NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust



Quality Account 2025/2026

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Foreword from Chief Executive Officer

I am pleased to present the Quality Account for The Royal Orthopaedic Hospital for 2025/2026. This report highlights our ongoing commitment to providing exceptional care and achieving remarkable quality improvements. Quality is the cornerstone of our care, and I hope you'll see this reflected throughout the report.

We are proud to be a patient-centred hospital - feedback, engagement and co-production continues to shape the services we offer and the quality which underpins them. Our vision is '***less pain, more independence, life-changing care'*** and this vision relies on delivering the highest standards of quality.

Over the past year we have continued to deliver against a comprehensive quality improvement framework. This has guided our efforts to enhance patient safety, clinical effectiveness, patient experience, and staff well-being. By analysing data, conducting clinical audits, and gathering feedback, we have identified areas for improvement and implemented targeted interventions. Our commitment to patient safety remains a top priority. We have invested in safety protocols, training programmes, and technologies to ensure the highest standards of care. Our commitment and investment are reflected in the quality outcomes we have achieved over the year, and I am grateful to our incredible team who make this possible.

The Care Quality Commission (CQC) did not conduct a full inspection at The Royal Orthopaedic Hospital in the past year, but we continue to build good working relationships with our regulatory body to ensure transparency, constructive dialogue and the highest standards of quality and safety are upheld.

I would like to thank every member of The Royal Orthopaedic Hospital team. The work of this team is outstanding, and quality is foundational in what they do. Of course, quality is not a destination, it is an ongoing journey for us. We are committed to continually improving what we do to ensure that our patients receive the very best care possible.

Matthew Hartland
Chief Executive Officer

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1.0. What is the Quality Account?

Patients want to know they are receiving the very best quality of care. Providers of National Health Service (NHS) healthcare are required to publish a Quality Account each year. These are required by the Health Act 2009, and the Health and Social Care Act 2012 in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 as amended ('the Quality Accounts Regulations'). Information on Quality Accounts can be found on the NHS website (formerly 'NHS choices') at *http://www.nhs.uk/quality-accounts*. NHS England requires all NHS Foundation Trusts to produce a Quality Account. Quality reports help Trusts to improve public accountability for the quality of care they provide.

A Quality Account is a report about the quality of services provided by an NHS provider. The report is an important way for providers to publish information on the quality of care it provides and to demonstrate improvements and developments in its services. The report enables local communities and stakeholders to review the progress that the Trust is making in delivering its Quality Priorities and to hold the provider to account.

The Trust is committed to continuously improving the services it provides to patients and their families. Within the Quality Account, we aim to make the following information available to stakeholders, patients, and the public:

- Our Quality Priorities for the year 2026/2027.
- Our progress against delivery of the Quality Priorities we outlined in 2025/2026.
- How we have performed against national quality indicators for patient safety, patient experience, and clinical effectiveness.
- How we have performed against local quality measures as agreed with our commissioners.
- How we will ensure that The Royal Orthopaedic NHS Foundation Trust maintains continuous quality improvement.

1.1. Who has been involved in producing the Quality Account?

The Quality Account has been developed by The Royal Orthopaedic Hospital (ROH) with input and assistance from a range of stakeholders, including:

- The ROH Council of Governors
- The ROH Quality and Safety Committee
- The ROH Clinical Quality Group
- The ROH Patient Engagement and Experience Group
- Audit Quality Improvement Learning and Analysis Group (AQUILA)

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1.2. Our hospital – The Royal Orthopaedic Hospital (ROH)

The ROH is a single speciality Orthopaedic hospital offering elective and specialist services at a local and regional level. Our vision is '***less pain, more independence, life-changing care***' and we are committed to delivering world leading outcomes and excellent patient experience in line with our values: ***Respect, Openness, Compassion, Excellence, Pride, and Innovation.***

Our patients benefit from a team of highly specialist clinicians, many of whom are nationally and internationally recognised for their expertise. We work with our local partners in the Birmingham and Solihull (BSol) Integrated Care System (ICS) to continue improving elective Orthopaedic services for patients across Birmingham and Solihull.

We are proud of the research and innovation led by teams at the ROH, including continuing to expand the number of orthopaedic researchers we have across the ROH with continued investment in the research. This alongside strengthened academia and commercial partnerships to deliver major grant funded research programmes led by ROH investigators utilising our Regenerative Medicine Research laboratory.

The ROH leads the Birmingham and Solihull ICS Musculoskeletal (MSK) Transformation Programme, which aims to standardise the design and delivery of MSK services for our population. The programme is underpinned by five workstreams focusing on: standardising procedure level pathways and clinical decision making; improving patient information and Advice and Guidance; developing digital solutions for self-management; enhancing public health promotion and prevention; and developing the MSK workforce for the future. This programme reports into the ICS Integrated Care Board and is closely aligned to the national Best MSK Health High Impact Strategy.

1.3. Equality and diversity

Equality is about creating a fairer society where everyone can fulfil their potential and have equal opportunity to achieve their desired outcomes and live without health inequalities. We recognise the rights of all our patients, visitors, and employees to be treated fairly and value the different perspectives they have to offer irrespective of age, gender, marital status, religious belief, ethnic background, nationality, sexual orientation, disability, and social status.

2.0. Our Quality Priorities for 2025/26

During 2025/2026 we continued to focus on quality improvement. We have developed the capability of our staff within the organisation through Quality Service Improvement and Redesign (QSIR) training.

We have continued to promote links between hospitals within BSol and built connections with third sector partners to ensure the quality of care and access to services for our patients is of the highest quality.

Last year we identified five priority areas for improvement as outlined below in Table 1.

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Quality Priority		
1.	**Safe**	Reduction in surgical site infection
2.	**Caring**	Art for Health – A holistic way to managing patient pain
3.	**Effectiveness**	Minimising the risks and potential impact of medical neglect among children and young people with limited engagement in health services due to existing health-related barriers
4.	**Responsive**	Reduction in length of time for patients to wait for access to the spinal service
5.	**Well-led**	Year 2 roll out of Service Accreditation

Table 1. Quality Priorities 2025/26

The Quality Priorities formed a key part of the working plan for the Clinical Quality Group (CQG) throughout the year, with a quarterly reporting cycle. The meeting is chaired by the Chief Nursing Officer. The five Quality Priorities (QP) for 2025/26 were presented to the CQG giving a summary of achievements.

2.1. Performance on 2025/26 Quality Priorities

Priority 1. Reduction in surgical site infection.

Safe	**Reducing Surgical Site Infection (SSI) risk rates for total knee replacement (TKR) and spinal surgeries undertaken at The Royal Orthopaedic Hospital (ROH) from 2025 onwards.**
Leads	Victoria Clewer – Head of IPC, TV & Deputy DIPC
Executive Lead	Nicola Brockie – Chief Nursing Officer and DIPC
Why we chose this QP?	Reducing the risk of surgical site infections (SSI) at ROH was first identified as a quality priority for 2024/25, following consecutive years (2022–2024) of 'higher outlier' status in total knee replacement (TKR) and spinal surgery categories. Although SSI risk rates have improved across all monitored categories, this priority was extended into 2025/26 to support the continued development and implementation of a bespoke ROH-specific SSI prevention bundle and a robust ongoing surveillance programme.
What actions have been taken?	Following on from the successful completion of actions from 2024/25, four additional actions were identified as key steps towards successful implementation of the ROH SSI prevention bundle: • Finalisation of all elements to be included in the ROH specific SSI prevention bundle. • Identify how to implement the bundle. • Develop and deploy an ongoing monitoring process to provide information on the adherence to the bundle.

	• Integrate bundle compliance metrics into local surveillance reporting.
How have we evaluated success?	Strengthening our understanding and application of statistical process control (SPC) charts has enhanced our ability to interpret surveillance data and establish a local benchmark. This benchmark provides a baseline against which trends and variations in SSI risk rates can be assessed. Local surveillance using SPC charts enables the timely identification of emerging trends that may require further investigation and discussion between the IPC team and clinical colleagues. This data is reviewed alongside comparable information shared by peer organisations with a similar surgical profile to ROH, enabling broader benchmarking and contextual interpretation of our SSI rates. The use of SPC charts also supports evaluation of the impact of interventions, including the introduction or modification of clinical practices. Overall success will be indicated by a sustained reduction in SSI risk following the implementation and embedding of the SSI prevention bundle for knee replacement and spinal surgeries, alongside the prevention of any further increase in SSI risk for hip replacement surgeries.
Actions Completed	Progress with the timely completion of planned actions has experienced some delays. Contributing factors include: • Variable engagement with the SSI Prevention Group, which resulted in several meetings needing to be deferred. In addition, limited availability of relevant clinical expertise at some meetings delayed decision-making on key elements for inclusion or exclusion within the bundle. • Challenges in reaching consensus on key components of the bundle. A significant amount of work was undertaken to review the available evidence base; however, further discussion was required to balance this alongside clinical experience to agree a clear direction.
Ongoing Actions	Once the bundle SOP has been finalised and ratified through the appropriate committee, implementation will commence. This will require engagement with clinical teams across outpatient, inpatient, and theatre settings, as well as surgical colleagues. Following implementation, processes to monitor compliance with the bundle will be established. It is anticipated that compliance will be formally recorded via AMaT and reported to the SSI Prevention Group, with escalation through governance structures to the IPC Committee.

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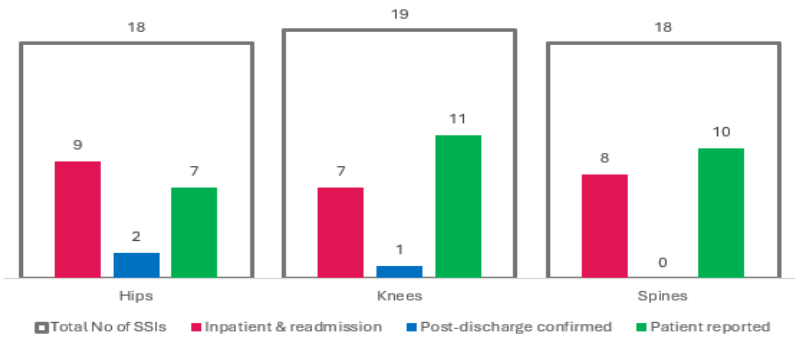
How has success been measured?

As a result of this work over the past two years, awareness of SSI and surveillance processes across the Trust has significantly improved.

Sustained success will depend on the effective implementation and embedding of the ROH SSI prevention bundle, alongside the consistent maintenance of high standards of practice that are actively supported and constructively challenged by clinical teams. This will be reflected in a reduction in SSI risk rates.

Interventions and their effectiveness will continue to be monitored through the quarterly SSI Prevention Group, with oversight provided by the IPC Committee and, where required, the Executive Quality and Safety Committee.

Chart 1: ROH 2025 SSI Data (January to December:



Total number of operations eligible for surveillance: Hips 1429, Knees 1687, Spines 813.

Chart 2: Total hip replacement surgery risk rate % (inpatient & readmissions, includes primary & revision surgeries):

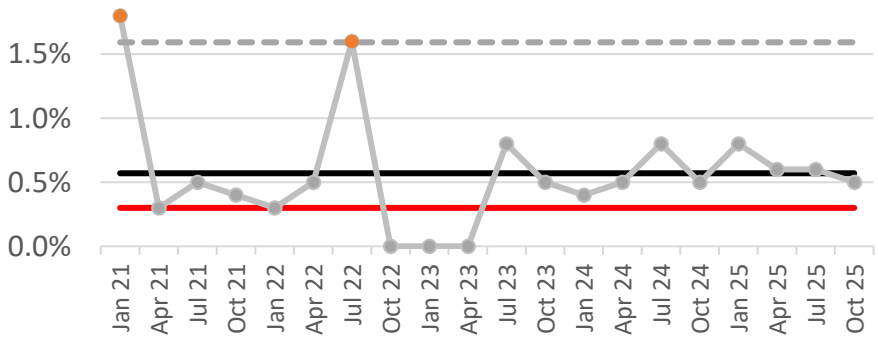


Chart 3: Total knee replacement surgery risk rate (inpatient & readmissions, includes primary & revision surgeries):

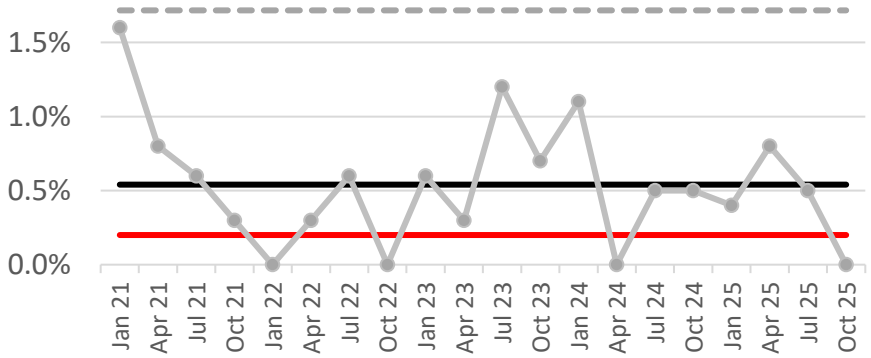
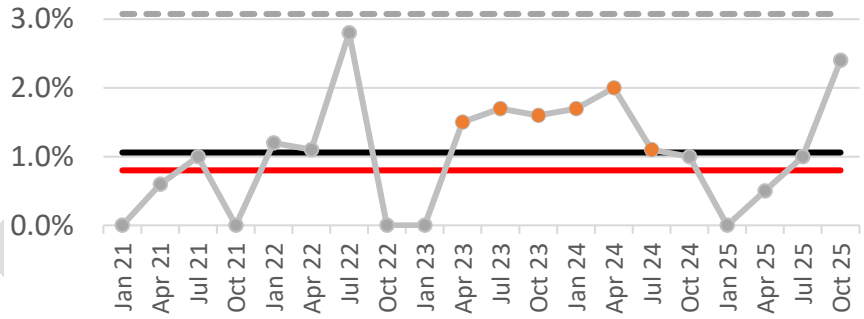


Chart 4: Spinal surgery risk rate per quarter (inpatient & readmissions, includes primary & revision surgeries):



Priority 2. Art for Health – A holistic approach to managing patient pain.

