The Royal
Orthopaedic Hospital
NHS Foundation Trust

Trust Board (Public) June

Wednesday 4th June 2025, 10:15h - 15:00h

Boardroom, Trust Headquarters

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Notice of Trust Board Meeting in Public on Wednesday, 4 June 2025

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 4 June 2025, in the Boardroom, Trust HQ commencing at **10:15.**

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

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

Tim Pile
Chair

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AGENDA
TRUST BOARD PUBLIC

Venue Boardroom, Trust Headquarters **Date** 4 June 2025: 10:15h – 15:00h

Members attending

Mr Tim Pile	Chair	(TP)
Ms Simone Jordan	Vice Chair & Senior Independent Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Mr Les Williams	Non Executive Director	(LW)
Dr Ian Reckless	Non Executive Director	(IR)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Simon Page	Non Executive Director	(SP)
Mrs Jenny Belza	Non Executive Director	(JB)
Miss Jan Teo	Non Executive Director	(JT)
Mr Matthew Hartland	Chief Executive	(MH)
Mr Mathew Revell	Executive Medical Director	(MD)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance

Ms Sharon Latham	Head of Patient Experience	(SL)	[Item 10]
Mr David Richardson	Head of Education & Training	(DR)	[Item 16]
Mr Uzo Ehiogu	Clinical Programme Lead Musuloskeletal Academy	(UE)	[Item 16]
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
		IN PUBLIC SESSION		
10:15	10	Patient Story	Presentation	SL
10:35	11	Apologies:	Verbal	Chair
	12	Declarations of Interest	ROHTB (6/25) 005	Chair
	13	Minutes of Board Meeting held in Public on 7th May 2025: *for approval*	ROHTB (5/25) 030	Chair
	14	Actions from previous meetings in public: *for assurance*	ROHTB (5/25) 030 (a)	SGL
	15	Questions from members of the public	Verbal	Chair

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10:40	16	MSK Academy Update: *for assurance*	ROHTB (6/25) 006	UE/DR
11:00	17	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (6/25) 007 ROHTB (6/25) 007 (a)	MH/TP
11:20	17.1	Council of Governors Update: *for assurance*	Verbal	SGL
11:25	18	Chief Finance Officer's report: *for information and assurance*	ROHTB (6/25) 008 ROHTB (6/25) 008 (a)	SW
11:45	19	Chief Operating Officer's report: *for assurance*	ROHTB (6/25) 009 ROHTB (6/25) 009 (a)	MP
12:00	20	Chief People Officer's report: *for assurance*	ROHTB (6/25) 010	SM
12:15	21	Quality Officers' report: *for assurance*	ROHTB (6/25) 011	MR/NB/ SGL
12:30		**LUNCH**		
13:30	22	Quality Priorities 2025/26: *for assurance*	ROHTB (6/25) 012 ROHTB (6/25) 012 (a)	NB
13:45	23	Robert Jones and Agnes Hunt Memorandum of Understanding: *for approval*	ROHTB (6/25) 013 ROHTB (6/25) 013 (a)	MH
		GOVERNANCE AND COMPLIANCE		
14:00	24	Freedom to Speak Up Update: *for assurance*	ROHTB (6/25) 014 ROHTB (6/25) 014 (a)	CJ
14:20	25	Safeguarding and Vulnerabilities Annual Report: *for approval*	ROHTB (6/25) 015 ROHTB (6/25) 015 (a) ROHTB (6/25) 015 (b)	NB
		UPWARD REPORTS FROM THE BOARD COMMITTEES		
14:35	26	Upward reports from the Board Committees: • Finance & Performance Committee • Quality & Safety Committee • Audit Committee	ROHTB (6/25) 016 ROHTB (6/25) 017 ROHTB (6/25) 018	LW IR GH
14:55		**MATTERS TO BE TAKEN BY EXCEPTION**		
	27	Performance Reports: *for assurance* a) Finance & Performance b) Quality Report	ROHTB (6/25) 019 ROHTB (6/25) 020	
	28	Any Other Business	Verbal	All

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	29	Meeting effectiveness	Verbal	All
15:00	**CLOSE: Date of next meeting: Wednesday, 2 July 2025 @ 09:00**			

Notes

Quorum:

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

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

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

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PUBLIC ATTENDANCE REGISTER – FY 2025/26 UPDATED TO MAY 2025

MEMBER	ATTENDANCE										TOTAL
	09/04/2025 **	07/05/2025	04/06/2025	02/07/2025	03/09/2025	08/10/2025	05/11/2025	03/12/2025	04/02/2026	04/03/2026	
Tim Pile (Ch)	✓	✓									
Ian Reckless	A	✓									
Simone Jordan	A	✓									
Gianjeet Hunjan	✓	✓									
Ayodele Ajose	✓	✓									
Les Williams	✓	✓									
Simon Page	✓	✓									
Jenny Belza	A	✓									
Jan Teo	A	✓									
Matthew Hartland	✓	✓									
Matthew Revell	✓	✓									
Nikki Brockie	✓	✓									
Marie Peplow	✓	✓									
Stephen Washbourne	✓	✓									
Sharon Malhi	✓	✓									
Simon Grainger-Lloyd	✓	✓									

KEY:

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

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

Tammy's Story

The Royal Orthopaedic Hospital
Trust Board Patient Story June 2025

Patient

Tammy* is 16 years old and was admitted to the ROH for surgery following a diagnosis of Ewings Sarcoma.

This story has been compiled after Tammy's mother contacted the Patient Experience Team to share their experience and express the families' thanks for the care and support they experienced during Tammys care pathway.

Tammy and her family want to share their story but do not want to be identified outside of their care team

Tammy was referred at the end of 2024 and had several appointments with the oncology team, preoperative assessment service and anaesthesia team while tests were undertaken and a treatment plan decided.

Throughout this time the whole family found the support from their Teenage Cancer Trust Nurse and the whole team helped them to deal with the darkness they felt.

Tammy underwent a femoral diaphysis – resection and reconstruction and the tumour was excised.

Following surgery Tammy was admitted to Ward 3 and remained as an inpatient for nearly three weeks.

It was this time on the ward that prompted Mum to get in touch once Tammy was discharged.

The email began……

My daughter had surgery recently and stayed in the above ward for approx 3 weeks. We were emotionally upset, full of worry and restless, our energy was at a low.

It went on to describe the impact of the team…..

“absolutely amazing, full of positivity, energy and made my daughter at ease with her recovery”

The nurses on the ward work hard, all were very lovely

Their work ethic is truly amazing and caring

The ladies that came to clean the rooms too were full of smiles in the morning and amazing. They really did make a difference to us.

The surgeon, his team, the anaesthetic team, The TCN were all truly truly amazing.

Tammy is now recovering at home with her family before moving on to the next stage of her treatment journey.

Mum wanted to share….

It is very difficult to put into words the strength that was given at such a low point.

The energy and strength that was given to was very much appreciated and we felt it to take the time out to inform you.

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TRUST BOARD DECLARATIONS OF INTEREST REGISTER

Name	Interest	Voting Member
Tim Pile **Chair**	• Council Member, Aston University	Yes
Jo Williams **Chief Executive**	• Trustee, Versus Arthritis	Yes
Matthew Hartland **Interim Chief Executive**	• Vice Chair, Shrewsbury Colleges Group (Effective from 1 February 2025)	Yes
Simon Grainger-Lloyd **Director of Governance**	• Foundation Governor, Ombersley Endowed First School (4 Year Term of Office from June 2024)	Yes
Steve Washbourne **Chief Finance Officer**	• Governor at University of Birmingham School • Independent Member of the Audit Committee at Aston University • Trustee, Sandwell Leisure Trust	Yes
Marie Peplow **Chief Operating Officer**	• None declared	Yes
Matthew Revell **Medical Director**	• Fellow of the Royal College of Surgeons • Member British Orthopaedic Association and British Hip Society • Founding Fellow of the Faculty of Medical Leadership and Management	Yes
Nikki Brockie **Chief Nurse**	• None declared	Yes
Sharon Malhi **Chief People Officer**	• Trustee, Victoria Academies Trust	Yes

Name	Interest	Voting Member
Simone Jordan **Non Executive Director & Vice Chair**	• Non Executive Director, George Eliot Hospital NHS Trust • Member of the Chartered Institute of Personnel and Development • Vice Chair & Non Executive Director, Leicestershire & Rutland Integrated Care Board (LLR ICB).	Yes
Les Williams **Non Executive Director**	• None declared	Yes
Gianjeet Hunjan **Non Executive Director**	• Non Executive Director, Black Country ICB • Lay Member, National Clinical Impact Awards - National Main Committee and West Midlands Committee • Governor, Oldbury Academy • Governor, Ferndale Primary School • Member of IHSCM • Member of HFMA • Fellow of Chartered Institute of Public Finance and Accountancy (CIPFA) • Member of Nishkam Healthcare Trust at local Gurdwara • Lay Panel Chair, Nursing and Midwifery Council	Yes
Ayodele Ajose **Non Executive Director**	• Legal Consultant to Law Firm Addleshaw Goddard LLP – Currently Assigned Full-Time to Group Lotus	Yes
Ian Reckless **Non Executive Director**	• Executive Director (Medical Director and Deputy Chief Executive), Milton Keynes University Hospital NHS Foundation Trust • Director, ADMK Limited (wholly owned subsidiary of Milton Keynes University Hospital NHS Foundation Trust) • Director, JTER Trading Limited (company involved in property services and antiques trading) • Fellow, Royal College of Physicians • Fellow, Faculty of Medical Leadership and Management	Yes

Name	Interest	Voting Member
Simon Page **Non Executive Director**	• Owner, Weathervane Consultancy	Yes
Jenny Belza **Non Executive Director**	• Governor, University College Birmingham	Yes
Jan Teo **Non Executive Director**	• Non Executive Director, Birmingham Community Healthcare Foundation Trust (1 March 2023 to 28 February 2026) • Company Director, 3 Castle Street (RTM) Limited • Oversight Board, K2CO (Dance Company)	Yes

The Royal Orthopaedic Hospital NHS
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MINUTES

Trust Board PUBLIC - DRAFT Version 0.1

Venue Boardroom, Trust Headquarters **Date** 7 May 2025: 0830h - 1045h

Members attending:

Mr Tim Pile	Chair	(TP)
Ms Simone Jordan	Vice Chair & Senior Independent Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Mr Les Williams	Non Executive Director	(LW)
Dr Ian Reckless	Non Executive Director	(IR)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Simon Page	Non Executive Director	(SP)
Mrs Jenny Belza	Non Executive Director	(JB)
Miss Jan Teo	Non Executive Director	(JT)
Mr Matthew Hartland	Chief Executive	(MH)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mr Matthew Revell	Executive Medical Director	(MR)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)

In attendance:

Ms Deborah Wright	Clinical Audit Facilitator	(DW)	[Item 1]
Mr Jamie McKenzie	Guardian of Safe Working	(JMK)	[Item 7]
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

1 Staff Story (DW)	**Presentation**
Deborah Wright (DW), Clinical Audit Facilitator, presented her journey at ROH, highlighting career progression, audit achievements, and passion for improving patient care. TP thanked DW for her presentation. The Board was invited to ask questions and comment. The points of particular note include:	

• SGL queried how does Clinical Audit link with Governance Team. DW explained that they don't work with the Governance Team currently and not had the opportunity to do that but would welcome it. • AA praised DW for her passion and questioned what skills she brought with her from her previous role. DW explained listening skills, treating everyone with respect, adapt to individual needs, recognising when people are unhappy and listening. DW raised also passion and determination to get the answer and complete the task to the best of ability. • MH questioned what is the one thing the trust should do to make it better. DW explained colleagues do not know what people do. Suggest an open office so people can learn what the other roles are across the Trust, so people understand what everyone does and how their job helps each other. MP raised that there is a lot to learn from retail and we should look at how we can use this in the Trust and look at customer service enhanced training. DW explained that previously was a coach and would love to support. TP thanked DW for sharing her story.	
2 Apologies (chair)	**Verbal**
There were no apologies to note.	
3 Declarations of Interest (chair)	**ROHTB (5/25) 001**
There were no new declarations to record to what has been published. There is an update required for IR as two of the declarations are no longer needed. IR to email through the changes and declarations of interest document will be updated accordingly.	
4 Minutes of Board Meeting held in Public on 9th April 2025: ***for approval*** **(chair)**	**ROHTB (4/25) 031**
The minutes of the meeting held in public on 9th April 2025 were **approved** by the board subject to the following changes: • Update to Call to Concern statement. NB to advise outside of the meeting the change needed.	
5 Actions from previous meetings in public: *for assurance* (SGL)	**ROHTB (4/25) 031 (a)**
No updates to note.	
6 Questions from members of the public (chair)	**verbal**

No questions were received in advance of the meeting	
7 Guardian of Safe Working Update: *for assurance* (JMK)	**ROHTB (5/25) 002** **ROHTB (5/25) 002 (a)**
Jamie McKenzie (JMK), Guardian of Safe Working. joined the Board to provide an update. The paper was taken as read. The key points highlighted include: • JMK assured the Board that Resident Doctors feel well-supported. • It was raised that the On Call room availability is still an issue and it would be good to consider how we can make more rooms accessible. The Board was invited to ask questions and comment. The points of particular note include: • SJ queried the international doctors experience and how are we supporting our international fellows. JMK explained they were younger and less experienced than expected. It meant they required training which fellow doctors who were supporting them found hard. Work has already been undertaken to get a better understanding of the level they are coming in at. SJ raised that the experience of the international nurses received was poor and would like it to be considered for all of our colleagues that join us internationally that we ensure we give them the right experience. • SM thanked JMK for the report and felt assured from the report that some of the previous issues have been addressed. SM raised that pastoral support is something that we still need to consider both for nurses and doctors equally. SM raised the statement in the report with regards to ensuring communication of any changes are made and queried what more could be done. JMK raised the Resident Doctors Forum is a great opportunity to share such information, and we should encourage attendance, this meeting can be underrepresented. JMK raised any changes should always consider the impact on Resident Doctors. • NB raised that we are hearing that the experience for our international colleagues has not been great and to provide assurance explained that this is being reviewed at system level. • JT queried how will all this information now been drawn together as it does not feel the key challenges are being tackled at present. JT requested a commitment that this is all brought together so that the problems that are causing the poor experiences. NB explained that there are nuances that means the groups have different needs, however the pastoral care could be extended across all the groups. NB explained this would be considered how all groups can be supported. • MP raised that it is clear that the Resident Doctors are looked after by a	

<table>
<tr><td>team of people at the Trust. JMK agreed with that statement.

TP thanked JMK for his update.

• SP queried the issue with the on-call rooms and asked for further detail. SW explained this has been addressed and the old private patient rooms have been converted into on call rooms. The issue seems to be whether we have enough rooms available. SM raised we have long term question to consider which is what do we need for the future.</td><td></td></tr>
<tr><td>8 Chair's and Chief Executive's update: for information and assurance (TP/MH)</td><td>ROHTB (5/25) 003
ROHTB (5/25) 003 (a)</td></tr>
<tr><td>MH presented the Chief Executive Update, and the paper was taken as read.

The key points highlighted include:

• National Update. The new leadership team is now in place and the Transition Team established. The Transition Team continue to engage with NHS Leaders and MH attended a recent event, where discussions took place on the forthcoming 10-year plan, operating model and preparing for next winter.

• It is clear the operating model will change with the dissolution of NHSE by October 2026. It is also expected the ICB will operate over a larger geographical footprint.

• The refresh strategy will be presented at the Board today for approval which has taken in all the feedback received from the private trust board session held in April.

• Federation of Specialist Hospitals. Commitment has been made on behalf of the organisation to improve our Referral to Treatment (RTT) position ahead of the planning guidance target date. This does require resource and conversations with NHS England are underway to work through how this can be supported.

• A review of the Coffee Catch Up Feedback has been undertaken, and it is acknowledged how valuable the feedback from these sessions are.

• MSK Community Roadshow - an excellent engagement opportunity to promote the work for the ROH in our local community.

    o TP supported the community bus and challenged how do we accelerate this. An opportunity to take this wider on behalf of the system. TP questioned how we change this into referrals rather than having to go through the GP.

        ▪ MH explained this has been discussed how we provide this ourselves without needing the bus.

The Board was invited to ask questions and comment.</td><td></td></tr>
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- IR queried the RTT acceleration and questioned what the approach will be. MH explained that as a Trust we are looking at how we best utilise the unused capacity. Currently modelling the impact and taking into account the growth plan. Consideration of how this affects the bottom line is also being considered.
- JB queried the proposed reduction in corporate workforce, the clinical decision-making tool and the evaluation of the community bus and raised how important it is to ensure this included the demographics covered in the review. MH explained the corporate workforce is part of a cost improvement programme which involves a reduction of 50% of the workforce that has increased since 2019. The approach we are taking is to review the whole of the organisations and not just corporate services. A service review for all clinical services, looking at flow, structure, how the team works, interacts with other parts of the organisations. From a corporate review this will be looking at benchmarking, reviewing what do we need to do vs what is nice to do it help us understand what is needed. SW raised that the corporate reduction equates to £70,000 for ROH but national evidence shows we are the one of the lowest which shows that the increase in corporate services has been quite minimal.
- MP explained that the clinical decision-making tool is now a system project and has started with orthopaedics but will be rolled out across the system. This will support the transition between primary care and secondary care. **ACTION Provide a one-page update on the action that is being taken to roll this out. MP**
- GH thanked the Charity Team for the Community Bus, and their enthusiasm really did make the event such a success.
    - JT raised that there is opportunity to join up with commercially and charitable groups to fund this.

TP highlighted the following points for the Chair Update.

- Took part in the Community Bus.
- Wellbeing Trolley with MH, staff engagement was fantastic. Praise to Laura, Wellbeing Officer for the work that takes place to put this in place.
- Welcomed four provider Chairs to discuss opportunities to collaborate further. A great opportunity to host the colleagues at the Trust.

9 Chief Finance Officer's report: ***for information and assurance***	**ROHTB (5/25) 004** **ROHTB (5/25) 004 (a)**

SW presented the Chief Finance Officer Report and report was taken as read.

The key points to highlight include:

- The Trust delivered a surplus in month of £2,490k against a planned surplus of £133k, generating a positive variance of £2,357k. This is due to a number of

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funding allocations in M12. This resulted in a deficit for the year of £1,630k.

- Income finished above plan of £3m. Related to additional income received in M12.
- Elective Recovery Fund (ERF) underperformance against target. Driven by elective underperformance and £3m stretch figure from the ICB.
- Private patient achieved £5.3m for the year. Review of last 6 months would have delivered £6.8m so there is potential for stretch in 25/26.
- Pay continued with the reduction in agency for 7 months consistently. Slight increase in Bank spends which is being reviewed.
- Continued spend on LLP, however there is a significant reduction of this in 25/26.
- There is no immediate requirement to request cash support, but it is dependent on the delivery of the Cost Improvement Programme (CIP).
- Capital allocation was £3.9m, spent £6.1m due to additional budget being allocated.
- CIP £5.3m and most schemes delivered recurrently.
- System position is not yet confirmed.

The Board was invited to comment and ask questions.

- LW praised the exceptional performance of the £5.3m delivery of CIP which is not an easy delivery to make. It is clear 2025/26 will be challenging and focus needs to be on productivity.
- SP questioned if we are confident as a Trust that we have made the fast start that was needed in Month 1. MH explained that we do not have Month 1 data yet but are confident that from the details that are available we are overachieving on activity v cost. MH explained that at the Financial Delivery Board is where the detail will be reviewed.
- SP queried when will the Board be given the detail of the Private Patient ambition. MP explained that this update will be provided at the June Board.
- GH raised that all figures that are shared are subject to the year-end audit process that is currently taking place.
</td><td></td></tr>
<tr><td>10 Chief Operating Officer's report: for assurance</td><td>ROHTB (5/25) 005
ROHTB (5/25) 005 (a)</td></tr>
<tr><td>MP presented the Chief Operating Officer's report, and the report was taken as read.
The key points to highlight include:</td><td></td></tr>
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• Activity is being reviewed weekly and provides a positive tool to be able to identify where any immediate improvements are required. • The Productivity Improvement Group has now concluded, and the closure report was presented to Finance and Performance Committee. • There is a requirement to now report weekly to the system. • Finalised April report confirms 65 week wait list is at zero. • Two new spinal consultants have now commenced which is helping progress the spinal capacity. • All operational metrics for April are on target. • Performance highlight for year-end include cancer green across all metrics and diagnostics green across all metrics. • Day case week evaluation was shared with Finance and Performance Committee. • Risk is loss of theatre capacity. MP confirmed that the motor has been tested and being installed today. • Even though there was loss of capacity in April the Trust still delivered over capacity in activity. • Shammas Rahim has joined the Trust as Associate Director of Operations for System Integration and Outpatient Transformation. • MSK Go Further Faster and have reduced the 18 weeks by 59%. • Notification of the annual review of GiRFT will take place on 30th July 2025. • 18,000 people across BSOL using the GetUBetter App. The Board was invited to comment and ask questions. • SJ questioned will the private patient update be presented as a separate business unit. MH confirmed that these conversations have been taking place and the model that stands is as a trading business unit on its own. • JB queried with the additional capacity in spinal where do we intend to end the year. MP explained that the plans were all built around the increased capacity with the aim to increase by at least 7-8%. MP will provide a detailed update in the report next month. **ACTION MP** • GH queried will the private patient report also consider the principles of the NHS values as well. MP explained the report will provide the Board with a number of options. GH requested that the full impact of cost is included. • LW raised that the increase in demand for private patient is due the reduction in NHS opportunity and if this improves. as it should with the Governments plans. we need to consider the reduction in private patient requirements. TP highlighted the big drive currently is to get the private work, which has always been done, to be done at ROH rather than anywhere else.	
11 Chief People Officer's report: ***for assurance***	**ROHTB (5/25) 006**
SM presented the Chief People Officer's report, and the paper was taken as read. The key points to highlight include:	

• The 'Me as a Manager' programme was discussed in detail at Staff Experience & OD Committee how we can ensure we capture the evaluations of the programme. • Assurance was provided on mandatory training and the national project. It was confirmed the digital passport has been paused by BSOL. • National Education and Training survey has been positive. There is work to do around harassment and discrimination. • Band 2/3 work continues. Union have accepted the BSOL offer, and reviews of nursing profiles continue, this will support the service review as part of the wider workforce transformation work that is taking place. • A joint programme pilot is currently underway with University Hospitals Birmingham and Nuffield Health to support colleagues with musculoskeletal (MSK) conditions. • Target operating model is a national piece of work. This will inform our response on how we deliver some of the services locally, and at system level. TP queried the MSK academy and would welcome a presentation on this at Board. **ACTION: RL/MR to provide paper to June Board.** TP queried why the staff passport has been stopped. SM explained that this part of the reprioritisation work.	
12 Quality Officers' report: ***for assurance***	**ROHTB (5/25) 007**
MR/NB/SGL presented the Quality Officers' report, and the paper was taken as read. The key points to highlight: • A Research and Development Summit has been held with Aston University, providing the opportunity to scope areas of mutual research interest. • Developing the Trust Quality Improvement & Development Day to bimonthly, operationally makes things more efficient and allow teams to train with each other. • The Trust is establishing an Advanced Practice Oversight Group (APOG). This has been designed to ensure that all Nursing and AHP undertaking advanced practice are achieving their four pillars. This will feed through to Quality and Safety in future via an upward report. • There has been one inpatient death since the last report and this will be discussed at next Quality & Safety Committee. • Further strengthening of the Health and Safety culture in the organisation. A schedule of audits are planned by our Health and Safety Adviser and she is	

working closely with our nursing teams. • Plans are underway to upskill and equip Freedom to Speak Up (FTSU) Champions to provide extra support to staff in this challenging climate. • The use of Artificial Intelligence is being explored to support corporate meetings.	
13 ROH Strategy 2023-2028: 2025 Refresh: ***for information***	**ROHTB (5/25) 008** **ROHTB (5/25) 008 (a)**
RL presented the refreshed ROH Strategy, and the paper was taken as read. The key points to highlight include: • The feedback provided by the Board at its April meeting was welcomed and has been incorporated into this version. • A robust implementation plan is crucial, and a detailed communication and engagement plan has been developed. • Communication of the strategy will be through briefings, posters, etc. ensuring we are bringing the strategy to life. • There will be a direct ask of people on service reviews to consider the strategy as well as part of this review. The Board was invited to comment and ask questions. The following points were of particular note: • SJ raised that continuous improvements still needs to be stronger and the key to engagement is to emphasise how we reduce waste. SJ queried how will we communicate and detail the expectation of our colleagues. RL explained that goal settings through appraisals will start the process, but work is needed on the communication. ○ SP agreed that continuous improvement should be a lever to drive the change. The strategy should be used to feel colleagues can make a difference and are empowered to do. RL explained that the improvement team are targeted with identify the changes made and capture these improvements made. The Board **approved** the refreshed strategy for publication.	
14 Equality and Diversity Report: ***for approval***	**ROHTB (5/25) 009** **ROHTB (5/25) 009 (a)**
SM presented the Equality and Diversity Report. The paper was taken as read and was presented for approval for publication. The report has been reviewed at Staff Experience & OD (SE&OD) Committee prior	

to presenting to the Board today. Since SE&OD, and the Community work that has been taking place, it is clear we are not capturing all the data we should from our patients. SJ raised that it is clear we are not using the data in the best way we could and this is something that would be discussed further at future SE&OD Committees. LW praised the report and the tone in which it is written. With the inclusion of the glossary is a great addition and considering the general public in the style of the writing. The Board **approved** the publication of the Equality and Diversity Report.	
UPWARD REPORTS FROM THE BOARD COMMITTEES	
15 Upward reports from the Board Committees: (cttee chairs) **a) Finance & Performance Committee** **b) Staff Experience & OD Committee**	**ROHTB (5/25) 010** **ROHTB (5/25) 011**
Finance and Performance Committee – LW The report was taken as read. • Discussions focused on the Month 12 performance and the outturn for 2024/25. • It is reassuring to confirm that colleagues continually assess and re-assess how care is delivered by detailed analysis and deep dives, and this month we received an excellent report on the Day Case Week in February which identifies how care can be both improved and made more efficient with up to 25% of hip and knee replacement patients being operated on as day cases in the future. • Alongside this, the approach the Committee takes to scrutinising performance in 2025/26 will be re-shaped around an Integrated Performance Dashboard which will secure an appropriate and effective focus on productivity, cost reduction and quality in 2025/26. • Finally, the NEDs on the Committee thanked the Executive Team for the dedication to delivery demonstrated by them and their teams across all dimensions. This is reinforced by recent changes to structure and strategy, as presented today, which I am confident will be successful. • While 2025/26 will be even more demanding, given changes to structures nationally and locally, and no sign of financial relief, delivery will continue to be the focus of the Committee and the Board going forward. JB queried the integrated performance dashboard and questioned what the timeline of this is being published, including quality and workforce data. SW explained that the original aim was March, but this was not achieved. It is believed	

we have an operational dashboard now and the next steps will be to include quality, and then workforce. The aim is by Quarter 1 to have the data by the end of June. The next focus is to look at what does the exception report look like. **Staff Experience & OD Committee – SJ** • The Committee received a very challenging staff story that was received that led to a difficult conversation about the experiences the colleague's had encountered. It was felt it would need a detailed discussion at a Board meeting in the future. • Sickness absence and turnover continues to be an issue. • Output of appraisals still remains an action as it is clear appraisals are taking place, and clear how colleagues feel but more detail is now needed on what the training needs are of colleagues and what support is needed to help people move through the organisation. • Workforce planning now in place and it is clear there is now a focus on using this skill in the right way. TP suggested that a presentation would be welcomed at a future Board. **ACTION: Provide a Workforce Planner Update to SE&OD and then present to the Board. SM** TP queried what action is being taken to address the concerns raised from the staff story. SJ explained that it will be followed up at future SE&OD and SM highlighted the RACE code update will be included at the June Board.	
Performance Reports	
16 Performance Reports: ***for assurance*** • **Finance & Performance** • **Quality Report** • **Workforce**	**ROHTB (5/25) 012** **ROHTB (5/25) 013** **ROHTB (5/25) 014**
The reports were taken as read.	
17 Any Other Business	**Verbal**
There was no further business to raise.	
18 Meeting Effectiveness	**Verbal**
Date of next meeting: Wednesday, 4 June @ 0900h	

PUBLIC SESSION

Next Meeting: 4 June 2025, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 28th May 2025

Number	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT.272	Vaccination Update	ROHTB (3/25) 012 ROHTB (3/25) 012 (a)	05/03/2025	Review and compare the absence data for those out with flu symptoms to demonstrate the risk of not having the flu vaccine and established if this can be used as part of encouraging uptake. Provide an update of outcome to the Board.	NB/AM	02-Jul-25	**ACTION NOT YET DUE**	
ROHTBACT.274	Chair and Chief Executive Update	ROHTB (5/25) 003 ROHTB (3/25) 003 (a)	07/05/2025	Provide a one page update on the clinical decision-making tool roll out programme	MP	02-Jul-25	**ACTION NOT YET DUE**	
ROHTBACT.276	Upward Reports to Board Committee - SE&OD	ROHTB (5/25) 011	07/05/2025	Provide an update from the Workforce Planner to the August SE&OD Committee and then present to the Trust Board in September.	SM	03-Sep-25	**ACTION NOT YET DUE**	
ROHTBACT.275	Chief Operating Officer's Report	ROHTB (5/25) 005 ROHTB (3/25) 005 (a)	07/05/2025	Provide a detailed update in the Chief Operating Officer's report on how the capacity in spinal will be increased by 7-8%	MP	04-Jun-25	**Included in COO report and discussed at Finance and Performance Committee in May. Propose Closure.**	
ROHTBACT.276	Chief People Officer's Report	ROHTB (5/25) 006	07/05/2025	Provide an update on the MSK Academy.	MP/RL	04-Jun-25	**Included on the agenda. Propose Closure**	

KEY:

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

MSK Academy

NHS
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NHS Foundation Trust

Building the MSK Academy

Uzo Ehiogu

MSc, MSc, BSc, BSc, MMACP, ASCC
Clinical Programme Lead, MSK Academy
Honorary Associate Clinical Professor UOB

LBU
LEEDS
BECKETT
UNIVERSITY

UNIVERSITY OF
BIRMINGHAM

Aston University
BIRMINGHAM UK

What is the MSK Academy?

To create an educational vehicle which enhances the expertise of healthcare professionals with knowledge and skills necessary for the delivery of excellent patient care and supports the influence and reputation of the hospital regionally and nationally.

An educational vehicle

Building on our expertise

Sharing knowledge and skills

Enhancing Patient care

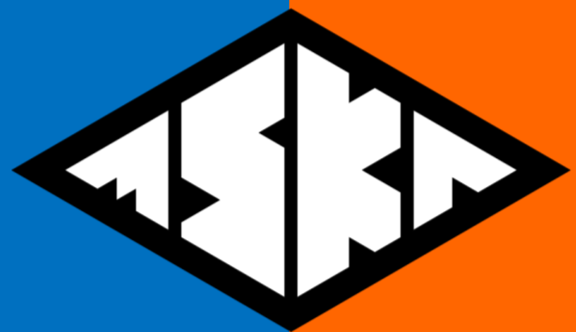
Supporting ROH influence and reputation

Our focus

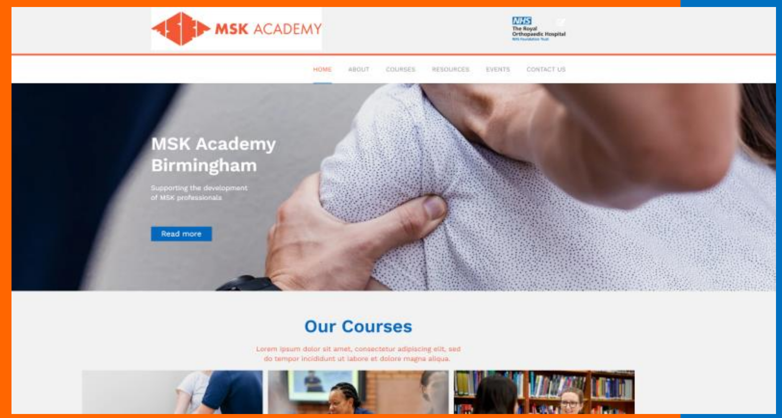
Our potential customers

- Primary Care
- Bsol ICS
- MSK / Ortho Units
- Early-years AHPs
- Nurses
- Clinicians
- Patients / communities
- Global online learners

What will we deliver?



- Virtual courses
- In-person training
- Webinars
- Orthopaedic module
- Conferences
- Lecture series
- Links to research
- Website resources



MSK Academy: Objectives and focus for 25/26.

Key actions during next 12 months:

- Scope out business plan for year 2 – 5 and resources required – In progress
- Conduct robust internal stakeholder engagement and communication (e.g. Audit, APPs, Pharmacy, Theatres) - In progress
  progress
- Deliver quarterly GP engagement events (MSK Management , referrals and examinations) – In progress
- Repurpose Undergraduate Academy examination videos into GP / FCP content on the MSK Academy website – Done
- Develop the Library and Knowledge Services Strategy to consider MSK Academy support – In progress
- Create a Standard Operating Procedure (SOP) for clinical support to lead and organise courses and events (e.g. PR, Marketing, event and delegate management resource) – Marketing, event and delegate management resource) – Done
- Build key stakeholder partnerships (e.g. Universities) for the development of products -In progress
- Establish MSK Academy Delivery group established, with small Faculty linking Research, Education and key enablers – Done
  Done
- Delivery of Early career practitioner programme (Band 5/6) (multi-professional MSK Assessment and Management course) – In Progress

MSK Academy

LESS PAIN
MORE INDEPENDENCE
LIFE-CHANGING CARE

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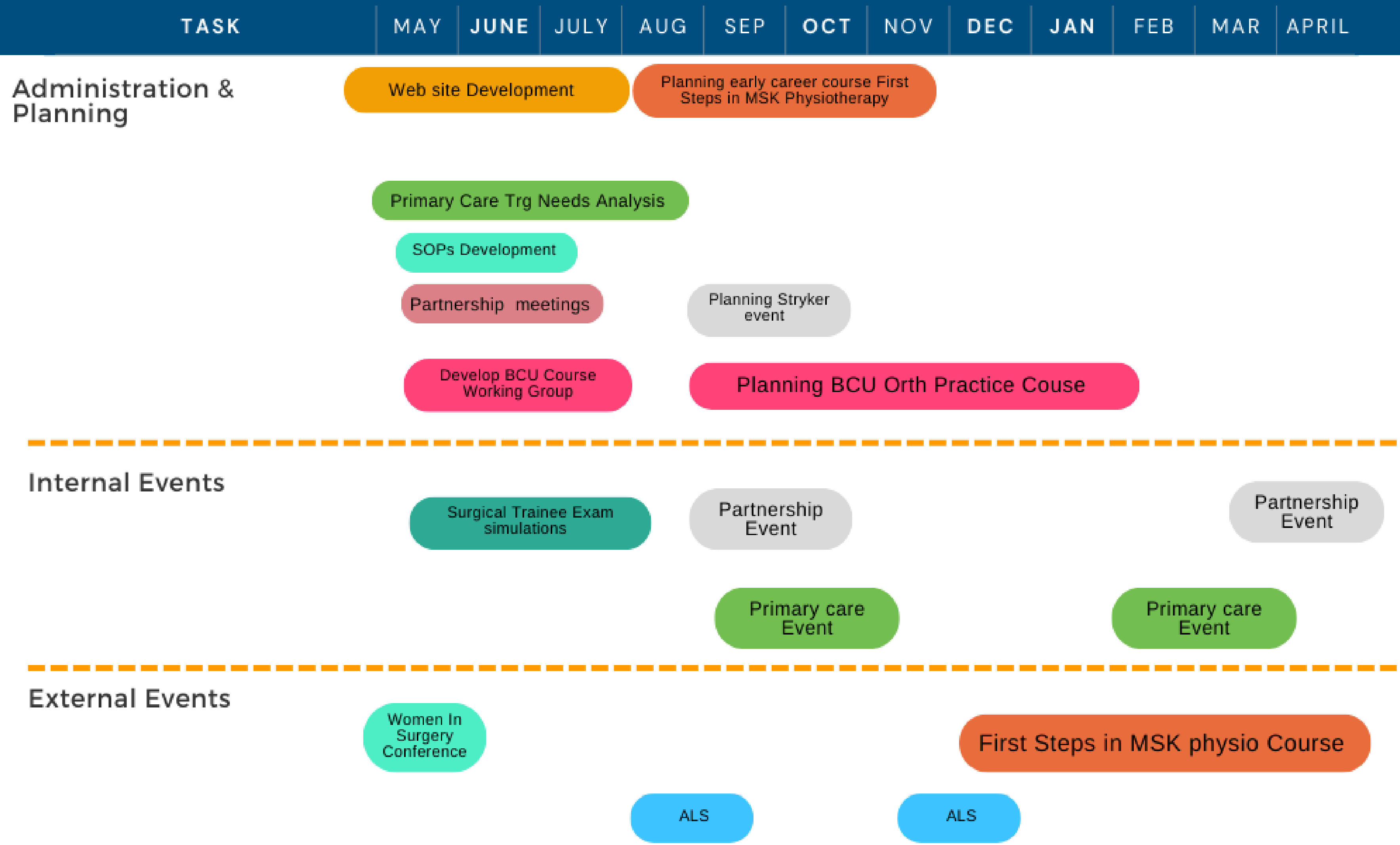
Year one: project timeline



MSK Academy

LESS PAIN
MORE INDEPENDENCE
LIFE-CHANGING CARE

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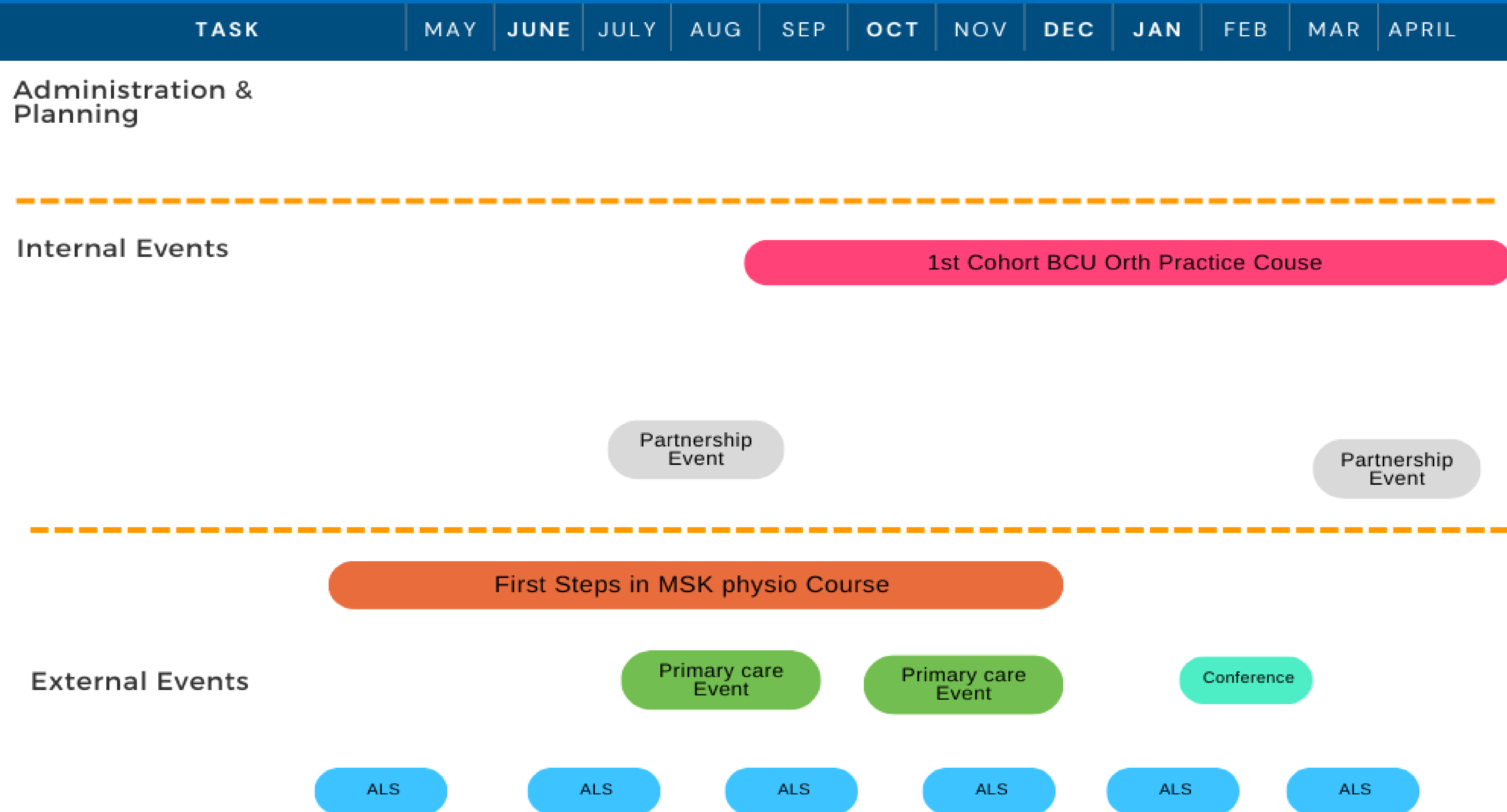
Year two: project timeline



Our long-term ambition

What we will be

The regional and national educational leaders in orthopedic education

Who we will support

- Early years AHPs
- Nurses
- Medics
- Primary Care

Where will we be

A strong online presence with reach, and slick in-person facilities.

How will we work

A well managed educational centre, well integrated into the Trust.

What will we achieve?

- Teaching our own and others
- Supporting skills development and recruitment
- Building partnerships and supporting strategy
- Revenue-generating

Challenges to growth

Challenge	Solution
Financial resources (e.g. back-fill, content creation)	• Undertaking market research to define what is needed to utilise time and resource effectively as we develop products. • Capitalising on resources / courses which already exist • Working with charity and communications to support growth and access to funds
Admin support for event management	• Refining process to make events as easy as possible • Working with Knowledge Hub to develop a sustainable model
Staff engagement	• Developing our internal network • Finding mutual benefit around promotion, reach and development etc • Building a communications plan
Customer / partner engagement	• Developing the website and marketing plan • Undertaking market research • Building on MSK Transformation learning and network (e.g. Primary Care links) • Working with finance to improve payment processes

Thank you for Listening

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TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Chief Executive**
AUTHOR:	**Matthew Hartland, Chief Executive**
DATE OF MEETING:	**4 June 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

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

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• N/A	• N/A

REPORT RECOMMENDATION:

The BOARD is asked to: receive and note the contents of this report.

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

Financial	X	Environmental	X	Communications & Media	X
Business and market share	X	Legal & Policy	X	Patient Experience	X
Clinical	X	Equality and Diversity		Workforce	X
Inequalities	X	Integrated Care	X	Continuous Improvement	

Comments:

ALIGNMENT TO TRUST STRATEGY ***(Indicate with 'x' all those that apply):***

Care	X	Community	X
Expertise		Services	X
People	X	Collaboration	

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

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

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

N/A

BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)***:**

N/A

PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)***:**

N/A

The Royal Orthopaedic Hospital **NHS**
NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

Report to the Trust Board (in Public) on 4 June 2025

1. INTRODUCTION

1.2 Welcome to the report from the Chief Executive from the Royal Orthopaedic NHS Trust.

1.3 This paper identifies some of my key activities since the last Board meeting, some of the most noteworthy events and updates for the Trust and updates from the Birmingham and Solihull system.

2. NATIONAL UPDATE

2.1 NHS Operating Model

The date of the dissolution of NHSE is still expected to be October 2026, however the NHSE and DHSC teams will be working much closer together in advance of this date.

The clustering of ICB's is expected to be implemented within the next few months, however, in order to meet NHSE requirements to reduce running costs this year. The impact on Birmingham and Solihull ICB, and the corresponding impact on specialised commissioning, is not yet confirmed.

We continue to support our colleagues at the ICB and NHSE in this difficult time and will continue to engage with NHSE and the ICB to understand and implement any proposed changes in way of working for the ROH.

2.2 Policy

Glen Burley, NHS England Financial Reset and Accountability Director, wrote to ICB and Trust chief executives during May setting out expectations with regard to elective care demand management. This commissioning initiative is to support the effective management of waiting lists which includes the requirement for providers to ensure that lists are continually reviewed and validated. We will work with the ICB and primary care on additional local initiatives in this regard, including new rules on Advice and Guidance.

2.3 Pay Awards / Industrial Action

The Secretary of State for Health and Social Care has recently accepted the independent Pay Review Bodies' headline pay recommendations for NHS staff. Staff on Agenda for Change terms and conditions will receive an uplift of 3.6%. Resident doctors will see an average uplift of 5.4% (a 4% rise plus a consolidated payment of £750), with a pay rise of 4% for consultants, specialty doctors, and specialists.

We are aware, however, that there is a risk of industrial action for which we will take mitigation action as appropriate as we have done previously.

Also, NHSE has published a new pay framework for Very Senior Managers which will be considered at Remuneration Committee.

3 CHIEF EXECUTIVE ACTIVITIES

3.1 Trust Strategy: 2025 Mid-Term Review

Following our mid-term strategic review, I formally launched the refreshed Trust Strategy at the May Team Brief to ensure clear and consistent communication across the organisation. To support understanding and alignment, it is now being cascaded through Line Managers with clearly articulated messaging, including a concise pocket guide for daily reference and a plan-on-a-page summary. Additional resources are being developed to link the overarching Strategy with departmental business plans, ensuring alignment is clear at every level. This multi-channel approach is designed to embed the Trust Strategy throughout the organisation, building ownership and improving engagement.

In parallel, we are commencing a phased service review process across both clinical and non-clinical areas over the next 12 to 18 months. This will begin with corporate teams, with a phased approach for clinical teams. The service reviews are being introduced to achieve several key objectives:

- Strategic alignment: Ensuring all services support the Trust's refreshed Strategy and delivery plan
- Sustainable transformation: Identifying opportunities for service redesign and financial efficiency
- Equity and consistency: Applying a transparent, data-driven framework to both clinical and non-clinical services
- Workforce transformation: Reviewing roles, structures and skills to build a future-ready and efficient workforce
- Improvement-focused: Embedding continuous improvement into service delivery through performance benchmarking and redesign
- Governance and assurance: Maintaining clear oversight through structured phases, review panels, and executive-level decision-making

This phased approach, running from May 2025 to September 2026, will enable in-year benefits while laying the foundations for long-term sustainability and strategic delivery. Board will receive regular updates following the first meeting of the Strategy Delivery Board in July.

3.2 National Orthopaedic Alliance

On 15th May I chaired the National Orthopaedic Alliance (NOA) Conference. Colleagues from orthopaedic units across the UK joined together and shared good practice and insight – it is always positive to connect and recognise where we have similar challenges but it showed that we have so many opportunities to collaborate and improve orthopaedic care, research and patient outcomes.

My congratulations to colleagues from the ROH who were shortlisted for awards including MSK colleagues for their work on GetUBetter, our Nursing colleagues for their ‘confirm and challenge’ programme which has supported workforce improvements, and our Oncology colleagues for their leadership and innovation in delivering the BOOM conference.

Unfortunately we were not successful but a huge thank you to colleagues for showcasing the Trust and the work we do so well.

3.3 Acute Provider Collaborative (APC)

The Acute Provider Collaborative met in May and in addition to recognising the proactive work led by the Trust on Orthopaedics and MSK, it was pleasing to receive support from the collaborative for the ROH-developed business case for GetUBetter. The case will now be presented to the BSOL Investment Committee with the aim of the app being permanently commissioned to improve the lives of patients and reduce demand on services.

3.4 ICB Board

The agenda for recent ICB Board workshops has been focussed on the impact the changes to the NHS operating model would have on BSOL ICB. As these have been for ICB Board members, I did not attend. The next full workshop is scheduled for 9 June. I continue to be the provider CEO rep on the ICB Finance & Performance Committee.

3.5 Federation of Specialist Hospitals

The report produced by members of the Federation of Specialist Hospitals entitled ‘The Power of Specialism’ is being discussed within NHSE with the continued ambition to inform the 10-year plan due to be published in the summer.

We have committed via the FOSH an ambition to deliver 92% of patients receiving treatment within 18 weeks by March 2027, two years earlier than the governments target. We are currently in dialogue with NHSE regarding the additional funding we will require to achieve this aim.

3.6 Medical Staff Committee

I attended the newly reformed Medical Staff Committee last week. I gave a situational analysis of the ROH and described future plans for the medium-term, followed by an open question and answer session with consultant and other medical colleagues. It was a productive meeting, with various operational and strategic topics raised, with a number of collective actions agreed.

3.7 ROH League

On Saturday 10 May I was privileged to attend the Annual General Meeting of the ROH League, which is a group of retired staff members, mainly physiotherapists and nurses, from the ROH. This was the 60th anniversary of the League and unfortunately this was their last meeting. It gave me another insight into just how important the ROH is to so many people, and how much pride they feel. It was a lovely day with lots of memories shared, and I thanked them on behalf of the Trust for the support they have given to us over the last 60 years.

The League have seen the hospital evolve in so many ways over the years, and I'm pleased that they supported my, and the Board's vision for the ROH for the next few years.

3.8 BSOL CEO and Execs time-out

Leaders from BSOL NHS Trusts, primary care and Birmingham Council met on 16 May as part of our regular development sessions. There were two key agenda items: we discussed the 10-year plan and how BSOL should respond when the plan is published in the summer and how the system prepares itself for winter, with an emphasis on locality models (with their immediate focus on urgent and emergency care) as described later in the paper.

3.9 NHS Confederation

I met with Matthew Taylor, Chief Executive of the NHS Confederation, on the 28 May. We discussed how the ROH is responding to the wider challenges of the NHS, our contribution to system working and our approach to 'Community' agenda. It was a successful meeting, with an agreement for further dialogue to support Confed thinking on health policy, particularly in relation to specialist hospitals and new care models.

3.10 Bourneville Village Trust

I visited Bourneville Village Trust (BVT) on 22 May and welcomed by David Robinson, a governor of the ROH and Pete Richmond, Chief Executive. It was great to hear about the support the ROH has received from BVT and the Cadbury family over the years, but we also discussed how we can further strengthen our relationship and opportunities for mutual support. This will be progressed through the implementation of our refreshed strategy and Board will be kept informed of progress.

3.11 ROH Internal Visits

I have continued to take time to visit colleagues throughout the Trust which has allowed me to meet staff, see the great work they do and give them an opportunity to share any issues they may have which are being progressed through appropriate channels.

4. ROH UPDATE

4.1 Financial Position

The Trust delivered a deficit in month of £377k against a planned deficit of £281k, generating an adverse variance of £104k for month 1. Whilst this is slightly worse than the plan for April, we have overperformed on income, underspent on pay with

low agency and bank usage and other operating expenditure is low compared to average spend in 2024/25 and average planned spend in 2025/26. The efficiency target for April was also largely met. Therefore, the variation in month is driven more from a reduced plan aligned to a reduced activity plan.

4.2 Performance

Headline reported performance metrics for April include 55.6% Referral to Treatment Time (RTT), an improvement on our March position by 0.97%. %. The number of patients waiting over 52 weeks continued to reduce ending the month with 506 patients over 52 weeks. Most patients waiting over 52 weeks are Spinal, for which a recovery plan is in construction. Of all other specialties only 11 patients now exceed 52 weeks and there will be 0 patients waiting over 52 weeks in all specialties (except Spinal) by the end of May 2025

We continue to achievement all national cancer and diagnostic standards and the Trusts productivity metrics continue to show improvement.

4.3 Segmentation

The Trust has been informed by the ICB that the latest segmentation rating of the Trust will be segment 3, due to the year-end financial outturn for 2024/5 of £1.6m deficit.

This, however, is under the 2024/25 National Outcome Framework regime which is changing for 2025/26. The new regime, now called the NHS Performance Assessment Framework is intended to be a more objective method to assess Trust performance and allow greater comparison of organisations.

An assessment of ROH's scores against the new framework, which is currently in consultation phase, is being undertaken and will be shared with Board when complete. The ambition will be to return to segment 2 as soon as possible.

4.4 Birmingham and Solihull Locality model

A strategic priority of the BSOL system has been the implementation of locality and neighbourhood working in the 6 localities within the BSOL system to deliver integrated care at scale.

Overseen by the Community Care Collaborative, infrastructure to support this is currently being implemented with the appointment of Senior Responsible Officers for each locality, being North, South, West, East, Central and Solihull. As the focus of the localities will initially be to improve UEC, as an elective provider the ROH will not lead a locality, however it is important that as an active system partner and to assist localities on elective pathways to release capacity for UEC, ROH make an active contribution and as such has aligned an Executive Director to each locality. Rebecca Lloyd will remain as the ROH representative on the Community Care collaborative.

A further paper will be presented to Board in due course.

4.5 Trust Management Group

Trust Management Group (TMG) has not met since that last Board meeting.

5 POLICY APPROVAL

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

- Recruitment and Selection Policy
- Disciplinary Policy
- Appraisal Policy
- Stress, Health & Wellbeing Policy
- Emergency Preparedness, Resilience and Response (EPRR) Policy

6 RECOMMENDATIONS

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

6.2 Note the contents of the report.

Matthew Hartland
Chief Executive
May 2025

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TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	**Chief Finance Officer's Report M1**
SPONSOR (EXECUTIVE DIRECTOR):	**Steve Washbourne, Chief Finance Officer**
AUTHOR:	**Steve Washbourne, Chief Finance Officer**
DATE OF MEETING:	**27th May 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Month 1 Financial Report

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Elective Income over performance Reduced spend in Bank and Agency	Small Variation to planned deficit in month

REPORT RECOMMENDATION:

The Committee/Board is asked to:

NOTE the Finance Report

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

Financial	x	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	
Clinical		Equality and Diversity		Workforce	
Inequalities		Integrated Care		Continuous Improvement	

Comments:

ALIGNMENT TO TRUST STRATEGY ***(Indicate with 'x' all those that apply):***

Care	x	**Community**	
Expertise	x	**Services**	x
People	x	**Collaboration**	X

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

Risk register and BAF

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

NA

BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)*:

NA

PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:

NA

CFO's Report Month 1

1. Summary

The Trust delivered a deficit in month of £377k against a planned deficit of £281k, generating an adverse variance of £104k.

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	10,843	11,024	181
Other Operating Income (Excluding top up)	436	509	73
Employee Expenses (inc. Agency)	(7,011)	(6,945)	66
Other operating expenses	(4,433)	(4,876)	(443)
Operating Surplus	(165)	(288)	(123)
Net Finance Costs	(123)	(100)	23
Net surplus/(deficit)	(288)	(388)	(100)
Remove donated asset I&E impact	7	11	(4)
Adjusted financial performance	(281)	(377)	(104)

Whilst this is slightly worse than planned, there is much to be positive about within the Month 1 position and operating expenditure is comparatively low, hence the variation in month is driven more from a reduced plan in month

2. 2025/26 Plan and Profile

The plan that was submitted for the year has been profiled across income, pay and non-pay to reflect two main factors; an increasing activity plan driven by theatre availability (there was planned theatre maintenance in Month 1 in addition to the equipment failure) and substantive consultant appointments, and a phased implementation of CIP. Therefore, the plan in month one only assumed elective income of 7.7% and non-pay expenditure of 7.08% in month compared to an average of 8.33%. Conversely pay was planned to be slightly above average at 8.54% as pay is expected to reduce during the year due to the impact of CIPs planned (e.g. reduction in temporary pay spend). This is detailed in Appendix A.

