The Royal Orthopaedic Hospital NHS Foundation Trust

Trust Board (Public) July

Wednesday 2 July 2025 - 11:15h-14:30h

Boardroom, Trust Headquarters

Notice of Trust Board Meeting in Public on Wednesday, 2 July 2025

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 2 July 2025, in the Boardroom, Trust HQ commencing at **11:15.**

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

Simon Page
Chair

The Royal Orthopaedic Hospital NHS Foundation Trust

AGENDA
TRUST BOARD

Venue Boardroom, Trust Headquarters **Date** 2 July 2025: 09:00h – 14:30h

Members attending

Mr Simon Page	Chair	(SP)
Ms Simone Jordan	Vice Chair & Senior Independent Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Dr Ian Reckless	Non Executive Director	(IR)
Ms Ayodele Ajose	Non Executive Director	(AA)
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 Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance

Mrs Alexandra Gilder	Deputy Director of Finance	(AGi)	
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
		IN PUBLIC SESSION		
11:15	14	Staff Story	Presentation	TBC
11:35	15	Apologies: Steve Washbourne, Jenny Belza, Les Williams, Jan Teo	Verbal	Chair
	16	Declarations of Interest	ROHTB (7/25) 008	Chair
	17	Minutes of Board Meeting held in Public on 4th June 2025: *for approval*	ROHTB (6/25) 021	Chair
	18	Actions from previous meetings in public: *for assurance*	ROHTB (6/25) 021 (a)	SGL
	19	Questions from members of the public	Verbal	Chair
11:40	20	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (7/25) 009 ROHTB (7/25) 009 (a)	MH/SP
11:55	21	Chief Finance Officer's report: *for information and assurance*	ROHTB (7/25) 010 ROHTB (7/25) 010 (a)	AGi

12:20	**LUNCH**			
12:50	22	Chief Operating Officer's report: *for assurance*	ROHTB (7/25) 011 ROHTB (7/25) 011 (a)	MP
13:05	23	Chief People Officer's report: *for assurance*	ROHTB (7/25) 012	SM
13:20	24	Quality Officers' report: *for assurance*	ROHTB (7/25) 013	MR/NB/ SGL
13:35	25	RACE Code Adoption*: for approval*	ROHTB (7/25) 014 ROHTB (7/25) 014 (a) ROHTB (7/25) 014 (b)	SM
	GOVERNANCE AND COMPLIANCE			
13:50	26	Insightful Provider Board Action Plan: *for assurance*	ROHTB (7/25) 015 ROHTB (7/25) 015 (a)	SGL
	UPWARD REPORTS FROM THE BOARD COMMITTEES			
14:00	27	Upward reports from the Board Committees: • Finance & Performance Committee • Staff Experience & OD Committee • Charitable Funds Committee	ROHTB (7/25) 016 ROHTB (7/25) 017 ROHTB (7/25) 018	LW SJ AA
14:25	**MATTERS TO BE TAKEN BY EXCEPTION**			
	28	Performance Reports: *for assurance* a) Finance & Performance b) Quality Report c) Workforce Report	ROHTB (7/25) 019 ROHTB (7/25) 020 ROHTB (7/25) 021	
	29	Any Other Business	Verbal	All
	30	Meeting effectiveness	Verbal	All
14:30	**CLOSE: Date of next meeting: Wednesday, 3 September 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.

PUBLIC ATTENDANCE REGISTER – FY 2025/26 UPDATED TO JUNE 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

TRUST BOARD DECLARATIONS OF INTEREST REGISTER

Name	Interest	Voting Member
Simon Page **Chair**	• Owner, Weathervane Consultancy	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**	• Chair of Labour Branch, Cradley Heath	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
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
NHS Foundation Trust

MINUTES

Trust Board PUBLIC - DRAFT Version 0.1

Venue Boardroom, Trust Headquarters **Date** 4 June 2025: 1000h - 1500h

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)
Mrs Jenny Belza	Non Executive Director	(JB)
Mr Simon Page	Non Executive Director	(SP)
Miss Jan Teo	Non Executive Director	(JT)
Mr Matthew Hartland	Chief Executive	MH)
Mr Mathew Revell	Executive Medical Director	(MD)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mrs Sharon Malhi	Executive Chief People Officer	(NB)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance:

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

IN PUBLIC SESSION	
10 Patient Story (SL)	**Presentation**
Sharon Latham (SL), Head of Patient Experience, joined the Board to share the story of a patient who wished for their story to be shared. The key points to highlight include: • The patient's mother approached the Patient Experience Team to share the experience of their daughter's care, and gave thanks for the care and support experienced during this really difficult time.	

• They emphasised the experience they have had here means that they now see a future for them as a family. The board was invited to ask questions and comment. Of particular note were the following points: • MR raised it is important to collect the positive and share these stories with the teams. MR highlighted that this is one clear direction of the Cancer Board to ensure we are listening to the patients and appreciating the experience they are going through. • TP challenged that it is important that we use these stories to not only ensure our colleagues are aware of what we are aiming to achieve but to also ensure we share these stories more widely. • NB highlighted that on this ward in particular it quite often has a number of young patients who have had to travel some distance to us, and it is important to remember this area is also there to support the families as well. Families are signposted to charities and other support groups to help them navigate the journey. • JB raised how important it is to note just how this is not only clinical individuals but non clinical people as well play an important role in impacting the care on this family. The Board thanked the family for allowing the story to be shared.	
11 Apologies: (Chair)	**Verbal**
There were no apologies to note.	
12 Declarations of Interest (chair)	**ROHTB (6/25) 001**
There were no new declarations to record to what has been published.	
13 Minutes of the previous meeting in public held on 4th June 2025 : *for approval* (chair)	**ROHTB (5/25) 030**
The minutes of the meeting held in private on 4 June 2025 were accepted and **approved** by the board.	
14 Actions from previous meetings in public: *for assurance* (SGL)	**ROHTB (5/25) 030 (a)**
All actions are in progress with updates to be provided at future meetings.	
15 Questions from members of the public (Chair)	**Verbal**
There are no questions received ahead of the meeting.	

16 MSK Academy Update: *for assurance*	ROHTB (6/25) 006

Uzo (UE) joined the Board to present an update on the MSK academy.

The key points to highlight include:

- MSK academy and its purpose.
- The details of how this will be delivered, including virtual courses, in person training, conferences, webinars and it is important if we want the work recognised, we need it to be accredited.
- Long term ambition is to be the regional, and national, educational leaders in orthopaedic education.
- The current activities include GP training, theatres study day, pharmacy training, clinical interview training for Advanced Practitioner Physiotherapists, and early career masterclasses.
- The challenges of delivery include the financial resources, the need for admin support, staff engagement and the customer and partner engagement.

The Board was invited to ask questions and comment.

Of particular note were the following points:

- JB raised the connections with primary care and questioned what is needed to expand that. JB also questioned what the resource is needed and is there a budget for this. UE explained that the process has commenced with the primary care network, including being a representative on the Primary Care Interface Group. UE explained there is no budget assigned to this currently and therefore work is being undertaken with what is available at no additional cost.
- SJ questioned who our competition is and is there opportunity to use AI in any of this. UE explained the competition that there are no other hospitals currently from an orthopaedic perspective do not offer anything for early careers. There are independent online traders who offer courses and tend to be career based. SJ raised we need to be clear on a niche market. UE explained that is why the early career practitioner is a key area to develop. SJ highlighted it would be useful to have a visual of this showing how we compare to our competitors.
- MR provided assurance that sitting around all this is a governance structure with the establishment of a multi professional group that now meet and report updates in this space, with clear terms of reference.
- SM raised that this work would support the health inequalities work.
- TP queried the charity's role in the development of this. RL explained this is part of the charity's three-year plan.

• JT queried how will all this be drawn together in a clear way to ensure this becomes a more strategic plan. JT raised it is also important to have a clear brand that allows us to stretch into a partnership so the different strands can be pulled together. • NB raised that a review of CPD funds needs to be undertaken to help support with this. UE agreed there is definitely an opportunity to accredit the work to allow for CPD funding to be allocated. • MP queried could volunteers be considered to support with the development of the MSK academy. TP thanked UE for the presentation and the achievements that have been delivered so far.	
17 Chair's and Chief Executive's update: *for information and assurance* (TP/MH)	**ROHTB (6/25) 007** **ROHTB (6/25) 007 (a)**
MH presented the Chief Executive Update, and the paper was taken as read. The key points to highlight include: • The national context, in particular the new NHS operating model which we are awaiting the details of what the clustering of the ICB will look like to ROH and the Birmingham and Solihull ICB. • Strategy update is included in the report but in future will come in form of an upward report from Strategy Delivery Group to future Board meetings. There are a number of sessions throughout June with the teams to undertake service reviews. • The National Orthopaedic Alliance (NOA) Conference took place on 15th May and MH was asked to Chair this. Recognition is given to the team for the work that was presented on the GetUBetter app, 'Confirm and Challenge' programme, and the leadership and innovation in delivering the BOOM conference. • The Acute Provider Collaborative met in May and ROH presented the business case for the GetUBetter app and was agreed to support presenting to the BSOL Investment Committee. • The Medical Staff Committee has been reformed and provides an opportunity for the consultants to meet with MH for an open conversation. It will report through Joint Locum Negotiating Committee (JLNC) going forward. • The ROH League held a meeting on 10th May and MH attended. It was their 60th anniversary meeting but also meant it was sadly their last one. • Finance position whilst the Trust has reported a deficit the Trust has 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 the average planned spend in 2025/26. The Board was invited to ask questions and comment. Of particular note were the following points: • LW queried the reference to the conversation with the Federation of Specialist Hospitals (FOSH) and the supporting of the Referral To Treatment (RTT) acceleration. MP confirmed conversations have taken place with NHSE and the Trust have been asked to produce a paper to detail what this model would look like for the ROH. MP explained we will be working closely with Robert Jones and Agnes Hunt (RJAH) as they are doing the same work. • SP queried the financial delivery and sought assurance on how we will deliver the quarter 1 targets. MH explained there are a number of groups now established that are keeping close to the detail which means action can be taken more promptly. The oversight groups maintain the attention to the detail that is needed. **<u>Chair Update</u>** TP confirmed that his role as Chair will cease at the end of June and following a rigorous recruitment process the Governors have appointed a new Chair. SP will commence in the role as Chair from 1st July 2025. The Board congratulated SP on the appointment as Chair and thanked TP for his service to ROH. The Volunteers Thank You event has taken place, and it was important to note the role they play in the organisation and the time and contribution they give. TP requested this acknowledge be shared with the Volunteers as it is greatly appreciated.	
17.1 Council of Governors Update: *for assurance* (SGL)	**Verbal**
SGL provided an update on the Council of Governors meeting that took place following the Board Meeting in May. The key points to highlight include: • The agenda covered a number of items, including a financial update with the presentation of the 2025/26 plan, the refreshed strategy, the staff survey results and an update on the CQC Well Led self-assessment action plan. • There are a number of Governors whose term of office expires next month, along with vacancies to fill including a Clinical Staff Governor post. The recruitment campaign for the Governor positions has commenced.	
18 Chief Finance Officer's Report: *for assurance* (SW)	**ROHTB (6/25) 008** **ROHTB (6/25) 008 (a)**

SW presented the Chief Finance Officer's report, and the paper was taken as read. The key points to highlight include: • The national pressure this year is to deliver Cost Improvement Programme (CIP) of 6.5%; the national average is 7%. • Our activity plan is based on individual consultant job plans. • Month 1 position is a fair and accurate review of what has been delivered; however, Month 1 has reported a deficit. • 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). • Cash remains tight but no additional funds have been requested. The Board was invited to ask questions and comment. Of particular note were the following points: • JB queried the CIP target and questioned the confidence on the delivery. SW explained that target is profiled across the year and confirmed all the major planned CIPs are delivering. TP raised that is important to plan to deliver more saving. SW confirmed that the plan does include additional CIPs to take it over the £9.4m delivery that is required. • SM explained that one of the key elements to deliver is part of the wider service review and transformation work. Therefore, work is taking place as part of organisational development. • GH queried speciality costing and questioned how this is being manged. SW explained there is work to take place with our consultants to ensure coding is accurate. MP explained that as part of the service reviews this detail would be explored as we focus on these areas as small business units to understand the cost of each speciality. MH explained these conversations will also take place as part of the wider planning work that will be undertaken as we move to a more forward look than we currently do. • TP highlighted the non-pay figure and questioned why the variance is so high considering LLP was not a driver of this. SW explained that the variation to plan will always be dependent on the value that plan is set at, and the actual	

expenditure incurred. The plan for the year was set on projected expectations of how cost would vary based on activity and workforce changes, but also the pace at how CIP would be delivered through the year. The non-pay plan for month 1 (£4,433k) is the lowest for the year as it assumed a low level of activity, and c£1m lower than month 12, and c£800k less than the average for the year (£5,221k). Additionally, the spend in month of £4,876k was the lowest spend for more than 12 months, and lower than the average spend in 24/25 (£5,422k). Therefore, the variation in this instance is driven from a lower plan rather than an increase in expenditure. We will of course continue to monitor non-pay levels, especially theatre spend as we move through the year. • SP raised concerns that the Board are not feeling assured that the breakdown of the plans is correct. MH explained that once Month 2 data is received the Trust will have a better picture of whether the planning is correct, and action will be taken if it is not. MH confirmed target focus is on non-pay, and this will be discussed in detail at the Financial Delivery Group before presenting to the Finance and Performance Committee at the end of the month.	
19 Chief Operating Officer's Report: *for assurance* (MP)	**ROHTB (6/25) 009** **ROHTB (6/25) 009 (a)**
MP presented the Chief Operating Officer's report, and the report was taken as read. The key points to highlight include: • The Trust is part of the validation sprint for Referral To Treatment (RTT). • All RTT metrics were delivered in April and on track to deliver in May. • 65-week target of zero patient has been delivered. • There is now weekly reporting to NHS England. The Trust continues to receive positive feedback and the Deputy Chief Operating Officer attends on behalf of the Trust. • The four key operational metrics are discussed at the weekly meeting with NHS England. • Detail trajectory for spinal will be presented to the June Finance & Performance Committee. • Overall elective performance has overachieved in Month 1, this was a reduced plan due to the planned theatre work. • Theatre improvement aligns to the service review and the Trust is preparing for the GiRFT reaccreditation in July. • On Model Hospital our theatre utilisation is at 87%. • Concern has been raised on physiotherapy waits but focus on the waiting lists means we are in a position where patients are now able to book within 12	

weeks of being referred which is a great improvement. The Board was invited to comment and ask questions. Of particular note were the following points: • SJ queried why do we not have a seamless surgery every week. MP explained that this is part of the improvement journey this area is going through. Having a specific focus energises the team, particularly with new members and some long-standing colleagues. It was suggested that it would be more appropriate to rename the week to emphasise the purpose is about focus. NB supported this by explaining this is a common initiative across the NHS, also known as perfect week, and allows the opportunity to really focus on perfection. SM highlighted that this also needs to be seen more widely as part of the Me as a Manager programme, emphasising accountability. • IR raised job planning remains high on the national agenda. MP explained that despite the step down of the working group this remains a focus. The working group was part of the improvements being made and as this transitioned to business as usual there is no need for the group. The trust is at 78% completed with signed off job plans, and the ownership now moves to divisional delivery, with support. IR queried how are the pay errors being addressed. MP explained the roll out of E Rostering will help ensure the errors risk is reduced. This will report through Staff Experience & OD Committee.	
20 Chief People Officer's Report: *for assurance* (SM)	**ROHTB (6/25) 010**
SM presented the Chief People Officer's report, and the paper was taken as read. The key points to highlight include: • Me as a Manager sessions continue to be rolled out, but more improvement is needed. Ambition is that 100% of the managers will undertake the programme. • The implementation of the Trusts Learning Management System continues. There have been some minor slippages, but we remain confident that the new portal will enable colleagues to engage with learning in a more efficient and effective way. • It has been confirmed that the headline pay recommendations have been accepted for NHS staff from the NHS Pay Review Body, the Review Body on Doctors and Dentists Remuneration and the Senior Salaries Review Body. • AI deployment is currently being scoped as part of a National AI group which will provide efficiencies across several areas. • We continue to face on going challenges with regards to Cyber and IG access issues for completion of core mandatory training modules albeit action is being	

taken to resolve this. • The challenge from Staff Experience and OD Committee is to be more assertive with our absence management approach. A regular assurance report will be provided to the Committee. • Next month the focus is on service reviews and workforce transformation priorities. The Board was invited to ask questions and comment. Of particular note were the following points: • AA queried that the Me as a Manager sits against a number of improvement metrics including staff survey, absence, etc and questioned how this will be measured. SM explained that a HR dashboard is being drafted to support the delivery of the wider workforce metrics. This will help identify the areas our leaders need support, and the first question asked will be have they attended the Me as a Manager programme.	
21 Quality Officers' Report: *for assurance* (MR/NB/SGL)	**ROHTB (6/25) 011**
MR/NB/SGL presented the Quality Officers' report, and the paper was taken as read. The key points to highlight include: • The first Quality Improvement Development Day has been held and was positively received. • A Women in Orthopaedic Surgery Day was held which was designed to welcome female school students to an orientation and education day. Over 100 pupils attended from surrounding educational establishments. • The Care Quality Commission (CQC) carried out an unannounced visit of the Childre & Young People (CYP) services on the 6 May 2026 and the outcome of the report is awaited. • Rebecca Furnival, Interim Head of Safeguarding and Lead Nurse for Domestic Abuse was invited to Westminster to a round table discussion as part of the work she undertakes on Domestic Abuse. • The Trust has been selected for phase 2 of the Managing Deterioration and Martha's Rule programme which commenced on 28 May 2025. This programme will also be supported with funding to aid implementation. • The Trust is reporting a significant improvement in its delivery of the Clinical Waste Strategy.	

• Health and Safety Group has met, and it has been confirmed we have an inspection by the H&S Executive; this will be a focused visit. An update will be provided to the next Board meeting. • The Governance Team was heavily involved in organising the material requested as part of the recent CQC inspection of the CYP pathway.	
LUNCH	
22 Quality Priorities 2025/26: *for assurance* (NB)	**ROHTB (6/25) 012** **ROHTB (6/25) 012 (a)**
NB presented the Quality Priorities 2025/26, and the paper was taken as read. The key points to highlight include: • A review of 2024/25 quality priorities is included in the report. • This has been presented to Quality & Safety Committee. • Whilst all the priorities for 2024/25 have been delivered it felt that two of these priorities should be carried over to further embed before they come business as usual. • Each priority was detailed as per the paper. • The Governors approval to support the quality priority assigned will be canvased virtually prior to the publication of the annual report at the end of June.	
23 Robert Jones and Agnes Hunt Memorandum of Understanding: *for assurance* (MH)	**ROHTB (6/25) 013** **ROHTB (6/25) 013 (a)**
MH presented the updated Robert Jones and Agnes Hunt (RJAH) Memorandum of Understanding (MOU), and the paper was taken as read. The key points to highlight include: • The feedback has been taken into consideration following the presentation at the Private Trust Board meeting in May. • RJAH Board will meet next month to approve. • It was noted the inclusion of Royal National Orthopaedic Hospital could be considered in the future should they wish join. • If the MOU is approved the next steps would be to arrange a Board-to-Board meeting. The Board was invited to comment and ask questions. Of particular note were the following points: • AA noted one of the purposes of the collaboration was the intention to greater	

enhance our innovation and use it to commercialise our work. She noted that the MoU was pitched as being non-legally binding, however given that there remained the potential for the two organisations to work separately on commercial initiatives which may bring them into competition, there needed to be a separate schedule that underlined the need for information shared to remain legally privileged. AA offered to make the necessary changes to the document ready to send to RJAH for their consideration at their July public Board meeting. **ACTION: AA to support SGL on behalf of the board to make the amendments required.** • SJ questioned how it will be clear what the priorities are. MH explained that this will be for the group to work together to identify what the priorities are and what is presented in the document is rather a long list. Subject to amendments and separation of documents as discussed, the Board approve the MOU as presented.	
24 Freedom to Speak Up Update: *for assurance* (CJ)	**ROHTB (6/25) 014** **ROHTB (6/25) 014 (a)**
Claudette Jones (CJ), Freedom to Speak Up (FTSU) Guardian, joined the Board meeting to present the Freedom to Speak Up Annual Report. The paper was taken as read. The key points highlighted include: • There is an update required on the figures sent to the National Guardian Office therefore the data in the paper requires updating accordingly once confirmation received. • Thanks were given to the Executive and Non-Executive Sponsors of Freedom to Speak Up as it is commented on by colleagues that they feel supported. • The data shows that staff are speaking up in the organisation, particularly around inappropriate behaviour. • It is reassuring to report there has been no incidents reported linked to patient safety. • The National Guardian Office have recently released a paper on overseas workers and thanks are given to the contributions from our Trust into this document. • Support has been given to overseas workers and feedback given to them directly. • Current focus for the Freedom to Speak Up Champions is to host a Trust Awareness Day in July and work around inclusion. • Best practice shared from the National Guardian Office.	

The Board was invited to comment and ask questions. Of particular note were the following points: • JT queried the triaging of concerns raised and questioned are we confident in taking something that is raised should it need it is done so correctly through the correct route. CJ confirmed that there is a safe space to hold the conversation, and should any concerns be raised, that could indicate a risk to patient safety there are a number of people it would be raised to make them aware. If it is a grievance, then discussion with HR and the colleague raising the concern is guided to how the matter could be resolved and support is giving to the individual if anonymity is key. SM confirmed that the HR team work closely with the FTSU Guardian, and escalation is undertaken if felt necessary, but the colleague raising the concern is made aware that confidentiality is maintained but there is a process to follow. SGL supported this comment and explained that the boundaries are set by the FTSU Guardian or Champions, so it is very clear that some things have to be escalated. • SJ raised that considering the conversations held at Staff Experience and OD (SE&OD) Committee, and at previous the Trust Board, the data indicate this could be wider than an isolated area previously thought and would welcome further conversation at the next SE&OD Committee. **ACTION Discuss FTSU report at June Staff Experience & OD Committee. SM** The Board thanked CJ for her work and asked thanks also be passed onto the Champions.	
GOVERNANCE AND COMPLIANCE	
25 Safeguarding and Vulnerabilities Annual Report: *for assurance* (NB)	**ROHTB (6/25) 015** **ROHTB (6/25) 015 (a)** **ROHTB (6/25) 015 (b)**
NB presented the Safeguarding and Vulnerabilities Annual Report, and the paper was taken as read. The key points highlighted include: • The paper has been presented and reviewed at the Quality and Safety Committee. • The Safeguarding Annual report is a regulatory report. The Vulnerabilities Annual Report is an addition by choice. • There is a more detailed document that sits behind the summary, but this was produced on the back of previous feedback. The Board was invited to comment and ask questions. • JB raised it should be noted the increased workload this team has to face and the importance of the work that happens.	

The Board approved the publication of the annual reports.	
UPWARD REPORTS FROM THE BOARD COMMITTEES	
26 Upward reports from the Board Committees: • **Finance & Performance Committee** • **Quality and Safety Committee** • **Audit Committee**	**ROHTB (6/25) 016** **ROHTB (6/25) 017** **ROTHB (6/25) 018**
<u>Finance and Performance Committee – LW</u> The paper was taken as read. The key point highlighted include: • Discussions focussed on the Month 1 performance and several positive improvements were noted. Much of the detail has already been presented in the Chief Executive and Executive Directors' reports earlier in the agenda and so will not be repeated here. • In terms of performance, although the capacity had been constrained by the theatre maintenance issues, activity performance was good. Effective control in some non-pay areas was demonstrated in the lowest levels of agency and bank staff spend for several years. • Positive discussions with NHS England had been held and it was clear that the end of Quarter 1 would be a key point for review of the trust's performance. • The uncertainty about funding for full implementation of the EPR was noted, along with the fact that discussions with NHS England continue to secure funding beyond the end of March 2026. • The Committee noted the good work undertaken to refresh the risks and accepted these updates. • Ideas for the further development of the Integrated Performance Dashboard had been supplied by the Non-Executive Directors individually and they offered to meet between committee meetings to progress the development of the Committee's dashboard, including a balanced scorecard, so that the Dashboard could be re-presented in June and confirmed by July. This will need to take account of the new National Performance Assessment Framework. • The Committee received an excellent deep dive report into the Hands and Spasticity Pathway which articulated productivity opportunities in referrals, outpatient services, pre-operative assessment, data capture and validation, and elective care capacity and delivery. An action plan including realisation of income opportunities and cost reductions in delivering surgical procedures, alongside reducing the waiting list numbers, is under development. Future Deep Dives will be undertaken through the Service Review process and will be reported directly to the Trust Board.	

Quality & Safety Committee – IR The report was taken as read. The key points to highlight include: • The Spinal Endoscopy Review is due to be completed in June and the final report will be presented to the Quality and Safety Committee in July, this will also then be presented to the Trust Board. • Two never event incident reports presented. Detailed discussions took place around these, and assurance provided with regards to the measures that have been put in place. • Quality Impact Assessment process was reviewed and this will be revisited. • Internal audit report reviewed for the Patient Safety Incident Framework report. **Audit Committee – GH** The report was taken as read. The key points to highlight include: • New External Audit Manager at Deloitte has been appointed to the Trust. • The internal audit workplan and counter fraud audit plan will be circulated to the Board outside of the meeting. • Declarations of interest register needs support by all leaders in the Trust to ensure colleagues are completing appropriately. MH added this could be added to the Team Brief this month.	
MATTERS TO BE TAKEN BY EXCEPTION	
27 Performance Reports: *for assurance* • **Finance & Performance** • **Quality Report**	**ROHTB (6/25) 019** **ROHTB (6/25) 020**
The reports were taken as read.	
28 Any Other Business	**Verbal**
There was no further business to discuss.	
29 Meeting Effectiveness	**Verbal**
Date of next meeting: Wednesday, 2nd July 2025 @ 0900h	

PUBLIC SESSION

Next Meeting: 2 July 2025, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 6th June 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	**HR and nursing have reviewed the data, but due to the limitation of how the data is categories we are unable link the sickness to vaccination data.**	
ROHTBACT.277	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.279	Freedom to Speak Up Update	ROHTB (6/25) 014 ROHTB (6/25) 014 (a)	04/06/2025	Discuss the Freedom to Speak Up report at Staff Experience & OD Committee in connection with the previous Staff Story feedback.	SM	20-Aug-25	**ACTION NOT YET DUE**	
ROHTBACT.274	Chair and Chief Executive Update	ROHTB (5/25) 003 ROHTB (5/25) 003 (a)	07/05/2025	Provide a one page update on the clinical decision-making tool roll out programme	MP	02-Jul-25	**This item is now a system wide item and forms part of a wider programme of work. An update on the MSK programme will be provided at the September Board meeting where this tool would be included.**	
ROHTBACT.278	Robert Jones and Agnes Hunt Memorandum of Understanding	ROHTB (6/25) 013 ROHTB (6/25) 013 (a)	04/06/2025	Provide support on behalf of the Board to the required amendments to the MOU.	AA/SGL	02-Jul-25	**MOU updated as per amendments discussed. 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

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Chief Executive**
AUTHOR:	**Matthew Hartland, Chief Executive**
DATE OF MEETING:	**2 July 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 2 July 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.

1.4 I would like to begin my update, however, with a public note of my, and the organisations, thanks to Tim Pile, our Chair who left the Trust when his term ended on 30 June.

Even though I only started at the Trust last year, Tim was at the Royal Orthopaedic Hospital for 13 years and has steered the Trust through some challenging times. He has achieved his ambition to hand the organisation over in a stronger position than he received it and has laid strong foundations for a successful future. I personally want to thank Tim for all he has done for the patients treated at this wonderful hospital.

1.5 I am very much looking to working with our new Chair, Simon Page. Simon already knows the ROH well as he is currently a Non-Executive Director of the Trust and I am sure his wealth of experience, earned over many years of senior leadership both within and outside the NHS, will continue our progress as a Trust.

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 are working much closer together in advance of this date.

The clustering of ICB's is expected to be implemented within the next few months in order to meet NHSE requirements to reduce running costs this year. It is expected that Birmingham and Solihull ICB will cluster with Black Country ICB. The corresponding impact on specialised commissioning is not yet confirmed. In addition, we are

expecting to receive more clarity on the role and structure of NHSE regions during the summer.

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

In June NHSE published the national Urgent and Emergency Care plan for 2025/6. The plan describes 7 priorities for the NHS to ensure winter 2025/6 is a safe and effective for patients as possible. As an elective provider, the ROH cannot directly implement a number of the expectations of the plan, but we have an important role to play in supporting our primary and secondary care colleagues to enable them to deliver the plan as well as possible. We will consider our response at the Strategy Board in July.

2.3 Pay Awards / Industrial Action

We have not received notification of the intention for any staff groups to take industrial action at this stage. We continue to engage with staff side and will take mitigation action as appropriate as we have done previously.

We are considering the implications of the new pay framework for Very Senior Managers which will be considered at Remuneration Committee in July. We have received confirmation that this cannot be paid until the Trust has received confirmation of its segment in the new NHS Oversight Framework.

3 CHIEF EXECUTIVE ACTIVITIES

3.1 Trust Strategy: 2025 Mid-Term Review

There are two elements of the refreshed Trust Strategy to update Board on:

I used June's Team Brief to continue the 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.

Strategy Delivery Board will meet for the first time in July and report to Board in September. It will oversee the Delivery Plan agreed alongside the strategy, but also consider new national policy, such as the NHS 10-year plan due to be published in early July and escalations from Trust Improvement Group. It will be a key part of the Trusts governance to drive improvement and I'm looking forward to chairing the first meeting.

In parallel, we have commenced the service review process across both clinical and non-clinical areas. The initial priority is corporate teams, with a phased approach for clinical teams with initial outcomes to be reviewed over the summer.

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

The NOA Board met in June. We discussed feedback on the national conference that was held in May, chaired by myself. Whilst we would have liked to see greater attendance, feedback was very positive with real practical benefit being taken back into represented organisations. We also agreed priorities for the 2025/6 financial year and the supporting work programme and discussed the impact the growth of orthopaedics in the independent sector has had on the specialist sector. This will inform ongoing discussions with NHSE and the Federation of Specialist Hospitals. The Board remains a good forum for us and I am pleased to increase my participation.

3.3 Birmingham Health Partners/Association of British Health Tech Industries

I attended an event hosted by Birmingham Health Partners with the Association of British Tech Industries. The event was to enhance links between the two member organisations and a number of opportunities for the ROH were discussed and agreed to be progressed.

3.4 Aston University Charter Dinner

It was a great pleasure to be asked to attend the Aston University Charter Dinner on 18th June. It was to celebrate 130 years of the University in its many forms and it was pleasing that our partnership with Aston was recognised by invites to myself and Matt Revell. It was also a good opportunity to continue our dialogue with Aston colleagues about the MOU we will be agreeing with them in the near future.

3.5 NHS Confederation conference.

I attended the NHS Confederation conference in June. Whilst there were not any new announcements from government or NHSE leadership, which there has been historically, it was great to connect with national and regional colleagues and see the innovations and best practice being undertaken across the NHS.

3.6 Acute Provider Collaborative (APC)

There has not been a meeting of the Acute Provider Collaborative since the last meeting. Following receiving support from the collaborative for the ROH-developed business case for GetUBetter last month the case was presented to the BSOL Investment Committee recently and a funding stream is being sought for the app to be permanently commissioned which will improve the lives of patients and reduce demand on services in line with NHSE expectations of commissioners.

3.7 ICB Board – Children and Young People

I attended the latest ICB Board workshop which was focussed on Children and Young People.

Whilst it was not discussed on the agenda, it was a reminder of the important work we do at the ROH for young people and I'll take this opportunity to inform the Board of a visit we had recently from Grace, a patient who was treated here for scoliosis 10 years

ago as a teenager. Grace has been a real advocate for the ROH and recently raised funds for the Charity by running a half marathon – an unthinkable feat a few years ago. A video of Grace's visit can be found on our website.

3.8 Federation of Specialist Hospitals

The Federation of Specialist Hospitals met in June and there were three main items for discussion. The report produced by members of the Federation of Specialist Hospitals entitled 'The Power of Specialism' that was submitted to NHSE has had a favourable response from Penny Dash, Chair of NHSE, who has asked a number of clarification questions. The response to such questions were discussed. Secondly, we discussed the situation of specialised commissioning within the restructure of NHSE. The outcome of this is unknown to date. Finally we discussed and agreed a position to be taken in the forthcoming NHSE 10-Year Plan Partners Council meeting to be held.

3.9 NHS Confederation

Following my meeting with Matthew Taylor, Chief Executive of the NHS Confederation, in May I have been invited to join the NHS Confederation Acute Advisory Network. I will be using the opportunity this gives to reinforce the importance and benefit of specialist hospitals and how we can operate in new care models.

3.10 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

It is pleasing to report that the Trust delivered a surplus in month of £402k against a planned deficit of £226k, generating a favourable variance of £628k in month. This results in a surplus of £25k for the first two months of the year, a favourable variance of £532k against plan.

This is clearly a positive position, achieved through both income overperformance to date, maintaining controls on levels of operating expenditure and delivery of CIP. A huge thank you to our staff for taking the required action to achieve this. There will be more challenging months to come, however, so focus will need to remain on both income and cost.

4.2 Performance

We have made a positive start to the year. Headline reported performance metrics for May include 58.33% Referral to Treatment Time (RTT), an improvement on our March position by 2.7% and significantly ahead of our target of 53.5%. This puts the ROH in the top quartile of Trusts. The number of patients waiting over 52 weeks will be zero by the end of June expect for spinal services, for which a recovery plan is in construction.

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

4.3 Segmentation

The national framework for Trust oversight is to change following conclusion of the consultation on the NHS Performance Assessment Framework. The new NHS Oversight Framework will be published by the end of June and is intended to be a more objective method to assess Trust performance and allow greater comparison of organisations. This will be in the form of league tables.

We have completed an assessment of the ROH's position against the draft framework but have not included that within today's Board papers as the metrics are likely to change. We will inform the Board at the meeting on the new framework and our expected outcome.

4.4 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:

- Medical Staff Leave Policy
- Emergency Preparedness, Resilience and Response (EPRR) Policy
- Positive Patient Identification 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
June 2025

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Finance Officer's Report M2**
SPONSOR (EXECUTIVE DIRECTOR):	**Steve Washbourne, Chief Finance Officer**
AUTHOR:	**Steve Washbourne, Chief Finance Officer**
DATE OF MEETING:	**2nd July 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Month 2 Financial Report

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Break-even position at Mth 2 Elective Income over performance Reduced spend in Bank and Agency CIP currently being delivered	Ongoing pressure on cash management and future delivery of CIP

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 2

1. Summary

The Trust delivered a surplus in month of £402k against a planned deficit of £226k, generating a favourable variance of £628k in month. This results in a surplus of £25k YTD, a favourable variance of £532k against plan.

Income & expenditure summary	Current month				Year to date			
	Plan £000s	Actual £000s	Variance £000s	%	Plan £000s	Actual £000s	Variance £000s	%
Operating income	11,792	12,291	499	4.2%	23,071	23,818	747	3.2%
Agency pay	(151)	(121)	30	20.0%	(302)	(226)	76	25.1%
All other employee expenses	(6,825)	(6,905)	(80)	(1.2%)	(13,685)	(13,744)	(59)	(0.4%)
Operating non pay	(4,927)	(4,775)	152	3.1%	(9,360)	(9,651)	(291)	(3.1%)
Total operating surplus / (deficit)	**(111)**	**490**	**601**	**5.1%**	**(276)**	**197**	**473**	**2.0%**
Non operating items	(123)	(97)	26	21.0%	(246)	(190)	56	22.8%
Surplus/(deficit) for the period/year	**(234)**	**393**	**627**	**5.3%**	**(522)**	**7**	**529**	**2.3%**
Less I&E impairments/(reversals) & (gains)/losses on transfers by absorption	0	0	0		0	0	0	
Surplus / (deficit) before impairments and transfers	**(234)**	**393**	**627**	**5.3%**	**(522)**	**7**	**529**	**2.3%**
Technical adjustments	8	9	1	16.0%	15	19	4	23.7%
Adjusted financial performance surplus/(deficit)	**(226)**	**402**	**628**	**5.3%**	**(507)**	**25**	**532**	**2.3%**
Less Non-Recurrent Deficit Support	0	0	0		0	0	0	
Adjusted financial performance surplus/(deficit) excluding non-recurrent deficit funding	**(226)**	**402**	**628**	**5.3%**	**(507)**	**25**	**532**	**2.3%**
EBITDA as a percentage of related income	**3.8%**	**8.4%**	**4.6%**		**3.7%**	**5.4%**	**1.8%**	
I&E margin	**(1.9%)**	**3.3%**	**5.2%**		**(2.2%)**	**0.1%**	**2.3%**	

Whilst this is clearly a positive position, driven mainly from an income overperformance in month, and achievement of CIP for the for first two years, we need to continue the current focus on controlling expenditure and delivery against CIP and income targets as there will be more challenging months to come.

2. Income

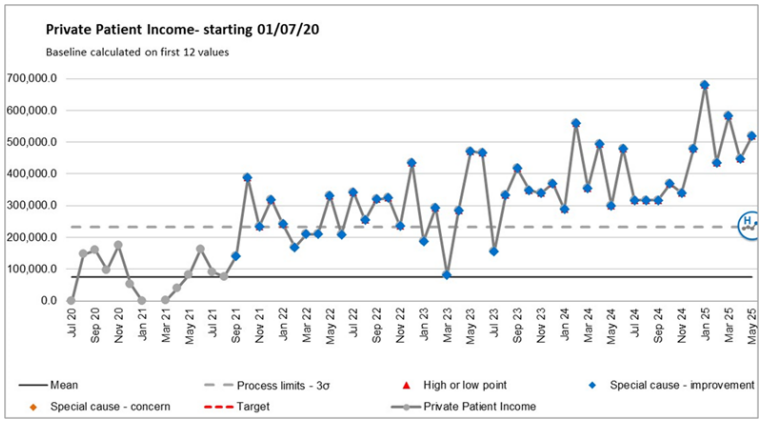
As previously discussed, the income position for 2025/26 has been reset based on activity delivered in 2024/25, and required activity to deliver the 2025/26 RTT targets. As the Trust underperformed on its elective activity during 24/25, this has resulted in a real-term reduction in income.

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 2 we continued to deliver an overperformance on variable elective patient care income which is now £535k YTD. This variable income is potentially still subject to be capped should the commissioner choose to apply an Indicative Activity Plan / Activity Management Plan

Activity undertaken in Q1 will be paid for in total, but a commissioner can impose an AMP to manage the trajectory for the rest of the year back to the value stated in the IAP. As shown in appendix A there is currently a risk across all commissioners except for NHS England which is underperforming. The total value of overperformance is £818,741 with BSOL ICB making up over 50% of this value.

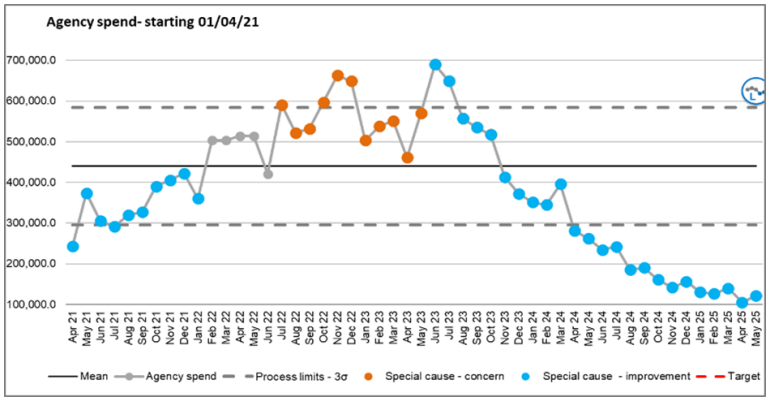
Private patients' income is £520k in month against a plan of £473k, giving an overperformance of £140k YTD.



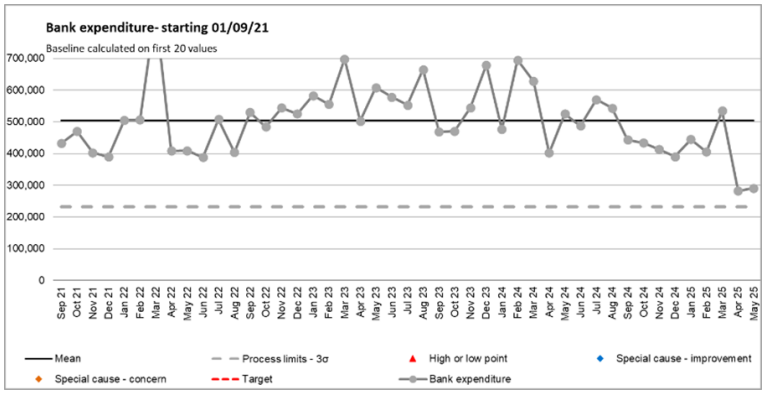
3. Pay

Pay expenditure is overspent in month by £50k, although remain £17k underspent YTD.

Agency spend is £121k in M2 (M1 £105k), or 1.7% of pay.

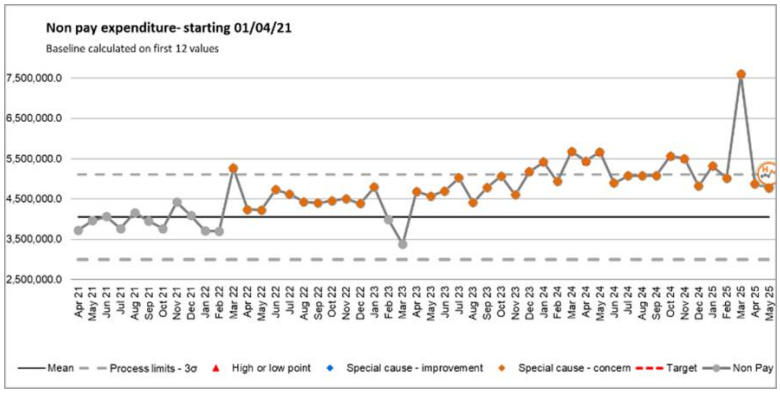


Bank expenditure is £291k in month against a plan of £369k (M1 £282k). Spend in Nursing of £41k (24/25 ave £111k) and Infrastructure of £95k (24/25 ave £145k) continue to be low. Spend in Medical staff of £97k is reflective of ADHs and on-call payments.



4. Non-Pay

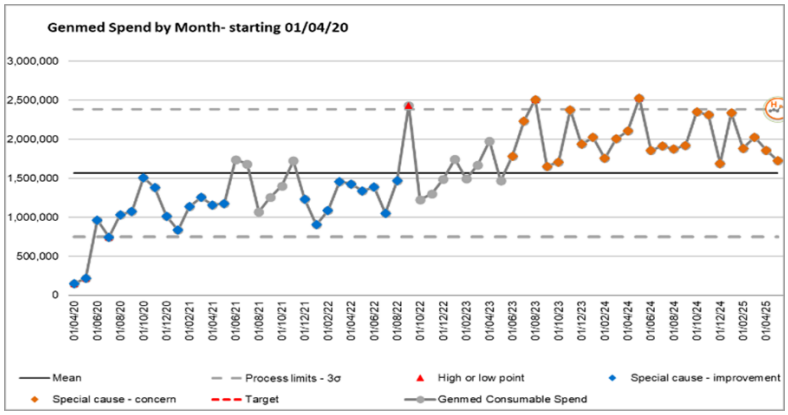
Non-pay spend of £4,775k was sightly reduced from M1 (£4,876k) and less than plan of £4,927k.



LLP spend increased to £209k (M1 £166k) resulting in an overspend of £81k at M2. A review of the overspend has been undertaken with reasons for the overspend;

- £10k replated to PP activity
- £7.5k late booking fees have been charged which are being negotiated
- £5k agreed to be recharged to BWCH for sessions delivered there
- £8k environmental issues
- £5k complex oncology spinal case; and
- Remaining balance relates to clinic capacity in spinal

Theatre spend in month continued to reduce to £1.72m from £1.86m in M1, reflective of additional controls and monitoring, and reduced levels of activity from 24/25.



5. Cash

The cash position remains challenging, with the movement in month being due to reduction in creditors as invoices were paid. Despite this, further support payments are not currently required. Despite the month end ledger cash position being £835k, the cash balance in the Trust's account has not dropped below £1.2m in month. The variance is due to a payment run which had been posted to the ledger, but would not clear the bank until after the receipt of our next commissioner mandate receipts. This was planned and controlled to ensure the de minimis cash requirement of £1m would not be breached

6. Capital

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

7. 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 £575k has been generated in month, with £984k now being delivered YTD against a plan of £1,038, 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.

			Year to date		
CIP Scheme	Month 1	Month 2	Plan	Actual	Variance
Bank reduction 10%	26.44	141.56	£86	£168	£81
Agency Reduction 30%	46	66	£112	£112	£0
LLP	194.55	0.45	£428	£195	-£233
Non Pay Other	66.68	60.32	£70	£127	£57
Optimising Medicines value	0	0			£0
Optimising energy Value	0	0			£0
Digital Optimisation	0	0			£0
Commercial income	75.47	92.53	£116	£168	£52
Service redesign	0	0	£14	£0	-£14
Bugdet management schemes		52	£87	£52	-£35
Total CIP schemes 25/26	409.14	574.86	£1,038	£984	-£54

8. System Position

The system position is shown below:-

Total Performance	YTD			FOT			Prior Month
	Current Plan £000s	Actual £000s	Variance £000s	Annual Plar £000s	FOT £000s	Variance £000s	variance £000s
BSOL ICB	-1,260	-1,182	78	0	0	0	0
BSMHT	694	-2,583	-3,277	4,200	4,200	0	-1,433
BCHC	-5	-1,189	-1,184	0	0	0	-496
BWC	0	-1,779	-1,779	0	0	0	-1,081
ROH	-507	25	532	35	35	0	-96
UHB	-7,360	-13,974	-6,614	-4,200	-4,200	0	-7,268
Total	-8,438	-20,682	-12,244	35	35	0	-10,375

Total Actual Surplus/(Deficit)	Trend		YTD
	M1 £000s	M2 £000s	£000s
BSOL ICB	-627	-555	-1,182
BSMHT	-1,086	-1,496	-2,583
BCHC	-604	-585	-1,189
BWC	-1,081	-698	-1,779
ROH	-377	403	25
UHB	-11,221	-2,753	-13,974
	-14,997	-5,685	-20,682

Total Variance	Trend		YTD
	M1 £000s	M2 £000s	£000s
BSOL ICB	0	78	78
BSMHT	-1,433	-1,843	-3,277
BCHC	-496	-688	-1,184
BWC	-1,081	-698	-1,779
ROH	-96	629	532
UHB	-7,268	654	-6,614
Total	-10,375	-1,869	-12,244

Appendix A: Elective Variable Income

	Actual			In month		Year to date	
Commissioner	**Month 1**	**Month 2**	**Year to date**	**Payment cap limit**	**Variance**	**Cap limit**	**Variance**
Armed Forces	8,302	9,111	17,412	0	**9,111**	**0**	**17,412**
QGH: NHS Herefordshire and Worcestershire ICB	432,033	599,316	1,031,350	£518,583	**-41,190**	**981,697**	**49,652**
QHL: NHS Birmingham and Solihull ICB	2,033,354	2,278,168	4,311,522	£2,026,275	**-125,252**	**3,835,814**	**475,708**
QNC: NHS Staffordshire and Stoke-on-Trent ICB	172,730	164,448	337,178	£131,654	**5,560**	**249,226**	**87,952**
QUA: NHS Black Country ICB	619,131	608,766	1,227,897	£607,555	**-75,306**	**1,150,124**	**77,773**
QWU: NHS Coventry and Warwickshire ICB	161,953	125,158	287,111	£93,430	**-5,608**	**176,867**	**110,243**
Spec Com	485,449	452,626	938,075	£645,275	**-192,649**	**1,221,529**	**-283,455**

Row Labels	Month 1	Month 2	Year to date	Plan	Variance
Day Cases	891,786	834,239	1,726,025	2,061,870	-335,845
Elective	2,565,379	2,858,079	5,423,458	4,633,068	790,390
Excess bed days EL	75,676	68,149	143,825		143,825
Outpatient FA Single Professional Consultant Led	322,149	421,043	743,192	771,604	-28,412
Outpatient FA Single Professional Consultant Led Non Face to Face	16,453	11,722	28,175	62,477	-34,302
Outpatient Procedures FA	6,533	5,394	11,927	86,240	-74,314
Outpatient Procedures FUP	34,976	38,968	73,943		73,943
Year to date	3,912,952	4,237,593	8,150,545	7,615,259	535,287

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:	**2nd July 20025**

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.

The Royal Orthopaedic Hospital NHS Foundation Trust

CHIEF OPERATING OFFICERS REPORT

Report to Trust Board – July 2025

1 LOCAL MATTERS FOR BOARD ATTENTION

1.1 The operational team continue to work on the delivery of the key NHSE operational performance targets 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

A suite of operational metrics in relation to RTT, cancer, diagnostics, activity delivery and key productivity metrics are monitored weekly against the agreed trajectory at the weekly Executive Oversight Group. This enables proactive monitoring of key performance metrics to deliver early rectification for any deviations from plan. The team continue to review indicative income performance on a weekly basis, utilising the prospective income framework to track progress on the activity aligned to the income trajectory. All RTT metrics were delivered in May 2025 and on writing this report all metrics for June 2025 are on track to deliver.

The Trust Improvement Group met for its inaugural meeting on 23rd June 2025. This Group will deliver oversight on all key continuous improvement projects and will provide an upward assurance report for the Trust Management Group.

Key programmes of work aligned to delivery of the Trust Operational Delivery Plan include:

- Theatre Improvement / Preoperative Assessment
- Outpatient Transformation programme
- Private Patients expansion
- National Imaging Services Accreditation Programme
- Trust Ambulatory Care Programme
- Procedure and profitability project

The Group will also oversee and support the delivery of action plans developed through service review programmes as required.

Work programmes will adopt the QSIR methodology supported by the newly developed Trust Project Management Office and a progress overview on some of the established projects is included in section 5 of this report.

2 NATIONAL CONTEXT AND DEVELOPMENTS

2.1 The System Operational Performance Confirm and Challenge Group is now chaired by the Regional Chief Operating Officer. This meeting takes place weekly and the Senior Operational team from the ROH continue to represent the Trust to provide assurance on performance against cancer standards, RTT and diagnostic delivery. The Trust continue to be commended on progress made on RTT recovery and the Trust's excellent delivery against cancer and diagnostics standards.

The ROH continue to take part in the National Validation sprint programme with enhanced technical and clinical validation to reduce patient waiting times. The trust year to date performance against NHSE agreed baseline has improved by 749 patients, representing a 21% improvement from baseline. This positive momentum reflects the continued success of our sprint initiatives, and the team are focused on maintaining this trajectory for the remainder of the quarter.

3. OPERATIONAL PERFORMANCE

The charts below provide a summary of the Trust's current performance against the agreed Trust trajectory reported to the May 2025 Finance and Performance Committee: -

3.1 The May 2025 RTT position closed at **58.33 %** an increase of **2.7 %** on the April 2025 reported position of **55.63 %** against a target of **53.54%** The number of patients waiting over 52 weeks will be **0** by 30th June for all specialties other than Spinal services. This reduction in patients waiting over 52 weeks supports the delivery of the NHSE target of no more than 1% of patients on the active waiting list waiting over 52 weeks by March 2026.

