Frimley Health

NHS Foundation Trust

PUBLIC BOARD OF DIRECTORS

PUBLIC BOARD OF DIRECTORS

6 September 2024

08:30 GMT+1 Europe/London

Board and Seminar Room, Frimley Park Hospital

AGENDA

1. AGENDA, WELCOME AND INTRODUCTION

REFERENCES

Only PDFs are attached

1. Public agenda 06.09.24 V3.pdf

Board of Directors Meeting in Public
Friday 6th September 2024, 08:30-11:30
Boardroom, Admin Block, Frimley Park Hospital

A G E N D A

Item		Lead	Action	Paper	Time
1.	Welcome and Introduction	Chair	-	Oral	08:30
2.	Apologies and Declarations of Interest	Chair	Declare	Oral	08:32
3.	VIP Awards	Chief Executive	Note	Oral	08:35
4.	Minutes of the previous meeting	Chair	Approve	Attached	08:45
5.	Action Log from the previous meeting	Chair	Note	Attached	08:47
6.	Patient Story	Chief Nurse	Note	Video Presentation	08:50
7.	Ward to Board: Discharge Team	Chief Operating Officer	Note	Slide Presentation	09:00
Strategy					
8.	Chief Executive's Report	Chief Executive	Note	Attached	09:20
Board Oversight and Assurance					
9.	Operating Plan Delivery Report a) COO Report b) Committee Chair Report Quality and Safety Report a) CNO/CMO Report b) Committee Chair Report c) Mortality Report People Report a) CPO Report b) Committee Chair Report c) Employment Equality Report 2023/24 Finance Report a) CFO Report b) Committee Chairs Report (Finance and Audit)	Chief Executive and Executive Leads	Assurance	Attached	09:30
	Short Break (10:30-10:40)				

Quality and Safety Reports					
10.	Guardian of Safe Working Hours Annual Report	Chief Medical Officer	Assurance	Attached	10:40
Governance and Compliance					
11.	Risk Review: • Corporate Risk Register • Board Assurance Framework	Chair	Note	Attached	10:55
12.	Responsible Officer's Annual Report	Chief Medical Officer	Assurance/ Endorse	Attached	11:05
13.	Use of Trust Seal Report	Company Secretary	Ratify	Attached	11:15
Other Business and Public Questions					
14.	Any Other Business • People Committee Terms of Reference	Chair	- Approve	Oral Attached	11:20
15.	Public Questions	Chair	-	Oral	11:25
	Date of Next Meeting: Friday 1st November 2024, 08:30 – 11:30, Lecture Theatre, John Lister Postgraduate Centre, Wexham Park Hospital				

2. APOLOGIES AND DECLARATIONS OF INTEREST

3. VIP AWARDS

Oral

4. MINUTES OF THE PREVIOUS MEETING

REFERENCES

Only PDFs are attached

4. Board Minutes Cover Sheet.pdf

4a. Public Board Minutes 050724 v2.pdf

Report Title	Minutes of the previous meeting
Meeting and Date	Public Board of Directors, Friday 6th September
Agenda Item	4.
Author and Executive Lead	Hannah Farmhouse, Assistant Company Secretary Caroline Hutton, Interim Chief Executive
Executive Summary	The attached minutes records the items discussed at the Board of Directors meeting held in public on Friday 5th July 2024.
Action	The Board is asked to **APPROVE** the minutes as a correct record of the meeting.
Compliance	NHS Provider Licence; Standing Order 14.1

Frimley Health NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC

Friday 5th July 2024, 08:30-11:30

Town Hall, Greenwood Offices, Heatherwood Hospital

MINUTES OF MEETING

Members Present:

Bryan Ingleby	Trust Chair
Na'eem Ahmed	Associate Non-Executive Director (from item 15)
Michael Baxter	Deputy Chair, Non-Executive Director
Gary McRae	Non-Executive Director
John Weaver	Non-Executive Director
James Clarke	Chief Strategy Officer
Tim Ho	Chief Medical Officer
Caroline Hutton	Interim Chief Executive
Matt Joint	Chief People Officer
Ellis Pullinger	Interim Chief Operating Officer
Kishamer Sidhu	Chief Financial Officer
Melanie van Limborgh	Chief of Nursing and Midwifery

In Attendance:

Leigh Bayo	Senior Hand Therapist (Ward to Board)
Lisa Buckingham	Head of Patient Experience (Patient Story)
Jo Gronmark	Head of Therapy (Ward to Board)
Anna Mughal	Principal lead for Paediatrics and Pelvic Health
Charlotte Quilliam	Senior Specialist Speech and Language Therapist (Ward to Board)
Sarah Rooke	Heads of Service in Therapies (Ward to Board)
Zoe State	Heads of Service in Therapies (Patient Story/Ward to Board)
Minoeska Teeuwen	Head of Occupational Therapy, Surgical Appliances and Hand Therapy (Ward to Board)
Laura Wootley	Senior Vascular Physiotherapist (Ward to Board)
Lauren Whitfield	Heads of Service in Therapies (Ward to Board)
Victoria Cooper	Acting Company Secretary
Hannah Farmhouse	Assistant Company Secretary (Minutes)
James Taylor	Head of Communications
Dorota Underwood	Committee Officer
Amandeep Singh Sachdeva	Speciality Doctor, WPH (observer)
Charles Fowles	Public Governor
John Lindsay	Public Governor
Sarah Peacey	Public Governor
Malcolm Treen	Public Governor
Rod Broad	Member of the Public
Mary Probert	Member of the Public

Apologies:

John Lisle	Non-Executive Director
John Weaver	Non-Executive Director
Jackie Westaway	Non-Executive Director

1. Welcome and Introduction

1.1 The Trust Chair opened the meeting and thanked the Governors and members of the public for attending.

2. Apologies and Declarations of Interest

2.1 Apologies were noted as above.

2.2 There were no declarations of interest.

3. VIP Awards

3.1 Caroline Hutton introduced the Values into Practice awards, which recognised the work of Frimley Health staff. There were around 70-80 nominations received each month from staff, patients and members of the public.

3.2 The first award was presented to Dr Anika Wijewardane, who was nominated by her colleagues and the Frimley Excellence team for proactively leading change in Frimley Park Hospital (FPH) Acute Medical Unit (AMU), with the implementation of a new MDT model of care, in line with GIRFT and other best practice. Caroline Hutton worked closely with Anika and commented on her passion and enthusiasm.

3.3 The second award was presented to Linda Kelly, an Oncology Secretary who was nominated by colleagues. Caroline Hutton read the citation which described how Linda spent over an hour on the phone with a patient who was recently diagnosed with cancer, listening to his worries and fears. As a result of Linda's care and compassionate the patient agreed to attend tests and appointments.

3.4 The third award was presented to Megan Parry, Frimley Health Charity Events Manager, for her work on the Run Frimley event. There were over 1,200 runners and feedback was fantastic. The event had evolved significantly and was now backed by significant corporate donors.

3.5 The final award was presented to Dr Tamara Howe, Consultant in Obstetrics and Gynaecology. Tamara was nominated for her engagement which supported the full recovery in FPH Gynae. 28-day Faster Diagnosis Standard performance went from 68% in April 2023 to 84% in April 2024, far exceeding the 75% National target.

3.6 The Board congratulated the Values into Practice winners.

4. Minutes of the previous meeting

4.1 The minutes of the meeting held on 3rd May 2024 were **APPROVED** as an accurate record.

5. Action Log from the previous meeting

5th May 2023 – 11.5 Programme Update

5.1 Caroline Hutton would attend the Transformation Board meeting and provide an update at the September Board of Directors meeting.

3rd May 2024 – 11.6 Performance Report

5.2 Ellis Pullinger reported that 25% of the non-admitted waiting list were paediatric patients, and a number exceeded 52-weeks. There were 108 patients over the 78-week wait for an outpatient appointment.

5.3 It was acknowledged that excessive waiting lists were a national issue and that the Trust's operating plan contained specific targets for the Trust. Operational prioritisation was key, and the Board would be notified of any material changes to the plan.

6. Patient Story

6.1 Melanie Van Limborgh introduced the Patient Story relating to the use of artificial corneas. The patient story was a BBC News interview with the patient, his wife and Frimley Health consultant, Mr Poole.

6.2 Zoe State advised that the patient, Mr Farley, started his treatment in September 2020 and was on the waiting list for a human graft. He waited for over one year and then when he did receive treatment the donated tissue unfortunately failed. This impacted Mr Farley's quality of life as he was unable to drive or carry out his daily activities, and the risk of him having a fall increased.

6.3 Mr Farley agreed to be the first patient to receive an artificial graft and his feedback on the care he received was excellent. He commented that he was well informed, and the graft greatly improved his quality of life, giving him his independence back. His only area for improvement was having to lie flat on a bed for 4 hours after the operation.

6.4 The Board **NOTED** the Patient Story.

7. Ward to Board: Therapies

7.1 The Board received the Therapies Ward to Board presentation and was given a short brief from each of the specialities.

7.2 The presentation highlighted the following key points:

- The therapies teams worked with every directorate within the trust. The service was structured to support clinical and leadership development, supporting the Trust's registered and unregistered workforce.
- The patient satisfaction survey reported the team were good at gaining consent, explaining their role and shared decision making. The team were also good at treating people with care and concern and respecting privacy and dignity.
- Areas for improvement included communication with wards and discharge. Actions were in place to address the areas.

7.3 Melanie van Limborgh thanked the team and asked for more information on videofluoroscopy. It was reported that radiographers were beginning to run weekly clinics with outpatient appointments.

7.4 Caroline Hutton recognised the Quality Improvement work carried out by the team. The team embraced the Frimley Excellence approach and were highly visible during morning briefs. Interaction between teams had improved.

7.5 Mike Baxter noted that the majority of the CQC self-assessment scores were 3, and asked how the Board could support the team to achieve 4s. Jo Gronmark advised that focus was on the team's ability to deliver care in a timelier manner, through workforce mapping and utilisation of Heatherwood Hospital, as well as delivering care earlier in the patient's pathway.

7.6 Gary McRae queried how the team worked with system partners. Jo Gronmark confirmed that the service worked closely with community colleagues and partners in the ICB. Unfortunately, neighbouring organisations had recently reduced their therapies teams, subsequently increasing pressure on the Trust's service.

7.7 Janet Rubin asked when the team anticipated achieving the optimal staffing model, and queried whether apprenticeships were being utilised. Jo Gronmark advised that there were some challenges

around apprenticeships, such as the cost and staff availability to provide cover, but she and Melanie van Limborgh were exploring the options. Regarding recruitment, a five-year plan was in place.

7.8 The Board of Directors **NOTED** the Ward to Board presentation.

8. Chief Executive's Report

8.1 The Trust Chair introduced the Chief Executive's Report and advised that Performance would now be reported on under the Board Assurance and Oversight item.

8.2 Caroline Hutton presented the Chief Executive's Report and highlighted the following key points:

- It was Caroline's last Board meeting as the Interim Chief Executive as Lance McCarthy would be joining the Trust on 20th August. Caroline thanked the Board for the opportunity and support.
- Dr Chris Orchard was appointed as the Chief of Service for Medicine, succeeding Dr Gareth Roberts who had taken on the new Chief of Service role for Transformation and Continuous Improvement.
- Junior Doctors were on strike from 27 June to 2 July. The teams worked hard to ensure that adequate cover was in place, to retain as much elective care as possible. There was a possibility of collective national action in primary care later in the summer, and the Trust was in early conversation with the ICB as this was unprecedented.
- The Trust and ICB joined a national operational planning meeting with Amanda Pritchard and Julian Kelly. It was recognised that a lot of hard work had gone on for the Trust to meet its targets. Focus was on financial delivery and the urgent care plan.
- The Trust's strategic objectives had progressed, and communications would be circulated in due course.
- The Care Quality Programme continued at pace and Caroline Hutton congratulated Melanie van Limborgh and her team on the fantastic work across the organisation.
- In relation to the New Hospital Programme, it was reported that Nigel Foster had stepped down as the Senior Responsible Officer (SIRO), and Kish Sidhu would take on the role. Due diligence and the pre-planning application process was ongoing.
- Transformation and Continuous Improvement were scheduled for discussion at the Private Board of Directors meeting. A major EPR upgrade was carried out.
- The Board congratulated the Pradip Patel, the former Trust Chair, as he was awarded a MBE in the King's Birthday Honours last month, in recognition of his service to healthcare.

8.3 Gary McRae asked if the Trust's operating plan was aligned with the ICB plan, and how the transformation programme would be reported to the Board. Caroline Hutton confirmed that the plans were drafted in collaboration and complimented each other. Kish Sidhu highlighted that the Trust made up 80% of the ICB, and so were naturally aligned. Caroline Hutton confirmed that the Board would receive updates on transformation and productivity.

8.4 There was discussion around the figures reported for virtual wards and it was noted that the length of stay figure required amending. **Action: Carol Deans**

8.5 The Board of Directors **NOTED** the Chief Executive's Report.

9. Board Oversight and Assurance

Quality and Safety Report

9.1 Melanie van Limborgh presented the Quality and Safety Report and highlighted the following key points:

- There was a rise in the number of falls. Work with the falls and therapies teams was ongoing and the number was being closely monitored.
- The Care Quality Programme (CQP) continued at pace. Melanie emphasised that the CQP focussed on quality improvement and highlighted areas of weakness.

9.2 Linda Burke added that the Quality Assurance Committee received the Patient Experience Annual Report and was pleased with the progress made, particularly against complaints. The Quality Assurance Committee were also sighted on the Infection Prevention Control (IPC) teams plans to move toward Water-Safe Care at Wexham Park Hospital, which involved removing sinks.

9.3 Janet Rubin noted that one of the CQC 'Must do' actions involved ensuring Mandatory and Statutory Training (MaST) medical compliance, and queried when the target would be met. Tim Ho explained that medical staff were required to complete MaST training as part of their appraisal and therefore compliance remained at around 90%. Melanie van Limborgh added that weekly CQP meetings took place, and that appraisals and MaST training was a standing agenda item.

9.4 The Quality Assurance Committee was exploring the presentation of data received in reports, and deep dives into areas of concern. At the last meeting the Committee received the Maternity Dashboard, which provided data for regional and national benchmarking. The Board discussed how it received data within the Performance report and Caroline Hutton provided assurance that EPIC had increased the availability and richness of data.

Operational Plan Delivery Report

9.5 Ellis Pullinger introduced the Operational Plan Delivery Report and advised that the Trust was on track to achieve 4 of the measures. He highlighted the Referral to Treatment (RTT) which set out maximum wait times for patients. The Trust would report 5 patients waiting over 78-weeks in June, and 2 were anticipated in July, both were awaiting corneal transplants.

9.6 The benchmarking analysis reported that the Trust was in the bottom quartile nationally, however this was due to an e-referral issue that was now resolved. Besides this, the Trust benchmarked well nationally, and the team would continue to monitor performance metrics closely.

9.7 Janet Rubin asked if the team had sought guidance from other Trusts whose emergency department (ED) performance metrics was in the higher quartiles. Ellis Pullinger confirmed that the team had frequent dialogue with colleagues from other organisations, particularly around mutual aid, and he was in regular communication with Chief Operating Officer colleagues.

9.8 Caroline Hutton commented that the Trust was experiencing high numbers of patients through ED and would continue to work with the ICB to improve patient pathways. Internally focus was on internal discharge policies, to reduce length of stay were possible.

9.9 Bryan Ingleby advised that NHS England had written to all Integrated Care Systems and Trusts regarding urgent and emergency care, and he had been in discussion with colleagues at the ICB regarding a joint plan which would be presented to Board in September.

9.10 Mike Baxter highlighted Did Not Attend (DNA) rates. Ellis Pullinger advised that patient-initiated follow-up (PIFU) rates were increasing and engagement with patients would help target the reduction of DNA rates. Tim Ho commented that a cultural shift was required to move away from automatically issuing follow-up appointments that were not necessary.

9.11 Caroline Hutton added that it linked to transformation and digital workstreams and there were opportunities to reduce DNA rates through the My Frimley Health Record (MFHR) app.

9.12 Gary McRae suggested that the report include re-attendance figures. Ellis Pullinger agreed it was an important metric and would follow up with his team offline.

Operations

9.13 Gary McRae introduced the Finance Investment Committee assurance statement and highlighted the following points:

- The Committee thoroughly discussed productivity and challenged the team to provide robust monitoring and trend analysis, to demonstrate differences.
- The Committee agreed that issues of joint planning, flexibility of service delivery and benchmarking should be further developed in ensuring the provision of maximum potential at Heatherwood Hospital and M Block.
- The Committee reviewed the Corporate Risk Register.

People

9.14 Matt Joint reported:

- The core people metrics, including vacancies, turnover, time to hire and sickness remained stable.
- There was a lot of focus on appraisal and MaST metrics.
- People managers had an important role in the Trust's financial position and cost controls were introduced to improve rigour.
- The Board would receive more detail on the People Plan and Strategy at future meetings.
- National Staff Survey feedback was being triangulated and there was a lot of activity around the Trust's zero tolerance to abuse and bullying campaign.
- The HR team were working on a communications to amalgamate the variety of support and benefits on offer to the workforce.

9.15 Janet Rubin noted that the number of substantive staff had increased, however the bank and agency spend had not decreased. Tim Ho advised that historically there were a number of difficult to recruit positions resulting int the Trust receiving assistance from the centre, and since then it had been difficult to move away from that approach. The team had been looking into additional Rostering controls, without compromising safety.

Finance Report

9.16 Kish Sidhu presented the Finance Report and highlighted the following key points:

- The Trust's year to date position at the end of month 2 was a deficit of £10.8m, which was £1.3m adverse to plan.
- I&E was adverse to plan, 81% was caused by the cost improvement programme (CIP), and escalation areas.

9.17 Gary McRae commented that the Finance Investment Committee expressed concern around the financial position for Month 2. There was also discussion around the CIP programme, productivity and efficiency measures, benefits realisation, and performance standards.

9.18 Caroline Hutton agreed it was important that the Trust articulated variations from original business cases, reasons why benefits may no longer be applicable, and countermeasures in place.

9.19 The Board of Directors **NOTED** the Performance report and Committee Assurance statements.

10. Sexual Safety Charter Report

10.1 Bryan Ingleby introduced the Sexual Safety Charter Report and reported that the Board of Directors had received a comprehensive briefing from Greta McLachlan at the last private board meeting.

10.2 Matt Joint presented the Sexual Safety in Healthcare Charter which considered the background to the charter, the Trust's strategic objectives and People strategy.

10.3 The National Staff Survey reported that 9% of staff within the organisation experienced some level of harassment, and whilst this was not atypical of an acute Trust, it was not acceptable.

10.4 The Trust had appointed a lead and begun reviewing relevant policies. A steering group was established in May and the commitment to the charter was launched. There was a lot of energy behind the commitment and a lot of staff had spoken up and shared their experiences, which was very impactful and empowering.

10.5 Gary McRae highlighted the link to the Freedom to Speak Up (FTSU) role, and the need for transparency and a safe space. Matt Joint agreed that an action plan and adequate resource was required. Work was underway to recruit a deputy FTSU Guardian and admin support.

10.6 Bryan Ingleby advised that the revised Performance Report would include updates on areas such as FTSU and the Sexual Safety Charter, so the organisation was assured that the Board were sighted on these important areas more than once a year.

10.7 The Board of Directors **NOTED** the Sexual Safety Charter Report.

11. Nursing and Midwifery Staffing

11.1 Melanie van Limborgh presented the bi-yearly Nursing and Midwifery Staffing report and highlighted the following key points:

- Workforce reviews were held between September-December 2023 and the budget would be presented to the Trust Management Board for approval. Actions would then be carried out over the coming 6-months.
- Despite challenges to HCA recruitment, there was a net gain of 212 new starters in the last 12 months. The success was due to a constant recruitment plan and incremental improvements.
- There was also progress around retention of registered nurses.
- Funding for Internationally Educated Nurses (IENs) was removed and thus the number of IENs was reviewed and reduced. The reduced forecast was 78 IENs, however it would remain under review in line with the launch of M Block.
- The average Care Hours per Patient Day (CHOOD) was 8.6 days, which benchmarked well regionally and nationally.
- Agency staff expenditure for mental health reduced following the recruitment of two band 7s on each site.
- The team were exploring university recruitment options to support maternity markers.
- Benchmarking against model hospital data, the Trust was performing favourably. In the areas slightly outside the national average, such as the Trust total percentage head room uplift, actions and strong roster controls were in place.

The Board of Directors **NOTED** the Nursing and Midwifery Staffing report.

12. Infection and Prevention Control Annual Report 2023/2024

12.1 Melanie van Limborgh presented the Infection Prevention and Control (IPC) Annual Report 2023/24, which had been presented to the Quality Assurance Committee and Healthcare Infection Control Committee.

12.2 It was an extensive report which covered the activities of the IPC team throughout the year. Highlights included:

- It was a very busy year for the IPC team. There were reductions to the number of healthcare associated infections.
- The Trust was the 17th lowest nationally for Clostridioides difficile infections.
- E. Coli infection rates were closely monitored.
- Focus was on anti-microbial stewardship.
- The operational impact of COVID-19 on the Trust was still evident.
- During the year there was a carbapenemase-producing Enterobacterales (CPE) outbreak linked to the water systems at Wexham Park Hospital. The team were working with national and international experts to develop a Water-Safe care capital project.
- Hand hygiene in patients and catheter care were key areas for improvement in the coming year.

12.2 Bryan Ingleby commented that an investigation took place following the CPE outbreak and the Board would consider the Morbidity and Mortality report in the private Board meeting due to the sensitive nature of the report. Regarding a Health Service Journal article, Bryan Ingleby confirmed that a correction was made.

12.3 The Board of Directors **NOTED** the Infection and Prevention Control Annual Report 2023/2024.

13. Risk Review

Board Assurance Framework and Corporate Risk Register

13.1 Bryan Ingleby introduced the Risk Review item and reported that the new Director of Corporate Affairs was due to join the Trust in October and would lead on risk once in post.

13.2 A Risk Management Review Group was established and a lot of work was ongoing to develop the Corporate Risk Register and Board Assurance Framework. The Board would spend some time thoroughly reviewing the Trust's approach to risk.

13.3 Janet Rubin queried whether the PR6 investment in EPR should include Heatherwood. Caroline Hutton confirmed that it should include everything.

13.4 The Board **NOTED** the Board Assurance Framework and Corporate Risk Register

14. Standing Financial Instructions

14.1 Kish Sidhu presented the Standing Financial Instructions (SFIs) for annual review. The SFIs were reviewed by the Audit Committee and following some amendments they were recommended for approval.

14.2 The revised SFIs had greater emphasis on control and accountability on the budget holder, rather than retrospective action.

14.3 Gary McRae commented that the revised version was a big improvement but there was still some work around communications required, to ensure that the document was used in a meaningful way. The Board agreed that refresher training was necessary.

14.4 The Board of Directors **APPROVED** the Standing Financial Instructions 2024.

15. Committee Terms of Reference

15.1 Victoria Cooper presented the Terms of Reference annual report.

15.2 The Board of Directors **APPROVED**:

1) Audit Committee Terms of Reference.
2) Nominations Committee Terms of Reference.
3) Performance and Remuneration Committee Terms of Reference.
4) Quality Assurance Committee Terms of Reference.

16. Any Other Business

16.1 There was no other business to discuss.

17. Public Questions

17.1 In relation to the Trust's CEO challenge, Sarah Peacey commented that there were requests for basic equipment and queried whether the new SFIs would empower staff to obtain such equipment. Kish Sidhu advised it was about better education and following the correct lines of authorisation.

17.2 Mary Probert asked when the New Frimley Park Hospital site would be made public. Caroline Hutton explained that there was a shortlist of sites that were going through the due diligence process. Kish Sidhu added that the sites would have to be validated by external parties. The Board would receive an Outline Business Case in October, and it was likely that the site would be announced in early 2025. Bryan Ingleby confirmed that as it was a significant transaction the Council of Governors would be involved and asked to provide formal approval.

17.3 Mary Probert thanked the Board and suggested that the Trust start planning the staffing model as soon as possible. Caroline Hutton agreed it would be a significant piece of work and the clinical strategy was underway.

17.4 Mary Probert commented that from her experience volunteering in ED with Health Watch, she observed that patients were trying other pathways such as pharmacies but ended up being referred to ED. Caroline Hutton agreed that it was a historic issue and patients would often present at ED because they know they can get the help they need. The Trust was looking at the urgent care model. Bryan Ingleby said it was important to feedback to the ICB.

17.5 John Lindsay said that the Patient Experience and Involvement Group had carried out a deep dive on DNA rates and there was a big improvement following the launch of MFHR, along with dedicated phone lines and the SMS service. Feedback from the public was that appointments could be changed at short notice.

17.6 Malcolm Treen highlighted parking at Frimley Park Hospital. James Clarke acknowledged that the site was over capacity and the estates team were reviewing ways to make improvements, such as reconfiguring spaces to create a few more. The staff car park was reviewed and around 40-50 spaces were created. The team were also exploring whether there were nearby sites the Trust could lease or the possibility of a park and ride/walk service.

18.	Date of Next Meeting
18.1	Friday 6th September 2024, 08:30-11:30, Board Room, Administration Block, Frimley Park Hospital

The minutes of the meeting were duly approved by the Board:

Name:	Bryan Ingleby
Signature:	
Date:	

5. ACTION LOG FROM THE PREVIOUS MEETING

REFERENCES

Only PDFs are attached

5. Public Action Log.pdf

BOARD OF DIRECTORS MEETING IN PUBLIC ACTION LOG

Friday 6th September 2024

AGREED ACTION	LEAD	END DATE
CLOSED ACTIONS		
5th May 2023 – 11.5 EPR Programme Update Board to receive outcomes from the EPR optimisation/managing change learning event. ***Update: A report following a two-year post 'go live' event is available in the reading room.***	Caroline Hutton	~~5 July 2024~~ 6 September 2024
3rd May 2024 – 14. Freedom to Speak Up Matt Joint and Steve Roots were challenged by the Board to adopt a new approach to target the 35% of staff who did not feel safe to speak up, and to set an ambition to improve the metric. ***Update:*** FTSU has received additional investment. An interim Band 7 Deputy Guardian has been recruited. We will make a permanent appointment to the role, along with an Administrator and up to three part-time clinical Guardians. This will increase our ability to respond to speaking up requests in a timely and effective way, increasing the confidence from staff that they will be heard. It will also enable a more proactive approach, in training, promoting, and triangulation data to amplify the voices of those speaking up. Specific support for medical disciplines will help review, embed, promote, and train FTSU and the importance of a speaking-up culture.	Matt Joint	6 September 2024
5th July 2024 – 8.4 Chief Executive's Report The length of stay figure in the Chief Executive's Report would be corrected.	Carol Deans	6 September 2024
ACTIONS IN PROGRESS		
1st March 2024 – 11.7 People Update The Board will receive a detailed update on actions the Trust is taking on staff wellbeing at a future Seminar.	Matt Joint	December 2024
3rd May 2024 – 13.2 Equality, Diversity and Inclusion – High Impact Actions The Board will receive an update on the progress being made on the Equality, Diversity, and Inclusion (EDI) High Impact Actions and the work of the EDI Committee at a future meeting.	Matt Joint	1 November 2024

6. PATIENT STORY

REFERENCES

Only PDFs are attached

6. Paul Griffin Patient Story Cover Sheet Aug 24 (002).pdf

Patient Story

Patient Story Name:	**Paul Griffin**
Meeting & Date:	Trust Board September 2024
Agenda Item	6.
Synopsis: **(inc directorate/ inpatient/outpatient/ hospital site)**	Paul Griffin was admitted to Wexham Park Hospital in June this year with a collapsed lung (pneumothorax). He attended the Emergency Department (ED) and was later transferred to Medicine Acute Dependency Unit (MADU). The patient attended ED after feeling 'something go' in his chest on Monday, June 17 2024 and after extensive discussions with his wife as to the appropriateness and merits of calling his GP, an ambulance or indeed self-presenting to ED. On attendance to ED he was subsequently diagnosed with a pneumothorax that required insertion of a chest drain. Five days after his admission he said he felt 'better than ever' – and put it down to the staff at Wexham Park. He said: "Thanks to them I have gone from a life-threatening emergency on Monday to feeling better than ever five days later"
Source of story: **(Complaint/compliment/ incident/ targeted invite)**	Story highlighted by Trust Communication and Engagement team after initially appearing in the Bucks Free Press on 9th July 2024 https://www.bucksfreepress.co.uk/news/24440675.wexham-park-hospital-better-world-class-hotel-says-patient/
Directorates/ Meetings/ Committees where story has been shared:	Shared with ED and MADU, Heads of Nursing and Matrons
Areas of good practice identified:	The patient describes his experience as 'amazing' and 'phenomenal'. Key areas of good practice include: • Prompt assessment, recognition of severity of his condition and treatment within ED • Staff were kind, caring, listened and explained procedures. He describes the staff as: "committed to patient care and comfort. They gel, they communicate, they talk, they discuss, they disclose, they explain, they look after every aspect of everything. It's like those formation air displays of old, the timing and perfection are both awesome. It almost makes being poorly a pleasure" • Communication between staff to expedite and coordinate treatment improved with headsets now being used within ED.

Issues identified:	No real issues or concerns identified, all positive in terms of Mr Griffins whole contact with Wexham park Hospital. • Availability of GP appointments mentioned however, ED was the most appropriate service for this patient to access. • Patients arrive expecting a negative experience – expecting long waits in waiting rooms which may negatively impact and deter patients from accessing our services. • Signposting to next steps within assessment process within ED not always known or appreciated.
Actions:	Despite the daily challenges our ED environments face, this scenario celebrates that the acutely unwell patient was proactively identified, with effective communication and coordination amongst teams and services, to ensure timely and effective treatment and management throughout the ED journey and through to the acute admitting ward. We know from multiple sources of patient feedback such as Friends and Family Test, Complaints, Patient Advocacy Liaison Services, and patient surveys that it is often the staff, attitude and communication that make the real difference between a positive experience or a negative one. It is hoped that this story being shared will demonstrate the value in effective communication and coordination of safe, effective, and appreciative care. This story is a fantastic demonstration of the Trust Values being upheld. 

7. WARD TO BOARD: DISCHARGE TEAM

REFERENCES

Only PDFs are attached

7. Ward to Board Complex Discharge Team FHFT Final Version 2024.pdf

Frimley Health
NHS Foundation Trust

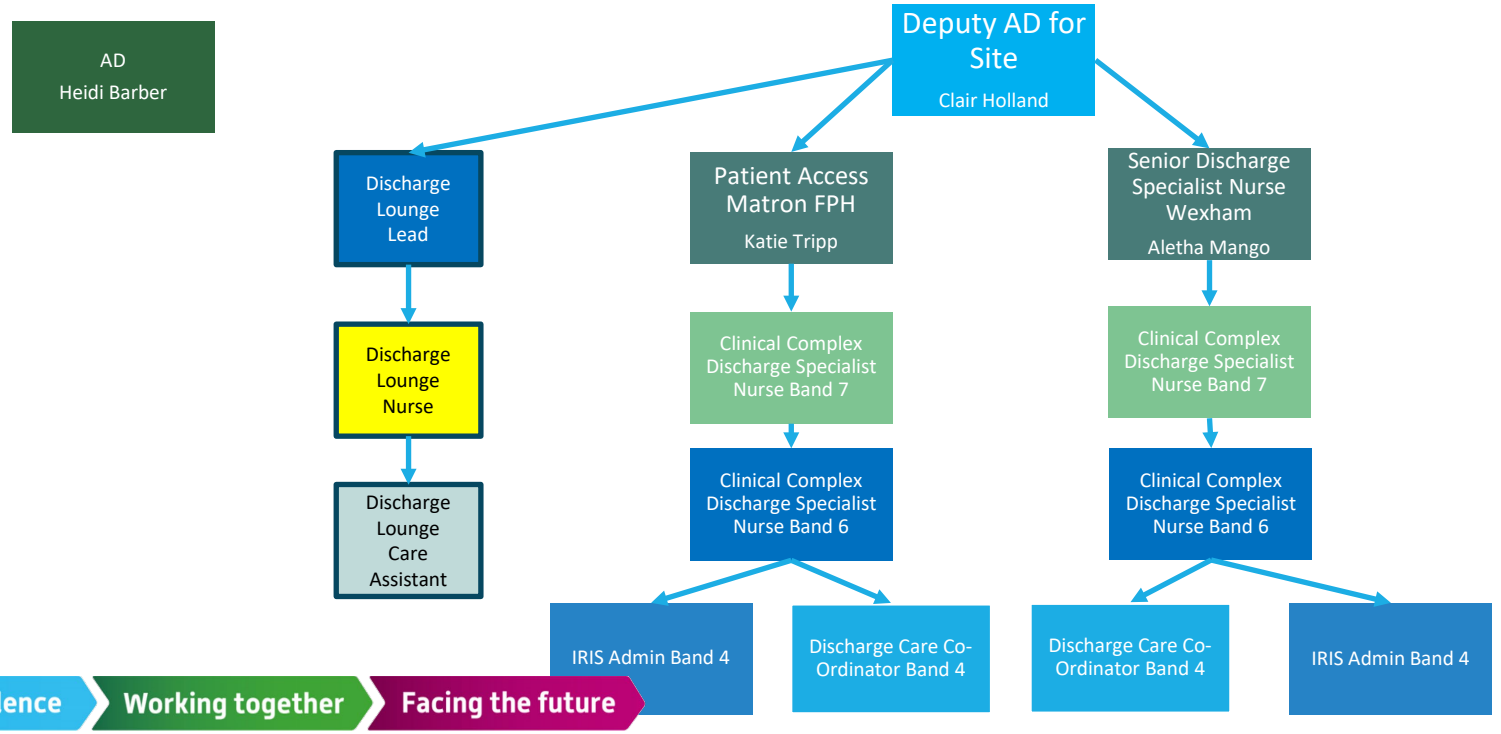
Complex Discharge Team & Discharge Lounge Ward to Board Presentation

September 2024

#LookTalkThinkDischarge

Service:

Total Staff Numbers		
Complex Discharge Specialist Nurse (Trained)	6 WTE FPH	5.9 WTE WPH
Discharge Care Co-Ordinator (unqualified)	7.76 WTE FPH	9 WTE WPH
IRIS Admin	1.0 WTE FPH	1.0 WTE WPH
Discharge Lounge (Trained)	4.0 WTE FPH	4.0 WTE WPH
Discharge Lounge (Untrained)	5.0 WTE FPH	5.0 WTE WPH



What the team say our roles and responsibilities are

Reduce Length of stay

SAFE

Engage patient and family

MDT Working

Timely Discharges

Discharge patients in safe and timely manner

Free up bed capacity

Co-ordinate

Collaborative working

Facilitate

Complex discharges

Holistic review of patients

Develop good working relationships

Effective discharges

Impacts of Covid on Discharge Team

Frimley Health NHS Foundation Trust

Pre Covid	During Covid	Post Covid
5 day service • 8-4 Mon - Fri	Changed to 7 day service overnight	7 day Service • 8-6 Mon-Fri • 8-4 Sat/Sun
Establishment for 5 day service	No increase of Establishment	Establishment increase
Day to day working of IRIS	Development of IRIS	IRIS
Section 2 and 5 referrals	Paper referral form created	Electronic referral form
Medically Stable For Discharges Delayed Transfer of Care Reporting	Daily Reporting	Development of Electronic reporting system via EPIC
Working with partners	Partners working from home	Partnership working
	Funding, development of Discharge Pathways 0 -3	Changes to funding and Discharge to Assess pathways

#LookTalkThinkDischarge

Our Frimley Health System

NHS
Frimley Health
NHS Foundation Trust

Serving a population of
820,000

Working across
225 SQ MILES

Covering
5 PLACES

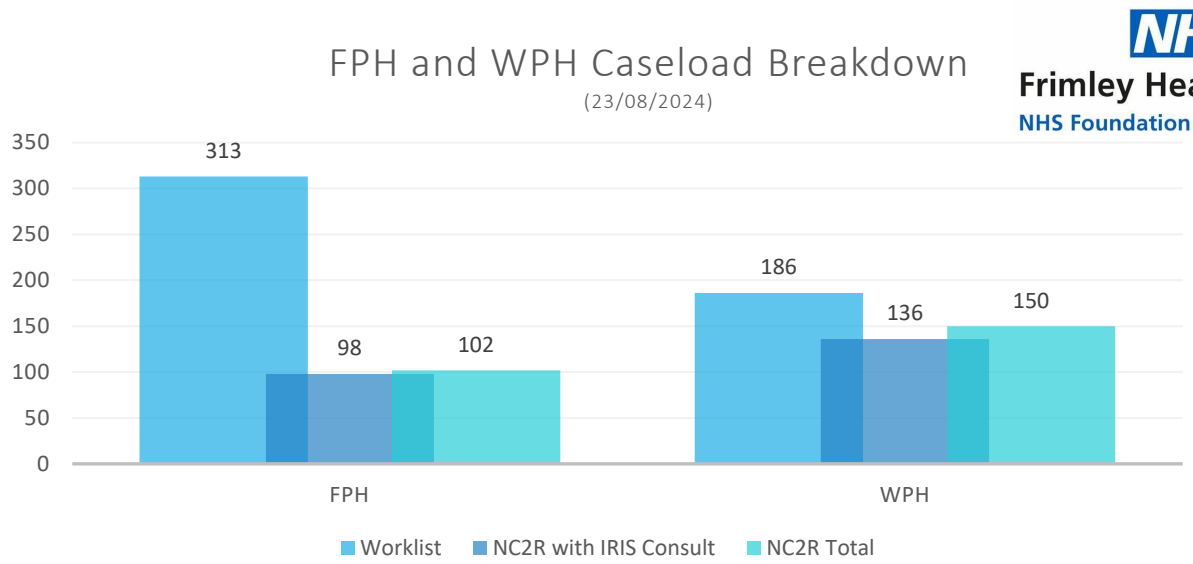
North East Hampshire & Farnham
Bracknell Forest
Windsor & Maidenhead
Slough
Surrey Heath

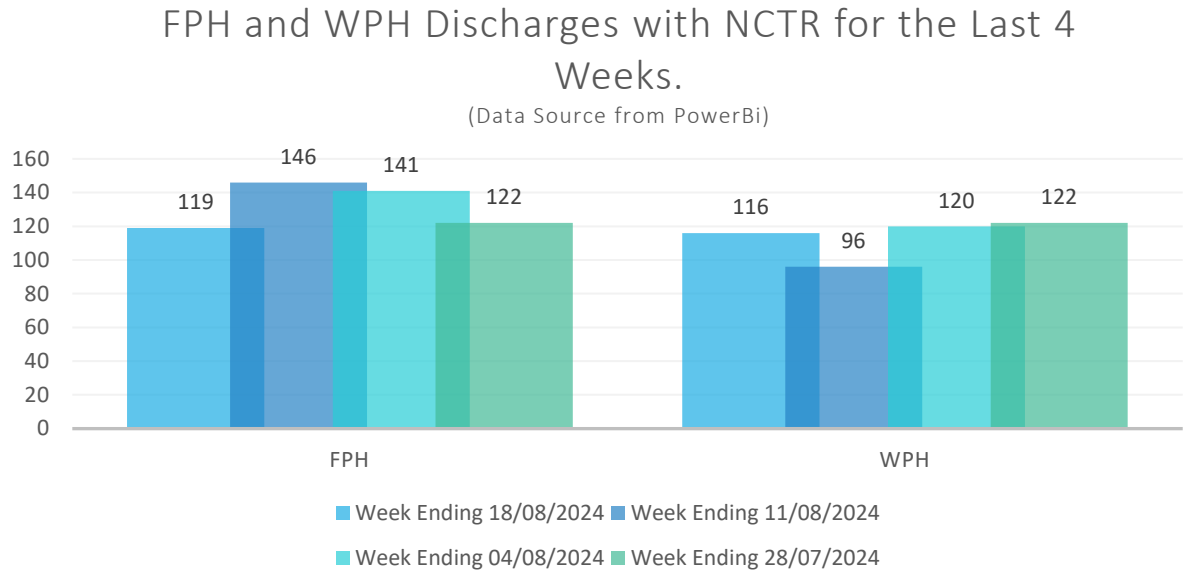
& North facing Buckingham System –
South Buckingham