Caring	**Art For Health – A holistic approach to managing patients' pain**
Leads	Liza Tharakan & Chronic pain team
Executive Lead	Nicola Brockie, Chief Nursing Officer
Why we chose this QP?	Prioritising art for health can be a transformative approach to improving patient outcomes, particularly for chronic and long-term care patients. Art therapy fosters emotional expression, reducing stress and anxiety while enhancing overall well-being. Studies have shown that engaging with creative activities aids in pain management by shifting focus away from discomfort and promoting relaxation. For patients facing extended treatment journeys,

	integrating art into holistic care offers a non-invasive, therapeutic tool that complements traditional medical interventions. Whether through painting, music, or storytelling, art fosters a sense of control and connection, empowering individuals to actively participate in their healing process. By making art a quality priority in healthcare, we cultivate a more compassionate, person-centred system that acknowledges the profound impact of creativity on recovery and resilience.
What actions have been taken?	**An Arts for Health programme was delivered.** • **Participants:** 23 individuals (predominantly female; aged 40s–70s) • **Delivery:** 28 group sessions • **Total attendances:** 148 • **Art modalities:** Pottery, Painting, Music, and Arts & Crafts • **Format:** Facilitated small-group sessions led by professional artists Participants attended between **1–4 sessions per art modality**, with the majority completing full four-session programmes.

How has success been measured?
 	
(Examples such as plan, booklet, teaching aids letter template etc).
	An audit was completed pre and post the programme to determine effects.
	
	Pre- and post-programme measures showed **statistically significant improvements**:
	
	• **Mental wellbeing (SWEMWBS):**
	  ○ Mean improvement: **+3.27**
	  ○ 80% of participants improved
	  ○ *p = 0.015*
	• **Pain self-efficacy (PSEQ):**
	  ○ Mean improvement: **+5.92**
	  ○ 77% of participants improved
	  ○ *p = 0.008*
	• **Health-related quality of life (EQ-5D):**
	  ○ Mean improvement: **+17.19**
	  ○ *p = 0.002*
	• **Creativity:**
	  ○ 94% of participants reported increased creativity
	  ○ Highly significant improvement (*p < 0.001*)

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These results indicate that participation was associated with meaningful improvements in wellbeing, confidence in managing pain, quality of life, and creative self-belief.

Participant feedback was overwhelmingly positive. Ratings for:

- **Engagement with artistic activities**, and
- **Value of the workshops in managing pain**

were consistently high (typically 8–10/10).

Common qualitative themes included:

- Improved relaxation and mood
- Effective distraction from pain
- Reduced feeling of isolation through peer support and connection
- Increased confidence and self-expression
- High satisfaction with facilitators, described as supportive and non-judgemental.
- Appreciation of a welcoming, low-pressure environment

Participants frequently described the sessions as highly meaningful and beneficial, with several referring to the programme as a valuable complement to existing pain management strategies.

Several participants described the programme as:

“Transformative”,
“A great prescription”, and
“Priceless for knowing you’re not alone”.

Areas for Improvement

Suggestions were minor and practical:

- Additional sessions or longer programmes
- Reduced feeling of rushing to complete projects
- Optional take-home resources for continued self-help.
- Signposting to ongoing community art opportunities

No significant negative feedback or safety concerns were identified.

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Priority 3. Minimising the risks and potential impact of medical neglect among children and young people with limited engagement in health services due to existing health-related barriers.

Effectiveness	**Minimising the risks and potential impact of medical neglect among children and young people with limited engagement in health services due to existing health-related barriers.**
Leads	Rebecca Furnival – Head of safeguarding and vulnerabilities
Executive Lead	Nicola Brockie- Chief Nursing Officer
Why we chose this QP?	Effective care requires a robust safeguarding framework that prioritises the protection and empowerment of vulnerable individuals. In line with Care Quality Commission (CQC) expectations, safeguarding practices must be embedded at every level of care delivery, with a clear understanding of the diverse and often complex needs of at-risk populations. Addressing health inequalities is a fundamental part of this commitment. A proactive, person-centred approach is essential to identify and remove barriers that prevent equitable access to safe, high-quality care. This includes recognising and responding to social, cultural, and economic factors that impact people's ability to receive the care they need. Collaboration is central to achieving this vision. We will work together with individuals, families, communities, and other professionals to provide joined-up care that focuses on what matters most to the people we support. By building strong partnerships, making our practices part of everyday care, and working closely with others, we aim to provide care that is effective, meets standards, and is fair, personalised, and long-lasting—leading to better outcomes and experiences for everyone.
What actions have been taken?	• Promote a safe and effective culture: Cultivate a culture of vigilance, accountability, and shared responsibility, ensuring safeguarding is embedded throughout all levels of care delivery. • Develop individualised care plans: Ensure that all care plans are tailored to the needs, preferences, and circumstances of everyone, with active involvement from the person receiving care and their family.

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	• Empower patients through shared decision-making: Ensure individuals are involved in their care choices, leading to improved engagement and satisfaction. • Provide education and support: Offer training to staff and resources to patients, carers, and families to help them make informed decisions about care. • Tailor services to meet needs: Adapt services to be more accessible and responsive to the unique needs of disadvantaged or at-risk populations, using a multi-disciplinary approach. • Engage in public health campaigns: Partner with community organisations to raise awareness of health inequalities and engage individuals in preventive health measures. • Multi-Disciplinary Team (MDT) meetings: Facilitate collaboration among healthcare professionals, safeguarding and vulnerabilities teams, and community workers to ensure care plans are coordinated and responsive.
Action underway	• Promote a safe and effective culture: Cultivate a culture of vigilance, accountability, and shared responsibility, ensuring safeguarding is embedded throughout all levels of care delivery -ongoing. • Develop individualised care plans: Ensure that all care plans are tailored to the needs, preferences, and circumstances of everyone, with active involvement from the person receiving care and their family - Completed. • Empower C/YP through shared decision-making: Ensure C/YP and their families are involved in their care choices, leading to improved engagement and satisfaction - completed. • Provide education and support: Offer training to staff and resources to patients, carers and families to help them make informed decisions about care. ongoing • Tailor services to meet needs: Adapt services to be more accessible and responsive to the unique needs of disadvantaged or at-risk populations, using a multi-disciplinary approach. completed

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	• Multi-Disciplinary Team (MDT) meetings: Facilitate collaboration among healthcare professionals, safeguarding and vulnerabilities teams, and community workers to ensure care plans are coordinated. completed
How has success been measured? **(Examples such as plan, booklet, teaching aids letter template etc).**	Assessing waiting lists for vulnerable or "at-risk" patients within our services to ensure their health needs are given priority with spinal services and named Doctor. - ongoing Prioritise care planning for vulnerable groups, with a focus on children in care and care leavers, to ensure their specific needs are recognised, supported, and met as they transition to independence (Promoting the health and wellbeing of looked after children NICE, 2020). - Completed The Safeguarding and Vulnerabilities Team continues to advocate for and represent children, young people, and adults receiving orthopaedic care in various multi-agency meetings with social care. Their active participation ensures that the health perspective is consistently reflected and effectively integrated into care planning and decision-making. - Completed Statutory role Named Nurse for Children and Young Adults due to commence role in April 26 as per section 11 and SAAF framework - Completed. To help reduce the impact of deprivation on vulnerable families, the safeguarding team works in partnership with National Express West Midlands to provide free bus travel for families attending health appointments. Completed Was not Brought Guidance reviewed and updated to reflect safeguarding process Completed. Safeguarding Children, Young People and Families Policy updated by head of safeguarding- approved at Committee Nov 25 Completed NICE audit completed by head of safeguarding for Child maltreatment – all domains met via AMAT – Completed Jan 26 Annual social services referrals audit completed by head of safeguarding in January 26 which provided assurance to the safeguarding committee that those children at risk are appropriately being referred for support before harm occurs. Completed

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	Head of service completed review of service following safeguarding and vulnerabilities team structure and service review – approved by Exec board on March 26 Completed Development of a young person's forum – deferred until June 26 due to Transitions CNS secondment at ADCU and structure changes within team. Trust External website reviewed by head of safeguarding and amendments sent to comms to action which include further signposting to community services for patients and families to access for support – March 26 Completed Safeguarding strategy revised to reflect commitments to patients and their families to be presented at committee in March 26 by head of safeguarding. Completed Trust safeguarding and vulnerabilities annual report underway to be completed and presented at safeguarding committee and trust board in May 26 ongoing

Priority 4. Reduction in length of time for patients to wait for access to the Spinal Service

Responsive	Reduction in length of time for patients to wait for access to the Spinal Service
Leads	Michelle Hubbard – Deputy Chief Operating Officer Supported by Sue Kelsall Clinical Service Manager
Executive Lead	Marie Peplow – Chief Operating Officer
Why we chose this QP?	The Spinal service waits nationally are challenged and are longer than clinically desired. This national issue is represented locally at the ROH, as the speciality is an outlier in comparison to all other ROH services. Rising waits lead to an increase in PALS concerns and complaints and potential patient harm due to delays in care. There are opportunities to increase innovative ways of working to reduce the long waiters within the Spinal service.
How has success been measured?	Elimination of 65 weeks. A reduction in waiting times. Achievement of the National imperatives for waiting times for the Trust in line with the annual plan.

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	A reduction in PALS concerns and complaints regarding waiting times.
Actions planned	Demand and capacity review detailed significant consultant capacity gap. This has led to the increase in consultant capacity which will come into effect in Q1 of 25/26. Other initiatives to improve productivity also include implementation of the 'go further faster' GIRFT templates for outpatient clinics. The service is also developing a pilot of triage clinics for new patients and super discharge clinics. Monitored through a small task and finish group chaired by the Deputy COO and the daily PTL meetings. The intention is to have the 1st clinics in May 25 to support patients that will breach 65 weeks in June, July and August 2025. After the pilot, the frequency of these clinics will be determined and job planned.
Closure Report	On the 31st March 2025, the Spinal Service had 486 patients waiting over 52 weeks with an average monthly tip in cohort of circa 300 patients each month. The RTT position for the Trust was 54.66%. On the 31st March 2026 the total number of Spinal patients waiting over 52 weeks has reduced to 96 and the total RTT position for the Trust closed at 65.5%. This achievement is due to a renewed focus predominantly within the Spinal services using super virtual new and follow up clinics and greater use of Advanced Pain Practitioners. Following a successful trial using premium rate capacity aligned to the NHSE RTT sprint, clinic templates continue to be modified to increase job planned capacity by replacing standard clinics with super virtual new patient clinics (where clinically appropriate). For example, an all-day face to face new Spinal Degenerative clinic would traditionally house 16 patients and an all-day virtual clinic houses 22 patients creating an additional 6 slots per all day clinic. Further work is underway to amend job plans and templates to include regular super virtual new and follow up clinics to increase overall capacity within the service. Spinal workshops continue supported by the Chief Operating Officer and Deputy COO.

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Priority 5. Year 2 of roll out of Service accreditation.

Well led	**Year 2 of roll out of Service Accreditation**
Leads	Emma Steele, Deputy Chief Nurse
Executive Lead	Nicola Brockie, Chief Nursing Officer
Why we chose this QP?	The service accreditation system is a quality assurance programme that follows a structured approach using a uniform set of standards to measure the quality of care delivered across clinical service units or areas. It is a key driver to improving patient care and celebrating good practice. Accreditation brings together key measures of nursing and clinical care into one overarching framework to enable a comprehensive assessment of the quality of care at ward, unit, or team level (NHS England, 2019) We have designed a bespoke Service Accreditation programme at ROH for nursing and allied health services which drives continuous improvement across the Trust. The design and implementation of our Service Accreditation program aiming for Outstanding Care Every Time will enable the Trust to deliver outstanding, safe, and quality care to our patients and our communities. This aligns with the Trust's strategic ambitions and provides a local assurance system for the Trust.
What actions have been taken?	• Established a Service Accreditation steering group using QSIR methodology approach to the project • Developed and followed road map. • Developed a set of standards against which to measure quality of care that demonstrates improvement. • Worked with AMaT to upload the standards and use the platform as a way of undertaking the review and displaying the results. • Created a core group of Assessors and have met to review standards and plan the assessment to ensure standardisation. • Pilot of 2 services completed in September 2024 • Phase 1 and 2 completed, and Accreditation certificates awarded. • Phase 1 services reassessed in November 2025

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	• Deputy Chief Nurse and QI Nurse attended Nursing Live Conference to give a talk on Setting up the Service Accreditation Process at ROH • Engagement with Communications Team to develop a landing page on the intranet to provide information and updates on the programme. • Phase 1 reassessment results to be shared with teams and certificates awarded by Chief Nursing Officer and CEO on 22nd April 26. • Phase 3 standards developed and agreed, AMaT to be updated and dates set to commence accreditation reviews in Theatre, Recovery and Critical Care services (HDU and CCOT)
How has success been measured? **(Examples such as plan, booklet, teaching aids letter template etc).**	Taking on board feedback and altering standards accordingly Monitor harms and pt experience. Outcomes have included feedback regarding varied use of Safety Huddle Boards – SOP developed and awaiting final sign off, we can then share, educate, and audit use of the huddle boards. Service Accreditation at ROH will now be business as usual.

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3.0 Our Quality Priorities for 2026/27

The Trust values the views of our key stakeholders and as in previous years has sought their involvement and feedback to ensure our plans accurately reflect the needs of our patients and the communities we serve. We have done this by consulting with staff, key stakeholders, patients, and members of the pubic using various methods including complaints, PALS and NHS CQC in-patient feedback. The consultation process took place during April and May 2026. Five specific areas to focus our attention in 2026/27 were identified.

	Quality Priority	Operational Lead	Executive lead
Safe	Strengthening IPC assurance through consistent audit, visible leadership, and triangulated intelligence to deliver safe, high-quality care across the trust	Vicki Clewer IPC lead	Nikki Brockie, Chief Nursing Officer
Effectiveness	Strengthening Safe Surgery processes	Talitha Neville, Theatre Matron Mike Allen, Theatres CSL & Patient Safety Team	Nikki Brockie, Chief Nursing Officer
Caring	Improving patient experience pre-surgery	Ben Smith, Associate Medical Director, Marie Raftery, Associate Director of Operations & Jennifer Pearson, Head of Nursing, Division 2	Matt Revell, Medical Director
Responsive	British Association of Daycase Surgery (BADS) Programme	Nas Uddin, Interim Deputy Chief Operating Officer & Alicia Stanton, Head of Service Improvement, Strategy and Delivery	Michelle Hubbard, Interim Chief Operating Officer
Well-led	Civility and Respect Programme	Clare Mair, Head of OD and Inclusion & Michael Hirons, OD, and Inclusion Manager	Sharon Malhi, Chief People Officer

Table 2: Quality Priorities for 2026/27

Priority 1. Strengthening IPC assurance through consistent audit, visible leadership, and triangulated intelligence to deliver safe, high-quality care across the trust

Safe	**Strengthening IPC assurance through consistent audit, visible leadership, and triangulated intelligence to deliver safe, high-quality care across the trust.**
Leads	Victoria Clewer, Head of IPC, TV & Deputy DIPC
Executive Lead	Nicola Brockie, Executive Chief Nurse & DIPC
Why we chose this QP?	Infection Prevention and Control (IPC) is a core component of the Care Quality Commission (CQC) 'Safe' domain, which requires providers to demonstrate effective systems to prevent and control infection, protect patients from harm, and ensure consistent, high-quality care delivery. Internal review of the Trust's IPC Board Assurance Framework (BAF) has identified gaps in the consistency of assurance, specifically in relation to variability in audit completion and quality, limited divisional ownership of IPC oversight, and a lack of systematic triangulation of intelligence from audits, walk rounds, and incidents. This quality priority has therefore been selected to strengthen IPC governance and assurance by implementing a structured, organisation-wide programme that standardises audit processes, embeds visible clinical leadership through walk rounds, and ensures that data is triangulated and used to drive improvement. This will provide robust, demonstrable assurance to the Board that IPC risks are effectively identified, managed, and mitigated in line with the CQC 'Safe' domain expectations.

