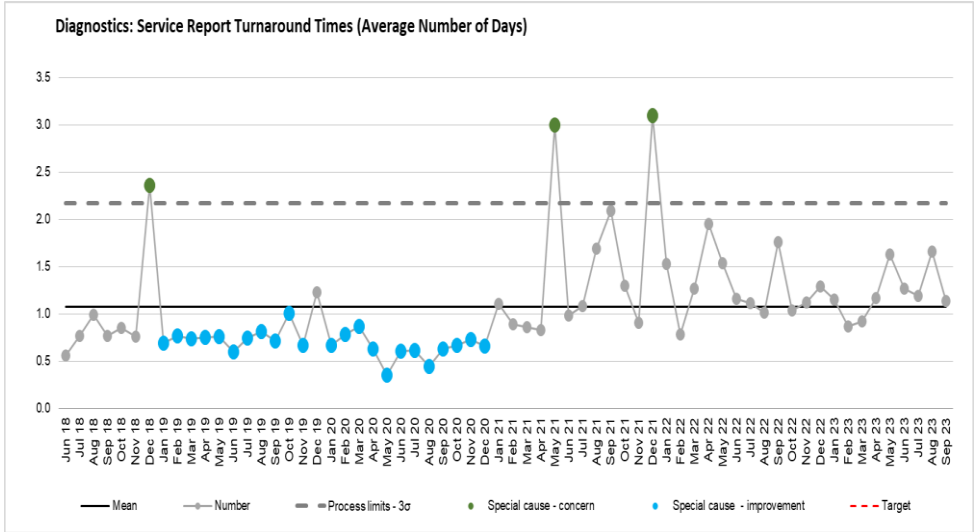
6. Diagnostic Performance

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









7. Diagnostic Performance

SUMMARY

The Imaging service achieved the 99% DM01 target in September 2023 closing the month at 99.89%. Order comms (electronic requesting) via PICS went live on 26/7/23 and has been well received. Mobile CRIS has been implemented to support electronic referrals, which will provide real time data for patients' imaging events and allow a swifter booking process, as orders, are directly received into CRIS.

The National 23/24 operational target remains at 95% which ROH are achieving; however, we have retained reporting against the traditional 6-week diagnostic target locally as our aspirational target within our constitution.

AREAS FOR IMPROVEMENT

To continue to ensure all capacity is fully utilised and minimise DNAs with the rollout of Dr Doctor, final testing is taking place.

Utilisation of diagnostics capacity will be maximised with the introduction of Dr Doctor W/C 23.10.23 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.

Speech recognition implementation is being discussed with the CRIS (Radiology Information System) team to commence a pilot in Imaging. An update will be provided at the November 23 meeting.

RISKS / ISSUES

The works to the 3T scanner have commenced 16/10/23 and the scanner will be out of action until January 2023 – the service is being re-provided on a mobile van.

The Medical Secretary vacancy has been recruited to and HR processes are in progress however, typing turnaround has exceeded the 2 weeks KPI. Mitigation is in place through the use of outsourcing to reduce turnaround, whilst the current vacancy is being filled. This is being monitored closely by the Associate Director of Operations. Oncology work is continued to be prioritised along with all MRI & CT scan reporting.

8. Cancer Performance

Summary Performance Figures – August 2023 (September 2023 Submission)

		August 23			
Target Name	National Standard	%	In target	Breach	Total
2 WW	93%	97.3%	107.0	3.0	110.0
31 First	96%	100%	10.0	0.0	10.0
31 day subsequent	94%	100%	8.0	0.0	8.0
62 day Standard	85%	80.0%	4.0	1.0	5.0
62 day (Cons Upgrade)	n/a	74.1%	2.5	1.0	3.5
28 day FDS REPORTED	75%	79%	91.0	23.0	114.0
Patients over 104 days (62 day standard)	0				

Performance

The trust were compliant with cancer standards with the exception of the 62 days standard and 62 days upgrade target. We had 1x full breach against the 62 days standard and 1 x full breach for the 62 days upgrade.

The root cause of 62 days standard was due to the patient being referred on day 27 requiring full diagnostic work up before malignancy was confirmed. The patient then required surgery involving the plastics and sarcoma surgical teams. The Patient was treated on day 89.

The root cause of 62 days upgrade standard was due to the patient pathway being complex involving multiple organisations.

We were compliant with the 28 days FDS standard. 79.8% against a target of 75%.

Risks /actions ongoing

ROH is actively participating and engaging with the weekly System Oversight Group for cancer recovery and receive positive feedback against overall performance standards.

8. New Cancer Target Changes

In August 2023 NHS England formally announced plans to change the existing Cancer Targets – by streamlining the existing 10 standards into 3. The new standards are expected to be formally launched in October 2023.

- The '2 week wait' standard becomes redundant. Initially 2 week wait clinics at ROH will continue as it links in with our existing daily MDT, MRI and USG Biopsy pathways – which will continue to be key for the 28-day FDS standard. The ROH will continue with its in-house aim of 10 days from receipt of referral to initial consultation.

- The 28-day Faster Diagnosis Standard (FDS) - remains with no change.
  - Patients should have cancer ruled out or receive their diagnosis within 28 days of urgent referral.
  - 75% of patients should meet this standard.

- The 62-day referral to treatment standard
  - People with cancer should start their treatment within 62 days of an urgent referral going forward this will include screening and upgrade patients, as a combined target.
  - 85% of people should meet this standard.

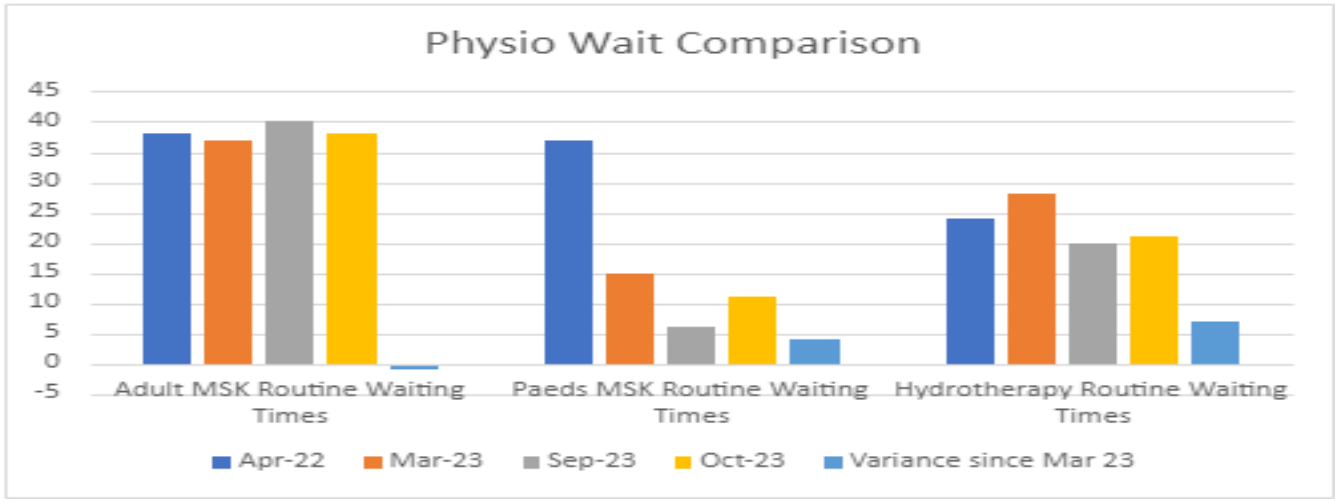
- The 31-day decision to treat to treatment standard
  - People with cancer should start their treatment within 31 days of the 'decision to treat' their cancer. This target now also includes subsequent treatments for cancer.
  - 96% of people **should** meet this standard.

- The below chart shows ROH August performance against the new cancer standards that will be reported from October 23 in the December 23 F&P pack

		Aug 23 (against new standards)			
Target Name	National Standard	%	In target	Breach	Total
31 DTTD to Treatment	96%	100%	18.0	0.0	18.0
62 day RTT to treatment	85%	76.5%	6.5	2.0	8.5
28 day FDS REPORTED	75%	79%	91.0	23.0	114.0
Patients over 104 days (62 day standard)	0				

9. Physio Waits

Physio Wait Comparison April 22 vs March and Oct (as at 16th)



Summary

Paediatric Physio waits continue to be maintained below 12 weeks.

Hydrotherapy waits are 21 weeks, with Adult physio waiting times reduced from 44 weeks in June/July down to 38 weeks as of 16th October.

Risks /actions ongoing

A comprehensive action plan has been produced to address the long waits associated with Adult MSK Routine appointments.
Sussex model has been shared with the team; however, they have been inundated with requests and we are waiting for a date to meet. Research has been conducted on the Sussex model. In the meantime, attending a workshop on 09.11.23 with 3rd sector groups such as Age Concern, Versus Arthritis and Arthritis UK to consider community appointment days with a view to educating and signposting patients to appropriate resources as part of the MSK transformation project ..

10. Private Patients

SUMMARY

There were 39 inpatients treated privately
There were 97 private outpatient consultations

The service has exceeded its inpatient activity plan in September by 11 patients.
The service has exceeded its income target in September by £61k

	M1	M2	M3	M4	M5	M6	YTD
Income Plan	306	306	306	306	255	253	1732
Activity Plan	9	24	35	24	37	28	157
Income to be collected	353	229	254	397	255	314	1802
Activity actual	47	37	41	55	38	39	257

The above figures are based on activity and income through the service which may not have been invoiced yet. Finance figures are based on what has been invoiced.

AREAS FOR IMPROVEMENT

The service is exploring the appetite from Surgeons to have regular PP lists in week. This will support activity planning, bed management and flow, as well as an enhanced experience for surgeons and their patients who can be advised with a degree of certainty of their procedure date.

The finance team are leading a redesign of the invoicing process to support faster payment and collection of fees. The team have taken over this role to understand the processes with a view to streamlining and determining whether this remains in private patients or transfers to the Finance team. A draft business case has been produced to support the development of the private patient service business unit.

Negotiations continue with the main insurers to allow the Trust to contract with them. This is beneficial for insurers, as well as the Trust, as the number of contacts will reduce from the private patient service and from patients requesting to be treated 'out of network'.

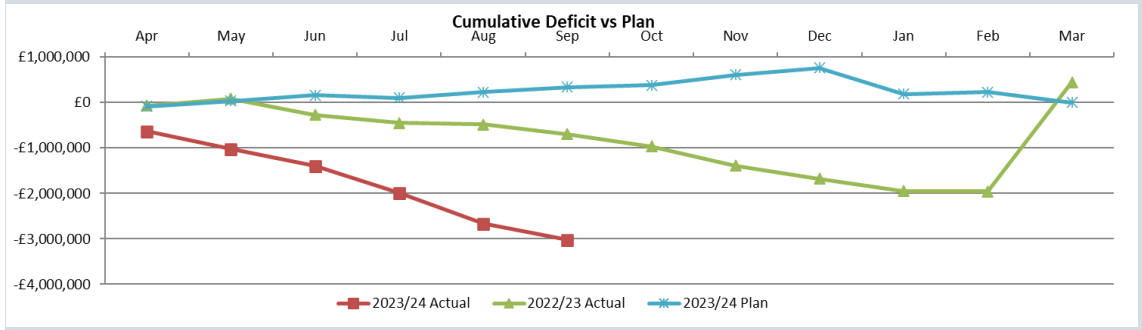
A strategy for the next 3 years is being presented to Trust Board in November 23.

8. Finance on a Page

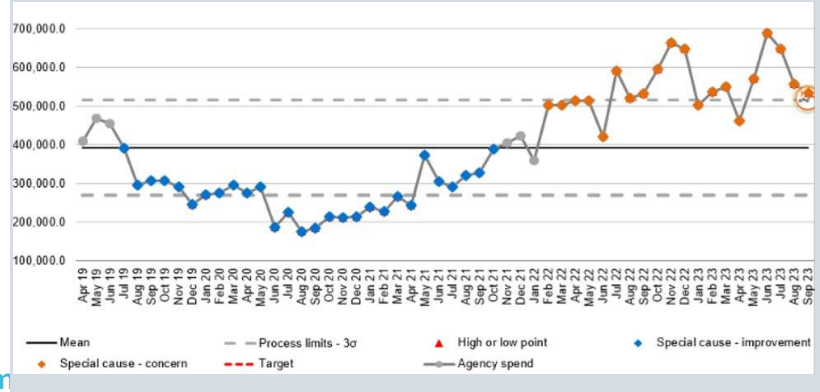
Month 6

FINANCIAL PERFORMANCE

Income and Expenditure category	£'000s								
	In Month			Year to date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Pay	-£5,941	-£6,500	-£559	-£37,460	-£37,966	-£505	-£94,746	-£73,757	£989
Non Pay	-£4,226	-£4,782	-£556	-£25,669	-£28,166	-£2,497	-£51,756	-£52,759	-£1,003
Income from patient care activities	£9,967	£10,104	£137	£61,617	£60,863	-£754	£122,811	£122,359	-£452
Other income	£422	£937	£515	£2,532	£2,797	£265	£5,064	£5,430	£366
Non operating costs	-£121	-£129	-£8	-£726	-£600	£126	£1,455	£1,355	£100
Remove capital donations	£7	£8	£1	£42	£46	£4	£82	£82	£0
TOTAL	£108	-£362	-£470	£335	-£3,026	-£3,361	£0	£0	£0



Agency as a % of paybill
9.10%



Recurrent efficiency % of forecast
100%

Efficiencies	YTD	Forecast
Plan	£2,263	£2,397
Actual	£2,397	£5,076
Variance	£134	£0

Better Payment practice code	Current Month	% movment previous month
By number	88%	1%
By Value	76%	3%
Operating expenditure days	5	-15

Capital performance	YTD	Forecast
Capital plan	£1,813	£3,909
Actual	£1,363	£3,909
IFRS 16	£0	£1,250
Variance	£450	-£1,250

9. Overall Financial Performance

SUMMARY

The Trust delivered a deficit in month of £362k against a planned surplus of £108k, generating a £470k adverse variance, resulting in a year to date deficit of £3,072k against a surplus plan of £293k, generating an adverse variance of £3,365k.

Income year to date is £489k below plan.

Pay expenditure is overspent by £505k. Non pay expenditure is overspent against plan with an adverse variance of £2,497k.

Agency spend remains a concern – although a reduction in agency spend has improved the percentage of pay bill from 8.7% last month to 8.4% as the current year to date position.

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

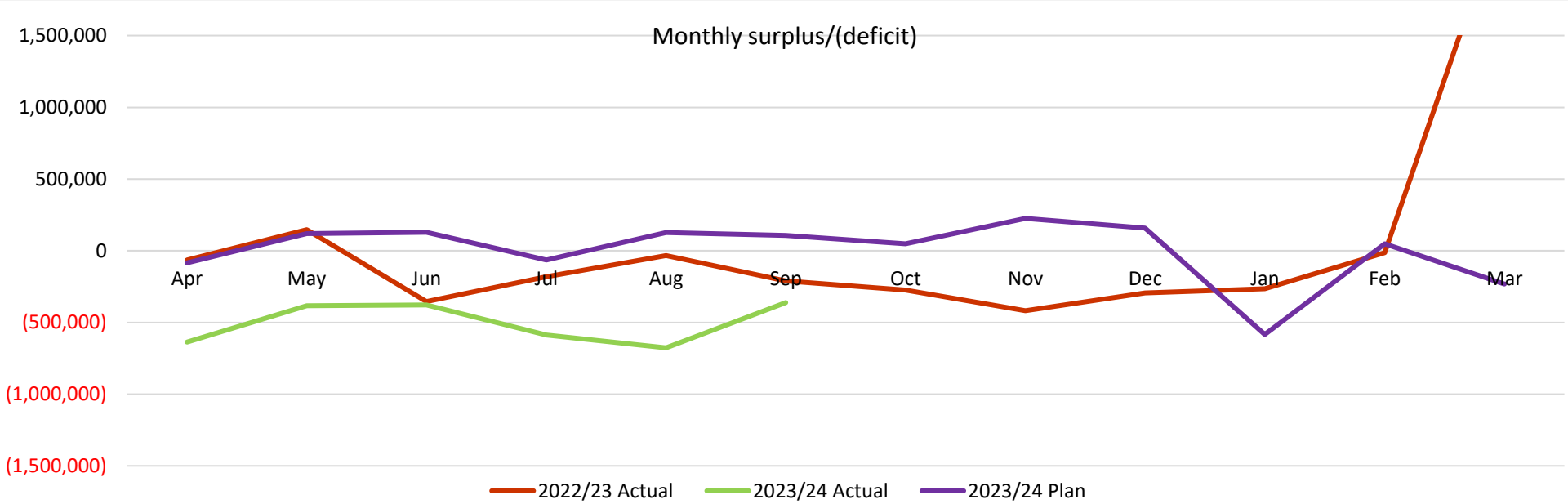
Forecast remains breakeven against plan.

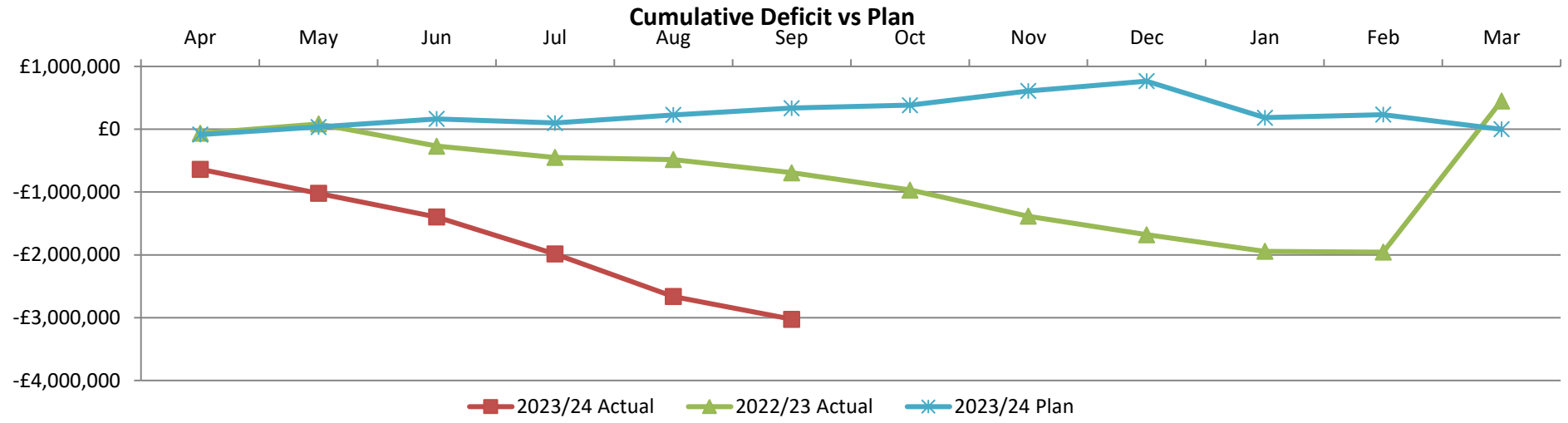
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	(489)	(505)	(2,497)	126	(3,365)
Year to date plan	64,149	(37,460)	(25,699)	(726)	293
Year to date actual	63,660	(37,966)	(28,166)	(600)	(3,072)
Variance compared previous month	(300)	393	(556)	(12)	(474)
Forecast Variance	(86)	989	(1,003)	100	0

9. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	61,617	60,863	(754)
Other Operating Income (Excluding top up)	2,532	2,797	265
Employee Expenses (inc. Agency)	(37,460)	(37,966)	(506)
Other operating expenses	(25,669)	(28,166)	(2,497)
Operating Surplus	**1,019**	**(2,472)**	**(3,491)**
Net Finance Costs	(726)	(600)	126
Net surplus/(deficit)	**293**	**(3,072)**	**(3,365)**
Remove donated asset I&E impact	42	46	4
Adjusted financial performance	**335**	**(3,026)**	**(3,361)**

9. Overall Financial Performance

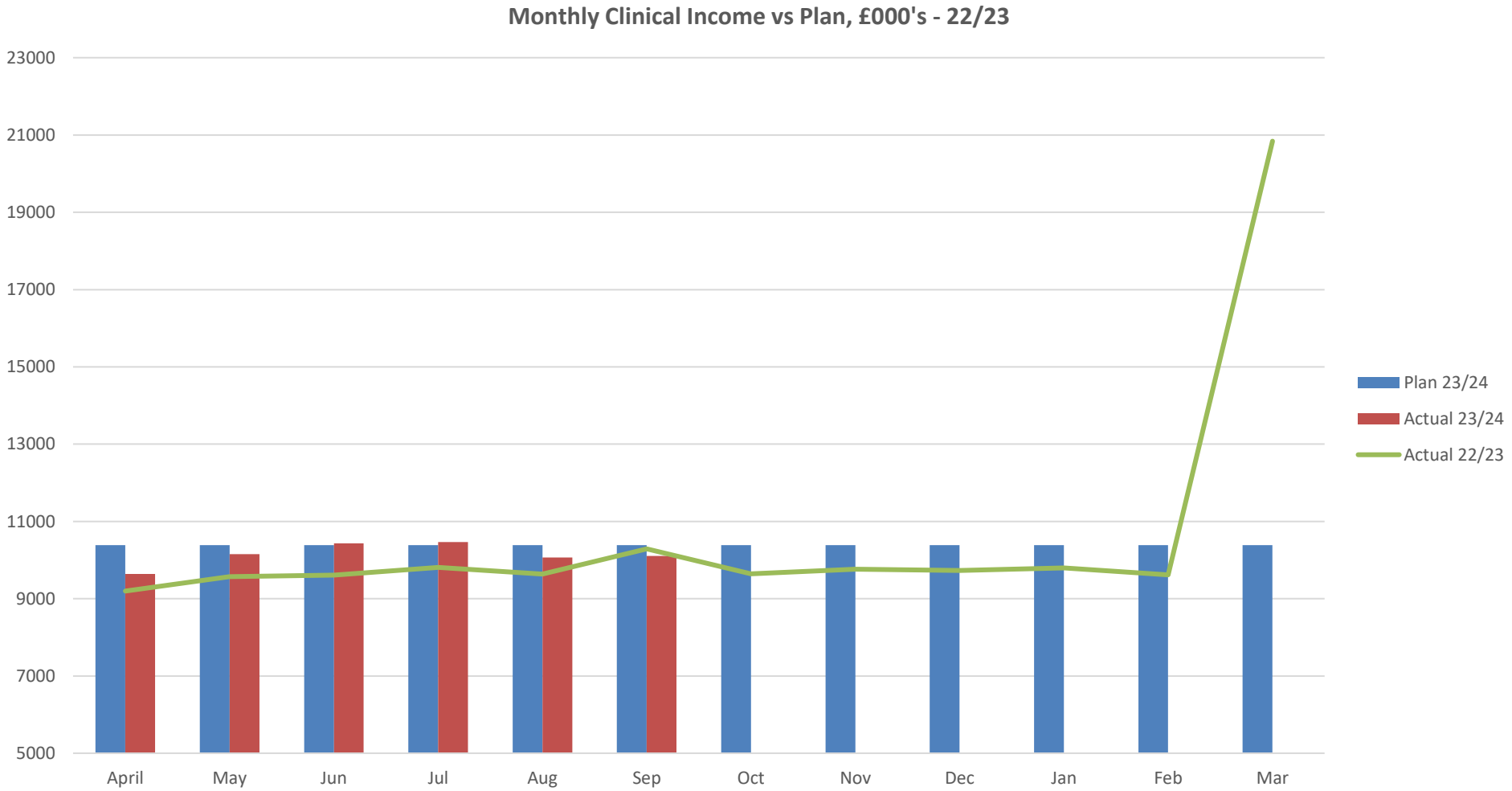




Financial Recovery Plan

	Base Case	Delivery Risk	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Month 5 YTD Deficit	**(2,664)**								
Mth 6-12 at current run-rate	(3,730)		(533)	(533)	(533)	(533)	(533)	(533)	(533)
Bad debt release - associate*	2,400								2,400
Pay award reserve release	500		71	71	71	71	71	71	71
Gen Med	460		66	66	66	66	66	66	66
BOP Recovery**	600		43	43	43	43	43	43	343
Grip and Control - agency	1,050		150	150	150	150	150	150	150
Grip and control - non pay	148			25	25	25	25	25	25
Grip and Control - income	125				25	25	25	25	25
Grip Control- Other	116				23	23	23	23	23
NR Annual leave accrual release	150								150
Productivity - Theatres	840				168	168	168	168	168
Job planned sessions owed repaid	116				23	23	23	23	23
2023/24 Revised FOT	**111**		**(203)**	**(178)**	**61**	**61**	**61**	**61**	**2,911**
2023/24 Cumulative YTD			**(2,867)**	**(3,045)**	**(2,984)**	**(2,923)**	**(2,862)**	**(2,801)**	**110**
Actual performance			**(326)**						
Variance			**-£123**						

10. Income



Please note the ERF target has been updated to reflect industrial action in April but discussions continue to reflect industrial action in following months. There is also discussions underway with NHS England regarding a proposed adjustment to target for specialised commissioner activity.

10. Income

SUMMARY

Income achieved during Month 1 to 6 is performing below plan by £489k.

The elective recovery fund (ERF) communications from NHS England has requested adjustment are now reflected in financial positions. A revised ERF baseline has been released by NHS England to adjusted for the strike action that occurred during April with strike action in other months still under consideration. The national target has been reduced by 2% for the year, from 112% to 110%, and work is underway to validate the revised baseline.

Private patient income is performing well against plan with a slight underperformance year to date Month 6 by £44k.