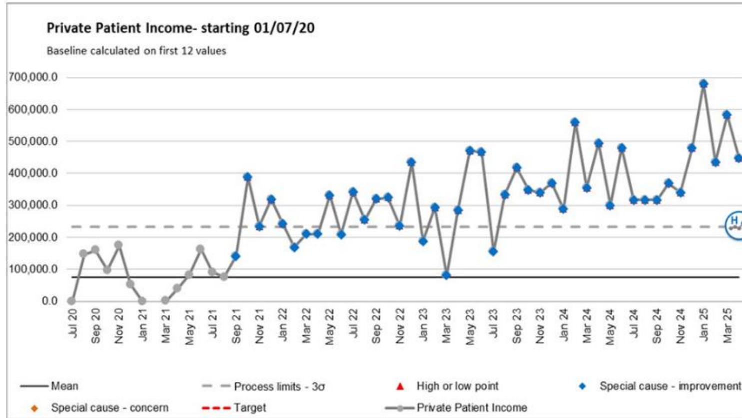
3. Income

As previously discussed, the income position for 2025/26 has been reset based on activity delivered in 2024/25, and required activity to deliver the 2025/26 RTT targets. As the Trust underperformed on its elective activity during 24/25, this has resulted in a real-term reduction in income.

The activity plan for the year has been set based on individual consultant work plans considering substantive consultant appointments, planned theatre maintenance and working days, and as activity is expected to increase through the year there is a correlating planned increase in income.

In Month 1 we delivered a small overperformance on patient care income of £181k (a further split of variable elective income is shown in Appendix B)

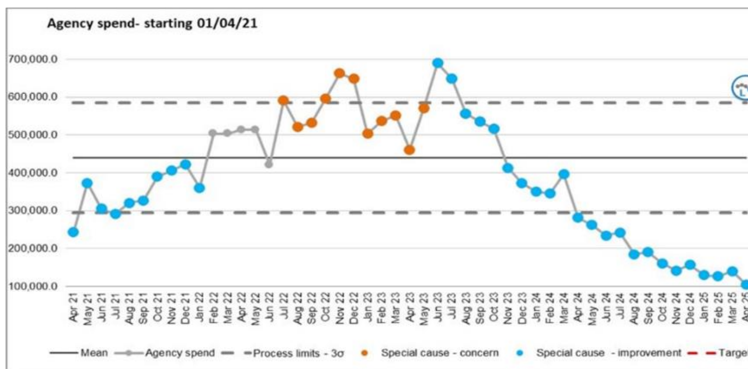
Private patients' income is £447k in month against a plan of £353k.



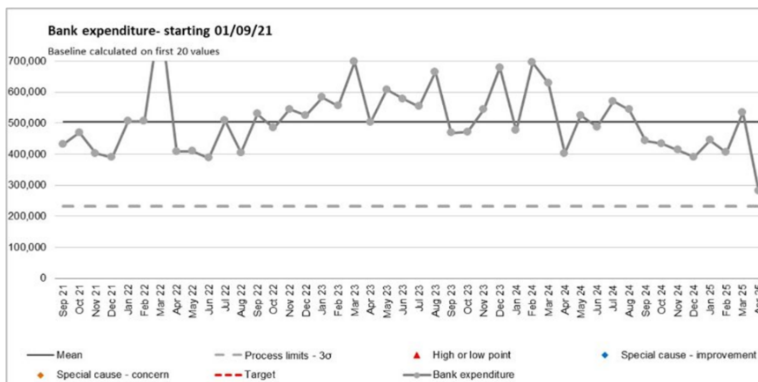
4. Pay

Pay expenditure is underspent in month by £66k.

Agency spend is £105k in M1 (24/25 Ave £188k), or 1.5% of pay.

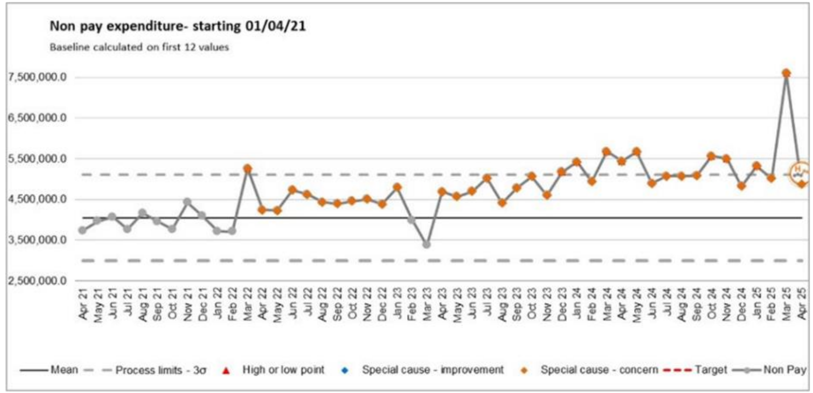


Bank expenditure has reduced to from £282k in month against a plan of £405k (24/25 Ave £466k). Whilst this is lowest spend for some time, it is reflective of a lower activity plan, reduced theatre capacity and ward closures for refurbishment.



5. Non-Pay

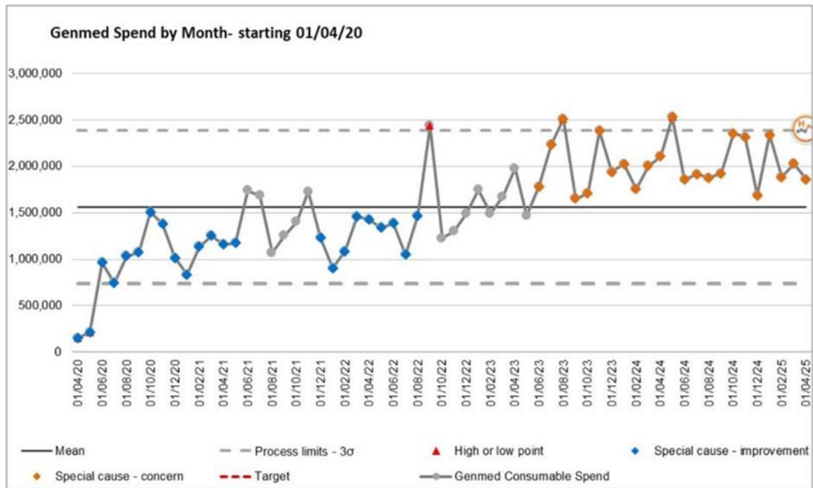
Whilst non-pay spend of £4,876k was above plan of £4,433k, it is below both the average spend in 24/25 (£5,422k) and average planned spend for 25/26 (£5,221k).



LLP spend of £166k was slightly more than planned by £19k, but this was offset by a reduction in ADHs expected of £26k, based on a plan of £93k (ADHs are included as bank pay expenditure).

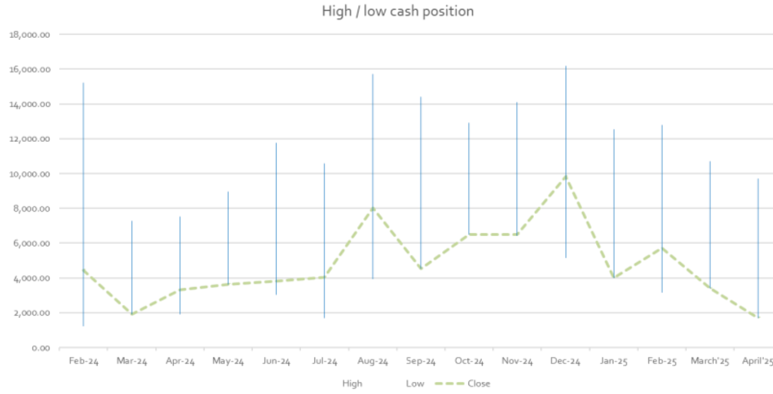
LLP Spend by specialty	Plan	Actual	Variance
Spinal	£20,283.33	£88,808.75	-£68,525.42
Arthroplasty	£111,800	£58,340	£53,460
Anaesthetic	15200	19585	-4385
	£147,283.33	£166,733.75	-£19,450.42

Theatre spend in month was slightly lower than 24/25 average spend but was still slightly higher than expected based on activity delivered. Further analysis of spend, timings and drivers is ongoing.



6. Cash

The cash position remains challenging to manage but remain above de-minimus levels



7. Capital

A summarised capital plan for the year is currently being prepared.

8. CIP and Route to Break Even

A target for the year has been set at £9.4m with plans fully identifying the target.

In month efficiencies of £409k has been generated against a plan of £445k, although this is probably an understatement of actual efficiencies delivered given the temporary spend position detailed earlier (inclusive of ADHs).

Quality Impact Assessments (QIAs) for schemes are in progress with the panel meeting weekly to review assessments.

CIP Scheme	Full year Plan	Recurrent full year effect	Plan April	Actual April	Variance
Bank reduction 10%				26.44	26.44
Agency Reduction 30%				46.00	46.00
LLP	2,705	2,779	214.00	194.55	-19.45
Non Pay Other	745	716	39.10	66.68	27.58
Optimising Medicines value	100	100	8.33	0.00	-8.33
Optimising energy Value	200	200	16.67	0.00	-16.67
Activity gap	0	0		0.00	0.00
Avoid duplication and low value activity	0	0	0.00	0.00	0.00
Digital Optimisation	776	811	55.33	0.00	-55.33
Commercial income	641	586	62.36	75.47	13.10
Service redesign	845	1,212	7.00	0.00	-7.00
Budget management schemes	743	811	42.30	0.00	-42.30
Workforce redesign	1,901	4,004	0.00		0.00
Executive led schemes	1,142	1,627	0.00		0.00
Total CIP schemes 25/26	**9452**	**12,850**	**445.10**	**409.14**	**-35.96**

9. System Position

The system position is shown below:-

System Surplus/(Deficit) including Non-Recurrent Deficit Funding	Expected Sign	SR_PLANYTD1_1 Surplus / (Deficit) Plan 27th March Plan 30/04/2025 YTD £'000	SR_PLANYTD2_1 Surplus / (Deficit) Plan 30th April Plan 30/04/2025 YTD £'000	SR_ACTYTD_1 Surplus / (Deficit) Actual 30/04/2025 YTD £'000	SR_VARYTD_1 Surplus / (Deficit) Variance 30/04/2025 YTD £'000	SR_PLANFOT1_1 Surplus / (Deficit) Plan 27th March Plan 31/03/2026 Year Ending £'000	SR_PLANFOT2_1 Surplus / (Deficit) Plan 30th April Plan 31/03/2026 Year Ending £'000
Birmingham And Solihull ICB	+/-	(872)	(627)	(627)	0	0	0
Birmingham And Solihull Mental Health NHS Foundation Trust	+/-	349	347	(1,086)	(1,433)	4,200	4,200
Birmingham Community Healthcare NHS Foundation Trust	+/-	(109)	(108)	(604)	(496)	0	0
Birmingham Women'S And Children'S NHS Foundation Trust	+/-	0	0	(1,081)	(1,081)	0	0
The Royal Orthopaedic Hospital NHS Foundation Trust	+/-	(282)	(281)	(377)	(96)	34	35
University Hospitals Birmingham NHS Foundation Trust	+/-	(2,648)	(3,953)	(11,221)	(7,268)	(4,200)	(4,200)
System Total	+/-	(3,582)	(4,622)	(14,997)	(10,375)	34	35

System Efficiency Total	Expected Sign	EFF_PLANYTD1_1 Efficiency Plan 27th March Plan 30/04/2025 YTD £'000	EFF_PLANYTD2_1 Efficiency Plan 30th April Plan 30/04/2025 YTD £'000	EFF_ACTYTD_1 Efficiency Actual 30/04/2025 YTD £'000	EFF_VARYTD_1 Efficiency Variance 30/04/2025 YTD £'000
Birmingham And Solihull ICB	+	8,257	8,502	8,502	0
ICB efficiency impacting providers within system	+	0	0	0	0
Birmingham And Solihull Mental Health NHS Foundation Trust	+	2,953	2,953	1,263	(1,690)
Birmingham Community Healthcare NHS Foundation Trust	+	1,559	1,521	897	(624)
Birmingham Women'S And Children'S NHS Foundation Trust	+	2,518	2,518	997	(1,521)
The Royal Orthopaedic Hospital NHS Foundation Trust	+	494	494	409	(85)
University Hospitals Birmingham NHS Foundation Trust	+	8,364	8,360	6,391	(1,969)
System Total	+	**24,145**	**24,348**	**18,459**	**(5,889)**

Appendix A: Plan Profile

Statement of comprehensive income	Expected Sign	Year Ending £'000	24/25 Ave	25/26 Ave	Month 1 £'000	Month 2 £'000	Month 3 £'000	Month 4 £'000	Month 5 £'000	Month 6 £'000	Month 7 £'000	Month 8 £'000	Month 9 £'000	Month 10 £'000	Month 11 £'000	Month 12 £'000	Year Ending £'000
Operating income from patient care activities	+	135,416	11,285	11,717	10,843	11,341	11,414	11,868	11,577	11,941	12,211	11,709	11,959	11,896	11,668	12,172	**140,599**
Other operating income	+	6,428	536	462	436	451	451	498	451	467	498	436	467	451	451	483	**5,540**
Employee expenses	-	(80,735)	(6,728)	(6,839)	(7,011)	(6,976)	(7,001)	(6,916)	(6,866)	(6,859)	(6,833)	(6,826)	(6,818)	(6,687)	(6,667)	(6,610)	**(82,070)**
Other OP Expense	-	(60,112)	(5,009)	(5,221)	(4,433)	(4,927)	(4,919)	(5,389)	(5,117)	(5,387)	(5,594)	(5,155)	(5,458)	(5,450)	(5,248)	(5,577)	**(62,654)**
OPERATING SURPLUS/(DEFICIT)	+/-	**997**	**83**	**118**	**(165)**	**(111)**	**(55)**	**61**	**45**	**162**	**282**	**164**	**150**	**210**	**204**	**468**	**1,415**
Operating income from patient care activities			**8.33%**		7.71%	8.07%	8.12%	8.44%	8.23%	8.49%	8.68%	8.33%	8.51%	8.46%	8.30%	8.66%	
Other operating income			**8.33%**		7.87%	8.14%	8.14%	8.99%	8.14%	8.43%	8.99%	7.87%	8.43%	8.14%	8.14%	8.72%	
Employee expenses			**8.33%**		8.54%	8.50%	8.53%	8.43%	8.37%	8.36%	8.33%	8.32%	8.31%	8.15%	8.12%	8.05%	
Other Op Expenses			**8.33%**		7.08%	7.86%	7.85%	8.60%	8.17%	8.60%	8.93%	8.23%	8.71%	8.70%	8.38%	8.90%	

Appendix B: Elective Variable Income

User Defined Activity field 2	ERF Criteria Sum of Activity Actual	ERF Criteria Sum of Price Actual	Non ERF Criteria Sum of Activity Actual	Non ERF Criteria Sum of Price Actual
Arthroplasty	121	888,888	24	179,816
Arthroscopy	110	609,720	32	135,351
Clinical Support	215	183,745	10	7,819
Foot & Ankle	33	127,511	1	2,665
Hands	128	235,859	6	7,911
Oncology	85	221,585	74	557,269
Oncology Arthroplasty	52	309,484	16	155,586
Paediatrics & Young Adults	2	14,041		
Spinal	73	314,598	12	26,834
Spinal Deformity	43	238,873	4	46,622
UHB	33	136,450	8	16,047
Young Adult Hips	61	176,411	10	19,824
Grand Total	**956**	**3,457,165**	**197**	**1,155,745**

	Values	POD		
	Sum of Price Actual		Sum of Activity Actual	
User Defined Activity field 2	DC	EL	DC	EL
Arthroplasty	4,727	884,161	10	111
Arthroscopy	191,182	418,539	48	62
Clinical Support	183,745		215	
Foot & Ankle	52,709	74,802	18	15
Hands	208,779	27,080	118	10
Oncology	94,508	127,077	64	21
Oncology Arthroplasty	10,315	299,169	13	39
Paediatrics & Young Adults		14,041		2
Spinal	34,119	280,480	36	37
Spinal Deformity	20,401	218,472	22	21
UHB	65,312	71,138	17	16
Young Adult Hips	25,989	150,422	34	27
Grand Total	**891,786**	**2,565,379**	**595**	**361**

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	**Trust Officers' Reports**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Chief Executive**
AUTHOR:	**Executive Directors**
DATE OF MEETING:	**4th June 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Officer's reports are being presented in the Public Trust Board to provide assurance on matters that are not covered in any other report presented to the Trust Board.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• The reports present a number of positive updates that do not feature in any other Board reports	• A number of risks and areas for concern are detailed in the reports

REPORT RECOMMENDATION:

The BOARD is asked to receive and note the updates

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

Financial	x	Environmental	x	Communications & Media	x
Business and market share	x	Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity	x	Workforce	x
Inequalities	x	Integrated Care	x	Continuous Improvement	x

Comments:

ALIGNMENT TO TRUST STRATEGY ***(Indicate with 'x' all those that apply):***

Care	**x**	**Community**	**x**
Expertise	**x**	**Services**	**x**
People	**x**	**Collaboration**	**x**

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

Financial sustainability and recovery

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

A number of matters reflect and impact on the overall System position, particularly the finance and operational performance

BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)***:**

None specifically

PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)***:**

None apart from the Chief Finance Officer's update at Finance and Performance Committee and Chief People Officer's update at Staff Experience and OD Committee.

FOR ASSURANCE

NHS
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CHIEF OPERATING OFFICERS REPORT

Report to Trust Board – June 2025

1 LOCAL MATTERS FOR BOARD ATTENTION

1.1 The operational team have a refreshed focus for 2025/26 working towards achievement of the referral to treatment metrics outlined below in advance of 31st March 2026:

1. 60% of the waiting list to be treated within 18 weeks
2. 67% of patients to receive a 1st appointment within 18 weeks
3. No more than 1% of the waiting list to be waiting over 52 weeks

The Referral to treatment (RTT) reduction plan and key operational performance indicators are monitored weekly against the agreed trajectory. This enables rectification plans to be put in place to deliver early resolution to mitigate any deviations from plan. The team are also continuing to review activity performance on a weekly basis utilising the prospective income tracker to track progress on the activity aligned to the income trajectory. All RTT metrics were delivered in April and on writing this report all metrics for May 2025 are on track to deliver.

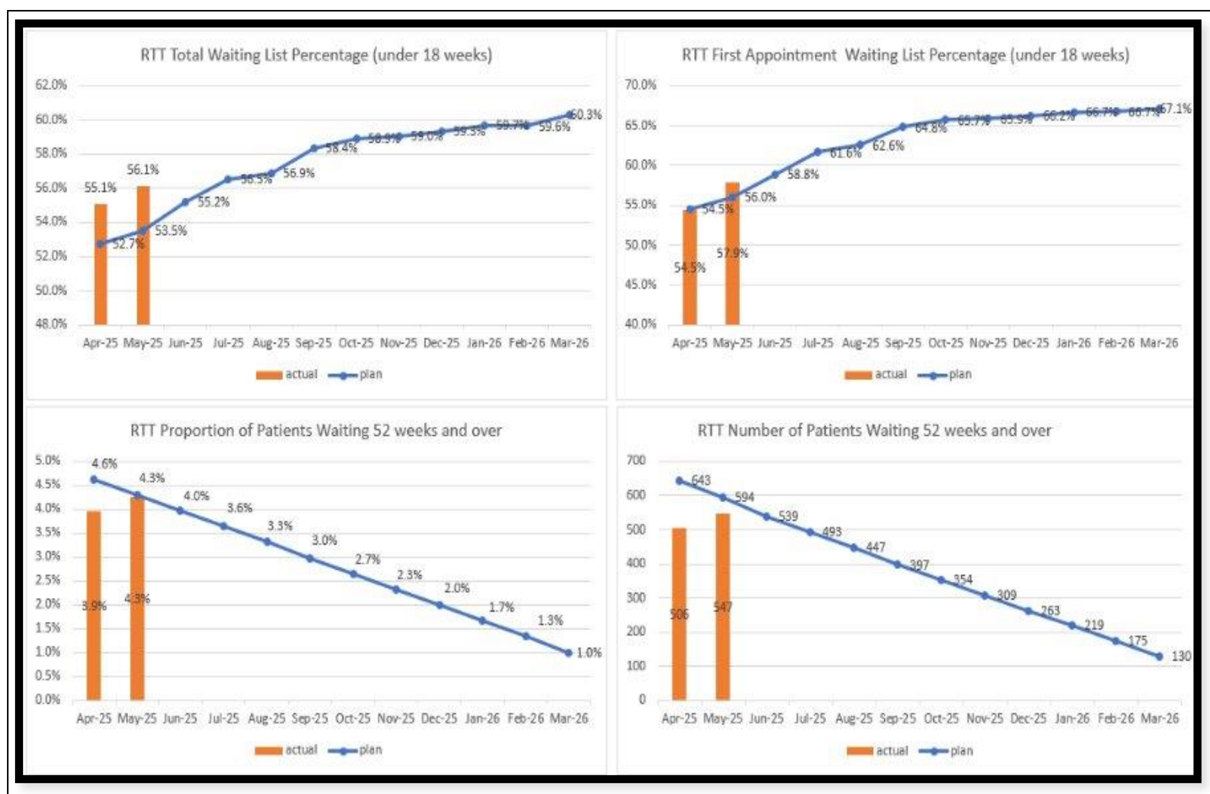
The Trust Improvement group will commence in June 2025 following further refining of scope and the terms of reference.

2 NATIONAL CONTEXT AND DEVELOPMENTS

2.1 The Deputy Chief Operating Officer continues to represent the Trust at the weekly system oversight group and reports performance against cancer standards, RTT and diagnostic delivery. This weekly meeting is supported by NHSE and system performance colleagues to monitor key operational metrics. The Trust continues to receive positive feedback from NHSE on progress made on RTT recovery, and the Trust’s excellent delivery against Cancer and Diagnostics standards. In the recent regional RTT report the ROH were sighted as ‘most improved’ in relation to RTT performance.

3. OPERATIONAL PERFORMANCE

The charts below provide a summary of the Trust's current performance against the agreed Trust trajectory reported to the April 25 Finance and Performance Committee:



3.1 The April 2025 RTT position closed at **55.63%** an increase of **0.97%** on the March 25 reported position of **54.66%**. The number of patients waiting over 52 weeks continued to reduce ending the month with 506 patients over 52 weeks. 495 patients waiting over 52 weeks are on the waiting list under Spinal. Of all other specialties only 11 patients now exceed 52 weeks and there will be 0 patients waiting over 52 weeks in most specialties by the end of May 2025.

3.2 A trajectory is in place for spinal services, and this will be presented at the June FPC committee for assurance. In addition, a quality priority has been set to reduce the waiting times in Spinal exploring innovative ways of working such as, pathway redesign including super triage and discharge clinics. The team is also undertaking a thorough review of Spinal clinic templates to ensure that all capacity is maximised and aligned to national best practice. The arrival of two new consultants will also increase capacity to reduce waits to be seen and a locum is being sourced to support the current loss of surgical capacity due to long term absence.

4 PERFORMANCE HIGHLIGHTS April 2025

Eradication of 65 week waits

4.1 The team achieved zero 65 weeks in April 2025 and is on track to maintain this performance for May 2025.

Elective Activity

4.2 The team achieved above plan for elective activity by 96 cases (9%) for April 25. This is an excellent start to the new year given the challenges faced with 3 theatres being unavailable from 9th March – 12th of May 2025. This significant over performance delivered an associated overperformance in income.

Private Patients

4.3 The team exceeded the plan for April 25 by £21K based on the current annual plan of £5.5 million. The forward look for May 25 is positive with the current position being £545K, £55K over plan. An ambitious plan is being set of £6.1 Million with a stretch plan of £6.5M detailed in a paper being presented at June Trust board.

5. TRUST IMPROVEMENT GROUP – KEY HIGHLIGHTS

The newly formed TIG will hold its first meeting in June 2025, however in transitioning from TPIG the following initiatives are underway to ensure momentum is maintained throughout Q1:

5.1 Private Patient Service

Showcasing the Woodlands Suite facilities and services directly to consultants and their secretarial staff in Q1 has delivered positive early results. The Secretary showcase led to the immediate scheduling of an additional theatre case and highlighted an opportunity to streamline the booking process, improving operational efficiency.

Engagement with consultants has been equally impactful. It has directly contributed to the recruitment of a new consultant, confirmed commitments to regular in-week theatre lists and evening clinics, and enhanced awareness of the private service offer. The stand at audit, presented in full brand colours, reinforced brand visibility supporting the wider marketing strategy.

5.2 Job Planning

The Job planning task and finish group has now been stepped down as all key objectives have been met and delivery will now move into business as usual. The Job planning policy is going through a final approval process, following consultation with the joint Local Negotiating Committee (JLNC). The consistency panel aligned to NHSE

IMPACT best practice is now in place with its inaugural meeting planned in June 2025. The Job planning process is progressing well (70% of job plans now signed off) across both divisions with a plan to complete all outstanding job plans by the end of June 2025.

5.3 Procedure profitability group

This group led by the Deputy Chief operating officer will continue with progress reported through TIG. Work is progressing with the spinal team, where a detailed audit has been completed to inform opportunities for improved data capture to improve coding. In addition, clinical engagement has commenced in Oncology and the Hands service to drive further improvements.

5.3 Theatre improvement group

A service review is planned to commence in June 2025 to support continued improvements in the theatre environment, aligned to the Trust service review strategy. In preparation for the service accreditation review due in July 2025, a ‘Seamless Surgery’ week is also planned to focus on improvements and prepare teams for the assessment process. The week will also involve a specific focus on the WHO checklist and theatre team briefings.

5.4 Outpatient Transformation

Outpatient transformation continues at pace with the appointment of a clinical Service Lead for Outpatient Services, delivering a strong triumvirate to support improvements. It is intended that a detailed presentation of progress in this area will be presented at the July Finance and Performance Committee.

6 KEY RISKS

6.1 The volume of Spinal patients over 52 weeks continues to be a risk to reducing the overall waiting times for the Trust. A rectification plan is now developed supported by a workshop that will be held in June 25 to implement innovative ways of working in line with the Trust’s quality priority.

The theatre estate continues to be a key risk despite the motor repairs completed in May 25 the overall plant is still a risk as identified on the Board Assurance Framework. Scoping of options to support the delivery of the Ambulatory Day Case Unit are currently being reviewed supported by the Interim Chief Executive.

7 WORK PLANNED IN NEXT MONTH

7.1 Reconfiguration of the theatre baseline to provide 50 weeks cover from Quarter 2 with the introduction of the recent consultant appointments. One theatre will be dedicated to private patient activity aligned to developing growth in this service by

offering regular sessions for surgeons to expand income generation aligned to an ambitious income target for 2025/26.

7.2 The Hands service deep dive has been presented to the Finance and Performance committee and the action plan will be incorporated into the Hands Service review.

7.3 The MSK programme continues to progress key deliverables and in May 25 the business case for the self-management tool ‘getubetter’ was presented at the Acute Provider Collaborative meeting to gain support to progress to the system Investment committee. The business case was received well and supported for onward progression to the next stage. The ROH leadership on the national ‘go further faster community physiotherapy waits’ was also discussed and the national recognition for improvements made was noted.

7. RECOMMENDATION(S)

7.1 The Board is asked to RECEIVE and ACCEPT the report.

Marie Peplow - **Executive Chief Operating Officer May 2025.**

FOR ASSURANCE

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

CHIEF PEOPLE OFFICER'S

Report to Trust Board (Public) – June 2025

1 LOCAL MATTERS FOR BOARD ATTENTION

1.1 During May we held wellbeing week which was warmly received by all staff and supported by representatives of the Board including the CEO and Chair. Informal feedback to date has been positive and the week was also used to receive feedback from patient facing teams about how the Trust's wellbeing offer could be further improved.

1.2 I had the privilege of attending the Trust Sexual Safety Bystander training in May. There was good attendance however further work is needed to engage wider staff groups further in attending. Feedback has been provided to the sexual safety working group.

1.3 The Me as a Manager sessions continue to be rolled out across the Trust and there has been positive engagement to date with over 60% of manages (from a total of 250 managers) having attending a briefing session about the programme. There is limited engagement with some of the development sessions offered therefore work is underway to consider what might be the reasons for this and how we can make these particular workshops more attractive to managers.

1.4 We continue to work through the implementation of the Trusts Learning Management system. There have been some minor slippages however an early demo of the portal provides great confidence that the new portal will enable our colleagues to engage with learning in a more efficient and effective way compared to our current solution.

2 NATIONAL CONTEXT AND DEVELOPMENTS

2.1 We have seen the publication of the VSM Pay Framework and also acceptance of the headline pay recommendations for NHS staff from the NHS Pay Review Body, the Review Body on Doctors and Dentists Remuneration (DDRB) and the Senior Salaries Review Body (SSRB). These increases will be backdated to April 2025.

This includes a pay rise of 4% for consultants, specialty doctors, specialists and GPs, with dentists also receiving a contract uplift to increase their pay. In addition, the Department of Health and Social Care has worked closely with unions to deliver on non-pay arrangements, agreed as part of last year's deals, to improve working conditions for these staff groups. Resident doctors will see their pay rise by an average of 5.4% (a 4% rise plus a consolidated payment of £750).

Agenda for Change (AfC) staff, which includes nurses, health visitors, midwives, ambulance staff, porters and cleaners will see their pay rise by 3.6%. This has increased the starting salary of a nurse, for example, from £27,055 in 2022 to 2023 to around £31,050 this year - an increase of around £4,000 over the last 3 years.

Alongside this, the government has also accepted the pay review body recommendation to allow the NHS Staff Council to undertake pay structure reform next year to resolve outstanding concerns about banding within the AfC pay structure.

2.2 On Monday 12 May the government published its Immigration White Paper outlining changes to the UK immigration system to restrict inward migration to the UK. The changes will impact the whole immigration system including illegal and legal migration routes of work, study, and family. The changes will link access to visas to skills and training by prioritising domestic training plans and industry workforce strategies, including for our sector. We will of course take time to understand the full implications of this new policy.

2.3 Building on the successful testing of the Entry Readiness Assessment aspect of the new regional Career Management system, the People, Talent and Culture team in the Midlands region are completing the development of the new system and inviting up to 100 leaders to join the pilot programme to test it. The pilot programme is designed to enable the equitable identification of talent in the region and optimising their chances for progression into senior leadership positions by making them visible and providing them with targeted development support. This pilot is aimed at leaders who aspire to become an Executive Director or Chief Executive Officer in the next 3-5 years. Local scoping of eligible candidates is taking place and will be agreed through the Executive Team.

3 Midlands AI Group

3.1 There are a number of initiatives being scoped as part of the National AI group which will provide efficiencies across several areas.

We are currently scoping the possibilities of shortlisting through AI and the implementation of coding through ESR to support with the production of reports

We will work with our IT colleagues with regards to the implementation of scribe for the purposes of improving our learning of key processes.

4 KEY RISKS

4.1 We continue to face on going challenges with regards to Cyber and IG access issues for completion of core mandatory training modules albeit actions are taking place to resolve this.

4.2 Sickness absence rates continue to pose a risk to service delivery as they are still above the KPI albeit they have improved over recent months. A regular assurance report will be provided to the Staff Experience & Organisational Development Committee (SE&OD) on actions being taken to bring these rates down to an acceptable level.

5 WORK PLANNED IN NEXT MONTH

5.1 Review our current employee assistance programme to ensure that it is fit for purpose and meets the needs of the Trust in terms of preventing absence and supporting wellbeing.

5.2 Commence service reviews within the respective teams to support delivery of the organisational transformation programme.

6 RECOMMENDATION(S)

5.1 The Board is asked to RECEIVE and ACCEPT the report.

Sharon Malhi
Chief People Officer
June 2025

FOR ASSURANCE

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

QUALITY OFFICERS' REPORT

Report to Trust Board on 4 June 2025

1 MEDICAL DIRECTOR'S UPDATE

1.1 The first Quality Improvement Development Day was held on 21st May 2025. This was led by Ben Smith, Associate Medical Director, Angharad MacGregor, Medical Directorate Manager, Alison Newman, PA to the Medical Director and Michelle Hubbard, Deputy COO. Initial feedback has been extremely positive.

1.2 On 14th May, the Trust hosted a Women in Orthopaedic Surgery day. This was led by Rebecca Lloyd, Director of Strategy, Ali Sprason, Charity Manager, Ruth Hughes, Fundraising Manager, Amanda Gaston, Deputy Chief Finance Officer & Jo Thomas, Associate Medical Director. It was designed to welcome female school students to an orientation and education day. The atmosphere and early feedback was hugely positive.

1.3 Clinicians and managers supported and were prominent in the National Orthopaedic Alliance's Annual Member Conference on 15th May. The Trust had finalists in three categories: Workforce Initiatives - Confirm and Challenge: Nursing Workforce Initiative (Emma Steele); Supporting Patients On Their Pathway – GetUBetter (David Rogers); and Innovation in Orthopaedics - BOOM Consensus Meeting (Guy Morris).

1.4 The Trust was represented at the West Midlands Health Technology Innovation Accelerator – Innovation Fest 2025 at Steam House at Birmingham City University. The keynote speech related to a joint project looking at Artificial Intelligence pre-operative prediction, with a panel held afterwards for questions and answers. We have secured another year's funding for this project (Hayley Phillips, BI Officer and Gareth Stephens, Head of Research, Effectiveness & Audit are leading this) and a pilot in Pre-operative assessment is planned.

1.5 The first meeting of a new Regional Research Delivery Network stakeholder group was held on 22 May at which potential opportunities in MSK and health inequalities were discussed. This would align with work we are starting with University of Birmingham – the ALIGN study, led by Gareth Stephens.

2 CHIEF NURSE'S UPDATE

Nursing

2.1 The Care Quality Commission (CQC) carried out an unannounced visit of the Children & Young People (CYP) services on the 6 May 2025 and the outcome report is awaited.

2.2 NHSE (Midlands) nursing team has undertaken a corporate nursing team review using ESR data, supplied by the Trust. Initially the data suggested that the corporate nursing team was an outlier, however following a review of multiple posts we coded, this resulted in the corporate nursing team moving back to the medium position and at this time no change is requested.

2.3 The National Safeguarding Steering Group (NSSG) in December 2024 tasked NHS Safeguarding with undertaking a system-wide annual statutory safeguarding workforce audit. The Trust has submitted the data as requested within the deadline. The guidance clearly outlined this was not a benchmarking audit, but part of a wider review process.

2.4 The Safeguarding team has also received the annual section 11 audit to ensure compliance with the safeguarding statutory requirements. This will be completed over the month of June.

2.5 The Trust has changed the current license holder (LH) for the Human Tissue Authority (HTA) from Steve Washbourne (Director of Finance) to Mathew Hartland (Chief Executive Officer) in month. All the license holder documentation displayed has been updated across the Trust to fulfil the HTA requirements. The biennial Human Tissue Authority peer review is planned for 5 June 2025; the outcome report will be shared in future reports and with the Quality & Safety Committee.

2.6 The Trust has been selected for phase 2 of the Managing Deterioration and Martha's Rule programme, which is due to commence 28 May 2025. This programme will also be supported with funding to aid implementation.

2.7 Dame Nicole Jacobs invited professionals from across health, social care and the third sector to the Palace of Westminster in May, to take part in a Round Table discussion on "Change is led by the survivors, and the allies of survivors". The focus on the discussion was to explore both opportunities and challenges in improving the way in which we identify and respond to domestic abuse. Rebecca Furnival (Head of Safeguarding and lead nurse at ROH for Domestic Abuse) was invited to take part in the discussion, in recognition of her contributions in the field.

Facilities

2.8 The NHS Clinical Waste Strategy set out the following segregation target: 60% offensive (tiger stripe) waste, 20% alternative (orange bag) waste and 20% Incineration waste. The Trust is reporting a significant improvement in April 25 having achieved that target as demonstrated below. 62% offensive (tiger-stripe) waste which is an increase from 23% in previous months. This is a potential annual saving of £23,860 per annum. I would like to thank Kinjal Patel, Waste Manager for her work in achieving this target, as she will be leaving us in June 25.

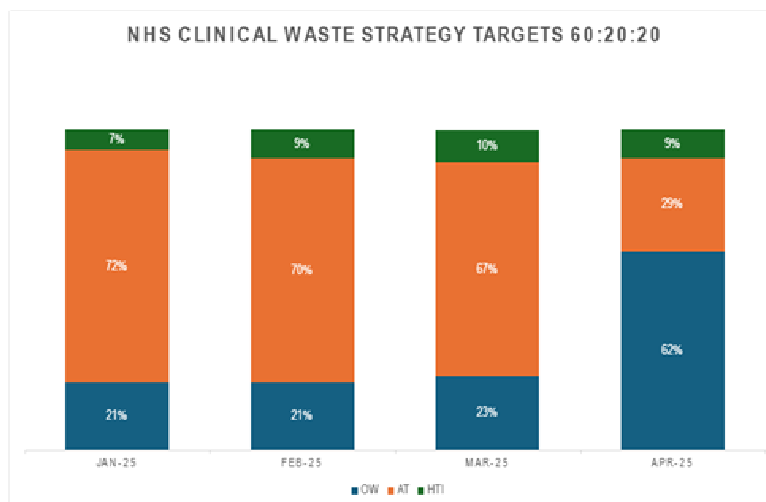


Table 1. Segmentation of clinical waste

3 DIRECTOR OF GOVERNANCE'S UPDATE

3.1 The quarterly Health & Safety Group meeting was held on 14 May, which saw good attendance and participation. There was some positive update on the improvement in compliance with the annual fire safety mandatory training position and a useful update on the progress with the roll out of the stress policy. An update on compliance with the national Violence Prevention & Reduction Standards was provided which showed a positive position.

3.2 The roll out of the Health & Safety audit programme continues and the outcome will be reported at the next Health & Safety Group and upward to the Quality & Safety Committee.

3.3 The Governance Team was heavily involved in organising the material requested as part of the recent CQC inspection of the CYP pathway and work is underway to debrief from the process and understand lessons learned to build into the wider organisational CQC readiness programme.

3.4 The Trust Chair recruitment process occurred in May, whereby a successor to Tim Pile was selected. Thank you to the interview panel which comprised a selection of governors, the Vice Chair and the regional NHSE Director who made a recommendation to the overall Council of Governors which was subsequently approved. Communications about the successful candidate will be issued during w/c 2 June 2025.

3.5 Interviews for the Programme Management Office (PMO) Manager were held on 12 May 2025 and congratulations are to be offered to Tammy Ferris, who was successful in her application. Tammy will retain her role as Corporate Services Manager, but will work with the Service Improvement team over the coming weeks to implement the PMO.

4 RECOMMENDATION(S)

4.1 The Board is asked to RECEIVE and ACCEPT the report.

Matthew Revell, Medical Director
Nikki Brockie, Chief Nurse
Simon Grainger-Lloyd, Director of Governance

June 2025

NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	**Quality Priorities 2025/26**
SPONSOR (EXECUTIVE DIRECTOR):	**Nikki Brockie, Chief Nurse**
AUTHOR:	**Nikki Brockie, Chief Nurse**
DATE OF MEETING:	**4 June 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The purpose of this paper is to present the final report on the quality priorities for 2024 / 2025 as previous presented to the Board.

The paper also asks for the Board support of the proposed quality priorities for 2025/ 2026.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Three priorities moved to business as usual. • Services accreditation phase 1 complete • Improved SSI's • Health inequalities incorporated into the Mid term Trust strategy	• Two priorities prosed to roll into 2025/26 to allow completion of the priorities.

REPORT RECOMMENDATION:

The Board is asked to: note and accept the report. Provide support for the quality priorities for FY 25/26

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

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	X
Clinical	x	Equality and Diversity		Workforce	X
Inequalities	X	Integrated Care		Continuous Improvement	x

Comments:

ALIGNMENT TO TRUST STRATEGY ***(Indicate with 'x' all those that apply):***

Care		**Community**	
Expertise	x	**Services**	x
People		**Collaboration**	x

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

Annual quality account

ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
Reduce inequalities, protect people form harm & Be there across the life course.
BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)*:
N/A
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
Previous quarterly reports Quality & Safety Committee May 2025

Quality Account 2024/25 – Quality Priorities (End of year report)

Report to Trust Board

1.0 Executive summary

1.1 The purpose of this paper is to present the final report on the quality priorities for 2024 / 2025 as previous presented to the committee.

1.2 Following evaluation of the Quality Priorities (QP) for 2023 / 2024, it was recommended that work continues on two priorities in the coming year. Therefore QP2 & QP4 rolled over into 2024 / 2025. This allowed time for initiatives to be monitored and outcomes to be assessed for effectiveness using a quality improvement methodology approach. The remaining three priorities were identified by reviewing the CQC in-patient survey results, complaints, PALS contacts, KPMG report (Health Inequalities) and the Nursing Plan for 2024 – 2028 (Draft).

1.3 In April 2024, the Council of Governors agreed to continue to sponsor QP4 as the work is planned to continue into 2024/ 2025. Executive lead and Operational Leads for each priority have been identified as outlined below:

	Quality Priority	Operational Lead	Executive lead
Safe	Reduction in surgical site infection.	Vicki Clewer IPC lead	Nikki Brockie Chief Nurse
Caring	Improve the quality of communication to our patients.	Karen Hughes, Head of Nursing Division 1, Nasir Uddin, Associate Director of Operations Division 1	Nikki Brockie Chief Nurse
Effectiveness	Development and Implement of the Health inequalities plan.	Nikki Brockie Chief Nurse & Rebecca Lloyd Deputy Director of Strategy	Mathew Hartland CEO
Responsive	Optimisation of patient's health prior to surgery.	Jennifer Pearson, Head of Nursing Division 2.	Nikki Brockie Chief Nurse
Well-led	Introduction of Service accreditation.	Emma Steele Deputy Chief Nurse	Nikki Brockie Chief Nurse

2 Quality Priorities for FY 24 / 25

2.1 Priority 1. Reduction in surgical site infection

Safe	**Reducing surgical site infection risk rates for knee replacement and spinal surgeries undertaken at ROH from 2024/25 onwards.**
Leads	Victoria Clewer – Infection Prevention and Control Lead Nurse
Executive Lead	Nicola Brockie – Chief Nurse and Director of IPC (DIPC)

Why we chose this QP?

Reducing SSI risk rates for knee replacement and spinal surgeries at ROH has been selected as a quality priority for 2024/25 onwards due to incidences of 'higher outlier' status across the following quarters:

Quarter/Months/Year	Category	Risk	Benchmark	Status
Q1 – Jan-Mar 2024	Knee replacement	0.7%	0.2%	Higher outlier
	Spinal surgery	1.7%	0.9%	Higher outlier
Q3 – Jul – Sep 2023	Knee replacement	0.7%	0.2%	Higher outlier
	Spinal surgery	1.7%	0.9%	Higher outlier
Q1 – Jan – Mar 2023	Hip replacement	0.0%	0.3%	Lower outlier
Q3 – Jul – Sep 2022	Hip replacement	1.6%	0.3%	Higher outlier
	Spinal surgery	2.8%	0.9%	Higher outlier

Significant decrease and sustained reduction of SSI risk rate was observed in knee replacement surgeries following the initial creation and implementation of the 'theatre focus group' which has since formed into the SSI prevention group. The main improvements brought about by the creation of this group was to reestablish an appropriate cleaning and decontamination regime within the theatre department as well as reinstating theatre etiquette and discipline, primarily with a review of the theatre 'red lines' denoting areas that require theatre attire and IPC practices to maintain cleanliness and sterility. The 2024/25 quality priority objective is to build upon this work and further address surgical practice, etiquette, and standards.

What actions have been taken?

Four key actions were identified to address the increased risk rate for knee replacement and spinal surgeries. These also further contribute to maintaining lower SSI risk rates for hip replacement surgeries and other surgeries for which surveillance is not currently undertaken.

1. Creation and implementation of an ROH specific SSI prevention bundle.
2. Formalise the reporting and sharing of UKHSA SSI surveillance quarterly reports.
3. Create an orthopaedic IPC collaborative between The Royal Orthopaedic Hospital, The Robert Jones and Agnes Hunt Orthopaedic Hospital and The Royal National Orthopaedic Hospital.
4. Adopt a PSIRF approach to SSI reviews and utilise themes/feedback alongside an establish formal audit process to inform future QI priorities and practice.

How have we evaluated success?

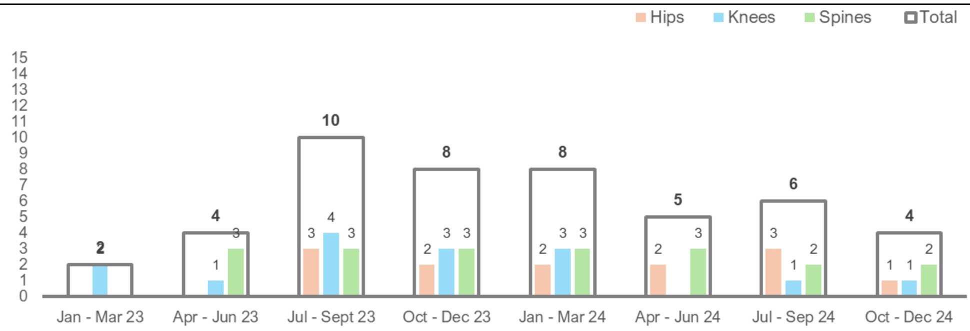
As part of the quality improvement work, use of statistical process control (SPC) charts has been implemented to monitor SSI risk rate, SSI incidence and plot interventions. In doing this we are able to monitor the work being undertaken and have a visual confirmation of its impact.

Success will be apparent if there is a sustained decrease in SSI risk for knee replacement and spinal surgeries and no further increase in SSI risk for hip replacement surgeries.

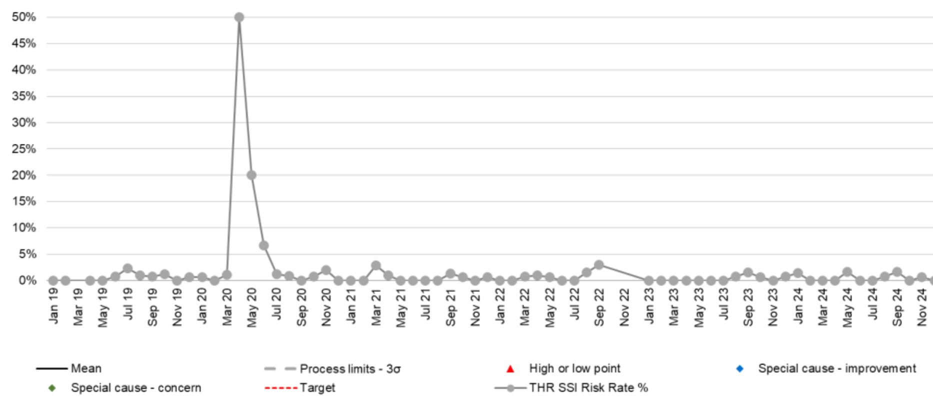
What does success look like?

- A sustained reduction in SSI risk rate for knee replacement and spinal surgeries.
- Embedded evidence-based surgical practices and an improvement in theatre standards and etiquette.
- Improved local benchmarked reporting and a collaborative approach to improvement.

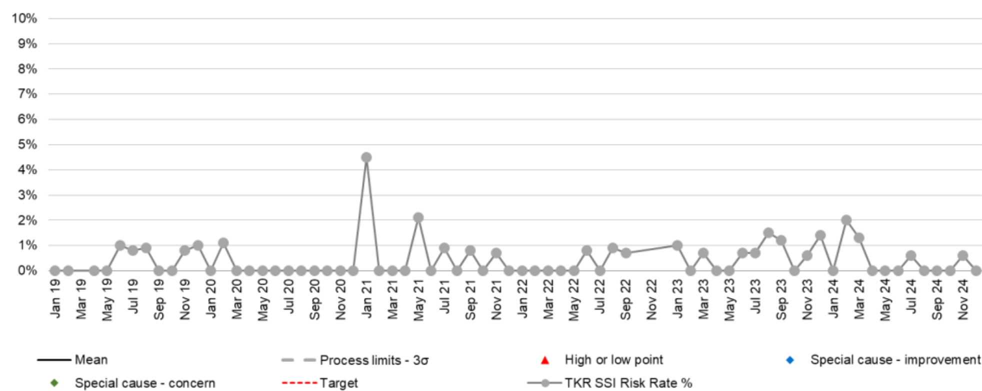
Actions Completed	1. ROH application and use of the UKHSA SSISS protocol has been reviewed to ensure an efficient service. Service provision and requirements have also been reviewed. Workforce capacity and capability to continue with existing surveillance programme has been confirmed. All staff who participate in the collection of data for the SSISS have undertaken UKHSA SSI training. 2. Process and timeframe for sharing SSI data has been reviewed and documented for future refence. IPCT attend speciality multi-disciplinary team meetings as requested/required to coincide with the release of quarterly SSI reports from UKHSA to facilitate discussion with surgeons. 3. To support the inclusion of clinical staff within the SSI prevention work an 'SSI dashboard' has been created and displayed within the theatre department to update all staff of the current SSI risk rates, improvement work and inform ways in which they are encouraged to get involved and support his work. 4. Collaboration between ROH and RJAH allows the free sharing of SSI risk rate data on a quarterly basis to allow benchmarking to take place. 5. ROH were early adopters of the PSIRF from an IPC perspective and much work has gone into continuously reviewing how SSIs are investigated. Work on reviewing this process for SSI reviews has been completed ensuring a meaningful through review of the data collected for all SSI reported. This includes the monitoring of compliance with 'one together' practice standards as well as facilitating ease of use for trend monitoring and escalation. The updated process has created an SSI register which is used to gather data to inform thematic reviews should future 'higher- outliers' be identified. This also allows real-time surveillance and monitoring of trends which will trigger further interventions such as targeted observations (one-together audits) of surgical practice, theatre/ward environments etc.
Ongoing Actions	1. A multidisciplinary approach is being taken to develop and implement an ROH specific SSI prevention bundle. This is based on NICE guidance and informed by the 'One Together' SSI prevention bundle – both of which are evidence-based tools, specifying practices that are recognized to minimise the risk of SSI. This action will continue into 2025/26 – with the bundle ready for implementation by the end of quarter 1 (June 2025).
How has success been measured?	Awareness of the SSI surveillance process within the theatre environment has already had a positive impact, IPC continues to be discussed regularly and is high on the agenda and taken seriously by all within the department and across the Trust. Ongoing success will be influenced by the embedding of the ROH SSI prevention bundle and continued high standards of practice. This will be reflected by a reduced SSI risk rate. Interventions and effectiveness is monitored at monthly SSI prevention group meetings in which the ROH SSI prevention bundle leads provide upward reports and monthly action log updates. These meetings are minuted. An overall group action log is kept tracking additional actions as required.



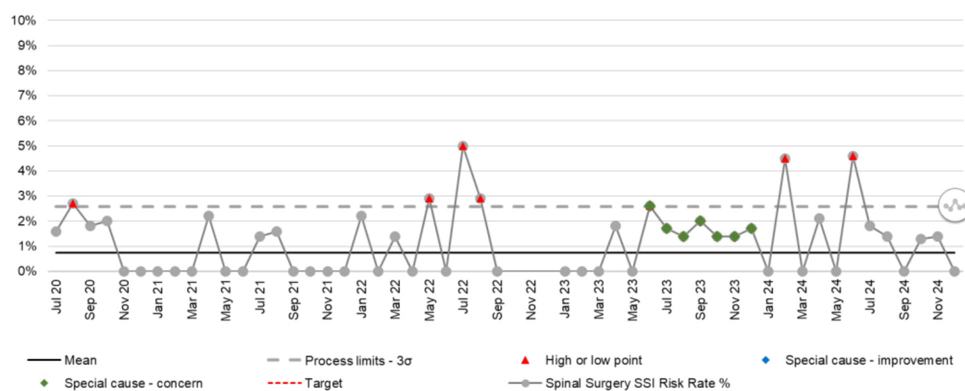
Total hip replacement surgery risk rate % (inpatient & readmissions, includes primary & revision surgeries):



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



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



2.2 **Priority 2. Improve the quality of communication to our patients.**

Caring	**Improve the quality of communication to our patients**
Leads	Karen Hughes, Head of Nursing Division 1, Nasir Uddin, Associate Director of Operations Division 1
Executive Lead	Nikki Brockie Chief Nurse
Why we choose this QP?	Medical and healthcare information can be complex, if people don't get clear and understandable information, they may make decisions that aren't right for them or not be able to access services at all. Our Patient Advice & Liaison (PALS) contacts data highlights that for patients who contact us 'Appointment' and 'Communication' issues remain. This quality priority was partially achieved in 2023/24; however, it was felt that additional focus was required on reducing occurrences of communication issues and further development of easy read letters. The MDT working group focused on these areas in 2024/25.
What actions have been taken?	• Review of process for enabling letter templates to be created/amended and added to PAS to ensure meet the Patient Information standards and are standardised where possible.

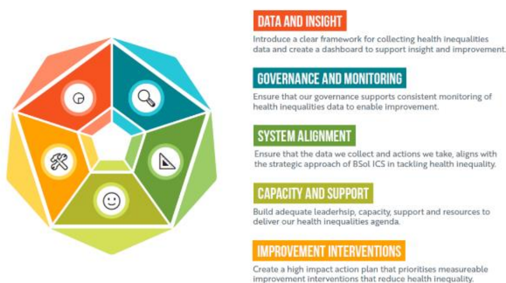
	• Review of all existing letter templates on PAS. • Review of text messaging process. • Review themes from patients' complaints/PALS which if addressed would improve patient experience. • Identify where this work can be maintained and monitored as 'Business as Usual'
How have we evaluated success?	• Review of complaints/ PALS data (relating to communication) • Approved letters on PAS meeting the required Patient Information standards. • Ongoing success will be influenced by the maintenance of this work and completion of the suggested outstanding actions.
Action completed	On-going monitoring of PALS/Complaints and Incidents relating to communication for themes/trends via Divisional Governance structures. • Established automated process to ensure any new/amendment letter template requests to IT for entry to PAS have been through Comms patient information process. • Review of all letter templates including for Therapies, ONKOS and CRIS and confirmed compliance against Patient Information standards and that they contained consistent up to date information. • Accessible Information Group re-established- chaired by Patient Access Clinical Service Manager who will continue this work. • Review of appointments team staffing structure to ensure appropriate for number of calls received and other workload. • Review of appointments SOPs to ensure processes for booking, changing and cancelling appointments are clear and include details of how this is communicated to patients. • Proposal paper was written for OMB regarding Trust use of Easy Read format for all appointments, following engagement with key stakeholders. Due to planned agenda item being Business Planning, not discussed. Virtual decision requested. • Reduced number of letter templates currently on PAS (started with 235)-on-going piece of work.
On-going actions	• Develop active directory of 'live' letter templates which are reviewed annually at Accessible Information meeting • Progressing proposal to move to easy read format for all appointment letters • Review of processes for patient text messaging as currently a free text option available. • Review of PAS manager access privilege to ensure only those who need for role have. • Archiving of all templates not required.

How has success been measured?	Themed complaints and PALS data was provided by the Patient Engagement Team. Overall based on the information available, concerns raised to PALS relating to communication have reduced from 82 in 23/24 to 50 in 24/25. Complaints have increased from 5 to 13. However, during this period there have been factors within operational teams and capacity which have impacted and were beyond the scope of this Quality Improvement, which have led to the increase in complaints relating to cancelled and rescheduled appointments, these are monitored in existing Governance and Operational forums. **Recommendations** • The clear read proposal is formally reviewed and a decision made by OMB. • The completion of outstanding actions and on-going monitoring to be via the Accessible Information Group, to ensure this becomes Business as Usual.