3.2 An improvement trajectory is in place for spinal services, and this was presented at the June Finance and Performance Committee for assurance. An aspirational trajectory has also been developed whereby the overall Trust position is at 70% by the end of March 2026 ahead of national imperatives, with Spinal services improving their yearend position to support this aspiration. This aligns with the Trust quality priority to reduce the waiting times in Spinal exploring innovative ways of working.

3.3 Stage 1 of an accelerated improvement workshop was held on Friday the 20th of June 2025, chaired by the Chief Operating Officer. Work presented included a detailed report of the Spinal clinic template review to ensure that all capacity is maximised and aligned to national best practice, a refreshed demand and capacity analysis was also shared including the capacity increase of the 2 new Spinal Consultants who commenced with the Trust in May 2025. The session included discussions with our extended scope spinal Physiotherapists looking at new ways of working including enhanced pre outpatient appointment triage to include review of imaging prior to 1st appointment and the potential to develop community appointment days for Spinal services.

Actions were collated and the Stage 2 Workshop will take place in July 2025 to engage the wider Multi-Disciplinary Team to deliver a pathway redesign implementation plan and a refreshed Spinal trajectory to support the aspirational Trust RTT target by March 2026. A Locum Spinal Consultant is being sourced to support the current loss of surgical capacity due to long term absence, interview are set for July. A full report will be tabled at the September 2025 Finance and Performance Committee as part of the trust service review programme.

4 PERFORMANCE HIGHLIGHTS April 2025

Eradication of 65 week waits

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

4.2 Elective Activity

The Team achieved above plan for elective activity by **29** cases for May 2025. This puts the activity position **129** ahead of plan YTD despite theatre downtime in May 2025 with Theatres reopening on 12th May 2025. This significant over performance has continued the April 2025 trend with an associated overperformance in Income.

4.3 Private Patients

The Team exceeded the plan for May 2025 by £141K. A new income plan has been set of £6.1M with an aspirational stretch plan of £6.5M to support the Trust Financial Sustainability Programme. The refreshed Private Patient Strategy was presented at the June 2025 Trust Board and well received with some insightful feedback to enhance plans for future growth. The Service is currently working on further service differentiation, exploring new markets and has plans to promote a small business unit operating model supported by the trust business development unit currently in development.

July 2025 will see the additional Communication and Marketing support dedicated to Private Services commence to support a refreshed marketing campaign both internally and externally. Rachel Richards and the Chief Operating Officer completed a series of drop in and walkabout sessions sharing the ambitions of the Private Service and engaging trust teams throughout May and June. These have proved successful with staff, demonstrating a real positive attitude around the expansion of Private Patient Services and some innovative suggestions to enrich the service going forward. An update on the progress of the Private Patient Services is planned for the September 2025 Trust Board.

5. TRUST PRODUCTIVITY IMPROVEMENT GROUP (TIG) – KEY HIGHLIGHTS

The newly formed TIG held its inaugural meeting in June 2025 and some of the key highlights of the first meeting are as follows: -

5.1 Procedure Profitability Group

Work is progressing with the Spinal Team where a detailed audit has been completed to inform areas where improvements can be made in data capture to improve coding. In addition, clinical engagement has commenced in Oncology and the Hands Service to drive further improvements. This work will drive the delivery of the specialty small business unit framework, for a greater understanding of cost and income per specialty can be articulated to inform investment decisions going forward.

5.2 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 'focus on surgery 'week is also planned at the beginning of July to focus on improvements and prepare Teams for the assessment process due on the 30th of July 2025. The week will also involve a specific focus on the WHO checklist and Theatre Team briefings, as well as alignment to scheduling best practice and the IMPACT productivity outcomes. There will also be an opportunity to focus on staff wellbeing, listening to suggestions on how the current environment can be improved from a staffing perspective, with the support of the Trust charity team.

5.3 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 2025 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. The accelerated improvement workshop described above in association with the Service Review now underway will support the mitigation of this risk and the overall reduction in waiting times for this service with a clear rectification plan to deliver RTT developed as part of this work programme.

May and June 2025 have seen a number of equipment breakdowns of the Digital X-Ray facilities due to their current age of this equipment. Breakdowns in equipment have been managed well by the team with minimal patient disruption. The replacement of the X-ray rooms is prioritised for the 2025 / 2026 capital plan currently being finalised which will mitigate this risk. Pre procurement equipment review work is already underway to enable replacement to be expedited as capital is released.

7 WORK PLANNED IN NEXT MONTH

7.1 Theatre Focus Week is planned for week commencing 7th July 2025 ahead of the Trusts GIRFT Elective Hub Accreditation Review on 30th July 2025.

7.2 The MSK Programme continues to progress key deliverables and in June 2025 the Business Case for the Self-Management Tool; 'getubetter'; was presented at the System Investment Committee. The Business Case was received well, and the Committee supported the ambition of the case, however it was felt the Business Case needed further strengthening relating to demonstration of potential financial benefits against the current backdrop of System financial constraints. A number of avenues are now being explored with the support of System Partners to agree a source of funding

for this initiative. The Team have been shortlisted for a HSJ Award for this initiative. Results will be shared at the next Trust Board meeting. A full progress update on the MSK programme is planned for the September Trust board.

7.3 Work continues within the Bsol system to finalise contracts with the independent sector, which should be complete by Mid July. The system plan is to repatriate some of the previously outsourced work back to the system. The ROH are working closely with system partners through engagement with the system elective hub as the lead provider for Orthopaedics and MSK to ensure we are ready to support this transition with the associated income stream once these negotiations are finalised.

8. RECOMMENDATION(S)

8.1 The Board is asked to **RECEIVE** and **ACCEPT** the report.

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

FOR ASSURANCE

CHIEF PEOPLE OFFICER'S

Report to Trust Board (Public) – July 2025

1 LOCAL MATTERS FOR BOARD ATTENTION

1.1 The Trust is currently working through the appraisal window which ends at the end of July 2025. Work has been ongoing to upskill managers in conducting effective appraisals. We are confident that we will have good compliance and are hoping that the interventions to support managers will result in more colleagues feeling that their appraisal was of a good quality and person centred.

1.2 During April and May, our Corporate teams have been focused on defining and establishing the Trust's approach to service reviews. This has been a great example of corporate teams working together to develop an approach to transformation across the Trust to support new ways of working. We hope that this process enables us to look through a different lens as to how we can ensure that we have a sustainable operating and workforce model with improvement at the heart of redesign.

1.3 The Trust has retained the Disability Confident Level 3 – Leader accreditation which is the highest level.

The accreditation assesses the support in place for staff members with disabilities at key stages of the employee life journey, from attraction and recruitment to development opportunities. The assessment allows us to highlight any gaps in our approaches from recruitment, onboarding and retention gaps which we can focus on in the future. Any work in this area will also benefit individuals from different diverse groups.

Retaining the Leader accreditation means that the Trust is highlighted nationally as an organisation that continues to make improvements to the experience of individuals with disabilities who:

- apply for roles

- are successful candidates

- may need reasonable adjustments and support in thriving at the Trust

The accreditation also means that we can use the Disability Confident mark on our external material to show our commitment to supporting individuals with disabilities. As Leader status, we are also involved in supporting other organisations through accreditation or with general information on the benefits

of the accreditation. We have previously received support from Shaw Trust when we originally applied for Leader accreditation.

Thank you to everyone involved in this work, especially project lead Laura-Tilley Hood, Wellbeing Officer and Alex Gilder, Chair of ABLE network.

1.4 The Trust has been awarded Silver level by the West Midlands Combined Authority (WMCA) for our work linked to all areas of Wellbeing.

The Trust has worked over the past 5 years with WMCA on different levels of accreditation; foundation, bronze and now silver.

The silver accreditation has allowed us to further demonstrate our commitment to wellbeing at the Trust in areas including:

- Enablers in Health
- Mental Health
- MSK
- Lifestyles
- External risks

Silver means there is more emphasis on showing evidence of financial support which is reflected in the cost-of-living support provided at the Trust and wellbeing weeks which include external organisations, sharing information on finance management, loans, citizens advice support etc, much of which is already embedded into our wellbeing at the Trust.

The Trust is now working with West Midlands Combined Authority (WMCA) to look at the requirements for Gold which concentrates on 3 areas of mental health, MSK and Lifestyles (smoking cessation, physical activities etc) to a higher level than silver. These areas align with our wellbeing priorities and will be mapped against the NHS wellbeing framework

Thank you to all our colleagues across the Trust who supported the submission, attended feedback sessions with WMCA or completed the Thrive at Work surveys. We will now be working towards achieving Gold level.

2 NATIONAL CONTEXT AND DEVELOPMENTS

2.1 The NHS is facing possible industrial action in England and Wales, primarily centred around pay disputes for Agenda for Change staff, including nurses. Unite the Union is balloting its members on whether to strike over a 3.6% pay award, which they deem insufficient given the rate of inflation and the existing staffing crisis in the NHS. Other unions are also considering similar action.

The core issue is the 3.6% pay increase offered to NHS staff on Agenda for Change contracts, which is below the current inflation rate and less than the

increases offered to other public sector workers. Unite is balloting its members in England and Wales, urging them to reject the offer and vote in favour of strike action. Other health unions are also consulting members about potential strike action.

In a separate but related situation, resident doctors are also being balloted for potential strike action overpay, with the ballot closing on July 7th 2025.

The British Medical Association (BMA) have also announced that thousands of consultants and specialist, associate specialist and specialty (SAS) doctors in England will be balloted on industrial action in the coming months.

The ballot, set to open on July 21st 2025 and close on September 1st 2025, is indicative only meaning it won't trigger industrial action. In contrast, the resident doctors' ballot, which closes on July 7, could lead to strike action lasting up to six months across England if it receives majority support.

3 KEY RISKS

3.1 Staff engagement as we work though some challenging months in terms additional scrutiny on recruitment in addition to the volume and pace of work is a key risk.

4 WORK PLANNED IN NEXT MONTH

4.1 Support teams with completion of service reviews and effective workforce planning.

4.2 Shift some focus to supporting leaders with robust management of short-term absences.

5 RECOMMENDATION(S)

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

Sharon Malhi
Chief People Officer
July 2025

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY OFFICERS' REPORT

Report to Trust Board on 2 July 25

1 MEDICAL DIRECTOR'S UPDATE

1.1 The Endoscopic Spinal Review has been received from the Royal College of Surgeons. (RCS). The full report will come through Quality and Safety next month. Restart arrangements are largely endorsed and clear. The team is working through individual recommendations, reflection and learning with support from the Governance Team.

1.2 Job planning for consultants 2025-2026 currently stands at 78%.

1.3 I attended the NHS Confederation Conference on 11-12 June. The Chief Executive's report has discussed the main features and discussions. For me, additional highlights were the session on robotic surgery, the session on experts by experience, AI physiotherapy and mobile screening stands.

1.4 I attended the joint Birmingham Health Partners (BHP)/Association of British HealthTech Industries (ABHI) event on 16th June with the Chief Executive as a representative of the Trust and as a BHP executive.

1.5 I attended the Aston Charter Dinner with the Chief Executive on 18th June. This was an overwhelming positive event celebrating 130 years of learning at the University.

1.6 I attended a regional roadshow with the outgoing and incoming National Medical Directors in Nottingham 18th June.

1.7 I, together with the Director of Strategy, attended a Knowledge Transfer event at Aston University on 19th June. We will take forward potential opportunities to work in partnership with Aston on our Intellectual Property/Commercialisation development.

1.8 The first attendance of the BSol South Locality meeting was on 20th May. The discussion centred on management of respiratory patients in particular and there was a wider discussion about infrastructure needed to meet winter pressures in 2025-26.

2 CHIEF NURSE'S UPDATE

Nursing

National / Regional

2.1 On 9 June 2025, the North East London NHS Foundation Trust where Alice Figueiredo committed suicide in July 2015, was convicted of breaching Sections 3(1) and 33(1)(a) of the Health and Safety Act. They were convicted of failing to ensure the safety of non-employees. In addition, the former ward manager has been convicted of breaching Sections 7(1) and 33(1) of the Health and Safety Act for failing to take reasonable care for health and safety. Following the conviction of the former ward manager, I am working with the NMC and Jenny Belza to undertake a piece of work with ward / department managers. This work will focus on outlining their responsibilities under the NMC Code of Conduct, the Trust values, and in their capacity as service leads.

2.2 During the month of June 2025, the Department of Health and Social Care carried out a national survey of Regulation 9(A): visiting and accompanying in care homes, hospitals and hospices. The survey focused on gaining insight into the impact of this regulation, and understanding the challenges organisations have faced in adhering to it. During the last month, I have taken the opportunity to test our adherence to this regulation, ensuring that the Trust supports open visiting and that our communication to patients supports this regulation. Apart from one letter (which has since been updated), we found no areas of non-compliance.

2.3 In early 2024, the NMC carried out an extraordinary review of the nursing, midwifery, and nursing associate education provision at Birmingham City University (BCU). Following the visit, gaps in assurance were noted and an action plan was developed in collaboration with local NHS Trusts and the NMC. Over the last year, BCU has worked with local providers and the NMC to make the necessary improvements. This month has seen the NMC de-escalate BCU off the action plan, stating '*de-escalation of NMC concerns, appropriate assurance has been agreed by the NMC board. No further action'*. This is a positive outcome for the students and local providers.

Local

2.4 All Chief Nursing Officers, Chief People Officers, and Chief Finance Officers have been written to by Dr Navina Evans (the Chief Workforce, Training, and Education Officer for England), Ducan Burton (Chief Nursing Officer for England), and Elizabeth O'Mahoney, Chief Financial Officer. The letter requests that all organisations review their job evaluation processes. In addition, Duncan Burton, via the CNO weekly communication, has requested that all CNOs within provider

organisations ensure nursing representation in the process. Currently, the Trust does not have representation from nursing in this process. However, one nurse is being trained, with a few additional nurses taking on this role in the coming year.

2.5 The NHS Standard Contract 2025/26 includes quality requirements for NHS Trusts to minimise *Clostridioides difficile* (C. difficile) and Gram-negative Bloodstream Infections (GNBSIs) rates to threshold levels set by NHS England. The Trust's thresholds for 2025/26 are as follows:

- *Clostridioides difficile* (toxin positive) – 0
- *Escherichia coli* BSI – 0
- *Klebsiella sp*. BSI – 0
- *Pseudomonas aeruginosa* BSI – 0

The Trust current position is as follows:

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

2.6 In June, the Trust was visited by NHS England and the ICS Infection Prevention & Control Nursing team. This was an annual engagement visit focused on being supportive and informative. The team undertook a walkabout of our clinical areas, noting good practice and sharing improvement opportunities. Initial feedback was positive, and a full report of the visit is awaited.

2.7 The Trust took part in the annual Acute Critical Care (ACC) workforce census, introduced in 2021 to gain an insight into the workforce baseline and understand changes in ACC capacity and workforce. The data is used for local and system level benefit (e.g., to support business cases) and to support national improvement efforts (e.g. Martha's Rule implementation).

2.8 At the beginning of June, the annual Human Tissue Authority (HTA) peer review was undertaken by an expert in HTA regulation. Initial feedback was positive following the extensive work carried out over the last year to address the Corrective Action & Preventive Actions (CAPA) following the HTA inspection in May 2024.

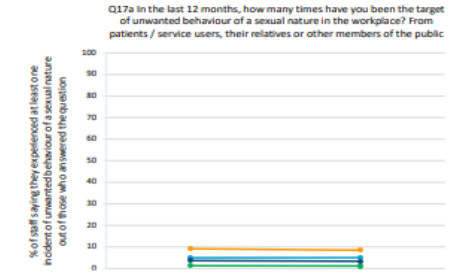
2.9 On 25 June, the Trust held its second Nursing & Allied Healthcare Professional conference; this year's theme was Advancing Care and Patient Safety through Research, Innovation, and Excellence. The Trust welcomed a wide range of speakers from across the NHS and Defence Medical Services. The day welcomed over 50 internal and external delegates and was sponsored by ROC and our suppliers.

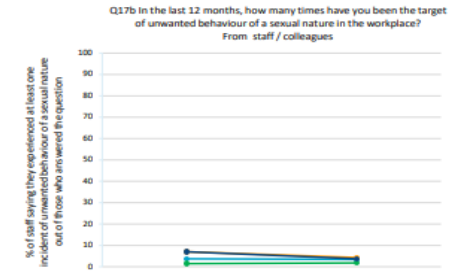
2.10 I had the privilege of attending the first workshop for the central localities working group. The meeting focused on how the system can support the Urgent and Emergency Care (UEC) pathway this coming winter. It focused on the Washwood Heath model and how that model could quickly be stood up in Moseley Hall Hospital in readiness for this coming winter. Work is commencing at pace.

2.11 Sexual Safety Charter update – following last year's launch of the Sexual Safety charter improvement work, we have continued to focus on raising awareness by promoting a zero-tolerance culture. In the month of June we launched the bystander training short scenario clips, this followed the face-to-face sessions delivered in May 25 by Dr Gill Harrop, Senior Lecturer in Forensic Psychology at the University of Worcester.

Reflecting back over the year with a view to assessing the impact of the work, we have noted an improvement in the staff survey data as demonstrated in Table 1. More locally the Safeguarding team has also reported an increase in disclosures, either from those reporting concerns or individuals seeking advice. Despite this improvement, we continue to raise awareness and support staff to speak up.

Table 1.





Below is the link to the training: Sexual Safety

2.12 In month, I attended the BSol Children's Health Programme Board, chaired by Matt Boazman, CEO of Birmingham Women's & Children's Hospital. This was the first formal meeting following two previous workshops tasked with defining the ask of the Programme Board. The meeting was well represented by Health and local

teams delivering services / care to CYP from across BSOL. The meeting focused on how data will influence the work of the committee, while ensuring the voice of the child.

3 DIRECTOR OF GOVERNANCE'S UPDATE

3.1 Change in patient safety/governance meeting structure at ICB

After consultation across the ICS, both at Executive Director level and also at an operational level, and via the Patient Safety Action Learning Set, there have been requests for a system-wide patient safety group, facilitated by the BSol ICB quality team, to address the following key roles:

Preventing Future Deaths

- To ensure that multi-organisation or system actions recommended from the Coronial Inquest Prevention of Future Deaths process are monitored, communicated and co-ordinated across the system and actioned in a timely way
- To provide a forum for discussion of individual provider organisations' actions from PFD and a forum for escalation
- To provide a forum to complete joint responses for system PFD notices

PSIRF

- To facilitate any required patient safety reviews under the PSIRF framework (e.g. PSII) across more than one organisation or system in an effective and timely manner and oversee delivery of system actions
- To identify risks across the system in relation to the delivery of the PSIRF framework
- To provide a system wide forum which is able to address strategic PSIRF actions such as increasing capability across organisations
- To ensure that patient safety and the PSIRF framework (Patient Safety Incident Response Framework) is robustly linked to CI teams, both within organisations and across the system, to ensure that learning from patient safety translates into meaningful improvement

Learning

- To provide a forum for peer support across the BSOL patient safety network and sharing good practice regarding improvement workstreams from such incidents

As a result, a new 'Patient Safety System Group' has been created and will meet bi-monthly. The group will report into the ICB Quality Group via the PSIRF

Implementation Group (PSIG) on a 6 monthly basis. Attendance from ROH will come from the Assistant Director of Governance & Risk and the Patient Safety Lead.

The first meeting of the Patient Safety System Group occurred on the 16th June 2025. The Terms of Reference for the group were discussed and agreed at the meeting.

3.2 System Support with Implementation of PSIRF - the Assistant Director of Governance & Risk has been approached by the ICB to help support a large GP practice with the implementation of PSIRF.

3.3 The planned inspection by the Health and Safety Executive went ahead at ROH on 18th and 19th June. The two inspectors (specialising in Occupational Health) were focusing on two topics; safer sharps and dermatitis. They were able to speak to various representatives across the Trust from clinical and non-clinical areas, spend time on wards and with facilities team. They also visited our Occupational health service at the Queen Elizabeth Hospital. We are waiting for formal feedback from the inspection, and were provided with some initial feedback on the 19th June – points raised are currently being actioned.

3.4 Further exploration of using Artificial Intelligence (AI) has taken place to support the administration functions in the Executive PA roles. NHS England has confirmed the preferred method to use is CoPilot, part of the Microsoft 365 package, and the Trust is going to be part of a pilot. The IT Team is currently working through participation agreement with the aim for the Executive PA Team to pilot using this to support meeting administration. The anticipated date to commence this will be towards the end of September once the licences have been obtained.

3.5 The Freedom to Speak Up Team is supporting an awareness event on 8 July to promote Civility & Respect. A stand will be organised outside Café Royale when staff can talk about the civility and respect framework and make a pledge. The event will provide the opportunity for staff to have a discussion with the Freedom to Speak Up Guardian and champions. The Executive and Non Executive leads for FTSU will also invite staff to have a cup of tea or coffee with them and have a discussion around the FTSU offering at the ROH.

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

DOCUMENT TITLE:	**RACE Equality Code (including anti racist statement)**
SPONSOR (EXECUTIVE DIRECTOR):	**Sharon Malhi, Chief People Officer**
AUTHOR:	**Alison Money, Deputy Chief People Officer** **Clare Mair, Head of OD and Inclusion**
DATE OF MEETING:	**2nd July 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This report gives an overview of the work being undertaken on:

- Accreditation for the RACE Equality Code quality standard
- Implementation of an anti-racist statement and commitment as part of the RACE Equality code

The Trust has partnered with the Governance Forum to undertake the RACE Equality Code assessment. This standard is designed to improve race equality and to tackle discrimination across the Trust. A key to the standard is to create a sustainable and lasting change, led by a diverse Board of senior leaders.

The methodology is split into four areas **Reporting, Actions, Composition and Education** and the assessment has included a number of actions including a document review, senior leader workshops for Trust Board members and a Trust Board member EDI survey.

A final stage before the quality mark is approved, is confirmation of a set of 'Apply and Explain' statements, to show commitment to the RACE Equality Code and to outline work that will be continued. The 'Apply and Explain' statements are included in this report, along with the ROH anti racist statement, for the committee to review and comment.

The RACE Equality Code work gives us an opportunity to embed anti racist practices at the Trust. The key actions needed are highlighted in the report and include:

- Launch the anti-racist statement and run managers awareness sessions to support the implementation of anti-racist practices at the Trust
- Ensure senior leaders are equipped to lead and role model on how to embed an anti-racist culture
- Embed the Civility and Respect approach alongside the anti-racist campaign, utilising the work developed by the People Promise project initiative
- Work with MMEG network and other staff voice network to understand key issues that impact staff members particularly around racism
- Confirmation of targets, how they will be achieved, what difference they will make and the reporting structure to show progress

These actions will be aligned to the overall EDI overall plan and progress will be monitored to ensure improvements are positively impacting staff and patients. Progress will also be monitored through pay gap reporting.

The Trust will continue to work with colleagues across the BSol ICS to share ideas and best practice.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVES	GAPS IN ASSURANCE/RISKS TO ESCALATE
- The work to achieve the RACE Equality Code quality make is in the final stages and will be completed by August 2025 - The Governance Forum have signed off the 'Explain and Apply' statements, subject to ROH senior leader sign off - Embedding anti racist practices at the Trust will be integral to continued work on the RACE Equality Code - The actions from the RACE Equality Code are aligned to the Workforce Race Equality Standard (WRES) reporting and Ethnicity Pay gap work and progress will be monitored	- The RACE Equality Code has identified areas that need to be addressed as a priority, which have also been highlighted in WRES indicators and the Ethnicity pay gap report. These include inclusive recruitment, treatment of staff and opportunities to progress

REPORT RECOMMENDATION:

To review the information and comment. To sign off the content of the Explain and Apply statements

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

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

Comments:

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

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

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

People risks

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

ICS Inclusion work

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

National WRES indicator data
Specialist Acute Trust and indicator results

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

Executive Director meeting – 14th June 2025
Staff Experience & OD committee – 25th June 2025

Trust Board – July 2025

RACE Equality Code Implementation

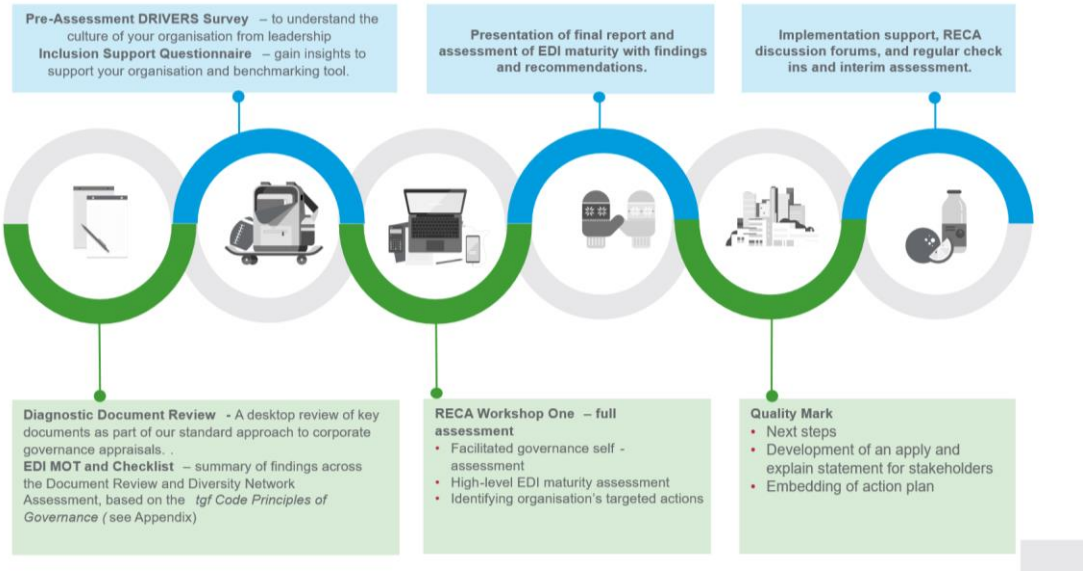
As part of our continued commitment to Equality, Diversity and Inclusion (EDI), the Trust has worked with Karl George from The Governance Forum to complete an assessment to achieve the RACE Equality Code quality standard.

The RACE Code methodology has been created to provide a targeted approach to addressing underrepresentation in Boards and senior leadership teams. RACE is an acronym for **Reporting, Actions, Composition and Education**.

This standard is designed to improve race equality and to tackle discrimination across organisations. A key to the standard is to create a sustainable and lasting change, led by a diverse Board of senior leaders.

The work at the Trust has been completed alongside other BSol Trusts to give a current picture of race equality and Equality, Diversity and Inclusion (EDI) progress across the Integrated Care System (ICS). Sharon Malhi, who is the Senior Responsible Officer for EDI, Talent and Leadership for BSol ICS has led the work both across the ICS and at the Trust with dedicated support from Clare Mair, Head of OD & Inclusion and Alison Money, Deputy Chief People Officer.

Table 1 below outlines the steps to achieve the RACE Equality Code standard



To work towards the RACE Equality standard, ROH has undertaken an in-depth, independent assessment, looking at how inclusive different aspects are for staff members and patients.

For the ROH, these steps have included:

- An initial awareness session with Trust Board members
- A survey completed by Trust Board members on their understanding of the current climate of EDI at the Trust
- A review of documentation in a range of areas including attraction, recruitment, governance, policies and procedures, leadership and representation
- Workshops with Trust Board members
- Workshops with project team consisting of Head of OD and Inclusion, Deputy Chief People Officer and the Chief People Officer
- Review of report by project team to show direction needed to highlight actions
- Trust attendance at networking events to share best practice

A report produced by the Governance Forum highlighted areas of good practice and key actions that needed to be taken to progress the ROH EDI agenda with a focus on race equality. The report is split into

- Reporting and Governance
- Action and Accountability
- Composition and Data
- Education and Culture

The final step for the assessment has been to develop a RACE Equality Code 'Apply and Explain' statement to include actions to be undertaken under the four headings above, considering feedback from the review. This statement has been developed with support from the Governance Forum.

Next steps

Progress on actions will be monitored as part of the overall EDI work at the Trust and assurance of progress provided to the Staff Experience and OD committee. The work will be integrated with the EDI actions for the Trust, including the work linked to Workforce Race Equality Standard (WRES) and Workforce Race Equality Standard (WDES) reporting and the Ethnicity Pay gap. Actions will also be shared with ICS colleagues as part of BSol Inclusion and Belonging work. A follow up assessment will be undertaken by the Governance Forum, 18 months after the Quality mark has been issued, to ensure actions are completed and improvements have been made against metrics.

Apply and Explain Statements

Below are the Apply and Explain statements, that were completed following the RACE Equality Code review. They consider information collected and reviewed during the assessment, as well as recommendations from the Governance forum.

Action: The next step is for the Apply and Explain statement to be reviewed by senior leaders at the Trust. Once approved internally, the Governance Forum will approve and issue the Quality mark.

RACE Equality Code Submission Form

1. REPORTING AND GOVERNANCE

A clear commitment to transparency with all stakeholders through the disclosure of concise, current information on the progress and impact of EDI initiatives across the organisation. Openness and transparency will be prioritised to foster an environment conducive to meaningful change, with clear guidelines on how stakeholders can access information.

The ROH statement

The Royal Orthopaedic NHS Foundation Trust is committed to transparency in how we report data for race and diversity. Strong governance underpins our data reporting approach. As part of the Trust governance framework the Chair, CEO and Trust Board members and Governors are fully committed to ensuring that data on progress for race and other protected characteristics is regularly reviewed at Trust Board, Staff Experience & OD (SE&OD) sub-Board committee and Governor's meetings.

In addition, the SE&OD committee receives data on a bimonthly basis to highlight key EDI metrics and reviews action plans to gain assurance on progress.

There is ongoing EDI development for Trust Board members to enable support and challenge for the EDI agenda. Part of this work includes Trust Board members regularly hearing the lived experience of patients and staff from diverse backgrounds.

EDI information is also shared at divisional level to ensure leaders are informed and therefore accountable for improving EDI outcomes. Network chairs and the wider network members review and comment on EDI data to ensure organisational actions are focussed on feedback from staff voice. We also share data through the following mechanisms:

- Regular divisional meetings
- Health Inequalities committee
- Regional ICS EDI forums
- Involvement with the Birmingham and Lewisham African and Caribbean Health Inequalities (BLACHIR) programme and actions

The Trust produces and publishes key NHS reports to ensure patients, staff and the community understand our progress and future plans which are presented in accessible ways.

These reports include Equality Delivery System (EDS with patient, staff and leadership domains) Workforce Race and Disability Equality Standards (WRES and WDES), Gender Pay Gap and the annual Equality and Diversity Report, each showing progress, targets and work planned to move the EDI agenda forward and improve the experience of our diverse colleagues.

These reports are published annually, in line with NHS requirements, on the Trust website under the Equality and Diversity section.
We are required to produce and deliver an NHS EDI Improvement plan which includes 18 areas of focus including senior leadership, inclusive recruitment, talent,

speaking up and inclusive recruitment and reducing bullying and harassment. This is shared annually with the SE&OD committee for assurance to track progress.

The Trust has just completed the first Ethnicity Pay gap report with actions that align to this work.

Information is regularly shared at network meetings and in departments triangulating other data to identify any issues. Colleagues also share information at departmental meetings with any comments or actions minuted.

We are using data to identify key area of focus on reducing inequalities around discrimination, inclusive recruitment, promoting future careers and opportunities for all staff, particularly for our minority ethnic colleagues. These areas are also highlighted through WRES and WDES work.

Examples of work being undertaken include:

- target to improve the results in the NHS staff survey around bullying and harassment for ethnic minority staff, to be in line with the best in our NHS sector by 2028.
- target to reduce 'unknown' in declaration rates for ethnicity and disability to zero, along with an increase of disability and ethnicity minority staff to reflect our community, by 2028.
- move towards parity of recruitment for disabled and ethnic minority colleagues by 2028.

These are the key targets for the Trust and progress is monitored through reporting shared with Trust board members.

All EDI information as well as key targets (listed above) are also shared with the BSol Integrated Care System (ICS) colleagues and the National NHS team for benchmarking. Equality and Diversity information for the NHS staff survey data is available on the NHS staff survey website for all to access.

In addition, the Trust utilises data from the following assessment tools to review progress and actions. This information is shared on the Trust website.

- reaccredited Disability Confident Leader status which includes elements of data analysis
- recently achieved Thrive at Work Silver accreditation through West Midlands Combined Authority which included elements for EDI work
- submission for the Inclusive Companies Top 50 assessment

This information will continue to be used to update and refresh our Equality, Diversity and Inclusion approach and plan in 2025/6 and our Trust Health Inequalities (including Core20Plus 5) strategy that was refreshed in 2024.

2. ACTIONS AND ACCOUNTABILITY

A list of measurable actions and outcomes that drive a shift in the organisation's approach towards delivering positive and sustainable change in race equity and

equality. Without clear targets and detailed plans for their achievement, genuine change will not occur, and accountability will be compromised.

ROH statement

Overall responsibility for the EDI agenda for patients and staff sits with the CEO with assurance provided to Trust Board on a regular basis and bi-monthly assurance at sub-Board committees.

The Chief People Officer is responsible for the EDI agenda and plan for staff members and reports into the Staff Experience and OD sub-Board committee on a bi-monthly basis. The Chief People Officer is the BSOL ICS Senior Responsible Officer for EDI and Talent and oversees the NHS EDI reporting as well as the national gender pay gap reporting.

The Chief Nurse is responsible for the Health Inequalities agenda and reports progress to the Quality and Safety sub-Board committee on a quarterly basis. This work includes involvement in the national BLACHIR programme.

The Trust has identified a number of EDI priorities from data analysis which are integrated into the strategic People Plan and aligned to the NHS People Promises. The People Plan along with the NHS reporting is integrated into the Trust's annual business planning cycle which means the actions are aligned to the overall Trust strategy.

The Trust publishes its annual Workforce Race and Disability Equality Standard reports and action plans as well as the Gender Pay gap on its website with specific actions, measures and clear ownership to drive equality.

Below are the key actions that we will deliver in the next 18 months aligned to the RACE Equality Code work. The actions have clear objectives, and progress will be reported through the governance structure highlighted above.

Action 1: Tackling discrimination - we will ensure that a programme of work, sponsored by senior leaders is developed and shared with staff members to eliminate any form of discrimination. The programme will include the launch and embedding of the anti-racist commitment, and the further rollout of active bystander training, speaking up and FTSU mechanisms and other learning initiatives. The programme will be communicated across the Trust with learning materials that are easy for all to access. The materials will be integrated into development programmes including the ROH 'Me as Manager' which is currently being rolled out to all managers.

Who: Chief People Officer with sponsorship from senior leaders

Metrics:

- Staff survey
- HR metrics
- FTSU information
- Incident reporting
- WRES and WRES indicators

Timing: 6 months programme to embed the programme into the organisation

Action 2: Inclusive recruitment - we will review inclusive recruitment practices to include attraction of a diverse talent pool, recruitment process with diverse interview panels, selection and supporting internal staff with applications. Data from WRES and WDES indicators show that candidates from diverse groups do not have equitable opportunity for roles. This is also an action noted from the recent Disability confident reaccreditation work.

Who: Chief People Officer

Metrics:

- Recruitment reporting HR metrics
- Improvements in WRES and WDES recruitment indicators to achieve parity and candidate feedback
- Improvements in the pay gap data where positive change needed is identified

Timing: 9 months programme

Action 3: Speaking up - we will further develop our engagement work to ensure that staff members and patients feel safe to speak up. This will include alignment with the active bystander training, civility and respect and further development of the sexual safety charter.

Senior leaders will provide support through continuing to listen to staff and patients lived experience, and supporting a relaunched coaching and mentoring programme.

Further work will be undertaken to support colleagues such as Freedom to speak up (FTSU) champions and staff network members to ensure that staff are able to easily access ways to speaking up. As part of this work, data will be reviewed and triangulated from different sources including FTSU and HR metrics to identify any specific teams, diverse groups or staff groups that need specific support.

Who: Chief People Officer, Chief Nurse and Director of Governance

Metrics:

- Improvement in HR metrics
- Improvements in specific staff survey results to align with best in sector
- Attendance on training course with 100% target
- Improvement in reporting FTSU cases

Timing: 18 months programme

Action 4: Career progression: We will identify and address any barriers to progression for diverse groups using data analysis from WRES and WDES, leavers questionnaires, appraisal conversations and staff survey feedback. We will ensure a structured Talent and Succession approach is implemented across the Trust; with tools that are designed to ensure fairness for diverse groups. Part of this work will include the development of stretch assignment, coaching and mentoring support and practical career development skills to ensure all staff, particularly from an ethnic

minority background and other underrepresented groups have access to these opportunities.

Who: Chief People Officer

Metrics:

- Improvement in leaver feedback and HR metrics
- Improvements in specific staff survey results to align with best in sector
- improved WRES and WDES indicators for recruitment and career progression to align to best in sector
- Feedback from attendance at different opportunities

Timing: 18 months programme

The above actions are incorporated into our Inclusion agenda and action plan and co-ordinated by the OD and Inclusion team. Our Chief People Officer is directly accountable for progress on the agenda, supported by the Trust Board. Our aim will be to continue to set clear targets to show our commitment to race equality and work to support other diverse groups.

3. COMPOSITION AND DATA

A set of key indicators designed to create tangible improvements in diversity at all levels of the organisation. Changing the narrative around what is acceptable requires both dialogue and data, leading to challenging conversations and necessary decisions, which the organisation is committed to making.

ROH statement

We review the diversity of our workforce to ensure we are progressing towards an organisation that is representative of the community that we serve.

Our total employees from an ethnic minority background representation have been increasing over the last ten years and is currently at 35%. This is above average for the NHS which is 26.4%. Work will continue to ensure this percentage is reflective across all staff groups at the Trust. Analysis from the first Ethnicity Pay Gap report will help to inform on the changes needed in this work.

For Trust Board members, 13% are currently from an ethnic minority background. The Trust plans to monitor this. The NHS national average is 15.6% for Trust Board members compared to 26.4% for all staff.

NHS reporting for WRES and WDES indicators allows us to review staff composition at all levels. This data is broken down into different pay bands and then further by clinical and non-clinical roles. We also monitor apprenticeship information. The information is collated from Electronic Staff Record (ESR) which is the HR system used at the Trust. Data is also reviewed from the reporting of the Gender and Ethnicity pay gap reports. Recruitment information is collated from the TRAC system and can break down candidate information into diverse groups and the different stages of recruitment, from application shortlisting to appointment.

Data from both the ESR and TRAC systems is broken down into single protected characteristics, however it is intended that future data analysis will provide more detailed information on intersectionality.

Staff have self-service access to update their information on the ESR system at any point, which includes EDI information. There is an annual online prompt to remind staff members to update their diversity information.

Staff network stands run during the year, and attendees are prompted to update their diversity information online. The ESR team at the Trust also runs sessions with teams to show staff how to use ESR; and part of this is how to update diversity information.

Part of the appraisal conversation is to prompt staff members to update their equality information.

Following the activities listed above, we have seen an increase in declaration information.

Our WRES and WDES data shows that staff from ethnic minority backgrounds and with disabilities are less likely to be appointed from shortlisting. The target for the Trust is to improve on this and move towards parity of 1.

We will use data from the staff survey on bullying and harassment to work with networks to understand where the key issues are. The target is to reduce bullying and harassment within the Trust and to be in line with the best in the sector by 2028.

We will work towards developing staff through career progression opportunities to narrow the gap between white colleagues and diverse groups, particularly staff from ethnic minorities and with disabilities.
We will use the following reporting to track our progress:

- Reports from NHS mandatory EDI reports including WRES and WDES
- NHS EDI Improvement plan
- Workforce report through bi-monthly SE&OD committee
- Trust Board updates
- Pay gap reports

We will continue to review information through ESR data and the staff survey. We will focus on triangulating data with:

- Staff experience
- Bullying and harassment
- Representation across pay bands
- HR cases
- Freedom to Speak Up data
- Patient data
- Incident reporting

Once we have full information, initiatives such as Civility and Respect, anti-racist commitment and active bystander training will be embedded in targeted areas and departments, to ensure staff feel safe and protected.

Our ambition as a Trust is to be in the top 5% of the best NHS Trust to work for by 2028. This work will be integral in achieving this ambition.

4. EDUCATION AND CULTURE

A robust organisational framework to develop the ethical, moral, social, and business rationale for diversity at all levels. This will be supported by inclusive and embedded programmes of continuous professional development aimed at challenging perspectives and prejudices, as well as acknowledging systemic and institutional practices.

ROH statement

The Royal Orthopaedic NHS Foundation Trust is committed to ensuring that the Trust values of Compassion, Openness, Pride, Innovation, Excellence and Respect are at the core of everything that we do; to support our patients, staff and community. We want everyone to feel safe and to be treated with civility and respect at the Trust. We believe a key part of this is through training and upskilling staff members and leaders on EDI with a civility and respect lens.

Through development and awareness sessions, we want everyone to have access to opportunities to learn about EDI. All staff members undertake EDI mandatory training on an annual basis and additional resources are available through our partners including Inclusive Companies.

Learning needs are reviewed during the appraisal conversation.

All our Management and Leadership programmes include EDI modules as standard, and the Trust Board continue with biannual EDI development sessions. In addition, the Trust will continue to run sessions (in different mediums) in the following topics:

- Active bystander training
- Enabling and Productive and Inclusive culture (EPIC) modules
- Inclusive recruitment
- Civility and Respect
- ICS Possibilities Beyond Limits programme for staff from ethnic minorities or with disabilities.
- Schwartz Rounds

The information is also available on the intranet, from comms messages and on posters. There is a specific learning hub for staff to access. There is also a career pathfinder tool for a number of occupational pathways.
The Trust Board has committed to becoming an anti-racist organisation and has achieved the first step through an anti-racist statement and commitment (attached)

There is a target to train 100% of managers in anti-racist programmes over a 12-month period.

The impact of these programmes will be measured through:

- % of staff from different diverse backgrounds attending courses
- WRES and WDES indicators to show progress
- Evaluation of the programmes with a target of 80% in good or very good
- Staff survey feedback on specific questions with an increase to match the highest achieving in the sector
- Tracking of progression for individuals into new roles or gaining qualification – to include apprenticeships
- Progress on EDI objectives for Board members

Through the work of senior leaders and staff networks, staff are encouraged to speak up in different forums if they do not feel psychologically sate. Managers are required to hold one to one and wellbeing conversations on a regular basis.

Meetings will include questions to ensure that staff feel psychologically safe.

Staff have access to external counselling if they need extra support. This is a self-referring process to remove any barriers for staff from diverse backgrounds.

Support from Professional Nursing Advocates (PNAs) is also available to ensure staff feel psychologically safe at the Trust.

The Royal Orthopaedic Hospital
Tackling racism and discrimination

NHS
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NHS Foundation Trust

Our commitment to tackling racism

The Royal Orthopaedic Hospital (ROH) is committed to being an actively anti-racist organisation, not just in words, but through action. Racism exists. It affects the health and wellbeing of both patients and staff, and it has no place in our Trust.

We are taking a stand to challenge racism wherever it shows up, in behaviours, systems, and outcomes. We believe that every person deserves to feel safe, respected, and included at work and in care. This is not only a moral duty, but vitally important to better outcomes for everyone.

Why this matters

For our people:
Racism affects how people are treated, how they feel at work, and how they are able to thrive. That's unacceptable.

For our patients:
Racial health inequalities lead to worse outcomes. Equity in care is non-negotiable

For our future:
Diversity, inclusion, and allyship fuel innovation, trust, and compassionate care.

A summary of our pledges and commitments

- **Zero tolerance:** We go beyond compliance to actively challenge racism in all forms
- **Leadership accountability:** Our Board ensures anti-racism is built into our strategies
- **Safe, Inclusive Culture:** Everyone plays a role in building a workplace of dignity and respect
- **Training and Education:** We equip staff to challenge bias, and support inclusion
- **Health Equity:** We're working to remove racial disparities in patient care and outcomes
- **Transparency:** We measure progress and report on it openly and proactively
- **Collaboration:** We partner with networks, communities, and experts to keep moving forward

See next page for our full pledges and commitments

Allyship starts with you

Being an ally means listening, speaking up, and using your voice to drive change. Whatever your role is within the trust, you make a difference. Here's how you can help:

Join conversations

Learn and challenge yourself

Support others

Get involved, especially through our networks like MMEG.

LESS PAIN
MORE INDEPENDENCE
LIFE-CHANGING CARE

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

Our pledges and commitments

Leadership and Accountability

- We pledge to embed anti-racist principles at all levels of our organisation and lead by example
- The Board will ensure that anti-racism is a priority in our strategic plans, policies, and everyday operations.
- We will establish clear goals, objectives and measures to eliminate racial disparities in recruitment, retention, promotion, and the overall experience of our staff highlighted through the work of the RACE Equality Code

Staff and Leadership Responsibilities

- All of us will actively contribute to creating and maintaining a safe, inclusive, and respectful working environment where through our own behaviours we treat colleagues with dignity and uphold a culture of mutual respect.
- All of us should engage in open communication, listen to diverse perspectives, be civil and respectful and courteous in our dealings with others and support managers to address any behaviours that undermine inclusivity and safety.
- We are all role models who will demonstrate behaviours which foster environments where everyone feels safe and respected, in accordance with the Trust values

Creating a Safe and Inclusive Workplace

- We are committed to creating a work environment where every individual, regardless of race or ethnicity, feels valued, respected, and supported.
- We will be working with all staff and staff networks to ensure everyone has a voice and is able to contribute and challenge towards our progress
- We will implement comprehensive training programmes that address bias, inclusion, anti-racism, active bystander, ensuring all staff are equipped to contribute to an anti-racist culture.

Supporting Our Patients and Our Communities

- As a healthcare provider, we recognise the adverse effects of racial inequalities on health outcomes. We are dedicated to improving access to care, eliminating disparities in patient experience, and promoting equitable health outcomes for all communities.
- We will engage with our local communities, particularly marginalised and minority groups, to better understand their needs and tailor our services to ensure fair and just healthcare delivery.

Monitoring and Reporting Progress/ Goals

- We will regularly monitor, evaluate, and report on our progress towards becoming an anti-racist organisation. This includes collecting and analysing data on staff demographics, patient outcomes, and service access to identify and address racial inequalities
- We will use National Staff Survey data to measure staff experiences
- We will monitor progress through the work of the RACE Equality Code
- We will hold ourselves accountable by being transparent with our staff, patients, and the public on the steps we are taking and the progress we are making.

Partnerships and Collaboration

- We recognise that achieving an anti-racist future requires collaboration.
- We will work with other NHS organisations, BSOL ICS providers, public sector bodies, and community groups to share best practices and drive collective progress towards addressing systemic racism across healthcare.
- We will work collaborative with external Inclusion experts to assess and benchmark our progress

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NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Insightful Provider Board**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Simon Grainger-Lloyd, Executive Director of Governance**
DATE OF MEETING:	**2nd July 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Following the presentation of the 'Insightful Provider Board' guidance at the February Trust Board, and the subsequent self assessment form that all Board members were invited to complete to help evaluate how insightful the Trust Board at ROH is, a gap analysis has been undertaken. This was presented at the April Trust Board meeting and an action plan has now been created to further support the Trust in ensuring we run an insightful provider board.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• It was agreed that the Trust is able to demonstrate it functions as an insightful provider board. • The Board committees are effective and have a clear purpose.	• The lack of integrated performance report and dashboard means the information is not as meaningful as it needs to be.

REPORT RECOMMENDATION:

The BOARD is asked to: note and accept the self assessment action plan.

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

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

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

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

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

Code of Governance

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)*:
Trust Board – April 2025

Insightful Provider Board – self-assessment

Overall assessment of: the boards approach to handling and acting on the information they receive. It also considers leadership behaviours and culture, and the metrics that can be used to better understand the organisation's performance.

The Insightful Provider Board Assessment and Action Plan

GOVERNANCE AND CULTURE		
Governance: *Effective governance arrangements are in place across their organisation. This is essential for the quality and timely flow of information to and from the board.*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS OR SHORTFALLS**
The chair's roles and responsibilities are clearly set out	Role profile for Chair Chair Recruitment Pack 2025	None
Rigorous skills-based recruitment and appointment process for non-executives, and they are independent	Recruitment Pack Non Executive CVs	None
The size of the board, the committee structure and processes reflect the size, services and complexity of the organisation	Comparison to peer organisations Committee structure covers all domains of quality, finance, workforce and operations Committee meetings apart from FPC are alternate months	None, although plan to review operation of Board and Committees in overview in coming months
The board receive the right information, presented in the right way and at the right time	Board workplan Performance dashboard	Performance data is extremely detailed – reporting by exception needed. (Integrated Performance Dashboard)
Robust internal controls across the trust to support the organisation wide transparency and accountability	Governance structure with clear accountabilities detailed. Annual Governance Statement of the annual report Newly established Financial Delivery Board and Trust Improvement Group	None specifically
The right structures are in place to escalate information through the organisations from the point of care to the board	Governance structure Governance review underway	None specifically although this will be enhanced when current governance review is completed
The board is able to hear patients, services users and staff voices in an authentic way as part of its leadership role	Patient/Staff story at Trust Board Non Exec/Exec Walkabouts 'Chat & Check' visits	None although a need to revisit the walkabouts plans

The roles and responsibilities of the Senior Independent Director are clear and agreed by the board	Code of Governance SID role description	None, although a refresh for the Board on the role of the SID has been requested

KEY ACTIONS REQUIRED TO ADDRESS GAPS

- Rapid implementation of an integrated performance dashboard needed to ensure the right information is presented in the right way.

GOVERNANCE AND CULTURE		
Culture: *Board members need to be regularly visible to provide opportunities for staff to engage and feed back. Fundamental to good oversight is curiosity and appreciative inquiry and knowing when to seek external review and when to directly address concern. The board shapes the culture of its organisation by how it operates and behaves.*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS OR SHORTFALLS**
The board role-models a culture of open and curious challenge	Board and Committee minutes	None and in fact, the challenge at Board is more greatly emphasised in minutes now
The Board understand when to seek external review and independent input	Committee minutes (Quality & Safety Committee as an example) Royal College of Surgeons review Internal and External Audit programmes Legal Services Contract Peer reviews	None
Most of the discussions are at the public board, and with clear justifications for any items discussed in private	Board agendas Board minutes	None, although a review of the operation of the Board is planned in coming months to establish if there is any further improvement that can be made
Issues are appropriately escalated from executives and the information is presented transparently	Committee Meeting Packs Board Packs	None specifically

The board balances operational performance with people performance at all levels of the organisation	Board agendas Committee agendas Board packs Committee meeting packs	None specifically, although needs to be an area of focus to ensure that going forward discussions on productivity and efficiency are balanced against quality & workforce
All board members have undertaken a 360-degree feedback	PDR paperwork	None. NED appraisals are due by 30 September 2025.
The board proactively seek views, listens to them and demonstrably follow up, and promote the value of 'speaking up' culture	FTSU Reports to Trust Board Staff and Patient stories	None
Freedom to Speak Up (FTSU) information is discussed at the board and is considered alongside other sources of information on organisational culture	Board agendas FTSU annual report Staff Survey Quality Report	None
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
• No specific actions needed.		