#LookTalkThinkDischarge

DATA

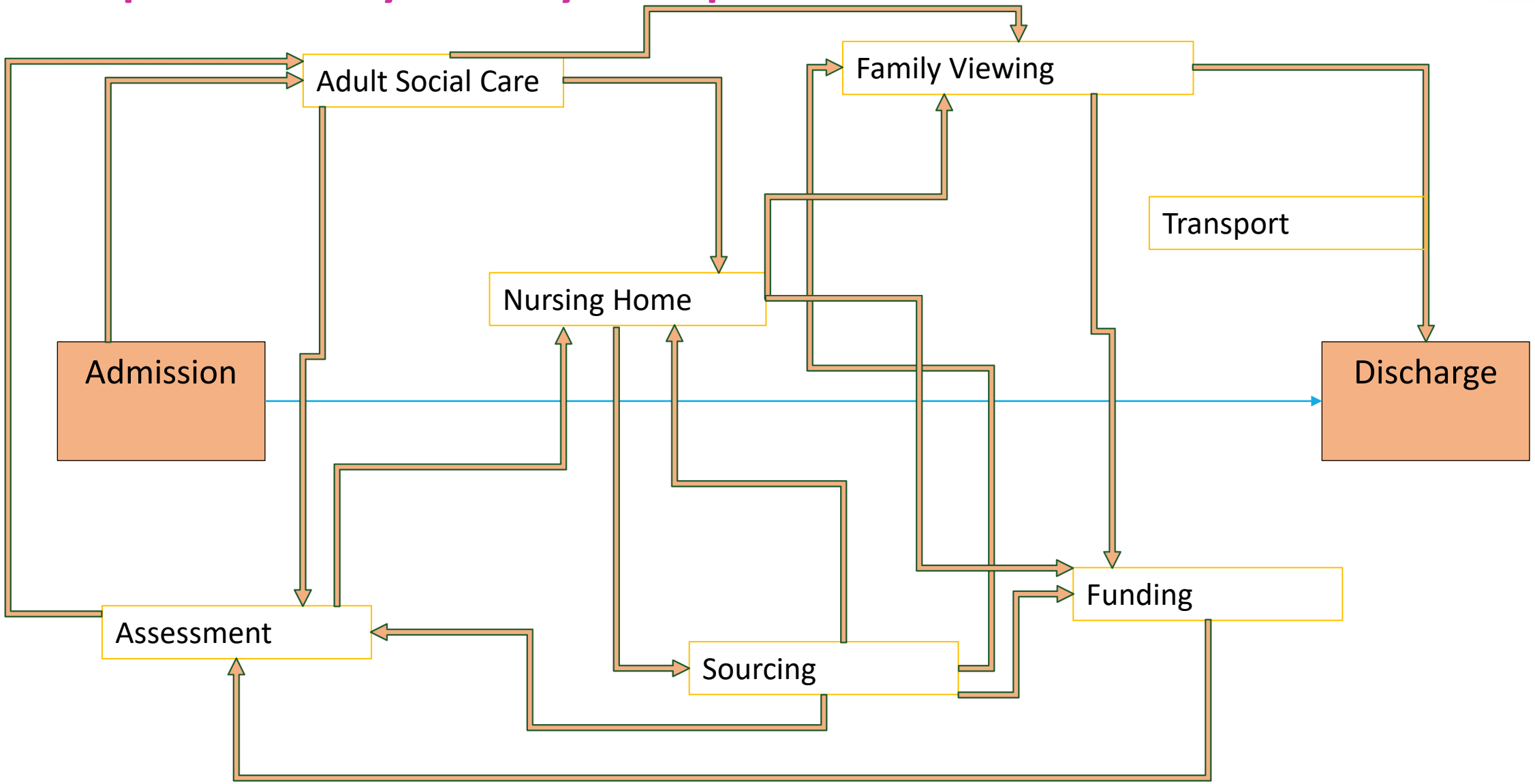
- Average case loads
- Not meeting Criteria to Reside (NCTR) variances
- Average weekly discharges from complex discharge team



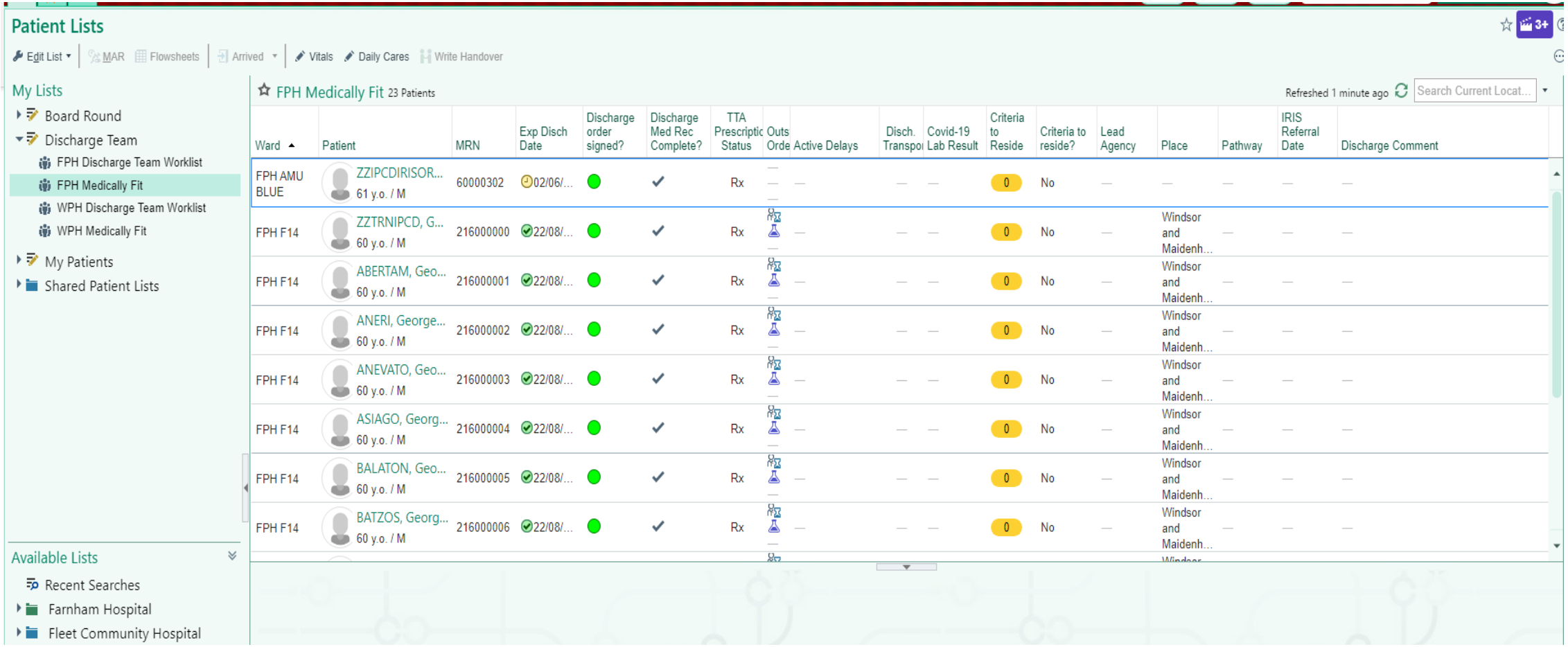


#LookTalkThinkDischarge

Complex Pathway Journey Example



EPIC



Taken from EPIC Playground – IG Compliant

Current and future challenges

- Cost of living crisis
- Winter fuel crisis
- Managing patient’s and family's expectations and choice
- Complexity of patients
- Lack of community care and Nursing Homes
- Legal

Future Plans

- Front Door
- Development of web page on intranet
- Continue to build on 7 day service – partnership working – not all cover 7 days
- Winter Planning
- Discharge awareness week #LookTalkThinkDischarge

IRIS

8. CHIEF EXECUTIVE'S REPORT

REFERENCES

Only PDFs are attached

8. CEO Cover Sheet.pdf

8a. CEO report_Trust Board_6 Sept 2024.pdf

Report Title	**Chief Executive's Report**
Meeting and Date	Public Board of Directors, Friday 6th September 2024.
Agenda Item	8.
Author and Executive Lead	Lance McCarthy, Chief Executive
Executive Summary	The Chief Executive's Report provides a bi-monthly update on key activities and events in the Trust. The report highlights the national context, the Trust's developments and achievements, and strategic updates.
Action	The Board is asked to **NOTE** the Chief Executive's report.
Compliance	Board Assurance

Chief Executive Report September 2024

This report provides an update on the key issues facing the Board since it last met.

1. INTRODUCTION

I am delighted to present my first board report as the Trust's CEO.

I want to take this opportunity to thank everyone for welcoming and supporting me in my first few weeks so warmly and particularly to thank Caroline Hutton for undertaking the role on an interim basis and for supporting my induction into the trust and ensuring a smooth transition between us.

As part of my preparation for coming into the role, the Chair and I had several discussions about the capacity of the executive team, particularly given the new hospital programme and the scale of our ambitions for digital and clinical transformation. I am therefore grateful that Bryan and the Nominations Committee have accepted the need for a deputy chief executive who will also act as senior responsible officer (SRO) for the new Frimley Park Hospital programme. I am delighted that the Nominations Committee has appointed Caroline Hutton to this new role, who is exceptionally well-placed to take it on; building on her time as interim chief executive as well as her extensive board level experience here and in other organisations. I am also pleased that Ellis Pullinger has agreed to stay on as interim chief operating officer while we recruit to fill the vacancy.

2. EXTERNAL UPDATE

New political landscape

There has been a significant change to our local MPs following the July general election. Of the nine constituencies that cover our catchment population, seven have new MPs. Congratulations to all who were elected. A map showing our current MPs and the changes to political parties can be seen below.

Secretary of State visit to Heatherwood

We were very pleased to welcome the new Secretary of State (SoS) for Health and Social Care, Wes Streeting to Heatherwood Hospital in July.

Caroline and the team at Heatherwood provided a tour of the hospital highlighting our digital innovation and continuous quality improvement work and arranged for the SoS to have an open and informal conversation with a range of clinical colleagues. He noted that our people talked with pride about their innovations and how continuous improvement is clinically led. The SoS also met with a patient who was full of praise for his treatment and care.

National pay awards

On 29 July, the government announced the 2024/25 pay award for colleagues under the remits of the NHS Pay Review Body and the Doctors' and Dentist's Review Body. All colleagues on Agenda for Change terms and conditions will be awarded a 5.5% consolidated uplift and all doctors and dentists will receive a 6% uplift (and an average of an 8% uplift for resident (junior) doctors). These will be backdated to 1 April 2024 and paid to colleagues in October.

In addition, the BMA has put a new offer from the government to its resident (junior) doctor members in England worth 22.3% on average over two years. This includes an additional 4.05% uplift for 2023/24. Should members accept this it will bring to end the industrial action that started in March 2023.

GPs collective action

GP members of the BMA began a countrywide collective action on 1 August to reduce certain work, but still fulfil their contractual obligations. The impact of this varies across different GP services and from area to area but includes some GPs limiting the number of patient appointments per day. To date, we have not seen any specific impact on our services and will continue to monitor this and work with colleagues to minimise any risk to our patients and services.

National protests and working together

The violent disorder that broke out in UK towns and cities in August has been very concerning. I know all Board members will condemn the malicious, racist and Islamophobic actions that were demonstrated at some of these events. Although we are not aware of any incidents that are directly related to the trust, many of our people have been feeling worried or anxious because of the disorder, particularly with the racism that has been shown. We will continue to support all our people who are struggling.

As a trust we are very proud of our diverse workforce and our shared values and we will not tolerate racism, discrimination, or abuse, from colleagues, patients, or visitors.

3. INTERNAL UPDATE

Performance update

Strong progress against our operational standards and financial obligations has been made through the first months of 2024/25 as we continue to drive to reduce access times across all our services and ensure value for money.

Of particular note is that improvements in our urgent care performance was recognised by NHSE colleagues in July by way of a de-escalation of support from tier 2 to tier 3.

Our planning for winter has started across the trust, working in collaboration with system colleagues to maximise our ability to meet the urgent care needs of our local populations.

Detailed performance information is available in the IPR.

Update on our £49m diagnostic and inpatient unit

We remain on track to open our new 74-bed inpatient and diagnostic unit at Frimley Park in early 2025. This will be a fantastic facility, key to supporting services through the winter and supporting our ongoing RAAC programme. It will also enable the creation of additional capacity in the main body of the hospital to support our elective recovery. Recruitment to the new roles will commence next week.

New Hospital Programme

The new government has indicated that it is undertaking a review of the national new hospital programme while aiming to deliver the most advanced and most urgent hospitals to a realistic timeframe. We are continuing to work closely with our national and regional partners to understand what this may mean for our new Frimley Park Hospital, whilst continuing to undertake technical, legal, and planning due diligence on potential sites for the new hospital, to support the determination of a preferred way forward.

People Initiatives

- We successfully launched a new flexible working policy in July accompanied by comprehensive resources and an extensive communication campaign, which has been well-received.
- We have made substantial progress in supporting colleagues through menopause with a new Menopause Friendly online resource, which offers a wealth of advice, including guidance for managers and individuals, educational sessions, and access to specialist support.
- We are developing a campaign to reinforce across all of our sites that abusive and violent behaviour towards colleagues is not acceptable, in response to a national increase in incidents reported through the annual staff survey.
- Nominations for Staff Awards for this year will shortly go live, focussed on recognising outstanding contributions made by colleagues across a range of categories.

New resident (junior) doctors

We welcomed 88 new resident (junior) doctors to us for their first year, at the start of August. As part of their week-long induction, our clinical education team ran a SIMley Health event at Heatherwood Hospital to help simulate a typical hospital shift and give the new doctors the opportunity to familiarise themselves with IT systems, write prescriptions, escalate cases, and interact with their clinical colleagues in a safe environment. A warm welcome to FHFT for all new doctors.

4. OTHER AREAS OF NOTE

HSJ Awards shortlist – Our ophthalmology team and our urgent and emergency care performance have been shortlisted for the Driving Efficiency through Technology and the Performance Recovery HSJ Awards respectively. Congratulations to the teams. The winners will be announced in November.

Annual B.A.M.E Health & Care Awards shortlist - Our practice development nurse for our Parkside private patient services, Joeyrial Garol, has been shortlisted for the Annual B.A.M.E Health & Care Awards, recognising the achievements of B.A.M.E health and care colleagues for making

significant improvements in career development support for B.A.M.E colleagues. The winners will be announced on 26 September.

National Paediatric Early Warning Score launch - Our paediatric service has launched the National Paediatric Early Warning Score (NPEWS) to improve the safety of all children and young people in hospital. It is a standardised approach to tracking the deterioration of children in hospital whilst they are inpatients, ensuring consistency in how deterioration is recognised.

Research and Innovation team - Our research team has been recognised for their work in a groundbreaking breast cancer trial, exceeding the recruitment target for the study, which is looking to improve quality of life for breast cancer patients.

July Members' health event – More than 200 people joined our latest member's event in July which focussed on Parkinson's disease. Thank you to consultant neurologist Dr Jeremy Stern for presenting at the event.

Annual Members' meeting – This year's Annual Members' Meeting will be held on 24 September at Heatherwood Hospital from 6.30pm until 8.00pm. There will be access to a marketplace of health information stands and new hospital information for all from 5.00pm. All members are welcome.

Downing Street visit – On 27 August, six FHFT colleagues had the opportunity to visit 10 Downing Street for an audience with the Prime Minster. Colleagues were nominated by their peers and line managers to represent the trust together with others from across the country.

ACTION: The Board is asked to note the CEO report.

Lance McCarthy, August 2024

9. OPERATING PLAN DELIVERY REPORT

REFERENCES

Only PDFs are attached

9. Performance Report Cover Sheet 060924.pdf

9a. FHFT - Performance report (for Board) - July 2024 v2.3.pdf

Report Title	Performance Report
Meeting and Date	Public Board of Directors, Friday 6th September 2024
Agenda Item	9.
Author and Executive Lead	Health Information Services Ellis Pullinger, Chief Operating Officer
Executive Summary	The Performance Report provides a summary of the Trust's performance against the national quality indicators. The report highlights: • Updates from relevant Executive team members in the following areas: Quality, Performance, People, Money • Enhanced performance reporting using SPC methodology linked to a number of metrics across a range of domains • Benchmarking reports • Use of resources, activity and CQC Insights reports
Action	The Board is asked to **NOTE** the Performance Report and receive assurance on the Trust's performance against the national quality standards.
Compliance	CQC quality standards and NHS performance standards

Our future FHFT

Committed to excellence | Working together | Facing the future

Frimley Health NHS Foundation Trust

Version 2.3

Performance report

September 2024




Contents

This report includes data over time to allow comparison with historic performance.
The targets and actuals relate to the reporting month July 2024 for the financial year 2024/2025
Please note that metrics where data is not currently of sufficient quality for external reporting have been excluded from the report. They are being monitored internally and will be added into the report as soon as they are available.

Cover sheet – Quality and Safety – Melanie van Limborgh, Tim Ho

Trust quality priorities 2024-25

We have finalised our quality priorities for the year, which include pressure injury prevention and sepsis recognition. These two areas were included in last year's priorities, but we have decided to keep our focus on these very important areas for the year ahead.

Quality account priorities set for 24/25 include work to review malnutrition, patient, family and carer experience of end-of-life care, Shared Decision Making and healthcare-associated E-coli bacteraemia related to urinary tract infections associated with a urinary catheter. We also continue to focus on pressure injury prevention with the ambition of reducing hospital acquired pressure injuries. During quarter one work was commenced using our Frimley Excellence quality improvement framework to support delivery of these priorities.

Pressure Injuries and Inpatient Falls

A task and finish group has been commenced in relation to pressure injury prevention in line with national requirements. The group will focus on implementing 'Purpose T', a new framework for recognising, diagnosing, and managing the risk of pressure injuries. We have seen an increase in category 3 and 4 pressure injuries and as a direct result have undertaken a cluster review using the 'SSKIN Bundle' as a model to identify common themes. A senior nurse has been appointed to lead the improvement workstream to incorporate the learning, new areas of focus and the implementation of the new National Wound Care Strategy Programme "Pressure Injury recommendations and clinical pathway" (2024).

In response to an increase in patient falls in the past year, we have identified a new Trust falls lead who will be spearheading initiatives to address this issue and reduce the incidence of falls within our facilities. Close monitoring of the incidents of falls continues with the new Trust falls lead spearheading initiatives to address the learning from the review of falls In addition, any reported category 3 or 4 and fall with significant injury is being reported weekly to Heads of Nursing and Matrons for oversight and leadership in the management of these high-risk patients. A launch summit for both improvement workstreams (Pressure Injuries and Falls) is being held on the 5th September.

Sepsis

Recognition and prompt treatment of sepsis in accordance with the National Institute of Clinical Excellence (NICE) clinical guidance is one of our strategic objectives for 24/25 and one of six quality priorities for the trust. We achieved over 90% for sepsis screening across the trust for the first quarter of the year, however we have not yet reached this for antibiotic administration. Improvement plans are in place to support this and include launch of new trust wide clinical guidance for August 24, together with a trust wide campaign to raise awareness and educate or clinical teams on the importance of this during September 24.

Clinical Ward accreditation programme

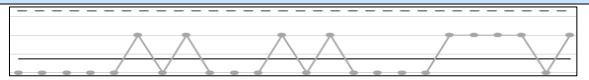
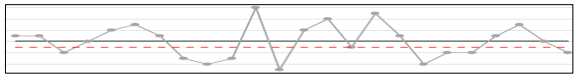
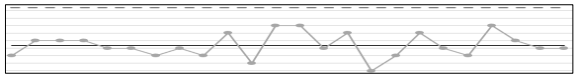
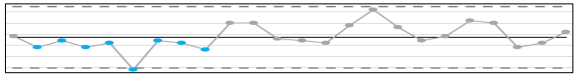
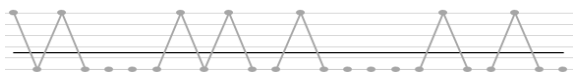
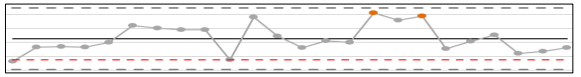
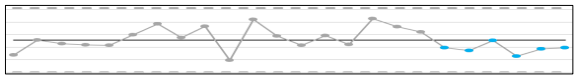
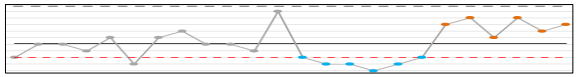
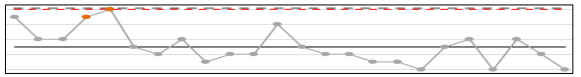
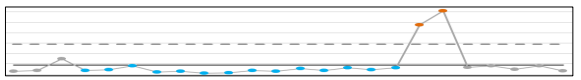
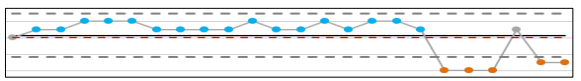
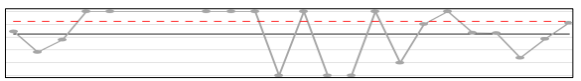
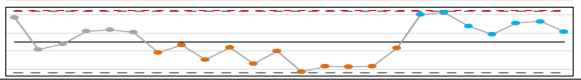
As part of our drive for continuous improvement across the trust and our CQP initiative, there are 27 wards and patient facing areas that have completed the ward accreditation programme. This provides assurance for patients and their friends and family regarding the care a ward or department provides. We are continuing to roll the programme out across the Trust.

Cover sheet – Quality – Committee assurance statement

Key Highlights and Discussion Points Including Assurance Points for Board	• Patient Safety Annual Report – implementation of InPhase was meeting new national reporting requirements. PSIRF plan and policy were implemented in April 2024. There was a 1.2% reduction in overall incident reporting year on year and overall decreases across key indicators. • Maternity Dashboard – Midwifery to Birth ratio remained stable through use of additional bank and agency staffing. 62.73 WTE recruited and due to start in October. • Maternity Mortality Report – Following a 10-year look back, it was reported that the Trust's rates were below national average. It was agreed in future to show benchmark data where national data is available. • Annual Report for Safeguarding Adults and Children – there were increases in referrals to Adult Social Care, s42 and DoLs applications. • The Committee received a report from BSPS on the Fuller Enquiry. • The first CQP and Star Clinical Accreditation Programme update was provided.
Key risks to Escalate	• There had been a 5.3% increase in the total number of falls year on year. • The Trust was over trajectory for all reportable infections. It was a national trend and the Trust was benchmarking well.
Recommendations/ Decisions Made	Not applicable.

Quality Scorecard – key indicators at-a-glance

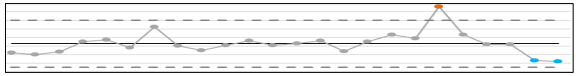
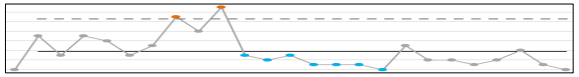
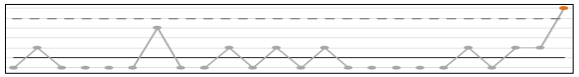
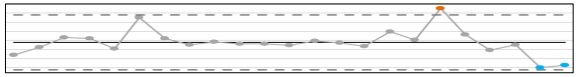
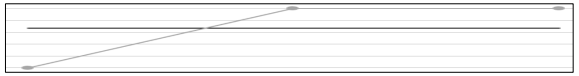
Improving Quality for Patients

Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	Run chart or SPC chart
MRSA~ (July 2024)	1	3	0	-		
C-Diff~ (July 2024)	4	26	≤5	-		
MSSA~ (July 2024)	3	16	0	-		
E.Coli (July 2024)	21	76	TBC	-		
Never Events~ (July 2024)	0	1	0	-		
Number of Falls (July 2024)	217	873	≤200	-	?	
Number of Falls (per 1,000 bed days) (July 2024)	4.97	4.95	TBC	L		
Number of Falls resulting in serious injury (June 2024)*~	7	21	≤2	H		
Number of Serious Incidents (July 2024)	2	14	≤10	-	?	
Mixed Sex Accommodation Breaches (July 2024)	17	121	0	-	?	
Patient FFT (July 2024)	92%	N/A	≥95%	L	?	
Complaint response time (40 day) – May 2024*	82.1%	71.4%	≥85%	-	?	
Complaint response time (60 day) – April 2024*	60.9%	60.9%	≥85%	H	F	

* - data is in arrears; ~ - numbers are too low for valid SPC assurance

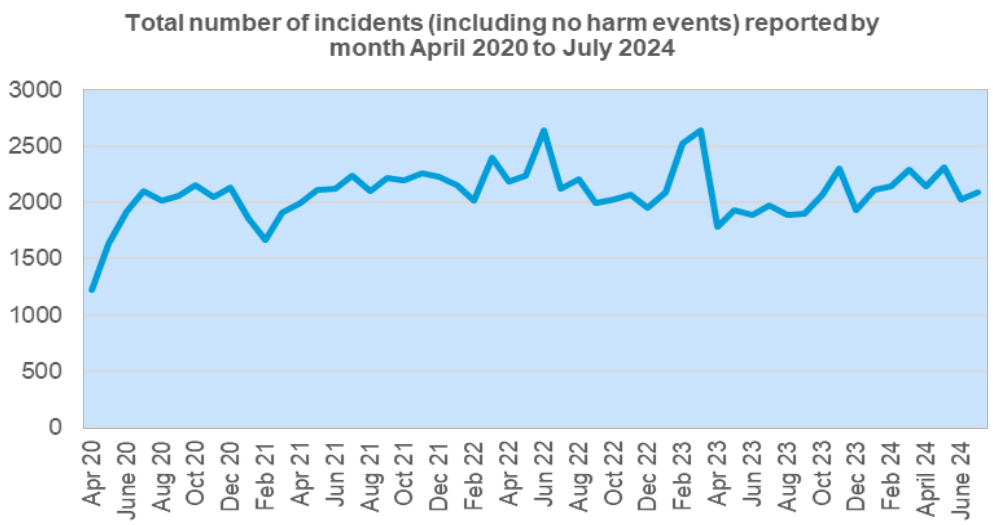
Quality scorecard – key indicators at-a-glance

Improving Quality for Patients

Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	Run chart or SPC chart
Pressure ulcers – hospital acquired (category 2) – June 2024	42	147	TBC	L		
Pressure ulcers – hospital acquired (category 3) – June 2024*	0	5	TBC	-		
Pressure ulcers – hospital acquired (category 4) – June 2024*	3	5	TBC	H		
Pressure ulcer rate – (per 1,000 bed days; category 2,3 and 4) – June 2024	1.05	1.18	TBC	L		
Sepsis screening – patients who needed screening received screening (%) – June 2024	92%	94%	TBC	Insufficient data for SPC analysis		
Sepsis treatment – patients who needed IV antibiotics received them in accordance with NICE timeframe (%) – June 2024	82%	79%	TBC	Insufficient data for SPC analysis		

* - numbers too small for valid SPC assurance

Serious Incidents – as at end July 2024



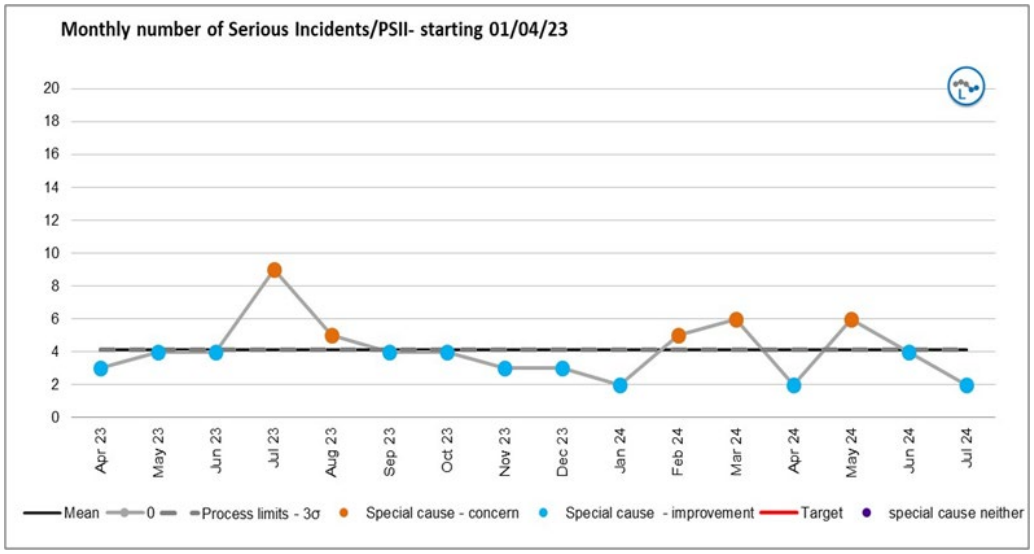
Month	Total Incidents Reported	Number of PSII's
June 2024	2026	4
July 2024	2093	2

Patient Safety Incident Investigation Categories June 2024 (4)

- 1 Diagnostic Incident
- 1 Maternity (mother only)
- 2 Maternity (Baby only)

Patient Safety Incident Investigation Categories July 2024 (2)

- 1 Maternity (Baby only)
- 1 Fall contributing to death



Maternity Services – Key Information (as of July 2024)

	July 24	YTD
Maternity SI	1	6
MNSI	0	2
RCA	0	2
Formal complaints	10	30
Training compliance	93.66% (overall)	93.66%
Midwifery 1:1 care in Labour	97%	99%
Midwife:birth ratio	1.25	1.25
Obstetric Weekly cover at each site	132	132
HSIB/NHSR/CQC concern or Board request for action	CQC action plan	
Coroner Reg 28 made to trust	Nil	Nil

CQC Must-Do Actions:

- We have successfully completed 3 out of 4 mandatory actions required by the Care Quality Commission (CQC).
- This action remains amber as we still have some topics that are required to be 85% compliant with all staff groups.
- Both midwives (94.18%) and medics (92.66%) are showing overall compliance which exceeds the trust target of 85%.
- Plans are in place with staff booked on to planned training, monthly updates on progress continue.

Serious Incidents Summary – July 2024

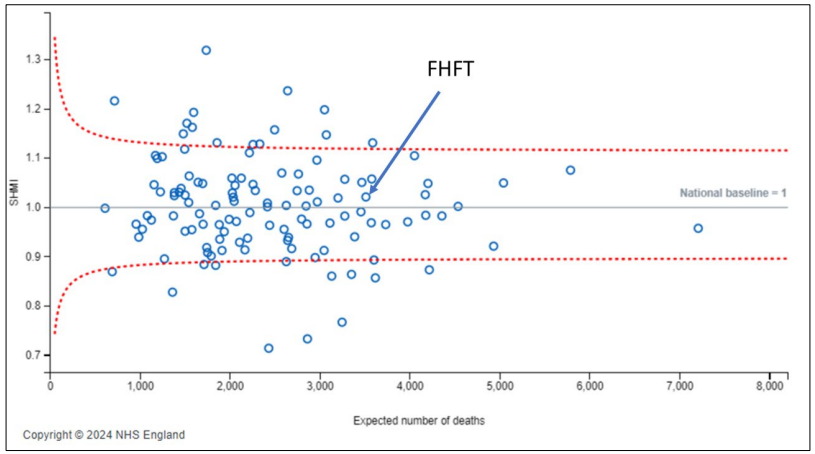
FPH:

- **Antepartum IUD:** A 27-year-old White British woman (gravida 1 para 0) with a low-risk pregnancy experienced intrauterine death (IUD) after a successful ECV procedure to correct breech presentation. Incident is currently being investigated.

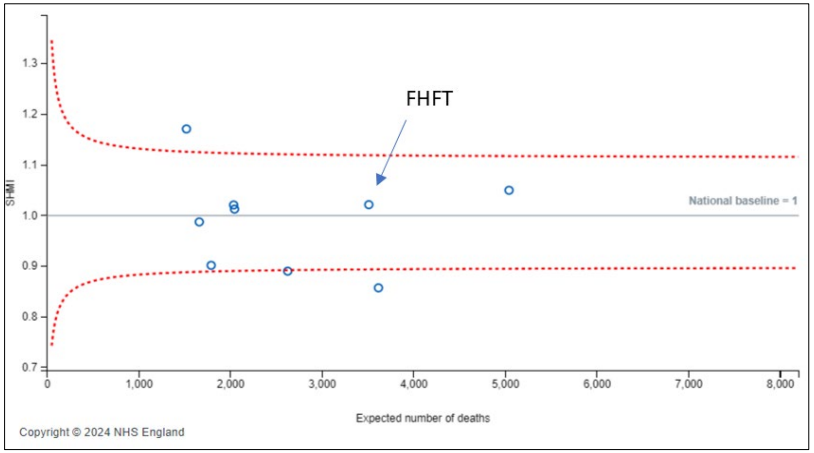
WPH:

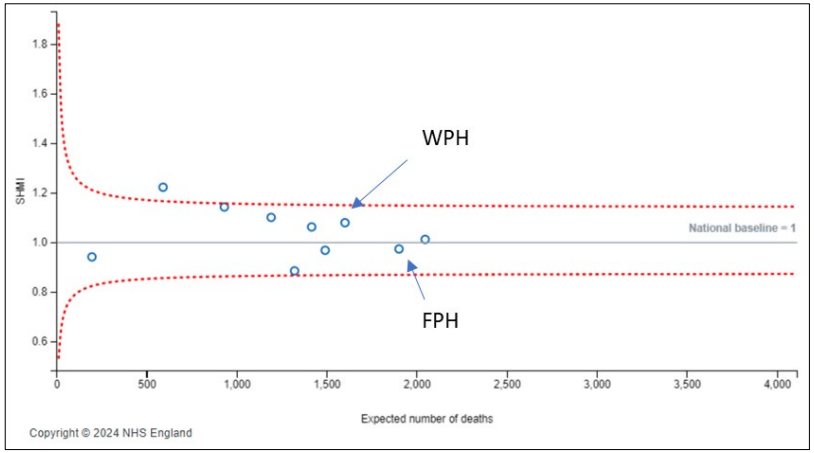
- There were no Serious Incidents reported or MNSI referrals made from Wexham Park Hospital in July 2024.

Mortality report – SHMI funnel plots

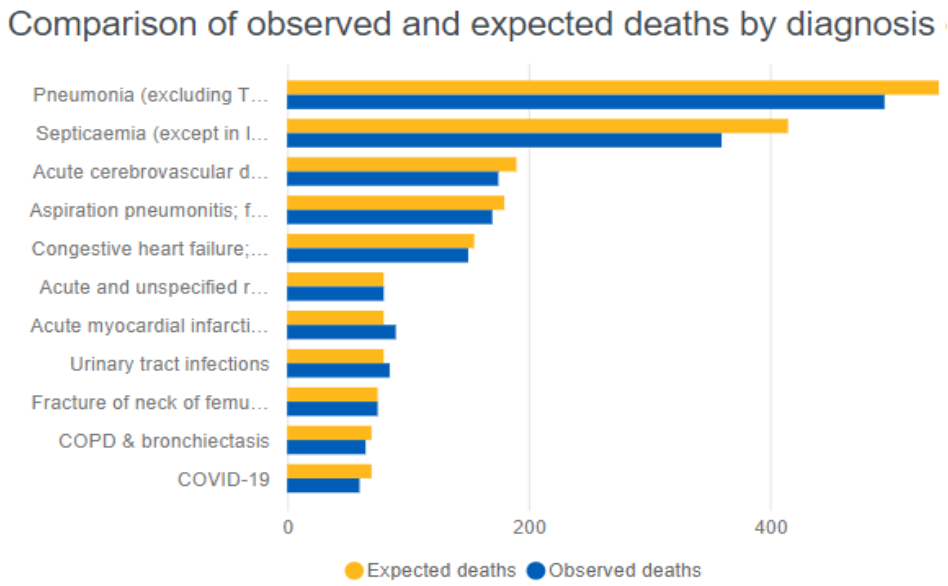


SHMI Compared to Neighbouring Trusts





Mortality report – SHMI for Top Diagnoses



Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	SHMI banding
Pneumonia (excluding TB/STD)	73	3625	495	540.00	0.91	As expected
Septicaemia (except in labour), Shock	2	1815	360	415.00	0.87	As expected
Acute cerebrovascular disease	66	1280	175	190.00		
Aspiration pneumonitis; food/vomitus	77	490	170	180.00		
Congestive heart failure; nonhypertensive	65	1155	150	155.00		
Acute and unspecified renal failure	99	645	80	80.00		
Acute myocardial infarction	57	1265	90	80.00	1.09	As expected
Urinary tract infections	101	1500	85	80.00	1.08	As expected
Fracture of neck of femur (hip)	120	915	75	75.00	1.06	As expected
COPD & bronchiectasis	75	1090	65	70.00		
COVID-19	143	675	60	70.00		
Organic mental disorders	42	580	60	65.00		
Fluid and electrolyte disorders	37	765	70	50.00	1.36	As expected
Gastrointestinal hemorrhage	96	685	45	50.00	0.96	As expected

Mortality report

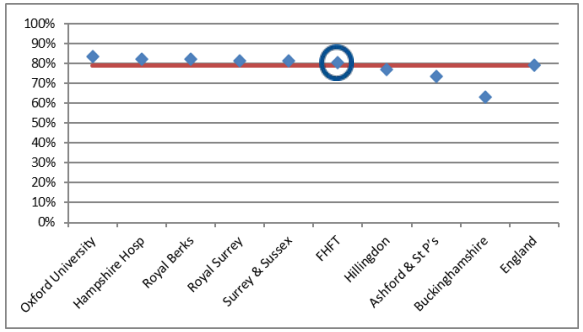
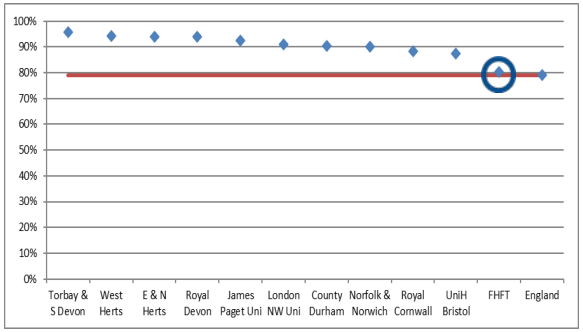
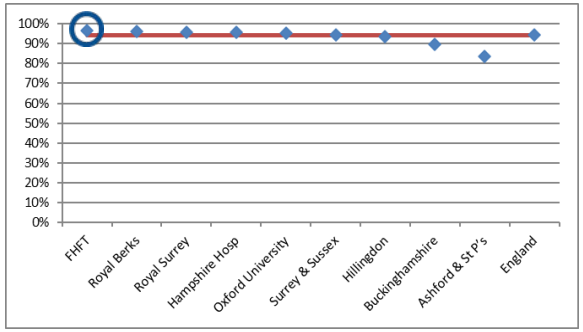
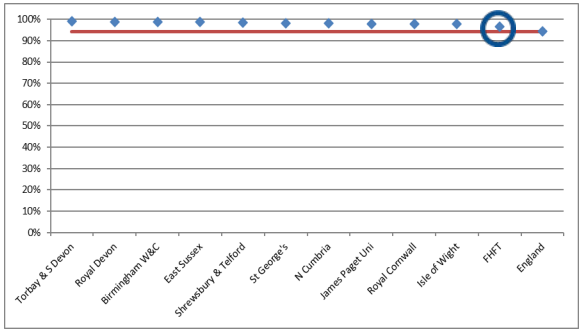
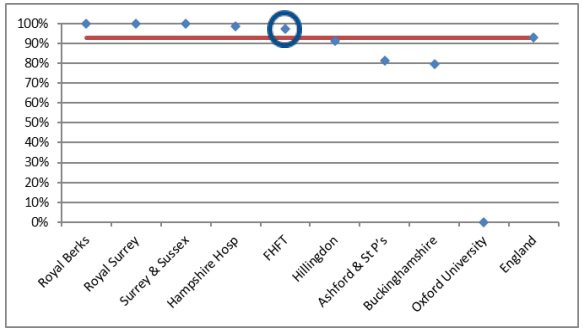
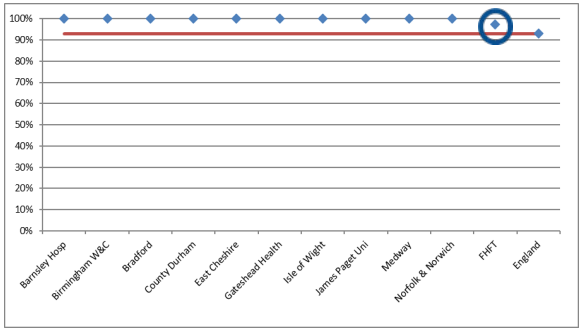
	Jul-23	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul-24	YTD
Number of inpatient deaths	201	203	209	225	221	216	305	238	246	196	194	194	212	796
Community Deaths screened	100	112	108	104	117	134	136	118	148	138	173	134	161	606
Total deaths screened (including < 30 days post-discharge)	301	315	317	329	338	350	441	356	394	334	367	328	373	1402
Cases sent for review	44	33	38	47	44	40	40	41	55	19	33	35	24	111
Total number of deaths judged > 50% likely to be due to problems with care	0	0	1	0	1	0	1	0	0	0	0	0	2	2
Number of deaths of patients with a Learning Disability	1	2	5	5	3	3	5	4	4	3	0	4	3	10
Cases sent to M+M review	44	33	38	47	44	40	40	41	55	19	33	35	24	111
Cases outstanding M+M review	6	9	8	15	7	12	22	21	15					
SHMI FPH	0.99	0.98	0.99	0.99	0.98	0.97	0.98	0.98	0.97					
SHMI WPH	1.05	1.05	1.07	1.07	1.07	1.06	1.06	1.06	1.08					
SHMI	1.01	1.01	1.02	1.02	1.02	1.01	1.01	1.02	1.02					