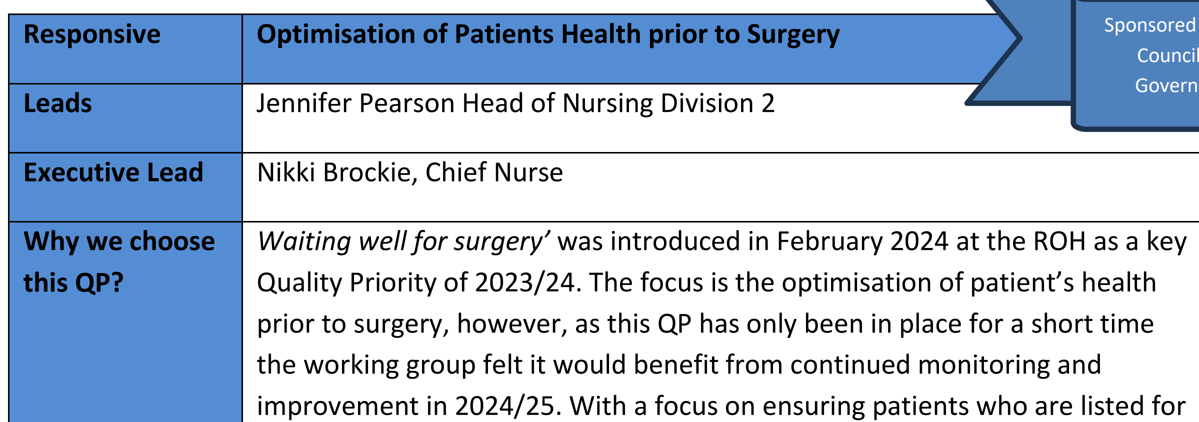
2.3 **Priority 3. Implement of the Health inequalities plan.**

Effectiveness	Develop and implement a Health Inequalities Plan with clear targets and objectives to improve patient access / experience and to meet the needs of our local population.
Leads	Nikki Brockie Chief Nurse & Rebecca Llyod Deputy Director of Strategy
Executive Lead	Mathew Hartland Chief Executive Officer
Why we chose this QP?	Health Inequalities are ultimately about differences in the status of people's health. But the term is also used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives – both of which can contribute to their health status (Kings fund 2022). Over the next year our ambition is to develop a plan that will meaningfully improve the MSK and orthopaedic care of our local population.
How have we evaluated success?	• Achieving the recommendations within the KPMG Health Inequalities report for FY 23/24 • Development of a trust strategy
Actions completed	• Development and delivery of the Health Inequalities action plan • Health Inequalities has been incorporated into the Trust refreshed mid-term strategy. With clear metrics outlined. • Development of an annual improvement action plan to be presents to Board. • There has been some deep dive into the data, but this remains difficult with work required in the coming year.

	• Alignment of the Trust to the FSH Health Inequalities work stream, networking and engagement with other FSH's. • Two Board members have undertaken the NHS Confederation Health inequalities for executive programme. • Governance is in place and alignment to the Board Assurance Framework has been undertaken. • Align with the LD & Autism strategy. With noted improvements in compliance of Oliver McGowan training. • Improvement engagement with BLACHAR work. • Variety of improvement initiative undertaken including: Health Hacks, Health Inequalities bus planned for April.
On-going actions	• It was presented and agreed at Board in April 25, that health inequalities would be monitored via the Trust strategy. This would be supported by an annual action plan that feeds into the annual delivery plan for the strategy.
How has success been achieved. will we evaluate success	• Approved Mid-term Trust strategy refresh. • Some improved data and understanding of our patient demographic affecting access and choice. • Improved governance and reporting routes. • Improved access for our local communities. • Improved engagement at system and national level.

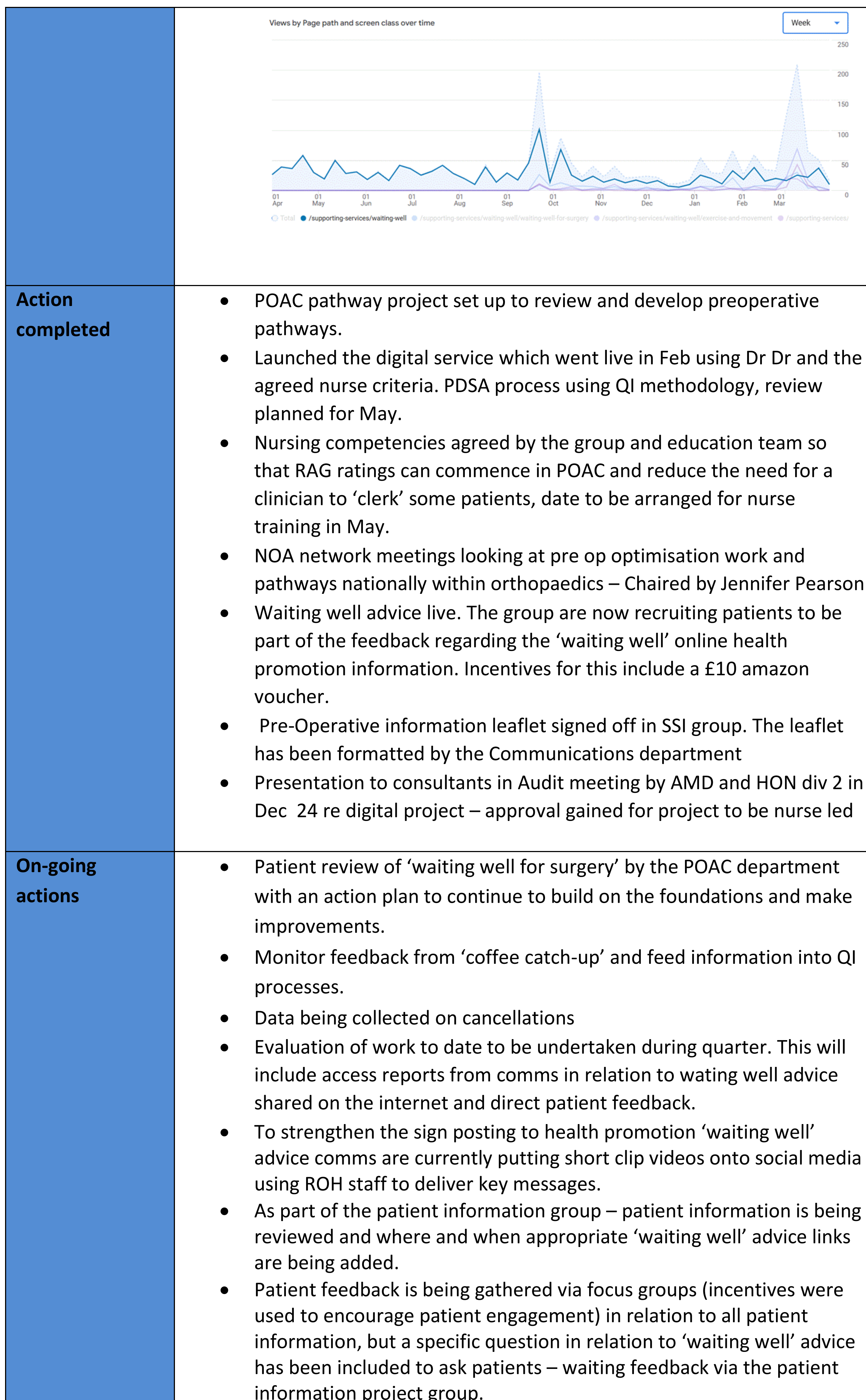


2.4 **Priority 4. Optimisation of patient's health prior to surgery**



Responsive	**Optimisation of Patients Health prior to Surgery**
Leads	Jennifer Pearson Head of Nursing Division 2
Executive Lead	Nikki Brockie, Chief Nurse
Why we choose this QP?	*Waiting well for surgery'* was introduced in February 2024 at the ROH as a key Quality Priority of 2023/24. The focus is the optimisation of patient's health prior to surgery, however, as this QP has only been in place for a short time the working group felt it would benefit from continued monitoring and improvement in 2024/25. With a focus on ensuring patients who are listed for

	surgery are optimised at the earliest possible point in their pathway through effective early screening processes. The working group were also keen to implement a digital solution that allows patients to share concerns about skin integrity prior to surgery, thereby reducing cancelations on the day.
What Actions have been taken?	• Developed a working group with aim to develop a pre-screening pathway working with divisional colleagues. The pathway has been signed off and agreed by stakeholders and training to implement this will begin in May 2025 • Worked with IT department to explore and evaluate the introduction of digital and remote pre-operative skin inspection tools. Implementation as able following a thorough evaluation and risk assessment. Ensure patient who are digitally excluded are considered and supported. This was launched in Feb 2025 using Dr Dr following agreement from surgeons and the implementation of a new nurse led criteria which allows autonomy of nurses to postpone patients if the criteria reveal infection or other which would be detrimental to surgery. This process is under review.
How have we evaluated success?	• Reduction in cancellations due to highlighting skin integrity issues • It is highly encouraging that patients now have access to a range of *Waiting Well* resources, and that staff across both OPD and POAC are demonstrating increased confidence and consistency in signposting patients to appropriate support and advice. • Analysis of the quantitative data suggests that uptake via QR codes remains limited. While website traffic shows some engagement, the number of visits remains relatively low in comparison to the volume of patients who have been provided with, or directed to, *Waiting Well* information. Qualitive data from communications has been collated. (see below) In response to the limited digital/QR engagement, the Communications Team has transitioned the *Waiting Well* website to a "business as usual" status. Moving forward, efforts will focus on enhancing outreach through short, engaging social media clips designed to more effectively capture patient interest and encourage wider access to key advice. Total views: 1,410 page views 762 unique users Views over time:



Action completed	• POAC pathway project set up to review and develop preoperative pathways. • Launched the digital service which went live in Feb using Dr Dr and the agreed nurse criteria. PDSA process using QI methodology, review planned for May. • Nursing competencies agreed by the group and education team so that RAG ratings can commence in POAC and reduce the need for a clinician to 'clerk' some patients, date to be arranged for nurse training in May. • NOA network meetings looking at pre op optimisation work and pathways nationally within orthopaedics – Chaired by Jennifer Pearson • Waiting well advice live. The group are now recruiting patients to be part of the feedback regarding the 'waiting well' online health promotion information. Incentives for this include a £10 amazon voucher. • Pre-Operative information leaflet signed off in SSI group. The leaflet has been formatted by the Communications department • Presentation to consultants in Audit meeting by AMD and HON div 2 in Dec 24 re digital project – approval gained for project to be nurse led
On-going actions	• Patient review of 'waiting well for surgery' by the POAC department with an action plan to continue to build on the foundations and make improvements. • Monitor feedback from 'coffee catch-up' and feed information into QI processes. • Data being collected on cancellations • Evaluation of work to date to be undertaken during quarter. This will include access reports from comms in relation to wating well advice shared on the internet and direct patient feedback. • To strengthen the sign posting to health promotion 'waiting well' advice comms are currently putting short clip videos onto social media using ROH staff to deliver key messages. • As part of the patient information group – patient information is being reviewed and where and when appropriate 'waiting well' advice links are being added. • Patient feedback is being gathered via focus groups (incentives were used to encourage patient engagement) in relation to all patient information, but a specific question in relation to 'waiting well' advice has been included to ask patients – waiting feedback via the patient information project group.

How has success been measured? **(Examples such as plan, booklet, teaching aids letter template etc).**	• PEEG group feedback • Patient feedback using questionnaires • Outcomes from POAC project group • Impact of cancellations on the day following launch of Digital Project

2.5 **Priority 5. Introduction of Service accreditation**

Well-led	**Introduction of Service Accreditation across all Clinical Areas**
Leads	Emma Steele, Deputy Chief Nurse
Executive Lead	Nicola Brockie, Executive Chief Nurse
Why we choose this QP?	The service accreditation system is a quality assurance programme that follows a structured approach using a uniformed 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) Previously The ROH did not have a formal service accreditation system for nursing and allied health services which drives continuous improvement across the Trust. The design and implementation of a 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
Actions completed	Accreditation awarded to all departments in Phase 1 at a celebration event on Tuesday 3rd December 2024 attended by Executive Nurse Nikki Brockie and Interim CEO Mathew Hartland Ward 1 – Silver Ward 2 – Silver Ward 3 – Silver Ward 4 – Gold Ward 12 – Gold ADCU – Gold Presented progress to Quality and Safety Committee in September 2024 and Trust Board in October 2024
On-going actions	Engage with other departments/staff groups to plan Accreditation for services Invite AHP colleagues to join Assessor group Phase 2 standards are progressing well. Areas include POAC, OPD, Discharge lounge, College Green and ROCS. Assessors training has taken place and the leaders for the areas have been briefed. Phase 2 assessments will commence week beginning 28th April. New Quality and Safety walkabout process is underway and evaluating well.
How has success been measured? **(Examples such as plan, booklet,**	• Increases staff engagement, encourages team working and improve staff morale, leading to reduced turnover, sickness, and reliance on temporary staff. • Monitor and track staff experience using Pulse survey (quarterly) and staff survey data specifically in relation to '*we feel empowered to make improvements*". • Improved ward-to-board assurance on the quality of care and compliance with fundamental standards which enables preparedness for external inspections. • Ability to review results on AMaT

teaching aids letter templat e etc).	• Taking on board feedback and altering standards accordingly

3.0

Monitoring and reporting

3.1 The quarterly reports are monitored via Clinical Quality Group with regular reports to this committee.

4 Proposed quality priorities for FY 25/26

4.1 In order to agree the proposed quality priorities the following has been taken into consideration: Complaints thematic review, PALS and Complaints data, incident themes and patters as presented in the quality priority, the operational plan for FY 2025/ 2026, PSRIF reports (thematic reviews, PSII's etc), previous initiatives and pilots.

4.2 The table below outlines the proposed quality priorities for 2025/26, with two priorities intended to roll over into the coming year. Improvement has been noted in both areas, however at the offset of these priorities in 2024/ 2025 it was intend that they would roll out over a two-year period.

	Quality Priority	Operational Lead	Executive lead
Safe (Roll over)	Reduction in surgical site infection.	Vicki Clewer IPC lead	Nikki Brockie Chief Nurse
Caring	Art for Health – A holistic approach to managing patient pain	Liza Tharakan & Chronic pain team	Nikki Brockie Chief Nurse
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.	Rebecca Furnival – Interim lead for Safeguarding and Vulnerabilities	Nikki Brockie Chief Nurse
Responsive	Reduction in length of time for patients to wait for access to the Spinal Service	Michelle Hubbard – Deputy Chief Operating Officer	Marie Peplow Chief Operating Officer
Well-led (Roll over)	Year 2 of the roll out of Service accreditation.	Emma Steele Deputy Chief Nurse	Nikki Brockie Chief Nurse

Priority 1. Safe

Safe	**Reducing Surgical Site Infection (SSI) risk rates for total knee replacement (TKR) and spinal surgeries undertaken at The Royal Orthopaedic Hospital (ROH) from 2024/25 onwards. (Rollover – year 2)**
Leads	Victoria Clewer, Lead Infection Prevention and Control Nurse
Executive Lead	Nicola Brockie, Executive Chief Nurse
Why we chose this QP?	Reducing the risk of surgical site infections (SSI) at ROH was 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 has been 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.
How will we evaluate success?	As part of our ongoing quality improvement initiatives, Statistical Process Control (SPC) charts are being utilised to monitor SSI risk rates, SSI incidence, and to track the timing and impact of implemented interventions. This approach enables real-time visualisation of progress and facilitates data-driven evaluation of the improvement work. Success will be defined by a sustained reduction in SSI risk for total knee replacement and spinal surgeries, as well as the prevention of any further increase in SSI risk for total hip replacement procedures.

	Definition of Success: • Demonstrable and sustained reduction in SSI risk rates across total hip replacement, total knee replacement, and spinal surgeries. • Consistent implementation of evidence-based surgical practices, alongside enhanced theatre standards and professional conduct. • Improved local benchmarking and reporting processes, supported by a collaborative, multidisciplinary approach to continuous improvement.
Actions planned	The 2024/25 quality priority centred on critically reviewing the evidence base for SSI reduction interventions, with the aim of collaboratively identifying those most relevant to orthopaedic surgery. This work supported the development of a bespoke SSI prevention bundle tailored to the needs of ROH. For 2025/26, the focus will shift to the implementation and evaluation of this bundle alongside the enhancement of our SSI surveillance processes. The key objectives for this period are: 1. Finalisation and rollout of the ROH-specific SSI prevention bundle. 2. Development and deployment of an audit framework to ensure consistent and appropriate application of the bundle. 3. Integration of bundle compliance metrics into local and national SSI surveillance reporting. Anticipated outcomes include: • Embedding of evidence-based surgical practices and the promotion of enhanced theatre standards and professional etiquette. • Strengthened local benchmarking and surveillance reporting, fostering a collaborative, data-informed approach to continuous improvement.

Priority 2. Caring

Caring	Art for health – Holistic approach to managing patient's pain
Leads	Dr Liza Tharakan & Chronic pain team
Executive Lead	Nikki Brockie Chief Nurse
Why we choose 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.
How will we evaluate success?	Measuring success in prioritising art for health requires a blend of qualitative and quantitative methods that capture the real impact on patients lived experiences. Here are keyways to assess progress: • **Patient-reported outcomes**: we will undertake a surveys and gain insight due medical reviews. Patients can provide feedback on how creative engagement influences their daily life. • **Daily activity improvements**: Observing changes in routine functioning, mobility, and engagement in social or recreational activities can indicate enhanced quality of life. • **Pain management effectiveness**: Monitoring pain perception before and after art interventions can help evaluate its therapeutic impact. • **Healthcare utilisation**: A decline in hospital visits or medication reliance may suggest that holistic approaches are complementing traditional care effectively. • **Clinical observations**: Doctors, nurses, and therapists can provide insights on patient responsiveness, adherence to treatment, and overall emotional resilience. Success isn't just about numbers—it's about witnessing patients feel empowered, engaged, and supported in their healing journeys.
Actions planned	• **Further roll-out of Art for Health sessions**: Expanding accessibility through hospitals, community centres, and online platforms to engage more patients. • **Building relationships with Birmingham City University for music options**: Partnering with music therapists and researchers to incorporate sound-based interventions into healthcare settings. • **Exploring a charity post for coordination**: Creating a dedicated role to oversee logistics, outreach, and program development. • **Seeking national charity funding**: Identifying grant opportunities and philanthropic support to ensure long-term sustainability.

Priority 3. Effectiveness

Effectiveness	**Delivering Safe, Effective and Inclusive Care -** 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, Interim head of safeguarding and vulnerabilities
Executive Lead	Nicola Brockie, Executive Chief Nurse
Why we choose this QP?	Effective care relies on a strong safeguarding framework that places the protection and empowerment of vulnerable individuals at its core. In accordance with Care Quality Commission (CQC) standards, safeguarding must be integrated throughout all levels of care delivery, underpinned by a clear understanding of the diverse and often complex needs of at-risk groups — including children and young people involved with social care, care leavers, those experiencing mental health challenges, individuals transitioning to adult services, and those with care and support needs such as learning disabilities and/or autism. 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.
How will we evaluate success?	• Case study examples to be provided to safeguarding committee and children and young persons group. • Conduct a monthly review of cases involving multiple 'Was Not Brought' and DNA (Did Not Attend) appointments to encourage patient engagement with health services and reduce potential health risks associated with non-attendance. Additionally, carry out an annual audit in accordance with internal 'Was Not Brought' and DNA guidelines to ensure compliance and inform service improvements. • Encourage feedback and involvement: Set up systems to collect regular feedback from patients and their families, using this input to enhance services and ensure they are meeting the needs of the community. Feedback collected using Ulysses and PALS.
Actions planned	• 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. • 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. • 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. • Multi-Disciplinary Team (MDT) meetings: Facilitate collaboration among healthcare professionals, safeguarding and vulnerabilities

	teams, and community workers to ensure care plans are coordinated.

Priority 4 Responsive

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 – Executive Chief Operating Officer
Why we choose 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 will we evaluate success?	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. 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 (3 consultants reviewing any consultants long waiting follow ups). 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.

Priority 5 – Well Lead

Responsive	Year 2 of the roll out of Service accreditation
Leads	Emma Steele – Deputy Chief Nurse
Executive Lead	Nicola Brockie – Executive Chief Nurse

Why we choose this QP?	Carrying on with the roll out of Service Accreditation throughout wards and departments at ROH.
How will we evaluate success?	Successful Accreditation Programme completed and then embedded.
Actions planned	• Phase 1 complete and Phase 2 underway, Phase 3 will be developed and completed by the end of 25/26 • New Quality and Safety Walkabout process developed and rolled out • Continual engagement with Service Accreditation Assessors to review standards and plan next phase • Develop bespoke standards for Phase 3 which includes Theatres, Recovery and Critical Care Services

Nicola Brockie Chief Nurse
&
Emma Steel Deputy Chief Nurse
May 2025

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	**Memorandum of Understanding with Robert Jones and Agnes Hunt**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Chief Executive**
AUTHOR:	**Matthew Hartland, Chief Executive**
DATE OF MEETING:	**4 June 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

There are three specialist orthopaedic hospitals in England: The Royal Orthopaedic Hospital NHS Foundation Trust (ROH), Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) and the Royal National Orthopaedic Hospital NHS Trust (RNOH).

ROH, RJAH and RNOH are all members of the National Orthopaedic Association (NOA). The NOA is a membership organisation that brings together orthopaedic providers across the country to put orthopaedics at the top of the agenda. The alliance is multidisciplinary and historically has led on collaboration across all orthopaedic services by providing opportunities for members to share experiences and address shared challenges with an aim of delivering consistent, high quality care for patients nationwide. The NOA also provides a voice for member organisations who feel that alone they can't influence change.

The NOA is currently undertaking a review of its purpose and from 2025 is to predominantly focus on policy and influence, with a lesser focus on collaboration of providers.

Whilst ROH and RJAH will continue to be members of the NOA, and continue to collaborate with RNOH, it is believed that there are a number of benefits for a more formal relationship between ROH and RJAH, particularly due to the geographical location of the two Trusts.

The Royal Orthopaedic Hospital NHS Foundation Trust and The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust have therefore agreed to work together to develop and implement a formal Strategic Alliance between the two Trusts.

The Parties wish to record the basis on which they will collaborate with each other as an Alliance. This Memorandum of Understanding (MoU) sets out:

- the key benefits of the Alliance
- the key objectives of the Alliance
- the principles of collaboration
- the model of collaboration
- the governance structures the Parties will put in place.

Following the presentation, consideration and discussion at June's Private Board meeting, and having received confirmation from RJAH of their Board's support, Board are asked to approve the Memorandum of Understanding (MOU) with Robert Jones and Agnes Hunt (RJAH).

Initial meetings of the Alliance Strategic Forum and Alliance Management Group are currently being scoped to enable, if supported, benefits from the alliance to be realised in 2025/26.

ASSURANCE PROVIDED BY THE REPORT:	
POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
N/A	N/A

REPORT RECOMMENDATION:

Following the presentation, consideration and discussion at June's Private Board meeting, and having received confirmation from RJAH of their Board's support, Board is asked to approve the Memorandum of Understanding (MOU) with Robert Jones and Agnes Hunt (RJAH).

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

Financial	x	Environmental	X	Communications & Media	x
Business and market share	x	Legal & Policy	X	Patient Experience	x
Clinical	x	Equality and Diversity	X	Workforce	x
Inequalities	x	Integrated Care	X	Continuous Improvement	x

Comments:

ALIGNMENT TO TRUST STRATEGY ***(Indicate with 'x' all those that apply):***

Care	X	Community	X
Expertise	X	Services	X
People	X	Collaboration	X

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

N/A

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

N/A

BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)***:**

N/A

PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)***:**

May 2025 in private.

DATED ---1 JUNE 2025 V9B---------

MEMORANDUM OF UNDERSTANDING

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

and

THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

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THIS MEMORANDUM OF UNDERSTANDING IS MADE BETWEEN:

(1) **THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST** of The Woodlands, Bristol Road South, Birmingham, B31 2AP ("**ROH**"),

and

(2) **THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST** of Twmpath Lane, Gobowen, Oswestry SY10 7AG ("**RJAH**"),

each a "Party" and, together, the "Parties".

1 Background

1.1 There are three specialist orthopaedic hospitals in England: The Royal Orthopaedic Hospital NHS Foundation Trust (ROH), Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) and the Royal National Orthopaedic Hospital NHS Trust (RNOH).

1.2 ROH, RJAH and RNOH are all members of the National Orthopaedic Association (NOA). The NOA is a membership organisation that brings together orthopaedic providers across the country to put orthopaedics at the top of the agenda. The alliance is multidisciplinary and historically has led on collaboration across all orthopaedic services by providing opportunities for members to share experiences and address shared challenges with an aim of delivering consistent, high quality care for patients nationwide. The NOA also provides a voice for member organisations who feel that alone they can't influence change.

The NOA is currently undertaking a review of its purpose and from 2025 is to predominantly focus on policy and influence, with a lesser focus on collaboration of providers.

1.3 Whilst ROH and RJAH will continue to be members of the NOA, and continue to collaborate with RNOH, it is believed that there are a number of benefits for a more formal relationship between ROH and RJAH, particularly due to the geographical location of the two Trusts. *See note at point 1.5*

The Royal Orthopaedic Hospital NHS Foundation Trust and The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust have therefore agreed to work together to develop and implement a formal Strategic Alliance between the two Trusts.

1.4 The Parties wish to record the basis on which they will collaborate with each other as an Alliance. This Memorandum of Understanding (MoU) sets out:

- the key benefits of the Alliance
- the key objectives of the Alliance
- the principles of collaboration
- the model of collaboration
- the governance structures the Parties will put in place.

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1.5 There is an intention, as part of the periodic review of the effectiveness of this collaborative agreement with RJAH, that consideration will be given to the involvement and participation of RNOH as and when appropriate.

2 Key benefits

2.1 The benefits of collaboration expected to be realised from the Alliance are described below.

The Alliance will:

a) Support the resilience and long-term delivery of specialist Orthopaedic and MSK services at a local, regional and national level.

b) Support long-term clinical and financial sustainability of both organisations.

c) Drive efficiencies and economies of scale from closer working between the two Trusts.

d) Provide opportunities for improved operational performance through collaboration.

e) Ensure capacity is utilised in the most effective and productive way, including formalising mutual aid.

f) Improve recruitment, retention and development of staff through effective joint workforce planning and staff wellbeing initiatives.

g) Improve population health for MSK and Orthopaedics for the populations of Birmingham, Solihull, Shropshire, Telford and Wrekin through collaboration on the reduction of health inequalities and contribution to the prevention agenda.

h) Enable innovation at greater pace through joint working.

i) As specialist elective hospitals, drive accelerated implementation of Elective Reform Plan through collaboration.

j) Drive quality improvement by peer review, sharing best practice, performance against quality metrics and benchmarking.

k) Provide a mechanism to align the contribution of ROH and RJAH to the aims of their respective ICB's/ICS's and provider collaboratives. This includes implementation of relevant priorities with respective Joint Forward Plans and system-wide strategies to achieve the three priorities of Hospital to Community; Analogue to Digital and Treatment to Prevention

l) Support the development of joint strategy for specialist orthopaedics and MSK services for the populations served.

m) Align improvement and transformation programmes where appropriate, bringing together shared learning, teaching, and joint working on common improvement.

n) Exploit the benefit of scale to enhance commercial opportunities within and external to the NHS.

o) Enhance research opportunities through joint bids, joint recruitment to trials, and stronger links across HEI in the wider Midlands.

p) Explore the potential for shared learning, cost efficiencies and benefit of scale with regard to the management and growth of respective charities.

3 Key objectives for the Alliance

3.1 The Parties shall explore options to deliver a number of key objectives. These may include, but will not be limited to, the following:

a) Undertake a review of fragile/challenged services to identify if opportunities exist for shared clinical models to improve service resilience;

b) Undertake a review of common standards and pathways across orthopaedics and MSK such that areas of best practice and consistency are identified;

c) Undertake a review of the clinical and non-clinical operating model of each organisation, identifying areas of best practice and potential efficiency.

d) Undertake a review of capacity and productivity, to understand where there may be benefits from sharing resource and creating resilience;

e) Undertake a financial review of each organisation to understand key pressures and drivers to the financial health of the trusts, including benchmarking of income, spend and efficiencies with recommendations to be made to each trust.

f) Explore opportunities between trusts for shared functions and/or shared posts to create consistency and efficiency;

g) Explore commercial opportunities at local, regional, national and international level, including joint bidding opportunities that may offer a greater impact than the organisations acting in isolation;

h) Undertake a review of the Charitable position of each organisation to understand opportunities to share expertise, share cost, develop joint bids as required and celebrate success;

i) Explore opportunities to learn from, and expand, the offering for Veterans;

j) Explore opportunities and develop mechanisms for mutual aid to support short-term pressures.

k) Explore opportunities to improve primary care engagement, and the profile of both NHS and private Orthopaedic and MSK services across the two organisations

l) Develop an R&D & Innovation framework between the two organisations and key partners to create a keen focus on horizon scanning, technology and future-looking systems, including AI developments; This will be for clinical and non-clinical functions.

m) Develop a benchmarking framework, i.e. 'what good looks like' in Orthopaedic care and MSK nationally and internationally, such that variation in service provision is identified and addressed in each organisation;

n) Undertake a programme of shared learning and best practice reviews, e.g. Clinical coding, LLPs, PSIRF, FTSU, Incidents, Policies, CQC readiness.

o) Develop a joint quality improvement framework, including peer review/support to improve the organisations' clinical outcomes, quality metrics and embrace continuous improvement, aligned to NHS Impact

p) Agree joint messaging in relation to strategy and policy contributions to National Orthopaedic Association and Federation of Specialist Hospitals

q) Explore joint Digital opportunities to enhance patient care and deliver operational efficiencies in the short and longer term;

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r) Undertake a review of financially challenged/'loss-making' services, exploring opportunities for greater alignment and resilience.

s) Consider scenarios and options available for both trusts in a model of greater provider collaboration.

t) Explore how each organisation can accelerate delivery of the Elective Reform Plan

u) Explore the benefits of joint workforce planning and development.

4 Principles of collaboration

4.1 The Parties agree to adopt the following principles for the Alliance:

- collaborate and co-operate. Establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required;
- be accountable. Take on, manage and account to each other for performance of respective roles and responsibilities;
- be open and transparent. Communicate openly about major concerns, issues or opportunities relating to the Alliance;
- learn, develop and seek to achieve full potential. Share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;
- adopt a positive outlook. Behave in a positive, proactive manner;
- adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, data protection and freedom of information legislation. In particular the Parties agree to comply with the requirements of the Conduct and Information Sharing Protocol attached to this MoU in Schedule 1;
- act in a timely manner. Recognise the time-critical nature of the elements of the programme and respond accordingly to requests for support;
- manage stakeholders effectively;
- deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and
- act in good faith to support achievement of the Key Objectives and compliance with these Principles.

5 Model of collaboration

5.1 ROH and RJAH shall collaborate under the 'Provider Leadership Board' model as described in the NHSE Provider Collaborative 2021 guidance:

- *Chief executives or other directors from participating trusts come together, with common delegated responsibilities from their respective boards (in line with their schemes of delegation), such that they can tackle areas of common*

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concern and deliver a shared agenda on behalf of the collaborative and its system partners.

- *This model can make use of an arrangement whereby a subset of the Board of each organisation can meet at the same time in the same place and can take aligned decisions. To ensure effective oversight of the provider leadership board, trusts should consider how to involve their non-executive directors in providing scrutiny and challenge.*

5.2 Therefore, each Board will retain its unitary status and organisations will retain their organisational sovereignty but will collaborate under the terms of the Alliance within this MOU.

5.3 There will be no change to the legal relationship of either Trust with DHSC/NHSE and their respective ICBs.

5.4 Trusts will continue to operate in line with their NHS Provider licence and the Code of Governance for the NHS.

6 Alliance Governance

6.1 Principles

The following guiding principles are agreed.

The Alliance's governance will:

- provide strategic oversight and direction;
- be based on clearly defined roles and responsibilities at organisation, function and, where necessary, individual level;
- align decision-making authority with the criticality of the decisions required;
- be aligned with the scope this MoU and appropriate for each stage (and may therefore require changes over time);
- leverage existing organisational, functional and user interfaces;
- provide coherent, timely and efficient decision-making; and
- correspond with the key features of the governance arrangements set out in this MoU.

6.2 Governance

There will be three tiers of governance:

i) **Alliance Strategic Forum**

Overall strategic oversight and direction to the Alliance shall be provided through the forum of the Alliance Strategic Forum (ASF). This will incorporate Chief Executive Officers and other Executive Directors, as identified by the Chief Executive Officers.

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ii) **Alliance Management Group**

The Alliance Management Group (AMG) provides strategic management of the Alliance at programme and workstream level. It will provide assurance to ASF that the Key Objectives are being met, and that the Alliance is performing within the boundaries set by ASF.

This group will initially consist of the Executive Teams (or equivalents) from the ROH and RJAH.

Additional members of the Alliance Management Board will be agreed at the ASF.

The Group shall be managed in accordance with the terms of reference set out in Schedule 2: to this MoU.

iii) **Alliance Workstream Forums**

Forums will be established as required.

Additionally, full Board to Board meetings will be held at least once per year

6.3 Alliance Support and Reporting

Support for the Alliance in the form of secretariat and PMO will come from the existing Trust establishment.

The Boards of ROH and RJAH will receive regular reports on the progress of the Alliance.

6.4 Conflicts

The Parties shall comply with the provisions of their respective policies for Managing Conflicts of Interest and NHSE guidance for the same.

6.5 Escalation

If either Party has any issues, concerns or complaints about the Alliance, or any matter in this MoU, that Party shall notify the other Party and the Parties shall then seek to resolve the issue by a process of discussion/consultation lead by the relevant Executives of the respective organisations. Failure to resolve any concerns through this route will require escalation to the Chief Executives of the two organisations.

6.6 Intellectual property

The Parties intend that, notwithstanding any secondment, any intellectual property rights created in the course of the Alliance shall vest in the Party whose employee created them (or in the case of any intellectual property rights created jointly by employees of both Parties, jointly in equal proportions).

Where any intellectual property right vests in either Party, that Party shall grant an irrevocable licence to the other Party to use that intellectual property for the purposes of the Alliance subject to consultation and agreement with third parties.

Nothing in this MoU shall give any Party any express or implied rights or licence to the other Party's Intellectual Property.

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6.7 Announcements

Where appropriate, the parties should agree joint communications.

6.8 Term and termination

This MoU shall commence on the date of signature by both Parties and shall expire in three years.

The MoU will be reviewed annually, with a view to be agreed by 31 March each year.

Either Party may terminate this MoU by giving at least three months' notice in writing to the other Party at any time.

Any costs incurred by the parties as a result of termination shall be shared pro-rata.

6.9 Variation

This MoU, including the Schedule, may only be varied by written agreement of the Parties.

6.10 Charges and liabilities

Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU unless where they have jointly agreed to fund aspects of the Alliance.

The Parties agree to share the costs and expenses arising in respect of the Alliance between them on a pro rata basis (if additional and agreed at the Alliance Management Group).

Both Parties shall remain liable for any losses or liabilities incurred due to their own or their employee's actions and neither Party intends that the other Party shall be liable for any loss it suffers as a result of this MoU.

It is expressly acknowledged by the Parties that each Party is, and shall remain, solely and exclusively accountable and responsible for all aspects of its performance.

6.11 Notices

Any notice, claim or demand in connection with this MoU shall be given in writing to the relevant Party at the address stated below (or any such other address as it shall previously have notified to the other Party). Any notice sent by first class post within the United Kingdom shall be deemed received 48 hours after posting. The relevant addressee, address and email address of each Party for the purposes of this MoU is:

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The Royal Orthopaedic Hospital NHS Foundation Trust

Address:	Bristol Road South, Birmingham, B31 2AP, United Kingdom
For the attention of:	Director of Governance
Tel No:	0121 685 4353
E-mail Address:	s.grainger-lloyd@nhs.net

Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust

Address:	Twympath Lane, Oswestry, Shropshire, SY10 7AG, United Kingdom
For the attention of:	Trust Secretary
Tel No:	01691 404000
E-mail Address:	dylan.murphy1@nhs.net

6.12 Status

Although this MoU is not legally binding it is intended to set out general principles the Parties will look to uphold in collaborating through this partnership.

Nothing in this MoU is intended to, or shall be deemed to, establish any partnership, joint venture or merged entity between the Parties, constitute either Party as the agent of the other Party, nor authorise either of the Parties to make or enter into any commitments for or on behalf of the other Party.

Signed by **MATTHEW HARTLAND**	....
for and on behalf of The Royal Orthopaedic Hospital NHS Foundation Trust	**CHIEF EXECUTIVE DATE**
Signed by **STACEY-LEA KEEGAN**	....
for and on behalf of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	**CHIEF EXECUTIVE DATE**

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Schedule 1: Conduct And Information Sharing Protocol

1. The following definitions and rules of interpretation shall apply to this Protocol:

    1.1. The following words shall have the following meanings unless the context otherwise requires:

"Project"	shall mean the project referred to in the MoU of which this Protocol forms part;
"Commercially Sensitive Information"	shall mean any and all trade secrets, confidential financial information and confidential commercial information, including without limitation, copyright material supplied under restrictive licence, business plans, product development details, methodologies, application solutions, software specifications, software code, software design and development details, names and sensitive information pertaining to Disclosing Party's customers and prospects and marketing information, information relating to the terms of actual or proposed sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by either Party, the publication of which a corporate entity in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions, providing that this shall not apply where the exchange of such information is permitted in accordance with this Protocol;
"Confidential Information"	shall mean any information which has been or will be supplied or made available directly or indirectly by Disclosing Party to Receiving Party in connection with the Arrangements, which is generally considered by Disclosing Party to be sensitive and/or , confidential, whether or not marked confidential, private or otherwise, including but not limited to Commercially Sensitive Information and sensitive information pertaining to Disclosing Party's service users and employees;
"Disclosing Party"	shall mean the Party disclosing Confidential Information;
"Receiving Party"	shall mean the Party receiving Confidential Information; and
"Related Persons"	shall mean, in respect of the relevant Party, that Party's directors, officers, employees, advisers, agents, consultants or contractors and includes persons who, at the time they or any Party performs an act under this Protocol, occupy any of these positions in relation to that Party.

    1.2. Other capitalised words or terms in this Protocol shall have the meaning set out in the MoU of which this Protocol forms part.

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1.3. Words in the singular shall include the plural, and vice versa.

1.4. A reference to a person shall include a reference to a firm, a body corporate, an unincorporated association or to a person's executors or administrators.

2. Neither Party shall use the other Party's Confidential Information for any purpose other than in connection with the carrying out of obligations under the Alliance and each Party undertakes that it shall not disclose to any person any Confidential Information (howsoever obtained) concerning or in connection with the Parties, or this Protocol, except as permitted by this Protocol.

3. In consideration of the provision of Confidential Information by the Disclosing Party, each Party in respect of Confidential Information for which it is the Receiving Party shall and shall procure that its Related Persons shall:

3.1. hold such Confidential Information in strictest confidence;

3.2. take all reasonable precautions in dealing with such Confidential Information so as to prevent any third party from having access to it;

3.3. use such Confidential Information solely in connection with the Arrangements;

3.4. permit access to such Confidential Information only to those of its personnel or Related Persons who need to know in connection with the Arrangements;

3.5. not take copies of such Confidential Information other than is strictly necessary pursuant to Clause 3.4.

4. To the extent Confidential Information to be shared between the Parties is not already in the public domain, the Parties have, in this Protocol, set out the principles relating to information sharing and both Parties shall comply with these provisions.

5. RJAH and ROH acknowledge their duties to comply with law in relation to the provision of the health services and in particular RJAH and ROH will comply with and cooperate in respect of obligations and requirements of the law relating to health and safety and data protection.

6. Each Party may only disclose the other Party's Confidential Information:

6.1. to its Related Persons who need to know such information for the purposes of carrying out any Party's obligations in relation to the Alliance;

6.2. which is in the public domain (other than as a result, whether direct or indirect, of breach of this Protocol); and

6.3. as may be required by law, court order, or any governmental or regulatory authority.

7. Prior to the disclosure of any Confidential Information to any Related Person, a Receiving Party shall inform them of the confidential nature of the material and of the provisions of this Protocol and, if requested by the Disclosing Party, it shall obtain a written undertaking from each of them in favour of the Disclosing Party to abide by the duties of confidentiality established hereunder. Whether or not the Disclosing Party makes a request pursuant to this Clause 3, each Receiving Party shall procure that each such person will observe the same restrictions on the use of the Confidential Information as are contained herein.

8. Each Party agrees that when creating data that will, or is likely to be, shared with the other Party under this Protocol and prior to disclosing any data to the other Party, it will use reasonable endeavours to exclude or anonymise any data that constitutes personal data or sensitive personal data and to the extent that any data includes personal data or sensitive personal data, where there is no legitimate reason for such data to be shared.

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9. Without prejudice to the generality of Clause 3, a Receiving Party shall exercise no less a degree of care in protecting the Confidential Information than it uses to protect its own information of like sensitivity and importance.

10. The obligations of confidentiality on a Receiving Party shall not apply to any Confidential Information to the extent that the Receiving Party can show (and it shall be for that Receiving Party to show):

    10.1. was in the lawful possession of that Receiving Party before such Confidential Information was disclosed by the Disclosing Party; or

    10.2. has been independently developed by any servant, agent or employee of that Receiving Party without access to or use or knowledge of the Confidential Information disclosed by the Disclosing Party; or

    10.3. is in or subsequently comes into the public domain other than by breach by a Receiving Party of its obligations hereunder or under any other confidentiality agreement between any of the Parties; or

    10.4. is received by that Receiving Party without restriction on disclosure or use from a third party where such third party has a lawful right to make such disclosure; or

    10.5. which that Receiving Party is required to disclose by law, court order or requirement of a recognised stock exchange provided that the Receiving Party shall notify the Disclosing Party of the requirement for disclosure and, prior to making any disclosure, the Receiving Party shall assist the Disclosing Party in taking reasonable steps to resist, avoid or minimise the disclosure.

11. Competition Law Guidelines

    11.1. The Parties acknowledge that the Parties shall take special care to comply with the terms of this Protocol regarding any sharing or disclosure of Commercially Sensitive Information to avoid any competition law concerns.

    11.2. The Parties agree to comply with the guidelines set out in this clause.

    11.3. No Party shall disclose to the other Party any information that constitutes Commercially Sensitive Information, except where either side agrees it is necessary in order for a project to be progressed.

    11.4. Each Party must continue to act, make bids and try to win new business in exactly the same way that it would have done in the absence of the Alliance.

    11.5. The Parties are separate competitors and they will continue to make decisions on such matters as bidding strategies and entry into new contracts independently of one another and negotiate separately with their respective actual and potential customers.

    11.6. If circumstances arise where the Parties participate in the same competitive tendering process, the Parties agree that their representatives shall not be permitted to be, and measures shall be put in place to prevent any representative being, involved in any capacity in the same tender process on behalf of both Parties.

    11.7. Both Parties must carry out their obligations and conduct all acts pursuant to this Protocol in a way that protects Commercially Sensitive Information.

    11.8. Data must not be exchanged that would allow the recipient to change its commercial position and measures shall be put in place to prevent the Directors transferring one Party's Commercially Sensitive Information to the other Party without express consent to do so.

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12. FOIA

12.1. The Parties acknowledge that they are subject to legal duties under the Freedom of Information Act 2000 (the "FOIA") which may require them to disclose, on request, information relating to this Protocol and that they are also subject to the Code of Practice on Openness in the NHS (4 August 2003).

12.2. If any Party receives a Request for Information (as defined in FOIA) relating to Confidential Information disclosed to them by the other Party, then, prior to any disclosure of information to which an exemption to FOIA may apply (the "Potentially Exempt Information"), it will:

12.2.1. immediately notify the other Party of such Request for Information;

12.2.2. discuss the Request for Information with the other Party and the Parties shall consider together whether or not an exemption to FOIA applies and the public interest factors both for and against disclosure (if applicable depending upon the potential exemption) in accordance with FOIA to determine whether the public interest in maintaining the exemption outweighs the public interest in disclosing such Potentially Exempt Information;

12.2.3. take into account any representations made by the other Party in relation to the Request for Information and any possible exemptions; and

12.2.4. consult with the other Party in relation to any proposed disclosure as to whether any further explanatory material or advice should also be disclosed with the information in question.

13. Any Confidential Information disclosed hereunder shall remain the property of the Disclosing Party. Disclosure of any Confidential Information to a Receiving Party or its Related Persons or Associated Companies does not imply or confer any licence or permission on that Receiving Party or its Related Persons to use the relevant information for any purpose other than in connection with the Arrangements.

14. Upon expiry or termination of this Protocol or at any time on the written request of the Disclosing Party, each or either of the (as the case may be) Receiving Party shall and shall procure that its Related Persons shall:

14.1. return to the Disclosing Party all such Confidential Information (including all copies held by the Receiving Party or its Related Persons);

14.2. destroy all copies of any analysis, compilation, studies, reports or other documents prepared by it for its use containing or reflecting or generated in whole or in part from any Confidential Information; and

14.3. expunge and destroy any Confidential Information from any computer, word processor or other device in its possession containing such information; and

14.4. if so requested, confirm in writing to the Disclosing Party that the provisions of this Clause have been complied with,

provided that it may retain a copy of the Confidential Information for record purposes; such retained copy shall remain subject to the terms of this Protocol.

15. This Protocol shall be effective from the date hereof and shall expire on:

15.1. the conclusion by the Parties of a further agreement in respect of the Arrangements which incorporates confidentiality obligations substantially similar to those contained herein; or

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16. Each Receiving Party acknowledges that neither the Disclosing Party nor any of their Related Persons is making any representation or warranty under this Protocol, either expressed or implied, as to the accuracy or completeness of the Confidential Information, and none of the Disclosing Party or any of their Related Persons will have any liability to either Receiving Party or any other person resulting from a Receiving Party's or its Related Persons' use of, or reliance placed upon the Confidential Information.

17. Each Party acknowledges and agrees that it will be responsible for any breach of the terms and conditions set out in this Protocol whether by it, its personnel or any of its Related Persons.

18. Each Party acknowledges and agrees that damages may not be an adequate remedy for any breach of this Protocol and that the Disclosing Party shall be entitled to seek the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Protocol.

19. No failure by a Party in exercising any right, power or privilege hereunder shall constitute a waiver by such Party of any such right, power or privilege, nor shall any single or partial exercise thereof preclude any further exercise of any such right, power or privilege.

20. If any provision in this Protocol is illegal, prohibited or unenforceable in any jurisdiction such illegality, prohibition or unenforceability will not invalidate the remaining provisions or affect the legality, validity or enforceability of the provisions in relation to any other jurisdiction.

21. Except as provided in this clause 22, this Protocol is made for the benefit of the parties to it and their successors and permitted assigns and is not intended to benefit, or be enforceable by, anyone else.

22. This Protocol shall be binding upon the Parties and their successors. Without prejudice to paragraph 22 above, no Party shall be entitled to assign any of its rights or obligations.

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Schedule 2: Alliance Management Group terms of reference

1 CONSTITUTION

This Alliance Management Group will not replace the formal Governance meeting structure of the component trusts but serves to complement it. It is hereby established to enable The Royal Orthopaedic Hospital NHS FT and Robert Jones & Agnes Hunt NHS FT to work collaboratively, with a shared purpose, on matters where there is benefit in terms of finances, efficiency, quality and innovations.

2 AUTHORITY

The Alliance Management Group is authorised by the Boards of its component NHS organisations to take all necessary actions to fulfil the remit described within these terms of reference, including commissioning reports and creating groups to deliver specific pieces of work.

The Alliance Management Group shall be fully and equally accountable to both Trust Boards for the delivery and oversight of its work.

3 PURPOSE AND SCOPE

The Alliance Management Group is designed to provide a strategic oversight framework for monitoring and directing the delivery of the projects within the Provider Collaborative, set out in its agreed Memorandum of Understanding.

4 DUTIES

The Alliance Management Group will:

- Agree a prioritised list of areas on which to focus its collaborative efforts, with the intention of delivering the Benefits and Objectives of the Alliance set out in its Memorandum of Understanding;
- Decide on the infrastructure and resource required to deliver the work of the Alliance;
- Agree on the timescales for the delivery of the Alliance's priorities;
- Receive reports on the delivery of the projects being undertaken within the context of the Alliance;
- Provide upward assurance to the Alliance Strategic Forum on the robustness and pace of delivery of the Alliance's projects;
- Receive routine benefits analyses of each Alliance project when delivered;
- Agree a common approach for communicating and celebrating the successes of the Alliance;
- Provide information for the Chief Executive updates to the component NHS Trust Boards;
- Test and challenge the articulated risks to the delivery of the work of the Alliance;

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- Monitor that the component organisations are operating in line with the requirements of the Alliance's Memorandum of Understanding

5 STANDING AGENDA

Agendas will be built around the Alliance's workplan, however the Alliance Management Group will intend to operate to a standing agenda, as follows:

- Declarations of Interest
- Minutes of the previous meeting
- Actions and decisions log
- Update from Alliance Strategic Forum
- Project reports: progress updates; risk log; benefits realisation analysis
- Clarification of decisions made and agreement of key messages
- Any other business
- Self-assessment of the effectiveness of the meeting

6 ADMINISTRATION AND FREQUENCY OF THE ALLIANCE MANAGEMENT GROUP

The secretariat for the Alliance Management Group will be provided from existing resources from the component NHS organisations.

The secretariat will take responsibility for:

- Agreement of the agenda with the Chair of Alliance Management Group and organising the collation of connected papers.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Advising the Group as appropriate

7 MEMBERSHIP

The Alliance Management Group will initially comprise of members of each organisation's Executive Team (or equivalent roles)

Additional members of the Alliance Management Group will be agreed at an Alliance CEO Forum.

The chair of the Group will rotate between the Chief Executive Officers (time period to be agreed).

The quorum for the meeting is five members, including at least two representatives from each of the two NHS organisations.

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5 REPORTING

Following each meeting, the minutes shall be drawn up and presented at the next Group meeting where they shall be considered for accuracy and approved.

A summary of discussions of the Alliance Management Group will be presented to the Trust Board via the regular assurance reporting arrangements.

The work of the Alliance will be presented in an annual report which will be shared with the Boards of the component NHS organisation and other interested parties by agreement of the Group.

6 REVIEW

The terms of reference should be reviewed and approved at least annually or sooner if required.

Date of adoption: **June 2025**

Date of review: **May 2026**

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NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Freedom To Speak Up update**
SPONSOR (EXECUTIVE DIRECTOR):	**Gianjeet Hunjan, Non-Executive Lead for FTSU** **Simon Grainger-Lloyd, Director of Governance**
AUTHOR:	**Claudette Jones, Freedom to Speak Up Guardian** **Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**4 June 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Freedom to Speak Up team continues to ensure that speaking up is business as usual at the Royal Orthopaedic Hospital NHSFT. The Trust continues to see positive improvement from the speaking up process and structure in place. This includes, but is not limited to listening sessions, teaching sessions, road shows and other resources such as FTSU confidential boxes and a dedicated email address and telephone number. The listening sessions are strongly supported by both Executive and Non Executive directors. Whilst engaged in any FTSU activity, the FTSU team can be identified by their green FTSU T-Shirts and lanyards. Workers reported that this approach provides a sense of unity and purpose in FTSU aims and gives them confidence to speak up, with the knowledge that they will be listened to. As a result of this approach, ROH has seen a higher number than previously of workers speaking up from various banding levels, overseas workers and minority workers. Cases are triaged by the Guardian and where necessary workers are signposted and supported to raise their concerns with their line managers, in line with the Trust FTSU flow chart for raising concerns. This promotes communication between workers and line managers. It is also designed to encourage and empower staff to work in partnership with senior leaders. As a result of this approach areas for further training becomes more transparent, and the Trust has seen more workers completing the FTSU training modules. To further improve learning and improvement, soft intelligence is shared with the relevant leadership teams to ensure workers are heard and supported and patient quality and safety maintained.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Updated policy • Detriment Document	• Reflection and planning tool to be signed off • Review and reflection form – currently liaising with IT • Data management system – currently liaising with IT

	• Part-time cover, limits planning opportunities

REPORT RECOMMENDATION:

The Trust Board is asked to:

RECEIVE and NOTE the update.

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

Financial	**x**	Environmental		Communications & Media	x
Business and market share		Legal & Policy	x	Patient Experience	**x**
Clinical	**x**	Equality and Diversity	x	Workforce	x
Inequalities	**x**	Integrated Care		Continuous Improvement	x

Comments:

ALIGNMENT TO TRUST STRATEGY ***(Indicate with 'x' all those that apply):***

Care	**x**	**Community**	
Expertise		**Sustainability**	
People	**x**	**Collaboration**	

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

National standards and requirements for FTSU set by the National Guardian's Office

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

Regional FTSU Guardian meetings and network

BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)***:**

From the National Guardian's Office and regional network.

PREVIOUS CONSIDERATION:

Update in April 2025 from the Non Executive FTSU Champion

1.0 Purpose of the Report

The purpose of this report is to provide the Trust's Board of Directors with an overview of the cases and themes reported through the FTSU Guardian route. For benchmarking and consistency, the data has been obtained from the National Health Model System. This system provides peer-to-peer data comparison and data analysis. Due to the setup of the system, the data covers the period of 2023-2024. The report will also provide an update on the Speak Up Reflection and Planning Tool completed by members of the Executive Team which has been collated. Actions from the plan will be used as guidance to further develop the Speaking Up Culture within the Trust.

1.1 Overview

This paper outlines cultural staff experience and engagement using a breakdown of the categories under which information is reported to the National Guardian Office (NGO) and fed into the NHSE Health Model System. The themes are 'bullying and harassment', 'patient quality and safety', 'detriment because of speaking up', 'anonymous reporting', 'workers safety and wellbeing', and cases relating to 'inappropriate attitude and behaviour'. The guidance from NGO since Feb 2024 is that cases with more than one theme should be reported separately, therefore, one case may contain multiple themes, each needing to be reported under the categories listed above.

The NGO FTSU Reflection and Planning Document is a tool designed to help the Trust Board identify areas of strength and any need for improvement within the FTSU agenda. This document is completed and is due to be signed off shortly so will be presented to the Trust Board in the autumn. Completing the document was facilitated by the FTSUG, Executive and Non-Executive FTSU Leads, with input from several senior leaders using virtual, email and SharePoint resources. Information was collated and the document populated. The high-level actions will guide the work of the FTSU team.

For clarity of the data, The Royal Orthopaedic Hospital (ROH) will be referred to as Provider, Whole time Equivalent = (WTE) and Quartile = (Distribution of data set).

2.0 All Cases Related to (2023 – 2024)

All Cases Q4 -2023-2024	Provider = 92	Peer Average = 35	National Value = 33	Quartile = 4
Cases reported per 1,000 WTE	Provider = 74.0	Peer Average = 7.24	National Value = 5.53	Quartile = 4
Total cases reported over 12 months rolling average	Provider = 158	Peer Average = 137	National Value = 119	Quartile = 3

The engagement from workers and the number of concerns raised demonstrates the benefit achieved from processes and structure being implemented across the Trust. It is also evident that workers are empowered to speak up because of the support and dedication shown by leaders. However, the part time WTE allocation for the FTSUG role limits comprehensive coverage by a single Guardian. There are risks and challenges in gaining feedback and outcomes from concerns as a result of this, therefore to rectify this, a new approach will be implemented moving forward, to clarify for managers and leaders

expectations around the need to respond in a timely manner by setting clear Key Performance Indicators. Proactive work is also being put in place to upskill FTSU champions with their signposting role. They will receive training on the following topics: ‘assertiveness linked with behaviour and values’, ‘conflict resolution and drama triangle’, and ‘psychological safety’ as well as awareness of the sex charter update.

2.1.0 Patient Safety and Quality:

To help ensure patient safety and quality a FTSU triangulation approach has been set up. This is used to foster learning, development and improvement by providing a safe space for workers to feel safe to raise concerns that can frequently affect patient safety and quality of care. All concerns are triaged and escalated to the relevant senior member of staff for action to be taken. Workers receive feedback from the Guardian and or senior member of staff.