BOARD COMMITTEES		
Board and Committees: *Boards should make the best use of committees, delegating where appropriate functions and responsibilities that are best considered in these forums to allow more dedicated time for detailed review and consideration. Committees should report regularly to the board in a balanced and insightful way which does not simply repeat the information and discussion that has already taken place at the committee.*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS OR SHORTFALLS**
The role of each board committee is clear, including what areas and organisational risks it covers and how it reports to the board	Committee Terms of Reference Annual Governance Statement and accountability section of the annual report	None
Areas and functions of the trust operations that require specific governance groups is established	Governance structure Newly established Financial Delivery Board, Trust Improvement Group and Strategy Delivery Board	None

Board agendas are planned in such a way over the year that all relevant areas of the trust's operations get the appropriate scrutiny	Board workplan	None, although Board workplan refresh is due
There is a balance between strategy – developing and delivering it – and day-to day operations	Board agendas Strategy Delivery Board	None. Good balanced focus.
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
• No specific actions needed.		

MEANINGFUL INFORMATION		
Insightful information: *Information should be framed and presented in a way that enables board members to understand the relevance of it to the agreed strategic objectives and processes for managing risk and gaining assurance. A consistent style of reporting should be adopted for board and committee reports*		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS OR SHORTFALLS**
There is a clear purpose for why each piece of information is escalated to the board	Board workplan Board agendas listing purpose of reports	None
Information is reported in a way that enables the board to see links to the strategic objectives and risks	Board assurance framework Board/Committee Paper Cover Sheets	None, although better completion of cover sheet should be an area of focus going forward
The board also receives information showing wider system performance across the provider's key operational areas	Performance reports Officers' reports	Integrated performance dashboard would ensure the wider system information is also shared.
The overall volume of information is appropriate to allow the board to see the bigger picture	Board agendas and times for each item allowed	Integrated performance dashboard to triangulate all the information.
Information is streamlined using data tools such as SPC	Performance Packs	Integrated performance dashboard that details by exception needed.
The board uses an integrated performance report and presents this in a way that	Board reports on the IPR	The roll out of the integrated performance report and dashboard is needed to allow

focuses the attention on meaningful data rather than expected variation and statistical noise		the attention to be focused in the right place and exceptions to be highlighted
The board's approach allows for information sources to be triangulated, included qualitative and quantitative data as well as soft intelligence to spot warning signals	Executive Director Reports. Performance Packs	Integrated performance dashboard to triangulate all the information.
The information supports the board to ensure a focus on continuous improvement across the organisation	Previous papers on the Continuous Improvement Framework and paper being developed in readiness for discussion at the SE&ODC in August 2025	The integrated performance refresh would further support this.

KEY ACTIONS REQUIRED TO ADDRESS GAPS

- Roll out of the integrated performance report and dashboard to ensure the data presented is meaningful and insightful.

6 DOMAINS TO CONSIDER

Information overload is a real risk. Minimising it requires a thoughtful consideration of the organisation's risks and priorities and the quality of the data to develop bespoke approach to reporting, and which allows the board to have meaningful discussions that support learning and decision-making.

I. STRATEGY

The board's strategy needs to enable the organisation to deliver clinically, financially and operationally sustainable services for the population. Boards must set aside time to ensure their strategy is clear and well-developed, with most of their time devoted to strategic objectives that have appropriate goals and demonstrating success.		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS OR SHORTFALLS**
The organisation's strategy reflects shared priorities across the system and an agreed contribution to the Joint Forward Plan and Capital Plan with ICB and system partners	Service and business development plans Trends and Forecasts National priorities Trust strategy	None
The trust is working collaboratively with system partners and its provider collaborative for the overall good of the system and population served	System meeting information Joint CEO meetings System quality meetings RJAH MoU	None
The board is assured that it is overseeing the delivery of its organisational strategy effectively and that this is responding to the needs of the local system strategy	Board Strategy Refresh Delivery plan Cover sheets Terms of Reference for the Strategy Delivery Board	None
The organisation is meeting, and will continue to meet, any regulatory direction placed on it or undertakings	Not applicable	None
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
• No specific actions needed.		

II. QUALITY
The quality of care provided, and its continued improvement, is a core responsibility of boards. They must be able to identify and act in response to early warning signs of poor-quality of care, and where harm has occurred this needs to be understood and addressed. To improve patient experience and outcomes, boards need a whole systems approach to collecting, analysing, using and learning from feedback for quality improvement.

ASSESSMENT CRITERIA	EVIDENCE	GAPS OR SHORTFALLS
The trust has, and will keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients having had regards to relevant NHS England guidance (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt)	Learning from Deaths PSIRF updates CQC self-assessments Clinical and internal audit outcomes Staff feedback Patient feedback Annual complaints report	None
Systems are in place to monitor patient experience, and there are clear paths to relay safety concerns to the board	Patient feedback Complaints, concerns and compliments Quality report Patient stories Quality & safety Committee upward reports	None
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
• No specific actions needed.		

III. PEOPLE		
Board members should routinely consider employee experience, including health and wellbeing of staff, ensure the working environment is safe and secure, and proactively manage and mitigate risks. They should also listen to and support staff to be appropriately empowered to be advocates for themselves, their colleagues, patients and service users.		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS OR SHORTFALLS**
Staff feedback is used to improve the quality of care provided by the trust	Staff survey WRES/WDES Action Plan Staff stories RACE Code statement	None specifically
Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels	Staff survey Appraisals Me as Manager Training Programme	None specifically, although focussed piece of work in theatres is planned to assess any improvement needed
Staff are able to express concerns in an open and constructive environment	FTSU data Staff survey Staff stories	None
Staff metrics are used to improve productivity, staff satisfaction and patient care	Headcount, salary bill, skills mix Use of agency/bank Staff health and wellbeing offering Workforce overviews Gender pay gap and ethnicity pay gap reports	None specifically
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
• No specific actions needed.		

IV. ACCESS AND TARGETS

Trusts boards will need to track how their organisations are delivering against national commitments. Board members should look at trends using Statistical Process Control (SPC) and other appropriate tools to identify situations where there might be significant negative or positive improvement.		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS OR SHORTFALLS**
Plans are in place to improve performance against the relevant access and waiting time standards	Operational Performance Plans	No further plans needed at this point
The trust is able to identify and address inequalities in access and waiting time to NHS services across its patients	Health Inequalities Action Plan	*More work needed on the data that is shared with the Board on inequalities*
Appropriate population health targets have been agreed with the Integrated Care Board	ICB strategy	None specifically
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
• Data that details the actions that needs to be taken to address health inequalities. • Wider link needed to the system delivery framework.		
V. PRODUCTIVITY		
There are a range of measures for each type of trust that boards can look at to ensure themselves they are delivering health and care services and using assets as effectively as possible.		
ASSESSMENT CRITERIA	**EVIDENCE**	**GAPS OR SHORTFALLS**
Plans are in place to deliver productivity improvements referenced in, for example, the Model Health System, the Insightful Provider Board guide and other relevant guides	Model hospital data Theatre utilisation Day case rates Workforce productivity – outpatient per consultant WTE, elective admission per clinical WTE Integrated Performance Dashboard	None
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
• No specific actions needed.		
VI. FINANCE		
Finance should not be considered in silo – it is a significant factor in how the trust prioritises resources and the impact this has on the services provided for patients and service users, and the wider finances of the system.		

ASSESSMENT CRITERIA	EVIDENCE	GAPS OR SHORTFALLS
The trust has a robust financial governance framework and appropriate contract management arrangements	Contract Management database	Contract management process requires strengthening.
Financial risk is managed effectively, and financial considerations (such as efficiency programmes) do not adversely affect patient care and outcomes	CIP plan/QIAs Financial and operational elements of the Corporate Risk Register and BAF Service Review framework	None specifically
The trust actively engages with system partners regarding the optimal use of NHS resources and supports the system's delivery of its planned financial turn-out	ICS Finance meetings	None
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
• Review of the contract management process		

Insightful Provider Board Action Plan

REF.	ACTION	RESPONSIBLE	COMPLETION DATE	PROGRESS	STATUS

Meaningful Information	Completion of the development of the integrated performance report and associated training for board members and report authors on advanced analytical tools like SPC and exception reporting to improve focus on strategic insights.	SW	End of Quarter 2 2025		
Access and Targets	Consideration of development of a systematic approach to capture and report health inequality data, with a specific focus on ethnicity and deprivation indicators at group level.	NB	End of Quarter 3 2025		
Finance	Undertake a review of the contract management process to ensure a robust financial governance process is in place.	SW	End of Quarter 3		

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 24 June 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Theatre Environment Issues: Operational disruption in theatres due to environmental challenges. Theatre availability and surgical scheduling have been impacted but activity levels were maintained. • EPR Funding Uncertainty: £18m previously allocated for the Electronic Patient Record (EPR) remains unsecured. Timing is critical to commit and utilise capital effectively and deliver the project to the agreed timeframe. • Pain management waiting times have improved slightly but a detailed demand and capacity review had taken place and highlighted there is a gap of two consultants. This is being reviewed further under the service reviews that are being undertaken and a business case may follow. • It was noted that theatre utilisation was at risk due to a number of staffing issues preventing being able to book to 100%. • There is a drive from NHS England to eliminate agency spend which is challenging for the Trust to eradicate completely due to structural issues around our Medics. • Sickness absence remains a key focus and whilst long term absence has started to reduce through full application of the policy, there is now a focus on compliance around short term absences to help drive this down. • It was noted that the Indicative Activity Plans (IAP) that are being created as part of the new contract arrangements carry a risk of not being agreed by Commissioners which in turn could affect the payments received for activity. The new processes give more authority to Commissioners to impose activity and income targets.	• Deep dive into the BADS data is being undertaken to ensure the data is accurate, as this may explain the reduction in performance. • An update on the Outpatients Transformation Programme will be provided at the next Finance & Performance Committee in July by the Associate Director of Operations. • Theatre Service Review: A full end-to-end theatre productivity review is being launched in July, aiming to enhance utilisation and efficiency. • Further development of the Integrated Performance Dashboard to take place with input from Non-Executive Directors to ensure the final version meets the criteria needed to provide assurance to the Board.

POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• Strong RTT Performance: RTT performance improved, now at 58.33% (5% above target). No 104 or 78-week breaches. The Trust is 4th most improved regionally. • Diagnostics and Cancer Standards: Diagnostics at 99.7% (above national 95% target), and all cancer performance standards met, including the Faster Diagnosis Standard. • Operational Activity: Activity performance is strong, with May delivering above plan despite a delayed theatre start. Day case activity and outpatient transformation are progressing well. • The Committee received an update on the trajectory for Spinal and this showed the Trust is ahead of the current plan, but additional capacity will be required to deliver the desired improvement and a report on discussions with clinicians will be made next month. • Physiotherapy waits have reduced from 36% of patients waiting over 18 weeks to now 16 weeks, with only 1% of patients waiting over 18 weeks. This has been achieved through additional national funding that has been received. • The Trust delivered a surplus in month of £402k against a planned deficit of £226k, generating a favourable variance of £628k in month. This results in a surplus of £25k YTD, a favourable variance of £532k against plan. • The Committee were presented with the Capital Plan for 2025/26. • The Committee received an update on the contract arrangements for 2025/26, with contracts due to be signed by the end of the week.	• The Committee agreed to remove the 19% virtual consultation target, it is deemed clinically and digitally unachievable in the current setting, to be removed from reporting. • The Committee approved the capital plan presented and recommended it be presented to the Trust Board in July for final approval.

Chair's comments on the effectiveness of the meeting: The Chair commented that the meeting gave people the opportunity to raise issues and it was agreed it was full agenda.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 25 June 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- The Committee noted the uncertainty as a result of the proposed national pay settlements for staff on Agenda for Change pay rates and for medical staff remained a concern.
- It was noted that the work to progress the System-wide collaborative service undertaking was being delivered more slowly than anticipated. Currently, the scope of this work is restricted to transactional HR and digital. A further update would be provided at the next meeting.
- Although sickness absence had reduced to some degree, overall this remained a concern for the Trust. Long term absence had reduced, however short term episodes had increased.
- The Trust considered an update on the position against the Workforce Race Equality Standards (WRES) and the Workforce Disability Equality Standards (WDES). There was concern that there had been a decline in the position against several of the indicators, particularly in relation to bullying and harassment experienced by those of an ethnic minority and those classed as disabled. The Committee agreed that this was a matter of serious concern and asked that an overview of the work to address the results be considered at the next meeting.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- The risk concerning productivity from a workforce perspective, in addition to the refreshed workforce element of the Board Assurance Framework to be presented at the next meeting.
- Work is underway to triangulate employment relation cases and Freedom to speak Up concerns in relation to bullying and harassment.
- The appraisal window was currently open and would close at the end of July 2025.
- The Committee asked for an evaluation of the impact of the 'Me as a Manager' course and this would be presented in October 2025.
- Update on work to improve the WRES and WDES results to be presented at the next meeting.
- Staff story to be presented by the Library Manager at a future meeting.
- It was agreed that more work was needed to emphasise the Zero Tolerance stance of the Trust to any unreasonable behaviour by patient and staff.

POSITIVE ASSURANCES TO PROVIDE

- The Committee welcomed a medical student to the meeting and was pleased to learn of the individual's positive experience at the Trust as part of their placement. It was noted that the time at the Trust had been well structured and organised and the student had generated an interest in sports medicine as part of their experience.
- It was noted that the work to ensure that the new Learning Management System was implemented in September 2025 was back on track and progressing well.

DECISIONS MADE

- The Committee supported the proposed RACE Equality Code statement and commended the work undertaken jointly with the Good Governance Forum. It was agreed that the work should be presented to the Trust Board for it to endorse.

• The Committee was supportive of the work underway to conduct service reviews to ensure that each area and department was structured appropriately and delivering a robust service. The comprehensiveness of the framework for staff to use was noted, however it was suggested that as part of the consideration of the service reviews, that the potential impact on quality needed to be evaluated, as well as making the link more explicit between reducing costs/waste and improved quality • It was noted that the Trust had been awarded a Silver level for the Thrive at Work initiative by the West Midlands Combined Authority in recognition of the Trust's wellbeing offering. • The number of employee relation cases was noted to have increased, however the Committee agreed that this reflected improved processes & management of cases and the reset underway in relation to culture and performance expectations • The Committee considered a report on ethnicity pay gap, noting that the average hourly rate for staff from a Black and Minority Ethnic (BAME) background was higher than that of staff from a White British background. It was noted that this was reflective of the demographic of those staff, particularly in senior medical roles in the organisation, however it was agreed to undertake further analysis of the senior cohort of all staff to understand how individuals had been developed and promoted. • The Committee received the Library Strategy and Annual Report, noting the effectiveness of the function and the magnitude of work delivered. It offered its thanks to the Library Team for its work.	

Chair's comments on the effectiveness of the meeting: The Committee agreed that meeting was effective and there was good assurance provided by the Executive on the work underway to address specific issues. The lighter agenda was noted to have given a greater opportunity to explore a range of matters.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM CHARITABLE FUNDS COMMITTEE

Date Group or Board met: 19 June 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• In terms of the investment portfolio, a discussion took place around cash balances. An update will be provided at November's meeting detailing the extent to which funds will be spent. • Concern of being mindful not to lose sight of spending the funds in the unallocated Charity was noted.	• A Business Development Team is being formed which will work with the Charity on plans around the redesign of the front of the hospital to house the ROC Hub. Proposals will be delivered post summer holidays. • The second phase of Health Hack is being revisited during September 2025. • Reference was made to an updated ROC operating model paper which has been reviewed by the Executive Team, and actions will now be taken forward, including developing a new Charitable Fund Investment & Reserves Policy.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Members received a draft copy of the Charity's Annual Report & Financial Statements for their review and comment. • A comprehensive Charity Report was received which included an update on the Charity Team, noting a warm welcome to Justine, Community Fundraiser, covering maternity leave. Other updates included numerous upcoming events, grant successes and an update on marketing. • The Charity's goal this year was to undertake more fundraising to increase the funds for the Charity. • In the financial update, there was nothing significant to report in terms of fund balances since the last meeting in March 2025. In terms of investment performance, a small reduction in valuation was highlighted, driven by a' global wobble' which was of no major concern. Utilising funds and using them appropriately is being focused upon.	• The following bid was approved by the Committee: ##348 Multifaith Room Refurbishment.

• Members received for further information and assurance an Insight Report relating ROC eTapestry following previous approval of this bid. • Members of the Committee received for information a total of four bid updates which included 6 month review updates of the previously approved bids. The Chair commented on how important it was to receive these updates as they helped measure progress and highlight how the Trust's money is being utilised. The Chair thanked the Charity Team for providing this information.	

Chair's comments on the effectiveness of the meeting: The Chair commented on the productiveness of meeting, noting efficient time for challenge and discussion on the various agenda items. She shared how much she enjoys Chairing these meetings and that ROC (Royal Orthopaedic Charity) is at the top of her list! The Chair thanked members for their attendance and looked forward to seeing everyone at the next meeting on 27 November 2025.

Finance and Performance Report

Month 2

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.

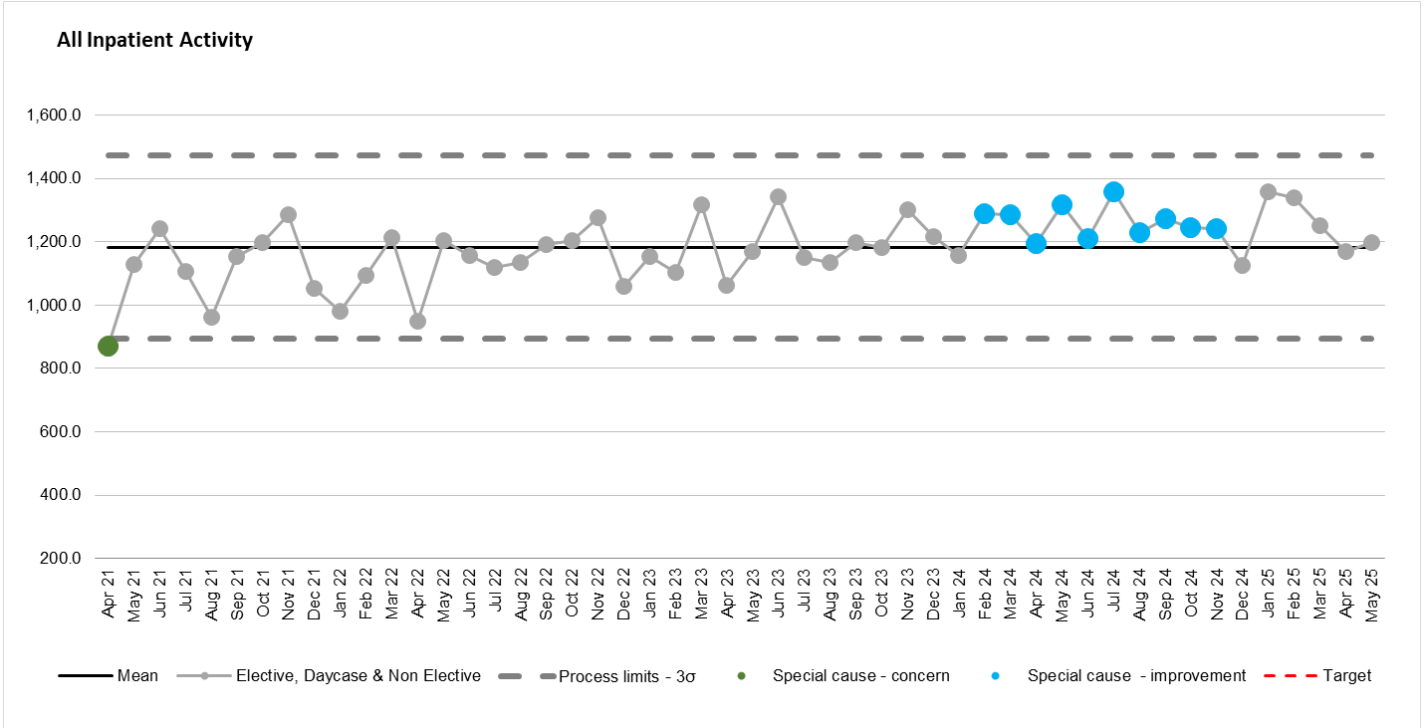
Operational Performance Summary

Performance to end May 25	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	58.33%	55.63%	53.54%	L	P
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	0	0	0	L	P
52 week waits (52 – 64 Weeks)	507	486	594	L	P
All activity YTD (compared to plan)	2,366	1,168	2,237		P
Outpatient activity YTD (compared to plan)	11,696 102.9% Cumulative	5,987 105.3% Cumulative	11,730 YTD Target		P
Outpatient Did Not Attend (YTD)	6.5%	7.0%	8%		P
PIFU (trajectory to 5% target)	579 10.4%	594 10.5%	512 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	7.9%	9.4%	19%		F
FUP attendances(compared to 19/20)	102.6%	108.6%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	113.3%	116.1%	120%		F
Diagnostics volume YTD (compared to plan)	4,192 Cumulative	2,097 Cumulative	4,034 YTD Target		P
Diagnostics 6 week target	99.7%	100%	99%		P

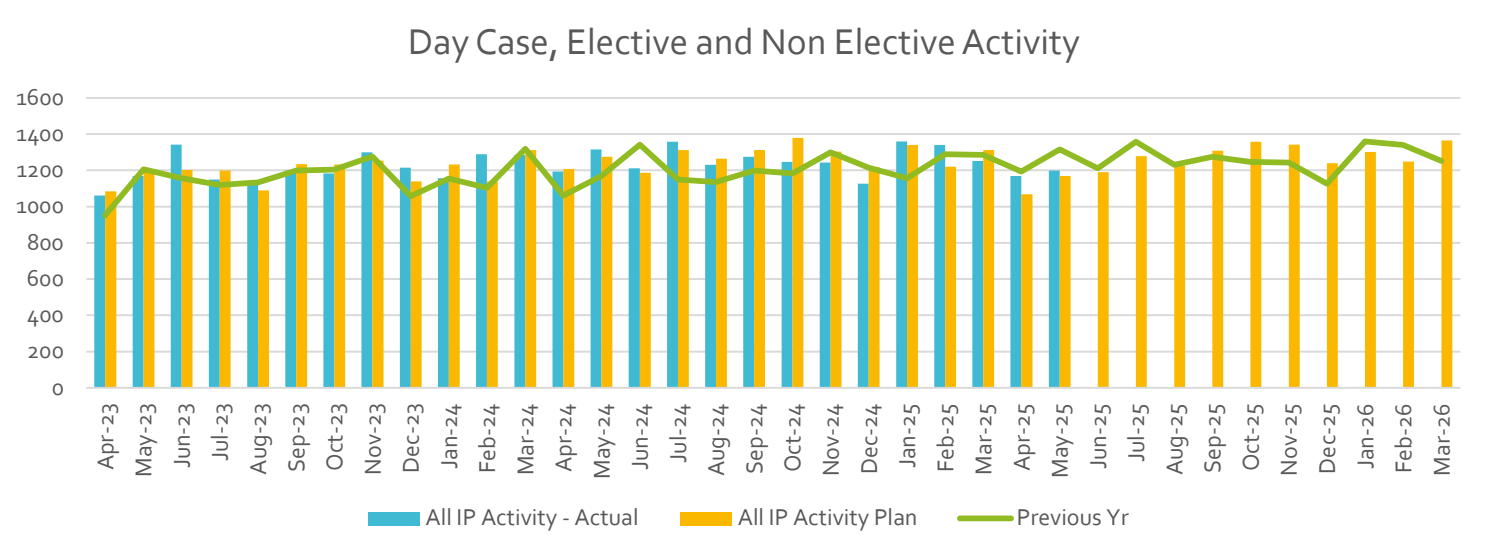
Operational Performance Summary

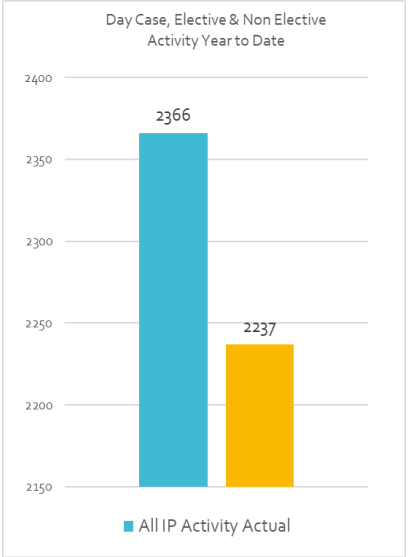
Performance to end May 25	In month	Previous month	Target	Variation	Assurance
Theatre utilisation	84.63%	90.4%	85%		
Theatre In Session Utilisation	84.53%	84.4%	85%		
Cancer - 31 day first treatment	100%	100%	96%		
Cancer - 62 day (traditional)	85.7%	95.2%	70% Nat 85% Trust		
28 day FDS	77.3%	81.1%	77%		
Patients over 104 days (62 day standard)	0	1	0		
POAC activity volume (YTD)	3,553 Cumulative	1,637 Cumulative	3,530 Cumulative		
Bed Occupancy (excluding CYP and HDU)	73.0%	71.4%	82-85%		
LOS - excluding Oncology, Paeds,YAH, Spinal	3.27	3.46	n/a		
LOS - elective primary hip	2.9	2.5	2.7		
LOS - elective primary knee	2.9	3.0	2.7		
BADS Orthopaedic: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period) Feb 25	53.5%	54.6%	85%		
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Feb 25)	37.5%	37.5%	-		

1. Activity Summary



1. Activity Summary





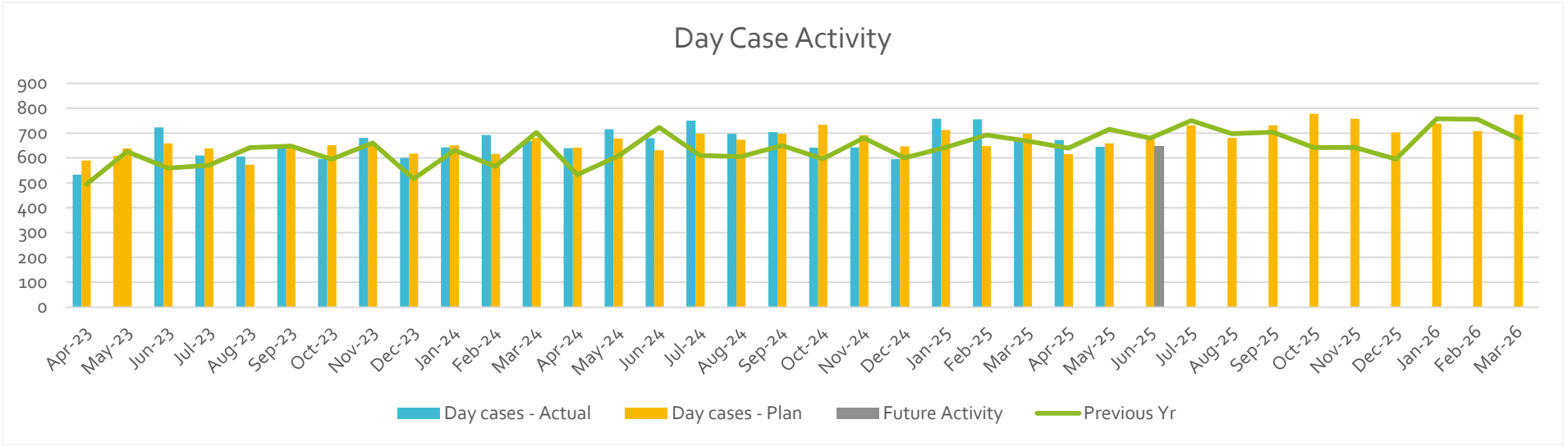
	Plan												Plan	Actual	% Achieved	Variance
	Activity Type	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Date	Year to Date	against plan	Year to Date
Trust Plan	Inpatient	434	488	492	525	523	553	557	563	513	540	520	567	922	1013	110%	91
	Daycase	615	659	676	731	680	731	777	758	702	739	708	775	1274	1317	103%	43
	NEL	19	22	22	22	22	23	23	22	23	22	21	23	41	36	88%	-5
	All Activity	**1068**	**1169**	**1190**	**1278**	**1225**	**1308**	**1357**	**1342**	**1238**	**1300**	**1249**	**1365**	**2237**	**2366**	**106%**	**129**

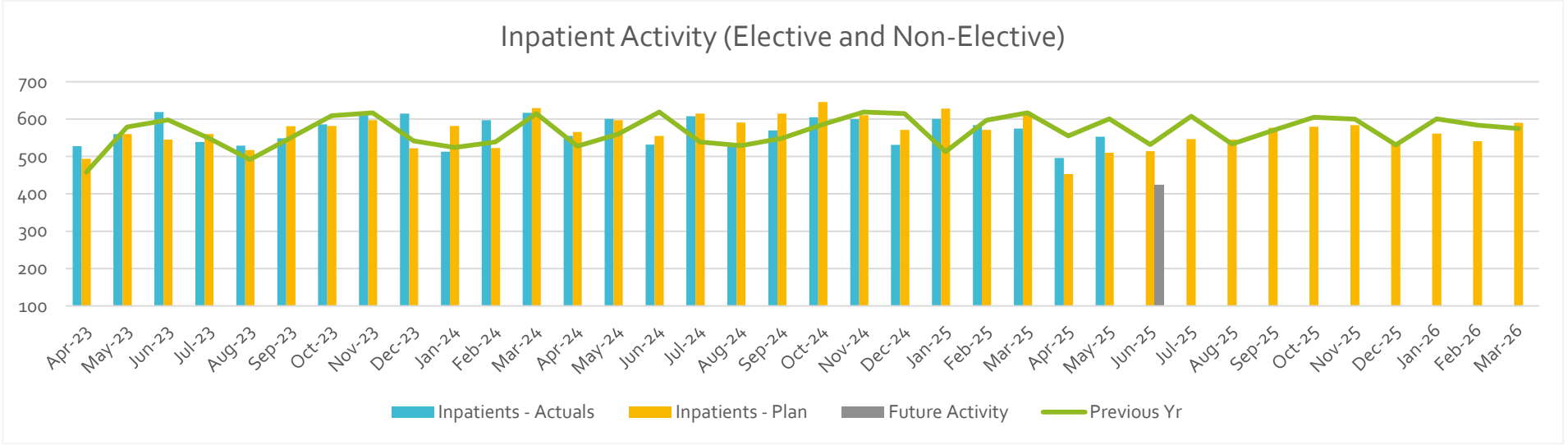
May 2025

The inpatient activity for the month of May 25 was 1,198 cases that translates to an over performance of **29 cases** (2.5%) against the agreed target of 1,169 cases.

YTD we are 129 cases (6%) ahead of the agreed YTD plan of 2,237 cases.

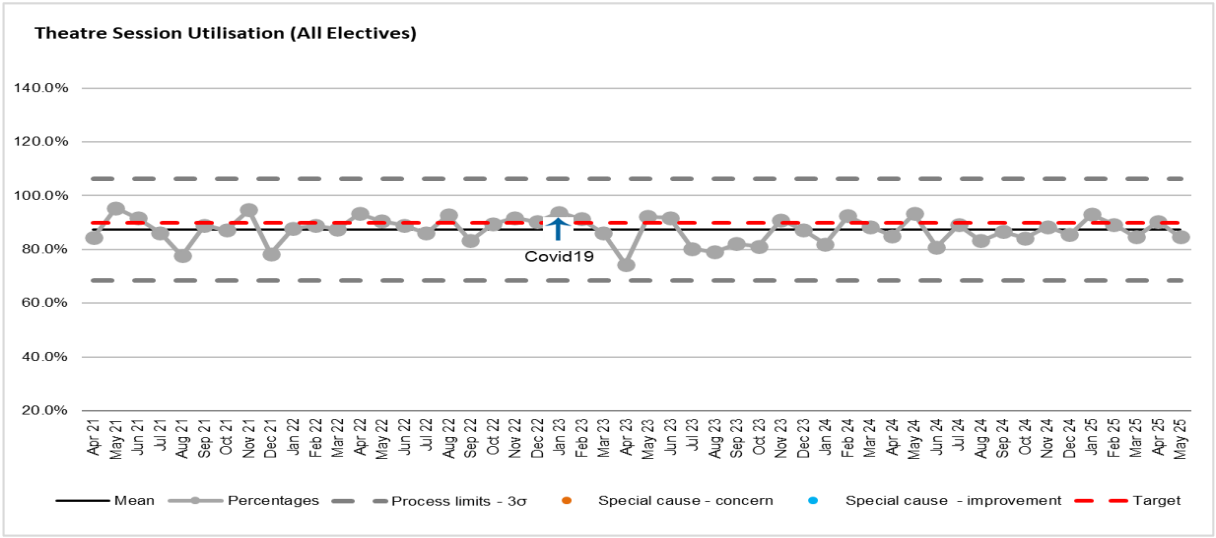
1. Activity Summary

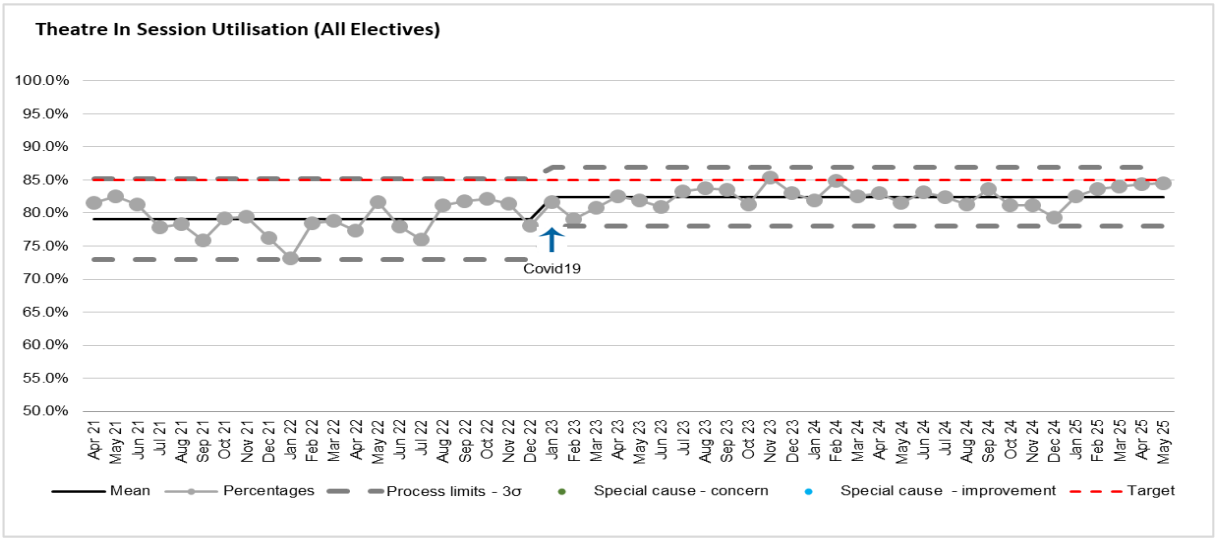




2. Theatre Utilisation

DATA QUALITY KITEMARK

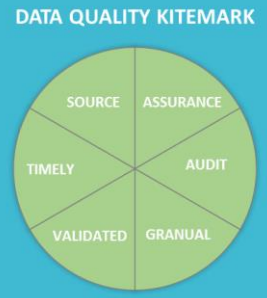




Elective Session Utilisation (May 2025)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	488	417	71	85.45%
UHB	26	18	8	69.23%
Totals	**514**	**435**	**79**	**84.63%**

Elective In Session Utilisation (May 2025)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1795	1521	274	84.74%
UHB	76	61	15	79.71%
Totals	**1871**	**1582**	**289**	**84.53%**

2. Theatre Utilisation



SUMMARY

Overall theatre session utilisation for May 25 was 84.63% with an overall in-session utilisation of 84.53%**.** The utilisation is based on the theatres that were physically available to the teams.

AREAS FOR IMPROVEMENT

Theatre 1, 2 & 4 returned to service and reopened in month from the 12th May.

We continue to work with our BCH colleagues to maximise their allocated theatres with a strong focus on POAC pts listed fit for surgery and protected appointment slots.

We suffered from environmental challenges within Theatres 11, 12 & 15 which IPC and estates have supported with, but this caused in list disruption and moving of Theatres.

The automatic send proof of concept work on highlighted lists has continued in May with improving results.
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 Surgery Focus Week planned for W/c 7th July ahead of the GIRFT Hub Accreditation review on 30th July 2025.

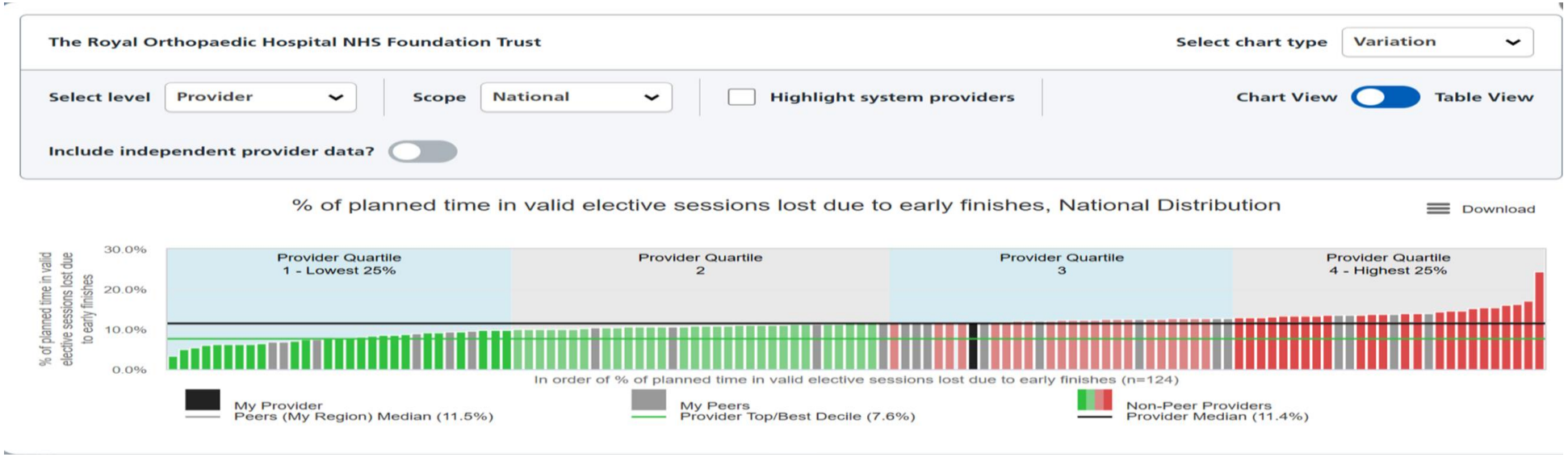
RISKS / ISSUES

Complex revisions and nursing support to keep lists fully utilised to support arthroplasty surgeons.

A review is underway regarding best use of POAC resources in line with specialty demand to improve access and timeliness of POAC.

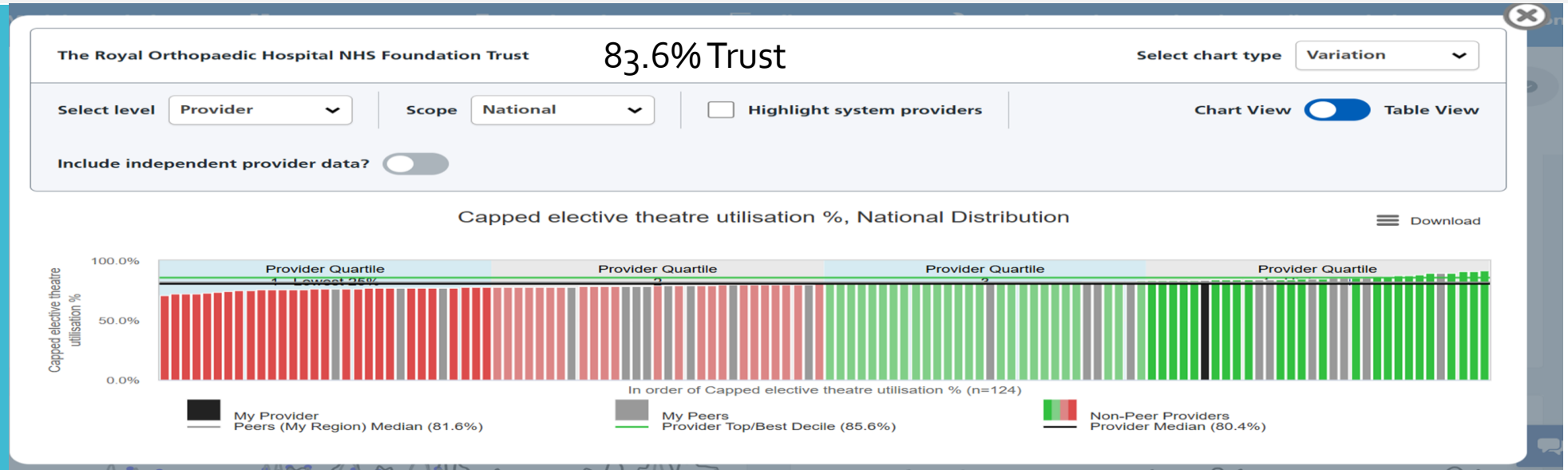
Latest Model Hospital Theatre Metrics

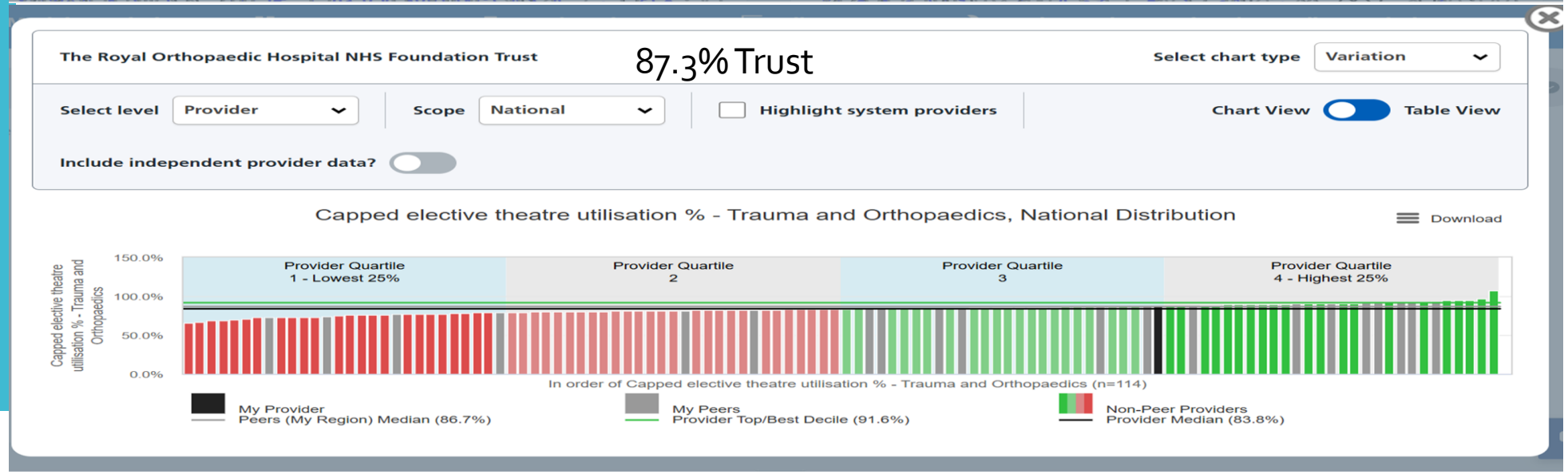
Average inter case turnaround time is 13 minutes and in quartile 2. Seamless surgery week will focus on how we can improve further on this metric.



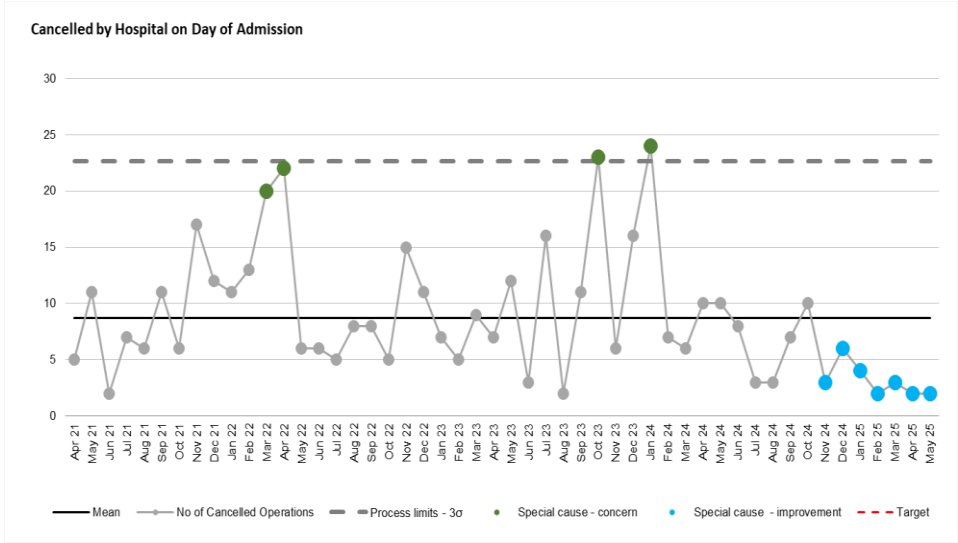
The Trust continues to improve on early finish times moving towards quartile 2

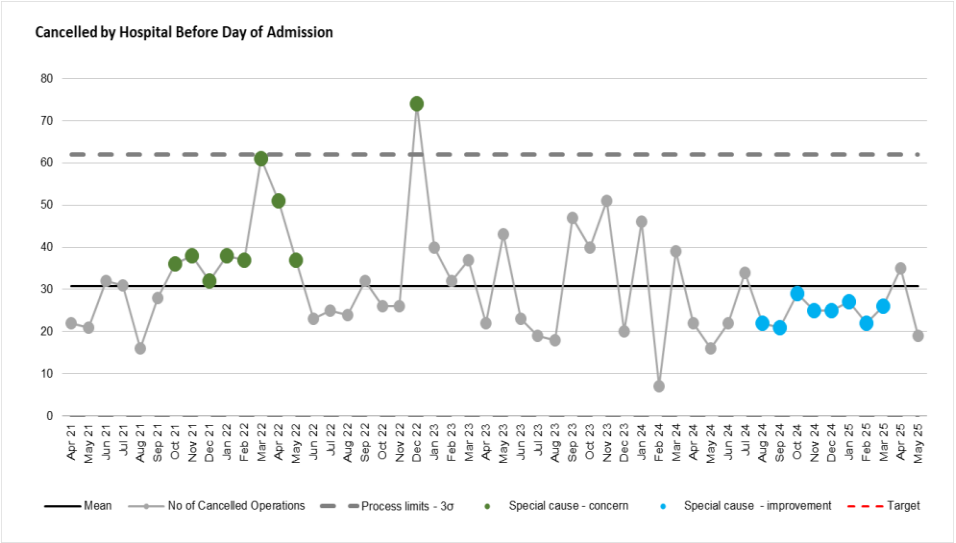
Latest Model Hospital Theatre Metrics



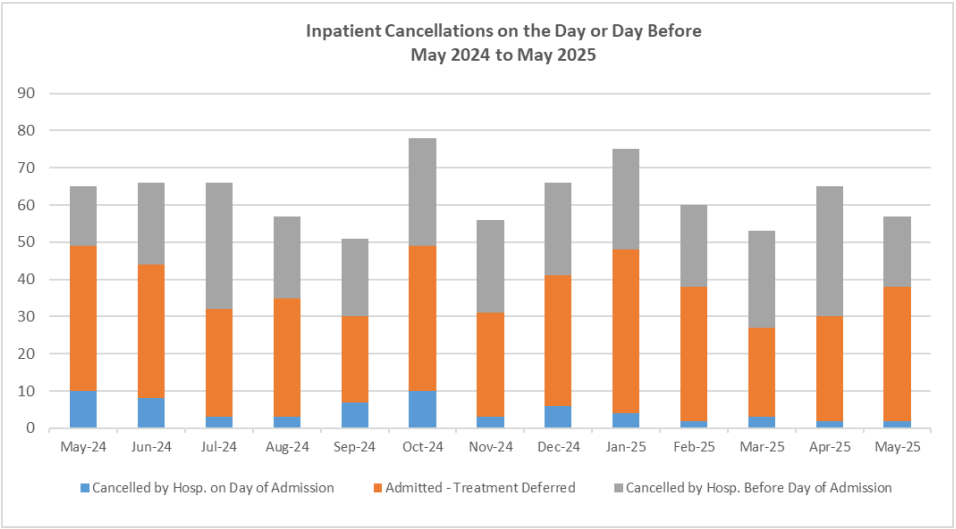


2. Theatre Utilisation/ Hospital Led Cancellations





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
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
May-25	2	36	19	57	0
Total	**63**	**429**	**323**	**815**	**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 May 2025:

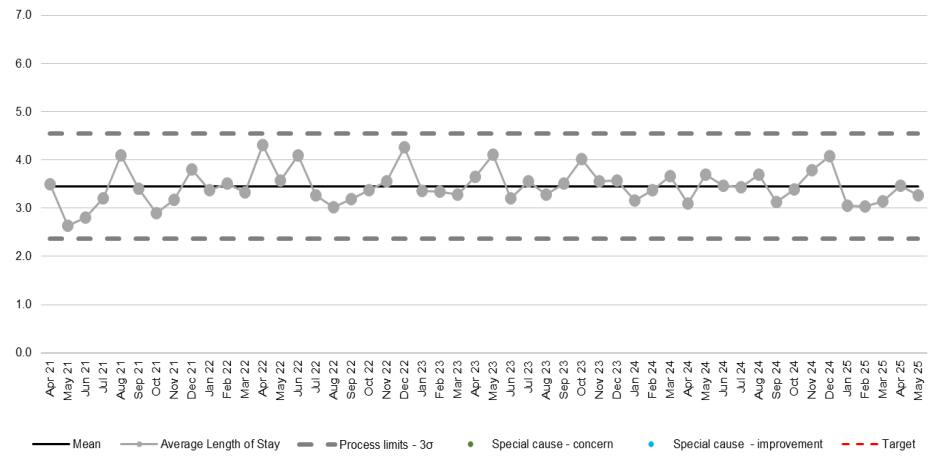
Patients cancelled on the day x 3	Patients admitted and had treatment deferred x 33	Patients cancelled by the hospital the day before the date of admission x 18
Total Clinical Cancellation: 1 Patient had increased risk of joint infection post op due to being MRSA positive. Surgeon decided not to proceed on the day. **Total Non-Clinical Cancellation:1** 1 set of equipment failed to be returned from Steris in the required timeframe.	**Clinical Total = 26** 11 x Medically unfit 5 x Skin integrity - insect bites/dog bites/ulcer etc. 8 x Patient self-cancelled / unwell / Change in plan / pt declined procedure, further investigation needed 2 x Symptoms Improved **Non-Clinical Total = 8** 6 x Lack of theatre time – due to complex cases and the impact of lost theatre capacity. 1 x No Interpreter 1 x Undeclared social issue	**Total Clinical Cancellation: 14** 4 x Medically unfit/further tests required 10 x Replaced by more urgent case due to theatre closures. **Total Non-Clinical Cancellation:** 4 4 x Surgeon unavailable

AREAS FOR IMPROVEMENT/ RISKS/ ISSUES

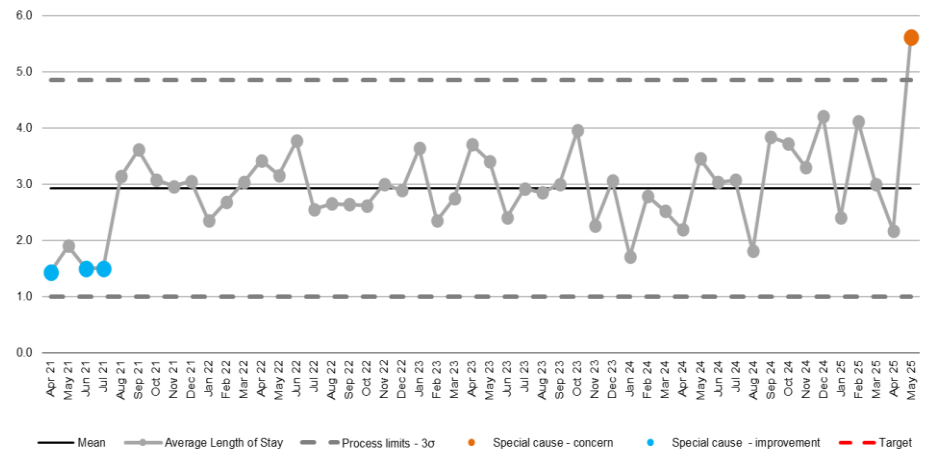
Daily monitoring of cancellations for non-clinical reasons that must be approved by Deputy COO, COO or Exec on call with the Escalation process re-emphasised to all staff. The Ops team continue to work with and support the 72hr call team in identifying medically unfit patients. The team are building up to the Focus on surgery week commencing the 7th July. The above data will form part of the foundation work in bringing all specialties together as part of a rigorous booking process for surgery looking to minimise clinical cancellations .