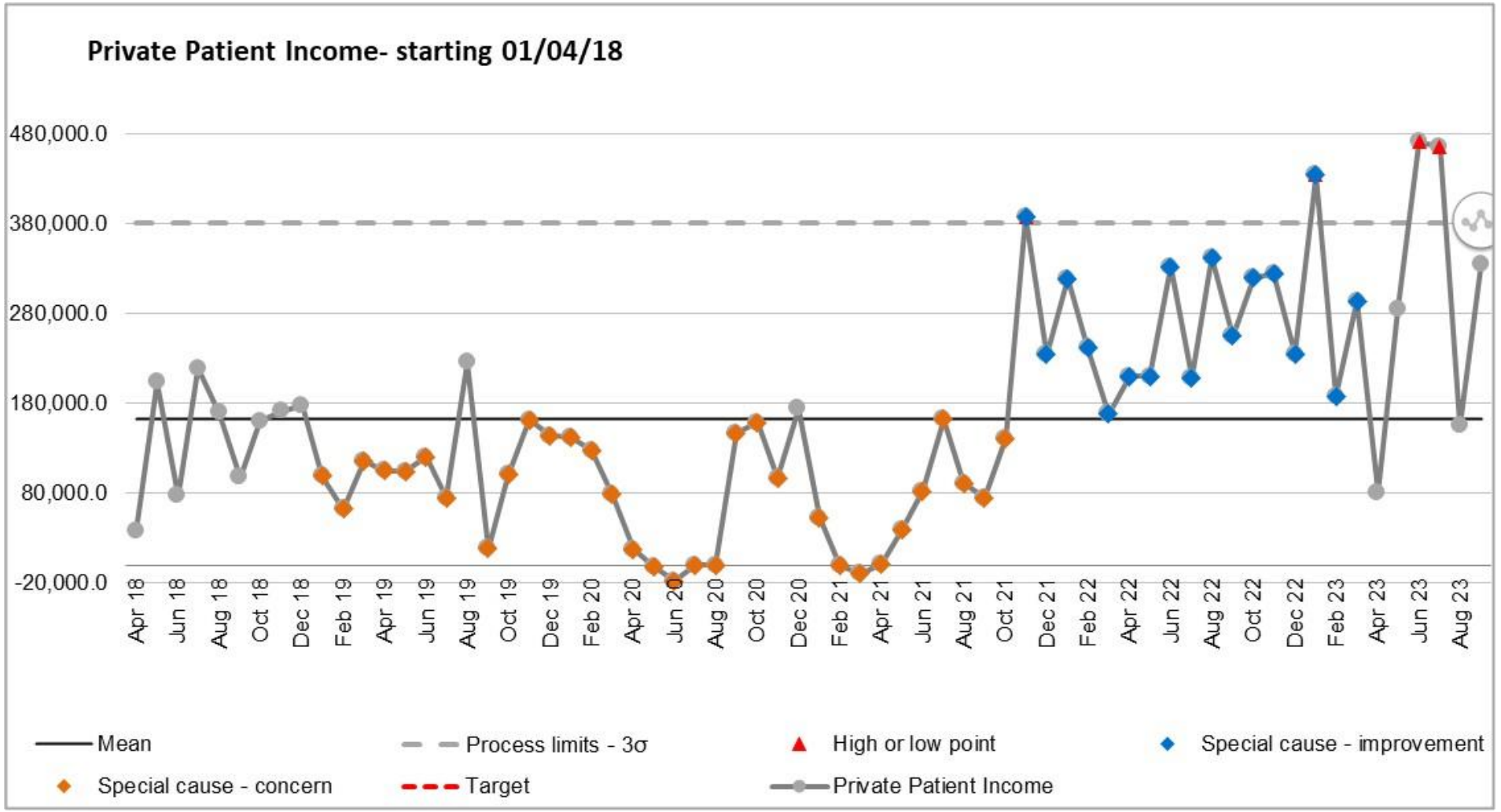
AREAS FOR IMPROVEMENT

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.

10. Income


Private Patient Income- starting 01/04/18
480,000.0
380,000.0
280,000.0
180,000.0
80,000.0
-20,000.0
Apr 18
Jun 18
Aug 18
Oct 18
Dec 18
Feb 19
Apr 19
Jun 19
Aug 19
Oct 19
Dec 19
Feb 20
Apr 20
Jun 20
Aug 20
Oct 20
Dec 20
Feb 21
Apr 21
Jun 21
Aug 21
Oct 21
Dec 21
Feb 22
Apr 22
Jun 22
Aug 22
Oct 22
Dec 22
Feb 23
Apr 23
Jun 23
Aug 23
Mean
Process limits - 3σ
High or low point
Special cause - improvement
Special cause - concern
Target
Private Patient Income

11. Expenditure

SUMMARY

Pay overall has a year to date deficit of £505k. Non pay expenditure is overspent against plan by £2,497k.

Although Agency spend remains below plan year to date, it is above price cap with agency spend as a percentage of pay bill at 9.1% year to date against an agency cap of 3.7%. This is an increase for the third month this year. Key drivers for high agency spend remain continued high sickness, high turnover rate and high vacancy levels. Within Month 6 agency expenditure there is c.£200k of expenditure that relates to previous months due to an issue with recording within the finance ledger system.

Non pay spend has also remained high in month generating an adverse variance of £2,497k year to date. Key drivers for this include higher than expected use of LLPs to provide surgeon sessions, continued high consumable spend in theatres, and above inflationary pressures particularly with regards to estates spend.

AREAS FOR IMPROVEMENT

Agency spend is above agency cap with 9.1% of our pay bill year to date spent on agency against a cap of 3.7%.

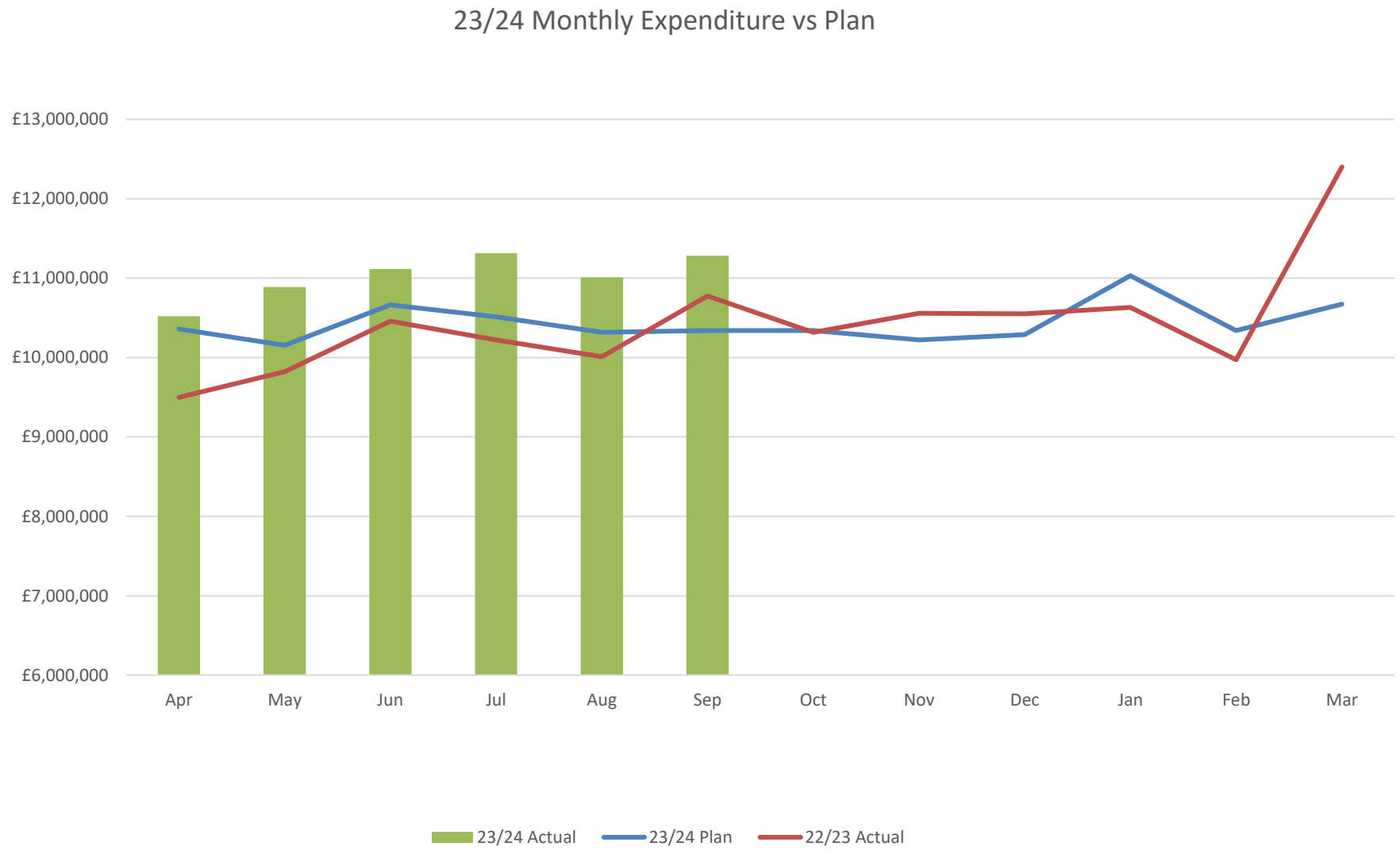
Theatre consumable spend reducing to planned levels.

LLP expenditure reduction.

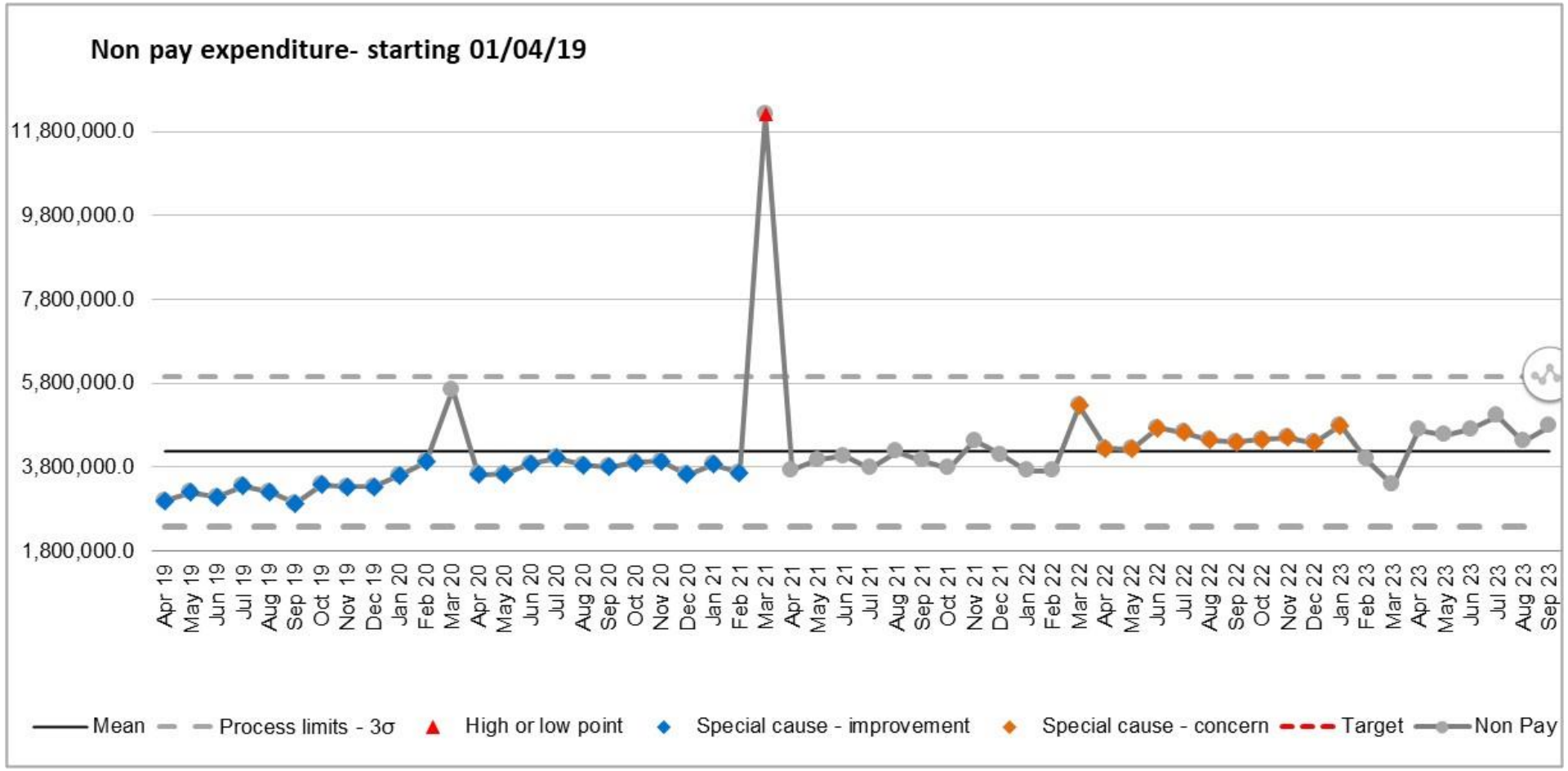
RISKS / ISSUES

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

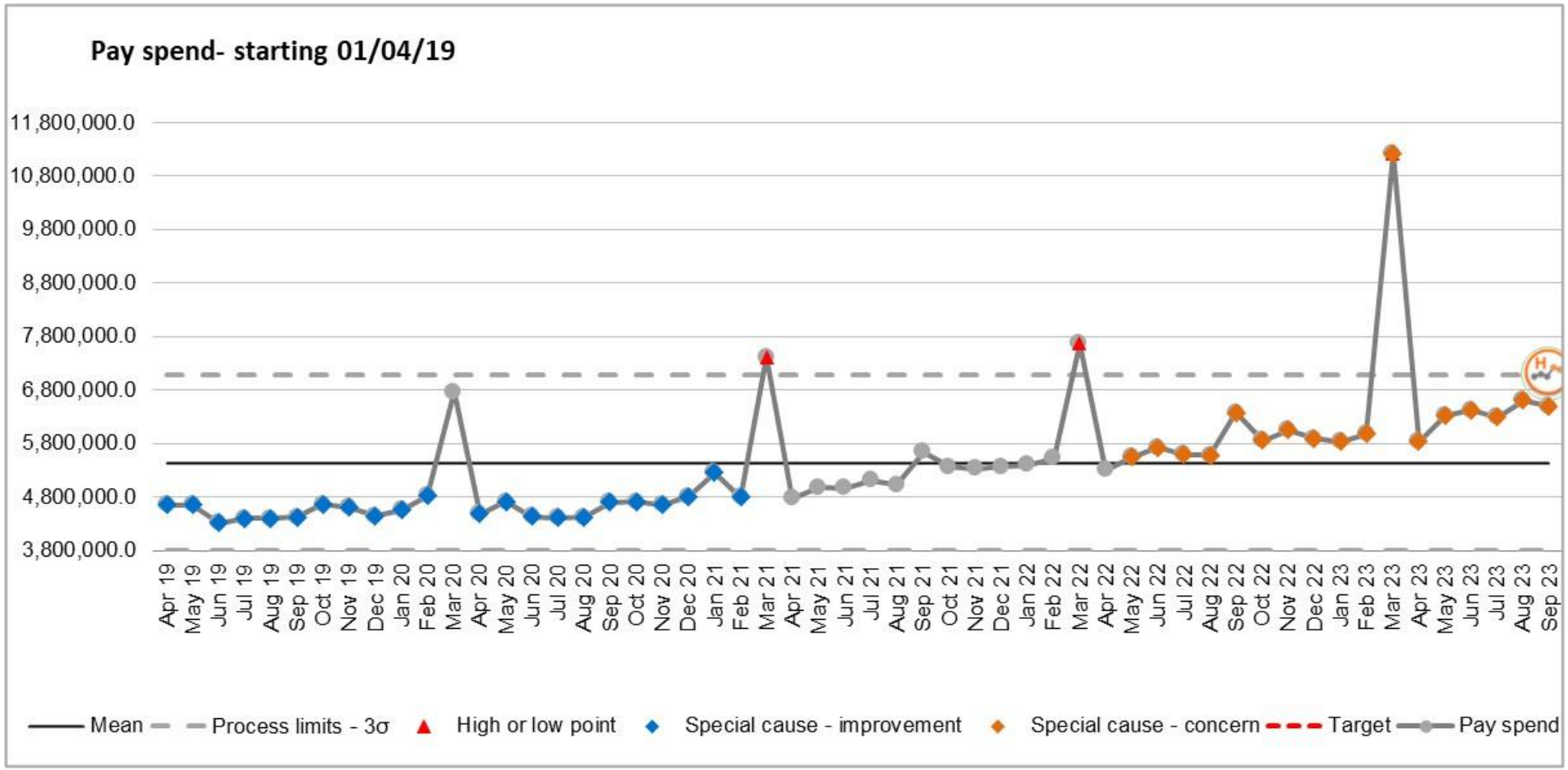
11. Expenditure



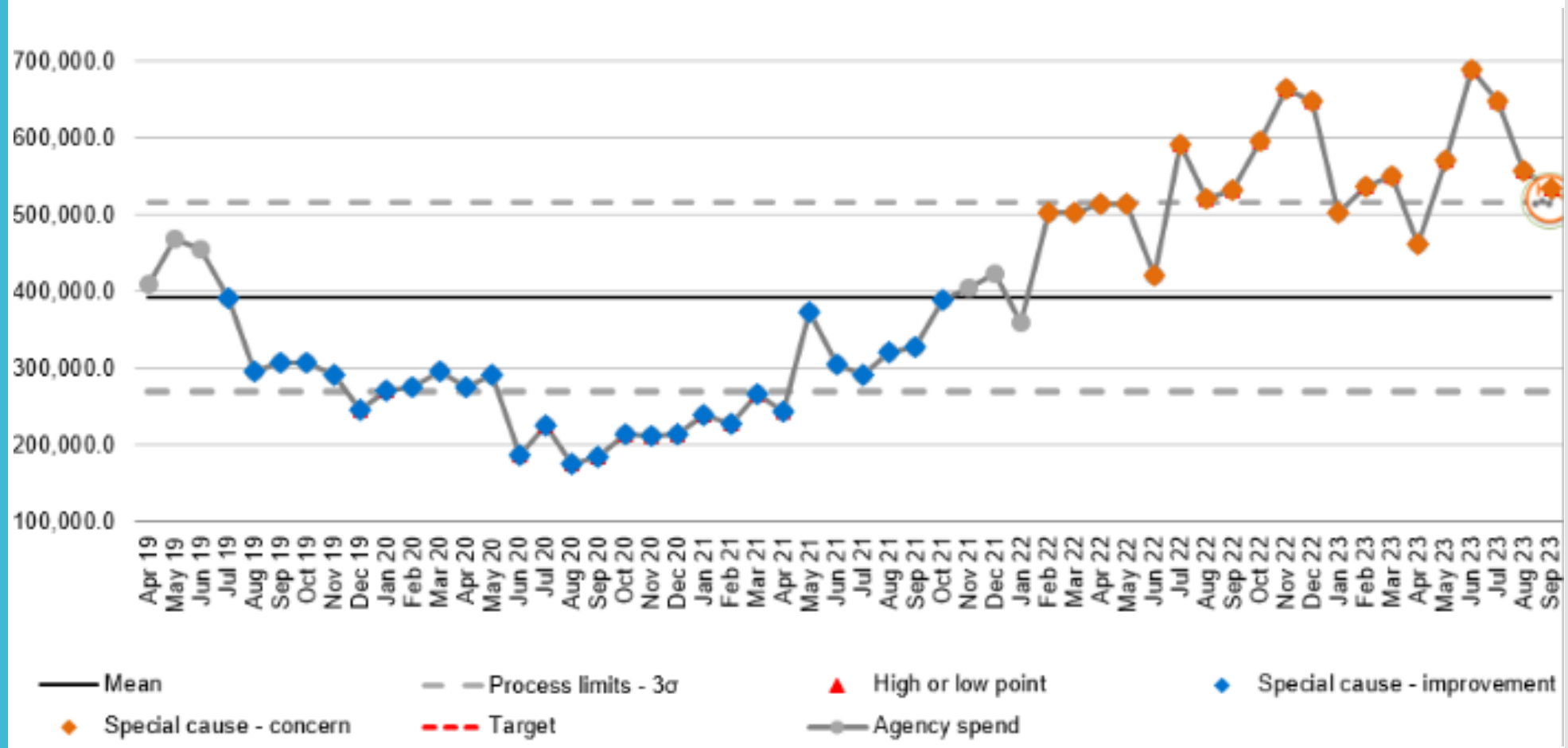
12. Non Pay Expenditure



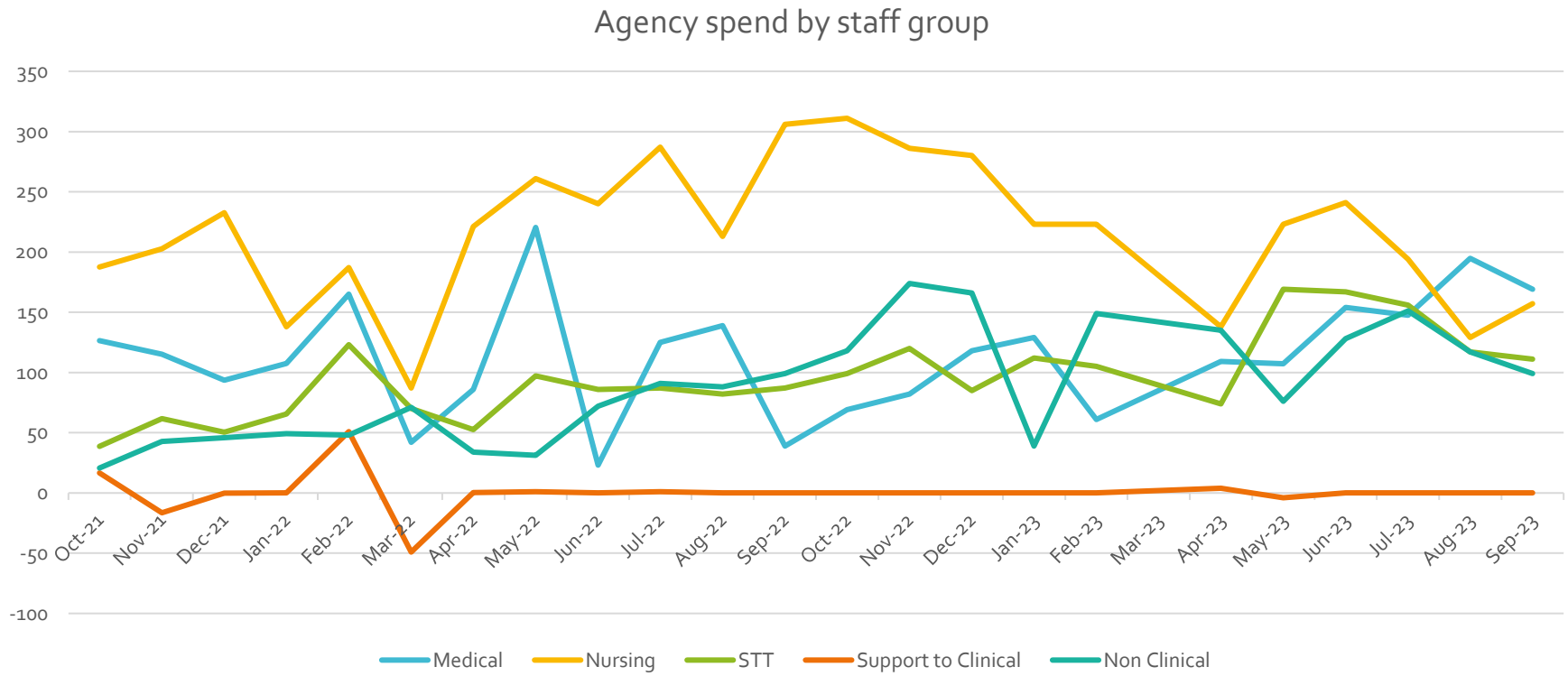
13. Pay Expenditure



14. Agency Expenditure



14. Agency Expenditure



14. Agency Expenditure

Agency Rephasing Reconciliation

Reported	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Total
Nursing	138	223	241	194	129	157	1,081
Therapies	65	140	129	119	72	151	674
Pharmacy	10	10	9	21	19	51	120
Medical	60	70	123	133	138	361	884
Non-Clinical	135	76	128	151	117	99	705
	408	**518**	**630**	**617**	**474**	**818**	**3,465**

Actual	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Total
Nursing	138	223	241	194	129	157	1,081
Therapies	69	145	148	133	91	90	674
Pharmacy	10	20	19	24	26	21	120
Medical	110	109	155	148	194	169	884
Non-Clinical	135	76	128	151	117	99	705
	462	**572**	**691**	**649**	**556**	**535**	**3,465**

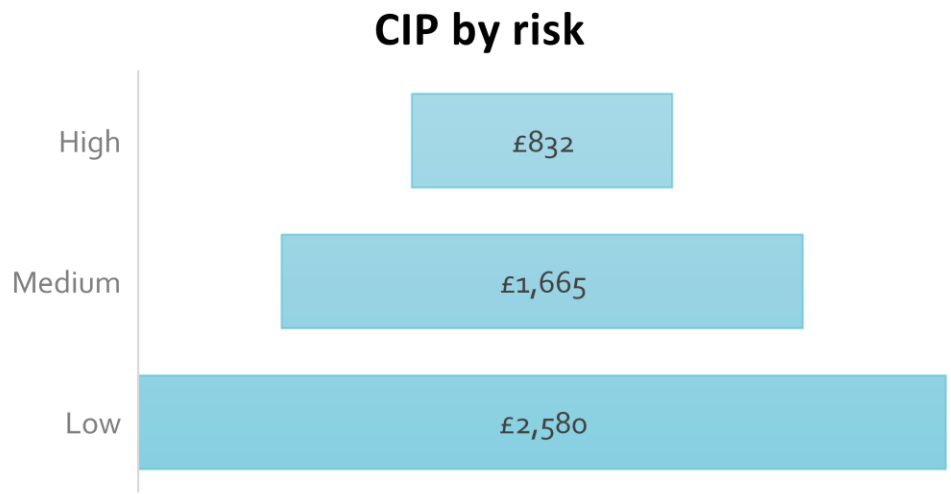
Variance	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Total
Nursing	-	-	-	-	-	-	-
Therapies	- 4	- 5	- 19	- 14	- 19	61	-
Pharmacy	-	- 10	- 10	- 3	- 7	30	-
Medical	- 50	- 39	- 32	- 15	- 56	192	-
Non-Clinical	-	-	-	-	-	-	-
	- 54	**- 54**	**- 61**	**- 32**	**- 82**	**283**	**-**

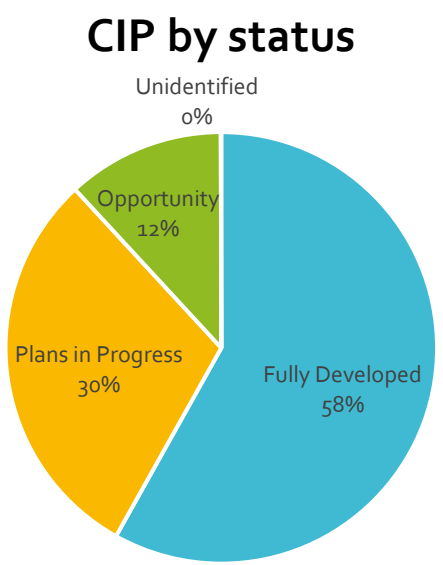
15. Cost Improvement Programme Summary

SUMMARY

Year to date savings to M6 totalling £2,397k have been delivered, against a plan of £2,263k, delivering a positive variance of £134k. The newly launched Financial Sustainability and Improvement Group commenced this month with an initial workshop held to discuss the terms of reference and identify areas of opportunity.