2.1.1 FTSUG Cases Relating to Patient Safety and Quality

Q4 2023-2024 Patient safety and Quality	Provider = 0	Peer Average = 7	National Values = 5	Quartile = 0
Cases reported per 1,000 WTE	Provider = 0.00	Peer Average = 1.18	National Values = 0.91	Quartile = 0
Patient safety and quality as a percentage	Provider = 0%	Peer Average = 17%	National Values = 15%	Quartile = 0
Patient safety and quality cases as 12 month rolling average	Provider = 17	Peer Average = 24	National Value = 2	Quartile = 2

2.2 Bullying and Harassment:

Concerns relating to bullying and harassment, worker safety and wellbeing and inappropriate attitude and behaviour are shared for triangulation with the Equality Diversity and Inclusion Team, HR People Partners, the OD Team and Quality and Safety Team. A monthly meeting is also held with the FTSUG, Inclusion Manager, People Partner Office and the Quality and Improvement Manager to review informal intelligence and where necessary provide support to improve and maintain Trust culture. The FTSU intervention is a pivotal part of Sexual Safety workstream which started this year. The Guardian is part of the working group and the FTSU service is advertised as ‘additional ways of raising concerns relating to sexual harassment or harm’.

2.2.1 FTSUG Cases Related to Bullying and Harassment

Q4 2023-2024 Bullying & Harassment	Provider = 3	Peer Average = 8	National Value = 5	Quartile = 2
Cases reported per 1,000 WTE	Provider = 2.43	Peer Average = 1.34	National Value = 0.88	Quartile = 4
Bullying and Harassment reported as a percentage	Provider = 3%	Peer Average = 19%	National Value = 17%	Quartile = 1
Bullying and Harassment reported over 12 month rolling average	Provider = 6	Peer Average = 27	National Value = 22	Quartile = 1

2.3.0 Cases Relating to Detriment Because of Speaking Up:

In 2023-2024 there were no cases at ROH relating to detriment because of speaking up.

Managers are encouraged to complete the FTSU modules, especially the module on Following Up, which will be useful when addressing ‘speaking up’ concerns. Concerns raised will now be reviewed by divisions to encourage shared learning, promote collaboration and encourage teams to take responsibility in a timely manner. The aim is that this approach will limit cases related to detriment from speaking up and improve FTSU cultural awareness.

2.3.1 FTSU Cases Relating to Detriment Because of Speaking Up

Q4 2023-2024 Detriment due to speaking up	Provider = 0.00	Peer Average = 0.00	National values = 0	Quartile = 0
Cases of Detriment per 1,000 WTE	Provider = 0.00	Peer Average = 0.00	National Value = 0.00	Quartile = 0.00
Cases of Detriment as percentage	Provider = 0%	Peer Average 0%	National Value = 0%	Quartile = 0%
Cases of Detriment as 12 month rolling average	Provider = 0	Peer Average = 1	National = 1	Quartile = 0

2.4.0 Who Is Raising Concerns (anonymous concerns):

In 2023-2024 there were no cases at ROH that were raised anonymously.

Concerns are received across the organisation from administrative workers, nursing, medical, additional clinical services. FTSU has also received concerns across different bands, including senior levels who are experiencing challenges with inappropriate attitude and behaviour from colleagues at senior levels. These have been shared with HR and relevant training is being put in place to address this. The 'Me as a Manager' training initiative is now rolled out and will form a vital tool to address some of these concerns. It is a credit to the Trust that staff are happy to raise concerns openly, however the Trust continues to promote operating in an open, honest and transparent culture.

2.4.1 Cases Reported to FTSUG Anonymously

Q4 2023-2024 Anonymous cases	Provider = 0	Peer Average = 2	National Value = 1	Quartile = 0
Anonymous cases reported per 1,000 WTE	Provider = 0.00	Peer Average = 2	National Value = 2.24	Quartile = 0
Anonymous cases as a percentage	Provider = 0%	Peer Average = 5%	National Value = 4%	Quartile = 0
Anonymous cases as 12 month rolling average	Provider = 0	Peer Average = 6	National Value = 6	Quartile = 0

2.5.0 Inappropriate Attitude and Behaviour:

There are areas with ongoing concerns across the Trust that are taking longer to resolve. This is due to the historic nature involving inappropriate attitude and behaviours. Some managers reported finding it challenging and time-consuming dealing with these issues. This has been shared with the HR department to ensure managers are provided with the relevant training to enable them to take relevant action to support workers and prevent adverse impact to patient safety.

2.5.1 Cases relating to Inappropriate attitude and behaviours

Q4 2023-2024 Inappropriate attitude and behaviour	Provider = 48	Peer Average = 13	National Values = 11	Quartile = 4
Inappropriate attitude and behaviour cases reported per 1,000 WTE	Provider = 38.82	Peer Average = 3.10	National Values = 2.00	Quartile = 4
Inappropriate attitude and behaviour cases as a percentage	Provider = 52%	Peer Average = 42%	National Values = 40%	Quartile = 3

Inappropriate attitude and behaviour as 12 month rolling average	Provider = 59	Peer Value = 55	National Value = 40	Quartile = 3

2.6.0 Workers' Safety and Wellbeing:

An increased number of concerns have been raised from overseas workers from an ethnic minority background. The issues appeared to relate to a lack of cultural and competency awareness. This has been escalated, and the Trust has acted by implementing quality and improvement days which will focus on these concerns on a quarterly basis. Ongoing work will also be carried out at a divisional and Trustwide level to support workers and improve competencies.

2.6.1 Cases Related to Workers Safety and Wellbeing:

Q4 2023-2024 Worker's safety and wellbeing	Provider = 39	Peer Average = 12	National Value = 8	Quartile = 4
Worker's safety and wellbeing cases reported per 1,000 WTE	Provider = 31.54	Peer Average = 2.48	National Value = 1.54	Quartile = 4
Worker's safety and wellbeing cases as a percentage	Provider = 42%	Peer Average = 32%	National Value = 29%	Quartile = 3
Workers' safety and wellbeing cases as 12 month rolling average	Provider = 74	Peer Average = 47	National Values = 30	Quartile = 4

2.7 FTSU Champions and support

There are currently 10 FTSU champions providing signposting support in the Trust. Champions receive bespoke training and are encouraged to complete all the FTSU Modules. The champions are trained in other areas depending on their specialities, such as safeguarding. They also represent various staff networks across the Trust. Regular FTSU team meetings are held to support champions and to plan awareness events. The meeting is facilitated by the Guardian, Executive Director and Non-Executive Director. FTSU support is available 24 hours via FTSU Boxes, FTSU dedicated email, telephone number and by champions who work shift pattern rotas, including weekends and night shifts. The FTSU team are working on plans for the July Trust Awareness Day which will include (1) safe space to speak up to Guardian, Executive and Non-Executive Director (2) a small survey to review FTSU awareness (3) provide 'listen with compassion' Trust value card for staff to hand to a colleague who demonstrate this value, as this appeared to have worked well during last October FTSU Awareness Month.

2.8 FTSU Feedback from Workers:

We are currently in the process of creating a formal way of receiving feedback from workers, through a FTSU form, which was also a recommendation from the FTSU favourable internal audit report. Currently, staff who have spoken up receive a thank you card and they are asked whether they would be happy to speak up again. This verbal feedback is documented. Most staff reported that they value the service of the FTSU team and feel safe to contact the team for help and support. Staff also reported feeling empowered to escalate concerns to their line managers after they have spoken to the Guardian. Evidence of this is the number of cases which are closed within 24 hours. More serious concerns are escalated as appropriate by the Guardian. The FTSU office is frequently used as a safe space for staff who need to speak to the Guardian. These staff can appear tearful and frustrated, but after having a discussion where they feel listened to, they reported feeling a sense of relief and have a clearer mindset to provide safe care. Two Band 7s staff stated that they were planning on leaving the Trust because they felt like they were ‘fighting against a brick wall’, but following a discussion with the FTSU Guardian, they decided to stay and work through the challenges with FTSU support. Several overseas workers reported that they felt afraid and did not know what else to do, or where to go. They started to lose trust, but having someone to listen to them provided a sense of relief. They also stated that they felt calm and able to speak openly to the Guardian knowing that they would not get into trouble. They found the advice useful and practical. They were happy to speak to the Guardian because they did not feel judged or unseen. They felt they were taken seriously. They appreciated getting feedback and felt that it was a big support having someone they could return to who would provide updates. They felt heard.

2.9 Concerns from Overseas Workers

There is a perception of disparity when applying policies between different groups of in some areas. It is positive to note that in some instances the concerns raised have been by staff acting as an ally on behalf of their colleagues or advocating for minority colleagues. However there has been a noticeable number of concerns raised from overseas workers during Q3 and Q4. This is encouraging as it demonstrates the courage of workers to speak up, supporting each other and acting as allies. Overseas workers are encouraged to attend staff networks to address cultural issues as well as, supported by colleagues.

The FTSU team increased visibility in areas where there were concerns raised of this nature to ensure these staff are particularly supported. Work is currently being done to address these concerns at divisional level. It is equally encouraging to see staff proactively working with the FTSU team to strengthen inclusion in the Trust. This is strong evidence of the impact of FTSU work and growth of awareness in the Trust. The FTSU Guardian remains active across the staff networks and continues to chair the Equality and Diversity network. The Network is getting ready to celebrate and raise awareness of inclusion in September.

2.10 Key Points from the FTSU National Update May 2025

2.10.1 How are Freedom to Speak Up Guardians Supported to Fulfil their Role?

It is strongly recommended by the National Guardian's Office that each organisation has a minimum of one full-time equivalent Freedom to Speak Up Guardian in place, aligned with the core role requirements. This recommendation is grounded in consistent themes emerging from our ongoing support calls, direct engagement with organisational leaders, and analysis of guardian data, including training compliance and worker survey results.

2.10.2 Sickness/ Annual Leave Cover

Where a Freedom to Speak Up Guardian is unavailable due to absence such as leave, sickness, or where variations in working hours mean no guardian is available during normal working hours, internal cover arrangements should be made. At ROH the FTSUG is supported by the FTSU Champions who work across the site on varied shifts, days, nights and weekends. There are also FTSU boxes, a designated email box and phone number. We are in the process of setting up a FTSU case management system and FTSU reporting forms in line with recommendation from the internal audit report.

The Freedom to Speak Up provision should not be considered an urgent response service, and 24-hour guardian cover is not essential, but all workers should be aware of how to contact their named guardian at any time. This may be via email, form submission, or a case management system. However, for out of hours concerns, all workers should be aware of escalation routes for any immediate patient safety, worker welfare or safeguarding concerns. During out of hours the Trust have a bleep system which is managed by a senior member of the Trust. One of the FTSU champions is a bleep holder on site. All bleep holders have support from the executive team member on call.

2.10.3 FTSUG Training and Networking

All Freedom to Speak Up guardians must complete the following relevant training provided by the National Guardian's Office:

• Foundation training - part one and part two. Part one is undertaken before registration with part two a requirement within three months of registration.

• Annual refresher training.

Guardians are also expected to join, and attend, their regional guardian network group. Network meetings provide a safe space for guardians to meet their peers regularly to discuss guardian related matters such as changes to policies, procedures or recommendations on how to go about their role.

2.10.4 Board and leadership responsibilities in relation to Freedom to Speak Up

All organisations must have adopted NHS England's national speak up policy. In line with good practice, non-NHS organisations should adopt the policy with local variations. **(ROH policy due for update December 2025)**

All organisations must appoint an executive lead for Freedom to Speak Up and a non-executive director, or equivalent in non-NHS organisations, who will support the Freedom to Speak Up Guardian and act as a means of escalation within the organisation. At the ROH Simon Grainger-Lloyd, Director of Governance is the Executive Lead and Gianjeet Hunjan is the Non Executive Lead.

2.10.5 Freedom to Speak Up National Awareness Month in October 2024:

Every October the National Guardian Office celebrates Speak Up Month, a campaign designed to raise awareness of the work and commitment of the Speaking up agenda, a recommended from the Robert Francis Report 2015. This is well embedded in the Trust and is now an event that is anticipated with enthusiasm. This year it was commemorated by roadshows, listening sessions, teaching sessions, walkabout visibility and activities. It was led by the Guardian, FTSU Champions, NED and FTSU Executive Director with support from the Communication Team. It was very positive, well accepted and supported by staff. Staff were provided with the Trust value card i.e. 'listen with compassion' and encouraged to write a message and give to a colleague who had shown this value during October. Staff stated that this was useful, and workers reported that it had a positive impact on morale and civility.

3 Recommendation

3.1 The Trust Board is asked to:

RECEIVE and ACCEPT the update

Claudette Jones
Freedom to Speak Up Guardian

28 May 2025

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	Trust Safeguarding and Vulnerabilities Annual Reports
SPONSOR (EXECUTIVE DIRECTOR):	Nikki Brockie, Chief Nurse
AUTHOR:	Rebecca Furnival, Interim Head of Safeguarding and Vulnerabilities
DATE OF MEETING:	4 June 2024

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

These annual safeguarding reports for The Royal Orthopaedic Hospital NHS Foundation Trust provides a comprehensive overview of the Trusts safeguarding and vulnerabilities activity between 1st April 2024 to 31st March 2025 and includes both children and adult and how we have fulfilled our safeguarding functions and safeguarding statutory requirements.

Collaboration Between Safeguarding and Vulnerabilities Teams

- Both teams share a commitment to protecting vulnerable individuals, ensuring that patients receive the right support based on their specific needs.
- They work together to identify and address safeguarding risks, providing a coordinated response to complex cases.
- The teams contribute to Trust-wide safeguarding initiatives, ensuring policies and procedures align with best practices and national guidance.

Patient safety and effective care maintained between 2024-2025 despite safeguarding concerns and vulnerabilities identified.

The safeguarding team and vulnerabilities team contributed to system wide and partnership working over the reporting year. This included working with the ICB, Social Care, Police, Acute Trusts, Community Teams, Primary Care, Third sector organisations etc.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Increase in referrals to the safeguarding and vulnerabilities team. Staff proactively identifying safeguarding and vulnerability concerns. This included a 74% of domestic abuse disclosures. • ROH's data and practices have also been included in Birmingham City Council's City-Wide Domestic Abuse Strategy Report, highlighting the Trust's valuable contribution to system-wide improvements in responding to domestic abuse • 78 Local Authority meetings and reviews—representing a 29% increase from the previous year.	• The DASVA (Domestic Abuse and Sexual Violence Advocate) funding is provided on a fixed-term 24-month contract, this will be reviewed over the coming year to explore longer term funding to meet the needs of the patients and staff • Improve compliance with mandatory safeguarding training- this continues to be a key focus across the trust. • Reducing health inequalities for children in care through multi agency collaboration

- 60 children in care identified and received support from the safeguarding team to reduce health inequalities following the NICE guidance for Children in Care.
- Mental Health and Dementia Team received a total of 358 notifications and provided direct frontline crisis support to 91 patients who expressed suicidal ideation immediate frontline support provided by MH/DEM to prevent acts of harm.
- 65 clinical and non-clinical staff received bespoke mental health training.
- the LD team received 1,532 notifications and helped 143 patients with admission planning and reasonable adjustment needs for elective and day case procedures
- Quarter 4 Transitions team supported 44 young people accessing care within the hospital, either as outpatients or during admission. This includes care planning and making reasonable adjustments.

- Addressing medical neglect through early identification and family engagement (quality priority 3 effective care)
- Attending local authority meetings growing reliance on health services to actively contribute/lead to multi-agency safeguarding efforts for children and young people.
- Work is underway to establish a formal BSMHT Service Level Agreement (SLA): This is currently being negotiated between the trust.
- covering mental health and dementia services.
- Lack of Mental Health Support for Under-18s: There is no mental health support service available for individuals under the age of 18 at ROH. Cases are escalated and addressed individually with services as they arise.
- The Learning Disability & Autism Team continues to address ongoing risks related to information sharing and patient flagging both locally and nationally (added to corporate risk register). This is careful monitored and address individually as required.

REPORT RECOMMENDATION:

The Board is asked to: note and accept the report. Provide support for the quality priorities for FY 25/26

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

Financial	x	Environmental		Communications & Media	
Business and market share		Legal & Policy	x	Patient Experience	X
Clinical	x	Equality and Diversity		Workforce	X
Inequalities	X	Integrated Care	x	Continuous Improvement	x

Comments: n/a

ALIGNMENT TO TRUST STRATEGY ***(Indicate with 'x' all those that apply):***

Care	x	**Community**	x
Expertise	x	**Services**	x
People	x	**Collaboration**	x

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

Our work aligns with risk registers, Board Assurance Framework (BAF), and national standards by actively supporting the identification and mitigation of key system risks—such as health inequalities, workforce pressures, and service quality. We ensure compliance with regulatory requirements (e.g. ICB assurance, CQC, NHS England standards) and contribute to performance metrics around access, outcomes, patient experience, and system efficiency. Through regular monitoring, reporting, and continuous improvement, we support assurance, accountability, and delivery of high-quality, safe, and effective care.

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

Our work aligns with the Birmingham and Solihull Integrated Care System (ICS) by supporting its key objectives: improving population health, reducing health inequalities, and enhancing patient experience through integrated, person-centred care. We contribute by promoting early intervention, fostering collaboration across services, leveraging digital tools for better outcomes, and supporting workforce sustainability. Our approach ensures equitable access, efficient service delivery, and improved health and wellbeing for local communities.

BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)*:
National Section 11 Audit compliance NHS Prevent and SCAT benchmarking The NHSE Safeguarding and Accountability and Assurance Framework NICE – Promoting Health and Wellbeing for children in Care NHS Learning Disability Benchmarking NCEPOD and NICE – Transitional Care NHS England – Dementia care
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
Previous annual report Quality & Safety Committee May 2025

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Safeguarding Annual Report **Summary** 2024-2025

Review and Resilience Planning for Safeguarding Leadership

Enhancing MCA and DoLS Knowledge Through Video-Based Refresher Training

Improving Compliance with Mandatory Safeguarding Training

Implementing the Domestic Abuse and Sexual Safety Charter Across the Trust

Promoting Accountability in Mental Capacity Documentation and Decision-Making

Reducing Health Inequalities for Children in Care Through Multi-Agency Collaboration

Addressing Medical Neglect Through Early Identification and Family Engagement

Improving Efficiency Through Integration of Electronic and Paper Records

BIRMINGHAM SAFEGUARDING ADULTS BOARD

BIRMINGHAM Safeguarding Children PARTNERSHIP

Birmingham and Solihull Integrated Care System
Caring about healthier lives

Executive Summary

The Royal Orthopaedic Hospital NHS Foundation Trust Safeguarding Annual Report 2024-2025 highlights the Trusts efforts and achievements in safeguarding children and adults. This includes safeguarding activity, multi-agency collaboration, training compliance, key challenges, priorities and recommendations for future improvements.
The Royal Orthopaedic Hospital can demonstrate that there are appropriate safeguarding governance systems in place for discharging their statutory safeguarding duties and functions in line with the following key legislation:

- Childrens Act 1989 and 2004
- Working together to Safeguard Children 2023
- Care Act 2014
- Domestic Abuse Act 2021
- Mental Capacity Act (MCA, 2005)
- Prevent - Counter Terrorism and Security Act, 2015 (Prevent Duty)
- Health and Social Care Act (2022)
- The NHSE Safeguarding and Accountability and Assurance Framework (SAAF 2022)

Each clinical department or area within the Trust has at least one designated Safeguarding and Domestic Abuse Champion. These Champions play a vital role in supporting safeguarding practices at a local level.

The Trust welcomed a newly appointed Named Doctor for children and adults who brings extensive experience and clinical leadership and will play a key role in supporting the Trust's commitment to high standards of care and protection for vulnerable individuals.

Audits

The following audits were completed between 2024-2025 in relation to adult safeguarding:

- Neglect awareness audit
- Adult social care referral audit
- Safeguarding documentation audit
- Exploitation awareness audit
- Mental Capacity and Deprivation of Liberty Safeguards documentation audit
- Domestic abuse awareness and routine enquiry audit

The following internal completed between 2024-2025 in relation to child safeguarding

- Early Help Awareness Audit
- Exploitation Awareness Audit
- Safeguarding Documentation Audit
- Neglect Awareness Audit
- Children's Social Care Referrals Audit
- Annual benchmarking promoting the health and wellbeing of looked after children (NICE, 2020)

These audits support continuous improvement and assurance that staff are recognising and responding appropriately to safeguarding concerns in line with local and national expectations.

Policies and Risks

The safeguarding and vulnerabilities team oversee and review 16 policies. In 2024-2025 the following policies were reviewed and approved at the Safeguarding Committee:

- Safeguarding Children, Young People and Families
- Safeguarding Supervision
- Safeguarding Adults at Risk
- Domestic Abuse – Patients and families
- Staff Domestic Abuse
- Mental Capacity Act (MCA) - Assessing Capacity and Complying with the Mental Capacity Act
- Deprivation of Liberty Safeguards

These updates ensure that the Trust's safeguarding practices remain in line with current legal frameworks and best practices, reinforcing our commitment to protecting vulnerable individuals across all services.

Safeguarding risks are regularly reviewed in collaboration with the Trust's Risk Officer. These risks are then presented for discussion and feedback at the bi-monthly Safeguarding Committee meetings, in addition to routine monitoring, an annual 'Confirm and Challenge' session was conducted with the Chief Nurse and the Risk Officer, providing strategic oversight and ensuring continued alignment with the Trust's priorities. As a result of strengthened governance and targeted action, the number of safeguarding risks has been reduced from 14 to 7 over the past year.

Training

The Adult Safeguarding and Children's Safeguarding Intercollegiate documents provide a clear framework that outlines the required competencies for safeguarding at various levels.

- Levels 1-3 correspond to different occupational groups, ensuring that all staff receive appropriate training based on their role and responsibilities.
- All named professionals receive Level 4 training which includes the Chief Nurse, Safeguarding Lead Nurse, Senior Safeguarding Named Nurse, Named Nurse, and Named Doctor.

Prevent training within the Trust is delivered via e-learning and face-to-face sessions. Level 3 Prevent WRAP training is delivered in person, with sessions provided monthly.

- Training compliance is monitored and reported through the Safeguarding Committee and escalated to the Quality and Safety Committee
- The Trust has consistently submitted all required external quarterly digital Prevent reports within the designated submission deadlines.

Training compliance is reported externally as a Key Performance Indicator (KPI) to the ICB as part of contractual obligations. It also serves as a critical assurance measure for meeting statutory safeguarding requirements for the relevant safeguarding boards and partnerships.

An annual review of the Safeguarding Training Needs Analysis was completed to ensure ongoing relevance and effectiveness. The Safeguarding Lead Nurse provides a monthly compliance report to the Trust's Assistant Director of Governance and Risk.

Safer Recruitment and Disclosure and Barring Service (DBS)

Safer Recruitment is a critical component of safeguarding children, young people, and adults at risk. It involves embedding safeguarding principles and promoting welfare at every stage of the recruitment process to minimise the risk of employing individuals who may be unsuitable to work with vulnerable groups. These procedures are a key part of Section 11 of the Children Act 2004, which places a duty on organisations, including NHS Trusts, to ensure safe recruitment practices and ongoing monitoring of individuals working regularly with children or vulnerable adults.

Person in Position of Trust (PiPoT): Managing Allegations Against Staff

When an allegation is made suggesting that a member of staff may be unsuitable to work with children or has caused harm, the Trust is required to make a referral to the Local Authority Designated Officer (LADO).

Over the past year, the Safeguarding Lead Nurse has been involved in two PiPoT cases. Each case is managed on an individual basis, with outcomes determined by the nature of the allegation and the staff member's role. The Safeguarding Lead Nurse works closely with the individual's line manager and the HR department to ensure that allegations are thoroughly investigated, and appropriate support is provided throughout the process.

Trust Safeguarding Activity 2024-2025

Between 2024 and 2025, the Safeguarding Team attended 78 Local Authority meetings and reviews—representing a 29% increase from the previous year. This rise reflects the growing reliance on health services to actively contribute to multi-agency safeguarding efforts for children and young people.
The largest proportion of concerns reported were for individuals aged 12-15 years old, further emphasising the need for early support during the transitional period between child and adult services. The safeguarding team collaborates with the Birmingham Women's and Children's Hospital (BWCH) safeguarding team, sharing information to ensure that children are effectively safeguarded across both services.
In 2024–2025, a total of 535 child safeguarding notifications were received, identifying a range of concerns. These included:

- 60 children in care
- 119 children in need
- 12 children identified by frontline staff within outpatient departments
- 50 children identified as being home educated or missing in education
- 16 children identified as being at risk of witnessing or experiencing domestic abuse
- 2 suspected non-accidental injuries

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. This initiative supports access to healthcare, reduces the risk of unmet health needs for adults, children and young people, and helps to lower the cost implications for the Trust associated with missed appointments.

Tackling health inequalities for children and young people in care and leaving care requires coordination between multiple professionals across the wider social, economic and environmental factors that influence their health, and services. 40 out of the 60 children in care identified were overseen and supported by the safeguarding team.

A 9% increase in adult safeguarding referrals compared to the previous year (2022–2023). The safeguarding team received a total of 651 adult safeguarding notifications raising concerns. The largest proportion of adult safeguarding cases reported involved individuals aged 75 years and over.

Activity analysis

- 54 vulnerable adults where multiple risks were identified.
- 312 adults disclosed domestic abuse concerns.
- 8 high risk hoarding concerns.
- 2 adult exploitation concerns
- 2 modern day slavery NRM referrals
- 4 care leavers identified.
- 15 FGM mandatory reporting
- 51 adult patients who had multiple did not attend appointments.
- 1 court of protection.
- 2 Position of Trust referrals
- 81 Mental Capacity concerns
- 54 Deprivation of Liberty Safeguards (DoLS) applications

In the past year, the Safeguarding Team received 312 notifications related to domestic abuse — a 74% increase compared to the previous year. This significant rise highlights both the ongoing prevalence of domestic abuse among individuals accessing our services and the growing awareness and confidence among staff in identifying and reporting such concerns.

In response to this rising demand, the Senior Named Nurse submitted a business case to The Royal Orthopaedic Hospitals Charities for two years of funding to employ a Domestic Abuse and Sexual Violence Advocate (DASVA). This proposal, supported by the Chief Nurse, was approved in November 2024. The funding will enhance the Trust's ability to provide specialist, dedicated support for patients and staff experiencing domestic abuse, sexual violence and sexual safety concerns, improving outcomes and ensuring effective intervention.

Supervision continues to be delivered face-to-face and offered monthly, bi-monthly, or quarterly, depending on the practitioner's role and level of responsibility. In most cases, supervision is conducted in group settings, fostering shared learning and peer support. Safeguarding supervision is reviewed and audited on an annual basis to ensure its effectiveness in promoting professional development and accountability.

2025-2026 safeguarding priorities

Review and Resilience Planning for Safeguarding Leadership	Enhancing MCA and DoLS Knowledge Through Video-Based Refresher Training	Improving Compliance with Mandatory Safeguarding Training	Implementing the Domestic Abuse and Sexual Safety Charter Across the Trust
Promoting Accountability in Mental Capacity Documentation and Decision-Making	Reducing Health Inequalities for Children in Care Through Multi-Agency Collaboration	Addressing Medical Neglect Through Early Identification and Family Engagement	Improving Efficiency Through Integration of Electronic and Paper Records

1. Following the planned retirement of the Safeguarding Lead Nurse in April 2025, the Chief Nurse will undertake a review of the safeguarding team's roles and responsibilities to ensure alignment with national regulatory frameworks and evolving service needs. Efforts will continue to reduce single points of failure within the safeguarding team, with a particular focus on strengthening the resilience of key roles. This will help ensure continuity of care, support, and leadership, strengthening the team's ability to respond effectively to safeguarding concerns. This review will support continuity, clarity, and effectiveness within the safeguarding function across the Trust.
2. A review of the Trust-wide training packages on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, with the aim of enhancing staff knowledge through the introduction of mini refresher sessions delivered via short, accessible videos.
3. Continue to improve mandatory training compliance across the Trust, ensuring staff remain up to date with essential knowledge and skills required for safe and effective practice
4. A key focus was placed on the Senior Named Nurse and DASVA's responsibilities for 2025-2026 in supporting the implementation of the Domestic Abuse and Sexual Safety Charter. This includes contributing to relevant policies, delivering targeted training sessions, and working collaboratively with departments to raise awareness and promote a culture of safety, respect, and zero tolerance towards abuse.
5. Staff to be encouraged to take greater accountability in documentation, particularly in evidencing decision-making, care and treatment planning, and reviews through the consistent use of Mental Capacity Assessment forms.
6. Continued efforts to reduce vulnerabilities and address health inequalities for children in care, through strengthened multi-agency collaboration, targeted health assessments, and improved access to support services tailored to their specific needs.
7. Ongoing work focused on reducing the risks and implications for children and young people experiencing medical neglect due to lack of engagement with health services. This included proactive identification, early intervention, and collaborative working with families and partner agencies to support sustained access to healthcare.
8. Complexity arises from the use of multiple electronic patient record (EPR) systems, alongside continued use of paper-based records. This fragmented approach creates barriers to seamless information sharing and can delay safeguarding responses, particularly in urgent or high-risk cases. Work is ongoing to explore solutions and improve integration across platforms.

Conclusion

The Royal Orthopaedic Hospital's Safeguarding Team is dedicated to ensuring the Trust fulfils its duties and responsibilities regarding safeguarding. The team adopts a whole-systems approach, working across both acute and community settings.

This annual report reflects safe and effective practices in line with our statutory and regulatory obligations, demonstrating overall strong compliance with both internal and external safeguarding standards. Moving forward, the team will continue to build upon existing initiatives to ensure that safeguarding processes remain robust, effective, and aligned with the core values of the Trust.

The Safeguarding Team would like to extend our sincere thanks to all our committed staff, supportive partners, external trainers, the Executive Team, and the Trust Board. Their ongoing positive collaboration enables us to uphold the principle that 'Safeguarding is Everyone's Responsibility.'

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Vulnerabilities Annual Report **Summary** 2024-2025

- Transition to Adult Services
- Learning Disability and Autism
- Dementia and Mental Health Service
- Vulnerabilities Champions

Executive Summary

The Royal Orthopaedic Hospital (ROH) remains dedicated to providing high-quality, patient-centred care to individuals with specific health needs, including those transitioning to adult services, people with learning disabilities and autism, and those living with dementia or mental health challenges. This report outlines the key achievements, priorities, challenges, and strategic directions in these areas, showcasing the Trust's ongoing efforts to enhance accessibility, inclusivity, and patient outcomes.

Transition to Adult Services

The Transition to Adult Services Team is dedicated to ensuring a smooth and supported transition for young people moving from paediatric to adult care. This service focuses on empowering young people to make informed decisions about their care, while addressing health inequalities stemming from social deprivation, care experiences, or geographic challenges.

In the year from April 1, 2024, to March 31, 2025, the team received 766 notifications and supported 44 young people, ensuring personalised care and reasonable adjustments. Positive feedback from patients and families will guide further improvements and service development.

Priorities:

- Continue to provide holistic support to young people, ensuring individual care plans and reasonable adjustments.
- Develop a more structured feedback system to improve service delivery and identify areas for development.
- Enhance collaboration with community and educational settings to shape the service.

Challenges:

- Managing the complexity of each transition and ensuring smooth coordination between paediatric and adult services.
- ackling the health inequalities faced by vulnerable young people, including those in care or from socio-economically disadvantaged backgrounds.

Learning Disability and Autism Service

The Learning Disability and Autism Team has worked diligently to meet the unique needs of individuals with learning disabilities and autism, focusing on ensuring they have access to appropriate care and reasonable adjustments.

Over the last year (April 1, 2024, to March 31, 2025), the team supported 1,532 notifications and helped 143 patients with admission planning and reasonable adjustment needs for elective and day case procedures. Building on these efforts, the team remains committed to improving patient experiences and ensuring positive outcomes for patients with learning

disabilities and autism.

Priorities:
- Expand the delivery of personalised care plans and reasonable adjustments for patients.
- Strengthen relationships with patients and their families to ensure that their feedback informs ongoing improvements.
- Continue the development of accessible resources and tools, such as the Easy Read Leaflet and communication toolkits.

Challenges:
- Overcoming barriers to communication, including the need for more robust systems for reporting and recording incidents involving patients with learning disabilities and autism.
- Ensuring that all staff are adequately trained and equipped to support patients with diverse needs.

Dementia and Mental Health Service

The Dementia and Mental Health Team focuses on delivering person-centred care for individuals with dementia and mental health conditions, promoting dignity and quality of life while reducing hospital-related complications.

During the period from 1st April 2024 to 31st March 2025, the Mental Health and Dementia Team received a total of 358 notifications and provided direct frontline crisis support to 91 patients who expressed suicidal ideation. Tailored support to patients with mental health concern and living with Dementia included personalised care plans, reasonable adjustments, and continuous engagement with patients and their families to ensure comprehensive and compassionate care.

Priorities:
- Continue to improve early diagnosis and intervention, particularly through initiatives like the Butterfly Scheme.
- Enhance staff training to ensure that staff are equipped to manage complex behaviours associated with dementia and mental health.
- Expand support for families and caregivers, ensuring they are part of the care planning process.

Challenges:
- Managing the complexity of dementia and mental health care, particularly in the hospital environment.
- Ensuring staff consistently have the necessary skills to provide high-quality care for patients with cognitive impairments and mental health conditions.
- Lack of Formal Service Level Agreement (SLA): There is no formal SLA between the Royal Orthopaedic Hospital (ROH) and Birmingham and Solihull Mental Health Trust, which can affect coordination of care.
- Lack of Mental Health Support for Under-18s: There is no mental health support service available for individuals under the age of 18 at ROH.
- Expiring Practitioner Contracts: The current contracts for two part-time Dementia and Mental Health Practitioners are set to expire in July 2025, potentially affecting service delivery.

Significant achievements over the past year include the successful implementation of the Butterfly Scheme, increased staff training initiatives, and improvements in early diagnosis. The Dementia and Mental Health Team remains dedicated to delivering compassionate care that respects the individuality and needs of every patient.

Vulnerabilities Champions

The Vulnerabilities Champions initiative at the Royal Orthopaedic Hospital is dedicated to ensuring patients with learning disabilities, autism, mental health conditions, and other vulnerabilities receive the best care. Champions are trained staff members who advocate for inclusive, personalised care and support vulnerable patients throughout their hospital experience.

Key Objectives:

- Raising Awareness: Advocating for patients' needs and promoting inclusive practices across the hospital.
- Training and Support: Champions receive specialised training to identify and address patient needs.
- Patient Advocacy: Acting as a voice for vulnerable patients to ensure their needs are communicated and met.
- Improving Patient Experience: Addressing care gaps to enhance the overall experience for vulnerable patients.
- Promoting Best Practices: Sharing best practices to ensure reasonable adjustments and inclusive care.
- Vulnerabilities Champions Day celebrates the achievements of champions, allowing them to reflect on their work, share experiences, and receive feedback for continuous improvement.
- This initiative fosters a culture of inclusivity, ensuring all patients receive the care and support they need.

Conclusion

In conclusion, the Royal Orthopaedic Hospital has made considerable progress in supporting individuals with complex needs across the Transition, Learning Disability and Autism, and Dementia and Mental Health services.

Despite challenges such as the complexity of transitions, communication barriers, and the need for ongoing staff training, the teams have remained dedicated to addressing health inequalities, enhancing care delivery, and improving patient experiences. Looking ahead, the Trust will continue to focus on these priorities, building on past successes and working collaboratively to ensure that all patients receive the highest standard of care tailored to their individual needs.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 27 May 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that Month 1 had a small deficit to plan. • Overspend in non-pay although actual spend was low, so variance driven by low planned spend (aligned to activity plan). • Quarter 1 would be the point of the first real assessment on finance, activity and performance. • The Committee was made aware that this is final year of Frontline Digitisation Process and there is a risk in ensuring funding is utilised or deferred. • It was noted that the BADS rate / Virtual consultations were below target.	• Deep dive will be commissioned into non-NHS healthcare spend. • Work will continue in finishing QIAs. • Continuing development of Performance Dashboard with the plan to present to the Trust Board in July. • Private patient report coming to June Board • CIP understated for month 1 – will be refreshed for month 2
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received the updated financial corporate risks which had recently been refreshed. • Improved RTT position ahead of planned trajectory. • Theatre session utilisation is ahead of plan. • It was noted activity overperformance against plan despite planned theatre refurb and unplanned plant failure. • Bank and agency spend is low and is the lowest it has been for some time, although reflective of activity performed. • Deep dive received for Hands and Spasticity which identified future options and opportunities for providing more innovative care, earlier intervention, and reduction of follow-ups. • The Committee discussed the integrated performance report and the focussed on the development needed to ensure it is fit for purpose.	• The Committee agreed the refreshed risks presented.

Chair's comments on the effectiveness of the meeting: The Chair commented on the encouraging discussions for the first meeting of the new financial year

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UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 21 May 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- It was noted that risk number 1893 Delay to Histology Reporting, has been raised, based on turnaround time performance worsening. There are now bi-weekly meetings in place with key stakeholders to minimise the delays and escalate where necessary.
- It was noted that there had been one inpatient death, and this is currently being reviewed.
- It was noted that complaints compliance remains below the KPI, but improving, with improved engagement across the Trust to deliver the KPI. The Trust however is delivering a 100% on the constitutional target of responding to patients within three days.
- The Committee received PSII reports for the two never events that occurred. It highlighted there were a number of failings, but assurance was provided with the action that has been taken to prevent future incidents of this nature.
- It was noted the Committees' concern with regards to issues in spinal and it was felt a report to the Board would be welcome on the action being taken to address this.
- The Committee discussed the cost improvement programmes and quality impact assessments but felt more assurance was needed as to the process that is followed which will be included in the planned July report.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- The Spinal Endoscopy Review has an estimated completion date in June from the latest Royal College of Surgeons update. It is hoped the report will be presented to this Committee in July.
- Work to produce a plan that details the trajectory to achieve the improvement required with complaint handling.
- The safer staffing report presented requires validating due to incorrect numbers being stated.
- The Duty of Candour policy is being redrafted to reflect the intention of the patient safety incident framework to something more compassionate and engaging.
- Undertake a deep dive on the WHO process in Theatres and present back to the Quality & Safety Committee in September.
- Provide an assurance document to demonstrate the quality impact assessment process has been followed robustly to the July meeting.
- Work is underway with the Human Tissue authority to establish the correct consent framework for the Research Tissue Bank after concerns were raised about this by the HTA.

POSITIVE ASSURANCES TO PROVIDE

- It was noted that the number of incidents being reported had increased on previous months which provides assurance that the reporting culture at the Trust remains robust.
- The Committee received the Patient Experience quarter 4 report and it was highlighted the work that is taking place to make improvements based on the feedback that is received.

DECISIONS MADE

- The Committee agreed that an update is required to all Board members on the action being taken in spinal to address some of the issues that are being flagged in a number of reports.
- The Committee agreed that the Safeguarding and Vulnerabilities Annual Report could be presented to the Board for approval to publish.
- The Committee accepted the proposed changes to the terms of reference and agreed they could be presented to the Board for approval.

• The Committee was presented with the draft quality priorities for 2025/26. • The Committee received the annual Safeguarding reporting and also the Vulnerabilities annual report. • The Committee received a surgical site infection (SSIs) report which had been revised following feedback from previous Committee meetings. • The Committee received a draft copy of the Quality Account for consideration ahead of the final copy being presented to the Trust Board at the end of June. • The Committee was provided with an update CNST report. • The Committee received the internal audit patient safety incident framework report. • The terms of the reference was reviewed as part of the annual process and proposed changes were accepted.	

Chair's comments on the effectiveness of the meeting: The meeting provided an opportunity to undertake a number of detailed discussions on key topics.

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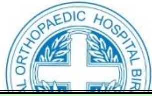
UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 2nd May 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that the internal audit action plan had been updated with a number of revised dates to completion of actions. It was acknowledged that this could impact the Head of Internal Audits opinion and there needs to be justification for the revision of dates. • It was noted that the declarations of interests' register had been updated and there has been a noticeable improvement, however there is still work to do to encourage colleagues to complete the declarations required.	• The Artificial Intelligence session that is being arranged for the Trust Board will take place following the completion of the internal audit report that is currently being undertaken. The session will be planned for the Board meeting in September. • The process and governance of the annual review of PAs to be established and embedded to ensure they are matched to the job plans. • As part of the patient safety incident response (PSIRF) audit the governance training has been updated to ensure PSIRF is included, and work is taking place to ensure patients are engaged with as part of the incident process. • The outcome of the counter fraud review that was undertaken with Mills & Reeves to be shared at both Staff Experience & OD Committee and this Audit Committee.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee welcomed Kelly De Gersigny from Deloitte's, as the External Audit Manager for the Trust. • The Committee received a comprehensive update from internal audit, including the consultant job planning, patient safety incident response and cyber assurance framework audits that have been completed. • The Committee was provided with assurance on the work that has taken place to address the actions highlighted in the consultant job planning audit. • The Committee was provided with assurance that the patient safety incident response framework had been implemented effectively. • The Committee was provided with assurance that there had been noticeable improvement in the Trust's cyber security processes.	• The Committee approved the internal audit workplan for 2025/26 could be presented to the Trust Board. • The Committee approved the counter fraud workplan for 2025/26 could be presented to the Trust Board. • The Committee approved the losses and special payments presented and are aware these will form part of the annual financial statement.



• The Committee was provided with assurance that the annual review of the Board Assurance Framework demonstrated progress and strengthening of our processes. • The Committee positively received the final version of the internal audit workplan for 2025/26. • The Committee was provided with assurance that the annual audit of the Trust's account is progressing as planned. • The Committee received the counter fraud workplan for 2025/26. • It was noted that as part of the Me as a Manager programme there is now a finance section which includes a section on counter fraud. • The Committee received the draft annual accounts for review. • The Committee was presented with the draft Annual Governance Statement.	

Chair's comments on the effectiveness of the meeting: The meeting provided the opportunity to have a good, engaging conversation on a set of wide-ranging subjects.

Finance and Performance Report

Month 1

Introduction

The Finance & Performance Report provides an overview of the Trust's performance against Key Performance Indicators (KPIs) that support the delivery of the Trust's Strategic Objectives.

A range of metrics will be assessed to give assurance of performance related to; finance, activity, operational and workforce requirements. In month and annual performance will be assessed with a clear explanation around any findings, including actions for improvement, learning and any risks and/or issues that are being highlighted.

Icons reading guide

Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

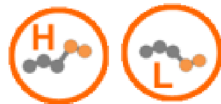
Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

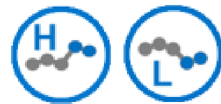
For KPIs that are not applicable to SPC; to identify exceptions we look at performance against target over the last 3 months - automatically assigning measures as an exception if the last 3 months have been falling short of the target in line with how we're calculating the assurance icon for non-SPC measures.

Variation Icons

Are we showing improvement, a cause for concern, or staying within expected variation?



Orange variation icons indicate special cause of **concerning nature** or high pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.



Blue variation icons indicate special cause of **improving nature** or lower pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

A grey graph icon tells us the variation is common cause, and there has been no significant change.

For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

The special cause mentioned above is directly linked to the rules of SPC; for variation icons this is if the latest point is outside of the control range, or part of a run of consecutively improving or declining points.

Assurance Icons

Can we expect to reliably hit the target?

An orange assurance icon indicates consistently (F)alling short of the target.

A blue assurance icon indicates consistently (P)assing the target.

A grey assurance icon indicates inconsistently passing and falling short of the target.

For measures without a target you will instead see the "No Target" icon.

Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months in comparison to the target, showing F or P icons if consistently passing of falling short.

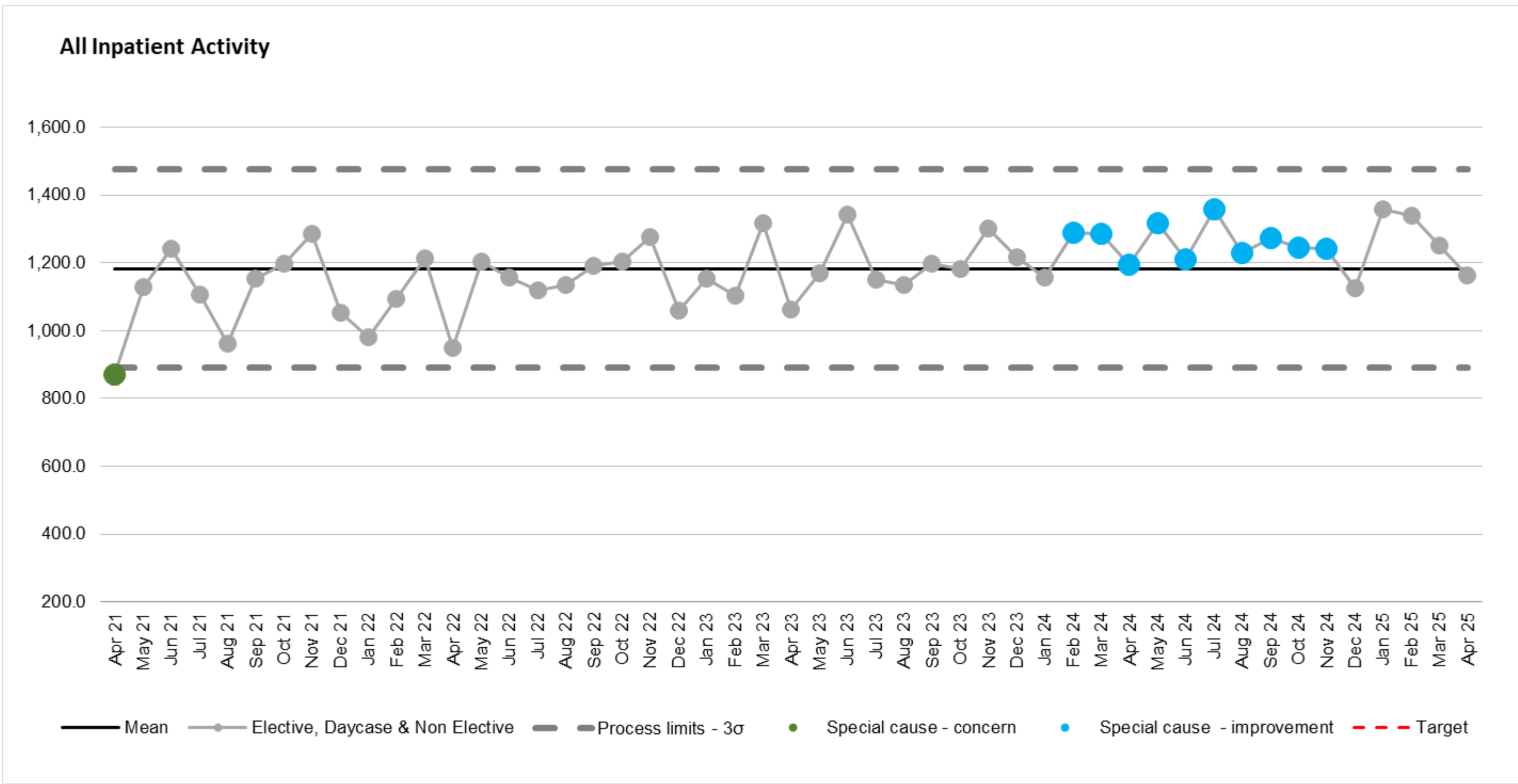
Operational Performance Summary

Performance to end April 25	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	55.63%	54.66%	52.75%		P
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	0	1	0	L	F
52 week waits (52 – 64 Weeks)	486	486	0	H	F
All activity YTD (compared to plan)	1,164	15,149	1,068		P
Outpatient activity YTD (compared to plan)	5,941 104.5% Cumulative	73,054 107.9% Cumulative	5,685 YTD Target		P
Outpatient Did Not Attend (YTD)	7.0%	7.0%	8%		P
PIFU (trajectory to 5% target)	594 10.5%	610 10.1%	512 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	9.4%	9.8%	19%		F
FUP attendances(compared to 19/20)	107.7%	102.9%	N/A		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	115.9%	113%	120%		F
Diagnostics volume YTD (compared to plan)	2,097 Cumulative	25,589 Cumulative	2,017 YTD Target		P
Diagnostics 6 week target	100%	99.91%	99%		P

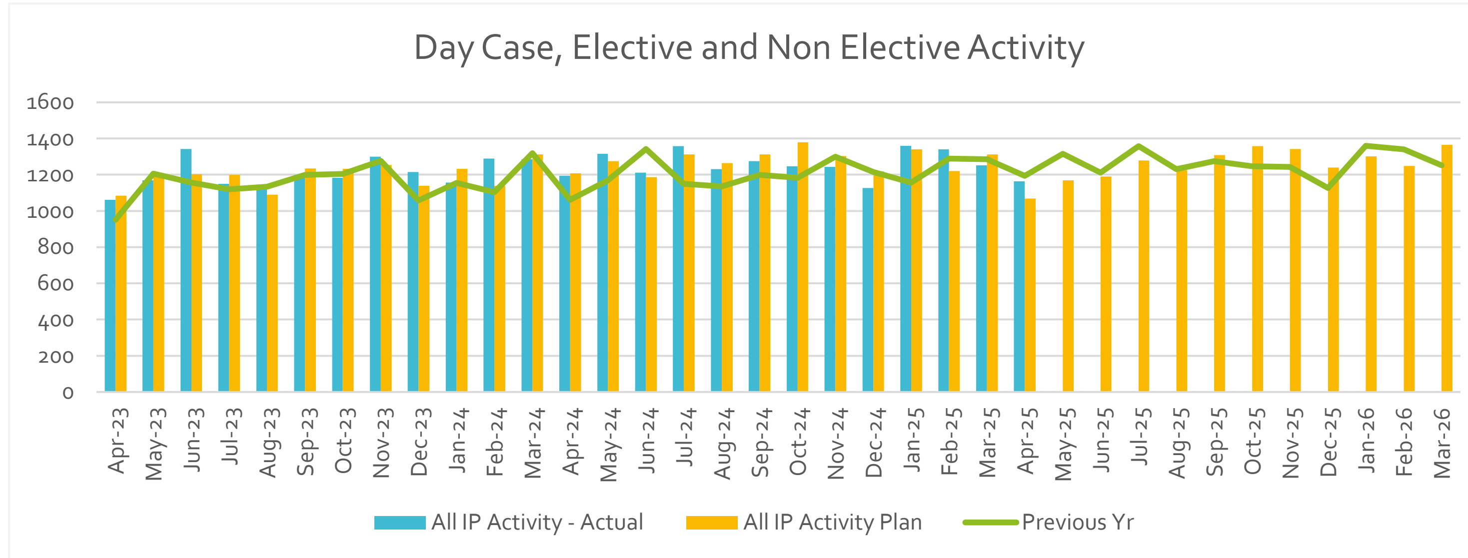
Operational Performance Summary

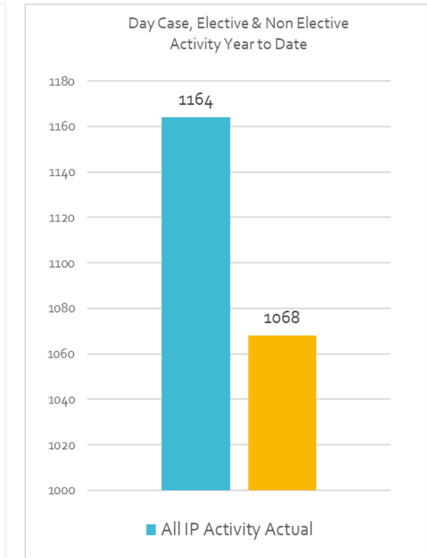
Performance to end April 25	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (Uncapped)	90.4%	84.6%	85%		P
Theatre In Session Utilisation (Uncapped)	84.4%	84.0%	85%		F
Cancer - 31 day first treatment	100%	100%	96%		P
Cancer - 62 day (traditional)	95.2%	76.7%	70% Nat 85% Trust		P
28 day FDS	81.1%	81.6%	75%		P
Patients over 104 days (62 day standard)	0	1	0		No Target
POAC activity volume (YTD)	1,628	25,281 Cumulative	1,765 Cumulative		F
Bed Occupancy (excluding CYP and HDU)	71.4%	76.9%	82-85%		F
LOS - excluding Oncology, Paeds,YAH, Spinal	3.46	3.15	n/a		No Target
LOS - elective primary hip	2.5	2.7	2.7		P
LOS - elective primary knee	3.0	2.7	2.7		P
BADS Orthopaedic: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period) Jan 25	54.60%	53.40%	85%		F
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Jan 25)	38.0%	37.5	-		No Target

1. Activity Summary



1. Activity Summary





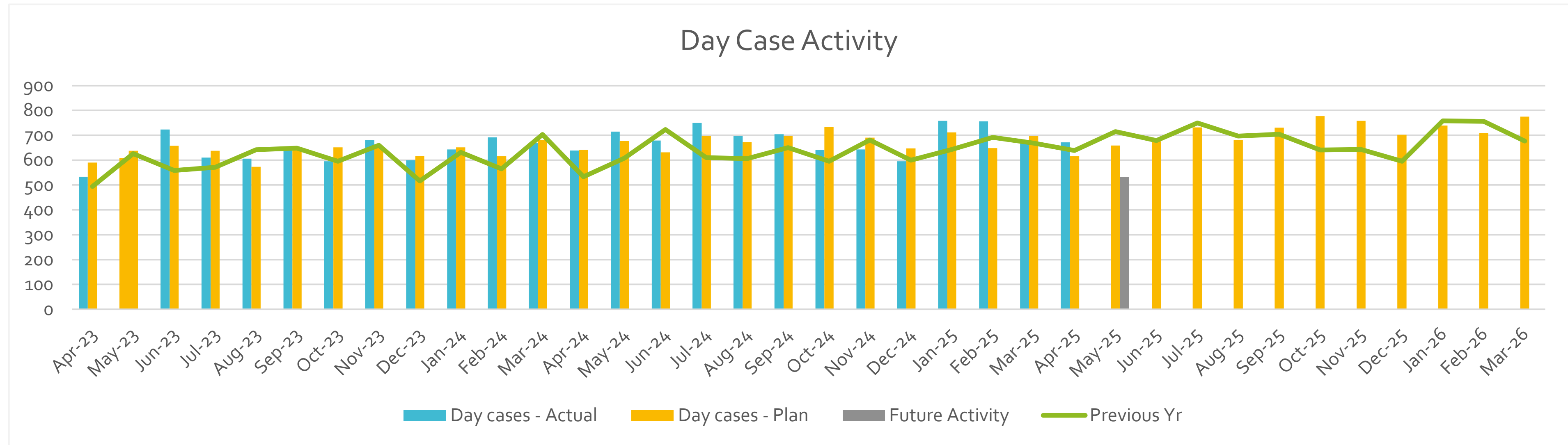
	Activity Type	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Plan Year to Date	Actual Year to Date	% Achieved against plan	Variance Year to Date
Trust Plan	Inpatient	434	488	492	525	523	553	557	563	513	540	520	567	434	482	111%	48
	Daycase	615	659	676	731	680	731	777	758	702	739	708	775	615	671	109%	56
	NEL	19	22	22	22	22	23	23	22	23	22	21	23	19	11	58%	-8
	All Activity	**1068**	**1169**	**1190**	**1278**	**1225**	**1308**	**1357**	**1342**	**1238**	**1300**	**1249**	**1365**	**1068**	**1164**	**109%**	**96**

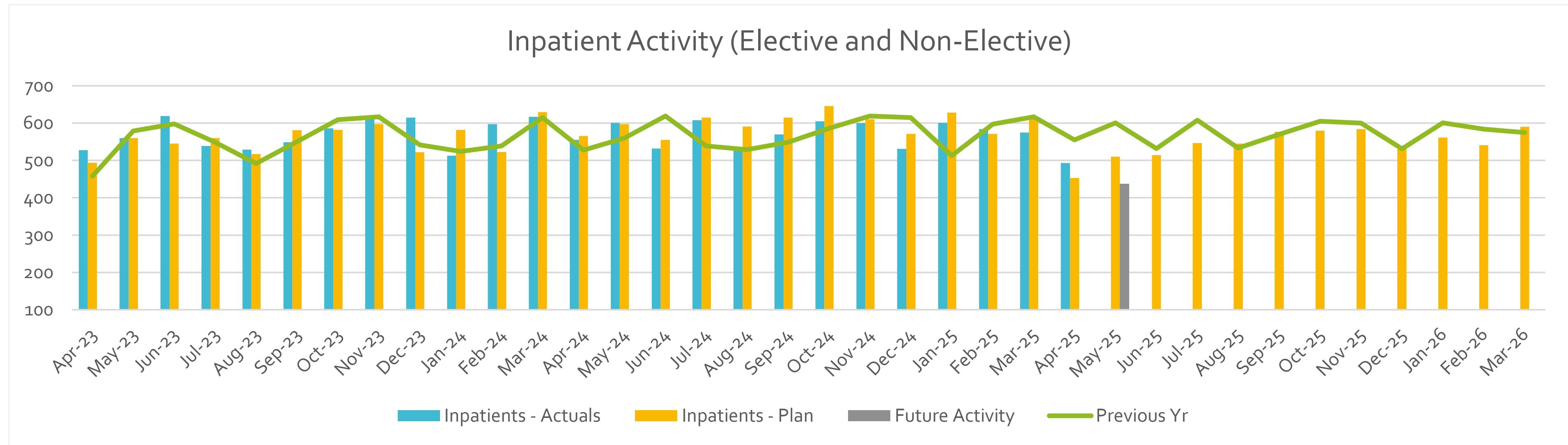
(Columns Apr-25 to Mar-26 are under the heading "Plan".)