+The number of completed reviews updates monthly and may increase as there is a 12-week review time

SHMI rolling over 12 months	Apr-23	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr-24	YTD
Number Spells	6432	7040	7177	7115	7412	7339	7342	7305	7129					
Number of deaths (in hospital or within 30 days of discharge)	242	261	242	264	237	246	256	245	246					
SHMI FPH	0.94	0.97	0.96	0.99	0.98	0.99	0.99	0.98	0.97	0.98	0.98	0.97		
SHMI WPH	1.08	1.09	1.07	1.05	1.05	1.07	1.07	1.07	1.06	1.06	1.06	1.08		
SHMI	1.00	1.02	1.01	1.01	1.01	1.02	1.02	1.02	1.01	1.01	1.02	1.02		

+The number of completed reviews updates monthly and may increase as there is a 12-week review time

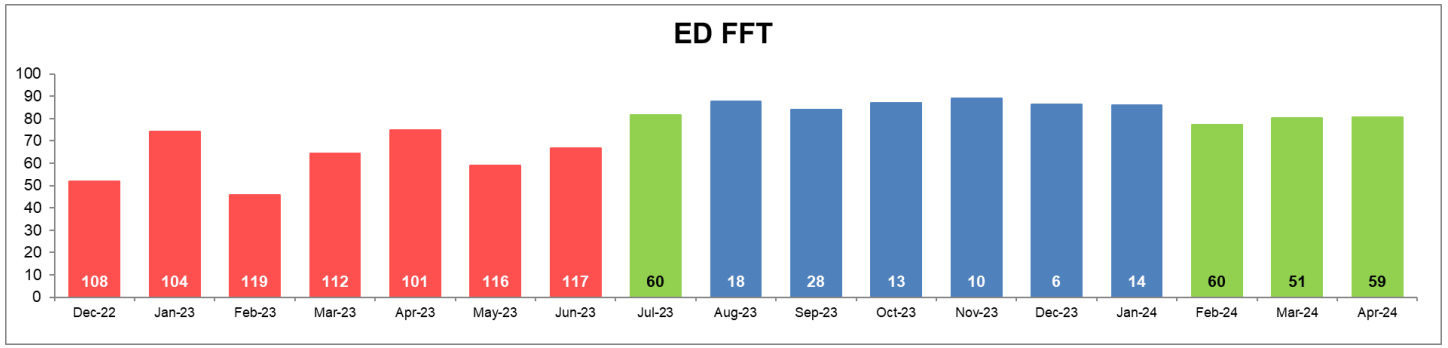
Benchmarking – selected measures

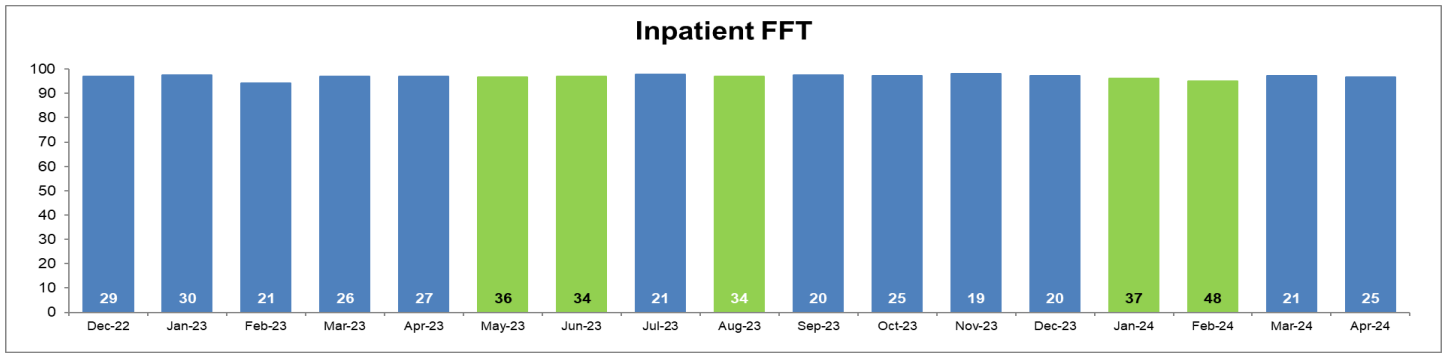
	Local trusts	Best in class	Rank	Quartile
ED FFT			59/122	2nd
Inpatient FFT			25/122	1st
Maternity FFT			36/118	2nd

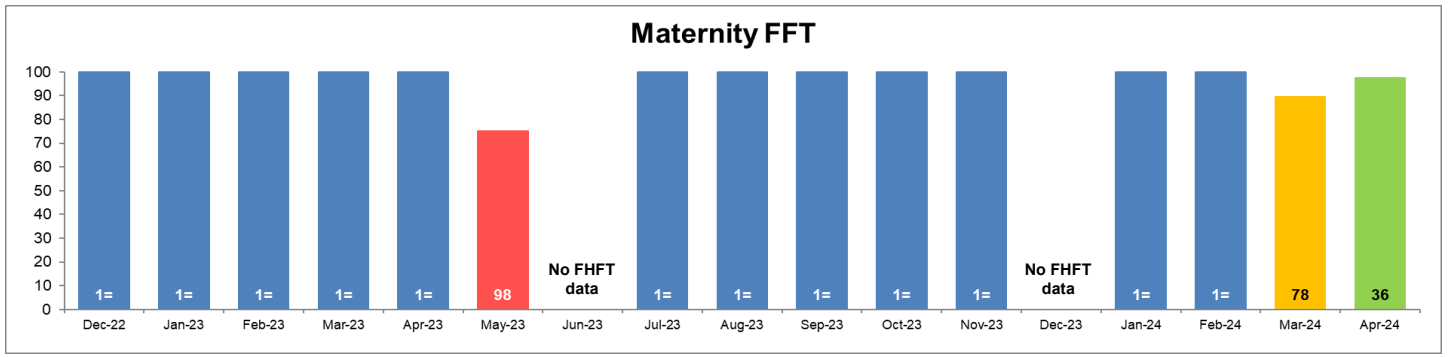
NOTE *– for each graph, the position furthest to the left is the best performing trust.* ***Data periods:*** *FFT = April 2024 (national data publication is currently delayed). Maternity Best in Class is truncated alphabetically as there are more than ten trusts who are performing at 100%. Best in class peer group has been expanded to include both Acute and Acute & Community trusts*

Benchmarking – FHFT historic monthly performance (selected measures)

- Quartile 1
- Quartile 2
- Quartile 3
- Quartile 4







***NOTE** – for each chart, FHFT's rank compared to other acute trusts is shown in the relevant column (national data publication is currently delayed). From March 2022 the cohort was expanded to include both acute and acute and community trusts, so the cohort now includes up to 125 trusts.*

Cover sheet – Performance – Chief Operating Officer

In terms of FHFT's relative performance against key performance indicators agreed within the Trust's Operating Plan, the closing position for July 2024 and forecast for August 2024 performance is outlined as follows:

Performance Standard	July Performance	FHFT Operating Plan Target	August Performance forecast	FHFT Operating Plan Target	Current National Target
ED (All Type)	72.75%	77%	75.08%	77%	77%
65-week waits	563	88	539	8	0 (Sept)
52-week waits	4839	1453	4700	1343	N/A
RTT waiting list	88,777	79,500	89,400	78,705	N/A
28-day FDS	80%	81.99%	81%	82.01%	75%
62-day	73.47%	74.07%	73%	75.10%	70%
DM01	13,581	13,746	13,500	13,608	N/A

In summary of what is on plan (and the Trust will carry on against its operating plan) and what is not on plan (and so requires action) at this point in the 2024/25 year – the Trust has 3 indicators on plan, and 4 off plan. FIC is asked to review the supporting paper for the remedial actions underway to address the 4 indicators off plan.

On plan	Off Plan
62-day cancer performance and backlog reduction	All Type UEC performance (notably Type 1)
28-day Faster Diagnosis Standard performance	65-week current performance (but still within trajectory)
DM01 (Diagnostic) waiting list	52-week current performance
	RTT Waiting List size and outpatient waiting times

Cover sheet – Performance

For areas which are off plan – there are a number of remedial actions against these which are being undertaken to bring these back to plan.

Indicator	Remedial Actions
ED performance	• Monthly Type 1 attendances was highest in May 2024 compared to previous 5 months and continued at same levels for June and July. CFO and COO have commissioned analysis comparing forward trend against workforce model to assess sustainability. • UEC Programme focusing on two areas: The first is non-elective Length of Stay with particular focus at Wexham where LoS remains higher (9.77) than target plan compared to Frimley where LoS is under plan (6.89). Weekly meeting held with clinic teams involving CMO, COO and CNO. Secondly is to improve take for 'push and pull' appropriate patients through Same Day Emergency Care (SDEC) units on both sites – increasing from 6-10% to 15% in Quarter 2 this year. • External ICS UEC programme to agree location and purpose of existing Urgent Care Centre (UCC) in Aldershot, which though contributing to Type 3 activity, is not being adequately used in terms of attendance volumes. Active discussions underway whether UCC should be co-located next to main ED at FPH - formal decision in September 2024.
Current 65-week waits	• Continue to focus on clearance of cohort of patients who will breach a 65-week wait for treatment by end of September 2024 as this will deal with current and potential tip-in patients. Good progress has been made on this – circa 14,100 of 15,600 patients in that cohort have already been treated and discharged since start of April. Ongoing focus on potential at risk specialties – notably ENT, Oral and Maxillofacial Surgery, Chemical Pathology, Gynaecology and Vascular Surgery. Plans continuing to drive towards achieving the zero target.
Current 52-week waits	• Main focus is on reducing waiting times through improved productivity and focus on utilisation of Outpatient capacity – as waiting times are driving disproportionate proportion of patients waiting over 52-weeks in certain specialties. • Developing proposals with ICB to rollout enhanced referral pathways, including increase us of DXS to help support demand management. Proposals being developed in Dermatology and ENT to support with alternative means of managing demand on the Trust. • Outpatient Transformation and GIRFT Further Faster programme focused on improving access through Outpatients for patients – being led by Transformation team and tracked via Trust Transformation Board. ENT, Gastro, Gynae, Neurology and Ophthalmology identified as first specialties to focus on.
RTT waiting list size (see Slide 21 on Performance Report	• Developing proposals with ICB to rollout enhanced referral pathways, including increase us of DXS to help support demand management. Proposals being developed in Dermatology and ENT to support with alternative means of managing demand on the Trust. • Outpatient productivity review ongoing to reduce DNAs, patient cancellations and increasing slot utilisation • Outpatient Transformation and GIRFT Further Faster programme focused on improving access through Outpatients for patients – being led by Transformation team and tracked via Trust Transformation Board. ENT, Gastro, Gynae, Neurology and Ophthalmology identified as first specialties to focus on. • Working with ICS on Evidence-Based Interventions Programme and identifying patients who could be appropriately discharged back to their GP as their treatments are not clinically necessary.

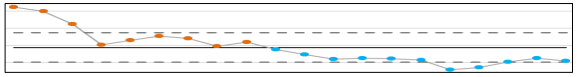
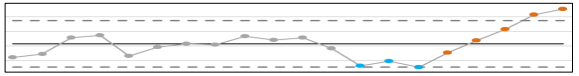
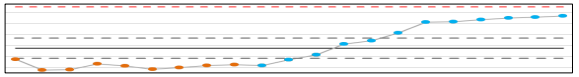
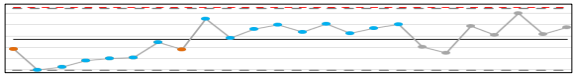
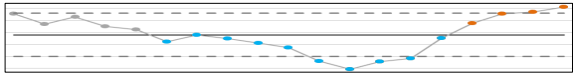
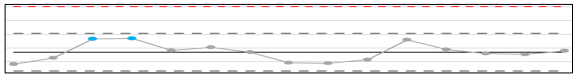
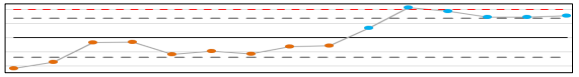
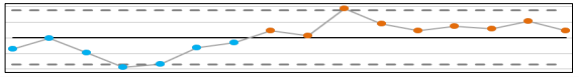
Cover sheet – Performance

In terms of Productivity Metrics – including those already referenced within the Board Performance Report – additional indicators are being tracked within the Trust to improve activity throughput.

Indicator	Trend	Commentary
Length of Stay	↑	Overall LoS for non-elective care has been above plan for both April and May – largely driven by higher LoS (10 at WPH / 7 at Frimley)
ED Demand	↑	Both ED departments have seen notable increases in activity between May and July, with FPH running at 5% above previous year levels and WPH running at 9% above previous year levels.
Admissions	↑	Overall admissions are running at below forecast levels but at roughly same as 2023 – mainly driven by WPH as FPH admissions are lower than 2023.
Discharges	→	Overall discharges are above 2023 levels and FPH is achieving target level but WPH remains some 20% short of target.
Non-Elective Overnight Activity	→	Non-Elective Overnight activity is running at circa 97% of plan currently – highlighting that non-elective activity remains generally static despite high ED demand.
Elective Overnight Activity	↓	Elective overnight capacity remains circa 15-20% behind plan due to staffing ?? bed plan being behind schedule and failing to release capacity at Wexham Park and Frimley Park.
Day Case Activity	↑	Overall Day Case activity remains on plan at circa 100% of plan at M5.
Outpatient New Activity	↓	Outpatient New Patient activity is running at circa 80% plan level. Ongoing focus on increasing new patients – reviewing clinic template size and reducing DNAs and patient cancellations.
Outpatient Follow Up Activity	↑	Overall Follow Up activity remains significantly higher than plan at 130% - exacerbating current new patient deficit against plan.
Outpatient Clinic Yield	↓	Overall clinic yield (number of patients seen in a clinic session) is averaging circa 7 against a target of 9.
Theatre Session Yield	→	No change from 2023 and retained average 4 units of activity in a 5 hour session. Target to return to 5.

Performance scorecard – key indicators at-a-glance

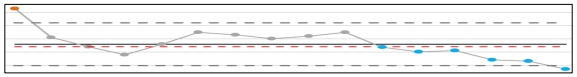
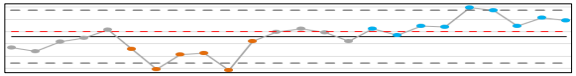
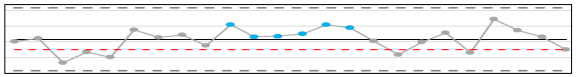
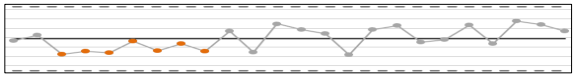
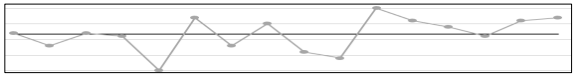
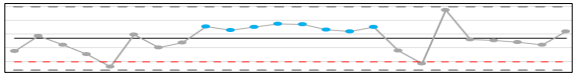
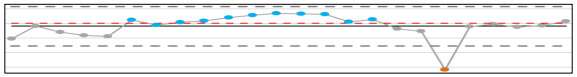
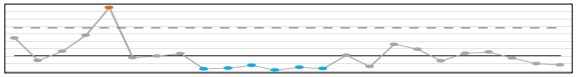
Transforming our Services

Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	Run chart or SPC chart
Number of patients waiting 52 weeks or more for treatment (July 2024)	4,778	N/A	≤807	-	F	
Number of patients waiting 65 weeks or more for treatment (July 2024)	543	N/A	TBC	L	F	
RTT waiting list size (PTL) – July 2024	88,048	N/A	N/A	H		
Diagnostics (% receiving diagnostic test within 6 weeks) – July 2024	86.8%	N/A	≥95%	H	F	
Stroke – percentage admitted within 4 hours (July 2024)	62.7%	62.6%	≥80%	-	F	
Inpatient bed days used by children with mental health problems (where no acute paediatric care is provided) – July 2024	65	N/A	TBC	-		
Under 18s on the RTT waiting list (July 2024)	7, 423	N/A	TBC	H		
ED waiting times within 4 hours – Type 1 (%) – July 2024	59.0%	58.5%	≥75%	-	F	
ED waiting times within 4 hours – all types (%) – July 2024	72.8%	72.9%	≥75%	H	F	
ED 12-hour breaches (%) – July 2024	8.9%	9.4%		H		

* - data relates to the performance of the ambulance trusts as a whole; it is not possible to disaggregate the performance for FHFT hospitals specifically

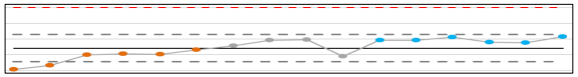
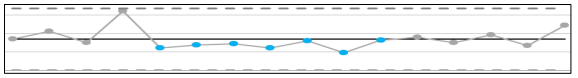
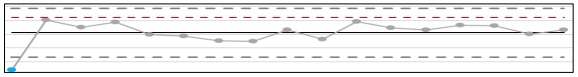
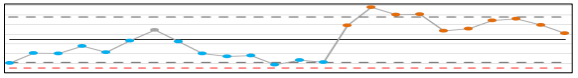
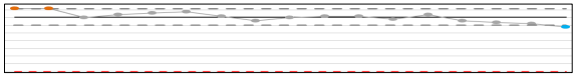
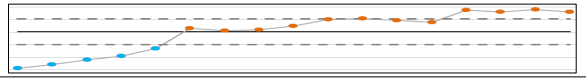
Performance scorecard – key indicators at-a-glance

Collaborating with our Partners

Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	Run chart or SPC chart
Cancer – performance against 62-day standard (July 2024)	4.7%	N/A	≤6.4%	L	?	
Cancer – performance against 28-day faster diagnosis standard (June 2024)	79.5%	N/A	≥75%	H	?	
Community services – 2-hour response (July 2024)	75.0%	84.3%	≥75%	-	?	
Community services – caseload discharges (July 2024)	1,367	5,515	TBC	-		
Community services – emergency readmissions within 30 days following discharge from a community ward (June 2024)	37	104	TBC	-		
Ambulance handovers – % within 15 minutes (July 2024)	75.8%	72.9%	≥65%	-	?	
Ambulance handovers – % within 30 minutes (July 2024)	95.7%	94.7%	≥95%	-	?	
Ambulance handovers – number over 60 minutes (July 2024)	17	123	0	-	?	

Performance Scorecard – key indicators at-a-glance

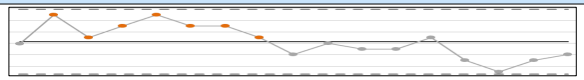
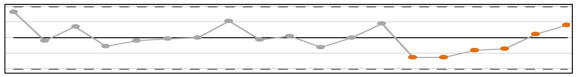
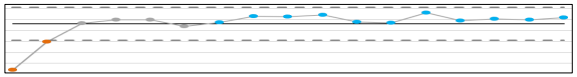
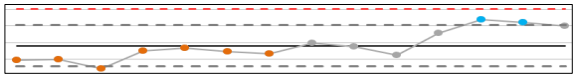
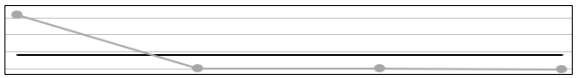
Productivity metrics

Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	Run chart or SPC chart
Day case rate (%) – July 2024	89.3%	89.3%	≥85%	H	P	
Theatre Utilisation (July 2024)	81.3%	80.9%	≥85%	H	F	
Cancelled operations (%) – July 2024	2.1	2.1		Insufficient data for SPC analysis		Insufficient data to create a run chart
Average elective acute length of stay (July 2024)	3.22	2.9	TBC	-		
Non-Elective Length of Stay – average acute length of stay (July 2024)	6.15	6.20	6.6	-	?	
Delayed discharges - No Criteria to Reside (July 2024)	222.1	240.4	TBC	H	F	
Outpatient DNA rate (%) – July 2024	7.9	8.1	≤5%	L	F	
Outpatient consultant-led new to follow-up ratio (July 2024)	1.46	1.47	TBC	H		

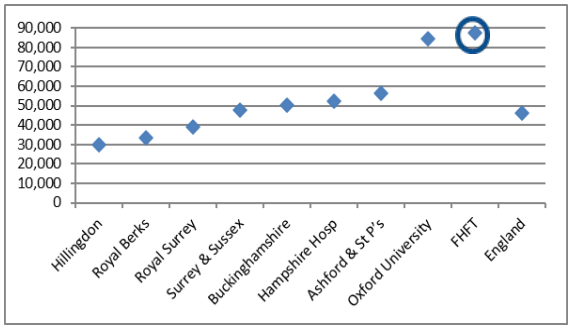
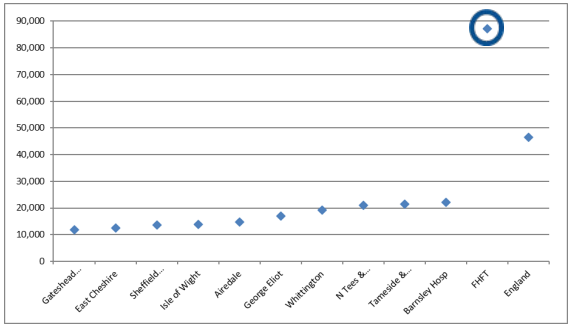
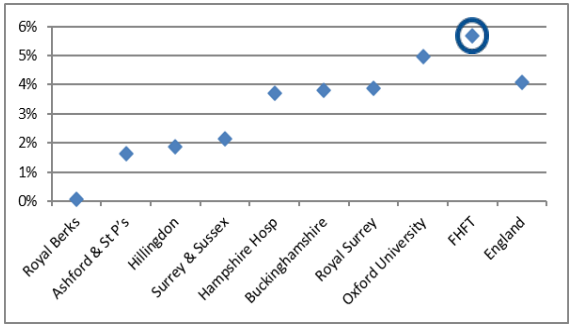
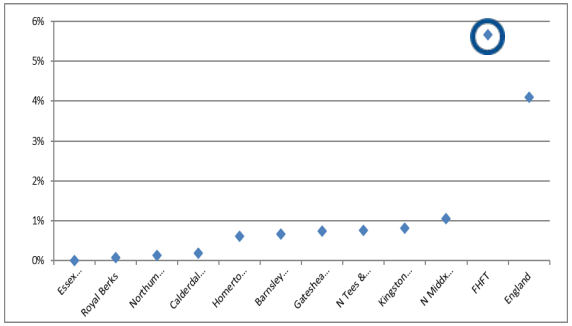
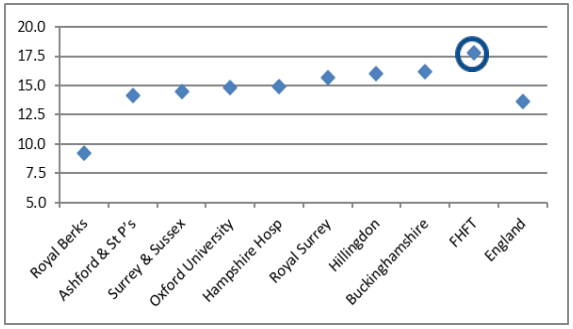
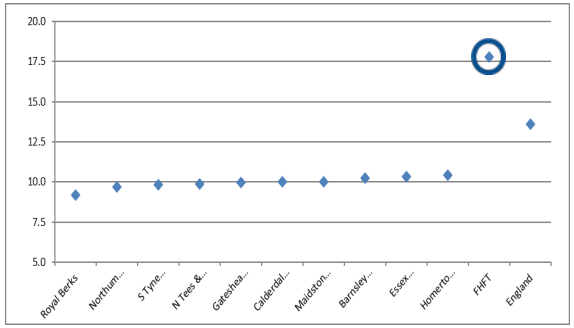
* **NOTE** – No Criteria to Reside was previously reported as Medically Fit For Discharge

Performance Scorecard – key indicators at-a-glance

Efficiency metrics

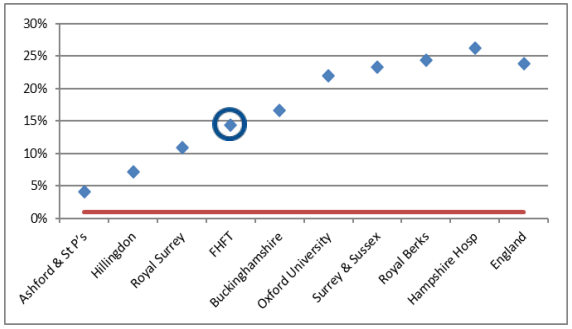
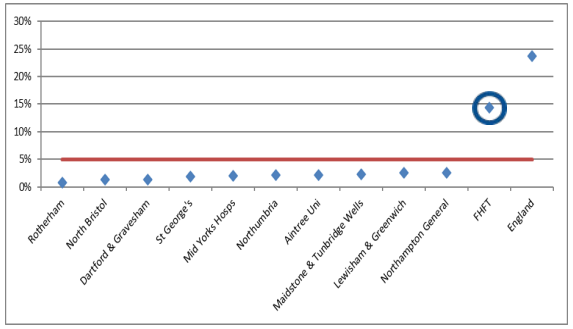
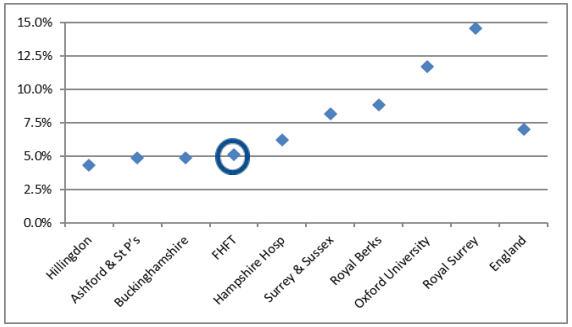
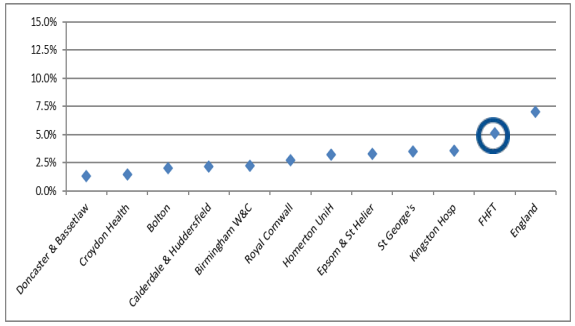
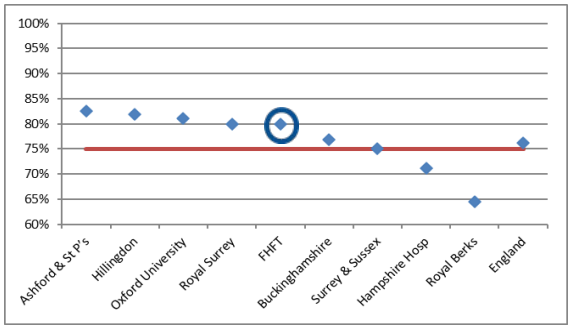
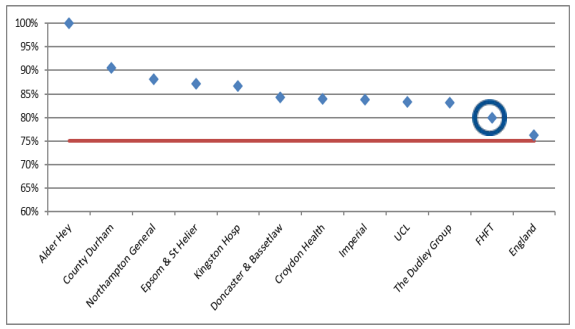
Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	Run chart or SPC chart
Outpatient appointment cancellation rate within 6 weeks – hospital initiated (July 2024)	1.9	1.8	TBC	-		
Ratio of RTT clock starts to stops (July 2024)	1.18	1.09	TBC	-		
Outpatient attendances with no procedure seen virtually (July 2024)	27.4%	27.0%	TBC	H		
Use of PIFU - proportion of patients who are put onto a PIFU pathway (July 2024)	5.5%	N/A	≥6.6%	-	F	
General and Acute Bed Base (July 2024)	1198	N/A	TBC	Insufficient data for SPC analysis		

Benchmarking – selected measures

	Local trusts	Best in class	Rank	Quartile
RTT – Total incompletes			103/122	4th
RTT – 52 plus weeks (% of total incompletes)			107/123	4th
RTT – Median RTT waiting time			116/123	4th

***NOTE** – for each graph, the position furthest to the left is the best performing trust. **Data periods:** RTT = June 2024*
Best in class peer group has been expanded to include both Acute and Acute & Community trusts so the cohort now includes up to 125 trusts.

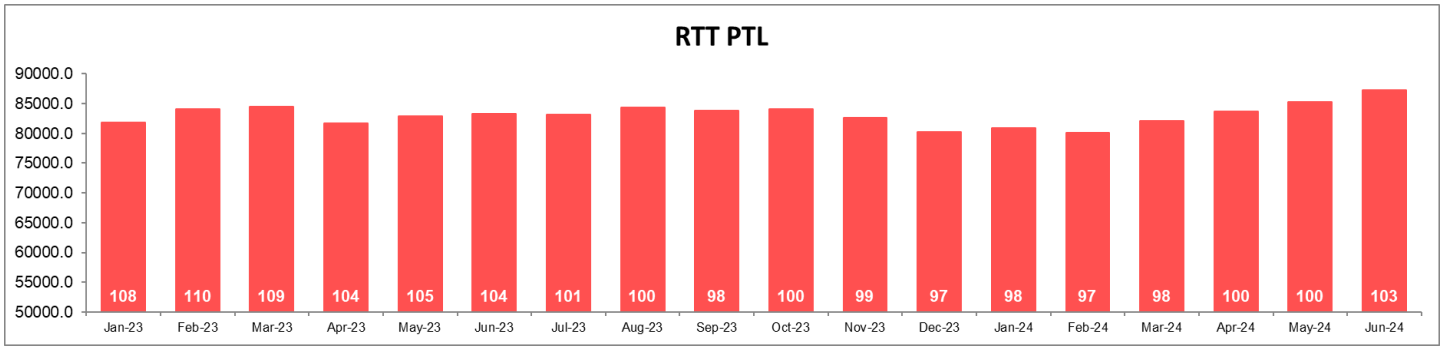
Benchmarking – selected measures

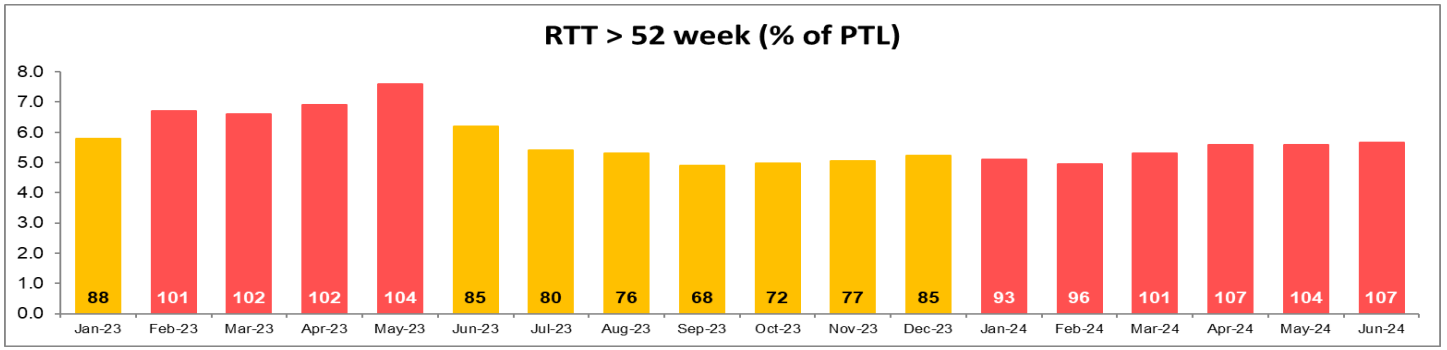
	Local trusts	Best in class	Rank	Quartile
Diagnostics			48/122	2nd
Cancer – Urgent PTL (proportion waiting over 62 days)			37/120	2nd
Cancer – 28-day faster diagnosis			39/121	2nd

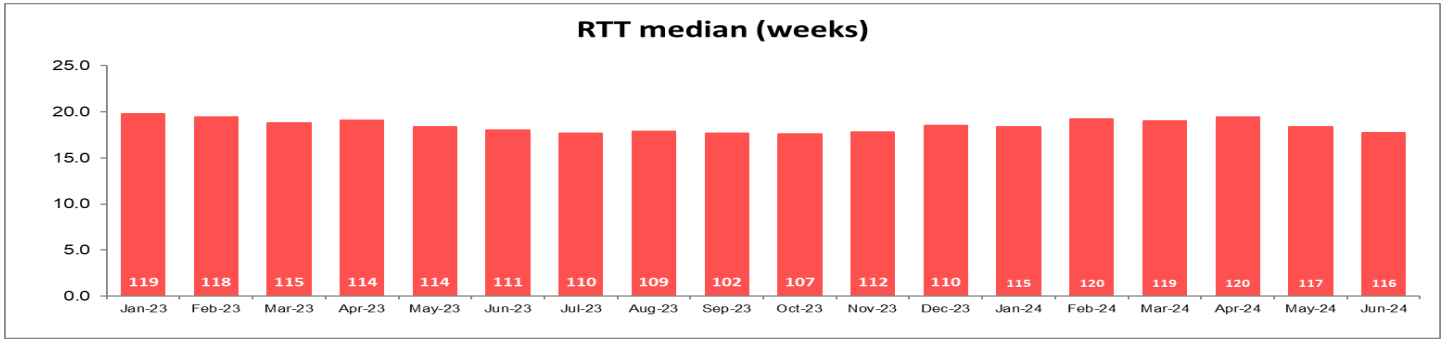
***NOTE** – for each graph, the position furthest to the left is the best performing trust. **Data periods: Data periods:** Diagnostics = June 2024; Urgent Cancer PTL – proportion waiting over 62 days – position week ending 07 July 2024; Cancer 28-day FDS = June 2024.*
Best in class peer group has been expanded to include both Acute and Acute & Community trusts so the cohort now includes up to 125 trusts.

Benchmarking – FHFT historic monthly performance (selected measures)

- Quartile 1
- Quartile 2
- Quartile 3
- Quartile 4



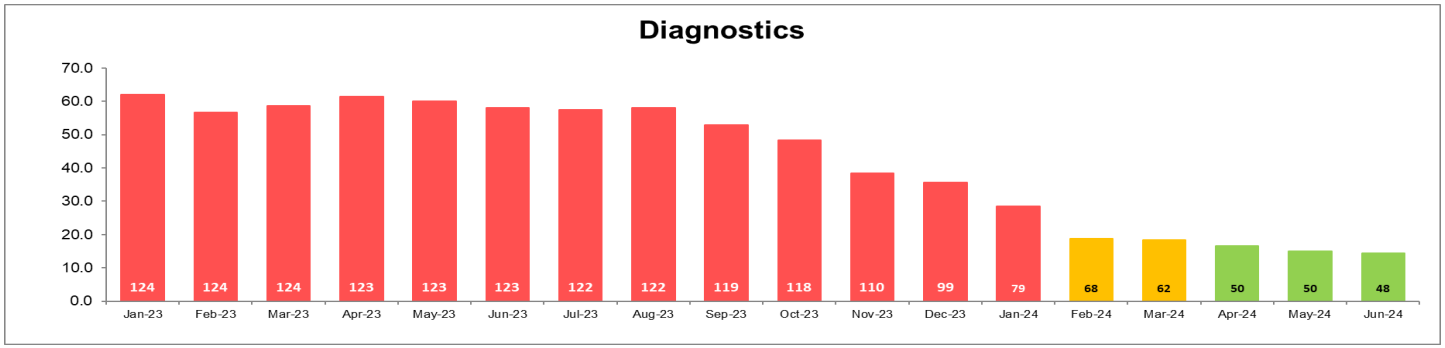


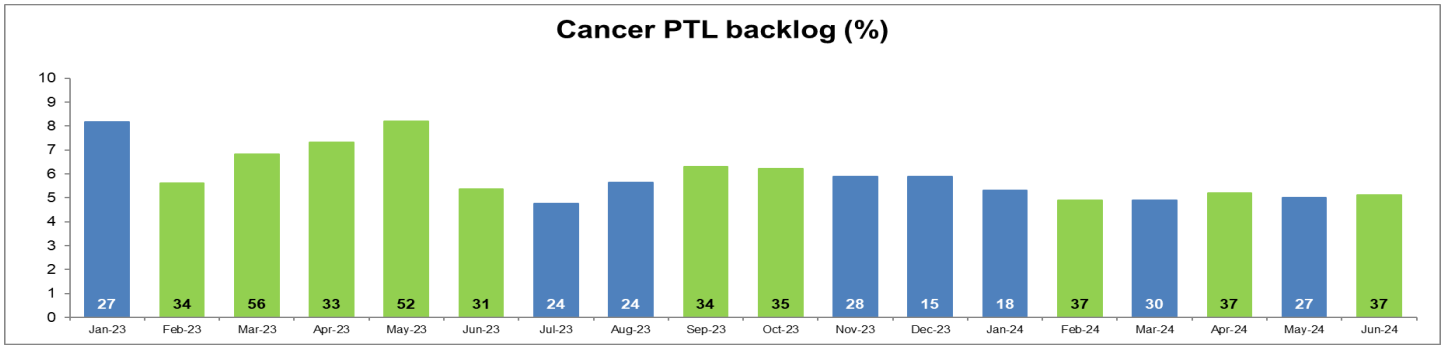


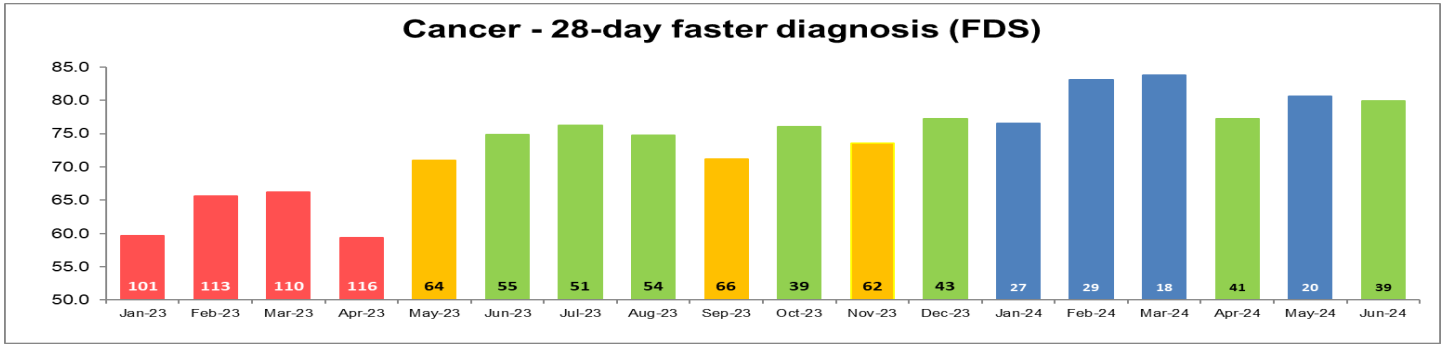
***NOTE** – for each chart, FHFT's rank compared to other acute trusts is shown in the relevant column.*
The cohort includes both acute and acute and community trusts and includes up to 125 trusts.

Benchmarking – FHFT historic monthly performance (selected measures)

- Quartile 1
- Quartile 2
- Quartile 3
- Quartile 4







***NOTE** – for each chart, FHFT's rank compared to other acute trusts is shown in the relevant column.*
The cohort includes both acute and acute and community trusts and includes up to 125 trusts.