How will we evaluate success?	**Process Measures**
	• ≥95% completion of scheduled IPC audits.
	• ≥90% compliance with agreed audit methodology (quality of observations, not just completion).
	• 100% delivery of:
	  ○ Bi-monthly Divisional Matron-led walk rounds
	  ○ Weekly DIPC/Head of IPC walk rounds.
	
	Outcome Measures
	• Sustained low rates of key HCAIs (e.g. Gram-negative BSI, C. *difficile*).
	• Reduction in recurring IPC audit themes (e.g. hand hygiene and PPE non-compliance).
	• Increased % of actions closed within agreed timescales.
	• Improved staff feedback on IPC visibility and leadership (via pulse surveys).
	• Evidence of divisional ownership (e.g. actions led locally, not escalated to IPC).

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	Assurance Measures
	• Routine reporting to IPC Committee with:
	  ○ Trend analysis
	  ○ Triangulated data (audit + walk rounds + incidents)

Actions Planned	1. Formalise the IPC Assurance Framework
	• Develop a standardised IPC assurance model linking:
	  ○ Audit
	  ○ Walk rounds
	  ○ Surveillance
	  ○ Incidents
	  ○ Define minimum expectations per division
	  ○ Agree governance route via IPC Committee
	
	2. Embed Divisional Ownership (Matron-Led Walk Rounds)
	• Transition to Divisional Matron-led bi-monthly IPC walk rounds
	• Align expectations with the Matron's handbook
	• Define a standard walk round framework:
	• Require documented actions and follow-up
	
	3. Strengthen Executive IPC Oversight
	• Formalise weekly DIPC/Head of IPC walk rounds:
	  ○ Implement a standardised checklist/tool
	  ○ Focus on high-risk / rotating areas
	• Introduce RAG-rated feedback mechanism:
	  ○ Immediate verbal feedback
	  ○ Written report within defined timeframe
	  ○ Escalation process for high-risk findings
	
	4. Improve Triangulation and Reporting
	• Develop a single IPC assurance dashboard:
	  ○ Audit data
	  ○ Walk round findings
	  ○ Incident trends
	  ○ Dept. managers regular updates on IPC BAF assurance (mapped to the 'hygiene code' criterion)
	• Bi-monthly reporting to IPC Committee including:
	  ○ Key risks
	  ○ Themes and learning
	  ○ Evidence how intelligence drives improvement actions
	
	5. Close the Loop
	• Ensure all findings generate:
	  ○ Clear actions
	  ○ Named leads
	  ○ Deadlines

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	• Track action completion rates
	• Share learning Trust-wide:
	  ○ Safety briefings
	  ○ Matron forums
	  ○ Governance meetings

Priority 2. Strengthening Safe Surgery processes

Effective	**Strengthening Safe Surgery Processes**
Leads	Talitha Neville, Theatre Matron Mike Allen, Theatres CSL & Patient Safety Team
Executive Lead	Nicola Brockie, Chief Nurse
Why we chose this QP?	This work was chosen as a quality priority to strengthen the WHO surgical safety process, improving consistency, communication, and reducing the risk of Never Events.
How will we evaluate success?	Monthly audits of the safety huddle and WHO team brief are being undertaken to monitor compliance and effectiveness. The introduction of the standardised booklet has improved this process by consolidating all relevant documentation into a single format, replacing previous use of loose paper records. Work is currently underway in collaboration with AMaT to transition this audit process to a digital platform. This will enable improved data capture, analysis, and inclusion within upward reporting structures. Less reported incidents related to surgical safety processes
Actions Planned	A group of Standard Operating Procedures (SOPs) is currently being developed to support key stages of the surgical safety pathway. These include the WHO team brief and debrief, sign-in and time-out processes, implant verification, and reconciliation of items alongside sign-out procedures. Once drafted, these SOPs will be circulated for feedback prior to formal approval. Following approval, a “Back to Basics” campaign will be launched to reinforce these processes. This will include displaying key information on theatre screens within staff areas, as well as

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	providing printed materials throughout the department to support awareness and compliance.

Priority 3. Improving patient experience pre-surgery

Caring	**Improving patient experience pre-surgery**
Leads	Ben Smith, Associate Medical Director, Marie Raftery, Associate Director of Operations, Jennifer Pearson, Head of Nursing, Division 2,
Executive Lead	Matt Revell – Medical Director
Why we choose this QP?	Patient engagement feedback has consistently highlighted concerns regarding waiting times on the day of surgery, particularly within the Admissions and Day Case Unit (ADCU). Patients reported being asked to arrive early in the day, often resulting in prolonged waiting periods before surgery, with some describing waiting for most of the day. This was frequently experienced as stressful and did not reflect a positive patient experience at what is already an anxious time. In response, walkabouts and direct patient feedback have prompted the development of improved informatics to better understand and monitor the time from admission to surgery, and to identify opportunities to enhance patient flow and communication. The Trust has a long-standing “send-in-time” (SIP to send) approach designed to support operational efficiency and theatre utilisation. While there have been no formal complaints or significant concerns raised about this process, we recognise the importance of evaluating its impact from the patient perspective. As part of this quality priority, we will review the current approach to understand both the operational benefits and the patient experience, ensuring that processes are optimised to reduce unnecessary waiting, improve flow, and enhance overall patient satisfaction. This work reflects our commitment to placing patient experience at the centre of service improvement.

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How will we evaluate success?	Success will be evaluated through a balanced set of measures that consider patient experience, operational efficiency, safety and staff experience. Core metrics will include a reduction in time from admission to surgery and improved theatre utilisation rates, ensuring that capacity is optimised without creating unnecessary delays for patients. Patient experience will remain central, assessed through Friends and Family Test results, real-time feedback, and targeted surveys focusing on waiting times, communication, anxiety and overall experience on the day of surgery. Equally, we will ensure that any changes maintain and enhance patient safety. This will include monitoring for any increase in clinical risk indicators such as delays impacting clinical condition, on-the-day cancellations for clinical reasons, or incidents related to flow and handover. The balance between efficiency and clinical need will be carefully considered to ensure patients are brought in at the right time for safe, timely care. Staff experience will also be a key measure of success, recognising that sustainable improvement relies on effective workflows and manageable workloads. Staff feedback will be sought to understand the impact on coordination, pressure within ADCU and theatres, and confidence that pathways support safe and high-quality care. Additional supporting metrics will include: • Variation in admission-to-theatre times • Late starts, overruns and list delays • Complaints, PALS contacts and concerns related to waiting • DNA rates or short-notice cancellations Together, these indicators will ensure that improvements deliver a better, safer and more efficient experience for patients, while also supporting staff to deliver care effectively.
Actions planned	• Finalise and implement a revised Standard Operating Procedure (SOP) for admission-to-theatre pathways, ensuring clear alignment with clinical prioritisation, safety considerations and patient communication • Establish routine reporting and regular circulation of key performance and experience data to clinical teams and governance forums, supporting oversight, transparency and continuous improvement

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	• Undertake a structured audit of the current "send-in-time" (SIP to send) process to assess its impact on patient experience, safety, operational flow and staff workload, and use findings to inform any required changes

Priority 4. British Association of Daycase Surgery (BADS) Programme

Responsive	**British Association of Daycase Surgery (BADS) programme**
Leads	Nas Uddin, Associate Director of Operations, Division 1 & Alicia Stanton, Head of Service Improvement, Strategy and Delivery
Executive Lead	Michelle Hubbard, Interim Chief Operating Officer
Why we choose this QP?	• BADS rates are a proxy for pathway efficiency and quality and align with the wider NHS goals of reduced waits, better flow, and lower harm. • Drives standardised pathways, reducing unnecessary variation between clinicians and services. • Drives improved quality by reducing infection risk and other complications related to inpatient stays. • Improves patient experience by reducing hospital stay, allowing recovery at home. • Directly supports responsiveness as reduced length of stay provides the opportunity for more capacity and improved flow. • Drives productivity supporting sustainability. • Supports right care, right place by utilising a day surgery unit or cohorted ward areas
How will we evaluate success?	The Day Case Delivery Group has been created to review and evaluate current surgical patient pathways including day case, 23-hour stay, and inpatient stay. The group focuses on whether pathways are fit for purpose, operating efficiently, and supporting optimal patient outcomes and flow. The group aims to identify barriers to achieving target length of stay and develop recommendations for improvement through a continuous improvement approach.

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	A 'deep dive' audit into 180 primary hip/knee patients with LOS ranging from 0-3 days with a focus on pathway compliance, flow, and discharge delays. This led to changes to the digital booking and listing process, increased patient communication, and a change to admission location. ACL audit of 152 patients with a focus on data validation and list order. Stakeholder engagement with spinal team leading to identification of a clinical champion, SOP review, and list order review.
Actions planned	• Review of day case eligible procedures • Restart of spinal day case Pathway Optimisation • Review of use of ADCU and 23hr stay ward. • Review and engagement around pathway compliance. Operational Improvements • Theatre list configuration Monitoring & Reporting • Ongoing monitoring of performance dashboard including data validation. • Ongoing tracking of benefits and impact

Priority 5. Civility and Respect Programme

Well-Led	**Civility and Respect Programme**
Leads	Clare Mair, Head of OD and Inclusion & Michael Hirons, OD and Inclusion Manager
Executive Lead	Sharon Malhi, Chief People Officer
Why we chose this QP?	• Civility and Respect impacts on the culture of the work environment and therefore influences levels of staff engagement – which is now a National Oversight Framework metric. • The ROH has an ambition to achieve engagement score of 7.4 in the National Staff Survey. Currently we are at 7.0, down from 7.12 in 2024. • There is also a proven link between levels of staff engagement and patient outcomes, creating civil and respectful workplaces will have a tangible, positive impact on patient experience.

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	• Sickness management is a priority for the ROH, respectful, supportive, and open cultures positively impact sickness rates. In teams with healthy work cultures, staff are less likely to take time off work, more likely to come back to work. • Staff are also less likely to be under additional work pressure due to colleagues being off sick, or working in departments with high turnover, unfilled vacancies etc. • To create safe workplaces and increased productivity – civility and respect is fundamental to creating an inclusive culture which is the foundation of a psychologically safe workplace – this promotes team cultures where learning flourishes, people feel able to contribute and challenge, all of which are markers of high performing teams. • Civility and respect supports higher levels of motivation, involvement, and advocacy for the service the staff provide.
How will we evaluate success?	• Initial feedback – the receptiveness of the audience to the messaging • Benchmarking Questionnaires – assessing experiences of incivility and disrespect before and after and capturing experiential feedback on the team culture and levels of staff engagement. • KPIs – staff turnover and sickness rates and reasons for sickness will be tracked. • Staff engagement scores for team will be tracked annually as part of the NOF from the Staff Survey feedback. • Pulse survey – at a Trust level we can track engagement scores 3 times a year, using the pulse surveys, over time we should see civility and respect training contribute to engagement scores stabilising and rising. We are not able to use the Pulse Survey to track individual team engagement scores, however. • HR Case work numbers should be positively impacted and reduce in those areas where the training has taken place. • The Bullying and Harassment hotspot reporting, incorporating, incident reporting, FTSU, HR work and NSS data, should see improvements in the teams we have worked with, high levels of incivility often correlate with higher instances of B&H.

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	• Incident reporting on incivility will be tracked too; it now has this as a separate category and can be tracked by team. • We will track staff experiences through WRES and WDES reporting, which records instances of bullying, harassment and abuse, and physical violence. • Unaddressed levels of incivility will often result in worsening behaviours that will show up as bullying etc.
Actions planned	• Theatres have had an initial roll out of the training, follow up with theatre managers is required. • Plans for sessions with Medics and ADCU are commencing, along with a request for Outpatients and CYP in Q2, at their request. • We are reviewing the Manager Training content to incorporate such things as: Civility & Respect awareness, active bystander skills, role modelling, conflict management, difficult conversations, professional boundaries, team charters, relevant HR processes, exploring real life scenarios and coaching conversations around behaviours to address problems before they escalate.

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4.0 Statements of Assurance

4.1. Priorities for improvement and statements of assurance

During 2024/2025 the trust had 14 relevant health services. The trust has reviewed and provided all the data available to them on the quality of care in these health services.

The 14 services provided by the Trust are:



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4.2 **Percentage of income generated by ROH services.**

During 2025/26 the trust provided and or subcontracted £142,938,092 of relevant health services.

The income generated by these health services reviewed in 2025/26 represents 95.69% of the total income generated from the provision of health services by The ROH during the year. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1st April 2023. Aligned payment and incentive contracts form the main payment mechanism under the NHSPS.

In 2025/26 API contracts contain both a fixed and variable element. The fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. These payments were accompanied by a variable-element to adjust income for actual activity delivered on elective services and advice and guidance services. Where actual elective activity delivered differed from the agreed level set in the fixed payments, the variable element either increased or reduced the income earned by the Trust at tariff price.

4.3 **Participation in national clinical and local clinical audits.**

During 2025/26, the trust participated in 4 national clinical audits that covered health services that the Trust provides. This was 100 percent of the national audits the Trust was eligible to participate in.

The national clinical audits that data collection was completed for during 2025/26 are listed below.

