17th November 2023

Notice of a meeting of the Council of Governors

Notice is hereby given to all members of the Council of Governors of the Royal Orthopaedic Hospital NHS Foundation Trust that a meeting of the Council of Governors will be held on Thursday, 23rd November 2023, at 14:00, to transact the business detailed on the attached agenda.

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

Members of the press and public are welcome to attend.

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

Tim Pile
Chair

Public Bodies (Admissions to Meetings) Act 1960

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AGENDA

COUNCIL OF GOVERNORS

Venue Boardroom, Trust HQ **Date** 23 November 2023: 1400h – 1600h

TIME	ITEM	TITLE	PAPER REF	LEAD
1400h	1	Exclusion of the press and public	Verbal	Chair
1402h	2	Chair appraisal	Verbal	SJ
1420h	3	Non Executive appraisals	Verbal	Chair
1445h	4	Apologies and welcome [#1]	Verbal	Chair
	5	Declarations of interest	Verbal	ALL
	6	Minutes of previous meetings on 18 May 2023	ROHGO (05/23) 000	Chair
	7	Update on actions arising from previous meetings	Verbal	SGL
1450h	8	Chair and Chief Executive's update	ROHGO (11/23) 001 ROHGO (11/23) 001 (a)	TP/JW
1510h	9	Continuous Improvement	ROHGO (11/23) 002 ROHGO (11/23) 002 (a)	AM
1520h	10	Patient Safety Incident Response Framework (PSIRF) policy and plan	ROHGO (11/23) 003 ROHGO (11/23) 003 (a) ROHGO (11/23) 003 (b)	AR
1530h	11	Quality Assurance Walkabouts	ROHGO (11/23) 004 ROHGO (11/23) 004 (a)	ES
1540h	12	Updates from the Board and Board Committees	ROHGO (11/23) 005 - ROHGO (11/23) 008	Chair & NEDs
1550h	13	Governor updates		
	13.1	Statutory Duties of Governors Action Plan Update	Verbal	SGL

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

1555h	14	For information: • Finance & performance update • Quality & Patient Safety update • Workforce update • Board Assurance Framework	ROHGO (11/23) 009 ROHGO (11/23) 010 ROHGO (11/23) 011 ROHGO (11/23) 012 ROHGO (11/23) 012 (a) ROHGO (11/23) 012 (b) ROHGO (11/23) 012 (c)	Chair
	Date of next meeting: Thursday 18 January 2024 @ 1400h – 1600h in Trust Headquarters			

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

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

COUNCIL OF GOVERNORS
DRAFT MEETING MINUTES

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

Members present

Tim Pile	Chair of the Board of Directors	TPI	[Chair]
Petro Nicolaides	Public Governor	PNi	
Tony Thomas	Public Governor	TTh	
Rheya Dole	Public Governor	RDo	
Anne Waller	Public Governor	AWa	
Rob Tallboys	Public Governor	RRo	
Arthur Hughes	Public Governor	AHu	
Robert Rowberry	Public Governor	RRo	
Pat Clarke	Public Governor	PCl	
Julia Liddle	Public Governor	JLi	
Matt Maycock	Staff Governor	MMa	
Wilson Thomas	Staff Governor	WTh	
Maxine Sanahan	Stakeholder Governor	MSh	
Hannah Abbott	Stakeholder Governor	HAb	
Dr Dagmar Scheel-Toellner	Stakeholder Governor	DS-T	

In Attendance

Simone Jordan	Non-Executive Director	SJo	
Richard Phillips	Non-Executive Director	RPh	
Gianjeet Hunjan	Non-Executive Director	GHu	
Ayodele Ajose	Non-Executive Director	AAj	
Les Williams	Non-Executive Director	LWi	
Chris Fearns	Non-Executive Director	CFe	
Jo Williams	Chief Executive	JWi	
Simon Grainger-Lloyd	Executive Director of Governance	SGL	
Steve Washbourne	Executive Director of Finance & Performance	SWa	[Item
Marie Peplow	Executive Chief Operating Officer	MPe	[Item 8]
Michelle Hubbard	Deputy Chief Operating Officer	MHu	[Item 8]
Nikki Brockie	Executive Chief Nurse	NBr	[Item 9]
Florence Dowling	Learning Disabilities Nurse	FDo	[Item 10]
Jane Dominese	Corporate Services Manager	JDo	[Secretariat]

Minutes		**Paper Reference**
1	**Exclusion of the press and public (Chair)**	**Verbal**
1.1	The Board resolved that representatives of the press and other members of the public be excluded from this part of the meeting having regard to the confidential nature of the business to be transacted, which would be prejudicial to the public interest.	
2	**Draft Annual Governance Statement and Accounts**	**ROHGO (5/23) 003**

2.1	SGL advised that the annual report had been prepared in line with the Annual Reporting Manual 2022/23 and that it followed a similar format to previous years. It was still in draft format, pending the finalisation of the Head of Internal Audit Opinion. It provided a positive summary of the Trust's achievements and internal control work, despite the impact of the Covid pandemic. The lessons learned from two Never Events that had occurred during the year were described. There had been no external assessments, such as an inspection by the Care Quality Commission. Considerable work was being undertaken to prepare for inspections. A copy of the approved Annual Report and Accounts would be circulated for comment at a later date. There were no questions on the Annual Governance Statement.	
2.2	SWa ran through the key points in the Annual Accounts, illustrating the changes from the previous year's position. The Operational surplus and financial performance return were outlined and the impact of the changes to the IRFS16 regulation was detailed. The HMRC VAT outcome associated with the managed service account was also described. SWa explained the implication of the increased cost savings required at System and National level. A break-even plan had been submitted by the System; however, this would carry additional, significant, risk and would add substantial financial pressure on the Trust. There were no questions on the Annual Accounts.	
3	**Welcome and Apologies**	**Verbal**
3.1	Apologies had been received from Brian Toner, Pat Clarke, Gavin Newman, Maxine Shanahan, Kirsten Kurt-Elli and David Robinson and were accepted. Apologies had also been received from Ian Reckless and they were also accepted.	
4	**Declarations of Interest**	**Verbal**
4.1	There were none notified.	
5	**Minutes of the previous meeting on 19th January 2023**	**ROHGO (01/23) 006**
5.1	It was noted that GHu was listed twice, in attendance and also in apologies received. She clarified that she had not been in attendance at this meeting. The minutes were approved as an accurate record subject to the amendment.	
5.2	Updates from Governors and questions on the papers were sought. AHu shared that he had attended a drop-in session that day and had received excellent feedback from a patient. The patient had also agreed to become a member of the patient forum.	
5.3	JLi added that she had met with a patient who had undergone rotor cuff surgery and had also received excellent feedback on the surgery and follow-up appointments.	
6	**Update on actions arising from previous meetings**	**Verbal**

6.1	SGL shared that an action plan, to achieve full compliance with the new statutory duties of Governors, was due for publication in the autumn and would be presented at the October meeting.	
6.2	Governors were invited to attend the Public Board meeting on 5th July and to participate in the celebrations for the 75th anniversary of the NHS.	
6.3	There were no questions or challenges on actions outstanding.	
7.	**Chair and Chief Executive's update**	**Presentation**
7.1	JWi thanked Governors for attending in person. She ran through her report detailing the Trust's activity, aspirations and performance highlights. She explained that the draft Strategic Plan had been presented at Trust Board and, following feedback, an updated version would be brought back to the June Board meeting. Safety of care was the Trust's highest priority, and it was essential that patients were aware of it and that it could be evidenced. The outcome of the Staff Survey was outlined, and the Trust's achievements detailed. The Trust's investment in Estates, the green agenda, inclusion, and the Trust's ambitious targets concluded her presentation.	
7.2	Questions were invited and it was explained that Robert Jones and Agnes Hunt NHSFT had been asked to take medical patients which had impacted on their ability to deliver elective activity. The Royal Orthopaedic Trust had taken the conscious decision to remain true to specialism.	
7.3	JWi explained that theatre access, despite mutual aid usage, was working well.	
7.4	TPi and JWi had attended numerous meetings at the ICS and BSol integrated care partnerships. Discussions had centred primarily around the 10-year strategy, integrated care and creating partnerships across the System.	
7.5	The NHSE regional team had visited in December and moved the Trust's segmentation rating from 3 to 2.	
8.	**Elective Hub Accreditation (MPe and MHu)**	**ROHGO (5/23) 009**
8.1	***MPe and MHu joined the meeting at 15:00*** MPe and MHu through their presentation, outlined the plans for accreditation as an elective hub, including project governance and evidence collection. They explained that the ROH would be assessed against 105 criteria across 5 domains. Notification would be received on 5th July, the same date as the Board meeting. If successful, an accreditation 'badge' would be received, a strategically important accolade and an endorsement of the Trust's expertise at National level.	
8.2	MPe was asked if the accreditation would impact relations with organisations within the System that did not have the 'badge'. She responded that the Trust would wish to help other partners to achieve the certification. The accreditation would place the Trust in a small group of nine other organisations, that also had the award and would allow the Trust to partner with other organisations at national level and would promote its position within the ICS. ***NBr joined the meeting at 15:15 and MPe and MHu left***	
9	**Quality Account Priorities (NBr)**	**ROHGO (5/23) 010 (a)**

	a) 2022/23 Progress **b) Proposed 2023/24**	**ROHGO (5/23) 010 (b)**
9.1	NBr presented the progress made with the 2022/23 Quality Priorities and outlined those developed for 2023/24. She explained that one of the priorities for the previous year, sponsored by the Council of Governors, had been to establish a bereavement service for the families of the Trust's outpatients. Unfortunately, the priority had not been fully met due to University Hospitals Birmingham NHSFT (UHB) withdrawing their bereavement services for a period of time. Multi-faith holidays and celebrations had been successful however there was ongoing recruitment for a Chaplain. The Learning disability improvement standards were also partially met as it had proved difficult to establish a forum due to Covid. Work would continue on these priorities.	
9.2	The 2023/24 priorities focussed on six areas. The Council of Governors were invited to sponsor one of the priorities and they chose Optimisation of patient's health prior to surgery. The Trust aimed to reduce health inequalities amongst the community it served, and it recognised that patients that were not fully ready for treatment were at a greater risk of significant complications after surgery. It was intended for targeted work to take place, including learning and education for nurses and other front-line staff.	
10	**Learning & Disability Autistic Strategy**	**Presentation**
10.1	FDo joined the meeting at 15:28 and opened by outlining the highlights of the strategy that had been previously reviewed by the Board. She explained the importance of patient voice and how that informed the strategy moving forwards. She added that the ROH treated a high number of patients with a learning disability or autism. Patient Survey and benchmarking data from NHSE were also utilised to inform the strategy. The team had grown and a further member of staff had been engaged to support the work. It was noted that the Patient Passport was well utilised and helped to avoid miscommunication.	
11	**Updates from the Board and Board Committees**	**ROHGO (5/23) 012 (a)** **ROHGO (5/23) 012 (b)** **ROHGO (5/23) 012 (c)** **Verbal** **ROHGO (5/23) 012 (d)**
11.1	RPh, in his capacity of Chair of the Finance and Performance Committee, shared the Month 12 figures. He added that the Committee had reflected on the past year and discussed the cost improvement challenges the Trust and System would be facing over the coming year. The Committee had received a presentation on Data Quality and the importance of interrogating good quality data as well as capturing it.	

	The Committee had noted the Trust's extraordinary performance despite industrial action. Activity had finished with a small surplus, an excellent achievement given the challenges and industrial action of the previous financial year. The planning process had been agile and responsive to changing requests.
11.2	CFe updated the Council of Governors on behalf of the Quality and Safety Committee. The Committee had met twice since the last Council of Governors meeting. Its remit was to focus on all areas of quality, in particular on infection and prevention control. Whilst the Council could be assured there were no specific concerns to report, they were advised that an external audit was taking place on a small number of *C.Difficile* cases; learning was being taken forward and there were no reported patterns of infections. The Annual Patient Safety Report had been received and was commended as was the Medicines Safety Officer Annual Report.
11.3	SJo advised, on behalf of the Staff Experience & OD Committee, that the Committee's meeting frequency had moved to every other month and the last meeting had taken place on 26th April. SJo drew the Council of Governors' attention to the increased number of incidents of abuse from patients towards staff and shared that it would be monitored. Childcare provision for staff was being sourced and work to support staff through the cost-of-living crisis was ongoing. The Workforce Planning audit recommendations had been received and accepted.
11.4	GHu shared that the Audit Committee had last met on 28th April and that the Internal Annual Plan had been completed. The Committee had been advised that, whilst performance against the Digital Security and Protection Toolkit had improved from the previous year, further improvements were still required. This would form part of the action plan agreed with NHSE. The Internal Audit plan for the next 12 months was being finalised and would be brought back to the Committee. The Counter Fraud contract had recently been extended for a further year and the Counter Fraud work plan would be brought to the next meeting. It had been agreed that Directors' Declarations of Interest should be published on the website. Improvements had been observed in divisional governance. The new BAF format had been adopted and was being updated with a view of it being presented at the next Audit committee meeting. External Audit feedback had been as expected and there were no issues raised. They confirmed the accounts had been submitted on time. The draft Accounts had been scrutinised by the Committee. They would be receiving the final Audited Accounts for recommendation to the Board on 26th June. The Committee had been advised that the Opinion of the Head of Internal Audit was being finalised but that it was positive.
11.5	TPi shared that Non-Executive Director walkabouts were taking place and observations would be feedback to Executives.

	Strike action plans and mitigations had been discussed alongside cost of living, staff retention and childcare arrangements. ***RPh left the meeting at 15:50***	
12	**Governor Updates**	**Verbal**
12.1	Governor walkabout sessions had not taken place as planned due to illness and annual leave. The next planned session would be taking place on 4th July. Governors would also be invited to take place in the Quality Assurance walkabouts that were being planned by the Executive Chief Nurse.	
12.2	JDo outlined the Governor Development Programme that had been put in place and explained that a series of online workshops had been developed. Further modules were also available via NHS providers and the complete programme would be shared with them via email and calendar invites.	
12.3	SGL shared that terms in office of the Public Governors would be coming to an end. Staff governor elections would also be taking place during late summer. Expressions of interest for the role of Deputy Lead governor would be issued shortly.	
12.4	The Chair thanked Dagmar Scheel-Toellner for her service, for championing the Trust and her continued contribution to the work of the ROH.	
13	**For information:** **a) Finance & Performance update** **b) Quality & Patient Safety update** **c) Workforce update** **d) Board Assurance Framework**	 **ROHGO (5/23) 014 (a)** **ROHGO (5/23) 014 (b)** **ROHGO (5/23) 014 (c)** **ROHGO (5/23) 014 (d)**
13.1	The documents presented in the Board pack were **RECEIVED AND NOTED**	
14	**Any Other Business (All)**	**Verbal**
14.1	Governors were invited to join the Public Board meetings.	
14.2	It was suggested that mandatory training for volunteers be re-evaluated so as to allow easy access to non-computer users.	
14.3	There being no other business the meeting closed at 16:02	
Date of the next meeting: 23rd November 2023, 14:00 – 16:00		

The Royal Orthopaedic Hospital NHS Foundation Trust

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive**
AUTHOR:	**Jo Williams, Chief Executive**
DATE OF MEETING:	**23 November 2023**

EXECUTIVE SUMMARY:

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

REPORT RECOMMENDATION:

The Council 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:

Trust Board on 1 November 2023

The Royal Orthopaedic Hospital NHS Foundation Trust

Chief Executive's Report to the Council of Governors

23 November 2023

1 EXECUTIVE SUMMARY

1.1 This paper provides an update regarding some of the most noteworthy events and updates since 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 launched our Trust strategy. Sessions were 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 unveiled 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 was held on 8 November 2023.

5 POLICY APPROVAL

5.1 Since the Council of Governors 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 Council is asked to discuss the contents of the report, and

6.2 Note the contents of the report.

Jo Williams
Chief Executive

15 November 2023

The Royal Orthopaedic Hospital NHS Foundation Trust

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Continuous Improvement Methodology**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Chief Executive Officer**
AUTHOR:	**Amos Mallard, Acting Deputy Director of Strategy & Head of Communications** **Rebecca Lloyd, Deputy Director of Strategy**
DATE OF MEETING:	**23 November 2023**

EXECUTIVE SUMMARY:

Context

Significant progress has been made over the past five years in how the ROH approaches improvement. QSIR (Quality, Service Improvement & Redesign) training continues to be delivered across all teams, as well as to partners in the Birmingham and Solihull Integrated Care System. There are complex programmes such as Day Case surgery, Outpatient Modernisation and MSK Transformation all of which are underpinned by QSIR and a focus on improvement at scale. The AMaT clinical assurance system has provided an excellent platform for the organisation to track audit and quality improvement projects from inception through to completion.

There is consensus that to build a culture of Continuous Improvement at the ROH, a collective approach is required that:

- Promotes a clear message about the Board's ambition for improvement
- Empowers staff to actively use QSIR tools in their roles on an ongoing basis
- Removes barriers to improvement and makes any approval routes easy to access
- Gives staff the opportunity to connect with other teams to learn and share knowledge
- Addresses the challenges faced in monitoring and sustaining change once a project draws to a close

Draft ROH Continuous Improvement Plan: IMPACT (Initiative for Maximising Performance and Advancing Care through Transformation)

Drawing inspiration from the NHS Impact (Improving Patient Care Together) improvement programme, a draft ROH Continuous Improvement Plan has been developed in line with this new national approach. The plan intends to capture the ROH ambition to drive improvement across all of our teams, articulating a shared responsibility to improve and shift the mindset towards 'even better if'.

The plan is strongly aligned to the Patient Safety Incident Response Framework and the focus on shared knowledge and learning, which is key if the ROH is to truly embed a continuous improvement culture.

The 'Impact journey' moves across five phases:

1. Building a shared purpose and vision
2. Developing leadership behaviours

3. Building improvement capability and capacity
4. Investing in people and culture
5. Embedding improvement into systems and processes

Detailed actions are included in the plan as to how the ROH can proactively enhance its continuous improvement offer across these five phases, and how to sustain change at every level.

There are five goals overarching goals included within the plan that include metrics for improvement, which will be how the plan is monitored and assurance provided that progress is being made:

1. Our team is well trained and equipped to continuously improvement
2. We have developed shared governance
3. We have developed effective continuous improvement huddles
4. We have developed strong leadership behaviours in our team
5. We support continuous improvement in our system

REPORT RECOMMENDATION:

The Governors are asked to discuss the draft Continuous Improvement Plan and methodology proposed.

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

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
		x

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

Financial	x	Environmental	x	Communications & Media	x
Business and market share	x	Legal & Policy		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:

The draft Continuous Improvement Plan is aligned to the new Trust Strategy 2023-2028.

PREVIOUS CONSIDERATION:

Trust Board on 1 November 2023

IMPACT

INITIATIVE FOR **MAXIMIZING PERFORMANCE** AND
ADVANCING CARE THROUGH **TRANSFORMATION**

CONTINUOUS IMPROVEMENT PLAN 2023-2025

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

CONTENTS

OUR LEADERSHIP COMMITMENT TO IMPROVEMENT

While this document offers a comprehensive plan for embedding and sustaining continuous improvement in our Trust, we know that culture is king. Improvement must be seen as part of what we do everyday,, not merely something we try to find time for. That goes for us as an executive team and for every member of The Royal Orthopaedic Hospital team.

We will do everything we can to facilitate improvement. This means providing people with space to improve, removing barriers, championing good ideas, and enabling improvement to flourish.

In return we need every member of the team to understand that they are responsible for improvement in their area - no one else can do it - you are the expert. We also need people to understand that improvement can be big changes or little changes. You have permission to make things better. If you face a barrier, speak up and the Senior Leadership Team will help remove it.

Ultimately, continuous improvement is all about patients. Every aspect of our collective work matters and contributes to the safe, effective, and outstanding care of the patients who walk through our doors every day. That is why we are committed to continuous improvement.

The Executive Team
The Royal Orthopaedic Hospital

OUR PURPOSE

LESS PAIN.
MORE INDEPENDENCE.
LIFE-CHANGING CARE.

Our vision

Less pain.
More independence.
Life-changing care

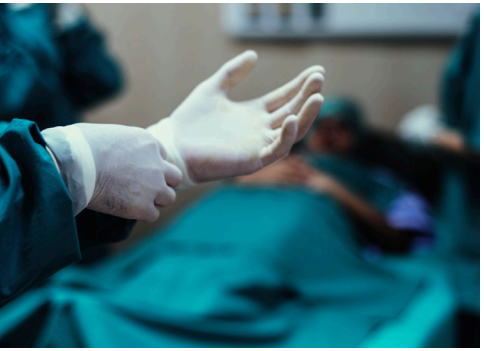
Our mission

We will deliver compassionate, patient-centred care that empowers people to regain their mobility, independence, and quality of life. Through efficiency, expertise, innovation and collaboration we will tackle health inequality and improve access to life-changing care.

Our values

Compassion
Openness
Pride
Innovation
Excellence
Respect

WHAT IS CONTINUOUS IMPROVEMENT?



What is continuous improvement?
Continuous improvement refers to an ongoing, deliberate effort to enhance all aspects of the hospital's operations, including patient care, administrative processes, and overall organisational performance.

Why do we do it?
To create a culture of continuous learning and adaptation within ROH, leading to better patient experiences and outcomes.

What does it involve?
It involves identifying opportunities for improvement, implementing changes, monitoring their impact, and making further adjustments as necessary to ensure the delivery of high-quality care, operational efficiency, and the best possible outcomes for patients.

Who is responsible for it?
Everyone in the organisation is responsible for continuous improvement. Our teams are the experts in their areas, so only they can unlock solutions and make improvements happen. It isn't for someone else to do, it's up to all of us.

Continuous improvement and the new Patient Safety Incident Response Framework (PSIRF)

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.

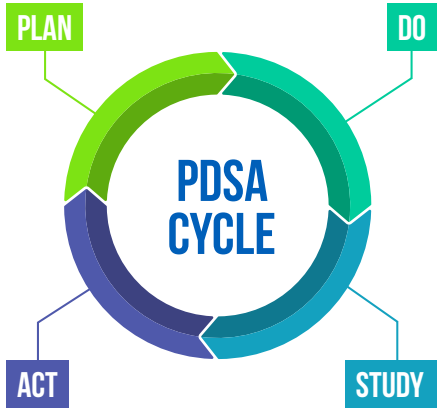
The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS.

A significant focus of patient safety and PSIRF is learning. How do we learn from what happens, apply this learning and in doing so, improve.

As we embed PSIRF in our Trust, we will ensure there is a robust alignment between PSIRF and out plans around continuous improvement.

Shared governance and continuous improvement
Shared governance is a collaborative decision-making framework within healthcare organisations that empowers frontline healthcare professionals, particularly nurses, to actively participate in and influence decisions related to patient care, practice, and clinical policies.

Continuous improvement and shared governance are both vital concepts within the ROH, aiming to enhance healthcare quality and engagement. They share a common goal of improving patient care but differ in focus, scope and structure. Continuous Improvement is an over-arching concept, applied in all areas. Shared Governance concentrates on clinical and nursing decision-making and improvement, with formalised structures and support. These two concepts are complimentary and work together to create a comprehensive approach to healthcare excellence at the ROH.



THE BENEFITS TO OUR PATIENTS AND OUR TRUST

Enhanced patient care
Continuous improvement efforts can lead to better patient outcomes, reduced errors, and improved overall quality of care.

Patient experience
A focus on improvement can lead to a more patient-centered approach.

Patient safety
Regularly reviewing and refining processes helps identify and address safety concerns.

Efficiency
Streamlining and eliminating inefficiencies can lead to shorter waiting times, quicker diagnoses, and improved resource utilisation.

Cost reduction
Identifying cost-saving opportunities through continuous improvement can help the hospital allocate resources more effectively and ensure financial sustainability.

Compliance
Adhering to evolving healthcare regulations and industry standards is critical for maintaining quality and compliance.

Employee engagement
Involving staff in improvement initiatives fosters a culture of engagement, motivation, and empowerment, which can lead to higher job satisfaction and retention.

Adaptation to new technologies
Keeping up with advances in medical technology ensures that the hospital can offer state-of-the-art treatments and diagnostic tools.

Long-term sustainability
Continuous improvement ensures that the hospital remains adaptable and resilient in the face of evolving healthcare challenges.

Reduced wait times
Optimised processes can lead to shorter wait times for appointments, procedures, and surgeries.

Staff development
Providing training and development opportunities as part of improvement efforts can help staff acquire new skills and stay updated on best practices.

Community health
Improvements in patient care and outcomes contribute to the overall health and wellbeing of the community served by the hospital.

EXAMPLES OF CONTINUOUS IMPROVEMENT

The concept of Kaizen

Kaizen is a Japanese term that translates to 'continuous improvement.'

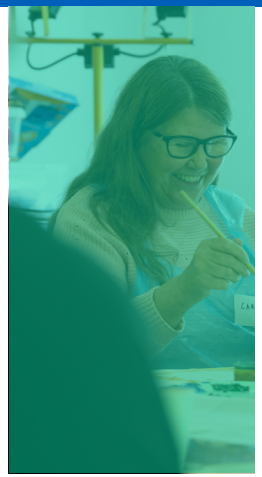
It is a concept and philosophy that emphasises making small, incremental changes and improvements in all aspects of an organization.

Kaizen encourages a culture of constant learning, problem-solving, and employee involvement to enhance efficiency, quality, and performance over time.

This approach is widely used in industries to drive long-term, sustainable improvement. We can learn a lot from Kaizen and apply it in our Trust.

Kai 改 Change

Zen 善 Good



Art 4 Health

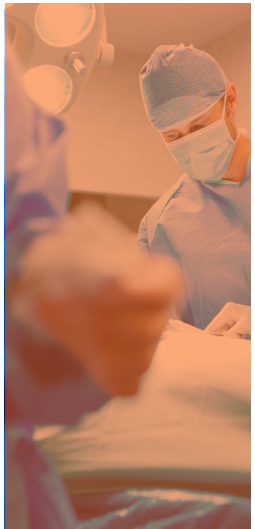
Pain Consultant, Dr Liza Tharakan submitted a poster entry to a charity initaitive which enabled colleagues to have an improvement idea funded. Her idea was to hold art workshops for chronic pain patients to support mental wellbeing and health. Liza's idea was chosen and funded.

The workshop was held at a partner venue and was successful and rated really highly by patients. Data is being complied to evaluate the impact of this intervention on patients mental health as they live with long-term pain. The communications team are submitting an article to be published in 'Clinical Services Journal' to spread learning.

Filing in the Pre-Operative Assessment Centre (POAC)

Whilst working in the POAC Admin team, Ryan McComb identified a backlog in POAC due to the volume of patient notes the department was storing making it difficult for colleagues to access the notes they needed quickly. After speaking with his Line Manager, they agreed to trial a new approach. Ryan split notes down into separate numbered packs of ten, which meant colleagues only had to know a pack nuber to quickly find the notes they needed.

The trial was successful and the time efficiency created gave the team time to work on other tasks. Subsequently, this approach has been used in other departments across the Trust.



Seamless surgery week in Theatres

The Theatres Department developed an improved concept called Seamles Surgery Week. This was an opportunity to deliver a week of seamless care with minimal delay and maximum efficiency. The team focussed during the week on improving communication, Theatre efficiency and and patient flow.

The results were excellent, with improved team working between Theatres and ADCU resulting in all patients waiting over 52 weeks receiving treatment. The team were more efficient, communication was better and patient feedback was more visible which supported engagement. Improvement focussed groups were established to make the improvements sustainable and keep staff engaged. The learning from this week has continued to inform the approach taken in Theatres.

GOVERNANCE AND SKILLS TO ENABLE CONTINUOUS IMPORVEMENT

What is our governance for implementing a good idea?

Generators for continuous improvement

- ☑ Incidents
- ☑ Risks
- ☑ Model Hospital
- ☑ Ideas / kaizen
- ☑ Patient engagement
- ☑ Quality control / surveillance breaches
- ☑ Clinical audit
- ☑ Prospective Divisional and Unit audit Plan
- ☑ AQILA outcomes surveillance
- ☑ CIP and efficiency proposals
- ☑ PSIRF
- ☑ Shared governance
- ☑ Annual Planning
- ☑ Appraisals
- ☑ Huddles
- ☑ CI focussed events

Improvement idea

Triage and support

Not viable

Viable and no support needed: progress

Viable and support needed

Register an AMAT

Metrics
Timelines
QSIR
Support

Service Improvement Board

AQILA

What is our methodology for implementing a good idea?

Quality Service Improvement Redesign (QSIR): *the way we do things around here*

We have made great progress in delivering QSIR training in our Trust, but we must continue to embed it and encourage staff to use it to enable it to have the fullest impact. Our focus for QSIR includes:

- ☑ QSIR is embedded as the singular methodology used at ROH.
- ☑ New entrants to QSIR come with a project ready to workshop
- ☑ QSIR graduates evidence QSIR use through PDR
- ☑ QSIR graduates form a network to support QSIR use, visibility and skills maintenance
- ☑ Evidence of improvement is recognised, celebrated and shared

HOW A GOOD IDEA IS IMPLEMENTED

Permission to act
We want to foster a culture where everyone feels able to identify an improvement and make it happen as quickly and efficiently as possible. Our governance structure needs to be streamlined as far as possible. We also need to spend more time educating our whole team about where they can find support and how improvement doesn't need to take a long time and be difficult. The examples below show how small to medium improvements can be initiated and approved quickly.

	Support Where to find initial support	**Approval** Who approves these changes	**Engagement** Who can support engagement
Example: pre-op advice A Nurse wants to create some new pre-operative advice resources to support patient optimisation.	✓ Communications Team	✓ Clinical Quality Group ✓ Shared Decision Making	✓ PEEG
Example: digital for paper A Therapy Assistant wants to introduce a new digital form to replace a paper one to support better use of equipment	✓ Digital Team ✓ IT Team	✓ TPAG	✓ Communications Team
Example: flexible working An Admin Team Leader wants to introduce a flexible working rota to their team to support staff wellbeing	✓ HR and Workforce	✓ Locally agreed	
Example: environment improvement The Imaging Team want to improve the waiting room environment for patients to enable better patient experience.	✓ Patient Experience Team ✓ Communications Team ✓ Estates Team ✓ Royal Orthopaedic Charity	✓ Locally agreed ✓ Health and Safety	✓ PEEG
Example: cost improvement A member of the Estates team sees an opportunity to save money by using a different supplier.	✓ Finance Team	✓ Locally agreed	

BUILDING A CULTURE OF CONTINUOUS IMPROVEMENT

Our ambition is to create an environment whereevery member of the ROH Team feels empowered to make improvements and sees it as part of their role. We want to see improvement ideas shift from the 'needs improving' category to the 'this could be even better if...' category.

Our team

Our organisation

Our system

Peer learning and knowledge sharing

- Improvement huddles
- Access to AMAT
- PDRs
- Have clinicians in leadership roles
- Drop-in sessions
- Access to networks
- Embed into recruitment
- IMPACT teams
- Transparent governance framework
- Visible and sustained commitment to improvement programmes from Board
- Framing improvement as a shared responsibility
- Improvement priorities and metrics are aligned with organisational and national objectives.
- Partnership working
- Access to funding
- Opportunities to showcase successful improvement initiatives
- Sharing best practice

Recognising and celebrating success

IMPACT TEAMS

IMPACT TEAM

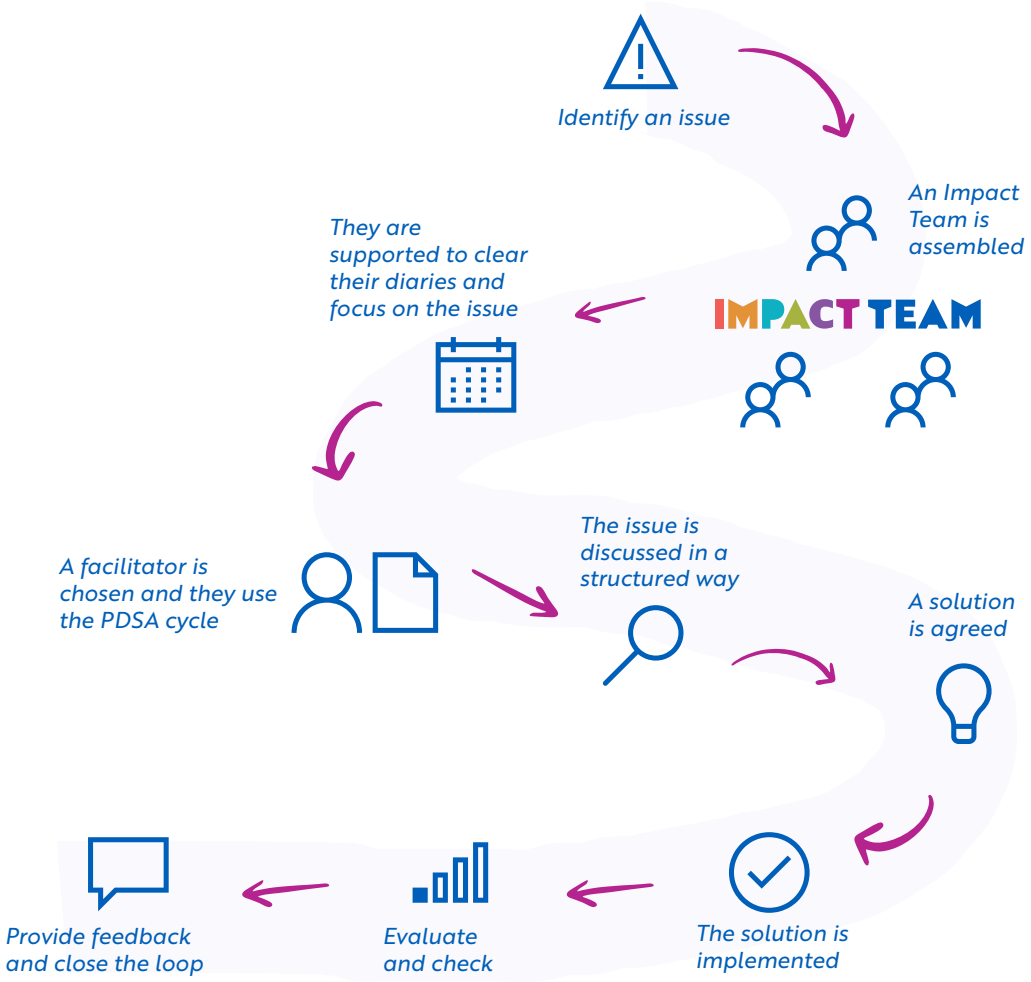
We have the solutions to the challenges we face. The biggest challenge is making time for improvement and getting the right people around the table. That's why tackling a challenge requires a dedicated team approach.