Cover sheet – People – Matt Joint

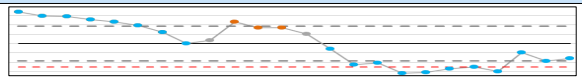
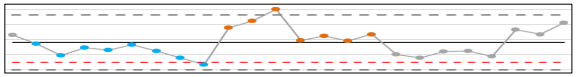
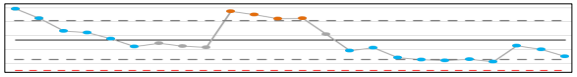
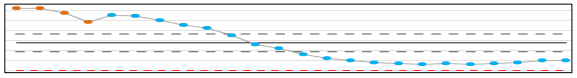
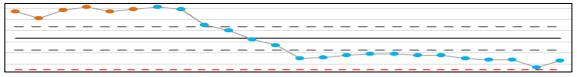
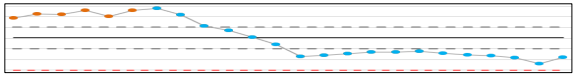
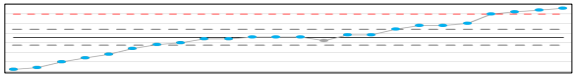
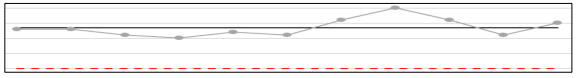
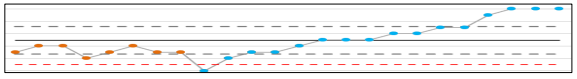
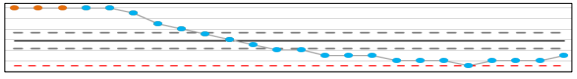
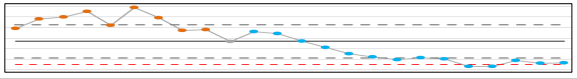
Executive Summary	**The core people metrics, including vacancies, turnover, time to hire and sickness remain relatively stable We have seen an upward turn in our staff turnover since the start of this financial year (11.02% Jul 24). The use of temporary staffing is higher than planned, particularly the use of nursing and midwifery bank staff and medical agency. This has, however, reduced significantly over the past 12 months. We are focusing on four key themes over the year to drive our culture and leadership initiatives, these are collaboration, compassion, equality, diversity, and inclusion (EDI), and learning.**
Background	Staff in post FTE marginally decreased compared to June, but overall, there is an increase in headcount compared to July 2023. Turnover has increased since the start of the financial year and is currently at 11.02%. As a comparator in July 2023 turnover was at 11.0% and fell towards the end of last financial year. We will be monitoring this trend closely, but it is likely to be a seasonal variation. Work continues to support the reduction of temporary staffing spend. This included the implementation of strict roster controls which is now complete. Work is currently being undertaken to review the effectiveness of the managed service provider and whether other options should be explored for some staff groups. High cost, long term medic locums have been identified and Medical Workforce are currently reviewing these and developing plans to reduce their use. Building on the launch of the sexual safety resources in May a working group has been created to review violence, aggression and other negative behaviours. This group will be looking at the data and trends to identify root causes and making recommendations to the Trust on work that needs to be done to support both staff and patients to feel safe. This will also review data from sources such as the NSS 2023 (and the 2024 data once available). Work to refresh the behaviours underpin the Trust values has also been identified as a key area to address and a working group will be commencing this work in August. This will also include key areas such as compassionate leadership and civility. Flexible working is a key element of the NHS People Promise and can significantly contribute to employee satisfaction. During July roadshows have taken place to help promote flexible working opportunities within the Trust. Our Annual Staff Awards are currently being agreed with the aim to launch the nomination process in August. The event will be held on 27th November.
Issues and Options	The last 18 months saw a significant reduction in vacancies and turnover. However, there has not been a corresponding decrease in the use of nursing bank staff or medical agency. This is not a sustainable position, and the actions outlined above are essential if we are to meet our financial targets.
Recommendation	The Directorates must continue to focus on improving roster controls and adhering to new guidance on budgetary approvals. It is also essential that there is continued focus on engaging our staff and responding to the recommendations arising from the National Staff Survey and quarterly Pulse surveys with each Directorate and Trust-wide.

Cover sheet – People – Committee assurance statement

Key Highlights and Discussion Points Including Assurance Points for Board	• Recruitment and Retention key metrics remain stable with some seasonal variations • Emphasis was on the Sexual Safety Charter, the Violence and Aggression Programme and Flexible Working. • National Staff Survey 2023 Actions – Focus was on the 'we are safe and healthy' metric, including the sub-scores of health and safety, burnout, and negative experiences, including working with managers to demonstrate compassionate leadership. • This work linked to the FTSU and ensuring staff felt safe to speak up in the workplace. • There was discussion around the progress and direction of the Culture and Leadership Programme. • The Committee received the Equality and Diversity Annual Report and Occupational Health and Safety Report for consideration. Equality and diversity remains a key focus for PC and the trust. PC continue to monitor this issue through the equality diversity and wellbeing committees as well as asking that all reports include equality and diversity focused metrics • There was push from the Committee for the Trust to utilise the apprenticeship levy.
Key risks to Escalate	Not applicable
Recommendations/ Decisions Made	Not applicable

People Scorecard – key indicators at-a-glance

Supporting our People

Metric	Current month	YTD	Target / concern threshold	Variation	Assurance	SPC chart
Monthly vacancy rate – all staff (July 2024)	9.4%	9.1%	≤ 8.5%	L	F	
Monthly vacancy rate – medical (July 2024)	10.2%	8.5%	≤ 5.0%	-	?	
Monthly vacancy rate – nursing (July 2024)	8.0%	8.4%	≤ 6.0%	L	F	
Trust turnover rate (July 2024)	11.0%	10.9%	≤ 10.0%	L	F	
Agency spend as % of pay bill (July 2024)	3.8%	3.7%	≤3.0%	L	F	
Agency spend total (£) – July 2024	£2.1m	N/A	£1.5m	L	F	
Appraisal rate % (non-medical) – July 2024	88%	87%	85%	H	F	
Appraisal rate % (medical) – July 2024	90%	87%	75%	Insufficient data for SPC analysis		
MAST training % (July 2024)	94%	94%	85%	H	P	
Sickness rate (rolling 12 month) – July 2024	3.4%	3.3%	≤ 3.2%	L	F	
Time to hire (days) – July 2024	46.4	46.1	≤45	L	F	

People Scorecard – key indicators at-a-glance

Supporting our People					
Metric	Annual metric	Target / concern threshold	Variation	Assurance	
% of staff say they experience discrimination from patients / service users, their relatives, or other members of the public (October 2023)	11.87%	TBC			Data taken from National Staff Survey – October 2023
% staff saying they experience incidents of bullying and harassment from line managers (October 2023)	9.57%	TBC			Data taken from National Staff Survey – October 2023
% staff saying they experience incidents of bullying and harassment from other colleagues (October 2023)	16.49%	TBC			Data taken from National Staff Survey – October 2023
% staff saying they experience incidents of discrimination from line managers or teams (October 2023)	9.36%	TBC			Data taken from National Staff Survey – October 2023

Cover sheet – Money – Key Points for M04 Financial Performance

- The Trust financial position shows a £18.9m adjusted deficit YTD, £1.5m worse than the submitted plan. This is an improvement of £0.8m on the previous month, led by an improvement in income (both privates and nhs).

- Agency costs in July 2024 were £0.3m higher than the £1.8m reported in June 2024. This is driven by more medical agency shifts and non-clinical costs within corporate have increased with new agency resources deployed.

- Bank costs had fallen every month between April and June in line with lower escalation, July saw an increase which was driven by high medical retrospective claims (some in relation to Industrial Action) and also a higher number of bank usage within Chief of Strategy and Estates (compliance activity and portering costs)

- In the year to date position a number of non-recurring benefits have been taken to resolve the 23-24 outstanding matter.

- The Trust has delivered £10.2m of Tier 1 efficiencies compared to a plan of £10.4m during the first four months of the year. The full year identified plans of £36.1m are forecast to deliver £33.2m in year against a target of £35.0m. Tier 2 schemes have delivered £3.7m of run rate savings compared with a year-to-date target of £3.1m.

- Capital spend (£88.5m plan) showed overall expenditure of £22.8m in the year, less than plan by £0.3m YTD, with the main shortfall being in Digital. The forecast remains to be budget for the year.

- Cash reduced from the £99.8m closing year-end balance to £61.6m at the end of July 2024 (£62.4m June 2024). This is £0.8m better than planned as draw down of PDC and loan movements offset the adverse I&E position.

Cover sheet – Money – Committee assurance statement

Key Highlights and Discussion Points Including Assurance Points for Board	The Finance Investment Committee last met on the 26th June and the Board received an assurance statement for this meeting at the July Public Board of Directors meeting. The next meeting will be held 2nd September 2024, and the Committee Chair will provide a verbal report at the 6th September 2024 Public Board of Directors meeting. The agenda for the 2nd September includes: Part 1 • Monthly Finance Report • M Block Update • Corporate Risk Register Review of the risks assigned to the Committee Part 2 • Operating Plan Delivery Report
Key risks to Escalate	Not applicable
Recommendations/ Decisions Made	Not applicable

Cover sheet – Audit – Committee assurance statement

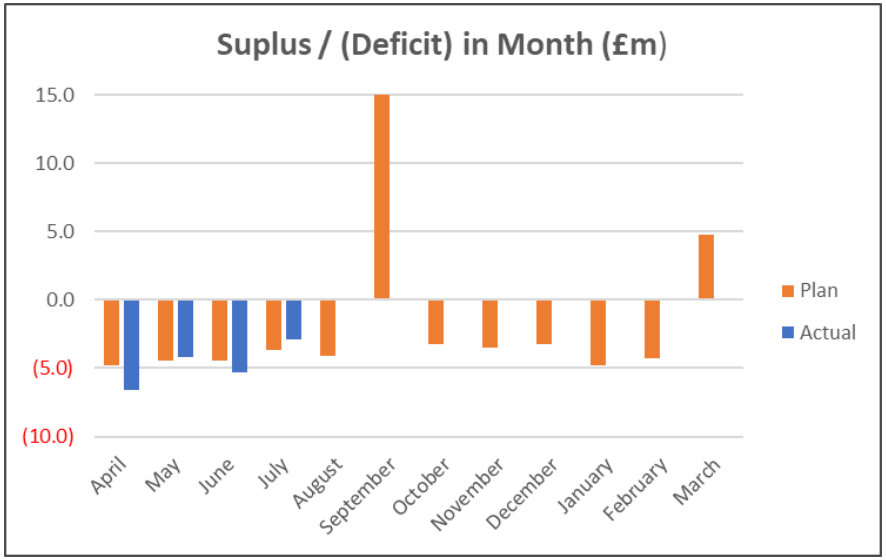
Key Highlights and Discussion Points Including Assurance Points for Board	The Audit Committee last met on 14th June and the Board received an assurance statement for this meeting at the July Public Board of Directors meeting. The next meeting will be held 4th September 2024, and the Committee Chair will provide a verbal report at the 6th September 2024 Public Board of Directors meeting. The agenda for the 4th September includes: • Internal Audit Report • Local Counter Fraud Report • Losses and Write Offs – Q1 • Annual Combined Costs Collection Submission • Board Assurance Framework & Corporate Risk Register Review
Key risks to Escalate	Not applicable
Recommendations/ Decisions Made	Not applicable

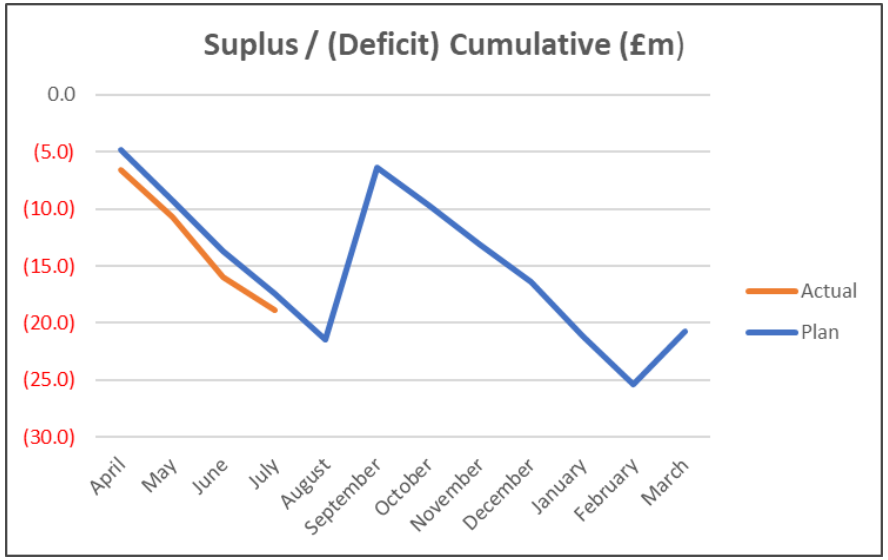
Money – Income and Expenditure Performance

Key messages in the month:

The Trusts year to date (YTD) position at the end of month 4 was a deficit of £18.9m, which is £1.5m worse than budget

- The favourable performance in July was largely due one-off credits received in July. Despite operational pressures faced by the Trust, progress has been made in reducing the number of escalation areas open during the month.
- The impact of controls requires much more rigorous planning and management to avoid performance demands driving up costs later in the year.
- The modernisation of reporting and deployment of performance information is allowing more sophisticated conversations on underlying improvements. Time to implement change and breadth of conversation will be a challenge.
- Looking forward the realisation of M-Block Elective income is a risk which needs assurances to be made more solid.





Money – Key Financial Indicators

Key Financial Indicators	Mth 4 Year to date 24/25			24/25 Full Year		
	Budget £m	Actual £m	Variance £m	Budget £m	Forecast £m	Variance £m
Income	339.0	338.6	(0.4)	1,036.8	1,035.3	(1.5)
Pay	(219.3)	(219.5)	(0.2)	(652.1)	(652.2)	(0.2)
Non-Pay	(118.2)	(119.4)	(1.1)	(348.6)	(346.6)	2.0
EBITDA	**1.5**	**(0.2)**	**(1.7)**	**36.1**	**36.4**	**0.4**
Financial items	(18.9)	(18.7)	0.1	(56.8)	(57.1)	(0.3)
Surplus / (Deficit)	**(17.4)**	**(18.9)**	**(1.4)**	**(20.7)**	**(20.7)**	**0.0**
CIPs	13.6	13.9	0.3	45.0	45.0	0.0
Substantive	187.4	187.9	(0.5)	560.4	558.4	2.1
Bank & Agency	31.9	31.6	0.3	91.7	93.9	(2.2)
Cash	**60.8**	**61.6**	**0.8**	**60.6**	**60.6**	**0.0**
Capex	**23.0**	**22.8**	**0.3**	**88.5**	**88.5**	**0.0**

Income : Lower than planed from ERF (£0.7m) and Private Patients (£0.4m), – partially offset by Other Income (Education & Training)

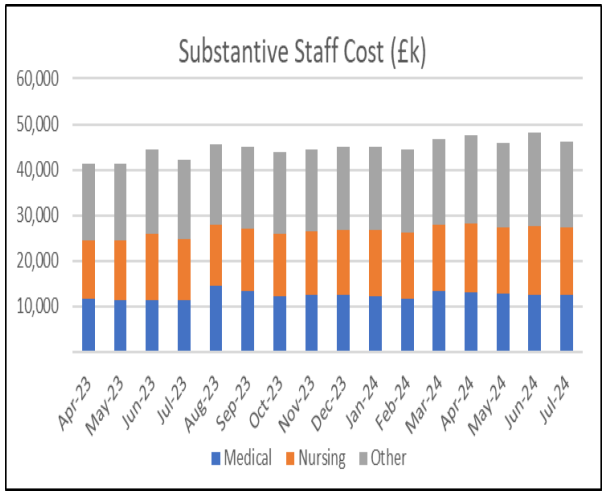
Pay: £0.2m worse than plan. Both substantive and bank/agency are under plan before the one-off item (£1.5m) in substantive and temporary staffing costs relating to Industrial action.

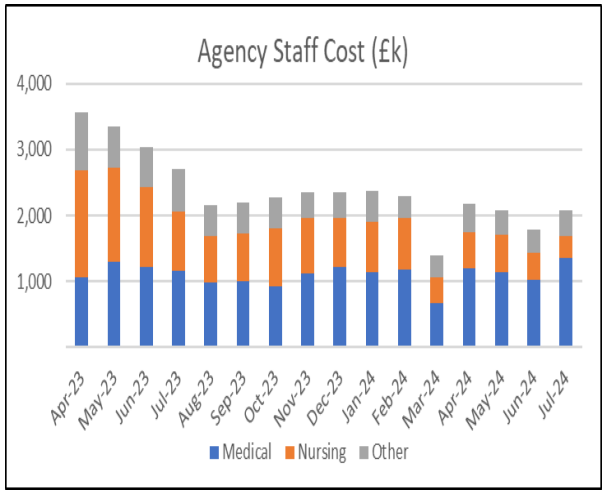
Non-Pay : £1.1m worse driven by drug spend (£0.9m) and M&S spend (£2.0m), partially offset by CNST rebate (+£1.1m). Consumables and drugs are being further investigated for stocking impact and causes of usage.

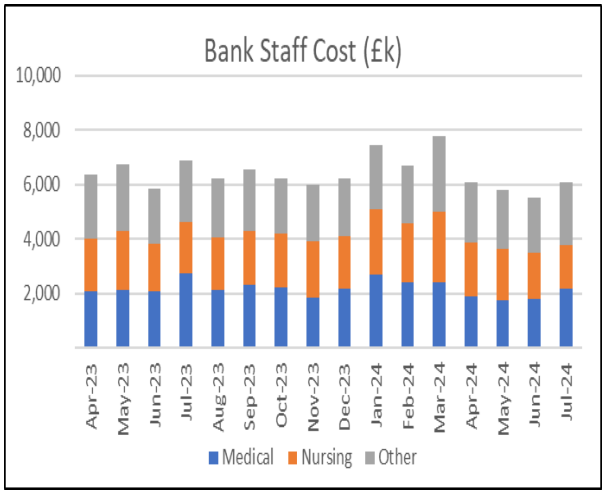
CIPs: Overall, the Trust has achieved £13.9m savings, against a plan of £13.6m. Work continues to identify the remaining £1.8m shortfall in full year forecast.

Capex: Capital spend (£88.5m plan) showed overall expenditure of £22.8m in year, behind plan by £0.3m YTD, predominantly against Digital Services.

Cash: Is £0.8m above plan as draw down of PDC and loan movements offset the adverse I&E position.







Money – Efficiency Performance: 2024/25 overview

Overall performance:
The total efficiency target for 2024-25 is **£45m**; **£35m of Tier 1** savings and **£10m of Tier 2** savings.

The Trust has identified **£36.1m** of Tier 1 efficiency savings. As at M4, **£10.2m** of Tier 1 savings have been delivered against a plan of £10.4m. Of the savings achieved, £6.3m (62%) are recurrent. The forecast for T1 savings is £32.2m of which 70% are recurrent. This is a favourable movement in forecast of **£1.8m** compared to M3.

The Trust has achieved **£3.7m** of Tier 2 savings, against a plan of **£3.1m.** These savings are all recurrent.

Overall, the Trust has achieved **£13.9m** savings, against a plan of **£13.6m**. The forecast overall is **£43.2m**, a **£1.8m** adverse variance, however this is a favourable movement in forecast compared to last month. Work continues to ensure planned schemes are on track to deliver, with a focus on recurrent schemes.

Project Categorisation	Sum of 2425 total	Sum of 2425 YTD plan	Sum of 2425 YTD Actual	Sum of 2425 YTD Variance	Sum of FORECAST	Sum of FORECAST VARIANCE
Tier 1 Directorate	26,521	6,810	8,163	1,353	25,987	-534
Tier 1 Trustwide	8,478	3,617	2,018	-1,599	7,179	-1,299
Tier 2	10,061	3,137	3,735	598	10,061	0
Grand Total	**45,061**	**13,564**	**13,916**	**352**	**43,227**	**-1,834**

Recurrent / Non Recurrent £'000	2425 total plan	M4 Plan	M4 Act	M4 Var	2425 YTD plan	YTD Actual	YTD Variance	FORECAST	FORECAST VARIANCE
Tier 1 recurrent	25,278	2,718	2,381	-337	7,697	6,342	-1,355	23,270	-2,008
Tier 1 non recurrent	9,722	479	1,308	829	2,730	3,839	1,109	9,896	174
Tier 2 recurrent	10,061	860	934	74	3,137	3,735	598	10,061	0
Grand Total	**45,061**	**4,057**	**4,623**	**565**	**13,564**	**13,916**	**352**	**43,227**	**-1,834**
recurrent %	78%	88%	72%		80%	72%		77%	
non recurrent %	22%	12%	28%		20%	28%		23%	

Money – Capital and Cash Month 4

Capital Expenditure (£m)	Annual Plan (£m)	Revised Annual Plan (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	FY (£m)	FY Variance (£m)	YTD Actual (£m)	Prior Month YTD Actual (£m)	Movement In Spend
Estates	61.3	61.3	16.9	17.0	- 0.0	61.3	-	17.0	11.7	5.3
Digital Services	5.5	5.5	1.7	1.4	0.2	5.5	-	1.4	1.1	0.3
Medical Equipment	5.5	5.6	1.7	1.7	- 0.1	5.6	-	1.7	1.2	0.6
NHP	16.1	16.1	2.8	2.7	0.1	16.1	-	2.7	1.9	0.7
Total Capital Expenditure	**88.5**	**88.5**	**23.0**	**22.8**	**0.3**	**88.5**	**0.0**	**22.8**	**15.9**	**6.9**

Key messages:

- Capital plan for the FY 24/25 retained at £88.5m having recognised the further £1.0m allocation awarded through the 23/24 Q4 UEC performance and £16.1m for the New Frimley Park Hospital Programme (subject to approvals by the national new hospital programme team) in the latest plan submission.
- Plan expenditure against estates programme (£61.3), digital services (£5.5m) and medical equipment (£5.5m) is funded through the Trust provider allocation of £34.3m and additional PDC funding awarded for the RAAC failsafe programme (£5.0m), ERF – M Block (£11.0m) and Slough CDC (£21.1m).
- Capital spend in M4 was £6.9m and is £22.8m ytd, now £0.3m behind plan ytd due to small variances across all areas with the largest in Digital Services although this is due to the profile of spend vs plan and expected to remain on budget for the year. Spend against the NHP programme is also £0.1m behind plan as recruitment to the programme team establishment continues.

	Mth 4 Year to date 24/25			24/25 Full Year		
	Budget	Actual	Variance	Budget	Forecast	Variance
	£m	£m	£m	£m	£m	£m
EBITDA	0.3	(1.8)	(2.0)	14.0	14.0	0.0
Working capital mov't	(6.0)	(6.4)	(0.4)	(12.0)	(12.0)	0.0
Capex	(23.0)	(22.7)	0.3	(88.5)	(88.5)	0.0
Capital donation	(0.1)	(0.1)	0.0	(0.4)	(0.4)	0.0
Disposals	0.0	0.0	0.0	18.6	18.6	0.0
PDC paid	(6.1)	(6.1)	0.0	(18.2)	(18.2)	0.0
PDC received	0.0	1.6	1.6	53.2	53.2	0.0
IFRS16 leases	(1.9)	(1.9)	0.0	(5.6)	(5.6)	0.0
Interest	1.2	1.7	0.4	3.8	3.8	0.0
Loans / other	(3.4)	(2.6)	0.8	(4.0)	(4.0)	0.0
Cashflow	**(39.0)**	**(38.3)**	**0.8**	**(39.2)**	**(39.2)**	**0.0**
Cash	**60.8**	**61.6**	**0.8**	**60.6**	**60.6**	**0.0**

Key messages:

- Cash balance as at the close of M4 finished at £61.6m, a movement of £38.3m from the opening balance of £99.8m at the start of the year although this reflects positively against the plan movement of £39.0m and balance YTD of 60.8m at £0.8m ahead of plan.
- The variance against plan is a result of; a net I&E deficit (incl interest) against plan of £1.5m as noted earlier in this report; offset by £1.6 of PDC drawdown ahead of the profile submitted in the annual plan.
- Working capital and technical adjustments YTD are £0.2m ahead of plan and will continue to be monitored throughout the year but are anticipated to remain to plan as the cash balance of £60.6m has been retained in the forecast.

Appendix

Activity (FHFT)

	21/22	23/24	Jul-23	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul-24	YTD
GP and general dental practitioner referrals to all outpatients																
NHS Buckinghamshire	12724	30588	2835	2523	2615	2920	3157	2277	3038	2047	2077	2354	2821	2969	2226	10370
NHS Frimley	156043	346339	31297	30701	28078	32793	33281	26762	33776	22090	22113	22282	26292	33494	25496	107564
Other CCGs	12287	25613	2426	2124	2245	2346	2593	1983	2649	1724	1723	1900	1926	3268	2366	9460
Sum:	181054	402540	36558	35348	32938	38059	39031	31022	39463	25861	25913	26536	31039	39731	30088	127394
Outpatient attendances																
New attendances	298963	393630	32883	30975	31479	33161	34424	26807	32707	30355	30928	31936	32980	31393	34827	131136
Follow-up attendances	613301	651042	51973	54647	54992	58258	61228	50898	62654	58395	54828	60593	61896	58948	65394	246831
Total	912264	1044672	84856	85622	86471	91419	95652	77705	95361	88750	85756	92529	94876	90341	100221	377967
Elective admissions																
Daycase	59472	69998	5612	5371	5930	6181	6882	5406	6064	5915	6114	6409	6645	6087	6895	26036
Overnight	11320	9765	828	886	868	843	857	672	760	673	699	721	829	735	828	3113
Regular day attenders	17393	15374	1369	1520	1366	1274	1096	948	1123	1093	1115	1124	1175	972	1066	4337
Total	88185	95137	7809	7777	8164	8298	8835	7026	7947	7681	7928	8254	8649	7794	8789	33486
Emergency department (ED) attendances																
Total ED attendances	257335	264219	21976	21041	22000	22533	22490	22122	22521	21753	23453	21824	23873	23084	23418	92199
Non-elective admissions																
Non-elective – Zero LOS admissions	26776	11332	825	978	1093	1117	1040	1125	944	947	1022	939	850	897	861	3547
Emergency Admissions (excluding Zero LOS)	49269	48032	4080	3901	3975	4125	4049	4090	4193	3888	4050	3840	3979	3821	3946	15586
Other Non-elective admissions	17604	20614	1644	1803	1677	1718	1808	1713	1724	1675	1888	1761	1851	1679	1776	7067
Non-elective admissions (total)	93649	79978	6549	6682	6745	6960	6897	6928	6861	6510	6960	6540	6680	6397	6583	26200
Maternity																
Number of live births	9451	9251	734	835	777	787	761	753	771	729	827	786	813	720	772	3091

Glossary

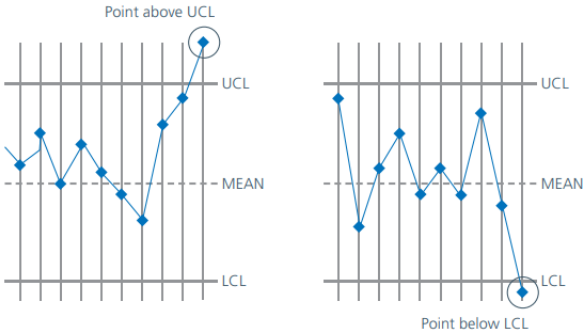
Term	Meaning
CIP	Cost Improvement Plan or Programme
FHFT	Frimley Health NHS Foundation Trust
YTD	Year-to-date

Statistical Process Control (SPC)

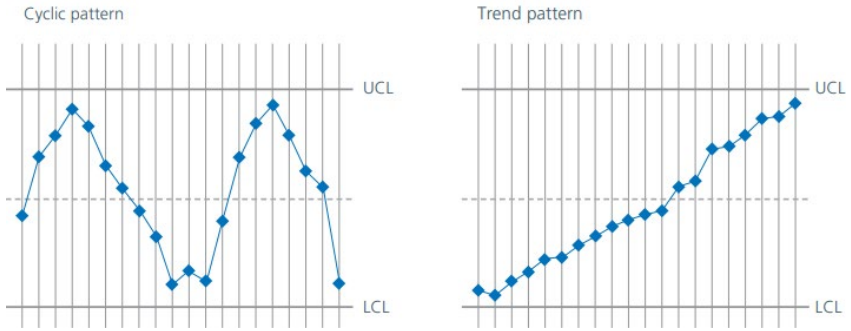
Statistical Process Control helps to understand what is the norm and what is different. Performance of a KPI is looked at over time and statistical analysis is used to calculate an "upper control limit" and a "lower control limit".

When interpreting SPC charts, there are 4 rules that help identify what the system is doing. If one of the rules has been broken, this means that "special cause" variation is present in the system. It is also perfectly normal for a process to show no signs of special cause. This means that only "common cause" variation is present.

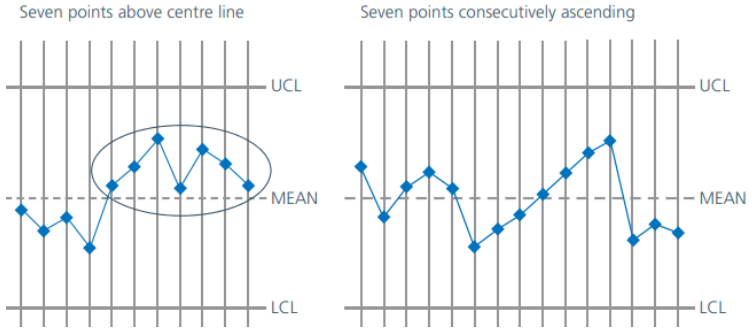
Rule 1 – any single point outside control limits



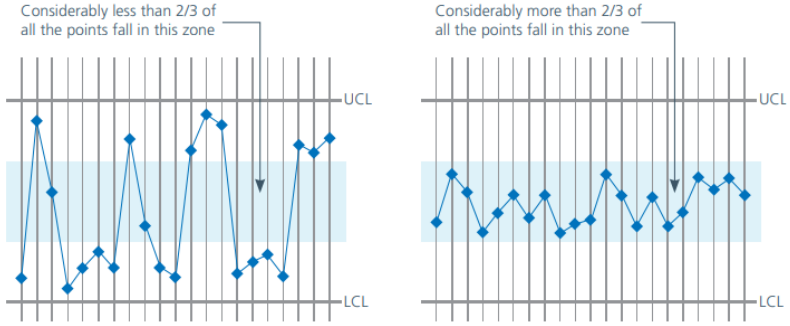
Rule 3 – any unusual pattern or trends within the control limits



Rule 2 – a run of seven points all above or all below the centre line, or all increasing or decreasing



Rule 4 – the number of points within the middle third of the region between the control limits differs markedly from two thirds of the total number of points



Produced with thanks to NHS England and NHS Improvement resources

Statistical Process Control (SPC)

This report uses icons to present the SPC analysis of each metric (where appropriate) and support interpretation of the analysis

Variation			Assurance		
-	H L	H L	?	P	F
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **Orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**)

Assurance icons: **Blue** indicates that the trust should consistently expect to achieve a target. **Orange** indicates that the trust should consistently expect to miss a target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation

Produced with thanks to NHS England and NHS Improvement resources

MORTALITY REPORT

REFERENCES

Only PDFs are attached

9. Cover Sheet M+M report (1).pdf

Report Title	Mortality and Morbidity Update
Meeting and Date	Board of Directors, 6th September 2024
Agenda Item	9.
Author and Executive Lead	Dr Alex Higton, Associate Medical Director for Patient Safety Dr Timothy Ho, Chief Medical Officer
Executive Summary	Mortality (SHMI) has been within expected limits since data has been available in April 23, following transition to Epic and resolution of early difficulties with National data submission. The Medical Examiner (ME) service transition to review of community deaths in addition to hospital deaths has made good process and on track to be fully compliant by the Sept 24 deadline. There is now a 7 day ME service to facilitate urgent reviews for rapid release for faith reasons and organ donation. Currently 10-17% of deaths are referred for deeper review (either Patient Safety Review of M+M review) and themes in learning from these are described below. After review 0.21% of deaths (5 deaths of 2372 in the last year) were thought to be potentially avoidable. This year we have appointed M&M leads for each acute site, and an M&M coordinator to assist with the administrative elements. We have updated the Learning from Deaths policy to reflect the changes in the ME service (expanding into the community) and Patient Safety Incident Review Framework (PSIRF). We have also transitioned from RL to In-Phase for Structured Judgement Reviews (the tool for M+M reviews) which makes recording and identifying themes easier.
Action	The Board is asked to **NOTE** the report.
Compliance	National Guidance on Learning from Deaths

Mortality Data:
SHMI has been within expected range throughout the reporting period.

Month	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Number Spells	6432	7040	7177	7115	7412	7339	7342	7305	7129
Number deaths *	242	261	242	264	237	246	256	245	246
SHMI	103.6	108.3	100.74	104.8	93.1	103.3	102.5	95.8	86.5

*within 30 days if discharge

Hospital Deaths – numbers referred to Coroner, Patient Safety team and for M&M:

	Frimley	Wexham	National Average
Coroner referrals	12% of which 44% go to inquest	14% of which 63% go to inquest	
Patient Safety Flag	7%	4%	
Mortality and Morbidity review	17%	10%	10-15%

Developments in the Medical Examiner Service:

- 7 day service went live in Apr 24 to facilitate urgent releases for faith reasons or tissue or organ donation
- 100% of non-coronial hospital deaths are reviewed by the ME team.
- By Sept 24 all community deaths will be reviewed. Currently 52% practices in Frimley ICB are regularly referring to ME service and 29% practices have made <5 referrals to date. All practices within our ICB have had a face-to-face or teams meeting to discuss the service.

Mortality and Morbidity Reviews:

- Structured Judgement Review (SJR) has been the usual review tool for mortality reviews for many years. With the transition from RL risk management system to InPhase we have modified the reporting tool for M+M reviews to make it more accessible for clinicians completing the reviews, and for external parties such as the Coroner.
- Around 10-17% of hospital deaths are referred for M&M review and this should be completed by the treating team in a multidisciplinary and reflective fashion, within 12 weeks of referral. The M+M team are supporting specialties to catch-up their backlogs of cases requiring review.

Frimley Health Foundation Trust	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Number of inpatients deaths	240	235	203	201	203	209	225	221	216	305	238	246
Community Deaths Screened	125	125	96	100	112	108	104	117	134	136	118	148

Total Deaths screened (including < 30 days post-discharge)	365	360	229	301	315	317	329	228	350	441	356	394
Cases sent to review	14	22	21	44	33	38	53	44	40	40	41	55
Total number of deaths judged > 50% likely to be due to problems with care	0	0	1	0	0	1	1	1	0	1	0	0
Number of deaths of patients with a Learning Disability	3	3	1	1	2	5	2	3	3	5	4	4
Cases Outstanding	1	3	5	6	9	8	15	7	12	22	21	15

- **Key themes and Learning from M+M reviews include:**
    - Late identification of dying
    - Early discussion and decision making about ceilings of care
    - Inappropriate admissions for patients with respect / advanced care plans for care at home
    - Poor communication – within team / interdisciplinary and with families
    - Importance of checking antibiotics / durations, medications dropping of prescription chart when course complete.
    - Use of a ward round proforma or checklist to ensure we don't miss unexpected issues.

EMPLOYMENT EQUALITY REPORT 2023/24

REFERENCES

Only PDFs are attached

9c. EDI Annual Report Board Cover.pdf

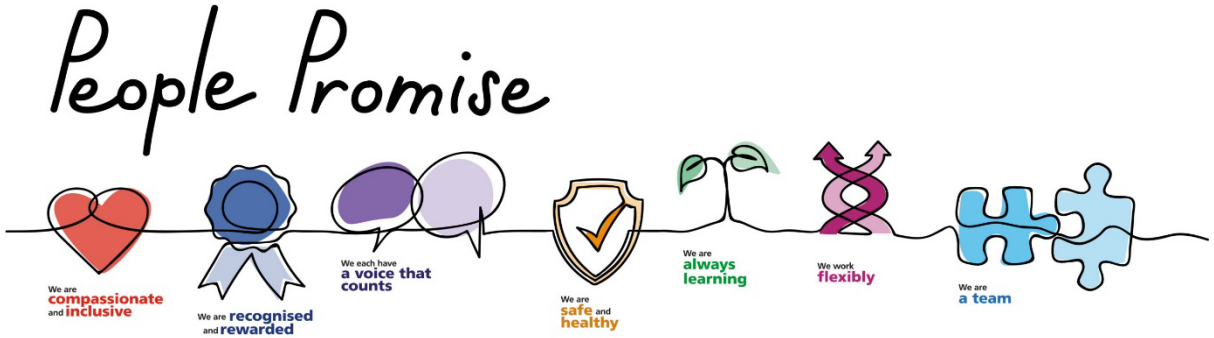
9c. Equality Report 2023-2024.pdf

Report Title	**Employment Equality Report 2023/2024**
Meeting and Date	Board of Directors, 6th September 2024
Agenda Item	9.
Author and Executive Lead	Shaminder Flora, Head of OD and EDI Matt Joint, Chief People Officer

Executive Summary	This report offers a summary of EDI activities over the past year, highlighting progress in relation to our:
	- **Organisational Culture**: fostering a culture of inclusion via EDI and Wellbeing interventions
	- **Organisational Compliance**: mandatory reporting requirements including:
	  ○ Workforce Race Equality Standard
	  ○ Workforce Disability Equality Standard
	  ○ NHS England High Impact Actions

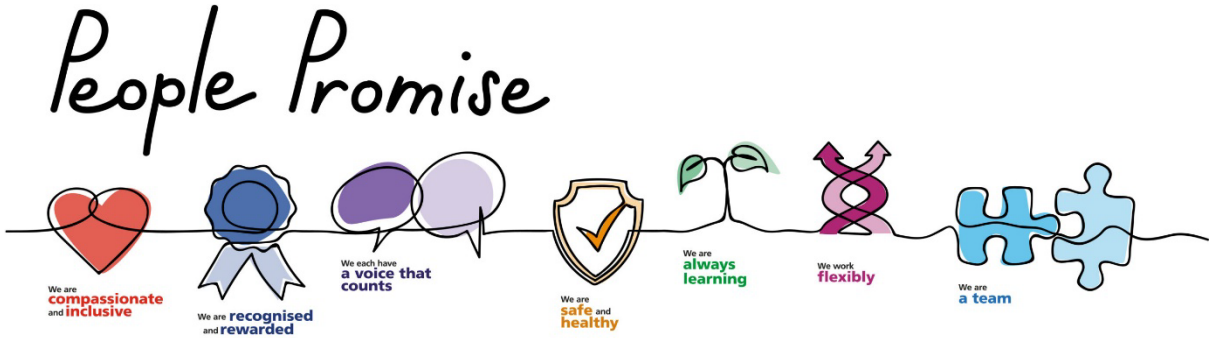
Action	The Board is asked to **NOTE** the Employment Equality Report 2023/2024
Compliance	Public Sector Equality Duties

Equality, Diversity and Inclusion Report 2023-2024



Contents

Section 1: Background



Equality, Diversity and Inclusion (EDI) at Frimley Health

Frimley Health serves multiple diverse communities that live in, Slough, Ascot and Camberley, Aldershot, Farnham and Windsor. The greatest asset we have, in helping us serve these communities, is the diversity of our people. We are proud of our globally diverse workforce; all committed to providing exceptional care as part of the Frimley family:

One team, many nationalities…

Albanian	Bolivian	Dutch	Guyanese	Jordanian	Northern Irish	Saint Vincentian	Sri Lankan
Algerian	Brazilian	Egyptian	Hong Kong	Kittitian	North Korean	Saudi Arabian	Swedish
American	Bulgarian	English	Hungarian	Latvian	Norwegian	Scottish	Swiss
Argentine	Burmese	Estonian	Indian	Lebanese	Omani	Serbian	Syrian
Australian	Canadian	Fijian	Iranian	Liswati	Palestinian	Seychellois	Taiwanese
Austrian	Chinese	Filipino	Iraqi	Lithuanian	Peruvian	Singaporean	Thai
Azerbaijani	Colombian	Finnish	Irish	Malaysian	Polish	Slovak	Trinidadian
Barbadian	Croatian	French	Israeli	Maltese	Portuguese	Slovenian	Turkish
Belgian	Cypriot	German	Italian	Moroccan	Romanian	South African	Ukrainian
Belizean	Czech	Greek	Jamaican	Motswana	Russian	South Korean	Venezuelan
Bhutanese	Danish	Grenadian	Japanese	New Zealander	Saint Lucian	Spanish	Welsh

We are proud of our globally-diverse workforce; all committed to providing exceptional care as part of the Frimley Family.