4.3.1. **National audits**

Governing Body	Project Title	Team	Lead	Progress
NHS DIGITAL	Elective Surgery National PROM'S Programme	Arthroplasty	Mr Y Agrawal	Hip Q1 compliance 100% Knee Q1 Compliance 100% Hip Q2 Compliance 98% Knee Q2 Compliance 99%
HQIP/QA	National Joint Registry (NJR)	Arthroplasty	Mr E Davis	100% latest audit compliance 97% Consent rate
BTA	Bedside transfusion audit	Trust wide	Mrs K Hughes	Submission of minimum data set completed
NAP 7	NAP 7 - Perioperative Cardiac Arrest	Anaesthetics	Dr B Smith	Completed. Trust compliance 98%

4.3.2. **National audits Cont.…**

Speciality	Brief description of audit/Improvements
Arthroplasty **PROMS**	There is a hold due to the changes with NHS digital we are not getting reports at this time however the team keep a monthly rolling ROH in house figure of the compliance on data collections. • 96% of hip replacements reported improvements, from Oxford Hip score. • 97% knee replacements reported improvements in health from Oxford Hip score. • 98% of hip participation rate post-operative questionnaire. • 98% of knee participation rate post-operative questionnaire. Telephonists now collect data by contacting the patient and completing the questionnaire with them. This has proved to be successful, and we now have an average of 98%. **Current participation rate at ROH** • 98% participation rate - 1247 primary hip procedures and 122 revisions have been completed 2025/26. • 97% participation rate – 1239 knee procedures and 101 revisions have been completed 2025/26. • PROMS data is reviewed at both AQILA and Quality and Safety Committee.
National Joint Registry (NJR)	All primary and revised arthroplasty is registered on the NJR system. In 2024/25 the audit compliance was 100% giving the Trust Gold provider status Therefore, we exceeded the national target in the last Three preceding years. The Trust is currently looking at the revisions and identifying areas for improvement.

NAP 7 Perioperative cardiac arrest	The Royal College of Anaesthetics will examine perioperative cardiac. We cannot look at recommendations for NAP 6 because this was Perioperative anaphylaxis. Report for NAP7 shows the Trust as compliant. Nap 8 is now underway.

Table 4: National Audits

4.4. **Local Audits**

A sample of completed audits for the last three months. All audits are scheduled to present at either AQILA / Clinical Audit meeting or both.

Speciality	Title	Summary/Actions
Small Joints	Audit of non-medical prescriber activity in the foot and ankle department.	This audit has demonstrated competency of all non-medical prescribers within the foot and ankle service and that they meet the standards of proficiency set out by the Royal College of Podiatry. Non-medical prescribers within the foot and ankle team provide a safe and efficient service to patients, benefitting the foot and ankle team by providing an autonomous prescribing service within the team, therefore streamlining patients' care pathways. This audit showed that 100% of prescriptions were appropriate and indicated to treat the presenting complaint. All drugs prescribed were within scope of practice for an advanced podiatrist. 100% of prescriptions were well written with all necessary demographic and drug information included. They were all signed and dated appropriately, and no prescriptions were returned or queried. 100% pf patients received a consultation with the prescribing practitioner prior to receiving the prescription to ensure there were no contraindications and to discuss potential side effects as well as the dosing regime, in accordance with Royal Pharmaceutical Society guidelines for non-medical prescribers. Where required, advice was sought from the multidisciplinary team (i.e. Microbiology / Bone Infection Service / Consultant in charge of care) to ensure the drug prescribed was appropriate and any necessary adjunct drug monitoring occurred during treatment. This ensured patient safety, appropriate use of antibiotics and made certain that clinicians adhered to local and national guidelines on antimicrobial stewardship.

Arthroplasty	Adequacy of consent for TKR	An apparent variability in the consenting process at the ROH has been noted, with much variability in terms of the risks being quoted to patient. we would therefore like to review the current standards regarding the consenting process for total knee replacements against National Standards/Guidelines. 1. Identify prevalence of 2-stage consent process. 2. Identify areas of variability. 3. Identify areas for improvements. We looked at 98 patients and the 95% compliance with the two-stage consent process is commendable and indicates that most patients are receiving a thorough explanation of the procedure and its risks. This is critical for ensuring that patients are making informed decisions about their healthcare. However, the gaps identified in the communication of risks suggest that there is room for improvement in ensuring that all relevant risks are consistently covered during the consent process. The findings of this audit highlight the need for a more structured approach to the consent process, with a checklist or standardised template that ensures all necessary risks, both general and specific, are discussed. This would help prevent any critical information from being inadvertently overlooked and ensure that the consent process meets the highest standards of care. The following actions have now been implemented. • Pre-printed consent forms. • Education standardised practice to consultants.

		We aim to carry out this audit again to see if the implementation of the above actions ensures that we have 100% compliance. If the preprinted consent form is effective, we need to look at other procedures and if we can implement this practice Trust wide.
Trust Wide	Wrist band	Completion of wrist band audit across all wards in line with NHS England guidance. All wards were 100% compliant. Small adjustments were made ensuring the band was not too tight however every patient had an accurate wristband in situ.
Imaging	Review of MRI imaging in young adult hip patients	• The outsourced MR scans failed to comply with set standards in this audit. Although the reports attempted to address clinical questions in majority of cases, high rates of missing data; example particularly missing assessments of version (53%), Cam/Pincers (80%), and Lateral structures (33%). • 30% of reports contained contrast statements stating that value of MR scan limited without contrast. • High rates of discrepancy vs in-house reporting with 26.7% classed as Major discrepancy (8 missed labral tears). • We advocate for in-house MSK reporting for complex MR scans.
Pharmacy	Divisional medicine management secure handling of medicine.	These audits provide assurance to the CQC that the organisation is managing and handling controlled drugs and other medications in line with regulations. Actions derived from the audits are shared with department managers and collaborative work is completed between pharmacy and departments to achieve better compliance across all areas. The results and actions are discussed in relevant meetings such as CDAO group and Medicines Safety Group.

4.5. Audit Overview

Below is the annual breakdown of the clinical audits registered for 2024/25 and the audits that are outstanding or require re-auditing. The Trust currently participates in five national audits; these audits are compulsory audits that are published each year as part of the quality accounts.

The local audits are registered within the Trust by clinicians to improve patient care and outcomes through systematic review of care against explicit criteria.

Any audits that do not meet the essential criteria initially set out at registration would require a re-audit following embedding of actions to check if the service has improved.

Division	Registered 2025/26	Audits outstanding	Audits requiring re-audit
1	51	32	8
2	60	36	4
Trust wide	14	8	3
TOTAL	125	76	15

4.6. Priorities for audits 2026/27

The Audit team are continuing to embed the new audit platform AMaT. All audits including clinical and ward audits are now live on the system and training has been given to all areas. A monthly report is distributed for clinical audit at Governance meetings and AQILA and a ward audit report sent to the Heads of Nursing for both divisions. This enables departments to share best practice, to measure and monitor improvements between departments to improve the overall care at the ROH. The ward and area audits are currently showing a compliance of 98% and a total of 411 actions have been completed which has improved the compliance.

The proposed 2026/27 audits are shown below:

- Elective Surgery National PROMS's Programme
- National Joint Registry
- Bedside Transfusion Audit
- Service Accreditation
- Divisional medicine Management CDAO Audits -Safe and Secure Handling of Medicines
- NAP 7- Perioperative Cardiac Arrest

The NICE guidance module has now been successfully rolled out on AMaT and all guidance back to 2021 has been disseminated to clinicians. We are working together with our

colleagues to complete baseline assessments, actions and audits on these guidelines when required and we currently have nine pieces of guidance that require baselines.

Given the restricted time limitations for some clinicians the audit team will continue to offer pro-former building, analysis and support with action planning as well as offering data input from our audit nurse we hope that this will encourage the completion of audits and positive outcomes moving forward.

4.7. **National Confidential Enquiries**

The Trust did not take part in any National Confidential Enquiries during 2025/26 as they did not cover the services that ROH provide.

4.8. **Clinical research**

The Trust continues to actively participate in all forms of orthopaedic and musculoskeletal (MSK) research, from basic science to clinical studies, demonstrating fully our 'bench to bedside' philosophy.

The priorities for 2025/26 have been to improve our key performance metrics as outlined by NHS England that will form the basis of future funding of the R&D department of ROH via the West Midlands Research Delivery Network (RDN). The targets are comprehensive, but can be broadly summarised into three key metrics:

- Number of participants recruited (weighting applied to more complex studies).
- Number of studies set up in 60-days or less.
- Number of studies who recruit their first participant within 30-days of opening.

4.8.1. **Information on participation in clinical research**

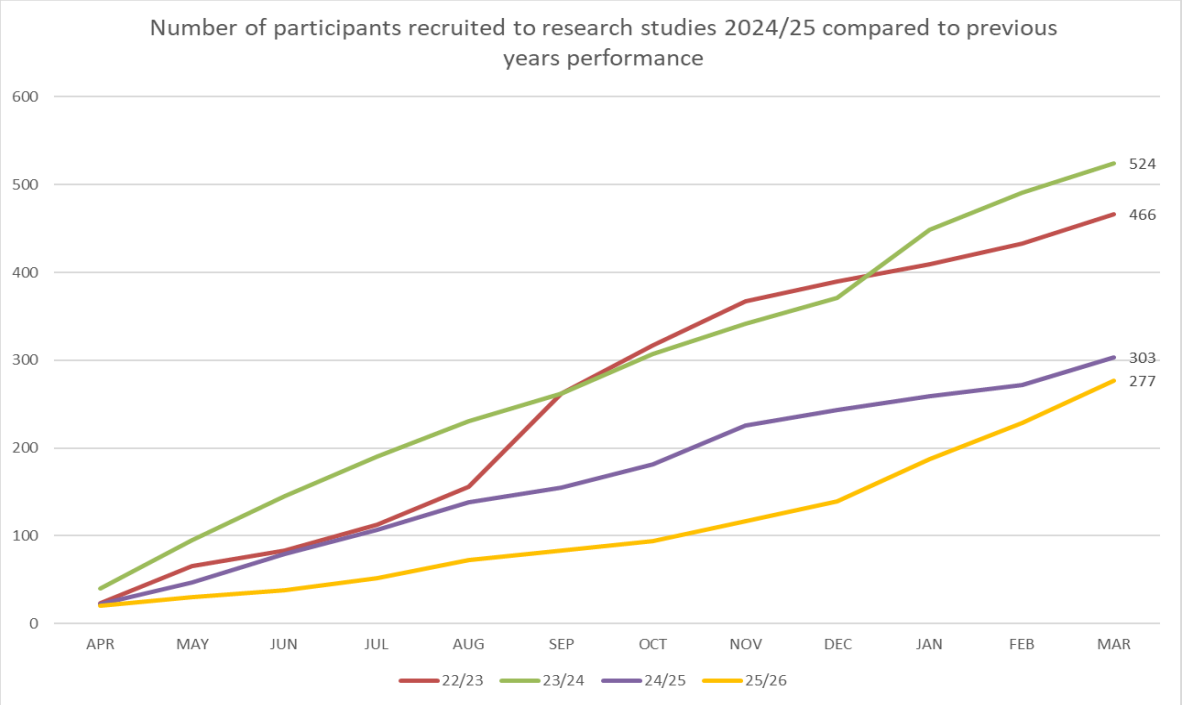
1. Number of participants recruited.

In 2025/26, the Trust saw an 8% reduction in recruitment of research participants at the Trust in comparison to 2024/25. The reduced numbers of research participants have been in line with the national picture for orthopaedic and musculoskeletal trials over the last 2-year period. In short, large multi-centre orthopaedic trials have not been funded as in previous years.

There is a strong signal that performance is improving, as 50% of research participants were recruited in the last quarter. This is due to the successful opening of studies such as Entelo Bio, the Birmingham Implant Retrieval Centre and Synergy.

Over the year, the trust has also seen the department deliver a record number of recruits to commercial research trials (n=76). This represents a 195% uplift on the recruited numbers last year (n=1) and a 133% uplift on our best year over the last 5-years (n=15).

There were no recruits to the Trusts Research Tissue Bank, over 2025/26 as recruitment was temporarily paused. Recruitment has re-started ready for 2026/27.



Total recruitment- All ROH research studies 2025/26, compared to previous years.

2. Number of studies set up in 60-days or less

The department has delivered a quality improvement project, led by the QSIR methodology, to reduce its study set up times. As a result, the department has reduced its average study set up times to 57 days in 2025/26, down from 124 days in 2024/25. This represents a huge improvement and means that 62% of studies at the Trust have met the RDN target of opening within 30 days. The department have also worked hard to capture the data and produce a live dashboard that enables us to monitor our metrics.

3. Number of studies who recruit their first participant within 30-days of opening

The department has managed to recruit the first participant within 30 days of opening in 22% of the studies it opened over 2025/26. The upcoming year will see a renewed focus on this target to ensure a similar improvement is achieved.

Other notable successes

- 2025/26 has seen the open its first multi-site trial as sponsor, a huge achievement for the Trust.
- Lucas Souza (Laboratory Manager) has been awarded an ORUK research fellowship and a place on the SPARKS programme (Aston University), Paul Malone (Consultant Hand Surgeon) has been awarded a BHP research fellowship and Sian Last (physiotherapist) has been awarded a BHP research internship.
- The Trust has successfully supported 7 junior research fellows.
- The quality of research publications continues to grow. The relative citation ratio (ratio measuring how frequently papers have been cited) of ROH publications grew from 212.68 in 2023 to 343.25 in 2024 (always reported a year in arrears).

4.9. **Information relating to registration with the Care Quality Commission (CQC) and special reviews / investigations.**

- The Trust is required to register with the Care Quality Commission, and its current registration status is 'without conditions.'
- The Care Quality Commission has not taken enforcement action against the ROH during 2025/26.
- The ROH received a CQC assessment of the Services for Children and Young People in May 2025. The outcome of this assessment was a rating of 'Good' for safe, effective, caring, responsive and well-led.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for children and young people	Good May 2025	Good May 2025	Good May 2025	Good May 2025	Good May 2025	Good May 2025

It was noted that the service for Children and Young People had a positive learning culture and people could raise concerns. Managers investigated incidents thoroughly. People were protected and kept safe. People were involved in assessments of their needs, which followed evidence-based care. Staff were kind, caring and compassionate. People could access the service to receive care and treatment. Leaders were visible, knowledgeable, and supportive, helping staff develop in their roles.

- The Trust received a formal CQC assessment against the CQC assessment framework in October / November 2019. The report from this visit was published in December 2019 and saw the ROH retain an overall rating of 'Good'.

4.10. **Information on the quality of data**

The Trust submitted records during 2025/26 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.8% for admitted patient care.
- 99.9% for outpatient care.

The percentage of records in the published data which included patient valid General Medical Practice Codes were:

- 100% for admitted patient care.
- 100% for outpatient care.