3. Length of Stay

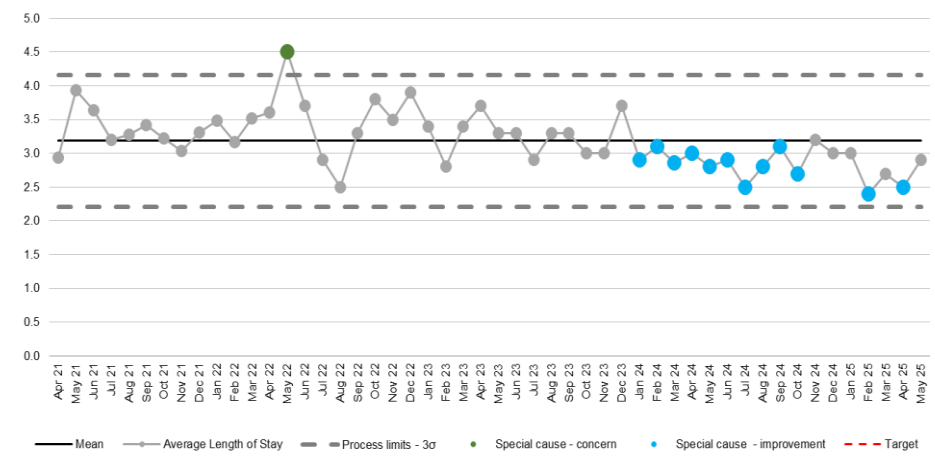
ROH Elective Average Length of Stay - Excluding Oncology, Paeds,YAH and Spinal



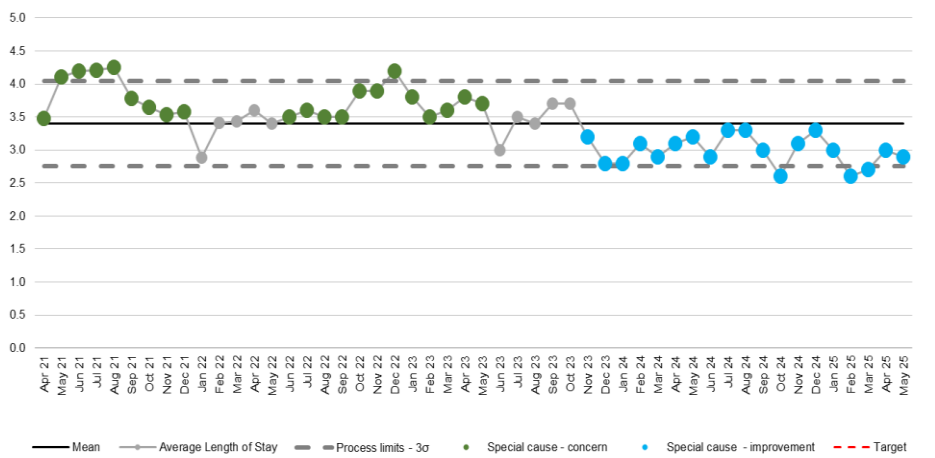
UHB Elective Average Length of Stay



Primary Hip Elective Average Length of Stay



Primary Knee Elective Average Length of Stay



3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips has increased to 2.9 days (2.5 days April 25) and primary Knees has decreased to 2.9 days (3.0 days April 25). The average length of stay for ROH patients excluding Oncology, Young Adult Hip and Spinal has decreased to **3.27 days** (3.46 days April 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 21 (15 April) 5 Oncology Arthroplasty (5 April) , 16 arthroplasty (10 April); 17 had an ASA score of 2 (mild systemic disease); 4 had an ASA score of 3 (a patient with severe systemic disease;

LOS >/=8 days as 9 (3 April), 3 Oncology arthroplasty (0 April) and 6 arthroplasty (3 April) . 7 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 had on going therapy needs, 5 required post discharge social care input i.e. package of care or rehab..

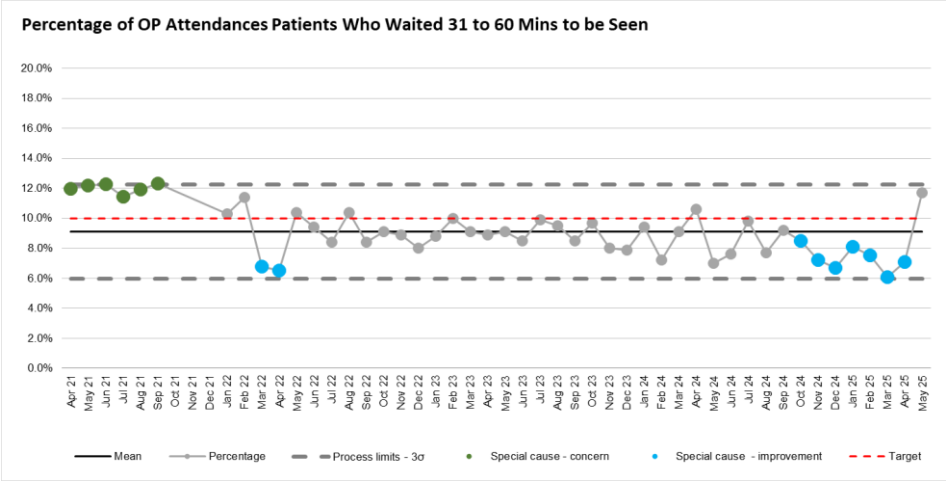
A review of all arthroplasty and oncology arthroplasty patients, identifies the number of patients with LOS >/= to 8 days as 28 (27 April).
9 were Oncology Arthroplasty, and 19 were Arthroplasty. This data included revisions, EPRs and other more complex surgeries.
Review of the 7 long stay patients with LOS >15 days, 4 were Arthroplasty and 3 Oncology arthroplasty.
Longest stay 31 days (31 April), was an Oncology arthroplasty Massive EPR. All stays >15 days reviewed on PICS appeared appropriate as had on-going Bone Infection Service, or other clinical/social care needs.

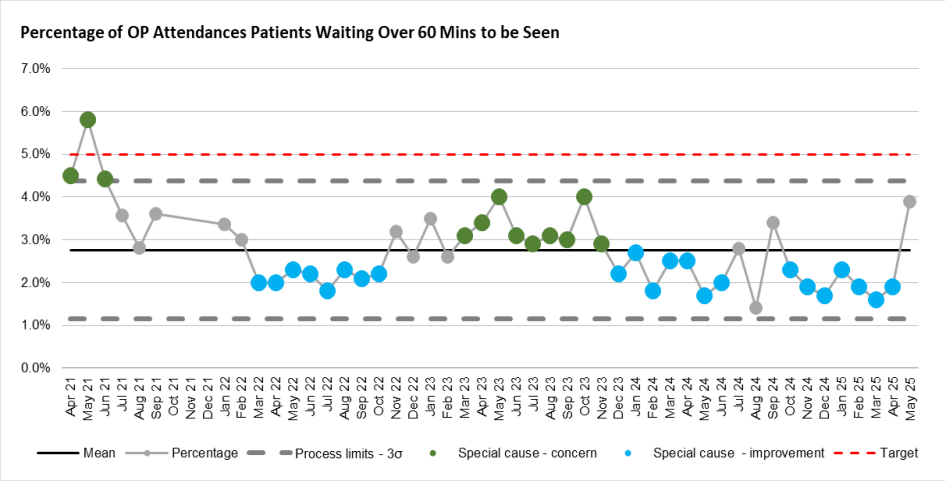
AREAS FOR IMPROVEMENT / ACTION PLAN

- Review scope of data included within report to ensure it aligns with what is being included by other organisations
- To note Bone infection, revision MRC and complex Oncology arthroplasty 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-Head of Nursing Div 1 to seek update.
- Alignment of support services to 7 day working, if arthroplasty lists to continue Saturdays. Avoiding the need to use on-call support services to enable timely discharges..
- Ambulatory unit for cohorting of all primary joint patients- a proof of concept trial with detailed auditing is being planned.
- Review LOS data by consultant to enable analysis of themes/trends.

4. Outpatient efficiency

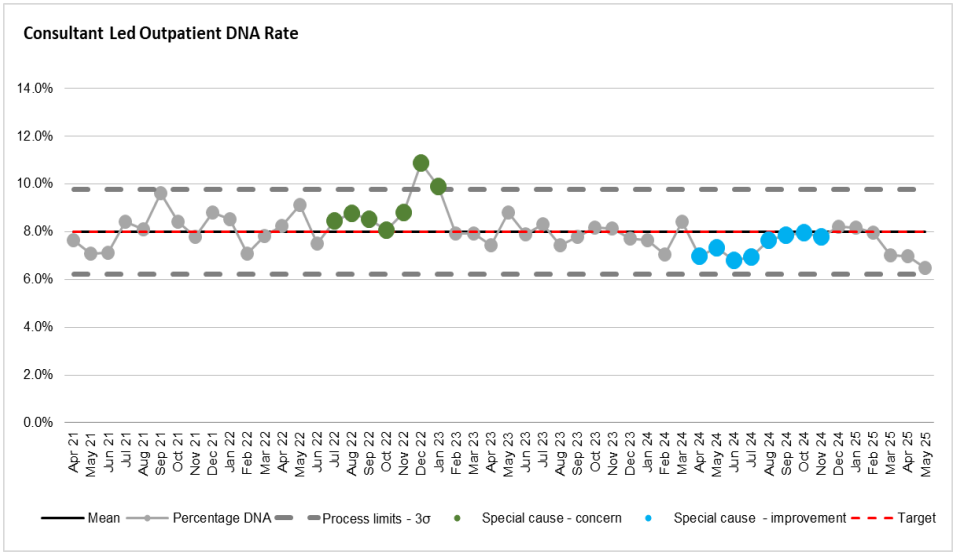
DATA QUALITY KITEMARK

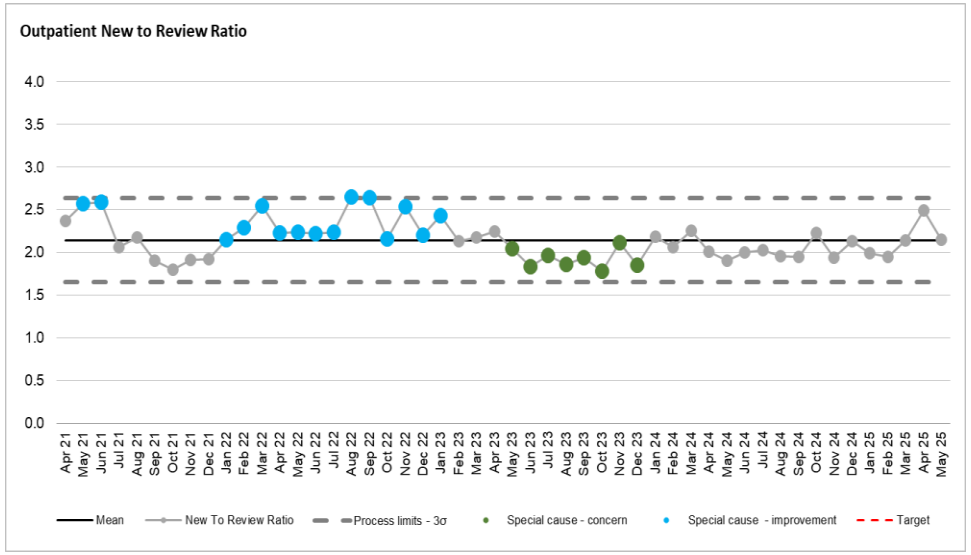


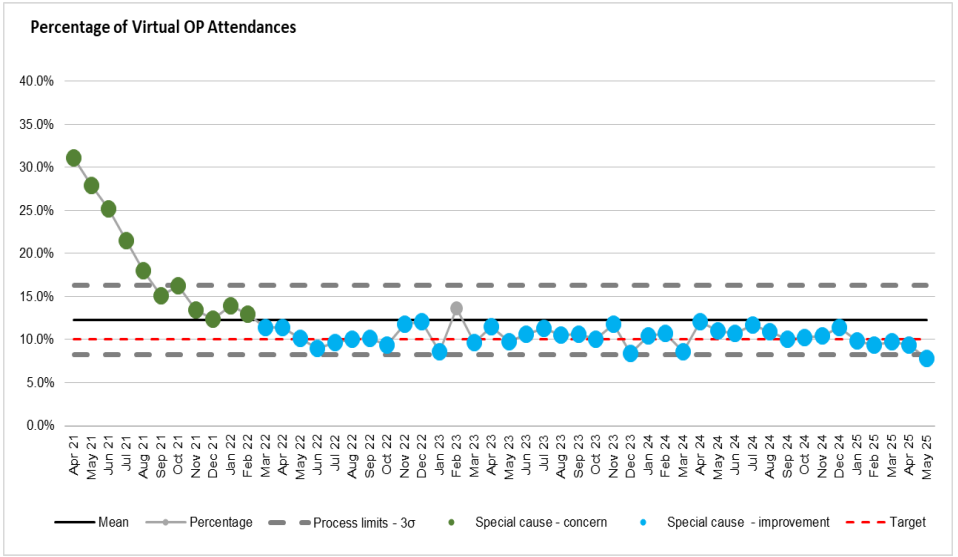


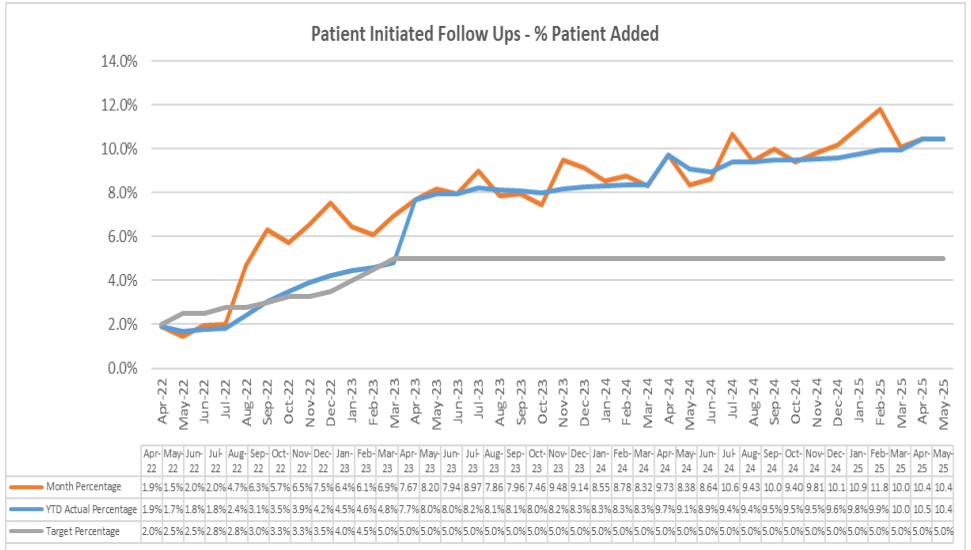
4. Outpatient efficiency

DATA QUALITY KITEMARK



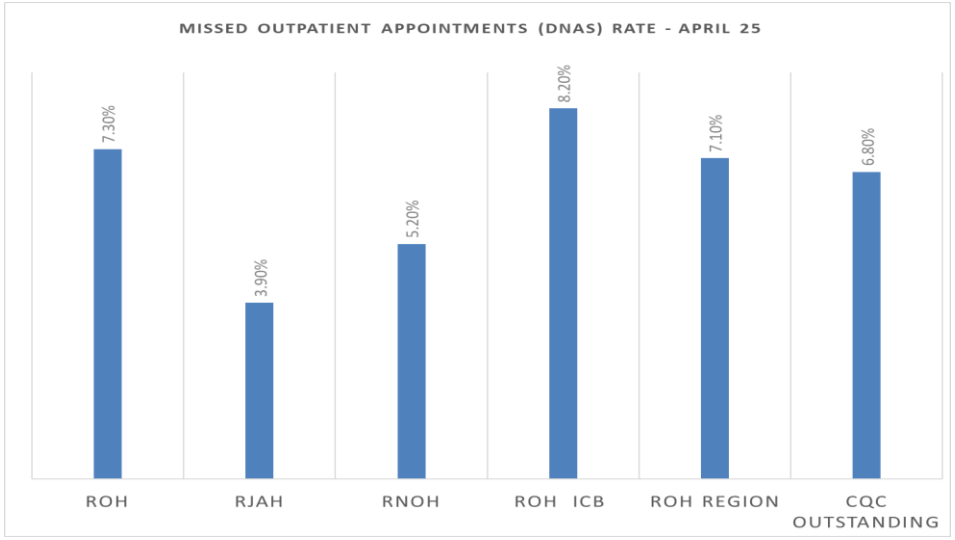


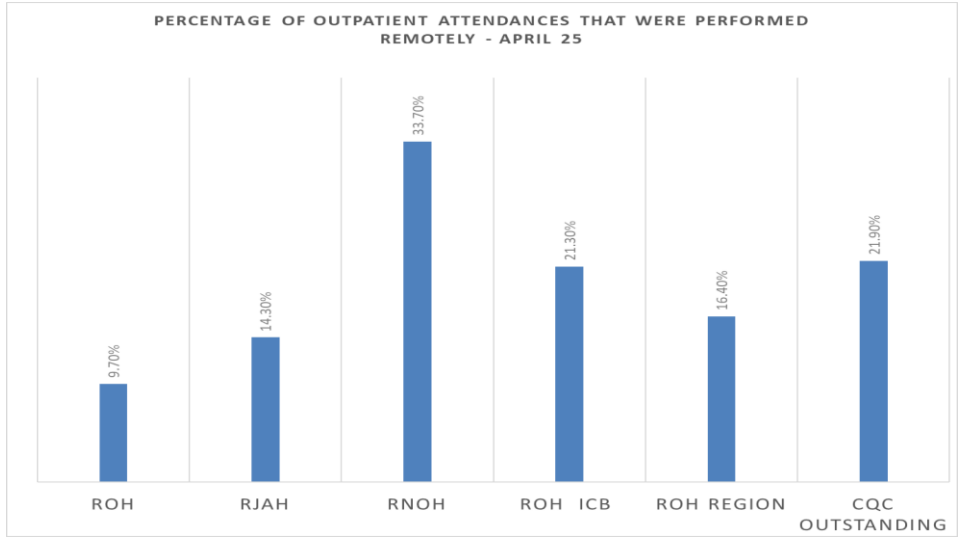


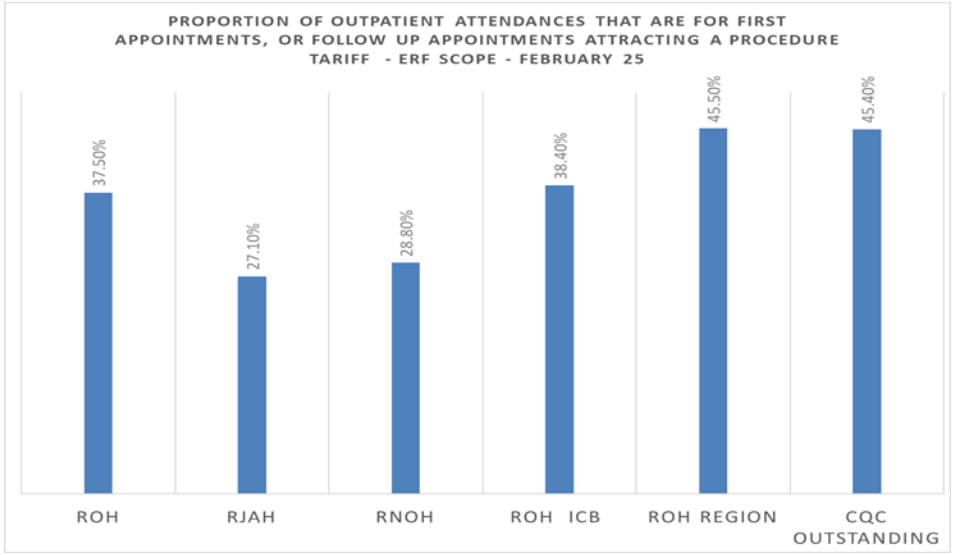


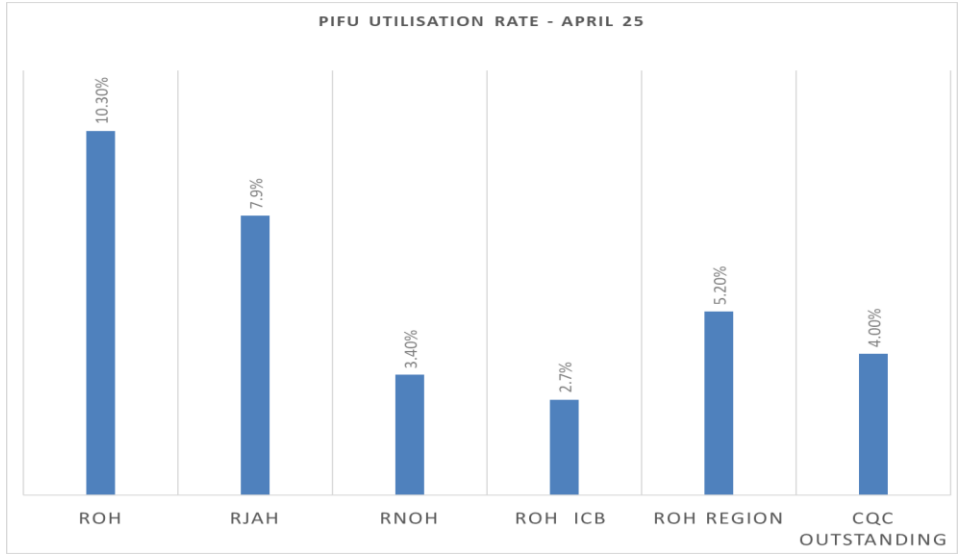
4. Outpatient efficiency

DATA QUALITY KITEMARK









4. Outpatient efficiency

DATA QUALITY KITEMARK

SUMMARY

May 2025 performance is as follows:

- 5,261 face to face and 448 virtual appointments
- 7.85% virtual in total.
- 10.4% of outpatient attendances moved to the PIFU waiting list. The overall YTD position is 10.4%.
- 6.48% achieved the missed appointment (DNA) rate – lower than the Trust target of 8% and an improvement on April 25 position of 6.96%

- **Clinic Waiting Times**
- 30-minute delays – not meeting Trust Target at **11.7**% **(Target 10%)**
- 60-minute delays – meeting trust target at **3.9**% **(Target 5%)**

AREAS OF IMPROVEMENT

Outpatient Utilisation

- Outpatient activity is **11% under plan** for new appointments **and 7% over plan** for follow ups in May 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 (where clinically appropriate). In addition, there has been some delays in cashing up clinics and a rectification plan is now in place to ensure that cashing up is undertaken in a more timely manner. This will be rectified with the future introduction of electronic outcomes.

- Clinical Portal is being rolled out in pilot specialities to remove notes from clinic. A paper will be taken to OMB in early July on next steps.

- Two new self-check-in kiosks have now been installed, and currently with IT to resolve some technical issues before these are turned on. They are expected to be live week commencing 23rd June 2025. The new kiosks will support collection of patient demographic data including ethnicity and communication needs.

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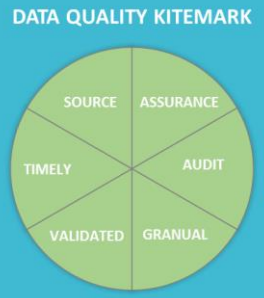
4. Outpatient Transformation



SPECIALTY PRIORITY UPDATES / HIGHLIGHTS

PIFU

The ROH continues to be a national exemplar for PIFU (6th nationally and top of the peer group on current Model Hospital data).

Discussions were held with Dr Doctor on 11/06 to agree a roadmap of priorities including use of the PIFU module. Currently being scoped – however limited automation due to integration issues with current PAS.

Robotics (RPA) options currently being explored to support timely closure of PIFU referrals that have reached the end of the pathway.

Missed Appointments

MSK testing paused due to Dr Doctor decision to withdraw support for SSIS integration for any further systems, and to move to full integration HL7 messaging. Discussions in progress to negotiate extension until full integration..

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.

Missed Appointments Improvement noted in March and April. Opportunities being explored – including following George Elliots example of volunteers contacting patients – Currently recruiting volunteers.

Reduction in Follow Ups

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.

Clinical Pathways (e.g. Specialist Advice)

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 several 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.

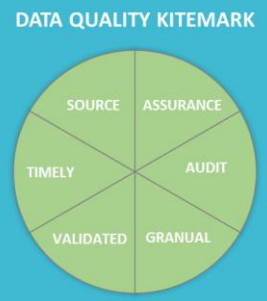
In the month of May (5th May to 1st June), 190 A&G referrals were received via the Electronic Referral System

Productivity & Efficiency

Re-focused group has met to prioritise the objectives outlined under the outpatient transformation group reporting to the Trust Improvement Group.

Review of NHS impact best practice guidance completed with an action plan in place.

5. Referral to Treatment -



SUMMARY

The Referral To Treatment (RTT) position for May 25 was 58.33% against the National Constitutional Target of 92%. This represents a 2.70% increase compared to the April 25 reported position of 55.63% that includes patients transferred from other providers. The LUNA report for data quality validation is consistently above 98%.

0 patients breached 65 weeks in May-25. 507 patients were waiting over 52 weeks in May 25 that is an increase from the trust wide position for April 25 that was 486 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 May 25, ROH received 2,745 referrals (101.52%) 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

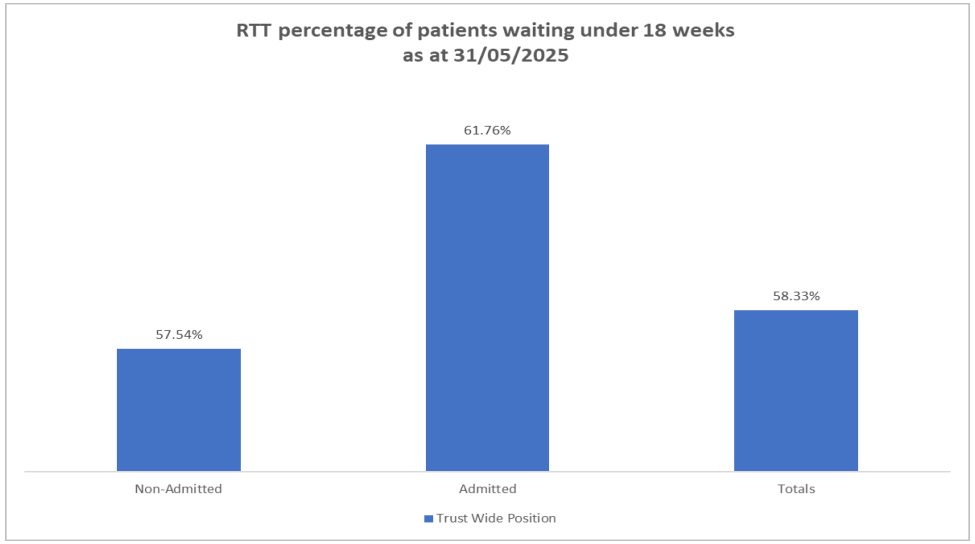
Spinal backlogs continue to be a concern with the team focussing on managing all patients currently over 55 weeks and preventing breaches of the 65 weeks standard, in addition to the management of urgent patients. In May 25, the management of the spinal daily patient tracking list meetings was handed back to the Division 1 Associate Director of Operations to maintain the current performance. Further demand and capacity work has been completed aligned to job plans and clinic templates that has been used to inform the Spinal trajectory.

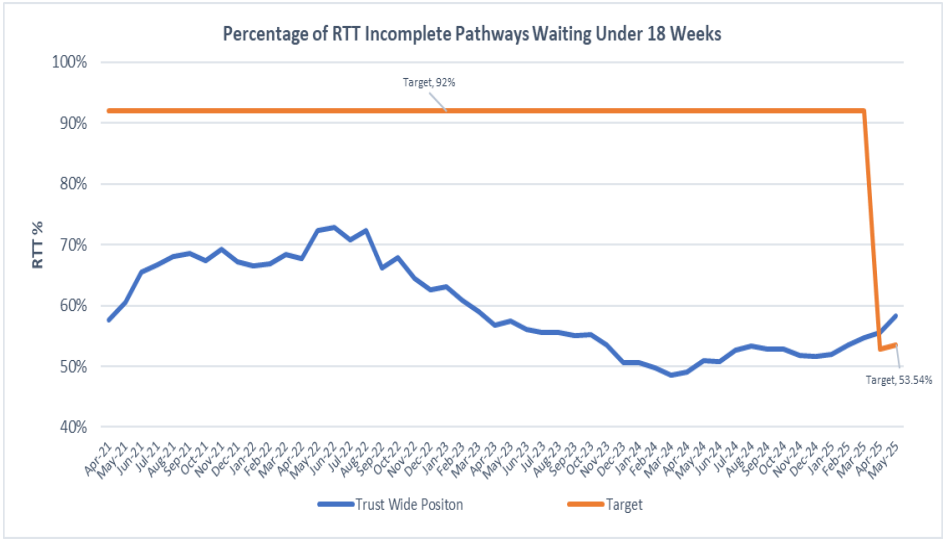
5. Referral to Treatment

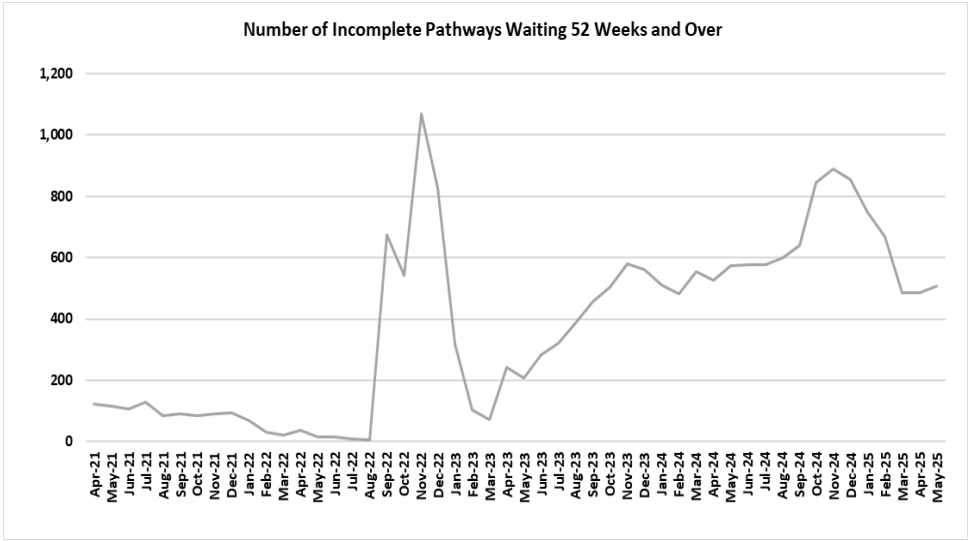
DATA QUALITY KITEMARK

	Trust Wide Position		
Weeks Waiting	Non-Admitted	Admitted	Totals
0-6	2,793	632	3,425
7-13	2,173	590	2,763
14-17	1,015	262	1,277
18-26	1,424	436	1,860
27-39	1,580	360	1,940
40-47	672	81	753
48-51	260	13	273
52 weeks and over	478	29	507
Total	10,395	2,403	12,798

Weeks Waiting	Non Admitted	Admitted	Totals
Under 18	5,981	1,484	7,465
18 and over	4,414	919	5,333
Month End RTT %	**57.54%**	**61.76%**	**58.33%**

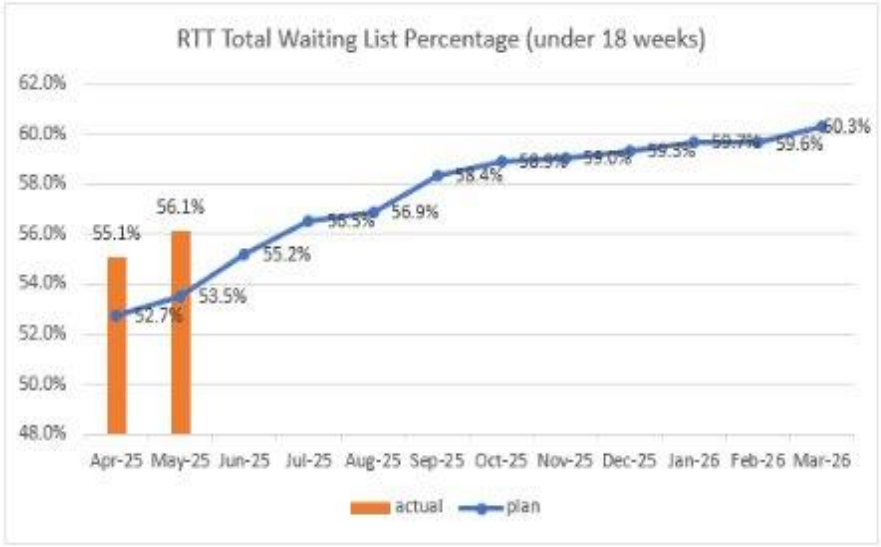


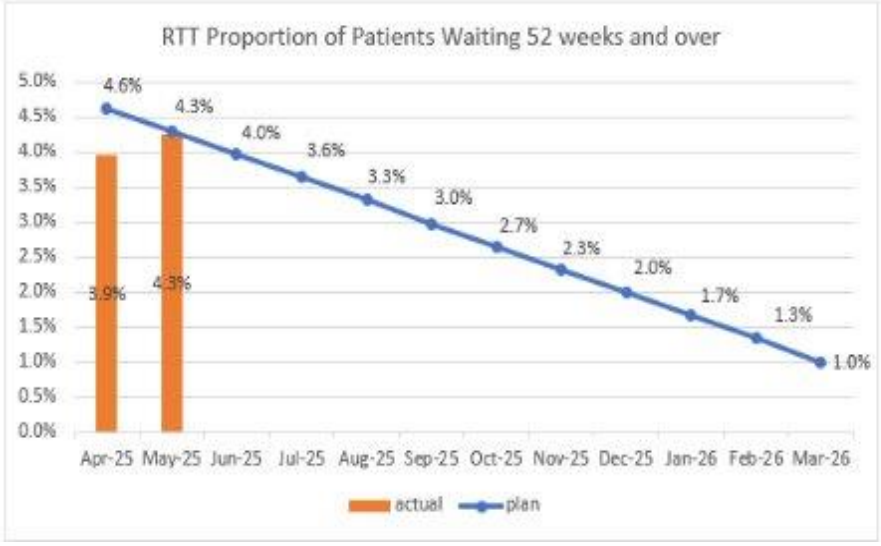




5. Referral to Treatment

DATA QUALITY KITEMARK

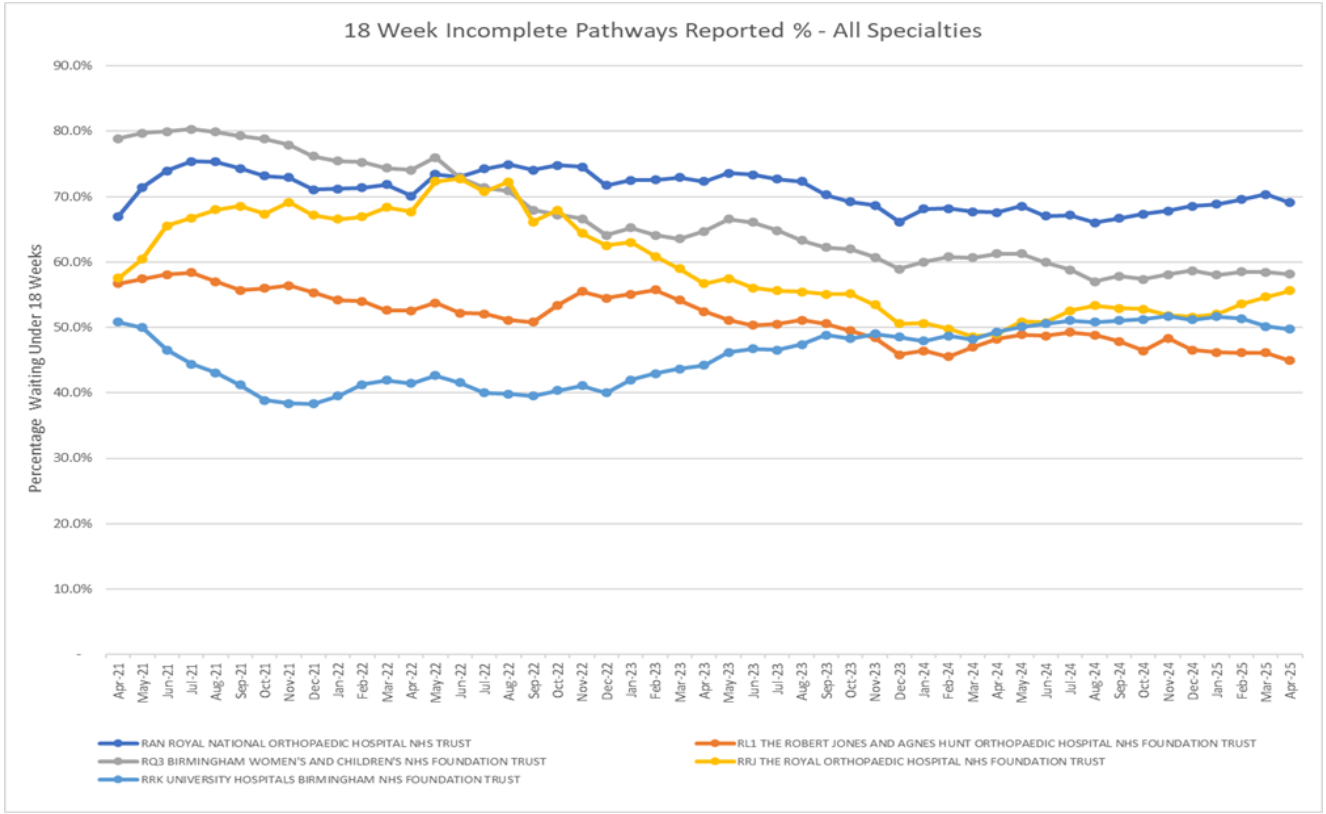




5. Referral to Treatment

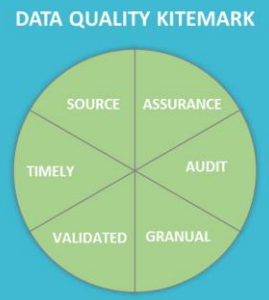
DATA QUALITY KITEMARK

18 weeks Incomplete pathways Benchmarking against other providers:

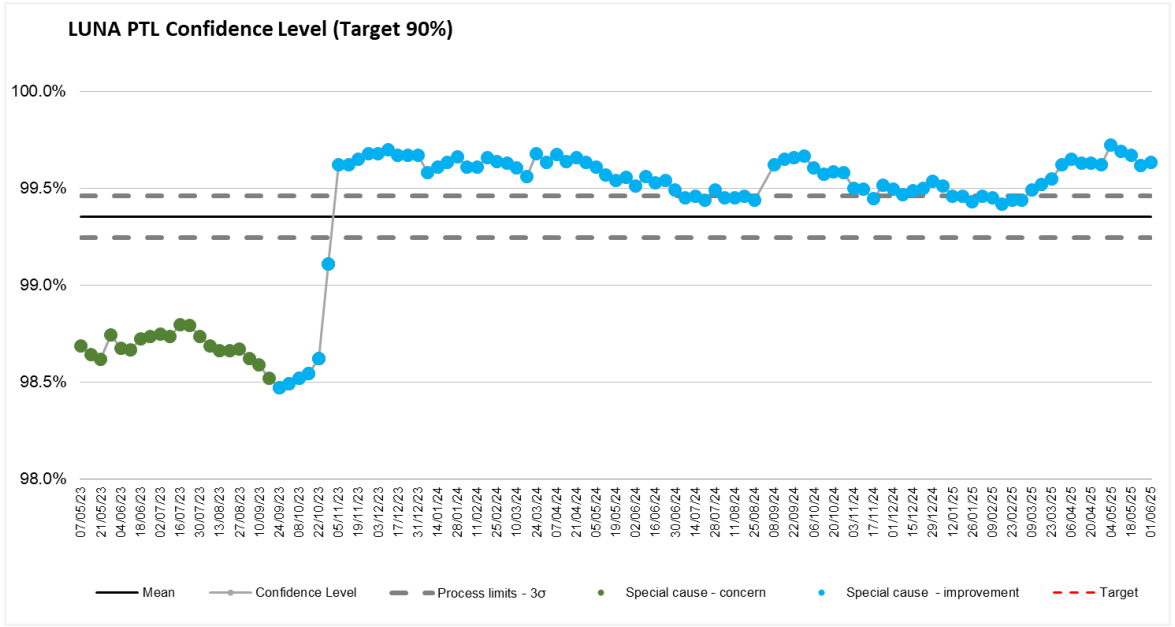


5. Referral to Treatment

Luna Data



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

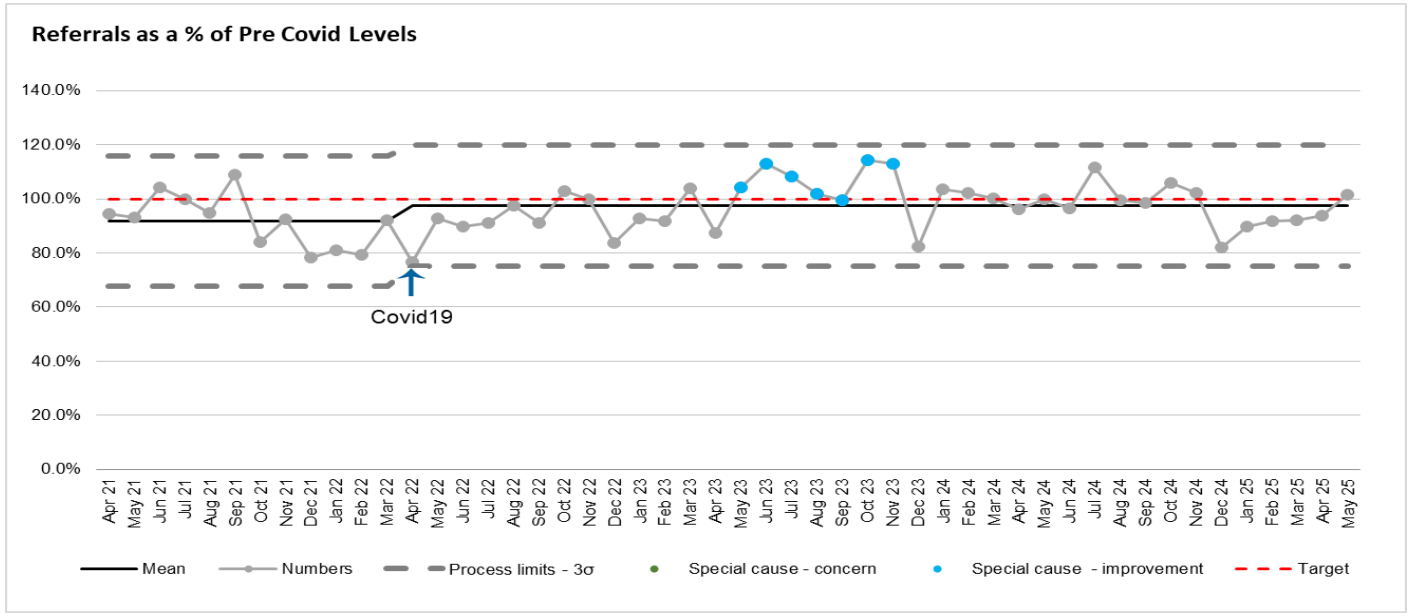


It is important to note the significant improvement from the data quality team utilising the LUNA data to continue to drive improvements. The latest chart suggests that the Trust has minimal errors identified by LUNA with a confidence rate in excess of 99.5%.

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-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Number of Referrals	2557	2521	2815	2704	2567	2941	2273	2495	2113	2236	2249	2516
Referrals as a % of Pre Covid Levels	94.56%	93.23%	104.11%	100.00%	94.93%	108.76%	84.06%	92.27%	78.14%	82.69%	83.17%	93.05%

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
2082	2522	2479	2573	2681	2515	2820	2728	2282	2532	2513	2835
77.00%	93.27%	91.68%	95.16%	99.15%	93.01%	104.29%	100.89%	84.39%	93.64%	92.94%	104.84%

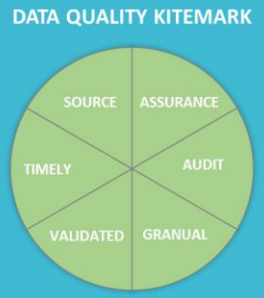
Month	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Number of Referrals	2363	2818	3059	2926	2752	2693	3093	3056	2224	2802	2760	2707
Referrals as a % of Pre Covid Levels	87.39%	104.22%	113.13%	108.21%	101.78%	99.59%	114.39%	113.02%	82.25%	103.62%	102.07%	100.11%

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
2595	2700	2613	3022	2692	2660	2860	2766	2221	2425	2485	2489
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
Number of Referrals	2540	2745										
Referrals as a % of Pre Covid Levels	93.93%	101.52%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

5. Referral to Treatment

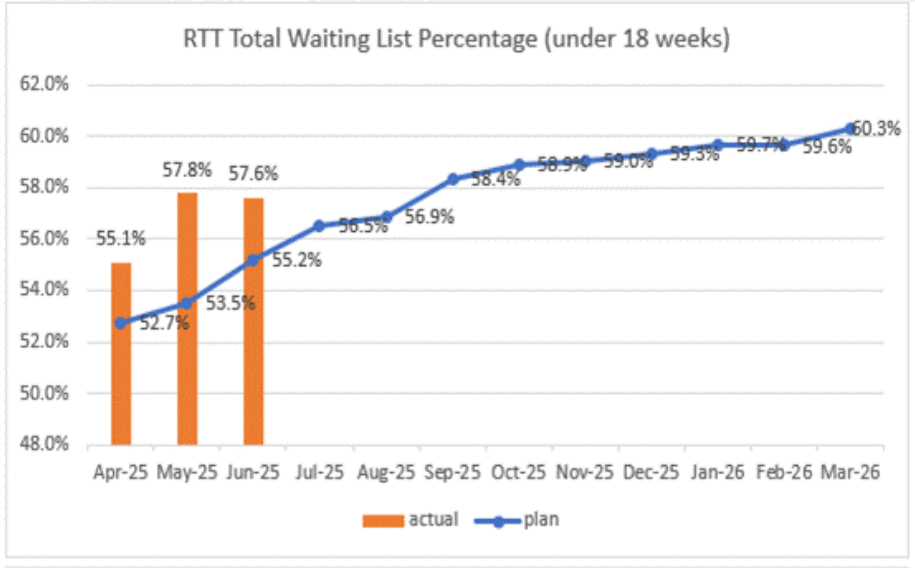
Specialty Breakdown

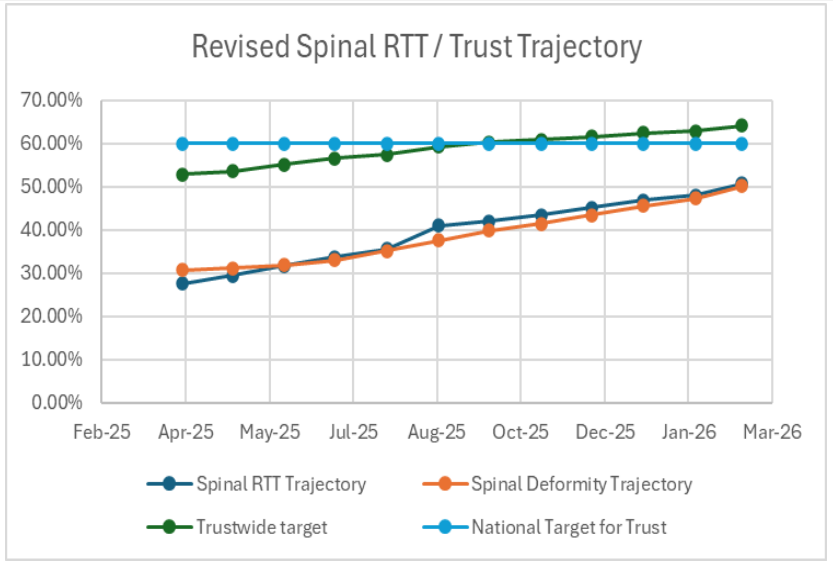


The national RTT target is for 92% of patients to be treated within 18 weeks. The table below highlights the current performance against this target by specialty. It also includes the number of patients currently waiting over 52 weeks prior to any tip ins. This will be used to support focussed intervention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





Spinal Rectification Plan

As of 18.06.2025, the current RTT for Spinal Deformity is 34.63% and Spinal is 35.14%. Although an improvement has been made this is not sufficient to reduce the number of patients waiting over 52 weeks or improve the overall Trust performance.

Chart 1 above provides Spinal's progress against the Trust's current trajectory.

Chart 2 above provides a trajectory to increase the Spinal position to 50% and the Trust wide position to 64.5%. This will support a faster reduction in long waits. The team have already applied a high proportion of productivity gains to the existing trajectory and to improve the trajectory across Spinal and Spinal Deformity to over 50% will require an extra 100 new outpatient appointment slots per month and an extra 15 TCIS per month.