What is an Impact Team?
An Impact Team is a short-term, multi-disciplinary team who unite to find a solution to a problem.

Who is in an Impact Team?
Impact Teams contain people who can help solve the problem, whether they are clinical or non-clinical. There is no limit to number, but everyone involved takes an active role.

What happens in an Impact Team?
An Impact Team can be called by anyone to address a small, medium or large issue. The team meets and uses QSIR / PDSA to find a solution.

How do we find time for Impact Teams?
The Executive and Senior Management Team will facilitate this by working with operational and management teams to ensure Impact Team members can be released from normal duties to focus on problem-solving. Tackling issues is not 'extra' it is a core part of everyone's work and the Trust will support this to happen.



IMPACT HUB

We will create a physical location that will facilitate Impact Teams to be able to meet and problem solve together.

SUSTAINING CHANGE

One of the most challening parts of continuous improvement is sustaining change. There are number of different things we need to focus on to sustain improvement.

Continuous monitoring
Implement robust monitoring systems to track key performance indicators (KPIs) and the impact of changes.

Standardisation
Ensure that successful improvements are standardised and integrated into daily workflows. This ensures that new practices become the norm.

Training and education
Provide ongoing training and education to staff to ensure they understand and adhere to the new processes and best practices.

Leadership support
Maintain leadership commitment and involvement in sustaining changes. Leaders should model desired behaviour and communicate the importance of the improvement.

Feedback loops
Establish feedback mechanisms that allow staff to provide input on the effectiveness of the changes and suggest further improvements.

Recognition and rewards
Continue to recognise and reward individuals and teams for their contributions to sustaining improvements.

Documentation
Maintain clear and up-to-date documentation of processes and procedures. This includes updating manuals, guidelines, and training materials to reflect the current best practices.

Peer accountability
Encourage peer accountability, where team members hold each other responsible for following the established processes and maintaining the improvements.

Communication
Keep all stakeholders informed about the progress and success of the changes. Regularly communicate the positive impact on patient care, safety, and operational efficiency.

Regular audits and reviews
Conduct regular audits and reviews of processes to identify any deviations and address them promptly.

Patient feedback
Continuously collect and analyse patient feedback to ensure that improvements align with their needs.

Learning from failures
Acknowledge that not all changes will succeed, and it's essential to learn from failures. Conduct post-implementation reviews and PSIRF.

OUR GOALS

We have developed five goals associated with our Impact Continuous Improvement Programme. This is what we will measure to assure ourselves that we are making progress.

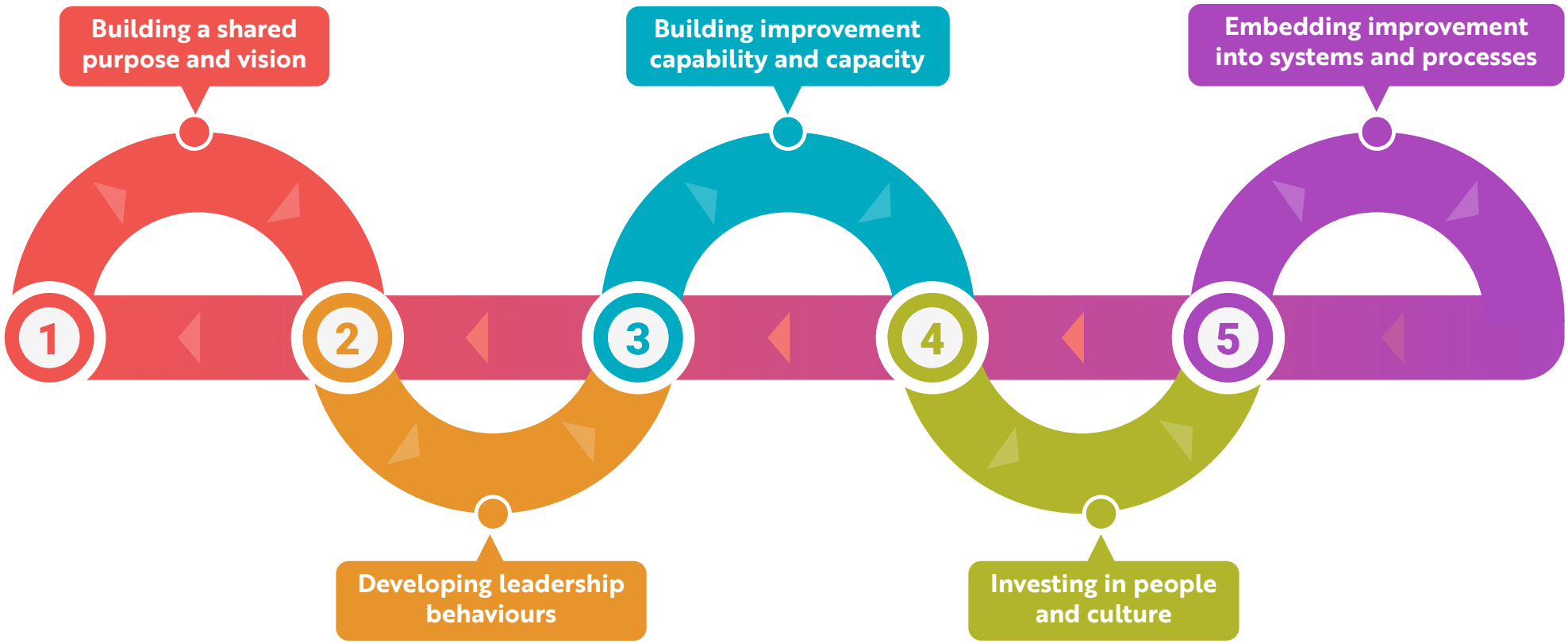
Goal		Measurement
1	Our team is well trained and equipped to continuously improve	100% of workforce trained in either QSIR fundamentals or QSIR Practitioner.
		Improvements in self-efficacy scores from pre to post scores following QSIR training by an average of 1 point per participant.
2	We have developed shared governance	Increase in number of new improvement initiatives by 5% year on year.
3	We have developed effective continuous improvement huddles	Positive feedback given from implementation of huddles with individuals recognising the benefit and impact these are having.
4	We have developed strong leadership behaviours in our team	All individuals to have a QI objective set within their PDR.
		Year on year increase in number of nominations for the improvement focussed category in the annual awards ceremony.
5	We support continuous improvement in our system	10% of all continuous improvement initiatives having a system improvement benefit identified.
		30% of QSIR courses slots made available tol BSOL partners to support sharing of good practice.

OUR CONTINUOUS IMPROVEMENT JOURNEY LOOP

IMPACT

INITIATIVE FOR MAXIMIZING PERFORMANCE AND ADVANCING CARE THROUGH TRANSFORMATION

Everyone has a role to play in continuous improvement. This Journey Loop identifies some of the key actions we need to take to strengthen our continuous improvement culture. This is both a journey and a loop because culture is not static. We must continually revisit how we work, how we lead and how we listen, to ensure improvement becomes cultural, not just a project. We are calling it IMPACT.



1 BUILDING A SHARED PURPOSE AND VISION

This stage is crucial as it aligns all stakeholders, fostering a unified sense of direction and motivation. A shared purpose and vision provide clarity, ensuring that everyone at ROH understands their role in achieving common goals through continuous improvement, ultimately enhancing collaboration and cohesion.

Key task	Rationale	Lead
Building understanding and support for our vision	The Trust has developed a new purpose: *Less pain. More independence. Life-changing care.* We must invest time into helping people connect with this purpose, building support, and helping people understand their role in making it happen. This will give us all a shared goal to work towards.	
Turning our values into actions	We have an established set of values that our team recognise and support. We must continue to bring these values into actions and behaviours in order to help people connect with them more fully. This will strengthen our values-based culture, creating stronger team dynamics which is needed for improvement to flourish.	
Launch our new strategy	Our refreshed strategy will provide out team with the broad objeectives for what the Trust wants to achieve in the next five years. This will enable improvement efforts to be focussed and aligned.	
Launch our supporting plans	Our supporting plans go into more detail about how we will accomplish our strategy. They include plans for particular staff groups like Nursing, and plans for topical areas like health inequality. They are all structured around improvement and will enable our team to align their improvement efforts.	
Continuous engagement	We must provide regular engagement opportunities at all levels of the organisation. It is vital that people can share ideas, issues, concerns and feedback within their team, department and to the Trust leadership. This enables people to feel heard and able to contribute. It is also important that we close this feedback loop so that people know their contribution is not just heard, but acted upon.	
Aligning with the quality priorities	We will ensure that our continuous improvement efforts align with and contribute to the quality priorities of the Trust. By doing so, we will coordinate improvement that has the greatest impact.	

2 DEVELOPING LEADERSHIP BEHAVIOURS

Effective leadership sets the tone for the entire organisation. By focusing on this stage, ROH ensures its leaders exemplify the behaviors that drive positive change, inspire their teams, and create a culture of continuous improvement.

Key task	Rationale	Lead
Build upon progress from the High Performing Leaders Who Care programme	The senior leadership team (SLT) of the Trust have undertaken a programme of leadership development together. This has resulted in a much stronger sense of shared purpose, a more connected network and some developmental projects the SLT wish to undertake. We must build upon this progress and ensure the momentum of this programme is carried forward into action. This will impact our whole organisation because the focus of this programme is making improvement happen.	
Develop a Leadership Charter	A leadership charter is a set of behaviours that senior leaders develop and agree upon. This provides a framework for what is and is not acceptable. It is important because it allows the SLT to self-regulate peer-to-peer and ensure that people work with shared behaviours and focus.	
Institute a regular Senior Leadership Team (SLT) monthly meeting	The SLT have only started to meet regularly as part of the High Performing Leaders Who Care programme. The SLT have seen significant benefit from this, so wnat to carry this forward into a regular SLT meeting, focussed on improvement.	
Leadership in shared governance	The shared governance programme has a strong focus on developing leadership. This will run alongside our Trust-wide leadership development and align with it.	

3 BUILDING IMPROVEMENT CAPABILITY AND CAPACITY

Enhancing the ability to innovate and improve is essential for ROH's success.
This stage empowers staff with the skills and knowledge needed to identify and implement improvements, fostering a culture of adaptability, ownership, and growth.

Key task	Rationale	Lead
QSIR training for all	QSIR is our improvement methodology. We will ensure everyone gets the opportunity to receieve QSIR training. We will ensure QSIR is used in our projects and programmes and we will encourage our teams to utilise their learning after they have been trained. We will also support partners in the Birmingham and Solihull Integrated Care System to adopt QSIR by supporting training regionally.	
Shared governance programme	The shared governance programme will support improvement in clinical area, particularly with Nurses. This programme will align with the Nursing strategy and ensure that we have a robust approach to improvement, based on shared governance.	
Quality Improvement Nurse role	The role of the Quality Improvement Nurse will be crucial for supporting continuous improvement and shared governance within the Trust. This role will enable ideas and insight to be harnessed and will support learning and improvement.	
Learning and Development programmes	We offer diverse learning and development opportunities at ROH. We will prioritise prioritize promoting these opportunities universally and will maintain consistent alignment with our continuous improvement ambitions.	
Instigate Impact Teams	Introduce Impact Teams (see page 13) to support collaborative improvement within the ROH.	
Instigate CI huddles	Continuous improvement huddles are well utilised in other Trusts to support rapid and timely improvement. We will introduce CI huddles at the ROH.	
Distributive responsibility	We must be deliberate in how both support people to improve and set expectations around improvement. The resonsibility for improvement must be shared. There is no 'one size fits all' approach, but we can learn from what works in othe places. Toyota, for example, expect a regular improvement from every team member, every week or every month. This sets expectations that everyone has a role in improvement and that it is expected regularly. We will do the same at ROH.	
Monitoring and reporting	We will continuously monitor the progress of improvement initiatives and report results to the Trust and our stakeholders. Transparency in reporting builds trust and accountability.	
Partnership	We will collaborate with partners to share best practices and leverage collective knowledge.	

4 INVESTING IN PEOPLE AND CULTURE

ROH recognises that its people are its most valuable asset. Investing in their development, wellbeing, and engagement not only ensures a motivated workforce but also reinforces a culture of continuous improvement and patient-centered care where everyone understands their role and works in a positive, improvement-focussed environment.

Key task	Rationale	Lead
Communication	Communication plays a vital role in supporting the development of a continuous improvement culture. This the production of and distribution of case studies to help people see improvement in action. Importantly, communication helps to close the loop and enable people to see the impact of improvement. We will develop specific and regualar communication focussed on improvement to share examples and encourage everyone to participate.	
Reward and recognition	We will recognise and reward improvement through celebration and awards. We will introduce an improvement focussed category in our annual awards. We will also introduce a new award system which is not bound to an annual calendar, but can be nominated and awarded quickly. This will give us opportunities to reward people for improvement and share this with the Trust to encourage others.	
Focal point	We will create a focal point for improvement by introducing a QSIR mural in a high traffic area of the trust so that people can find training opportunities and see example of improvement.	
Incentivising improvement	The Royal Orthopaedic Charity (ROC) exist to support the work of the hospital. We will work with ROC to build opportunities for funded development opportunities (e.g. competitions where the best improvement idea is funded). This will help accelerate ideas which require funding.	
Feedback mechanisms	We will establish feedback mechanisms that allow staff to provide input on improvements, voice concerns, and offer suggestions and allow us to act on this feedback to show that their input is valued.	
Patient-centred focus	We will always emphasise the ultimate goal of improving patient care and safety. Our teams will be engaged in discussions about how improvements directly benefit patients and their experiences.	

5 EMBEDDING IMPROVEMENT INTO SYSTEMS AND PROCESSES

To sustain progress, ROH must integrate improvement practices into its core operations. Embedding improvement into systems and processes ensures that positive changes become the norm, delivering consistent quality care and operational excellence.

Key task	Rationale	Lead
Governance	Governance is important for allowing ideas which require oversight and clinical and corporate input to flow through the organisation safely. Good governance is supportive, not restrictive. It is appropriate and simple to engage with. Some improvements will not need formal governance (e..g. moving around a room to make work flow easier) but some will (e.g. a new clinical protocol or pathway). In the instances where an idea requires governance, it should be transparent, there should be a triage function to make it easy to find support and there should be no duplication. We will ensure our governance structure supports improvement and the people who make it happen.	
Instigate CI huddles	Continuous improvement huddles are well utilised in other Trusts to support rapid and timely improvement. We will introduce CI huddles at the ROH.	
Business planning	The business planning process is important because it captures the large scale improvements a team wants to make in the next 12 months. We will ensure this process is more collaborative in teams, providing training and support to get the whole team involved so that ideas can be shared and improvement intentions agreed.	
PDR	The Personal Development Review (PDR) process is a key touch-point for setting goals for people and having improvement focussed conversations. We will ensure the PDR process reflects our continuous improvement ambitions so that every person feels included in improvement and an expectation is set that they are responsible for advancing it.	
Investment in learning	We will continue to invest in learning and education associated with continuous improvement and ensure that it is inclusive and easy to access for everyone.	
Cross-functional teams	We will support cross-functional improvement teams that include members from different departments. This can promote collaboration and diverse perspectives when solving complex problems.	
Data-driven decision making	We will ensure business intellgence supports the Trust to monitor key performance indicators and measure the impact of changes.	
Standardisation	We will look to standardise processes and procedures whenever possible to reduce variability and errors. We will learn from one another and from others and we will implement best practice to ensure it is consistently followed.	

ALIGNING CONTINUOUS IMPROVEMENT WITH STRATEGY

Our strategic objectives

CARE

Deliver outstanding care that is safe, seamless and patient centred

EXPERTISE

Innovate, improve, research and teach

PEOPLE

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

COMMUNITY

Work with our community to reduce health inequality and support prevention

SERVICES

Provide efficient, effective and sustainable services

COLLABORATION

Collaborate to support improvement; locally, regionally and nationally

How our objectives align with continuous improvement

By consistently seeking ways to enhance patient-centered care, we demonstrate a commitment to continuous improvement and a focus on delivering compassionate and effective services.

By investing in training and development, we will maintain a high level of expertise, which we can share and drive forward improvement across all domains of the Trust

By actively involving staff in process improvement efforts, we will empower our team to contribute their expertise and insights, fostering a sense of ownership and pride.

By working with our community to reduce health inequality and support prevention, we will improve how we care and support community health and wellbeing.

By continuously evaluating data, process and and feedback and adjusting services accordingly, we can meet the evolving needs, demands and expectations of patients

By prioritising collaboration with partners, we can ensure that patients receive comprehensive and coordinated care and that quality improves consistently.

ALIGNING CONTINUOUS IMPROVEMENT WITH OUR VALUES

Compassion and continuous improvement

- Continuous improvement ensures that patient care processes are regularly reviewed and refined to enhance the overall experience, demonstrating compassion by addressing patient needs and concerns more effectively.
- By continuously improving communication and empathy training for staff, the hospital fosters a culture of compassion, where healthcare professionals consistently show empathy and understanding to patients and their families.

Openness and continuous improvement

- Embracing continuous improvement means being open to feedback from both patients and staff, allowing for transparency in addressing issues and making necessary changes.
- An open approach to continuous improvement encourages sharing best practices and lessons learned, creating a culture of knowledge exchange and collaboration among healthcare providers.

Pride and continuous improvement

- Continuous improvement helps the hospital take pride in its commitment to delivering the best possible care, as it strives to constantly raise the bar on patient outcomes and service quality.
- Staff members can take pride in their work when they actively engage in improvement initiatives, seeing their contributions directly enhance patient experiences and healthcare delivery.

Innovation and continuous improvement

- Continuous improvement drives innovation by encouraging staff to seek new, more efficient, and effective ways to provide care, leading to the adoption of innovative technologies and treatment methods.
- By fostering a culture of continuous improvement, the hospital becomes a hub for innovative ideas, where creativity is nurtured, and novel solutions to healthcare challenges are embraced.

Excellence and continuous improvement

- Continuous improvement is essential for achieving and sustaining excellence, as it allows the hospital to regularly assess and refine its processes, striving for the highest standards of care.
- Through continuous improvement, the hospital consistently aims to exceed benchmarks, set new performance goals, and achieve a reputation for excellence in orthopaedic care.

Respect and continuous improvement

- Continuous improvement reinforces a culture of respect by valuing the input and feedback of all stakeholders, including patients, families, and staff, ensuring that their perspectives are considered and respected.
- By continuously improving diversity and inclusion practices, the hospital demonstrates respect for the unique backgrounds and needs of its diverse patient population and workforce.

FIND OUT MORE

The Service Improvement Team
alicia.stanton1@nhs.net

Learning and development
roh-tr.learning@nhs.net

QSIR training
alicia.stanton1@nhs.net

Digital Transformation Team
roh.digital@nhs.net

QSIR: 'THE WAY WE DO THINGS AROUND HERE'

Our methodology for continuous improvement is called QSIR (Quality Service Improvement Redesign). The QSIR methodology is a systematic approach to enhancing quality and service delivery.

Want to get QSIR trained? Contact ...

NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

LESS PAIN
MORE INDEPENDENCE
LIFE-CHANGING CARE

The Royal Orthopaedic Hospital NHS Foundation Trust

COUNCIL OF GOVERNORS

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:	**23 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 Council is asked to review 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

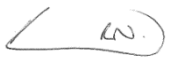
Or email:-

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

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Quality and Safety Reviews report**
SPONSOR (EXECUTIVE DIRECTOR):	**Nikki Brockie, Chief Nurse**
AUTHOR:	**Emma Steele, Deputy Chief Nurse**
PRESENTED BY:	**Emma Steele, Deputy Chief Nurse**
DATE OF MEETING:	**23rd November 2023**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Quality and Safety Reviews have been recommenced at ROH. The review process is designed for the team to understand if wards/departments are providing care that is safe, caring, effective, responsive to people's needs and well-led, in line with the CQC key lines of enquiry. The reviewers determine an overall score for each domain based on their findings. A report is compiled, and an action plan developed.
We invite and welcome Governors to join these visits.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
• Overall good patient experience and staff engagement • Process will help towards Ward Accreditation	• Areas to complete Action plans and provide evidence/assurance

NOT APPLICABLE	n/a

REPORT RECOMMENDATION AND ACTION OR DECISION REQUIRED:

The Committee is asked to: note and accept.

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

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

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

Patients element of Trust strategy

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

None specifically

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 18 October 2023

FOR INFORMATION

ROHGO (11/23) 004 (a)

The Royal Orthopaedic Hospital NHS Foundation Trust

Quality and Safety Reviews at ROH

1 EXECUTIVE SUMMARY

1.1 Quality and Safety Reviews have been recommenced at ROH. The review process is designed for the team to understand if wards/departments are providing care that is safe, caring, effective, responsive to people's needs and well-led, in line with the CQC key lines of enquiry. The reviewers determine an overall score for each domain based on their findings. Staff engagement and participation is crucial, and the reviewers ensure that they speak to a variety of staff, patients, and visitors during the visit. These reviews provide us with useful information as we start to work on introducing Ward Accreditation.

1.2 A report is generated, and the ward/department leaders devise an action plan to address any issues identified.

2 Review Team

2.1 The reviews are led by the Deputy Chief Nurse and members from Nursing, Governance, Education, Corporate Nursing, AHP, Pharmacy, Medical and Operational teams are invited to join. It is important to have a multi-disciplinary approach to the reviews to gain insights and an understanding of the service, practices and patient/staff experience in the areas visited.

3 Process

3.1 Dates for the review are planned in advance and the team meet first to decide which areas will be visited, usually the group will split into two teams and agree two areas to be visited.

3.2 Areas to be visited are decided by the group and can be nominated by the Matron/Head of Nursing if there is a specific issue that they would like to focus on

3.3 Each reviewer is designated a theme in line with CQC lines of enquiry. Safe, Effective, Caring, Responsive and Well Led. There are a number of questions to answer within each domain and information can be gathered by talking to patients and staff or reviewing documentation.

3.4 If any immediate concerns are noted, the reviewer informs the nurse in charge so that the issue can be rectified.

4 Feedback

4.1 The team return to meet to give initial verbal feedback. This enable the Matron/Head of Nursing to hear the feedback and discuss with the ward/department manager. This ensures timely feedback is provided prior to the final report.

4.2 Feedback is sent electronically to the Deputy Chief Nurse and an overall report is compiled with a rating for each domain in line with CQC; Outstanding, Good, Requires improvement or Inadequate.

The overall report is reviewed by the Ward/department leads with their Matron and an action plan is devised. The report is also shared with Operational colleagues as there may be actions within their remit. Actions are added to Ulysses and closed when assurance and evidence provided. Actions are to be discussed and tracked at the Divisional Governance meetings.

5. Findings

5.1 Six areas have been reviewed and reports compiled and sent.

5.2 It is rare that there are any immediate concerns to be rectified during the visit. On two occasions a drug trolley/COSHH cupboard were left unlocked

Patient feedback overall is very good.

Staff like working for the organisation and would advise family and friends to have treatment here. Staff are not all able to identify members of the Exec Team.

Ward/Department	Overall Score	Comments
ADCU	Good with requires improvements	Proactive with Safeguarding concerns raised. Some patients had a long wait for surgery and were fasted for a long time. Delays not always communicated to patients in the waiting room.
POAC	Good with elements of Outstanding	Estates work in bathroom highlighted – now actioned. Excellent MDT work in CRAD especially with Safeguarding.
Main OPD	Good	Good patient feedback and staff engagement with a 'Staff thank you' box in the staff room. Staff feel the

		clinic capacity could be managed more effectively.
Ward 3	Good	Good patient and staff feedback. Newsletter with inappropriate information removed.
Ward 4	Good	Good patient and staff feedback. Excellent examples of effective communication with patients with communication challenges
Ward 12	Good with elements of Outstanding	Great leadership recognised. Overall, very good patient feedback but some issues around pain control post op.

6. Next Steps

6.1 Reviews to be undertaken Bi-annually.

6.2 Monitor actions

6.3 Use information gathered to commence Ward Accreditation

Emma Steele
Deputy Chief Nurse
November 2023

Update from the Trust Board on 1 November 2023

- ✓ First staff story – housekeeper. Described some personal challenges where he had needed support from counselling services. Also described need to reduce waste and for equity of treatment regardless of role.
- ✓ Outline of additional work to support staff through Cost of Living crisis including financial advice from HSBC
- ✓ Good progress being made on reducing Time to Hire and improving establishment
- ✓ Discussed risk appetite and how this would be applied at ROH
- ✓ Received annual report on equality & diversity
- ✓ Continuous Improvement approach outlined
- ✓ Support from all areas of the Trust with meeting the challenges posed by national operational and financial pressures
- ✓ Development of PSIRF implementation plan

- ✓ Included visit by Andy Street, West Midlands Mayor

- ✓ Difficult financial context and need to reduce reliance on temporary staffing
- ✓ Low uptake of vaccinations

- ✓ Approved PSIRF plan and policy ready for the System ‘Go Live’ of 6 November 2023
- ✓ Approved changes to Board Assurance Framework
- ✓ Approved approach to private patient offering
- ✓ Approved revised terms of reference for Audit Committee

- ✓ Grateful thanks offered to all for the hard work in such challenging times

PAPER REFERENCE: ROHGO (11/23) 006

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: ROHGO (11/23) 007

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: ROHGO (11/23) 008

NHS
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.

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.

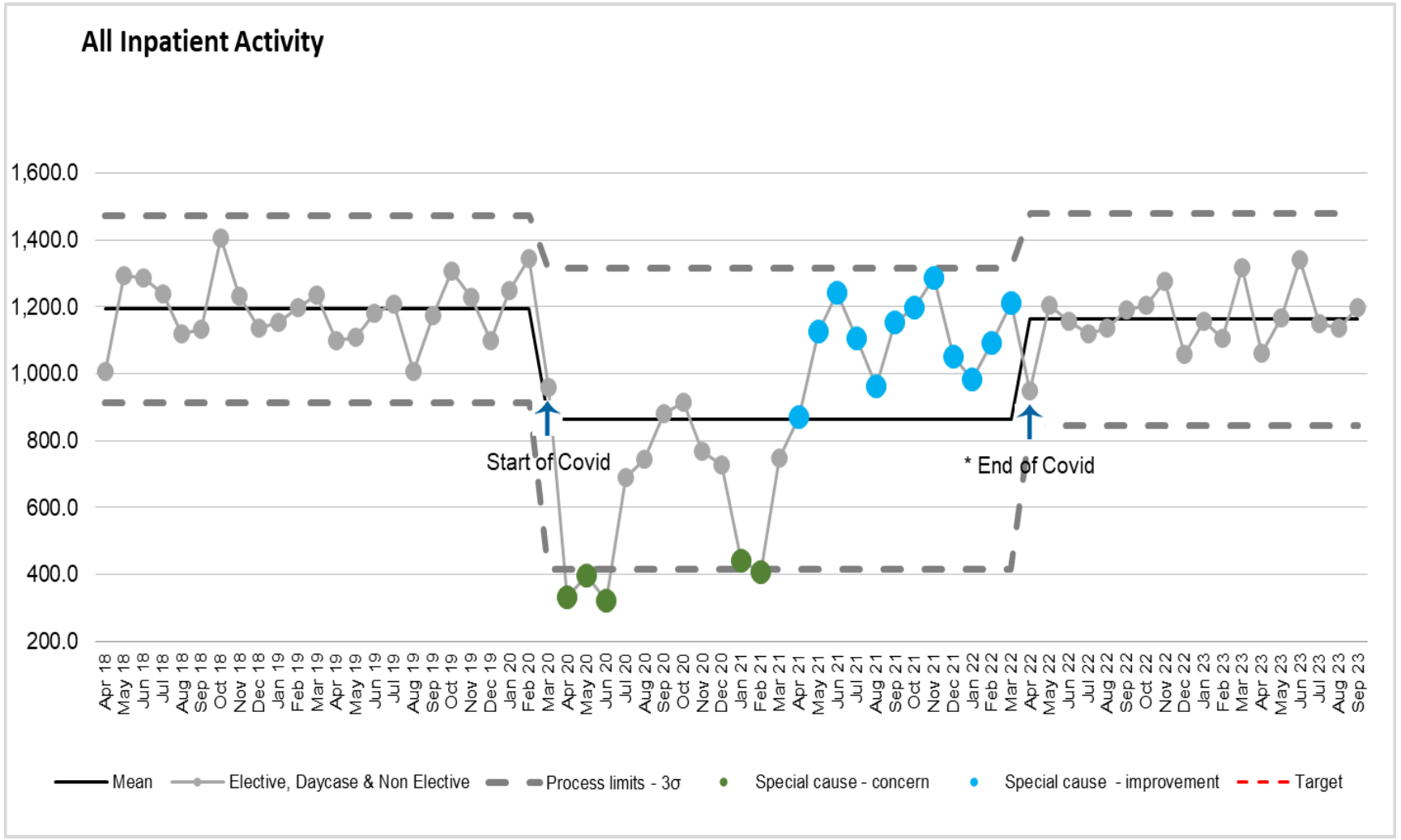
Operational Performance Summary

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

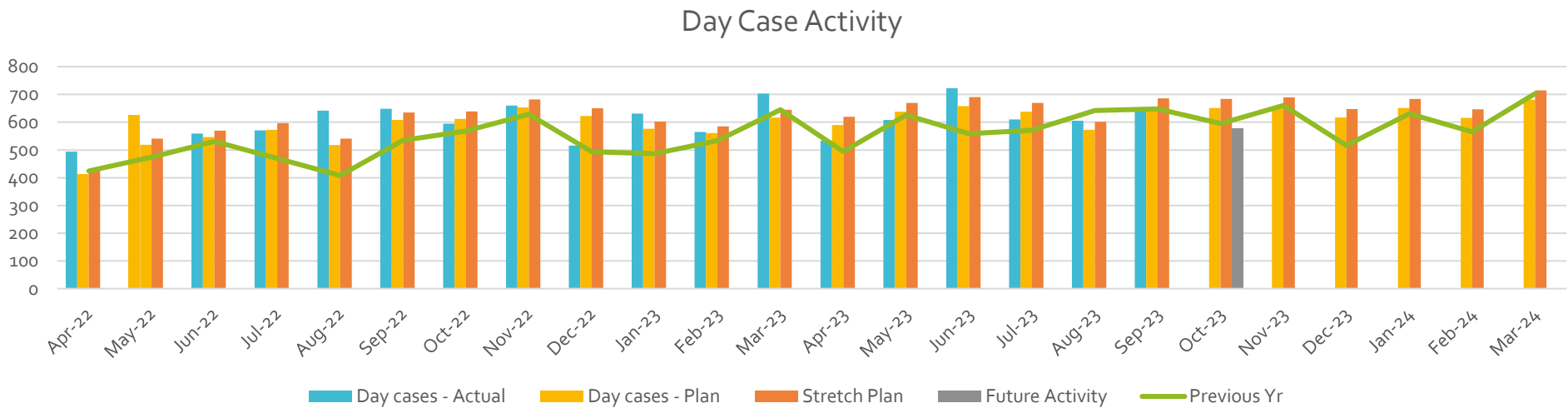
Operational Performance Summary

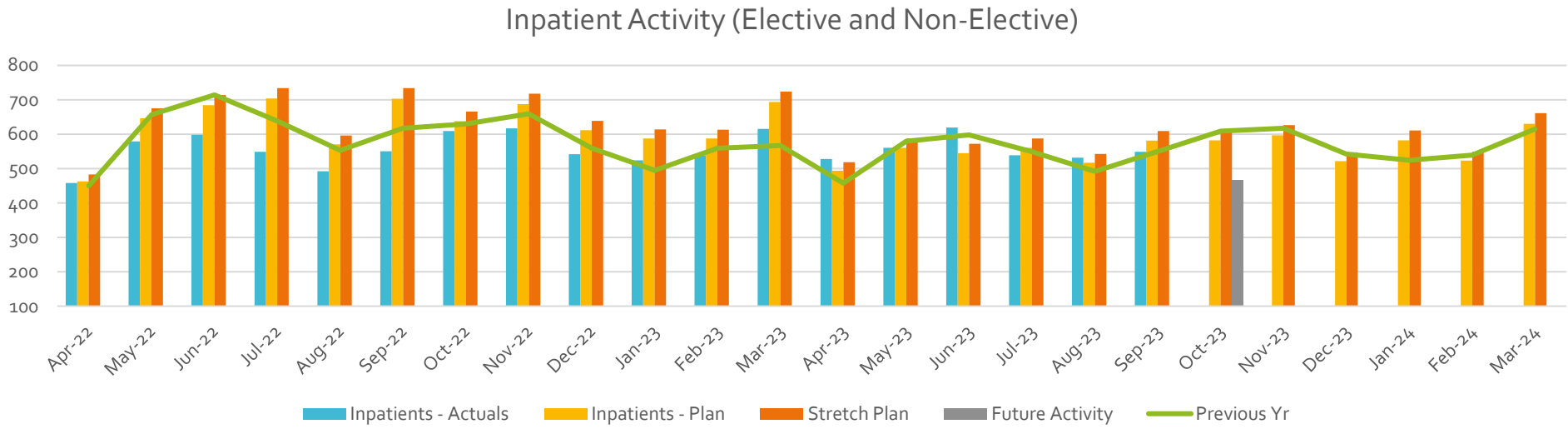
	In month	Previous month	Target	Variation	Assurance
In theatre session utilisation	83.6 %	79.0%	85%		
Cancer - 2 week wait (May – Apr)	97%	98%	93%		
Cancer - 31 days first treatment	100%	100%	96%		
Cancer - 31 days subsequent (surgery)	100%	100%	94%		
Cancer - 62 days (traditional)	80%	80%	85%		
Cancer - 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