£000s				
CIP Category	Year to date Plan	Year to date Actual	Variance	Forecast
Pay	234	25	(£209)	£679
Non pay	£1,779	£2,333	£554	£3,897
Income	£250	£39	(£211)	£500
Grand Total	**£2,263**	**£2,397**	**£134**	**£5,076**





16. Statement of Financial Position

SUMMARY

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

As explained in last month's report, there has been a particular reduction in cash in the current month due to a number of planned payments required to be made within M6, in addition to the ongoing deficit position. There was the receipt of some large invoices for late 22/23 and early 23/24 expenditure agreed in the contract reviews with suppliers, and the payment of the PDC half year dividend.

	2022/23 M12	2023/24 M6	Movement
		(£'000)	
Intangible Assets	1,339	1,174	(165)
Tangible Assets	69,123	67,774	(1,349)
Total Non Current Assets	**70,462**	**68,948**	**(1,514)**
Inventories	19	19	-
Trade and other current assets	12,839	12,328	(511)
Cash	7,591	1,845	(5,746)
Total Current Assets	**20,449**	**14,192**	**(6,257)**
Trade and other payables	(20,229)	(15,827)	4,402
Borrowings	(18,339)	(16,973)	1,366
Provisions	(1,329)	(1,328)	1
Other Liabilities	(273)	(2,043)	(1,770)
Total Liabilities	**(40,170)**	**(36,171)**	**3,999**
Total Net Assets Employed	**50,741**	**46,969**	**(3,772)**
Total Taxpayers' and Others' Equity	**50,741**	**46,969**	**(3,772)**

17. Cash


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

18. Capital

Stream	Scheme Name	Board Approval	Spent to Date	23/24 Forecast	Variance to Plan	24/25 Pre-commitment
Strategic Estates	Oncology office refurbishment/relocation	1,200,000	2,543	696,927	503,073	549,889
Strategic Estates	Appointments team office space *	100,000	0	0	100,000	
Strategic Estates	Relocation of Facilites to the Old Pharmacy building	310,000	236,996	310,000	0	
Strategic Estates	Porters Lodge**	50,000	0	175,978	(125,978)	
Strategic Estates	ROH Creative Design Studio	55,000	41,572	55,000	0	
Strategic Estates	Omnicell installation	70,000	7,125	70,000	0	
Strategic Estates	Replacement for room 3 from a fluoroscopy room to a digital x-ray room	30,000	20,528	30,000	0	
Strategic Estates	Café Royale Refurbishment	210,000	94,078	225,000	(15,000)	
Green estate	Pool	100,000	125,373	125,373	(25,373)	
Estates Maintenance	Pool	375,000	122,938	375,000	0	
Equipment	Anaesthetic machines x 6	477,004	428,032	428,032	48,972	
Equipment	Replacement of 3T MRI scanner	275,000	187,880	554,608	(279,608)	
Equipment	Pool	200,000	19,931	200,000	0	
Information Technology		0	75,988	75,988	(75,988)	
Reserve		46,996	0	177,095	(130,099)	
SCIF		410,000	0	410,000	0	
		3,909,000	1,362,982	3,909,000	(0)	549,889
TOTAL						
	Strategic Estates	2,025,000	402,841	1,562,905	462,095	549,889
	Green estate	100,000	125,373	125,373	(25,373)	0
	Estates Maintenance	375,000	122,938	375,000	0	0
	Equipment	952,004	635,842	1,182,640	(230,636)	0
	Information Technology	0	75,988	75,988	(75,988)	
	Reserve / SCIF	456,996	0	587,095	(130,099)	0
		3,909,000	1,362,982	3,909,000	(0)	549,889

* 23/24 forecast included within oncology as phase 1

** not yet committed

19. System

SUMMARY

The ICB continues to experience significant pressure across most providers in month 6, although all providers, except for UHB, have submitted plans to deliver breakeven positions at the end of the year.

The year-to-date position is largely due to a mix of continuing industrial action, impact of inflation, and the significant level of CIP that needs to be delivered on a monthly basis

Organisation	Surplus / (Deficit) - Adjusted Financial Position							Prior Month		Movement		YTD per recovery plan		
	Plan	Actual	Variance		Plan	Forecast	Variance	Actual	Variance	Actual	Variance	Actual	Difference	Actual
	YTD	YTD	YTD	YTD	Year Ending	Year Ending	Year Ending	YTD	YTD	YTD	YTD	YTD	YTD	FOT
	£000	£000	£000	%	£000	£000	£000	£000	£000	£000	£000	£000s	£000s	£000s
Birmingham And Solihull ICB	5,116	3,033	(2,083)		-	-	-	3,549	-2,207	(516)	124			
Birmingham And Solihull Mental Health NHS Foundation Trust	-	(495)	(495)		-	-	-	-532	-532	37	37	-455	-40	2
Birmingham Community Healthcare NHS Foundation Trust	264	(443)	(707)		-	-	-	-969	-1,189	526	482	-507	64	58
Birmingham Women'S And Children'S NHS Foundation Trust	-	(1,556)	(1,556)		0	0	0	-1,067	-1,067	(489)	(489)	-800	-756	0
The Royal Orthopaedic Hospital NHS Foundation Trust	335	(3,026)	(3,361)		(0)	-	0	-2,664	-2,891	(362)	(470)	-2,867	-159	110
University Hospitals Birmingham NHS Foundation Trust	(8,700)	(49,128)	(40,428)		-	(54,199)	0	-39,352	-29,952	(9,776)	(10,476)	-46,732	-2,396	-66,920
ICS Total	(2,985)	(51,615)	(48,630)	-	(0)	(54,199)	1	(41,034)	(37,837)	(10,581)	(10,793)	-51,361	-3,287	-66,750

20. Workforce

Trust Workforce Metrics	Aug-23	Sep-23	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1325	1354	29	-	-
Staff In Post - Full Time Equivalent	1172.40	1197.69	25.29	-	-
Staf Turnover % - Unadjusted	13.07%	15.41%	2.34%	↑	<=11.5%
Staf Turnover % - Adjusted	11.54%	10.56%	-0.98%	↓	<=11.5%
Total WTE Employed as % of Establishment	83.99%	85.59%	1.60%	↑	>=93%
Total WTE Employed as % of Establishment - Clinical	81.04%	82.13%	1.09%	↑	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	89.28%	91.89%	2.61%	↑	>=96%
% Of Attendance	94.07%	93.48%	-0.59%	↓	>=96.3%
% Of 12 mth MAA Attendance	94.24%	94.20%	-0.04%	↓	>=96.3%
% Staff received mandatory training last 12 months	89.48%	87.50%	-1.98%	↓	>=93%
% Staff received formal PDR/appraisal last 12 months	65.68%	66.76%	1.08%	↑	>=95%
% of Sickness - Trust wide Long-term	3.40%	3.50%	0.10%	↑	-
% of Sickness - Trust wide Short-term	2.53%	2.30%	-0.23%	↓	-
Return To Work Completion %	46.93%	60.56%	13.63%	↑	>=80%

20. Workforce

Summary / Highlights

In September, 87.50% of staff had completed their mandatory training within the last 12 months which is a slight decrease from August. 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.

Turnover (both Unadjusted and Adjusted) have been increasing over the last months this trend has changed. Turnover unadjusted stands at 15.41% which is an increase from August which was 13.07%.

The percentage of staff attendance in the month has decreased slightly to 93.48%.
The Establishment of WTE is still below target and has increased to 85.6% from 83.9% in August.
Clinical staff are currently 82.13% established in terms of WTE.
Non-Clinical staff are currently 91.89% established in terms of WTE.

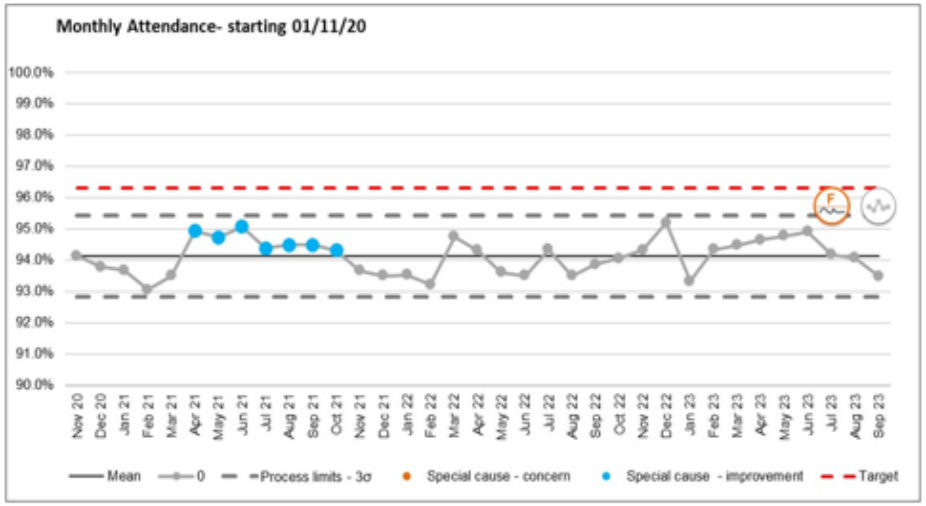
Risks / Issues

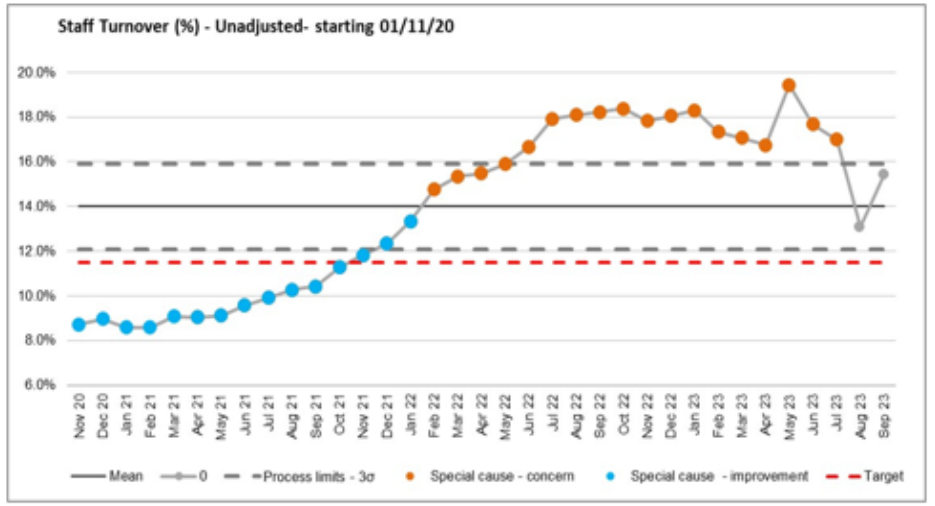
Cost of living seems to be affecting the NHS as a whole, the Trust is doing its upmost to alleviate the impact. Other Trusts seem to be able to offer higher bands, this has seen some employees move on.
Staff with no PDR/Appraisal will have no way of been appraised and will have no personal goals.
Return 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.

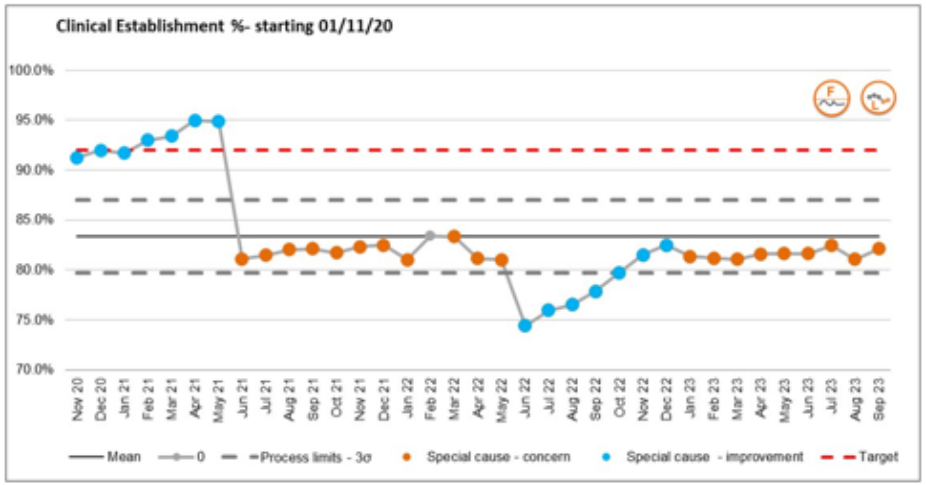
Actions

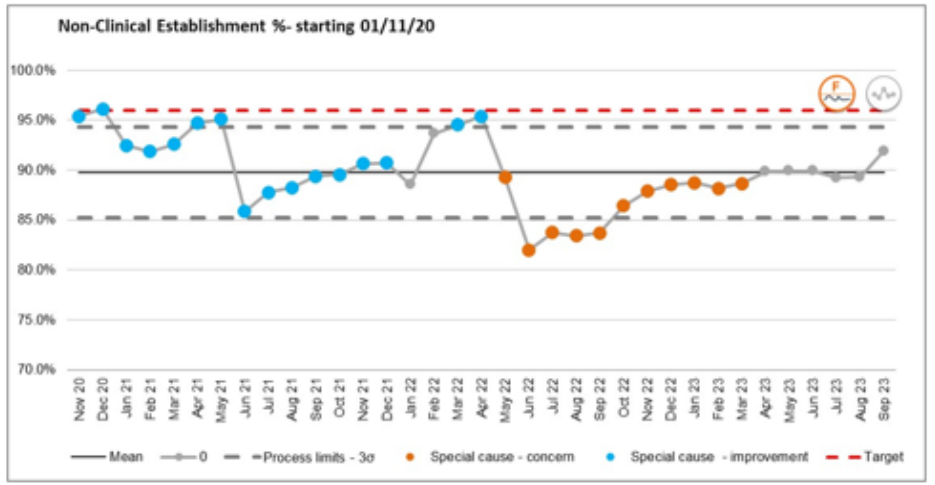
Recruitment activity has increased to help get the Establishment back up to where we need to be.
HR to review the Staff Turnover and investigate the reasons and dig deeper into them, HR provides a deeper dive into the data and will be running a Leavers Process working group to tackle some of the themes.
Absence is also being monitored in HR, and a deep dive into sickness is also being provided.

20. Workforce

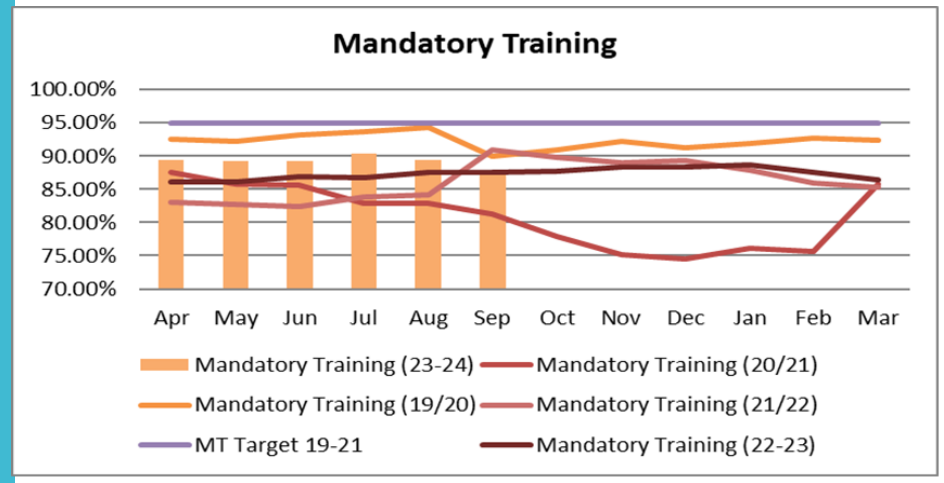


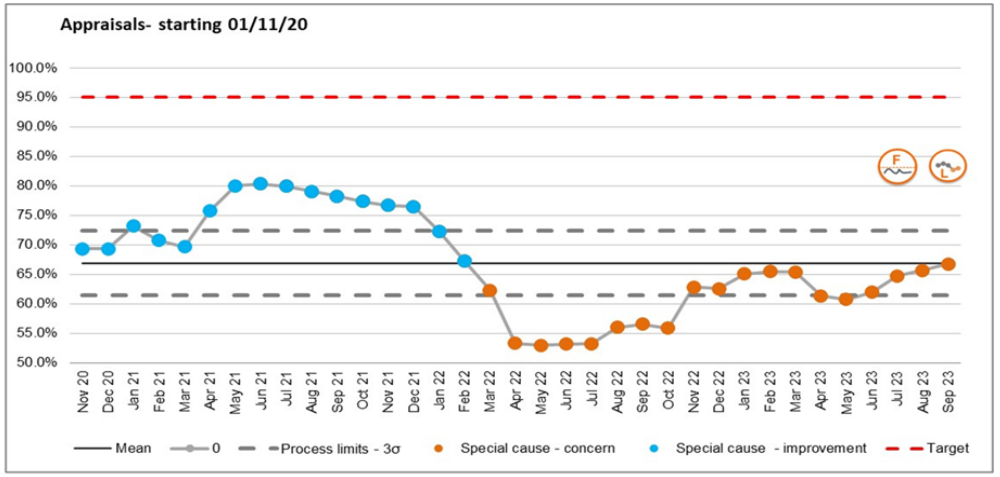


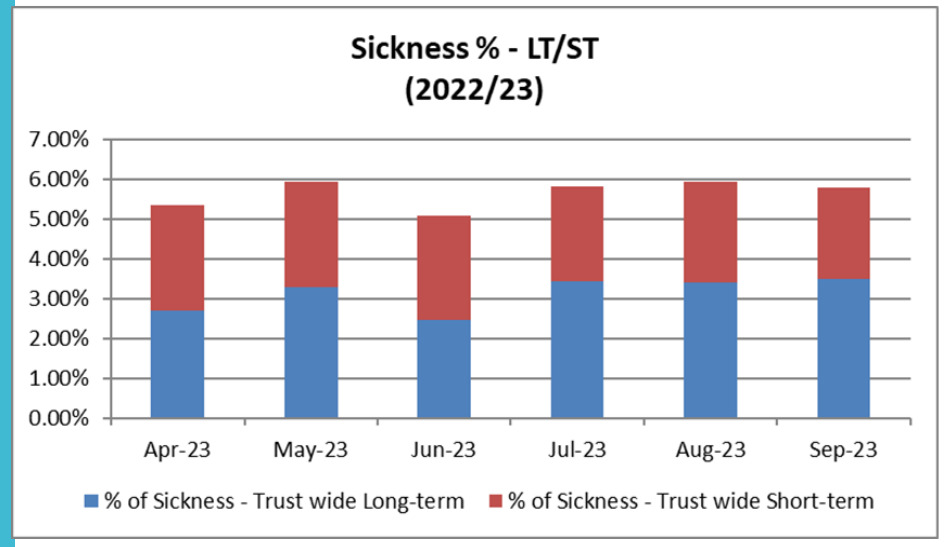


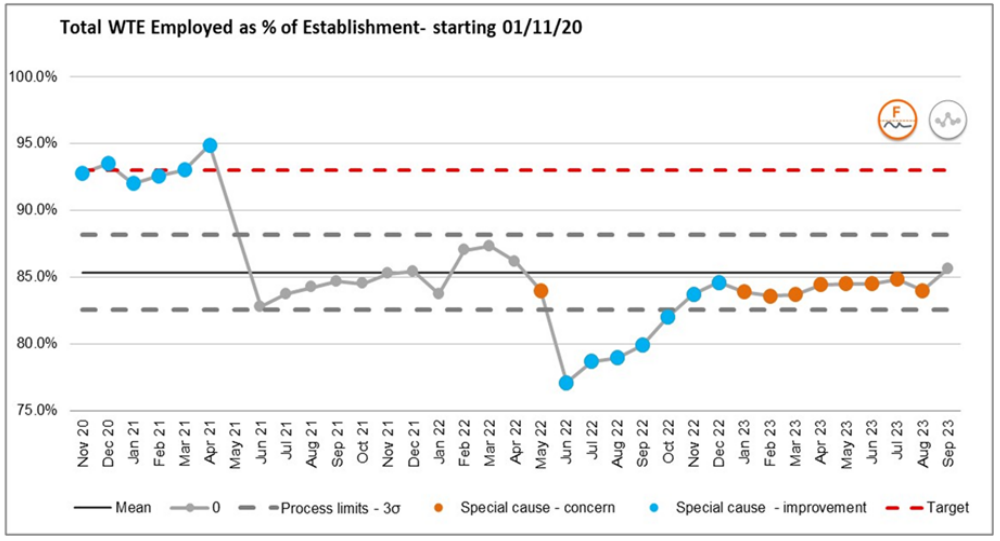


20. Workforce









The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY AND SAFETY REPORT

October 2023 (September 2023 Data)

EXECUTIVE DIRECTOR:	Simon Grainger Lloyd	Director of Governance
	Nikki Brockie	Chief Nurse
	Marie Peplow	Chief Operating Officer
AUTHOR:	Adam Roberts	Assistant Director of Governance & Risk

ROHTB (11/23) 016

Quality Report – October 2023 (September 2023 Data) – Summary Dashboard

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	2022/2023	2023/24
Incidents	296	308	329	310 (↓)	283 (↓)	292 (↑)	374 (↑)	269(↓)	378 (↑)	341 (↓)	323 (↓)	297 (↓)	411 (↑)		
Serious Incidents	1	0	0	1	0 (↓)	2 (↑)	0 (↓)	1(↑)	1	0 (↓)	0	0	0	8	2
Inpatient Deaths	0	0	0	0	0	0	0	0	1 (↑)	0 (↓)	1 (↑)	1	0	1	2
VTEs (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Falls	3	10	5	9 (↑)	3 (↓)	7 (↑)	5 (↓)	12(↑)	9 (↓)	7 (↓)	7	8 (↑)	8	79	44
Pressure Ulcers: Cat 2 (Avoidable)	0	0	2 (↑)	0	0	0	0 (0	0	0	0	0	0	0	5	0
Pressure Ulcers: Cat 3 (Avoidable)	0	0	0	1	0	1	0 (0	0	0	0	0	0	0	2	0
Infections	1	1	1	1	0	1 (↑)	0 (↓)	0 (↓)	0	1 (↑)	1	2	1	9	5
Complaints	6	4	4	3	2	4 (↑)	1 (↓)	3(↑)	2 (↓)	2	5 (↑)	1	3	45	15
Litigation	0	0	3	0	0	2 (↑)	2	0(↓)	0	0	3 (↑)	0	0	9	3
Coroners	0	0	0	0	0	0	0	0(↓)	1 (↑)	0 (↓)	1 (↑)	0	0	0	2

1. INTRODUCTION

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

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

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

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

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

2. Incidents Reported

In the month of September 2023, there were a total of **411** Incidents reported on the Ulysses incident management system. The breakdown of those incidents is as follows;

No Harm = 264
Low Harm = 138
Moderate Harms = 7
Severe Harm = 0
Near Miss = 2

Moving forward, an SPC chart will be created to better visually illustrate the numbers and trends in relation to incident reporting and there will also be further change to this section, and the wider report, to reflect our PSIRF plan following implementation and go live with the new framework.