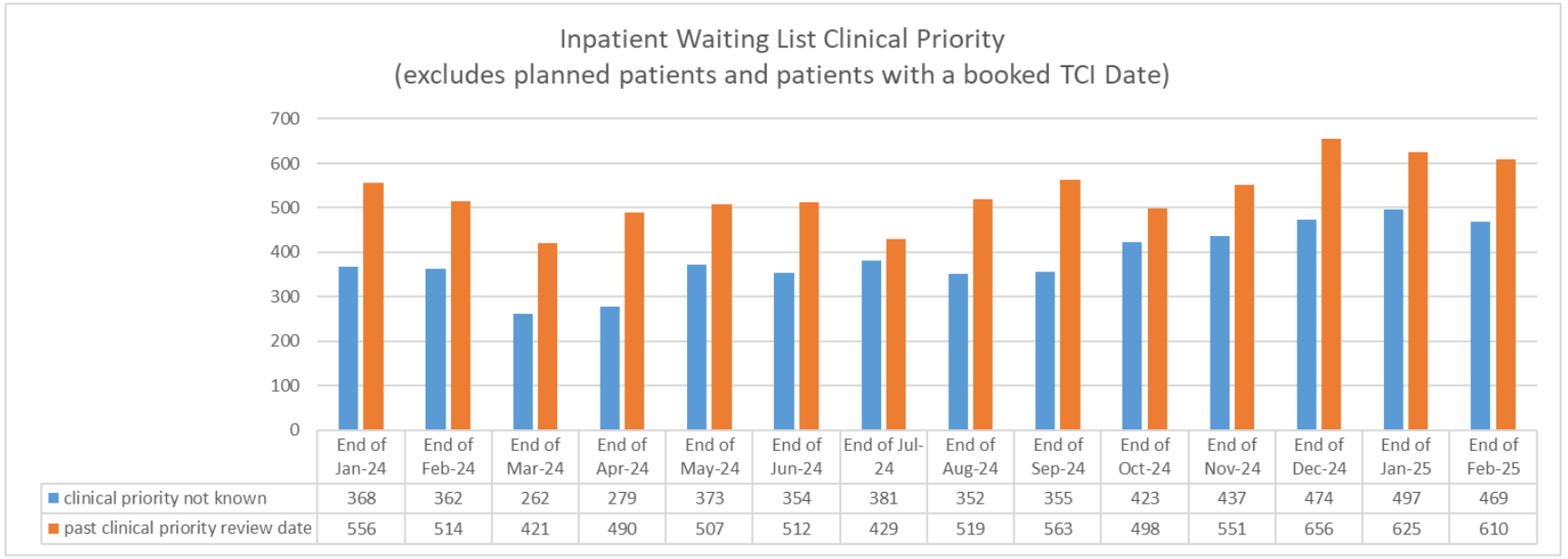
If this was provided solely using premium rate capacity, then the cost would be circa £102,000 per month. There is a current backlog of circa 470 patients waiting over 52 weeks and one option would be to scope adding this amount of capacity over the next couple of months dependent on clinical engagement and willingness to review a higher volume of patients.

A Spinal workshop is being chaired by the COO on Friday 20th June 2025, and a verbal update will be provided on further options to improve the RTT position. However, it is likely that premium rate spend will be required to improve the overall RTT position.

5. Referral to Treatment

DATA QUALITY KITEMARK

Overdue Clinical Priority:



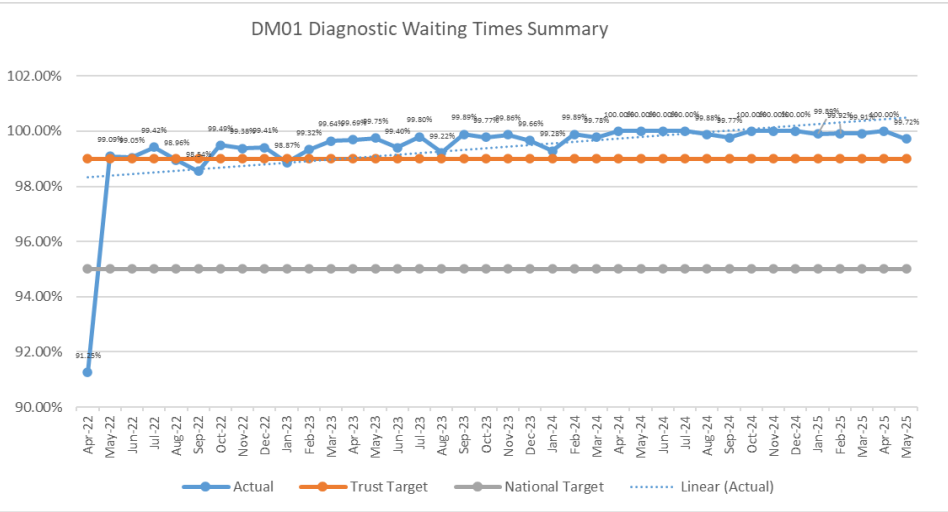
	End of Jan-24	End of Feb-24	End of Mar-24	End of Apr-24	End of May-24	End of Jun-24	End of Jul-24	End of Aug-24	End of Sep-24	End of Oct-24	End of Nov-24	End of Dec-24	End of Jan-25	End of Feb-25
clinical priority not known	368	362	262	279	373	354	381	352	355	423	437	474	497	469
past clinical priority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

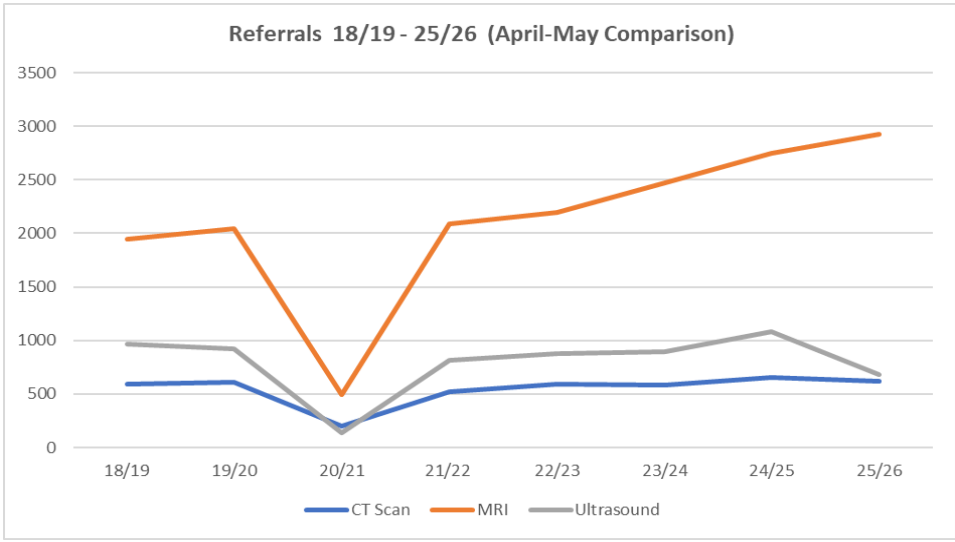
The number of patients with an unknown clinical priority has increased by 68 patients, however, the numbers that have past the clinical priority review date has reduced by 65 patients. The information continues to be shared monthly with individual services and clinicians to manage individual clinical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

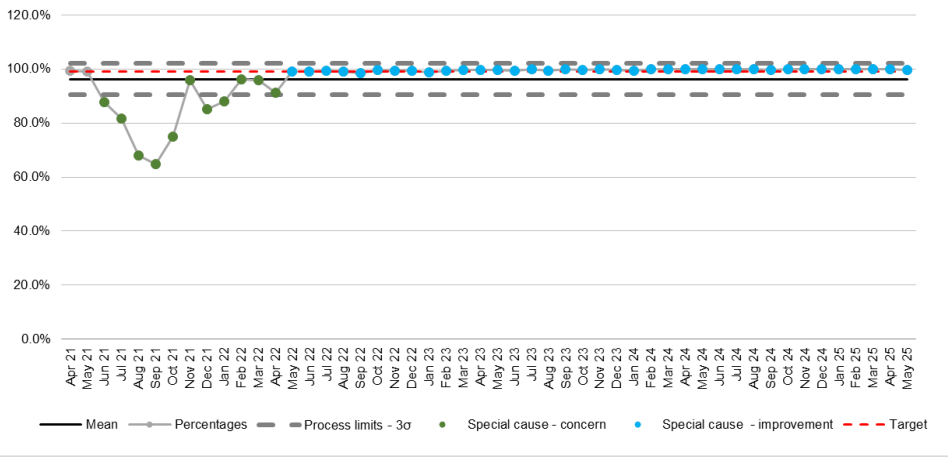
6. Diagnostic Performance

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

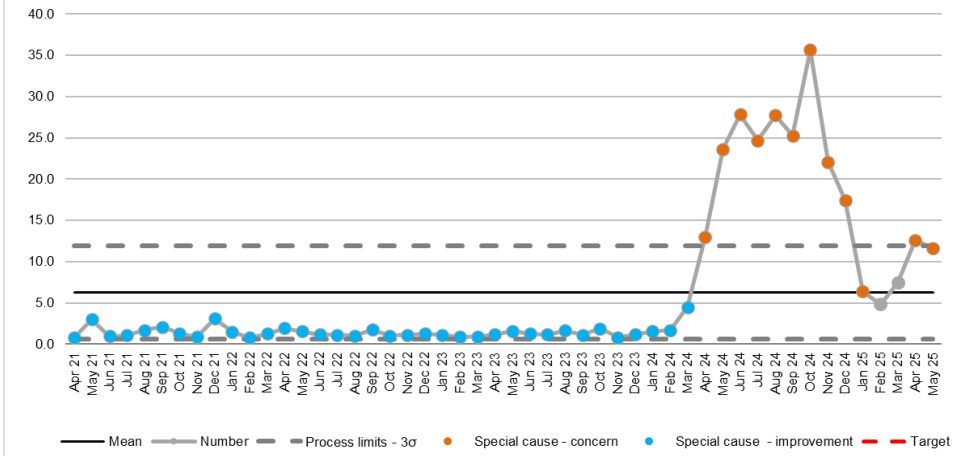




Diagnostics: Percentage of Patients Waiting Under Six Weeks



Diagnostics: Service Report Turnaround Times (Average Number of Days)



7. Diagnostic Performance

SUMMARY

The Imaging Department achieved the 99% DM01 target in May 2025 closing the month at 99.72%. The National 24/25 operational target remains at 95% which ROH continues to achieve consistently despite reduced capacity in ultrasound, and multiple breakdowns of one of the MRI scanners

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.

Capital plans for 25/26 include replacing the CT scanner and 2 x X-ray rooms, as these are out of full-service cover from December 2025. We have been on 2 x site visits to look at different suppliers X-Ray rooms, we are now awaiting quotes.

Discussions have started regarding an interim provision of Interventional CT service during CT scanner refurbishment. The team have met with 2 x private providers and are discussing with BSOL Diagnostic providers whether or not the Trust can redirect activity & capacity to avoid going to the independent sector. Successfully appointed into 2 x WTE Band 5 X-ray Radiographer vacancies.

Restarted QSI application – currently reviewing all existing SOP's. Aim to achieve "Working Towards" status by July 2025.

RISKS

There is an ongoing current risk with Consultant Radiologist workforce vacancies. The post will be readvertised following approval process.

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 – April 25 (June 2025 Submission)

		April 25 (complete)			
Target Name	National Standard	%	In target	Breach	Total
31 DTTD to Treatment	96%	100%	22.0	0.0	22.0
62 day RTT to treatment	70%	85.7%	9.0	1.5	10.5
28 day FDS REPORTED	77%	77.3%	58	17	75
Patients over 104 days (62 day standard)				0	

Performance

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

The 62-day metric was achieved at 85.7 %. A total of 11 treatments were applicable to the trust, 9 of those were compliant and the remaining 2 patient's breached. The root cause of the delays for the 62-day breach were due to medical conditions and complex pathology.

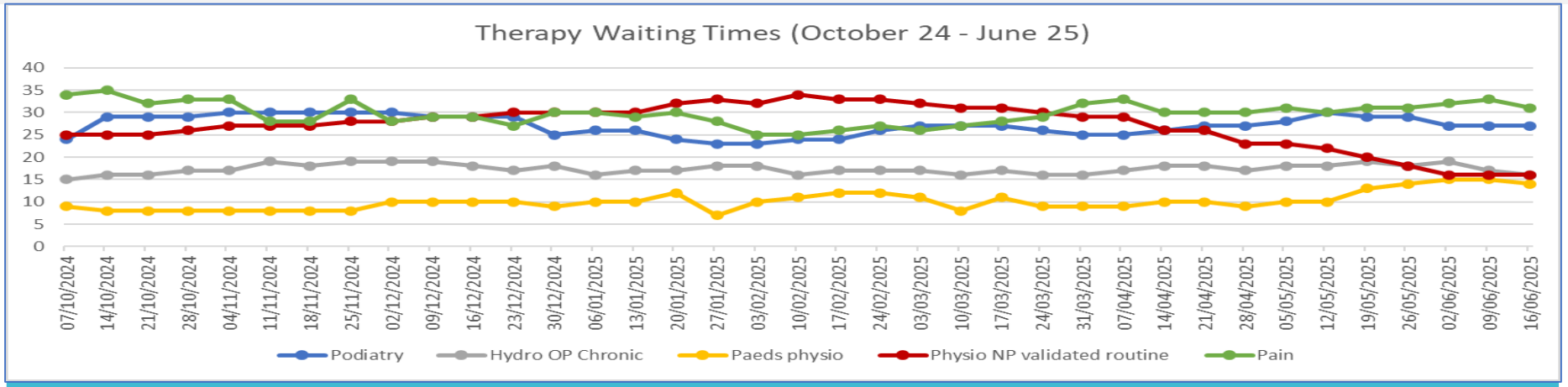
- 0.5 shared breach; This patient was a direct 2ww referral into the ROH. The root cause of the delay was due to patient choice delaying their diagnostic biopsy by 21 days due to a holiday. This resulted in a later tertiary out to UHB for Radiotherapy and the breach was shared with the treating trust.
- 1 full Breach. This patient was a consultant upgrade following spinal MDT. The root cause of delay was due to patient choice as patient delayed their pathway by 40 days due to personal circumstances and would not come to clinic to consent for surgery. Patient only consented on day 60 of their pathway and therefore full breach was allocated to the ROH.

Risks /actions ongoing

The team continues to receive positive feedback on cancer pathways and remains compliant against all three metrics for the past 12 months. Interventional radiology capacity is still limited for CT guided biopsies currently 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, resilience and unity within the UHB Histopathology Dept continues to be raised. Turnaround times remain poor, although FDS is currently compliant, the malignant cases for April was only achieved at 58% compliance. It is also becoming challenging for ROH to achieve the standard. Twice weekly escalation continues to the Director of pathology at UHB. Specimens requiring next generation sequencing is becoming more frequent and has an average turnaround time of 28 days. Bi-Weekly meetings are now in place with ROH and UHB Ops colleagues to discuss turnaround times and quality improvement projects. Concerns are also reported to the weekly system oversight group and action plans are reviewed and monitored at cancer board.

9. MSK Waits



Summary – data as per 16/06/25

The chart above shows changes in waiting times over recent months. Waiting times remain challenging for Podiatry (27 weeks) and Pain Management (31 weeks). Please see the next slide for further information on Pain. Further detail on Podiatry will be included in next month's pack. However, physiotherapy waiting times have reducedsignificantly from 33 week with 36% of patients over 18 weeks in January, to 16 weeks with only 1% over 18 weeks. The main drivers for this are waiting list initiatives and funding from GIRFT. Initiatives have included validation, assessment clinics for approximately 800 patients, recruitment to vacancies and additional resources, caseload and template reviews and a further Mini Community Appointment Day with 867 patients attending on 14th June 25.

• Risks / Actions Ongoing

- Recruitment continues to be a challenge for physiotherapists, and a locum is in place to support whilst on going recruitment continues.
- There is a risk regarding sustaining waiting time improvement now that GIRFT funding has ceased with a 23% increase in physio referrals compared to previous years. The team where possible continue to follow the GIRFT methodology to help mitigate.
- Administrative workforce challenges remain managing a PTL of circa 3,000 pts. Capacity and demand modelling and a wider workforce review is underway for all MSK services including admin.
- The team is working on modernising and digitising the self-referral form.
- Text messaging is currently on hold due to HL7 live feed issue. Discussions in place with IT and Dr Doctor.

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9. MSK Waits - Pain Management

Summary – data as per 16/06/25

The previous slide includes the waiting times for a first appointment in Pain Management that have fluctuated between 28 and 33 weeks - since January 2023.The referral chart above shows that referrals have gradually increased since Covid and returned to pre-covid levels in 23/24. Referral rates in 24/25 exceeded this by 15% with no increase in workforce. A Demand & Capacity model has been produced that suggests a further 2 FTE consultants are needed to balance demand and capacity. If the current staffing model was expanded, additional nursing and psychology hours would also be required and reflected in a business case.

Mitigations / Actions

- Additional ad hoc capacity is now in place and will focus on outpatients with the intention of reducing the wait to be seen.
- Clinic templates are being benchmarked with peers to understand scope for increasing existing clinic capacity
- An ROH anaesthetist that is also a pain consultant at another trust has been approached to understand whether he would provide further ad hoc pain management capacity
- Pain Management programmes have been restarted now the psychology vacancy has been filled.
- Dedicated speciality waiting list validation has commenced to cleanse the data
- The team are exploring potential for self-management / education session prior to first appt.
- Undertaking a workforce review and potential business case to increase capacity

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10. Private Patients

SUMMARY

The service has a revised planned revenue of £6.1m in 25/26 with a stretch target of £6.5m

- May revenue is forecast at £537,308 (£8,342 behind plan)
- The service is currently £8,567k behind plan to achieve £6.1m (YTD)
- Tariff with WPA has been renegotiated with an average 20% uplift .

	Apr-25	May-25	YTD
(£6.1m)	£385,000	£546,000	£931,000
Income Actual	£384,775	£537,658	£922,433
Variance	-£225	-£8,342	-£8,567

AREAS FOR IMPROVEMENT

An operational delivery plan presented to Trust Board on 4th June has been approved.
The main areas of focus to achieve the revenue plan in 25/26 are;

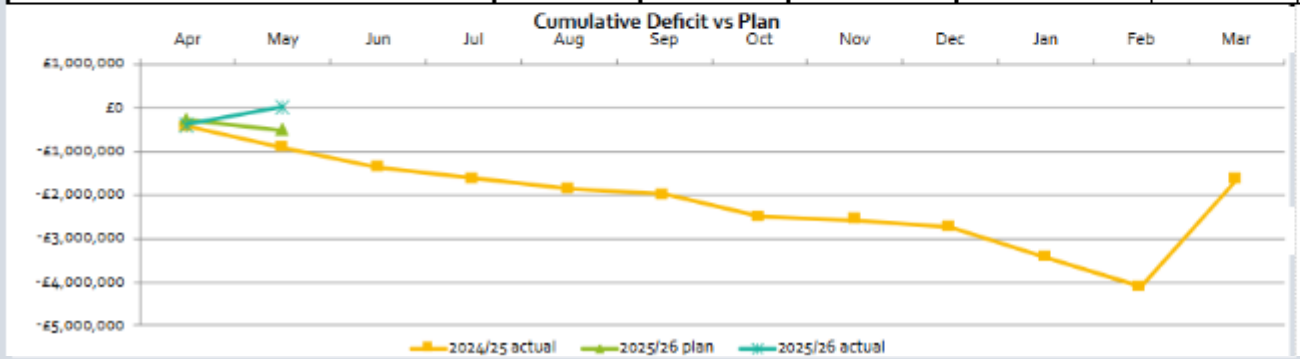
- Allocate 1 theatre per day to private work.
- Grow the overseas market – partnering with the local independent sector and exploring opportunities with overseas health brokers.
- Further interrogation of Trust systems to understand cost and profit margins.
- Undertake business case to support software 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

Month 2

FINANCIAL PERFORMANCE

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	£11,341	£11,694	£353	£22,184	£22,711	£527	£140,599	£140,599	£0
Other income	£451	£598	£147	£887	£1,107	£220	£5,540	£5,540	£0
Pay	-£6,976	-£7,026	-£50	-£13,987	-£13,970	£17	-£82,070	-£82,070	£0
Non Pay	-£4,927	-£4,775	£152	-£9,360	-£9,651	-£291	-£62,654	-£62,654	£0
Non operating costs	-£115	-£89	£26	-£231	-£171	£60	-£1,380	-£1,380	£0
TOTAL	-£226	£402	£628	-£507	£26	£533	£35	£35	£0



Agency as a % of paybill =1.6%

Efficiencies	YTD	Forecast
Plan	£1,038	£9,450
Actual	£984	
Variance	-£54	

Capital	YTD	Forecast
Plan (exc IFRS16)	£270	£25,365
Actual	£220	£25,365
IFRS 16	£0	£465
Variance	-£50	£0

Better Payment practice code	YTD	% move't prev month
Non-NHS		
By number	73.5%	0.9%
By Value	78.2%	4.3%
NHS		
By number	57.7%	-3.0%
By Value	19.3%	-1.0%
Total		
By number	73.0%	0.8%
By Value	68.5%	1.4%

12. Overall Financial Performance

SUMMARY

The Trust delivered a surplus in month of £402k, generating a year to date surplus of £25k which is £523k better than plan.

Income performed better than plan by £747k year to date. NHS chargeable activity overperformed by £520k year to date. Private patient income overperformed by £140k, and other income by £282k.

Pay expenditure is underspent by £17k year to date. Agency spend in month was 1.6% of paybill year, with an underspend of £76k. Bank expenditure reduced in month with a year to date underspend of £201k.

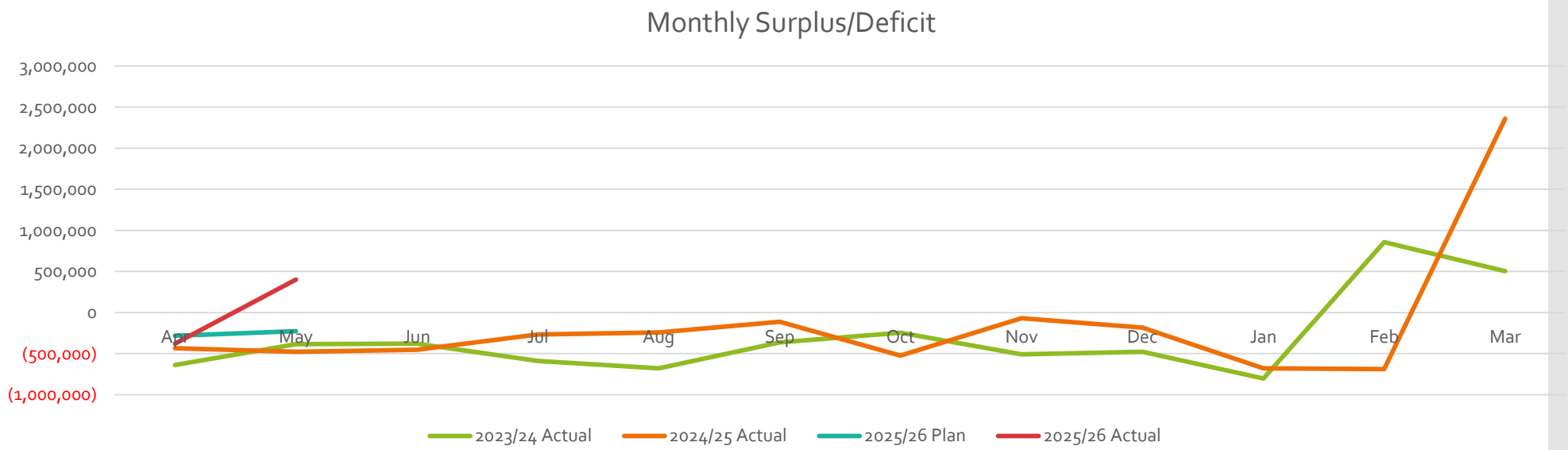
Non pay expenditure overspent in month by £50k increasing the year to date deficit to £291k. This is primarily driven as a result of; underperformance on non pay CIP schemes and clinical supplies.

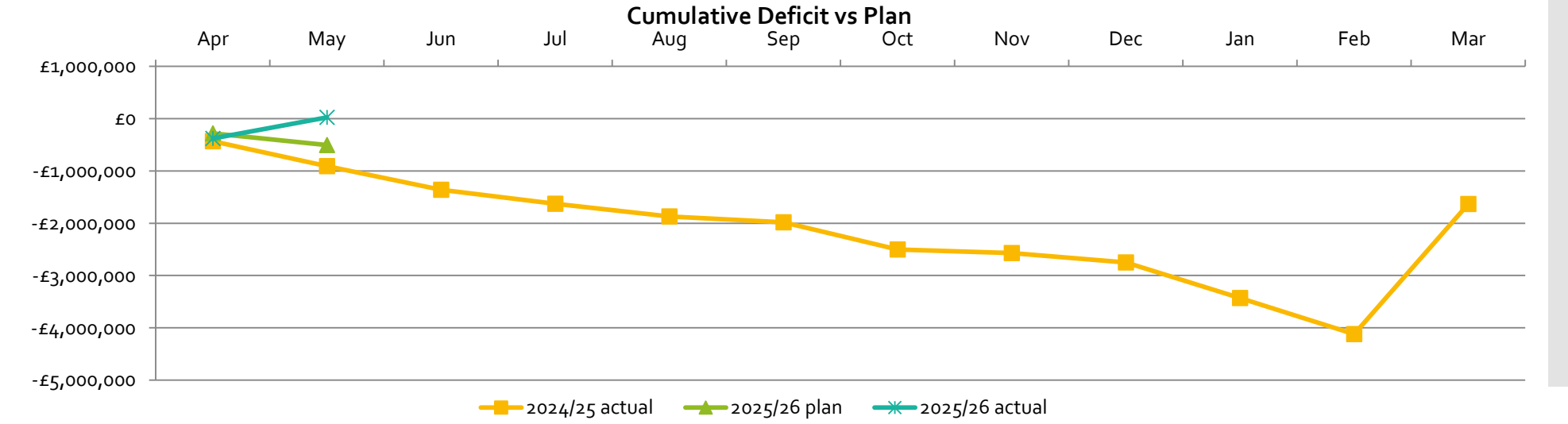
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	747	17	(291)	60	532
Year to date plan	11,526	(13,987)	(9,360)	(231)	(507)
Year to date actual	23,818	(13,970)	(9,651)	(183)	25
Variance compared previous month	↑	↑	↑	↑	↑

12. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	22,184	22,711	527
Other Operating Income (Excluding top up)	887	1,107	220
Employee Expenses (inc. Agency)	(13,987)	(13,970)	17
Other operating expenses	(9,360)	(9,651)	(291)
Operating Surplus	**(276)**	**197**	**473**
Net Finance Costs	(246)	(190)	56
Net surplus/(deficit)	**(522)**	**7**	**529**
Remove donated asset I&E impact	15	19	4
Adjusted financial performance	**(507)**	**25**	**532**

12. Overall Financial Performance





13. Income

SUMMARY

Income performed better than plan by £747k year to date. NHS chargeable activity overperformed by £520k year to date. Private patient income overperformed by £140k, and other income by £282k.

Elective activity overperformed against plan by £520k with £8.1m delivered against a plan of £7.5m.

AREAS FOR IMPROVEMENT

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

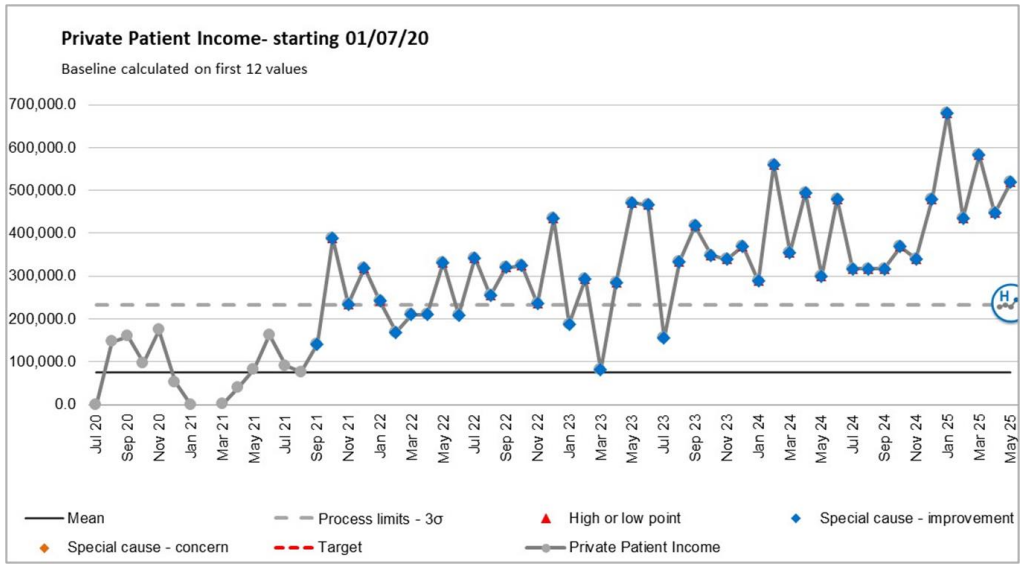
RISKS / ISSUES

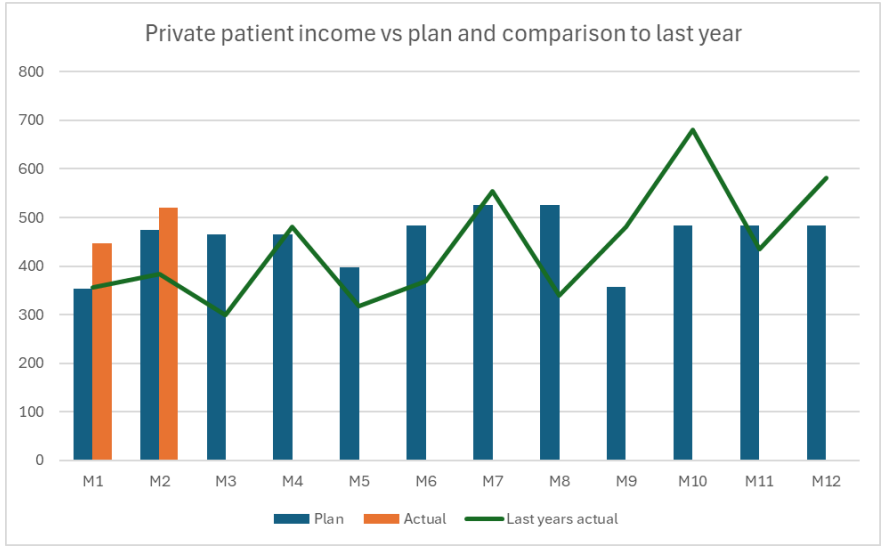
Overperformance of NHS funded activity will not be reimbursed, meaning it is important to stay within the commissioned income cap.

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

13. Income

NHS income

Performance in chargeable elective activity compared to the payment cap limit by commissioner is shown below. The activity included in the performance include;

- Elective inpatients
- Day case
- Outpatient procedures
- Outpatient first attendance

	Actual			In month		Year to date	
Commissioner	**Month 1**	**Month 2**	**Year to date**	**Payment cap limit**	**Variance**	**Cap limit**	**Variance**
Armed Forces	8,302	9,111	17,412	0	**9,111**	**0**	**17,412**
QGH: NHS Herefordshire and Worcestershire ICB	432,033	599,316	1,031,350	£518,583	**-41,190**	**981,697**	**49,652**
QHL: NHS Birmingham and Solihull ICB	2,033,354	2,278,168	4,311,522	£2,026,275	**-125,252**	**3,835,814**	**475,708**
QNC: NHS Staffordshire and Stoke-on-Trent ICB	172,730	164,448	337,178	£131,654	**5,560**	**249,226**	**87,952**
QUA: NHS Black Country ICB	619,131	608,766	1,227,897	£607,555	**-75,306**	**1,150,124**	**77,773**
QWU: NHS Coventry and Warwickshire ICB	161,953	125,158	287,111	£93,430	**-5,608**	**176,867**	**110,243**
Spec Com	485,449	452,626	938,075	£645,275	**-192,649**	**1,221,529**	**-283,455**

There is a net overperformance against payment cap limit of £535k which has been included within the year to date position.

Payment cap limit performance will be managed by individual commissioner, as such there is risk with commissioners where we have an overperformance against the limit. As shown in the above there is currently a risk all commissioners except for NHS England which is underperforming. The total value of overperformance is £818,741 with BSOL ICB making up over 50% of this value.

14. Expenditure

SUMMARY

Pay expenditure is underspent by £17k year to date. Agency spend in month was 1.6% of paybill year, with an underspend of £76k. Bank expenditure reduced in month with a year to date underspend of £201k.

LLP expenditure against plan has overspent by £62k in month which increases the year to date overspend to £81k. This is offset in part by the reduction in ADH spend which is underspent against plan by £72k year to date.

AREAS FOR IMPROVEMENT

- Identification of CIP

RISKS / ISSUES

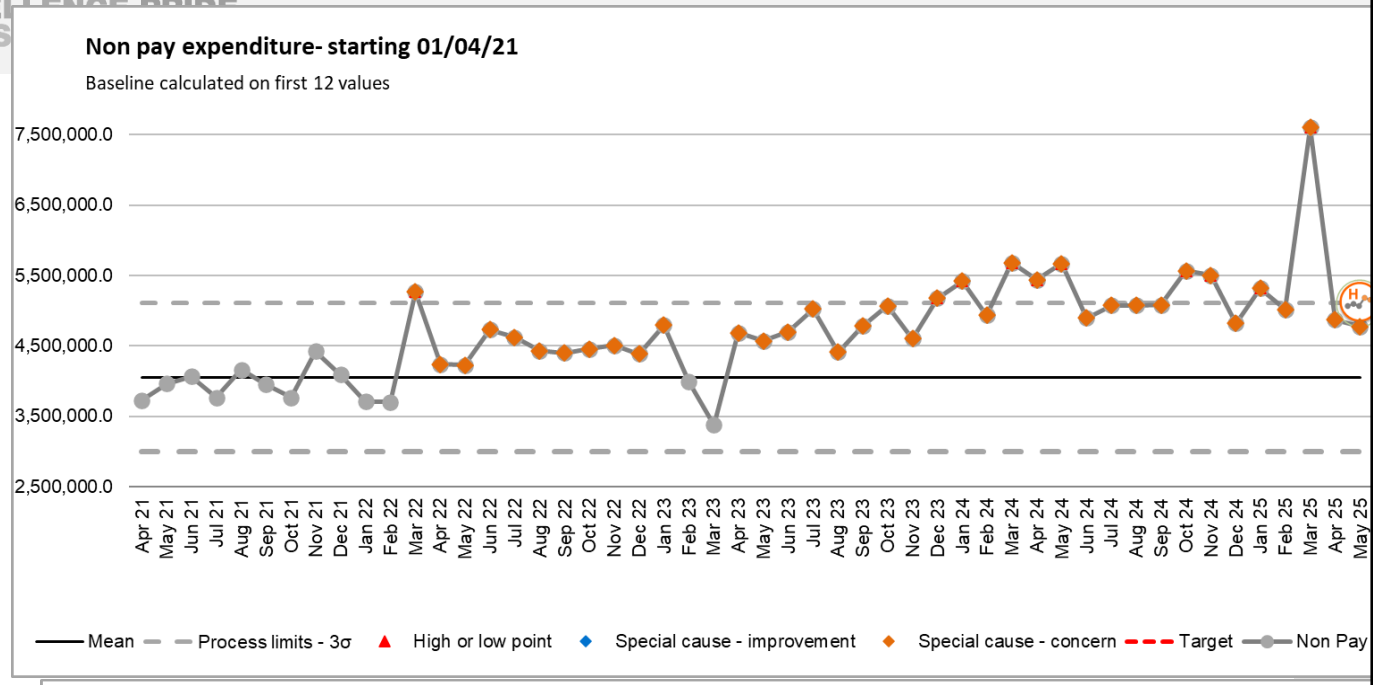
- CIP delivery risk

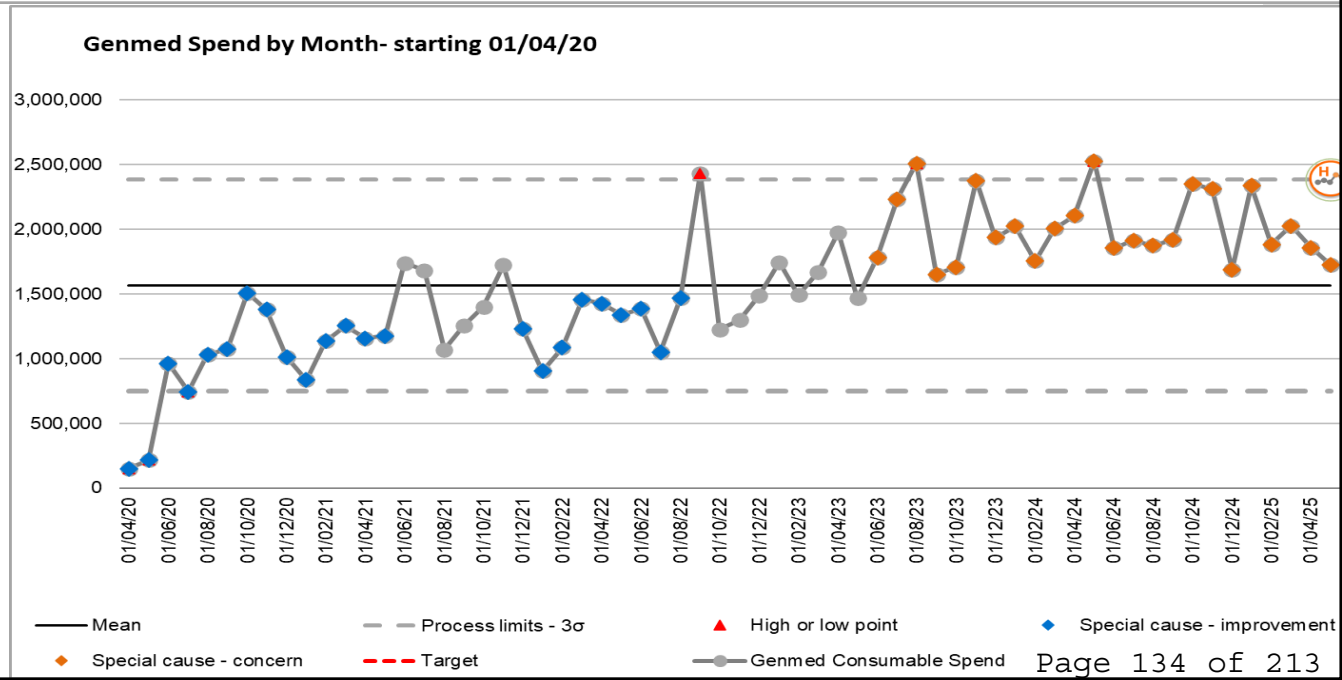
14. Non Pay Expenditure

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.





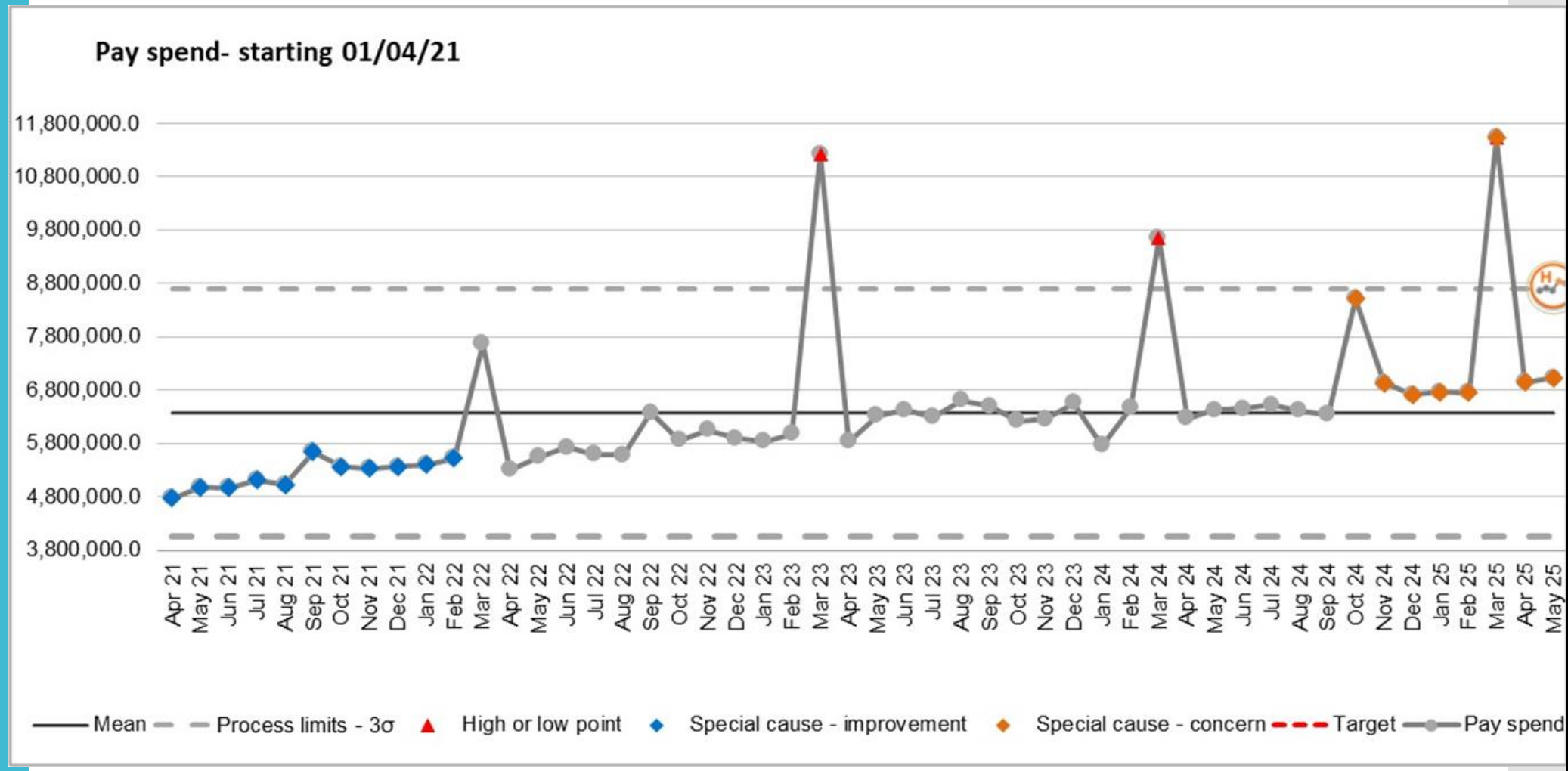
15. Non Pay Expenditure

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 increase in LLP spent to £209k.
ADH (medical bank) expenditure has performed positively against the reduction plan with an overperformance of £72k against the reduction plan.

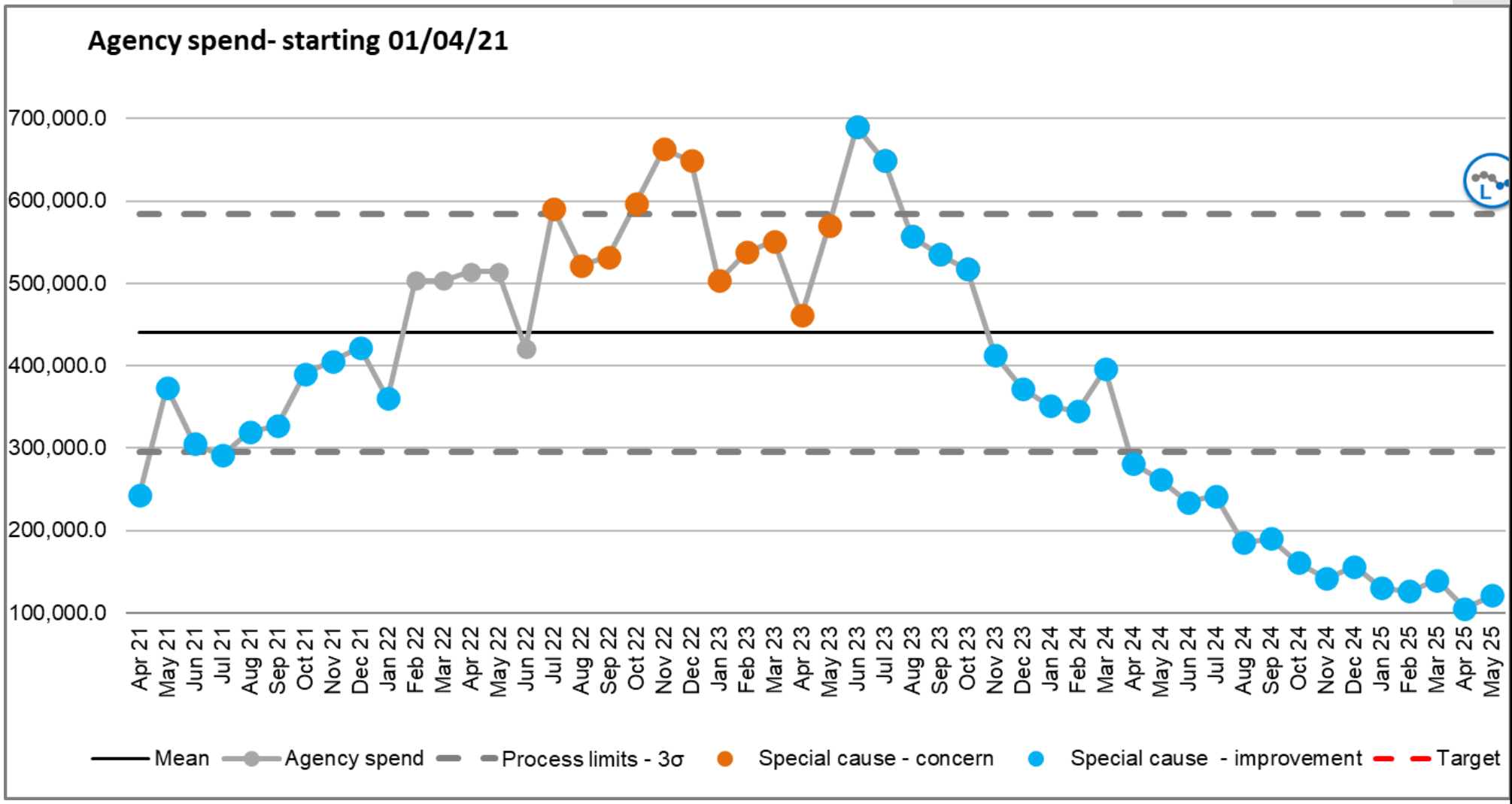
	£'000s			Substantive wte surgeons
Year	LLP	ADH	Total	
17-18		1,672	1,672	63.28
18-19		1,950	1,950	61.57
19-20	274	1,503	1,777	64.48
20-21	271	432	703	70.22
21-22	1,460	438	1,898	75.58
22-23	1,865	882	2,747	71.66
23-24	3,382	1,067	4,449	70.22
24-25	3,629	1,307	4,936	77.66
25-26	376	87	463	79.56

16. Pay Expenditure

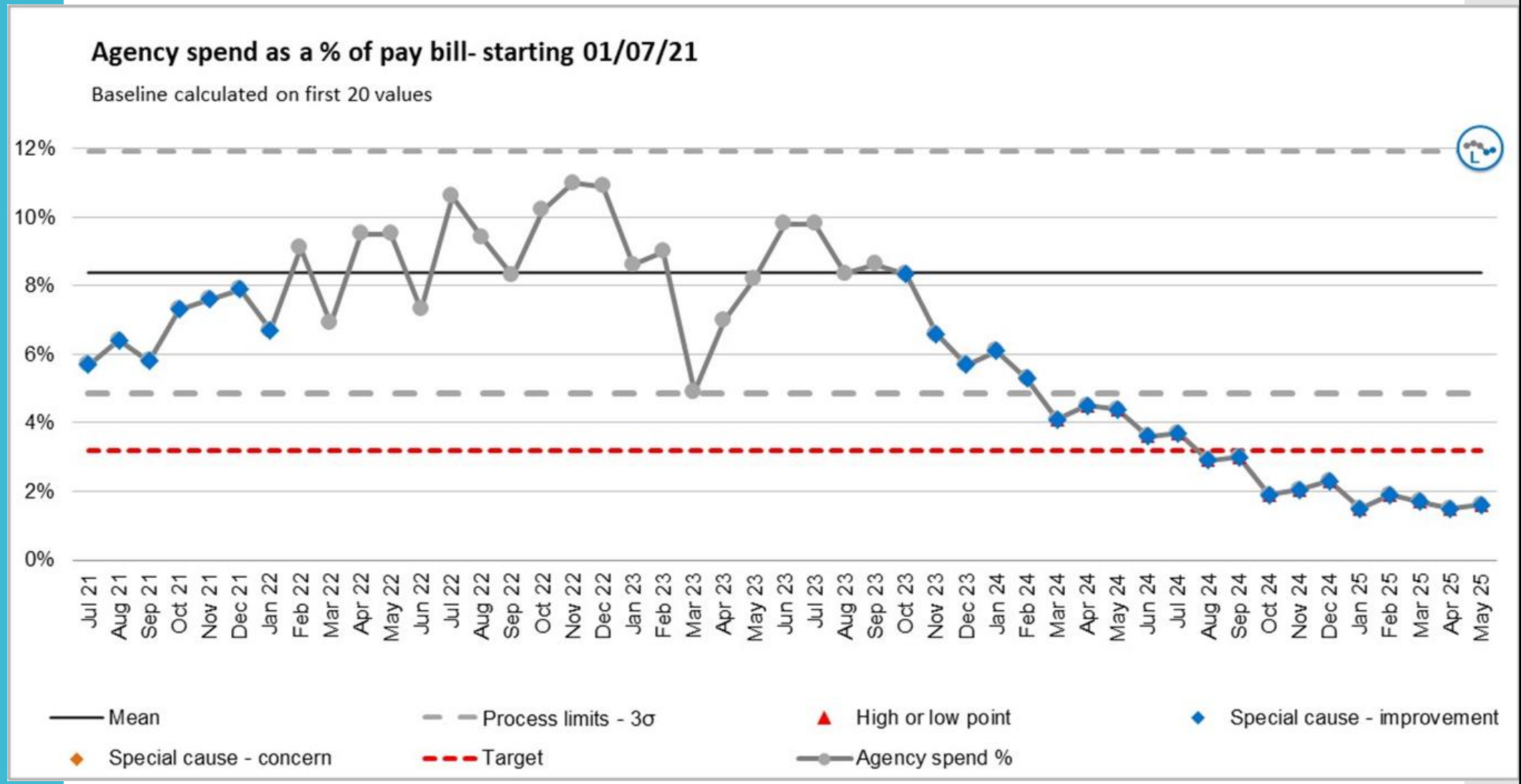


March'25 value includes pension adjustment
October'24 pay value includes back dated pay award

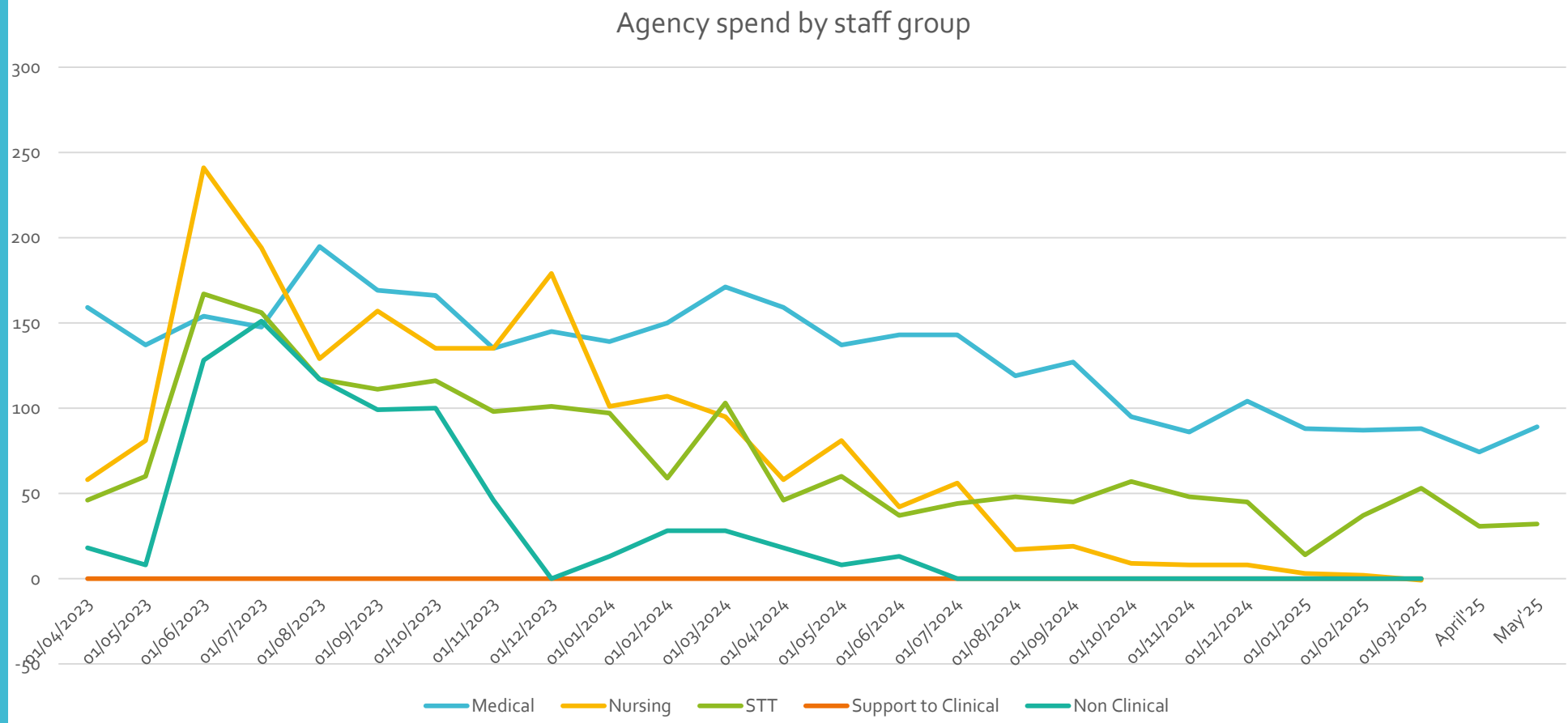
17. Agency Expenditure



17. Agency Expenditure

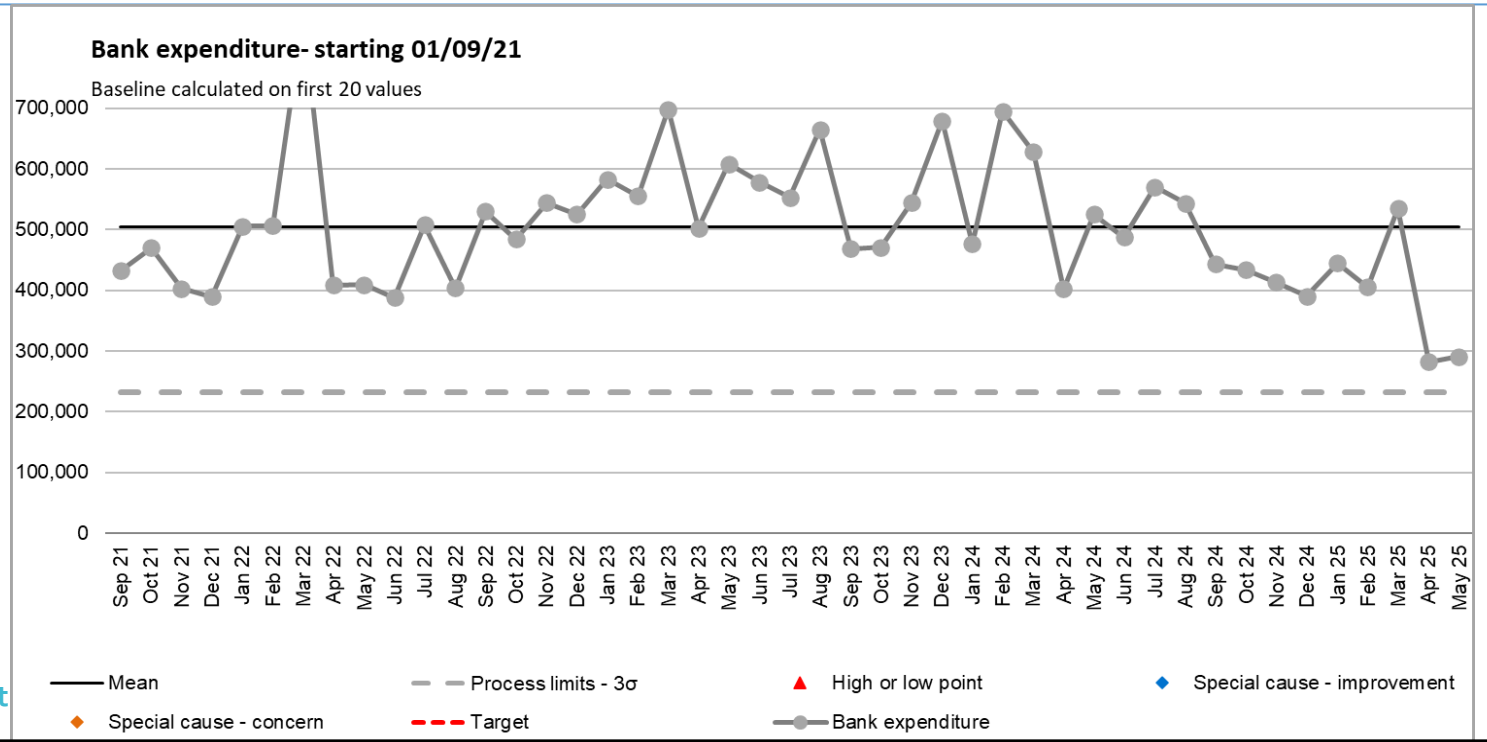


17. Agency Expenditure



17. Bank Expenditure

Bank expenditure	£'000s													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April'25	May'25
Registered nursing	108	122	110	136	116	101	95	112	118	92	109	108	46	41
Healthcare scientists and Scientific, therapeutic and tech	26	35	32	47	25	33	41	38	38	34	35	38	31	38
Support to clinical	52	70	60	86	78	55	56	61	69	55	38	94	33	20
Total medical and dental staff bank	56	91	51	61	107	88	117	85	52	124	88	142	56	97
NHS infrastructure support	138	136	155	189	200	151	125	117	111	140	119	157	107	95
TOTAL	402	525	487	570	543	443	434	413	390	445	404	534	274	291



18. Cost Improvement Plan

SUMMARY

In month efficiencies of £575k has been generated increasing the year to date achieved to £964k against a plan of £1,038k. 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.