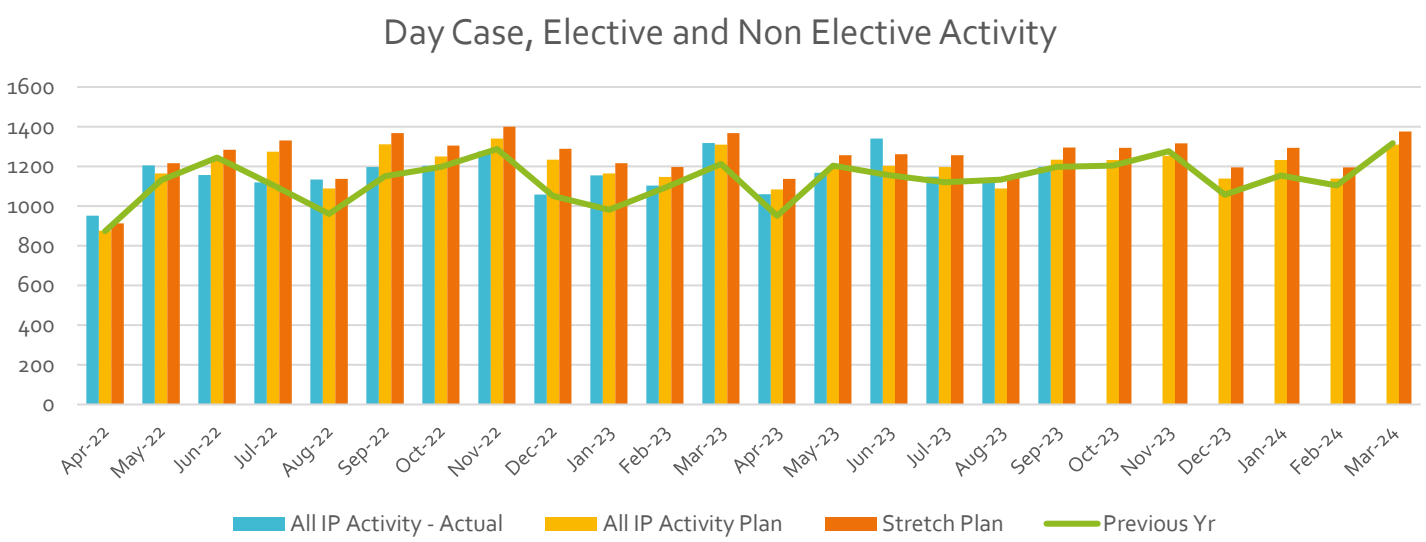


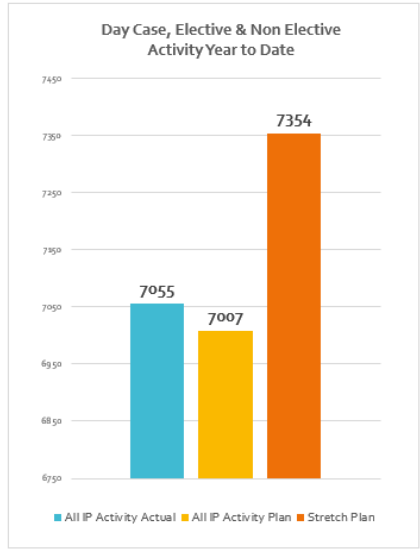
1. Activity Summary





1. Activity Summary



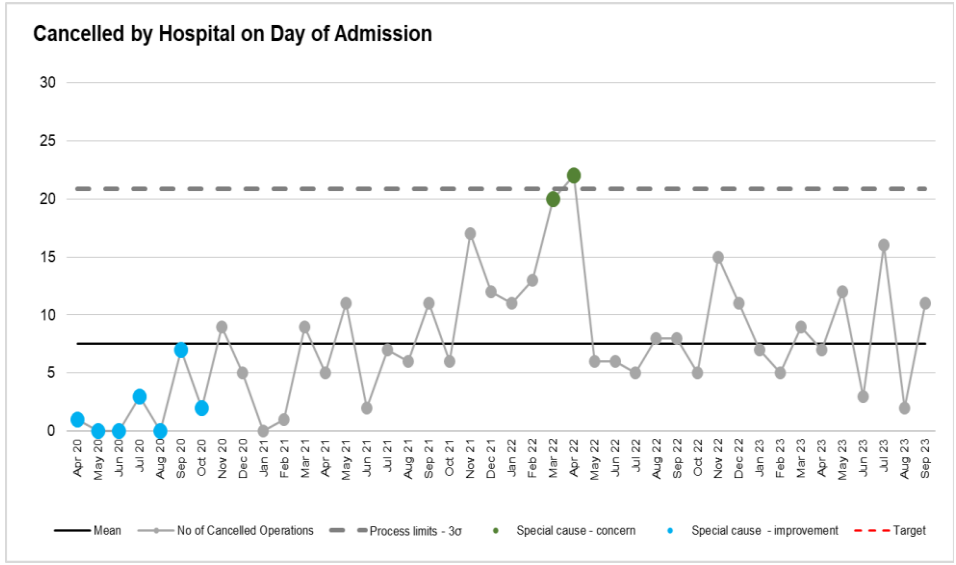


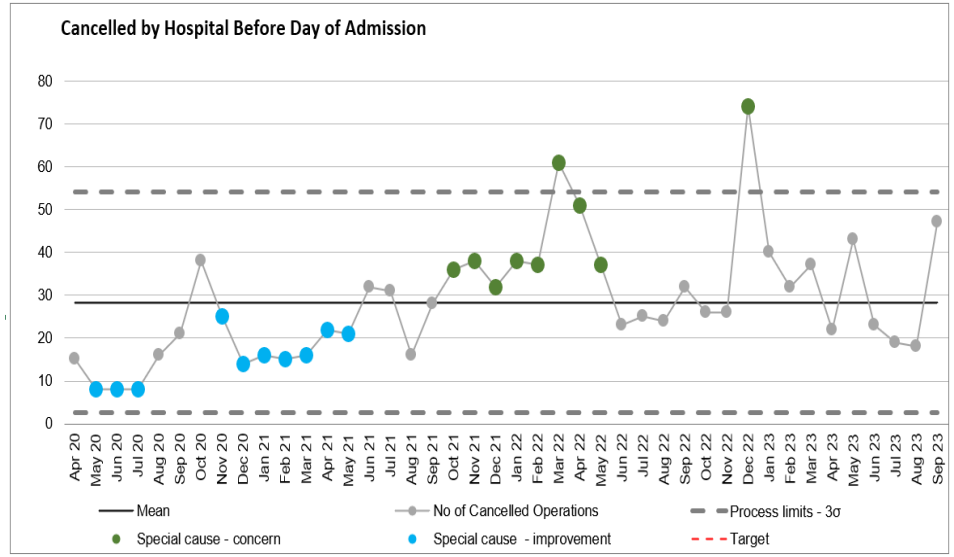
		Plan												Plan	Actual	% Achieved	Variance
	Activity Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Year to Date	Year to Date	against plan	Year to Date
Trust Plan	Inpatient	483	547	533	547	505	568	569	584	510	569	511	616	3183	3168	100%	-15
	Daycase	590	638	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

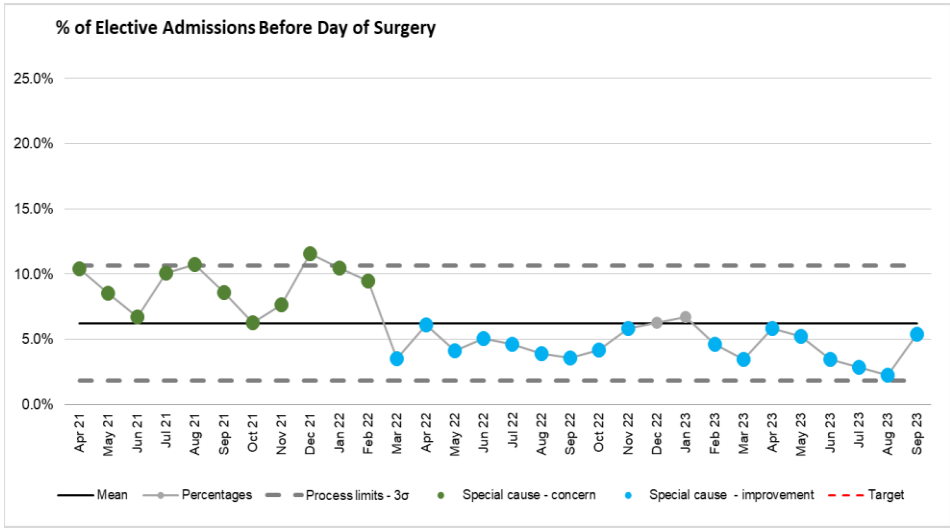
Actual in month 1199 vs 1234 System Plan (Variance -35)
YTD position against Actual vs System plan is 100.7% (Variance +48)
Overall impact of the industrial action in September is estimated at 65 cases therefore delivery against target is better than predicted

2. Theatre Utilisation/ Hospital Led Cancellations

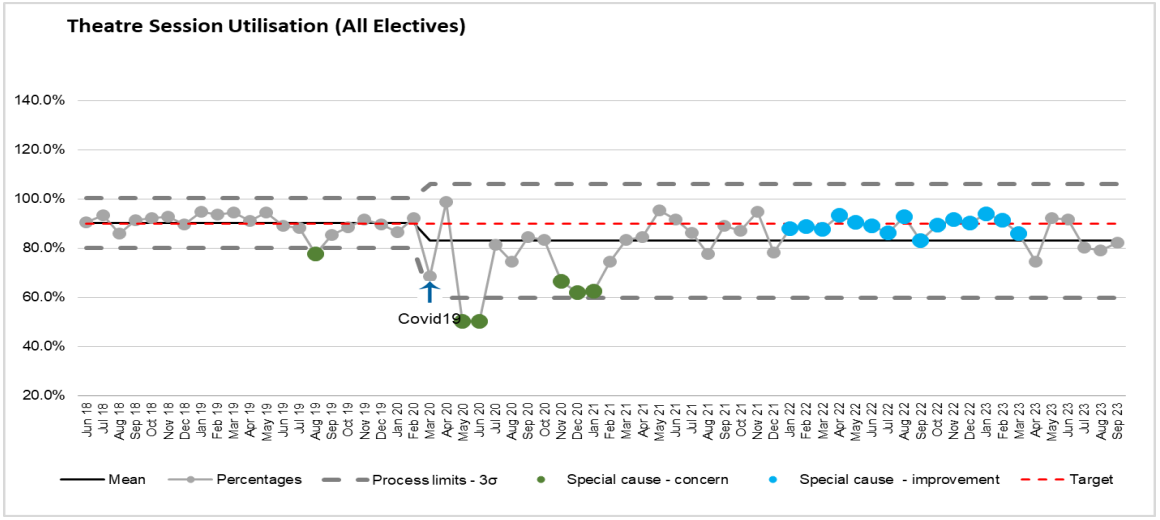


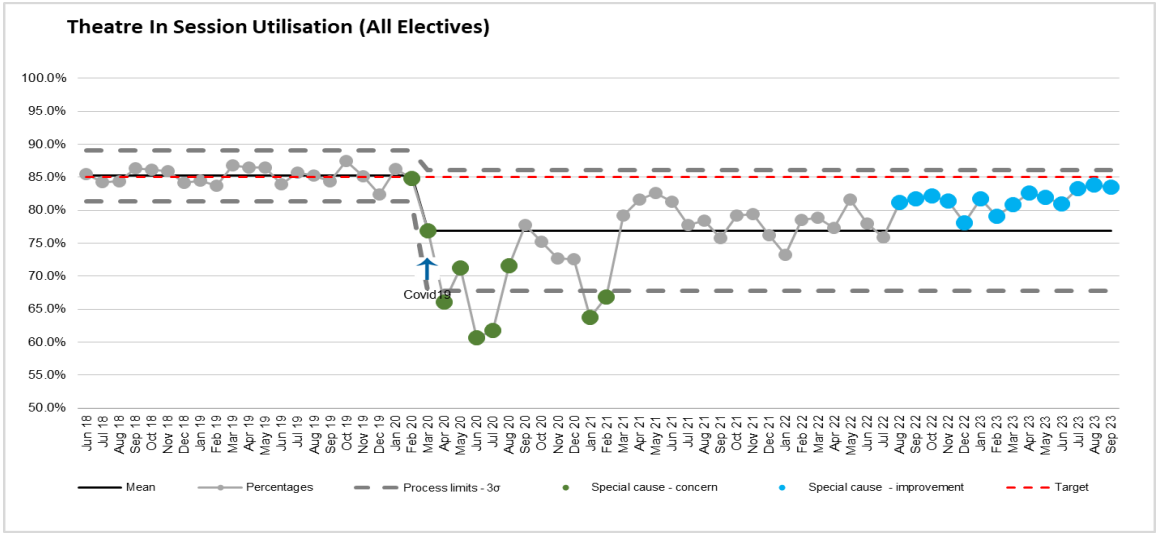


Year - Month	Cancelled by Hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by Hosp. Before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
Sep-22	8	29	32	69	0
Oct-22	5	35	26	66	0
Nov-22	15	18	26	59	0
Dec-22	11	24	74	109	0
Jan-23	7	25	40	72	0
Feb-23	7	29	33	69	0
Mar-23	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

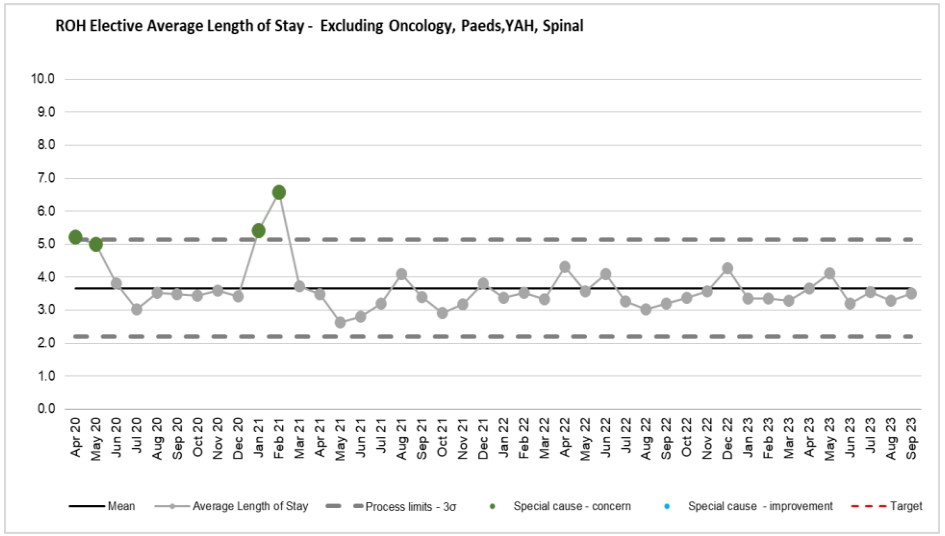
AREAS FOR IMPROVEMENT

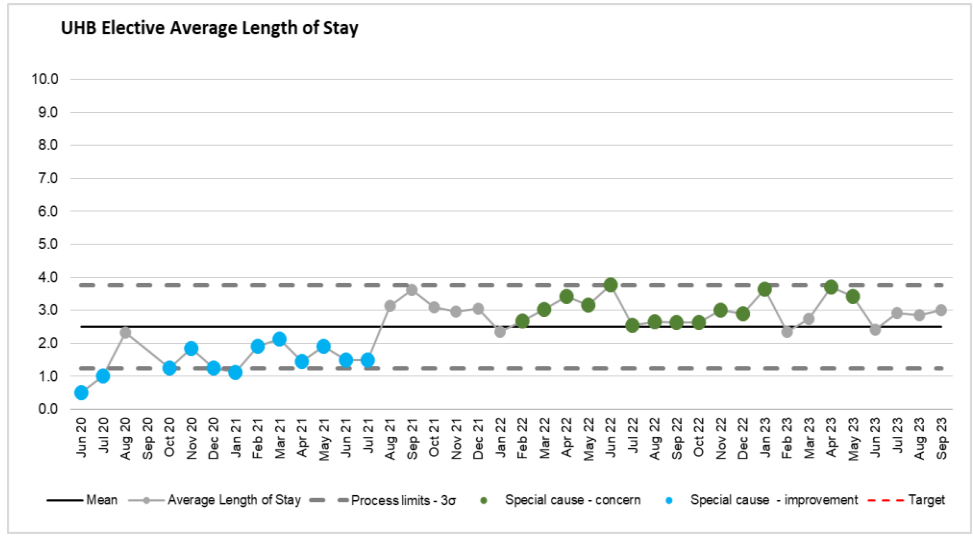
A deep dive to investigate why patients are cancelled due to them no longer requiring surgery or patients changing their mind about surgery to take place, The deep dive will focus on any learning / process changes required to prevent / reduce the risk of this continuing. Work commenced in September and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

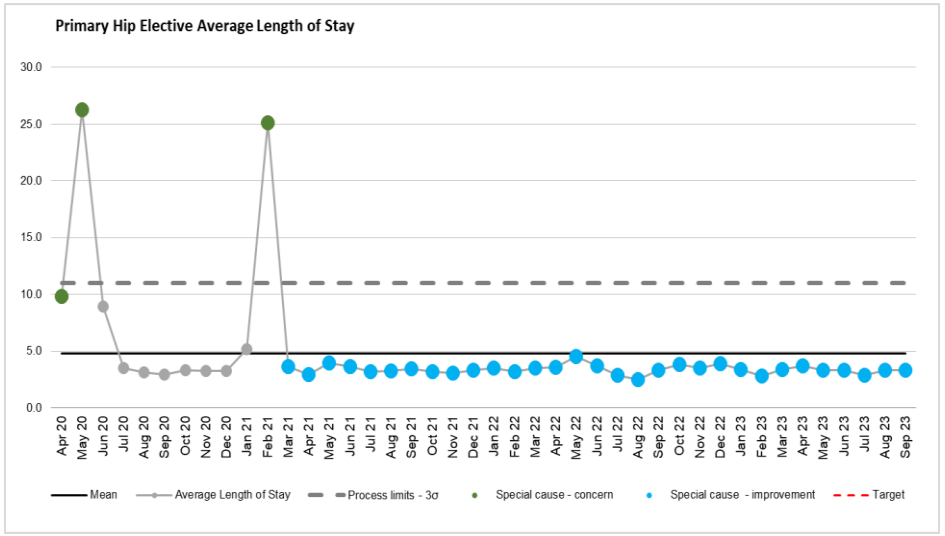
RISKS / ISSUES

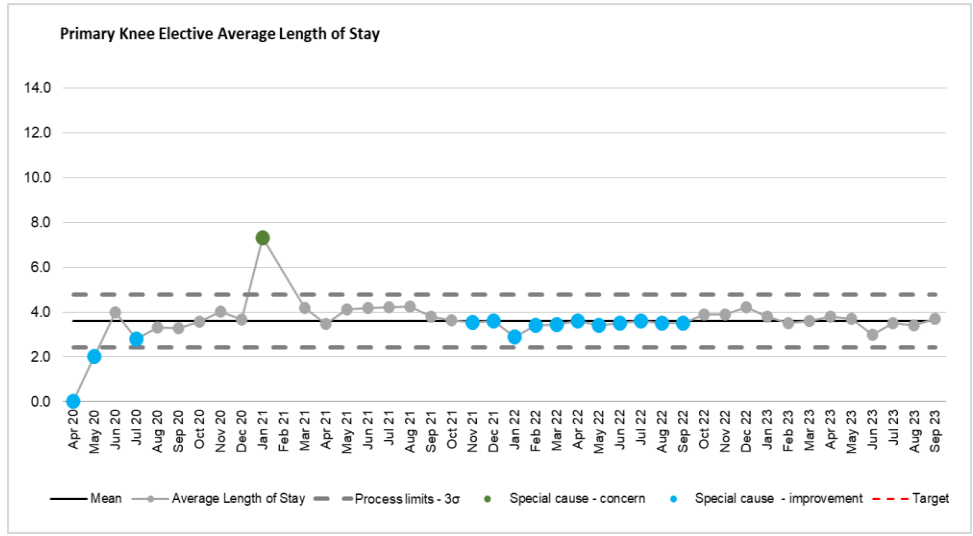
Increase in number of patient led cancellations to be mitigated by short notice cancellations patients. Reinstated standby lists for UHB patients to mitigate last minute cancellations. Division 2 triumvirate reviewing POAC capacity in line with specialty need.

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

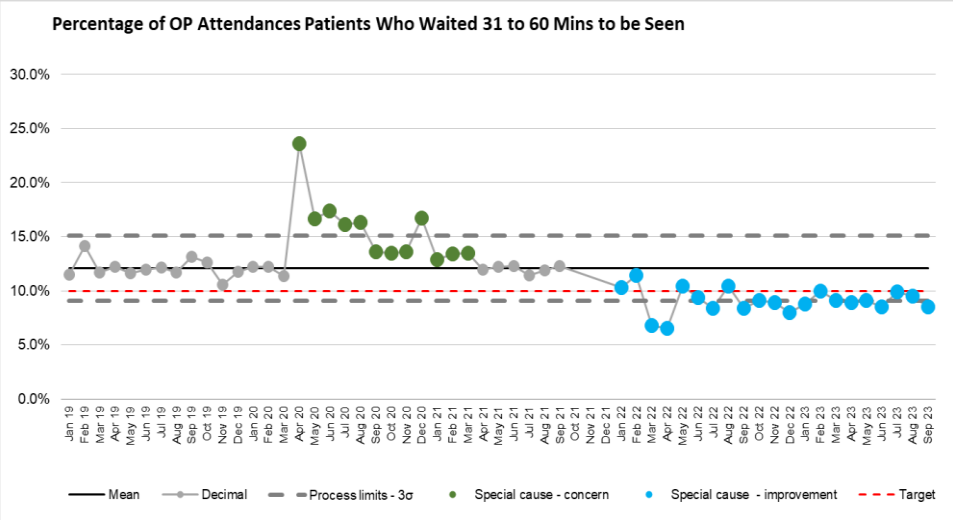
Head of Nursing Division 1 and Deputy COO to continue to work with BI, Model Hospital and GIRFT leads to ensure data collected and shared is comparable and enables focus on any actual areas for improvement and safe reduction in LOS.

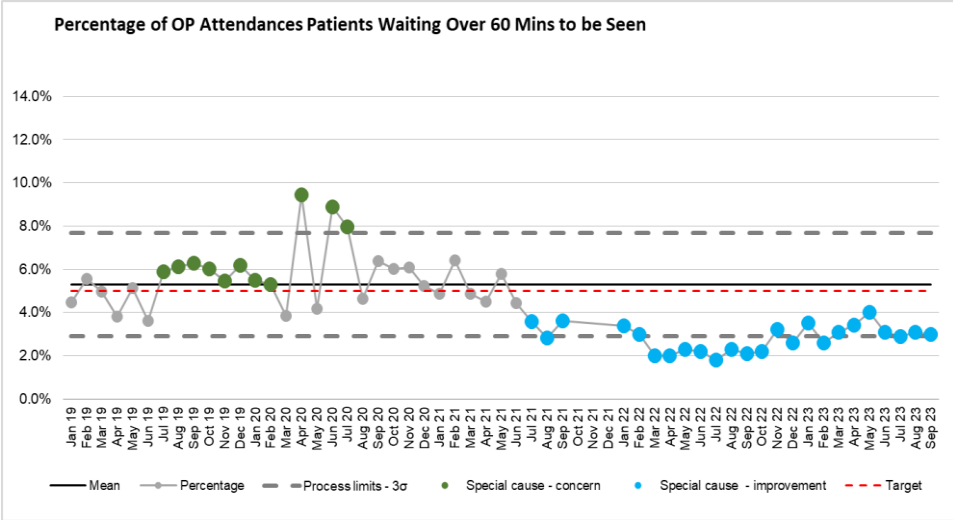
Continued focus on identifying any potential complex discharge/ social care needs at Pre-operative Assessment stage supported by additional physician sessions.

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’.

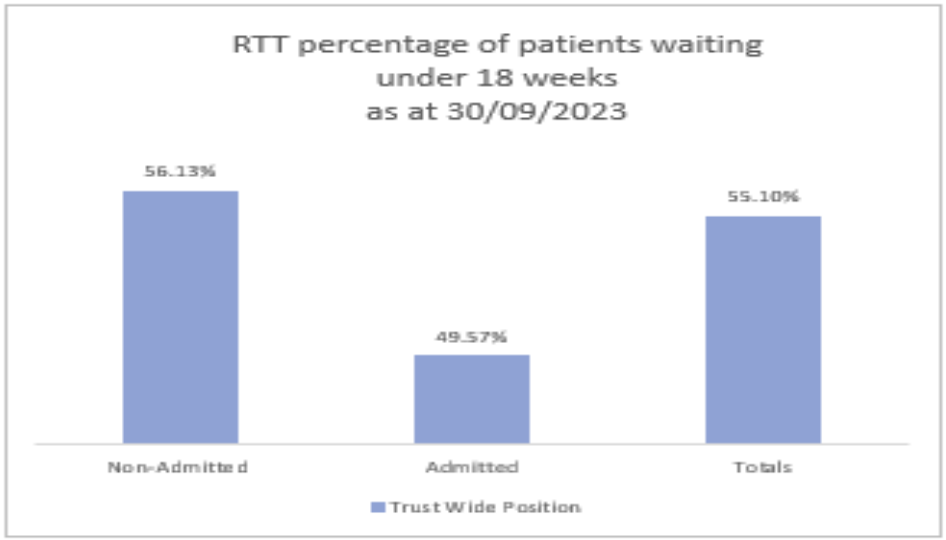
RISKS / ISSUES

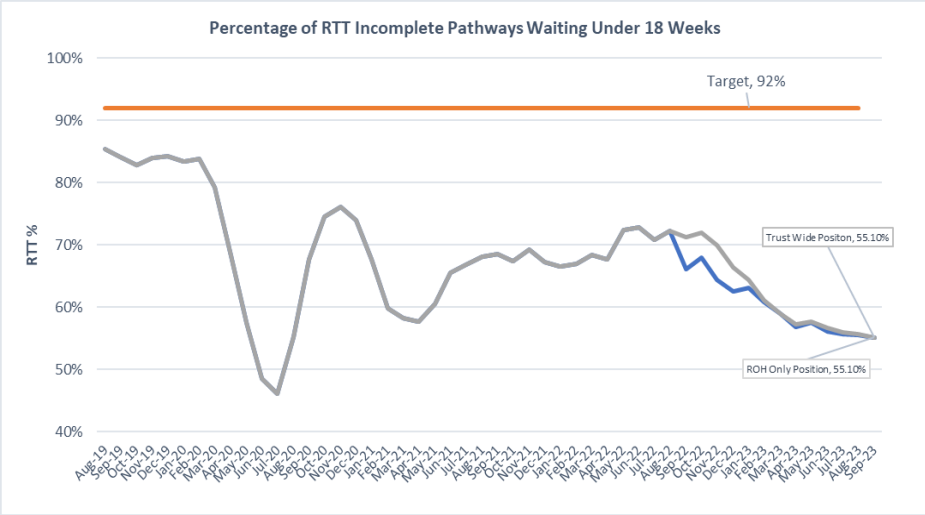
Outpatient Incident reports continue to be actively managed and investigated, ensuring feedback has been provided to the reporters

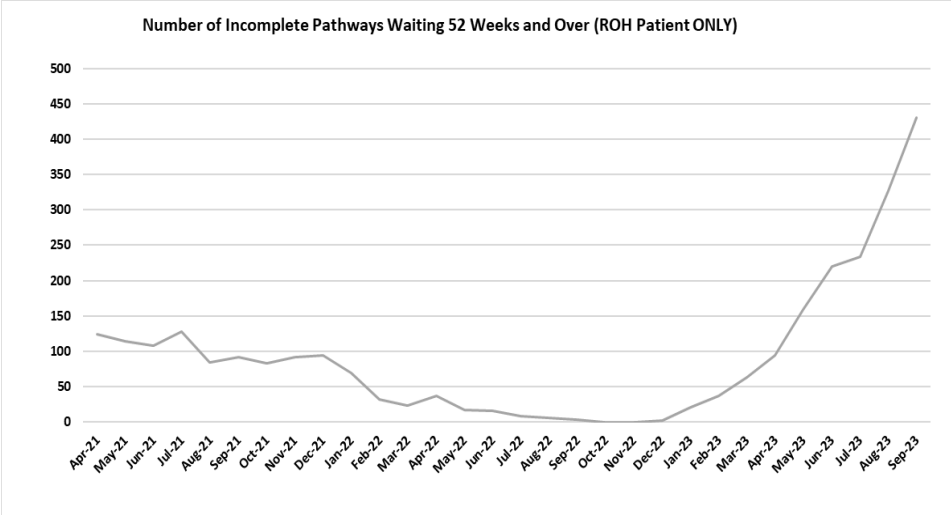
5. Referral to Treatment

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%**



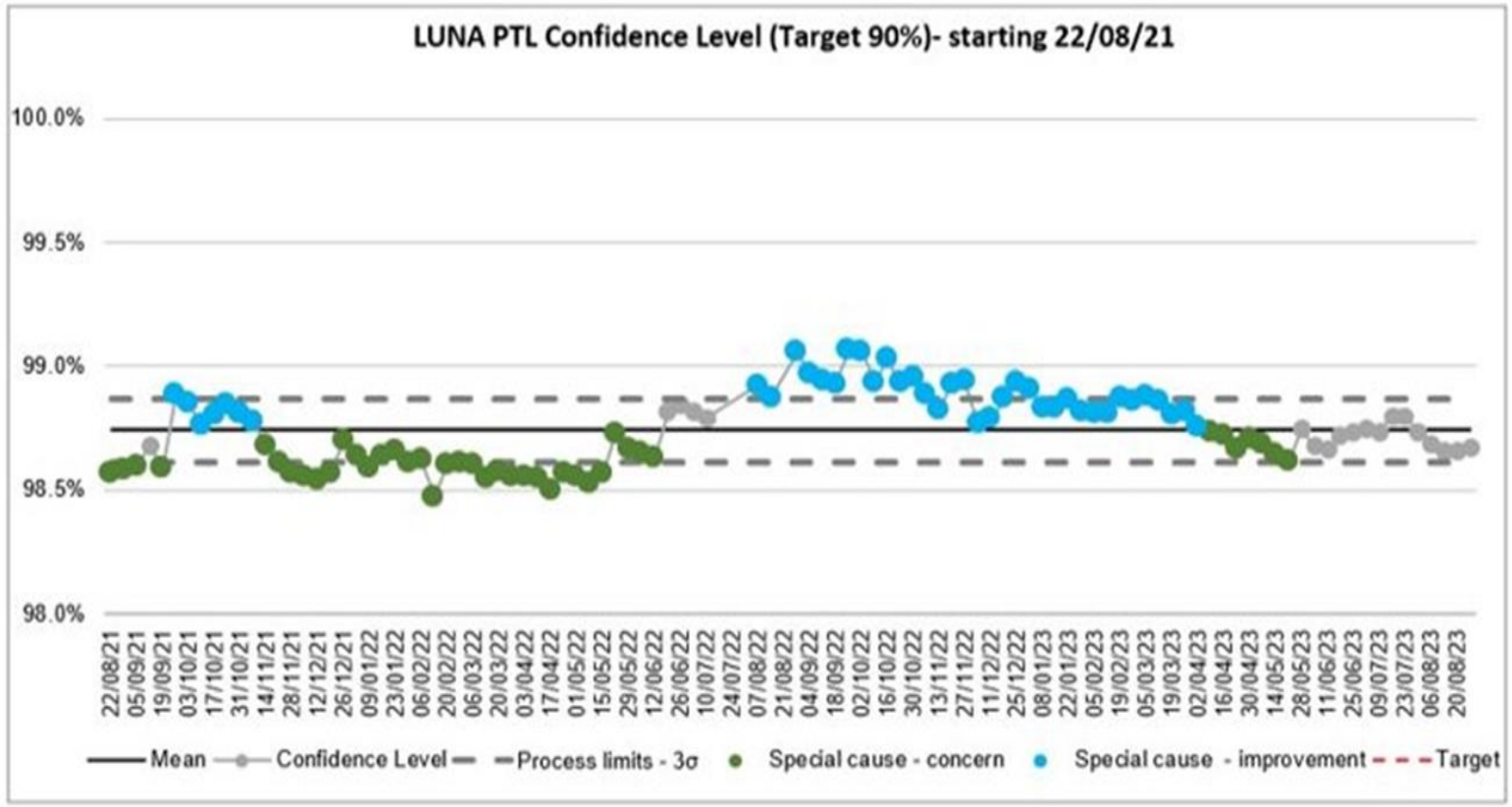




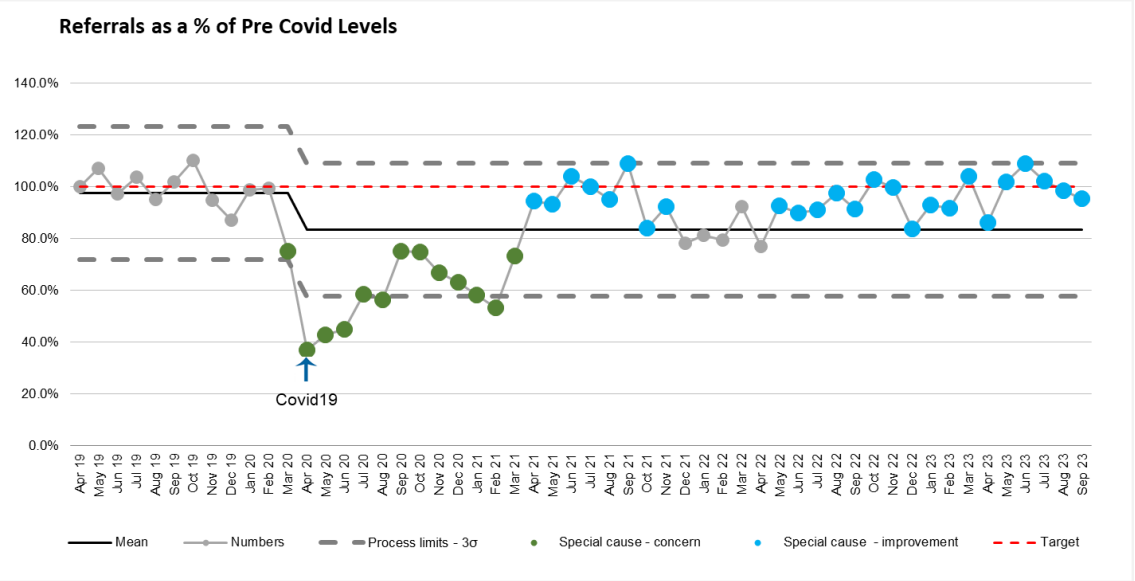
5. Referral to Treatment

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



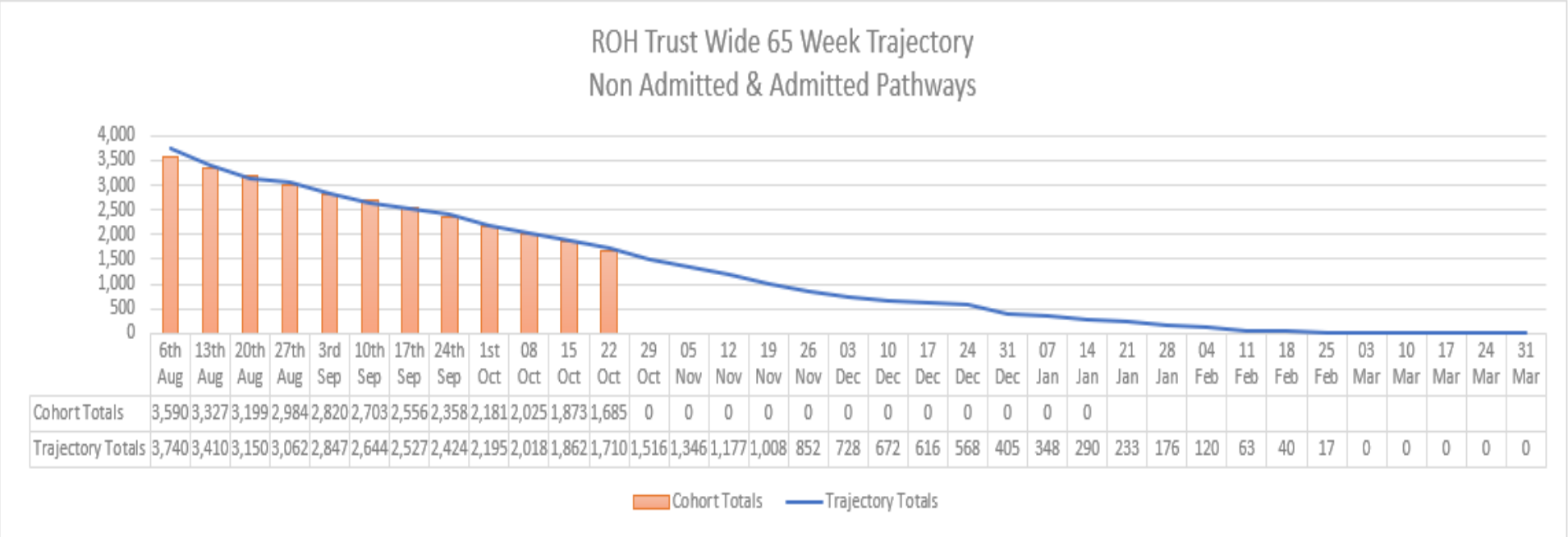
Month	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Number of Referrals	2706	2895	2626	2801	2574	2752	2976	2561	2351	2667	2683	2030	996	1154	1213	1578	1522	2034	2019	1803	1704	1574	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