April 25

The inpatient activity for the month of April 25 was 1,164, that translates to an over performance of **96 cases** (9%) against the agreed target of 1,068 cases. This is an excellent start to the new year given the challenges faced with available elective capacity throughout March, April and into May 25. (3 theatres unavailable from 9th March – 12th of May 2025)

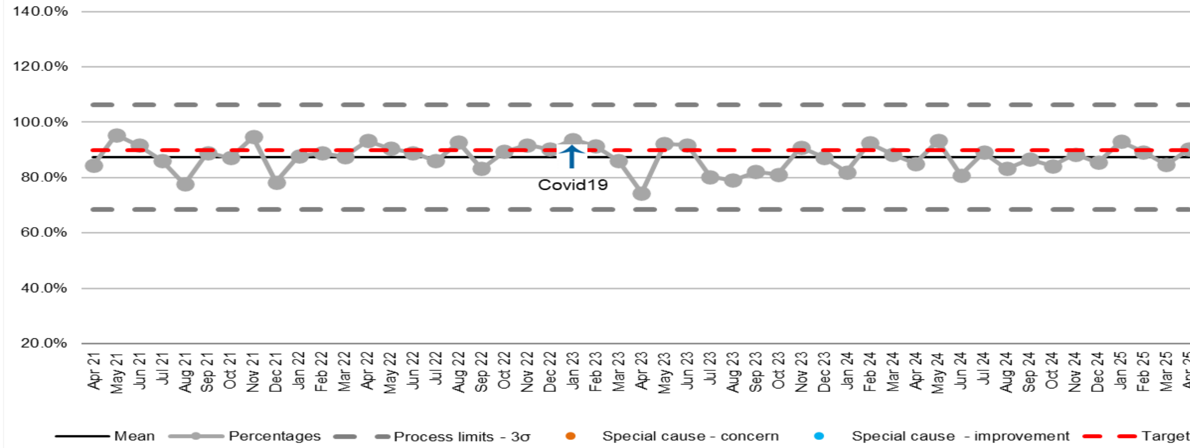
1. Activity Summary

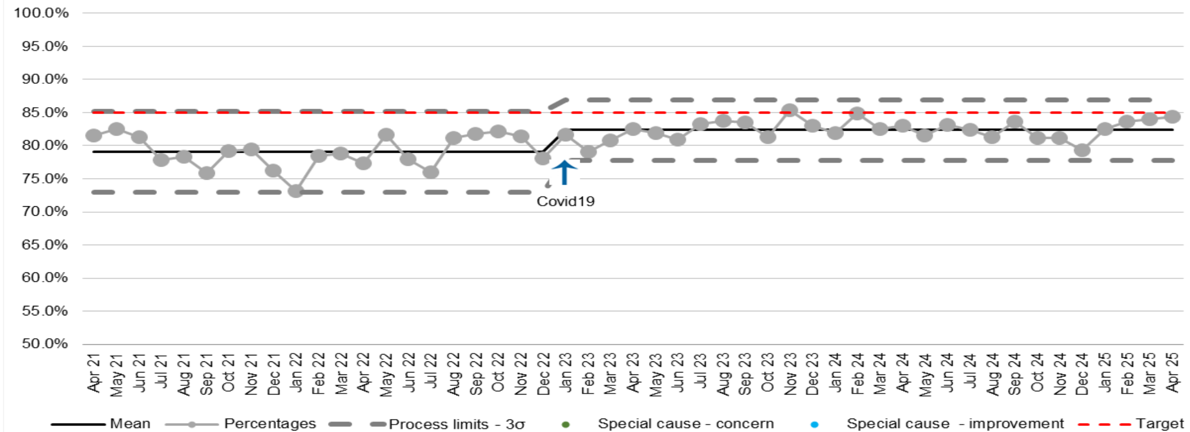




2. Theatre Utilisation

DATA QUALITY KITEMARK





Elective Session Utilisation (April 2025)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	419	382	37	91.17%
UHB	30	24	6	80.00%
Totals	**449**	**406**	**43**	**90.42%**

Elective In Session Utilisation (April 2025)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1663	1403	260	84.35%
UHB	108	92	16	84.78%
Totals	**1771**	**1494**	**277**	**84.38%**

2. Theatre Utilisation

DATA QUALITY KITEMARK

SUMMARY

Overall theatre session utilisation for April 25 was 90.42% with an overall in-session utilisation of 84.38%. The utilisation is based on the theatres that were physically available to the teams to utilise for the month of April 25 and excludes closed theatres.

AREAS FOR IMPROVEMENT

As previously reported, 3 theatres remained closed due to the failure of 2 air plant motor systems that continued to be unavailable during the month of April 25. The contingency plans instigated during March 25 maximising all available capacity and minimising cancellations in activity.

The motor plant systems were removed from the theatre department on the 9th April and taken to a specialist company who successfully repaired both motors and they were reinstalled and commissioned for use on the 12th May 25.

Despite these infrastructure challenges, April 25 activity overperformed by 9% (+ 96 cases), delivering an income surplus .

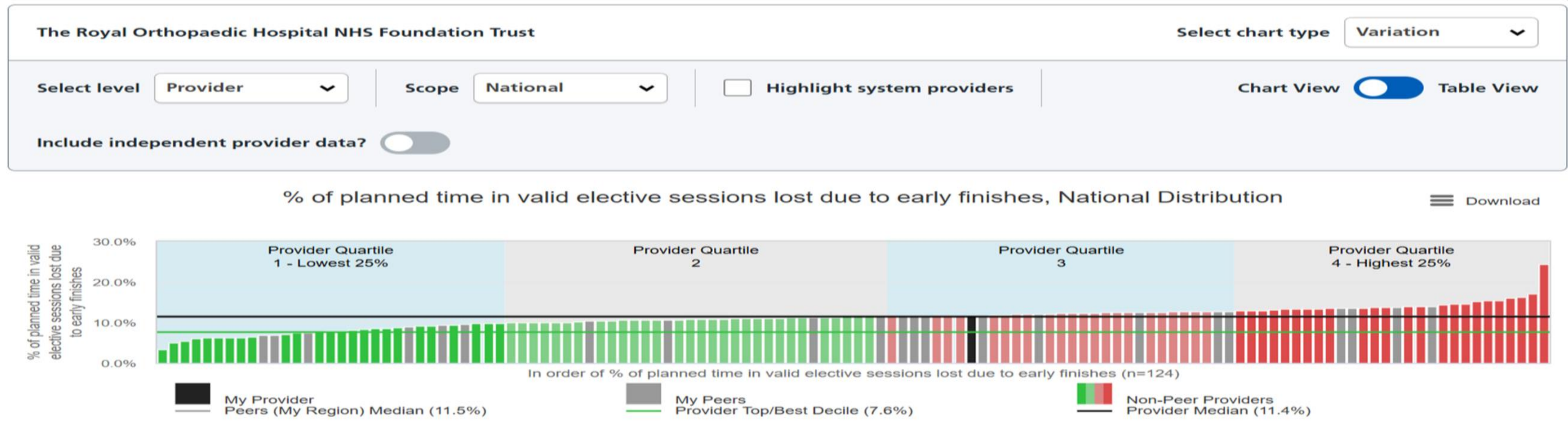
The theatres and POAC improvement group continue to focus on areas of best practice outlined in the NHS England Impact documentation. Early finishes is a continued area of focus with a drive to implement a robust 'standby patient process' to offset short notice cancellations. This will form part of a further Seamless Surgery Week planned for June 25 ahead of the GIRFT Hub Accreditation review on 30th July 2025.

RISKS / ISSUES

POAC improvement group is focussing on aligning capacity with waiting list demand at a specialty level.
A review is underway regarding best use of POAC resources in line with specialty demand to improve access and timeliness of POAC.

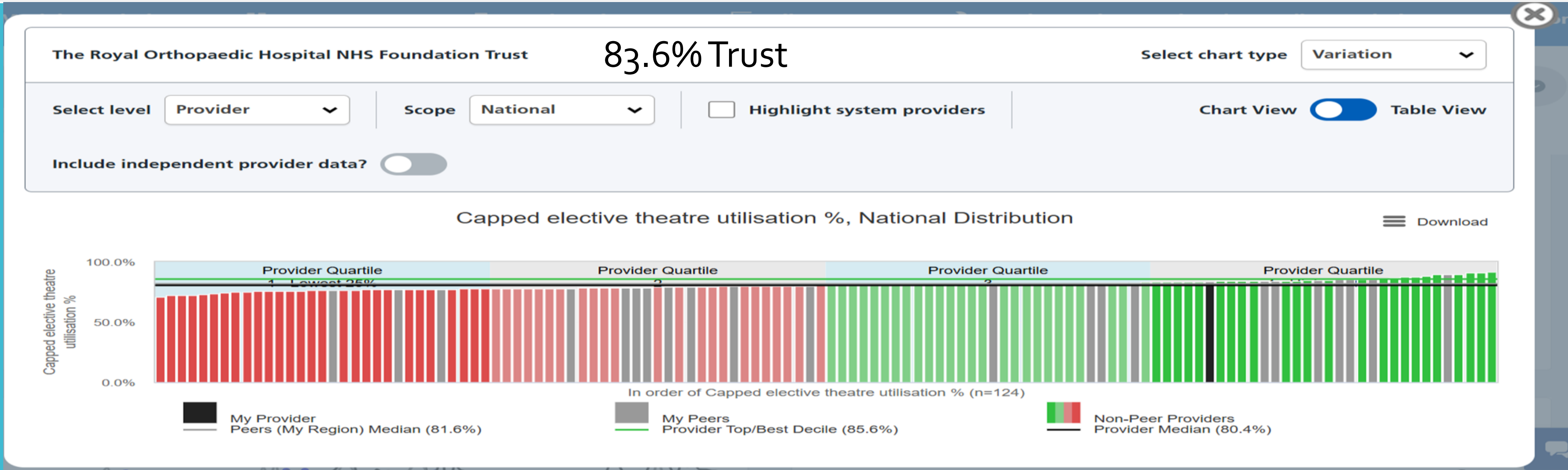
Latest Model Hospital Theatre Metrics

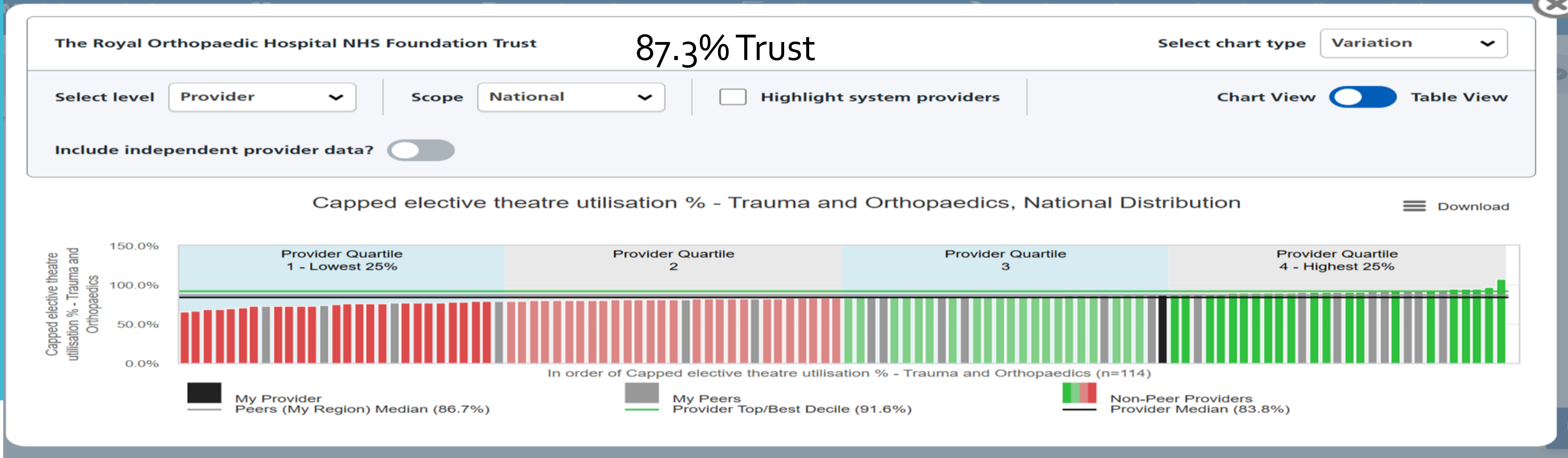
Average inter case turnaround time is 13 minutes and in quartile 2. Seamless surgery week will focus on how we can improve further on this metric.



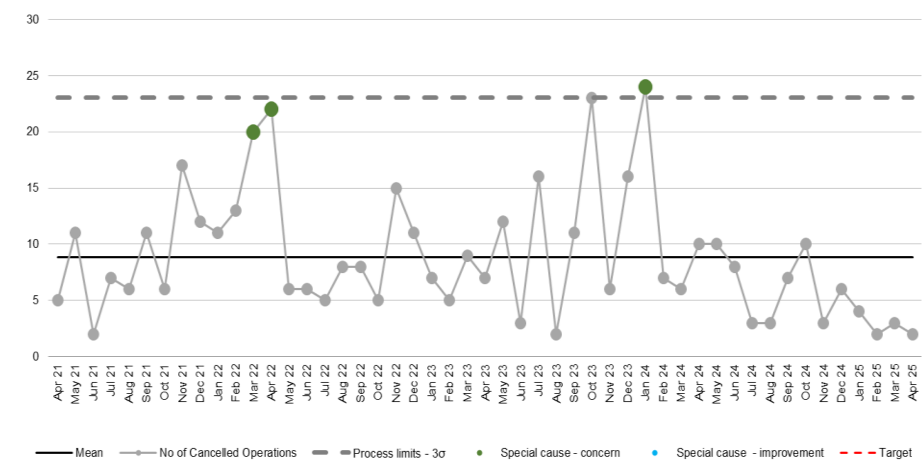
The Trust continues to improve on early finish times moving towards quartile 2

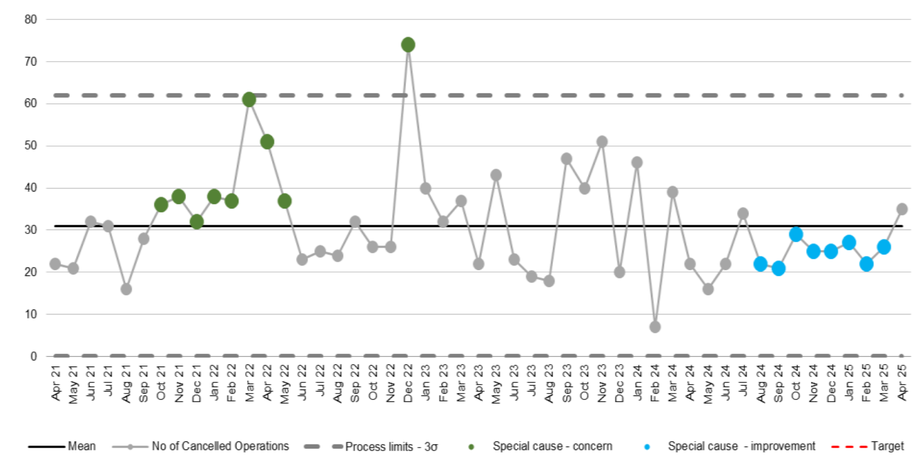
Latest Model Hospital Theatre Metrics



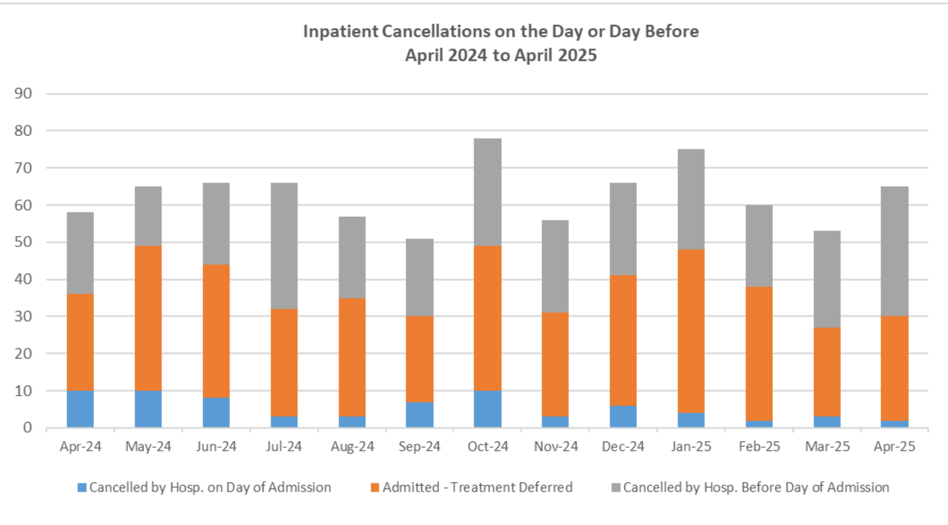


2. Theatre Utilisation/ Hospital Led Cancellations





Year - Month	Cancelled by Hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by Hosp. Before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
Apr-24	10	26	22	58	0
May-24	10	39	16	65	0
Jun-24	8	36	22	66	0
Jul-24	3	29	34	66	0
Aug-24	3	32	22	57	0
Sep-24	7	23	21	51	0
Oct-24	10	39	29	78	0
Nov-24	3	28	25	56	0
Dec-24	6	35	25	66	0
Jan-25	4	44	27	75	0
Feb-25	2	36	22	60	0
Mar-25	3	24	26	53	0
Apr-25	2	28	35	65	0
Total	71	419	326	816	0



2. Theatre Utilisation/ Hospital Led Cancellations

SUMMARY

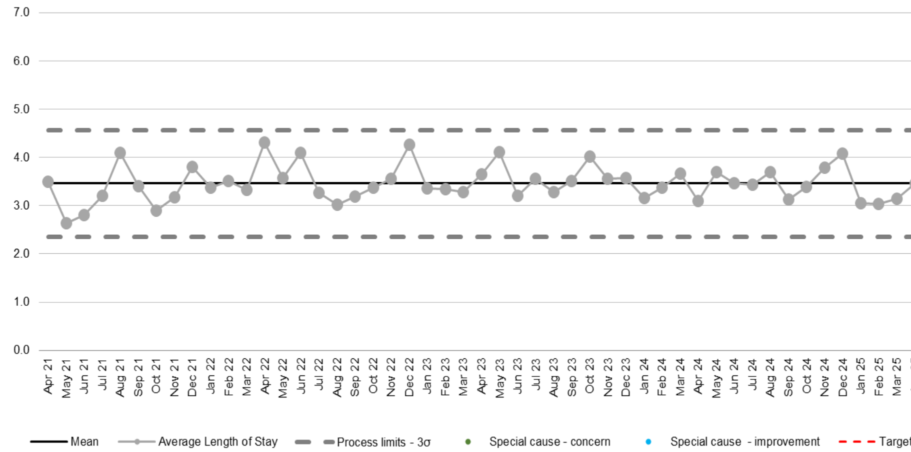
The number of cancellations / deferrals detailed on the previous slide do not include patients who were either emergency or urgent cases. These cases are more difficult to avoid due to very short notice bookings. The table below provides details of the cancellations for April 2025:

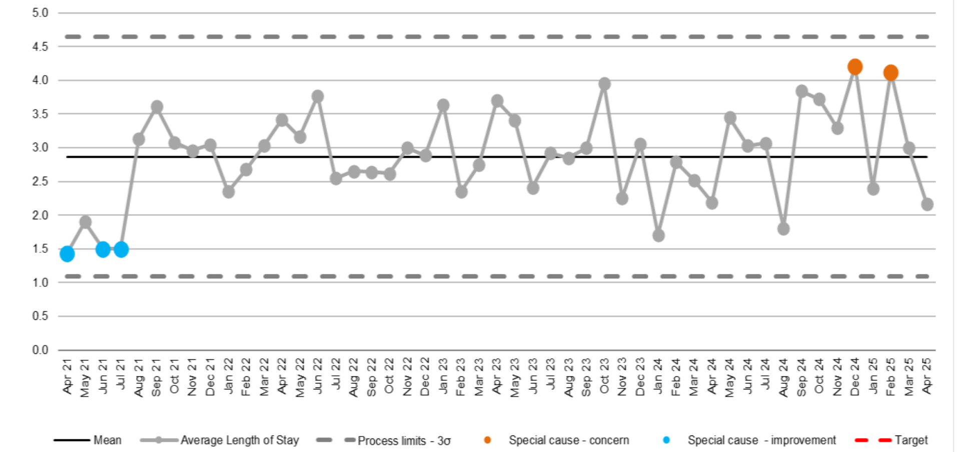
Patients cancelled on the day x 2	Patients admitted and had treatment deferred x 28	Patients cancelled by the hospital the day before the date of admission x 35
Clinical Total = 0 Non-Clinical Total = 2 2 x Lack of Equipment	Clinical Total = 21 16 x Medically unfit 2 x Skin integrity - insect bites/dog bites/ulcer etc. 1 x Patient self-cancelled / unwell / Change in plan / pt declined procedure 2 x Replaced by more urgent case due to theatre closures. Non-Clinical Total = 7 5 x Lack of theatre time – due to complex cases and the impact of lost theatre capacity. 1 x Lack of HDU capacity 1 x patient led requested change in TCI date.	Clinical Total = 23 12 x Medically unfit/further tests required 5 x Patient self-cancelled / unwell / Change in plan / pt declined procedure 5 x Replaced by more urgent case due to theatre closures. 1 x Skin integrity - insect bites/dog bites/ulcer etc. Non-Clinical Total = 12 3 x TCI date not convenient for patient/change in TCI date before procedure date. 4 x Surgeon unavailable 4 x Theatre closures 1 x Lack of equipment

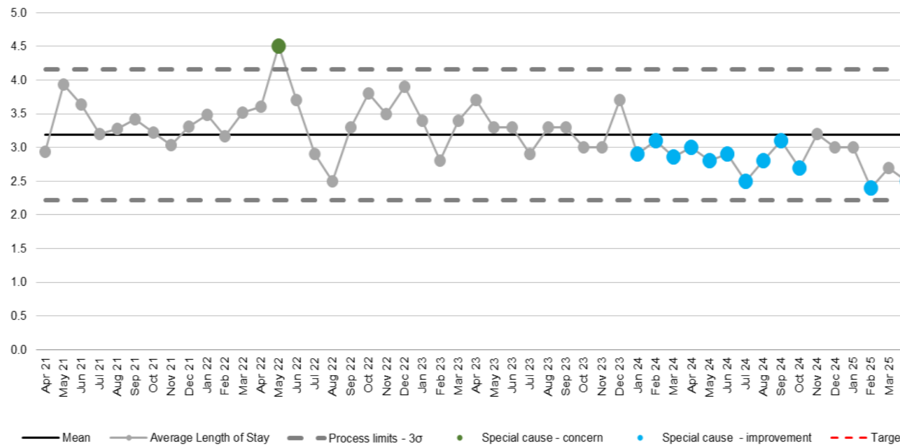
AREAS FOR IMPROVEMENT/ RISKS/ ISSUES

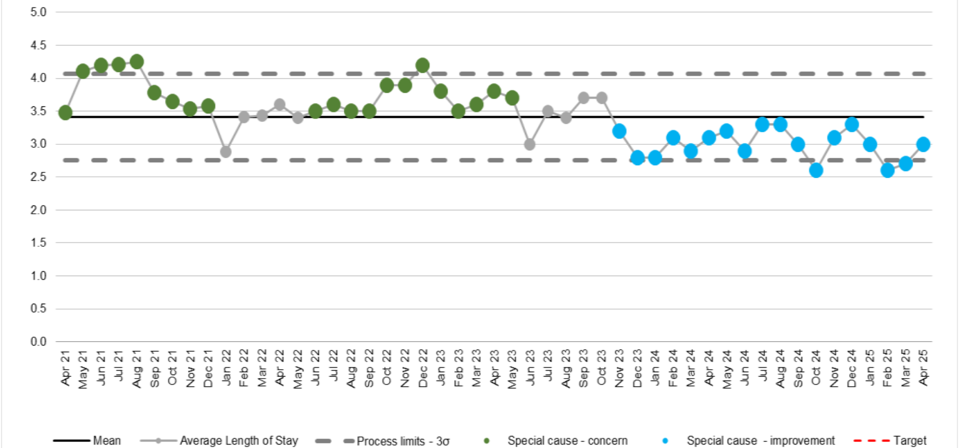
Daily monitoring of cancellations for non-clinical reasons that must be approved by Deputy COO, COO or Exec on call.
The loss of 3 theatres has resulted in the team maximising the remaining capacity available to us. Lists have been merged that would have ordinarily been filled at short notice. The emergency theatre continues to be used at the risk of elective cases being cancelled on the day should an emergency present and all other theatres are in use.

3. Length of Stay









3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips has decreased to 2.5 days (2.7 days March 25) and primary Knees has increased to 3.0 days (2.7 days March 25). The average length of stay for ROH patients excluding Oncology, Young Adult Hip and Spinal has increased to **3.46 days** (3.15 days March 25).

A review of the ROH data for arthroplasty and oncology arthroplasty primary hips and knees identifies the number of patients with LOS >/= 5 days as 15 (16 March) 5 Oncology Arthroplasty (7 March) , 10 arthroplasty (9 March); 12 had an ASA score of 2 (mild systemic disease); 3 had an ASA score of 3 (a patient with severe systemic disease;

LOS >/=8 days as 3 (4 March), 0 Oncology arthroplasty (3 March) and 3 arthroplasty (1 March) . 2 had an ASA score of 2 (mild systemic disease); . 1 had an ASA score of 3 (a patient with severe systemic disease; On review of clinical noting for patients with LOS >/=8 days all 3 had on-going clinical /therapy needs.

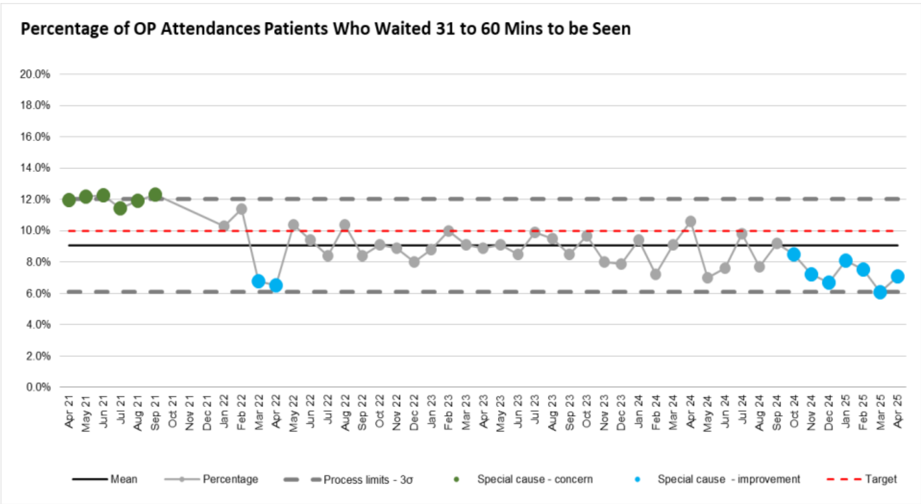
A review of all arthroplasty and oncology arthroplasty patients, identifies the number of patients with LOS >/= to 8 days as 27 (20 March).
13 were Oncology Arthroplasty, and 14 were Arthroplasty. This data included revisions, EPRs and other more complex surgeries.
Review of the 8 long stay patients with LOS >15 days, 3 were Arthroplasty and 5 Oncology arthroplasty.
Longest stay 31 days (63 March), was an Oncology arthroplasty EPR. All stays >15 days reviewed on PICS appeared appropriate as had on-going Bone Infection Service, or other clinical/social care needs.

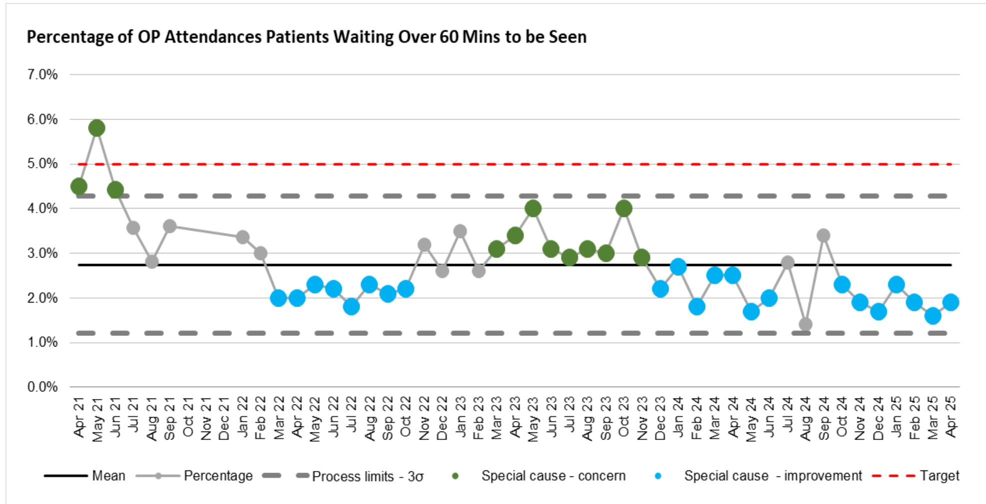
AREAS FOR IMPROVEMENT / ACTION PLAN

- Review scope of data included within report to ensure it aligns with what is being included with by other organisations
- Bone infection, revision and MRC patients contribute considerably to the longer length of stays.
- Number of patients converting from day case to overnight stay for non-clinical reasons. Findings of Division 2 review awaited.
- Alignment of support services to 7 day working, if arthroplasty lists to continue on Saturdays. Avoiding the need to use on-call support services to enable timely discharges..
- Demand and capacity delivered as part of annual business planning to identify any workforce challenges.
- Renewed focus on BADS data reporting to productivity improvement group following changes to dataset.
- 'Day case' pathway refresh week – confirmed importance of ensuring patients are prepared pre-operatively in accordance with other day case criteria and that it works well provided this is done.
- Review LOS data by consultant to enable analysis of themes/trends.

4. Outpatient efficiency

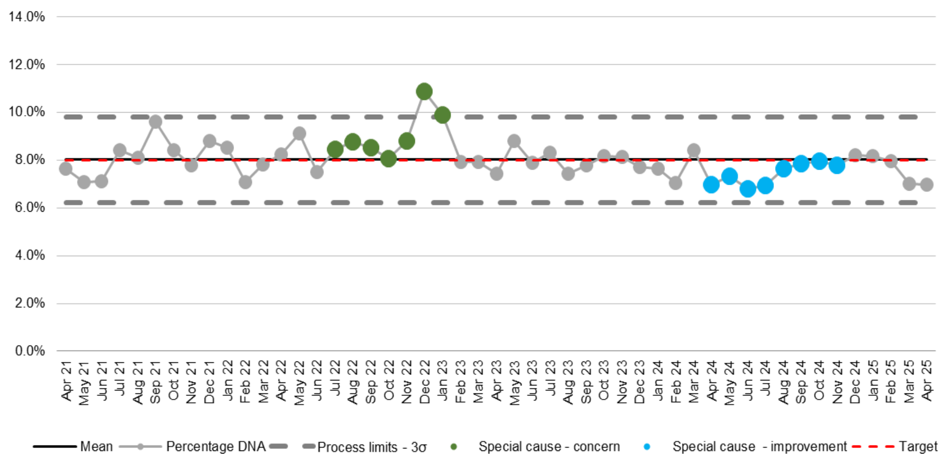
DATA QUALITY KITEMARK

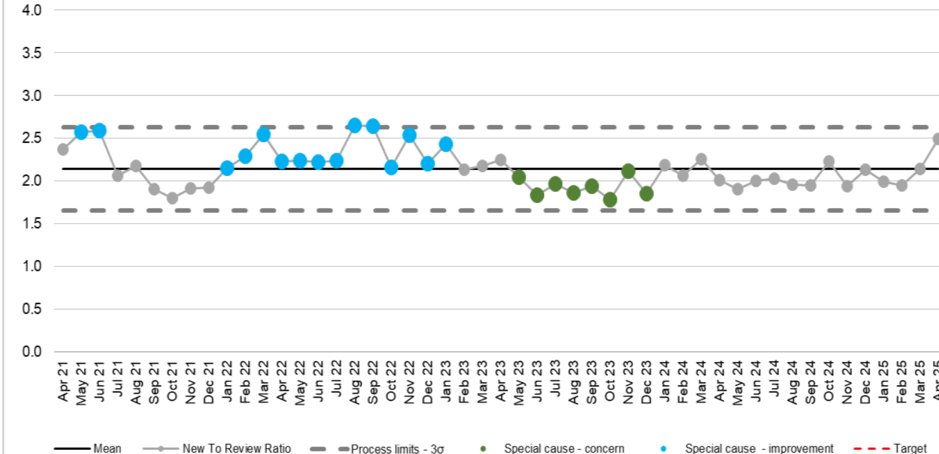


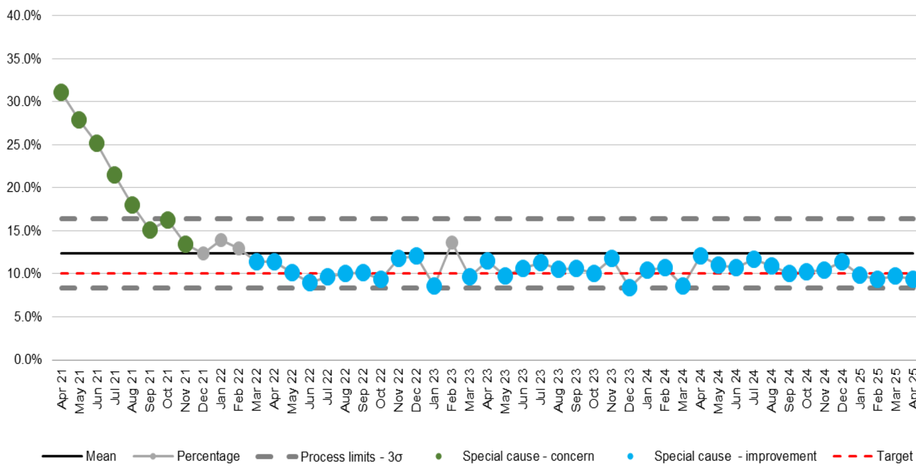


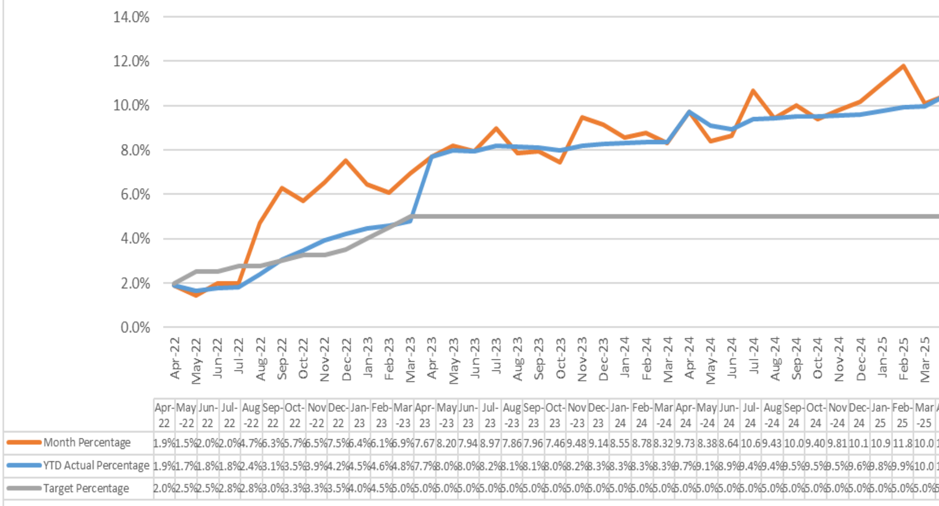
4. Outpatient efficiency

DATA QUALITY KITEMARK





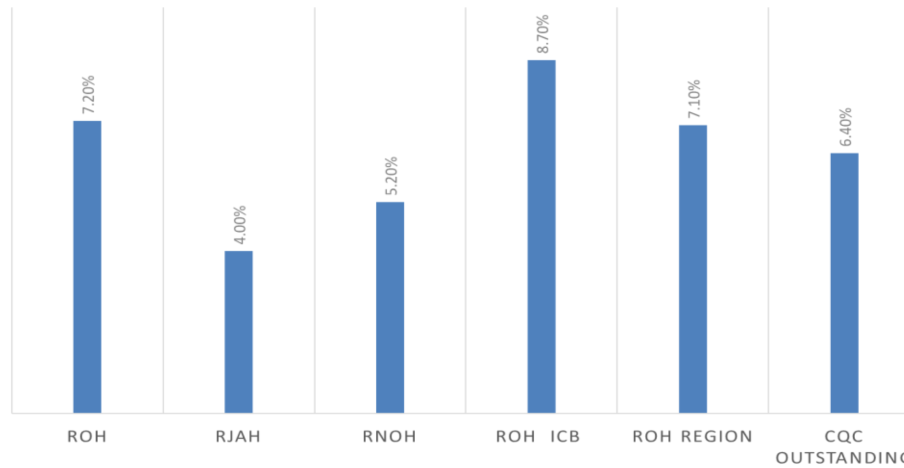


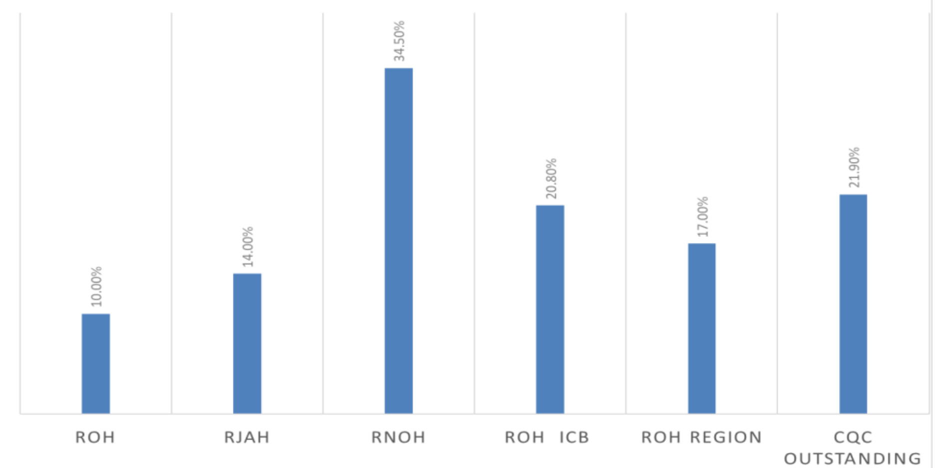


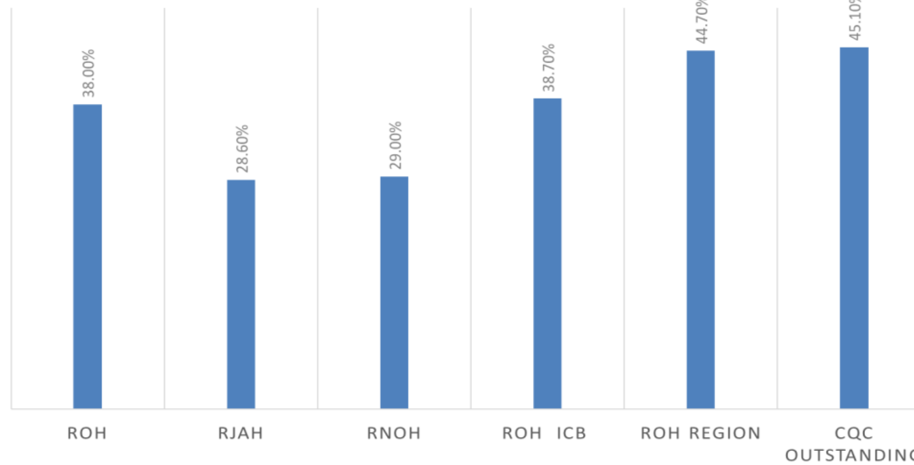
	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Month Percentage	1.9%	1.5%	2.0%	2.0%	4.7%	6.3%	5.7%	6.5%	7.5%	6.4%	6.1%	6.9%	7.67	8.20	7.94	8.97	7.86	7.96
YTD Actual Percentage	1.9%	1.7%	1.8%	1.8%	2.4%	3.1%	3.5%	3.9%	4.2%	4.5%	4.6%	4.8%	7.7%	8.0%	8.0%	8.2%	8.1%	8.1%
Target Percentage	2.0%	2.5%	2.5%	2.8%	2.8%	3.0%	3.3%	3.3%	3.5%	4.0%	4.5%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

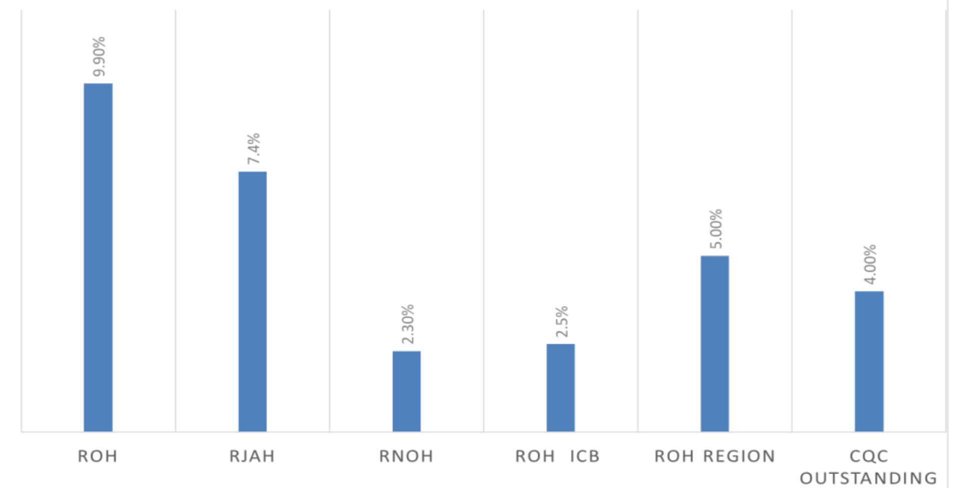
	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Month Percentage	7.46	9.48	9.14	8.55	8.78	8.32	9.73	8.38	8.64	10.6	9.43	10.0	9.40	9.81	10.1	10.9	11.8	10.0	10.4
YTD Actual Percentage	8.0%	8.2%	8.3%	8.3%	8.3%	8.3%	9.7%	9.1%	8.9%	9.4%	9.4%	9.5%	9.5%	9.5%	9.6%	9.8%	9.9%	10.0	10.5
Target Percentage	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

4. Outpatient efficiency









4. Outpatient efficiency

DATA QUALITY KITEMARK

SUMMARY

April 2025 performance is as follows:

- 5,384 face to face and 557 virtual appointments
- 9.38% virtual in total.
- 10.5% of outpatient attendances moved to the PIFU waiting list. The overall YTD position is 10.5%.
- 6.96% rounded to 7% missed appointment (DNA) rate – lower than the Trust target of 8% and an improvement on April 24 position of 7.01%

- **Clinic Waiting Times**
- 30-minute delays – meeting Trust Target at **7.1**% **(Target 10%)**
- 60-minute delays – meeting trust target at **1.9**% **(Target 5%)**

AREAS OF IMPROVEMENT

Outpatient Utilisation

Outpatient activity is **16% under plan** for new appointments **and 16% over plan** for follow ups in April 25. Clinic codes continue to be reviewed in line with the GIRFT Further Faster recommendations with opportunities being scoped to convert follow up capacity to new capacity.

The Clinical Portal is being rolled out to all specialties over the next 3 months which will mean that notes will be gradually withdrawn from the outpatient's department. Two new self-check-in kiosks have also been ordered and should be available in June 25. The new kiosks will support collection of patient demographic data including ethnicity and communication needs.

A workforce and efficiency review is underway to right size the Appointments Team to include a review of all processes and opportunities to automate.

Appointments

KPIs continue to be met by the team and additional data is being explored to be added including PIFU information, Advice and Guidance performance and clinic utilisation.

4. Outpatient Transformation

DATA QUALITY KITEMARK

SPECIALTY PRIORITY UPDATES / HIGHLIGHTS

PIFU	Missed Appointments	Reduction in Follow Ups	Clinical Pathways (e.g. Specialist Advice)	Productivity & Efficiency
The ROH continues to be a national exemplar for PIFU (6th nationally and top of the peer group on current Model Hospital data). Coding is being scoped for the Dr Doctor PIFU module to automate validation of the waiting list and create a record for patient requests to be seen. Robotics (RPA) options currently being explored to support timely closure of PIFU referrals that have reached the end of the pathway.	MSK testing and bugs have delayed roll out. Revised go live predicted for late May (from the end of April 25). NHS Way finder has gone live for stage 2. A renewed focus on patient access to the NHS app will be in place in line with the Elective reform planning guidance operational imperatives. E-meet and greet module in Dr Doctor being explored. Missed Appointments Improvement noted in March and April. Opportunities being explored – including following George Elliots example of volunteers contacting patients – currently being scoped with the Volunteers service and George Elliot.	Further review of clinic templates to ensure that capacity is maximised for new patients. Focus on spinal clinics to maximise productivity.. Clinical Audit of outpatient follow up delays for Spinal patients led by Matt Revell.	Internal primary care interface group now in place supported by COO /CMO attending system steering group with good collaboration and two-way communication channels now in place across a number of clinical and non-clinical development programmes. The Clinical support decision making tool has been agreed by the system investment committee developed tested and concept proven via the ROH MSK steering group. Activity has been confirmed for A&G via national reporting team. In the month of April, 217 A&G referrals were received via the Electronic Referral System, 167 were closed, and 262 were active at month end. Overall trend is a continuous increase in A&G referrals.	Re-focused group has met to prioritise the objectives outlined under the outpatient transformation group reporting to the Trust Productivity Group. Review of NHS impact best practice guidance completed action plan in place.

5. Referral to Treatment -

DATA QUALITY KITEMARK

SUMMARY

The Referral To Treatment (RTT) position for April 25 was 55.63% against the National Constitutional Target of 92%. This represents a 0.98% increase compared to the March 25 reported position of 54.66% that includes patients transferred from other providers. The LUNA report for data quality validation is consistently above 98%.

0 patients breached 65 weeks in April 25. 486 patients were waiting over 52 weeks in April 25 that is a reduction from the trust wide position for March 25 that was 487 patients. Many of the patients sit within the Spinal Service, and referrals are currently being triaged, and additional support is in place from the MSK team as per outcomes of the spinal 'deep dive' and patient tracking monitoring of the 65 weeks position.

During April 25, ROH received 2,531 referrals (93.60%) compared to pre covid levels. 2,704 is the average monthly referrals received Pre-Covid. The team are undertaking a review of all directory of services to ensure they accurately reflect the services at a sub-specialty level and reflect our waiting times.

AREAS FOR IMPROVEMENT

Spinal Services: The 65-week position for Q1 within the Spinal department continues to be a priority. To support ongoing delivery, additional capacity is being facilitated by the appointment of a new consultant specialising in spinal deformity.

Large and Small Joints & Oncology: Both departments are now aligned with the Zero 52 weeks target, effective from May 2025.

Sprint Validation Performance: As of the most recent data, we are ahead of our Year-To-Date baseline position by 749, representing a 21% lead. This positive momentum reflects the continued success of our sprint initiatives, and we are focused on maintaining this trajectory for the remainder of the quarter.

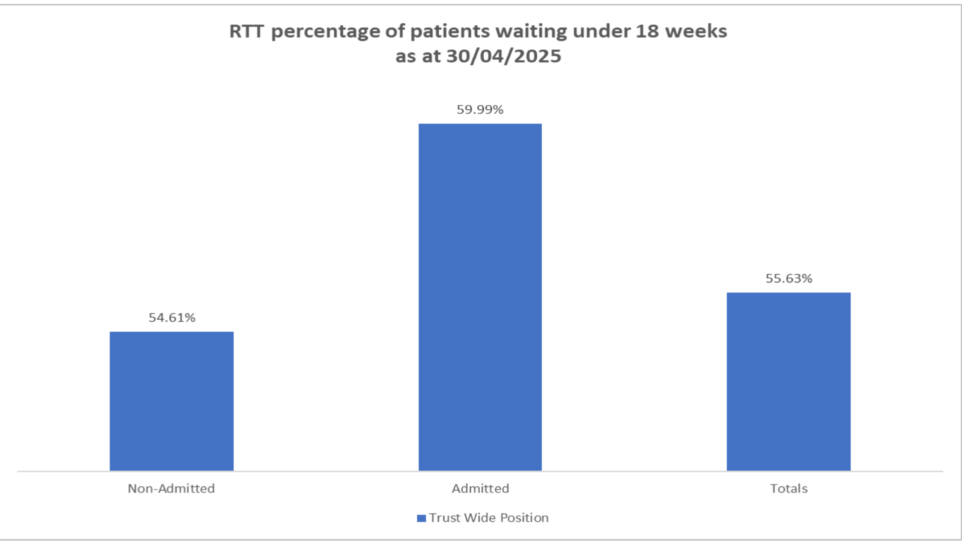
RISKS / ISSUES

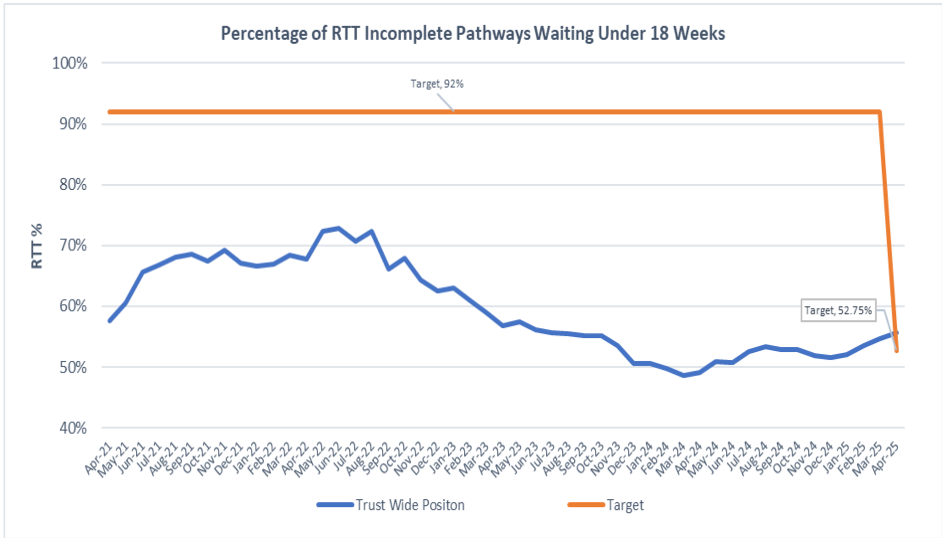
Spinal backlogs continue to be a concern with the team focussing on managing all patients currently over 55 weeks and preventing breaches of the 65 weeks standard. The management of the spinal daily patient tracking list meetings has been handed back to the Division 1 Associate Director of Operations to maintain the current performance.