Meet the EDI Team

The dedicated EDI team comprises:

Shaminder Flora, Head of OD and EDI

Shaminder joined the Trust in 2019, and her portfolio includes: Organisational Development, Leadership Development, and more recently Well- being and Equality, Diversity & Inclusion.

'If our people feel an affinity with their colleagues and supported by their line manager to fulfil their potential, it will enable us to offer a safe environment for them to work in, and ultimately offer the best care to our patients.'

Najeeb Rehman, Equality & Diversity Manager

Najeeb joined the Trust over 10 years ago and has worked in the EDI space since his arrival. What has kept him working with us?

'Being in a position to make a difference for the community, patients and staff.

Deborah Rogers, Equality & Diversity Officer

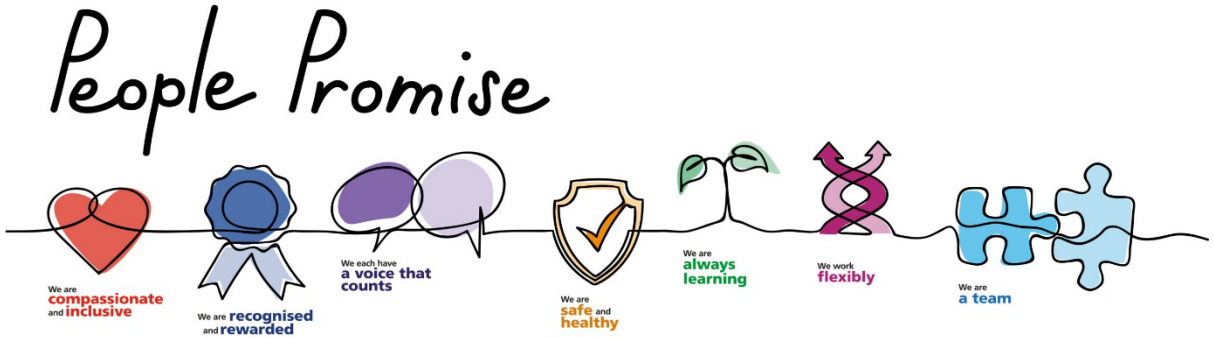
Deborah joined the Trust in 2015 and ventured into the EDI space in 2017.

'I am passionate about EDI. I believe that when people feel valued they can be themselves and thrive. I learn new things every day and am given the opportunity to share this knowledge. My role is interesting and rewarding, although at times a little challenging!'

The Team's remit is broad covering both internal and external aspects of EDI at FHFT. Headline areas of work for the team include:

Internal	**External**
Training on Bias Awareness, Reciprocal/ Mutual Mentoring,	Community work e.g. Rushmoor BC
Supporting our People Networks and the calendar of events	Overseeing our Changing Places Facilities
Conducting Impact Equality Assessments	Attending Patient Safety Forums
Facilitating Interpreting/British Sign Language services	Healthwatch
WDES/WRES reporting	
NHS England High Impact Action Implementation	
Supporting Learning Disability Nurses	

Section 2: Our Approach to Equality, Diversity and Inclusion

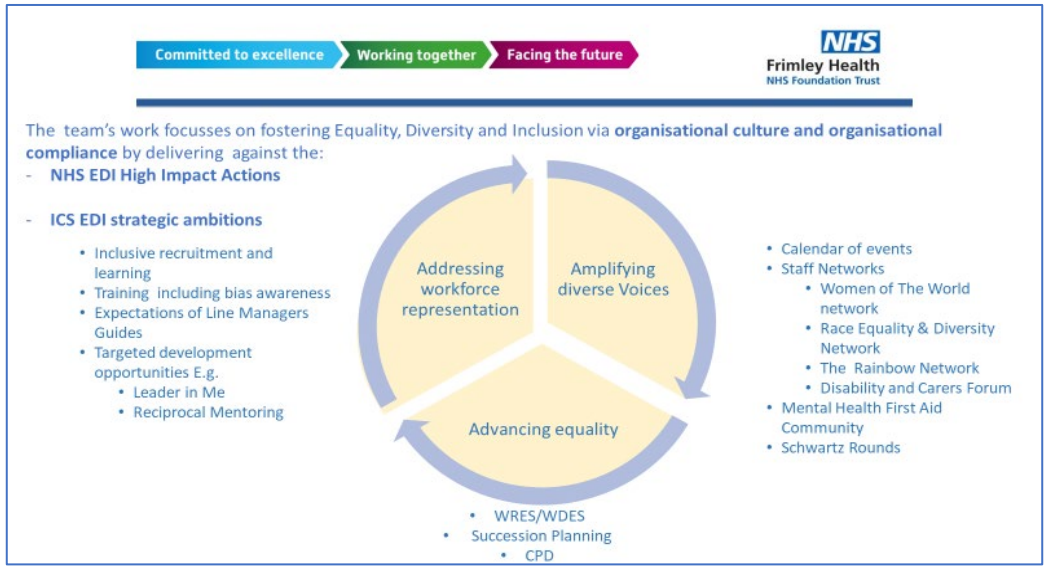


Our Approach to EDI

Our EDI Strategy

Our EDI Strategy was formulated with two categories in mind: organisational compliance and organisational culture. It complements our work on the NHS England High Impact Actions, and has three headline areas:

- Amplifying Diverse Voices
- Advancing equality
- Addressing workforce representation



Our ambition is for EDI to become a part of our DNA at FHFT, where everyone is able to realise their potential as well feel a sense of belonging irrespective of their background. We were delighted to see the results of the National Staff Survey Results 2023 tell us:

92.4% of staff say they feel trusted to do their job

71.6% of staff say the people they work with show appreciation to one another

75.7% of staff say the people they work with are polite and treat each other with respect

Conversely, the National Staff Survey Results 2023 also told us:

11.9% of staff say they experience discrimination from patients / service users, their relatives, or other members of the public

25.6% of staff say they felt pressure to come to work from manager when not feeling well enough

48.1% of staff say they work additional paid hours per week for the organisation, over and above contracted hours (*120/122)

Staff from BAME groups most likely to do additional hours, financial pressure but reliance of staff on doing the hours.

The key priorities arising from the National Staff Survey Results align with the key findings from the Culture & Leadership Programme. As part of a Frimley Excellence approach, continuous improvement work is underway, with a series of counter measures currently being scoped by clinical and non-clinical staff in the areas of:

1. Compassionate Leadership and
2. We are Safe and Healthy; inclusive of negative experiences. I.e. responding to staff who say they experience discrimination from patients / service users, their relatives, or other members of the public

Two guiding principles are helping us implement the EDI agenda across the Trust

- EDI is everyone's responsibility
- Adopting a data driven approach

Frimley Excellence

Our EDI Governance

EDI Committee

Implementation of the EDI Strategy and NHS England High Impact Actions is overseen by our EDI Committee. Established in January 2024, the EDI Committee is chaired by Professor Geeta Menon and Eleanor Shingleton Smith, Deputy HR Director. The Committee seeks to devolve responsibility for EDI to a local level by inviting all Triumvirate Leadership Teams to attend quarterly Committee Meetings to report on progress against the NHS England High Impact Actions. The Committee feeds directly into the CEO on progress.

Professor Geeta Menon: Chair, EDI Committee

'I prefer to talk about this as diversity, inclusion and belonging. Diversity is a fact and having a seat at the table. Equity is a choice. Inclusion is an action and having a voice at the table. It's that feeling that you are being listened to and valued regardless of your differences. Not just being a part of a team but feeling like you are a part of it and making worthy contributions. Belonging is an outcome and having your voice heard. I am confident that every conversation I have as an immigrant who is an Asian woman will create a ripple effect and create changes in people's perceptions and behaviours. As Maya Angelou says - 'People will forget what you said, people will forget what you did but people will never forget how you made them feel.'

Eleanor Shingleton Smith, Chair, EDI Compliance Sub Committee

'EDI is the opportunity to create inclusive cultures and a sense of belonging to an organisation. Inclusive cultures mean that everyone feels they are a part of the team and can engage, no matter what their role or background and so that everybody's voice counts and there is a rich diversity of ideas. There's a level playing field, barriers are knocked down and intolerance and discrimination are things of the past. Feeling included is fundamental to a sense of belonging and that is what keeps people in a place or organisation - that sense of being connected, cared for and caring of others and feeling valued, respected and supported'.

EDI Compliance Sub Committee

This Committee is led by Eleanor Shingleton Smith, and will proactively analyse and monitor our WRES and WDES, and Equal Pay data every quarter to ensure we are on track to meet our annual targets. Attendees will include the: Head of Workforce Information, the Head of Recruitment and the Head of Medical Workforce. This subcommittee will feed into the EDI Committee, offering assurance and or recommendations on what actions need to be taken and where to ensure the Trust is realising its ambitions.

Committee Achievements (to date)

Board Seminar

We were delighted to attend a Board seminar recently to convey and consolidate the importance of EDI at the most senior levels. The presentation covered:

- The differences between Equality, Diversity & Inclusion
- Psychological Safety
- The NHS England High Impact Actions (including WDES and WRES reporting headlines)

Corporate EDI Objectives and Metrics

In adopting a data driven approach that also advocates EDI is everyone's responsibility; corporate objectives have been set that signal our commitment to non- discrimination in the workplace. The Board has agreed to incorporate these objectives:

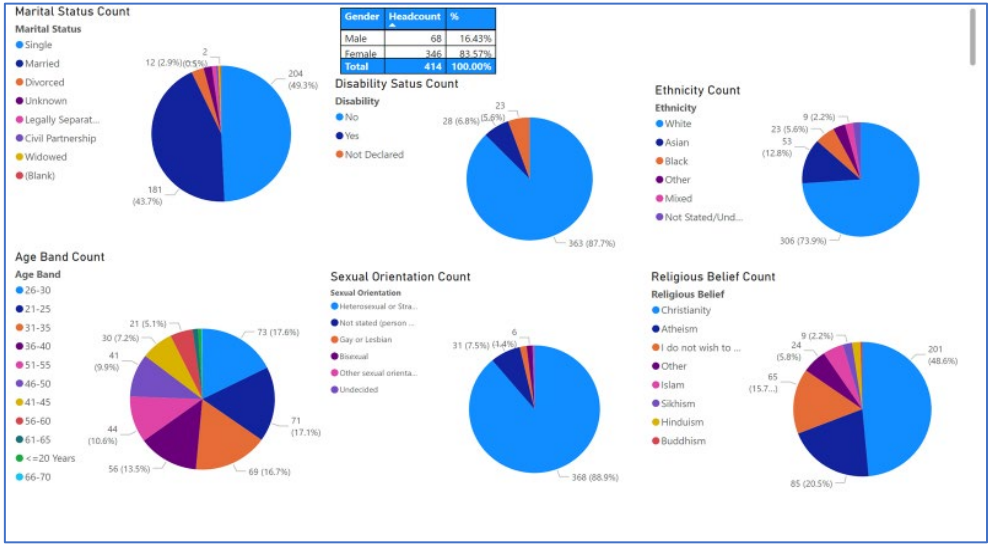
- **Creating an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur**

Metrics will include:

  - Year-on-year reduction in incidents of bullying and harassment from line managers or teams (target tbc.)
- **Representation**
  - Year on year improvement in race and disability representation leading to parity (WRES/WDES) (target tbc.)
  - Year on year improvement in representation of senior leadership (8C and above) (WRES/WDES) (target tbc.)

EDI Dashboard

An EDI Dashboard has been developed by our Workforce Information team that will enable local teams to gauge progress on the recruitment, retention and progression of colleagues by offering benchmarking data every quarter. The aim is to offer an analysis report to each Directorate to chart their progress, alongside recommendations.



Inclusive Recruitment

Led by our Resourcing Team, an inclusive recruitment pilot is being launched across x4 of our Directorates (including HR). Key changes include:

- Support with making job adverts more inclusive
- Mandating Inclusive Recruitment and Selection training for Managers
- Band 7 and above positions to be recruited for via CVs
- Interview questions to be given out in advance for candidates who have disclosed Neurodiversity

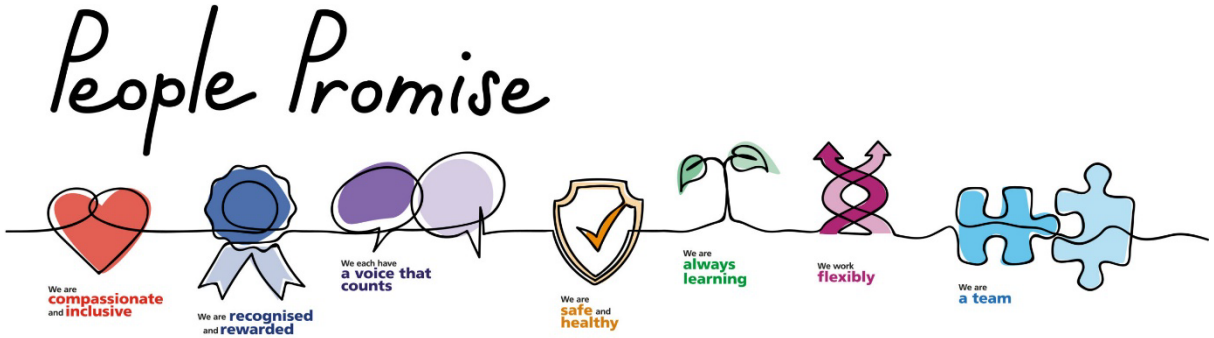
Succession Planning

Led by our OD function, succession planning has also started for critical posts across the Trust. The Associate Director of Learning and Organisational Development meets with the Triumvirate Leadership Teams to support their succession plans and identify areas of opportunity in relation to our EDI Strategy segment: Advancing Equality. The work is reported to the EDI Committee, to identify priority areas of action.

Supporting Positive Action Development Programmes

"Leader in Me" is a two-day leadership initiative targeting Bands 5 and Band 6 BAME employees at FHFT, addressing the decline in diversity beyond Band 6. In collaboration with the RED Network, the OD team established this program to nurture identified talent for career advancement. The program's success is evident, with a waitlist of over 130 employees and four annual cohorts of 30 delegates each. Post-program, delegates join a Teams channel for ongoing collaboration, sharing resources, and addressing challenges through peer support. Additionally, delegates receive a "Scope for Growth" consultation to pinpoint career development areas. Future action learning sets will leverage the National Staff Survey and WRES data to enable leaders to devise and implement solutions within the Trust.

Section 3: Reporting Updates



Workforce Race Equality Scheme 2024 Summary

The Trust's BME density has grown over the past 5 years, from 36.39% in 2019 to 48.41% in 2024. There is an improving picture within all pay bands, with an increase in BME density in every pay banding including Agenda for Change, Medical and Other. The exceptions are Agenda for Change Band 1 (now closed) and Agenda for Change Band 9 which has fewer than 5 staff. Indicator 9 remains red because the benchmark is 48.41% (Trust BME density in 2024).

Indicators 2 to 4 use the statistical 4/5th rule indicating whether practices have an adverse impact on an identified group compared with another. If the likelihood of an outcome for one group compared to another is less than 0.80 or higher than 1.25, then the process would be identified as having an adverse impact. It is noted that 2024 data indicates there is no adverse impact with respect to indicator 2, 3 and 4 for BME applicants or staff.

WRES Indicator	2019	2020	2021	2022	2023	2024
Indicator 1: Ethnicity by pay banding					↑	↑
Indicator 2: Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants	2	1.3	1.38	1.17	0.9	0.8
Indicator 3: Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	1.2	1	1.1	1.3	0.6	0.9
Indicator 4: Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff	0	1	1.3	0.9	1.4	0.9
Indicator 9: Representation of BME people amongst Board members as at 31st March 2024						18.75%

Indicators 5 to 8 below show that the perceptions of BME staff have improved in 2023, with indicators 6 to 8 being better than average compared with other acute and community trusts. Indicators 5, 6 and 8 still show a worse experience for BME staff compared with white staff and remain red. Indicator 7 on career progression is amber because the gap between the experience of BME and white staff has significantly reduced, but work is still required to close it.

WRES Indicator - National Staff Survey items	2019	2020	2021	2022	2023	Improved or deteriorated at FHFT	Compared to other acute and community trusts	Status
Indicator 5: % of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public	31.33%	33.63%	30.73%	30.90%	28.55%	Improved	Worse than average	
Indicator 5: % of white staff experiencing harassment, bullying or abuse from patients, relatives or the public	29.12%	27.44%	27.16%	28.29%	25.48%	Improved	Worse than average	
Indicator 6: % of BME staff experiencing harassment, bullying or abuse from other staff	23.72%	25.96%	24.39%	24.69%	21.65%	Improved	Better than average	
Indicator 6: % of white staff experiencing harassment, bullying or abuse from other staff	20.97%	22.43%	21.12%	20.83%	19.26%	Improved	Better than average	
Indicator 7: % of BME staff believing that their trust provides equal opportunities for career progression or promotion	51.09%	50.42%	50.05%	51.58%	55.74%	Improved	Better than average	
Indicator 7: % of white staff believing that their trust provides equal opportunities for career progression or promotion	61.91%	62.60%	59.51%	60.92%	60.34%	No significant change	Better than average	
Indicator 8: % of BME staff experiencing discrimination at work from other staff	12.96%	14.52%	15.23%	13.62%	12.65%	Improved	Better than average	
Indicator 8: % of white staff experiencing discrimination at work from other staff	5.73%	5.33%	5.84%	5.98%	6.60%	Improved	Better than average	

An action plan is being developed, building on last year's, in conjunction with our RED Network and will be published on the Trust's website in due course.

Workforce Disability Equality Standard Summary 2024

Staff disclosure of information to the Trust about whether they are disabled or not has steadily increased over the past 5 years. The chart on the right shows that in 2024, 3.1% of our people have indicated they are disabled, compared with 2.3% in 2019. There has also been a 19.2% improvement in staff letting the Trust know they do not have a disability. This means there is a 20% reduction in those who have not stated whether they have a disability or not to 16.9% in 2024. This is important because data about employment outcomes and staff experience is more accurate, meaning we have more opportunity to be able to understand and to reduce negative experiences for disabled staff.

Year	Disability	Not Disabled	Not Stated
2019	2.30%	60.80%	36.90%
2020	2.30%	70.80%	26.90%
2021	2.40%	73.20%	24.40%
2022	2.60%	75.40%	22.00%
2023	2.70%	77.00%	21.30%
2024	3.10%	80.00%	16.90%

There has been an increase in the proportion of disabled staff in Agenda for Change Bands 1, 3, 5 and 7 to 8C and in Medical pay bands. Indicator 10 is red because the benchmark is 3.1% (proportion of staff who have disclosed a disability in 2024).

Indicators 2 and 3 use the statistical 4/5th rule indicating whether practices have an adverse impact on an identified group compared with another. If the likelihood of an outcome for one group compared to another is less than 0.80 or higher than 1.25, then the process would be identified as having an adverse impact. It is noted that 2024 data indicates there is no adverse impact with respect to indicator 2 and 3 for disabled applicants or staff.

WRES Indicator	2020	2021	2022	2023	2024
Indicator 1: Disability by pay banding				↑	↑
Indicator 2: Relative likelihood of non-disabled candidates being appointed from shortlisting compared to disabled candidates	0.9	0.7	0.8	0.4	1.1
Indicator 3: Relative likelihood of disabled staff entering the formal disciplinary process compared to non-disabled staff	0	0	2.2	0	0
Indicator 10: Representation of disabled people amongst Board members as at 31st March 2024					0.00%

National Staff Survey indicators 4a to 9a show that (in all but one case) the perceptions of disabled and non-disabled staff in the Trust have improved or stayed the same in 2023. However, even though perceptions have become more positive within the Trust, a number of indicators are worse than average when compared with other acute and community trusts.

Indicator 6 on disabled staff feeling pressure to come to work when not feeling well enough is the one indicator that has deteriorated in 2023.

Indicators all remain red or amber even if they have improved as the experience of disabled staff is worse than it is for non-disabled staff within the organisation. The Trust is also flagging as worse than the average acute and community trust in some cases so this is a prompt for further action to betaken.

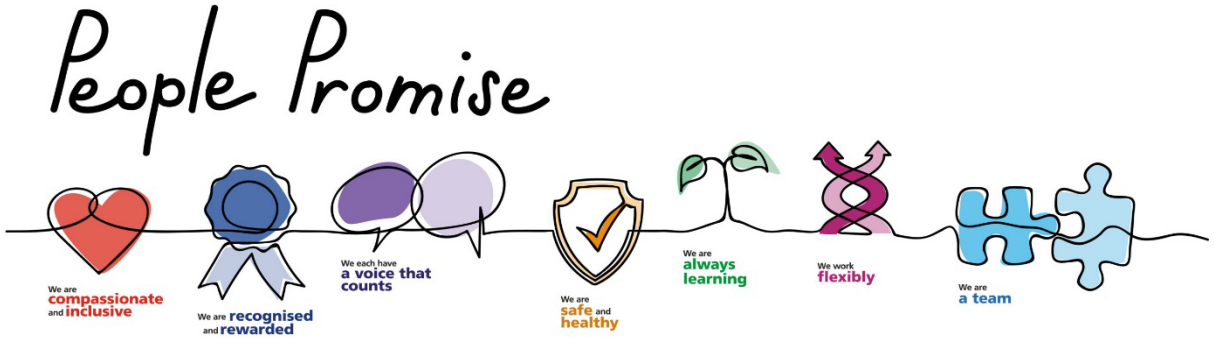
WDES Indicator - National Staff Survey items	2020	2021	2022	2023	Improved or deteriorated at FHFT	Compared to other acute and community trusts	Status
Indicator 4a: % of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public	32.56%	33.53%	37.26%	33.00%	Improved	Worse than average	
Indicator 4a: % of non-disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public	27.44%	27.16%	28.29%	25.48%	Improved	Worse than average	
Indicator 4b: % of disabled staff experiencing harassment, bullying or abuse from managers	17.49%	16.91%	16.93%	17.04%	No significant change	Worse than average	
Indicator 4b: % of non-disabled staff experiencing harassment, bullying or abuse from managers	11.24%	9.74%	9.49%	7.90%	Improved	Better than average	
Indicator 4c: % of disabled staff experiencing harassment, bullying or abuse from other staff	22.22%	24.55%	26.96%	22.67%	Improved	Better than average	
Indicator 4c: % of non-disabled staff experiencing harassment, bullying or abuse from other staff	17.42%	16.26%	16.36%	15.56%	Improved	Better than average	
Indicator 4d: % of disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	45.91%	48.53%	43.49%	46.39%	Improved	Worse than average	
Indicator 4d: % of non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	44.49%	47.42%	42.75%	47.81%	Improved	Worse than average	
Indicator 5: % of disabled staff believing that their trust provides equal opportunities for career progression or promotion	51.65%	50.12%	50.71%	53.70%	Improved	Better than average	
Indicator 5: % of non-disabled staff believing that their trust provides equal opportunities for career progression or promotion	58.76%	56.85%	58.17%	58.72%	No significant change	Better than average	
Indicator 6: % of disabled staff who have felt pressure from their manager to come work, despite not feeling well enough to perform their duties	36.83%	36.28%	31.92%	34.74%	Deteriorated	Worse than average	
Indicator 6: % of non-disabled staff who have felt pressure from their manager to come work, despite not feeling well enough to perform their duties	24.01%	26.57%	23.70%	23.36%	No significant change	Worse than average	
Indicator 7: % of disabled staff who are satisfied with the extent to which the organisation values their work	41.42%	33.29%	34.31%	34.99%	No significant change	Worse than average	
Indicator 7: % of non-disabled staff who are satisfied with the extent to which the organisation values their work	55.33%	46.37%	45.14%	51.10%	Improved	Better than average	
Indicator 8: % of staff with a long lasting health condition or illness saying their employer has made reasonable adjustments to enable them to carry out their work			70.25%	70.56%	No significant change	Worse than average	
Indicator 9a: Staff engagement score for disabled staff	6.75/10	6.6/10	6.36/10	6.54/10	Improved	Better than average	
Indicator 9a: Staff engagement score for non-disabled staff	7.32/10	7.15/10	6.98/10	7.21/10	Improved	Better than average	

An action plan is being developed, building on last year's, in conjunction with our Disability Network and will be published on the Trust's website in due course.

High Impact Actions

Action	Update
1.Measurable objectives on EDI for Chairs Chief Executives and Board members.	The Chair of FHFT has ensured these are in place
2.Overhaul of recruitment processes and embed talent management processes	Data collated from our inclusive recruitment pilots, development programmes and succession planning work will report into the EDI sub Committee.
3.Eliminate total pay gaps with respect to race, disability and gender	The EDI Compliance Sub Committee will be analysing this.
4.Address Health Inequalities within their workforce.	This is a core area of focus arising from the results of our National Staff Survey data. The EDI and Wellbeing teams will work closely together to support this improvement activity
5.Comprehensive Induction and onboarding programme for International recruited staff.	A comprehensive induction & onboarding programme is in place for International Recruits
6.Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.	This is a core area of focus following the results of our National Staff Survey data and has been incorporated into our FHFT Scorecard.

Section 4: Creating A Safe, Inclusive and Kind Culture



Our People Networks

We currently have x5 People Networks, as part of the Amplifying Diverse Voices segment of our EDI strategy.

Race Equality Diversity Network

Arguably, the most evolved of our People Networks this Network is focussed on delivering against:

Vision Statement

The Race, Equality and Diversity (RED) Network aims to support and empower FHFT staff of a global majority background to achieve their full potential.

Aims

- Ensure recruitment processes are inclusive- from advert to appointment.
- Network members have access to support and resources that facilitate career progression, leadership skills and increasing confidence.
- 'You can't be what you can't see/dream.' To shine a spotlight on global majority staff in senior roles.

- Raise awareness of the RED network to grow membership and ensure we have representation across the board in terms of banding, profession, and directorate.

Women of the World

The Women of the World Network is dedicated to supporting and empowering women from all walks of life. Here is an excerpt of an article that was published in our newsletter on International Women's Day 2024:

'The network Launched in March 2022 in celebration of International Women's Day, and the name was chosen by the network members. The Network aims for women to

- *connect with each other*
- *have discussions around issues important to them and*
- *meet other women from a variety of roles within the Trust.*

To date our meetings have been held on teams, except for a small social event for those who wanted to meet in person. We have had some wonderful guest presenters who have covered topics such as

- *women's financial wellbeing,*
- *menopause &*
- *imposter syndrome'*

The Rainbow Network

The Rainbow Network was set up for our LGBTQ+ community and requires our continued investment. Key achievements made by the Network include

- launching a LGBTQ+ Charter.
- Hosting a speaker series with the Network sponsors

The EDI team has worked hard to send signals to the community about our commitment to LGBTQ+ equality. This has included:

- Mounting the Rainbow flag, hanging Rainbow bunting and displaying Rainbow bollards to signal our solidarity
- Hosting Rainbow Network events
- Organising Rainbow displays across each site
- Working with Radio Frimley to promote PRIDE
- Dedicated speaker series sessions

Disability & Carers Forum

The Disability and Carers Forum offers peer support.

Women in Leadership

The Women in Leadership Network launched in May this year. Sponsored by Drs Pippa Skippage and Amrita Kumar, we were delighted to welcome circa 40 women to Greenwood offices to the Network's inaugural event. Speakers shared their personal career stories and insights into the tensions working women often sometimes face. The Network is planning to meet every quarter to support women through their career journeys with practical workshops and continuing speaker series.

Neuro Inclusion Task Force

In January 2024, the NeuroInclusion Task Force was established to leverage the expertise of neurodivergent employees to enhance Trust-wide accessibility. Collaborating with Organisational Development, the Task Force developed facilitator guidelines for accessible learning at FHFT. Sixty employees from diverse fields contributed by refining training instructions, evaluating pilot sessions, revising the Appraisal Policy, and creating a NeuroInclusion Padlet for neurodiversity education. The Occupational Health team has approached the Task Force to advise on adjustments for neurodivergent employees. Additionally, our recruitment team has requested the Task Force's experience and knowledge to overhaul FHFT's recruitment process to ensure accessibility.

EDI & Wellbeing: working well together

o

The following has also been put in place to support a safe, kind and inclusive culture:

- Launching a Trust Wellbeing Strategy involving staff from across the Trust for co-production
- Renewing staff induction to include awareness of a more holistic staff wellbeing offer and the importance of self-care
- Holding Wellbeing & Self-Care Events for Staff which involved active participation from different Trust Teams and also staff from the Trust Networks who promoted the various Staff Networks including the NeuroDiverse Taskforce
- Raising awareness of the many benefits of the Trust's EAP offer to increase accessibility and usage by more staff e.g. Menopause & Men's Health Webinars, Wisdom App

- Increasing awareness of Wellbeing resources and events e.g. Library Teams supporting Awareness Calendar Events, Radio Frimley creating adverts and supporting wellbeing campaigns &events
- Relaunching MHFA training programme and its supporting Community –
    - increasing staff awareness of MHFAs through co-production of Vlogs and refreshing the MHFA offer
- Attending Staff Team events &Leadership Development Days promoting the diverse Well Being offer
- Facilitating Group Coaching &Peer Support groups covering different subjects across generational groups
- Streamlining the MHFA offer of FHFT to ensure an even spread across all areas of the Trust and to align with staff survey results.
- Providing an offer of 'express' seated yoga at the WPH Health and Wellbeing Event, allowing colleagues to fit the session into their working day and remaining flexible to mobility requirements.
- Initiating conversations about the FHFT food strategy and awaiting links into this network, in the hope to offer more healthy choices, in particular for those working night shift patterns.

Schwartz Rounds

Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. Their purpose is to explore the challenges and rewards that are intrinsic to providing care and not to solve problems or focus on the clinical aspects of patient care.

We have recently evolved the model to Pop Up Schwartz. These Pop-Up Schwartz form part of the Wellbeing Strategy at FHFT and are intended to be used as a 'taster' to the approach. It is available to all clinical and non-clinical teams or departments who are considering implementing Schwartz within their standard practice

TRIM

TRiM is a trauma-focused peer support system designed to help people who have experienced a traumatic, or potentially traumatic, event. We have been able to build a TRIM infrastructure in the following teams:

- Emergency Department at Wexham Park Hospital and Frimley Park Hospital
- Paediatrics
- Cardiology team at Wexham Park Hospital and Frimley Park Hospital

Menopause Friendly Employer

As an inclusive employer we want to ensure all our people feel supported during the stages of life. Our aim is to change mindsets and attitudes towards menopause, making it easier to talk about. We want everyone to understand what menopause is and talk openly about it. This isn't just about people experiencing menopause - everyone needs to know so they can support colleagues, family and friends.

We want our people experiencing menopause symptoms to feel confident to ask for support if they need it to continue to be happy and successful at work. Finally, we would like our managers to understand menopause and confidently have good conversations and know how to support.

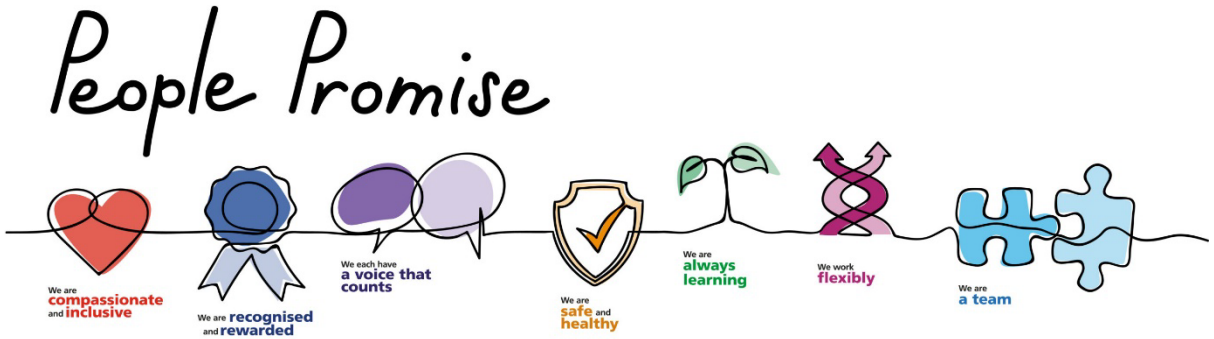
This project has been led by our People Promise Manager, and we currently have trained a total of 44 Menopause Advocates across the Trust who are on hand to support and signpost our people when needed.

Sexual Safety Charter

We are committed to ensuring that our people are safe. As part of this commitment, we have signed the Sexual Safety in HealthCare Charter. As a result, we will be taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this.

Section 5

What gets measured gets managed



Plans for 2024 and beyond?

We will continue to bring each segment of the EDI strategy into fruition, with key priorities including:

- Analysing data in relation to recruitment, retention, CPD, pay and progression
- Increasing disclosure of disability and sexual orientation
- Working with our People Networks to develop countermeasures in relation to the above
- Re launching our Management Essentials Programme
- Commissioning work on Civility
- Scaling our development programmes to target colleagues as positive action e.g.
    - The Leader in Me Programme
    - Mutual Mentoring
    - Aspiring Senior Leaders Programme
    - Reciprocal Mentoring
- Supporting the National Staff Survey Continuous Improvement Projects in relation to:
    - Compassionate Leadership
    - We Are Safe Healthy – (negative experiences)

Conclusions

Our commitment to EDI is clearly demonstrable. And our data tells us, progress is being made as we close the Equality Gap. But we cannot rest on our laurels. Senior management engagement, and accountability remain critical if we are to carry on making progress in this area. Adopting a data driven approach will enable us to see areas of opportunity and strength to enable appropriate countermeasures to be put in place accordingly. Finally, leadership support and holding others to account, will also be required if we are to promote sustainable change.

10. GUARDIAN OF SAFE WORKING HOURS ANNUAL REPORT

REFERENCES

Only PDFs are attached

10. Guardian of Safe Working report August 2024.pdf

10a. Guardian of Safe Working Report August 2024 Appendix 1.pdf

Report Title	Guardian of Safe Working Report
Meeting and Date	Board of Directors, 6th September 2024
Agenda Item	10.
Author and Executive Lead	Kunal Khanna & Hayley Moore, Guardians of Safe Working Matt Joint, Chief People Officer
Executive Summary	The timeframe for this report is 1st June 2023 to 31st May 2024 and provides the Board with an update on junior doctors' well-being and exception reporting. The summary headlines are: **Exception Reporting** The timeframe for this report spans the continuing period of recovery after the COVID-19 global pandemic as well as the "Junior Doctors'" Strikes. There has been a slight reduction in the overall number of exception reports and a slight reduction in the proportion of reports submitted for missed educational opportunities, potentially reflecting some improvement in the number of rota gaps. There have been an increased proportion of reports from ST1 grade doctors and above which could be explained by their increased familiarity with the systems. The anticipated increase in exception reporting numbers following the introduction of exception reporting for 'locally employed doctors' which commenced in September 2022, has not yet been seen. There has been an increase in exception reports from General Surgery and work has ensued to ensure that surgical rota gaps are filled and that training opportunities and ward responsibilities are balanced. There was a clear spike in exception reports in Jan/Feb 24, which may be related to the 9 days doctor strike action In Dec 23/Jan 24. The spikes in exception reports in this time related to the Obstetrics and Gynaecology rota leading to formal rota review, meetings with the chief of service and rota overhaul for August 2024. This demonstrates the value of exception reporting in contemporaneously providing objective evidence of a problem in the trust, which could be presented to the executive team as evidence of the need for resolution. The majority of exception reports are closed through payment rather than time off in lieu, but an increasing proportion are closed through TOIL (10% compared to 5% nationally). This is a positive finding in addressing trainee fatigue and increasing patient safety.

	Junior Doctors Forum The engagement of trainees and trust grade doctors in the JDF has not been as good as we hoped, but a significant improvement on the previous years engagement. 3 previous JDFs have been cancelled due to junior doctor strike action. The latest cross-site JDF had to be postponed due to industrial action and therefore could not take place in person. It took place online a week later with excellent engagement from the board, exec team, HR and well-being teams as well as the JDF committee. This year with the return of "in person" induction and the continuation of a cross site JDF will hopefully improve engagement. It is also important to note that the likely change of name to the "Resident Doctors' Forum" will occur after ratification at the first JDF committee meeting in September 2024. **Facilities Update** The JDF and GOSW continue to focus on wellbeing. There are significant issues with low morale, fatigue and mental health crisis management. As Guardians of Safeworking, we continue to maintain strong links with the well-being teams at the Trust and the mess teams cross-site. Well-being was highlighted as an area of concern in the 2021 Guardian of Safe Working report and there have been vast improvements and changes since that time. Executive team support has been vital and it has become easier in the last year to guide trainees to the correct support now that pathways have been consolidated and are clearer. Increased focus this year has been on rest facilities within the mess at Wexham Park and Frimley Park hospitals as it was discovered that certain areas of maintenance within the mess, particularly at Wexham, had been poorly maintained. We have met with the mess account holder at Wexham to review and re-establish service agreements for the coffee machine and purchase new sofa covers and soft furnishings. Funding has also been approved for an ED well-being event for trainees in ED at Wexham Park Hospital. We will improve education around the Freedom to Speak up Guardian and continue to improve on rest facilities at both sites.
Action	The Board is asked to **NOTE** the Guardian of Safe Working Hours report.
Compliance	Guardian of Safe Working Hours Directive

Appendix 1

Guardian of Safe Working Hours Report

For period 01/06/23 to 31/05/24.

Background

As Guardians of Safeworking for trainees and locally employed doctors at FHFT, our primary role is to champion safe working hours and educational time for all non-Consultant grade doctors at the trust. This includes scrutiny of the exception reporting system, establishing and facilitating an effective Junior Doctor Forum (JDF) and leading efforts to improve working conditions through engagement in the BMA's Fatigue and Facilities Charter.

The following report outlines and summarises our findings for the period 01/06/23 to 31/05/24 (Q2) at Frimley Health NHS Foundation Trust.