4.11. **Information Governance assessment report**

Information Governance (IG) ensures that the Trust manages information securely, lawfully, and appropriately. This includes all personal data (for example, patient and staff records) as well as wider organisational corporate information.

The Trust is required to demonstrate compliance annually with the Data Security and Protection Toolkit (DSPT), which is a self-assessment that assesses performance across key outcomes developed by NHSE relating to data security and information governance.

Following the baseline interim submission in December 2025, the Trust's DSPT position has been independently audited, with a level of Significant Assurance achieved, subject to minor improvements. These are being managed and monitored through Audit Committee. Areas identified for further development relate primarily to information asset management and the mapping of data flows. Work is in progress to address these areas, with targeted improvements to strengthen organisational control and resilience ahead of the June 2026 submission.

The Trust continues to strengthen its cyber security posture in response to increasing national threats, with ongoing audit, monitoring and staff training and awareness.

Information governance is supported by established governance arrangements, with regular reporting to senior leadership and Board committees to provide assurance and oversight. Overall, the Trust continues to maintain appropriate controls to ensure that information is handled safely and in line with legal and regulatory requirements.

4.12. **Payment by results Clinical Coding audit.**

The clinical coding team is highly experienced, with all coders having several years in post, ensuring consistent expertise and high-quality coding in line with national standards, including ICD-10 and OPCS-4. Coding supports accurate financial reporting, with independent quality assurance provided by IQVIA to validate data quality and optimise income opportunities. Ongoing collaboration with clinicians and pre-operative teams, alongside internal peer review processes, supports continuous improvement in coding accuracy, quality, and compliance.

4.13. **Improvements in data quality**

The Trust has several operational and clinical systems that collect and store data about patients. This data is critical to the running of the ROH to ensure effective and timely care to patients and enables the Trust to plan and make future business decisions. High quality data is essential to aid business intelligence reporting and ensure operational efficiency. The Trust has the following actions in place to ensure good data quality:

- There is a Data Quality Group chaired by the Chief Operating Officer and includes key stakeholder members from the Business Intelligence, Operations, Education, and Training teams. This group monitors data quality KPIs, audits and addresses any risks and issues that arise.
- The Business Intelligence team carries out over 75 automated data quality checks on the Trust data, creating reports which highlight data quality issues. These are shared on the Health Informatics dashboard accessible by operational staff to action and resolve.
- The Trust has a Data Validation team focusing on waiting list management which identifies and resolves errors caused by data quality.
- The Trust has a Systems Training Advisor whose role is to support staff carrying out system training on key patient systems with an emphasis on accurate and timely record keeping.
- Clinical coders regularly advise consultants to ensure accuracy and depth of coding.
- The Integrated Performance Dashboard has improved the accessibility and depth of reporting available to relevant parties; this allows data to be viewed in a timely manner.

4.14. **Medical Rota Gaps**

Our postgraduate workforce continues to be resilient. The Trust management have continued to support the doctors and the trust is still considered one of the most supportive employers in the region.

There is a Guardian of Safe Working (GSW) in post, to ensure that our doctors have the support they require to raise issues relating to safe working. This is supported electronically

by our Exception Reporting Process; Allocate. Exception Reporting is managed by our Guardian and supported by the Medical Workforce Department.
The Guardian also completes a quarterly Guardian of Safe Working Report, including data of our Exception Reports and Mitigating Actions. A final extended Annual Report is presented at the end of each academic year to the Trust Board of Directors.

The post graduate tutor supports and oversees the postgraduate doctors' training and administrative needs.

Information is provided to postgraduate doctors on induction and guidance is available to all staff via the hospital internet pages. A comprehensive Post Graduate Doctor Handbook is provided and regularly updated.

There are monthly Postgraduate Doctors' Forum meetings to listen to and improve our doctors' experience of working at the ROH. Senior management support ensures minimal rota gaps and regular review of processes to maintain safe working practices. There are fewer GP trainees in the region and in the hospital with gaps being filled by a combination of mid-level doctors and locums when necessary.

Doctors have access to a mess area/business lounge and steps have been taken to appoint a postgraduate doctors wellbeing champion. The minutes of the postgraduate doctors' forum evidence the cycle of requests and improvements that are being made throughout the year in response to feedback from the doctors.

4.15. **Patient Safety Incidents**

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Year	Number of Patient Safety Incidents reported	Number of Patient Safety Incidents with severe harm	% of Patient Safety Incidents that resulted in severe harm
2025/26	3515	6	0.17%

Table 8: Patient Safety Incidents 2025/26

The Trust considers that this data is as described for the following reasons:

- The Trust submits Patient Safety Incidents to the Learning from Patient Safety Events (LFPSE) service, the primary purpose of this service is to improve healthcare safety by recording and analysing patient safety incidents, risks, and good practices, replacing the NRLS (The National Reporting and Learning System).
- The Trust grades incidents from no harm to severe harm and uses the definitions provided by the LFPSE and the Duty of Candour Regulation 20 to categorise the level of harm.
- All reported incidents are subject to review by a member of the Governance team at The Trust who will seek clarity on the level of harm at the bi-weekly Divisional

Governance meetings from clinical staff where necessary and amend the initial categorisation if required.

- The Trust actively promotes a culture of incident reporting so that issues can be identified, actions initiated, and lessons learned.
- The Trust wide information relating to patient safety and patient experience activity is contained within the Trust's Quality Report that is presented bi-monthly at the Clinical Quality Group and Quality and Safety Committee and monthly at Trust Board. Monthly reports are also shared with BSol ICB via contracting meetings.
- The Trust bi-weekly Divisional Governance meetings include review of any incidents that are graded by the reporter as moderate harm or above, any complaints and local and divisional risks.
- Actively encourage the reporting of incidents by reviewing our feedback mechanism through our incident reporting system, Ulysses.
- Final versions of patient safety investigation reports are anonymised and sent to all clinicians, these are discussed at local level and at Trust wide forums.
- Both internal and external review and audit of the implementation of PSIRF shows good implementation of the policy.

4.16. **Learning from Deaths**

At the Trust, all deaths within 30 days of surgery are included in the Learning from Deaths process, regardless of whether the death is in hospital or outside the hospital. This is due to low number of inpatient deaths and therefore the additional cases add value.
Following the completion of an initial screening tool the Associate Medical Director examines the written record breaking an analysis down by phases of care, taking into account the External Medical Reviewer assessment. In this Structured Judgement Review, each phase of care is examined, and judgement statements generated about any notable features of care, both good and bad. The assessor reaches a verdict about the quality of care for each phase and the care overall. They identify whether there was any aspect of avoidability in the death.

Where there are opportunities to review and improve care, a separate review can be undertaken in accordance with the Patient Safety Incident Response Framework (PSIRF).

During 2025/26 there were:

- 6 x inpatient deaths
- 19 x deaths within 30 days post discharge

Whilst the Learning from Death process has raised no concerns regarding the trusts care or avoidability, actions have been undertaken as part of ongoing improvement work. These include;

- The policy lead for Venous Thromboembolism is reviewing the policy in relation to clarity on standards of documentation.
- Introduction of enhanced monitoring for all patients who are assessed as a cancer diagnosis being "possible", to support timely investigation and diagnosis. This was already in place for those whose symptoms indicated a "likely" diagnosis and has been extended.

4.17. **Readmission**

Readmissions to hospital usually represent a significant complication of treatment or the concern of a significant problem after treatment such that a patient is brought back into hospital for investigation or treatment.

Years	2017/ 18	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26
Readmission Rate	1.0%	1.4%	1.4%	1.3%	0.8%	1.0%	0.9%	0.7%	0.7%

Figure 10: Readmission from 2017/18 to 2025/26

Readmission rates at the trust have remained consistently low over the reporting period, demonstrating sustained quality of care and effective post-operative management. Since 2017/18, rates have ranged between 0.7% and 1.4%, with a long-term average of approximately 1.0%.

Following a slight increase during the COVID-19 period in 2019/20 and 2020/21, readmission rates have shown a sustained downward trend, improving to 0.7% in both 2024/25 and 2025/26; the lowest rates recorded across the nine-year period.

Overall, the data presents a positive and reassuring picture, indicating continued service stability, strong clinical outcomes, and ongoing improvements in patient care quality across the organisation.

The accompanying SPC chart (below) demonstrates that variation in readmission rates has remained within expected control limits throughout the reporting period, with no evidence of sustained special cause variation. The recent reduction to 0.7% represents continued improvement and reinforces the overall stability and reliability of the service.

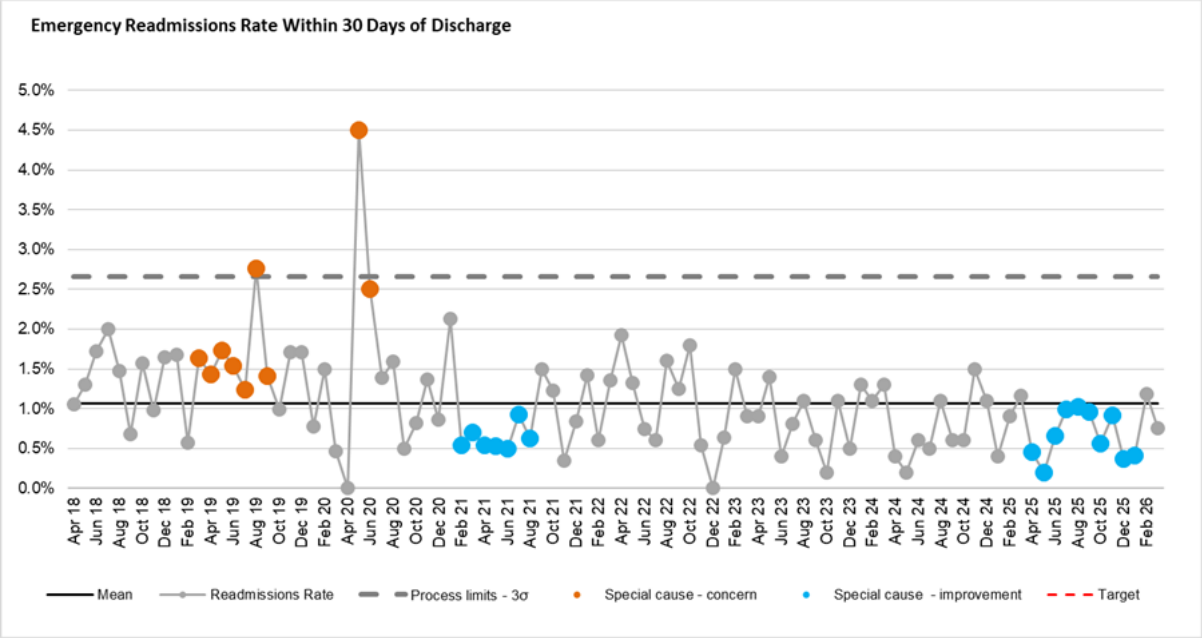


Figure 11: SPC Chart – Emergency admission rate within 30 days April 2016 to February 2026

4.18. Response to personal needs

The responsiveness to personal needs information is from five questions contained within the National Inpatient Survey. These questions are:

- Were you as involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about the medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the hospital?

The last in-patient survey was published in 2025 by patients receiving care in November 2024. The results have been reviewed and an action plan developed.

The Trust was rated as "much better than expected" overall in the 2024 survey compared with other NHS trusts nationally. This represents a significant achievement and reflects consistently high levels of patient-reported experience across multiple domains of care.

4.19. Venous Thromboembolism (VTE)

The Trust continues to closely monitor VTE risk assessment completion. National standard requirement is a minimum 95% VTE risk assessment of all inpatients on admission.

Month	VTE 25/26
April	98.81%
May	99.31%
June	99.21%
July	99.58%
August	96.99%
September	99.11%
October	99.51%
November	98.76%
December	99.22%
January	98.39%
February	96.43%
March	96.53%

Qtr	No assessed	No admitted	%
Qtr. 1	3372	3402	99.12
Qtr. 2	3531	3581	98.60
Qtr. 3	3587	3617	99.17
Qtr. 4	3323	3422	97.10

Figure 11. VTE on admission risk assessment completion; 25/26

- All patients +16 years who are coded as in-patients and admitted on PICS (Patient Information and Prescribing System) have a mandated VTE risk assessment on admission. No prescribing can occur until the initial risk assessment is complete. For Injection procedure completed in the Out-Patients this is a paper-based process.
- Validation process in place for any identified as missed from data.
- 95% risk assessment requirement exceeded without exception 1st April 2025 to 31st March 2026.
- All reported suspected or proven Hospital Acquired VTEs are reviewed in accordance with Governance process. These have been aligned to PSIRF methodology.
- VTE Exemplar re-validation is due May 2026.

4.20. *Clostridioides difficile* Infection (CDI)

Clostridioides difficile infections are monitored and reported monthly, with an IPC review conducted on every toxin-positive Community-onset, Healthcare Associated (COHA) or Hospital-onset, Healthcare Associated (HOHA) case.

The control of infection is of paramount importance for our patients; during 2025/26, the Trust was set a threshold of zero toxin-positive CDI cases. A total of two cases were reported during this period. While this represents an increase of one toxin-positive case compared to the previous year, the overall number of *Clostridioides difficile* cases (including non-toxin-positive cases) has decreased from six in 2024/25 to five in 2025/26.

Both cases underwent post-infection review, confirming timely symptom recognition, appropriate testing, and adherence to isolation precautions, with no concerns identified in

clinical management, environmental decontamination, or infection prevention and control (IPC) practices. Both patients had a history of antimicrobial use, a recognised risk factor for CDI, and the cases were not considered to be associated with transmission within the Trust.