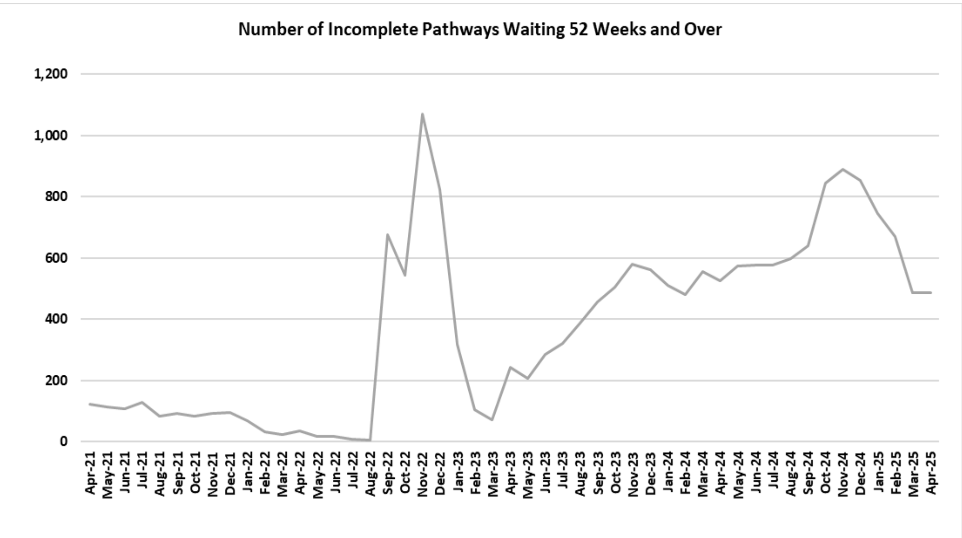
5. Referral to Treatment

	Trust Wide Position		
Weeks Waiting	**Non-Admitted**	**Admitted**	**Totals**
0-6	2,786	633	3,419
7-13	2,146	582	2,728
14-17	699	241	940
18-26	1,667	476	2,143
27-39	1,635	355	1,990
40-47	688	82	770
48-51	250	13	263
52 weeks and over	441	45	486
Total	10,312	2,427	12,739

Weeks Waiting	Non Admitted	Admitted	Totals
Under 18	5,631	1,456	7,087
18 and over	4,681	971	5,652
Month End RTT %	**54.61%**	**59.99%**	**55.63%**

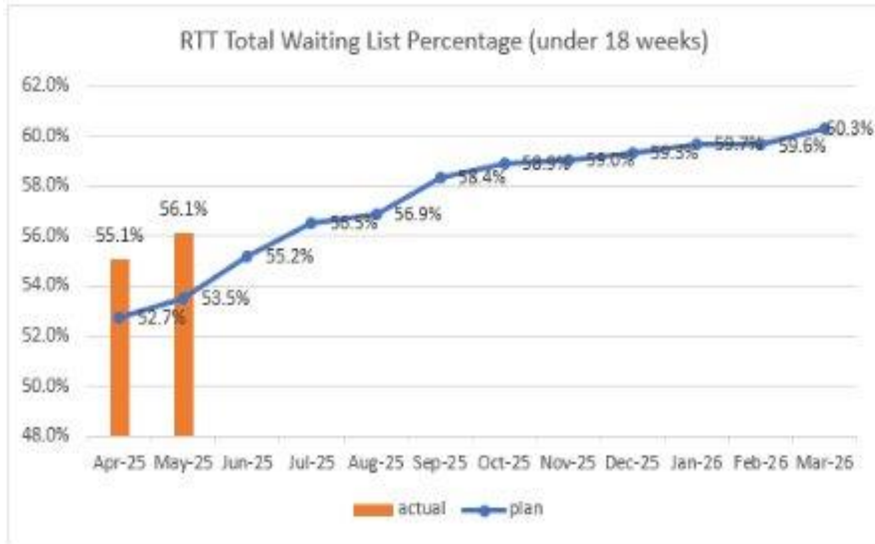


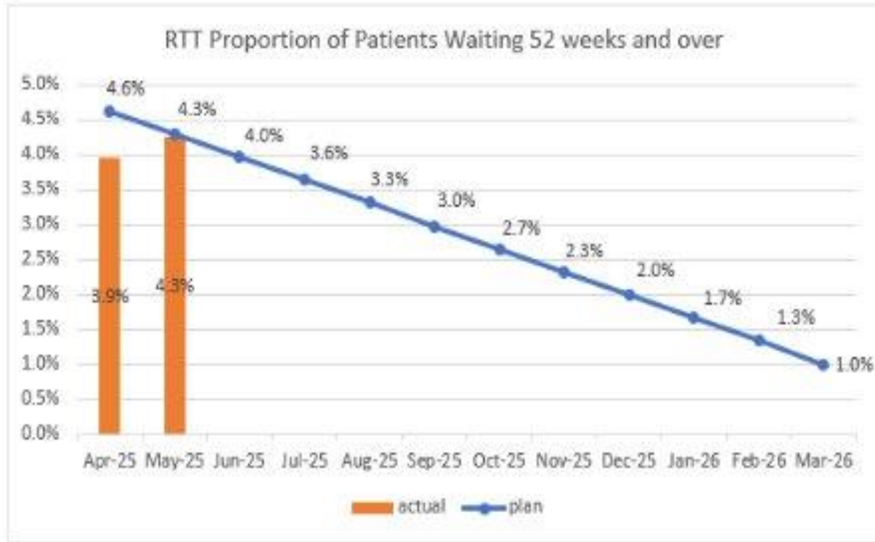


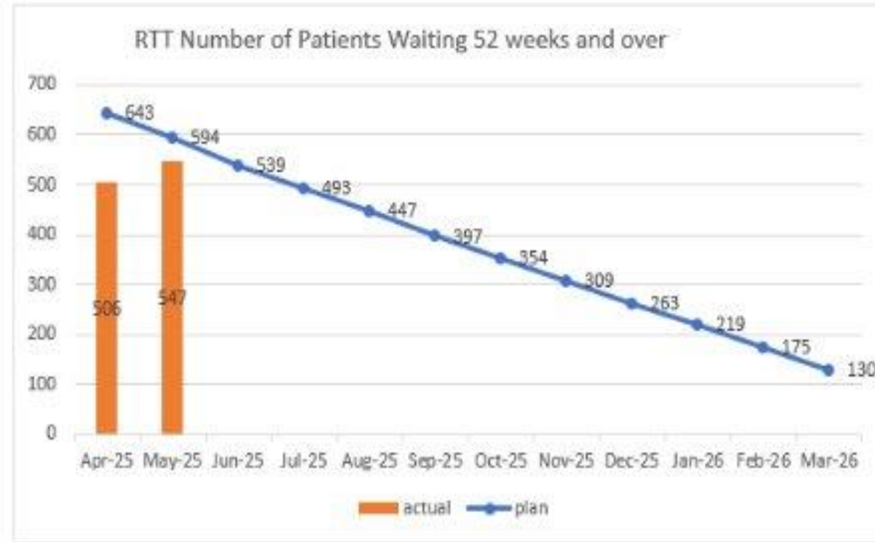


DATA QUALITY KITEMARK

5. Referral to Treatment







5. Referral to Treatment

DATA QUALITY KITEMARK

18 weeks Incomplete pathways Benchmarking against other providers:

18 Week Incomplete Pathways Reported % - All Specialties

Percentage Waiting Under 18 Weeks

90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
-

Apr-21, May-21, Jun-21, Jul-21, Aug-21, Sep-21, Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22, Apr-22, May-22, Jun-22, Jul-22, Aug-22, Sep-22, Oct-22, Nov-22, Dec-22, Jan-23, Feb-23, Mar-23, Apr-23, May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24, Apr-24, May-24, Jun-24, Jul-24, Aug-24, Sep-24, Oct-24, Nov-24, Dec-24, Jan-25, Feb-25, Mar-25

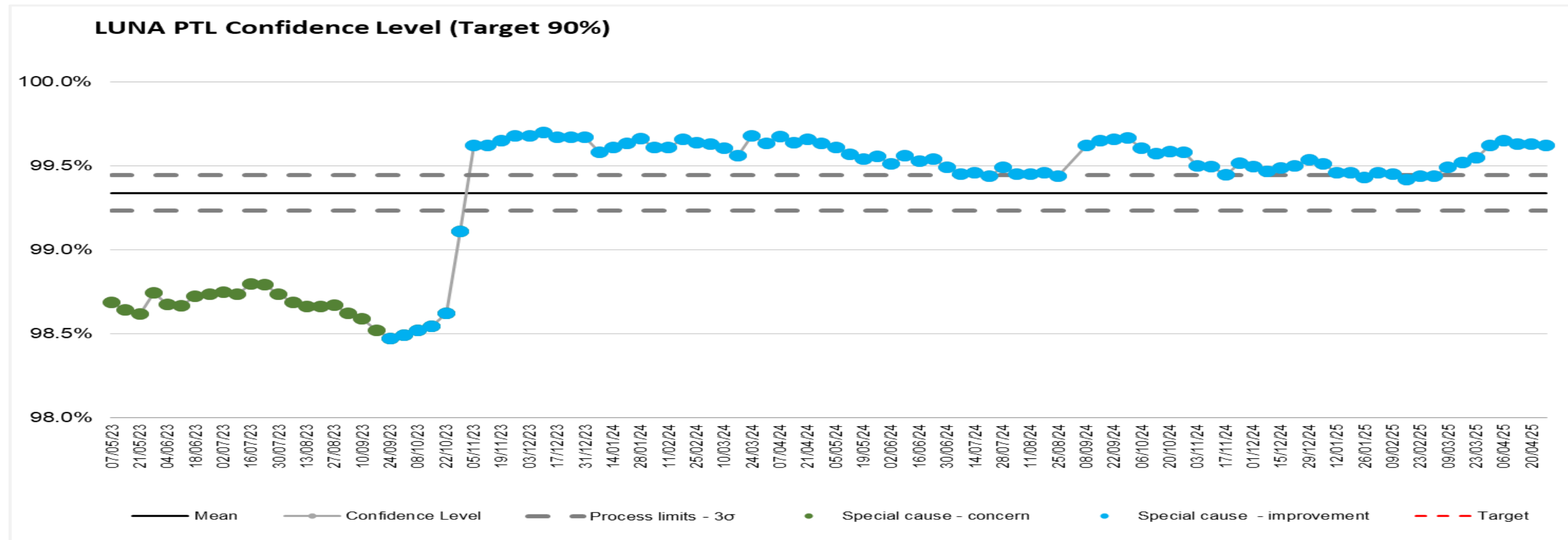
RAN ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST
RL1 THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
RQ3 BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST
RRJ THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
RRK UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

5. Referral to Treatment

Luna Data

DATA QUALITY KITEMARK

The chart below shows LUNA National Data Quality report data for the Trust, and our average confidence levels for our RTT data has consistently remained above 98% against a target of 90%. Over the last 24 months, the average confidence levels in our weekly data submissions have remained above 98%, with no areas of concern highlighted. In the last 2 weeks we have had a focus on the technical pathway inconstancies, which has demonstrated a further improvement of our waiting list data quality.

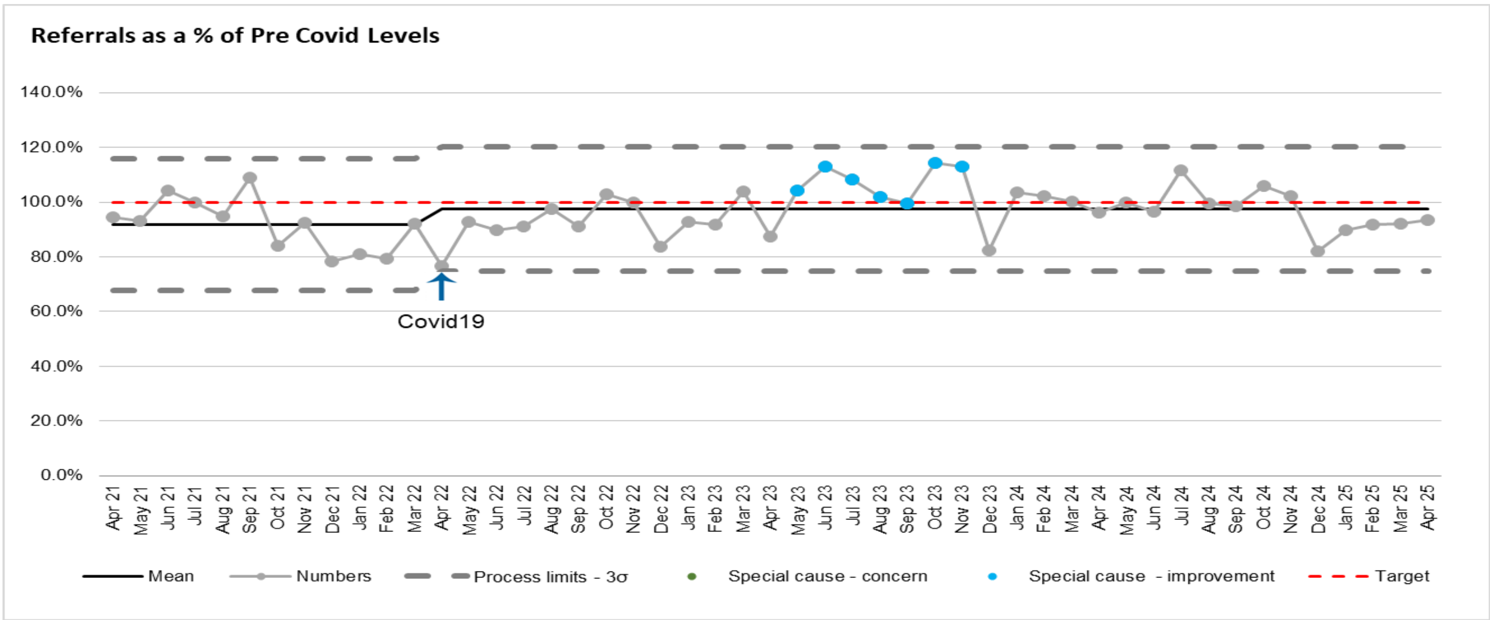


It is important to note the significant improvement from the data quality team utilising the LUNA data to continue to drive improvements. The latest chart suggests that the Trust has minimal errors identified by LUNA with a confidence rate in excess of 99.5%.

KPMG Audit highlights: KPMG provided a rating of significant assurance with minor improvement opportunities. A total of four findings, of which one is medium – a small sample of incorrect clock starts by a few days, and three are of low-level priority as follows: recommends a monthly reconciliation from data sent through to final RTT submission, clock stop times and ensuring maintenance of RTT trainers for new PAS users.

5. Referral to Treatment

DATA QUALITY KITEMARK



Month	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of Referrals	2363	2818	3059	2926	2752	2693	3093	3056	2224	2802	2760	2707	2595	2700	2613	3022	2692	2660	2860	2766	2221	2425	2485	2489
Referrals as a % of Pre Covid Levels	87.39%	104.22%	113.13%	108.21%	101.78%	99.59%	114.39%	113.02%	82.25%	103.62%	102.07%	100.11%	95.97%	99.85%	96.63%	111.76%	99.56%	98.37%	105.77%	102.29%	82.14%	89.68%	91.90%	92.05%

Month	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Number of Referrals	2531																							
Referrals as a % of Pre Covid Levels	93.60%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

5. Referral to Treatment

Specialty Breakdown

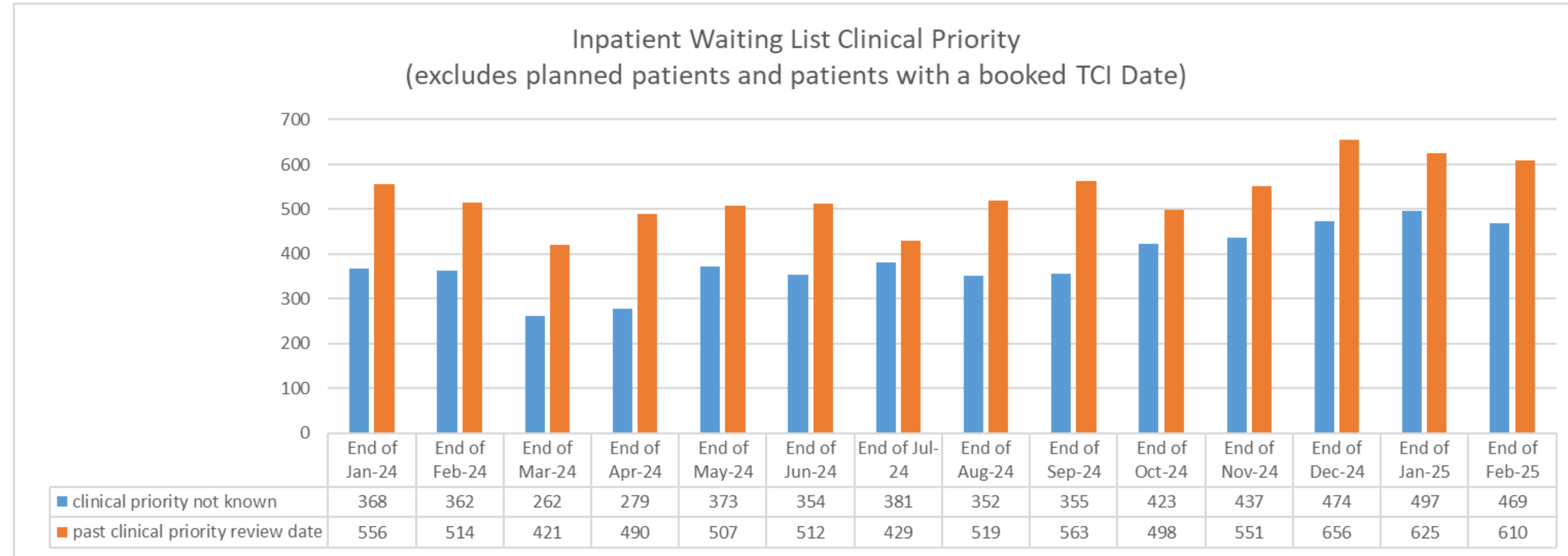
DATA QUALITY KITEMARK

The national RTT target is for 92% of patients to be treated within 18 weeks. The table below highlights the current performance against this target by specialty. It also includes the number of patients currently waiting over 52 weeks prior to any tip ins. This will be used to support focussed intervention going forward:

Specialty	Number of patients over 52 weeks with an incomplete RTT pathway	RTT % as of 19.05.25
Arthroplasty	0	69.87%
Arthroscopy	4	69.67%
Clinical Support	3	62.78%
Foot and Ankle	0	72.78%
Hands	5	48.57%
Oncology	0	89.92%
Oncology Arthroplasty	0	80.44%
Spinal	304	30.27%
Spinal Deformity	223	34.77%
Young Adult Hips	1	59.13%

5. Referral to Treatment

Overdue Clinical Priority:



	End of Jan-24	End of Feb-24	End of Mar-24	End of Apr-24	End of May-24	End of Jun-24	End of Jul-24	End of Aug-24	End of Sep-24	End of Oct-24	End of Nov-24	End of Dec-24	End of Jan-25	End of Feb-25
clinical priority not known	368	362	262	279	373	354	381	352	355	423	437	474	497	469
past clinical priority review date	556	514	421	490	507	512	429	519	563	498	551	656	625	610

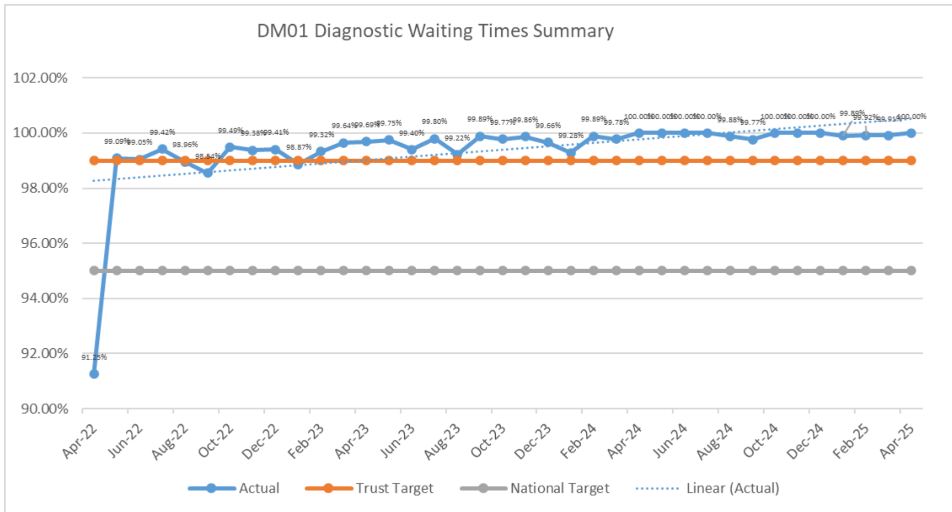
The number of patients with an unknown clinical priority has increased by 68 patients, however, the numbers that have past the clinical priority review date has reduced by 65 patients. The information continues to be shared monthly with individual services and clinicians to manage individual clinical practice and at the Monthly CSLS meeting.

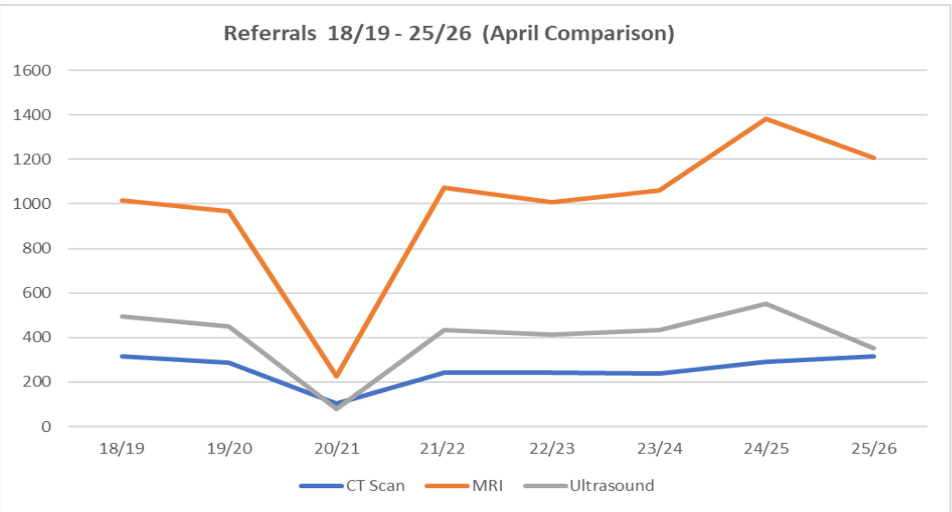
Large Joints and Small Joints team will pilot a focussed process review of all patients marked 'clinical priority not known' to ensure these are appropriately clinically prioritised. To be discussed in F&P meeting in July 2025.

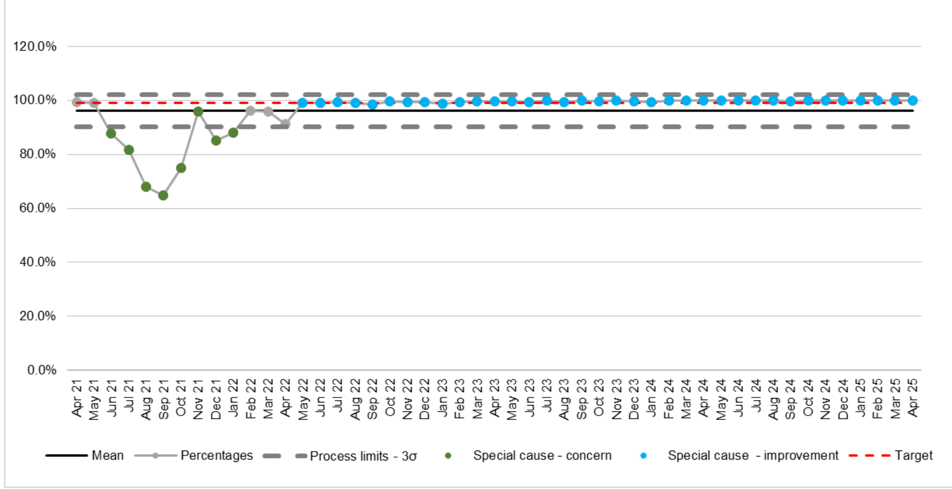
DATA QUALITY KITEMARK

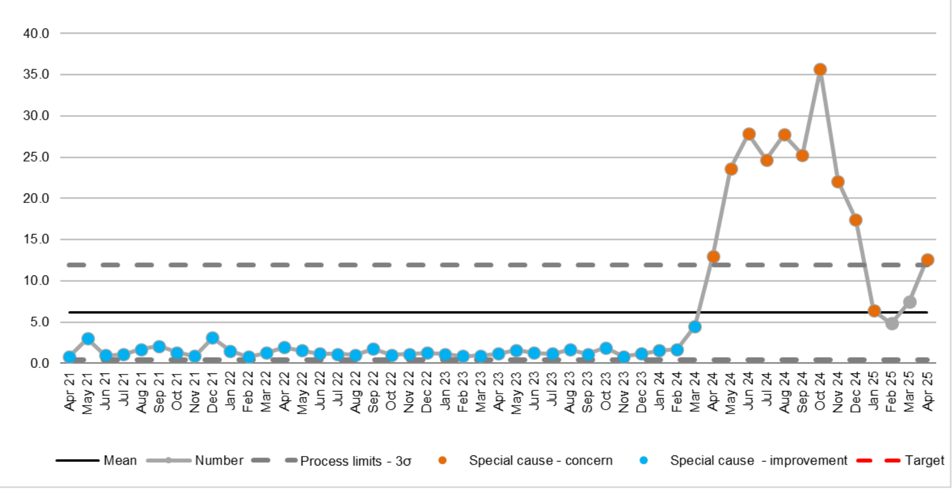
6. Diagnostic Performance

% of Patients Waiting <6 Weeks for Diagnostic Test - National Standard is 99%









7. Diagnostic Performance

SUMMARY

The Imaging Department achieved the 99% DM01 target in April 2025 closing the month at 100%. The National 24/25 operational target remains at 95% which ROH continues to achieve consistently despite reduced capacity in ultrasound.

AREAS FOR IMPROVEMENT

Reporting - The team continue to outsource Radiology Reporting – Turnaround time for outsourcing is 72 hours from receipt for MRI. All Oncology and non-medical referrer x-rays continue to be prioritised.
In house reporting – Oncology and Young Adult Hips (YAH) need to be reported in house due to the speciality. Oncology are prioritised but due to reduced Radiologist capacity, the wait for YAH reports is currently at 8 weeks, however any urgent scans are prioritised.

Business planning for 2025/2026 is complete. Capital plans include discussions to replace the CT scanner and 2 x X-ray rooms in the next financial year. The X-ray rooms have been assessed by 2 suppliers, and we are awaiting quotes as these are out of full-service cover from December 2025.

Discussions have started regarding an interim provision of Interventional CT service during CT scanner refurbishment.

Interviews for 2 x WTE Band 5 Radiographers to fill current vacancies have been scheduled for 15/16 May 2025.

RISKS

There is an ongoing current risk with Consultant Radiologist workforce vacancies.

Support to the Oncology service continues with reduced Interventional lists and MDT support. Regular meetings with the Head of Imaging and the Oncology CSM continue to ensure capacity concerns are escalated early and mitigated to avoid impact on cancer performance.

The team are scoping the option of further auto-reporting to support the reduced workforce.

8. Cancer Performance

Summary Performance Figures – March 25 (May 2025 Submission)

		March 25 (complete)			
Target Name	National Standard	%	In target	Breach	Total
31 DTTD to Treatment	96%	100%	26.0	0.0	26.0
62 day RTT to treatment	70%	95.2%	10	0.5	10.5
28 day FDS REPORTED	77%	81.1%	77	18	95
Patients over 104 days (62 day standard)				1	

Performance

The trust was compliant against all three cancer waiting time targets for March 2025.

The 62-day metric was achieved at 95.2%. A total of 11 treatments were applicable to the trust, 10 of those were compliant and the remaining 1 patient was a shared breach with the referring trust.
The root cause of the delays for the 62-day breach were due to medical conditions and complex pathology.

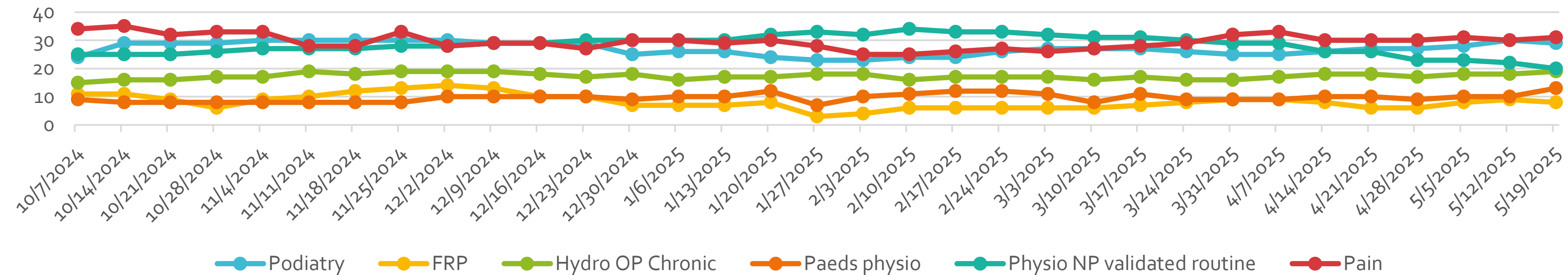
- 0.5 shared breach; This patient was a Tertiary referral into the ROH on day 43. We were unable to meet the 24 day target due to elective spinal capacity. Patient was reviewed by the spinal oncology CSL and the planned surgical date had no impact on harm to the patient, as the tumour was a very low grade. The patient was treated on day 112.

Risks /actions ongoing

The team continues to receive positive feedback on cancer pathway performance and has remained compliant against all three metrics for the past 12 months. Interventional radiology capacity is still limited for CT guided biopsies due to a reduction in workforce. The risk is being mitigated locally with biopsies being performed in theatre, where possible and all patients are currently having diagnostics scheduled within 10 days.

Challenges remain with Histopathology turnaround times, although FDS is currently compliant for ROH it is becoming difficult to achieve the FDS standard. This has been escalated to the COO at UHB and is raised at the weekly system oversight group. The Director of Pathology at UHB attended cancer board and has agreed to more regular interactions with the teams to understand how they can minimise delays. Bi-weekly meetings have now been set up with all key stakeholders.

9. MSK Waits



Summary – data as per 19/05/25

The chart above shows changes in waiting times over recent months. Waiting times remain challenging for Podiatry (29 weeks) and Pain Management (31 weeks). However, physiotherapy waiting times are starting to reduce due to GIRFT funding (29 weeks).

The MSK Community Bus initiative took place W/C 28th April 25, this was a positive initiative providing access to physiotherapists for the day at the 3 venues it visited within the community.

• Risks /actions ongoing

- Recruitment continues to be a challenge for physiotherapists and occupational therapists. Locum use is in place to support whilst on going recruitment continues
- Administrative workforce challenges remain managing a PTL of circa 3,500 pts. Capacity and demand modelling as well as a wider workforce review will be undertaken

.

10. Private Patients

SUMMARY

- The service has a planned revenue of £5.5m in 25/26 with a stretch target of £6m although the feasibility to extend this target and the resources required to are currently under review.

- April revenue was £384,775 (£31,375 over plan)
- May revenue is forecast at £557,308 (£83,538 over plan)
- The service is currently £7,187k behind achieving the £6m stretch target (YTD)

Private Patients Income Actuals	Apr-25	May-25	YTD
- Inpatients	£374,183	£545,924	£920,107
- Imaging diagnostics	£9,422	£9,944	£19,366
- Room hire	£1,170	£1,170	£2,340
Total income	£384,775	£557,038	£941,813
£5.5m Plan	£353,400	£473,500	£826,900
Variance against £5.5m plan	£31,375	£83,538	£114,913
£6m plan	463000	486000	£949,000
Variance against £6m plan	-£78,225	£71,038	-£7,187

AREAS FOR IMPROVEMENT

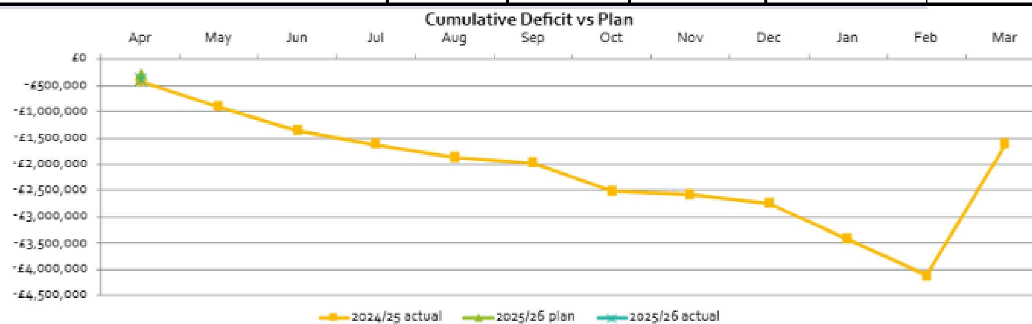
An operational delivery plan is currently in development for the Executive Team and Trust Board to detail the main areas of focus for the 25/26 financial year and the resource required to grow the service into 2027.

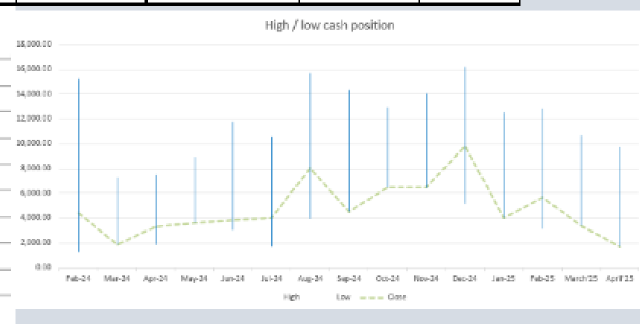
The main areas of focus to achieve the revenue plan in 25/26 are;

- Allocate 1 theatre per day to private work.
- Grow the overseas market – partnering with the local independent sector and exploring opportunities with overseas health brokers.
- Further interrogation of Trust systems to understand cost and profit margins.
- Undertake business case to support software that supports billing and increases efficiency in administrative processes.
- Further enhance patient experience on the Woodlands Suite with bespoke hospitality training provided to all staff.
- Drop-in sessions for consultants to shape the further development of private patient services.

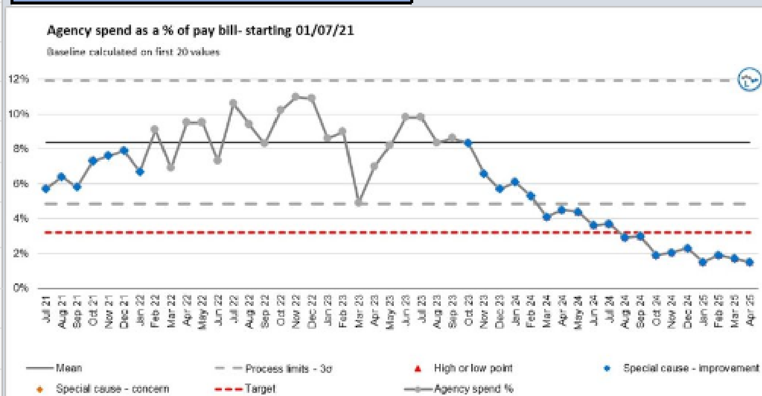
11. Finance on a Page

Income and Expenditure category	£'000s								
	In Month			Year to date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income from patient care activities	£10,843	£11,024	£181	£10,843	£11,024	£181	£140,599	£140,599	£0
Other income	£436	£509	£73	£436	£509	£73	£5,540	£5,540	£0
Pay	-£7,011	-£6,945	£66	-£7,011	-£6,945	£66	-£82,070	-£82,070	£0
Non Pay	-£4,433	-£4,876	-£443	-£4,433	-£4,876	-£443	-£62,654	-£62,654	£0
Non operating costs	-£123	-£100	£23	-£123	-£100	£23	-£1,380	-£1,380	£0
TOTAL	-£288	-£388	-£100	-£288	-£388	-£100	£35	£35	£0





Agency as a % of paybill =1.%



Efficiencies	YTD	Forecast
Plan	£445	£9,450
Actual	£409	
Variance	-£36	

Capital	YTD	Forecast
Plan (exc IFRS16)	£187	£25,365
Actual	£174	£25,365
IFRS 16	£0	£465
Variance	-£13	£0

Better Payment practice code	YTD	% move't prev month
Non-NHS		
By number	72.5%	n/a
By Value	73.9%	n/a
NHS		
By number	60.7%	n/a
By Value	20.3%	n/a
Total		
By number	72.2%	n/a
By Value	67.1%	n/a

12. Overall Financial Performance

SUMMARY

The Trust delivered a deficit in month of £377k, against a defcit plan of £281k.

Income performed better than plan by £254k. Private patient income overperformed by £94k, NHS funded activity overperformed by £84k, and other income by £49k.

Pay expenditure is underspent by £66k. Agency spend in month was 1.5% of paybill year, with an underspend of £46k. Bank expenditure reduced in month.

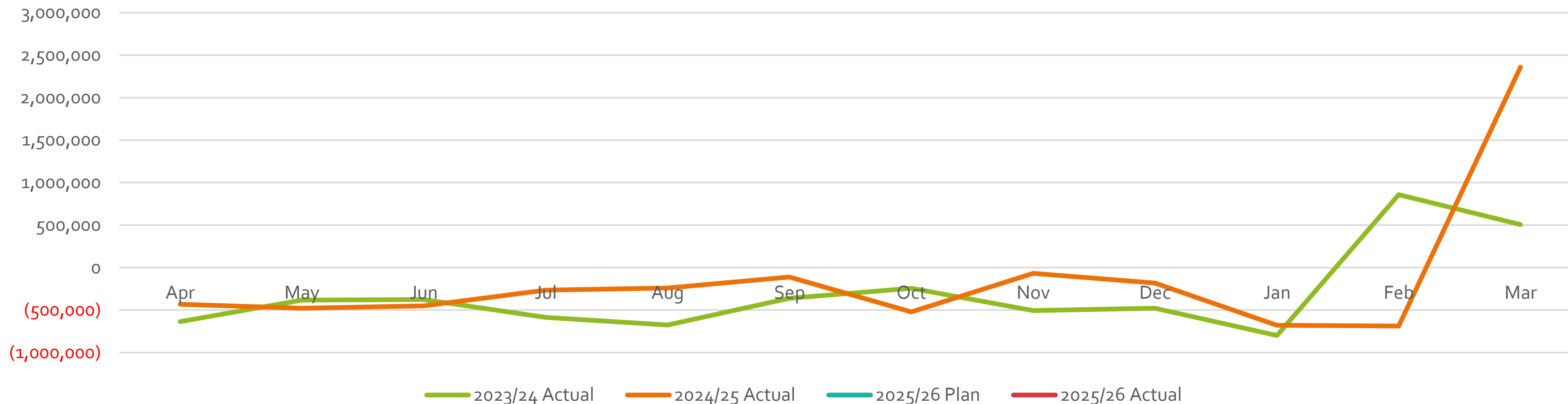
Non pay expenditure overspent in month by £440k. This is primarily driven as a result of; underperformance on non pay CIP schemes and clinical supplies.

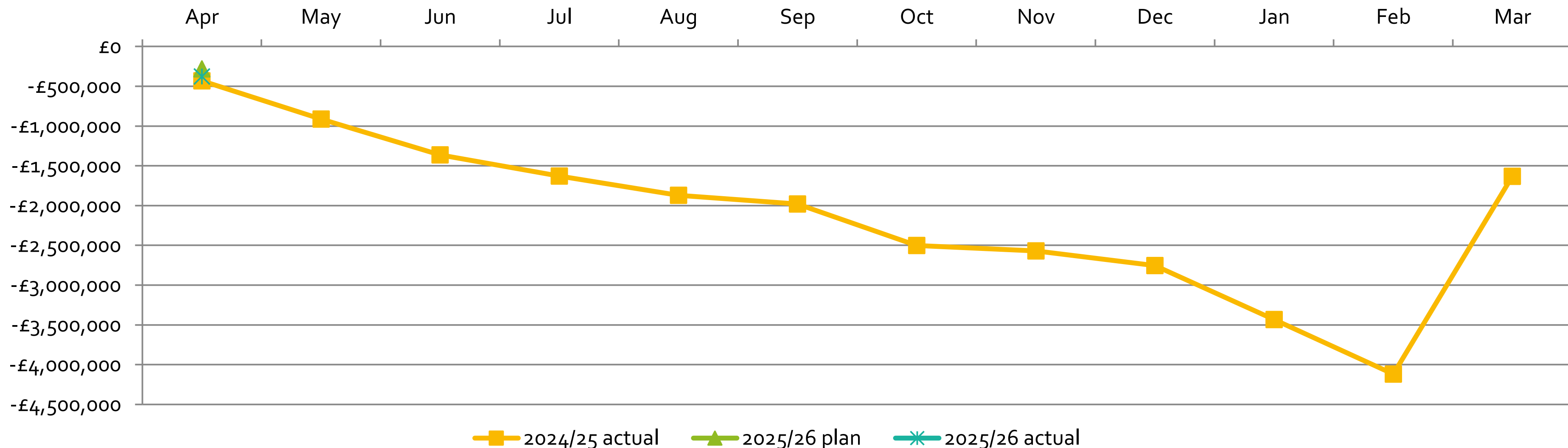
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	254	66	(440)	23	(100)
Year to date plan	11,279	(7,011)	(4,433)	(123)	(288)
Year to date actual	11,533	(6,944)	(4,873)	(100)	(388)
Variance compared previous month	⇧	⇧	⇩	⇧	⇧

12. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	10,843	11,024	181
Other Operating Income (Excluding top up)	436	509	73
Employee Expenses (inc. Agency)	(7,011)	(6,945)	66
Other operating expenses	(4,433)	(4,876)	(443)
Operating Surplus	**(165)**	**(288)**	**(123)**
Net Finance Costs	(123)	(100)	23
Net surplus/(deficit)	**(288)**	**(388)**	**(100)**
Remove donated asset I&E impact	7	11	(4)
Adjusted financial performance	**(281)**	**(377)**	**(104)**

12. Overall Financial Performance





13. Income

SUMMARY

Income performed better than plan by £254k. Private patient income overperformed by £94k, NHS funded activity overperformed by £84k, and other income by £49k.

Elective activity overperformed against plan by £259k with £3.4m delivered against a plan of £3.2m.

AREAS FOR IMPROVEMENT

Ensuring elective activity remains within the commissioned income cap
Daily activity estimated income reporting

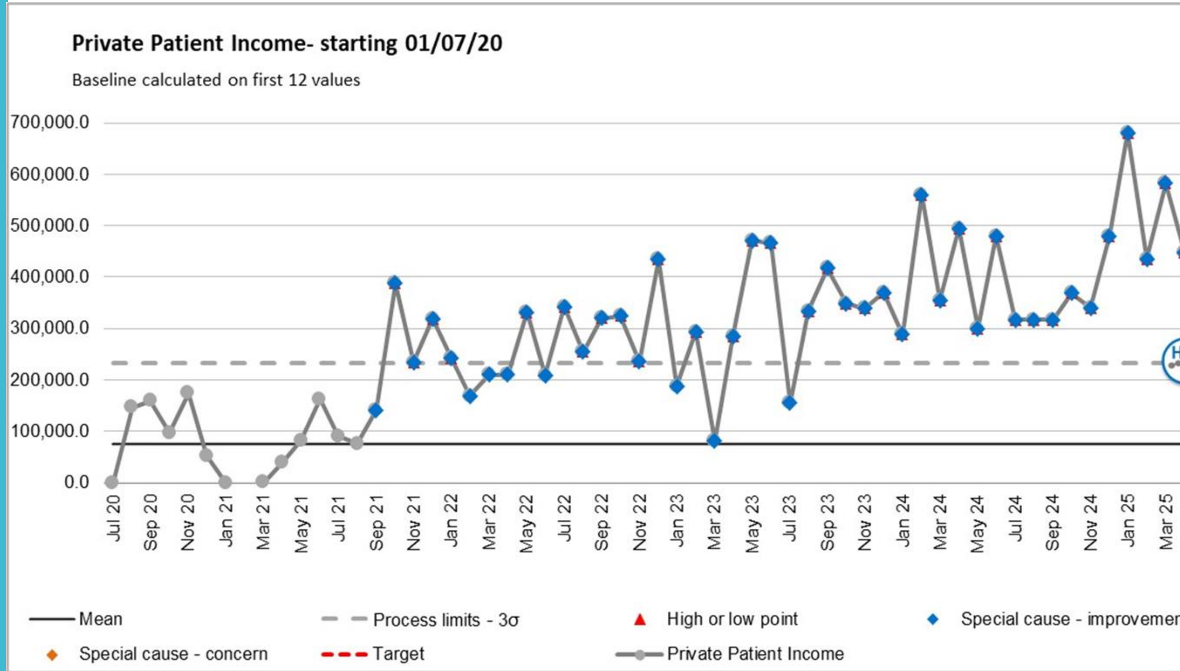
RISKS / ISSUES

Overperformance of NHS funded activity will not be reimbursed, meaning it is important to stay within the commissioned income cap.

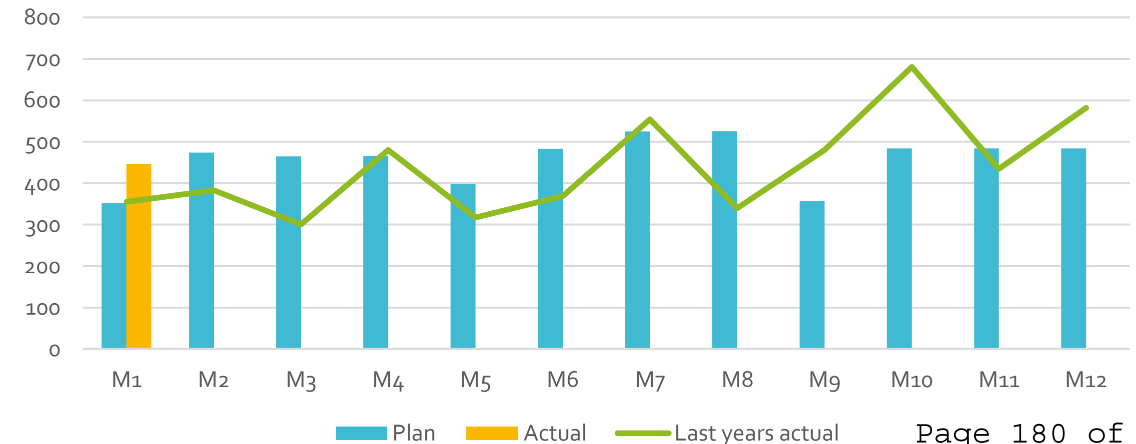
Non recurrent funding has been included within plans, generating an underlying financial risk for 2025/26 and beyond.

13. Income

Private patient income



*note that the private patient income reported is different to the value reported in the operational report. The finance value includes all private patient activities and is based on the same principles of NHS reported income of being accounted for based on discharge date and not TCI



14. Expenditure

SUMMARY

Pay expenditure is underspent by £66k. Agency spend in month was 1.5% of paybill year, with an underspend of £46k. Bank expenditure has reduced in line with plan with an underspend in month of £123k.

Non pay expenditure overspent in month by £440k. This is primarily driven as a result of; underpedformance on non pay CIP delivery by £90k and £250k spend above plan on clinical supplies.

LLP expenditure against plan has overspent by £19k, which is offset by the reduction in ADH spend which is underspent against plan by £26k.

AREAS FOR IMPROVEMENT

- Identification of CIP

RISKS / ISSUES

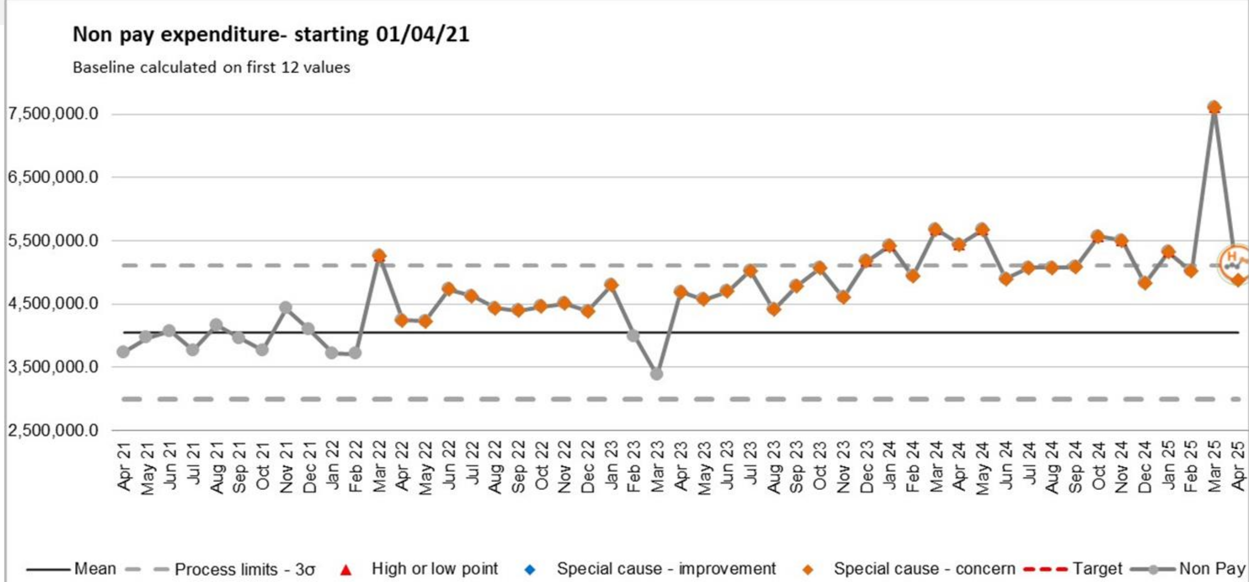
- CIP delivery risk

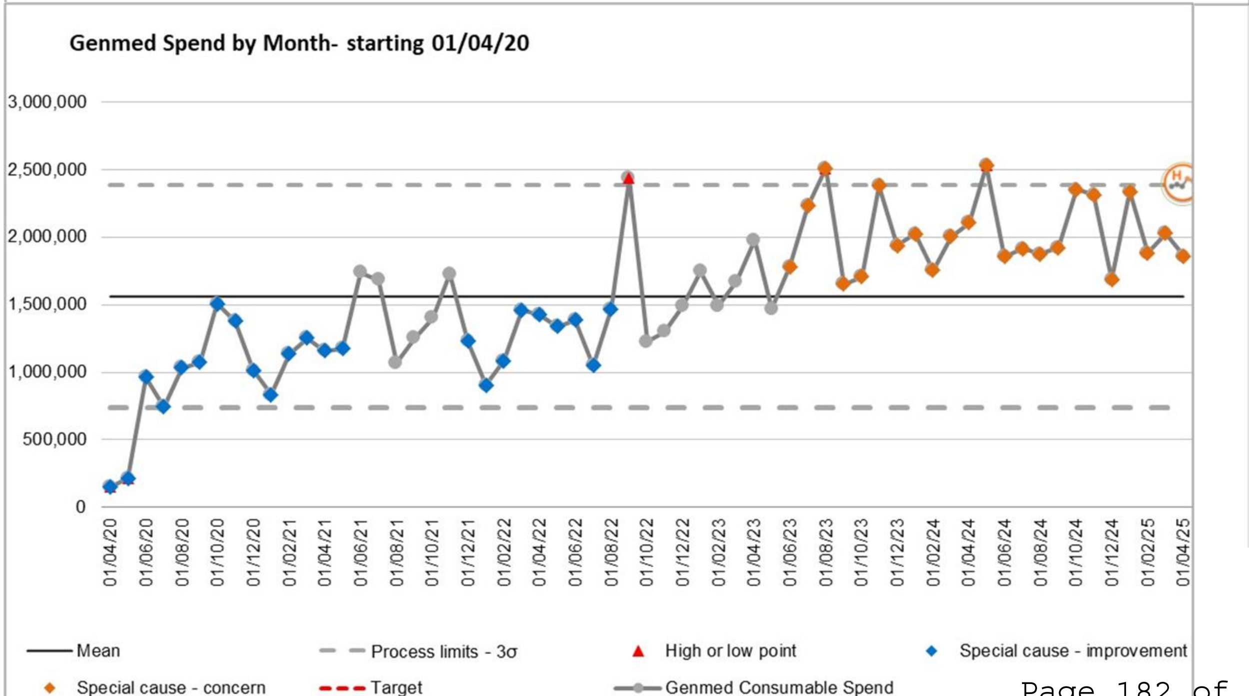
14. Non Pay Expenditure

Genmed spend mirrors closely the overall non-pay spend due to its value proportionally against non-pay spend. Most other non-pay spend is fairly consistent month on month.

It can be noted however that the additional controls being put in place are beginning to stabilise Genmed spend in comparison to the increases seen previously. The increase this month is largely due to the purchase of some power tools which are below the threshold for capitalisation.

An additional control to control non-consumable related spend is in the process of being trialled for a month.





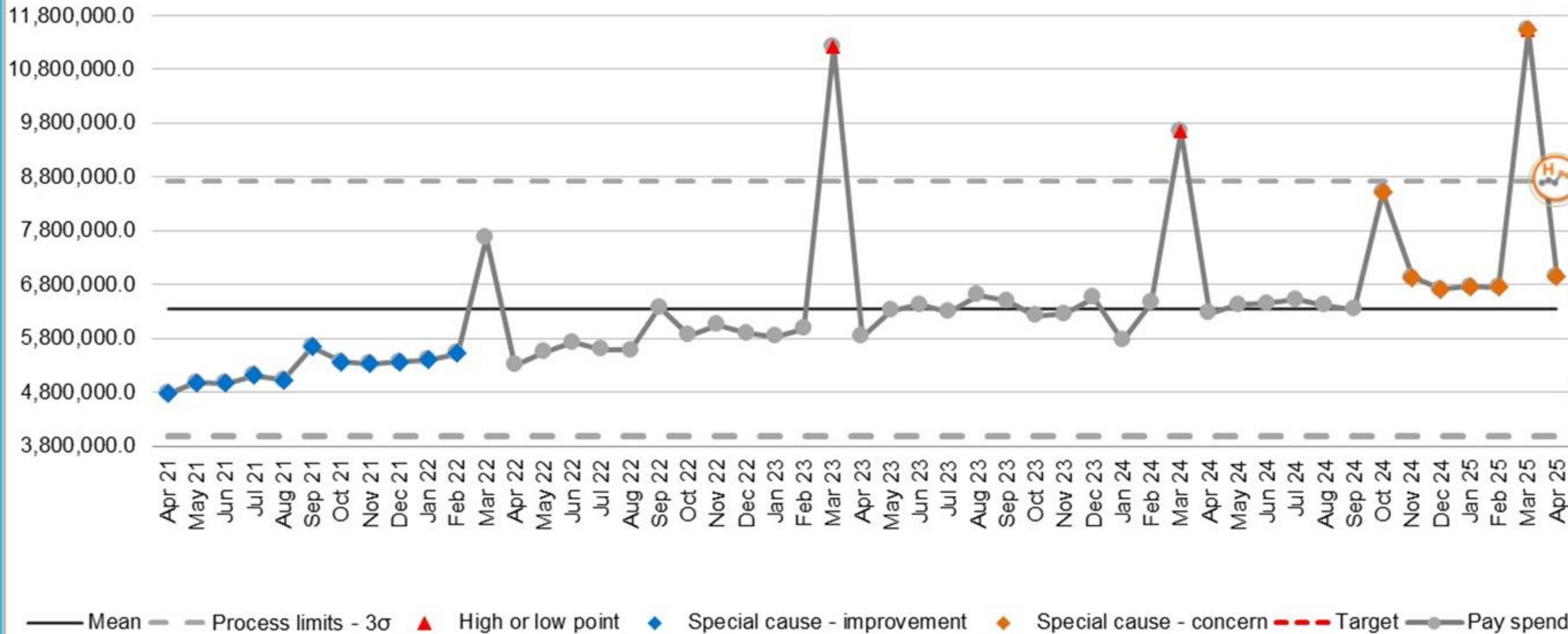
15. Non Pay Expenditure

SUMMARY

Premium rate additional sessions remain a key element of the cost improvement plan, with a reduction in LLP expenditure planned of £2.7m. In month there was an underperformance of £19k against the expected cost reduction plan, with £166k spent against a plan of £147k.
ADH (medical bank) expenditure has performed postively against the reduction plan with an overperformance of £26k against the reduction plan with £66k spent agasint a plan of £93k.