Overview of report:

1. Exception reporting numbers and trends
2. JDF
3. Fatigue and Facilities charter
4. Key amendments to the 2016 Junior Doctor contract and impact on the Trust

Exception reporting data

1 fine issued in the reporting period- missed breaks

1st June 2023 to 31st May 2024

- Total ERs = 370
- Equates to average of 31 ERs/month (decreased)
- 5% due to hours/rest (previously 4%)
- 11% due to education (previously 24%)
- 66% from Foundation group (previously 60%)
- 51% from General Medicine (previously 71%)
- 20% from General Surgery (previously 13%)
- 8% from T&O (previously 8%)

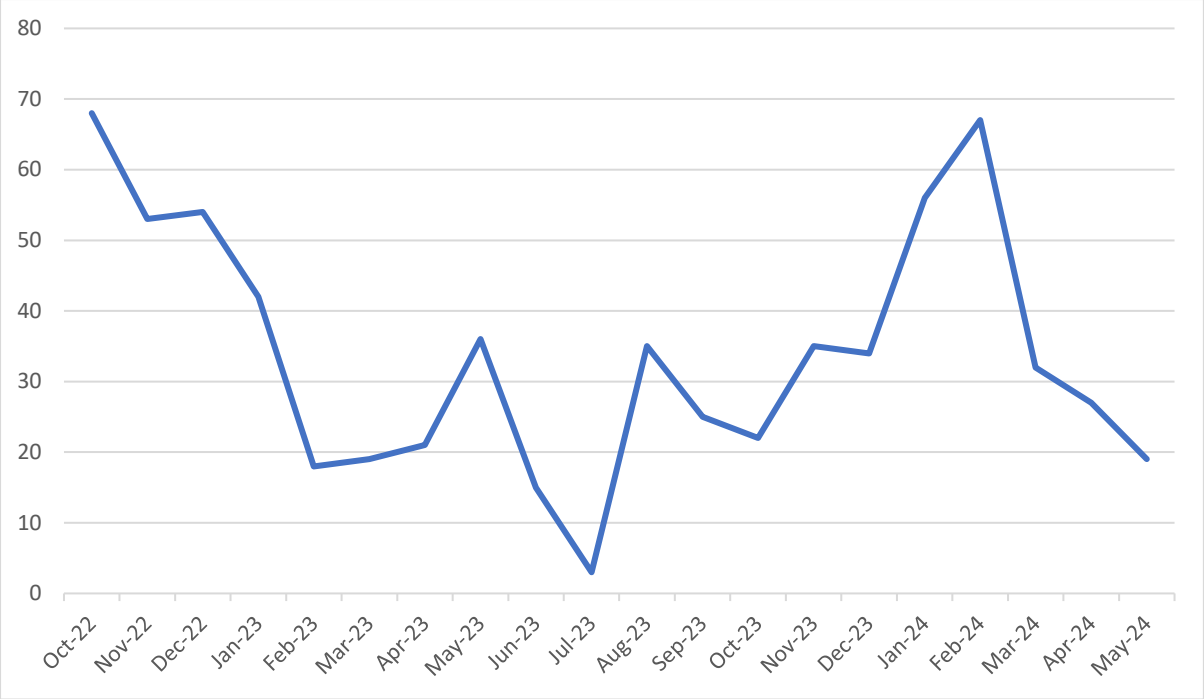


Figure 1 - No. of total exception reports (both sites) by month

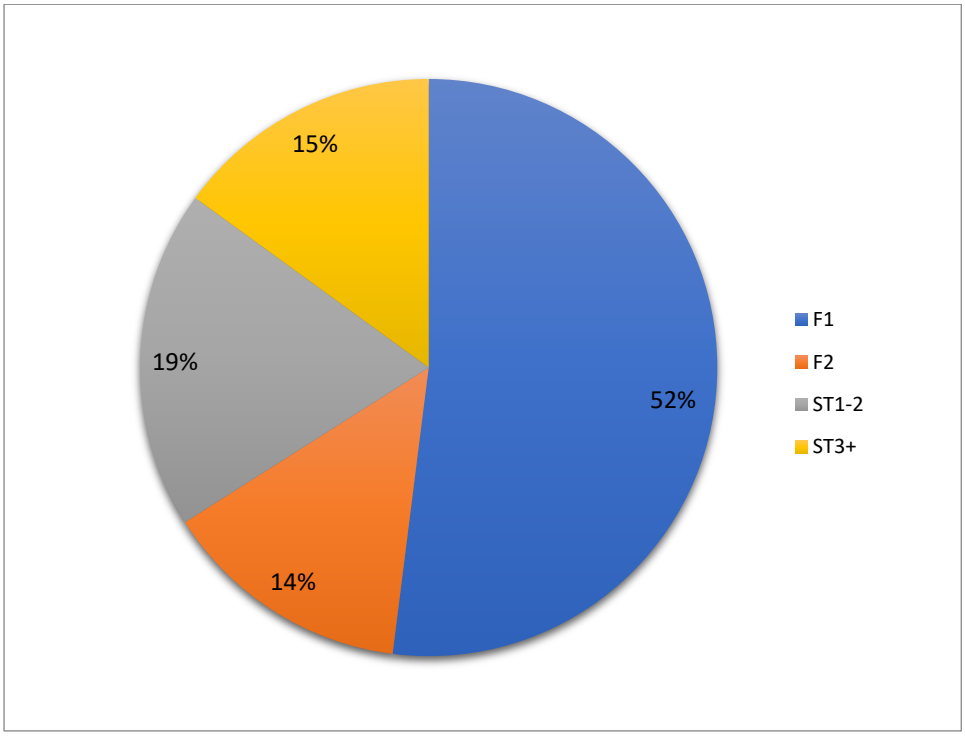


Figure 2 – Exception reports by grade (both sites)

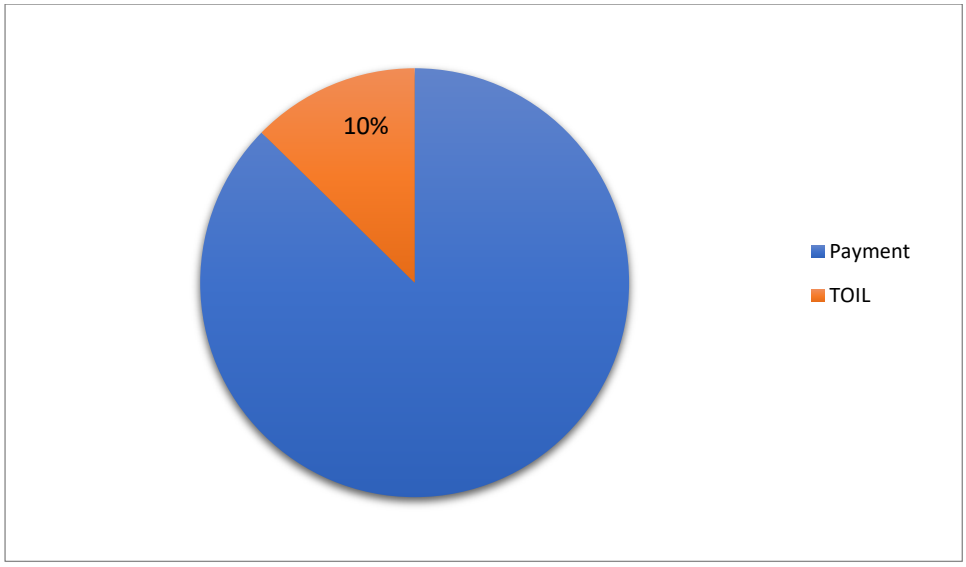


Figure 3 – Exception report actions

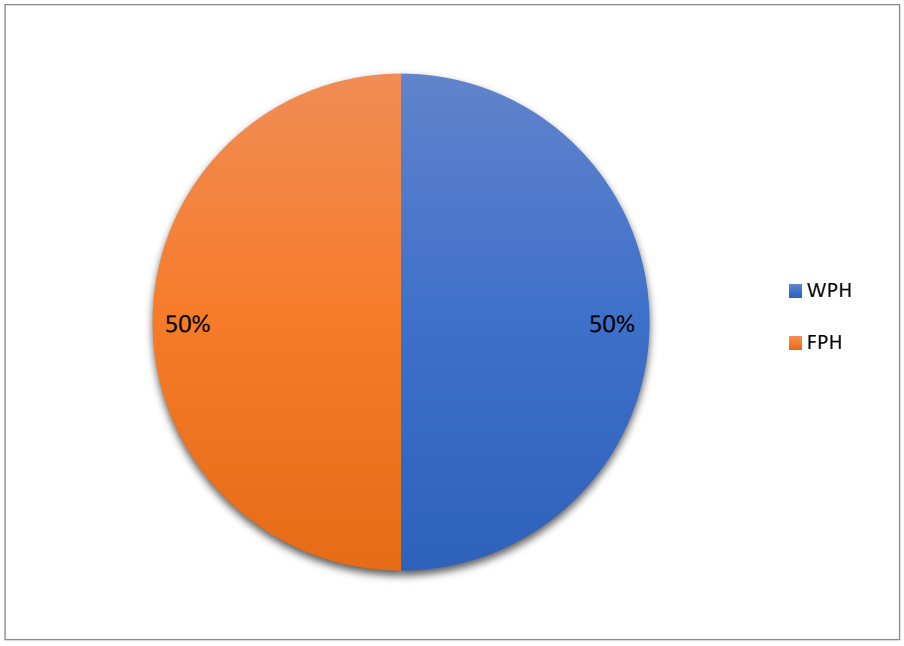


Figure 4- Exception reports by site

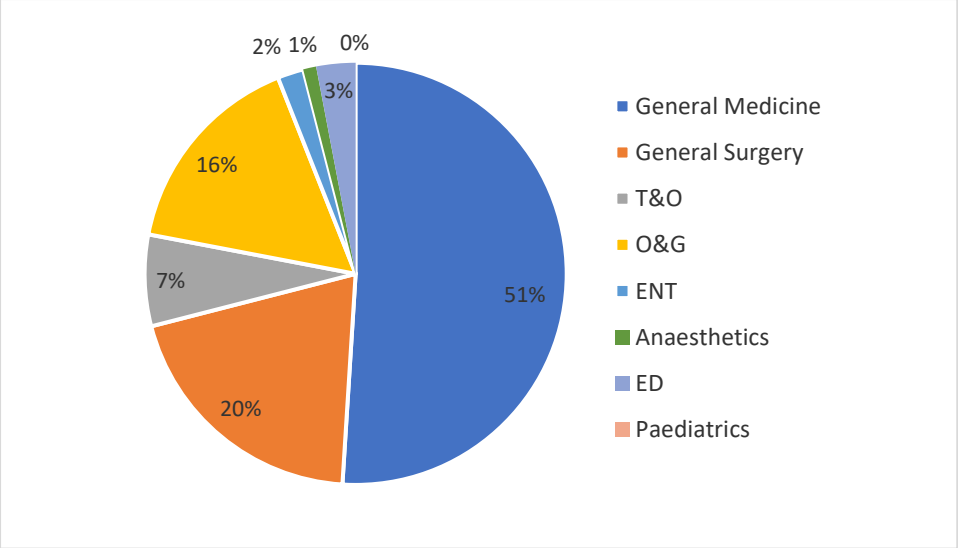


Figure 5 – Exception reports by specialty

Summary of data:

1. Increasing proportion of exception reports from ST1 and above.

    - These grades are increasingly familiar with exception reporting having been some of the first cohorts to learn the process and system.
    - Improved acceptance around higher grades using the exception reporting system with less stigma and an improved culture.

2. Increase in exception reports from General Surgery.

    - Ongoing discussions regarding surgical rotas and lack of training opportunities/increased ward responsibilities.

3. Noted spike in exception reports in Jan/Feb 24.

    - Possible consequence of 9 days doctor strike action In Dec 23/Jan 24.
    - Spikes in exception reports in this time related to the Obstetrics and Gynaecology rota leading to formal rota review, meetings with the chief of service and rota overhaul for August 2024.
    - This demonstrated the value of exception reporting in contemporaneously providing objective evidence of a problem in the trust, which could be presented to the executive team as evidence of the need for resolution.

4. Exception reporting opened up to Trust Grade doctors in September 2022. A gradual increase in overall ERs has been noted as a result.

5. Majority of exception reports closed through payment rather than time off in lieu, but increasing proportion closed through TOIL (10% compared to 5% nationally). This is a positive finding in addressing trainee fatigue and increasing patient safety.

Junior Doctors Forum (JDF)

3 previous JDFs have been cancelled due to junior doctor strike action. The latest cross-site JDF had to be postponed due to industrial action and therefore could not take place in person. It took place online a week later with excellent engagement from the board, exec team, HR and well-being teams as well as the JDF committee. This year with the return of "in person" induction and the continuation of a cross site JDF will hopefully improve engagement. It is also important to note that the likely change of name to the "Resident Doctors' Forum" will occur after ratification at the first JDF committee meeting in September 2024.

At the JDF, exception reporting, as described above was discussed. The LNC provided an update stressing the importance of junior doctor involvement as many of the priorities are shared and can be sorted more quickly. The Chief Executive discussed the Frimley excellence approach and the benefits of giving staff the skills and knowledge and provide them with confidence to implement ideas. She also stressed that junior doctors can contact the exec team with their ideas of improvement and they will be listened to and supported. The importance of working with the Director of Medical Education to improve the doctors' mess was also discussed. The junior doctors' mess was discussed and it was stressed that this needs improvement. The DME, Mess Committee and the Guardians of Safe Working will look at the funding and ways to improve it. The wellbeing team discussed the importance of junior doctors' wellbeing and issues with fatigue and mental health. A wellbeing event has been set up in ED and the wellbeing page, events and spaces were signposted. The JDF committee presented a body of work that they had done surveying junior doctors and the issues that were a priority to them. Rota gaps, early advertisements of the gaps and fair standardised pay for undertaking these were highlighted as prioties as well as the inclusion of self development and administrative time in the rotas.

Facilities and Well-being

Trainees' well-being remains of paramount importance. There are significant issues with low morale, fatigue and mental health crisis management. As Guardians of Safeworking, we continue to maintain strong links with the well-being teams at the Trust and the mess teams cross-site. Well-being was highlighted as an area of concern in the 2021 Guardian of Safe Working report and there have been vast improvements and changes since that time. Executive team support has been vital and it has become easier in the last year to guide trainees to the correct support now that pathways have been consolidated and are clearer.

Increased focus this year has been on rest facilities within the mess at Wexham Park and Frimley Park hospitals as it was discovered that certain areas of maintenance within the mess, particularly at Wexham, had been poorly maintained. We have met with the mess account holder at Wexham to review and re-establish service agreements for the coffee machine and purchase new sofa covers and soft furnishings.

Funding has also been approved for an ED well-being event for trainees in ED at Wexham Park Hospital.

Summary

The timeframe for this report spans a continued period of recovery during and after recent junior doctor industrial action.

A spike in exception reporting in Jan/Feb 24 evidenced issues raised by industrial action and rota issues, particularly affecting obs/gynae at Wexham Park Hospital. Exception reports provided evidence that these issues needed to be addressed urgently, which they have been.

Positive findings from this year's trends in exception reporting include increased proportion of reports from middle/senior grades and increased closure of reports through time off in lieu. These findings demonstrate improving culture around exception reporting and improved use of the system to reduce doctors' fatigue/improve patient safety.

Two Guardians of Safe Working for the trust has already proved highly beneficial in the exception reporting loop being closed faster than ever before and in trainee engagement. Induction and JDF engagement has also seen improvement from August 2023.

Trainee wellbeing remains of paramount importance with a consolidation of services over the past year and faster access to support services as a result. The Guardian of Safe Working was established and remains an initial point of contact for many trainees in crisis. Guiding trainees to the appropriate support has improved drastically over the past year due to well-being team and executive team involvement.

As always, we would like to thank the executive team and board for their continued support of the exception reporting process, trainee wellbeing and us, as Guardians of Safe Working.

11. RISK REVIEW

REFERENCES

Only PDFs are attached

11. Risk Cover Paper August v2.pdf

Report Title	**Risk Review**
Meeting and Date	Public Board of Directors, Friday 6th September 2024
Agenda Item	11.
Author and Executive Lead	Eamonn Brady (Patient Safety and Clinical Governance Lead), Henry Wilding (Deputy Chief of Nursing & Midwifery), Victoria Cooper (Acting Company Secretary) Executive Directors
Executive Summary	The Board is presented with the following documents: • Updated Board Assurance Framework (BAF) to reflect Q1 data and confidence levels for achieving each strategic objective. • Updated Corporate Risk Register (CRR) following a review in August 2024. The following risks on the CRR have been archived following that review: a) Completion of Annual Appraisals b) GP Referral and Advice & Guidance Management Since the last Board Meeting, a new Trust Risk Management Review Group has been established where the risks are reviewed collectively by the Executive team. This forum will also inform further changes required to the BAF.
Action	The Board is asked to **NOTE** the current status of the Board Assurance Framework and Corporate Risk Register.
Compliance	NHS Board Risk Management

11.1 CORPORATE RISK REGISTER

REFERENCES

Only PDFs are attached

11a. Corporate Risk Register August 2024 (1).pdf

Corporate Risk Register 2024-2025
August 24

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Frimley Health NHS Foundation Trust

Level of Risk	April	May	June	July	August	September	October	November	December	January	February	March
Extremely High	7	7	7	7	5							
High	6	6	6	6	5							
Moderate	8	8	5	5	8							
Low	2	2	2	2	1							
TOTAL	**23**	**23**	**20**	**20**	**19**							

New Risks / Risks Revised for 24/25

Descriptor	Grade

Risks Regraded or removed from the Risk Register

Descriptor	Previous Grade	New Grade

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

High Risk Tracker as at June 24

Chart Ref	Risk Name	Source	Current Score			Target Score	Score Trend			Date Risk Added
			C	L	R		Previous Month	3 months ago	6 months ago	
A	Bed Capacity & Flow	FH	4	5	20	8				Aug-21
B	ED Performance	FH	4	5	20	8				Apr-23
C	Winter Pressures	FH	4	5	20	8				Apr-23
D	Reduction in Financial Freedoms	FH	4	4	16	6				Nov-22
E	Waiting for diagnosis / treatment	FH	4	3	12	8				Oct-21
F	Medium Term implications of Financial Environment	FH	5	3	15	15				Jun-23
G	FPH RAAC Roof planks/tiles	FH	5	4	20	4				Aug-20
H	Cyber Security	FH	3	3	9	9				Oct-21
I	Operational Pressures Impacting Financial Performance	FH	5	5	25	6				Jun-23
J	Industrial Action	FH	4	2	8					May-23
K	Water & Drainage		4	4	16					Jun-23

Likelihood	Consequence				
	Insignificant	Minor	Moderate	Major	Catastrophic
Rare					
Unlikely				J	
Possible			H	E	F
Likely				D K	G
Almost Certain				A B C	I

	Risk Description				Initial Risk before controls are applied				Current Risk				Target Risk (appetite or agreed threshold if higher)					
Risk Number	Link to BAF	Risk Description	Source of Risk	Date Risk Added	Consequence	Likelihood	Total	Current Control Measures	Consequence	Likelihood	Total	If Current / Target risk, what Further Actions are being taken to close the gap	Consequence	Likelihood	Total	Actions owner	Review Date	Assurance Committee
1	SA 3&4	**Bed Capacity and Flow** We continue to experience high non elective demand together with high numbers of patients who are Non criteria to reside which in addition puts pressure on our elective capacity and plans. There is a risk that at times of peak or sustained demand, we will compromise patient care, specifically patient experience and patient safety.	Locally identified risk	Aug-21	4	5	20	* Comprehensive review of specialty ward layout and bed use completed on both acute sites. Hospital full policy in place utilising use of discharge lounge, fit to sit and boarding spaces in defined and risk assessed areas * Site Assurance meetings twice daily on acute sites with multidisciplinary attendance. * Close cooperation with system partners particularly around patients with extended length of stay and for those patients who are medically stable for discharge but require ongoing care. * Weekly LoS review meetings on both sites tracking patients with extended length of stay * 'Criteria to Reside' process in place to document reason for each patient required to remain in hospital. * Use of EPIC discharge functionality including EDD's * Weekly ICS Gold level escalation calls. Each 'place' has onsite representation in order to support complex discharge. * Daily tracking of internal delays * New bed Escalation & De-escalation Policy completed * Every moment review of OPEL level for each acute site	4	5	20	**Reviewed June 2024** * Continued live risk across both acute sites. Continued use of escalation beds and Opel status 3&4 in Q1 24/25 * COO continues to chair the monthly FHFT internal UEC board covering the four workstreams:- 1) Acute front door 2) 0 -72hr Workstream 3)Everyday matters 4) Pt flow - Clinical Site * COO Co-Chairs the monthly Frimley ICS UEC board which focuses on all system wide improvement programmes	4	3	12	Chief Operating Officer	Sep-24	Quality Assurance Committee
2	SA 4	**Waiting for diagnosis/treatment** Longer waits for diagnosis and treatment resulting in potential harm to patients	Locally identified risk	Aug-21	4	4	16	* Clinical prioritisation at each point of: referral, request for investigation, treatment agreed. * Management of waiting lists through booking in priority order. * Clinical validation programme contacting patients with no action undertaken in the previous 12 weeks or planned in the coming 12 weeks. * Waiting list management and oversight through weekly operational managers meeting and bi-weekly operational performance with ADs. * Non-clinical validation programme to review all waiting lists. * Harm reviews undertaken for any patients where potential harm may have occurred and any learning actioned * GP escalation process in place. * Oversight of clinical prioritisation by the Clinical Prioritisation Committee. * Weekly senior review of priority 2 patients over 4 weeks from DTA and cancer patients over 62 days.	4	3	**12**	**Reviewed July 2024** * Urgent and prioritised focus on EPIC data quality and reporting continues with Exec oversight and increased resource. Issues still being resolved and impacting on reporting and validation - work ongoing * Continued pressure on non elective demand requires daily management of capacity to ensure diagnostic activity is maintained with operational pressures requiring the use of Endoscopy for escalation beds * Additional day case/OP activity to replace lost elective activity and WLI, opening of Heatherwood creates new 'green' space for activity. * Further increasing 'grip and control' on management of list through winter to ensure focus is maintained. * Ring-fenced bed capacity to enable Endoscopy to function as a diagnostic space. * Templates review led by service with EPIC team to focus on correcting clinic templates designed to create more new patient capacity as well as support roll out of My Frimley Health app which will create capacity for operational teams. * Plan for Heatherwood to rollout additional treatment room capacity in Spring 2024 - now in place. * Further development of reports within EPIC to support oversight and grip of productivity metrics. * Reporting is built and run consistently on a weekly basis. Focus is now on productivity and efficiency through use of Power BI tools to support with delivery. * Continued pressure on non elective demand requires tight management of capacity to ensure surgical and diagnostic activity is maintained. Endoscopy has been removed from escalation list. * Additional day case/OP activity to replace lost elective activity and WLI, Heatherwood performance is optimising and driving improvement for waits using that site. * Increasing 'grip and control' on management of list through Performance meeting chaired by DoP – overseen by internal Planned Care Board. * Developments from EPIC e.g. use of MFH App which could improve access to patients being governed by COSG and Transformation Board. * Further Community schemes being developed in ENT, Gynae and Derm which will support demand reduction. Oher schemes required to support with specialty waiting times being manageable.	4	2	8	Chief Operating Officer	Sep-24	Quality Assurance Committee
3	SA 1	**Management of Patients in Mental Health crisis** Potential risk to safe management of both adults & children with mental health needs following exponential rise in presentations post pandemic, increase in complexity and acuity and length of stay. Risk of patients not receiving appropriate therapeutic intervention which could lead to further exacerbation & harm (for patients and staff). Risk of caring for patients in acute mental health crisis within acute hospital environment	Local Identified Risk/pandemic	Apr-23	4	4	16	* Band 8B MH Lead in post *Revised meeting and governance arrangements - MH/Acute/ED Interface group - MH working group, reporting to - Executive Safegaurding Committee * Violence Prevwntion Workng Group * RCRP bromze/silver tactical meetings * ED Frequent attenders/High intentsity user meeting * Mind and Body Programme reviewing - Enhanced Care Framework - Diversion from ED/Acute - Escalation pathway - Safe Harbour/Haven * Daily reporting and escalation through ops/COO/DepCNO regarding MH patients, detention status,length of stay, enhanced care needs * Epic risk assessment to support enhanced care needs * Audit and daily review of Epic risk assessmentsto inform deployment of available of resources * Development of bank MHCA role * Increase in CMAHS provision at FPH - funding, team composition, hours of service, and inclusion of NE Hampshire within service model * Direct engagement with agency RMN/MHCA workers to review handover, induction, supervision processes * Staff open sessions and updates * MH Clinical Education Lead on site 2/7 week supporting students *BDO audit Oct 2023 of MHA application and use. Resulting actions on track * Increased provison of de-escalation training (181 staff trained July-Dec 2023, plan for 270 Jan-July 2024) *Buckingham New University MH skills module, 21 completed Jan 24, further 30 due to start April 24 * MHA (Mental Health Act) training for site managers undertaken by SABP/BHFT (Berkshire Healthcare NHS Foundation Trust) * Security and clinical team interface meeting launched March 2024 reviewing incidents, interventions, restraint. * Receipt of SABP daily sit rep detailing current position, 136 capacity, bed state and outstanding referrals	4	4	16	**August Update** * Enhanced care risk assessment developed within EPIC and in line with policy (expected Sept 23). launched 16/10/23 - Ongoing refinement with EPIC team to allow daily reporting * Litigation and enviromental risk assessments being developed and embedded within EPIC (expected May 2024) - DCN to check the EPIC implementation and status * Working group established to review impact of Right care Right Place adoption by police - phase 1 complete, Phase 2 regarding voluntary ED attendances to be implemented Sept 24 * Core 13 CAMHS service at FPH in establishment. RC/Cons Psychiatrist and service lead in post. Ongoing recruitments to liaison teams. Service hours continue 08.00-17.00, to be extended upon further appointments * Commissioning Support Unit review of Adult MH services at FPH and WPH completed. Review of staff, partner, commissioner, service user feedback. Due for formal sign off 26 April 2024, and wider sharing, distribution and adoption of actions - DCN to finalise details in line with MH leads in the ICB * Engagement with South East Temporary Staffing Collaborative Mental Health project board * Review of site lockdown and ward access control provision acoprss all sites underway. Next meet 07/05/24 *Business Case for two additional B7 Registerd Mental Health Nurses - out for advert *Recruitment underway and budget allocation for enhanced care has been distributed across clinical specialities *Out to advert and recruiting bank Band 6 RMN's	4	2	8	Chief of Nursing & Midwifery	Sep-24	Quality Assurance Committee

4	SA 1	**Infection Control** Failure to meet the statutory and mandatory best practice requirements for Infection Prevention & Control will increase the risk of healthcare-associated infections (HCAIs) in the context of post pandemic transition to living to living with COVID - impact of pandemic on national increase in some HCAI's e.g. CDiff	Local Identified Risk	Apr-23	4	4	16	Existing Controls & Audit Activity * IPC Annual Plan in place, including IPC team structure, PICP and Board, Audit & Surveillance annual programme. * Programme of Post-Infection Review of mandatory reportable HCAIs (including nosocomial COVID) to identify actions and learning to be shared. * IPC online learning (both IPC Level 1 and Level 2) is supplemented by a programme of clinical-based education sessions, including hand hygiene and PPE use. * IPC Governance Structure headed up by HICC. The Built Environment Committee and Decontamination Steering Group. * The IPC Team work closely with the Frimley ICS and NHSE South East IPC Network, to ensure compliance with all national guidance. * Quarterly reporting to Care Governance and QAC including BAF updates * Water Safety and Ventilation Safety Subgroups in place and meeting monthly. * Responding to national guidance changes re: IPC measures for respiratory virus infections. IPC Team working closely with the Site/Operational Teams, to manage operational pressures related to any subsequent waves of COVID-19 or other infectious agent.	4	3	12	**Updated August 2024** • Trust exceeded the threshold set for all mandatory-reportable HCAIs (with the exception of MSSA bacteraemia) in 2024/25. • FHFT IPC Team working with Frimley ICB on actions relating to catheter care & hydration, to reduce avoidable CAUTI-associated bacteraemia. • Antimicrobial Stewardship Subgroup recommenced January 2024, chaired by CMO, to support resumption of activities • The IPC Team have updated their IPC incident review matrix in line with PSIRF and is awaiting review with the Patient Safety Team. * Ongoing outbreak management of CPE. Led by CNO/DepCNO with regional and national input, reviewing link with drainage systems. Actions include sink rationalisation, removal of sink from clean utility environments, reducing drain blockages, and increased CPE surveillance for key environments •National Point Prevalence Survey of Healthcare-Associated Infection and Antimicrobial Usage Sept/Oct 2023 participated in by the IPC Team. Overal HCAI prevalence of 8.9% for the Trust. Full formal report from UKHSA anticipated in the second week of May 2024. - Actions from the report to be disseminated •The IPC Team continues to lead on the programme of FFP3 respirator fit-testing in the Trust, however this is not sustainable and requires Executive support for a non-clinical fit-testing team for assurance of a robust programme for furture pandemic planning.	4	2	8	Chief of Nursing & Midwifery	Sep-24	Quality Assurance Committee
5	SA 1	**Maternity Services** Maternity services nationally are under intense scrutiny and required transformation. Failure to respond to national learning and direction could lead to loss in confidence and reputation locally	National Requirement / locally Identified Risk	Apr-23	4	4	16	* Birth-rate Plus completed 2020 recomoissioned for 24/25 * Detailed Staffing Plan in Place with robust escalation policies for times of peak demand. * Maternity recruitment improved significantly - Q3 plans to be fully recruited at Frimley Park site with minimal (<5WTE vacancies) at Wexhm Park site. * Maternity clinical outcomes are in line with national benchmarking * Maternity Governance Structures in place * Board Safety Champions, including monthly meetings established. * Oversight and challenge from an established LMNS (Local Maternity Network System) in place. * Maternity Improvement work commencing with CN and MD oversight * Ockenden Plan completed * Retention Midwife role established * Midwife to birth ratio reporting monthly	4	3	12	**June 2024 update** *Recruited // students who will qualify in October/November 24 and will enable full recruitment to be achieved at the Frimley Park site and minimal vacancies at the Wexham Park site. The service has not seen this midwifery establishment so complete in the past 7 years. * IEM pipeline to date we have employed 15 IEMs, this pipeline of recruitment has now been ceased in May 2024. *Build works to triage rooms at Frimley Park to enhance assessment process is being progressed alongside labour Ward Roof work to address RACC issues within trust. At the Wexham Park site reallocation of Day Assessment Unit to implement triage system more effectively in progress. * EPIC optimisation continues, and production of Obstetric Dashboard completed, data is much improved although there is additional manual collection of data to populate Dashboard which is shared through governance process by Heads of Midwifery. * National Maternity Dashbord reviewed monthly to determin if outliers in any of metrics reported * CQC report published for both sites maintained Good Rating Overall, action plan in progress with 2 outstanding actions that will be closed by end of quarter 2. *CNST year 5 compliance achieved, financial reimbursement confirmed. Progressing with year 6 to demonstrate compliance to trust board and ICB in January 2025. Submission of declaration to NHS Resolution due 3rd March 2025.	4	2	8	Chief of Nursing & Midwifery	Jun-24	Quality Assurance Committee
6	SA 3&4	**Emergency Department overcrowding and performance** Continued high volumes on emergency demand through both emergency departments with limited flow and tight bed capacity through the hospitals results in overcrowding and pressure in ED. Changes in primary care practice and the recovery of Covid backlogs has seen a significant increase in ED attendances on both acute sites, particularly for patients with minor illness and injury. There are no UTC/walk in centres supporting either Emergency Department currently. All of the above creates risk of increased ED occupancy, Ambulance queues and long waiting times leading to potential delay in patient treatment, ambulance delays to other calls, reduced quality of care, patient experience and patient safety and reputation risk. National requirements to improve waiting times for emergency care include reduction in waiting times for urgent ambulance attendances, over 76% of patients to be discharged from ED within 4 hours, reduction in patients waiting over 12 hours and reduction in LoS. From May 2023 FHFT returned to reporting the 4 hour access standard from previously working for several years to a pilot standard which encouraged patients to spend longer in the department while their treatment was delivered (CRS pilot). This is a significant change for the whole organisation which requires faster flow and behavioural change to deliver improved waiting times	National Requirement / locally Identified Risk	Apr-23	4	5	20	* 08.30 daily team brief monitoring activity and situation awareness in A&E for all Trust top leaders and assurance meetings throughout the day * Hospital at night handover meetings include monitoring and management of waiting times and overcrowding issues into the night * Implemented NHS 111 First criteria and planned appointments for 111 patients 24/7 across all age groups. * Brants Bridge Minor Injuries Unit reopened post COVID in order to provide an alternative pathway from ED for patients with minor injury. * Plans progressing to maximise use of SDEC and Ambulatory pathways to move activity away from ED help to reduce overcrowding * Multidisciplinary Urgent Care Board in place to manage Urgent Care Program including ED performance, SDEC, 111 First, and discharge planning pathways. * UEC improvement plan in place and active management includes: 1) Acute front door - with key focus on return to 4 hour standard, reduction in 12 hour attendance waits and ambulance handover times to support reduction in ambulance delays. Weekly Exec lead meetings in place to monitor progress 2) 0 -72hr Workstream - SDEC and assessment unit models to avoid admission where possible and reduce LoS 3)Everyday matters - to improve and expedite discharge and reduce LoS to create flow and capacity 4) Pt flow - Clinical Site *Fortnightly regional meetings to discuss the plans and progress	4	5	20	**Reviewed June 2024** * Working with system partners focussing on reducing ED attendances and sign posting patients to alternative care pathways via NHS 111. Dependent on primary care urgent care strategy; ongoing planning * GP minor illness pilot is in place at both Frimley and Wexham. Working with system partners and primary care to continuously improve this service to maximise benefit through winter * Parallel work underway, overseen through the UEC strategy group reporting to UEC Board, UCC agreed to be located in Slough and Aldershot aim for opening service for MiMi November 2023. Completed with review underway for 2024/25. To conclude this review through the 2024/25 ICS UEC Board in Q.2 2024/25. * Continued focus on eliminating ambulance handover waits through use of agreed Ambulance Handover SOP with supported escalation for nursing cover or booking of ambulance technicians to care for patients when queues do occur * Continued working with ECIST with focus on discharge pathways to improve flow and reduce overcrowding in ED * Review of better use of SDEC pathways to stream patients either directly to SDEC's or quickly from ED to specialist services * Improved volume to front door GP service, aiming for >15% * IPS agreed and shared with the Trust, education and comms plan to be completed * EPIC ED dashboard in progress with escalation triggers * Surgical SDEC opened at WPH March 23 * Frailty Assessment trolleys returned at FPH March 23 and opened at WPH in April 23 - completed however high risk for OOH capacity crisis * Reintroduction of EAC model underway through NEL improvement plan - November 2023 * Fit 2 Sit cubicles Majors implemented to reduce loss time for ambulance handover	4	2	8	Chief Operating Officer	Sep-24	Quality Assurance Committee

7	**SAs 3 & 4**	**<u>Winter Pressures</u>** Concern that the forthcoming Winter 24/25 will present significant operational challenges over and above those of a normal winter. A number of factors have been identified as giving cause for concern including ongoing challenge with discharges out of hospital, higher acuity within hospital and pressure on demand within ED. The combination of these factors will place significant operational pressures on the Trust potentially disrupting elective care and leading to poor patient experience, quality and patient safety.	Local Identified Risk	Apr-23	4	5	**20**	• Weekly modelling of urgent care demand and IPC numbers to forecast and inform decisions through planning teams. • Previous winter plans details work force and additional capacity plans • Multidisciplinary Urgent Care Board in place workstreams initiated to cover SDEC performance, Criteria Led discharge, and discharge planning pathways • Close working with ICB and system partners to plan, monitor and react to pressures through winter. • Every Day Matters programme in place to support reduction of Length of Stay and improving flow within hospital. . .	4	5	**20**	**Reviewed June 2024** * Ongoing winter pressures sustained with impact on bed capacity described * Virtual wards and increased social care capacity for complex needs in place but likely to have limited impact * Local seasonal pressures reflect the national position with high numbers of medically fit combined with occupancy attendance challenges and no robust plans to discharge at scale through winter * Virtual wards implemented including support for UCR cross site * Further development with BHFT required * Home First and HomeLink implemented as pilot for P1s * Winter 23/24 completed - revert winter bed model changes and implement bed planning programme for SDECS and Ring fence in advance of 2024/25 winter period. * Planning commenced for Winter 24/25 with Frimley ICS including options for capacity for Non criteria to reside patients.	4	2	8	Chief Operating Officer	Jan-24	Finance & Investment Committee
8	**SA 4**	**<u>FPH RAAC Roof planks/tiles</u>** The natural deterioration of FPH RAAC roof planks which are in c60% of the hospital since it was built in 1974, results in a limited life expectancy such that NHSEI require these as well as RAAC present in the walls to be eliminated by 2030. RAAC planks will deteriorate over time and this can be exacerbated by: water pooling in gutters and leaking roofs lead to softening of roof RAAC planks and corrosion of the rebar, roof planks damaged due to excess weight on the roof due to the installation of new plant and equipment on the roof or existing plant and other objects with excess weight, roof planks damaged due to people walking on the roof, roof planks damaged due to snow and ice. Therefore there is a risk of injury or death to patients, visitors, and staff due either to delamination of a roof plank whereby a part of it falls, or a sheer collapse with no warning due to limited bearing on the concrete support beam..	Survey and annual risk assessment by structural engineer. NHSI/E action plan including a deadline of 2035 to remove RAAC planks. Trust identified as one of 3 high priorities	Aug-20	5	5	25	* RAAC Planks Programme established to manage the risk with 2 projects: Maintaining Safety, & Contingency planning * Remedial works in response to structural surveys have been undertaken since 2012 at a cost of c£5m prior to 2020/21. Programmes of remedial works have been undertaken in 20/21 and 21/22. £9.5m programme of remedial works for 2022/23 has been completed. * Surveys have been carried out by structural engineers who have highlighted high priority areas for remediation works. Annual routine surveys of all RAAC Planks commenced and were completed for 2022/23, including 'hard to access' areas * Trust Estates and Facilities staff and contractors including the fire brigade have been made aware of the issue and correct ways to access the roof. * A Roof access policy has been developed to ensure that loading on the roof is kept to a minimum. * There is a detailed RAAC Plank programme risk register	5	4	20	**<u>Reviewed July 24</u>** * Works to support end bearings is one site and the rolling programme of full fail safe works continue alongside annual surveys of all unsupported planks * Regular Communications to all staff to raise awareness of warning signs so that these can be acted upon promptly have been undertaken and will continue. * A series of business continuity plans have been written. Exercises involving ICU have been undertaken and further exercises are planned in respect of FPH 'Streets'. Planning to continue in relation to large scale evacuation exercise to involve ICS and other key partners. *Following the completion of a Strategic Outline Case to eliminate RAAC, the Trust has now been included in the government's New Hospitals Programme with the prospect of a new FPH whereby RAAC can be eliminated. This means that works to maintain safety must continue until the new hospital can be brought into use. * M Block redevelopment is due to complete in December 24 with the upper floor wards becoming operational in early 2025. This will release 18 beds for RAAC plank decant to facilitate the rolling programme of fail safe works * 2024 annual report received which recommends installation of end bearing supports in all first floor wards that have RAAC planks, plus a rolling programme of failsafe works in all first floor wards starting with F1 (currently on site), F5 (in design), F11 (in design). Also the continuation of works in Theatres 9 and 10 (on site), CDS (on site), C block (completes in July 24, except the computer room) and outstanding works adjacent to theatres 3 and 4 (planned for new year). A programme of all other outstanding areas to then follow as decants allow. * End bearings and high risk planks in F5 and F11 have been added to this programme following Gurney's 2024 report. •The exercise related to the Streets (Ex WISPA 3) has been held and featured a collapse of a section of the roof and was delivered over two sessions 1) for operational Teams (Security, Fire safety, Estates, Capital) along with Hospital Bronze and the Silver Commander 2) The Silver Commander, Gold Commander, Media and Comms, Health and Safety, Capital and Estates. •Ward based training and exercises have been conducted across wards / depts on the first floor (Ex WISPA Lite) these focussed on signs and recognition of a potential RAAC issue along with initial actions and generic Business Continuity considerations) •Following the WPH Fire and the FPH Fire alarm issues a programme of evacuation training and exercises has been developed and is currently being rolled out across FPH initially but will then progress to WPH. These session focus on evacuation principles that would support a Ward / Dept in the event of a spontaneous incident requiring full or partial evacuation. •From an external perspective the Trust participated in the NHSE SE Regional Exercise in June 23 (Ex Hiertan) which focused on how the region would look to support a hospital which was forced to undertake a full evacuation. •Additionally we have participated in a Frimley ICB led exercise (Ex Crunchie) which aimed to raise awareness to RAAC related issues with Multi agency partners who would be required to support the Trust if a large scale	5	2	10	Chief Strategy Officer	Jul-24	Finance & Investment Committee
9	**SA 6**	**<u>Cyber Security</u>** A large scale cyber-attack could shut down the IT network and cause major disruption to the availability of essential patient and other information for a prolonged period	Strategic Objectives	**Oct-21**	4	4	16	* Regular review of Trust plans by NHS Digital • Data Security and Protection Toolkit compliance with cyber security IG requirements • Oversight by IG Committee • Internal Audit annual review of Toolkit evidence • Regular Trust staff cyber risk awareness campaigns • Proactive alerts and response from Trust Cyber Team on NHS Digital CareCERT alerts specific to RDU • Trust Cyber Team hold Cyber accreditation and have CPD as part of Appraisal/PDP * Host based intrusion prevention systems * Anti-malware installed on all managed devices SCCM Central Patch Management * Policies Standards & Procedures * Web filtering * Network Monitoring * Annual penetration testing * Vulnerability management * Web Application firewall * Assurance dashboard to increase visibility of the network with a single, near real time view to better manage vulnerabilities, remediation and compliance • Multi Factor Authentication (MFA) being rolled out to all staff to reduce	3	3	9	**<u>Reviewed June 2024</u>** * Large number of unsupported and Legacy systems are being managed as part of the Trust decommissioning programme of work with additional security controls implemented to lower risk of a security breach • We are continuing to work closely with the EME team on ensuring medical devices will meet all necessary security requirements • Cyber Security training to be increased and form part of the refreshed IG mandatory training requirement for all staff. • Incident response plans finalised with EPRR – tabletop exercise undertaken but will continue to be built upon. • Work being undertaken to improve compliancy to the Data Security and Protection Toolkit (DSPT) moving closer to a "standards met" status • Multi Factor Authentication to be expanded to privileged network accounts and access to all remote systems to bring in line with NHS England policy change • Data backup infrastructure being reviewed due to legacy solution not performing optimally and the requirement for immutability of data to be met. Due to the ongoing nature of the Cyber threat, and constantly changing threat landscape it is recommended that the risk should remain on the corporate risk register – there will be a continual programme of work with the Trust cyber security team to address new threats as they arise	3	3	9	Chief Executive	Aug-24	Audit Committee