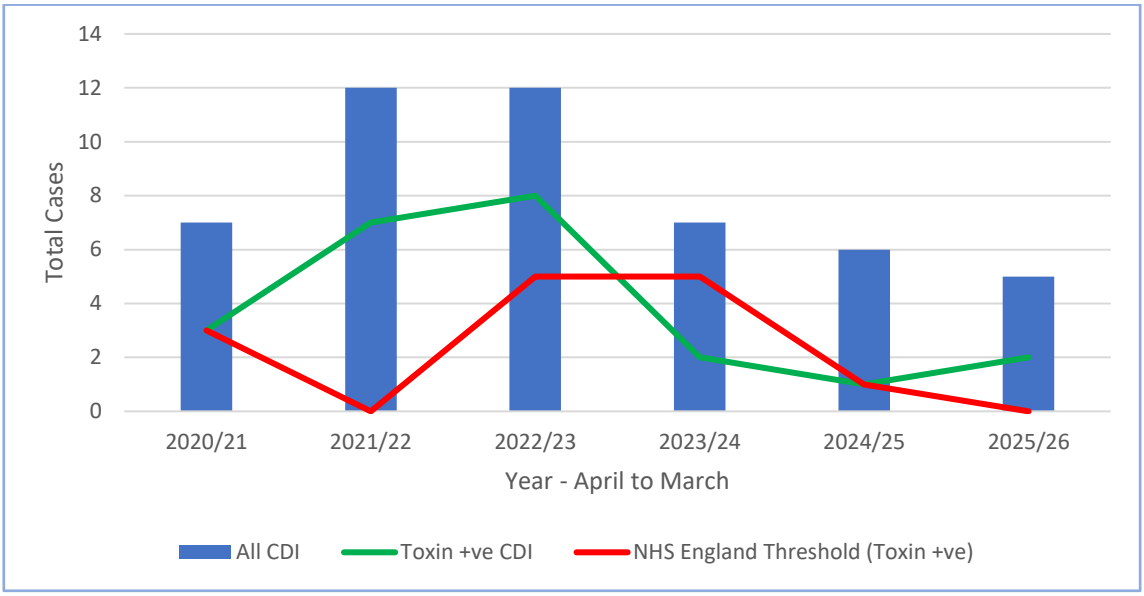


Figure 13: *Clostridioides difficile* cases reported by ROH between 2020/21 to 2025/26

The trust is taking the following actions to maintain this indicator, and so improve the quality of its services:

- Maintain robust surveillance systems to enable the continuation of real-time monitoring of all suspected and confirmed CDI cases, with routine reporting through IPC governance structures.
- Strengthen antimicrobial stewardship ensuring collaborative working with pharmacy and clinical teams to:
    - Promote appropriate antibiotic prescribing
    - Reduce unnecessary antimicrobial exposure
    - Encourage adherence to prescribing guidelines
- Reinforce IPC practices to continue promotion of:
    - Adherence to hand hygiene protocols (particularly soap and water for CDI)
    - Use of appropriate personal protective equipment (PPE)
- Ensure high standards of environmental cleanliness by maintaining effective cleaning and decontamination processes, including the use of sporicidal agents where indicated.
- Facilitation system-wide collaboration, working with system partners to improve information sharing regarding patients with prior CDI risk factors, including recent healthcare exposure and antimicrobial use.

4.21. Compliance with national targets and regulatory requirements

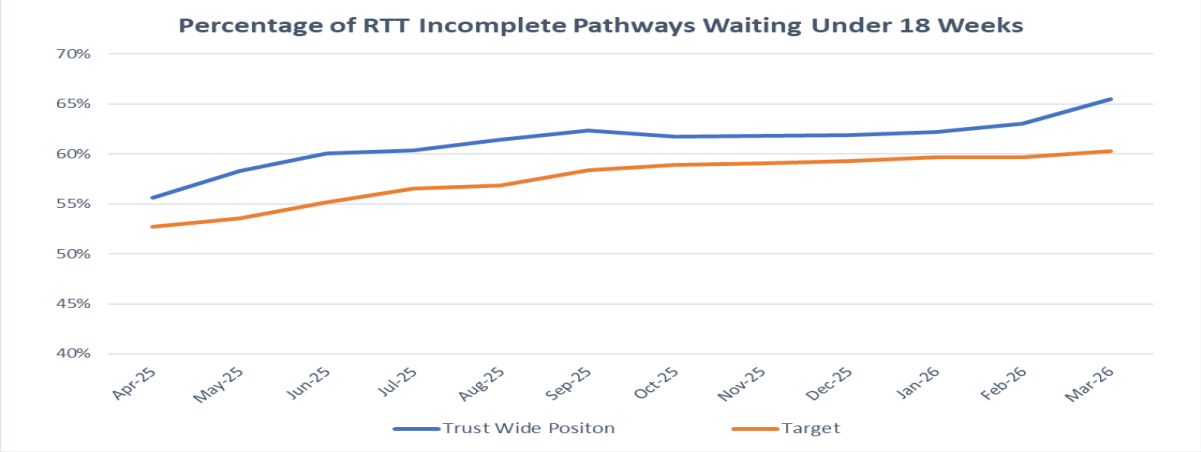
4.21.1 Referral to Treatment (RTT)

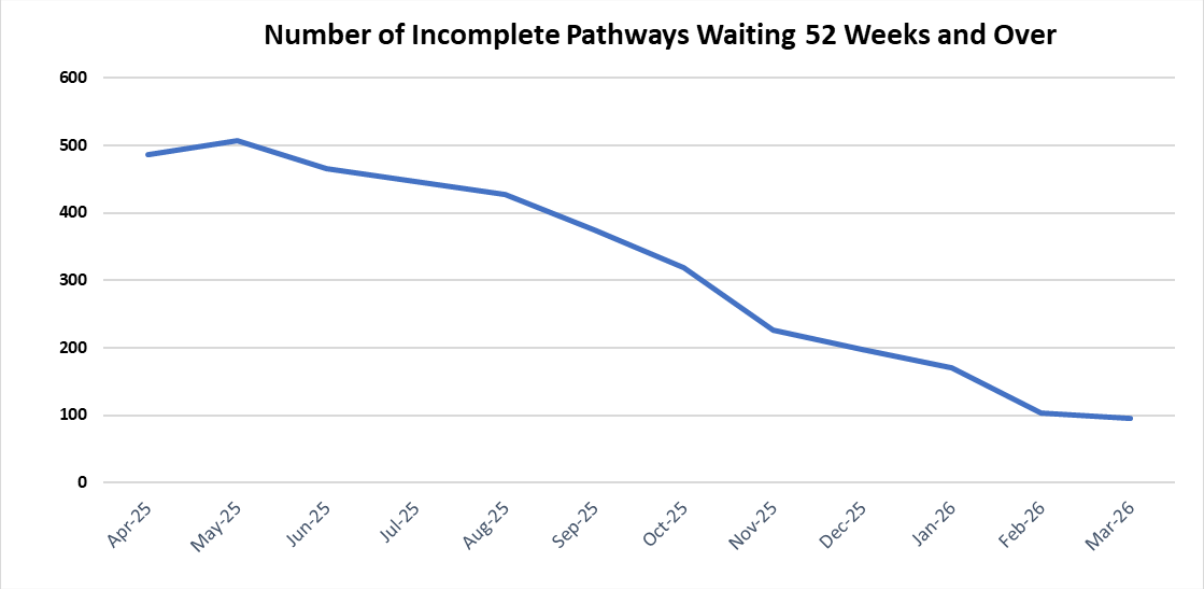
The Referral to Treatment (RTT) position for March 2026 ended at 65.5% above the Trust target by 5.2% demonstrating an improvement towards the national constitutional standard

to treat 92% of patients on the RTT waiting list within 18 weeks of receipt of the referral. The Trust continues to maintain a position of 0 patients waiting more than 65 weeks for treatment. The Trust exceeded the target of less than 1% of the total waiting list waiting more than 52 weeks with an end of year position of 96 patients waiting over 52 weeks (x% of the total waiting list). 52 weeks breaches remain only in the Spinal service that continues to be challenged both regionally and nationally. There is a continued focus on Spinal pathway transformation with improved use of advanced pain practitioners and new initiatives such as super triage and discharge clinics now in place.

Operational performance metrics are monitored internally at weekly/daily patient tracking list (PTL) Meetings, Theatre Planning, Theatre Lookback Meetings and Divisional Management Board in order to provide full assurance that all admitted and non-admitted waiting lists are being actively managed. These oversight meetings aim to reduce the number of patients waiting over 18, 52 and 65 weeks. Additional PTL meetings are scheduled at the discretion of the Deputy Chief Operating Officer should the number of long waiters increase.

The graphs below represent the changes in incomplete pathways during 2025/26 and the reduction in patients waiting over 52 weeks for treatment:





4.22. Cancer treatment targets

Cancer standards

The table below represents the 25/26 performance against cancer targets:

Performance Indicators: Cancer Services 2024/25	**Target**	**Q1**	**Q2**	**Q3**	**Predicted Q4 (**Not validated due to March 26 submission date)
% patients receiving subsequent treatment within 31 days (surgery)	96%	100%	100%	100%	100%
% cancer patients treated within 62 days of referral	70%	82.8%	78.5%	79.7%	76.9%
Faster Diagnostic standard (FDS)	77%	79.9%	80.4%	78%	75%

Year to date the Trust has seen a significant improvement in the delivery of cancer standards and has continues to meet all national targets despite challenges with late tertiary referrals and shortages in Histopathologists. Quarter 4 was particularly challenging due to a further reduction in pathologists and increased turnaround delays.

Individual root cause analysis with detailed timelines are completed for all patients who breach the 62-day standard. These patients are discussed and monitored at the Cancer Board and as part of the trust harm review process. Any lessons learnt are captured and changes in process adopted. Improvements are continually being made to optimise these patient pathways to ensure the highest quality of care is delivered.

The Trust had 2 positive peer reviews during the year and has continued to lead on an international level for sarcoma treatment and research, hosting the national BOOM (Birmingham Orthopaedic Oncology Meeting) which was attended by representatives from around the globe.

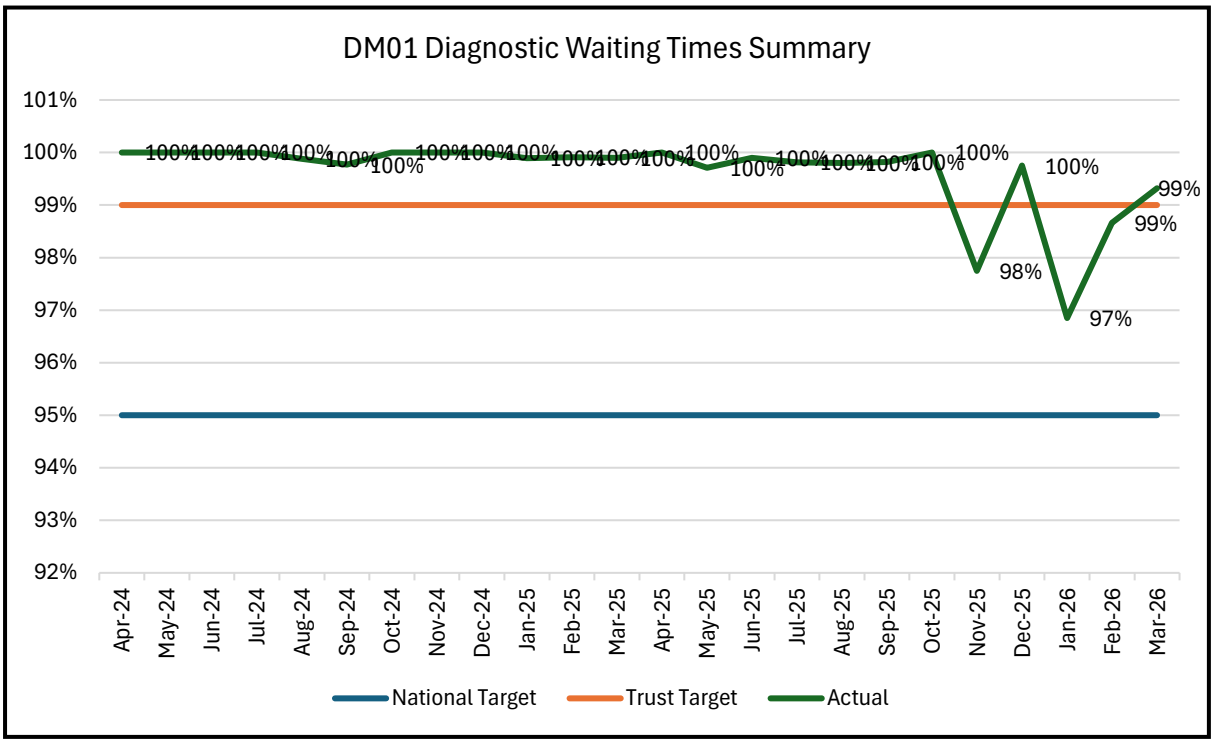
The Trust is one of only five specialist metastatic bone and sarcoma centres in the United Kingdom and receives referrals from a wide geographical spread. Some of the patients have been referred to the Trust after a prolonged pathway and are of high complexity which makes treatment within 62-days challenging to achieve.

4.23. **Diagnostics within 6 weeks**

Diagnostic performance

During 2025/26 the Imaging team consistently achieved the diagnostic standards target with the service performing over 99% for 10 months of the year. There was a slight drop for below 99% for 2 months of the year due to issues with the MRI scanner, however the national target of 95% was exceeded for the whole year demonstrating excellent performance:

The 2025/26 diagnostic DM01 performance is demonstrated in the graph below:



The Imaging service also continues to provide system partners, Birmingham Women's Hospital 2 MRI sessions per week to support patient waiting times.

5.0. The Trusts internal quality measures

The Trust monitors a variety of information and feedback to assess the service it provides for: patient safety, clinical effectiveness, and patient experience.

The Trust has 4 main meetings that oversee quality:

- **Quality & Safety Committee:** Chaired by the Non-Executive Director for Quality and Safety.
- **Quality & Safety Executive:** Chaired by the Chief Executive Officer.
- **The Clinical Quality Group:** Chaired by the Chief Nursing Officer. This committee is responsible for clinical safety and risk.
- **AQILA:** Chaired by the Medical Director. This committee is responsible for overseeing clinical effectiveness.

5.1. **Are we keeping our patients safe and protecting them from avoidable harm**?

The NHS monitors the number of incidents and the harm those incidents caused. We can then focus in on areas of concern and ensure we learn from them.