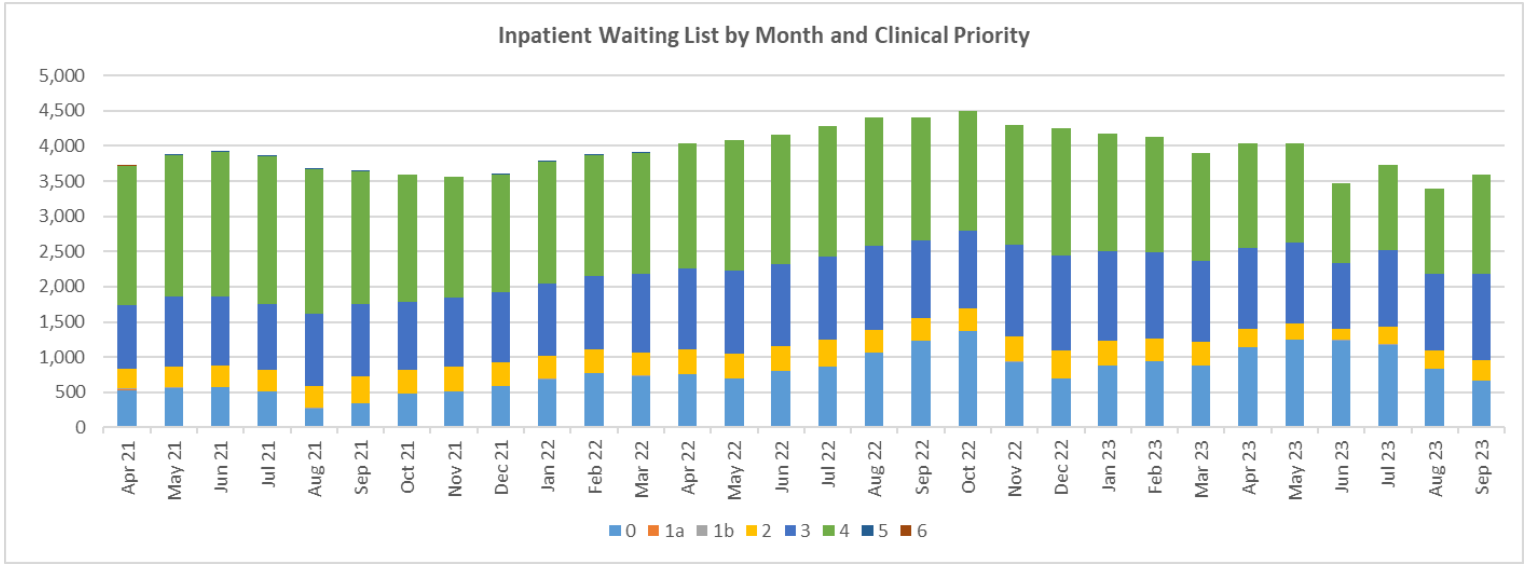
Below is the current Trust trajectory for the delivery of 0 x 65 week waits in line with the NHSE and system targets:



	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%

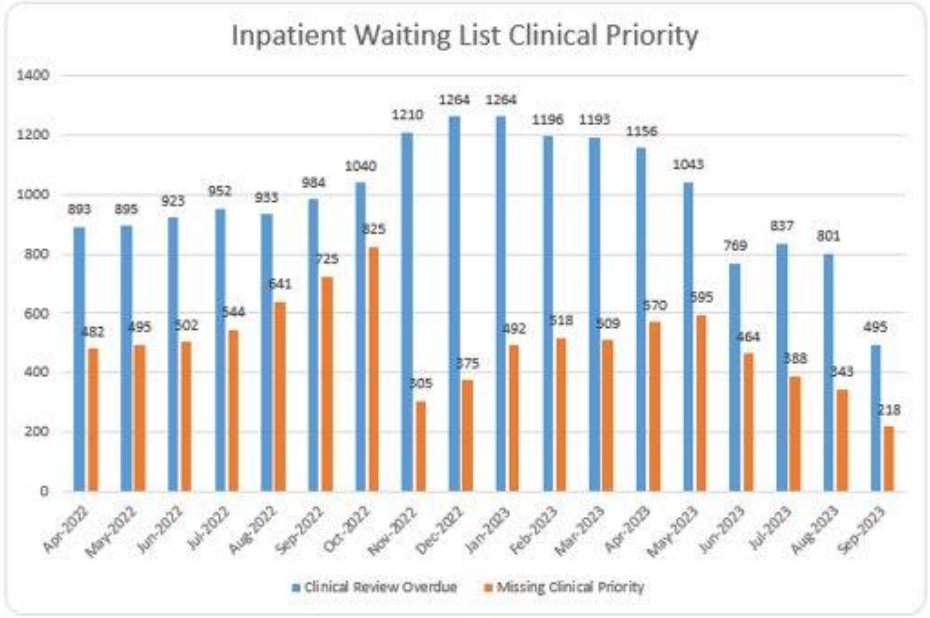
All specialities review and update admitted patients without a priority status. Regular review meetings are held to ensure that all patients are given a priority score. This data is reviewed monthly at the CSLs meeting in conjunction with the Medical Director.

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.

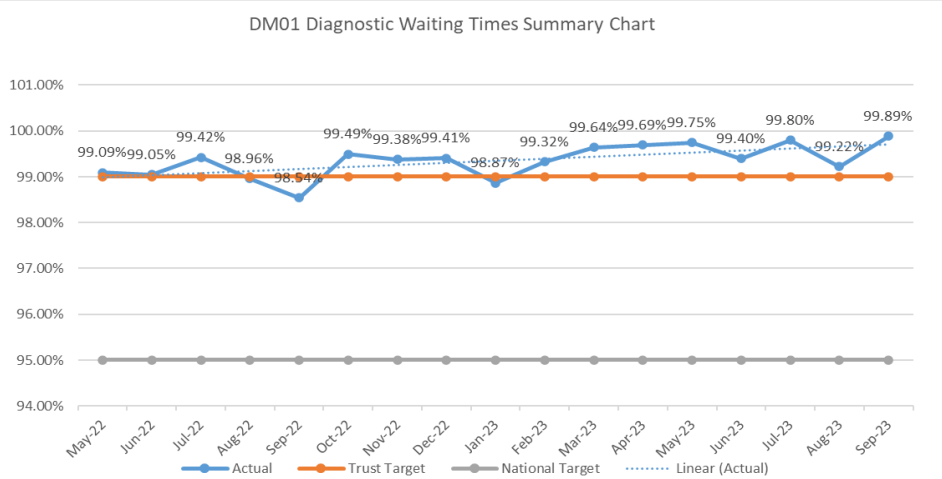
The Validation team are providing extra support to spinal service to help manage patients through the pathway and all patients down to 12 weeks have been sent a text message to determine whether they wish to remain on the waiting list in line with national guidance.

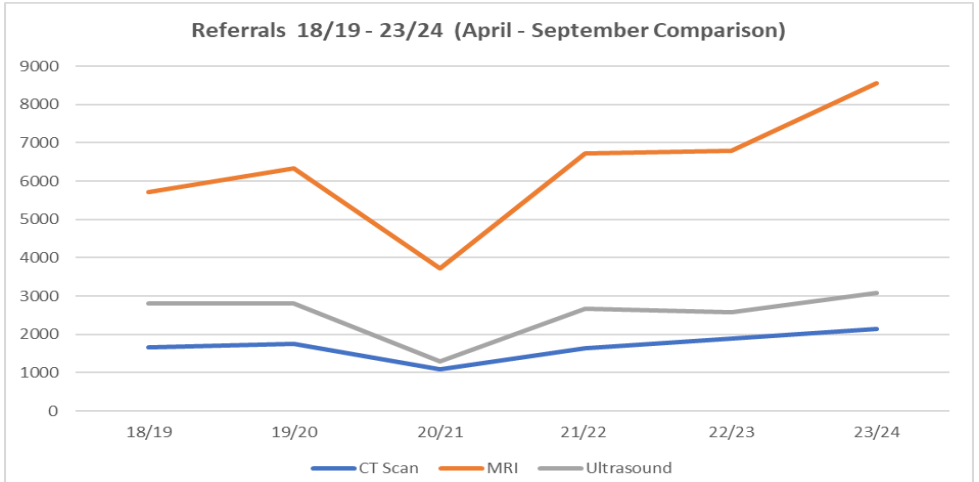
RISKS / ISSUES

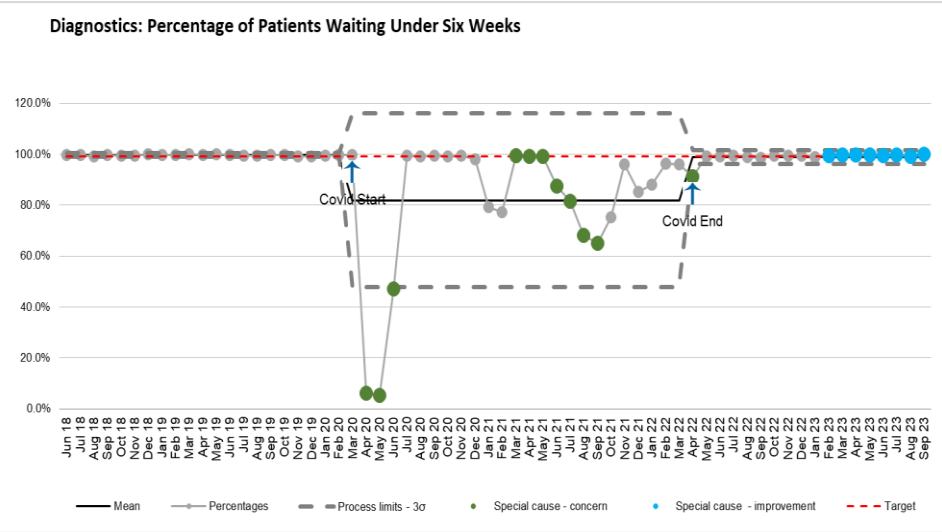
Due to the continued success of the ROH's management of long waiters from other providers, further requests have been received from NHSE, GIRFT and the system for help with long waiting patients across England. These requests will need to be considered and monitored closely to ensure ROH continues to 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.

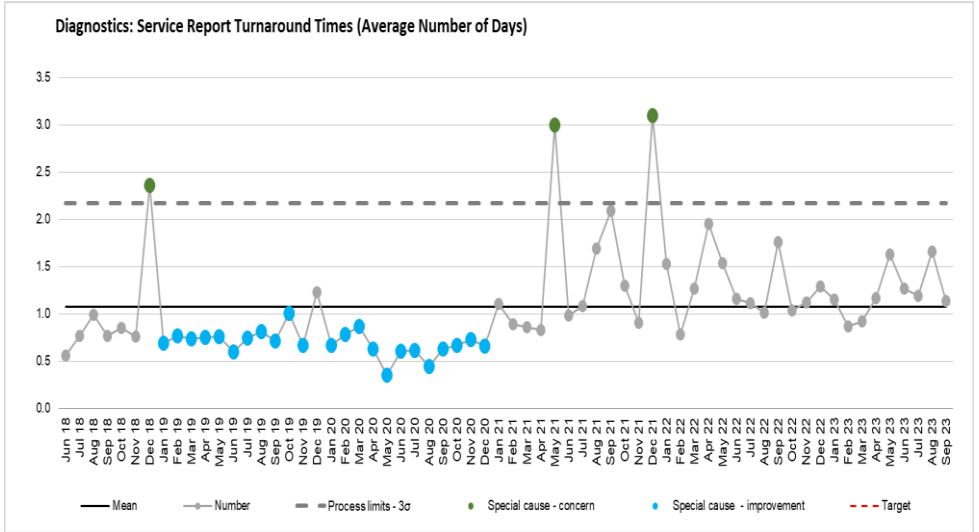
6. Diagnostic Performance

% 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.

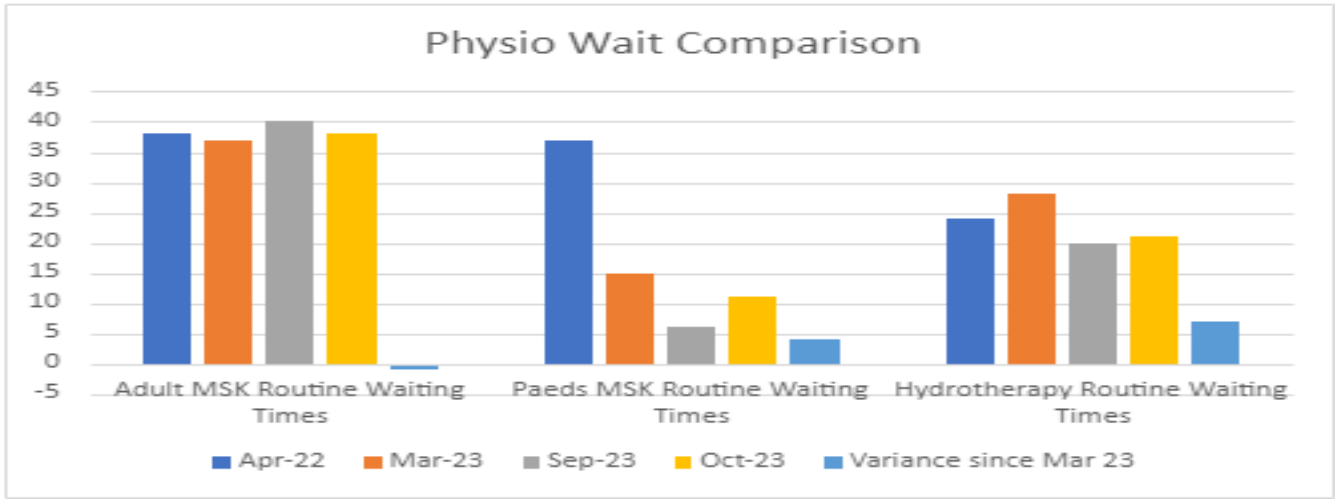
- The 31-day decision to treat to treatment standard
  - People with cancer should start their treatment within 31 days of the 'decision to treat' their cancer. This target now also includes subsequent treatments for cancer.
  - 96% of people **should** meet this standard.

- 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'.

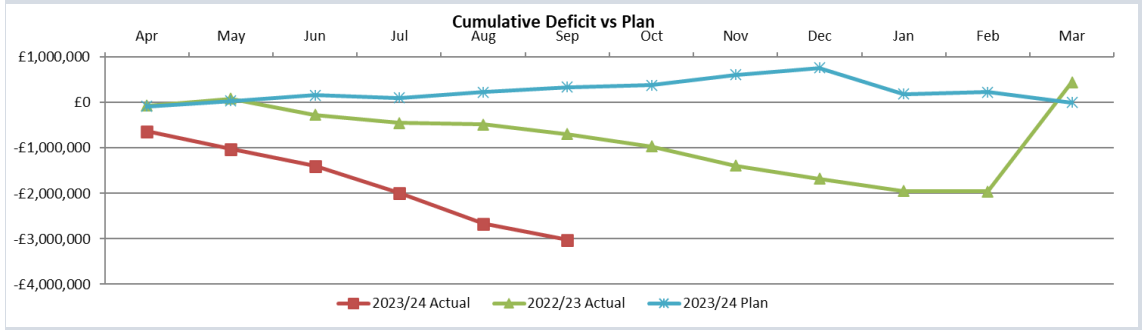
A strategy for the next 3 years is being presented to Trust Board in November 23.

8. Finance on a Page

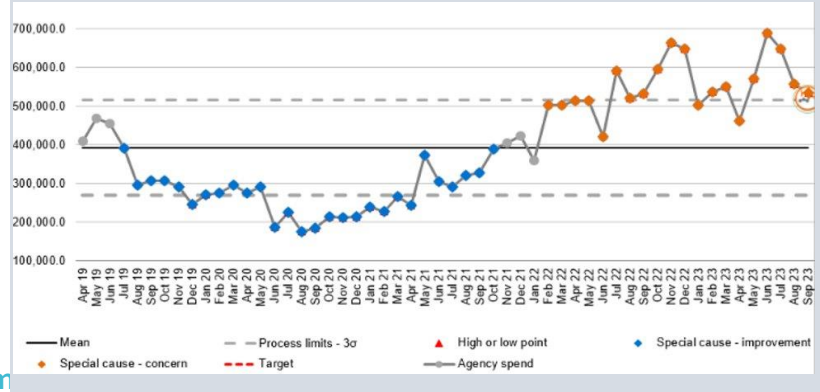
Month 6

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.

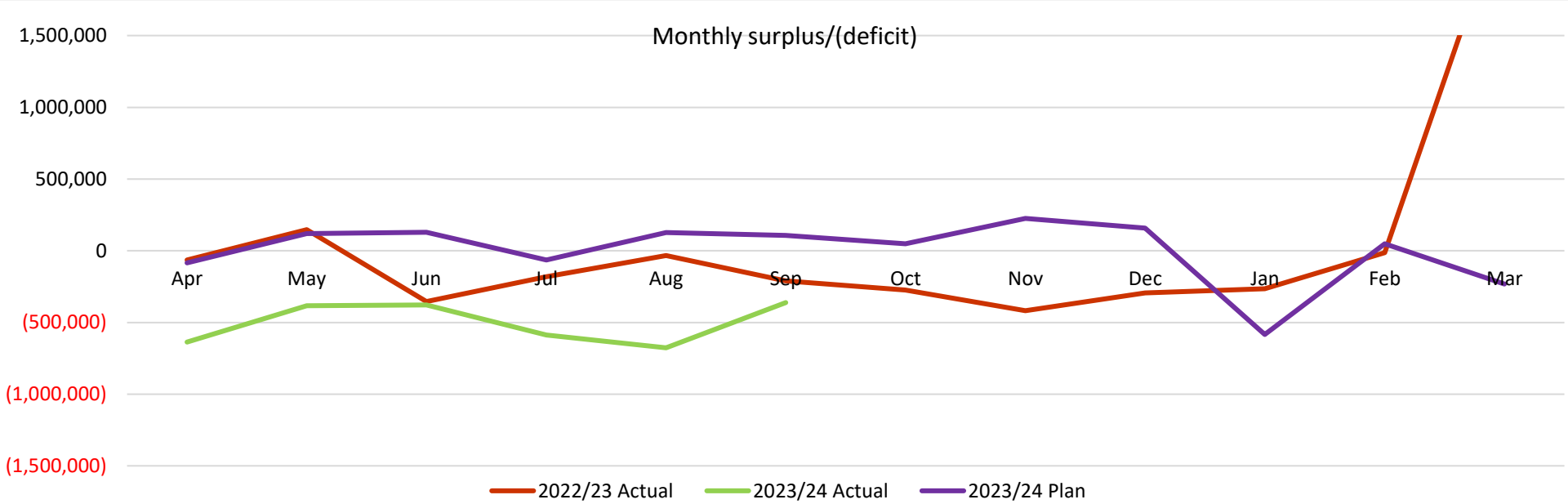
Forecast remains breakeven against plan.

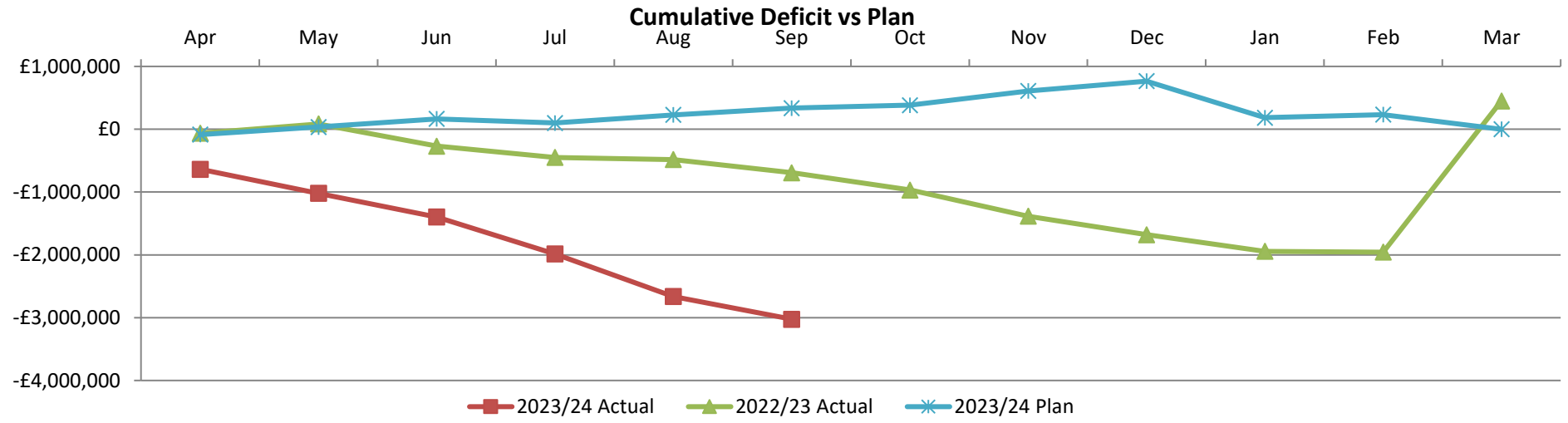
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	(489)	(505)	(2,497)	126	(3,365)
Year to date plan	64,149	(37,460)	(25,699)	(726)	293
Year to date actual	63,660	(37,966)	(28,166)	(600)	(3,072)
Variance compared previous month	(300)	393	(556)	(12)	(474)
Forecast 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

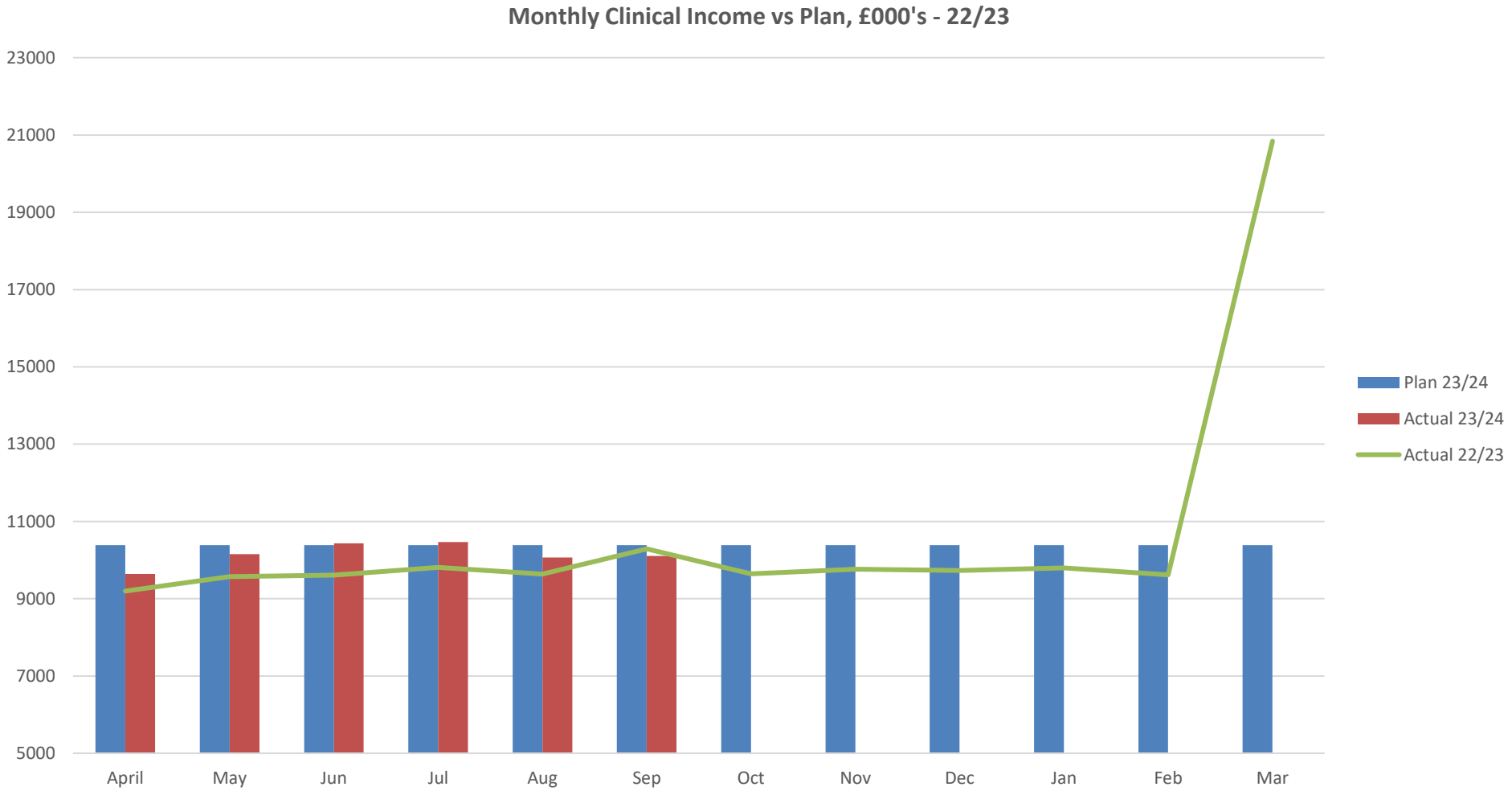




Financial Recovery Plan

	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.

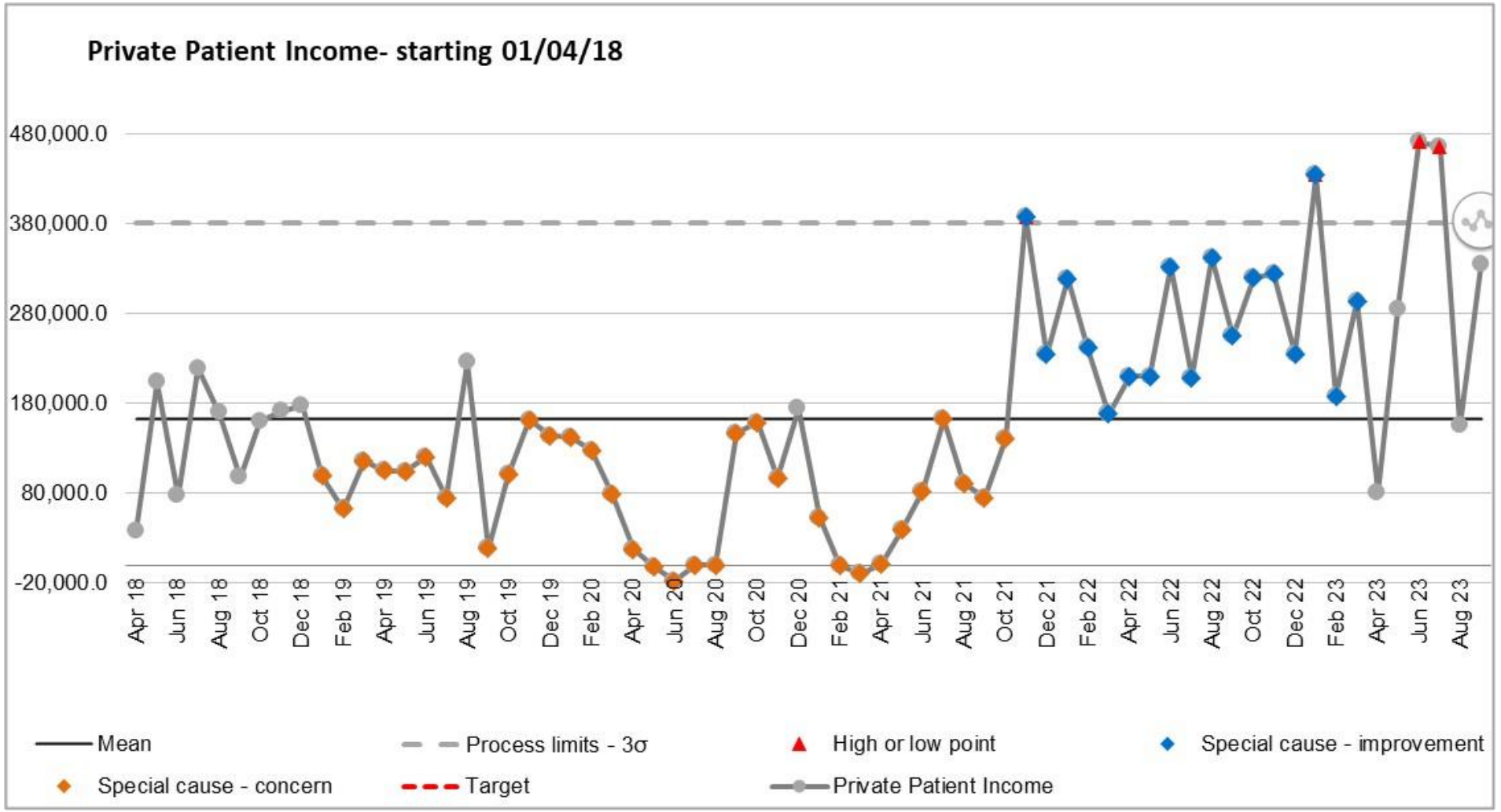
AREAS FOR IMPROVEMENT

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%.

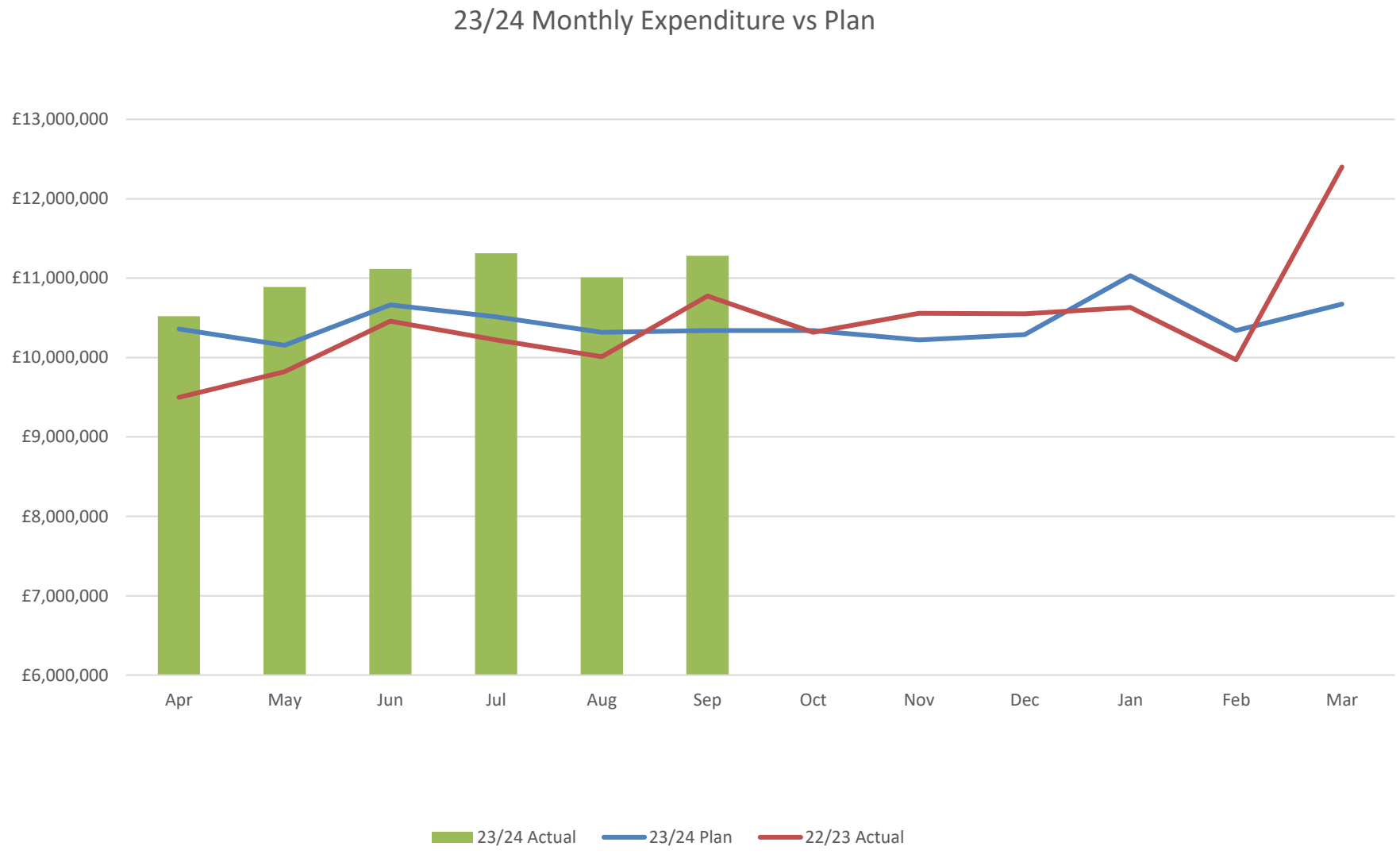
Theatre consumable spend reducing to planned levels.