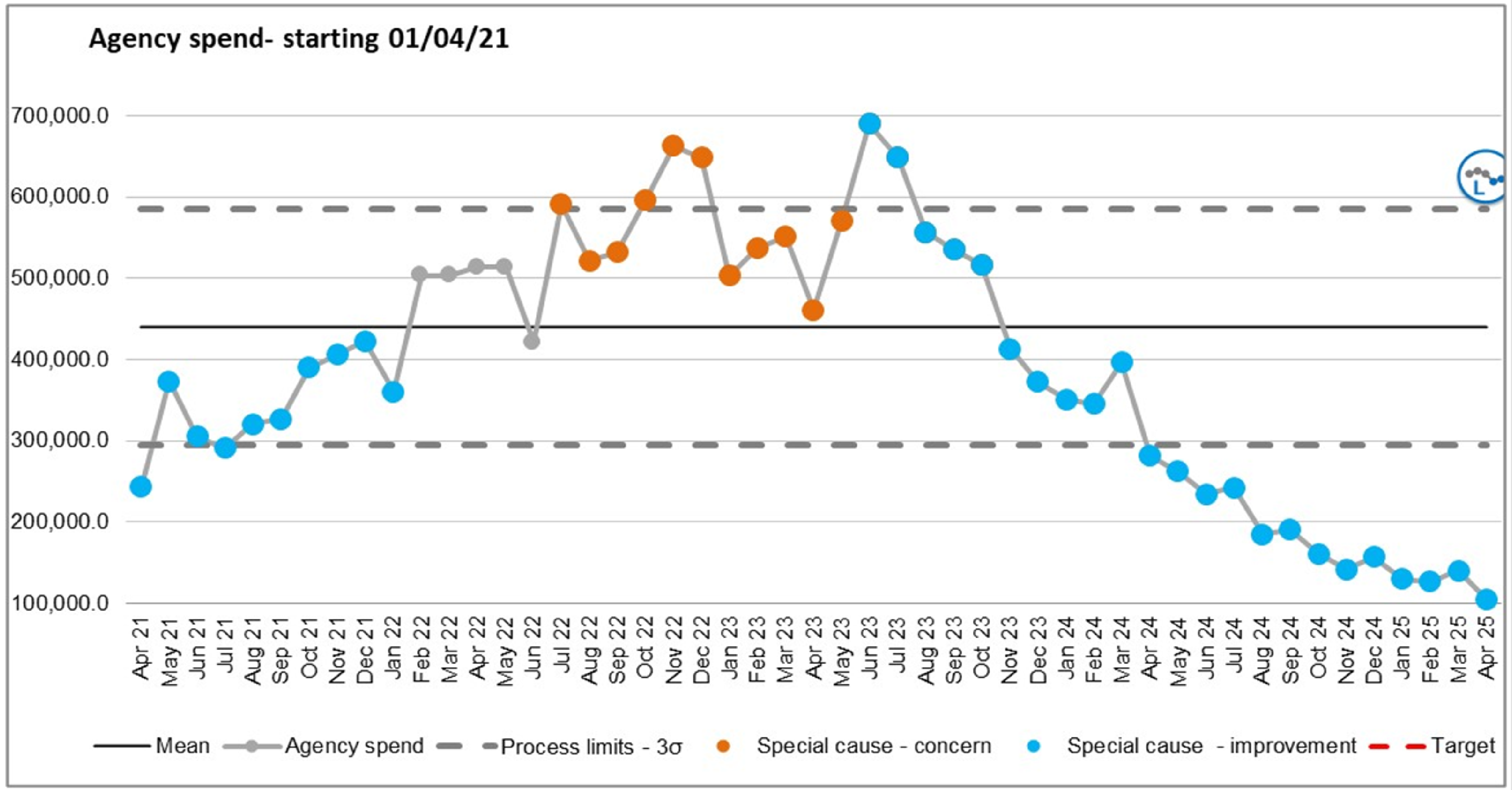
	£'000s			Substantive wte surgeons
Year	LLP	ADH	Total	
17-18		1,672	1,672	63.28
18-19		1,950	1,950	61.57
19-20	274	1,503	1,777	64.48
20-21	271	432	703	70.22
21-22	1,460	438	1,898	75.58
22-23	1,865	882	2,747	71.66
23-24	3,382	1,067	4,449	70.22
24-25	3,629	1,307	4,936	77.66
25-26	166	66	232	79.56

16. Pay Expenditure

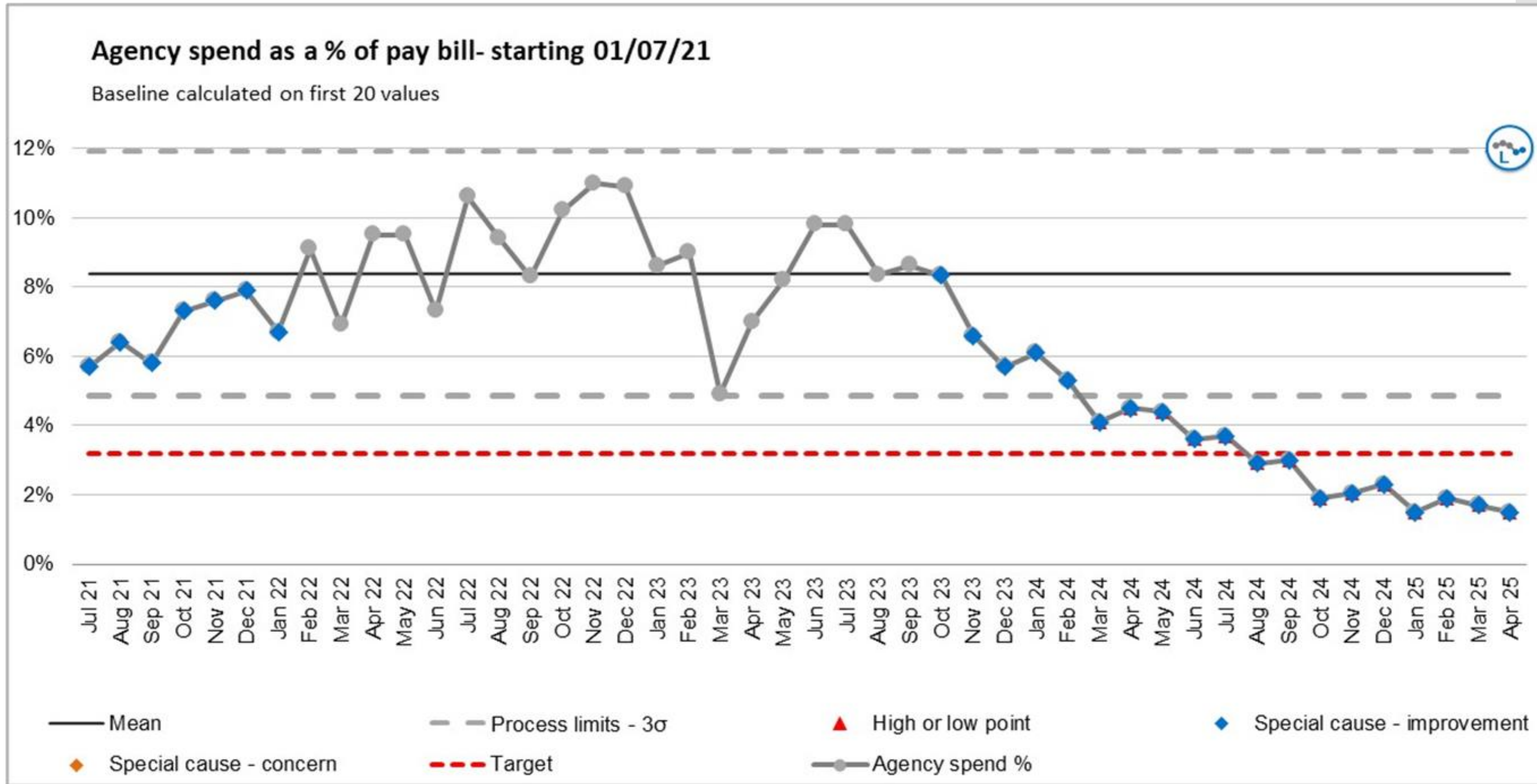


March'25 value includes pension adjustment
October’24 pay value includes back dated pay award

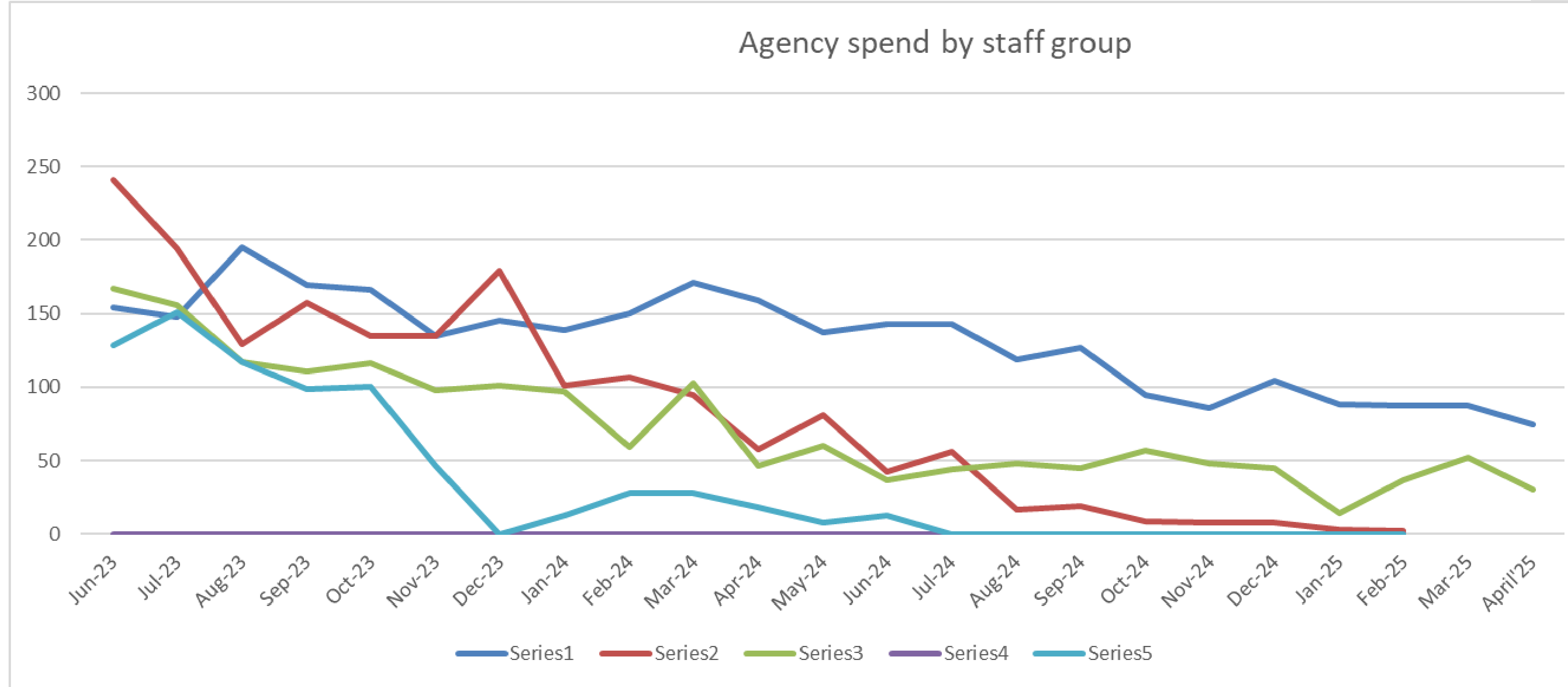
17. Agency Expenditure



17. Agency Expenditure

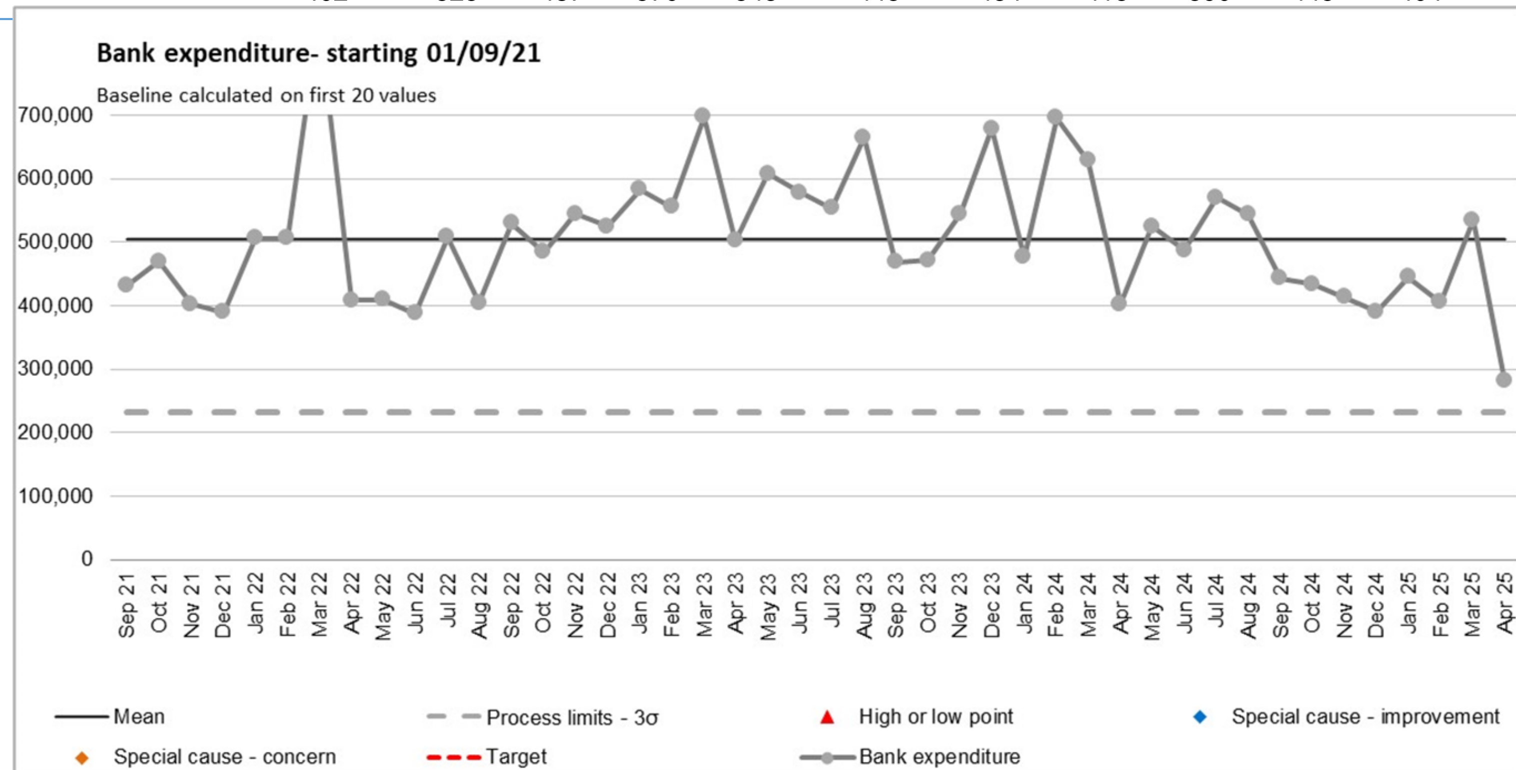


17. Agency Expenditure



17. Bank Expenditure

Bank expenditure	£'000s												
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April
Registered nursing	108	122	110	136	116	101	95	112	118	92	109	108	46
Healthcare scientists and Scientific, therapeutic and tech	26	35	32	47	25	33	41	38	38	34	35	38	31
Support to clinical	52	70	60	86	78	55	56	61	69	55	38	94	33
Total medical and dental staff bank	56	91	51	61	107	88	117	85	52	124	88	142	56
NHS infrastructure support	138	136	155	189	200	151	125	117	111	140	119	157	107
TOTAL	402	525	487	570	543	443	434	413	390	445	404	534	274



18. Cost Improvement Plan

SUMMARY

In month efficiencies of £409k has been generated against a plan of £445k. A target for the year has been set at £9.4m with plans fully identifying the target.
Quality Impact Assessments (QIAs) for schemes are in progress with the panel meeting weekly to review assessments.

CIP Scheme	Full year Plan	Recurrent full year effect	Plan April	Actual April	Variance
Bank reduction 10%				26.44	26.44
Agency Reduction 30%				46.00	46.00
LLP	2,705	2,779	214.00	194.55	-19.45
Non Pay Other	745	716	39.10	66.68	27.58
Optimising Medicines value	100	100	8.33	0.00	-8.33
Optimising energy Value	200	200	16.67	0.00	-16.67
Activity gap	0	0		0.00	0.00
Avoid duplication and low value activity	0	0	0.00	0.00	0.00
Digital Optimisation	776	811	55.33	0.00	-55.33
Commercial income	641	586	62.36	75.47	13.10
Service redesign	845	1,212	7.00	0.00	-7.00
Budget management schemes	743	811.	42.30	0.00	-42.30
Workforce redesign	1,901	4,004	0.00		0.00
Executive led schemes	1,142	1,627	0.00		0.00
Total CIP schemes 25/26	9452	12,850	445.10	409.14	-35.96

18. Financial Delivery Board

SUMMARY

- Financial Recovery Group (FRG) has been replaced with Financial Delivery Board
- Membership consists of all executive directors,

•The purpose of the group is; '*to provide detailed prospective oversight of the delivery of the Trust's annual financial plan, developed in line with the requirements of the national planning guidance. The Board will provide an opportunity to confirm and challenge delivery of the annual financial plan and to understand and agree mitigations where areas may be off track.*

- The group will focus on;
- Reviewing overall financial postion and forecast outturn
- Cost Improvement Programme progress

Risks/Issues

•Capacity of teams and individuals to support all programmes of work
Short term focus of financial recovery initiatives at the detriment to long term financial sustainability

• Actions

- Embed new group

20. Statement of Financial Position

SUMMARY

The main movements in the balance sheet have been in relation to the reduction in cash and movements in the working capital balances.

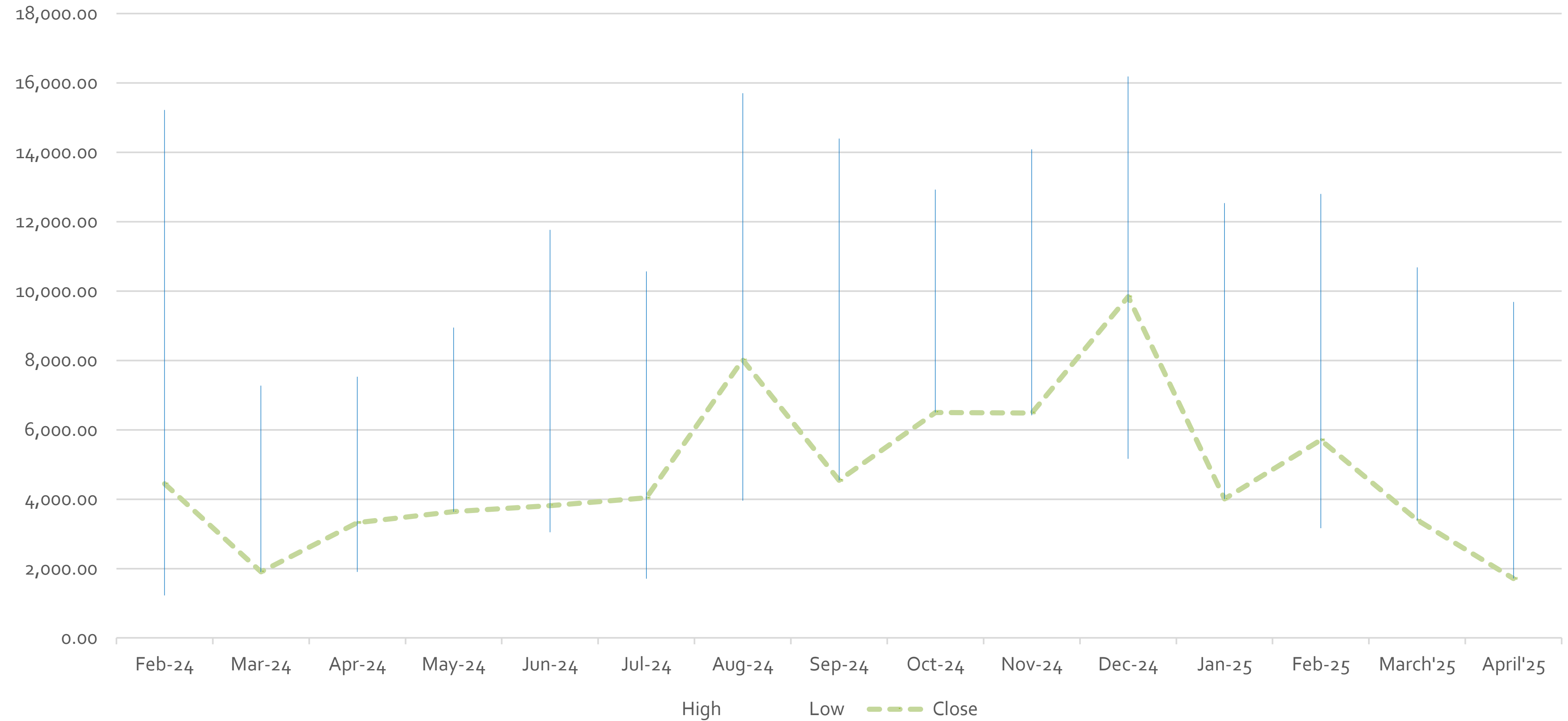
The cash position remains challenging, with the movement in month one being due to reduction in creditors as invoices were paid, for example to Genmed. Despite this, further support payments are not currently expected to be needed in 2056-26.

Provisions remain high due to a new provision – as described at last F&P Committee this has been considered and approved at Audit Committee.

	2024/25 M12	2025/26 M1	Movement
Intangible Assets	933	902	(31)
Tangible Assets	66,859	66,173	(686)
Total Non Current Assets	**67,792**	**67,074**	**(718)**
Trade and other current assets	18,580	17,141	(1,439)
Cash	3,293	1,579	(1,714)
Total Current Assets	**21,873**	**18,720**	**(3,153)**
Trade and other payables	(18,235)	(16,276)	1,959
Borrowings	(13,722)	(13,489)	233
Provisions	(3,014)	(3,014)	-
Other Liabilities	(6,332)	(5,232)	1,100
Total Liabilities	**(41,303)**	**(38,011)**	**3,292**
Total Net Assets Employed	**48,362**	**47,783**	**(579)**
Total Taxpayers' and Others' Equity	**48,362**	**47,783**	**(579)**

21. Cash

- The cash position remains challenging to manage within the in-month peaks and troughs.
- Continued focus is being places on ensuring that cash is being managed robustly, whilst also trying to maximise Better Payment Practice Performance.



22. System Position

The system revenue position for April is £12.8m deficit, generating a £8.2m variance from plan. Efficiencies are behind plan by £5.9m.

System Surplus/(Deficit) including Non-Recurrent Deficit Funding	Expected Sign	SR_PLANYTD1_1 Surplus / (Deficit) Plan 27th March Plan 30/04/2025 YTD £'000	SR_PLANYTD2_1 Surplus / (Deficit) Plan 30th April Plan 30/04/2025 YTD £'000	SR_ACTYTD_1 Surplus / (Deficit) Actual 30/04/2025 YTD £'000	SR_VARYTD_1 Surplus / (Deficit) Variance 30/04/2025 YTD £'000	SR_PLANFOT1_1 Surplus / (Deficit) Plan 27th March Plan 31/03/2026 Year Ending £'000	SR_PLANFOT2_1 Surplus / (Deficit) Plan 30th April Plan 31/03/2026 Year Ending £'000
Birmingham And Solihull ICB	+/-	(872)	(627)	(627)	0	0	0
Birmingham And Solihull Mental Health NHS Foundation Trust	+/-	349	347	(1,086)	(1,433)	4,200	4,200
Birmingham Community Healthcare NHS Foundation Trust	+/-	(109)	(108)	(604)	(496)	0	0
Birmingham Women'S And Children'S NHS Foundation Trust	+/-	0	0	(1,081)	(1,081)	0	0
The Royal Orthopaedic Hospital NHS Foundation Trust	+/-	(282)	(281)	(377)	(96)	34	35
University Hospitals Birmingham NHS Foundation Trust	+/-	(2,648)	(3,953)	(11,221)	(7,268)	(4,200)	(4,200
System Total	+/-	(3,582)	(4,622)	(14,997)	(10,375)	34	35

System Efficiency Total	Expected Sign	EFF_PLANYTD1_1 Efficiency Plan 27th March Plan 30/04/2025 YTD £'000	EFF_PLANYTD2_1 Efficiency Plan 30th April Plan 30/04/2025 YTD £'000	EFF_ACTYTD_1 Efficiency Actual 30/04/2025 YTD £'000	EFF_VARYTD_1 Efficiency Variance 30/04/2025 YTD £'000
Birmingham And Solihull ICB	+	8,257	8,502	8,502	0
ICB efficiency impacting providers within system	+	0	0	0	0
Birmingham And Solihull Mental Health NHS Foundation Trust	+	2,953	2,953	1,263	(1,690
Birmingham Community Healthcare NHS Foundation Trust	+	1,559	1,521	897	(624
Birmingham Women'S And Children'S NHS Foundation Trust	+	2,518	2,518	997	(1,521
The Royal Orthopaedic Hospital NHS Foundation Trust	+	494	494	409	(85
University Hospitals Birmingham NHS Foundation Trust	+	8,364	8,360	6,391	(1,969
System Total	+	24,145	24,348	18,459	(5,889

20. Workforce

SUMMARY

- Strength rose slightly in April by 5.16 FTE despite restrictions on recruitment via the Vacancy Control Panel. Strength has risen by c. 18 FTE since the start of Jan 2025.
- Turnover fell in April after an increase in March but still remains about start of year levels (11.23% v 10.93%).
- Long term sickness increases whilst short term sickness decreased by a similar level. Overall sickness rates remain well above target. RTW completion improved.
- The Trust appraisal window remains open and compliance is expected to fluctuate until it closes at the end of July at which point a clear view on compliance becomes available.

Risks/Issues

- The Trust sickness absence rate remains an issue.
- Strength needs to monitored closely linked to CIP.

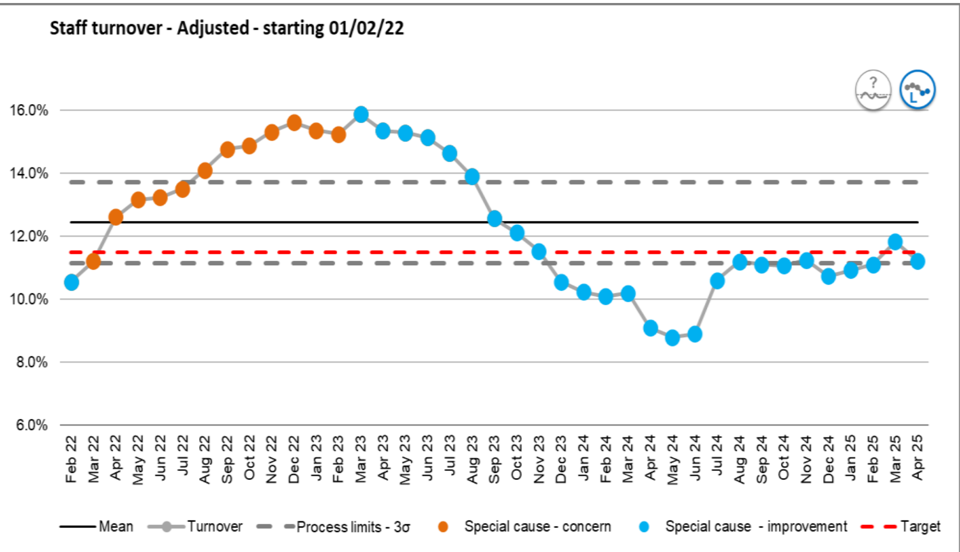
Actions

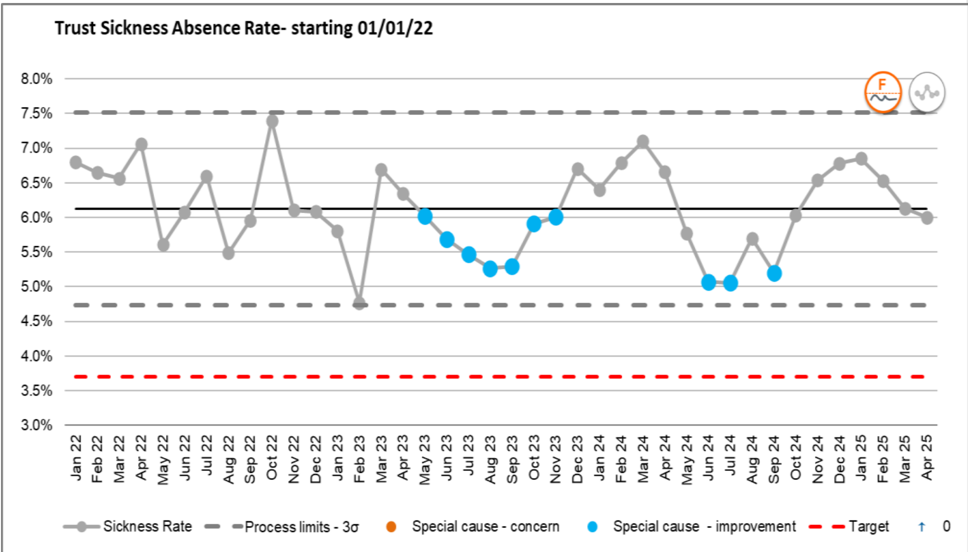
- HR have a full action plan in place associated with improving sickness absence rates.
- Training is in place to improve the quality of appraisals whilst maintaining the level of compliance.

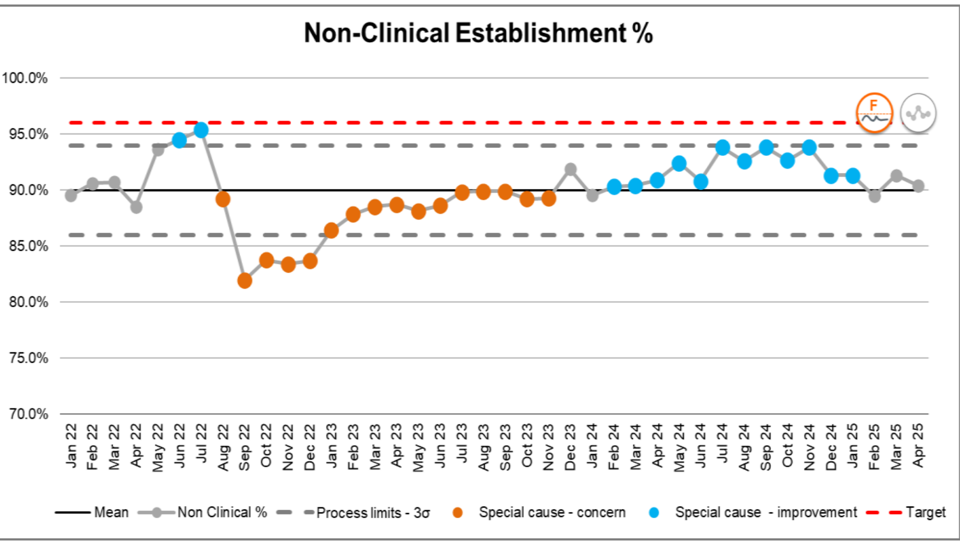
20. Workforce

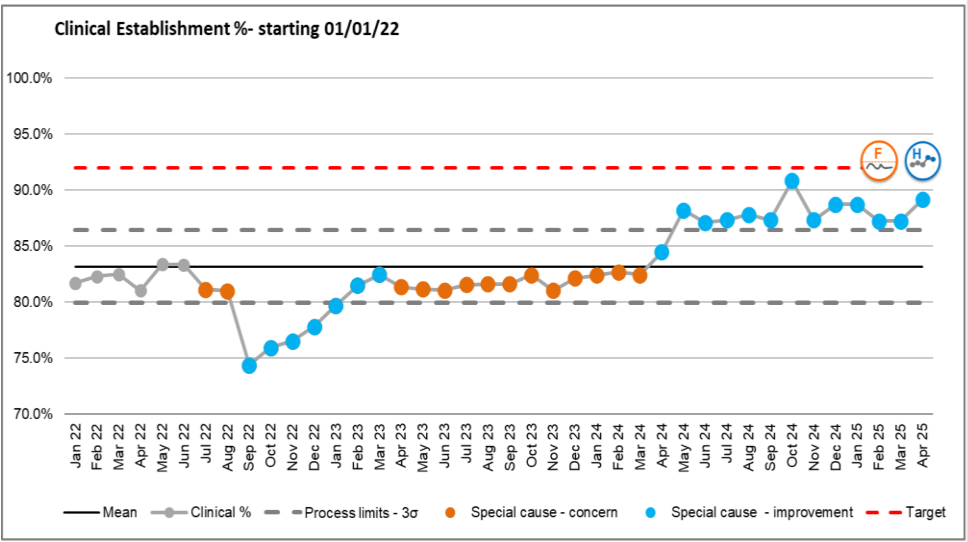
Trust Workforce Metrics	End of Mar-25	End of Apr-25	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1479	1483	+4	-	-
Staff In Post - Full Time Equivalent	1308.94	1314.10	+5.16	-	-
Staf Turnover % - Adjusted	11.83%	11.23%	-0.60%		<=11.5%
Total WTE Employed as % of Establishment - Clinical	87.25%	89.14%	+1.89%		>=92%
Total WTE Employed as % of Establishment - Non-Clinical	89.47%	90.40%	+0.93%		>=96%
% Of Attendance (12 months)	94.04%	94.00%	-0.04%		>=96.3%
% of Sickness - Trust wide Long-term	3.40%	3.74%	+0.34%		-
% of Sickness - Trust wide Short-term	2.71%	2.26%	-0.45%		-
% Staff received mandatory training last 12 months	89.92%	86.99%	-2.93%		>=93%
% Staff received formal PDR/appraisal last 12 months	90.10%	84.92%	-5.18%		>=95%
Return To Work Completion %	63.30%	67.44%	+4.14%		>=80%

20. Workforce

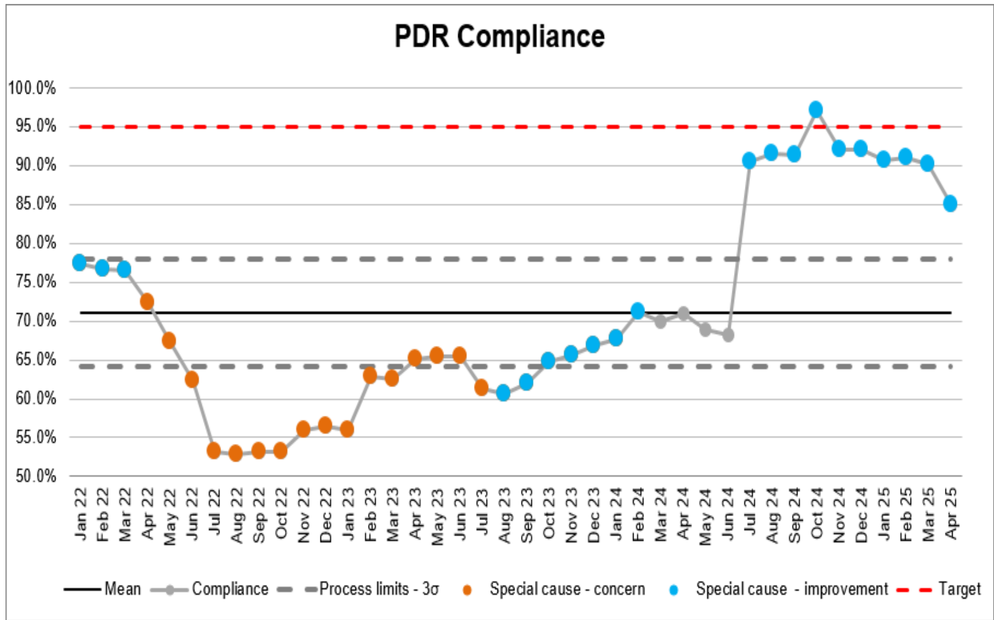








20. Workforce



The Royal
Orthopaedic Hospital
NHS Foundation Trust

Integrated Performance Dashboard

Integrated Performance Dashboard

Metric Grouping	Metric Name	Reporting Status	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Latest Variation	Latest Assurance	Target
Inpatients	IP Activity YTD Plan	YTD	1,208	2,482	3,668	4,980	6,244	7,556	8,935	10,237	11,455	12,795	14,014	15,326	1,068	-	-	-
Inpatients	IP Activity YTD Actuals	YTD	1,194	2,510	3,721	5,079	6,309	7,583	8,829	10,072	11,198	12,557	13,897	15,149	1,164	-	-	-
Inpatients	IP Activity YTD Performance %	YTD	98.8%	101.1%	101.4%	102.0%	101.0%	100.4%	98.8%	98.4%	97.8%	98.1%	99.2%	98.8%	109.0%	-	-	-
Inpatients	IP Activity YTD Variance	YTD	-14	28	53	99	65	27	-106	-165	-257	-238	-117	-177	96	H	P	-
Inpatients	IP Activity Electives YTD Plan	YTD	554	1,138	1,680	2,282	2,862	3,464	4,096	4,694	5,254	5,868	6,428	7,030	434	-	-	-
Inpatients	IP Activity Electives YTD Actuals	YTD	535	1,116	1,632	2,225	2,740	3,288	3,869	4,443	4,949	5,528	6,099	6,646	482	-	-	-
Inpatients	IP Activity Eletives YTD Performance %	YTD	96.6%	98.1%	97.1%	97.5%	95.7%	94.9%	94.5%	94.7%	94.2%	94.2%	94.9%	94.5%	111.1%	-	-	-
Inpatients	IP Activity Electives YTD Variance	YTD	-19	-22	-48	-57	-122	-176	-227	-251	-305	-340	-329	-384	48	H	P	-
Inpatients	IP Activity Daycases YTD Plan	YTD	642	1,319	1,950	2,647	3,320	4,017	4,750	5,441	6,088	6,800	7,448	8,145	615	-	-	-
Inpatients	IP Activity Daycases YTD Actuals	YTD	639	1,354	2,033	2,783	3,480	4,184	4,825	5,468	6,063	6,821	7,577	8,254	671	-	-	-
Inpatients	IP Activity Daycases YTD Performance %	YTD	99.5%	102.7%	104.3%	105.1%	104.8%	104.2%	101.6%	100.5%	99.6%	100.3%	101.7%	101.3%	109.1%	-	-	-
Inpatients	IP Activity Daycases YTD Variance	YTD	-3	35	83	136	160	167	75	27	-25	21	129	109	56	H	P	-
Inpatients	IP Activity Non-Electives YTD Plan	YTD	12	25	38	51	62	75	89	102	113	127	138	151	19	-	-	-
Inpatients	IP Activity Non-Electives YTD Actuals	YTD	20	40	56	71	89	111	135	161	186	208	221	249	11	-	-	-
Inpatients	IP Activity Non-Electives YTD Performance %s	YTD	166.7%	160.0%	147.4%	139.2%	143.6%	148.0%	151.7%	157.8%	164.6%	163.8%	160.1%	164.9%	57.7%	-	-	-
Inpatients	IP Activity Non-Electives YTD Variance	YTD	8	15	18	20	27	36	46	59	73	81	83	98	-8	-	-	-

Integrated Performance Dashboard

Metric Grouping	Metric Name	Reporting Status	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Latest Variation	Latest Assurance	Target
Inpatients	IP Activity Monthly Plan	Monthly	1,208	1,274	1,186	1,312	1,264	1,312	1,379	1,302	1,218	1,340	1,219	1,312	1,068	-	-	-
Inpatients	IP Activity Monthly Actuals	Monthly	1,194	1,316	1,211	1,358	1,230	1,274	1,246	1,243	1,126	1,359	1,340	1,252	1,164	-	-	-
Inpatients	IP Activity Monthly Performance %	Monthly	98.8%	103.3%	102.1%	103.5%	97.3%	97.1%	90.4%	95.5%	92.4%	101.4%	109.9%	95.4%	109.0%	-	-	
Inpatients	IP Activity Monthly Variance	Monthly	-14	42	25	46	-34	-38	-133	-59	-92	19	121	-60	96	H	P	-
Inpatients	IP Activity Electives Monthly Plan	Monthly	554	584	542	602	580	602	632	598	560	614	560	602	434	-	-	-
Inpatients	IP Activity Electives Monthly Actuals	Monthly	535	581	516	593	515	548	581	574	506	579	571	547	482	-	-	
Inpatients	IP Activity Electives Monthly Performance %	Monthly	96.6%	99.5%	95.2%	98.5%	88.8%	91.0%	91.9%	96.0%	90.4%	94.3%	102.0%	90.9%	110.9%	-	-	
Inpatients	IP Activity Electives Monthly Variance	Monthly	-19	-3	-26	-9	-65	-54	-51	-24	-54	-35	11	-55	47	H	P	
Inpatients	IP Activity Daycases Monthly Plan	Monthly	642	677	631	697	673	697	733	691	647	712	648	697	615	-	-	-
Inpatients	IP Activity Daycases Monthly Actuals	Monthly	639	715	679	750	697	704	641	643	595	758	756	677	671	-	-	
Inpatients	IP Activity Daycases Monthly Performance %	Monthly	99.5%	105.6%	107.6%	107.6%	103.6%	101.0%	87.4%	93.1%	92.0%	106.5%	116.7%	97.1%	106.6%	-	-	
Inpatients	IP Activity Daycases Monthly Variance	Monthly	-3	38	48	53	24	7	-92	-48	-52	46	108	-20	41	H	P	
Inpatients	IP Activity Non-Electives Monthly Plan	Monthly	12	13	13	13	11	13	14	13	11	14	11	13	19	-	-	-
Inpatients	IP Activity Non-Electives Monthly Actuals	Monthly	20	20	16	15	18	22	24	26	25	22	13	28	11	-	-	
Inpatients	IP Activity Non-Electives Monthly Performance %	Monthly	166.7%	153.8%	123.1%	115.4%	163.6%	169.2%	171.4%	200.0%	227.3%	157.1%	118.2%	215.4%	57.7%	-	-	
Inpatients	IP Activity Non-Electives Monthly Variance	Monthly	8	7	3	2	7	9	10	13	14	8	2	15	-8	-	-	-
Inpatients	LOS - Trust Wide All Services	Monthly	3.5	4.0	4.2	3.9	4.1	3.5	3.8	4.3	4.5	3.3	3.4	3.7	4.1		-	-
Inpatients	LOS - Excluding Oncology, Paeds,YAH, Spinal	Monthly	3.09	3.70	3.47	3.43	3.69	3.13	3.39	3.78	4.08	3.05	3.03	3.15	3.46		-	-
Inpatients	LOS - Elective Primary Hip	Monthly	3.0	2.8	2.9	2.5	2.8	3.1	2.7	3.2	3.0	3.0	2.4	2.7	2.5		P	2.7
Inpatients	LOS - Elective Primary Knee	Monthly	3.1	3.2	2.9	3.3	3.3	3.0	2.6	3.1	3.3	3.0	2.6	2.7	3.0		F	2.7
Inpatients	Admitted Treatment Deferred	Monthly	26	39	36	29	32	23	39	28	35	44	36	24	28		-	-
Inpatients	Cancelled By Hospital On Day of Admission	Monthly	10	10	8	3	3	7	10	3	6	4	2	3	2		-	-
Inpatients	Cancelled By Hospital Day Before Day of Admission	Monthly	22	16	22	34	22	21	29	25	25	27	22	26	35		-	-

Integrated Performance Dashboard

Metric Grouping	Metric Name	Reporting Status	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Latest Variation	Latest Assurance	Target
Outpatients	OP Activity YTD Plan	YTD	5,466	10,628	16,701	23,078	26,722	32,491	38,868	45,245	49,496	55,873	61,339	67,715	5,685	-	-	-
Outpatients	OP Activity YTD Actuals	YTD	6,215	11,929	17,687	24,152	29,769	35,699	42,182	48,312	53,903	60,716	66,751	72,999	5,941	-	-	-
Outpatients	OP Activity YTD Performance %	YTD	113.7%	112.2%	105.9%	104.7%	111.4%	109.9%	108.5%	106.8%	108.9%	108.7%	108.8%	107.8%	104.5%	-	-	-
Outpatients	OP Activity YTD Variance	YTD	749	1,301	986	1,074	3,047	3,208	3,314	3,067	4,407	4,843	5,412	5,284	256	H	P	-
Outpatients	OP Activity First YTD Plan	YTD	1,747	3,396	5,337	7,374	8,539	10,382	12,420	14,458	15,816	17,854	19,601	21,638	1,992	-	-	-
Outpatients	OP Activity First YTD Actuals	YTD	2,091	4,000	5,893	7,977	9,836	11,810	13,851	16,010	17,866	20,150	22,147	24,111	1,675	-	-	-
Outpatients	OP Activity Eletives YTD Performance %	YTD	119.7%	117.8%	110.4%	108.2%	115.2%	113.7%	111.5%	110.7%	113.0%	112.9%	113.0%	111.4%	84.1%	-	-	-
Outpatients	OP Activity First YTD Variance	YTD	344	604	556	603	1,297	1,428	1,431	1,552	2,050	2,296	2,546	2,473	-317	L	F	-
Outpatients	OP Activity Follow Up YTD Plan	YTD	3,402	6,614	10,394	14,362	16,630	20,221	24,189	28,158	30,804	34,772	38,174	42,142	3,446	-	-	-
Outpatients	OP Activity Follow Up YTD Actuals	YTD	3,794	7,318	10,893	14,966	18,478	22,175	26,379	30,112	33,589	37,806	41,578	45,616	3,999	-	-	-
Outpatients	OP Activity Follow Up YTD Performance %	YTD	111.5%	110.6%	104.8%	104.2%	111.1%	109.7%	109.1%	106.9%	109.0%	108.7%	108.9%	108.2%	116.0%	-	-	-
Outpatients	OP Activity Follow Up YTD Variance	YTD	392	704	499	604	1,848	1,954	2,190	1,954	2,785	3,034	3,404	3,474	553	H	P	-
Outpatients	OP Activity Procedures YTD Plan	YTD	318	618	971	1,341	1,553	1,888	2,259	2,629	2,876	3,247	3,564	3,935	247	-	-	-
Outpatients	OP Activity Procedures YTD Actuals	YTD	330	611	901	1,209	1,455	1,714	1,952	2,190	2,448	2,760	3,026	3,272	267	-	-	-
Outpatients	OP Activity Procedures YTD Performance %s	YTD	103.9%	98.9%	92.8%	90.2%	93.7%	90.8%	86.4%	83.3%	85.1%	85.0%	84.9%	83.2%	108.1%	-	-	-
Outpatients	OP Activity Procedures YTD Variance	YTD	12	-7	-70	-132	-98	-174	-307	-439	-428	-487	-538	-663	20	H	P	-

Integrated Performance Dashboard

Metric Grouping	Metric Name	Reporting Status	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Latest Variation	Latest Assurance	Target
Outpatients	OP Activity Monthly Plan	Monthly	5,466	5,162	6,073	6,377	3,644	5,769	6,377	6,377	4,251	6,377	5,466	6,377	5,685	-	-	-
Outpatients	OP Activity Monthly Actuals	Monthly	6,215	5,714	5,758	6,465	5,617	5,930	6,483	6,130	5,591	6,813	6,035	6,248	5,941	-	-	-
Outpatients	OP Activity Monthly Performance %	Monthly	113.7%	110.7%	94.8%	101.4%	154.1%	102.8%	101.7%	96.1%	131.5%	106.8%	110.4%	98.0%	104.5%	-	-	
Outpatients	OP Activity Monthly Variance	Monthly	749	552	-315	88	1,973	161	106	-247	1,340	436	569	-129	256			-
Outpatients	OP Activity First Monthly Plan	Monthly	1,747	1,650	1,941	2,038	1,164	1,844	2,038	2,038	1,358	2,038	1,747	2,038	1,992	-	-	-
Outpatients	OP Activity First Monthly Actuals	Monthly	2,091	1,909	1,893	2,084	1,859	1,974	2,041	2,159	1,856	2,284	1,997	1,964	1,675	-	-	
Outpatients	OP Activity First Monthly Performance %	Monthly	119.7%	115.7%	97.5%	102.3%	159.7%	107.1%	100.2%	106.0%	136.6%	112.1%	114.3%	96.4%	84.1%	-	-	
Outpatients	OP Activity First Monthly Variance	Monthly	344	259	-48	46	695	130	3	121	498	246	250	-74	-317			
Outpatients	OP Activity Follow Up Monthly Plan	Monthly	3,402	3,213	3,780	3,969	2,268	3,591	3,969	3,969	2,646	3,969	3,402	3,969	3,446	-	-	-
Outpatients	OP Activity Follow Up Monthly Actuals	Monthly	3,794	3,524	3,575	4,073	3,512	3,697	4,204	3,733	3,477	4,217	3,772	4,038	3,999	-	-	
Outpatients	OP Activity Follow Up Monthly Performance %	Monthly	111.5%	109.7%	94.6%	102.6%	154.9%	103.0%	105.9%	94.1%	131.4%	106.3%	110.9%	101.7%	116.0%	-	-	
Outpatients	OP Activity Follow Up Monthly Variance	Monthly	392	311	-205	104	1,244	106	235	-236	831	248	370	69	553			
Outpatients	OP Activity Procedures Monthly Plan	Monthly	318	300	353	371	212	335	371	371	247	371	318	371	247	-	-	-
Outpatients	OP Activity Procedures Monthly Actuals	Monthly	330	281	290	308	246	259	238	238	258	312	266	246	267	-	-	
Outpatients	OP Activity Procedures Monthly Performance %	Monthly	103.9%	93.7%	82.2%	83.1%	116.2%	77.3%	64.2%	64.2%	104.4%	84.2%	83.7%	66.4%	108.1%	-	-	
Outpatients	OP Activity Procedures Monthly Variance	Monthly	12	-19	-63	-63	34	-76	-133	-133	11	-59	-52	-125	20			

Integrated Performance Dashboard

Metric Grouping	Metric Name	Reporting Status	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Latest Variation	Latest Assurance	Target
Outpatients	OP for first or follow-up Attendances attracting a procedure tariff	Monthly	38.18%	37.66%	37.57%	36.59%	37.33%	37.36%	34.51%	38.66%	37.44%	37.95%	37.35%	37.50%	38.00%			
Outpatients	Outpatient Clinic Session Utilisation	Monthly	82%	79%	81%	81%	77%	76%	80%	81%	73%	83%	80%	80%	81%		-	
Outpatients	Outpatient Clinic Slot Utilisation	Monthly	78%	78%	79%	80%	78%	78%	77%	77%	76%	80%	79%	79%	80%		-	
Outpatients	Outpatient Did Not Attend (YTD)	Monthly	7.0%	7.3%	6.8%	6.9%	7.6%	7.8%	7.9%	7.8%	8.2%	8.1%	8.0%	7.0%	7.0%			8%
Outpatients	PIFU	Monthly	9.7%	8.4%	8.6%	10.7%	9.4%	10.0%	9.4%	9.8%	10.2%	11.0%	11.8%	10.1%	10.5%			5%
Outpatients	Virtual Consultations	Monthly	12.1%	11.0%	10.8%	11.7%	11.0%	10.0%	10.2%	10.5%	11.4%	9.9%	9.3%	9.8%	9.4%			
RTT	RTT Total Waiting List Planned Percentage	Month Ending	49.05%	50.86%	50.75%	52.58%	53.36%	52.90%	52.81%	51.84%	51.61%	52.01%	53.14%	54.66%	55.63%			52.75%
RTT	RTT First Appointment Waiting List Percentage	Month Ending	49.65%	52.32%	52.03%	52.73%	53.57%	53.28%	53.08%	52.11%	52.79%	53.62%	53.06%	54.06%	54.46%			54.51%
RTT	RTT Total Waiting List Size	Month Ending	15,750	15,731	15,473	15,486	15,709	15,069	14,901	14,561	14,517	13,777	13,291	12,738	12,739			13,896
RTT	RTT Patients Waiting 65 Week waits	Month Ending	36	40	35	18	9	0	1	0	13	19	6	1	0			0
RTT	RTT Patients Waiting 52 week waits (52-64 weeks)	Month Ending	490	534	541	560	590	641	843	889	842	727	672	487	486			643
RTT	RTT Proportion of Patients Waiting 52 weeks and over	Month Ending	3.34%	3.65%	3.72%	3.73%	3.81%	4.25%	5.66%	6.11%	5.89%	5.41%	5.10%	3.83%	3.82%			4.63%
Theatres	Theatre Session Utilisation	Monthly	85.04%	93.35%	80.82%	89.18%	83.24%	86.52%	84.19%	88.40%	85.48%	93.07%	89.23%	84.64%	90.42%			85%
Theatres	Theatre In-Session Utilisation Upcapped	Monthly	83.04%	81.50%	83.17%	82.35%	81.33%	83.59%	81.19%	81.21%	79.36%	82.47%	83.64%	84.04%	84.38%			85%
Theatres	Average Number Of Operations Per List	Monthly	2.85	3.13	3.03	2.93	2.97	2.90	2.64	2.84	2.78	3.05	3.08	2.96	3.15		-	
Theatres	Average Mins Late Starts(minutes) *Based on 9pm Start Time	Monthly	3	2	0	0	0	2	1	1	0	1	0	0	0		-	
Theatres	Average Early Finishes (minutes)	Monthly	96	89	85	90	86	87	94	92	117	94	85	83	82		-	
Theatres	Average Patient Turnaround (minutes)	Monthly	12	12	11	14	13	12	17	14	13	14	13	11	13		-	

Quality Report

May 2025 (April 2025 Data)

Introduction

- This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Integrated Care System for routine engagement and assurance meetings.
- The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Icons reading guide

Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

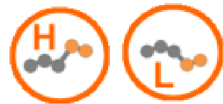
Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

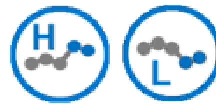
For KPIs that are not applicable to SPC; to identify exceptions we look at performance against target over the last 3 months - automatically assigning measures as an exception if the last 3 months have been falling short of the target in line with how we're calculating the assurance icon for non-SPC measures.

Variation Icons

Are we showing improvement, a cause for concern, or staying within expected variation?



Orange variation icons indicate special cause of **concerning nature** or high pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.



Blue variation icons indicate special cause of improving nature or lower pressure do to (H)igher or (L)ower values, depending on whether the measure aims to be above or below target.

A grey graph icon tells us the variation is common cause, and there has been no significant change.

For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

The special cause mentioned above is directly linked to the rules of SPC; for variation icons this is if the latest point is outside of the control range, or part of a run of consecutively improving or declining points.

Assurance Icons

Can we expect to reliably hit the target?

An orange assurance icon indicates consistently (F)alling short of the target.

A blue assurance icon indicates consistently (P)assing the target.

A grey assurance icon indicates inconsistently passing and falling short of the target.

For measures without a target you will instead see the "No Target" icon.

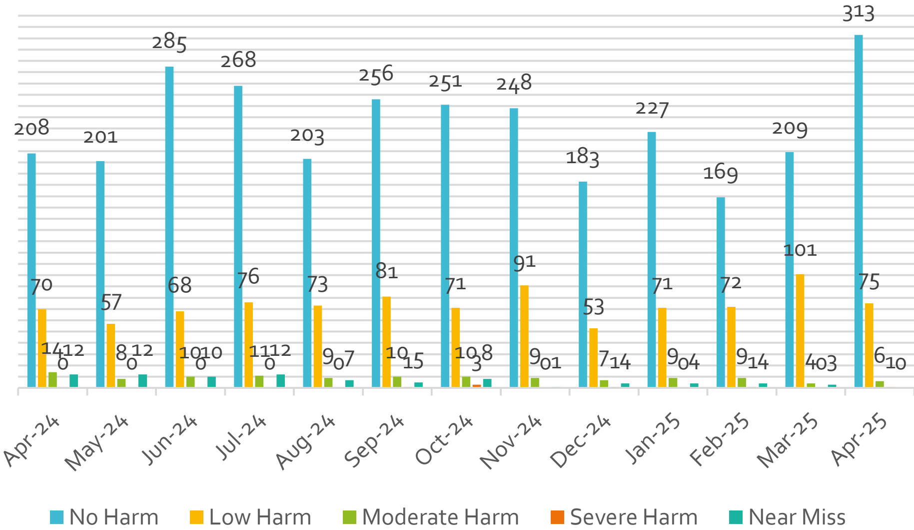
Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

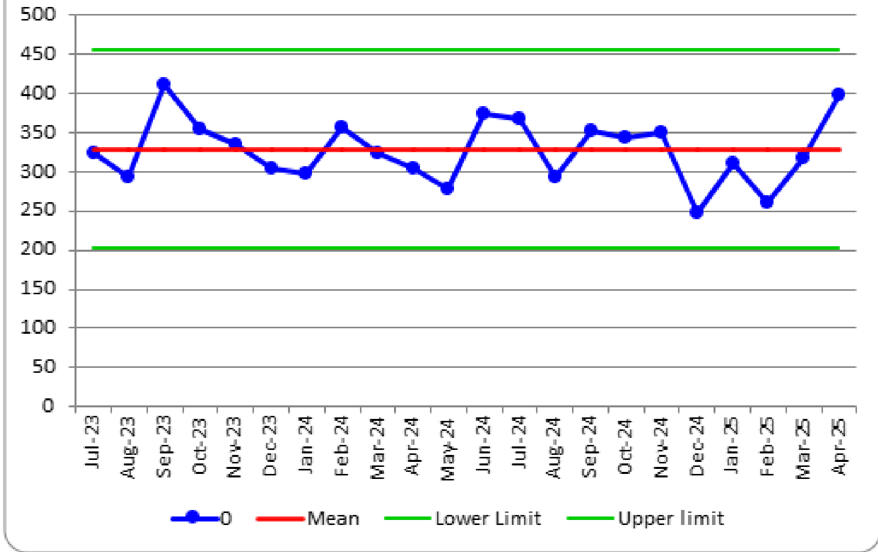
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months in comparison to the target, showing F or P icons if consistently passing of falling short.