10	**SA 5**	**Medium term implications of financial environment** There is uncertainty in the medium term outlook which may adversely impact the Trust financially, with a risk that the Trust will be unable to meet its breakeven control total in the current and future years. Pressures include inflation continuing to run significantly higher than funding levels, and although Covid funding has largely ceased the Trust is still incurring a higher cost base following the pandemic. NHS Funding uplifts uncertain beyond next election	Financial	May-24	5	4	20	* Monthly financial reporting through EPODG and Financial Investment Committee * Monthly Finance meetings with cost centre managers and directorates with increased focus forecast out turn and future years * Medium term financial model, with regular reiterations * Procurement support to all contracts to ensure optimal management of inflationary risks * Clearly articulate pressures not covered by funding envelope	5	3	15	**Reviewed Aug 2024** * Ensure alignment of planning assumptions with ICB * Development of next FHFT medium term Strategy • Keep abreast if changing financial regime requirement and influence regionally and nationally where possible	5	3	15	Chief Financial Officer	Sep-24	Finance & Investment Committee & Trust Board
11	SA 5	**CIPS** The Trust has a CIP target of £45m for 2024/25. Targets include a mixture of Directorate and Transformational schemes. At the beginning of the May £41.4m of plans had been identified with £16.4m fully developed and £24.7m with plans in progress. The risk of not delivering the full savings target would be that the Trust will not be able to remain within its breakeven financial envelope for the year.	Financial	May-24	5	4	20	* Weekly CIP & Efficiency meetings are held with directorates chaired by COO or CFO with attendance of PMO and directorates. * Monthly reporting of CIP and Efficiencies to EPODG and Financial & Investment Committee. * Close scrutiny and challenge of Directorate financial position and forecast through Directorate Performance Reviews / Directorate Finance Reviews and Trust Management Board	3	2	6	**Reviewed Aug 2024** * The current forecast CIP delivery is in line with plan with 72% expected to be delivered recurrently * PMO, Finance Business Partners and directorates meet on a weekly basis and prioritises those directorates who are behind plan. * Additional CIP and efficiencies continuously being sought (including benchmarking and learning from ICBs in more formal turnaround) * Review of further opportunities with ICB System Sustainability group • ICS focus on strategic priorities including overseeing pan-ICS work streams to deliver financial balance and service changes and greater scale and pace than could be delivered by organisations individually	3	2	6	Chief Financial Officer	Sep-24	Finance & Investment Committee & Trust Board
12	**SA 5**	**Operational Pressures Adversely Impacting Financial Performance.** There is a risk that operational pressures result in higher length of stay (LoS) for patients than planned which in turn leads to higher numbers of open escalation beds and increased agency staffing. There is a risk if the Trust falls being its financial plan that it has restrictions placed upon it either at a system or regulator level.	Financial	May-24	5	4	20	* Daily management of pressures though operational teams including bed capacity and flow * Weekly meetings with ICB colleagues on operational pressures AND Interim financial support measures into Medicine * Demand and capital plans mapping bed requirements throughout year including planned ward closures / openings * Clear articulation of financial consequences of excessive LoS (and consequential impact on elective capacity) * Close scrutiny and challenge of Directorate financial position and forecast through Directorate Performance Reviews / Directorate Finance Reviews and Trust Management Board	5	4	20	**Reviewed Aug 2024** * Further engagement with neighbouring ICBs on discharges (additional risk their financial pressures will disincentivise discharging patients in our hospitals) * Maximise use of community and virtual ward capacity * De-escalation plan implementation	3	2	6	Chief Financial Officer	Sep-24	Finance & Investment Committee & Trust Board
13	SA 5	**Reduction of Financial Freedoms** There is a risk if we do not achieve a financial break-even, additional controls will be put in place by NHSE.	Financial	May-24	4	4	16	* Current submitted plan does not deliver breakeven but was submitted in alignment with system position. * Monthly financial reporting through to EPODG and Financial Investment Committee to Trust Board * CIP & Efficiency meetings / processes * Close scrutiny and challenge of Directorate financial position and forecast through Directorate Performance Reviews / Directorate Finance Reviews and Trust Management Board * Reporting to ICB Finance & Performance Committee * Collaboration with ICB on overall financial position	4	4	16	**Reviewed Aug 2024** * Continue with all current controls / actions throughout 2024/25. * Identification of further areas for CIP and Efficiencies, including learning from neighbouring ICBs in even worse financial positions * Continue with budget holder training * Roll-out of no PO, no pay over the summer. * Increased oversight from sub-board committees of actions being taken. * Additional controls around Agency spend have been introduced	2	2	4	Chief Financial Officer	Sep-24	Finance & Investment Committee & Trust Board
14	**SA 1**	**Aseptic Preparation Suite** The pharmacy aseptic suite at Wexham Park makes individualised chemotherapy for patients having cancer treatment. The unit structure no longer meets the technical requirements and has been assessed as high risk by the NHS Quality Control service. Additionally the two isolators are reaching the end of their useful life and require replacement on order to maintain the service. A replacement of the unit and isolators is required as failure of the unit would result in the Trust not being able to treat cancer patients with chemotherapy.	Locally identified risk	Feb-23	4	4	16	* Completion of actions as advised by the QC inspection including remedial works to the current unit. * Progression of design works to support the business case for a replacement unit * Monthly inspections of fabric of the unit with remedial actions prioritised as necessary	4	3	12	**Reviewed July 2024** * Outline case on options to improve either the Aseptic Unit itself and/or options for a regional hub model for this service has been discussed at EPOD through May and June 2024. Trust is actively looking at capital options (including a modular unit). EPOD will consider this final case option in July 2024. * Revise contingency plans for unit in the event of the need to complete remedial works or failure of testing - this is now completed and shared with the Executive Team in May 2024. * Completed revised daily to strategic staff planning process - June 2023 * Staffing plan in place - programme of upskilling staff continues as well as recruiting for any vacancies. * Close monitoring of situation and regular national quality inspections in place	4	3	12	Chief Operating Officer	Sep-24	Quality Assurance Committee
15	SA 1,2 &3	**Industrial Action** No imminent resolution of the junior doctor dispute, placing continued reliance on consultants and other staff to cover during IA. Consultants have balloted on IA and a proportion of FHFT consultants have stated they will not cover IA for less than the BMA rate card. We may be unable to provide safe cover for the Trust during IA or could be forced to pay unaffordable rates to consultants (the BMA rates are an increase of approximately 100% over current rates). There is a wider risk of disruption across various professions balloting to strike and that the ongoing IA will impact morale as well as patient care and waiting lists. Further risk as from 10/8/23, Trusts no longer able to utilise locums to backfill people on strike	Locally identified risk	May-23	4	5	20	Mitigations include * local negotiation with the JLNC to ensure that consultants support critical areas for Junior Doctor IA. * Optimising use of locums, SAS Doctors, nurse practitioners and other staff. * Extensive strike planning led by EPRR team. * Comparable planning ongoing for consultant strikes. * HR planning including the Pay Assurance Group oversight of IA rates for appropriate roles, including alignment with other Trusts in the region and nationally. * Additional initiatives to support morale and wellbeing through the periods of IA and IA recovery.	4	2	8	Reviewed August 2024 * The consultants have reached an agreement with Government and the junior doctor dispute appears to have found a resolution. Continued implementation of mitigation measures during each strike round with review of effectiveness and any residual risk * Business continuity plan in place for strikes and currently BAU * Monitoring the potential of nursing actions * Monitor the progression of the Agenda for Change payscales - inline with the general election * Look to review the potential of new strikes in other work groups, potential for striking in HCA's and Nursing colleagues, in light of the settlements achieved by the doctors.	4	2	8	Chief People Officer	Sep-24	People Committee

16	SA 1	**Water & Drainage Systems** Due to an aging estate and a concurrent program of redevelopments, extensions and revisions to the water and drainage system to accommodate expanding services, there is a risk to the integrity and safety of the water and drainage systems across the trust sites. Water and drainage systems can be a reservoir for infections which can impact patient and staff safety, access, experience, and trust and confidence in our services	Locally identified risk	Jun-23	4	4	16	* Water Safety Group meeting monthly (with increased frequency as required). * WSG reporting to Built Environment Committee, reporting to HICC, reporting to QAC. * Quarterly and annual IPC reporting of HAIs, to CGC, QAC, Execs and Trust Board * Well established process of reporting, SII, and outbreaks as required. * Access and use of regional and national expert advice as required. * IPC BAF reported to Board by exception * Continual surveillance and reporting of trends/risk/concerns by IPC team * Monthly Capital Group Meeting reviewing all change/development requests with involvement and consideration of IPC impact * Existing refurbishment program to replace and refit aging and out of date sinks, drains and environment (eg removal sensor taps and TMV) * Authorised Water Engineer role in post * Proactive programme of water flushing and testing across site (legionella and pseudomonas) * Enhanced testing for augmented care areas (ITU, once, renal) * Use of tap filters to support legionella risk as short term measure * Point of use signage promoting appropriate use of available sinks * Hand hygiene audits and inspections regularly undertaken IPC audits and inspections * Availability of alcohol gel * Appropriate use of PPE and glove reduction program * Active program of system inspection and maintenance * Housekeeping team undertaking cleaning of sinks and showers, faucets as daily task * Increased IPC training and support in key areas, along with audit and inspections. * Local comm prepared for key areas (eg Eden ward, W5/6/7/8) with regard to sink rationalisation and increased screening, alcohol gel use after hand wash.	4	4	16	**Reviewed August 2024** * Removal of all dead legs (section of pipework with no active flow) where accessible - underway and ongoing. * Increased consideration and risk assessment for alterations and extensions to existing water/drainage system as part of Capital Group Meeting and impact creation of dead legs/disruption of biofilms * Rationalisation of sinks in clinical areas being undertaken * Ongoing CPE Outbreak meetings at WPH , although reduced frequency since August due to redcuing incidents and time requred for remaining actions. Meetings attended by National lead from New Hosp Prog, regional UKHSA and IPC and local estates/leads impacted. * Increased surveilance and testing of CPE (to include admission/discharge of Eden, W5/6/7/8) * Review and consideration for waterless environments (currently ITU and Interventional Radiology scoping options) TMB approval of sink rationalisation within ITU	4	2	8	Chief Nurse / Chief Executive	Sep-24	Quality Assurance Committee
17	SA 2	**Board Stability** There are risks to Board stability arising from a high turnover of executive directors and imminent NED departures which will impact on the continuity and experience of the Trust Board	Workforce	Aug-23	4	4	16	* There is an opportunity to increase diversity and enhance the board skills mix through director recruitment * An experienced interim Director of Finance is in place until a substantive appointment is made. The previous Director of Finance continues to be employed at FHFT which ensures a link with legacy financial information * Deputy Directors & Corporate teams * Key posts of Director of Finance & Chief Nursing Officer appointed to, commence January 24	4	2	8	**Reviewed June 2024** * Most of the senior positions within the board are now recruited to with interims in place for CEO and COO * Awaiting the arrivial of the new CEO expected end of August * Discuss the risk with Exec colleagues at Trust Risk Management Group, this risk may have changed to a new item * to be reviewed by the chairman to ensure that he os happy to archive. * to review the FM recommendations to ensure that there	4	2	8	Chief Executive	Sep-24	People Committee
18	SA 4	**Capital and resourcing to address bulit asset compliance** There is a risk that there will be insufficent capital to undertake all remedial and mitigation works necessary to ensure that the Trust's built in assets and infrastructure achieve an acceptable level of performance.		Jun-24	4	4	16	*Continuous confirmation of prioritisation of spend especially where existing commitments may enable the shifting of captal *Further developent of the capital priortisation process introduced in 2023/24 *On-going invetment in specialist resource within the Trust to provde greater internal focus on compliancy issues at senior levels in the Trust *Greater emphasis on the importance of compliancy and investment and infrastruture as part of the prioritisation of works in the bulit environment *Improved data collection and investment in digital approaches to monitoring perfromance (linked to the New Frimley Park Hospital MVP of "smart hospital" and NHP "levelling up" agendas	4	4	16	**New Risk** - June 2024	4	2	8	Chief Strategy Officer	Sep-24	Finance and Investment Committee
19		**Patients not being followed up in an appropriate clinical timescale** Trust has a significant backlog of patients where it is not clear on the next step on their pathway (140,000). There are also a contingent of patients that have the pathway set but do not have a scope for booking. Impact: Potential for patients to come to harm due to not be treated within the appropriate timescales. This can be seen in the Serious Incidents reported	Incident Reporting, EPIC perfomance monitoring	Aug-24	4	3	12	* Weekly reporting for backlog monitoring which is sent to all teams * Incident monitoring to capture cases where harm has occurred * List being reviewed by diagnosis to determine risk category and urgency	4	3	12	**Reviewed August 2024** * Demand and capacity review being completed with the specialties * Admin lead validation of the waiting list * Clinical review of the list once urgency and category has been ascertained	4	2	8	Chief Operating Officer / Medical Director	Sep-24	Quality Assurance Committee

11.2 BOARD ASSURANCE FRAMEWORK

REFERENCES

Only PDFs are attached

11b. V7 BAF 2024-25.pdf

Frimley Health NHS Foundation Trust
Board Assurance Framework 2024/25

Index

Board Assurance Framework 2024/25

This BAF records the following principal risks to the Trust's strategic priorities:

PR1 Failure to protect patients from harm and deliver improvements for patients
PR2 Failure to support our workforce and deliver the best possible working experience for our people
PR3 Failure to collaborate with our system partners to reduce the need for hospital care
PR4 Failure to provide consistent excellent care as 'One Frimley' in the event that demand for services overwhelms capacity
PR5 Failure to deliver the Trust's financial plan and agreed trajectories
PR6 Failure to build on the investment in EPR and deliver the system benefits

The key elements of the BAF are:

- A description of each principal Risk and the associated risk appetite
- Risk scores informed by the Corporate Risk Register
- The strategic threats that are likely to impact on the principal risk
- Level of confidence that the annual strategic objectives will be delivered
- Level of confidence that the 2025 strategic ambitions will be achieved

Key to Strategic Objective/Ambition Ratings:

Confidence Level	Definition
1. Very likely	Almost certain achievement of strategic ambition
2. Likely	Well on track to achieve strategic ambition
3. Possible	Further action required to increase likelihood of achieving strategic ambition
4. Unlikely	Current trajectory indicates unlikely achievement of strategic ambition
5. Very unlikely	There is very little prospect of achieving the strategic ambition

Frimley Health NHS Foundation Trust
Risk Appetite Statement

- **Risk appetite** is the amount an organisation is prepared to accept, tolerate, or be exposed to at any point in time.

- **Specifically:**

  - The aim of determining risk appetite is to provide an overarching framework for the conduct of the organisation
  - The risk appetite is defined by the Trust Board of Directors to provide guidance and principles in relation to risk management
  - The risk appetite provides a means of communicating the Trust's views and expectations on risk

- **Risk Appetite Statement for Frimley Health NHS Foundation Trust**

  - Frimley Health NHS Foundation Trust recognises that its long-term sustainability depends on the delivery of its strategic ambitions and its relationship with its patients, the public and its strategic partners within the ICS. The Trust endeavors to establish a positive risk culture within the organisation where unsafe practice, for example clinical or financial is not tolerated, and where every member of staff feels committed and empowered to identify, correct and escalate system weaknesses.

  - Accordingly, the Trust will not accept risks that materially impact on patient safety. However, the Trust has a greater appetite to take considered risks with regard to their impact on organisational issues. The Trust's greatest appetite is to pursue innovation and challenge current working practices and reputational risk in terms of its willingness to take opportunities where positive gains can be anticipated within the constraints of the regulatory environment.

  - Risk appetite scores for each of the individual risks aligned to the Strategic Ambitions are recorded within the detail of the Board Assurance Framework, using the matrix attached at the end of the document, within a scoring range of 0 (no risk appetite) to 5 (acceptance of significant risk)

Strategic Ambition (SA1)	Improving Quality for Patients		
Strategic Objective 2025	FHFT to be in the top 10 trusts for safety and patient experience		
Principal Risk	Recognised deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm, poor clinical outcomes and poor patient experience		
Lead Executive	Chief of Nursing and Midwifery	**Risk Appetite: LOW**	

Cumulative Risk Score		Informed by Current Corporate Risk Entries	Current Score (Q1)	Consequence and Likelihood
Q1	**12**	Industrial Action	**8**	**4x2**
Q2		Management of patients with mental health issues and learning disabilities	**16**	**4x4**
Q3		Water Drainage System	**16**	**4x4**
Q4		Ability to provide safe and effective maternity services	**12**	**4x3**
		Infection Control	**12**	**4x3**
		Aseptic Preparation Suite	**12**	**4x3**

Delivery of 2024-25 Strategic Objectives by 31 March 2025: Achieve a CQC rating of 'Outstanding' overall alongside delivering improvements in Patient Experience (National Patient Experience Survey) and Safety (the Quality Priorities).

	Executive confidence level				
Measures	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the objective will be achieved**
90% achievement of antibiotic screening within 1 hour. NICE Guidance NG51					90% screening target achieved throughout quarter 1
90% achievement IV antibiotics given in line with NICE Guideline. NICE Guidance NG51.					Current performance across quarter (April – 72% May – 82% June- 82%) below target of 90%. All specialties have improvement plans in place. New trust guidance in place to support implementation of NICE Guidance. September will see large scale awareness and education events launched to support further improvements.
Number of clinical accreditations (100) and out of hours quality visits (2 per site) completed by March 2025)					Despite performance improving across the quarter (April 35% May-45% June 52%) significant challenges remain as patients presenting to ED often appear well, without a National Early Warning Score (NEWS) that would normally trigger an emergency response. Cautionary use of antibiotics together with current volume/demands within the emergency departments can result in delays. This is also a regional challenge. Improvement plan in place

Number of clinical accreditations (100) and out of hours quality visits (2 per site) completed by March 2025)					26 Accreditation assessments conducted in first Quarter. Findings reported to EPOD. 2 Out of Hours visits. Findings reported to Care Quality Programme.
FFT Percentage of Patients that feel overall they had a Good or Very Good Experience (Friends and Family Test)					91.47% Trust Wide. 96.0% Excluding ED. Focusing on improving Emergency Department scores. Data as at end of Quarter 1.
85% of complaints responded to within 60 or 40 days.					April 40 day – 57% May 40 day - 78% April 60 day – 91%

Delivery of 2025 Strategic Objective by 31 March 2025: To be in the top 10 Trusts in the country for patient safety and experience

Confidence Level **1. Very likely** **2. Likely** **3. Possible** **4. Unlikely** **5. Very unlikely**	**Executive Confidence Level**				
	Q1	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the strategic objective will be achieved**
	3				The current challenges and level of risk exposure are impacting on our confidence level. However, achievement of the 2025 strategic objective is possible with further targeted action.

Strategic Threats ***What might cause this to happen?***	***Existing Controls*** ***How we are managing the risk***	**Assurance on Controls** ***Evidence that the existing controls are effective***	***Assurance Gaps*** ***&*** ***Actions to address gaps***
Shortfall in appropriately trained clinical staff or insufficient capacity in staffing establishment to meet rising NHS service demand may lead to increased incidence of avoidable harm and poor patient experience	• Workforce recruitment and retention projects with local, regional, and national funding streams. • Improved development of domestic supply • Defined safe medical & nurse staffing levels for all wards & departments • Daily staffing meetings to ensure transparency of staff resource and how risk is being managed • 'Teams in Distress' wraparound support including targeted recruitment and retention planning, OD and team development interventions as required • Ongoing discussions with NHS to influence national policy and backlogs	• Workforce Governance Group (NWAG) in place with oversight of recruitment pipeline, domestic & IEN, retention, temporary staffing and rota controls • Monthly Performance Report to Board – including SPC analysis • Bi-annual Safe Staffing Reports to the Board • Establishment Reviews • Weekly reporting of key people metrics • Agreed trajectory for improvement on time to hire with weekly monitoring • Part of NHSE HCA recruitment programme to reduce HCA vacancies to zero. Site visit completed in 2023 supportive demonstrating improved picture	Uncertainty of future IEN pipeline

	• Ongoing review of IEN pipeline • Staffing hotspots identified and mitigation plan in place • Implemented a Managed Service Provider model to manage supply of agency staff • Completed establishment review and EPOD approved right sizing nursing establishment across inpatient wards. Currently recruiting against establishment. EPOD approval of ED and MADU establishments to reduce temporary workforce and recommendations on how long-term escalation use should be managed and staffed. • Funding secured to recruit to establishment • Recruitment team has sufficient capacity to recruit new staff	• Future pipeline IEN midwives for 2023/24 • Ongoing Managed Service Provider model for agency management. Demonstrating ongoing reduction in unit costs. • Recruiting effectively, overall vacancy rate 10.4%, nursing vacancies 11.2%, medical staff 8.5% with positive trajectory. • Nursing staffing capacity risk score reviewed and reduced to 9 reflecting gains made in agency reduction (and average unit cost), turnover, retention and recruitment. Moderate risk remains reflecting reliance on IENs and resulting training needs and cultural adjustments, along with anticipated winter escalations. To be removed from the Risk Register	
Demand: Sustained demand across the Trust sites leading to a loss of focus on patient safety and quality of care	• Winter planning and surge planning response • Formal SI review process with action planning and audit of changes in practice • CEO sits on ICB Board and chairs the Provider Collaborative Group • Chief Nurse attends ICB Quality Committee • Care Governance Committee and QAC triangulating safety, experience, effectiveness information • Patient Experience tracker and patient surveys • Insights from complaints and PALs • Weekly modelling of urgent care demand and IPC numbers to forecast and inform decisions through planning teams. • Multidisciplinary Urgent Care Board in place workstreams initiated to cover SDEC performance, Criteria Led discharge, and discharge planning pathways • Close working with ICB and system partners to plan, monitor and react to pressures through winter. • Every Day Matters programme in place to support reduction of Length of Stay and flow within FHFT hospitals.	• Monthly Performance Report to Board – including SPC analysis • National inpatient survey, PET, and Friends and Families test. • Quarterly reporting on the Quality Account and Patient Experience to QAC • Annual reports to the board including health and safety, patient safety, risk management strategy, maternity declaration, safeguarding, health & wellbeing, FTSU. • CQC insights report • National audit reports • Review of Safety FAB dashboards at Ward level • ICB oversight of patient demand and system response • Complaints Internal Audit (moderate assurance) • SE Regional Quality Dashboards • Sepsis compliance. Sepsis Committee. Audit of compliance. Progress and clinical practice reviewed at Care Governance Committee. Assurance/Quality Assurance Committee. • Accreditation and Out of Hours assurance programmes have been scheduled for the remainder of the year.	

An outbreak of infectious disease that forces ward closures or major re-configuration of patient pathways	• IPC Annual Plan in place, including IPC team structure, PICP and Board, Audit & Surveillance annual programme. • Programme of Post-Infection Review of mandatory reportable HCAIs (including nosocomial COVID) to identify actions and learning to be shared. • IPC online learning (both IPC Level 1 and Level 2) is supplemented by a programme of clinical-based education sessions, including hand hygiene and PPE use. • IPC Governance Structure headed up by HICC. The Built Environment Committee and Decontamination Steering Group. • The IPC Team work closely with the Frimley ICS and NHSE South East IPC Network, to ensure compliance with all national guidance	• QAC oversight of IPC reports, including nationally amended IPC BAF • Formal mortality reviews • SE Quality Dashboard with benchmarked information • ICB monitoring of community and prevalence of infectious diseases • Establishment of deputy DIPC role • Antimicrobial stewardship chosen as a 2023/24 strategic objective. Group led by Chief Pharmacist • Gram-negative bacteraemia reduction plan. • Responding to national guidance changes re: IPC measures for respiratory virus infections. • Water Safety and Ventilation Safety Subgroups in place and meeting monthly. Two-weekly meeting in place to complete action for the implementation of the NHS Standards for Healthcare Cleanliness. • The IPC Team has updated their IPC incident review matrix in line with PSIRF and is awaiting review with the Patient Safety Team.	
Human Behaviour: Supporting staff to maintain safety in a challenging environment of overwhelming demand for care, industrial unrest and workforce shortages	• Registration and re-validation of clinical staff • Formal SI Review Process with action planning and audit of changes in practice • Feedback from serious incidents & Never Events shared at cross site forums i.e. Patient Safety Committee, Medication Safety Committee • Collective review of all never events undertaken • Human Factors training programme in situ • Updating clinical guidelines and easy access for staff through use of Guideline App • EPIC optimisation around areas such as medication, administration and Ophthalmology • Additional initiatives to support morale and wellbeing through the periods of IA and IA recovery.	• Monthly Performance Report to Board – including SPC analysis • Ward assurance metrics • MaST training compliance • Board oversight of serious incidents • Clinical audit programme and monitoring • SLC and QAC oversight of SI workstream action plan • People Committee and Board oversight of wellbeing actions to support staff • Oversight dashboards of key safety and workflow metrics • Monthly Patient Safety learning TEAMs meetings for all clinical staff, nursing & medical • Continued implementation of mitigation measures during each strike round with review of effectiveness and any residual risk	

Strategic Ambition (SA2)	Supporting our People		
Strategic Objective 2025	To be in the top 10 best trusts to work for		
Principal Risk	Failure to realise our People Plan objectives and deliver the best possible working experience for our people		
Lead Executive	Chief People Officer	Risk Appetite: LOW OR MODERATE	

Cumulative Risk Score		Informed by Current Corporate Risk Entries	Current Score (Q1)	Consequence and Likelihood
Q1		Industrial Action	8	4x2
Q2		Board Stability	8	4x2
Q3				
Q4				

Delivery of 2024-25 Strategic Objectives by 31 March 2025: Be a 'Great Place to Work' by delivering improvements in Employee Experience (National Staff Survey) and Retention (Turnover and Vacancies)

	Executive confidence level				
Measures	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the objective will be achieved**
Reduction in Trust vacancy rate (12.9% to 9%)					Vacancy rate at or close to target and appears to be stable.
Reduction in Time to Hire (79 days to 40)					Time has more than halved in 12 months (now at comparative upper quartile performance). Further improvements (to reach sub 40 days) will require improvement/Investment in recruitment systems.
Agency spend capped at £1.8m per month					Reducing medical spend is critical and the cost reduction programme is showing a positive trajectory.
Reduction in Trust Turnover (15.38% to 12%)					Rapid reduction in turnover at end of Q4/early Q1 and has been relatively stable, although showing a slight increase through Q1.
5% improvement in staff recommending the Trust as a place to work					Measurement taken in National Staff Survey in Q3.

Delivery of 2025 Strategic Objective by 31 March 2025: To be in the top 10 best trusts to work for

Confidence Level **1. Very likely** **2. Likely** **3. Possible** **4. Unlikely** **5. Very unlikely**	Executive Confidence level				
	Q1	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the strategic objective will be achieved**
	4				The current workforce challenges and external market factors, of which we have no control, suggest that we are unlikely to achieve the 2025 strategic objective. However, the delivery of the People Plan and further targeted actions are likely to improve the current trajectory. The NHS Long Term Workforce Plan will also support the strategic aim.

Strategic Threats ***What might cause this to happen?***	***Existing Controls*** ***How we are managing the risk***	**Assurance on Controls** ***Evidence that the existing controls are effective***	***Assurance Gaps*** ***&*** ***Actions to address gaps***
Inability to attract and retain staff due to external market factors resulting in critical workforce gaps in clinical and non-clinical services.	• Interim People Plan currently in place, long term People Strategy in development that will align to the new Trust Strategy. • HR monitoring reports on recruitment, retention & numbers of vacancies • Recruitment strategy/plans are in place, with active recruitment in place for hotspots • Processes to identify and escalate vacancy risks in place • Temporary staffing collaborative at system level • NHSE recruitment programme to reduce HCSW vacancies to zero. • Developing talent pool for prospective HCA roles • Focus on recruitment/retention of key staff groups critical to elective recovery • Review of the managed service provision to ensure this is effectively aids the Trust in its aim of reducing agency spend. • Working with high cost, long term medical locums to facilitate them to join the Trust as substantive employees. • Implemented a Managed Service Provider model to manage supply of agency staff • Ongoing recruitment campaigns to fill vacant posts, at Heatherwood and Heathlands • Inclusive recruitment work ongoing • Co design of ICS People Strategy and associated workplan with Partners across Frimley ICS	• The vacancy rate is 9.4% (July 2024) and lower for nurses (8.0%) & AHPs, but higher for medics (10.4%). • Sickness absence rate is 3.2% (May 2024) • People Committee and Board oversight of staffing levels • Reduction in Trust vacancy, rate, time to hire reduced from 76 (June 23) to 43.1 and turnover reduced to 10.6% (May 24). Turnover has increased steadily over the past 4 months (11.02% in July 2024). • Ongoing Managed Service Provider model for agency management. Currently being reviewed for effectiveness across all staff groups. • Nursing Workforce Assurance Group continues to provide oversight and governance to working and operational groups. • Plan in place to address various retention, wellbeing, staff survey and other people actions.	External economic conditions and industrial unrest continue to impact on human behaviour with people choosing to retire or leave the service
A significant loss of workforce productivity due to reduction in staff availability, low morale and poor job satisfaction, which could adversely impact on patients and service users	• Retention strategy/plans are in place to help reduce unnecessary turnover • Leadership development programmes and leadership network in place • Access to coaching and mentoring • Management Essentials Programme in place • Management and Leadership Competency	• Weekly reporting of turnover rates and monthly monitoring at corporate and directorate level • People Committee oversight of People Plan • EPOD oversight of People metrics • 100-day new starter and leavers surveys continue to be used to identify good practice and areas for improvement.	

	Framework developed • People Promise Exemplar site programme commenced • HR Business Partners developed action plans with areas of particular concern, monitored by senior HR and OD team • Cost of living measures - signposting staff to benevolent support	• Retention target is 10%. Staff turnover in July 2024 was 11.02% • Plan in place around retention and part of People Strategy for 22/23. The Trust has permanently established our People Promise Manager to ensure that there is a long term focus on the People Promise and the elements within it. Current areas of focus are menopause, flexible working and overall improvements to employee experience.	
Insufficient organisational focus on people or staff engagement which could lead to a lack of workforce cohesion and disengagement with the organisation (inconsistent values and behaviours in line with desired culture)	• Well-being activities and intervention • Action plan in place to address concerns raised in 2022 Staff Survey • Regular Executive Listening Events • Focus on more active consultation with different demographic groups • Implementation of refreshed EDI strategy and priorities incorporating six high impact actions, WRES and WDES • Management Essentials, Leadership Network and development programmes in place • Implementation of FHFT internal coaching network • Succession planning/talent management directorate planning for critical posts at tier 2/3 • Refresh of appraisal system to support talent management • Alignment of leadership and team effectiveness offering with Magnet4Europe and Continuous Improvement strategies • Measures to support and build talent from diverse and junior levels including reverse mentoring and stepping up programmes • Learning and OD provide support where teams raise concerns. • The Trust committed to the NHS Sexual Safety charter and has since been embedding resources related to this topic. This was launched in May 2024. • Working group on violence, aggression and negatives behaviours has started work on identifying themes and will further develop interventions to help reduce issues. • Values refresh programme commencing August 2024.	• SLC oversight and directorate monitoring of staff survey action plan • Pulse survey results • Monitoring of WRES and WDES standards • People Committee oversight of People Plan • System leadership for six high impact actions on EDI • 100-day new starter and leavers surveys continue to be used to identify good practice and areas for improvement. • Launched the Culture & Leadership Programme	

Strategic Ambition (SA3)	Collaborating with Partners		
Strategic Objective 2025	To reduce the need for hospital-based care by working collaboratively with system partners		
Principal Risk	Working more closely with local health and care partners does not fully deliver the required benefits for patients		
Lead Executive	Chief Operating Officer	**Risk Appetite: HIGH**	

Cumulative Risk Score		Informed by Current Corporate Risk Entries	Current Score (Q1)	Consequence and Likelihood
Q1		Industrial Action	**8**	**4x2**
Q2		Bed capacity and flow	**20**	**4x5**
Q3		ED Overcrowding and Performance	**20**	**4x5**
Q4		Winter pressures	**20**	**4x5**

Delivery of 2024-25 Strategic Objectives by 31 March 2025: Achieve the 4hr A&E target (77% from April 2024) – ahead of National Targets and deliver improvements in our Non-Elective Length of Stay

	Executive confidence level				
Strategic Objective	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the objective will be achieved**
Reduce number of MFFD by 45 at peak to 180					The Frimley ICS System did deliver the operating plan target to have circa 220 patients in the no criteria to reside category by June 2024. The July and August positions are above target (i.e. not below 220). The System target is to get to 180 NCTR by March 2025. The confidence level for this target is possible and so the confidence level is 3.
Reduce NEL LoS to 7.1 days					The Frimley Park Hospital site is below 7.1 days in July and August 2024. The Wexham Park Hospital site is over 9 days. As a result, the aggregate target is not being met but the confidence level should remain at 3 as there is a clear action plan in place to deliver it.
Increase in % of patients that are discharged/admitted from ED within 4 hours from arrival					Operating Plan target is to deliver 78% by March 2025. The Trust' internal plan is to meet 77% month on month through Quarters 2 and 3 of 2024/25. Aggregate performance at Trust level is averaging between 70-75% so the overall improvement ask is a further 3% - this is achievable.

Delivery of 2025 Strategic Objective by 31 March 2025: To reduce the need for hospital-based care by working collaboratively with system partners

Confidence Level **1. Very likely** **2. Likely** **3. Possible** **4. Unlikely** **5. Very unlikely**	**Executive Confidence level**				
	Q1	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the strategic objective will be achieved**
	2				Despite the high level of risk exposure and patient demand for hospital services, system partners are working collaboratively to reduce the need for hospital-based care. It is likely that the strategic ambition will be met.

Strategic Threats ***What might cause this to happen?***	***Existing Controls*** ***How we are managing the risk***	**Assurance on Controls** ***Evidence that the existing controls are effective***	***Assurance Gaps*** ***&*** ***Actions to address gaps***
Conflicting priorities of ICS partners, misalignment with financial plan and/or ineffective governance arrangements resulting in poor engagement, and limited ability to influence further service integration.	• Provider boards involved in developing ICS Strategy, Joint Forward Plan and UEC Strategy • Endorsement of ICB governance structure and shared workplan • CEO dialogue with system partners and other regional providers • Continued engagement with system partners to design new system operating framework • CEO chairs Provider Collaborative Group • FHFT Exec leadership allocated to the 5 ICS 'Places' • Work with ICB Board Partners and Non-Executive Members to ensure broad expertise and attention to constructing the ICB transformation delivery framework in the right way	• TMB oversight of strategic ambitions • Full Board engagement within Frimley ICS • Frimley ICS established and aligned with national guidance • Trust Board approval of Joint Forward Plan • System endorsement of revised 2023/24 Financial Plan	Significant system pressures impacting on delivery and recovery
Clinical service strategies and/or commissioning intentions that do not sufficiently anticipate evolving healthcare needs of the local population which limits our ability to care for patients in the right place, at the right time	• Support Frimley ICS to deliver the Core 20 plus 5 approach - working jointly with place teams and partners to focus on 20 % of our most deprived population • Frimley ICB work with public health and other partners to improve uptake of immunisation and screening programmes • Frimley ICB take a population health management approach to target resources and programmes to areas of inequalities • Frimley ICB plan to embed an inclusive approach to engagement/co-production through the People and Communities Strategy • ICS Cardiovascular disease prevention group focused work to reduce the burden of CV disease morbidity and mortality • System Winter Plan in place	• Frimley ICB clarity of key delivery control information such as milestone planning, risks, issues, dependencies and benefits forecasting • Establishment of the ICB Transformation & Delivery Board to create a supportive forum, building on the success of the ICS Programme Delivery Board (2017 –2019) to ensure there is mutual accountability and visibility of risk to delivery	
A schism in relationships with professional groups arising from industrial action and NHS pressures at a national and regional level may negatively impact on collaborative partnerships and alliances within the ICS	• Regular dialogue with internal trade union representatives • Support from national and regional colleagues • System collaboration and agreement	• ICS People Board established with representation across partner organisations and Trade Unions. Programme of work underway with PMO oversight and assurance reporting • Continued implementation of mitigation measures during each strike round with review of effectiveness and any residual risk	

Strategic Ambition (SA4)	**Transforming Our Services**		
Strategic Objective 2025	To provide consistent excellent care as 'One Frimley Health'		
Principal Risk	Demand for services overwhelms capacity which adversely impacts on ability to deliver consistent excellent care as 'One Frimley'		
Lead Executive	Chief Medical Officer	**Risk Appetite: MODERATE**	

Cumulative Risk Score		**Informed by Current Corporate Risk Entries**	**Current Score (Q1)**	**Consequence and Likelihood**
Q1		Waiting for diagnosis/treatment	**12**	**4x3**
Q2		Bed capacity and flow	**20**	**4x5**
Q3		ED Overcrowding and Performance	**20**	**4x5**
Q4		Winter pressures	**20**	**4x5**
		RAAC Roof Tiles at FPH	**20**	**5x4**

Delivery of 2024-25 Strategic Objectives by 31 March 2025: Achieve the Cancer 62 day target (80% by March 2025) and Cancer 28 day Faster Diagnosis Standard (FDS) (85% by March 2025) ahead of National Targets, Achieve 113% in Elective Care – ahead of National Targets and, eliminate 65 Week Waits (by September 2024) – in line with National Targets, Deliver the Major Programmes that support Strategy Transformation including our CDCs, M Block and New Hospital Programme

	Executive confidence level				
Strategic Objective	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the objective will be achieved**
Reduce Waiting List – eliminate 65 week waits by September 24					65 week position influenced mainly by two specialties. One is outsourcing till end of September and is likely to recover its position. The other has extra resource planned but has not started. The forward trajectory is better and is ahead of plan to hit the 65 week position.
Deliver 85% theatre utilisation					YTD position is 80.9% and has been running at this level since 4/24. Further work in theatres on-going to optimize booking.
Deliver 85% day case rate					YTD is 89.3% and stable at this level.
Outpatient activity to be 46% new or follow up with procedure					OP with procedure is currently 71% YTD.

Delivery of 2025 Strategic Objective by 31 March 2025: To provide consistent excellent care as "One Frimley Health"

Confidence Level	**Executive Confidence level**				
	Q1	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the strategic objective will be achieved**
1. Very likely **2. Likely** **3. Possible** **4. Unlikely** **5. Very unlikely**	**3/4**				The main determinant is the 65week position.

Strategic Threats ***What might cause this to happen?***	***Existing Controls*** ***How we are managing the risk***	**Assurance on Controls** ***Evidence that the existing controls are effective***	***Assurance Gaps*** ***&*** ***Actions to address gaps***
Continued growth in demand for care arising from: **• An ageing population** **• Increased acuity leading to more admissions and longer length of stay** **• Flu epidemic or other infectious diseases** **• Insufficient primary care capacity to cope with patient demand**	• Integrated working with ICS partners on planning and delivery through winter • Planning for additional social care and care home capacity underway • GP escalation process in place • Improved volume to front door GP service, aiming for >15% • Working with system partners to reduce ED attendances and sign posting patients to alternative care pathways via NHS 111. • Development for replacement M Block beds for next winter – completion due December 2024 • Multidisciplinary Urgent Care Board in place workstreams initiated to cover SDEC performance, Criteria Led discharge, and discharge planning pathways • Establishment of 2 UCC in Slough and Aldershot to support patient demand • Continued working with ECIST with focus on discharge pathways to improve flow and reduce overcrowding in ED	• Site Assurance meetings twice daily on acute sites with multidisciplinary attendance. • Shared responsibility with Frimley ICS - close cooperation with system partners particularly around patients with extended length of stay and for those patients who are medically stable for discharge but require ongoing care. • UEC Strategy and Joint Forward Plan • System Winter Plan in place	
Reductions in availability of hospital bed capacity caused by increasing numbers of MFFD (medically fit for discharge) patients remaining in hospital	• Creating capacity and improved access for SDEC services and ambulatory care services • Escalation capacity and clear escalation process utilised as required in order to manage peaks of demand. • Revised plans for Every Day Matters programme supported by QI approach, to drive improved discharge processes including board rounds, optimising TTO process and earlier discharge planning driven by EDDs • Planning for increased presence at weekends and bank holidays particularly through bank holidays to provide additional support to discharge Including MADE planned throughout the year • Work to drive compliance in use of Epic discharge functionality	• Increase in % of patients that are discharged/admitted from ED within 4 hours from arrival remains a strategic objective. • Weekly ICS Gold level escalation calls. Each 'place' has onsite representation in order to support complex discharge. • Daily tracking of internal delays • New bed Escalation & De-escalation Policy completed • Every moment review of OPEL level for each acute site • Weekly LOS meetings and data review with COS • New bed Escalation & De-escalation Policy completed with reference to ringfenced Parkside/elective beds	

Workforce: Shortage of clinical staff or fatigue leading to inconsistent service delivery	• Staffing hotspots identified and recruitment plans in place • GIRFT plan with clear priority areas drive for a "One FHFT pathway" across all sites and services. • Clinical prioritisation at each point of referral • Management of waiting lists through booking in priority order. • Harm reviews undertaken for any patients where potential harm may have occurred and any learning actioned	• Elective Recovery Reports to Board • Heatherwood Board chaired by DMD: oversight of elective waiting lists and Trust wide oversight through senior operational managers meeting and bi-weekly operational performance with ADs. • GIRFT Implementation Group monitors and reviews pathway implementation • Waiting list management and oversight through weekly operational managers meeting and bi-weekly operational performance with ADs. • Transformation Board	
Failure to meet the elective recovery trajectories which impacts adversely on funding and patients waiting for treatment.	• Elective recovery funding scheme and work programme in place for 2024/25 • Heatherwood Board established to maximise theatre activity and productivity through 'super week' activities • Established RAAC Planks Programme to manage the risks and minimise disruption on theatre usage at FPH from planned inspections and/or remedial works • Bed planning for NEL (SDEC) & EL ring-fenced beds to support national elective programme & return to 4hr standard • Winter plan to create cohorted areas for optimal management of urgent care pathways and LoS and protection of elective pathways by fully utilising the Heatherwood hospital capacity • Additional day case/OP activity to replace lost elective activity and WLI, opening of Heatherwood creates new 'green' space for activity. • Plan for Heatherwood to rollout additional treatment room capacity in Autumn '23.	• Elective Recovery Reports to FHFT Board • Senior ICB and regional engagement • Elective Care Steering Group oversight • Activity review meetings held between the Chief Operating Officer and Director of Finance, which includes an assessment of financial impacts, including the Elective Recovery Fund • Epic stabilisation work has improved elective activity reporting.	