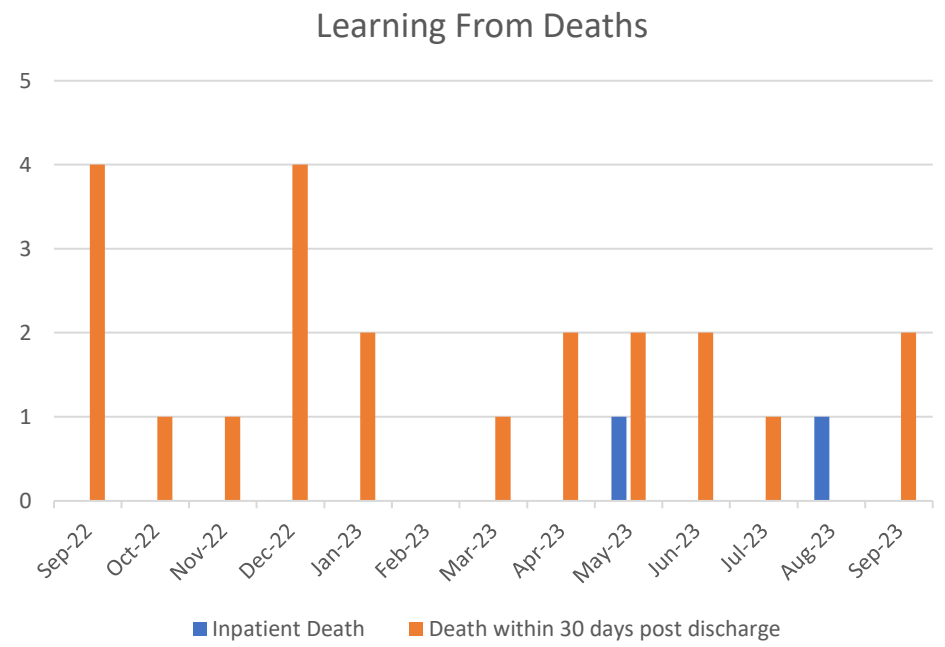
3. Patient Deaths

Inpatient Deaths

There were 0 inpatient deaths reported during September 2023

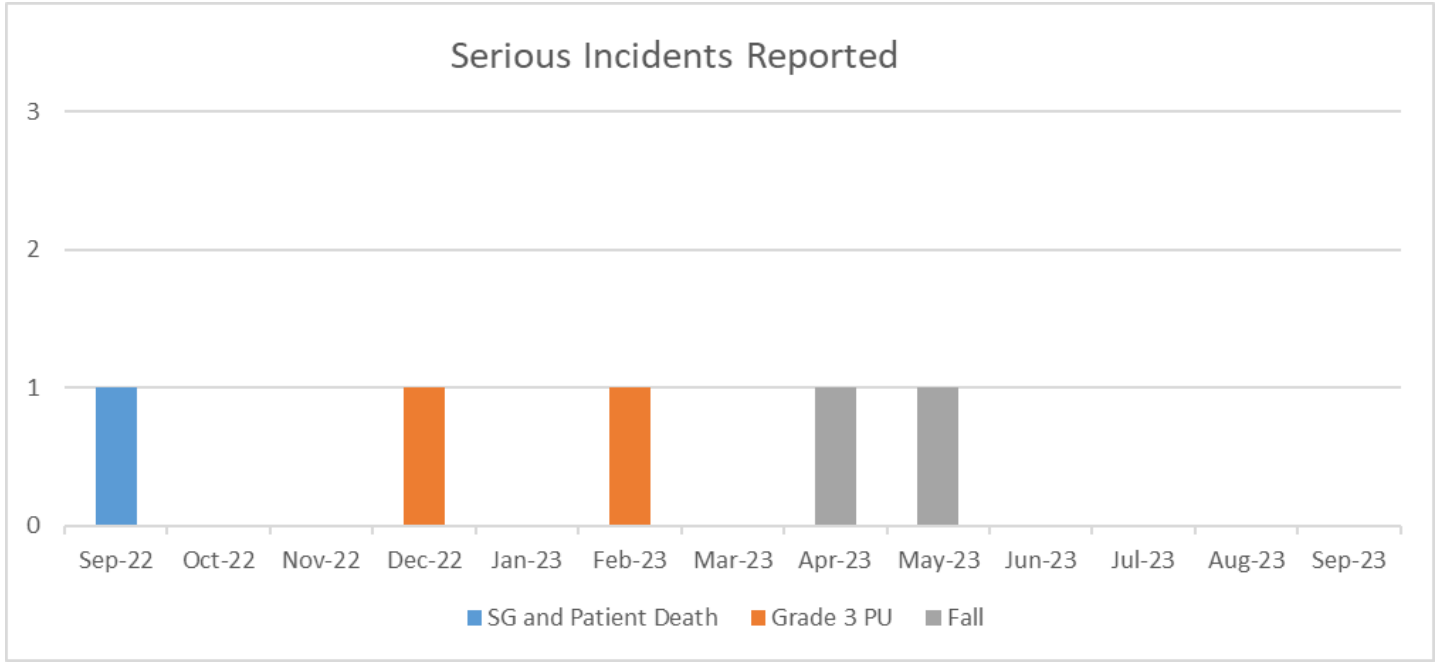
Deaths within 30 days post discharge

There were 2 deaths that occurred within 30 days post discharge reported during September 2023. The date of death for both occurred in September and the graph has been updated to reflect this.



4. Serious Incidents

There were 0 Serious Incidents reported in September 2023



5. Potential Moderate Harm & Severe Harm Incidents

There were **7** potential Moderate Harm incidents reported in September 2023

All incidents have been tabled at Divisional Governance Meetings and are currently being investigated via divisional governance processes.

Summary of Potential Moderate Harm Incidents

- **1 x Ward 1** – SSI related incident
- **1 x Theatres** – Skin Damage from Equipment
- **1x HDU** - VTE
- **1 x Ward 3** – VTE
- **1 x Ward 2** – SSI related incident
- **1 x Oncology** – Wrong Diagnosis
- **1x POAC** – Found with Injury Cause Unknown

6. Update on Moderate Harm Incidents from August 2023

There were 5 potential Moderate Harm incidents reported in August, which were then reported on within the September 2023 Quality Report. An update on each of these incidents can be found below:

- **Ward 3 – SSI related Incident**
  Post Infection Review (PIR) investigation is in progress, awaiting theatre input before completion. Progress and sign off monitored and managed via divisional governance process

- **Theatre – SSI related Incident**
  PIR investigation is in progress. Progress and sign off monitored and managed via divisional governance process

- **Ward 2 – SSI related Incident**
  PIR investigation complete, sent to IPC team for comments – will then be added to divisional governance agenda for sign off.

- **Oncology – Clinical Assessment / Care**
  Shared with UHB. Awaiting manager's input. Progress monitored via divisional governance process.

- **Ward 4 – Slips, Trips and Falls**
  SNR completed. No lapse in care identified. No further action required. Downgraded to low harm.

7. Near Miss Incidents

There were **2** Near Miss incidents reported in September 2023

All incidents have been tabled at Divisional Governance Meetings. Both incidents were managed locally and closed.

Summary of Incidents

1 x Ward 12 – Medication Error related incident (Missing Signature)

1 x Pharmacy related incidents (Out of Date medication)

8. Learning from Serious Incidents (SI), Never Events (NE) and RCAs

There were 2 RCAs closed in September 2023

1. Ward 4 - Inpatient Fall

Unavoidable fall - good practice identified, good teamwork identified.

Learning
To remind all staff of continuous need for good documentation which supports evidence of current practice.

2. ADCU – VTE

Unavoidable VTE

Learning
No recommended actions or learning.

9. Venous thromboembolism (VTE) Incidents

There were 2 VTE incidents reported in September 2023

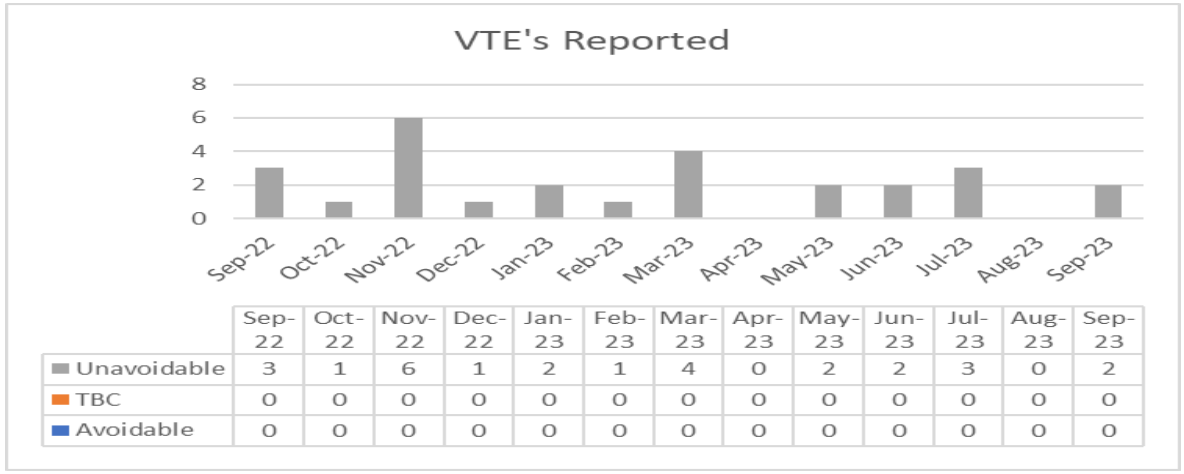
Both VTE's are currently being investigated. Provisionally graded as unavoidable, pending final report.

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

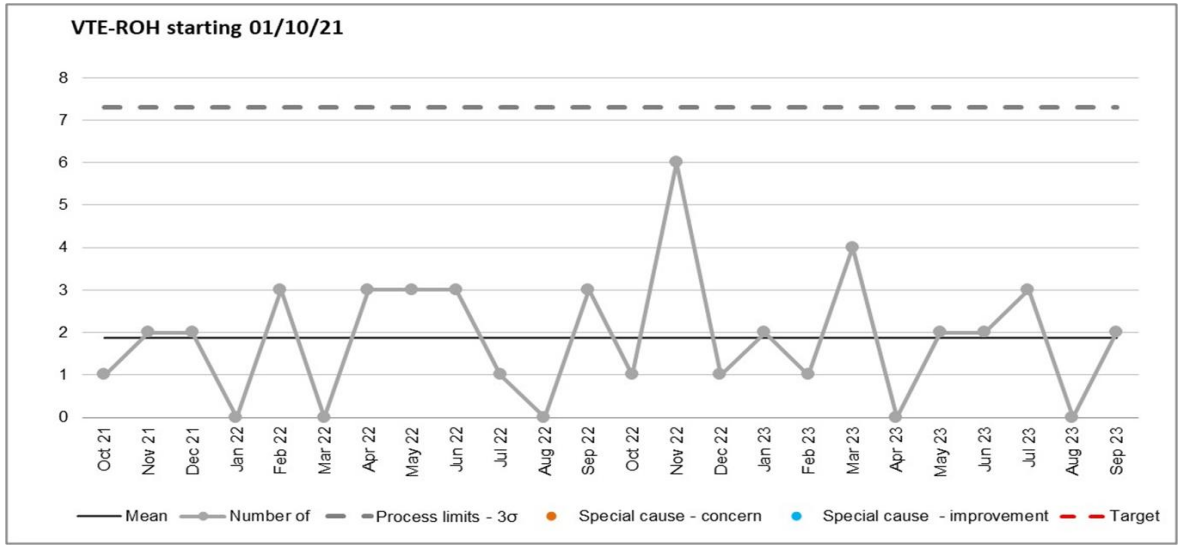
Pre-validation figure for September 2023 = **99.06%**

<u>Quality Improvement work underway</u>

Latest NICE Guidance relating to VTE management has been reviewed and discussed at VTE Committee – Trust deemed compliant with Guidance – minor amendment to VTE Policy needed to reflect changes for patients with Covid 19 – this work is underway.



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



10. Falls

8 Inpatient falls incidents reported in September 2023 – same as previous month.

No Harm = 7
Low Harm = 1

Trends

All 8 were unwitnessed falls.
2 of the falls were bathroom related.
3 of the falls related to patients mobilising against advice

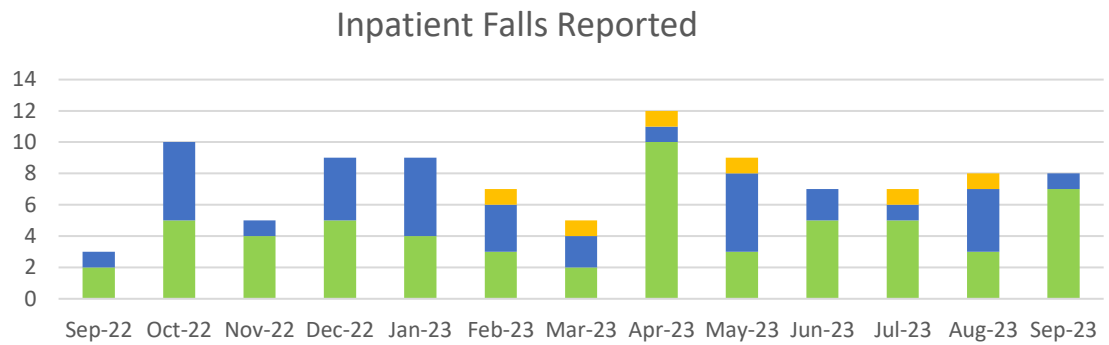
Quality Improvement Work Underway

New SOP including change in criteria for falling leaves campaign to highlight in-patients at higher risks of falls, awaiting resubmission to Clinical Quality Group for approval.

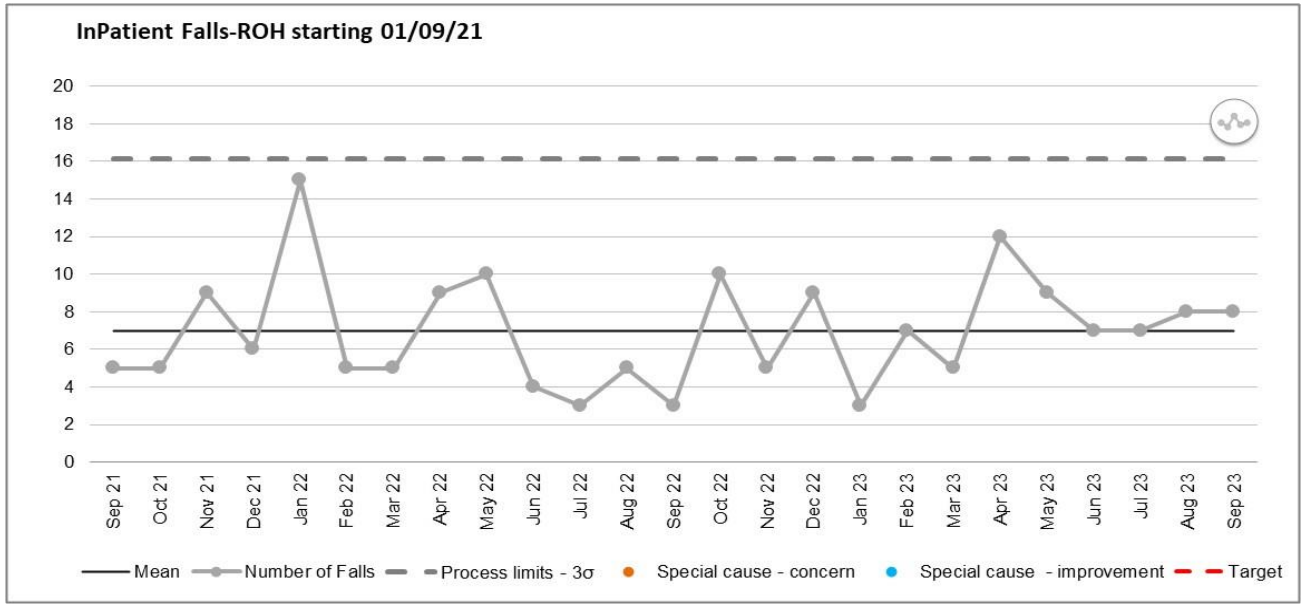
New falls / dementia information boards for out-patient areas designed and on order now.

Quality walkabouts – have been launched with a safety lens. Report to follow.

Writing induction for new doctors starting in the Trust, outlining responsibilities for falls management.



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	1	1	1	1	0	1	1	0
Low Harm	1	5	1	4	5	3	2	1	5	2	1	4	1
No Harm	2	5	4	5	4	3	2	10	3	5	5	3	7



11. Pressure Ulcers

0 Category 3 or 4 PU reported in September 2023

1 x Category 2 ROH acquired PU incident reported in September 2023 – is currently under investigation

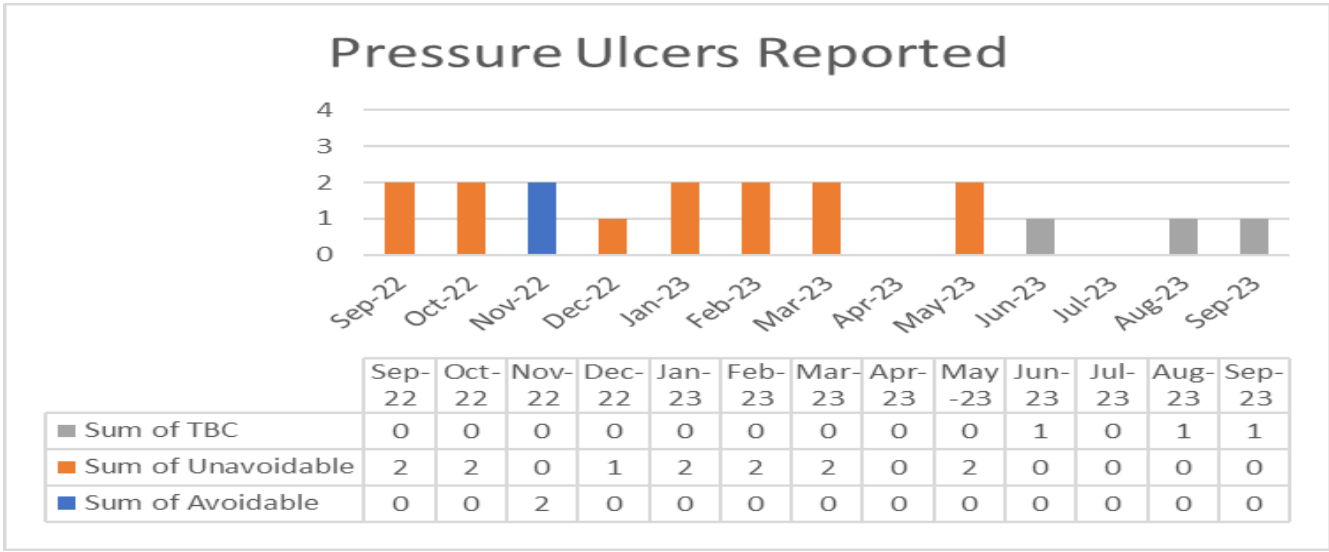
Update on 1 x Category 2 ROH acquired PU incident reported in September Quality Report 2023. (August 2023 data) - remains under investigation

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

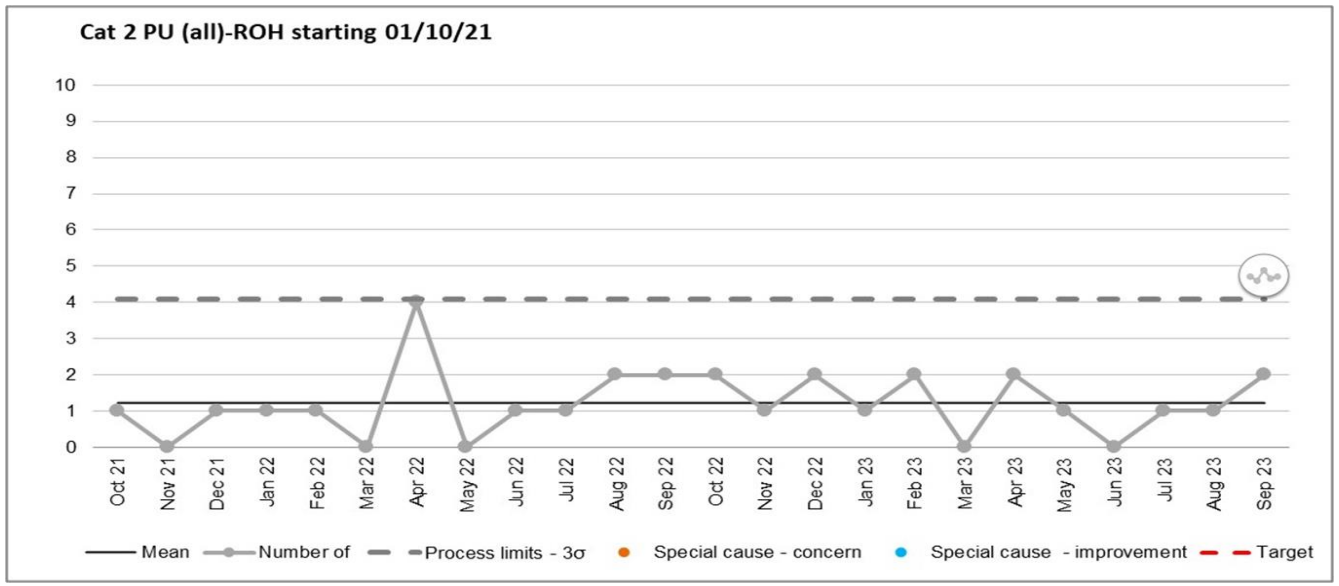
- What's under the dressing?' Campaign is being worked up to be rolled out in month.
- TV referrals have now gone to online to speed up process.
- Education continues to be rolled out at all forums. (example. HCA training)

<u>Risks/Issues</u>

- **Aqua cell dressing skin damage** – 9 patient affected reported by ROCS team, reported to MHRA and company (Some indication of other issues). Replacement dressing being trailed. One concern raised about new dressing; however, they continue to be used at present.



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



12. Sepsis - Quarter 1 Audit

Objective
To monitor and improve compliance with prescribing and administrating IV antibiotics within 1 hour of recognising Sepsis

Results
Patients screened: 8
Positive sepsis screens: 6
Total compliant: 4

Compliance 67% against a Target 90%

Deeper dive into data showed that all red flag sepsis received antibiotics within 1 hour of recognition. All amber flag sepsis received antibiotics within 3 hours. This is in line with national and local guidelines.

Action Plan

Re-engage with sepsis link nurses - Study day with updates took place on the 11th of August
RRT deteriorating patient study day to be replaced with a nationally recognised course Acute Illness Management (AIM) - Launch due early 2023 - this will cover sepsis and patient deterioration.
RRT to continue to collect sepsis audit forms - On-going
AMaT to be adjusted in Q2 to review red and amber flag sepsis - On-going
Q2 to be shared at divisional governance meetings, as well as resus and deteriorating patient committee - On-going
World Sepsis Day Bake Off - Completed—Recovery crowned the winners.
Sepsis info cards designed and printed - Completed—these caused a storm on X (twitter) with lots of other Outreach teams asking if they could steal the idea!

13. Infection Prevention Control

Below are the Statutory requirement/Reportable Infections and are included within this report for awareness. A detailed IPCC report is submitted to Quality and Safety quarterly. All infections are reported and scrutinised at the IPCC committee.

Infections Recorded in month and Year to Date (YTD)	September 2023	YTD
Methicillin-Resistant Staphylococcus Aureus bloodstream infection (MRSA BSI)	0	0
Post 72-hour Clostridium difficile infection (CDI)	1	1
Methicillin-Sensitive Staphylococcus Aureus bacteraemia (MSSA BSI)	0	1
E.coli BSI	0	1
Klebsiella spp. BSI cases	0	0
Pseudomonas aeruginosa BSI cases	0	0

14. Complaints

Complaint Information

The Trust received **1** complaints in August
Below are the summaries for complaints received

1. Poor Follow up care
2. Lack of Communication / processes
3. Patient needs not met
4. Lack of care provided
5. Failure to provide satisfactory care

2 Complaints are for Division 2 (POAC and Imaging) and 3 are for Division 1 which were all Spinal.
In August 2023, the complaints team **closed 1** formal complaints. **This complaint breached** the agreed timeframe with the patient; however this was communicated with them.
At the time of producing this report we **currently have 5 open** formal complaints, and 2 reopened complaints. All complaints are for Division 1. 1 Reopened complaint is for Division 2

Complaint Resolution Meetings

The Trust offers meetings to the complainant in the verbal and written acknowledgement and in the response letter. Often complainants will wait for the first written response before arranging a meeting as they then have a clearer picture of what has happened with the concerns raised within their complaint. Where the Trust did not meet the complainant's expectation in the first response or meeting, the Trust encourages complainants to write to us with any additional comments, questions or recommendations that will satisfy the complainant.
During a period of four years, it is evident that the Trust has received less reopened complaints. It is believed that this is due to the offer to meet with each complainant and a better quality of response letter

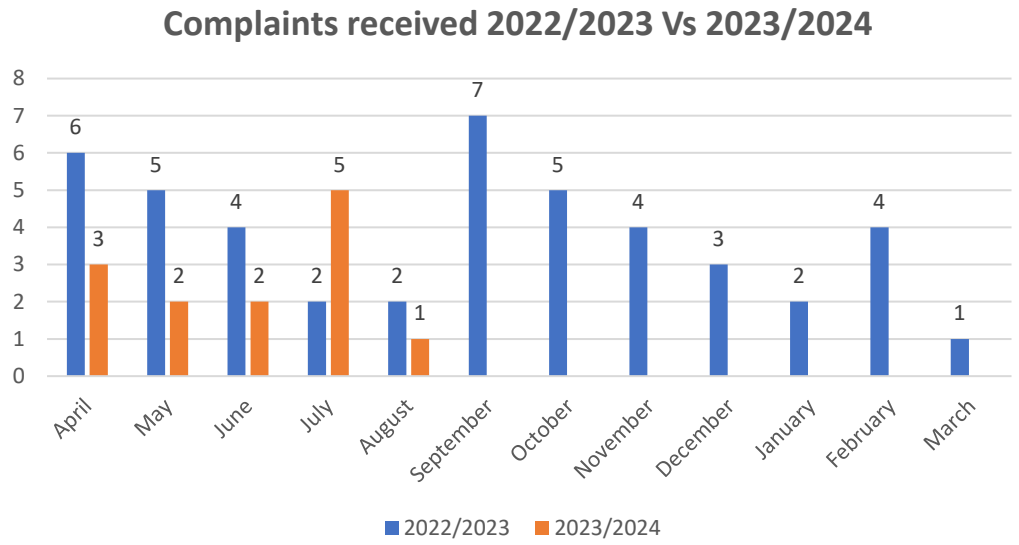
In August 2023, the Trust received **1 reopened complaint. –** Currently waiting for complaint resolution meeting dates.