LLP expenditure reduction.

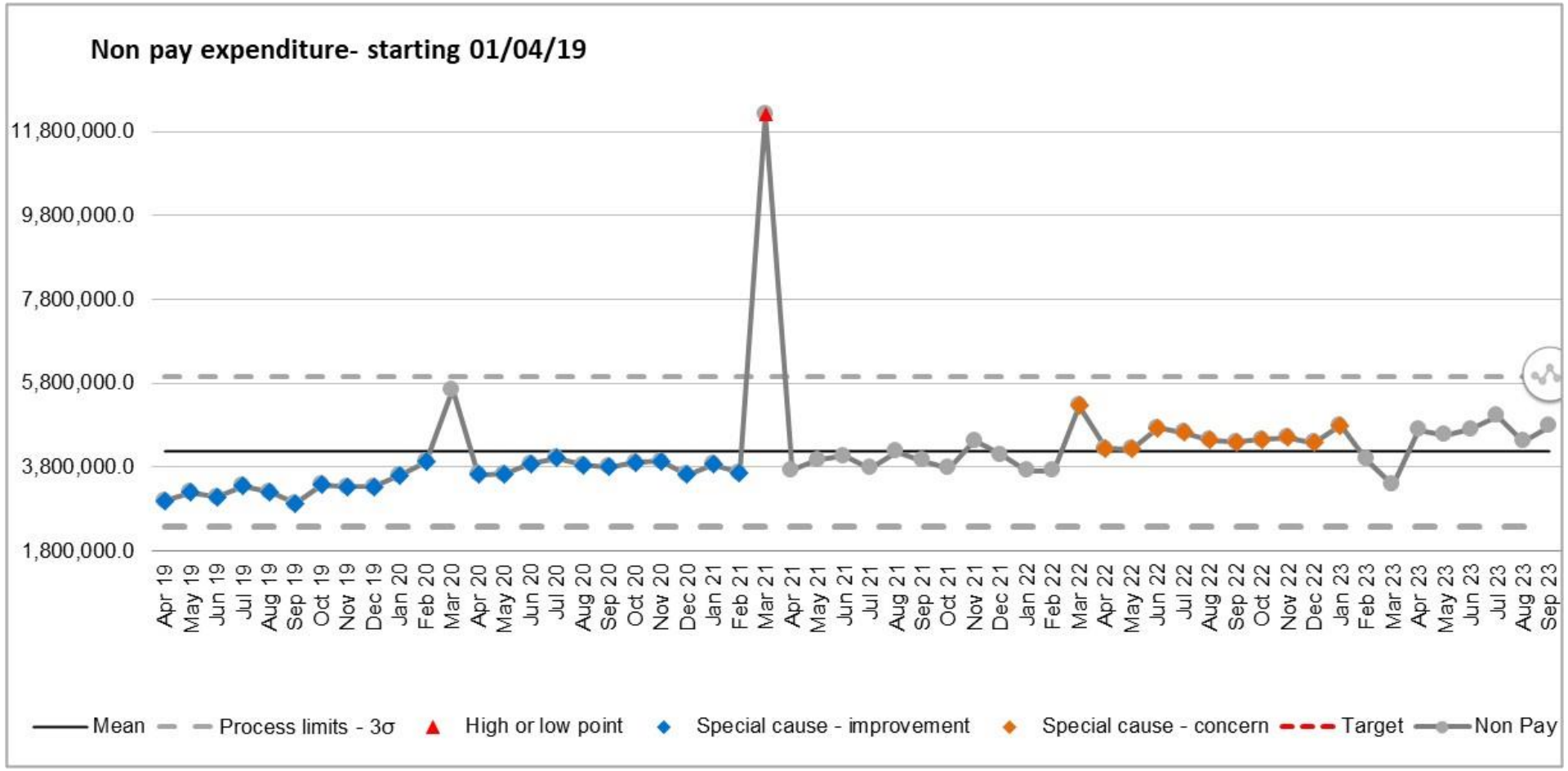
RISKS / ISSUES

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

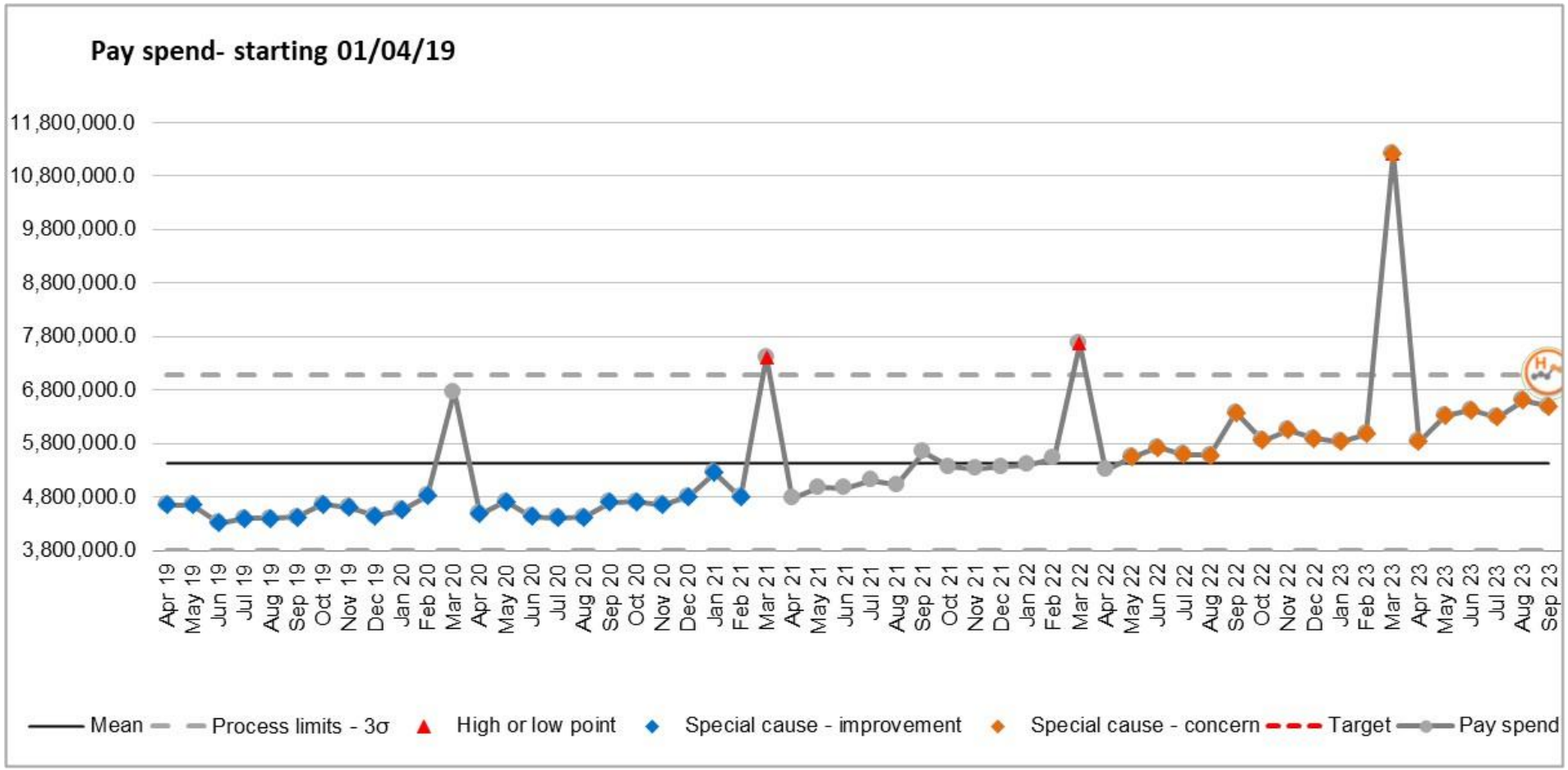
11. Expenditure



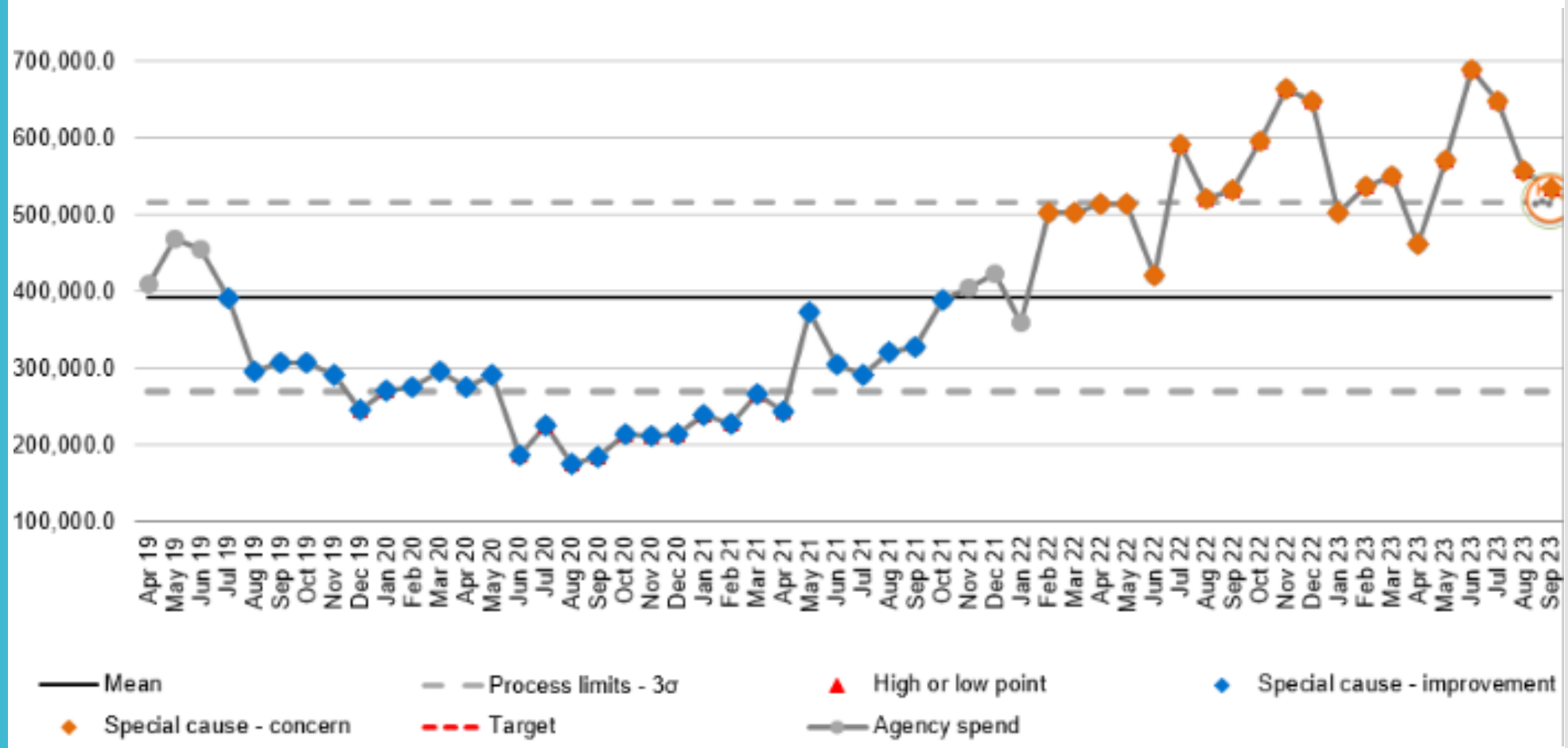
12. Non Pay Expenditure



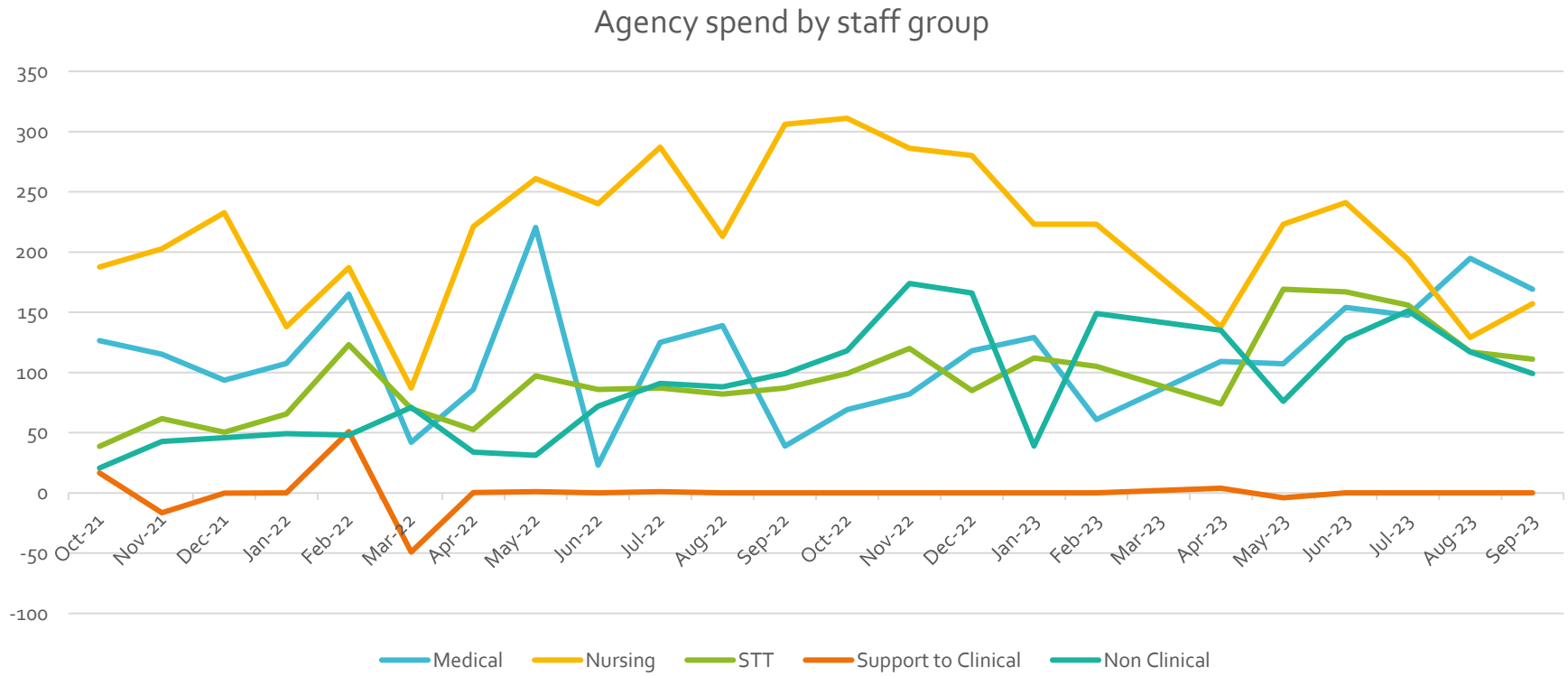
13. Pay Expenditure



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**

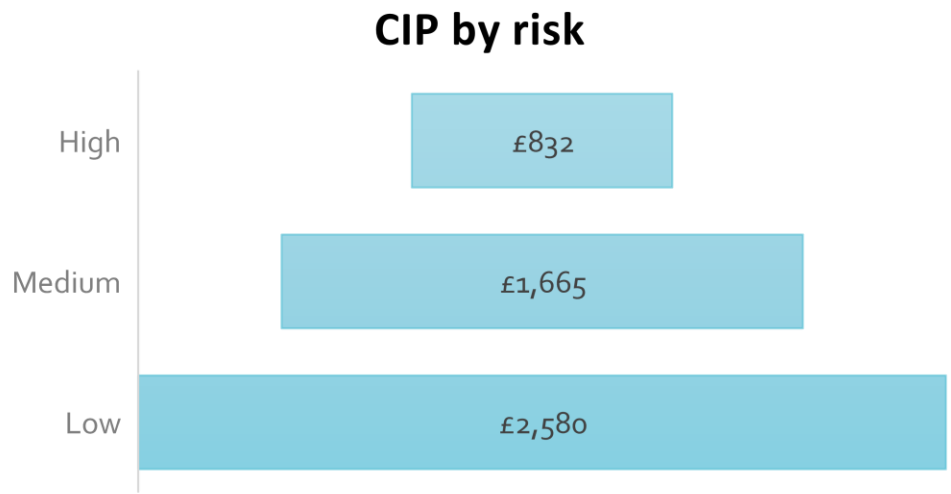
Variance	Mth 1	Mth 2	Mth 3	Mth 4	Mth 5	Mth 6	Total
Nursing	-	-	-	-	-	-	-
Therapies	- 4	- 5	- 19	- 14	- 19	61	-
Pharmacy	-	- 10	- 10	- 3	- 7	30	-
Medical	- 50	- 39	- 32	- 15	- 56	192	-
Non-Clinical	-	-	-	-	-	-	-
	- 54	**- 54**	**- 61**	**- 32**	**- 82**	**283**	**-**

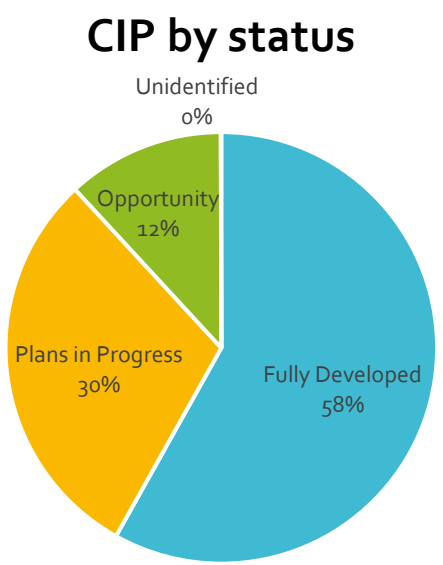
15. Cost Improvement Programme Summary

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.

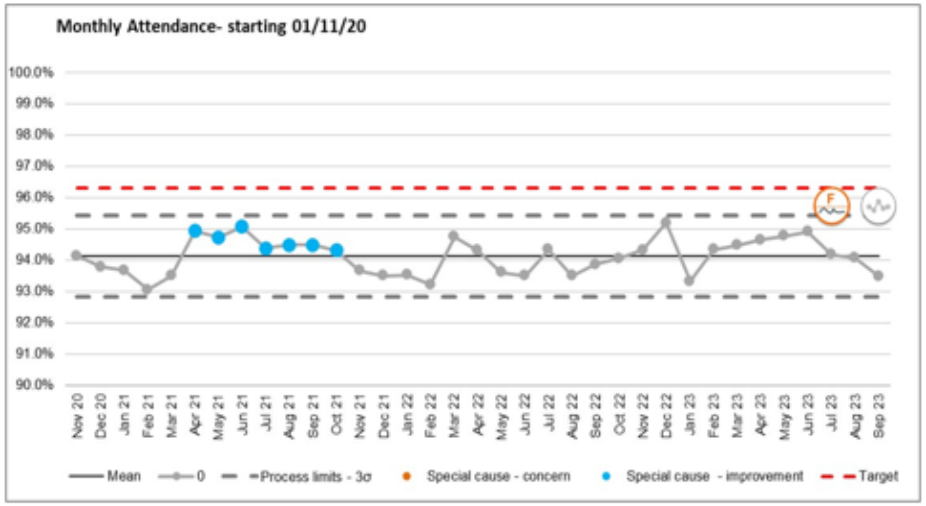
Risks / Issues

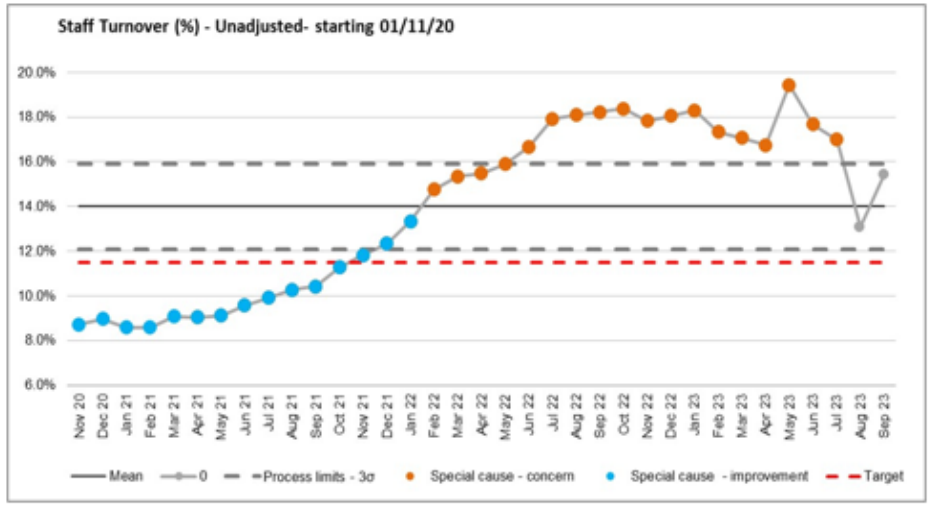
Cost of living seems to be affecting the NHS as a whole, the Trust is doing its upmost to alleviate the impact. Other Trusts seem to be able to offer higher bands, this has seen some employees move on.
Staff with no PDR/Appraisal will have no way of been appraised and will have no personal goals.
Return 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.

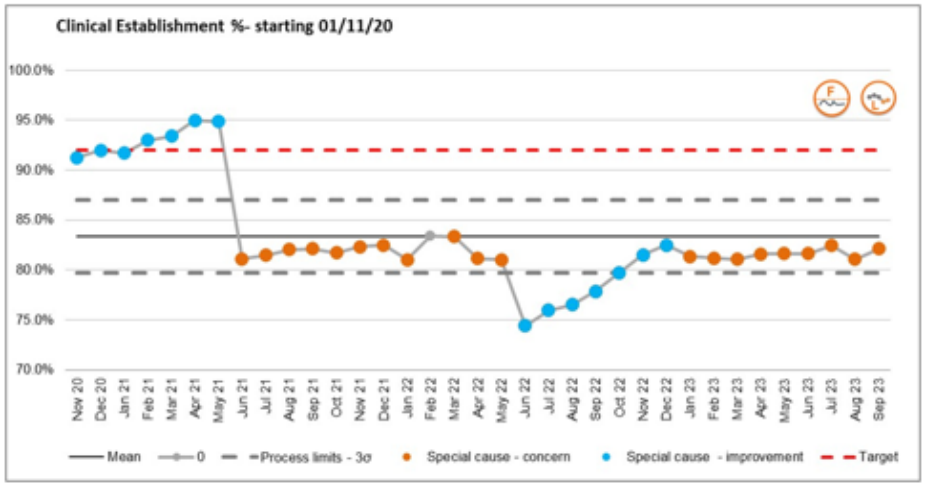
Actions

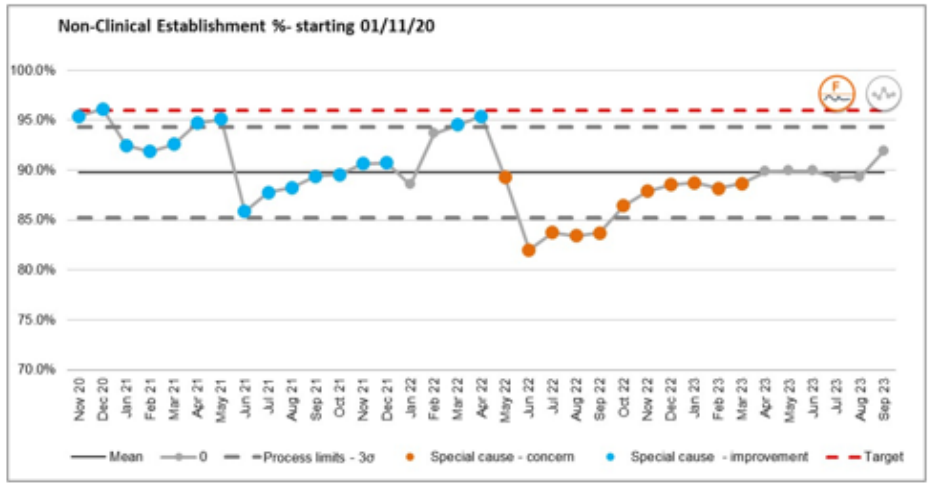
Recruitment activity has increased to help get the Establishment back up to where we need to be.
HR to review the Staff Turnover and investigate the reasons and dig deeper into them, HR provides a deeper dive into the data and will be running a Leavers Process working group to tackle some of the themes.
Absence is also being monitored in HR, and a deep dive into sickness is also being provided.

20. Workforce

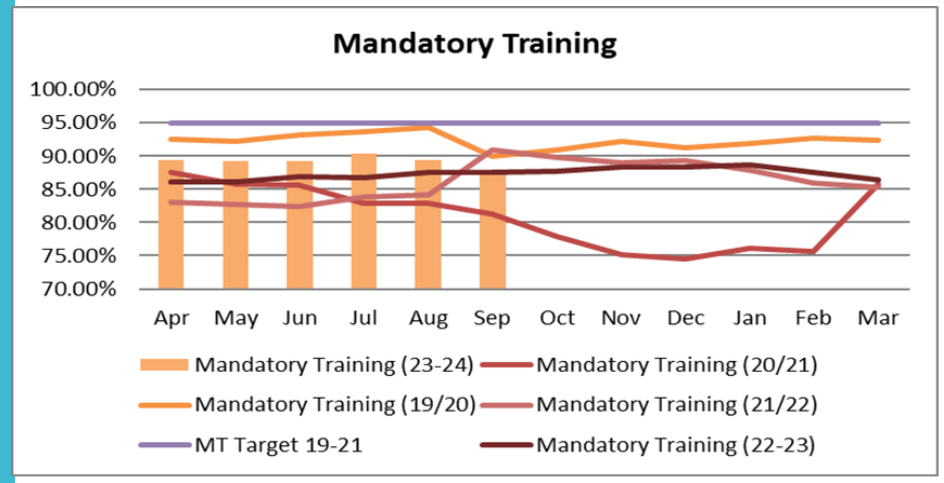


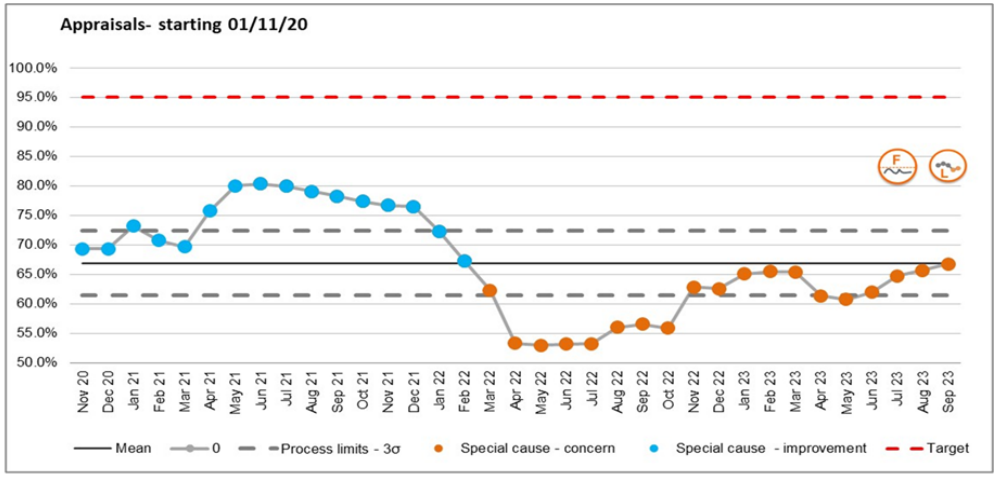


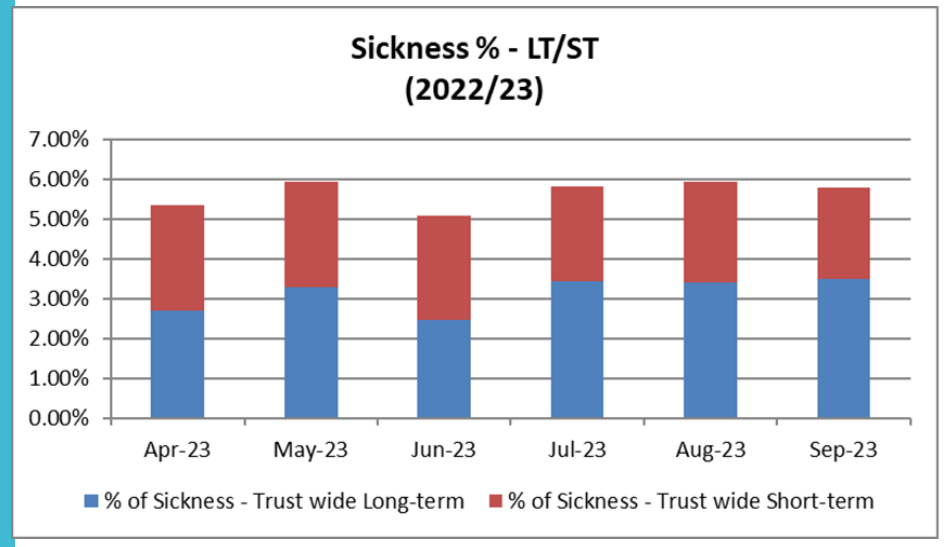


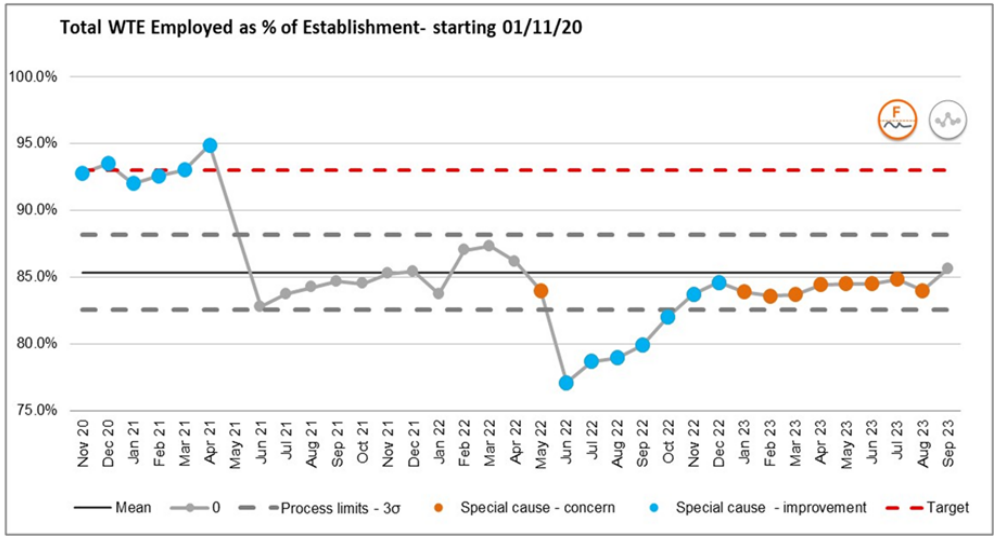


20. Workforce









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.