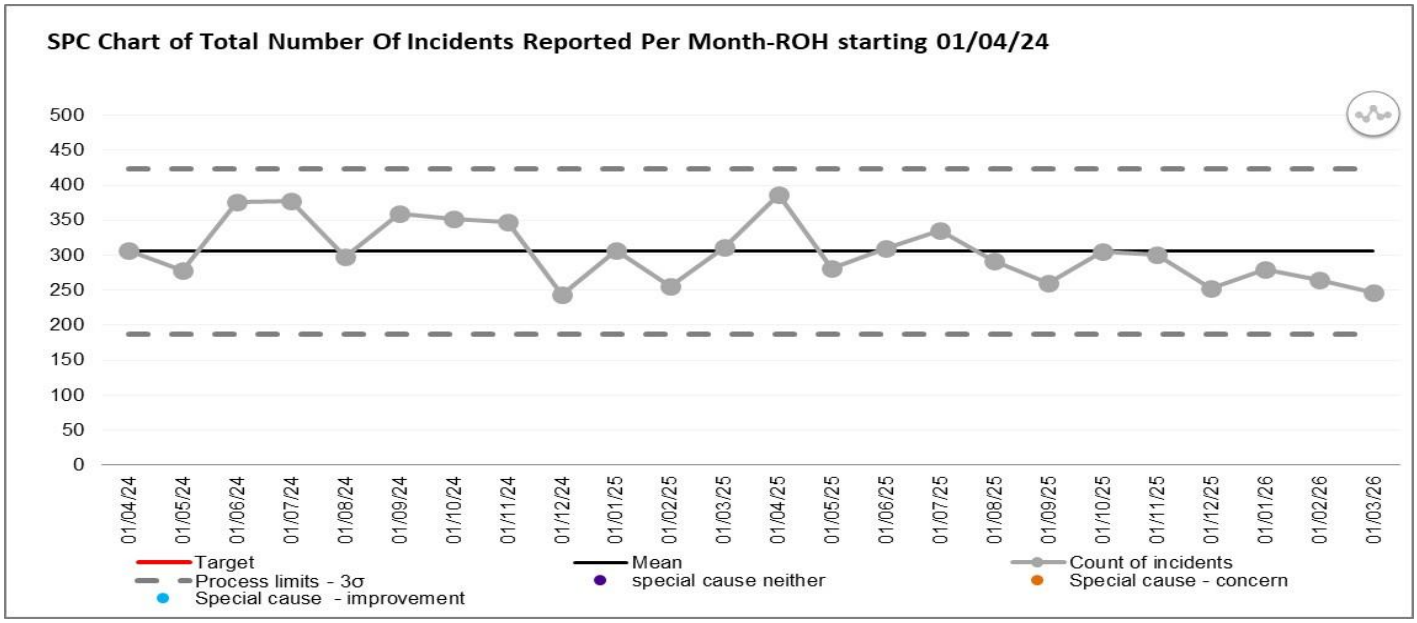


Figure 21: Incidents by Harm 2024-26

There is not a 'correct' number of incident reports as a 'low' reporting rate should not be interpreted as a safe organisation as it may represent underreporting, nor should a 'high' reporting rate be interpreted as 'unsafe' as it may represent a culture of openness. It is generally regarded as better to have a high rate with the majority being of no or low harm. A no blame culture is encouraged at the trust, and this is reflected in a high rate of reporting with the majority being incidents of low or no harm.

5.1.1 **Serious Incidents**

The implementation of the Patient Safety Incident Response Framework (PSIRF) has enabled a move toward a proportionate response focused on opportunities to learn. One of the key principles within PSIRF, is that safety incidents are caused by multiple, interacting contributory factors. This means that actions need to make changes on a systems level, in addition to provision of learning opportunities for staff. A review of the actions demonstrates 3 key themes – actions resulting in systems change, information sharing to improve knowledge and sharing of good practice.

+Systems based actions.

Systems based actions focus on making fundamental changes to the way work is done and are particularly effective in creating the conditions for sustained long term impact. These types of actions require greater resources so are utilised on priority areas. Some examples include the reorganisation of the theatre storage room so that incompatible components are stored separately and the change made to the discharge process so that bloods taken on the day of discharge are medically reviewed before the patient is sent to the discharge lounge.

1. **Information sharing to improve knowledge.**

PSIRF promotes a proportionate approach by ensuring resources are allocated where there are opportunities for learning. The report formats have been designed to draw out the learning and ensure the information is accessible. Feedback from staff has been positive regarding the accessibility and usefulness of the new formats.

2. **Sharing of good practice**

There is a growing body of evidence, that learning is not just about adding something which is not there, but also recognising, reinforcing, and refining what already is. There is an increasing role for learning from excellence. Some of the reviews have reinforced excellent practice, including a well maintained and up to date bowel chart which supported quick identification and treatment of infection and the recognition that a patient was struggling post discharge, so remedial actions were quickly put in place to prevent re-admission.

5.2**. Our patient experience.**

During 2025/26, the trust continued to strengthen its commitment to patient-centred care by ensuring that the voices of patients, carers, and families actively shaped service development and improvement. Creating a culture where feedback informed learning, improvement, and innovation remained a core priority throughout the year.

Throughout 2025/26, patient feedback was consistently placed at the heart of service evaluation and quality improvement. We maintained a robust and inclusive approach to gathering patient insight across multiple channels, ensuring that feedback reflected the full healthcare journey.

This included:

- National and local surveys, such as the Care Quality Commission (CQC) In-Patient Survey and trust bespoke in-patient and outpatient surveys, enabling both benchmarking and local responsiveness.
- Friends and Family Test (FFT) feedback, which provided timely insight into patient satisfaction and highlighted areas of excellence as well as opportunities for improvement.
- Compliments and positive feedback, which were actively shared with teams and included in the Quality Reports to recognise compassionate care, reinforce best practice, and support staff morale.
- PALS enquiries and formal complaints, which were reviewed thematically to identify learning, address concerns promptly, and drive service improvements.
- Healthwatch Birmingham feedback and social media comments, offering real-time, independent perspectives on patient experience.

We systematically reviewed and triangulated feedback from across all sources to identify emerging themes and recurrent issues. This intelligence directly informed:

- Service-level improvement actions
- Education and training priorities for staff
- Improvements to communication, environmental factors, and patient information
- Strengthened “You said, we did” feedback loops, demonstrating to patients how their views had influenced change

Clear governance arrangements ensured that patient experience insight was regularly reviewed at divisional and Trust-wide forums, supporting accountability and sustained improvement.

Our partnership with Healthwatch Birmingham continued to add significant value during 2025/26. Healthwatch representatives:

- Maintained regular liaison with the Head of Patient Experience
- Actively participated in the Patient Engagement & Experience Group
- Shared community feedback, lived experiences, and emerging themes

This collaboration ensured an independent and transparent patient voice influenced service design and evaluation, supporting co-production and inclusive engagement.

As a result of this work in 2025/26:

- Patient feedback was more consistently used to inform service improvement planning
- Staff awareness of patient experience themes increased across clinical and non-clinical areas

- Patients and families experienced greater visibility of how their feedback led to tangible improvements
- The Trust further embedded a culture of listening, learning, and continuous improvement

5.2.1 **Complaints**

Between 1 April 2025 and 31 March 2026, the Trust received 89 formal complaints from patients, relatives, or third parties. This represents a 5% increase compared with the previous year. Of these, 87 complaints progressed through the Trust's formal complaints process, with two complaints withdrawn.

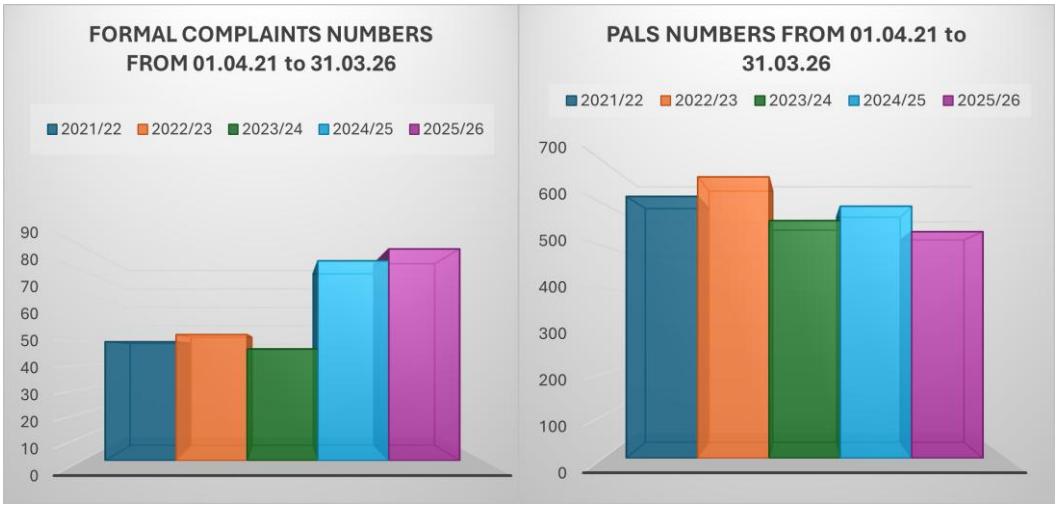
While the number of complaints has continued to rise, the rate of increase has slowed significantly compared with 2024/25. Although activity remains higher than historical levels, the volume represents an overall 207% increase compared with earlier baseline years, reflecting greater awareness of complaints processes, improved access to feedback routes, and increased confidence among patients and families to raise concerns.

A key indicator of the quality and effectiveness of the Trust's complaints handling is the number of complaints that are reopened following a response, where complainants feel their concerns have not been fully addressed. Between 1 April 2025 and 31 March 2026, the Trust received requests to reopen three complaints from patients or their families. This represents 3% of all complaints closed during the same period. All reopened complaints were subsequently reviewed and resolved to the satisfaction of the complainants, demonstrating the Trust's commitment to listening, responding appropriately, and resolving concerns.

The Complaints Department remains proactive in managing incoming complaints. Investigation timeframes vary based on complexity, but we strive to resolve issues within thirty working days. If additional time is needed for a thorough review, we maintain close communication with patients and complainants around time scales to ensure that they receive a comprehensive response.

Resolution meetings are increasingly utilised to enhance communication and achieve successful outcomes, and the Trust adheres to the PHSO Principles of Remedy when addressing formal complaints.

The Annual Complaints and Patient Experience Report 2025/2026 will offer more detailed insights into PALS, Complaints, and Patient Experience and will be shared here Royal Orthopaedic Hospital - Patient experience.



Figures: 2025 and 2026 PALS and complaints numbers for last 5 years

*Data source: Patient Experience Department/ Ulysses system

The top three themes identified from the complaints in 2025/2026 were:

- **Clinical queries**, including delays in diagnosis or treatment, difficulties accessing treatment, adverse treatment outcomes, and insufficient clinical information.
- **Appointments**, including delays in being seen, lack of follow-up appointments, and delays in receiving results due to appointment availability.
- **Values and behaviours**, relating to the attitude and conduct of medical, nursing, and administrative staff.

In 2025/26, **94 individual action plans** were created in response to PALS enquiries and formal complaints. This represented a reduction compared to 2024/25 and reflects improved practice, with actions increasingly identified and addressed during the investigation process and resolved prior to the final complaint response.

All complainants were offered the opportunity to provide feedback on how their concern was handled, both verbally and through satisfaction surveys. This feedback continued to inform learning, support service improvement, and strengthen the Trust's approach to compassionate, responsive care.

5.2.2. **Patient Advice and Liaison Services**

During 2025/26, the Trust received 594 PALS contacts from patients and relatives, representing a 10% reduction compared to 2024/25. This decrease reflects ongoing work to address concerns promptly and effectively at the most appropriate level.
The Trust continued to focus on early resolution, ensuring that patients and carers received timely, clear, and accurate information to support informed decision-making. The Patient Engagement Team worked proactively throughout the year, providing support to patients and carers raising concerns and guidance to staff responsible for resolving them.
This approach helped to promote resolution, improve patient experience, and strengthen learning across services.

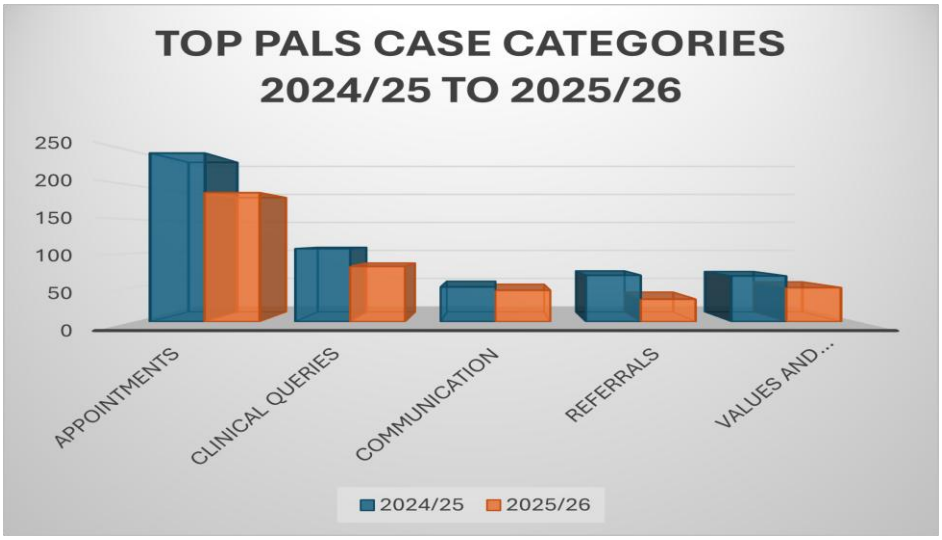


Figure 25: PALS Case Themes

During 2025/26, the PALS team continued to deliver a responsive and accessible service, providing timely support where concerns were identified. Patients and relatives contacted the service through a range of channels, including face-to-face, telephone, online, and email, ensuring accessibility for all.

PALS contacts covered a wide range of issues, including concerns, problems, and enquiries. Each contact was assessed on an individual basis, with proactive action taken to resolve matters as efficiently and effectively as possible. The Patient Engagement Team provided support both to patients and carers raising concerns and to staff involved in resolving them.

Themes and trends identified through PALS were routinely compared with other sources of patient experience data and reviewed through Divisional Governance meetings, Divisional Management Boards, and wider Trust forums where appropriate, supporting learning and service improvement.

The top three categories of PALS contacts in 2025/26 were:

- **Appointment concerns**, including waiting times, referrals, and cancellations.
- **Clinical queries**
- **Values and behaviours of staff**

5.2.3. **Patient Experience Surveys**

The trust is committed to delivering exceptional patient care, underpinned by quality, compassion, and excellence in specialised elective services. Central to maintaining and enhancing these standards is the Trust's commitment to systematically gathering, analysing, and responding to patient experience feedback. This feedback is actively used to inform learning, drive service improvement, and ensure that patient needs remain at the heart of decision-making.

Throughout the year, the Trust utilised a range of patient experience surveys to capture the views of patients and visitors at key points along their care pathway. These surveys provided valuable insight into what matters most to patients and supported continuous improvement across services, reinforcing the Trust's commitment to patient-centred care.