In August 2023, the Trust received **1 meeting request**

RISK AND ISSUES WITHIN PATIENT EXPERIENCE

1 complaint breached in August 2023.
All complaints opened in August were for Division 1

Complaints



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

Complaint Year Totals	
April 2022- March 2023	45
April 2023 - August 2023	14

ROHQS (10-23) 002 (a)

Complaints KPI's

KPI	Complaints %
April 2023	100%
May 2023	67%
June 2023	75%
July 2023	100%
August 2023	0%

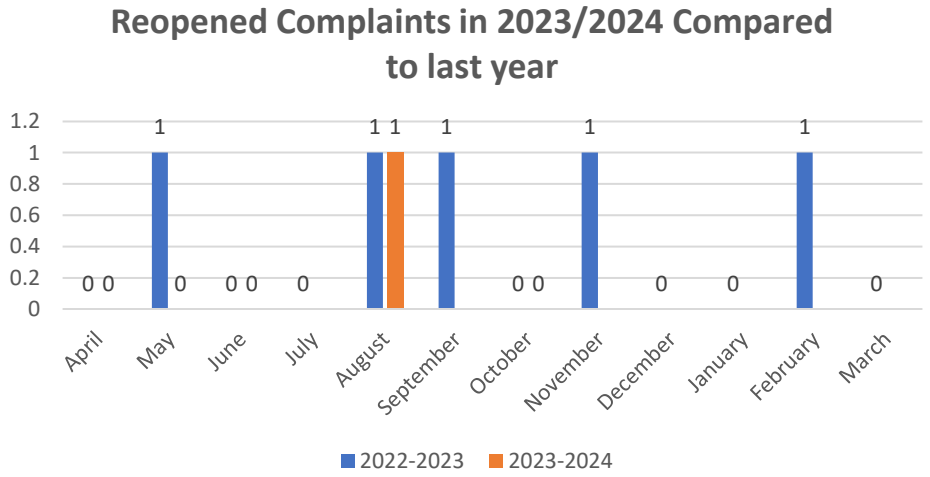
0%-79%
80%-90%
91%-100%

The KPI was not met in August 2023. This is due to the 1 complaint we had open had breached.

Actions from Complaints

In August 2023 0 actions identified on the complaint received, despite request
Immediate action plans were completed for none of the complaints received
LOOP's were not completed for any complaints for the month of August

Complaint Themes



The Trust received 1 reopened complaint in August 2023 who also requested a complaint resolution meeting. The complainant was not satisfied with the response they received and agreed to attend a resolution meeting with the lead.

We also received 1 Private Suite complaint; this is not recorded in our numbers but is being tracked through our process.

The Trust received 1 request from the PHSO, the complaints team have provided all the necessary requested information to the PHSO and are now awaiting further instruction.

Themes

1. Lack of Care and Treatment
2. Care Received
3. Nursing Care Received

What We Did

1. Raised in divisional governance meeting to track themes.
2. Complaints raised in Ward MDT meeting
3. Concerns raised in consultant MDT meeting

15. Litigation and Coroners

New claims

0 new claims were received in September 2023

Pre-Application Disclosure

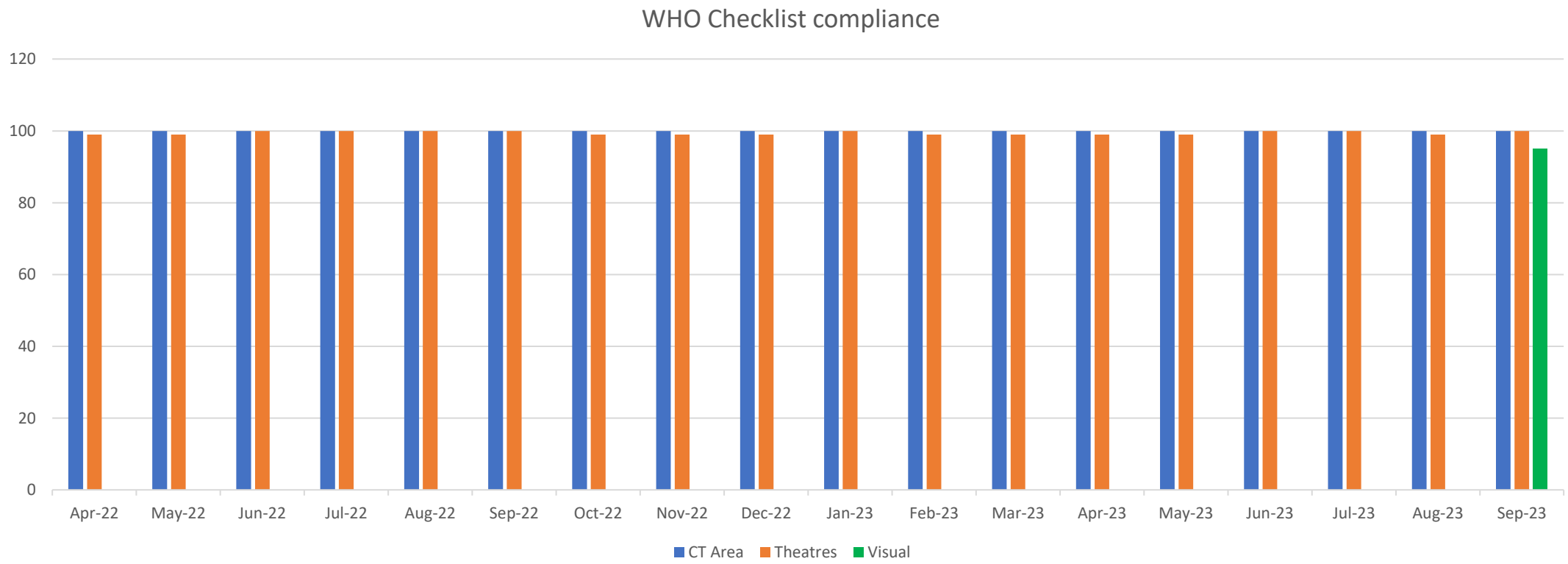
2 new requests for Pre-Application Disclosure of medical records were received in September 2023

Coroner's Inquests

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

16. 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**.**



17. CAS Alerts

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2023/012/DHSC	Shortage of verteporfin 15mg powder for solution for injection. Verteporfin is indicated for the treatment of adults with exudative (wet) age-related macular degeneration (AMD) with predominantly classic subfoveal choroidal neovascularisation (CNV) or adults with subfoveal choroidal neovascularisation secondary to pathological myopia. Verteporfin is also used in the treatment of ocular cancer in specialist centres. Verteporfin is used off-label for the management of central serous retinopathy with photodynamic therapy.	National Patient Safety Alert - DHSC	28-Sep-23	Assessed - not relevant to organisation's services.	20 Oct 23
NatPSA/2023/011/DHSC	Shortage of methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules, and guanfacine prolonged-release tablets There are supply disruptions affecting various strengths of the following medications which are licensed for the treatment of attention deficit hyperactivity disorder (ADHD).	National Patient Safety Alert - DHSC	27-Sep-23	Assessed - not relevant to organisation's services.	11 Oct 23

Outstanding Alerts from Previous Months

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2023/010/MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls. The MHRA continues to receive reports of deaths and serious injuries from entrapment or falls relating to medical beds, bed rails (also known as bed safety rails), trolleys, bariatric beds, lateral turning devices and bed grab handles (also known as bed levers or bed sticks). Chest or neck entrapment in bed rails is currently listed (number 11; 2018) as a 'Never Event' according to the NHS. This National Patient Safety Alert provides further background and clinical information and actions for providers.	MHRA	31 Aug 23	Issued to MDSO. Issued to Falls Lead (Alison Woodbridge) for review / necessary actions. On-going…	1 Mar 2024
NatPSA/2023/007/MHRA	Potential risk of underdosing with calcium gluconate in severe hyperkalaemia. This alert highlights the Adult Renal Association Clinical Practice Guidelines (2020) recommendation on calcium gluconate use to support organisations to update local policies and guidelines for the treatment of severe hyperkalaemia in adults. The MHRA has also published a Drug Safety Update article with further information.	MHRA	27 Jun 23	**24 Jul 23:** **Email from MDSO-** *'Dr Rea is leading on this. Depending on how the alert affects us this could change to Dr Gowni.'* *On-going...*	1 Dec 2023

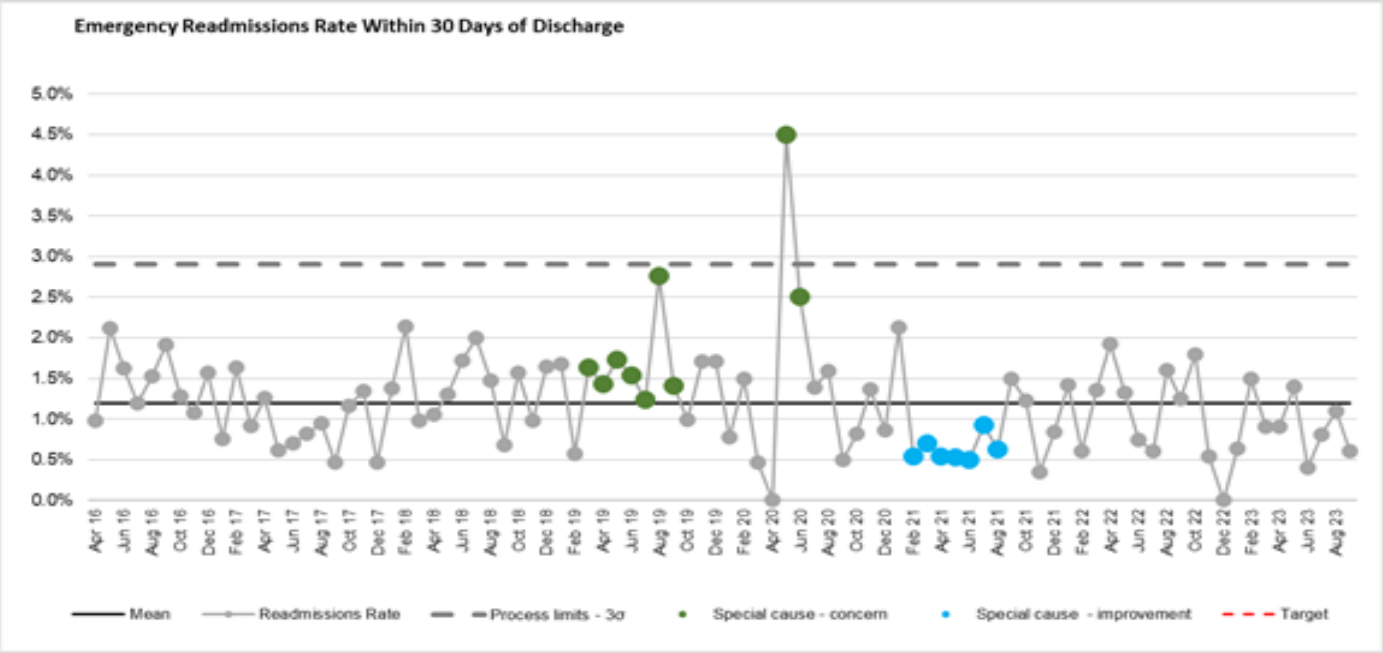
18. Safeguarding

KPI	Sept 2022	Oct-22	Nov-22	Dec-22	Jan-22	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Safeguarding Adult Notifications	36	27	51	31	31	35	17	43	21	44	43	47	37
Safeguarding Children Notifications	43	44	42	26	26	76	23	37	29	55	51	42	25
Adult Level 2	86.01%	84.53%	85.14%	81.83%	81.83%	80.28% (↓)	80.19% (↓)	82.27% (↑)	83.12% (↑)	84.68% (↑)	86.22% (↑)	86.22%	85.48% (↓)
Adult Level 3	86.52%	83.30%	80.31%	75.68%	75.68%	75.2% (↓)	76.37% (↓)	77.84% (↑)	80.15% (↑)	83.02% (↑)	83.11% (↑)	82.06% (↓)	83.15% (↑)
Level 4	66.67%	66.67%	75.00%	75.00%	75.00%	60% (↓)	80.0% (↑)	80.00%	80.00%	80.00%	100% (↑)	100% (↑)	100.00%
Child Level 2	85.87%	84.12%	84.54%	81.16%	81.16%	79.93% (↓)	79.85% (↓)	82.18% (↑)	82.86% (↑)	84.68% (↑)	86.14% (↑)	86.12% (↓)	85.23% (↓)
Child Level 3	84.52%	83.10%	80.12%	75.29%	75.29%	75.2% (↓)	76.37% (↑)	78.03% (↑)	80.15% (↑)	82.82% (↑)	83.11% (↑)	81.68 (↓)	82.8% (↑)
Mental Capacity Act MCA	85.78%	84.48%	84.97%	81.67%	81.67%	80.19% (↓)	80.36% (↑)	82.44% (↑)	83.21% (↑)	84.85% (↑)	86.39% (↑)	86.35% (↓)	85.88% (↓)
Deprivation of Liberty Safeguards DoLs	85.87%	84.48%	85.05%	81.58%	81.58%	79.93% (↓)	79.93%	82.09% (↑)	82.95% (↑)	84.68% (↑)	86.22% (↑)	86.27% (↑)	85.63% (↓)
Prevent Awareness	91.70%	90.04%	91.01%	89.88%	89.88%	89.40%	88.96%	90.14%	89.86%	90.49%	91.24% (↑)	91.32% (↑)	89.98% (↓)
WRAP (prevent level 3)	82.86%	80.15%	81.80%	81.06%	81.06%	78.55% (↓)	80.2% (↑)	82.19% (↑)	83.89% (↑)	85.68% (↑)	87.89% (↑)	87.41% (↓)	86.15% (↓)
FGM	0	3	1	1	1	2	1	3	0	1	0	5	2
DOLS	11	5	7	6	6	4	0	7	0	6	4	4	2
MCA	4	7	4	4	4	0	1	3	4	1	4	2	7
PIPOT cases	1	1	0	0	0	1	0	0	0	0	1	0	0
PREVENT Notifications	0	0	0	0	0	0	0	0	0	0	0	0	0

Actions underway to recover position:

- Training dates until April 2024 have been uploaded onto ESR and the Trusts Intranet. The Communications Team have sent a Trust wide bulletin including all the safeguarding training available and to signpost staff how to access training. Ongoing work to enable onsite training rooms to be booked for SG training up to at least 6 months in advance to enable wards and other clinical teams to better rota and schedule staff to attend.
- 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

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



	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
No of Readmissions	9	3	0	3	7	5	4	7	2	4	5	3
Denominator	556	556	486	468	468	546	465	494	554	482	469	500
% Readmissions	1.6%	0.5%	0.0%	0.6%	1.5%	0.9%	0.9%	1.4%	0.4%	0.8%	1.1%	0.6%

20. Freedom to Speak Up Update

Concerns Raised

There were 6 concerns raised in August 2023 and 1 concern raised in September 2023; there were in relation to the following themes:-

- Inappropriate attitude and behaviour
- Poor support from managers
- Staff wellbeing

Employee safety and wellbeing

No direct issues raised relating to patient's safety and quality. However, some employee related issues raised could potentially affect patient safety, such as staff retention and the impact on staff wellbeing. Staff reported being treated in an inappropriate manner and with lack of respect and poor support from managers. FTSUG identified areas where staff were reluctant to raise issues of concern due to the perception that nothing will be done. There were also concerns that nothing will be done because of the influence of some line managers. Workers seemed to be happy to speak up to the Guardian but reluctant for their cases to be escalated. This posed a safety barriers as the Guardian is unable to escalate workers concerns without their consent. Questions also raised around making the canteen available out of hours for theatre and ward staff working shifts

Learning and Improvement Work Underway

Remains the same, with a focus on:-

- 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
- Collaborative working with FTSU Guardian, Matron and Head of Nursing to ensure action taken to support staff and embed learning

Operational Performance

August 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 August 23	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	55.48%	55.61%	92%		F
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	30	13	0	L	F
52 week waits (52 – 64 Weeks)	358	309	0	H	F
All activity YTD (compared to plan)	5,856	4,719	5,773		P
Outpatient activity YTD (compared to plan)	27,149 100.3% Cumulative	21,564 100.4% Cumulative	27,055 YTD Target		P
Outpatient Did Not Attend (YTD)	7.4%	8.3%	8%		P
PIFU (trajectory to 5% target)	425 8.1%	439 8.2%	202 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	10.5%	11.3%	19%		F
FUP attendances(compared to 19/20)	90.7%	89.6%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	107.8%	104.8%	120%		F
Diagnostics volume YTD (compared to plan)	9,703 Cumulative	7,624 Cumulative	7,765 YTD Target		P
Diagnostics 6 week target	99.2%	99.8%	99%		P

Operational Performance Summary

Performance to end August 23	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (Uncapped)	79.0%	80.4%	85%		
Cancer - 2 week wait (May – Apr)	98.0%	98.8%	93%		
Cancer - 31 day first treatment	100%	94.1%	96%		
Cancer - 31 day subsequent (surgery)	100%	100%	94%		
Cancer - 62 day (traditional)	80%	61.5%	85%		
Cancer - 62 day (Cons upgrade)	100%	81.8%	n/a		
28 day FDS	77%	80.4%	75%		
Patients over 104 days (62 day standard)	1	0	0		
POAC activity volume (YTD)	10,363 Cumulative	6,079 Cumulative	7,712 Cumulative		
Bed Occupancy (excluding CYP and HDU)	72.8%	59.6%	82-85%		
LOS - excluding Oncology, Paeds,YAH, Spinal	3.28	3.39	n/a		
LOS - elective primary hip	3.30	2.90	2.7		
LOS - elective primary knee	3.40	3.50	2.7		
BADS Daycase rate (Note: due to time lag in month is May'23)	75%	78%	85%		

Monthly Workforce & OD Report

September 2023

CONTENTS

Introduction

This report shows the Workforce and OD information for the months of September 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 85.59% of WTE employed against the Establishment which is a positive improvement of 1.6%
- Staff adjusted turnover has improved this month and is within Trust target at 10.56%
- Sickness absence remains high but steady. High levels of absence due to mental health reasons gives cause for concern.
- Return To Work meetings are still not being recorded fully currently 60.56%

Positive Assurances

- There is work planned to gain improved feedback from leavers and to take action before staff leave.
- There is a more urgent piece of work required to evaluate our current support provision associated with staff suffering with their mental health and if managers have the right education from the team to support staff.
- With a better established and settled recruitment team we have managed to increase activity and this has helped increase the Establishment.

Key Risks

- The rise in mental health related absence requires diagnosis and it may be that work related stressors are a contributor.
- Staff with no PDR/Appraisal may have a lack of clear objectives and development plans.

Next Steps

- More training and support will be provided to line managers about how to support staff with mental health and sickness absence.
- Completion of the actions associated with the Recruitment and Retention Action plan.

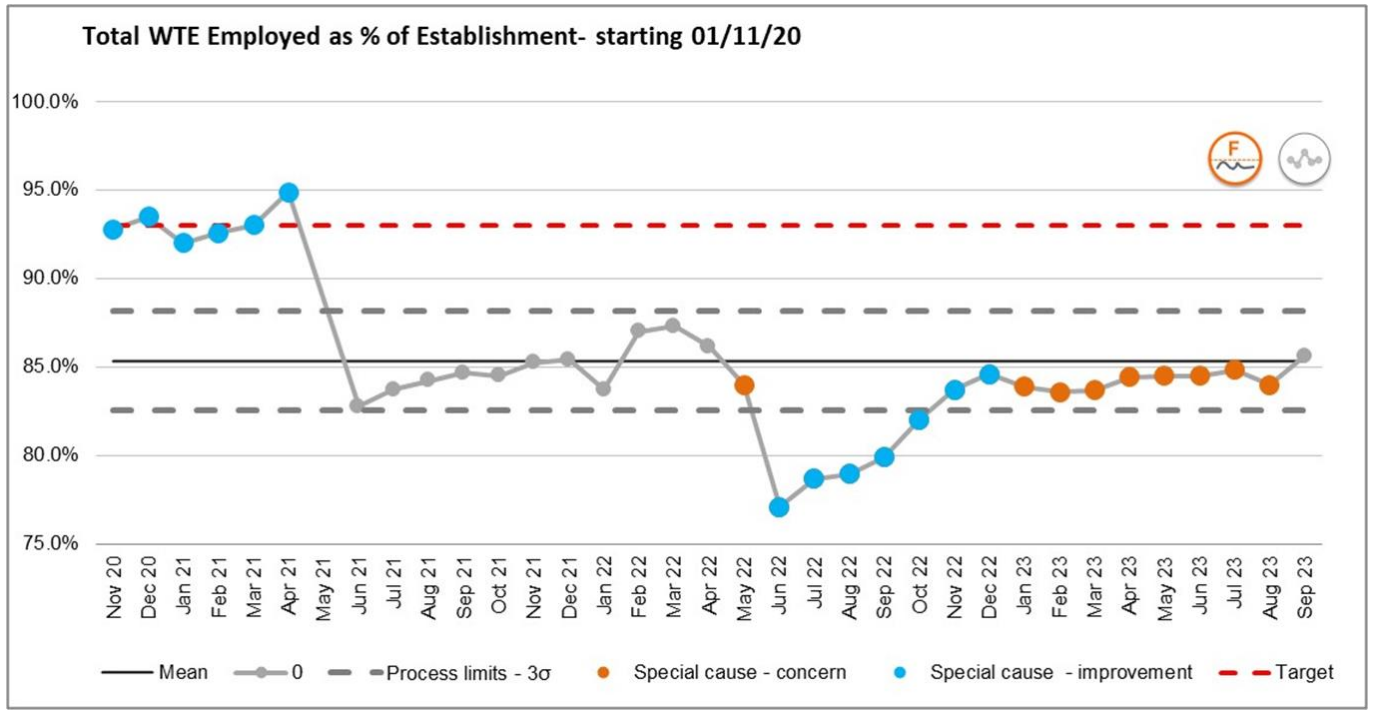
1. Workforce Overview

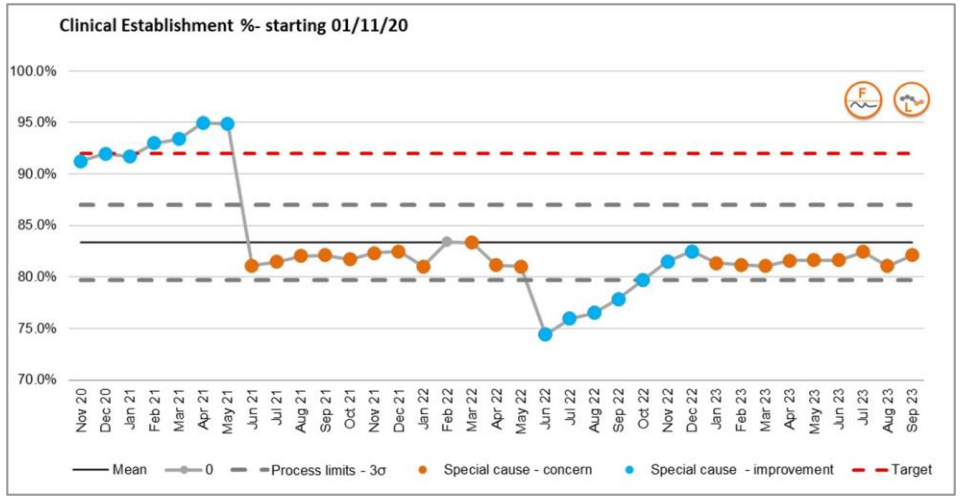
Trust Workforce Metrics	Aug-23	Sep-23	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1325	1354	29	-	-
Staff In Post - Full Time Equivalent	1172.40	1197.69	25.29	-	-
Staf Turnover % - Unadjusted	13.07%	15.41%	2.34%	↑	<=11.5%
Staf Turnover % - Adjusted	11.54%	10.56%	-0.98%	↓	<=11.5%
Total WTE Employed as % of Establishment	83.99%	85.59%	1.60%	↑	>=93%
Total WTE Employed as % of Establishment - Clinical	81.04%	82.13%	1.09%	↑	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	89.28%	91.89%	2.61%	↑	>=96%
% Of Attendance	94.07%	93.48%	-0.59%	↓	>=96.3%
% Of 12 mth MAA Attendance	94.24%	94.20%	-0.04%	↓	>=96.3%
% Staff received mandatory training last 12 months	89.48%	87.50%	-1.98%	↓	>=93%
% Staff received formal PDR/appraisal last 12 months	65.68%	66.76%	1.08%	↑	>=95%
% of Sickness - Trust wide Long-term	3.40%	3.50%	0.10%	↑	-
% of Sickness - Trust wide Short-term	2.53%	2.30%	-0.23%	↓	-
Return To Work Completion %	46.93%	60.56%	13.63%	↑	>=80%

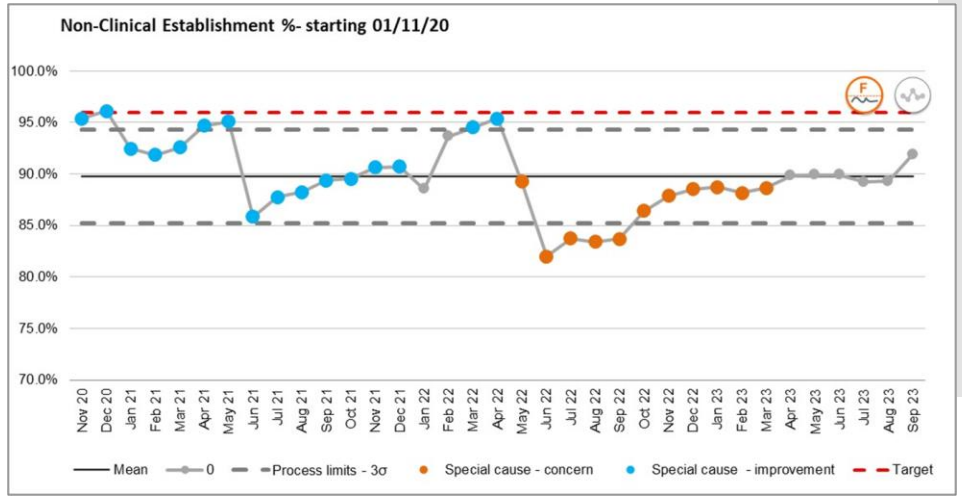
2. Establishment

At the end of September, the number of staff on payroll stood at 1354 (WTE 1197.69) which is an increase of 25.29 WTE from August.

The Total WTE Employed as a % of the Establishment this month was 85.59% which is an improvement of 1.6% but below the Trust target of 93%.