	Year to date		
CIP Scheme	Plan	Actual	Variance
Bank reduction 10%	£86	£168	£81
Agency Reduction 30%	£112	£112	£0
LLP	£428	£195	-£233
Non Pay Other	£70	£127	£57
Optimising Medicines value			£0
Optimising energy Value			£0
Digital Optimisation			£0
Commercial income	£116	£168	£52
Service redesign	£14	£0	-£14
Bugdet management schemes	£87	£52	-£35
Total CIP schemes 25/26	£1,038	£984	-£54

18. Financial Delivery Board

SUMMARY

- First meeting of revamped group met on 19/05
- Next meeting on 18/05
- Membership consists of all executive directors,
- The group focussed attention 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 being due to reduction in creditors as invoices were paid. Despite this, further support payments are not currently expected to be needed in 2056-26. Despite the month end ledger cash position being £835k, the cash balance in the Trust's account has not dropped below £1.2m in month. The variance is due to a payment run which had been posted to the ledger, but would not clear the bank until after the receipt of our next commissioner mandate receipts. This was planned and controlled to ensure the de minimis cash requirement of £1m would not be breached.

Other liabilities has increased due to some income being paid in advance for the year (i.e. deferred income). This will reduce during the course of the year.

	2024/25 M12	2025/26 M2	Movement
Intangible Assets	933	870	(63)
Tangible Assets	66,859	66,268	(591)
Total Non Current Assets	**67,792**	**67,138**	**(654)**
Trade and other current assets	18,580	21,407	2,827
Cash	3,293	835	(2,458)
Total Current Assets	**21,873**	**22,242**	**369**
Trade and other payables	(18,235)	(15,891)	2,344
Borrowings	(13,722)	(12,910)	812
Provisions	(3,014)	(3,014)	-
Other Liabilities	(6,332)	(9,202)	(2,870)
Total Liabilities	**(41,303)**	**(41,017)**	**286**
Total Net Assets Employed	**48,362**	**48,363**	**1**
Total Taxpayers' and Others' Equity	**48,362**	**48,363**	**1**

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 draft Month 2 position is a £20.7m deficit, £12.2m worse than plan. The in-month position is a deficit of £5.7m, an improvement on the £15m deficit from Month 1, with all organisations showing an improved position except BSMHT. The in-month variance is £1.9m behind plan. Efficiencies for the year to date are at £40.2m against a plan of £49m, with 84% of the total delivered recurrently.

Total Performance	YTD			FOT			Prior Month variance £000s
	Current Plan £000s	Actual £000s	Variance £000s	Annual Plar £000s	FOT £000s	Variance £000s	
BSOL ICB	-1,260	-1,182	78	0	0	0	0
BSMHT	694	-2,583	-3,277	4,200	4,200	0	-1,433
BCHC	-5	-1,189	-1,184	0	0	0	-496
BWC	0	-1,779	-1,779	0	0	0	-1,081
ROH	-507	25	532	35	35	0	-96
UHB	-7,360	-13,974	-6,614	-4,200	-4,200	0	-7,268
Total	-8,438	-20,682	-12,244	35	35	0	-10,375

Total Variance	Trend		YTD £000s
	M1 £000s	M2 £000s	
BSOL ICB	0	78	78
BSMHT	-1,433	-1,843	-3,277
BCHC	-496	-688	-1,184
BWC	-1,081	-698	-1,779
ROH	-96	629	532
UHB	-7,268	654	-6,614
Total	-10,375	-1,869	-12,244

Total Actual Surplus/(Deficit)	Trend		YTD £000s
	M1 £000s	M2 £000s	
BSOL ICB	-627	-555	-1,182
BSMHT	-1,086	-1,496	-2,583
BCHC	-604	-585	-1,189
BWC	-1,081	-698	-1,779
ROH	-377	403	25
UHB	-11,221	-2,753	-13,974
	-14,997	-5,685	-20,682

20. Workforce

SUMMARY

- Sickness absence is improving but remains at a high rate above target.
- The establishment figure has been static which is likely to continue whilst service reviews take place which will change vacancy figures.
- Turnover improved and we had a positive reduction in first year leavers, with high turnover mostly being related to retirement.
- Mandatory training compliance reduced slightly
- We're in the middle of the appraisal window and expect fluctuating compliance rates

Risks/Issues

- High sickness absence rates will have an impact on productivity and financial performance.

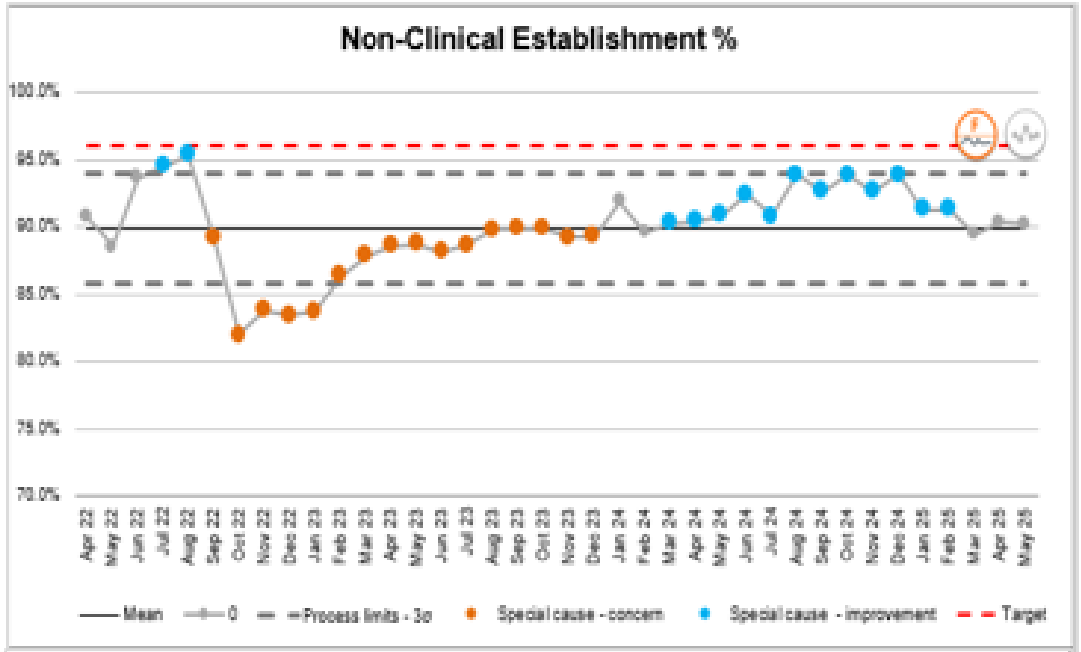
Actions

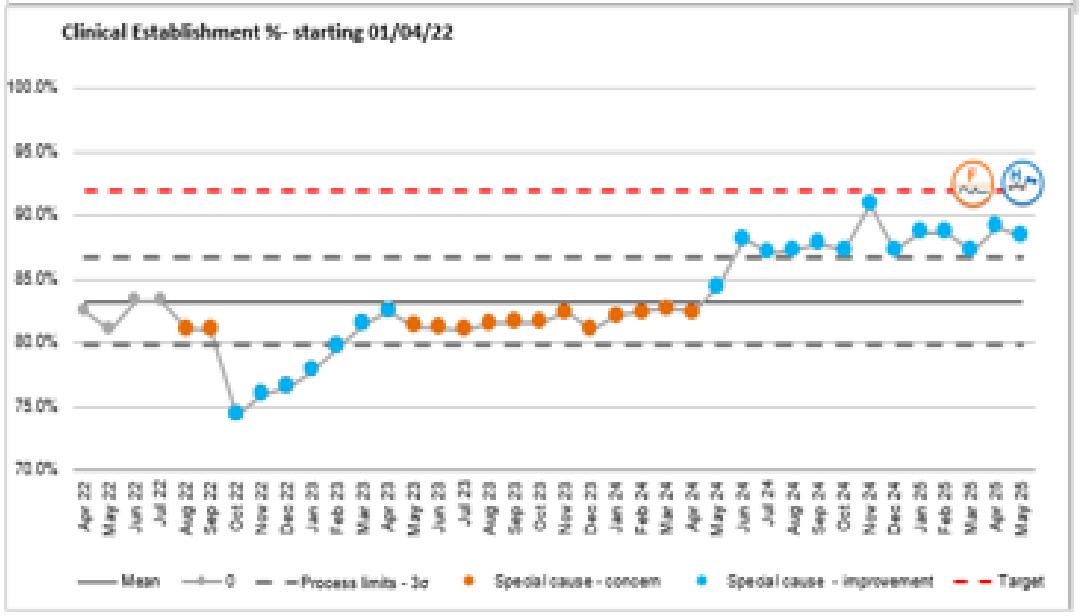
- We have a full action plan related to sickness absence and improving managerial compliance with the sickness absence policy and the support available to staff.
- Turnover continues to be monitored

20. Workforce

Trust Workforce Metrics	Apr-25	May-25	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1483	1486	3	-	-
Staff In Post - Full Time Equivalent	1314.09	1314.99	0.9	-	-
Staf Turnover % - Adjusted	11.23%	10.73%	-0.50%		<=11.5%
Total WTE Employed as % of Establishment - Clinical	89.76%	89.14%	0.00%	-	>=92%
Total WTE Employed as % of Establishment - Non-Clinical	90.45%	90.40%	0.00%	-	>=96%
% Of Attendance	94.27%	94.32%	0.05%		>=96.3%
% Staff received mandatory training last 12 months	86.99%	86.63%	-0.36%		>=93%
% Staff received formal PDR/appraisal last 12 months	84.92%	84.92%	0.00%	-	>=95%
% of Sickness - Trust wide Long-term	3.17%	3.57%	0.40%		-
% of Sickness - Trust wide Short-term	2.50%	2.16%	-0.34%		-
Return To Work Completion %	67.44%	61.22%	-6.22%		>=80%

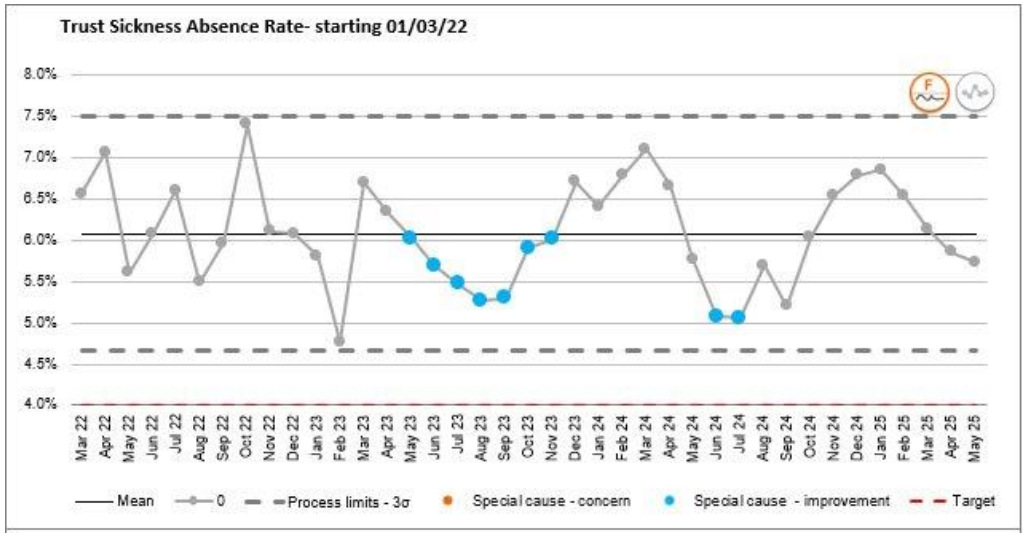
20. Workforce

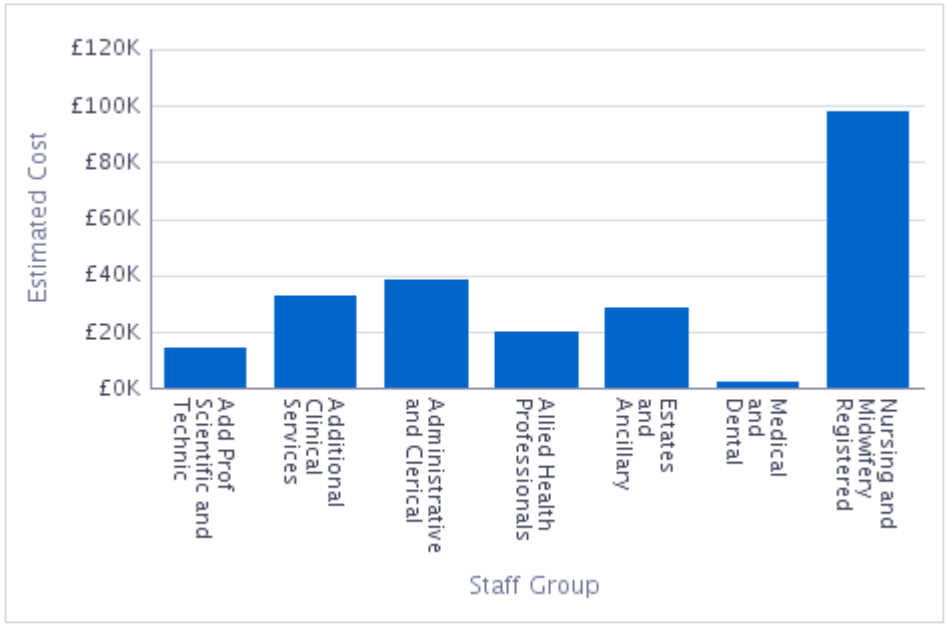


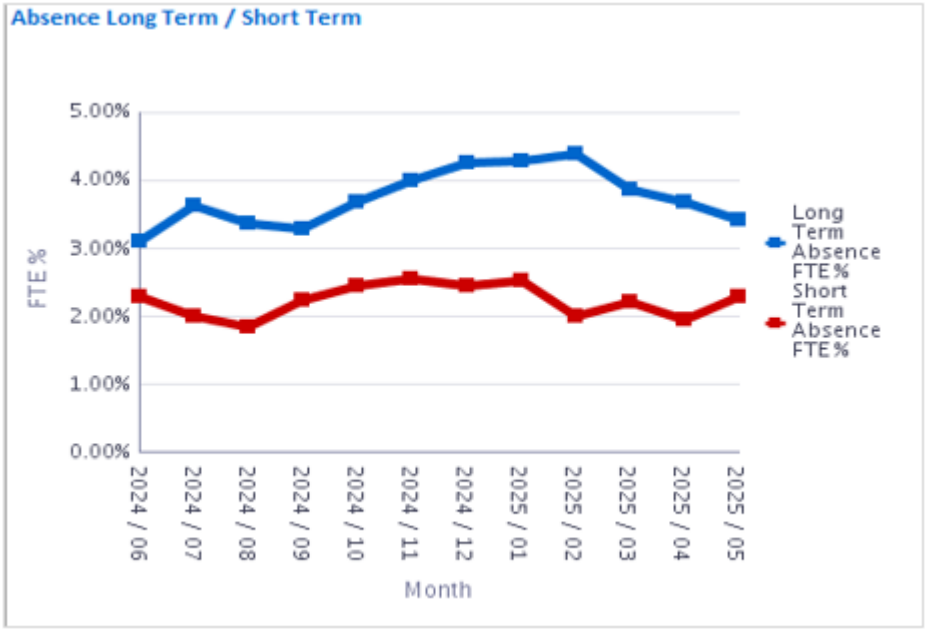


20. Workforce

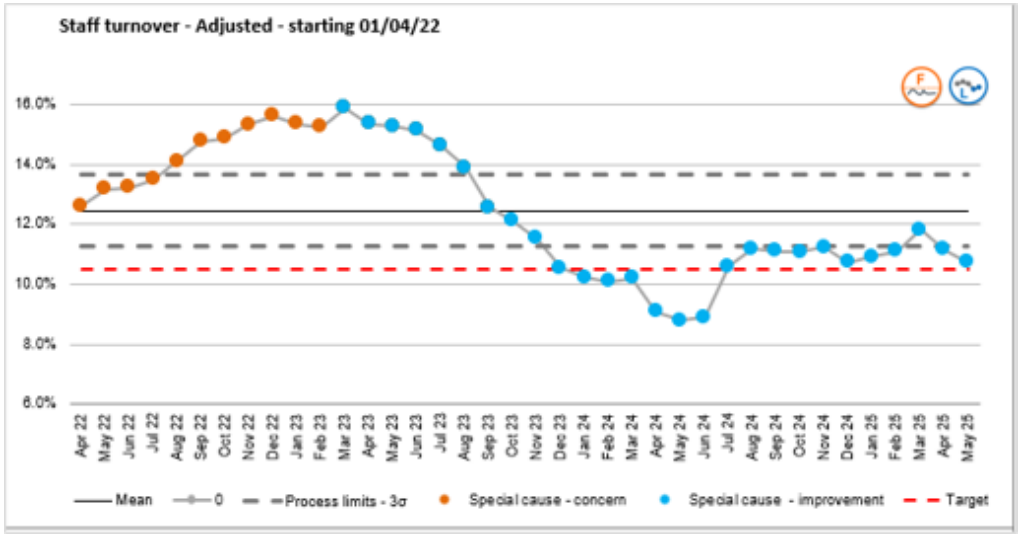
Absence cost is linked to the pay of the individual absent from work, rather than the overall cost of sickness absence

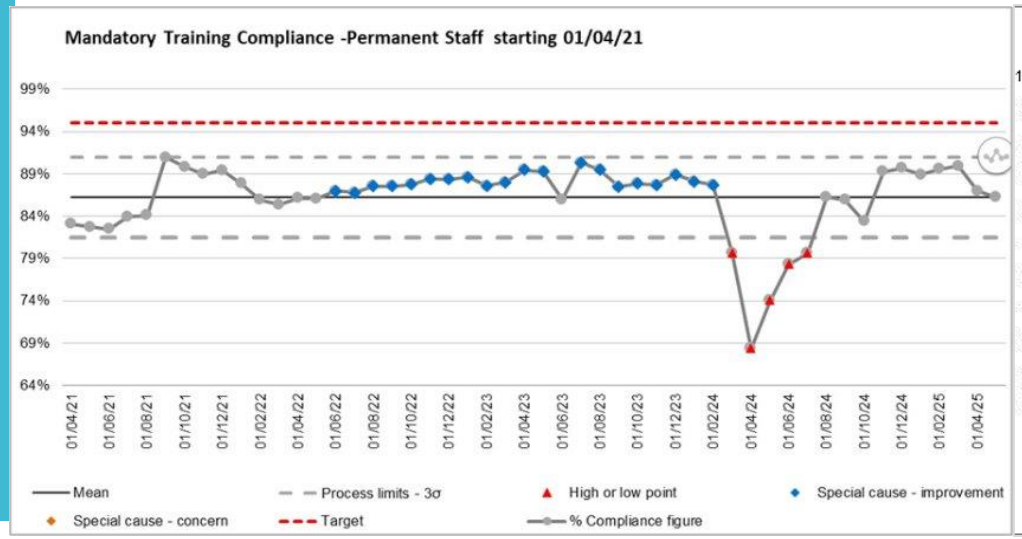


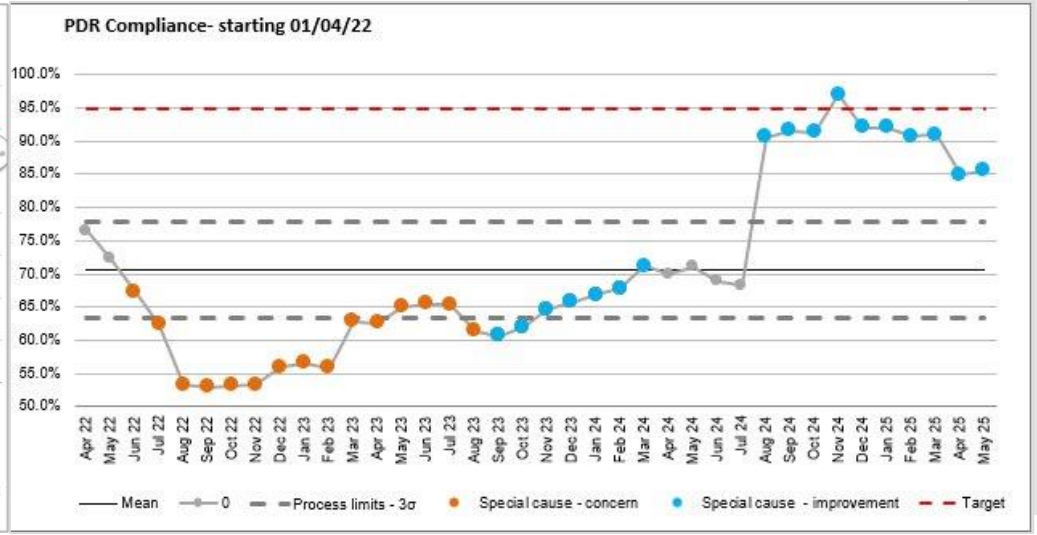




20. Workforce







NHS
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	May-25	Trend	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	2,237	-	-	-	-
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	1,168	2,366	-	-	-	-
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%	109.4%	105.8%	-	-	-	-
Inpatients	IP Activity YTD Variance	YTD	-14	28	53	99	65	27	-106	-165	-257	-238	-117	-177	100	129				-
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	922	-	-	-	-
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	485	1,013	-	-	-	-
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%	111.8%	109.9%	-	-	-	-
Inpatients	IP Activity Electives YTD Variance	YTD	-19	-22	-48	-57	-122	-176	-227	-251	-305	-340	-329	-384	51	91				-
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	1,274	-	-	-	-
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	672	1,317	-	-	-	-
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%	109.2%	103.4%	-	-	-	-
Inpatients	IP Activity Daycases YTD Variance	YTD	-3	35	83	136	160	167	75	27	-25	21	129	109	57	43				-
Inpatients	IP Activity Non-Electives YTD Plan	YTD	12	25	38	51	62	75	89	102	113	127	138	151	19	41	-	-	-	-
Inpatients	IP Activity Non-Electives YTD Actuals	YTD	20	40	56	71	89	111	135	161	186	208	221	249	11	36	-	-	-	-
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%	87.7%	-	-	-	-
Inpatients	IP Activity Non-Electives YTD Variance	YTD	8	15	18	20	27	36	46	59	73	81	83	98	-8	-5		-	-	-

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	May-25	Trend	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	1,169	-	-	-	-
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	1,168	1,198	-	-	-	-
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%	109.4%	102.5%	-	-	-	
Inpatients	IP Activity Monthly Variance	Monthly	-14	42	25	46	-34	-38	-133	-59	-92	19	121	-60	100	29				-
Inpatients	IP Activity Electives Monthly Plan	Monthly	554	584	542	602	580	602	632	598	560	614	560	602	434	488	-	-	-	-
Inpatients	IP Activity Electives Monthly Actuals	Monthly	535	581	516	593	515	548	581	574	506	579	571	547	485	528	-	-	-	
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%	210.9%	-	-	-	
Inpatients	IP Activity Electives Monthly Variance	Monthly	-19	-3	-26	-9	-65	-54	-51	-24	-54	-35	11	-55	47	47				
Inpatients	IP Activity Daycases Monthly Plan	Monthly	642	677	631	697	673	697	733	691	647	712	648	697	615	659	-	-	-	-
Inpatients	IP Activity Daycases Monthly Actuals	Monthly	639	715	679	750	697	704	641	643	595	758	756	677	672	645	-	-	-	
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%	206.6%	-	-	-	
Inpatients	IP Activity Daycases Monthly Variance	Monthly	-3	38	48	53	24	7	-92	-48	-52	46	108	-20	41	41				
Inpatients	IP Activity Non-Electives Monthly Plan	Monthly	12	13	13	13	11	13	14	13	11	14	11	13	19	22	-	-	-	-
Inpatients	IP Activity Non-Electives Monthly Actuals	Monthly	20	20	16	15	18	22	24	26	25	22	13	28	11	25	-	-	-	
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%	157.7%	-	-	-	
Inpatients	IP Activity Non-Electives Monthly Variance	Monthly	8	7	3	2	7	9	10	13	14	8	2	15	-8	3		-	-	-
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	3.7			-	-
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	3.27			-	-
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	2.9				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	2.9				2.7
Inpatients	Admitted Treatment Deferred	Monthly	26	39	36	29	32	23	39	28	35	44	36	24	28	36			-	-
Inpatients	Cancelled By Hospital On Day of Admission	Monthly	10	10	8	3	3	7	10	3	6	4	2	3	2	2			-	-
Inpatients	Cancelled By Hospital Day Before Day of Admission	Monthly	22	16	22	34	22	21	29	25	25	27	22	26	35	19			-	-

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	May-25	Trend	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	11,371	-	-	-	-
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	5,993	11,705	-	-	-	-
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%	105.4%	102.9%	-	-	-	-
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	308	334		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	3,984	-	-	-	-
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	3,435	-	-	-	-
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%	86.2%	-	-	-	-
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	-549		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	6,892	-	-	-	-
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	4,050	7,740	-	-	-	-
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%	117.5%	112.3%	-	-	-	-
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	604	848		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	494	-	-	-	-
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	268	530	-	-	-	-
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%	108.5%	107.3%	-	-	-	-
Outpatients	OP Activity Procedures YTD Variance	YTD	12	-7	-70	-132	-98	-174	-307	-439	-428	-487	-538	-663	21	36		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	May-25	Trend	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	5,686	-	-	-	-
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	5,993	5,712	-	-	-	-
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%	105.4%	100.5%	-	-	-	
Outpatients	OP Activity Monthly Variance	Monthly	749	552	-315	88	1,973	161	106	-247	1,340	436	569	-129	308	26		H	P	-
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	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	1,760	-	-	-	
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%	88.4%	-	-	-	
Outpatients	OP Activity First Monthly Variance	Monthly	344	259	-48	46	695	130	3	121	498	246	250	-74	-317	-232		L	F	
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	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	4,050	3,690	-	-	-	
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%	117.5%	107.1%	-	-	-	
Outpatients	OP Activity Follow Up Monthly Variance	Monthly	392	311	-205	104	1,244	106	235	-236	831	248	370	69	604	244		H	P	
Outpatients	OP Activity Procedures Monthly Plan	Monthly	318	300	353	371	212	335	371	371	247	371	318	371	247	247	-	-	-	-
Outpatients	OP Activity Procedures Monthly Actuals	Monthly	330	281	290	308	246	259	238	238	258	312	266	246	268	262	-	-	-	
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%	108.5%	106.1%	-	-	-	
Outpatients	OP Activity Procedures Monthly Variance	Monthly	12	-19	-63	-63	34	-76	-133	-133	11	-59	-52	-125	21	15		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	May-25	Trend	Latest Variation	Latest Assurance
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%	6.5%			
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%	10.4%			
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%	7.9%			
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%	58.33%			
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%	58.58%			
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	12,798			
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	507			
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%	3.96%			
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%	84.63%			
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%	84.53%			
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	3.19			-
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	0			-
Theatres	Average Early Finishes (minutes)	Monthly	96	89	85	90	86	87	94	92	117	94	85	83	82	84			-
Theatres	Average Patient Turnaround (minutes)	Monthly	12	12	11	14	13	12	17	14	13	14	13	11	13	16			-

Quality Report

June 2025 (May 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.

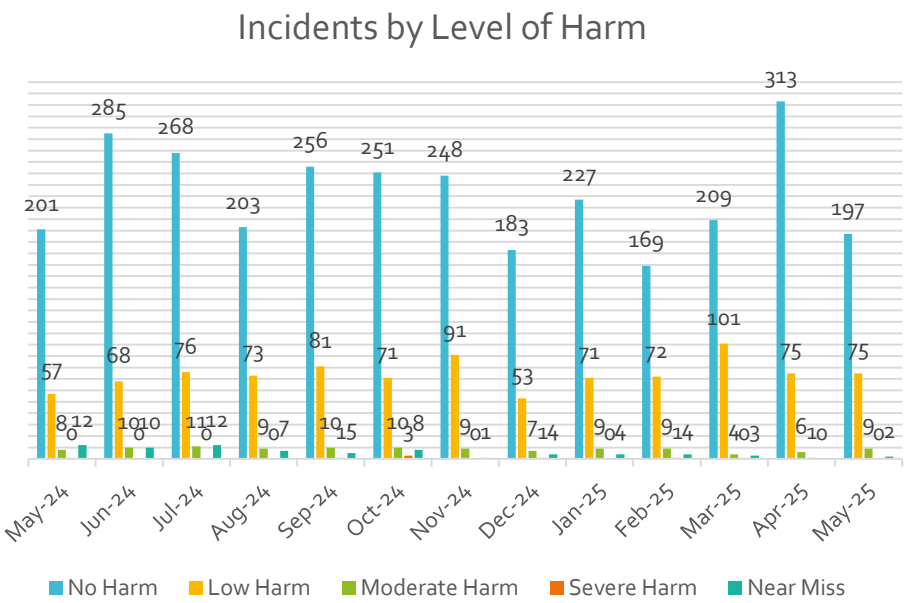
Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

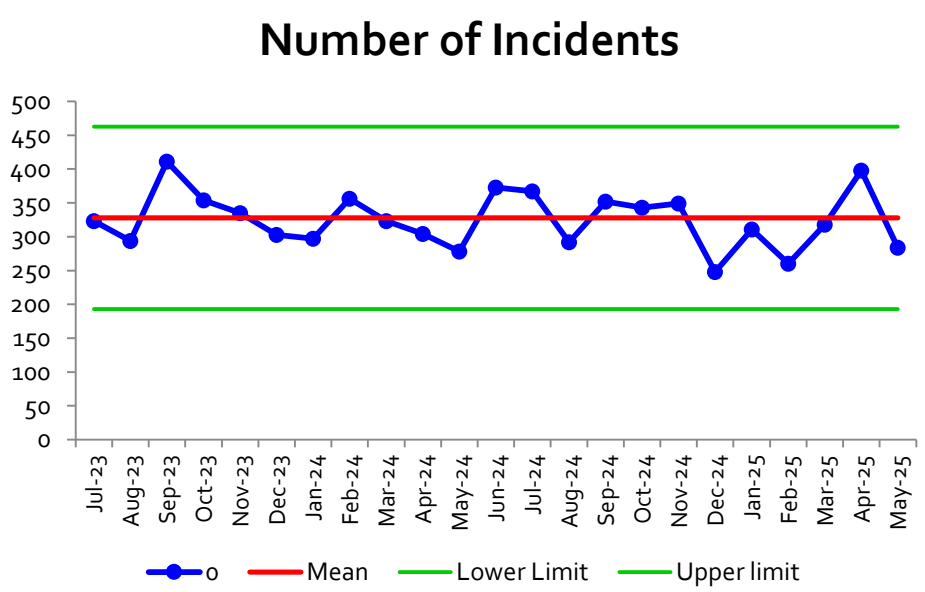
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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

Governance Performance Summary Dashboard

Performance to end May 2025	In month	Previous month	Variation	Assurance
Total No of Incidents Reported	284	398		
Inpatient Deaths	0	1		
PSII's (Patient Safety Incident Investigations)	1	0		
Never Events	1	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)	10	8		
Infection Incidents (Reportable)	0	0		
Complaints	5	8		
Claims	2	0		
Inquest	0	0		
RIDDOR Reportable Incidents	0	2		

Incidents Reported





Quality Improvement & Learning

There were 284 incidents reported within the Trust during May 2025. The number of reported incidents has shown a decrease. This could be due to the May bank holidays and school holidays. Please note – there was a large increase in the number of incidents in April due to the reporting of long wait spinal patients.

During May, there was a never event reported on 26/05/25, the incident was a wrong side spinal block. The incident has been discussed within both divisions and a 72-hour report completed. Division 2 will take the lead in the PSII investigation as the incident occurred in theatres.
The patient was informed of the error and given the correct procedure after being given time to make an informed decision regarding further treatment.
The patient is well, and verbal DoC has taken place. Actions and identified learning will be summarised in a future report

Incidents Reported... (continued)

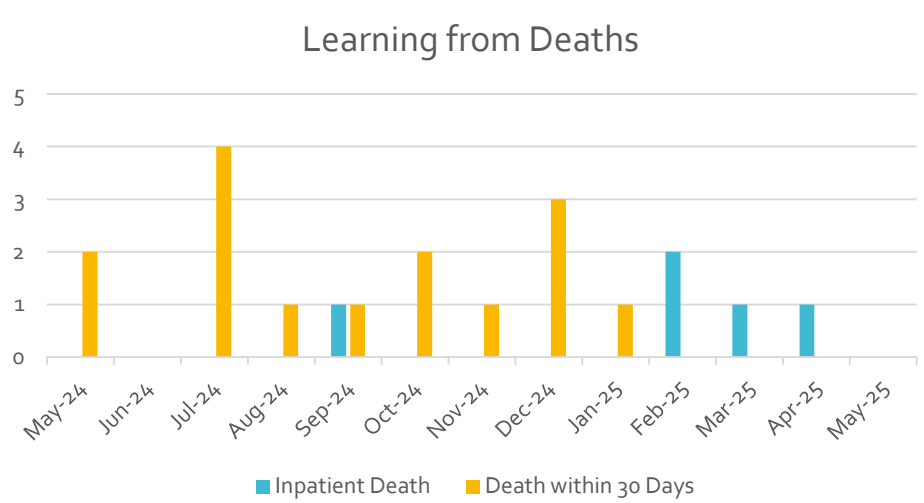
Financial Year 2025-2026

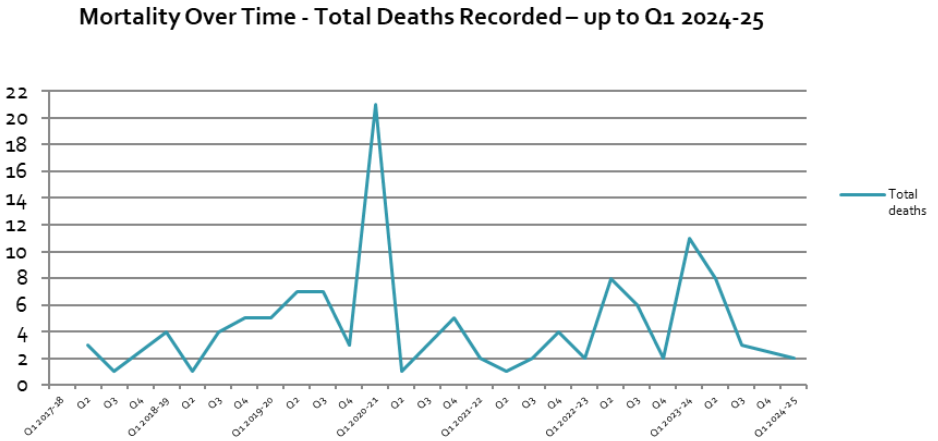
PSIRF Investigation Method	In Month	Last month	Year to Date
PSII	1	0	1
AAR	1	0	1
MDT	0	0	0
Thematic Review	0	0	1

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

*2 PSII's were stood down, total 7 completed PSII's

Learning from Deaths





Quality Improvement & Learning

There were no reported inpatient deaths in May 2025.

Update – Inpatient death reported in April 25 Quality Report - *An IPC PSIRF review is being undertaken into the infection, as per our PSIRF response plan.*
IPC has completed their investigation into the E-coli infection and have found no concerns regarding the detection of E-coli and cannot find evidence to suggest the infection was ROH acquired.

Improvements were identified in regard to documentation and review of microbiology reports (noting sensitivity to medication).

Thematic Review
Thematic review is in progress, updates and any identified learning will be included in a future report.

Infection Prevention & Control

Infections Recorded in month and Year to Date (YTD)	May 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	0	1
Klebsiella spp. bloodstream infection	0	0
Pseudomonas aeruginosa bloodstream infection	0	0

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.

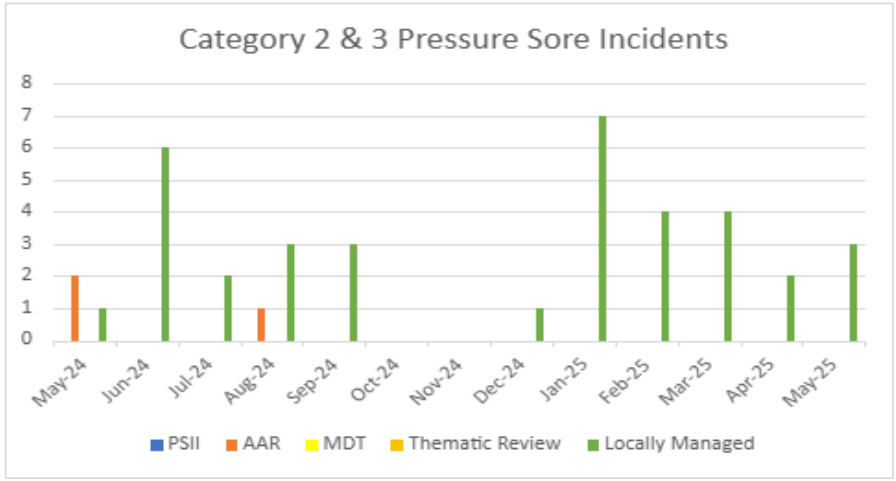
Evaluation of current decontamination practices against NHS guidelines, IPC standards, and regulatory frameworks (e.g., HTM 01-01, HTM 01-05). Identification of gaps or inefficiencies in the process. Analysis of audit data, including previous compliance rates and incident reports.

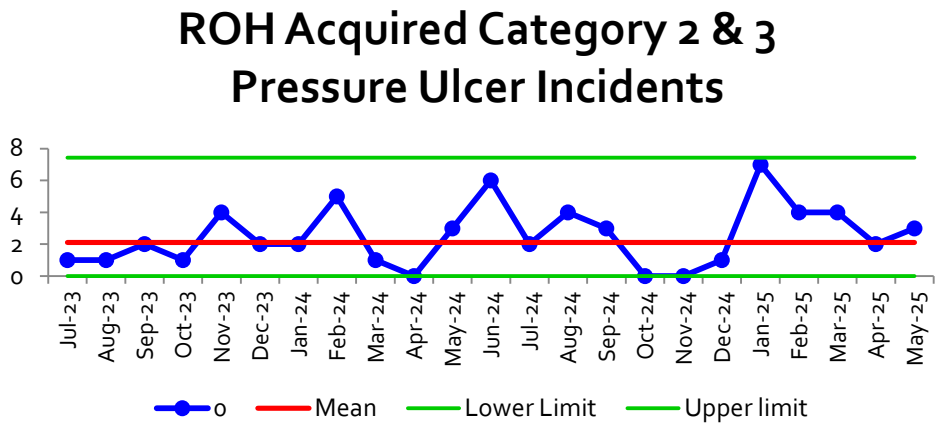
Collaboration with decontamination staff, clinical departments, and estates to gather insights and identify practical challenges. Staff awareness and adherence to decontamination protocols assessed through surveys or direct observations.

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 happen by the start of Q2 2025.

Tissue Viability





Quality Improvement & Learning

There were 3 reported category 2 Pressure Ulcer incidents that were ROH acquired or deteriorated in May 2025. There have been 2 confirmed as no lapse in care and a PU Triage Questionnaire is underway for an incident reported on ward 4.

Update on Blistering Thematic Review – Discussed within clinical governance and agreed in principle. SMART actions sent for approval. Summary of learning and actions to follow in a future report.

Quality Improvement

Mattress Management

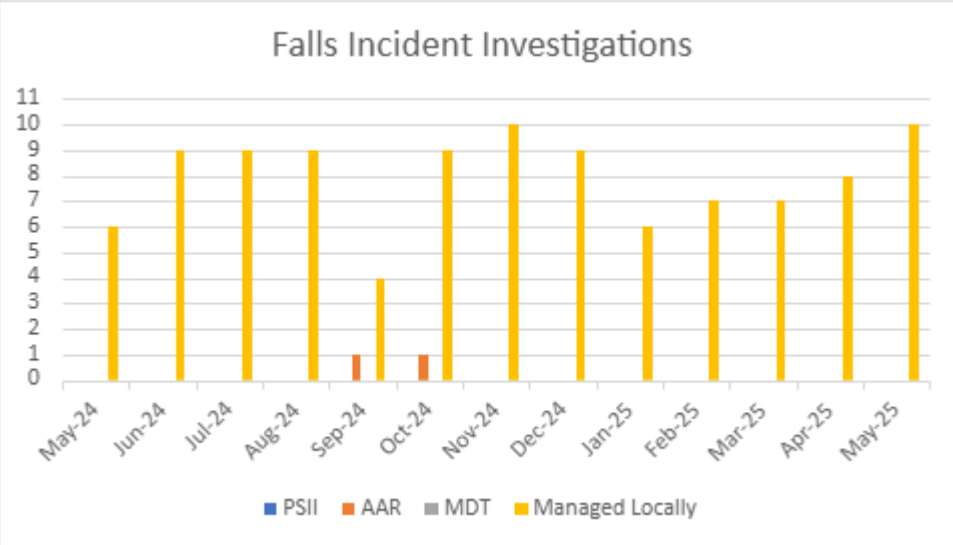
Background

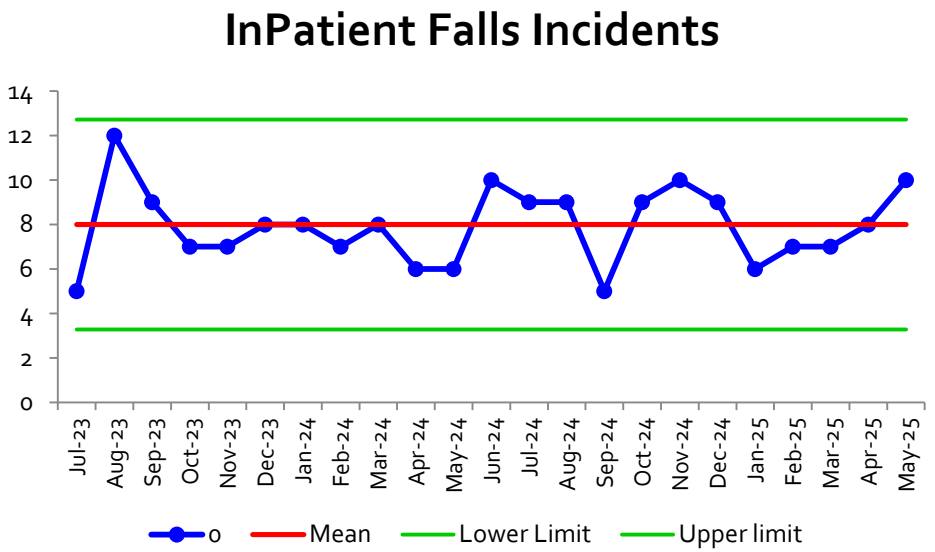
A significant proportion of pressure-relieving mattresses currently in use across the Trust are beyond their recommended service life. These include dynamic systems (alternating pressure combined with foam-based) that are subject to daily wear and tear in high-acuity environments. Ageing mattresses may fail to provide adequate pressure redistribution, increasing the risk of hospital-acquired pressure ulcers (HAPUs), particularly among high-risk patients. Worn or damaged components can lead to compromised infection prevention standards due to impaired cleanability or fluid ingress.

Issue has been added to the TV Risk Register.

Plan is to purchase a new fleet of mattresses – a short business case is to be developed and submitted to the Chief Nurse in the near future.

Falls





Quality Improvement & Learning

There were 10 inpatient falls reported in May 2025. All incidents were managed locally. There is a slight increase in the number of inpatient falls this month, with several patients losing their balance or becoming dizzy/faint. All incidents were rated as no or low harm.