During 2025/26, a range of surveys and engagement activity took place, including but not limited to:

- Care Quality Commission (CQC) National In-Patient Survey
- ROH bespoke in-patient experience surveys including the in-depth inpatient survey which helps inform us of the potential concerns that may be raised during the CQC inpatient survey
- ROH outpatient experience surveys
- Friends and Family Test (FFT)
- Targeted service-specific surveys and engagement events
- Social media and online feedback
- Coffee catch-up events
- Compliments and concerns given to our Patient Advice and Liaison Service (PALS)

The intelligence gathered through these mechanisms was reviewed alongside other sources of patient feedback to inform improvement actions, support quality assurance, and enhance the overall patient experience.

5.2.4. **Friends and Family Test (FFT)**

We recognise that there is no more effective way to improve our services than by listening to what patients and their families think, feel, and experience throughout their care journey. The Trust values all feedback and is committed to learning from everything that is shared to drive meaningful improvement.

Feedback highlighting exceptional care is actively shared with teams across the organisation. Staff consistently report how valued and motivated they feel when positive feedback and recognition for going the extra mile is passed on, helping to reinforce compassionate, high-quality care. Feedback identifying areas of good practice or concern is used to inform Trust-wide learning, celebrate excellence, and support the development of targeted quality improvement programmes in response to emerging themes and trends.

Between 1 April 2025 and 31 March 2026, the Trust received 12,511 responses from patients and carers through the Friends and Family Test (FFT). This extensive and meaningful volume of feedback enabled robust analysis of recurrent themes of praise and concern, supported the sharing of insights with relevant teams, informed staff training priorities, promoted best practice, and celebrated excellence across the organisation.

Patient feedback is collected via multiple accessible routes, including paper-based forms, online submissions, and QR codes, ensuring equitable opportunities for all patients, carers, and families to share their experiences. By learning from both positive experiences and

challenges, ROH continues to enhance patient care and ensure that patient voices remain central to service improvement and decision-making.

5.2.5. **CQC adult inpatient survey**

The Care Quality Commission (CQC) published the 2024 Adult In-Patient Survey results in September 2025, capturing the experiences of patients who stayed at least one night in hospital during November 2024. The survey is part of the national NHS Patient Survey Programme and provides valuable insight into patient experience across key stages of the inpatient journey, including admission, care and treatment, communication, dignity and respect, and discharge planning.

Overall Results

The Trust was rated as "much better than expected" overall in the 2024 survey compared with other NHS trusts nationally. This represents a significant achievement and reflects consistently high levels of patient-reported experience across multiple domains of care.

- Patients reported particularly positive experiences in areas including:
- Being treated with respect, dignity, kindness, and compassion
- Communication with clinical staff
- Feeling involved in decisions about their care and treatment.
- Trust and confidence in doctors and nurses
- These findings demonstrate that patient expectations were exceeded across several key aspects of inpatient care at ROH.

Responses were received from patients who had received inpatient care at ROH, contributing to a national dataset of over 62,000 patient responses. This feedback provided robust assurance on the quality of patient experience and enabled benchmarking against other NHS organisations.

Outcomes and Learning

- The Trust reviewed the survey results through established governance structures, including patient experience and divisional quality forums. Key outcomes from the 2024 survey included:
- Reinforcement of existing good practice in compassionate, person-centred care
- Sharing positive feedback with teams to recognise staff excellence and sustain high standards.
- Use of findings to inform ongoing quality improvement activity, staff development, and service planning
- Continued focus on maintaining strong communication, involvement, and personalised care throughout the inpatient pathway.
- The results provided strong assurance to the Trust Board that inpatient services at ROH continue to deliver high-quality care aligned with the Trust's values and strategic objectives.

In summary the 2024 CQC Adult In-Patient Survey confirmed that ROH delivers an excellent inpatient experience, performing significantly better than many other trusts nationally. The findings highlight the dedication, professionalism, and compassion of staff and reinforce the Trust's ongoing commitment to listening to patients and using their feedback to drive continuous improvement.

5.3 Learning Disability Standards

The trust takes part in the annual benchmarking project against the Learning Disability Improvement Standards, led by the NHS Benchmarking Network. The eighth round of benchmarking was completed in March 2026, the full report will be published in autumn 2026.

The submission for 2026 covered the period April 2024 - March 2025 and included organisational level data, a patient survey, parent/ carer survey, staff survey, and case note review.

Challenges faced with data gathering included operational engagement to respond to data requests, staff engagement with survey completion and patient engagement in survey completion.

Initial themes standing out from organisational level data collection include system improvement, communication and accessibility and operational processes.

Positive improvements have been made through the time period with quality improvement work being implemented across the Trust including the communication toolkit, development of a service leaflet and creation of a training leaflet to complement the Oliver McGowan Mandatory Training.

Next steps: an initial report will be presented at Safeguarding Committee in May 2026 which will highlight the initial findings from the submitted data. Once the full report is published in autumn 2026 actions will be collated in the wider learning disability and autism action plan and fed into the review of the learning disability and autism policy.

6.0. Leadership management and governance of the organisation

The Governance structure and processes have long been strongly embedded within the trust around patient safety incidents and complaints, with evidence of learning from incidents within the investigation reports.

During 2023/24 the ROH implemented the new Patient Safety Incident Response Framework (PSIRF), as required by NHS England. The ROH went 'live' with PSIRF, along with all other Trusts within BSol ICB system, on the 6 November 2023. The Trusts PSIRF Policy and PSIRF Response Plan, as approved by Trust Board and BSOL ICB, have been embedded into the trusts governance structure and processes.

The Trusts PSIRF Policy and PSIRF Response Plan set out the key responsibilities of the key internal and external stakeholders. The PSIRF Policy and Response Plan also set out clearly the governance structure for review and investigation of patient safety incidents under the new PSIRF.

A summary of the key roles and responsibilities are set out below:

Chief Governance Officer

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

Chief Nursing Officer

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

Assistant Director of Governance & Risk

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

- Oversight of the development and management of the PSIRP within the Trust.
- Developing strategies, designing, and implementing systems to raise awareness of and improvement of incident reporting, risk assessment, risk registers, investigation processes including training in learning response tools.
- Organisation wide trend analysis to identify cross cutting themes including the identification of health inequalities.
- Ensuring that learning from adverse events and incidents is shared across the Trust and where relevant the health system.
- Ensuring appropriate notification of incidents to relevant internal and external stakeholders, agencies, and regulatory bodies.
- Notifying the Chief Executive, Directors, Non-Executive Directors, and all other relevant stakeholders, of unexpected deaths or other serious incidents that may attract media attention.
- Providing appropriate advice and support to the Chief Nursing Officer and Chief Medical Officer to enable accurate identification, reporting and investigation of incidents.
- Ensuring an effective quality assurance process is in place to monitor the quality of investigations, associated reports, and action plans.

- Ensuring an effective tracking system is in place so that investigation and learning response data and progress against action plans can be monitored and reported on to the Trust Board and sub committees.
- Ensuring that evidence is collected and appropriately stored to validate the implementation of recommendations and actions arising from PSIIs.
- Ensuring assurance evidence can be retrieved in a timely way when required by the Trust Board or other internal or external stakeholders, as appropriate.

Divisional Triumvirate & Governance Team

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

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

Additionally, the key internal Trust Board and Committee responsibilities are as follows:

Board of Directors

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

Quality and Safety Committee

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

- The Trust has a strong patient safety incident reporting culture in which patient safety incidents are promptly identified and reported and investigated.
- PSIIs are being appropriately identified, managed, and investigated and any resulting actions and learning are being addressed and embedded.
- Trends in patient safety incidents are being reviewed and managed on a Trust wide basis.
- Quality improvement and learning from patient safety incidents are being identified and implemented.
- In collaboration with the Divisions and the Governance Team, the Quality and Safety Committee will also ensure that divisions are:
    - Reporting, managing, and investigating patient safety incidents in line with this policy and the accompanying plan.
    - Ensuring implementation of recommendations and quality improvement plans from serious incident investigations.

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

Executive Governance Meeting

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

External oversight of trust's governance structures and processes, particularly in relation to PSIRF is provided by Birmingham and Solihull Integrated Care Board (BSol ICB).

BSol ICB seeks assurance on PSIIs and any other patient safety incident matters and provides scrutiny and oversight via regular monthly contracting and patient safety oversight meetings.

6.1. National People Pulse Survey



The National Quarterly Pulse survey (NQPS) is run three times a year in January, April, and July. All staff have access to completing this survey. The survey provides a pulse check

Figure: National People Pulse Survey in ROH**

with staff member throughout the year and enables a comparison against the National Staff survey (NSS). The nine staff engagement questions from the National Staff survey form the basis of the survey, which is administered by the National NHS Team. Staff can access the survey via a link or QR code. Q1 engagement with the survey was poor, following increased promotion, Q2 and Q4 participation rates have increased significantly.

Trust level staff engagement	Q1 25/26	Q2 25/26	Q4 25/26	Improved?
Motivation	NA	6.43	6.12	⬇
Involvement	NA	6.98	6.30	⬇
Advocacy	NA	7.38	6.74	⬇
Overall staff engagement	**NA**	**6.93**	**6.39**	⬇



6.2 **NHS Staff Survey**

Each year, the trust participates in the annual NHS Staff Survey (NSS). Staff who are employed by, or under contract to the ROH, are asked to complete the survey. Bank staff members are also asked to complete a survey and have a separate set of results.

The findings are shared with staff members through communication channels, at directorate level, focus groups, team meetings, as well as the range of management meetings, including Executive Directors, Trust Board, and other committees. There are also staff survey

awareness stands to share the information. Managers are given departmental information (where numbers of responses allow) and this detail is used in ongoing staff survey action planning, a 'You Said, We Did' campaign, staff appraisals, team development, and to support the Annual Business Planning process.

All Trust staff, employed on September 1st, 2025, were invited to complete the National Staff Survey. The response rate was 55% (797 staff) using a mix mode of online and paper copy completions. The ROH is in the Acute Specialist benchmarking group with 12 other specialist acute trusts. The median response rate for our sector was 49%.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.43	5.99	6.79	6.52	5.77	6.64	6.75	7.00	6.24
Best result	7.95	6.47	7.35	6.90	6.16	6.84	7.31	7.54	6.64
Average result	7.60	6.07	6.81	6.39	5.77	6.49	6.88	7.19	6.20
Worst result	7.15	5.60	6.52	5.99	5.09	5.76	6.44	6.65	5.51
Responses	791	793	779	779	765	782	790	792	793

Figure 29: People Promise elements and themes, overview.

*Data source Survey Coordination Centre NHS

7.0. Achievement in year

Electronic Patient Record (EPR)
We signed a contract with InterSystems to implement a new Electronic Patient Record (EPR) system. The new system will ensure our clinicians have the best tools to deliver world-class care and a seamless experience.

ROH holds first MSK community roadshow
We visited three locations across Birmingham to help local residents to self-manage their pain. With a big red bus in tow, and the fantastic support of our colleagues, we helped 395 patients with problems ranging from lower back pain to shoulder, hip and knee pain. Thanks to the support and funding of ROC.

Launched MSK Academy
ROH launched the MSK Academy to empower healthcare professionals with the expertise and skills in musculoskeletal (MSK) conditions to provide exceptional patient care through in-person, virtual and online/on-demand learning.

Welcomed Wes Streeting
Wes Streeting came to see how the Trust's work on helping patients with musculoskeletal problems is helping to reduce the electives care waiting list, through innovations in orthopaedics in operating theatres, such as the use of robotics, and research.

Awarded RACE equality code
The Quality Mark is a national standard recognising organisations that demonstrate strong leadership, accountability, and measurable action in advancing race equality.

Introduced CHAIN programme
We introduced CHAIN (Cycling against Hip Pain), a new cycling programme to support patients with hip pain from osteoarthritis. The 8- week programme takes place at Cocks Moors Woods Leisure Centre in Kings Heath and provides patients with education on self-management while building up their strength and confidence through cycling.

Ranked level 1 NOF
The Royal Orthopaedic Hospital has been recognised as one of the top performing NHS trusts in the country under the new NHS Oversight Framework 2025/26, achieving a Level 1 rating (the highest possible score).

Research spotlight
- SPARK THE MIDLANDS programme success: A team at the Royal Orthopaedic Hospital NHS Foundation Trust (The ROH) has secured a place on the SPARK THE MIDLANDS programme for its project developing a minimally invasive anti-cancer and bone regenerative injectable paste, using the cancer-killing properties of gallium.
- PORTRAIT trial kicks off: £1.5 million grant to investigate radiotherapy after surgery for metastatic disease
- Decision making in spines gets funding: ROH secured funding for project to understand clinical decision making in adult scoliosis surgery

Strategic alliance with RJAH
The Royal Orthopaedic Hospital NHS Foundation Trust and the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust have jointly signed a Memorandum of Understanding to set out the terms of their alliance.

Silver thrive at work accreditation
We gained the Silver Thrive at Work Accreditation, a programme run by the West Midlands Combined Authority which celebrates organisations that create a workplace that promotes employee health and wellbeing.

Nursing stories
We had the pleasure of meeting Joy McCliskie who worked as a nurse at the ROH from 1940-1948. She shared her experiences working during the war and how much nursing has changed over the decades, from stone hot water bottles to tin hats.

8.0. Quality Account Statement

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The Royal Orthopaedic Hospital NHS Foundation Trust

Quality Account 2025/2026

Statement of Assurance from NHS Birmingham and Solihull Integrated Care Board

May 2026

1.1 Birmingham and Solihull Integrated Care Board (ICB) as coordinating commissioner for The Royal Orthopaedic Hospital NHS Foundation Trust, welcomes the opportunity to provide this statement for inclusion in the Trusts 2025/2026 Quality Account.

1.2 A draft copy of the Quality Account was received by the ICB on 6th May 2026 and the review has been undertaken in accordance with the Department of Health and Social Care Guidance. This statement of assurance has been developed from the information provided to date.

1.3 The information provided within this account presents a balanced report of the healthcare services that The Royal Orthopaedic Hospital NHS Foundation Trust, provides. The report demonstrates the progress made by the Trust against the 2025/2026 priorities. It identifies what the organisation has done well, where further improvement is required and what actions are needed to achieve these goals and the priorities set for 2026/2027.

1.4 We have worked closely with The Royal Orthopaedic Hospital NHS Foundation Trust, over the course of 2025/2026. The ICB recognises the progress made with a number of key initiatives including musculoskeletal pathway transformation; implementation of the surgical site infection bundle; and digital improvements to improve waiting times and equitable access. We are committed to continuing to engage with the Trust in an inclusive and innovative manner and hope to continue to build on these relationships as we move forward into 2026/2027.

Yours sincerely,

Sally Roberts
Chief Nurse/Clinical & Quality Officer
Birmingham, Black Country and Solihull (Cluster) Integrated Care Board