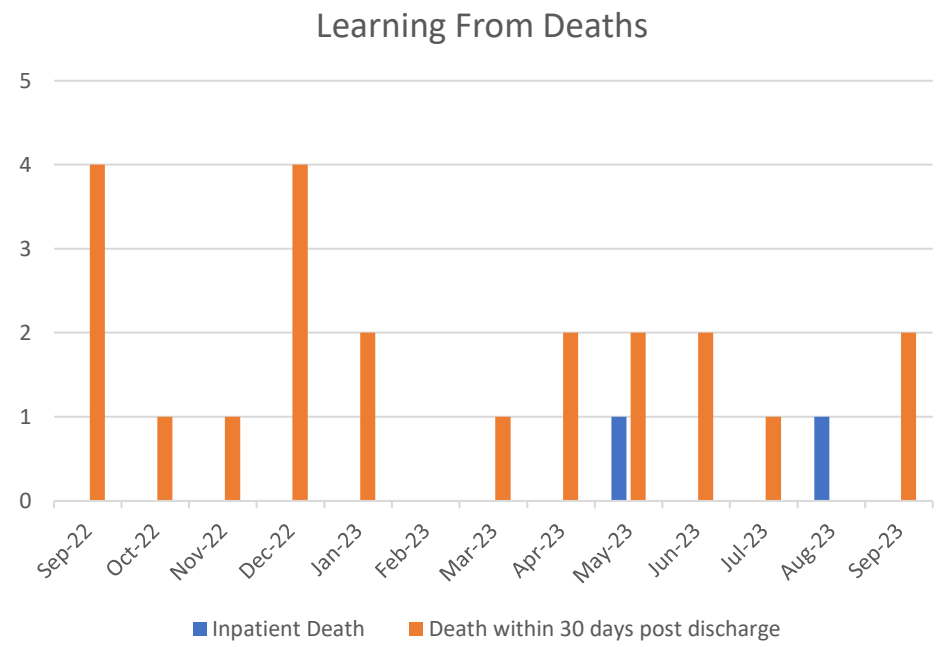
3. Patient Deaths

Inpatient Deaths

There were 0 inpatient deaths reported during September 2023

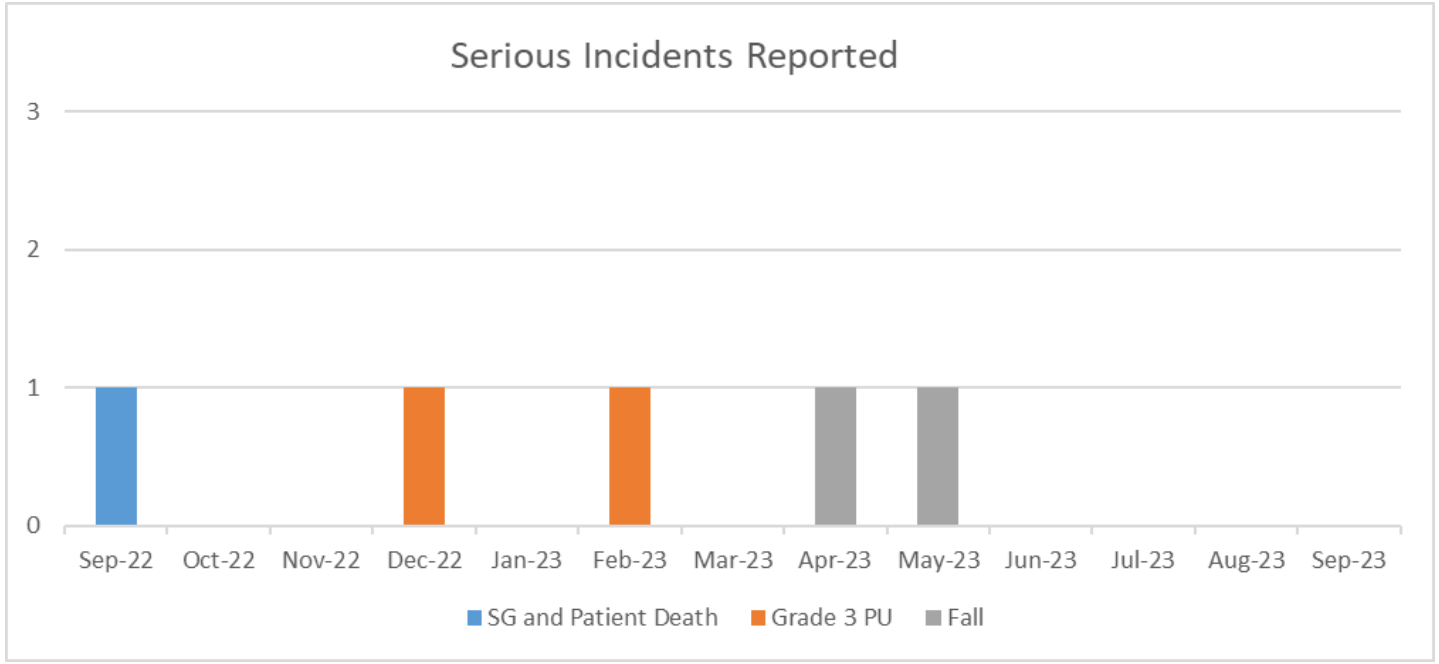
Deaths within 30 days post discharge

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

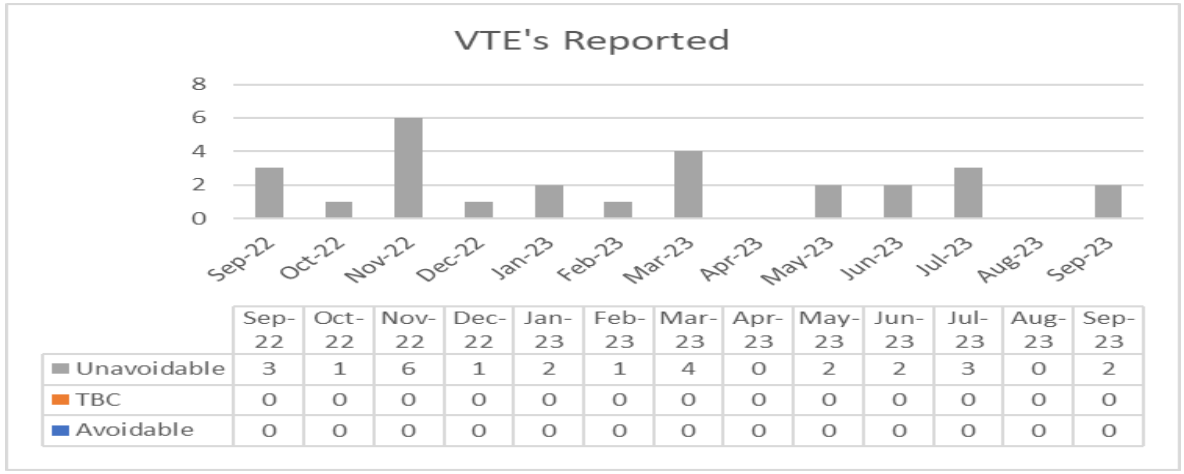
Both VTE's are currently being investigated. Provisionally graded as unavoidable, pending final report.

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

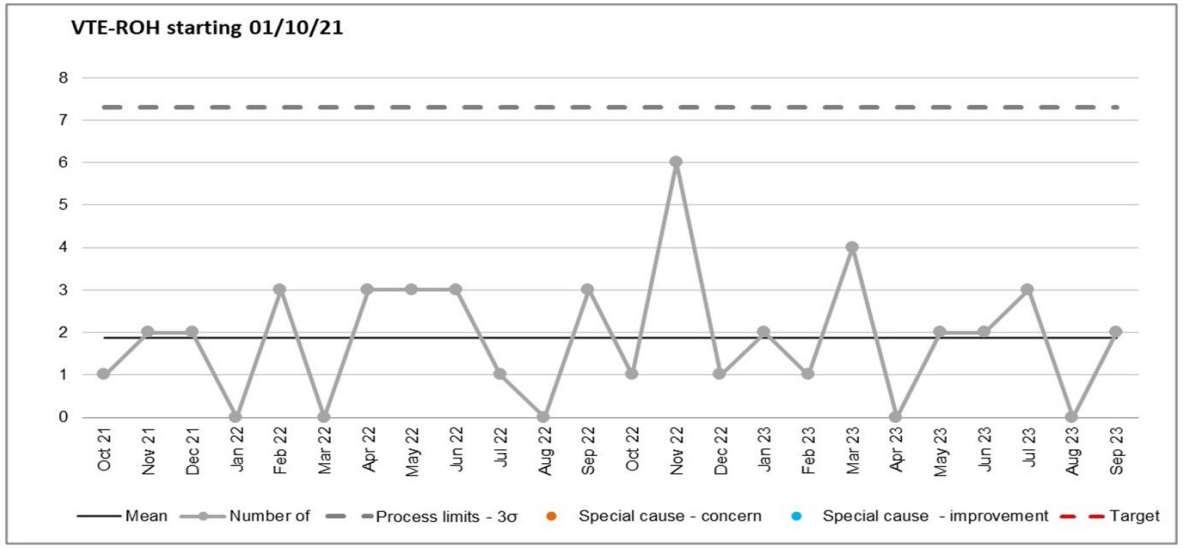
Pre-validation figure for September 2023 = **99.06%**

<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

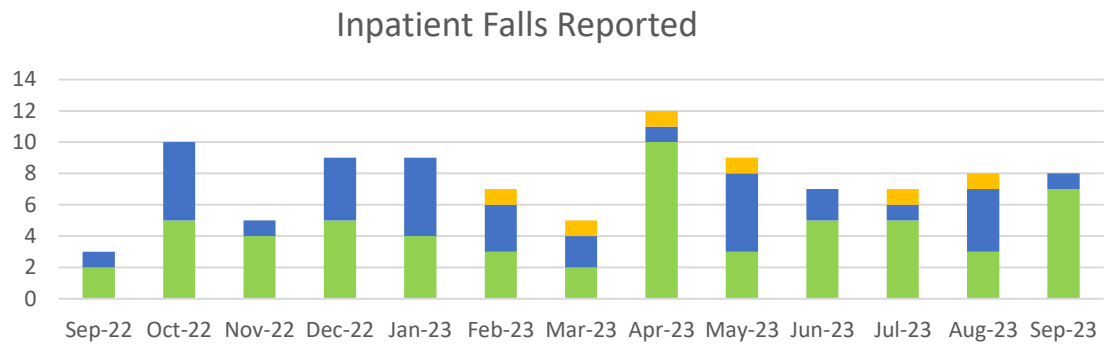
Quality Improvement Work Underway

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.

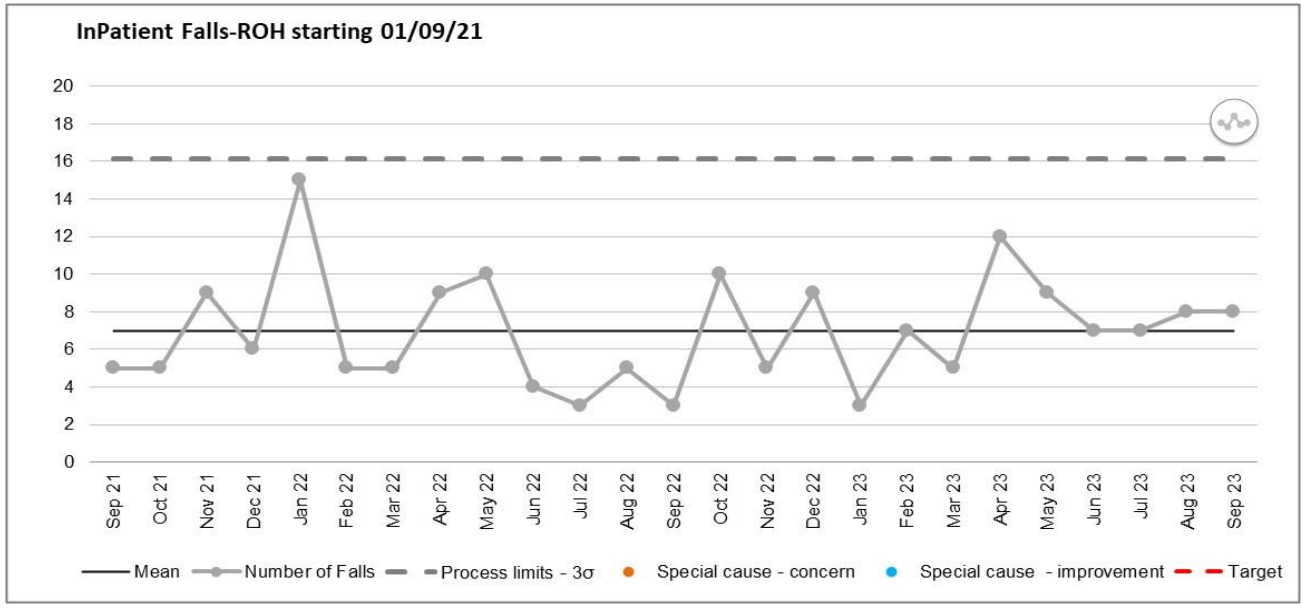
New falls / dementia information boards for out-patient areas designed and on order now.

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

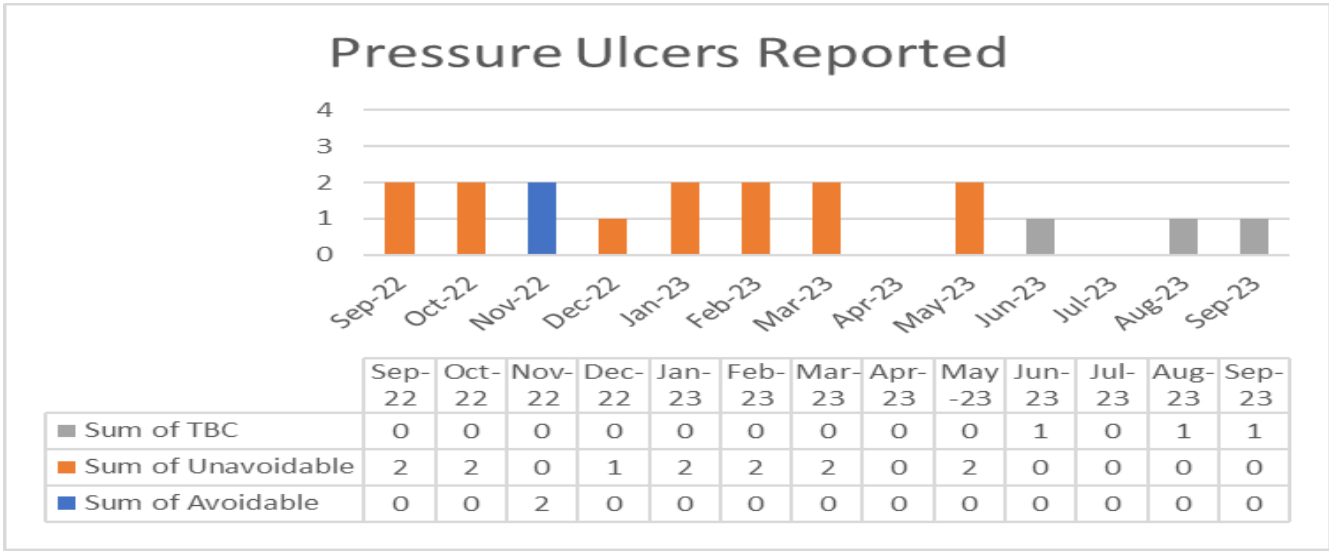
Update on 1 x Category 2 ROH acquired PU incident reported in September Quality Report 2023. (August 2023 data) - remains under investigation

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

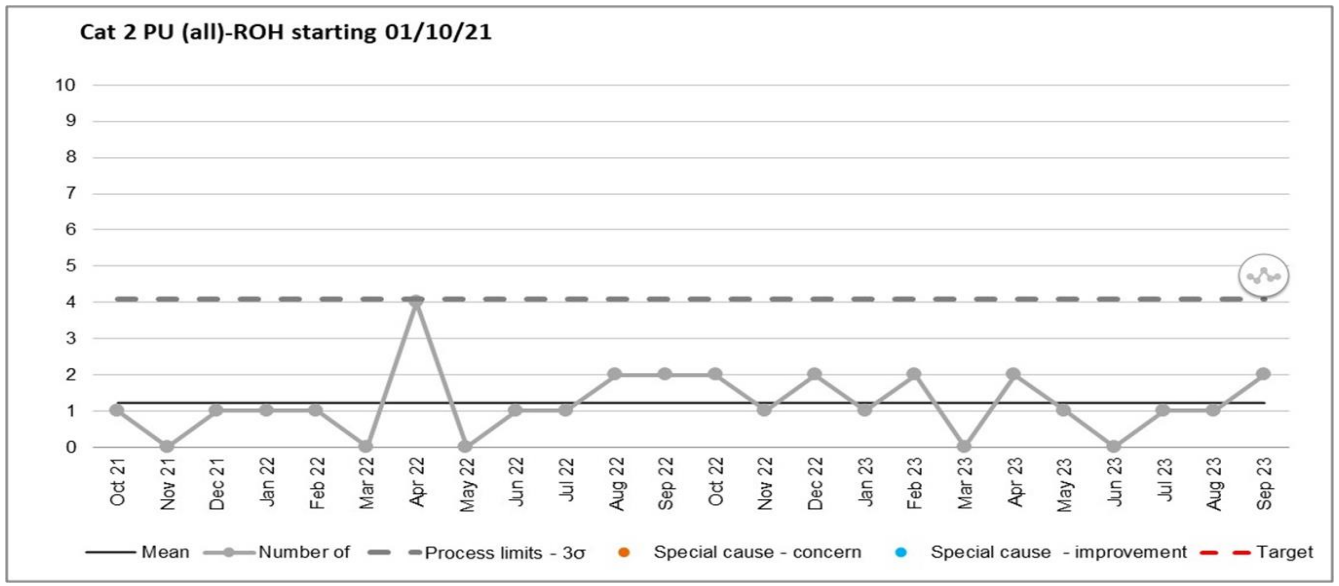
- What's under the dressing?' Campaign is being worked up to be rolled out in month.
- TV referrals have now gone to online to speed up process.
- Education continues to be rolled out at all forums. (example. HCA training)

<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

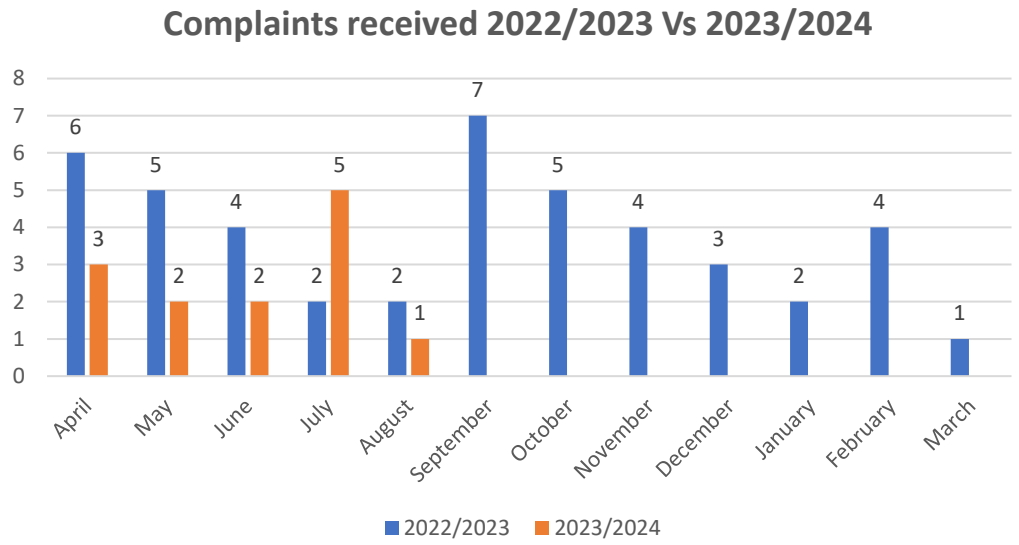
In August 2023, the Trust received **1 reopened complaint. –** Currently waiting for complaint resolution meeting dates.

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%

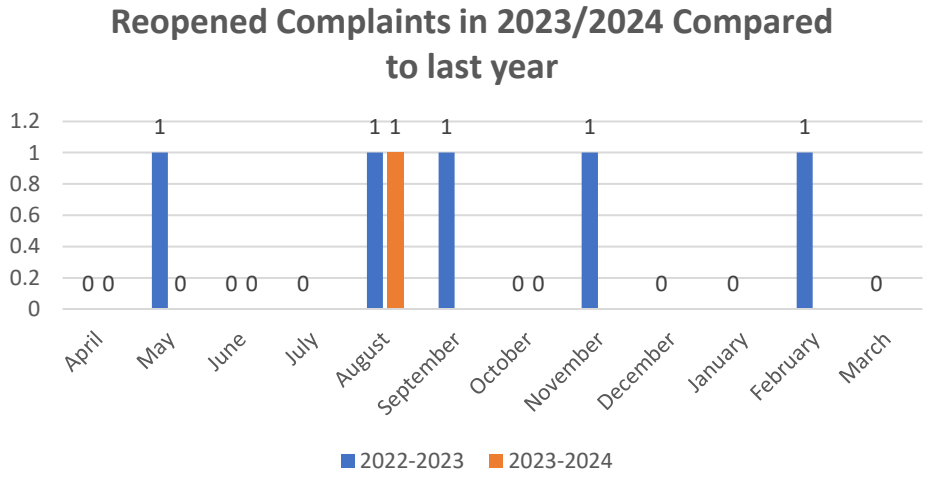
0%-79%
80%-90%
91%-100%

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

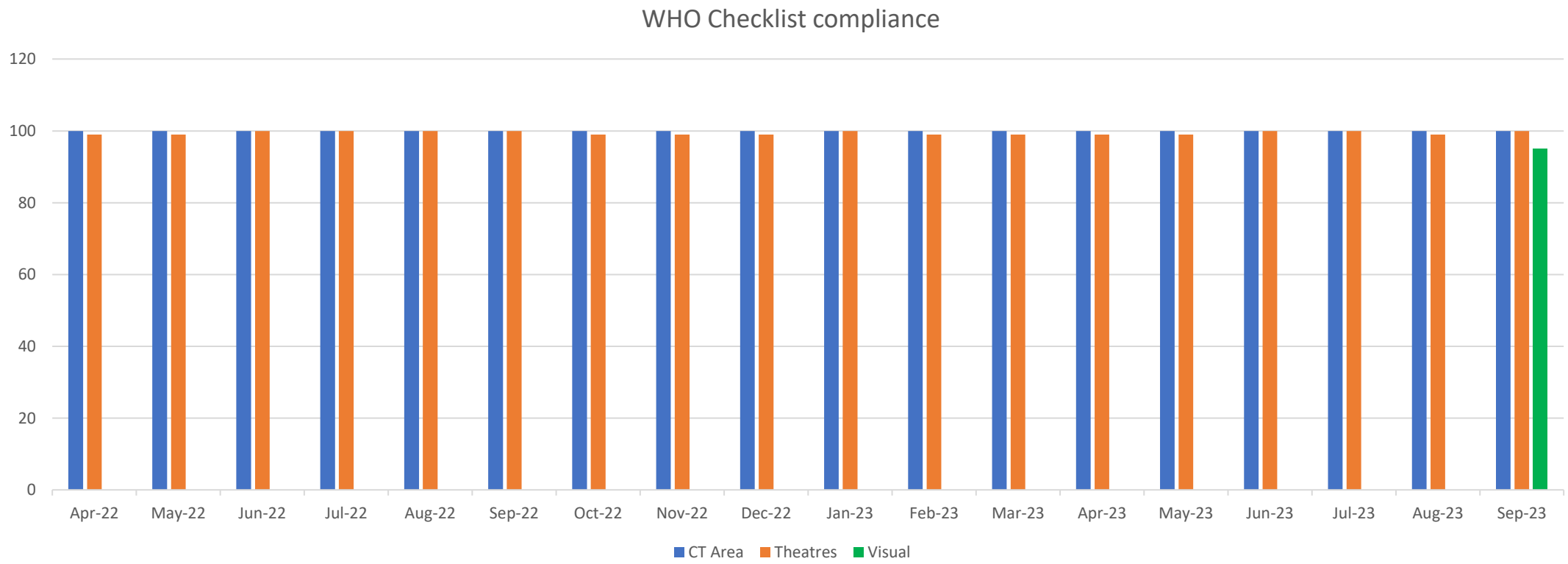
2 new requests for Pre-Application Disclosure of medical records were received in September 2023

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

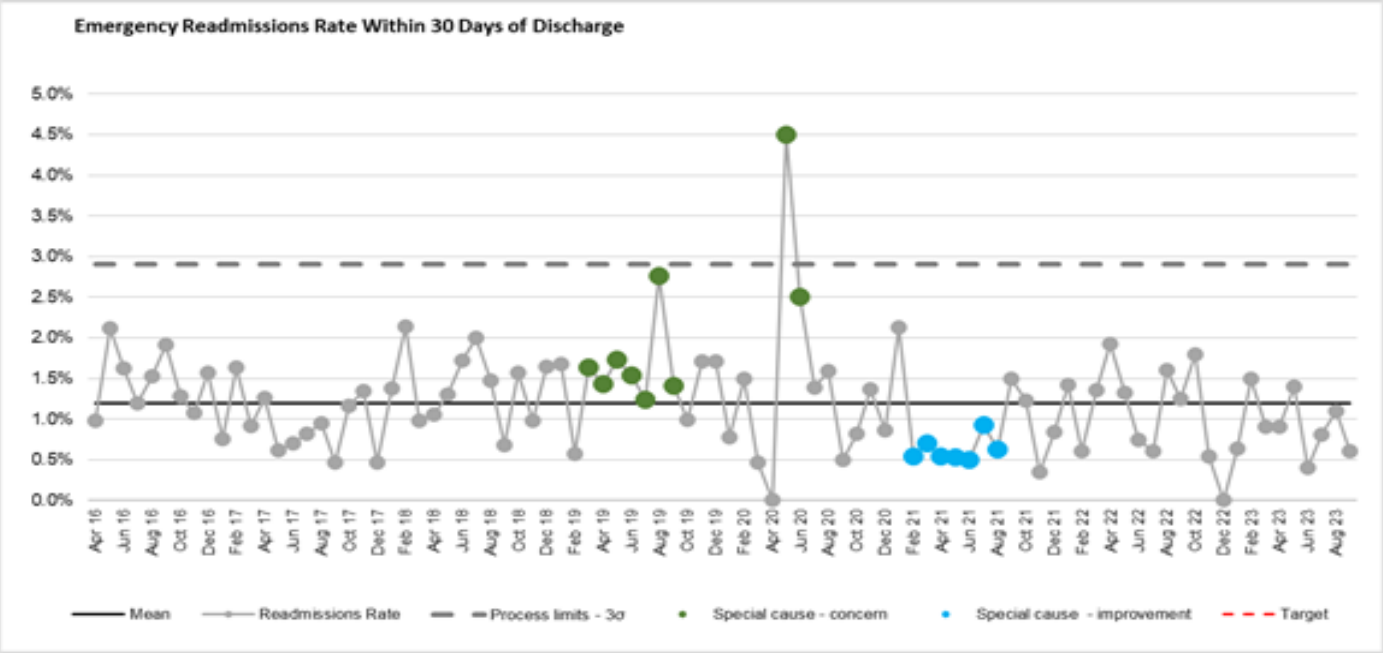
18. Safeguarding

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.

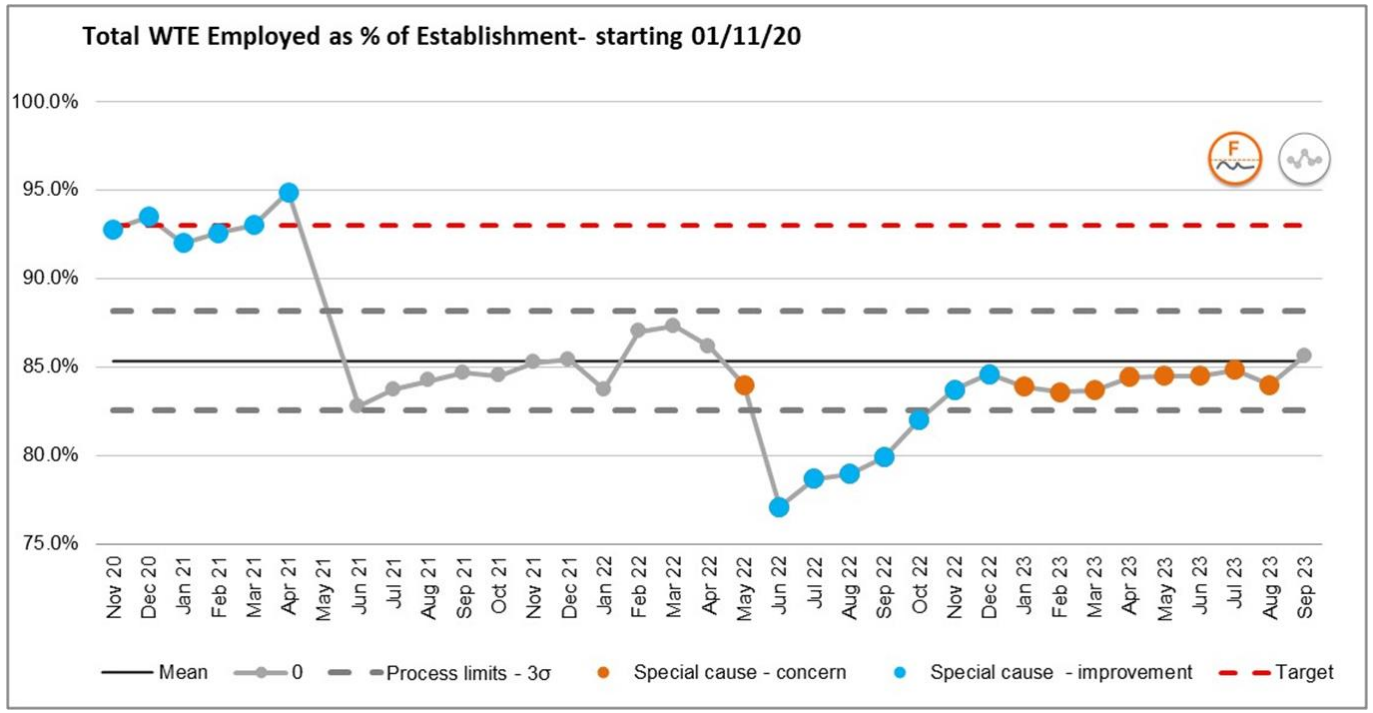
1. Workforce Overview

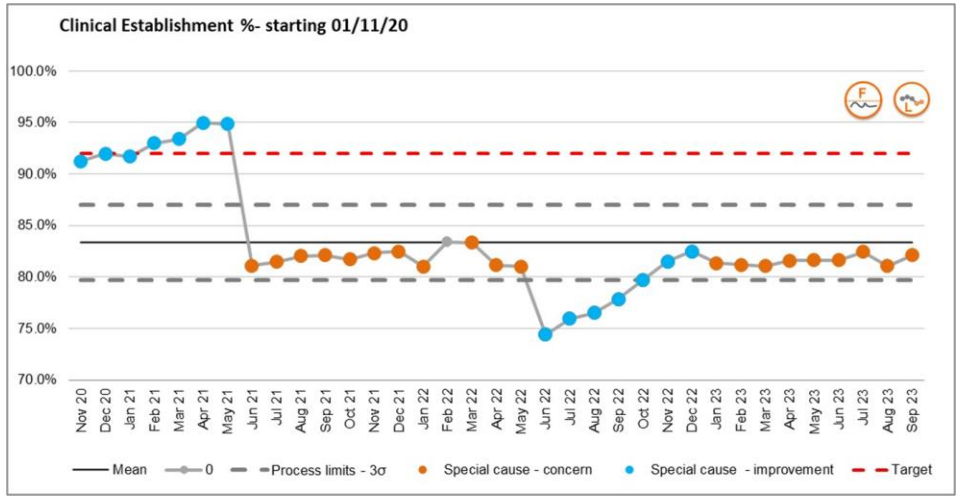
Trust Workforce Metrics	Aug-23	Sep-23	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1325	1354	29	-	-
Staff In Post - Full Time Equivalent	1172.40	1197.69	25.29	-	-
Staf Turnover % - Unadjusted	13.07%	15.41%	2.34%	↑	<=11.5%
Staf Turnover % - Adjusted	11.54%	10.56%	-0.98%	↓	<=11.5%
Total 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%

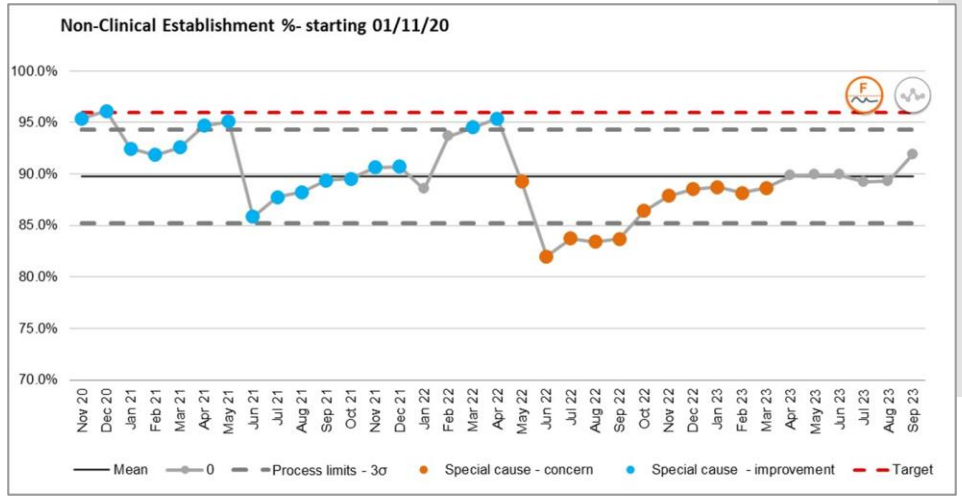
2. Establishment

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%.





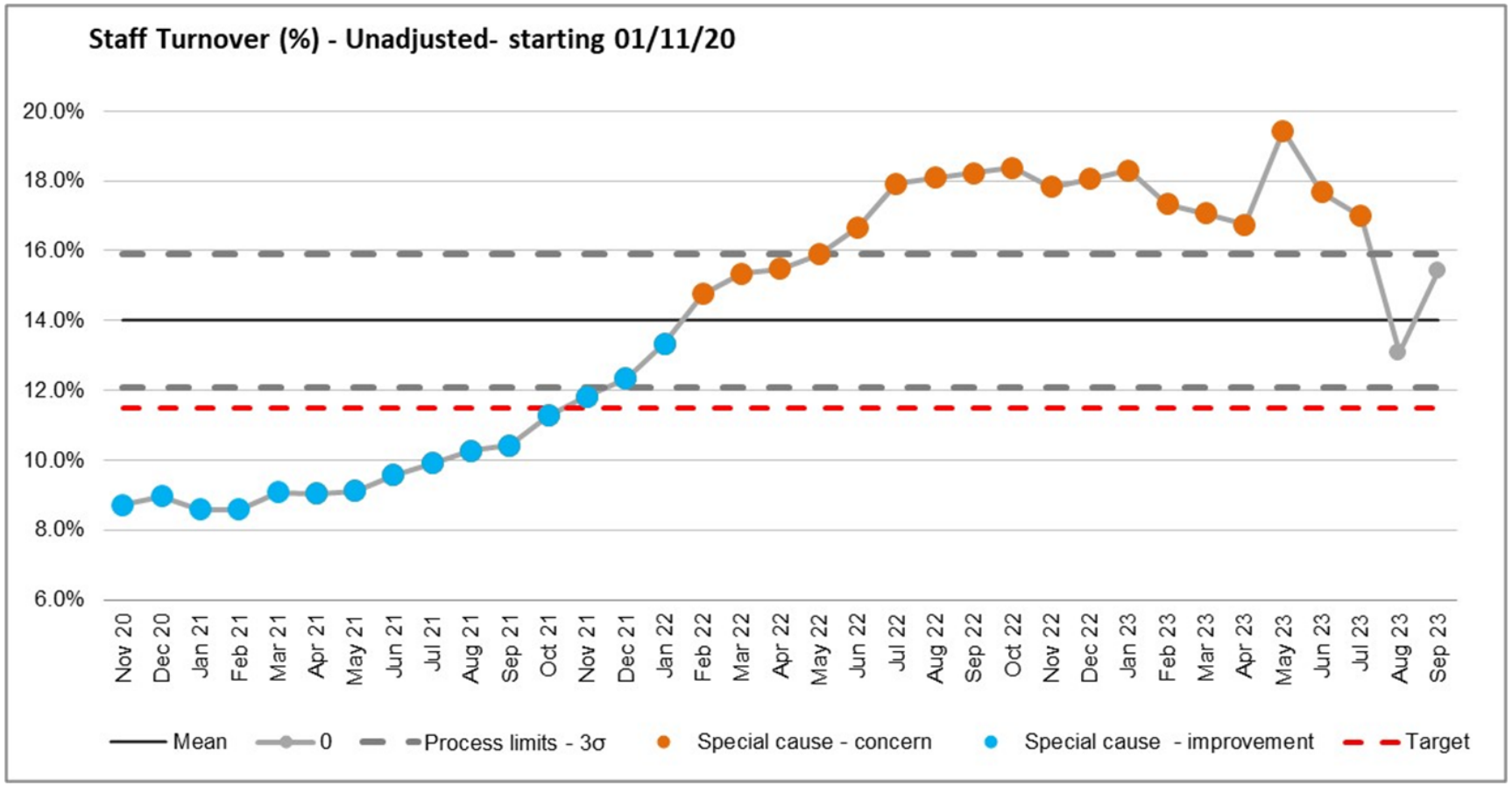


3. Turnover & Retention

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



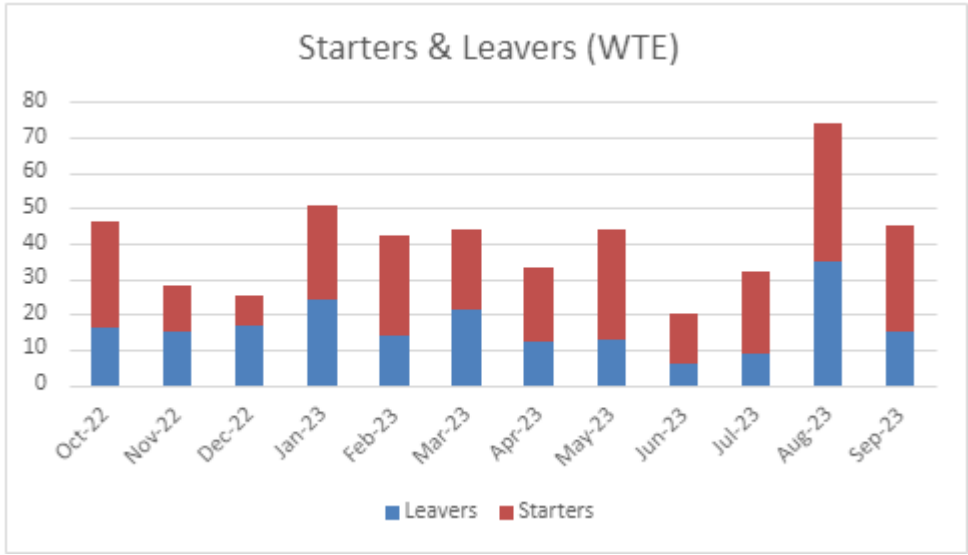
Staff Group	FTE
Add Prof Scientific and Technic	20.86%
Nursing and Midwifery Registered	14.03%
Additional Clinical Services	12.97%
Allied Health Professionals	12.30%
Estates and Ancillary	11.61%
Administrative and Clerical	10.90%

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.