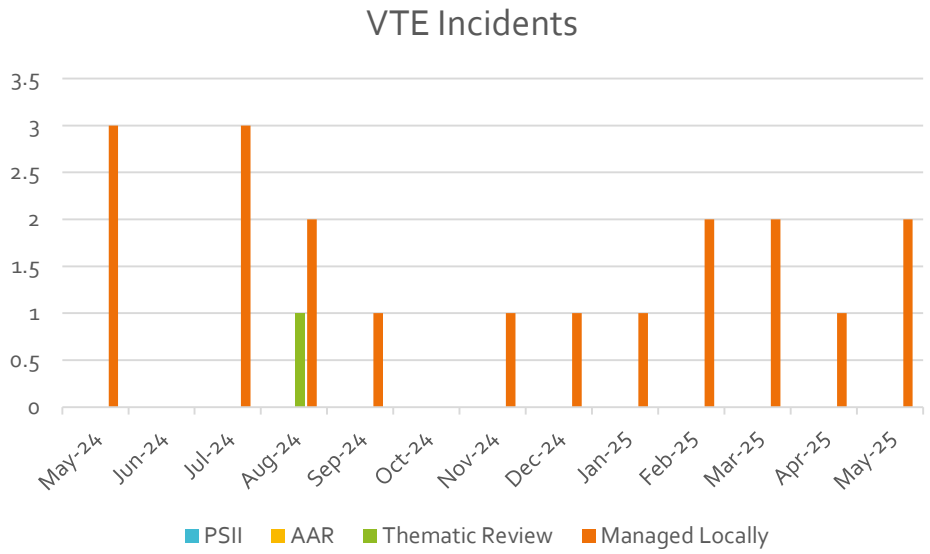
Themes

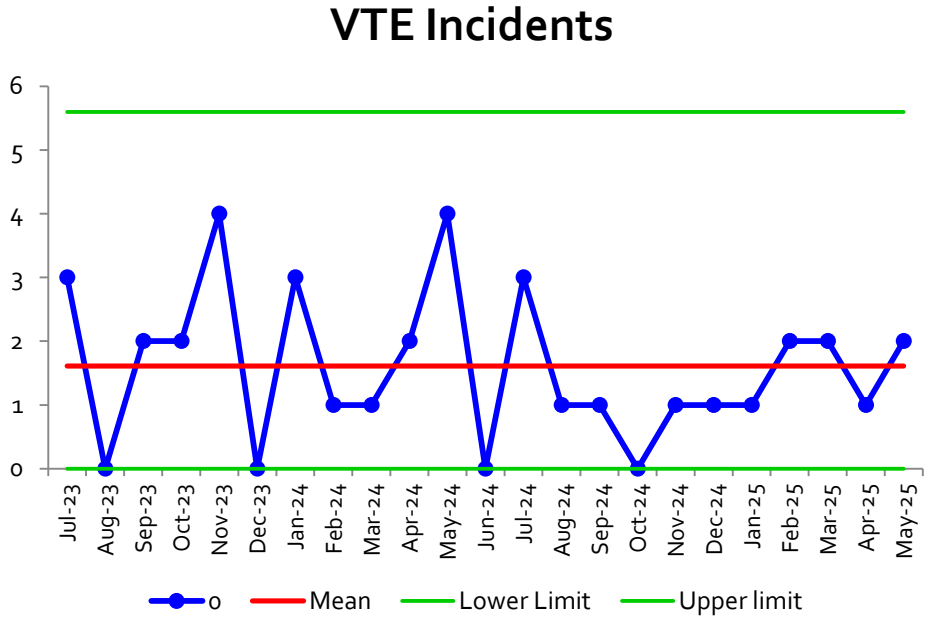
- 4 of the reported falls were reported on ward 4
- 4 of the reported falls were reported on ward 2

Quality and Improvement Work

- Falling leaves usage audit to be added to AMaT to monitor and improve compliance, this will be audited on quarterly basis initially.
- Identified that currant bed rails policy needs updating, renaming and extending to incorporate additional areas, looking to form a working group to review/update.
- Updated NICE falls guidance – plan to review at next Falls/Dementia meeting.
- BSoL ICS Falls Prevention Strategy 2025-2028 launched, need to review Trust against the strategy.

VTEs





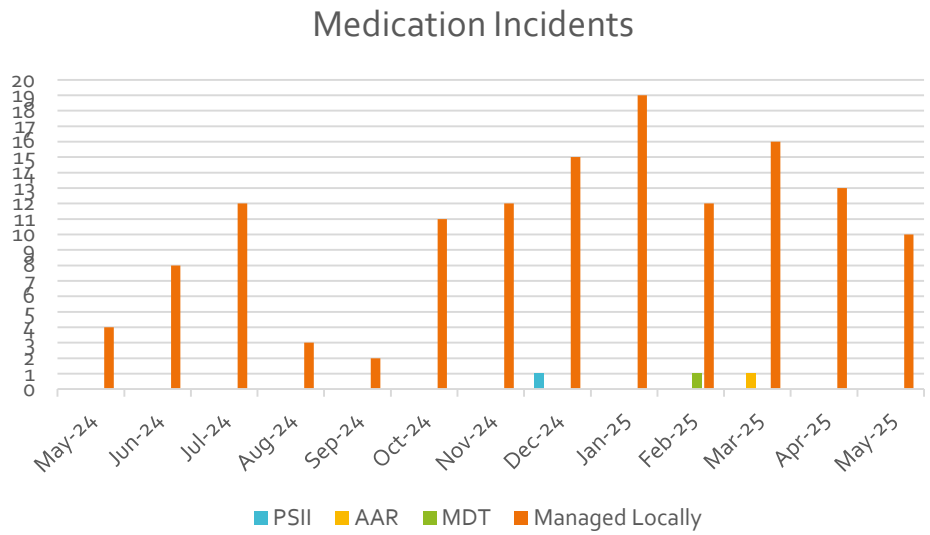
Quality Improvement & Learning

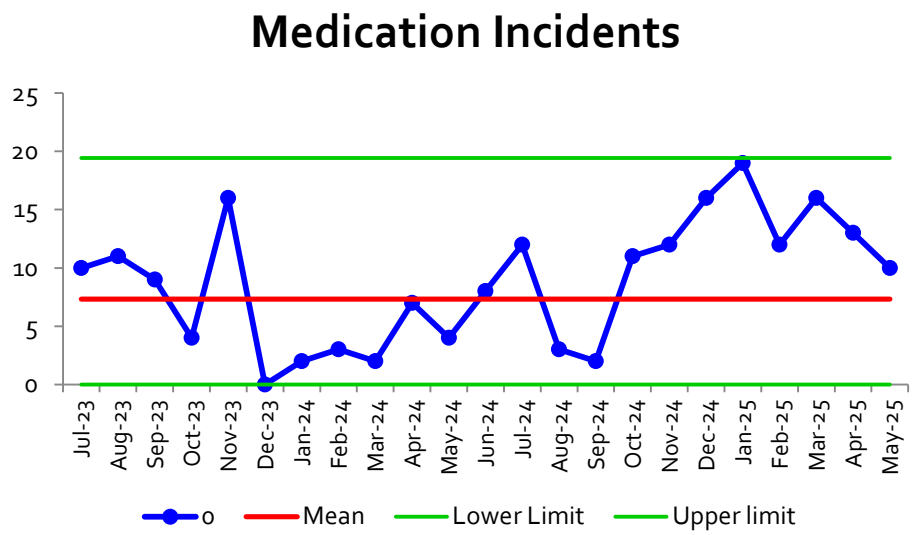
There was 2 confirmed VTE incidents reported in May 2025. VTE triage assessment to be completed to determine avoidability and will be managed in line with the current PSIRF Framework should further investigation be required. So far, for this financial year, all reported VTE incidents have been deemed 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 10 Medication incidents reported in May 2025. All incidents were managed locally.

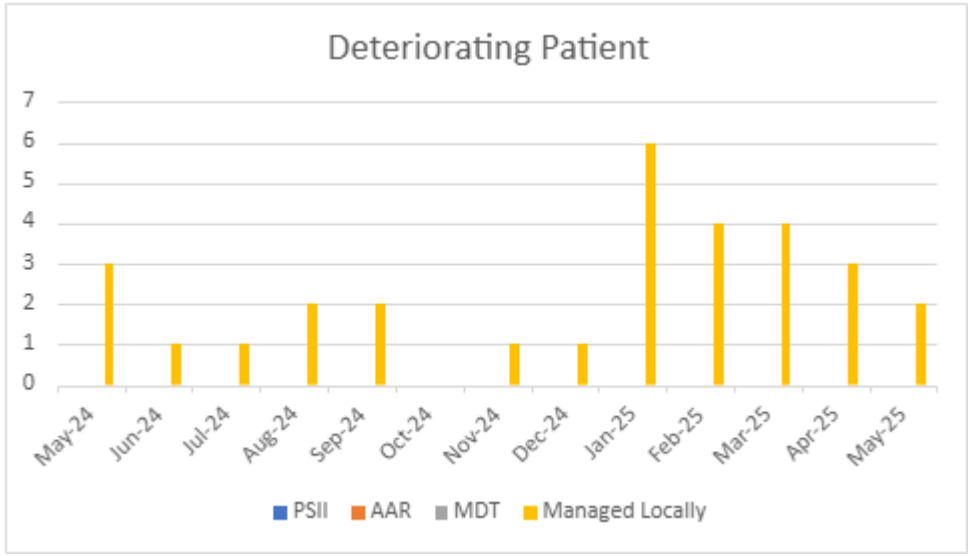
Update on AAR reported in April Quality Report:

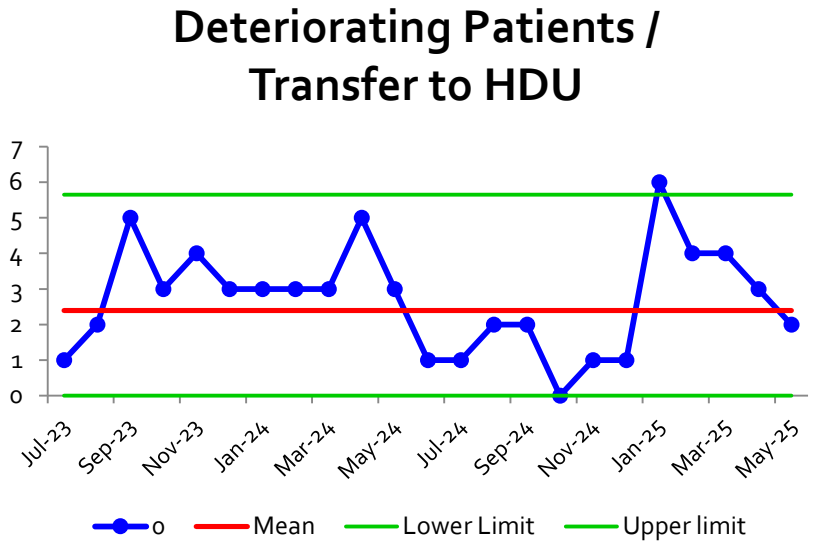
AAR 50968 (Med Error – Wrong Antibiotics) Report discussed within divisional governance, additional detail required regarding the circumstances and culture around preparation of meds. Further details of actions and learning to be included in a future report once the AAR has been completed and signed off..

Quality Improvement Work

A working group for acute pain short life, set up in April 2025 in response to the MHRA alert on prolonged release opiates, has now met twice and the interim updated acute pain guideline was launched on the 9th June. A plan of education for all clinical areas and staff is underway.

Deteriorating Patients



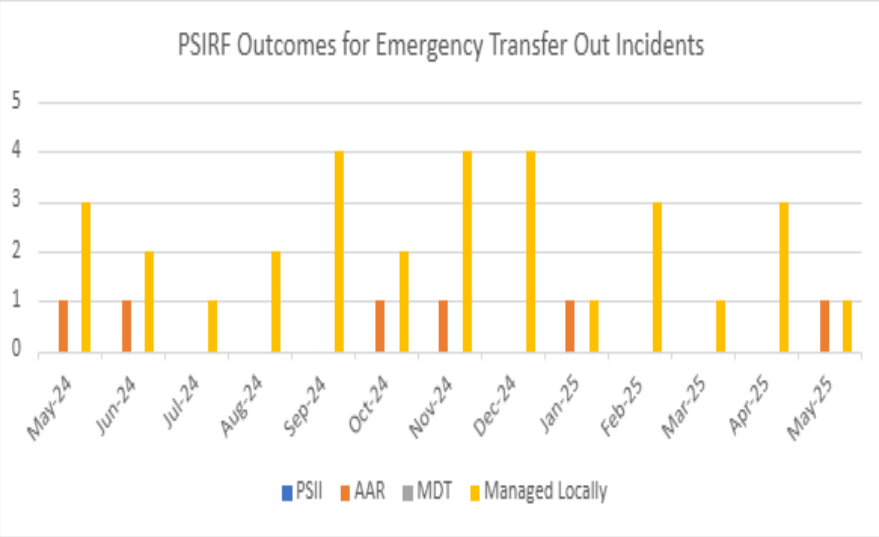


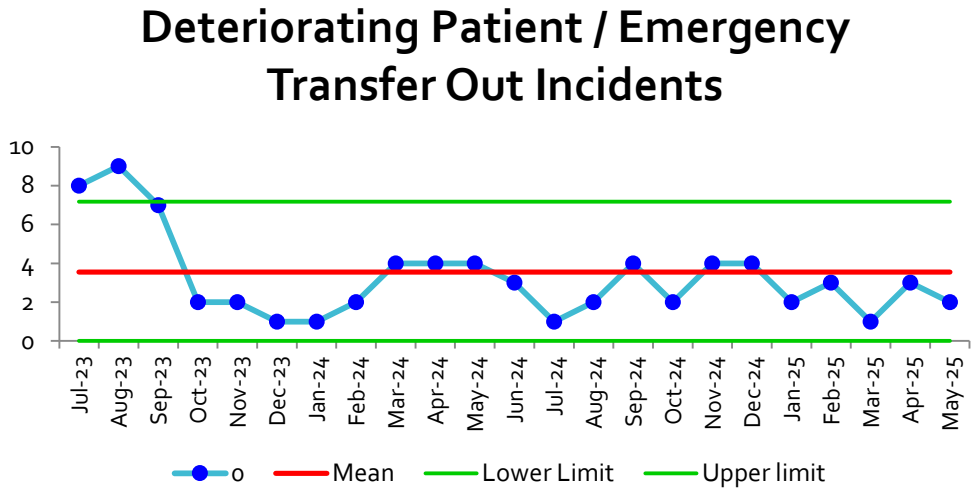
Quality Improvement & Learning

There were 2 deteriorating patient incidents reported in May 2025. 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 2 emergency transfer out incidents reported in May 2025.

Incident 51772 (Emergency Transfer out of Trust) – Patient transferred from ward 1 for urgent diagnostic procedure to rule out a PE. Patient was transferred out unnecessarily, causing distress to the patient and their family. After discussion, it was agreed an AAR would be completed, with actions and learning to be detailed in a future report.

Complaints

Complaint Information

The Trust received **5** complaints in May 2025

Below are the departments that received complaints

- Large Joints – 1
- POAC – 1
- Patient Experience – 1
- Podiatry – 1
- Spinal – 1 – Reopened complaint

In May 2025, the complaints team closed **3** formal complaints. **1** complaint breached the timeframe agreed with the complainant.

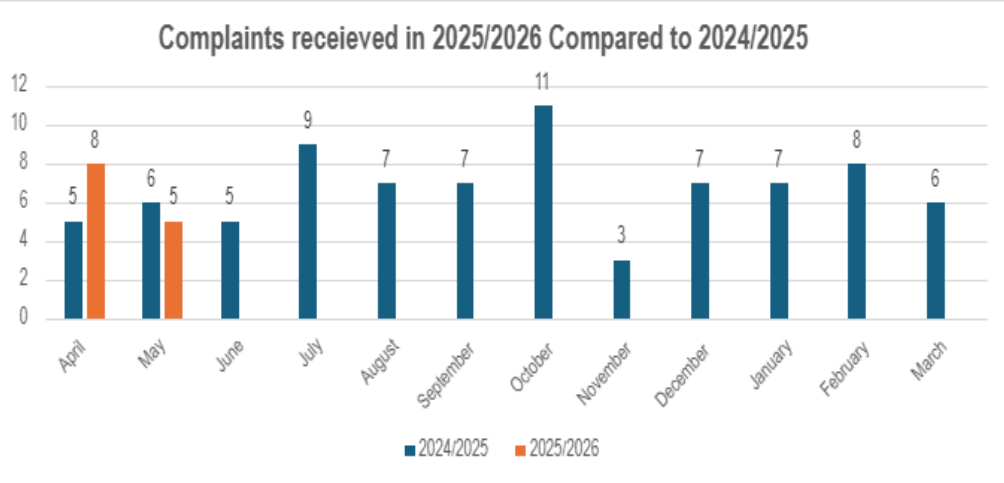
KPI = 66%

At the time of producing this report (06.05.2025) we currently have **16** formal complaints open
4 are reopened complaints **, 1** of these are in relation to the Private Service.

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 May 2025 the Trust received 1 requests for a resolution meeting – this is in relation to their re-opened complaint.
In May 2025 Trust conducted 0 complaint resolution meetings

Complaints



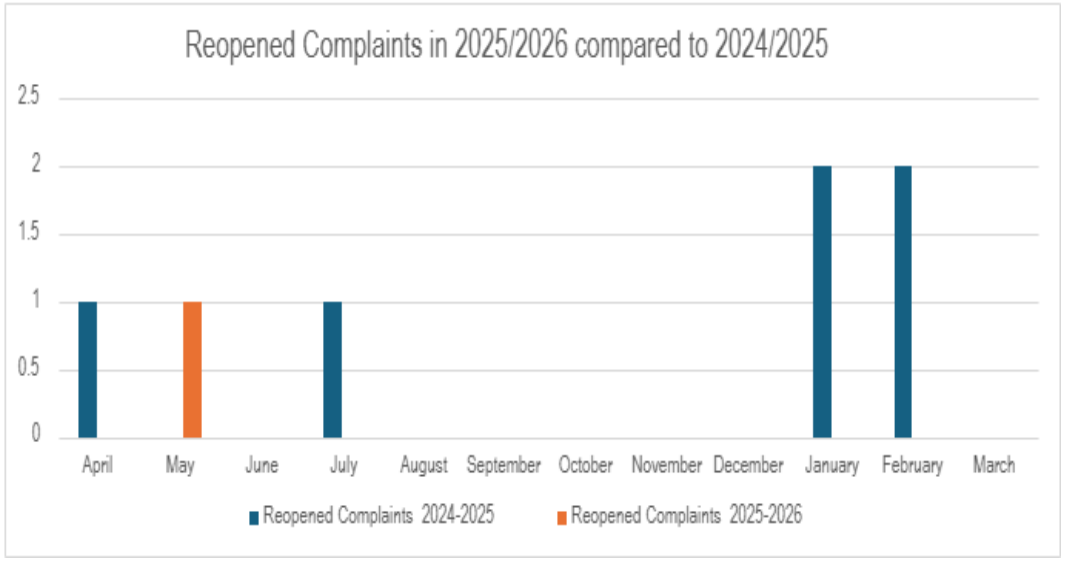
KPI	Complaints %
April 2024	43%
May 2025	66%

Complaint Year Totals	
April 2023 - March 2024	42
April 2024 – March 2025	92
April 2025 – May 2025	12

Themes of complaints received

- Values and behaviour of staff
  - Treatment received
  - Clinical Treatment received
- Unhappy with complaint responses
  - Conflicting information
  - Processes

Complaints



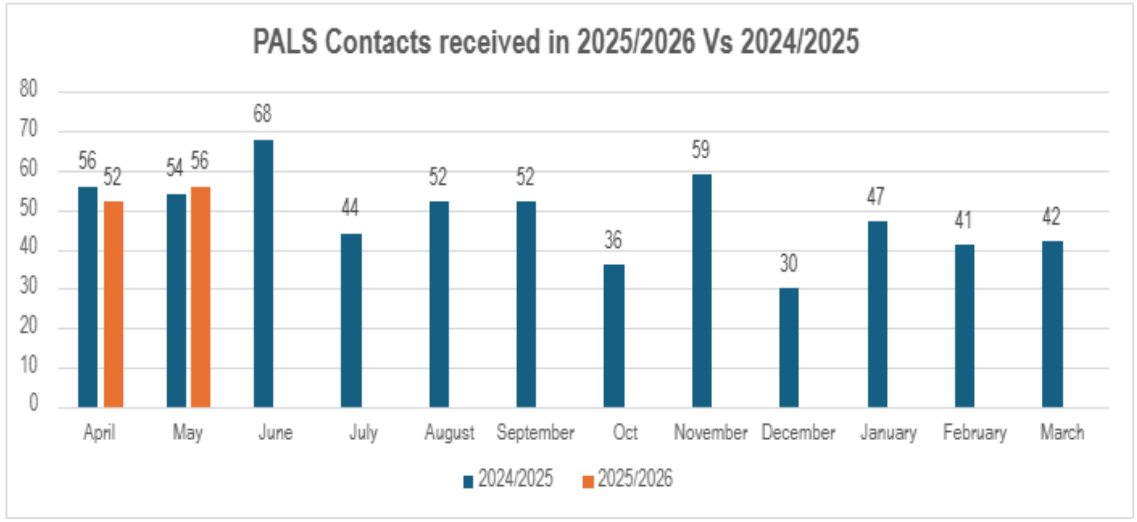
Reopened complaints

The Trust received 1 request to reopen a complaint in May 2025

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

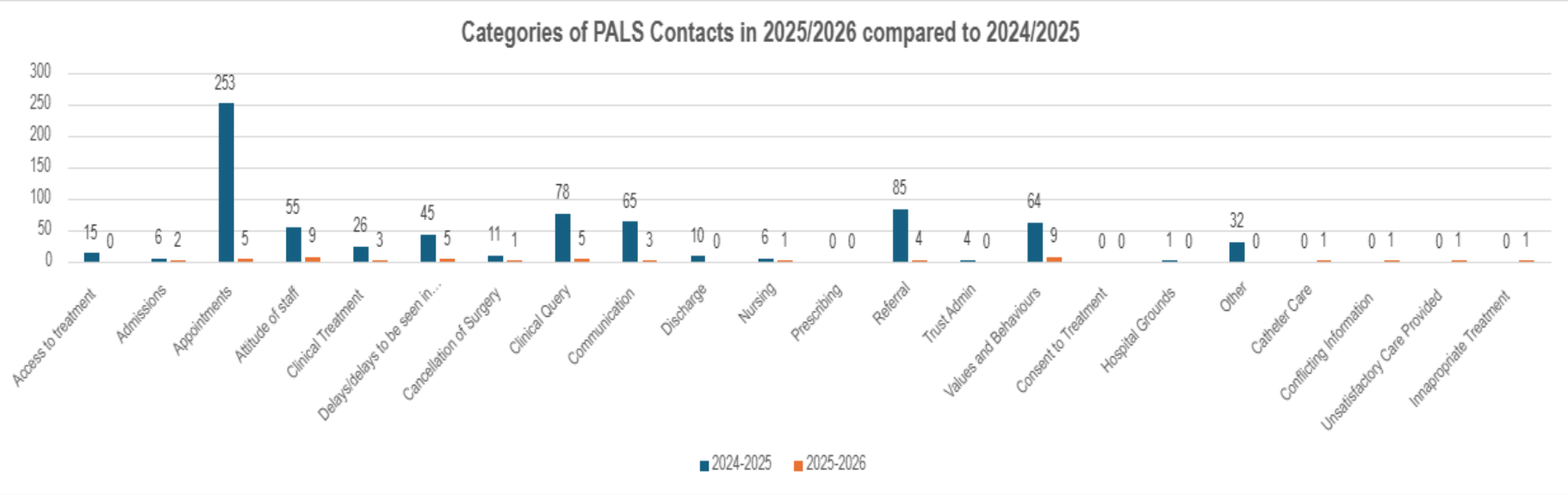


KPI	
April 2025	83%
May 2026	74%

15 PALS Concerns breached in May 2025

o PALS Case we received the complainant disclosed that they or their close family were Veterans or Current members of the Armed Forces.

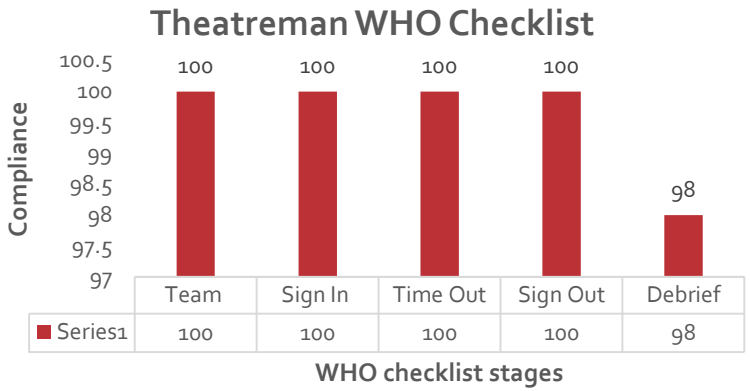
PALS Themes

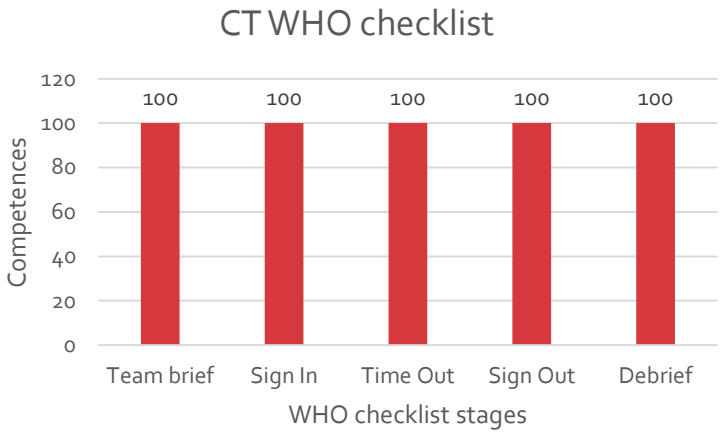


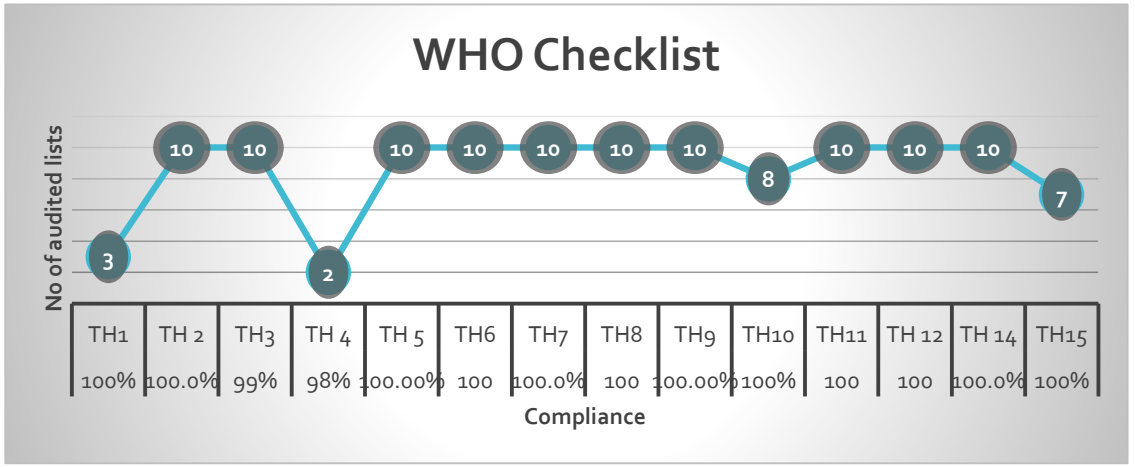
What we have done / are doing:

- 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 and 4 did not submit 10 audits. Although both theatres were closed for most of May, it was still feasible to complete additional audits. The team has been reminded of the importance of completing audits in a timely manner.

Work in Progress – WHO Checklist Review

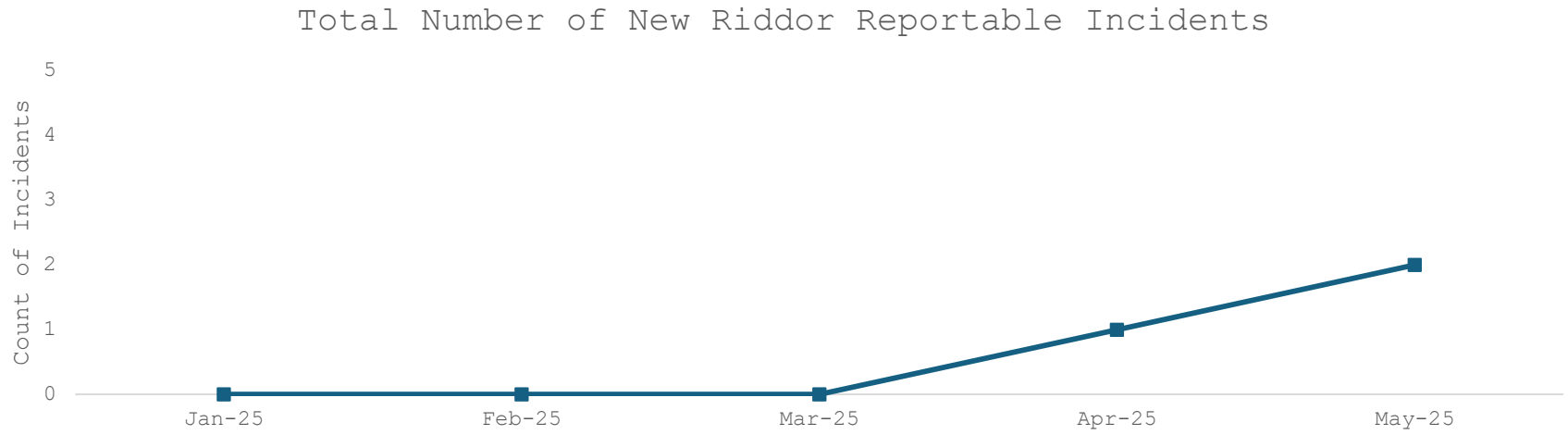
CAS Alerts

No new CAS alerts received in May 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...

RIDDOR reportable staff incidents



Quality Improvement & Learning

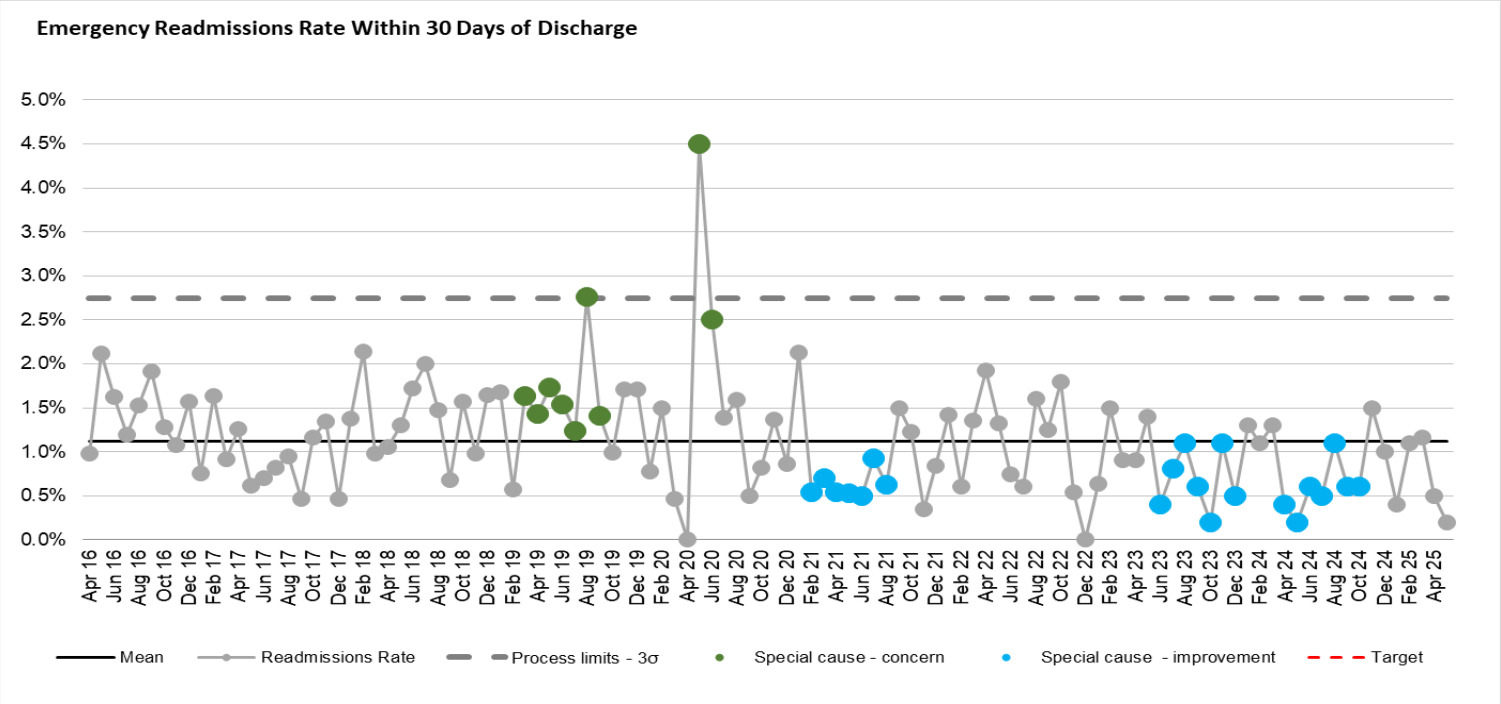
- Improvements to training / awareness with Managers; cover RIDDORs in detail in Me as a Manager training.
- Making adaptations to CMT (H&S) training to sign post Managers for more detail on RIDDOR requirements.
- HR to provide sickness absence data on a monthly basis flagging up anything under 'MSK' or potentially work related. This is expected to help identify and capture any staff health/injury issues that might not be correctly entered on Ulysses or where the absence data has not been attached to incidents on Ulysses
- Following HSE inspection, we will work with Occupational Health to improve process around occupational illnesses / referrals to OH and reporting back to ROH
- Benchmarking against RIDDOR reporting stats from other hospitals.

In regard to the above chart, the governance team are working with the Health & Safety advisor to include historic RIDDOR data back to April 2024 to make the data more meaningful and offer more insight into trends and enable more comprehensive assurance around RIDDOR incidents.

Safeguarding Training Compliance

KPI	May 2025
Safeguarding Adult Notifications	45
Safeguarding Children and Young People Notifications	44
Adults Level 1- Target 90%	94.23%
Adult Level 2 -Target 85%	92.73%
Adult Level 3- Target 85%	85.74%
Level 4- Target 90%	80.0%
Child Level 1 -Target 90%	94.01%
Child Level 2- Target 85%	92.06%
Child Level 3- Target 85%	80.00%
Mental Capacity Act MCA- Target 85%	93.47%
Deprivation of Liberty Safeguards DoLs	93.47%
Prevent Awareness- Target 95%	90.64%
WRAP (prevent level 3)- Target 90%	84.71%
FGM	1
DOLS	2
MCA	**3**
PIPOT cases	**0**
PREVENT Notifications	**0**

Readmissions



	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
No of Readmissions	3	3	5	3	3	8	5	2	5	6	2	1
Denominator	472	559	458	510	535	544	476	552	531	516	445	506
% Readmissions	0.6%	0.5%	1.1%	0.6%	0.6%	1.5%	1.1%	0.4%	0.9%	1.2%	0.4%	0.2%

Freedom to Speak Up

There were 6 concerns raised to FTSU in May 2025.

The themes from concerns raised were in relation to:-

- Worker's safety and wellbeing 5
- Attitude and behaviour 1

All cases were escalated to the relevant manager
No anonymous concerns

Quality Improvements & Learning

Future quality improvement work relating to FTSU includes plans to have:-

- Electronic forms and database
- Champion signposting
- Feedback after Speaking Up

Safe Staffing

Nursing

May data for June 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	Fill Rate Day- Nurses	Fill Rate Day- Non reg	Fill Rate Night- Nurse	Fill Rate- 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	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	80%	104%	106%	108%	128	0	91.21%	9.70%	13.72%	4.69%	9.04	7.8	0	0	34	0	0	1	0	0	29%
Ward 2	80%	90%	103%	104%	278.5	44	92.79%	9.60%	11.75%	0%	15.14	7.4	0	0	51.5	2	0	5	1	0	40%
Ward 3	101%	106%	110%	139%	127.5	0	98.26%	18.65 %	3.73%	8.57%	19.81	7.2	0	0	254	2	2	1	0	0	43%
Ward 4	100%	99%	103%	103%	27.75	0	84.77%	16.24 %	5.33%	0%	15.63	8.1	0	0	0	1	1	4	1	0	42%
Ward 12	81%	113%	102%	145%	208.25	0	80.30%	17.46 %	5.31%	10%	9.52	8.8	0	0	170	1	0	0	1	0	90%
HDU	86%	55%	84%	100%	0	0	92.05%	2.42%	3.85%	0%	3.3	25.5	0	0	0	1	0	0	0	0	81%
Total/Combined /Average	88%	95%	101%	117%	128	7	89.9%	12.3%	7.3%	3.9%	12	10.78	0	0	84.92	7	3	11	3	0	54%

Quality Improvements & Learning

Dashboard continues to be developed, and additional narrative will be available from next month

Safe Staffing

Core Services

May data for June report	Fill Rate (KPI >90%=Green, 80-90%=Amber, <79%=Red)						Workforce				Roster Safe Care Indicators			Nurse Sensitive Indicators			Patient Satisfaction		
Ward Name	Fill Rate Day-Nurses	Fill Rate Day-Non reg	Fill Rate Night-Nurse	Fill Rate- Non reg	RNA Day Hours	RNA Night Hours	Total WTE as % establishment (%)	Turnover (%)	Sickness (%)	Maternity (%)	Red Flags Opened	Red Flags Closed	Enhanced Care Hours	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
Outpatients	64%	76%	100%	100%	0	0	70.25%	22.96%	6.67%	5.41%	0	0	0	0	0	0	0	0	1%
ADCU	48%	62%	100%	100%	149.25	0	93.28%	2.81%	8.57%	2.38%	0	0	0	1	0	0	1	0	16%
POAC	90%	86%	100%	100%	0	0	91.61%	7%	7.44%	0%	0	0	0	0	0	0	0	0	15%
Theatres	71%	66%	100%	100%	90.5	0	89.67%	9.47%	6.82%	1.33%	25	0	0	1	0	0	0	0	N/A
Theatres recovery	65%	74%	100%	100%	0	0	93.87%	7.12%	10.42%	3.23%	0	0	0	0	0	0	0	0	N/A
Discharge Lounge	99%	75%	100%	100%	0	0	81.55%	0%	5.09%	0%	0	0	0	0	0	0	0	0	30%
CYP OPD	100%	111%	100%	100%	0	0	61.31%	33.63%	13.40%	0%	~	0	0	0	0	0			
Total/Combined	76.71%	78.57%	100%	100%	34.25	0.00	83.08%	11.86%	8.34%	1.76%	25	0	0	2	0	0	1	0	16%

Allied Health Professionals

May data for June report	Fill Rate						Workforce				Nurse Sensitive Indicators		
Ward Name	Fill Rate Day- Nurses	Fill Rate Day- Non reg	Fill Rate Night- Nurse	Fill Rate- Non reg	RNA Day Hours	RNA Night Hours	Total WTE as % establishment (%)	Turnover (%)	Sickness (%)	Maternity (%)	Medication Administration Error or concern	Skin Damage	All Reported Falls
In-patient Physio	58.00%	100.00%	100.00%	100.00%	N/A	N/A	97.78%	10.25%	6.80%	4.17%	0	0	0
Outpatient Physio	72.00%	100.00%	100.00%	100.00%	N/A	N/A	97.78%	10.25%	6.80%	4.17%	0	0	0
Radiology MRI	100.00%	100.00%	100.00%	100.00%	N/A	N/A	95.73%	0%	4.49%	0.00%	0	0	0
Radiology X-Ray/CT	100.00%	0.00%	100.00%	100.00%	N/A	N/A	85.75%	13.59%	5.46%	3.13%	0	0	0
Total/Combined	82.50%	75.00%	100.00%	100.00%			94.26%	8.52%	5.89%	2.87%	0	0	0

Operational Performance Summary

Performance to end May 25	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	58.33%	55.63%	53.54%	L	P
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	0	0	0	L	P
52 week waits (52 – 64 Weeks)	507	486	594	L	P
All activity YTD (compared to plan)	2,366	1,168	2,237		P
Outpatient activity YTD (compared to plan)	11,696 102.9% Cumulative	5,987 105.3% Cumulative	11,730 YTD Target		P
Outpatient Did Not Attend (YTD)	6.5%	7.0%	8%		P
PIFU (trajectory to 5% target)	579 10.4%	594 10.5%	512 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	7.9%	9.4%	19%		F
FUP attendances(compared to 19/20)	102.6%	108.6%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	113.3%	116.1%	120%		F
Diagnostics volume YTD (compared to plan)	4,192 Cumulative	2,097 Cumulative	4,034 YTD Target		P
Diagnostics 6 week target	99.7%	100%	99%		P

Operational Performance Summary

Performance to end May 25	In month	Previous month	Target	Variation	Assurance
Theatre utilisation	84.63%	90.4%	85%		F
Theatre In Session Utilisation	84.53%	84.4%	85%		F
Cancer - 31 day first treatment	100%	100%	96%		P
Cancer - 62 day (traditional)	85.7%	95.2%	70% Nat 85% Trust		P
28 day FDS	77.3%	81.1%	77%		P
Patients over 104 days (62 day standard)	0	1	0		No Target
POAC activity volume (YTD)	3,553 Cumulative	1,637 Cumulative	3,530 Cumulative		P
Bed Occupancy (excluding CYP and HDU)	73.0%	71.4%	82-85%		F
LOS - excluding Oncology, Paeds,YAH, Spinal	3.27	3.46	n/a		No Target
LOS - elective primary hip	2.9	2.5	2.7		P
LOS - elective primary knee	2.9	3.0	2.7		P
BADS Orthopaedic: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period) Feb 25	53.5%	54.6%	85%		F
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Feb 25)	37.5%	37.5%	-		No Target

Workforce Performance Report

Prepared by:
Matt Dingle, Head of HR
Clare Mair, Head of OD & Inclusion
David Richardson, Head of Education and Training

Ref: June, 2025/ HR&OPS

Scorecard

Topic	KPI	May 2025	TREND
Occupied Establishment	93%	89.6%	-
Turnover (adjusted)	10.5%	10.73%	↓
Staff in post - FTE	N/A	1314.99	-
Sickness absence	4%	5.73%	↓
Appraisals	95%	85.58%	↓
Disability declaration rate	7.5%	7.04%	↓
Workforce Wellbeing – A/Leave	N/A		N/A
Mandatory Training	93%	86.63%	↓

Section One:

HR & OD and Inclusion

Prepared by: Matt Dingle, Head of HR; Clare Mair, Head of OD & Inclusion

Presented by: Alison Money, Deputy Chief People Officer

Ref: June, 2025/HR&OPS

HR & OD and Inclusion

Summary:

- Turnover has reduced in month and there has been a notable decrease in first year leavers.
- Recruitment figures are low this month due to vacancy control measures
- Sickness absence is reducing month on month, however a decrease in long-term absence has been offset by an increase in short-term absence.
- Bank and agency rates remained static; work is ongoing to reduce temporary workforce reliance in line with CIP plans
- Employee relations casework is high with a 66% increase on the previous report
- Appraisal window underway with six weeks remaining for all appraisals conversation to be completed

Areas for Improvement:

- We remain focussed on sickness absence improvements, with a strong focus on managerial compliance and staff support.
- We have a large amount of employee relations casework
- Continued work on reducing undisclosed information on ESR for protected characteristics
- Ensuring managers and staff have correct information and training to complete a good quality appraisal before deadline

Risks / Issues:

- If sickness absence rate remains high, this will impact our productivity and financial performance
- High employee relations casework can increase anxiety and discontent in the organisation.
- Staff being able to attend important learning sessions with current pressures on delivering patient care

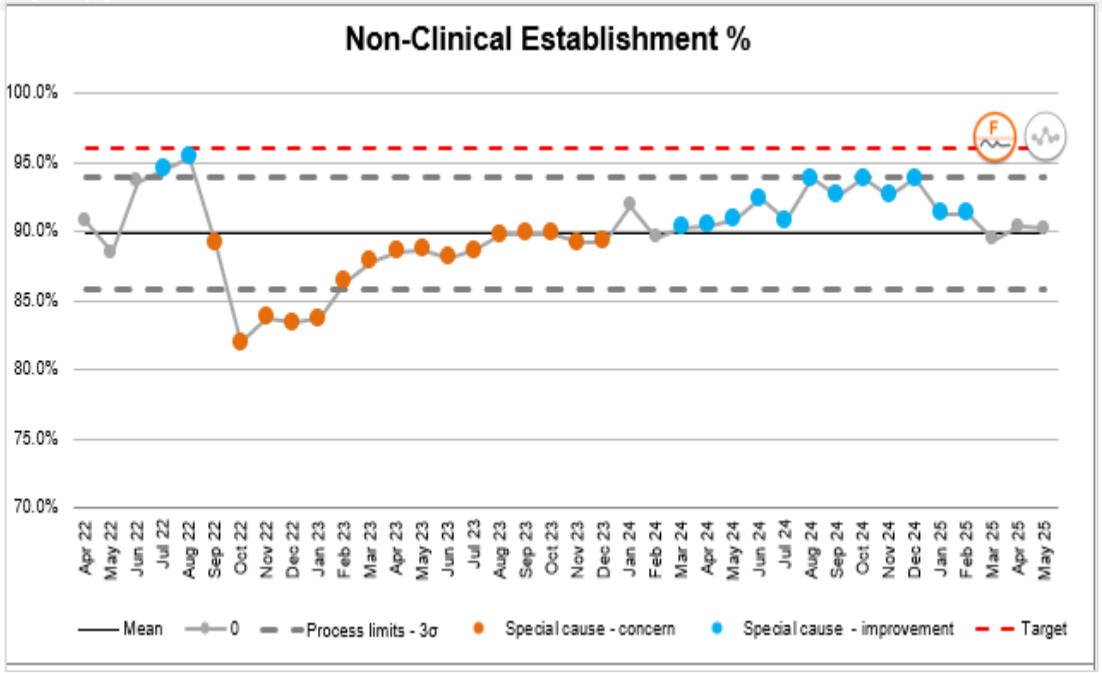
Action Plan:

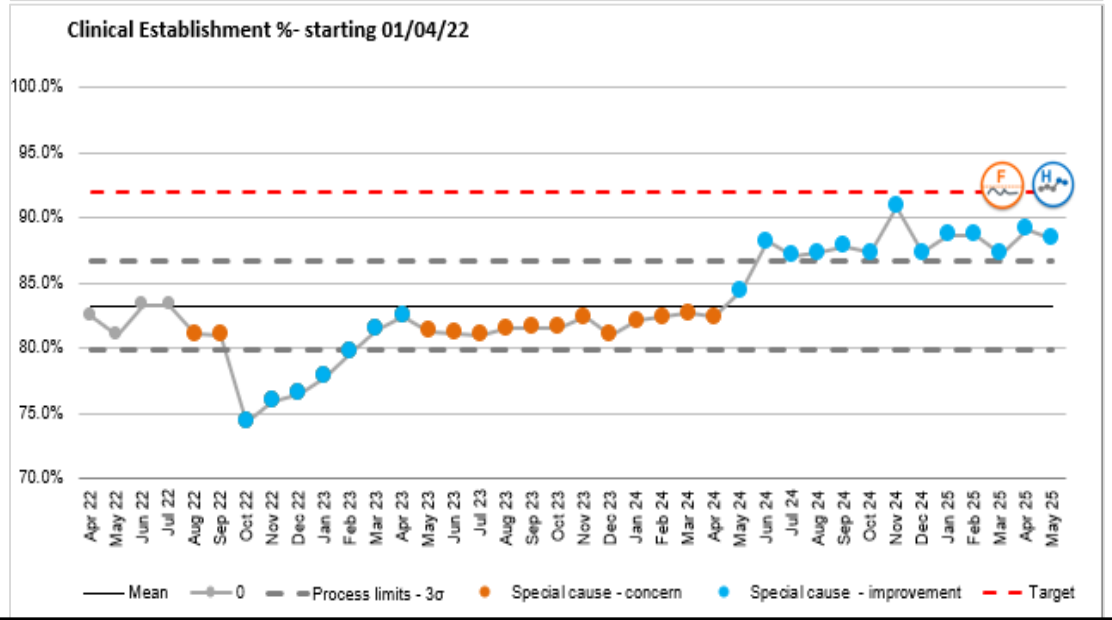
- Our number of hearings and escalation of staff with poor attendance rates will continue.
- Focus on informal resolution when issues come to light will help lower casework figure
- Progress recruitment of MSK Triage role

Occupied Establishment

KPI	93%
May, 2025	89.6%
Trend	-

The true establishment figure is complicated by vacancy control and work is ongoing between HR & Finance to align the ledger and create an accurate view of Trust vacancies. This will develop as the Trust reviews budgets to achieve CIP targets.





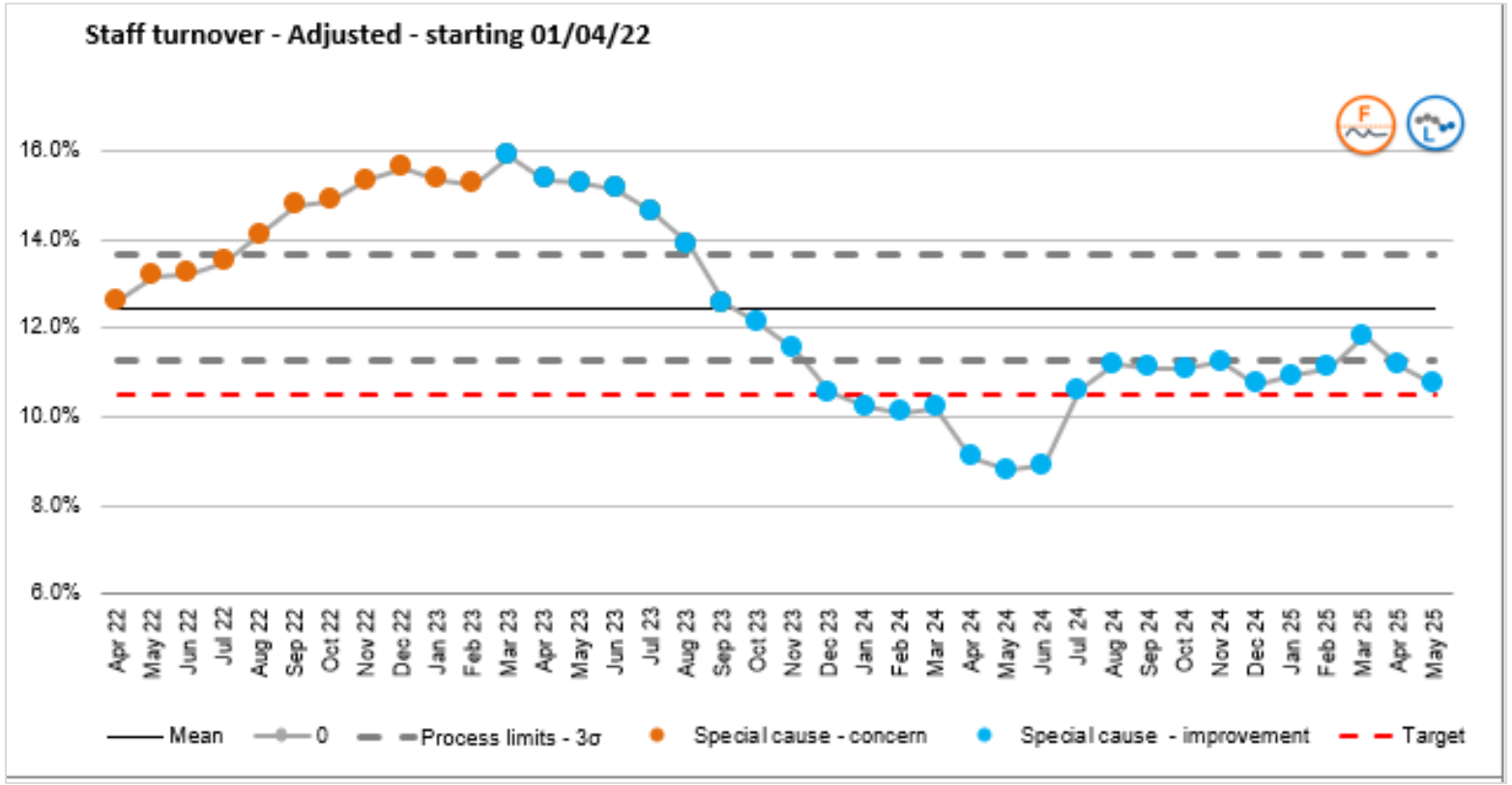
Turnover (adjusted)

KPI	10.5%
May, 2025	10.73%
Trend	↓

Adjusted turnover *is all turnover minus:*

- *Junior doctor rotation*
- *Flexible retirement*
- *End of FTC*

Adjusting turnover provides more meaningful data around Trust performance



May 2025 leavers

May proved a more positive month for turnover.