Governance Performance Summary Dashboard

Performance to end April 2025	In month	Previous month	Variation	Assurance
Total No of Incidents Reported	398	318		
Inpatient Deaths	1	1		
PSII's (Patient Safety Incident Investigations)	0	1		
Never Events	0	0		
VTE Incidents (Avoidable)	0	0		
Category 2 Pressure Ulcer Incidents (Avoidable)	0	0		
Category 3 Pressure Ulcer Incidents (Avoidable)	0	0		
Falls (Total No of Inpatient Falls)	8	7		
Infection Incidents (Reportable)	0	0		
Complaints	8	6		
Claims	0	0		
Inquest	0	0		

Incidents Reported





Quality Improvement & Learning

There were 398 incidents reported within the Trust during April 2025. The number of reported incidents has shown an increase due to improvements in the reporting of incidents where patients have waited for 52 weeks or more and are reviewed under the Trust's harm review process.

Incidents Reported – Learning from PSIIs

Quality Improvement & Learning

Learning from PSII relating to the Wrong Site Surgery Never Event (initially reported in November 2024 Quality Report)

Areas of Improvement Identified:

- Operations performed by trainees with indirect supervision must be identified during team brief
- Consultants are to discuss competence with trainees and identify any critical points within a procedure where supervision must be present
- Proximity of supervision varies and there are well defined levels, these must be communicated at team brief - ongoing
- There must be a defined escalation route and named consultant surgeon available to respond if help is needed and this must be made clear at list planning and recorded at team brief – ongoing

Learning from PSII relating to a medication error (initially reported in February 2025 Quality Report)

Areas of Improvement Identified:-

- Remove high volume heparin ampoules from ROH all locations
- Continue annual stocklist review in all clinical areas- items not used in previous 12 months to be removed or relocated to emergency Omnicell
- Ensure minimum stock of protamine available and in date within out of hours Omnicell cabinet
- Addition of barcode scanning on Omnicell cabinets for intravenous medicines in HDU where high numbers of intravenous or high-risk medicines are stocked and administered
- Hospital wide EPR in near future will be closing the loop with Positive Patient ID and barcoded wrist bands on patients
- All staff to be reminded of the 5 rights of medicines administration, via safety huddles and poster material in clinical areas
- Annual refresher training for nursing colleagues on the 5 rights of medicines administration
- Snapshot audit of omnicell intravenous drug removal times versus medicine administration times
- Antidote list to be reviewed annually by the medicines safety group and ensure in date stock available
- Update the risk assessment for any future temporary relocations to ensure the below factors are mitigated
- Familiarisation of staff with new location across different shift patterns
- Reinforce the importance of contemporaneous documentation of events in clinical noting, communication between teams with respect to high-risk surgical procedures & the importance of referring to clinical noting before patient review
- Trust to consider ways of improving communication for wrong drug incidents to all relevant clinical staff in a timely manner
- All staff to undertake Respect and Civility awareness training- Mersey care programme

Incidents Reported – Learning from PSIIS - continued

Quality Improvement & Learning

Learning from PSII relating to the Wrong Implant Never Event (initially reported in November 2024 Quality Report)

Areas of Improvement Identified:

- Remove company representative badge access to the implant room to prevent representatives from collecting implants without ROH staff
- On-going monitoring of the Implant Time Out & verification process as required the Safe Surgery policy (including the use of theatre whiteboards)
- Implement the National Joint Registry scanning software in all theatres
- Review the current knee systems used at the trust to see if variation can be reduced

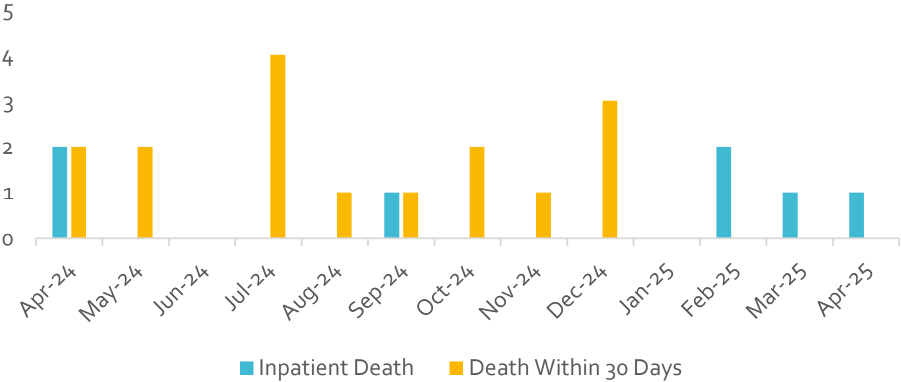
Incidents Reported... (continued)

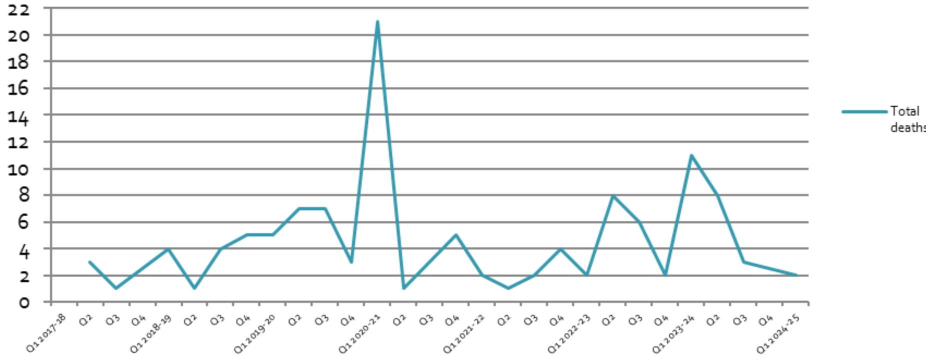
Financial Year 2025-2026

PSIRF Investigation Method	In Month	Last month	Year to Date
PSII	0	1	0
AAR	0	1	0
MDT	0	0	0
Thematic Review	1	1	0

PSIRF Investigation Method	2024-2025
PSII	9
AAR	23
MDT	2
Thematic Review	4

Learning from Deaths





Quality Improvement & Learning

There was 1 inpatient death reported In April 2025.

Thematic Review

Due to the recent increase in inpatient deaths, a thematic review will be undertaken to ensure that patients with co-morbidities are appropriately assessed and deemed suitable for surgery. The review will focus on clinical decision making, communications between referring and receiving teams, and the criteria used to determine surgical eligibility. The aim is to identify any gaps or risks, strengthen patient safety measures and ensure the excellent person-centred care.

Infection Prevention & Control

Infections Recorded in month and Year to Date (YTD)	April 2025	YTD*
Methicillin-Resistant *Staphylococcus aureus* (MRSA) bloodstream infection	0	0
HOHA/COHA toxin positive *Clostridioides difficile* infection (CDI)	0	0
Methicillin-Sensitive *Staphylococcus aureus* (MSSA) bloodstream infection	0	0
E.coli bloodstream infection	1	1
Klebsiella spp. bloodstream infection	0	0
Pseudomonas aeruginosa bloodstream infection	0	0

*Financial year running from April to March.

NHS Standard Contract objectives for minimising Chloridoids difficile infection (CDI) and Gram-negative blood steam infections - ROH thresholds:

	CDI (Toxin +ve)	*E.coli* BSI	P. *aeruginosa* BSI	*Klebsiella* Sp. BSI	MRSA BSI
2023/24	5	0	0	1	0
2024/25	1	2	0	0	0
2025/26	TBC	TBC	TBC	TBC	TBC

QUALITY IMPROVEMENT WORK

IPC Safety Priorities IPC safety priorities for 2025/26 have been identified following a review of all IPC incidents. Further detail of why these have been selected is provided in the Patient Safety Incident Response Plan (PSIRP) for IPC related incidents.

Surgical Site Infections [Criterion 3,4 & 5]

- Minimising incidence of Surgical Site Infections in patients undergoing Arthroplasty (hip and knee replacements) and Spinal surgery.

A ROH SSI prevention bundle is being created. To do this, six areas for improvement have been identified and each of these have been assigned a lead to drive forward the gathering of an evidence-base and facilitate any changes requiring implementation.

- Pre-op patient information and engagement & Pre-operative washing
- Perioperative warming
- Surgical prophylaxis & Surgical practice standards
- Incision management

Infection Prevention & Control – continued…

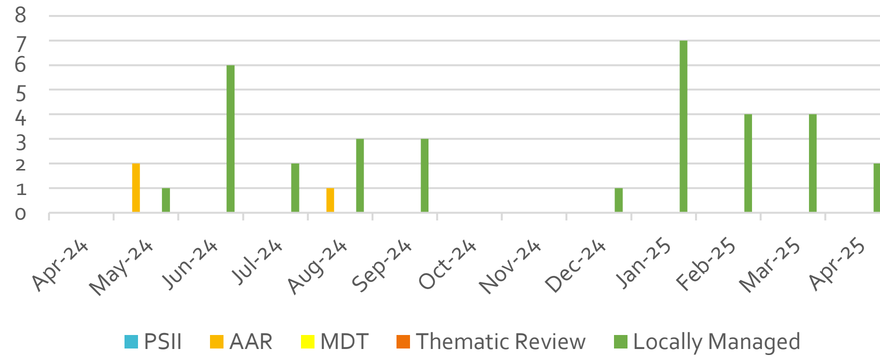
Quality Improvement & Learning - continued

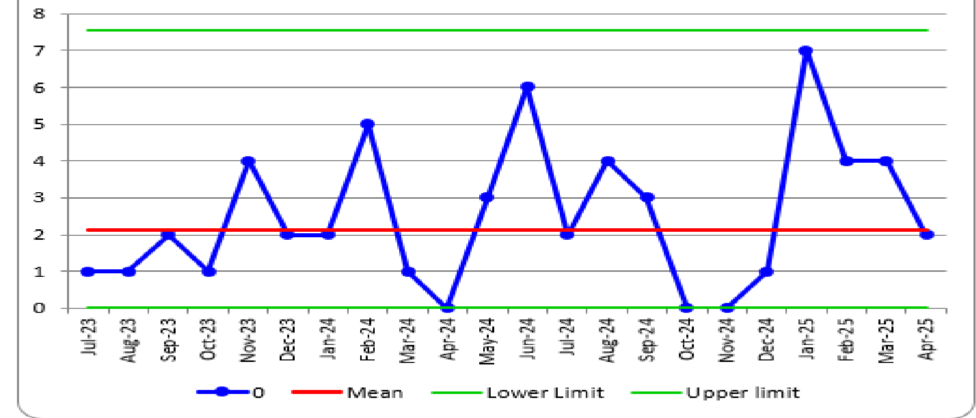
It is anticipated that the ROH SSI prevention bundle will be created by the end of quarter 1 with a view to implement in quarter 2. Feedback and work progress is provided at monthly SSI prevention group meetings chaired by the DIPC. A four-box report from the SSI prevention group is submitted to the IPCC for review and information.

Cleanliness [Criterion 1, 2, 4, 6, 9]
Improving the standard of cleaning of the physical healthcare environment and healthcare equipment.
As one of the IPC team's main quality improvement initiatives for 2025/26, a comprehensive review of the decontamination processes is to be undertaken collaboratively with the facilities team and clinical departments with the aim of Identifying and evaluating key procedures for effectiveness, compliance, and sustainability.
This work will involve:
A full review of decontamination procedures is conducted, covering all relevant areas (e.g., cleaning protocols and equipment processing. Identification of key processes, responsibilities, and compliance with national standards and Trust policies.
Evaluation of current decontamination practices against NHS guidelines, IPC standards, and regulatory frameworks (e.g., HTM 01-01, HTM 01-05). Identification of gaps or inefficiencies in the process. Analysis of audit data, including previous compliance rates and incident reports.
Collaboration with decontamination staff, clinical departments, and estates to gather insights and identify practical challenges. Staff awareness and adherence to decontamination protocols assessed through surveys or direct observations.
Development of action plans based on findings to improve decontamination workflows and compliance. Pilot testing of process improvements in selected departments, with iterative refinements based on feedback.

This work has not yet been started but it is anticipated this will being by the start of Q2 2025.

Tissue Viability





Quality Improvement & Learning

There were 2 category 2 Pressure Ulcer incidents that were ROH acquired in April 2025, both incidents were managed locally and deemed unavoidable, with no lapses in care identified.

There is a thematic review currently underway due to multiple patients being affected by wound blistering. The TV team are looking into the dressing used during procedures.

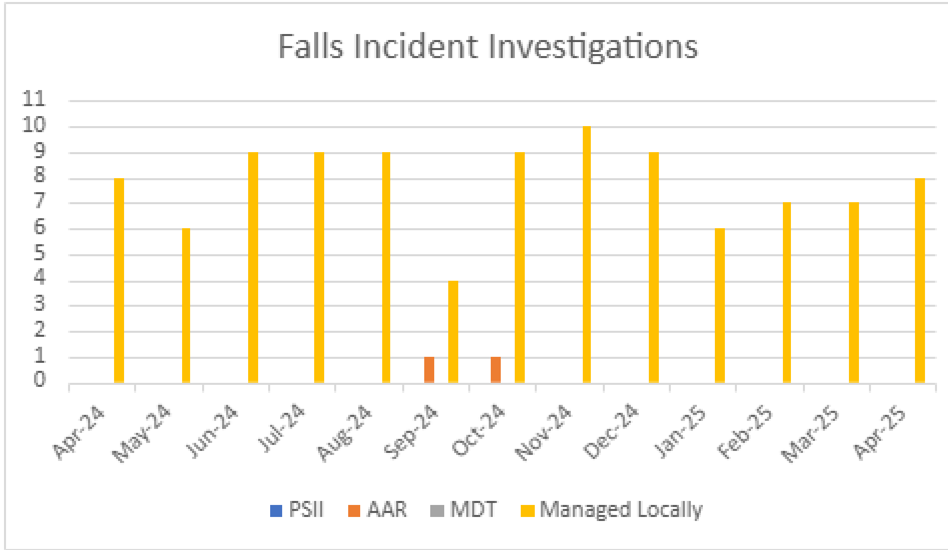
Quality Improvement

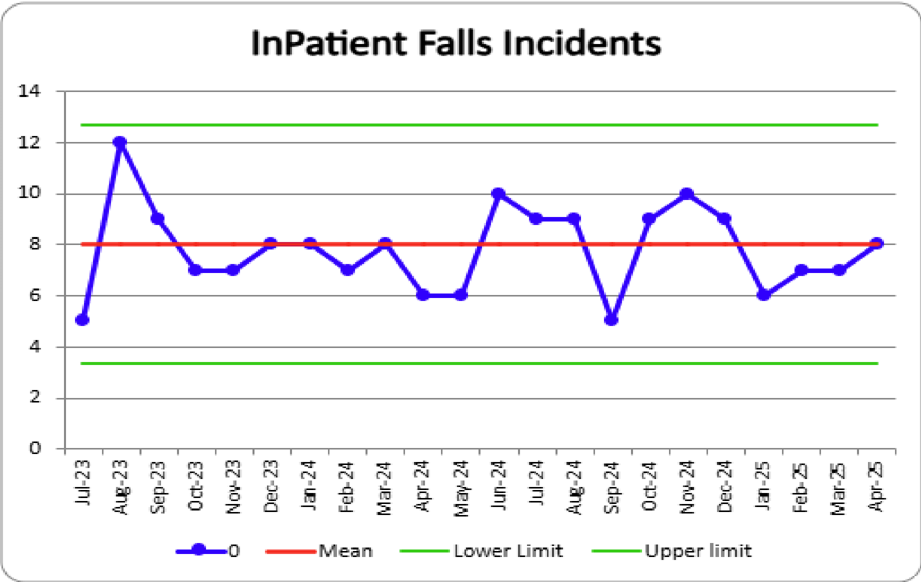
Purpose T implementation plan now completed

Collaborative working

Proposed quarterly benchmarking exercised with Royal National Orthopaedic Hospital

Falls





Quality Improvement & Learning

There were 8 inpatient falls reported in April 2025. All incidents were managed locally.

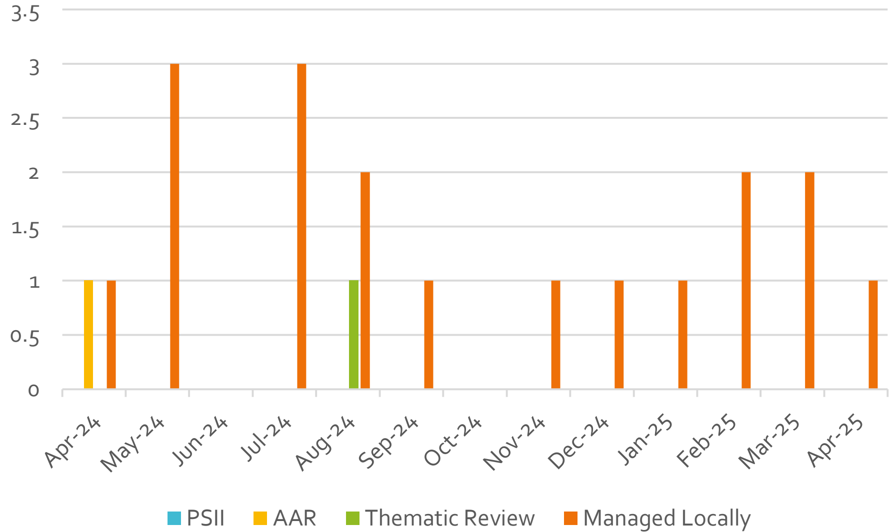
Themes

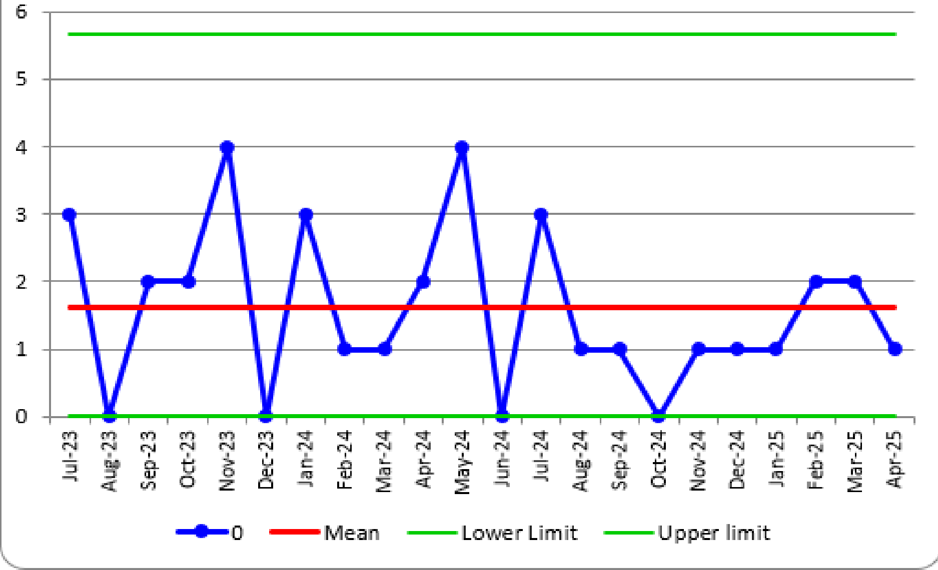
- 3 of the reported falls were reported on ward 12
- 7 of the reported falls were unwitnessed
- 3 of the reported falls were against medical advice

Quality and Improvement Work

- Audit of falling leaves usage completed – compliance is variable across wards. Plan for audit to be added to AMAT and audit plan to monitor and improve compliance – re-audits to be completed on a quarterly basis.
- Mini audit planned to review trend of patients mobilising against advice

VTEs





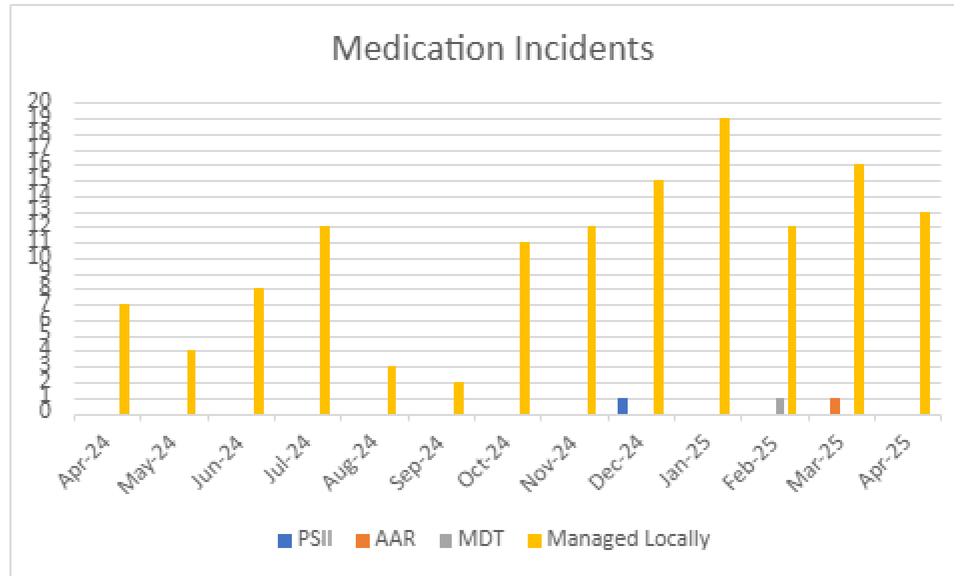
Quality Improvement & Learning

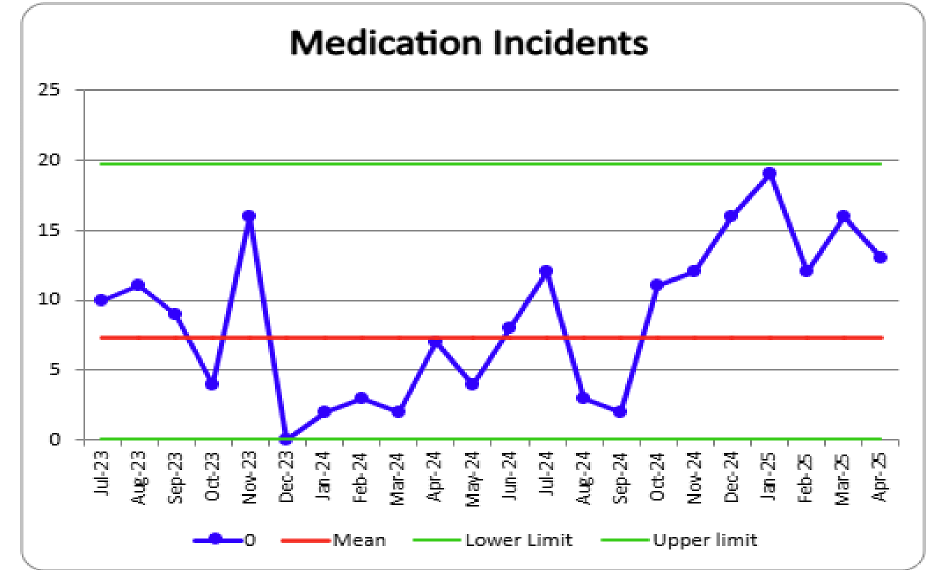
There was 1 confirmed VTE incident reported in April 2025. VTE triage assessment to be completed to determine avoidability and will be managed in line with the current PSIRF Framework should further investigation be required. All reported VTE incidents have been deemed unavoidable on completion of triage form.

VTE On Admission Assessment Compliance

Compliance figure for April 2025: 98.81%

Medication Errors





Quality Improvement & Learning

There were 13 Medication incidents reported in April 2025. All were managed locally.

The PSII for the incident relating to the wrong administration of heparin has been completed. Details of the identified learning are on slide 6 of this report

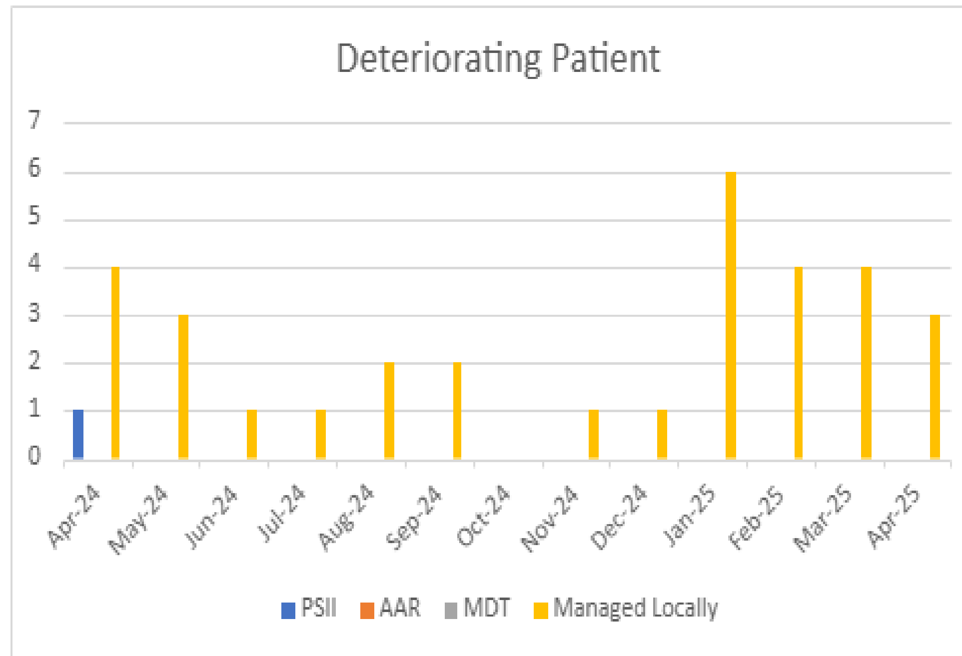
Completed Thematic Review of Opioid Prescribing

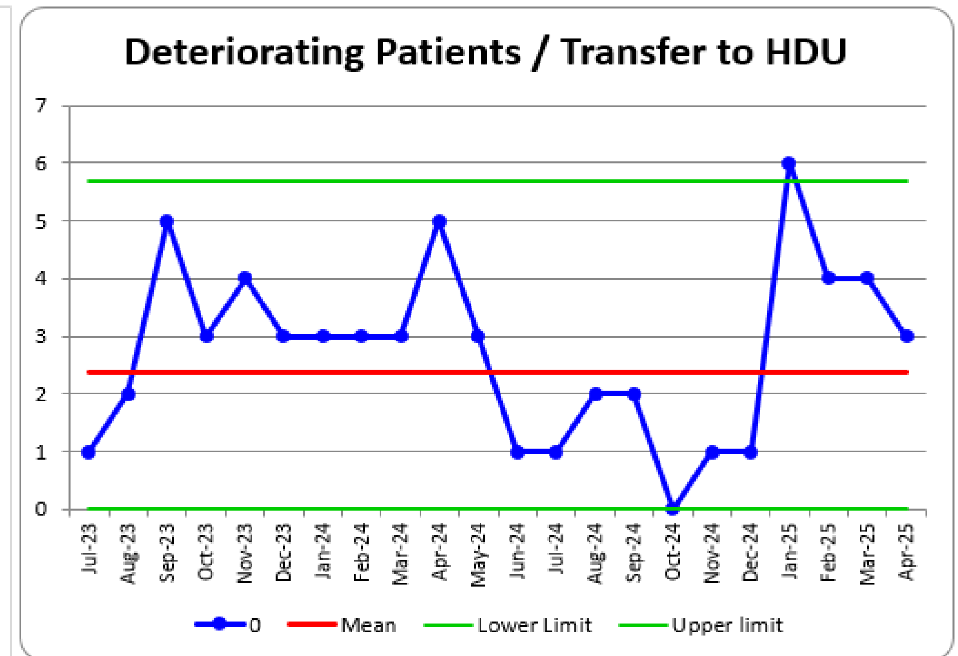
Findings from the review are detailed below:-

The incidents reviewed highlight several areas for improvement, including education and training for all healthcare professionals involved in managing pain and discharge counselling on pain relief. Addressing these issues requires a combination of enhanced staff training, better communication between health care professionals, improved adherence to protocols, and stronger patient involvement in their care.

An action plan has been developed and will be reviewed by the Medicine Safety Group to improve staff and patient education around prescribing, administration and discharge of pain related medication, in particular opioid use. An opioid stewardship working group is being developed to support and follow up the ongoing work around opioid stewardship within the Trust.

Deteriorating Patients



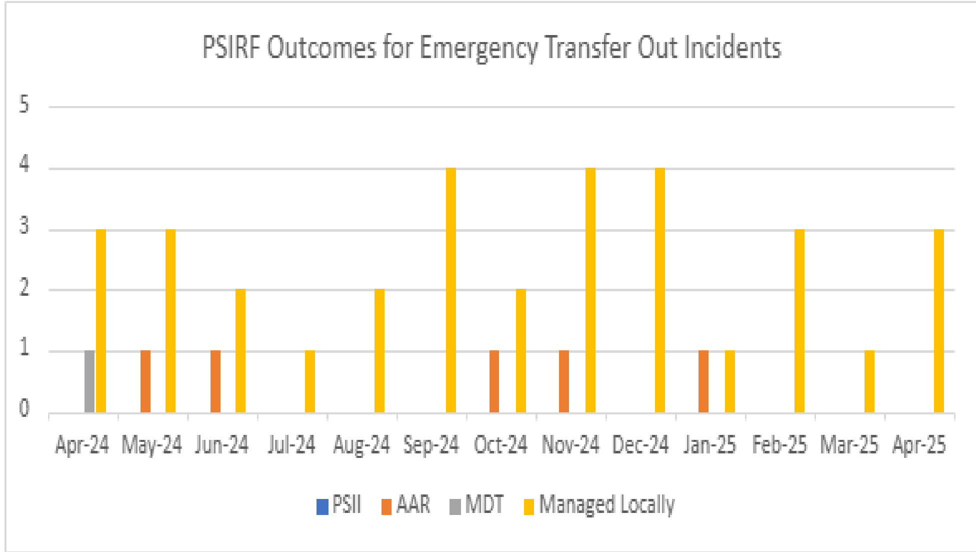


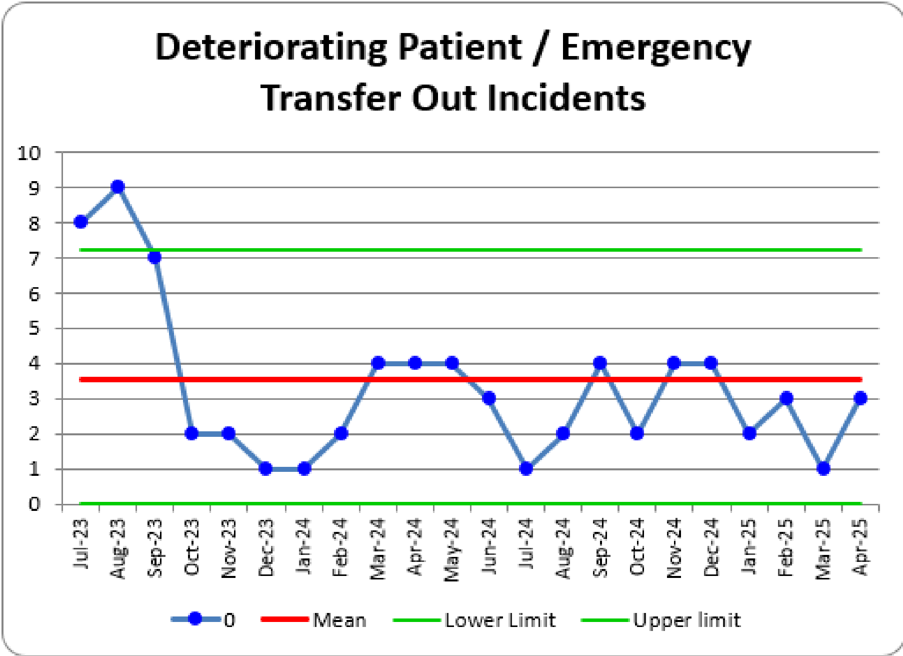
Quality Improvement & Learning

There were 3 deteriorating patient incidents reported in April 2025, however, 2 incidents submitted were for the same event. All have been managed locally.

Within the incidents reported, there is no themes or trends. All deterioration in the affected patients was dealt with in a timely manner, with appropriate treatment and escalation.

Emergency Transfers Out





Quality Improvement & Learning

There was 3 emergency transfer out incidents reported in April 2025. All incidents were managed locally, as escalation and transfer were confirmed to have been timely and appropriate.

Complaints

Complaint Information

The Trust received **8** complaints in April 2025

Below are the departments that received complaints

- Large Joints – 2
- POAC – 1
- Pain Management – 2
- Theatres – 1
- Ward 2 – 1
- Anaesthetic - 1

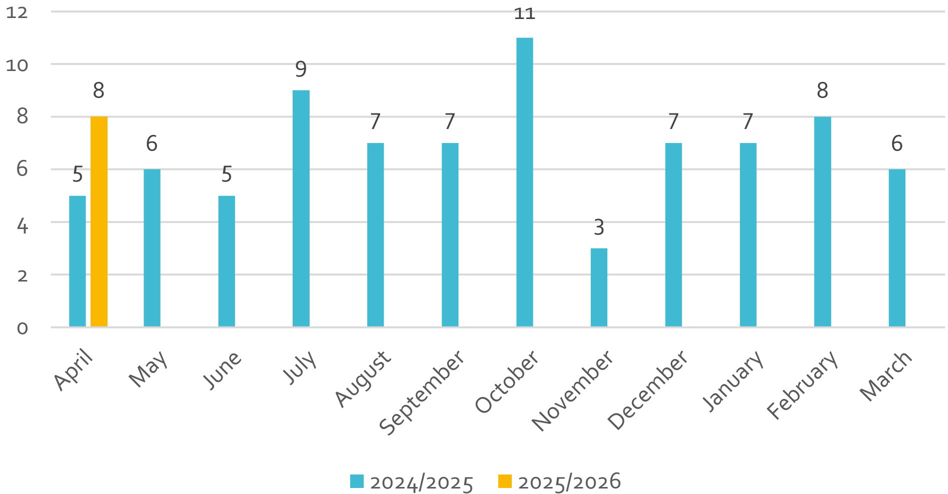
In April 2025, the complaints team closed **7** formal complaints. **4** complaints breached the timeframe agreed with the complainant.
KPI = 43% -

At the time of producing this report (06.05.2025) we currently have **18** formal complaints open
2 are reopened complaints
1 is a private complaint

Complaint Resolution Meetings and Reopened Complaints

The Trust offers meetings to the complainant in both the verbal and written acknowledgement letter and also within the response letter. Where the Trust did not meet the complainant's expectation in the first response or meeting, the Trust encourages complainants to write to us with any additional comments, questions or recommendations that will satisfy the complainant.
In April 2025 the Trust received 0 requests for a resolution meeting.
In April 2025 Trust conducted 0 complaint resolution meetings

Complaints



KPI's

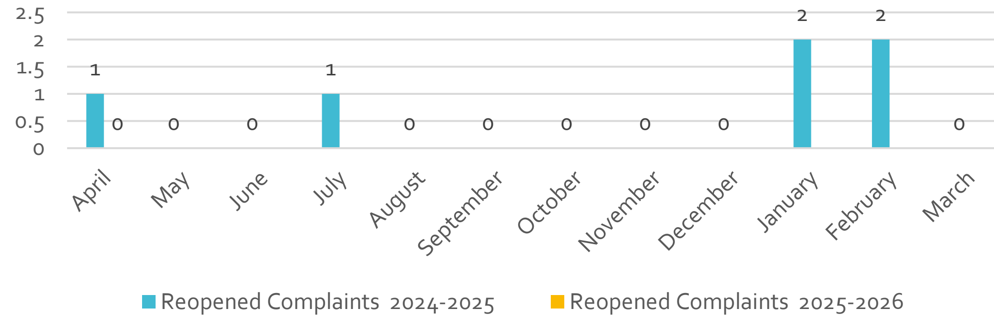
KPI	Complaints %
April 2024	43%

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

4/7 complaints breached the agreed timeframe with the complainant

Complaint Year Totals	
April 2023 - March 2024	42
April 2024 – March 2025	92
April 2025 – May 2025	8

Complaint Themes



Reopened complaints

The Trust received 0 requests to reopen a complaint in April 2025.

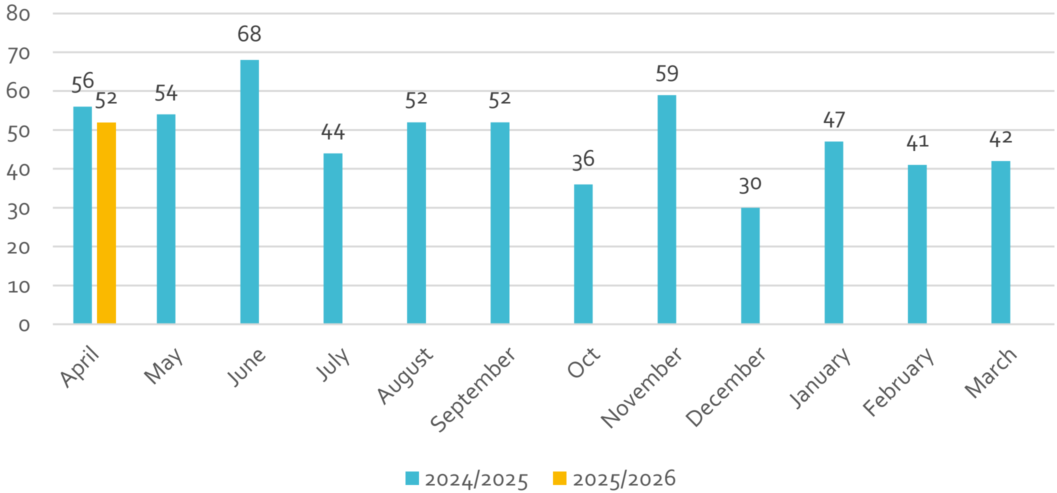
Themes of complaints currently open

1. Clinical Query
2. Communication
3. Attitude of Staff

What We Did / Are Doing

1. Raised in divisional governance meeting to track themes.
2. Tracked in Executive Governance Meeting
3. Ensuring actions are created and entered to Ulysses and action plans.
4. Ensuring relevant departments are aware of concerns
5. Requesting updates on outstanding actions in bi-weekly governance meetings
6. HoPE sending out weekly reminders to triumvirate, executives and identified leads
7. Internal investigations – PALS department is making it more clear which cases they have resolved before reaching the divisions.

Patient Advice and Liaison Service - PALS



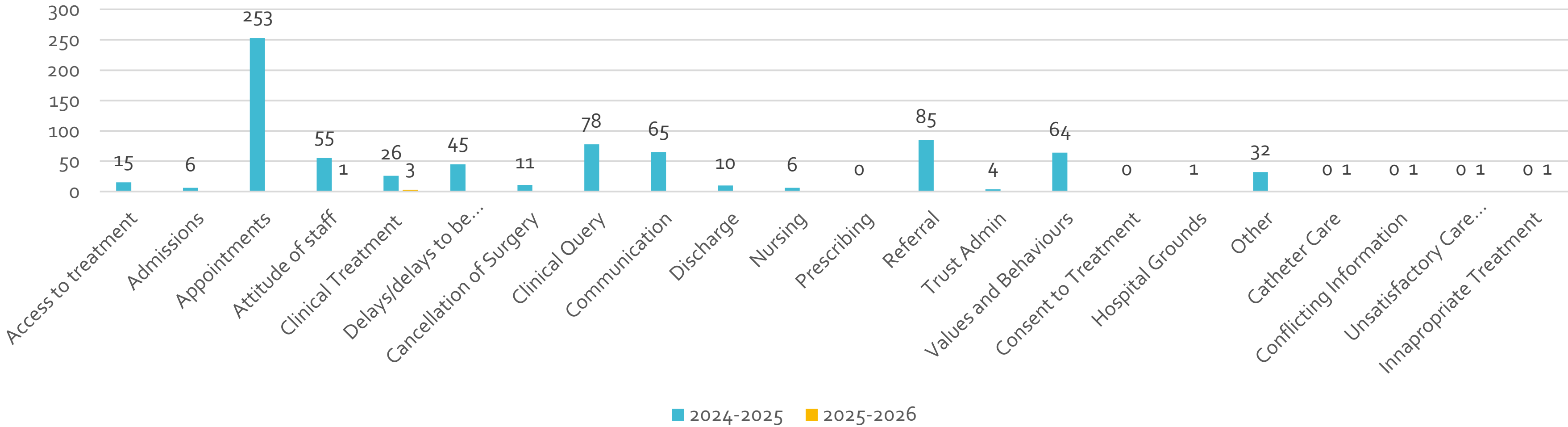
KPI's

KPI	
April 2025	83%

6 PALS Concerns breached in April 2025

o PALS Case we received the complainant disclosed that they or their close family were Veterans or Current members of the Armed Forces.

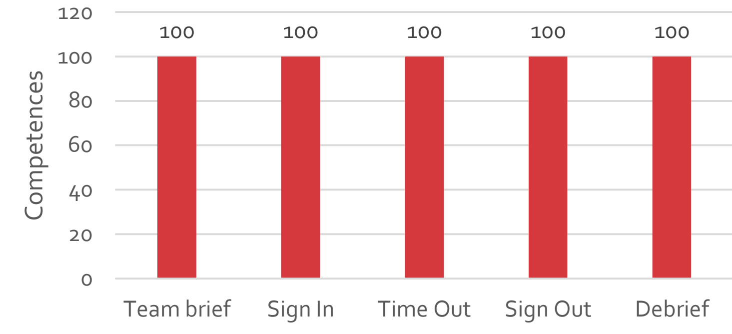
PALS Themes

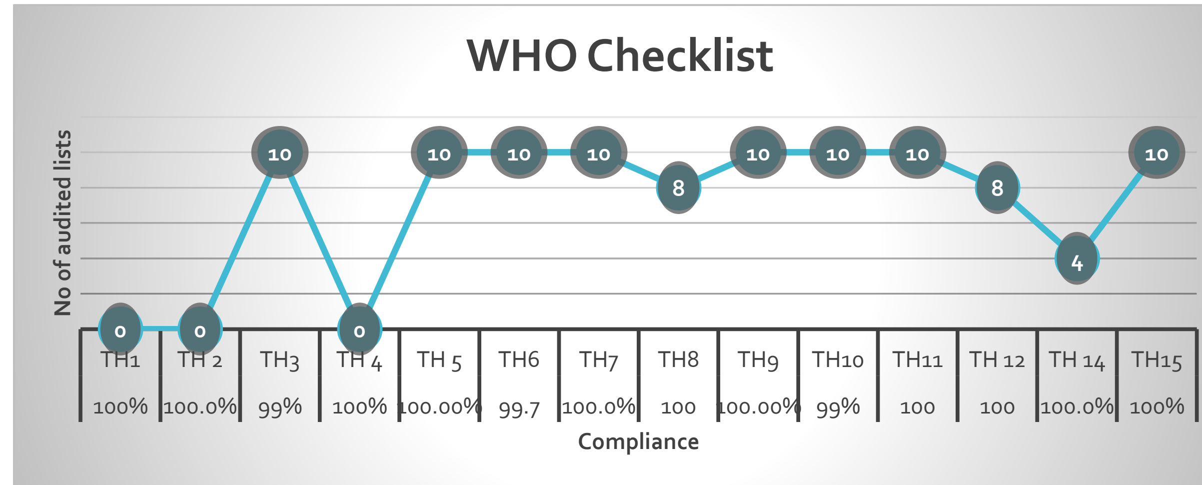


What we have done / are doing:

- Tracked in Executive Governance Meetings and via bi-weekly divisional governance meetings
- Tracked and discussed at weekly meetings between Head of Patient Experience, Head of Nursing and Associate Director of Ops.
- Escalation to ensure PALS cases are responded to.
- Head of Patient Experience sending out individual reminders on outstanding PALS alongside the weekly reminders and is meeting with leads to support resolution.
- PALS Team are managing and resolving PALS contacts within their remit.

WHO Audits





Quality Improvement & Learning

Theatres 1,2 and 4 did not submit audits due to theatre closure.

Work in Progress – WHO Checklist Review

CAS Alerts

No new CAS alerts received in April 2025.

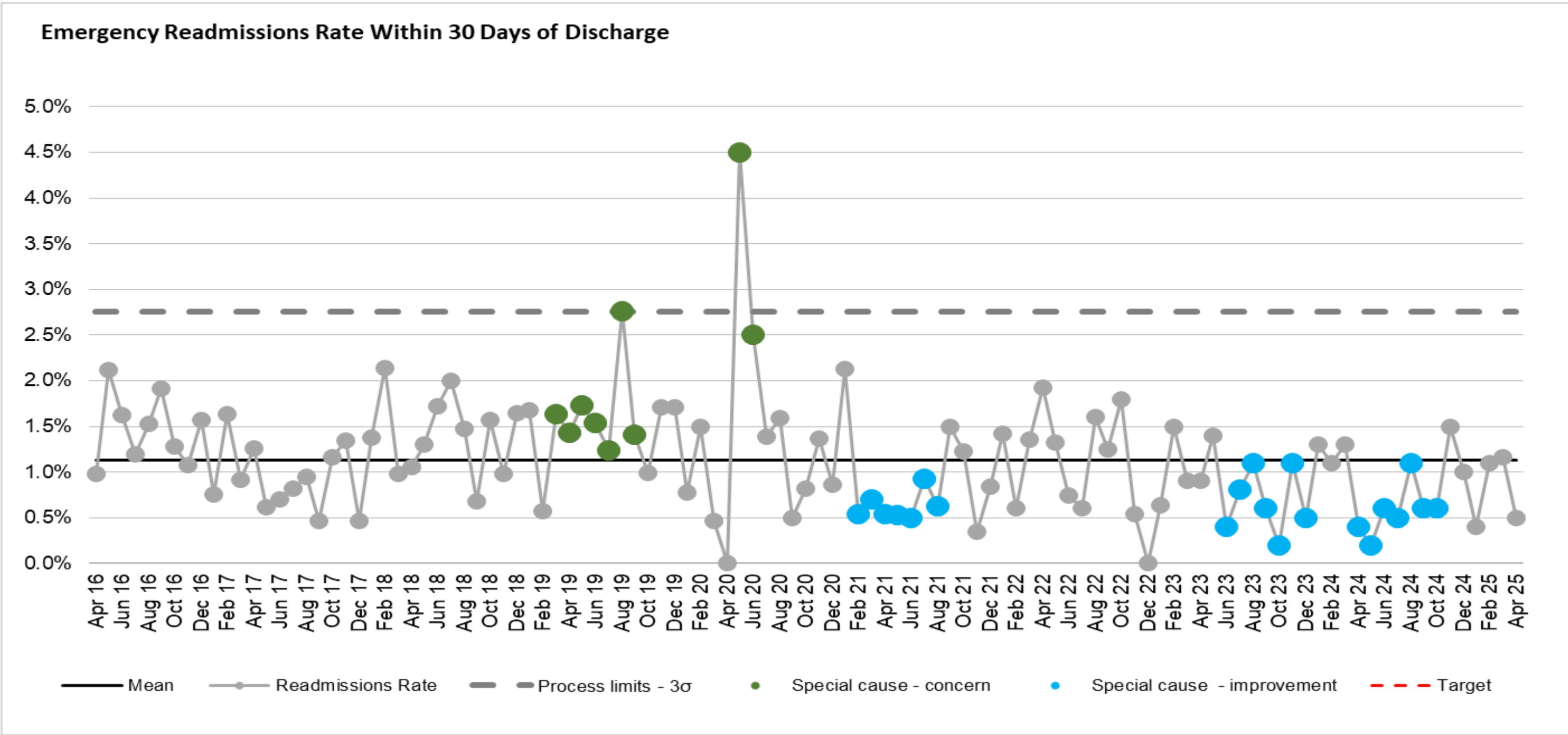
Ongoing CAS Alerts

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2023/010/MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls. The MHRA continues to receive reports of deaths and serious injuries from entrapment or falls relating to medical beds, bed rails (also known as bed safety rails), trolleys, bariatric beds, lateral turning devices and bed grab handles (also known as bed levers or bed sticks). Chest or neck entrapment in bed rails is currently listed (number 11; 2018) as a 'Never Event' according to the NHS. This National Patient Safety Alert provides further background and clinical information and actions for providers.	MHRA	31 Aug 23	**11 April 2024:** **Email from MDSO:** *'National issues are preventing closure of this alert. Working with BSol and Birmingham Citywide to address issues. Alert on risk register and discussed at divisional governance'.* **Estates:** Beds tagged to aid compilation of Estates inventory. Beds & bedrails now to be serviced by our in-house engineers. Update from Patient Safety Team (16.04.25): Progress made. Policy being updated, waiting for bed rail risk assessment to be updated within the community). Ongoing....	1 Mar 2024. On-going...

Safeguarding Training Compliance

KPI	April 2025
Safeguarding Adult Notifications	35
Safeguarding Children and Young People Notifications	34
Adults Level 1- Target 90%	95.03%
Adult Level 2 -Target 85%	92.66%
Adult Level 3- Target 85%	85.69%
Level 4- Target 90%	80.0%
Child Level 1 -Target 90%	94.81%
Child Level 2- Target 85%	92.06%
Child Level 3- Target 85%	85.56%
Mental Capacity Act MCA- Target 85%	93.20%
Deprivation of Liberty Safeguards DoLs	93.20%
Prevent Awareness- Target 95%	90.13%
WRAP (prevent level 3)- Target 90%	84.41%
FGM	3
DOLS	2
MCA	2
PIPOT cases	0
PREVENT Notifications	0

Readmissions



	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
No of Readmissions	1	3	3	5	3	3	8	5	2	5	6	2
Denominator	534	472	559	458	510	535	544	476	552	531	516	444
% Readmissions	0.2%	0.6%	0.5%	1.1%	0.6%	0.6%	1.5%	1.1%	0.4%	0.9%	1.2%	0.5%

Freedom to Speak Up

There were 14 concerns raised to FTSU in April 2025.

The themes from concerns raised were in relation to:-

1 concern raised in relation to - inappropriate attitude and behaviour impacting worker wellbeing. Resolved locally by worker following safe space to talk and support from FTSUG.

11 concerns raised in relation to - inappropriate attitude and behaviour, favouritism, exclusion, micromanagement, potential bullying, and harassment, overlook for internal promotion. Issues escalated to relevant line management; concerns also addressed by individual workers. FTSU currently waiting for outcome, learning and improvement.

2 concerns raised in relation to: overlook for internal promotion, inappropriate attitude, and behaviour. No request for FTUG to escalate concerns further.

Quality Improvements & Learning

Future quality improvement work relating to FTSU includes plans to:-

- Electronic forms and database
- Champion signposting
- Feedback after Speaking Up

Safe Staffing

April data for May report	Fill Rate (KPI >90%=Green, 80-90%=Amber, <79%=Red)						Workforce				Care Hours Per Patient Day		Roster Safe Care Indicators			Nurse Sensitive Indicators				Patient Satisfaction		
Ward Name	Day- RN Nurses	Day- Non Reg	Night- RN Nurse	Non Reg	RNA Day hours	RNA Night hours	Total WTE as % establishment (%)	Turnover (%)	Sickness (%)	Maternity (%)	Cumulative count of pts at 23.59 per day	Actual CHPPD	Red Flags Opened	Red Flags Closed	Enhanced Care Hours	Hand Hygiene Audit	Medication Administration Error or concern	Pressure Ulcers Category 2,3 & 4	All Reported Falls	No. of PALs Contacts	No. of New Complaints	No. of FFT
Ward 1	85%	121%	107%	158%	205.5	0.0	91.20%	10.20%	10.65%	0.00%	9.37	16.74	0	0	241.5	94.6%	0	0	2	0	0	48
Ward 2	81%	104%	100%	100%	24.0	11.0	92.78%	9.58%	11.14%	0.00%	7.68	19.53	0	0	11	~	0	0	0	0	1	2
Ward 3	96%	107%	104%	124%	139.5	0.0	98.26%	19.19%	3.48%	5.38%	20.66	13.12	0	0	58	100.0%	1	0	1	1	0	44
Ward 4	97%	108%	109%	110%	157.5	0.0	84.77%	16.54%	2.68%	3.51%	15.4	17.77	0	0	184	99.2%	1	0	1	0	0	12
Ward 12	84%	105%	104%	114%	267.7	11.0	80.24%	18.13%	7.45%	9.96%	13.42	17.43	0	0	12	100.0%	1	1	3	0	0	37
HDU	89%	51%	88%	1	0.0	0.0	92.05%	2.42%	6.56%	0.00%	3.47	50.12	0	0	11	100.0%	1	1	0	0	0	60
Outpatients	83%	69%	100%	1	0.0	0.0	70.24%	23.10%	3.13%	6.02%	0	0.00	0	0		97.3%	0	0	0	0	0	14
ADCU	51%	71%	100%	1	174.8	0.0	94.33%	5.25%	7.29%	2.82%	0	0.00	0	0		100.0%	0	0	1	2	0	100
POAC	85%	93%	100%	1	0.0	0.0	91.60%	7.69%	6.10%	0.00%	0	0.00	0	0		95.6%	0	0	0	0	2	257
Theatres	0.72	0.62	1	1	69.0	0.0	89.75%	9.94%	10.27%	1.98%	0	0.00	3	0		99.6%	0	0	0	0	1	N/A
Theatres recovery	0.54	0.76	1	1									4	0		98.8%				0	0	N/A
Discharge Lounge	1.05	0.8	1	1									0	0		96.7%				0	0	77
CYPOPD	1	0.94	1	1																		
In-patient Physio	0.58	1	1	1																		
Outpatient Physio	0.72	1	1	1																		
Radiology MRI	1	1	1	1																		
Radiology X-Ray/CT	1	0	1	1																		

Operational Performance Summary

Performance to end April 25	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	55.63%	54.66%	52.75%		P
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	0	1	0	L	F
52 week waits (52 – 64 Weeks)	486	486	0	H	F
All activity YTD (compared to plan)	1,164	15,149	1,068		P
Outpatient activity YTD (compared to plan)	5,941 104.5% Cumulative	73,054 107.9% Cumulative	5,685 YTD Target		P
Outpatient Did Not Attend (YTD)	7.0%	7.0%	8%		P
PIFU (trajectory to 5% target)	594 10.5%	610 10.1%	512 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	9.4%	9.8%	19%		F
FUP attendances(compared to 19/20)	107.7%	102.9%	N/A		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	115.9%	113%	120%		F
Diagnostics volume YTD (compared to plan)	2,097 Cumulative	25,589 Cumulative	2,017 YTD Target		P
Diagnostics 6 week target	100%	99.91%	99%		P

Operational Performance Summary

Performance to end April 25	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (Uncapped)	90.4%	84.6%	85%		P
Theatre In Session Utilisation (Uncapped)	84.4%	84.0%	85%		F
Cancer - 31 day first treatment	100%	100%	96%		P
Cancer - 62 day (traditional)	95.2%	76.7%	70% Nat 85% Trust		P
28 day FDS	81.1%	81.6%	75%		P
Patients over 104 days (62 day standard)	0	1	0		No Target
POAC activity volume (YTD)	1,628	25,281 Cumulative	1,765 Cumulative		F
Bed Occupancy (excluding CYP and HDU)	71.4%	76.9%	82-85%		F
LOS - excluding Oncology, Paeds,YAH, Spinal	3.46	3.15	n/a		No Target
LOS - elective primary hip	2.5	2.7	2.7		P
LOS - elective primary knee	3.0	2.7	2.7		P
BADS Orthopaedic: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period) Jan 25	54.60%	53.40%	85%		F
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Jan 25)	38.0%	37.5	-		No Target