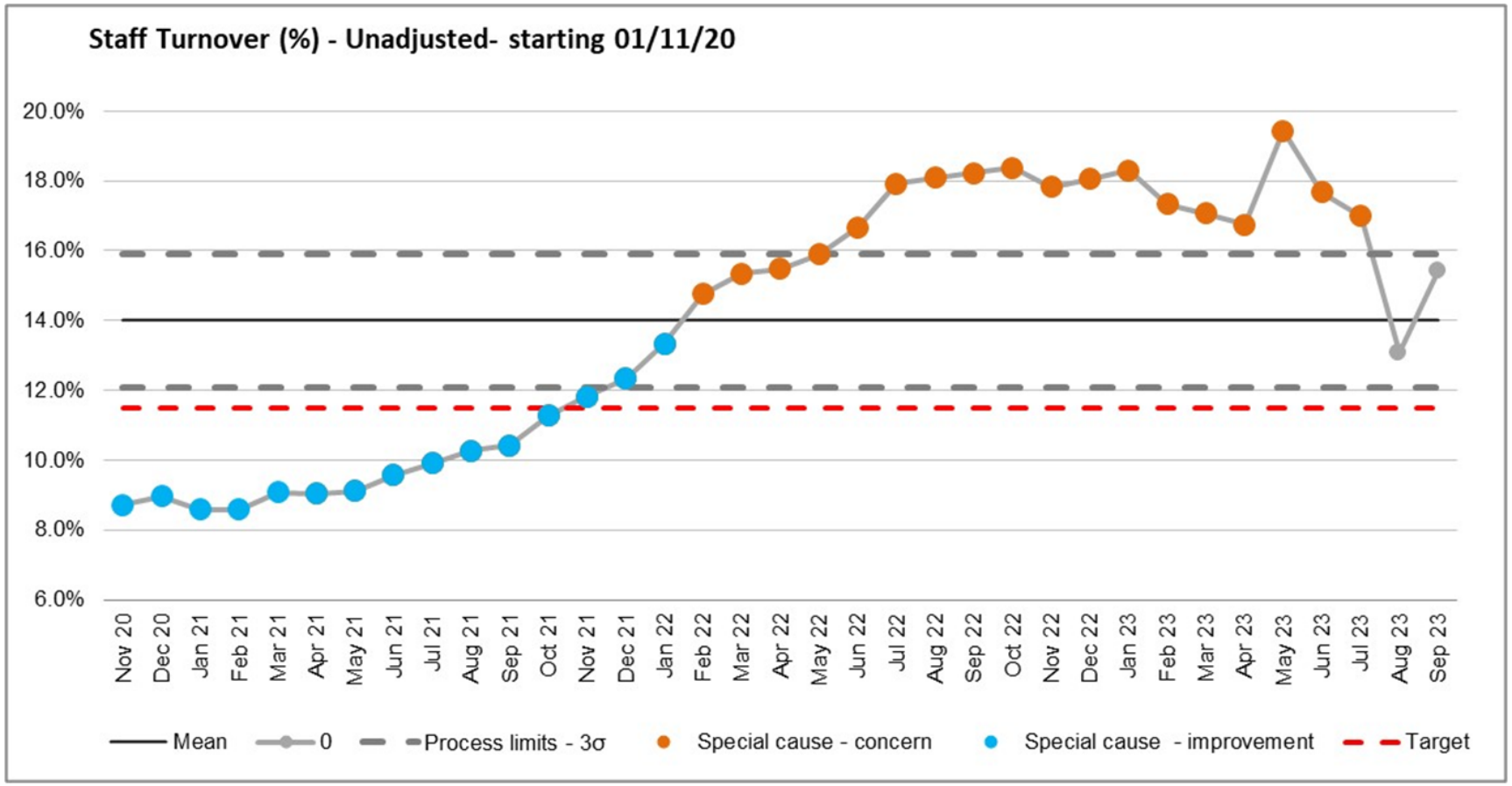


3. Turnover & Retention

August is an outlier month for unadjusted turnover due to the Junior Doctor Rotation.

Trust reported a positive reduction of adjusted turnover in September at 10.56% and within Trust target of 11.5%

Adjusted turnover: all turnover excluding junior doctor rotation, end of fixed term contracts and retire and return



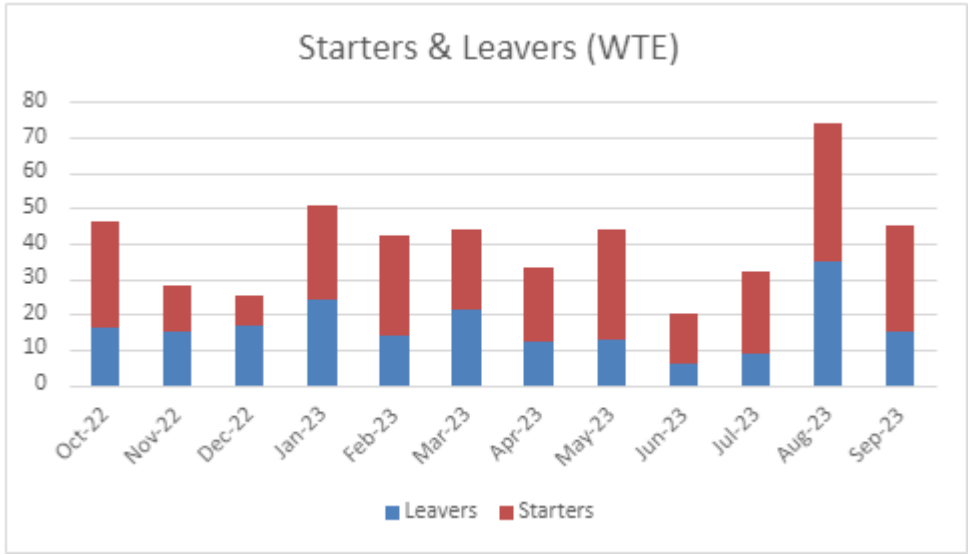
Staff Group	FTE
Add Prof Scientific and Technic	20.86%
Nursing and Midwifery Registered	14.03%
Additional Clinical Services	12.97%
Allied Health Professionals	12.30%
Estates and Ancillary	11.61%
Administrative and Clerical	10.90%

Org L4	FTE
303 Division 1 - Patient Services	17.99%
303 Corporate Directorate	15.94%
303 Division 2 - Patient Support	14.56%
303 Division 4 - Estates and Facilities	10.32%

4. Starters & Leavers

Over the last 2 months, the main reasons for staff leaving (according to ESR data) were Work Life Balance, Retirement and To Undertake Training, which is different to previous months.

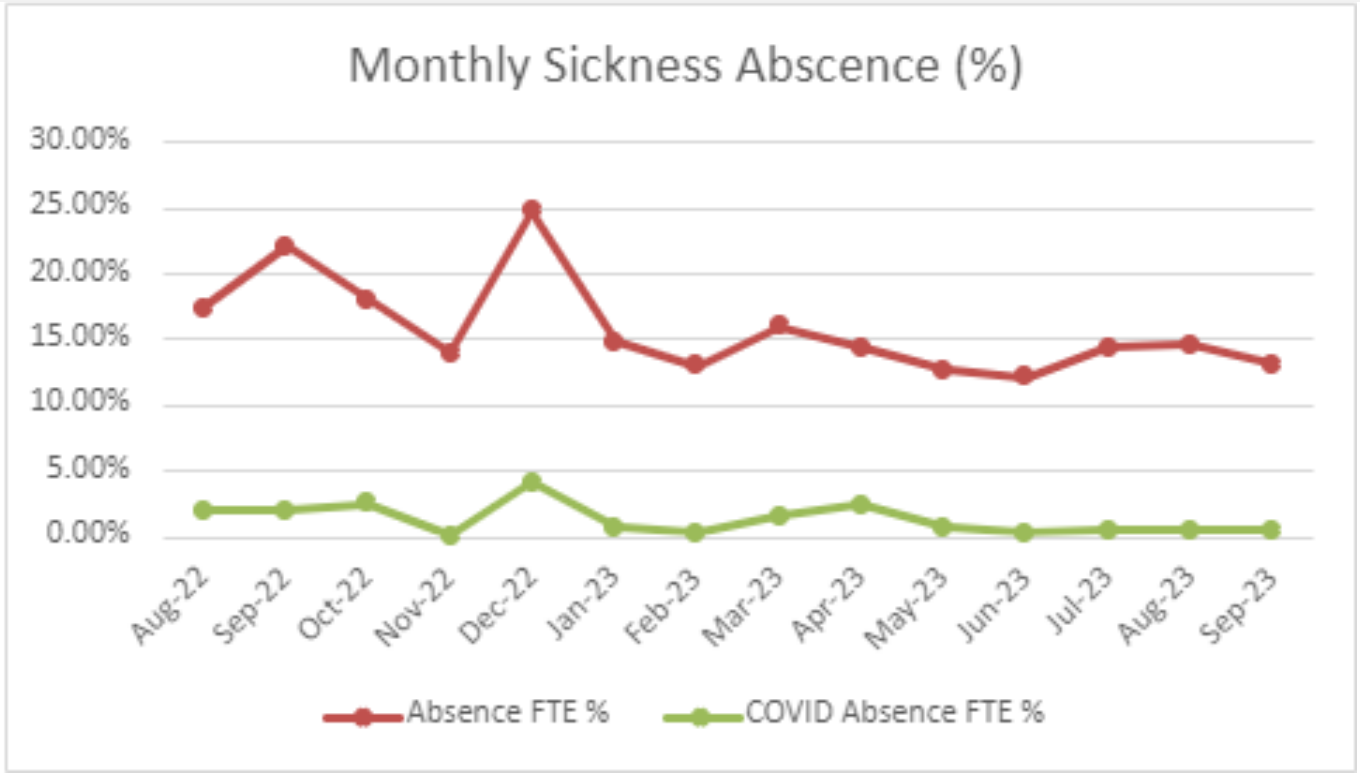
It is positive that 3 members of staff have taken advantage of flexi retirement, which retains the member of staff.



5. Attendance & Sickness

Attendance for this month was 93.48% (sickness absence % = 6.52%) and Attendance for the rolling past 12 months was 94.20%. 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 Injury/Fracture enter the top 5 reasons.



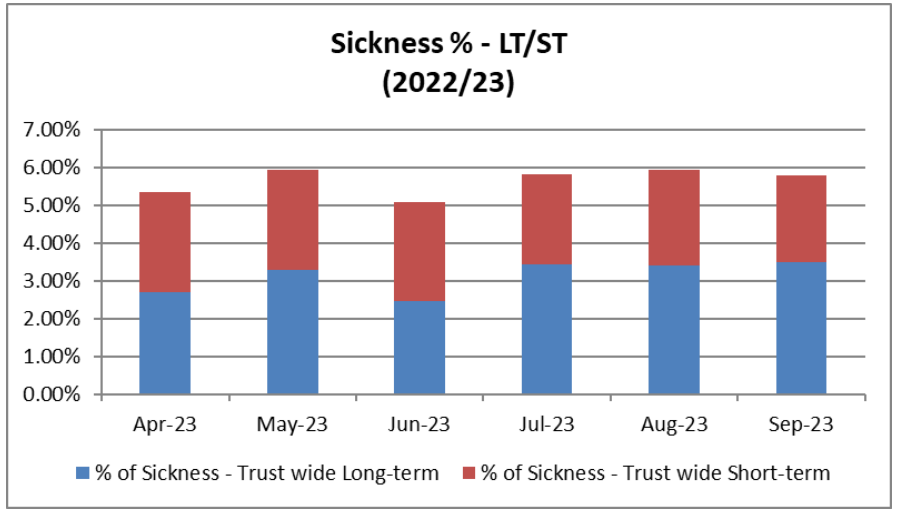
This chart shows that 12% of the WTE were off with sickness which started in Sept 2023 (not inc Long Term Sickness) and of that sickness 0.5% is attributed to Covid, this against the WTE figure of 1197.69

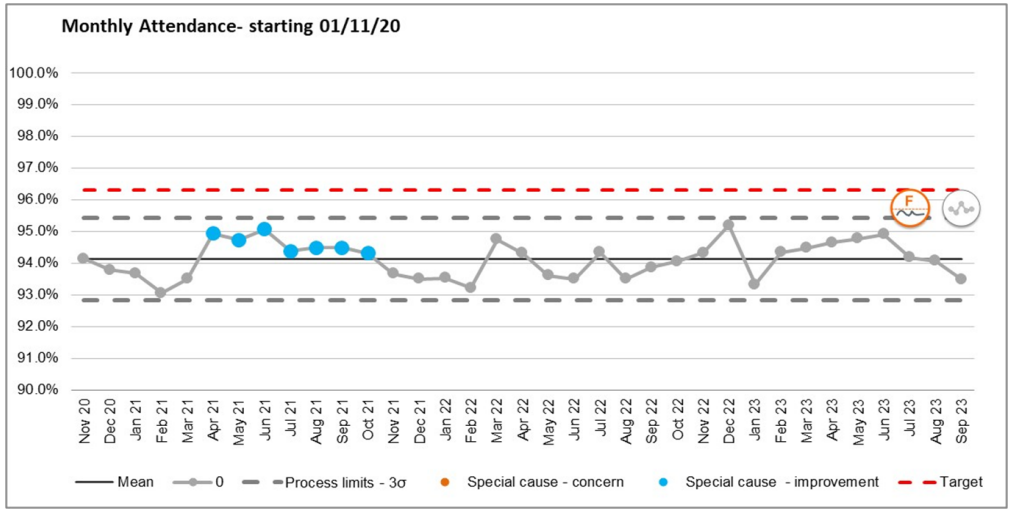
Top Absence Reasons In the Last 12 Months by FTE Days Lost	Count of Episodes	FTE Days Lost	Estimated Cost Of Absence
Anxiety/stress/depression	203	7302.596	£579,350.85
Cold, Cough, Flu - Influenza	801	4793.513	£427,918.25
Musculoskeletal problems	147	2412.788	£201,418.37
Gastrointestinal problems	491	2243.001	£182,542.46
Injury Fracture	61	1553	£121,657.06

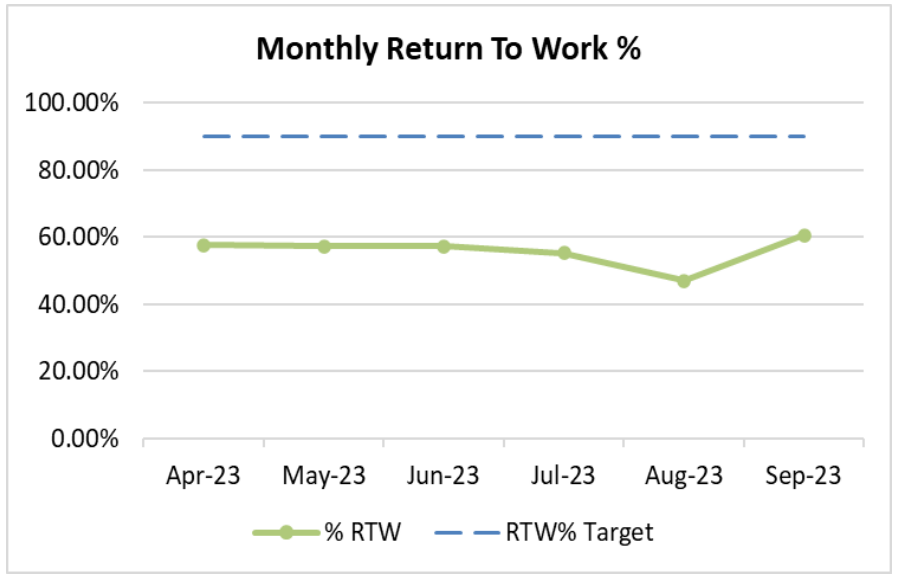
5. Attendance & Sickness

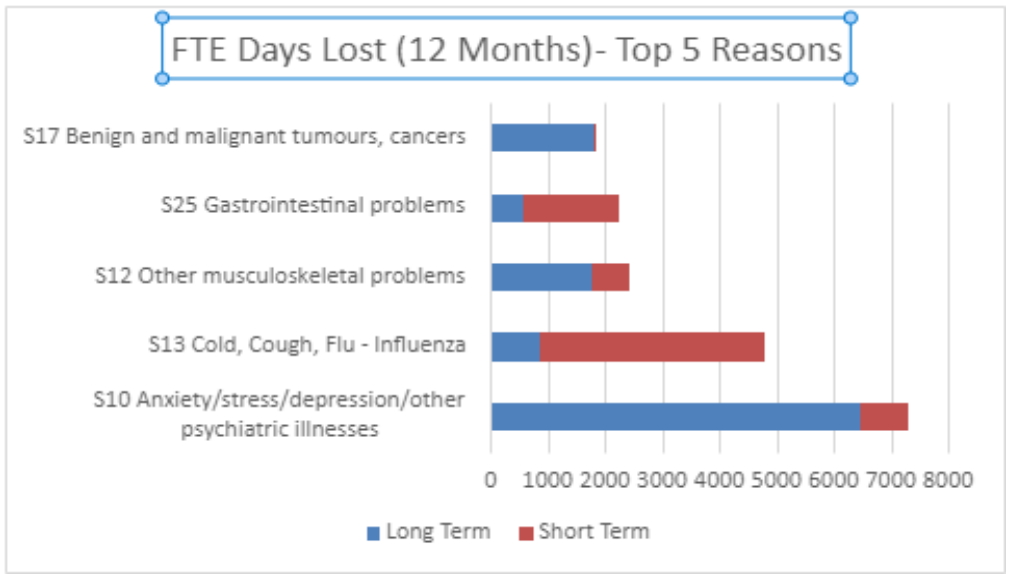
Return To Work Discussion Meetings Following Sickness Absence

Trust wide Return To Work (RTW) interviews increased to 60.56% in September, compared to 46.93% in August. This still remains below the Trust Target of 80%.









Monthly OD and Staff Engagement Report

October 2023

CONTENTS

Key Points

Executive Summary

- Work continues through the OD and Inclusion team and Staff Networks to ensure that staff are well engaged and have the opportunity to share ideas through staff voice.
- There is updated information on the latest Pulse Survey results for 2023/2024 Quarter 2, which shows positive improvements

Positive Assurances

- There has been an increase in two areas of Motivation, Improvement in the latest People Pulse survey
- There was an overall increase in the Staff engagement score in the latest People Pulse survey to 7.06
- There has been positive engagement at the recent awareness sessions run across the Trust including staff survey support sessions
- Annual leave booked is slightly lower compared to last year but still on target

Key Risks

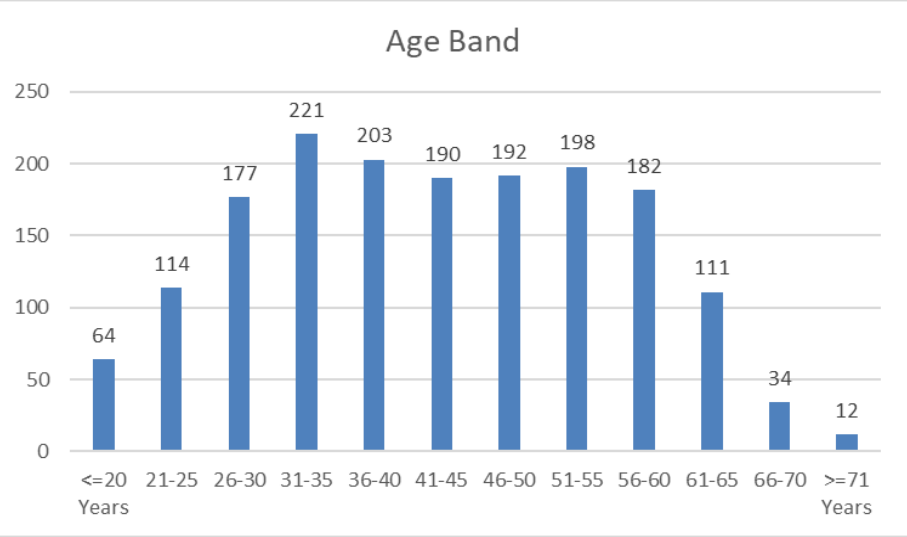
- Staff with no PDR/Appraisal will have no way of being appraised, agree personal goals or have the opportunity to speak to managers about personal wellbeing
- There has been a slight decline in the Disability Declaration rate to 6.83 which will be reviewed for any issues in the new starter process

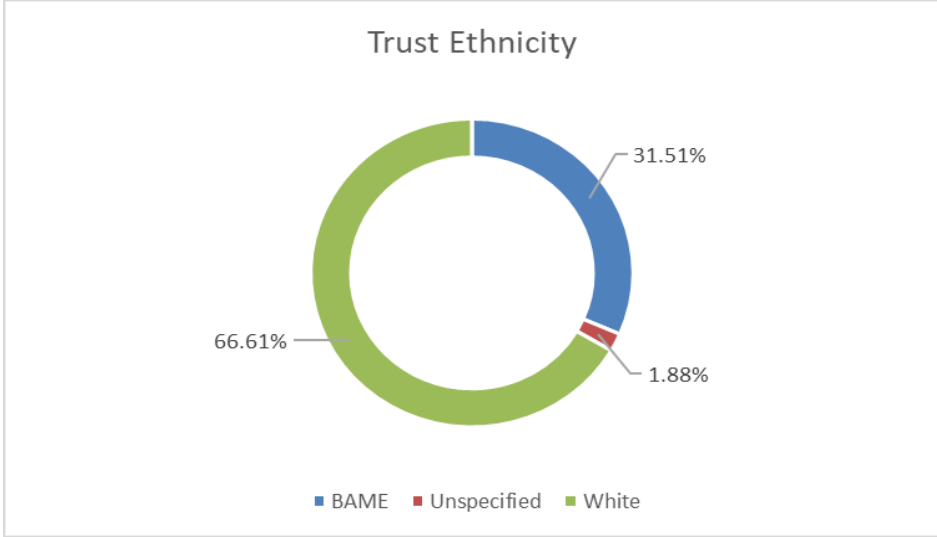
Next Steps

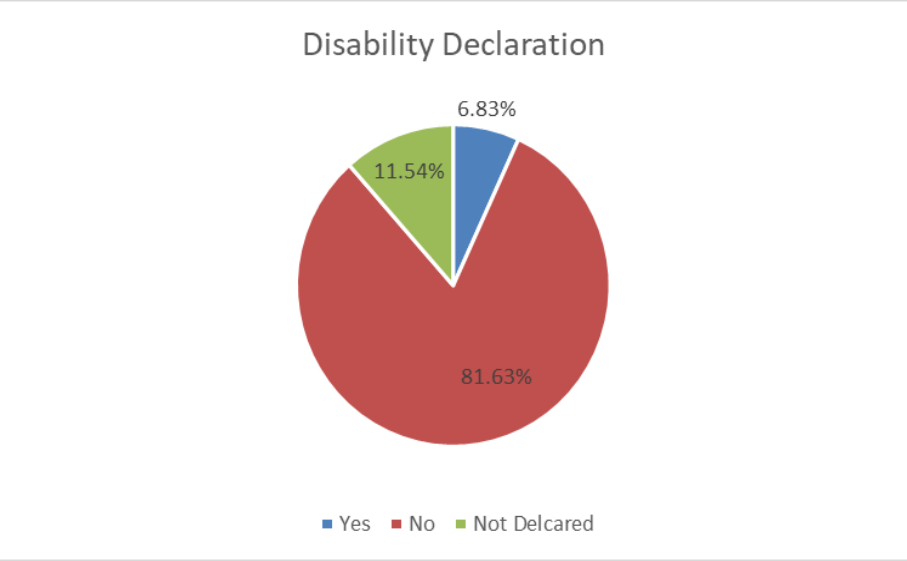
- Planning for Staff Network priorities in the next 12 months has begun to fit with the Inclusion strategy
- Continuing work with the National Staff survey fieldwork
- Finalising details in Wellbeing plan with focus on confirmed metrics against each priority

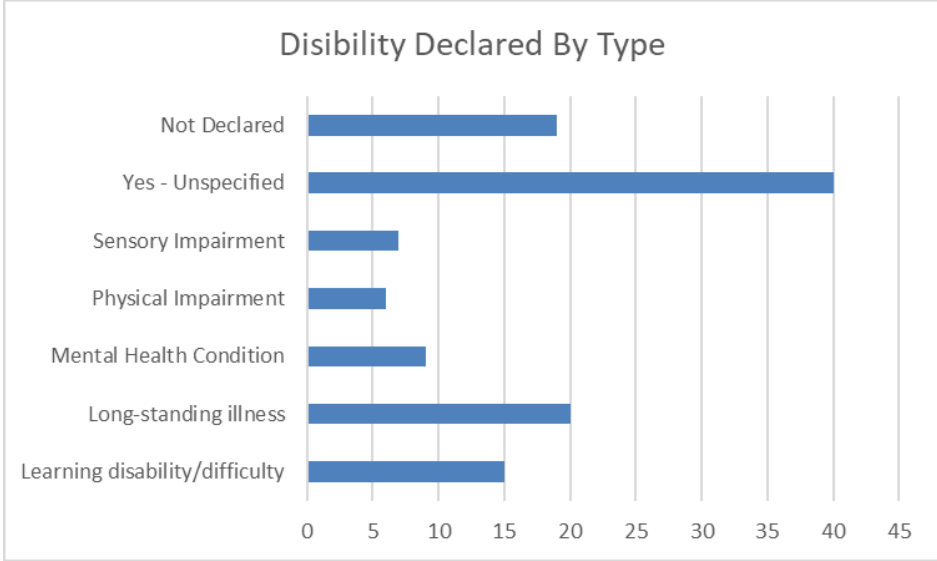
1. Workforce Demographics

The Trust is made up of 70.08% female and 29.92% male staff
Our current status of staff with a disability is 6.83% with 11.54% of staff still to declare their disability status, this has decreased slightly due to new members of staff joining without declaring. Staff are being encouraged to update their equality and diversity details through Electronic Staff Record.