Strategic Ambition (SA5)	Making Our Money Work		
Strategic Objective 2025	To be in the top 10 trusts in the country for efficiency		
Principal Risk	Failure to deliver the Trust's financial plan and agreed trajectories		
Lead Executive	Chief Finance Officer	**Risk Appetite: MODERATE**	

Cumulative Risk Score		Informed by Current Corporate Risk Entries	Current Score (Q1)	Consequence and Likelihood
Q1		Operational Pressures adversely impacting financial performance	**20**	**5x4**
Q2		Medium term implications of financial environment	**15**	**5x3**
Q3		Reduction of Financial Freedoms	**16**	**4x4**
Q4		CIPs	**6**	**3x2**

Delivery of 2024-25 Strategic Objectives by 31 March 2025: Achieve our Finance 'Income and Expenditure' Plan, Achieve our allocated Capital Plan

	Executive confidence level				
Strategic Objective	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the objective will be achieved**
Delivery of the 2024/25 Financial Plan					-£2.3m Monitoring and corrective actions are yielding results
Delivery of required efficiency target					-£0.7m Additional valuation work in progress

Delivery of 2025 Strategic Objective by 31 March 2025: To be in the top 10 Trusts in the country for efficiency

Confidence Level	Executive Confidence level				
1. Very likely	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the strategic objective will be achieved**
2. Likely					
3. Possible	**3.**				The national financial constraints together with system accountability for break even suggest possible achievement of the strategic objective at this stage. The confidence level may increase as the year progresses with the delivery of the Finance Plan.
4. Unlikely					
5. Very unlikely					

Strategic Threats ***What might cause this to happen?***	***Existing Controls*** ***How we are managing the risk***	**Assurance on Controls** ***Evidence that the existing controls are effective***	***Assurance Gaps*** ***&*** ***Actions to address gaps***
A national reduction in funding, change in financial trajectory, or inflationary pressures resulting in a revised financial plan and requirement to reduce the financial deficit for the healthcare system	• Monthly financial monitoring processes and forecasts • Engagement at ICB and regional level, including pressing for additional funding for costs outside our control e.g. RAAC impairments and impact. • Keep abreast of changing financial regime requirement and influence regionally and nationally where possible • Development of 3-year finance plan with medium term financial modelling • Development of next FHFT 5-Year Strategy • Procurement support to all contracts to ensure optimal management of inflationary risks • Clearly articulate pressures not covered by funding envelope	• Board, Audit Committee and FIC oversight • ICB Finance and Performance Committee • Monthly Finance meetings with cost centre managers and directorates with increased focus forecast out turn and future years • Ensure alignment of planning assumptions with ICB	Uncertainty that transformation can be delivered at sustainable cost
The ICB system deficit results in a negative financial impact to the Trust.	• Financial plans developed in partnership with ICB colleagues for 23/24 • Collaboration with ICB on overall financial position • Investment Case Tracker in place to monitor business case spending • Capital plan in place with priorities identified • ICB dual focus on in year recovery alongside long-term financial sustainability. • Ensure alignment of planning assumptions with ICB	• FIC review of Trust and ICB's financial position • Capital Planning Committee • External Audit Unqualified Opinion on Trust's accounts for 2023/24 and with sufficient arrangements in place to achieve value for money • FHFT representation at ICB Board and other key decision-making forums. • ICB Director of Financial Sustainability appointed • System endorsement of revised 2023/24 Finance Plan	NHS Funding uncertain beyond next election

Strategic Ambition (SA6)	Advancing Our Digital Capability		
Strategic Objective 2025	To be in the top 10 most digitally advanced Trusts in the country		
Principal Risk	Failure to build on the investment in EPR and deliver the system benefits		
Lead Executive	Deputy Chief Executive	**Risk Appetite: MODERATE**	

Cumulative Risks to Advancing our Digital Capability		Informed by Current Corporate Risk Entries	Current Score (Q1)	Consequence and Likelihood
Q1		Cyber Security	**9**	**3x3**
Q2				
Q3				
Q4				

Delivery of 2024-25 Strategic Objectives by 31 March 2025: Achieve the benefits of EPIC alongside the delivery of the Digital Projects Portfolio for this year

	Executive confidence level				
Strategic Objective	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the objective will be achieved**
To deliver the agreed portfolio of Digital programmes for 24/5					Clear portfolio of projects agreed at COSG and owned by the Digital PMO. New Head of Digital Programmes appointed with accountability for delivery of this programme of work
Achieve the benefits from Epic					The newly formed Transformation Board is overseeing delivery of this objective – a number of existing and new groups will lead on the clinical and operational transformation required to achieve the benefits agreed

Delivery of 2025 Strategic Objective by 31 March 2025: To be in the top 10 most digitally advanced Trusts in the country

Confidence Level **1. Very likely** **2. Likely** **3. Possible** **4. Unlikely** **5. Very unlikely**	Executive Confidence level				
	Q1	**Q2**	**Q3**	**Q4**	**Rationale for confidence level that the strategic objective will be achieved**
	1.				The current portfolio of projects, focus on delivery, and oversight of the transformation board give a clear direction and underpinning milestones to deliver this objective. Work to support the New Hospital ensures the Trust is at the leading edge of delivering new technologies to improve the quality and efficiency of care delivery

Strategic Threats ***What might cause this to happen?***	***Existing Controls*** ***How we are managing the risk***	**Assurance on Controls** ***Evidence that the existing controls are effective***	***Assurance Gaps*** ***&*** ***Actions to address gaps***
A large-scale cyber-attack that shuts down the IT network and causes major disruption to the availability of essential patient information for a prolonged period	• Regular review of Trust plans by NHS Digital • Regular Trust staff cyber risk awareness campaigns • Proactive alerts and response from Trust Cyber Team on NHS Digital CareCERT alerts specific to RDU • Trust Cyber Team hold Cyber accreditation and have CPD as part of Appraisal/PDP • Host based intrusion prevention systems • Anti-malware installed on all managed devices • SCCM Central Patch Management • Policies Standards & Procedures • Web filtering • Network Monitoring • Annual penetration testing • Vulnerability management • Web Application firewall • Large number of unsupported and Legacy systems are being managed as part of the Trust decommissioning programme of work with additional security controls implemented to lower risk of a security breach • Cyber Security training to be increased and form part of the refreshed IG mandatory training requirement for all staff. • Multi Factor Authentication (MFA) being rolled out to all staff to reduce the risk of compromised email accounts, this will be expanded to privileged network accounts to bring in line with NHS England policy change	• Data and Security Toolkit compliance with cyber security IG requirements • Oversight by IG and Audit Committee • Annual Internal Audit review of Toolkit evidence • Assurance dashboard in place to increase visibility of the network with a single, near real-time view to better manage vulnerabilities, remediation and compliance • Incident response plans finalised with EPRR – tabletop exercise complete • Due to the ongoing nature of the Cyber threat, and constantly changing threat landscape the cyber security risk remains on the corporate risk register – there is a continual programme of work with the Trust cyber security team to address new threats as they arise	
Insufficient capacity and capability in the digital team to advance the organisation's digital maturity	• Digital Services Oversight Group • Clear corporate plan of enabling digital projects • Ongoing support for EPR stabilisation/optimisation • Aspiration and focus areas for digital interventions and enablers are included in the Joint Forward Plan and are a shared priority for system partners	• ICB Digital Costed Plan for the Frimley system in place which provides a coherent focus on priority areas and risks to delivery • EPR Programme Board oversight of digital resource • Regular reports to FIC and Board	
Insufficient focus on Epic system optimisation leading to shortfall in financial benefits and clinical productivity	• EPR in optimisation phase with appropriate workstreams in place to realise system benefits • EPR Programme Board oversight of plans, risks and incorporating lessons learned from implementation • Workstream meetings created under new EPR	• EPR Programme Board oversight of all EPR matters • EPR External Assurance • Finance & Investment Committee review of EPR benefits realisation post implementation • Regular updates to Board and external stakeholders to	

	Programme Director for Stabilisation • The EPR FBC equates to a series of cash releasing and non-cash releasing benefits which are tracked and monitored through EPR programme governance • A number of other programmes and BAU areas join up with EPR including Heatherwood, length of stay, elective recovery, and the people programme. • The lessons learned work continues with the NHSE Frontline Digitisation team. Focus has now moved to optimisation – plan for the future and lessons learned from other Trusts/what Frimley can add to lessons for those Trusts going live in future. • Ongoing escalation with Epic senior leaders regarding system issues • Regular liaison with NHSE	provide assurance • TMB and IG oversight of all strategic initiatives and regular review by executive team • Stabilisation dashboard established and review incorporated into new and ongoing governance structure • Stabilisation and reporting plan agreed with PWC/NHSE • The stabilisation process is nearing completion Reporting has been a focus with a workstream focused on the statutory reports (DM01, CDS) which have now been submitted.	

12. RESPONSIBLE OFFICER'S ANNUAL REPORT

REFERENCES

Only PDFs are attached

12. Board Cover Paper RO Annual Report.pdf

12a. RO Annual Report 2023-24.pdf

Report Title	**Responsible Officer's Annual Report Appraisal Year 2023/24**
Meeting and Date	Board of Directors, 6th September 2024
Agenda Item	12.
Author and Executive Lead	Dr Timothy Ho, Chief Medical Officer and Responsible Officer supported by Angela Yannoulias, Associate Medical Director, Professional Standards and Claire Steel, Head of Medical Director Services
Executive Summary	• Appraisal rates increased compared to previous years. • Number of connected doctors continues to increase. This growth is mostly at the trust doctor grade. • Appraisal team now fully staffed allowing plans for quality assurance and peer review to move forward. • A new requirement for a professional standards quality assurance process will be reviewed and implemented over the coming year.
Action	The Board of Directors is asked to **RECOMMEND** that the Trust Chair sign Statement of Compliance ahead of submission to NHS England.
Compliance	The Responsible Officer role is set out in legislation[1]. NHS England requires responsible officers to produce an annual report and submit it to the Board. A Designated Body Statement of Compliance must be submitted to NHS England by the end September each year.

[1] The Medical Profession (Responsible Officers) Regulations 2010

Frimley Health NHS Foundation Trust

Responsible Officer's Annual Report
Appraisal Year 2023/24

Purpose of the Paper

This report serves to inform the Trust board on the progress made in relation to medical appraisal and revalidation for the appraisal year April 2023 to March 2024, highlight the areas of risk and outline planned actions to respond to those areas.

The Chair is also asked complete the statement of compliance (Section 7).

Background

Medical revalidation aims to strengthen the way that doctors are regulated; improve the quality of care provided to patients; improve patient safety; and increase public trust and confidence in the medical system. Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations and it is expected that the board will oversee the Trust's compliance.

Summary

Resource

The Revalidation Team carried a vacancy throughout the review period but did appoint a new Medical Appraisal and Revalidation Administrator who started in April 2024. This has had an impact on the development plans of the team.

Appraisal rates

There has been a significant increase in the "appraisal completed" and "appraisal completed or approved missed" rates. It is believed that this is a result of two factors:

- Embedding of the L2P system with more frequent automated reminders.
- Specific focus on identifying doctors that appear not to be engaging and moving them through the overdue process more quickly. This resulted in a greater number of requests to the GMC to write to the doctors about their non-engagement.

Connections

At the end of 23-24 the number of doctors connected to Frimley Health's designated body list is 979; this is 7% increase year on year. 326 new connections were made in year. We also appraise military doctors and GDC registered maxillofacial dentists.

All consultants, specialty doctors (including staff grade and associate specialists) and trust doctors (also known as locally employed doctors as distinct from deanery trainees) hold a connection to the trust. Additionally, some bank doctors are connected if their bank work at Frimley Health constitutes the majority of the work that they do.

Year	FPH	WPH	Total
23/24	552	427	979
22/23	520	395	915
21/22	482	370	852
20/21	480	374	854
19/20	496	346	842
18/19	426	343	769
17/18	392	302	694
16/17	359	308	667
15/16	333	301	634

Summary of Actions

- Undertake peer review
- Restart appraisal quality assurance and appraiser peer review
- Pilot LED appraisal via Portfolio
- Pilot using Frimley EPR data for appraisal
- Review the Messenger Review recommendations
- Establish a professional standards quality assurance process

Section 1 – Qualitative/narrative

1A – General

The Board of Frimley Health NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Dr Timothy Ho, Chief Medical Officer.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

The service is supported by:

- Associate Medical Director - Professional Standards
- Head of Medical Director Services
- Professional Standards Adviser
- Medical Appraisal and Revalidation Administrators

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

The appraisal and revalidation team monitor new connections and receive information from the Trust's Human Resources department regarding starts, leavers and changes.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

The Medical Appraisal and Revalidation Policy has been agreed in year and was published in April 2024.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

A peer review of this organization's appraisal and revalidation processes has been agreed in principle with neighbouring trusts. A date is to be set.

Action for Next Year:
Arrange for a peer review of the appraisal and revalidation processes.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are

supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Agency locum doctors:

NHS England South Region has recommended better exit reporting for agency locum doctors to support their revalidation.

Action: Circulate message and resources to directorates regarding supporting the appraisal and revalidation of agency locums via exit reporting. Chiefs are reminded that appropriate feedback on locum doctors is provided.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Since January 2023, Frimley Health NHS Foundation Trust has successfully adopted the L2P (Learn to Perform) appraisal platform. The L2P system is designed to streamline the appraisal process for medical professionals, making it more efficient and user-friendly. This transition has gone smoothly, with positive feedback from the staff about the new system's ease of use.
There has been a significant increase in compliance with appraisal which reflects the successful implementation of L2P and improved overdue notice systems.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Where appraisal is overdue doctors are sent automated reminders by the L2P. additionally there is a 4-stage process of reminders generated by the appraisal and revalidation team. If this fails, then the GMC is asked to write to the doctor about their non-engagement (REV6 notification).
There are processes for extending a doctor's deadline based on their specific personal circumstances.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

An updated medical Appraisal Policy was published in April 2024.

1B(iv) Our organisation has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The Trust currently has 197 trained appraisers for approx. 1000 appraisals/ This ratio falls within the recommended 5-20 appraisals per appraiser per year.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year: Organise appraiser peer review.
Comment: This has been deferred to 2024-25.

Action from last year: Hold appraiser event
Comment: This was held in June 2024.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

The Appraisal and Revalidation service is overseen by the Medical Appraisal and Revalidation Governance group. The group met twice in the year and received an update in lieu of a meeting in March 2024.

Action from last year: Undertake quality assurance process.

Comments: Quality control continues to take place with the review of every appraisal by the Chief of Service or Deputy Chief of Service. This action has been carried over. A broader quality assurance process is planned.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one

of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

For the Medical Appraisal Doctors are provided with:

- Event profile containing details of complaints, claims or moderate and above incidents drawn from RL/ In Phase (Trust incident reporting platform). Nil reports are sent if there is no relevant data.
- Activity/ outcome data from the Hospital Evaluation Data system has only been provided for some of the year due to a gap in data submitted by the Trust (post Frimley EPR implementation). We expect to resume issuing these reports by November 2024. This is only available for consultants where they are the named consultant for a patient's care.
- If a trained appraiser, Appraiser evaluation report

It is hoped that the new Frimley EPR system will provide a way for doctors to view a dashboard of their own activity and outcome and we have started work on a pilot with the Health Information Team.

Action for next year:

- Continue work on pilot.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

> The Trust's policy "Maintaining High Professional Standards" continues to provide a framework for managing concerns about a doctor's conduct and/ capability. Appendix B summarises the Trust's activity in addressing concerns across both sites.

During 2023-24, the Responsible Officer and team continued to meet with our designated GMC Employer Liaison Adviser (three times per annum as per our normal schedule, and intermittently between scheduled dates as required). Where appropriate, the Practitioner Performance Advice Service has been contacted.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

The Trust Board are informed about investigations carried out under the 'Maintaining High Professional Standards' policy.

Action for next year: Establish a professional standards quality assurance process and enhanced reporting to Board.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

The Trust engages in the Transfer of Information process using the MPIT forms. We have an established line of communication with the GMC local employment advisor to seek advice, corroborate and discuss issues relating to medical staff. In accordance with best practice, we seek advice from the Practitioner Performance Advisory service.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC guidance: Effective clinical governance to support revalidation).

Each department and the Trust has established clinical governance processes including audit programmes. The patient safety team also reviews consultant level data.

Action for next year: Undertake a self-assessment against the *updated Effective clinical governance to support revalidation* (GMC 2024) and produce a plan for any improvements.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

The Trust submitted responses to the Thirwall and Fuller inquiries this year. The Paediatrics and Pathology directorates reviewed their processes in the light of these inquiries.

The Trust has a monthly care governance committee where directorates and specific services report on their clinical governance processes.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

All clinicians who are subject to a formal investigation under the MHPS policy are discussed with the chief executive and Board oversight is delivered in the confidential part of the Board meeting.

Action for next year: Review the Messenger Review recommendations and report on Trust work in relation to this.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

> The trust has an established grievance procedure including an appeals process. The Maintaining High Professional Standards policy also has an appeals process.
>
> The trust receives feedback about the processes more generally via the Joint Local Negotiating Committee.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

> Action for next year: (As above) Establish a professional standards quality assurance process and enhanced reporting to Board.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

> The Responsible Officer, Associate Medical Director, Head of Medical Director Services, Professional Standards adviser and Appraisal and Revalidation Administrators attend the Network Meetings.
> Action for next year: (as above) undertake peer review with other trusts

Section 2 – metrics

Year covered by this report and statement: 1April 2023- 31March 2024.
All data points are in reference to this period unless stated otherwise.

2A – General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March 2024	979

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

		Compared to 22-23 N=915
Total number of appraisals completed	832 (85%)	652 (71%)
Total number of appraisals approved missed	130 (13%)	178 (19%)
Total number of unapproved missed	17 (2%)	85 (9%)

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	132
Total number of late recommendations	2
Total number of positive recommendations	116
Total number of deferrals made	18
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

Reasons for deferral NB: there can be more than one reason						
Appraisal activity	Colleague feedback	Complaints	Interruption to practice	Patient feedback	Significant events	Subject to ongoing process
4	**6**	**0**	**5**	**7**	**0**	**0**

2D – Governance

Total number of trained case investigators	10
Total number of trained case managers	2
Total number of new concerns registered	10
Total number of concerns processes completed	8
Longest duration of concerns process of those open on 31 March	9 months

Median duration of concerns processes closed	Not previously recorded data. This will start from 2023-24.
Total number of doctors excluded/suspended	2
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	258
Number of new employment checks completed before commencement of employment	258

2F Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	n/a

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

Action	**Status**
Undertake appraiser peer review	Agreed in principle with local trusts but not completed
Development of the appraisers – refresher course	Some appraisers have accessed Miad refresher training due to own circumstances. Appraiser event 13 June 2024.
Re-establish new appraiser audit	No technical solution within L2P so will need to be developed.
Establish peer review/ calibration of professional judgements system amongst appraisers	Deferred to 2023-24
Send Policy to Policy Review Group to be published.	Published
Review provision of appraisers and work with directorates to ensure sufficient appraisers trained	Ratio now within limits

Circulate message and resources to directorates regarding supporting the appraisal and revalidation of agency locums via exit reporting.	No technical solution within L2P so will need to be developed.
Institute an overdue notice system that moves more quickly to the GMC Rev6 process.	Implemented
Explore with Director of Clinical Education how educational portfolios might be used for appraisal for trust doctors thus minimising duplication of effort.	In progress with system ready to be tested. Q3.
Follow up request made to Frimley EPR team regarding data for appraisals.	In progress. Agreed to start with one specialty. Also linking in with GIRFT work on the National Consultant Information Programme (NCIP)
Survey doctors about the experience of using L2P to inform future guidance and feedback to L2P.	Completed.

Actions still outstanding

- Hold appraiser refresher event
- Undertake peer review with other trusts
- Re-establish new appraiser audit
- Undertake appraiser peer review
- Re-establish new appraiser audit
- Establish peer review/ calibration of professional judgements system amongst appraisers
- Circulate message and resources to directorates regarding supporting the appraisal and revalidation of agency locums via exit reporting.
- Test then implement system of using educational portfolios for appraisal for trust doctors.
- Pilot using Frimley EPR data for appraisals.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

- Undertake a self-assessment against the *updated Effective clinical governance to support revalidation* (GMC 2024) and produce a plan for any improvements.
- Review the Messenger Review recommendations and report on Trust work in relation to this.
- Establish a professional standards quality assurance process and enhanced reporting to Board.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

As L2P enters a stable phase, it is anticipated that several stalled development initiatives can be resumed.

The following areas are earmarked for attention and advancement:

- **Peer Review**: Enhancing the peer review process to ensure thorough and constructive feedback.
- **Quality Assurance Programme**: Implementing a robust quality assurance programme to maintain high standards in appraisals.
- **Refresher Training for Appraisers**: Providing refresher training sessions to appraisers to ensure they are well-equipped with the latest appraisal techniques and knowledge.
- **Portfolio-Based Appraisal for Trust Doctors**: Introducing a portfolio-based appraisal system specifically tailored for trust doctors to better capture their professional development and achievements.
- **EPR-Based Data for Doctors to Download**: Enabling doctors to download relevant data from the EPR system, facilitating easier access to necessary information for their appraisals.

These initiatives aim to enhance the overall appraisal process, ensuring it is comprehensive, effective, and supportive of continuous professional development.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Frimley Health NHS Foundation Trust

Name:	Bryan Ingleby
Role:	Chair
Signed:	
Date:	

Appendix A

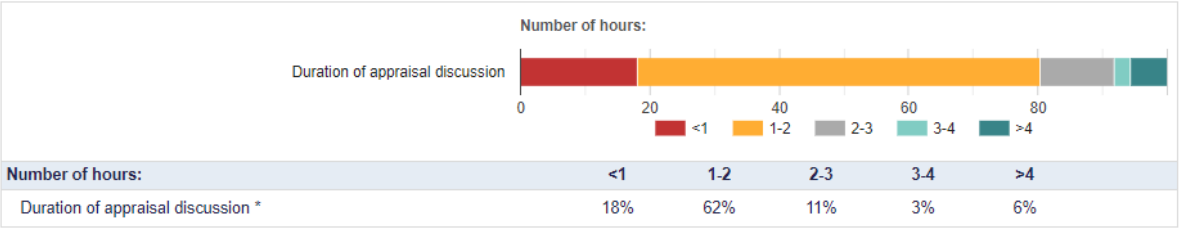
Appraisal Rates at Frimley Health NHS Foundation Trust for doctors whom the designated body has a prescribed connection as 31/03/23						
		Number of prescribed connections	Completed appraisal	Approved incomplete or missed appraisal	Unapproved incomplete or missed appraisal	**% completed appraisals and agreed deferrals**
Consultants	FPH	268	257	9	2	99%
	HWP	211	198	10	3	99%
	Total	479	455	19	5	99%
Staff Grade, Associate Specialist, Specialty Drs	FPH	54	44	6	4	93%
	HWP	45	39	5	1	98%
	Total	99	83	11	5	95%
Temporary or short-term contract holders *	FPH	230	164	64	2	99%
	HWP	169	128	36	5	97%
	Total	399	292	100	7	98%
Honorary	FPH	0	0	0	0	-
	HWP	2	2	0	0	100%
	Total	2	2	0	0	100%
Total	**FPH**	552	465	79	8	99%
	HWP	427	367	51	9	98%
	Total	979	832	130	17	98%

*temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed term employment contracts etc.

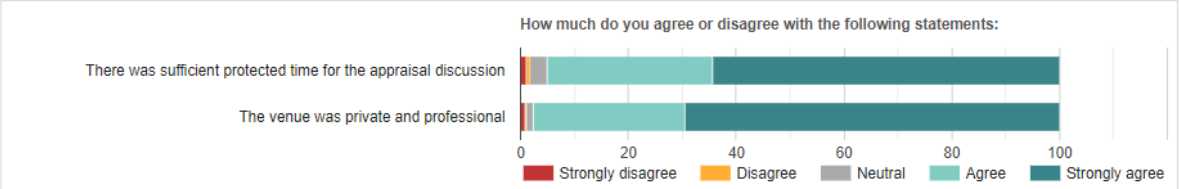
Appendix B

Aggregated results of post-appraisal questionnaires

Environment and timing

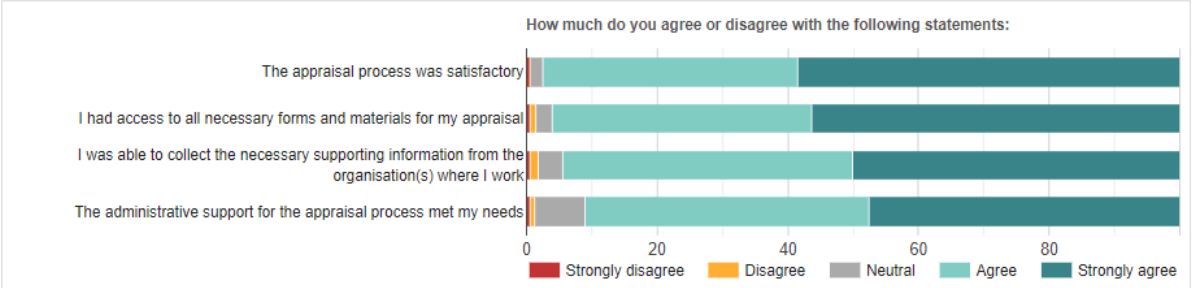


Number of hours:	<1	1-2	2-3	3-4	>4
Duration of appraisal discussion *	18%	62%	11%	3%	6%



How much do you agree or disagree with the following statements:	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Average
There was sufficient protected time for the appraisal discussion *	1%	1%	3%	31%	64%	4.57
The venue was private and professional *	1%	0%	1%	28%	69%	4.65

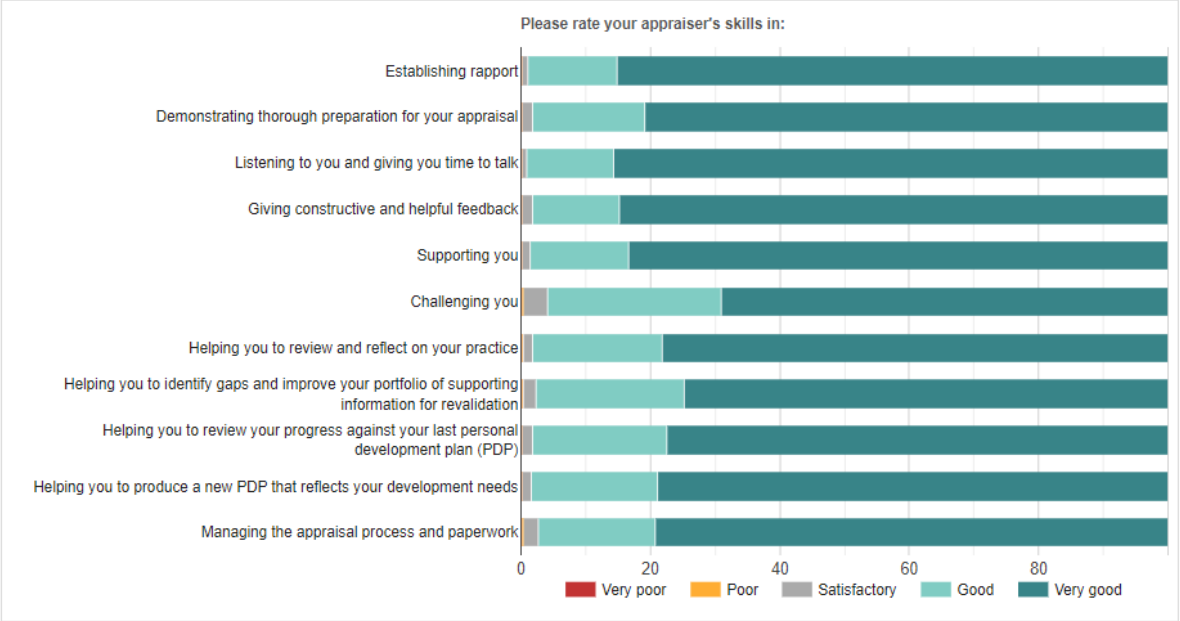
Administration and management of the appraisal system



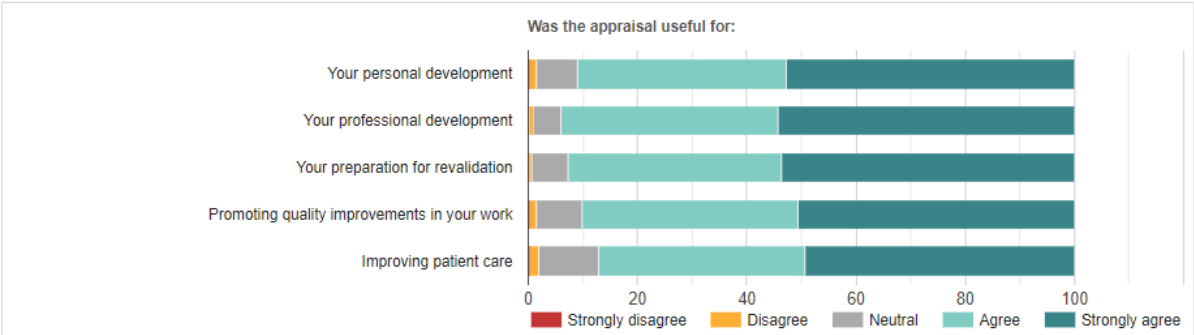
How much do you agree or disagree with the following statements:	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Average
The appraisal process was satisfactory *	1%	0%	2%	39%	58%	4.55
I had access to all necessary forms and materials for my appraisal *	1%	1%	3%	40%	56%	4.50
I was able to collect the necessary supporting information from the organisation(s) where I work *	1%	1%	4%	44%	50%	4.42
The administrative support for the appraisal process met my needs *	1%	1%	8%	44%	48%	4.37

Your appraiser

Please give your appraiser feedback for their personal development



The appraisal overall



Was the appraisal useful for:	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Average
Your personal development *	0%	1%	8%	38%	53%	4.42
Your professional development *	0%	1%	5%	40%	54%	4.47
Your preparation for revalidation *	0%	0%	7%	39%	54%	4.46
Promoting quality improvements in your work *	0%	1%	9%	39%	51%	4.39
Improving patient care *	0%	2%	11%	38%	49%	4.34

13. USE OF TRUST SEAL REPORT

REFERENCES

Only PDFs are attached

13. Seal Report.pdf

13a. Seal register 24_25.pdf

Report Title	Use of Trust Seal Report
Meeting and Date	Public Board of Directors, Friday 6th September 2024
Agenda Item	13.
Author and Executive Lead	Victoria Cooper, Acting Company Secretary Lance McCarthy, Chief Executive
Executive Summary	In accordance with the Trust's Standard Orders the attached report confirms the use of the Trust Seal from 1 April 2024.
Action	The Board is asked to **RATIFY** the use of the Trust Seal.
Compliance	Trust Standing Orders

Frimley Health NHS Foundation Trust

FRIMLEY HEALTH NHS FOUNDATION TRUST

REGISTER OF SEAL

ITEM NO	DATE	ITEM REQUIRING SEAL	DOCUMENT APPROVED AND AUTHORISED (sign)	APPROVED FOR SEALING BY CHAIRMAN, CHIEF EXECUTIVE OR EXECUTIVE DIRECTOR (sign)
001	16/04/24	Rooftop Lease relating to the communications site situated at Wexham Park Hospital, Slough SL2 4HL Executed as a Deed between Frimley Health NHS Foundation Trust (Landlord) And EE Limited and Hutchison 3G UK Limited (Tenant)	Victoria Cooper Acting Company Secretary	James Clarke Chief Strategy Officer

NHS
Frimley Health
NHS Foundation Trust

FRIMLEY HEALTH NHS FOUNDATION TRUST

REGISTER OF SEAL

ITEM NO	DATE	ITEM REQUIRING SEAL	DOCUMENT APPROVED AND AUTHORISED (sign)	APPROVED FOR SEALING BY CHAIRMAN, CHIEF EXECUTIVE OR EXECUTIVE DIRECTOR (sign)
002	03/05/24	FPH Remedial Roof Works, Theatres 9 & 10 Contract Document Register (including appendices) – JCT Intermediate Contract with Contractors Design 2016 Executed as a Deed between Frimley Health NHS Foundation Trust (Landlord) And Neilcott Construction Limited	Victoria Cooper Acting Company Secretary	Kishamer Sidhu Chief Finance Officer

Frimley Health NHS Foundation Trust

FRIMLEY HEALTH NHS FOUNDATION TRUST

REGISTER OF SEAL

ITEM NO	DATE	ITEM REQUIRING SEAL	DOCUMENT APPROVED AND AUTHORISED (sign)	APPROVED FOR SEALING BY CHAIRMAN, CHIEF EXECUTIVE OR EXECUTIVE DIRECTOR (sign)
003	03/05/2024	Schedule of Works – Contraction Version – DIPU M Block Substation Executed as a Deed between Frimley Health NHS Foundation Trust (Landlord) And MTX Contracts Limited	Victoria Cooper Acting Company Secretary	Kishamer Sidhu Chief Finance Officer

Frimley Health NHS Foundation Trust

FRIMLEY HEALTH NHS FOUNDATION TRUST

REGISTER OF SEAL

ITEM NO	DATE	ITEM REQUIRING SEAL	DOCUMENT APPROVED AND AUTHORISED (sign)	APPROVED FOR SEALING BY CHAIRMAN, CHIEF EXECUTIVE OR EXECUTIVE DIRECTOR (sign)
004	03/05/2024	Contract Documentation FPH – MEP Roof Reinforcement Phase 2 Main Contract Executed as a Deed between Frimley Health NHS Foundation Trust (Landlord) And Neilcott Construction Limited	Victoria Cooper Acting Company Secretary	Kishamer Sidhu Chief Finance Officer

Frimley Health NHS Foundation Trust

FRIMLEY HEALTH NHS FOUNDATION TRUST

REGISTER OF SEAL

ITEM NO	DATE	ITEM REQUIRING SEAL	DOCUMENT APPROVED AND AUTHORISED (sign)	APPROVED FOR SEALING BY CHAIRMAN, CHIEF EXECUTIVE OR EXECUTIVE DIRECTOR (sign)
005	03/05/2024	Parent Company Guarantee Relating to a M Block Substation at FPH Executed as a Deed between Frimley Health NHS Foundation Trust (Landlord) And Neilcott Construction Limited	Ellis Pullinger Interim Chief Operating Officer	Kishamer Sidhu Chief Finance Officer

Frimley Health NHS Foundation Trust

FRIMLEY HEALTH NHS FOUNDATION TRUST

REGISTER OF SEAL

ITEM NO	DATE	ITEM REQUIRING SEAL	DOCUMENT APPROVED AND AUTHORISED (sign)	APPROVED FOR SEALING BY CHAIRMAN, CHIEF EXECUTIVE OR EXECUTIVE DIRECTOR (sign)
006	31/05/24	Agreement Pursuant to Section 106 of the Town and Country Planning Act 1990 relation to land at Upton Hospital, Albert Street, Slough SL1 2BJ Executed as a Deed between Frimley Health NHS Foundation Trust, NHS Property Services Limited And Slough Borough Council	Victoria Cooper Acting Company Secretary	Kishamer Sidhu Chief Finance Officer

Frimley Health NHS Foundation Trust

FRIMLEY HEALTH NHS FOUNDATION TRUST

REGISTER OF SEAL

ITEM NO	DATE	ITEM REQUIRING SEAL	DOCUMENT APPROVED AND AUTHORISED (sign)	APPROVED FOR SEALING BY CHAIRMAN, CHIEF EXECUTIVE OR EXECUTIVE DIRECTOR (sign)
007	26/07/24	Slough CDC Project JCT Pre-construction Services Agreement 2016 – Pre-Construction Services Agreement Executed as a Deed between Frimley Health NHS Foundation Trust, & Western Building Services Ltd	Victoria Cooper Acting Company Secretary	Kishamer Sidhu Chief Finance Officer

Frimley Health NHS Foundation Trust

FRIMLEY HEALTH NHS FOUNDATION TRUST

REGISTER OF SEAL

ITEM NO	DATE	ITEM REQUIRING SEAL	DOCUMENT APPROVED AND AUTHORISED (sign)	APPROVED FOR SEALING BY CHAIRMAN, CHIEF EXECUTIVE OR EXECUTIVE DIRECTOR (sign)
008	28/08/24	a) Lease of Woodlands Modular Relocatable Facility at Frimley Park Hospital b) Lease of Grassy Knoll Temporary Imaging Facility at Frimley Park Hospital c) Retrospective Licence for Alterations relating to Grass Knoll Temporary Imaging Facility at Frimley Park Hospital d) Retrospective Licence for Alterations relating to Woodlands Modular Relocatable Facility at Frimley Park Hospital e) Deed of Surrender relating to Temporary Premises at Frimley Park Hospital f) Sublease of CT Area at Grassy Knoll Temporary Imagining Facility at Frimley Park Hospital g) Deed of Variation and Extension in relation to contract for the provision of MRI services at Frimley Park Hospital Executed as a Deed between Frimley Health NHS Foundation Trust, & Inhealth Limited	Victoria Cooper Acting Company Secretary	Kishamer Sidhu Chief Finance Officer

14. ANY OTHER BUSINESS

Oral

14.1 PEOPLE COMMITTEE TERMS OF REFERENCE

REFERENCES

Only PDFs are attached

14. ToR Cover Sheet (1).pdf

Report Title	**Annual Review of Committee Terms of Reference**
Meeting and Date	Public Board of Directors, 6th September 2024
Agenda Item	14.
Author and Executive Lead	Hannah Farmhouse, Assistant Company Secretary Victoria Cooper, Acting Company Secretary
Executive Summary	This report presents the Board with the People Committee terms of reference (ToR) for Board approval, following their annual review. The People Committee Terms of Reference were presented to the Committee for annual review in April 2024. Amendments were made offline following the meeting and the revised Terms of Reference were then circulated and approved via eGovernance on 14th August 2024. The new version can be found in the Reading Room and a summary of the amendments is below. Once approved the new versions of the ToR will be available on the Trust's website. • Section 1 and 2 – wording simplified. • Section 4 – Objectives updated • Section 5 - Updated to include Director's Report • Section 6 – Membership updated to reflect new Executive titles. Chief Operating Officer removed and Chief Medical Officer or deputy added. • Section 7 – Quorum amended from one to two Non-Executive Directors and from two to one Executive Directors, to align with other Board Committees. To include the Chief People Officer or nominated deputy in the quorum. • Section 10 – wording simplified.
Action	The Board of Directors is asked to **APPROVE** the revised People Committee Terms of Reference.
Compliance	Trust Constitution and Committee Terms of Reference.

15. PUBLIC QUESTIONS

Oral

16. DATE OF NEXT MEETING

Friday 1st November 2024, 08:30 - 11:30, Lecture Theatre, John Lister Postgraduate Centre, Wexham Park Hospital