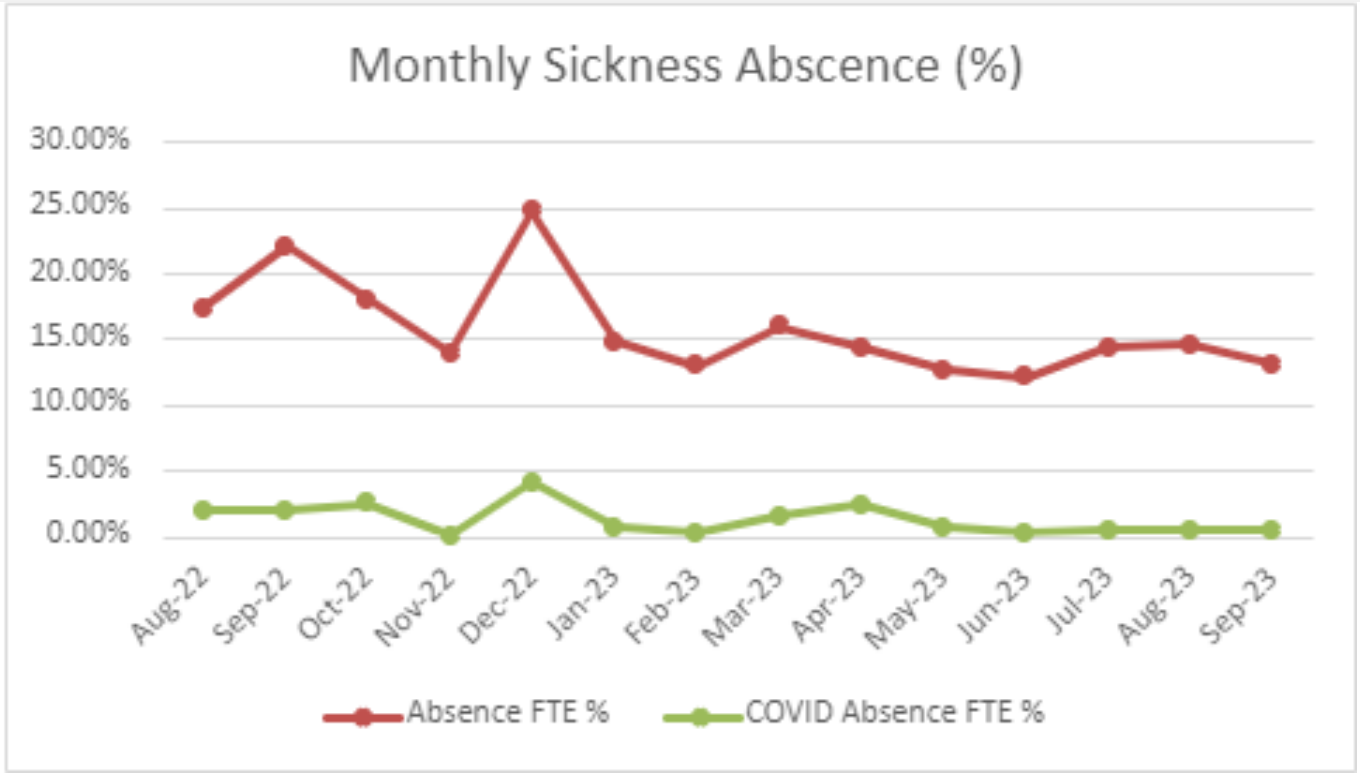
It is positive that 3 members of staff have taken advantage of flexi retirement, which retains the member of staff.



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.



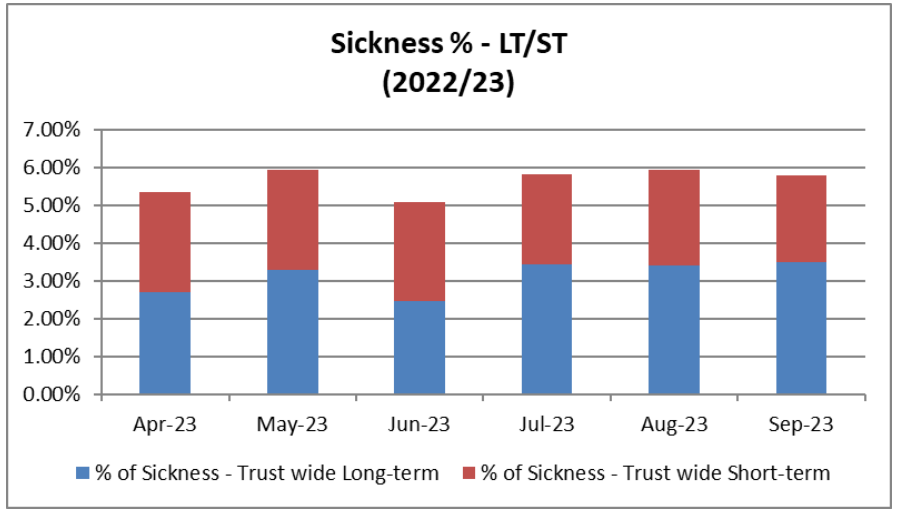
This chart shows that 12% of the WTE were off with sickness which started in Sept 2023 (not inc Long Term Sickness) and of that sickness 0.5% is attributed to Covid, this against the WTE figure of 1197.69

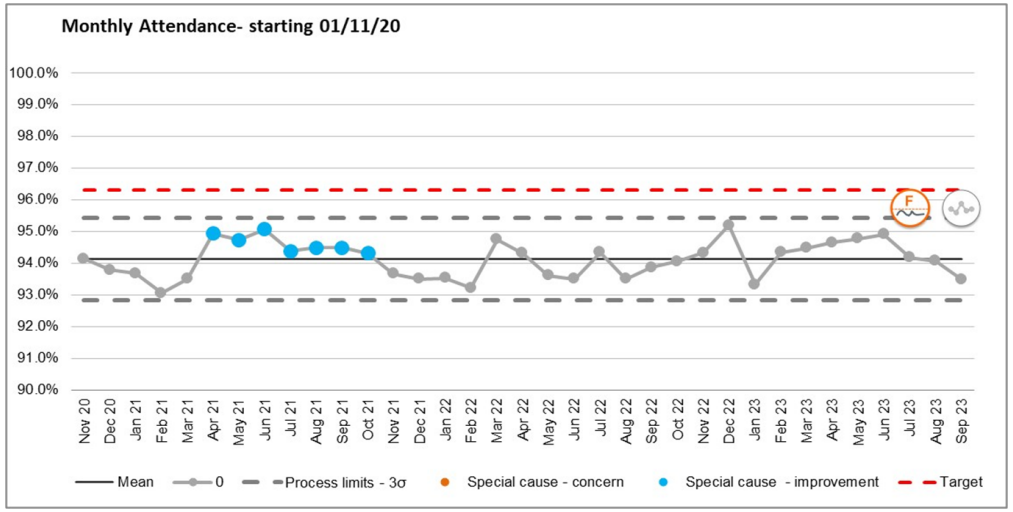
Top Absence Reasons In the Last 12 Months by FTE Days Lost	Count of Episodes	FTE Days Lost	Estimated Cost Of Absence
Anxiety/stress/depression	203	7302.596	£579,350.85
Cold, Cough, Flu - Influenza	801	4793.513	£427,918.25
Musculoskeletal problems	147	2412.788	£201,418.37
Gastrointestinal problems	491	2243.001	£182,542.46
Injury Fracture	61	1553	£121,657.06

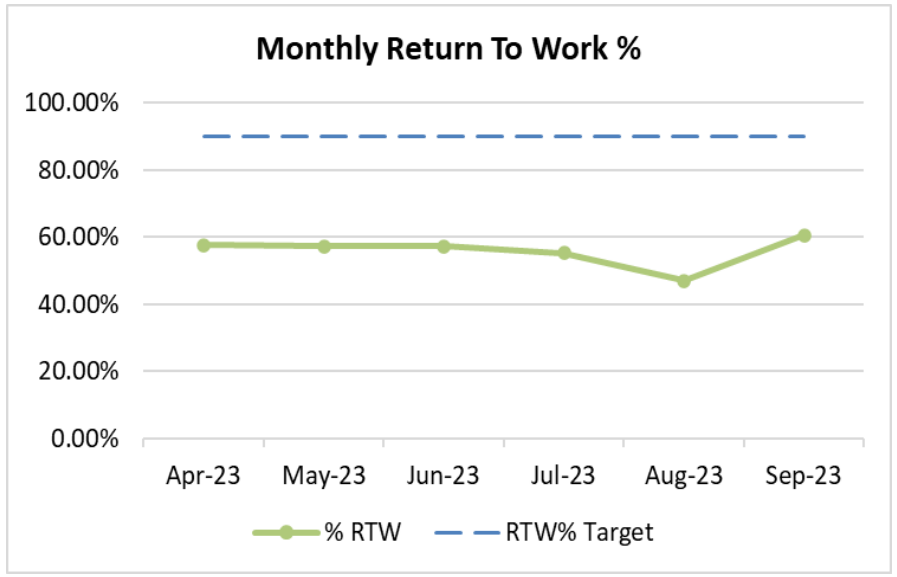
5. Attendance & Sickness

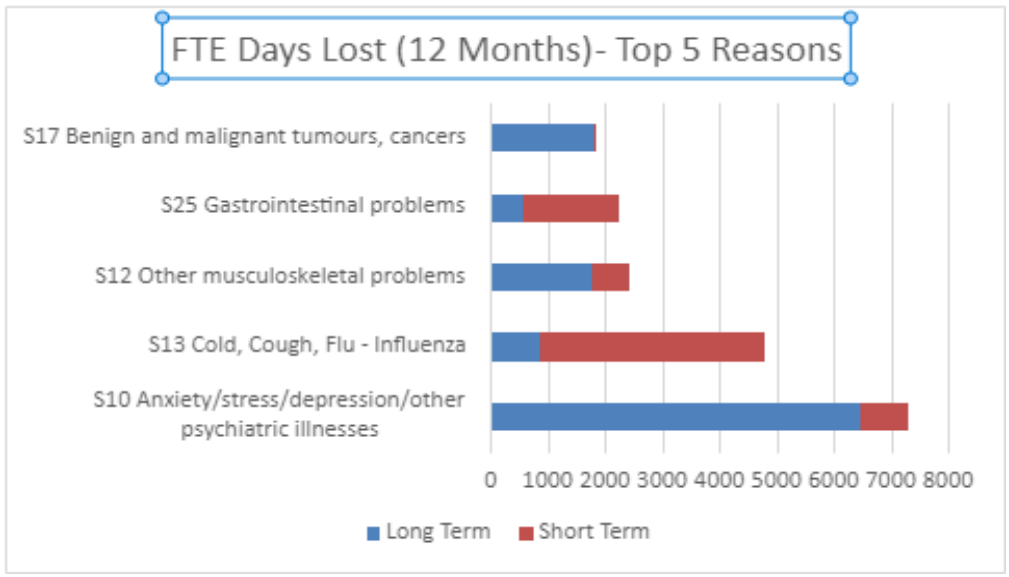
Return To Work Discussion Meetings Following Sickness Absence

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

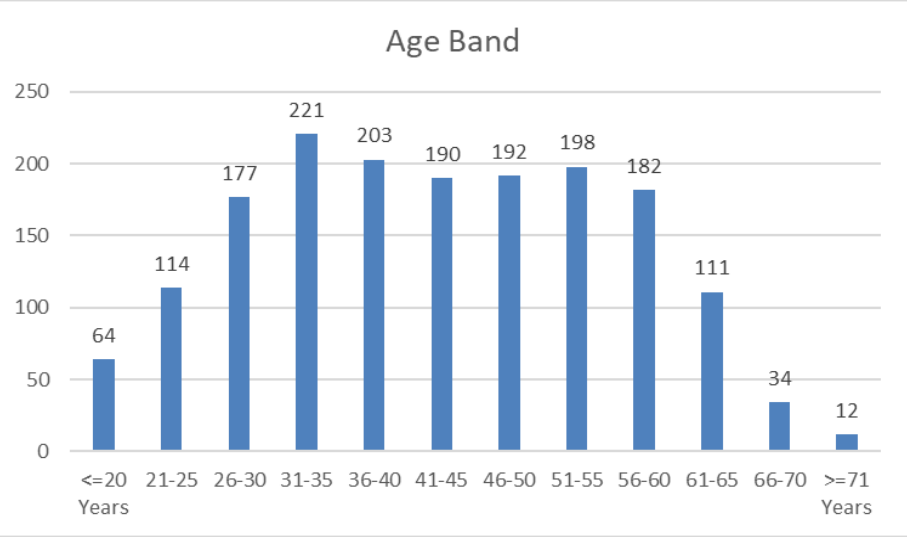
- Staff with no PDR/Appraisal will have no way of being appraised, agree personal goals or have the opportunity to speak to managers about personal wellbeing
- There has been a slight decline in the Disability Declaration rate to 6.83 which will be reviewed for any issues in the new starter process

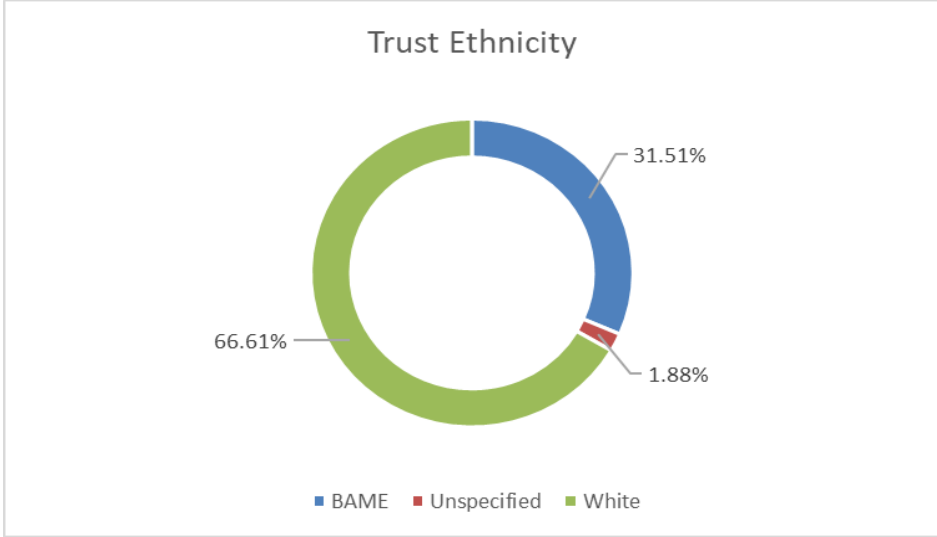
Next Steps

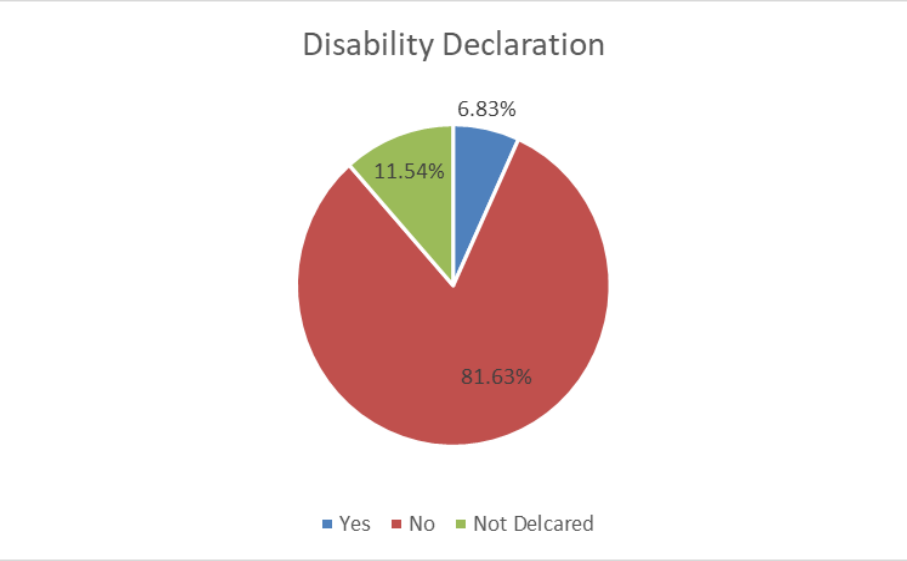
- Planning for Staff Network priorities in the next 12 months has begun to fit with the Inclusion strategy
- Continuing work with the National Staff survey fieldwork
- Finalising details in Wellbeing plan with focus on confirmed metrics against each priority

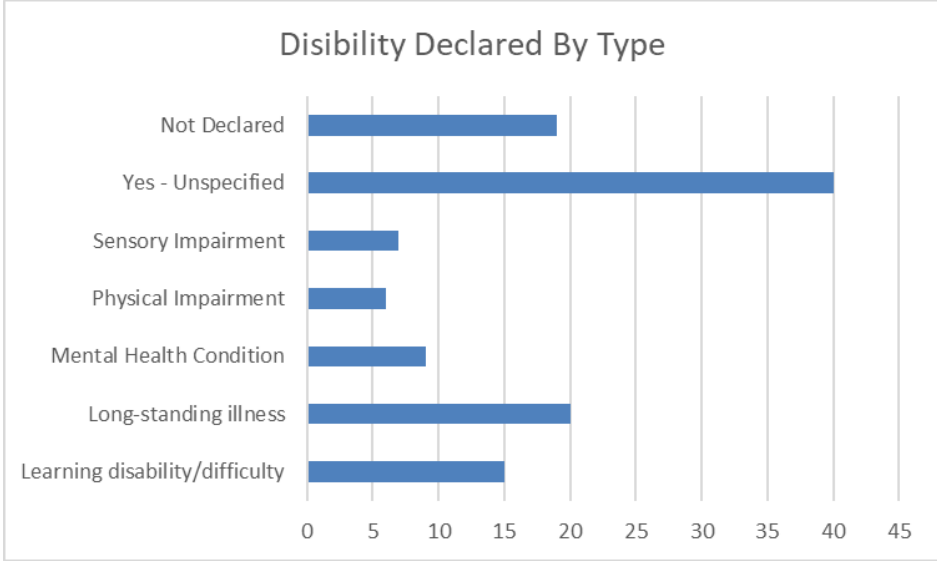
1. Workforce Demographics

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.



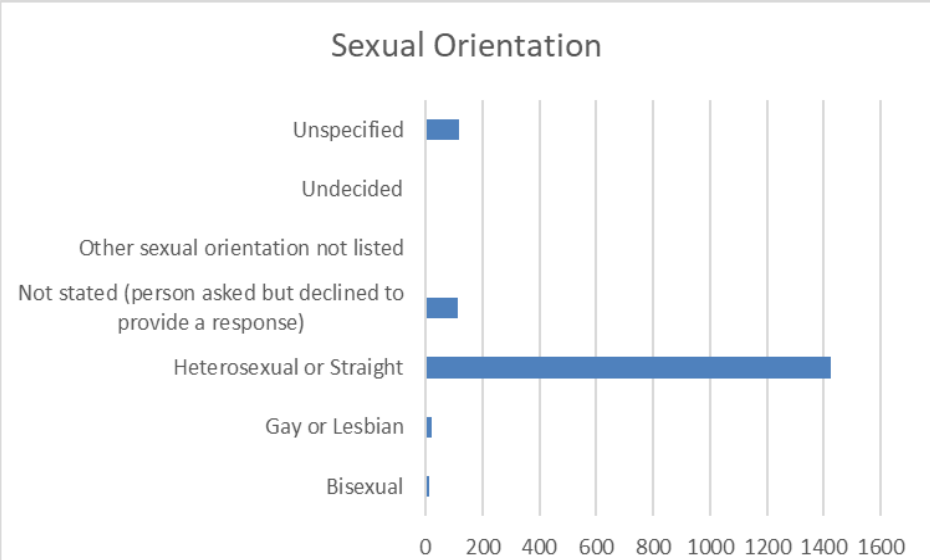


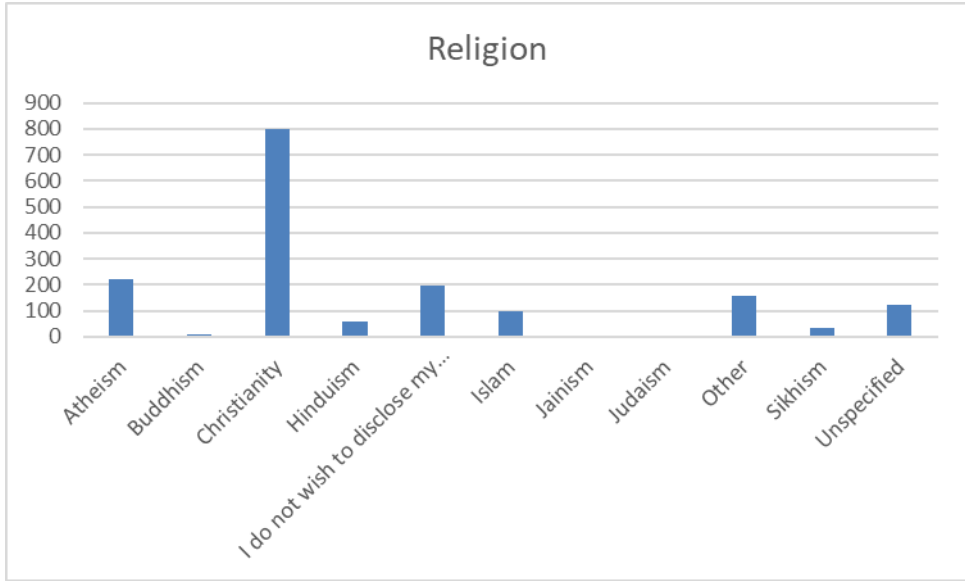


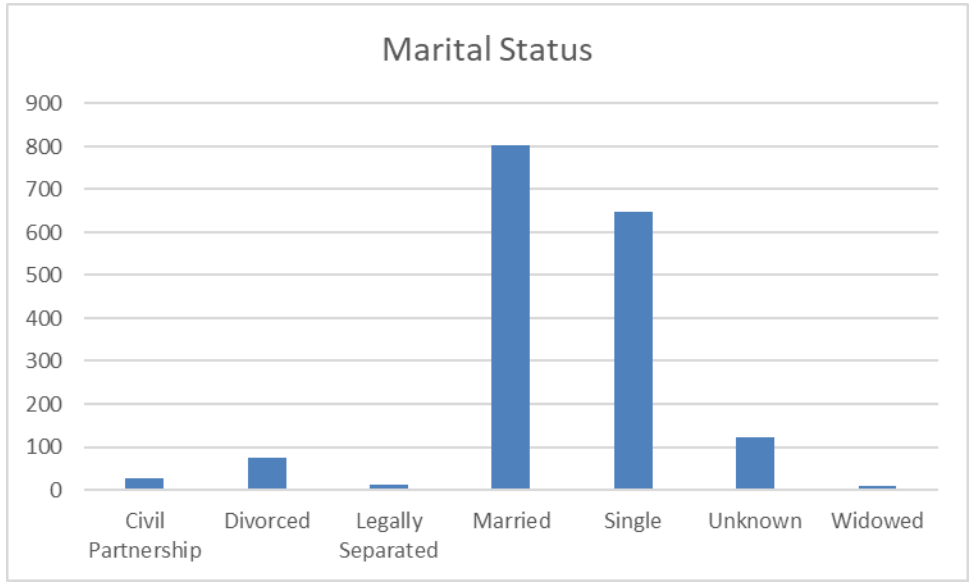


2. Workforce Demographics cont.

Currently in the Trust we have 28 staff members on Maternity or Adoption Leave



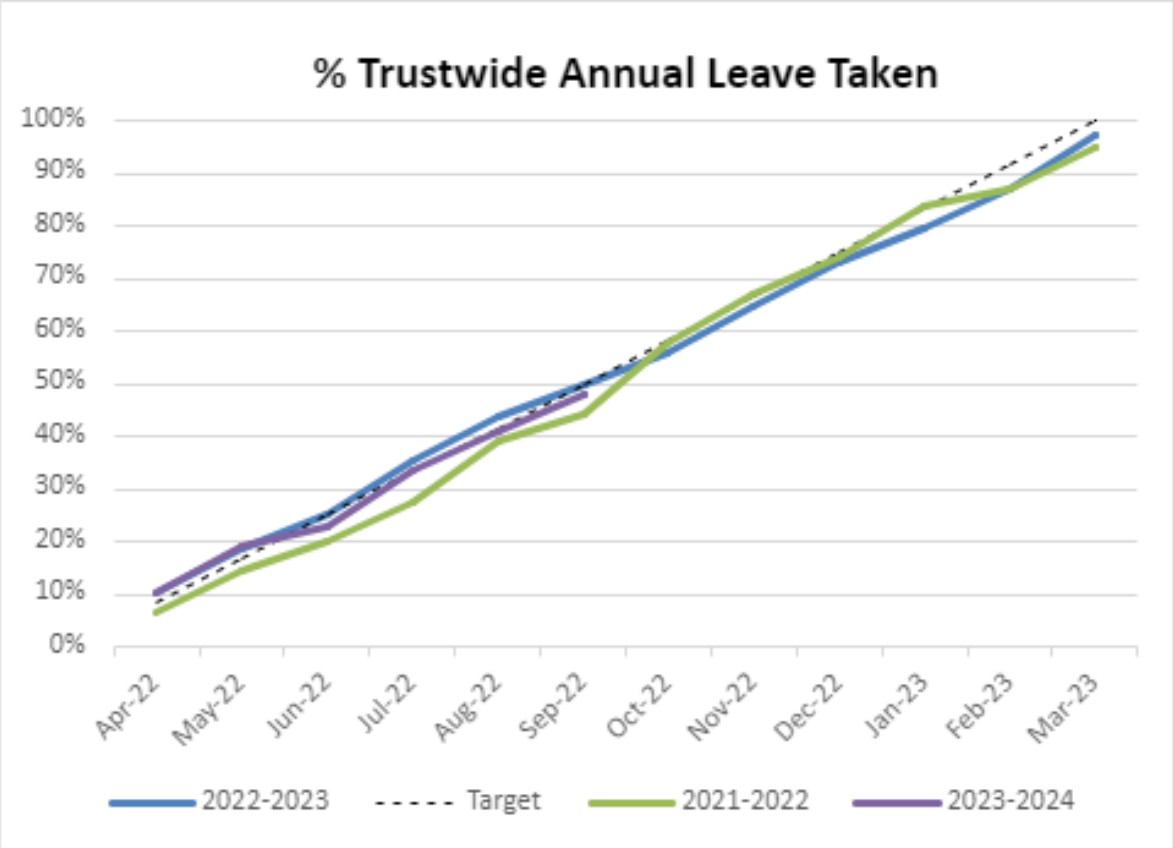




3. Workforce Wellbeing – Annual Leave

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.

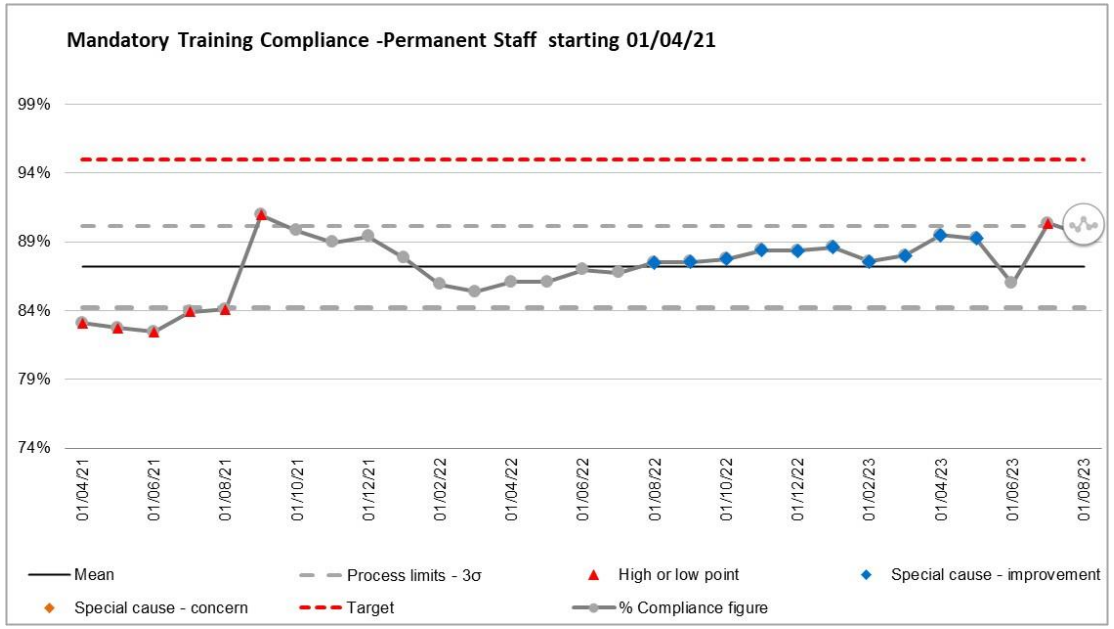
The mandatory training compliance figure is the average of 6 core mandatory modules. In April 2023 IG & Data Security ceased to be reported through ESR following the launch of Metacompliance Cyber Security and IG modules. Separate reporting is provided by IT to Heads of and individuals are being chased. Lockouts have begun for those non-compliant.

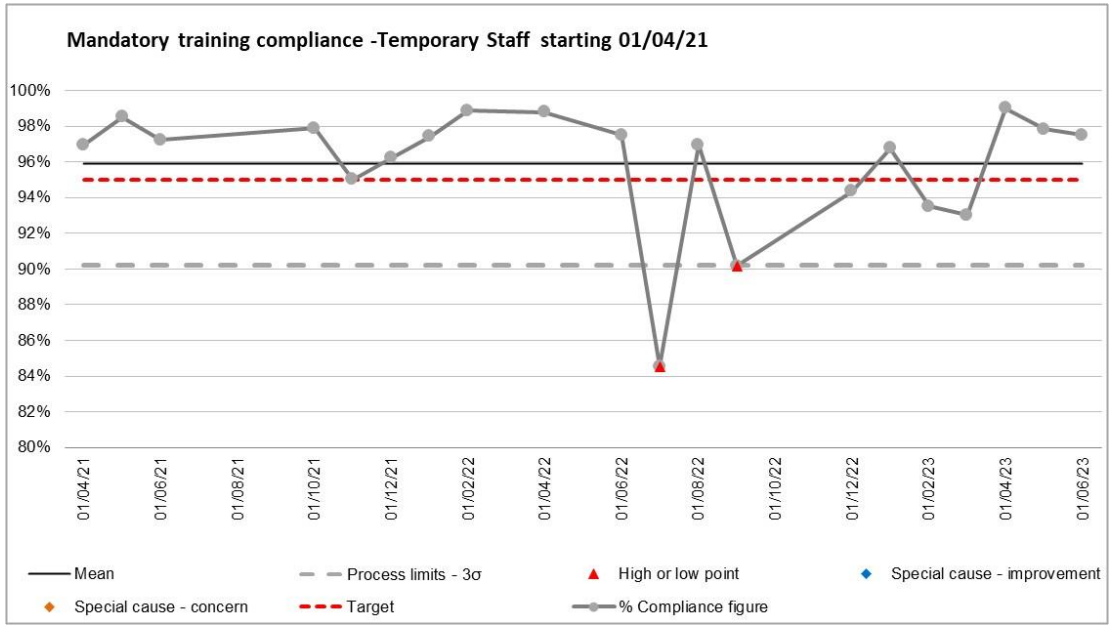
In addition there are still a number of departments where staff do not have easy access to computers and are not provided with an ESR log in, or there are delays with nhs.net email account. Work continues to ensure all staff have an NHS email account and have access to a PC.

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.