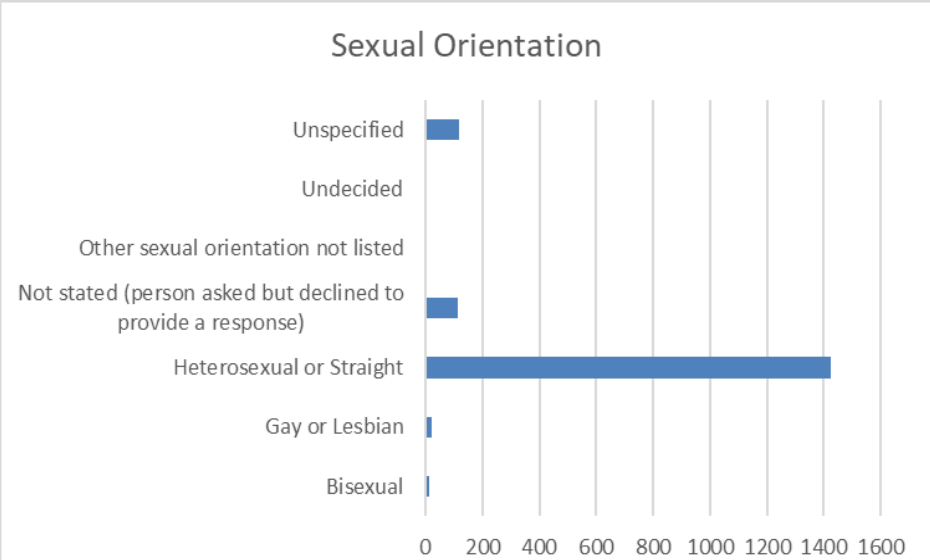


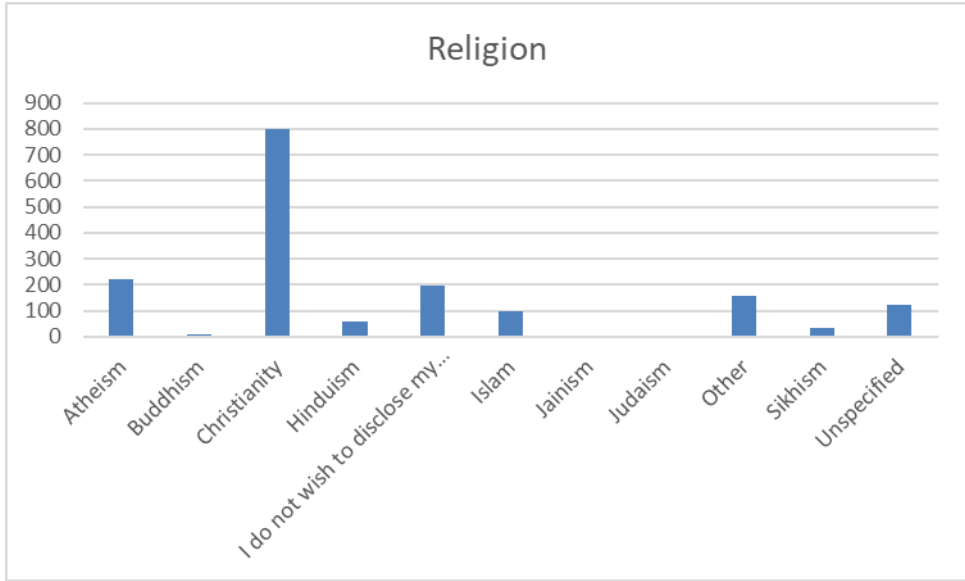


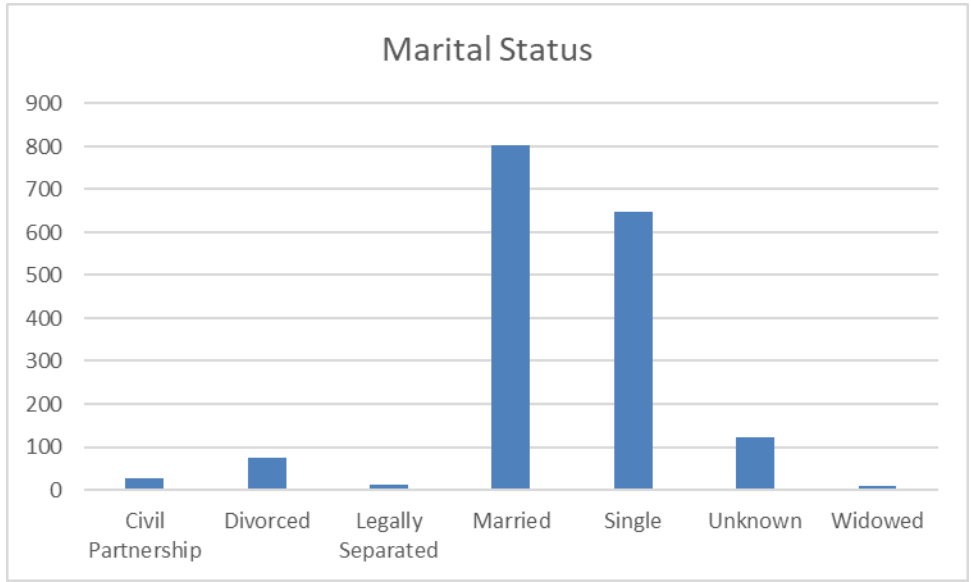


2. Workforce Demographics cont.

Currently in the Trust we have 28 staff members on Maternity or Adoption Leave



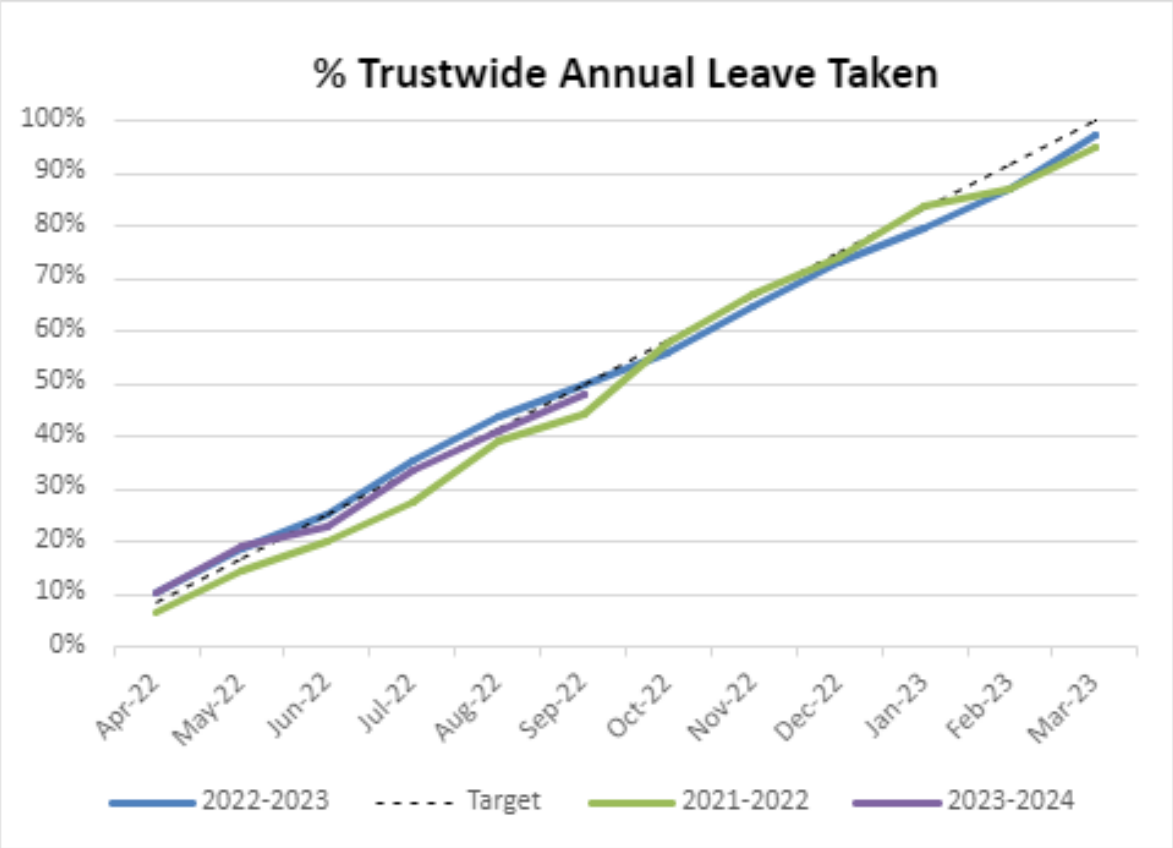




3. Workforce Wellbeing – Annual Leave

Annual Leave

At the End of Q2 (Sep 23) for the financial year, AfC staff have taken 47.85% of their annual leave entitlement. At this point in the year, staff are expected to have taken at least 50% of their annual leave entitlement, to support staff in having regular rest breaks. This is slightly less than the previous year but still on target.



Division	% Annual Leave Taken
303 Corporate Directorate	46.16%
303 Division 1 - Patient Services	49.45%
303 Division 2 - Patient Support	46.27%
303 Division 4 - Estates and Facilities	51.57%
Trust Total	**47.85%**

Staff Group	% Annual Leave Taken
Add Prof Scientific and Technic	38.65%
Additional Clinical Services	49.30%
Administrative and Clerical	48.43%
Allied Health Professionals	44.59%
Estates and Ancillary	51.20%
Nursing and Midwifery Registered	50.23%

Workforce Experience and Engagement

Disability Declaration Rate

DDR 2022					DDR 2023						
Jan	Mar	June	Sept	Dec	Feb	March	May	July	Sept	Nov	Dec
4.0	5.2	5.3	4.3	5.7	6.3	6.2	6.9	7.0	6.83		

Support metrics

Initiative	June	July		September	
Number of members of staff network meetings – (All members of all staff networks – from June)	310	305		303	
Number of attendees at staff network meetings	6	33		29	
Number of hits on Staff Networks intranet site – (**Viewers** – how many individual staff members have viewed site/ **Views** – number of people visiting site more than once from July)	524	40 Viewers 58 Views		77 Viewers 11 Views	
Number of hits on Health & wellbeing intranet site/ Wellbeing new link (**Viewers** – how many individual staff members have viewed site/ **Views** – number of people visiting site more than once from July)	405 Viewers 110 Views	59 Viewers 602 Views	149 Viewers 483 Views	52 Viewers 98 Views	120 Viewers 145 Views
Entrance swipe to Wellbeing room / Dome (from July)	208	Not Available		266 / 216	

4. Results for Staff Surveys on Staff Engagement (How it feels working at the ROH)

	People Pulse Quarter 2 2023/2024	People Pulse Quarter 1 2023/2024	People Pulse Quarter 4 2022/2023	People Pulse Quarter 2, 2022/2023	People Pulse Quarter 1, 2022/2023	People Pulse Quarter 4, 2021/2022	ROH National Survey (NSS) October – November 2021	NSS National Results October-November 2021	NSS National Results October- November 2022
Overall Staff Engagement	7.06	7.01	7.03	7.04	7.00	6.94	7.40	6.8	6.8
Q1. I often/always look forward to going to work.	56%	56%	52%	55%	54%	52%	58%	53%	54%
Q2. I am often/always enthusiastic about my job.	69%	69%	66%	68%	67%	65%	73%	67%	70%
Q3. Time often/always passes quickly when I am working.	68%	68%	69%	68%	68%	66%	70%	73%	71%
Q4. There are frequent opportunities for me to show initiative in my role.	69%	69%	66%	63%	66%	69%	76%	72%	74%
Q5. I am able to make suggestions to improve the work team/department.	70%	70%	69%	67%	66%	65%	75%	70%	73%
Q6. I am able to make improvements happen in my area of work.	62%	61%	62%	59%	59%	57%	58%	53%	57%
Q7. Care of patients/service users is my organisations top priority.	85%	83%	80%	81%	78%	79%	84%	76%	83%
Q8. I would recommend my organisation as a place to work.	71%	66%	70%	68%	66%	71%	74%	59%	72%
Q9. If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation	85%	84%	86%	87%	86%	87%	90%	68%	85%

- The results show an improvement in 4 out of the 9 questions across the theme of Staff engagement.
- These improvements are across the two areas of Advocacy (Q4-6) and Involvement (Q7-9)

KNOWLEDGE HUB EDUCATION

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Mandatory Training Statistical Process Review Charts

Statistical Review of Mandatory Training compliance from 1st April 2021 to 31st August 2023

Training compliance summary – 31st August 2023

Pg.	COURSE	Compliance %age	COMMENTS	TREND
3	Core Mandatory Training – Permanent Staff	89.48%	Compliance is improving. If we break this down per compliance module it increases further for some elements of the Core Skills Training Framework (CSTF).	
3	Core Mandatory Training – Temporary Staff	97.89%	Based on staff working on the Bank (end June data due to new data not being available).	
4	Performance and Development Reviews	65.68%	Decrease on previous month, low percentage compliance. Me as a Manager will support with signposting process and training support.	
5	Basic Life Support – Level 1	58.70%	Should be nearer to 95% target as we are over 1 year since this new level was introduced for non-clinical staff.	
5	Hospital Life Support – Level 2	81.84%	New module including Paediatric BLS requirements provided to Clinical Staff since April 2022; snapshot reporting now aligned.	
6	Immediate Life Support	79.55%	Quite a good increase. Additional sessions have been scheduled, against the trajectory so expect to see an improvement within the next few months.	
6	Advanced Life Support	70%	Anaesthetics staff non-compliant continue to be chased for evidence of completion; as provided externally.	
7	Paediatric Immediate Life Support	93.33%	Small number of staff to complete this to achieve 100%.	
8	Patient Handling	85.71%	Good progress overall this year but less stable during the last few months; need to sustain improvement.	
8	Conflict Resolution	87.85%	Slight increase this month.	
9	NEWS2	97.54%	Consistently achieved over 95% compliance since June 2022.	
9	Safe use of Insulin	88.66%	Staying the same over the last few months	
9	VTE	91.56%	Stayed the same over the last few month	
10	CONSENT	93.51%	Slight increase on last months.	
10	IPC2	89.48%	Continual increase during the last few months	
10	Food Hygiene	92.35%	Slight increase on last month	
11	Cyber & IG	74.21%		

Core Mandatory Training: Permanent and Temporary Staff

The top data chart shows the Core Mandatory training compliance figure for all substantive staff. We continue to see small incremental improvements month on month and briefly entered the 90% zone in July.

Data Observations: When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process.

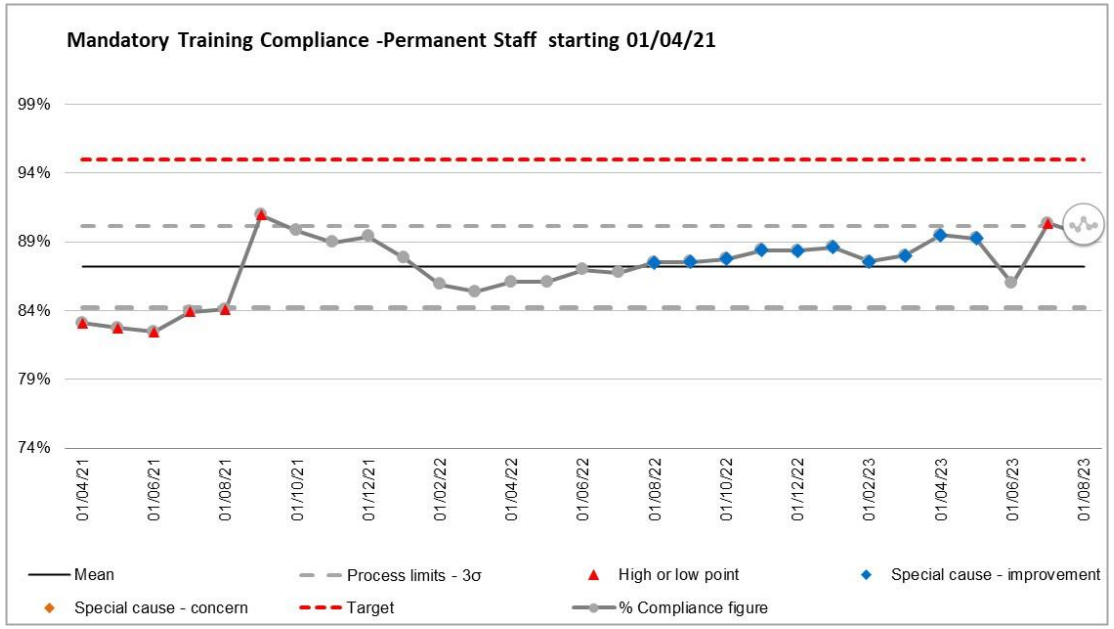
The mandatory training compliance figure is the average of 6 core mandatory modules. In April 2023 IG & Data Security ceased to be reported through ESR following the launch of Metacompliance Cyber Security and IG modules. Separate reporting is provided by IT to Heads of and individuals are being chased. Lockouts have begun for those non-compliant.

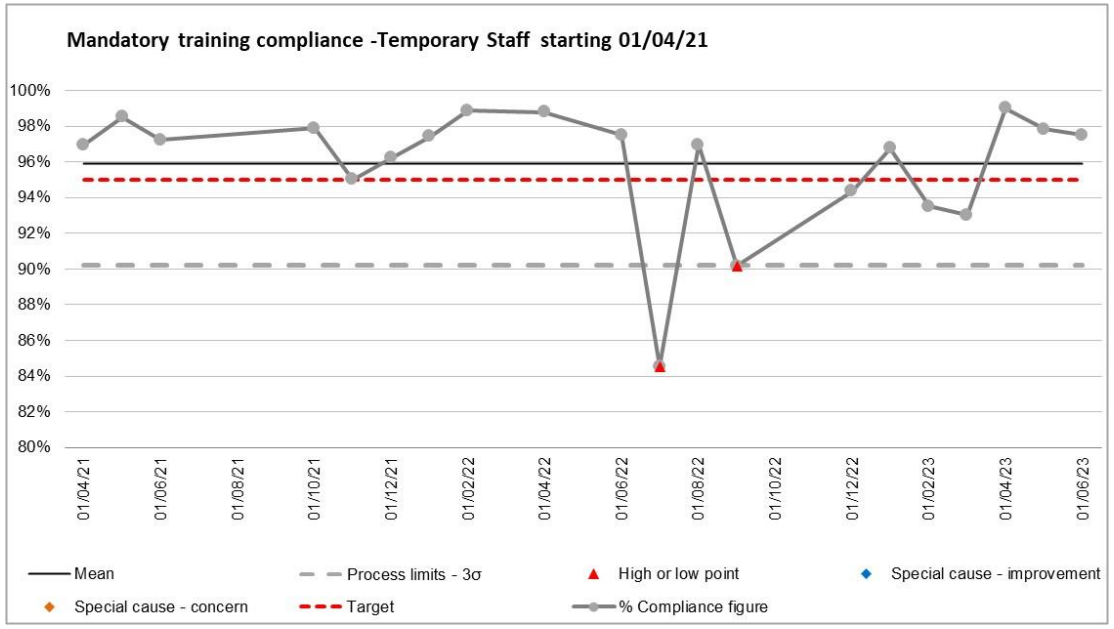
In addition there are still a number of departments where staff do not have easy access to computers and are not provided with an ESR log in, or there are delays with nhs.net email account. Work continues to ensure all staff have an NHS email account and have access to a PC.

The lower data chart shows the Core Mandatory training compliance figure for Bank / Temporary staff.

Data Observations:

Reporting has improved and needs to be maintained to demonstrate an improvement and consistent achievement of target. Data is based on staff working bank shifts.





Core Mandatory Training Compliance by Module:

This data chart shows the compliance of each module within the Core Skills Training Framework, which makes up the Core Mandatory Training Compliance.

This is made up of 6 modules, 4 of which have 3 yearly renewal requirements, 2 have an annual renewal requirement.

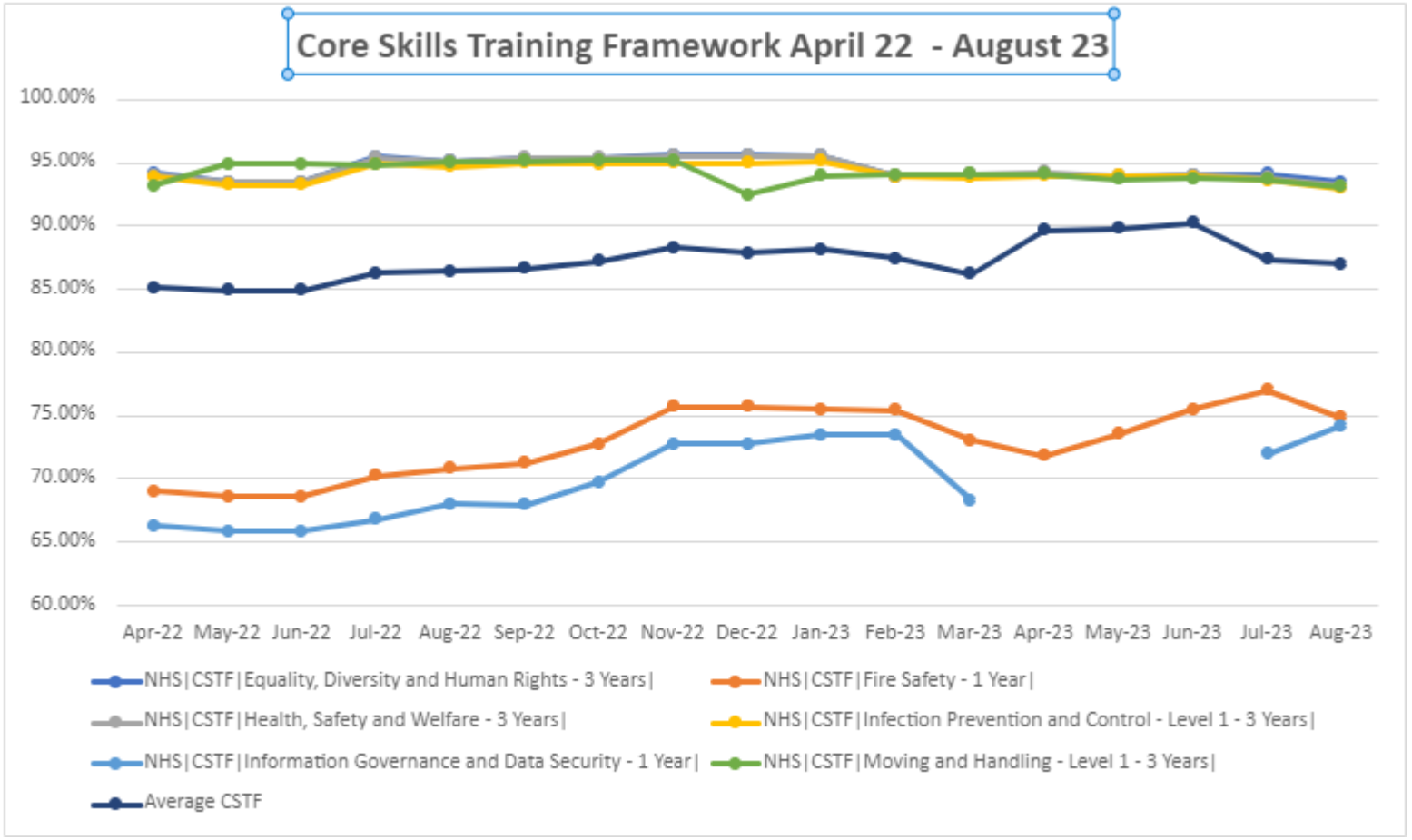
The average of these modules creates the overall Trust compliance figure.

Data Observations:

This graph clearly demonstrates that the annual renewal modules, Fire and Information Governance with Data Security, are tracking at a lower compliance figure than the 3 yearly renewal modules.

This there brings down the overall average compliance.

In July and August 2023, when we reintroduced the new Information Governance and Data Security compliance it brought the average down from 90.23% to 86.96%.

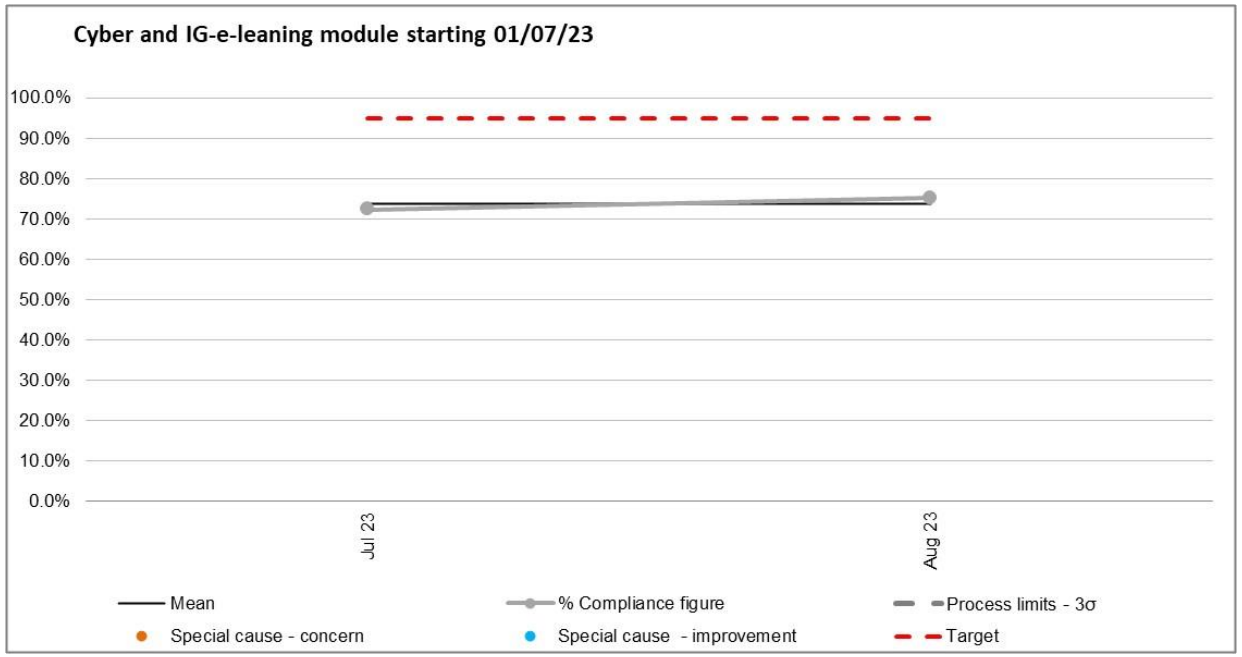


Information Governance and Data Security

The new Information Governance and Data Security modules, hosted by Metacompliance, were introduced in February 2023 replacing the Data Security and Information Governance modules on ESR.