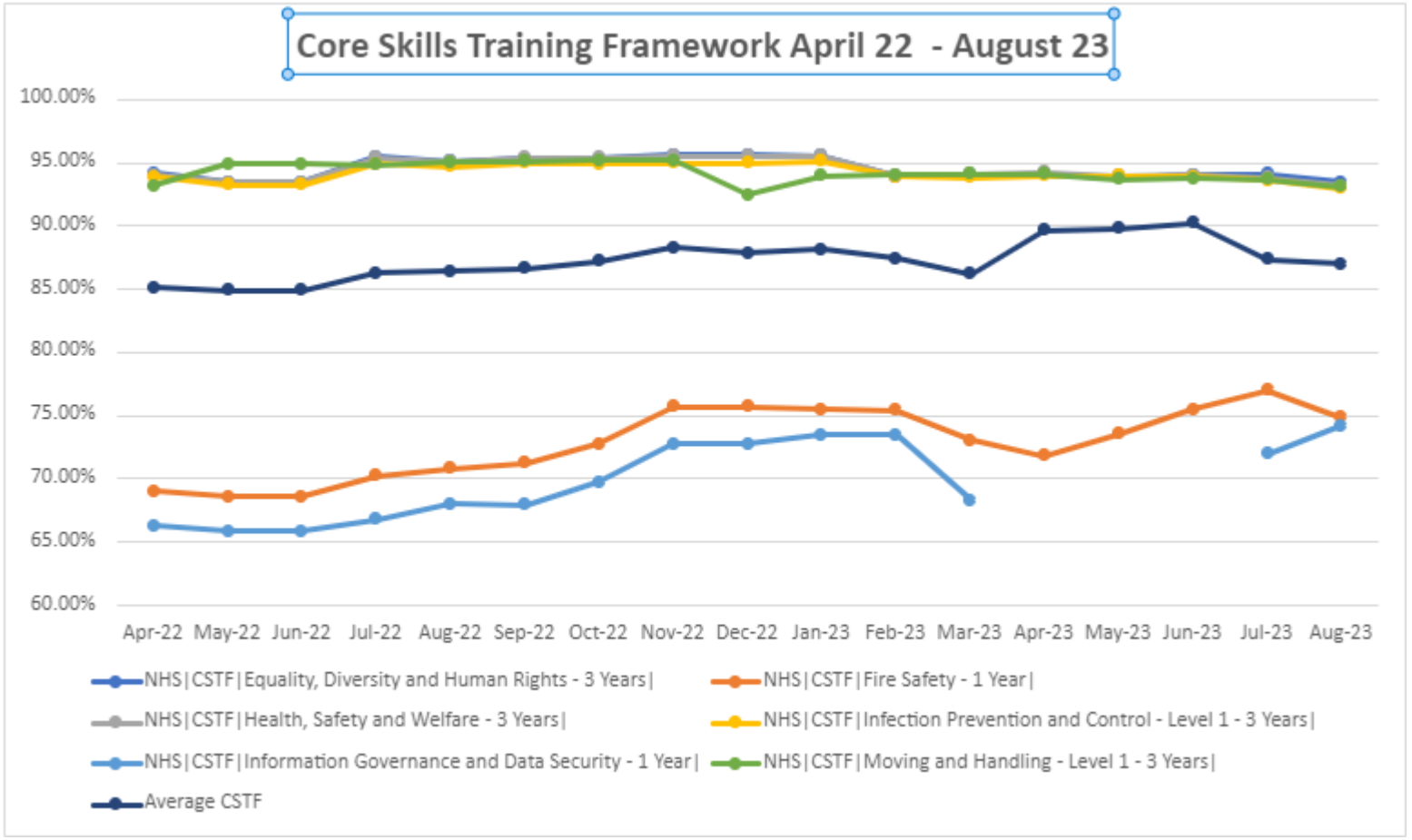
The average of these modules creates the overall Trust compliance figure.

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%.

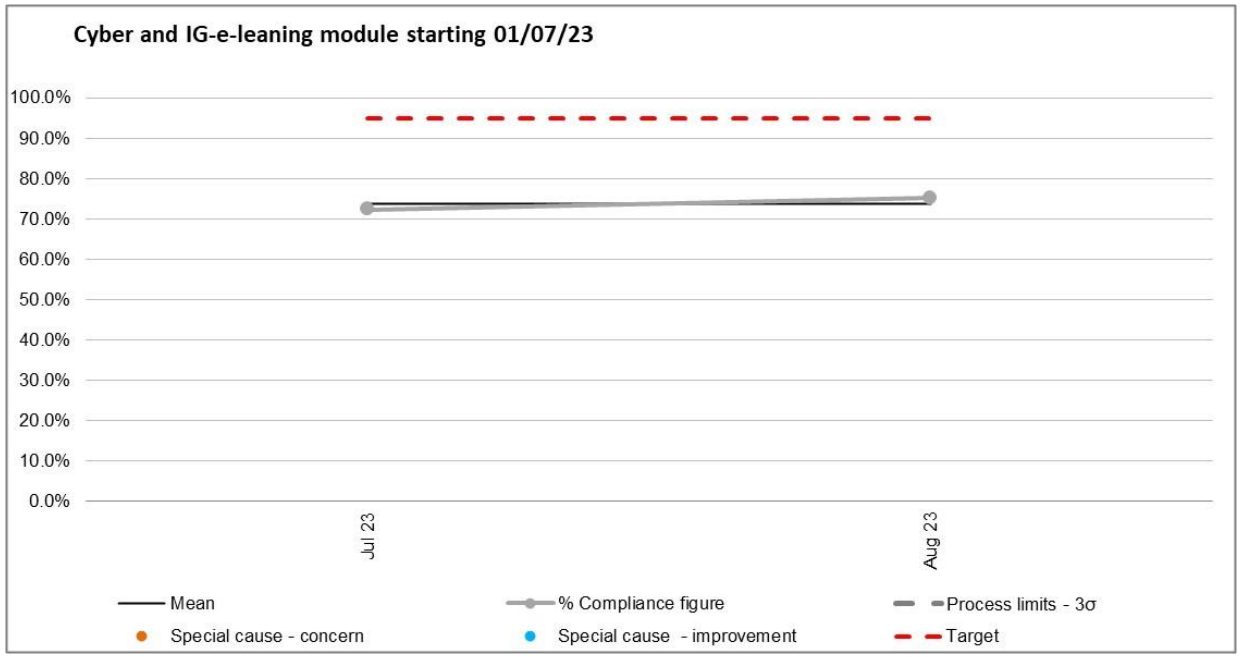


Information Governance and Data Security

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.

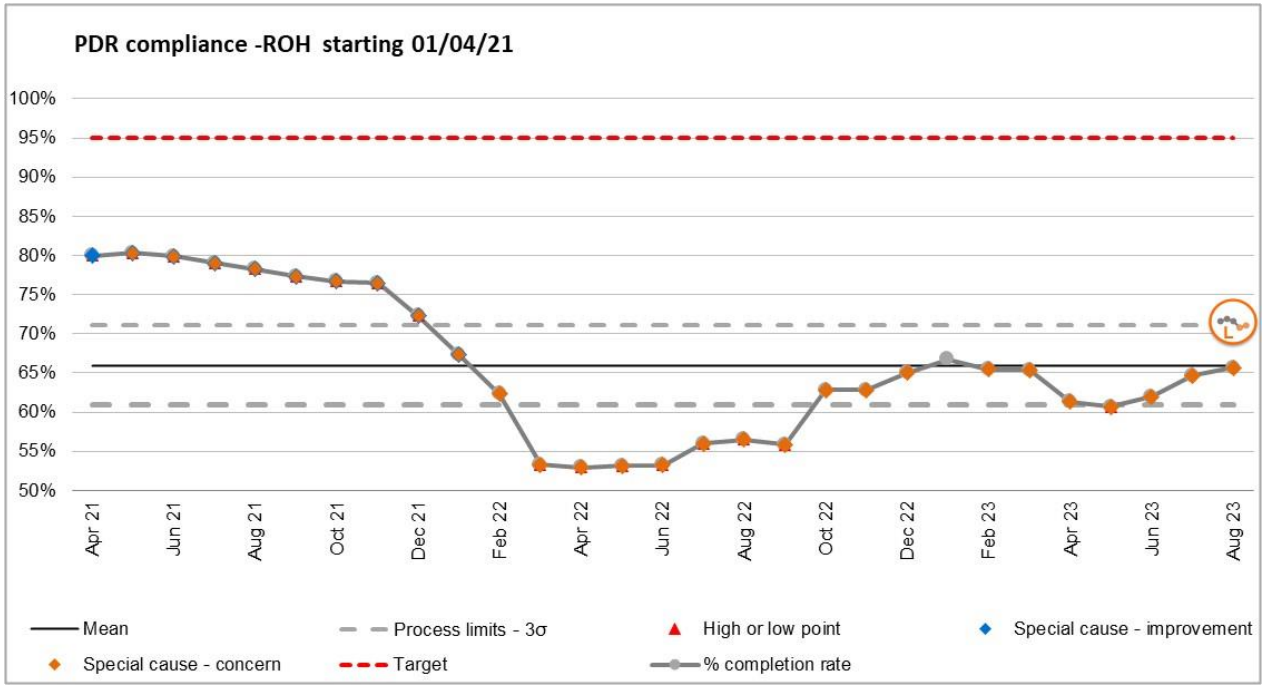
As reporting sits outside of ESR we are working with the BI & IT teams to develop accurate reporting.

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.

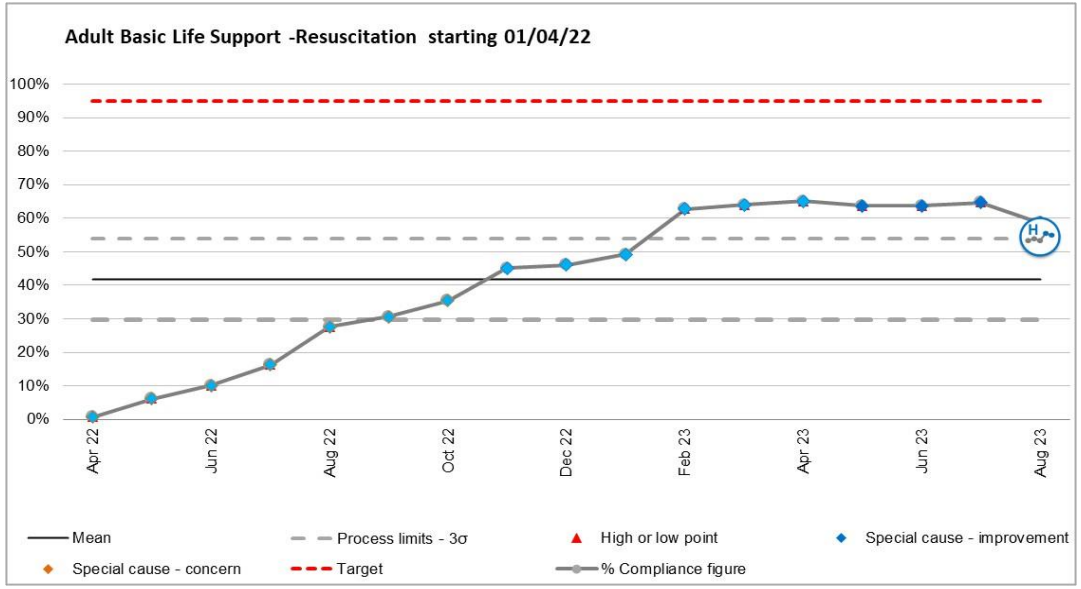
The Trust is currently revising its Performance Management and appraisal process, with the aim of improving these outcomes.

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.

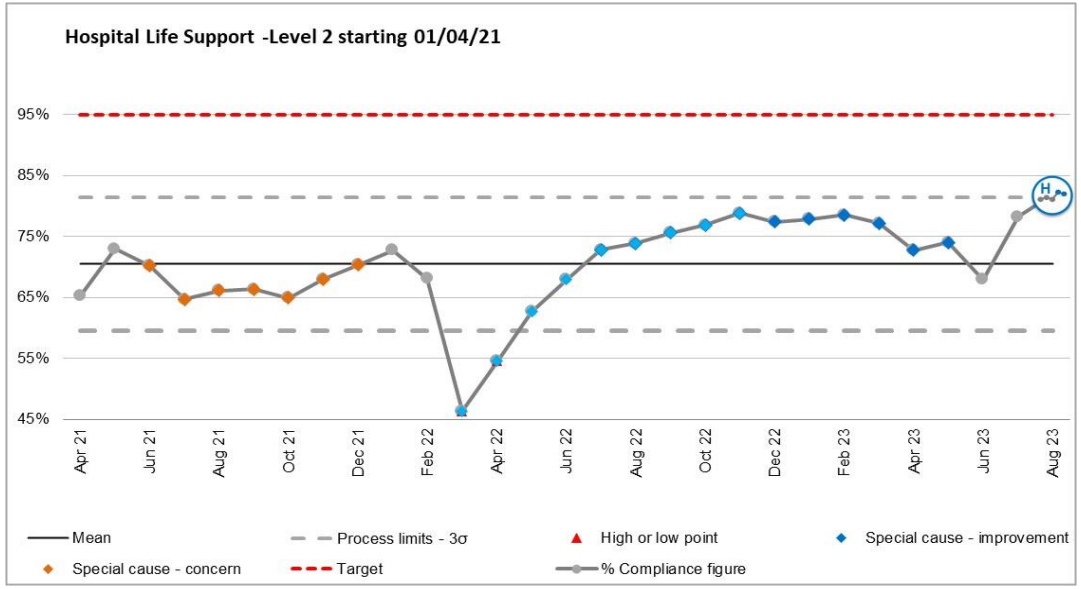


Hospital Life Support

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.

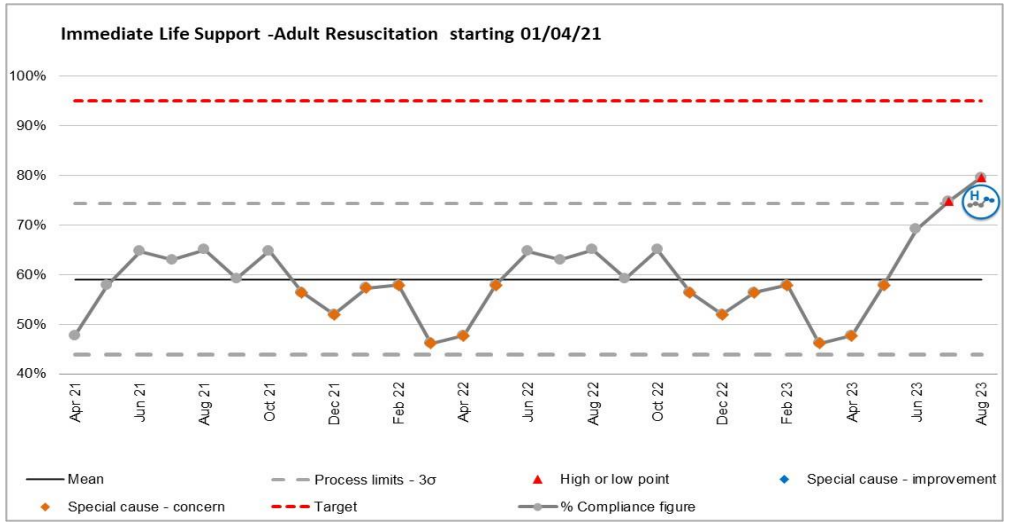


Adult Immediate Life Support

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.

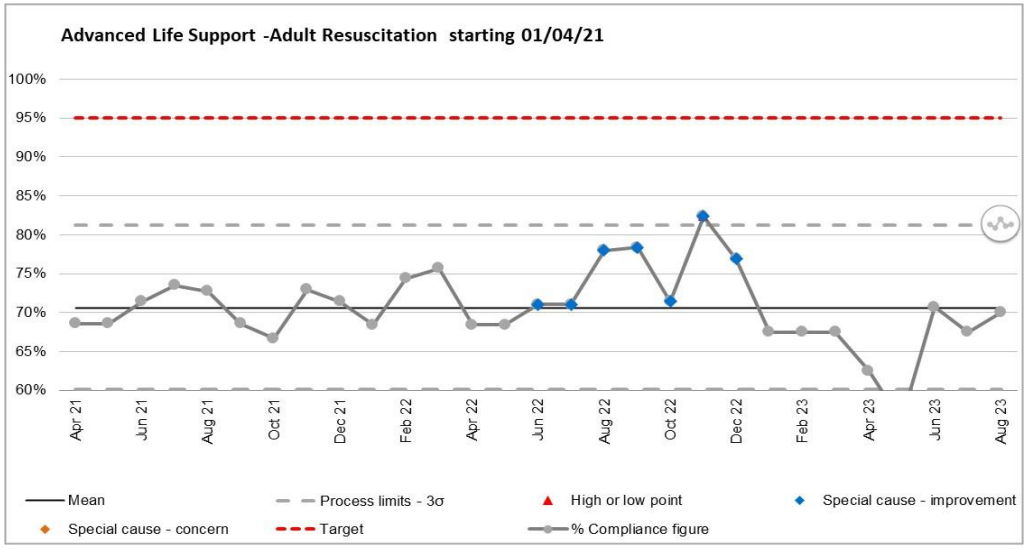


Adult Advanced Life Support

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

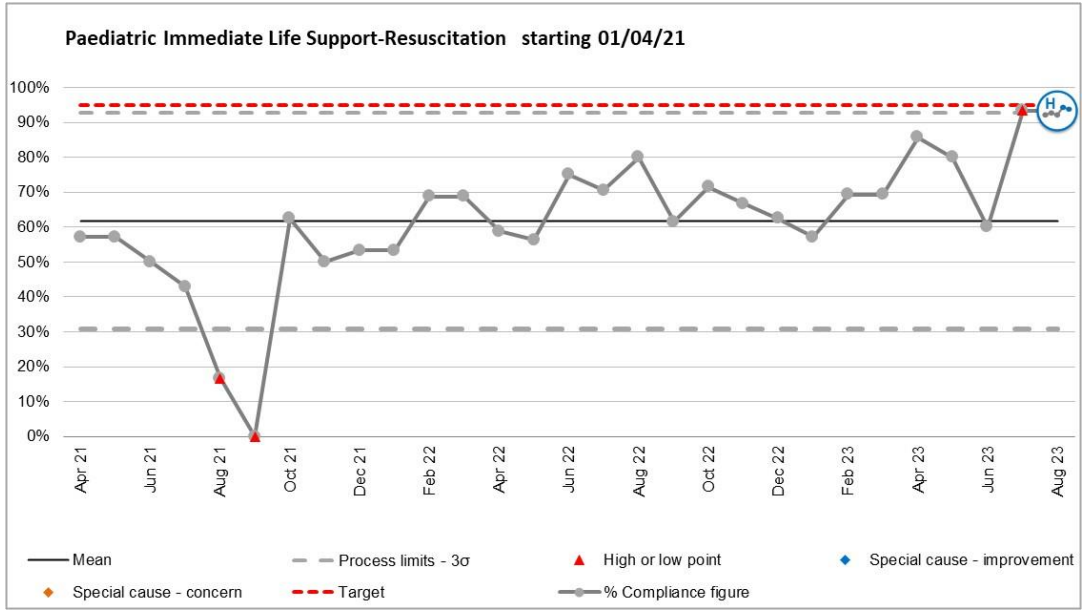
Paediatric Basic Life Support is now included within the Hospital life support training sessions.

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.

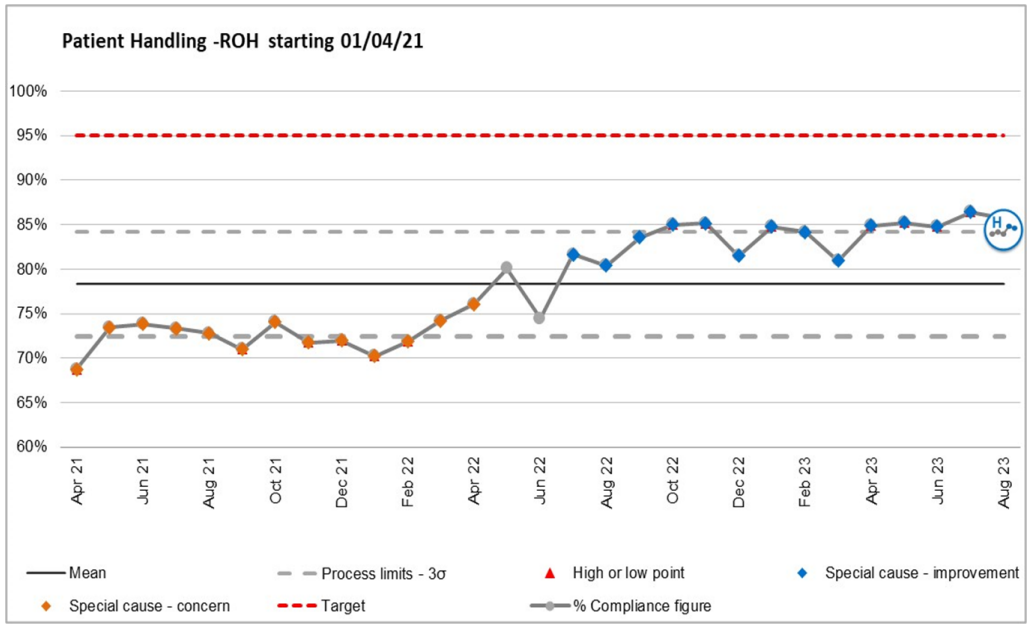


Patient Handling

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:

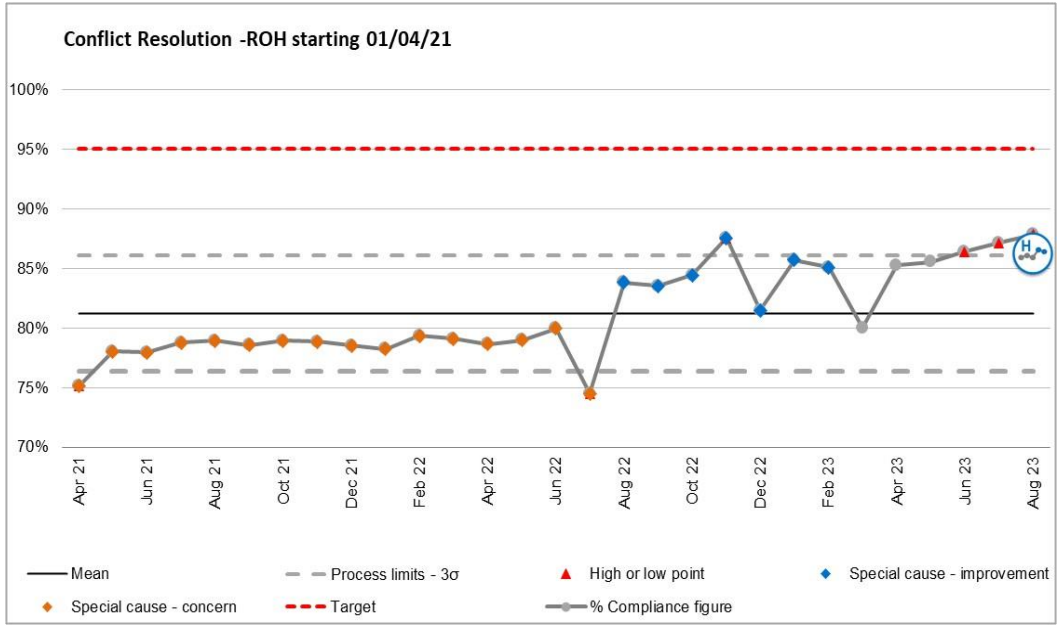
Compliance is hovering around 85%, a small increase in July. The key issue to address here is attendance as there are sufficient classes but attendance has been poor recently.



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.

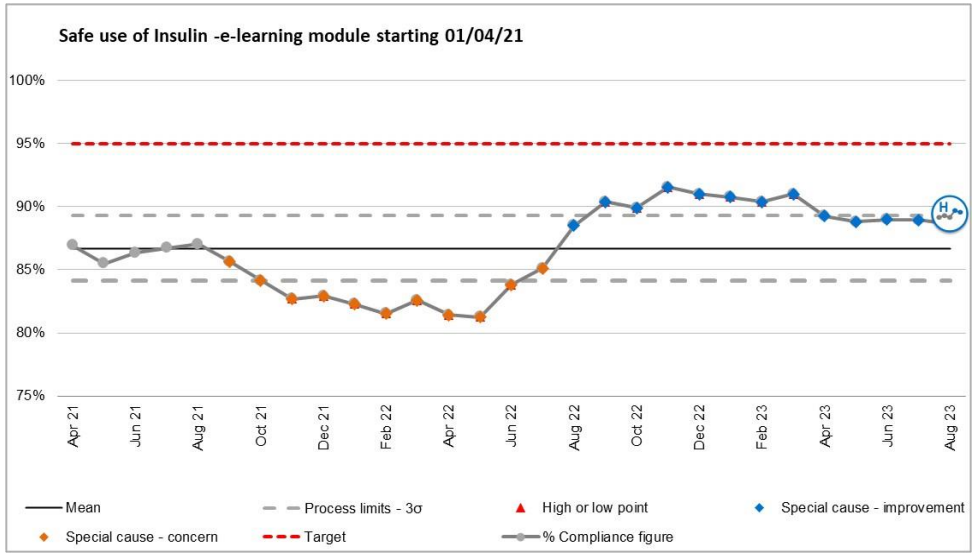


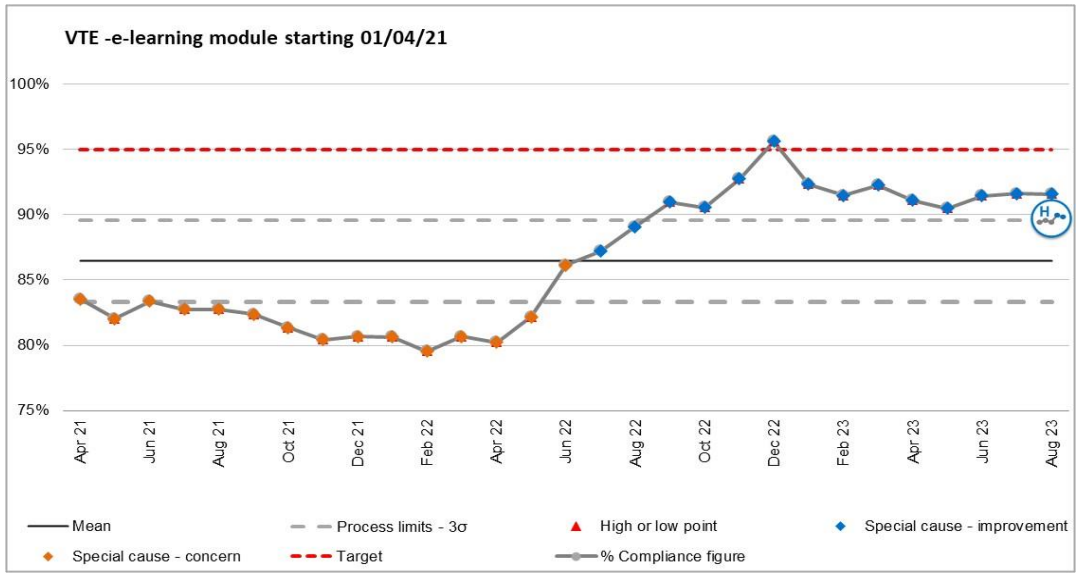
VTE, Safe use of Insulin, NEWS2

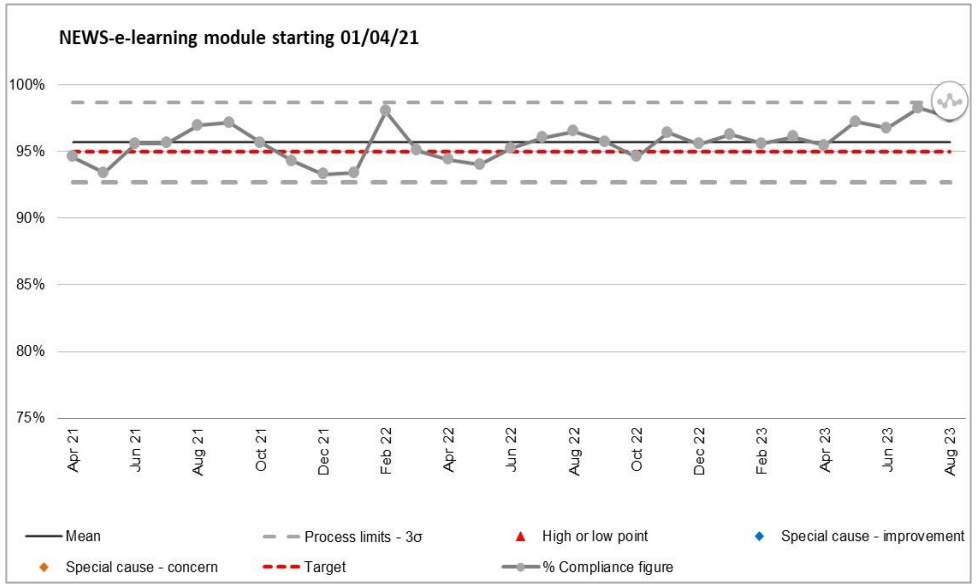
VTE: Completion of the VTE module has show a significant positive increase since February 2022, with highest compliance rating recorded in December 2022 when we were at target.

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.





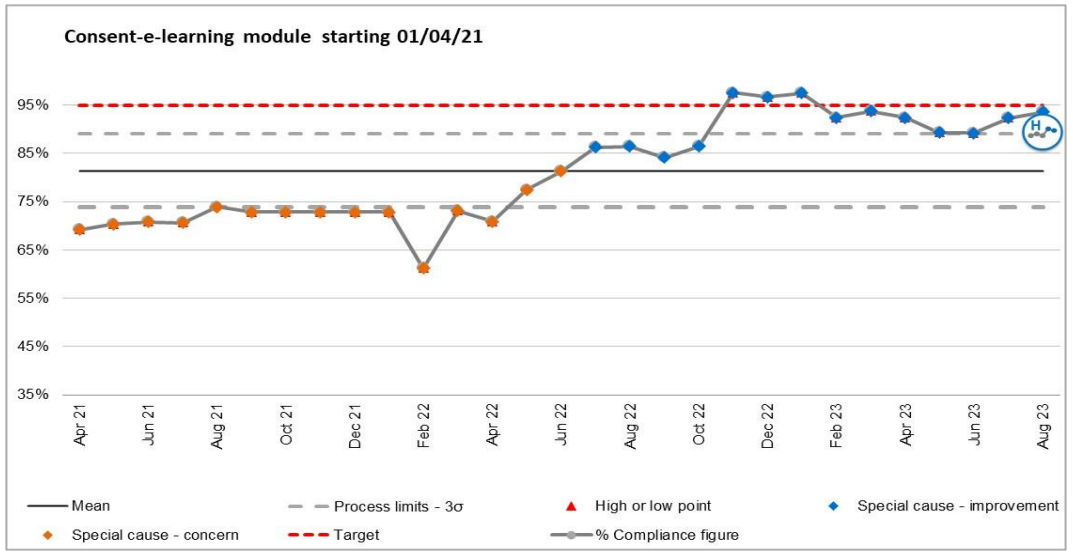


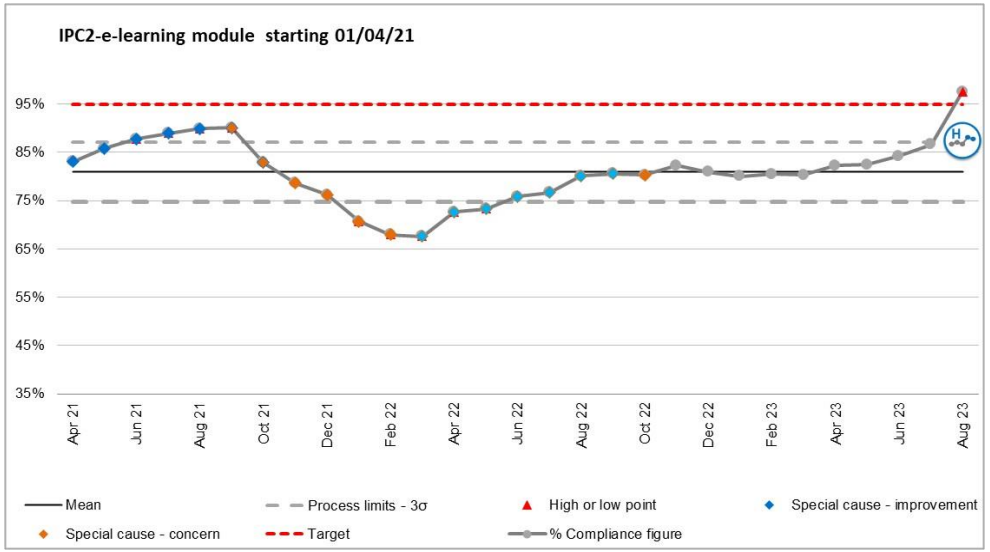
IPC Level 2, Food Hygiene, Consent

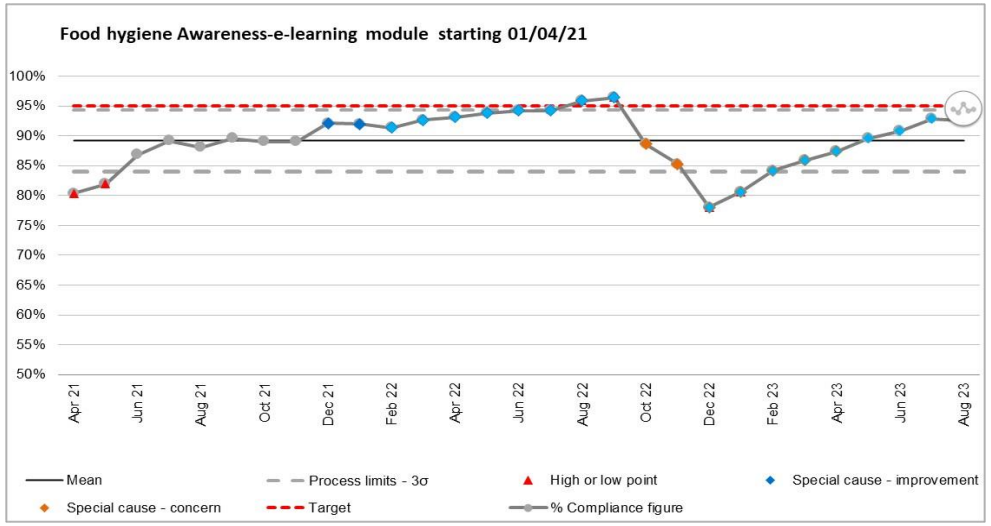
The **Infection Prevention and Control Level 2 and Food Hygiene** Modules were new modules introduced in October 2020. For both modules compliance has shown positive improvements since then.

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.







REPORT REF: ROHGO (11/23) 012

COUNCIL OF GOVERNORS

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:	**23 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 Council is asked to: familiarise themselves with 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 and November Trust Board meetings.

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]