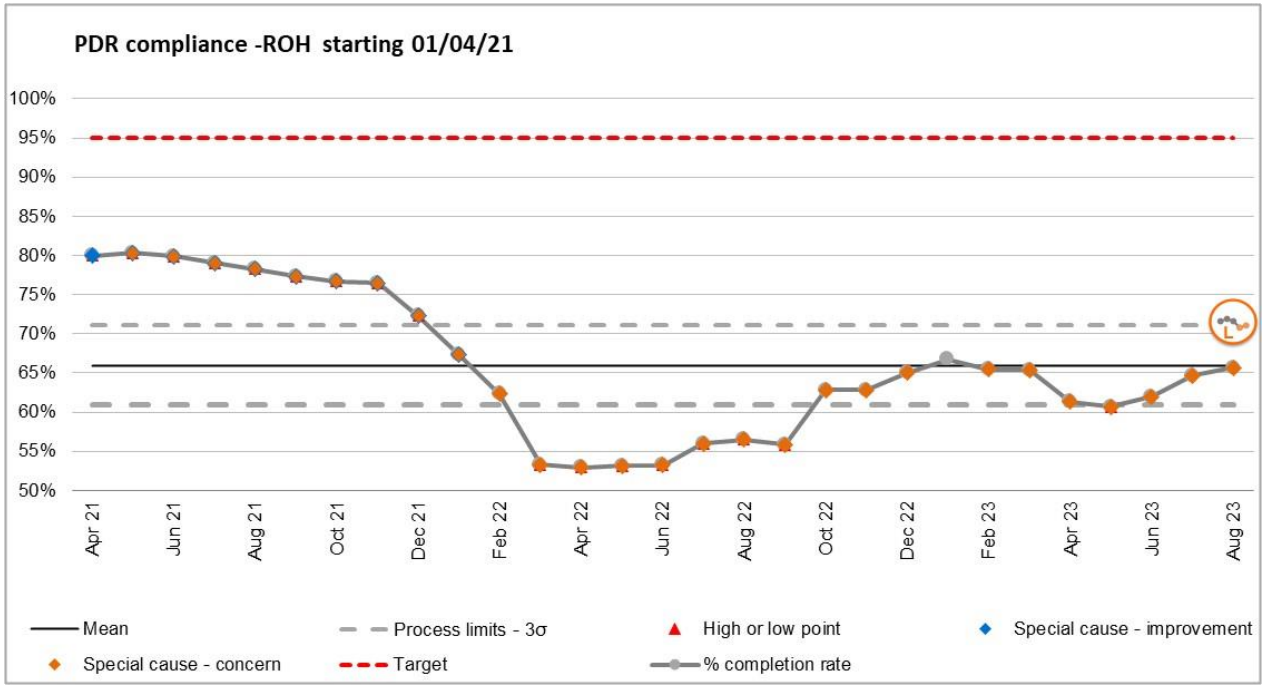
As reporting sits outside of ESR we are working with the BI & IT teams to develop accurate reporting.

Reporting on the compliance figures for these modules commenced in July 2023, and will be monitored monthly. It is highly anticipated that compliance will increase during the year due to the lock out challenges.



Performance and Development Reviews

This data chart shows the Annual Performance and Development Review compliance figure for all Trust staff. This figure is taken from the ESR system, so only relates to information recorded in ESR. Local figures may be higher dependant on efficiency of ESR maintenance.



Data Observations:

When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process.

We are continuing to run below the mean - this evidence could suggest that line managers are still not entering PDR data into ESR.

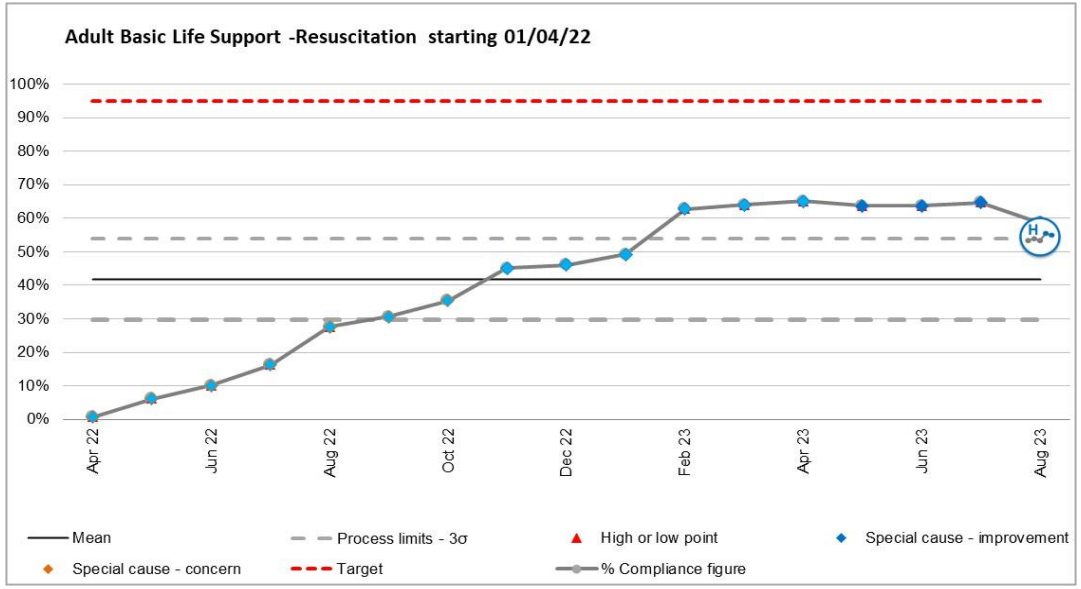
The Trust is currently revising its Performance Management and appraisal process, with the aim of improving these outcomes.

Basic Life Support – Non-Clinical Staff

The data chart below shows the Basic Life Support compliance figure for relevant Trust staff.

This is a new requirement for all non-clinical staff from 1st April 2022, and is provided via e-learning.

Compliance figures are expected to increase during the year; data has dipped at end of August. There has been a glitch with accessing the leaflet which we are working to restore.

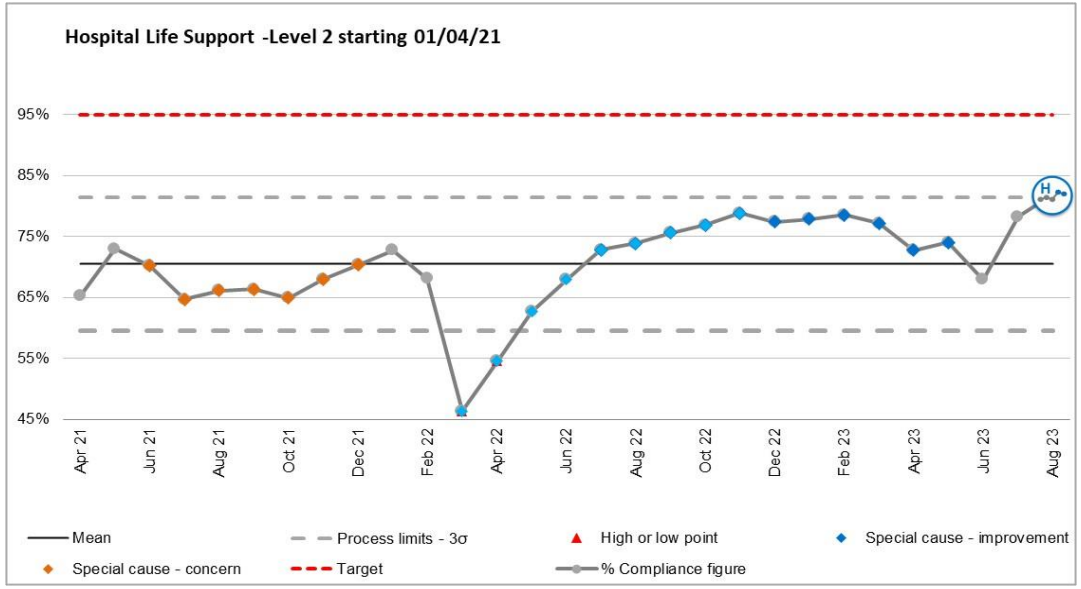


Hospital Life Support

The chart below details the Hospital Life Support (including Adult and Paediatric training) compliance figure for relevant Trust clinical staff.

Data Observations:

The training requirements for resuscitation were changed in March 2022, where all clinical staff were required to complete a HLS course or higher. This impacted on the compliance figure in March, which has shown a significant increase since then. Additional activity in July has helped to boost compliance.

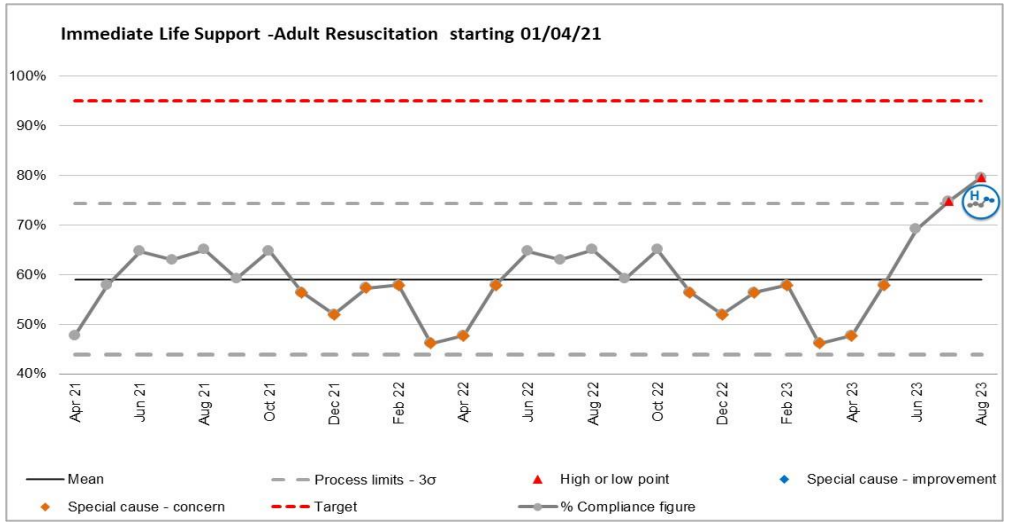


Adult Immediate Life Support

The data chart below shows the Adult Immediate Life Support compliance figure for relevant Trust staff.

Data Observations:

March/April have hit a low point statistically, the significant factor being a change to the administration centre. ILS compliance has been compounded by issues with access to The Resus Council e-learning element which has to be completed in advance of the course. Additional courses in June/July have helped to boost compliance, particularly for Theatre staff.

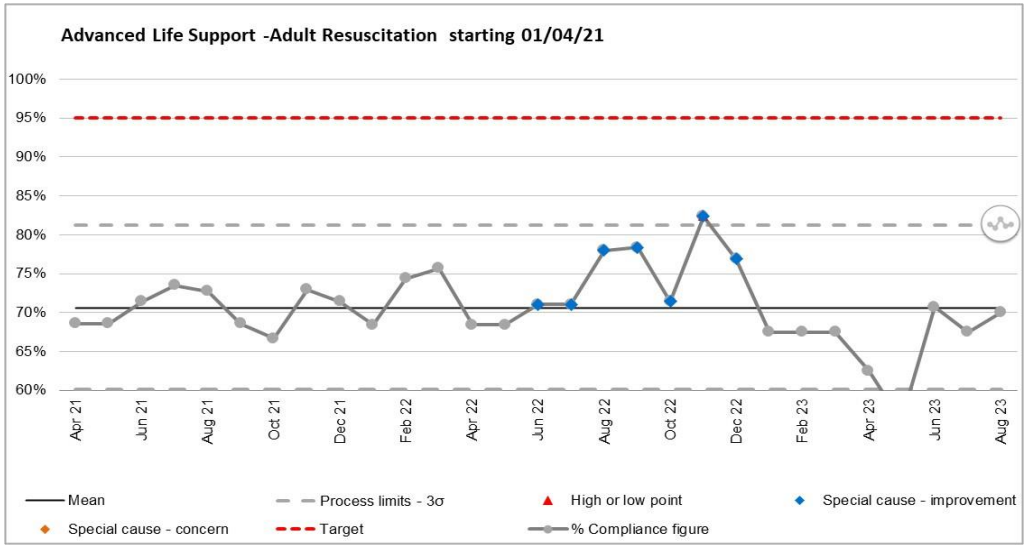


Adult Advanced Life Support

The data chart below shows the Adult Advanced Life Support compliance figure for relevant Trust staff.

Data Observations:

Compliance with ALS training showed a significant decrease since September 2020, with compliance hovering under the average of 76%. Certificates are required as evidence of compliance following attendance at external courses.



Paediatric Immediate Life Support

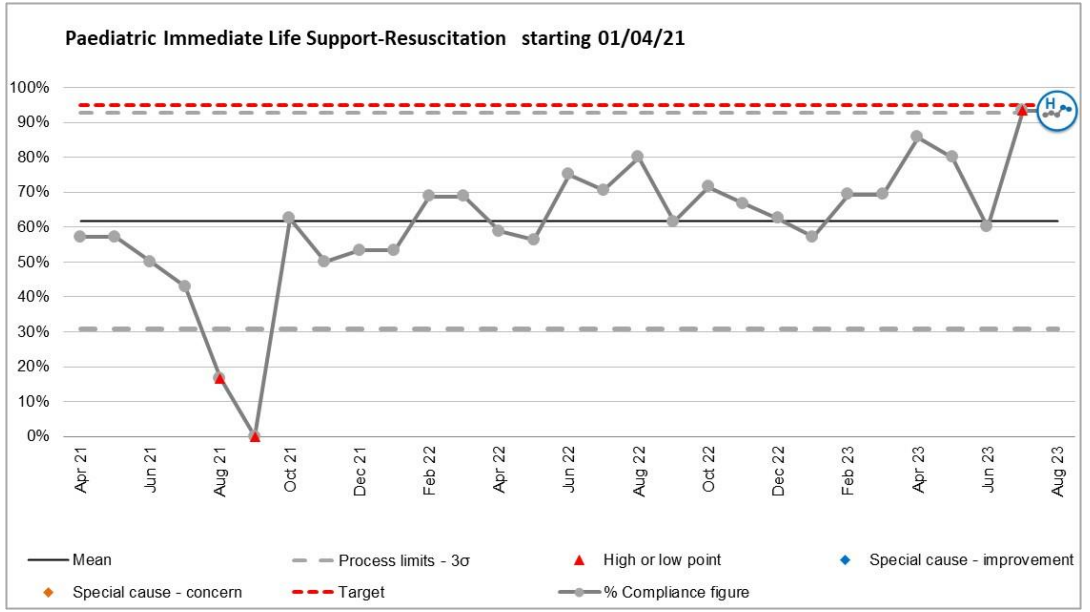
Paediatric Basic Life Support is now included within the Hospital life support training sessions.

This data chart shows the Paediatric Immediate Life Support compliance figure for relevant Trust staff.

Data Observations:

Compliance with Paediatric Immediate life support shows a steady trending increase in compliance over the last 12 months.

Very close to target / small numbers in the trajectory.

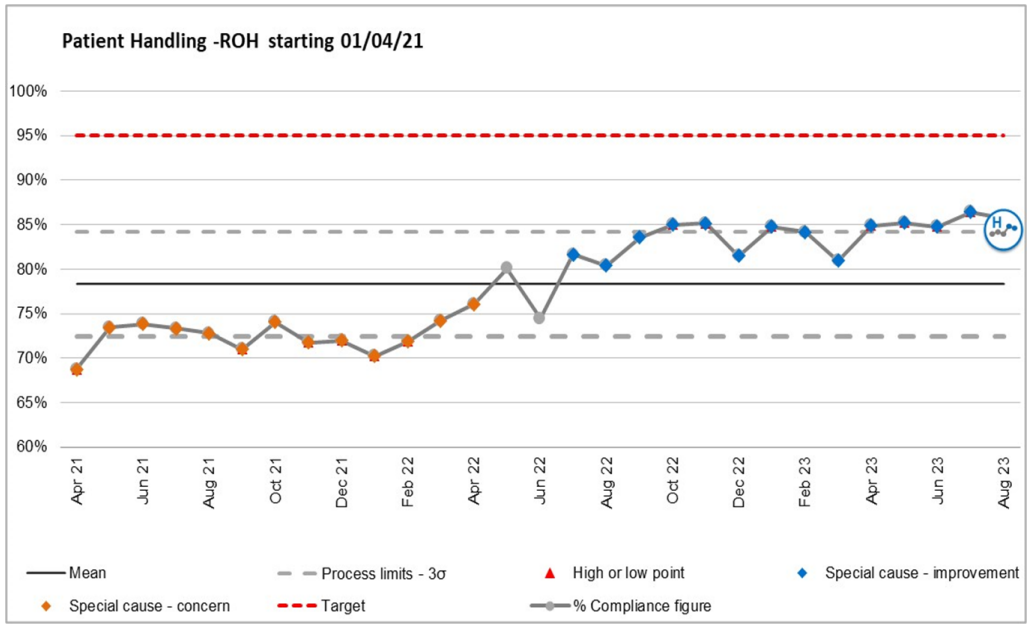


Patient Handling

The data chart below shows the Patient Handling training compliance figure for all Trust staff. This training has a requirement to be repeated every two years.

Data Observations:

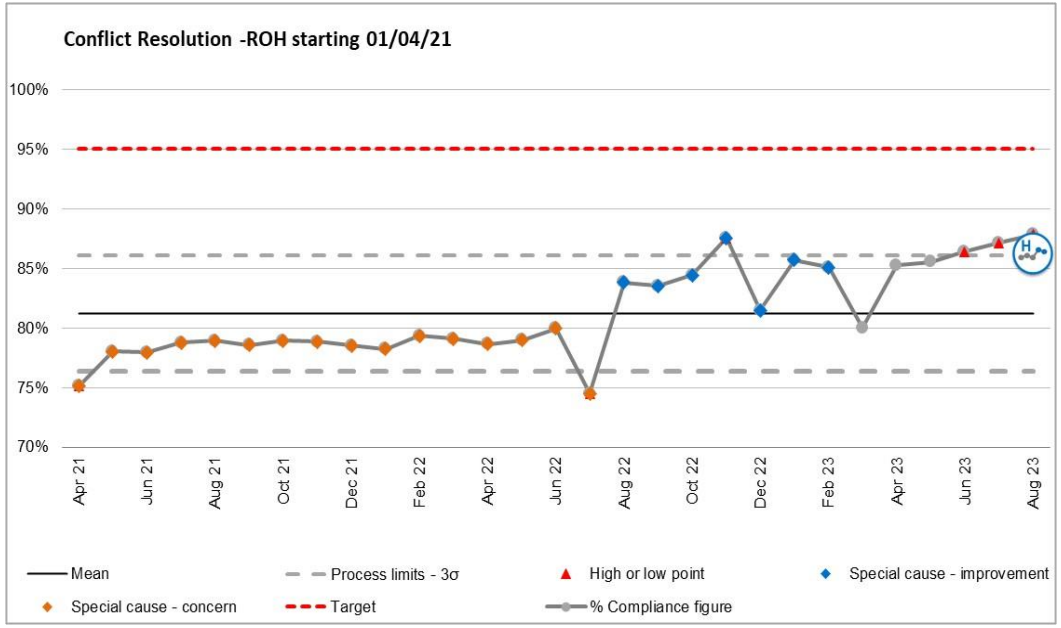
Compliance is hovering around 85%, a small increase in July. The key issue to address here is attendance as there are sufficient classes but attendance has been poor recently.



Conflict Resolution

The data chart below shows the Conflict Resolution training compliance figure for all Trust staff. This training has a requirement to be completed once only, with refresher sessions on a personal needs basis.

Data Observations: Compliance data has hovered closed to the average of 79% for the last 12 months, with a positive improvement to 87.75% + in the last 2 months.

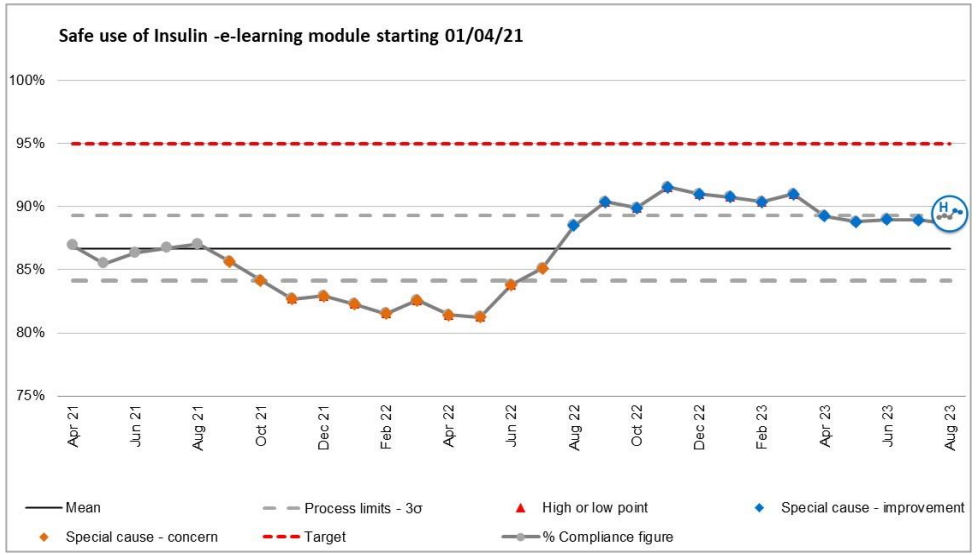


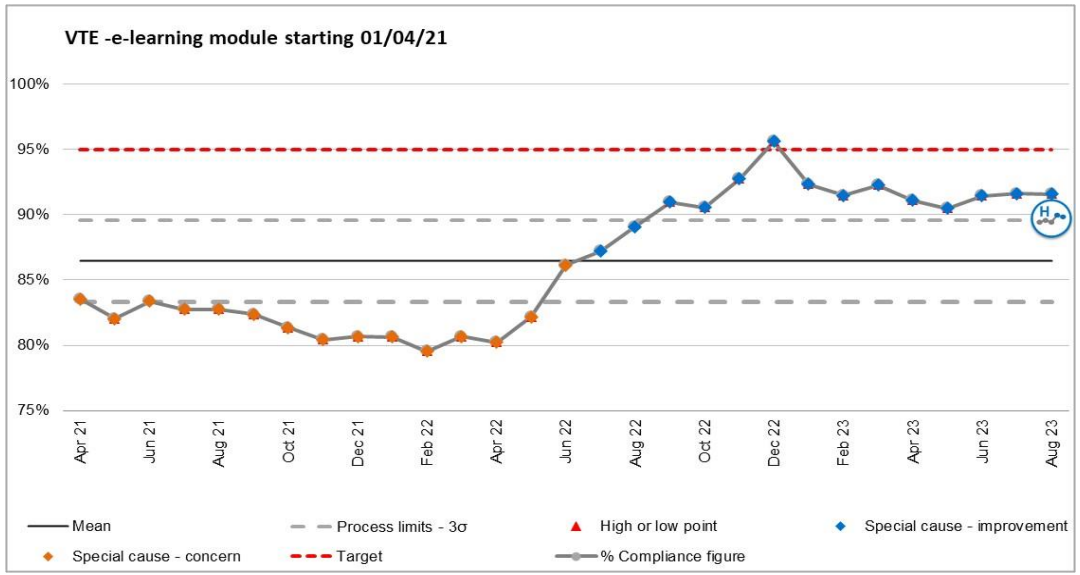
VTE, Safe use of Insulin, NEWS2

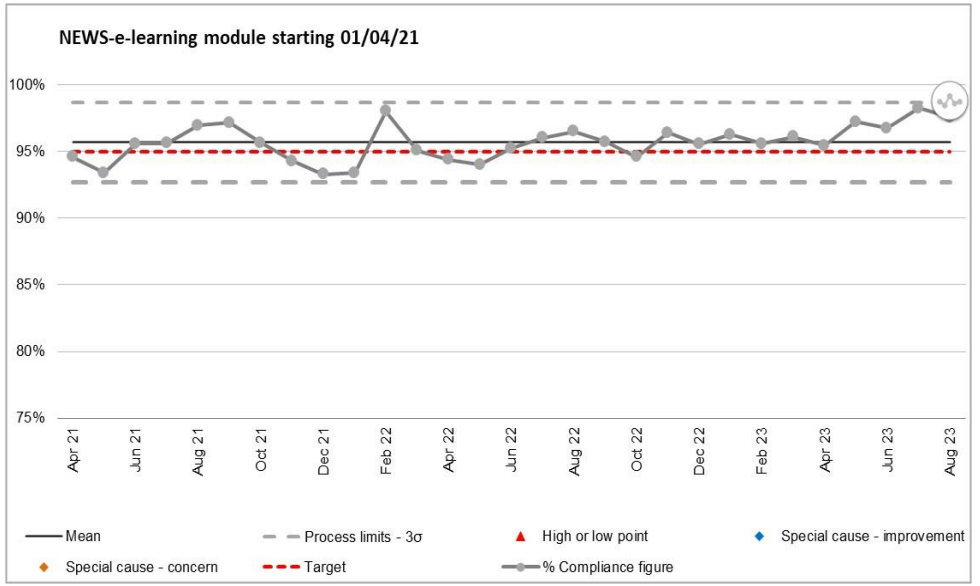
VTE: Completion of the VTE module has show a significant positive increase since February 2022, with highest compliance rating recorded in December 2022 when we were at target.

Safe use of Insulin: also shows a significant positive increase in compliance figures since April 2022, with its highest compliance rating recorded in October 2022.

NEWS 2: NEWS2 compliance has shown a significant improvement since October 2020, achieving over 95% compliance since November 2022.







IPC Level 2, Food Hygiene, Consent

The **Infection Prevention and Control Level 2 and Food Hygiene** Modules were new modules introduced in October 2020. For both modules compliance has shown positive improvements since then.

Consent training: Consent training has a 3 yearly renewal, following its initial introduction in October 2017. The original e-learning module was discontinued in October 2020, and a new module was sourced from BMJ and confirmed in January 2021. An improvement over the last few months has now dipped back down below the target of 95%.

Food Hygiene: Renewals are now due as this is a 3 yearly compliance, working with Facilities to renew elearning.