- The turnover rate reduced by over 1%
- Retirement was the main reason for leaving
- Most turnover was non-clinical staff.
- Leavers were mostly longer serving staff, rather than first year leavers.

There was one dismissal due to long-term sickness and one individual resigned during a disciplinary process.

There were two leavers in the first year. One decided on a career change via training and the other left us after 8 days, due to receiving a better job offer

Length of service	
Less than 1 year	2
2 - 5 years	4
5 - 10 years	3
1 - 2 years	2
10 - 20 years	1
20 - 25 years	1

Clinical & Non-clinical	
Non-clinical	10
Clinical	3

Starters – May 2025

Only three new starters in May 25 due to the ongoing vacancy control measures

We are currently meeting national TTH target of 8 weeks, however lower workloads will have made this easier to achieve.

Post	Department	FTE
Therapy Admin Assistant	Therapies	0.48
Occupational Therapist	Therapies	1
Operating Department Practitioner	Theatres	1

A reasonable time for recruitment could be:

Time to approve – 7 days
Advertisement – 14 days
Shortlisting – 7 days
Interview – 7 days
Clearances – 20 – 30 days (depends on role)
Total = 55 to 65 days

Employee Relations

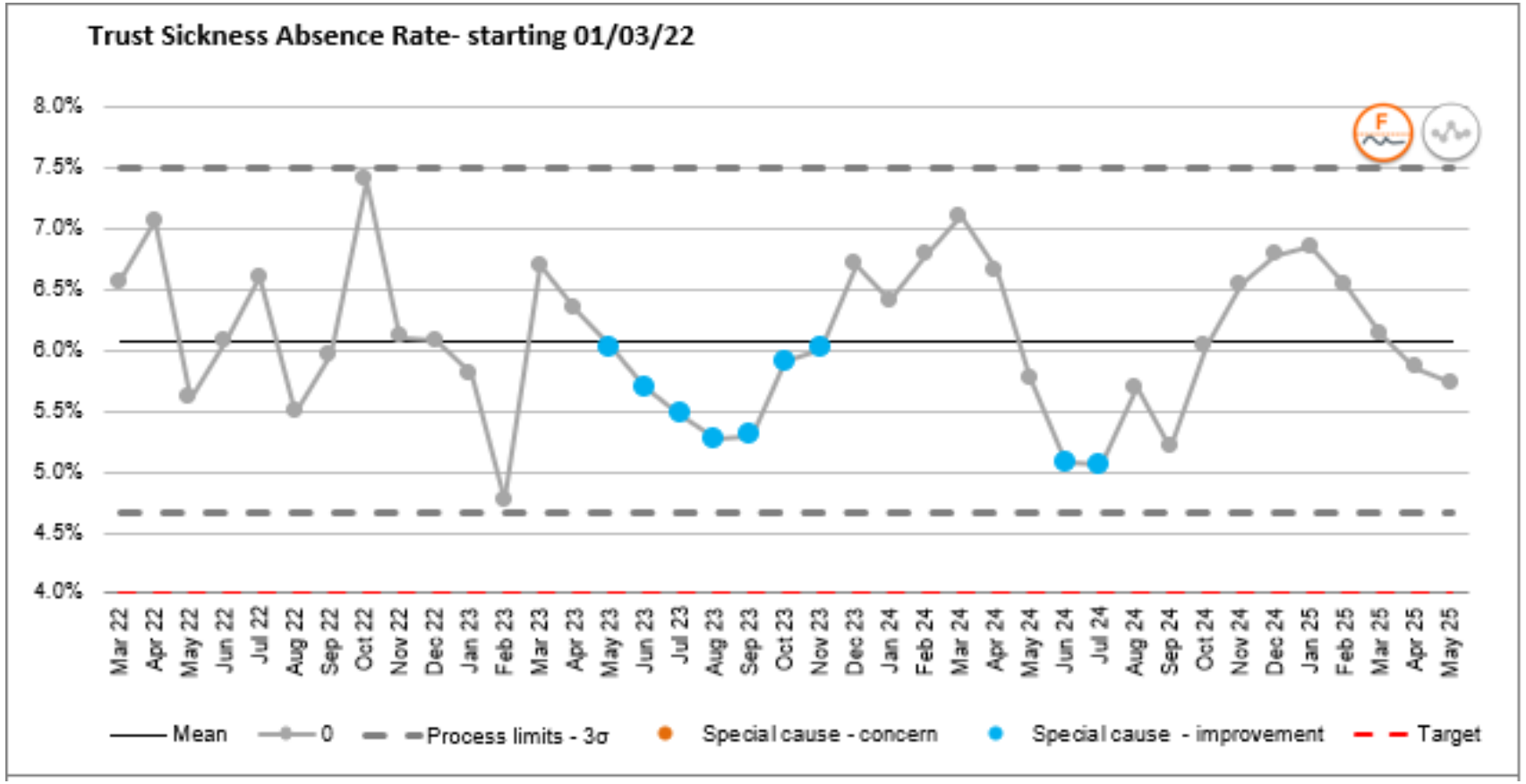
Case numbers have increased by 66% since last report, largely due to an increase in LT and ST cases reaching stage 3 of the attendance process, also due to issues which have arisen within a specific dept which have triggered multiple investigations

Case Type	Cases open			Total	Suspended/ Excluded	Cases Closed / Concluded in Apr/May/Jun to date
	<8 Weeks	8- 12 Weeks	>12 Weeks	20		
Discipline	4	1	2	7	3	1
Grievance		1	1	2		0
Formal Capability	2	1	2	5		0
MHPS			1	1	1	0
Final Stage Sickness	5			5		2

Key Themes:

- The >12-week capability cases have been delayed due to long-term sickness absence and a grievance process which paused the capability proceedings, there are plans in place to progress both cases within the next month
- The >12-week conduct cases were delayed due to an expansion in allegations and outstanding management documentation, dates are in place for June to conclude all 3 cases.
- Sickness Outcomes: 1 termination, 1 reissued targets for monitoring period.
- Conduct Outcome – resigned prior to hearing
- Suspensions are risk assessed and reviewed on a four-weekly basis.
- Reviews of Disciplinary and Civility and Respect policies are underway to reduce formal investigations, support early resolution and embed restorative just and learning culture.

Sickness	
KPI	4%
May - 2025	5.73%
Trend	↓

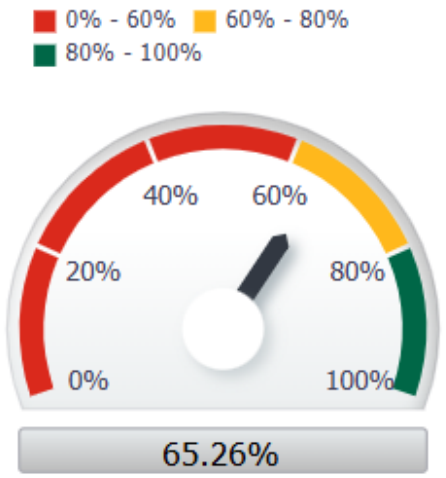


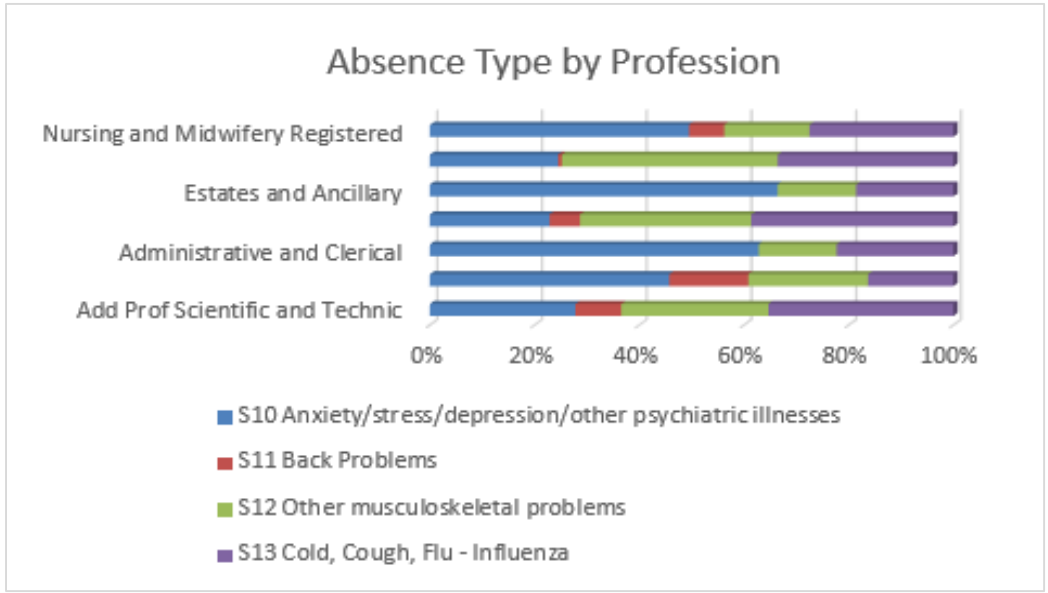
Sickness absence

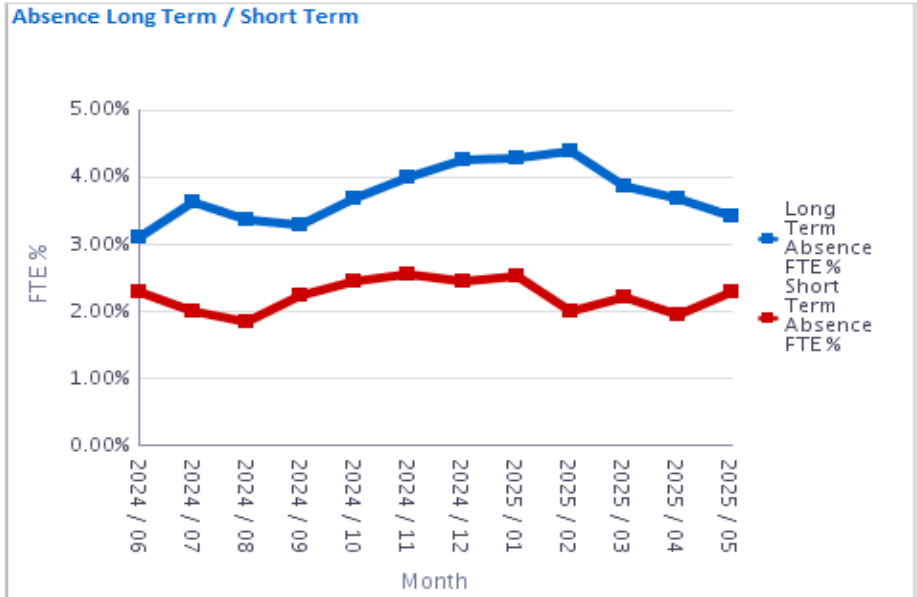
Our audits are suggesting that there is a higher rate of return to work completion, at around 85% compared to what is detailed on ESR.

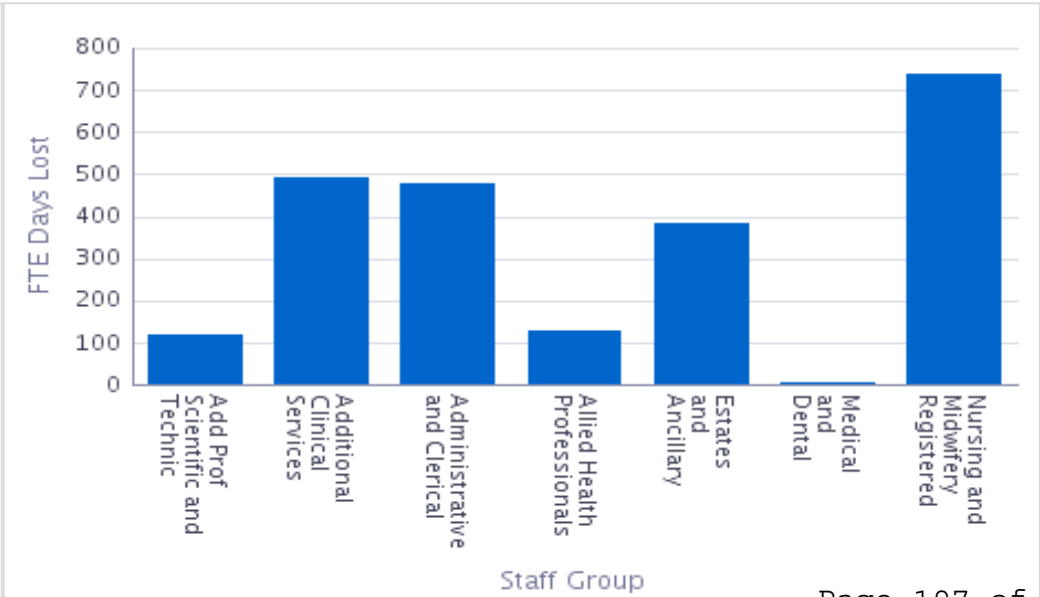
Workshops are expected to help increase this figure by scrutiny.

Return to work compliance (logged on ESR)









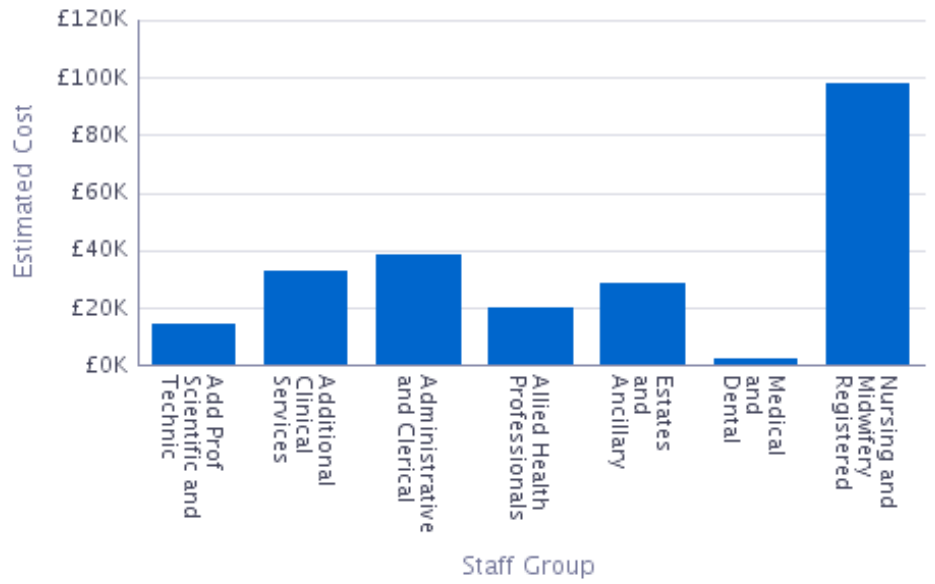
Sickness absence

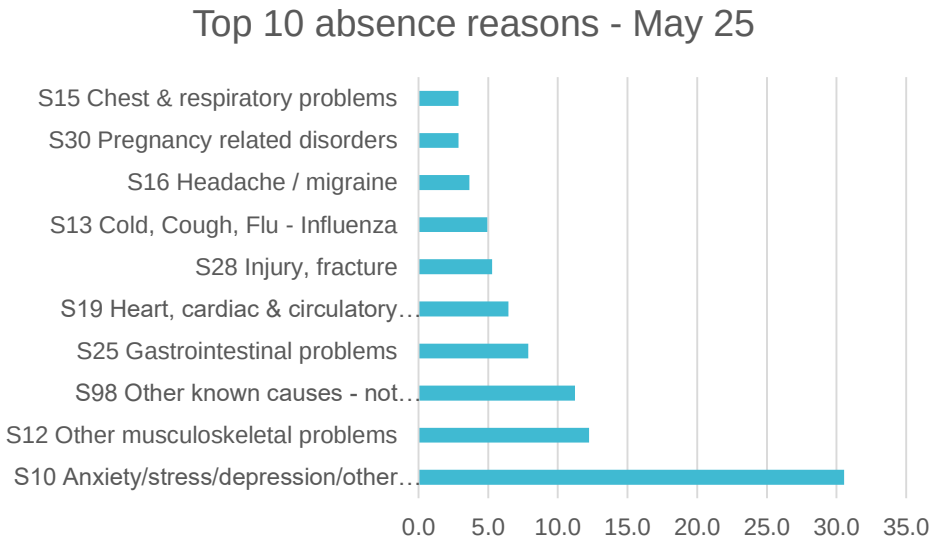
Absence cost the Trust £233,966 in May this is based on the financial value of absentees and doesn't include the cost of replacement.

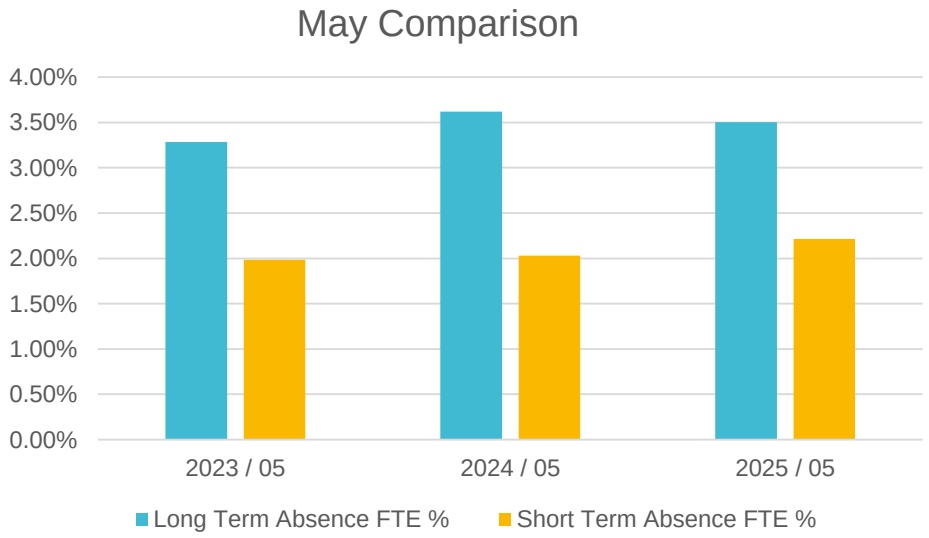
A decrease in long-term absence is positive, however we haven't seen the decrease in short-term absence that we would have expected this time of year.

Mental health related absence remains a cause for concern.

System benchmarking for sickness absence for April and May was not provided in time for this report.



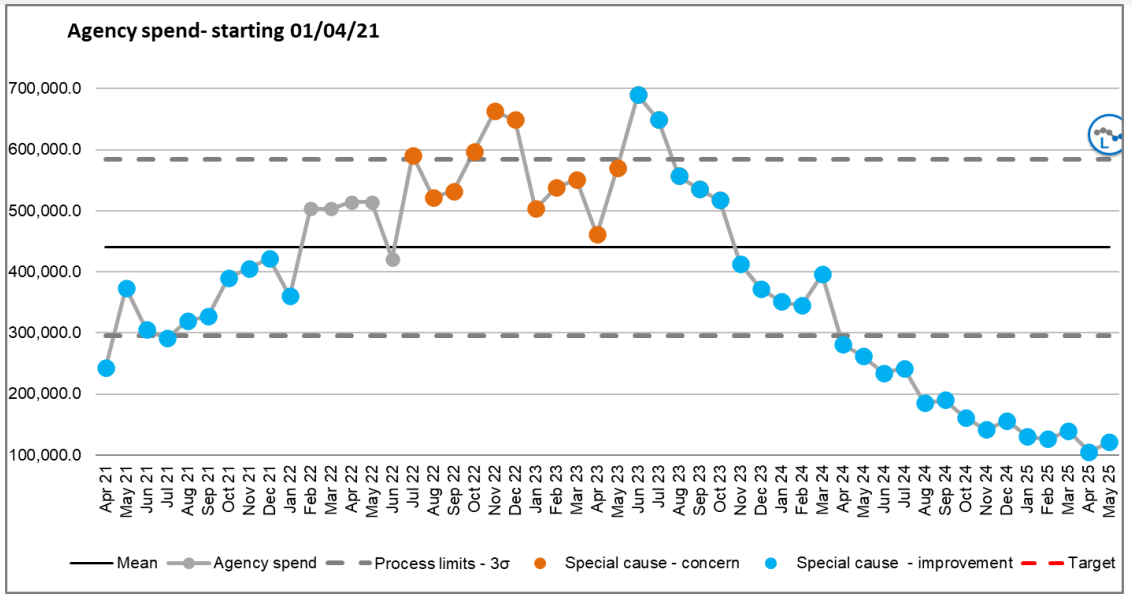


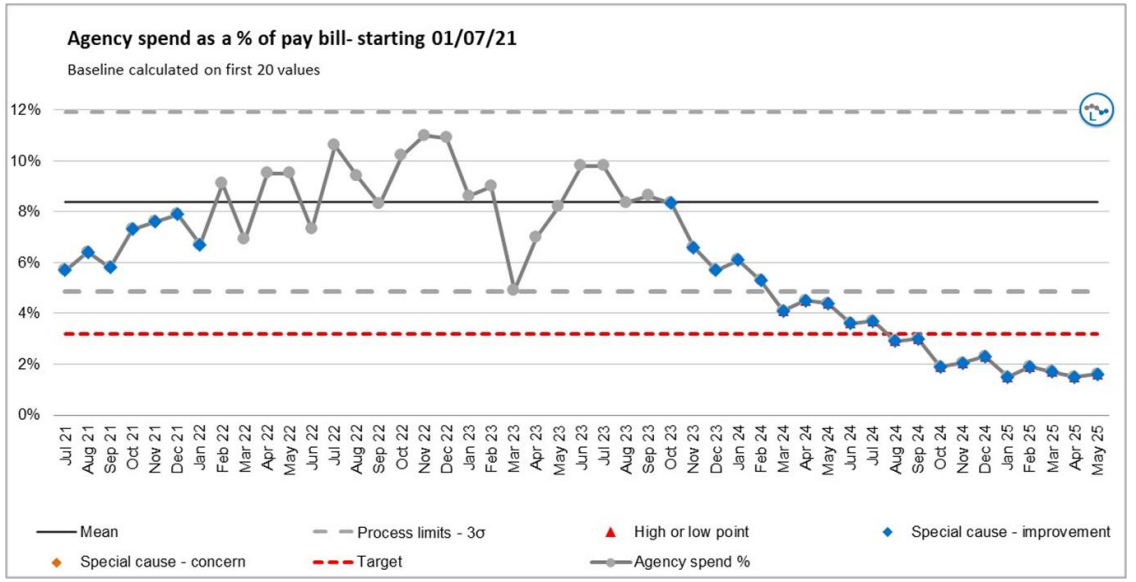


Temporary Workforce

Agency expenditure remains static and the remaining agency usage in the Trust is mainly via medical staff at SHO/Registrar level.

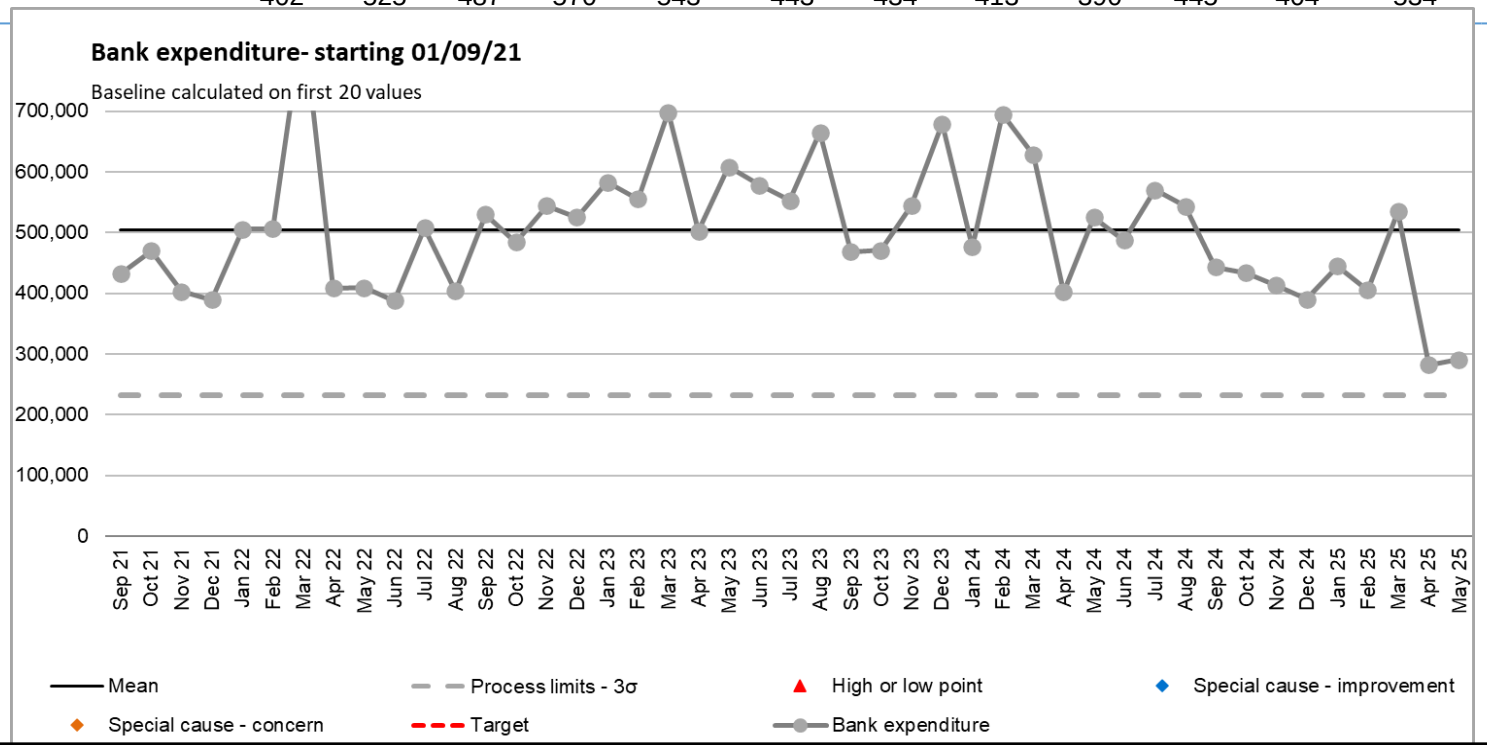
There are plans in place to reduce this premium rate of expenditure over time.





Temporary Workforce

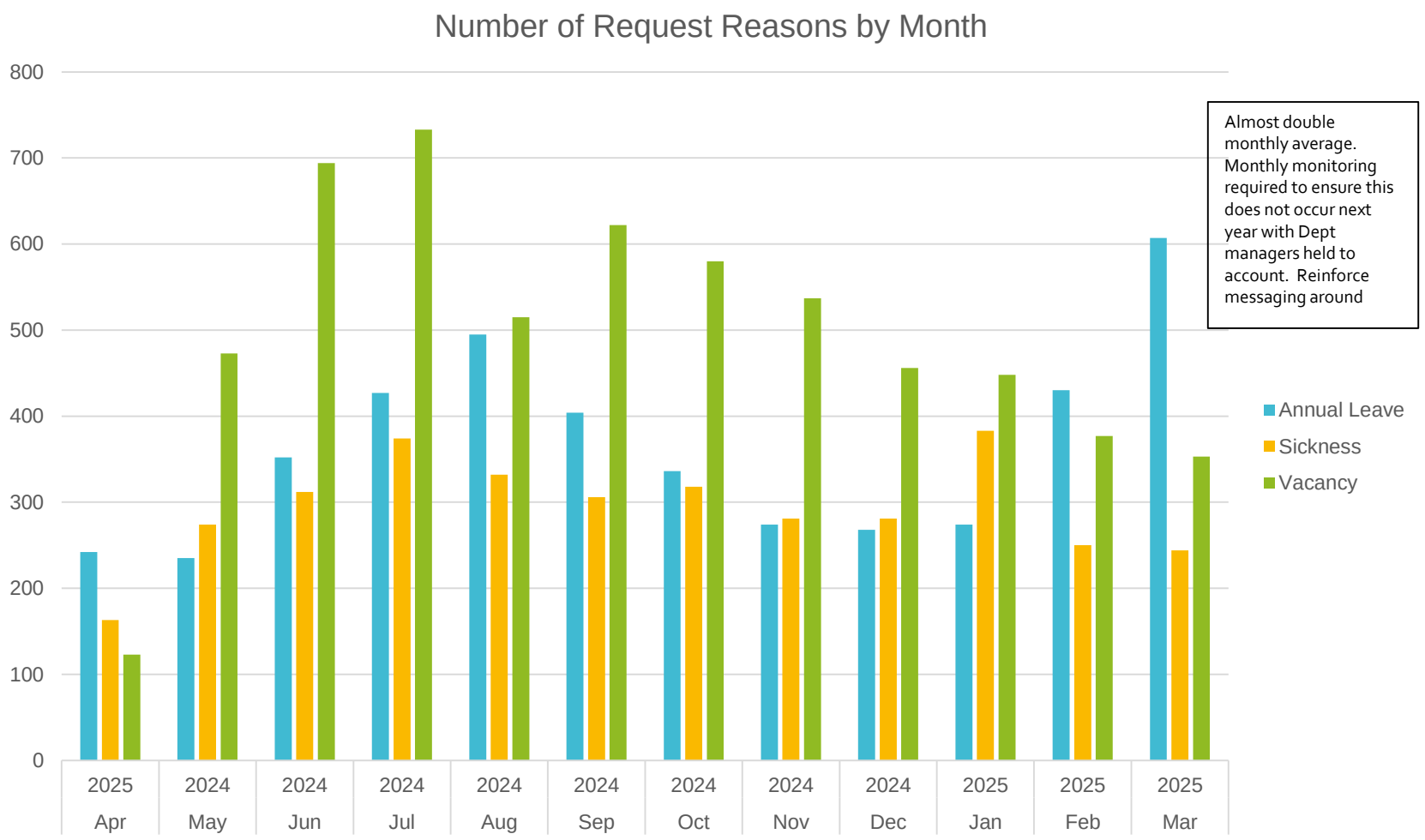
Bank expenditure	£'000s													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April'25	May'25
Registered nursing	108	122	110	136	116	101	95	112	118	92	109	108	46	41
Healthcare scientists and Scientific, therapeutic and tech	26	35	32	47	25	33	41	38	38	34	35	38	31	38
Support to clinical	52	70	60	86	78	55	56	61	69	55	38	94	33	20
Total medical and dental staff bank	56	91	51	61	107	88	117	85	52	124	88	142	56	97
NHS infrastructure support	138	136	155	189	200	151	125	117	111	140	119	157	107	95
TOTAL	402	525	487	570	543	443	434	413	390	445	404	534	274	291



Temporary Workforce

This graph highlights the importance of effective workforce planning as there is a noticeable increase in bank expenditure towards the end of the financial year and in the summer months.

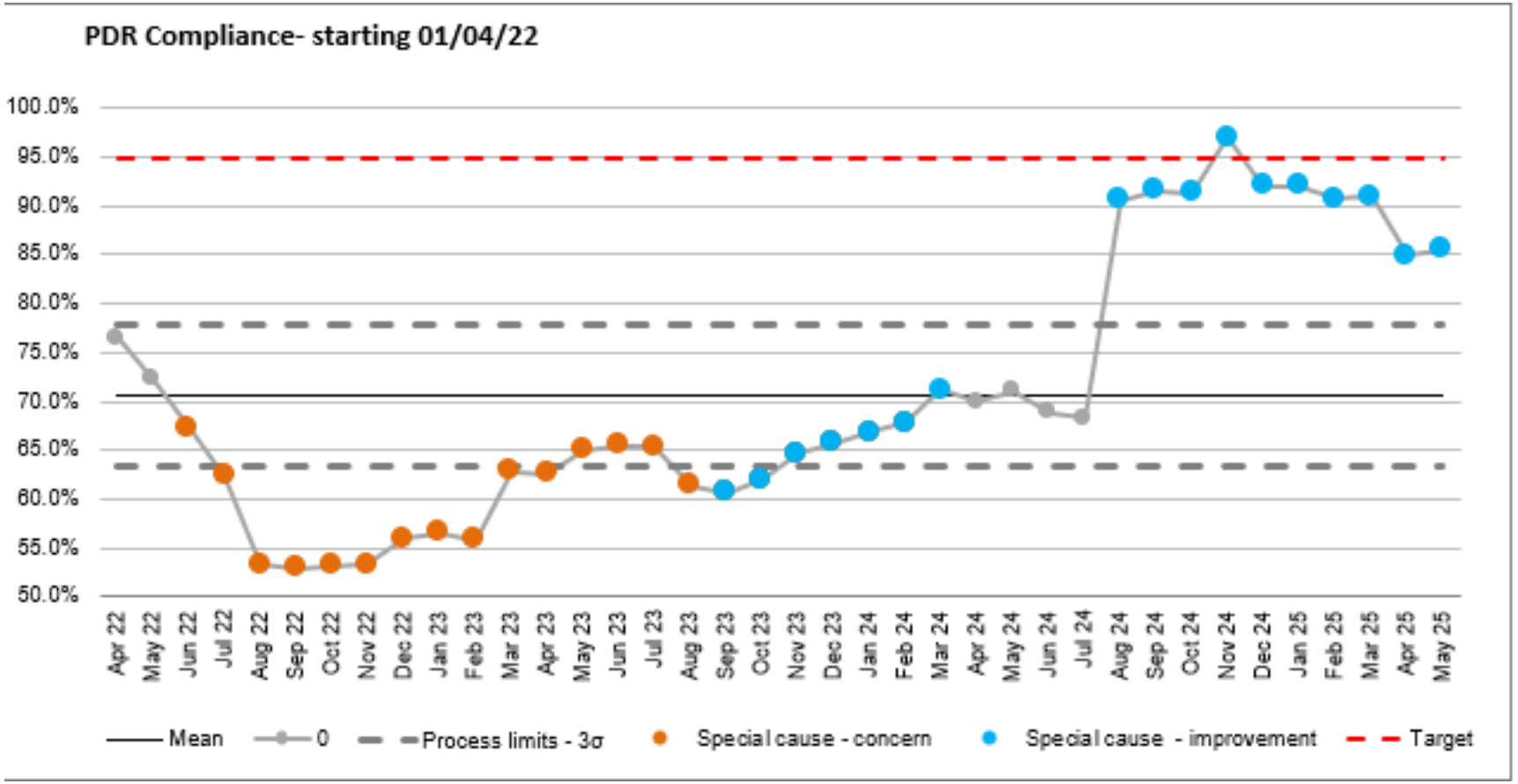
We are working with managers around how they more effectively plan their workforce across a year to avoid the need to engage temporary workforce to cover gaps.



Appraisals

KPI	95%
May, 2025	85.58%
Trend	↓

This is Year 2 of the appraisal window approach for AfC staff taking place between April 1st and July 31st. The number of appraisal completions as at May 31st equates to:
April – 153
May – 37
Total: 190
Completion rate update reports are being sent out to Directorates as a reminder for managers to complete appraisals and update ESR in a timely manner

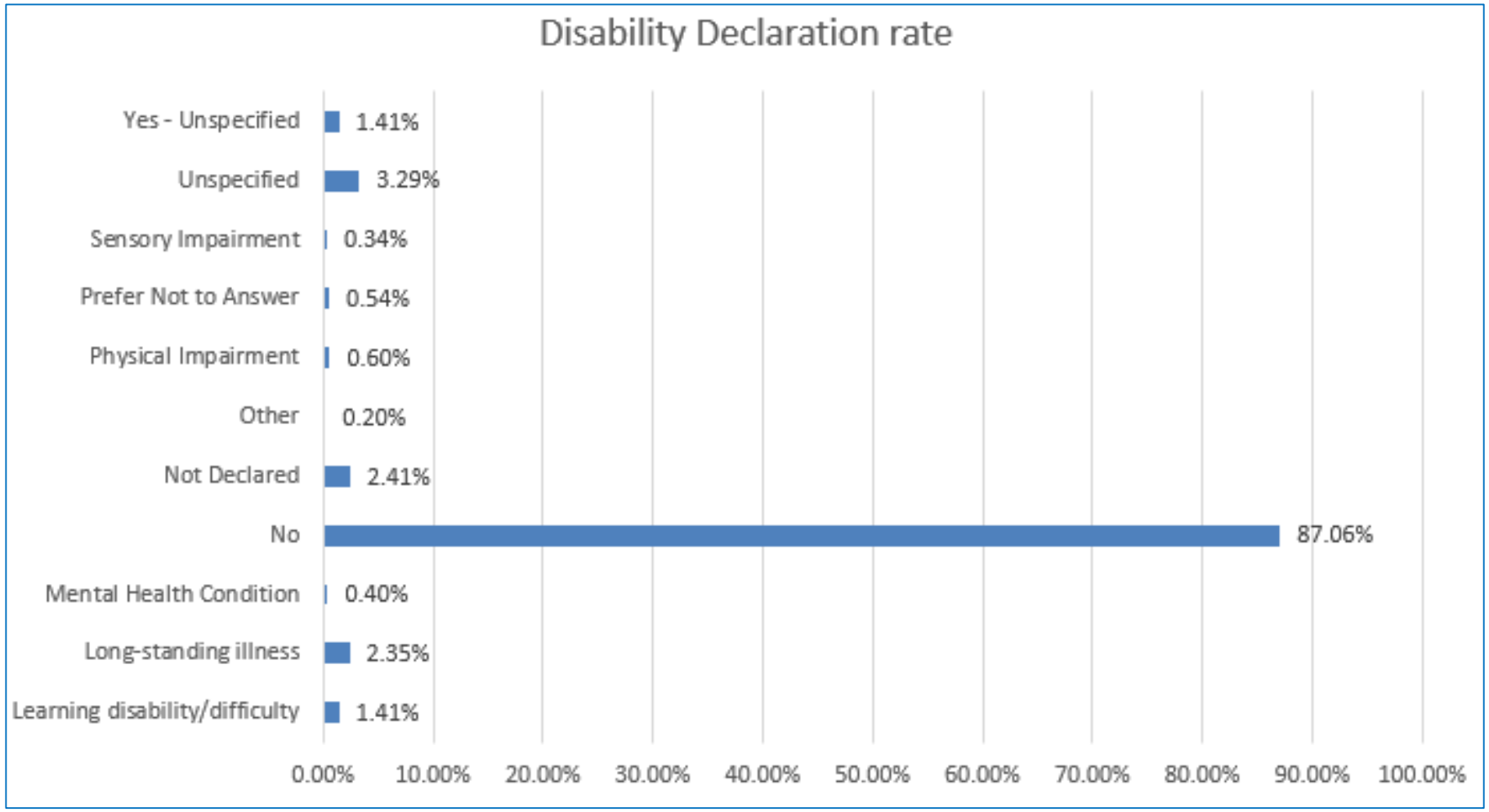


Training for managers is scheduled through the Appraisal window either in short face to face sessions, videos or information on intranet site. The focus of the appraisal conversation is around high performance, development and support to ensure every colleague contributes to the delivery of the strategic objectives.

Workforce Experience

KPI	7.5%
May, 2025	7.04%
Trend	↓

In the staff survey for 2024 23.8% of staff members confirmed they had a long term health condition. However on ESR, the percentage for the disability declaration rate is lower as shown in this update. With support from the staff networks, progress continues to be made on decreasing the number of undisclosed entries on ESR across the nine protected characteristics



Section Two:

Education and Training

Prepared by: Claire Felkin, Training & Development Manager

Presented by: Claire Felkin, Training & Development Manager

Ref: <May>, <2025>/HR&OPS

Education and Training

Summary:

This month has seen a slight decrease in compliance to 86.63%. The figure continues to hover around 86/87% despite continuous reminders from Execs in addition to reminders built into ESR. We are achieving the mean (average) but continue to sit below the target of 93% overall. Recent technical issues with Cyber and Information Governance may be a causal effect as these modules along with Fire Safety require annual renewal. For example, Fire is 80% and Cyber is 77% whereas the average figure for the 3 yearly modules is 93%.

Areas for Improvement:

Oliver McGowan Tier 1 & 2 sessions for 2026 are now available to book via ESR. These continue to be delivered through the ICS who provide OMMT facilitators and individuals with lived experience of Autism and Learning Disabilities. We achieved our target of 33% for March 2025 for Tier 2.

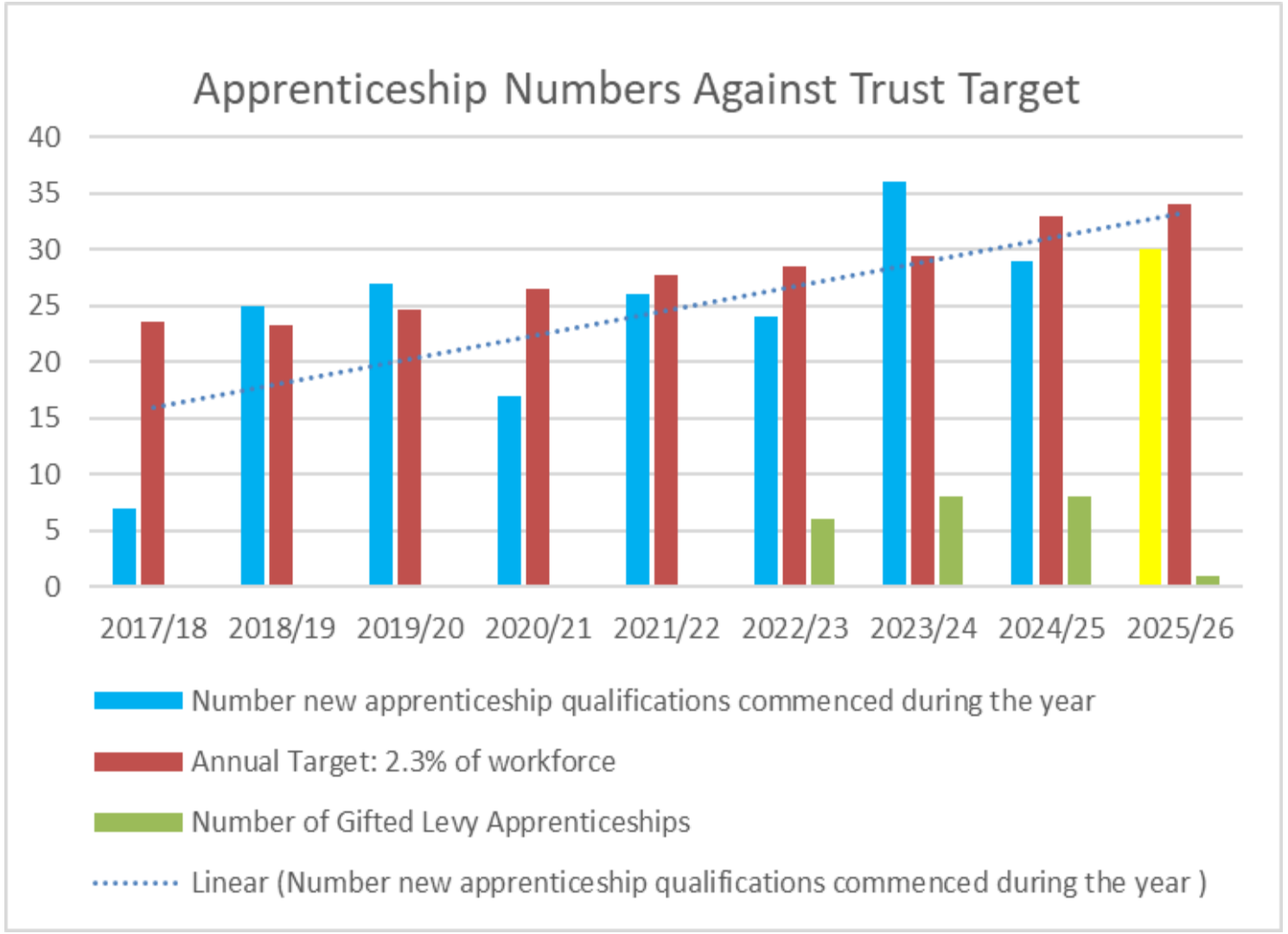
Risks / Issues:

- There was a technical issue with accessing Cyber and IG elearning during May which has affected compliance. This is now working again.
- Fire continues to be under 80%.
- Oliver McGowan Tier 1 & 2 dates have only recently become available following a short gap due to ICS planning window for the new financial year.

Action Plan:

- We have planned target communications to chase those out of date with Fire Safety. In May, we targeted Resus Level 1 compliance which has increased this month.
- Oliver McGowan Tier 2 will be held on site monthly for the rest of 2025 making it easier for staff to access.
- We have 100 places available for Oliver McGowan Tier 1 online 1-hour workshop on MS teams, also bookable via ESR.
- We are progressing the implementation of the Learning Management System.
- We have adopted the MOU allowing staff to bring competencies across from other Trusts and we are following progress with the National STATMAND review.

Apprenticeship Activity	
Actual KPI (25/26)	9 / 34
Projected (25/26)	29 / 34
2024/25	28 / 33
2023/24	36 / 29

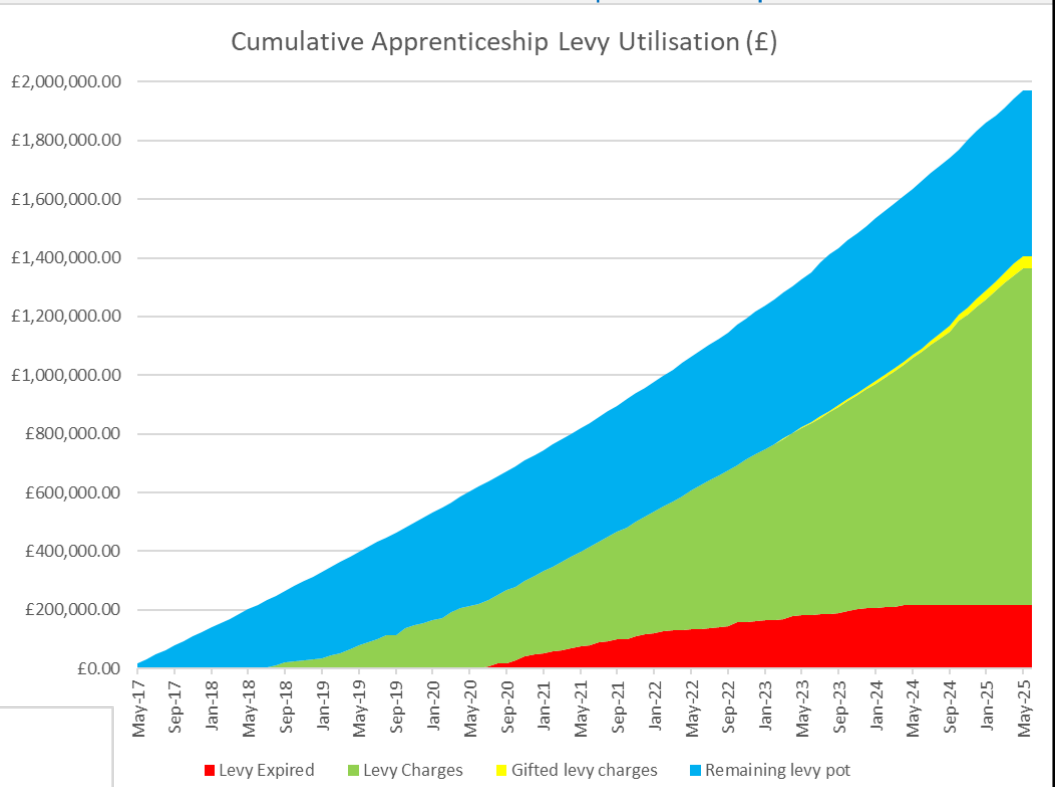


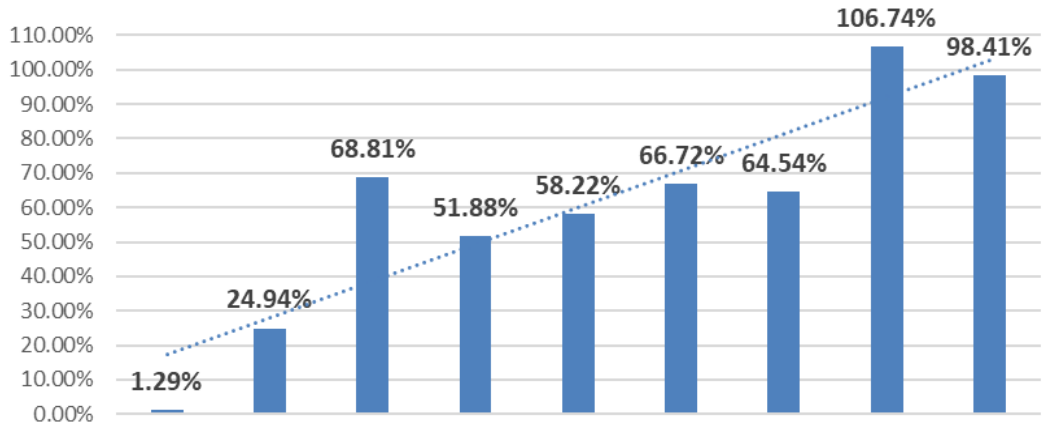
At 31st May 2025, the Trust has 9 new apprenticeship starts. 2 x L3 Business Admin, 1 x L3 Team Leader, 1 x L5 Student Nurse Associate, 1 x L6 Operating Department Practitioner, 1 x L7 Accountancy and 3 x L7 Senior Leader. There are 3 additional in the pipeline to commence in the next 6 months; 1 x L7 Digital and Technical Specialist and 2 x L3 Pharmacy Technicians. And there are currently an additional 17 in discussion. So there is potential for 29 against a target of 34.

Apprenticeship Levy Funding

Total Levy	£1,969,987.71
Levy Charges	60.34%
Levy Expired	10.99%
Remaining levy	28.67%

In relation to the apprenticeship levy funding investment, we have utilised 60.34%, with 2.16% of this being gifted to smaller charitable organisations. Our expired levy has dropped to under 11%, with no funds expiring since April 2024, and our remaining level has decreased from 30.76% in January 2025 to 28.67% in May 2025.





When comparing utilisation of funding per year, vs the actual funding allocated to the levy within that year, we can see that 2024/25 was our most productive year, and 2025/26 utilising 98% of its investment within the first 2 months.

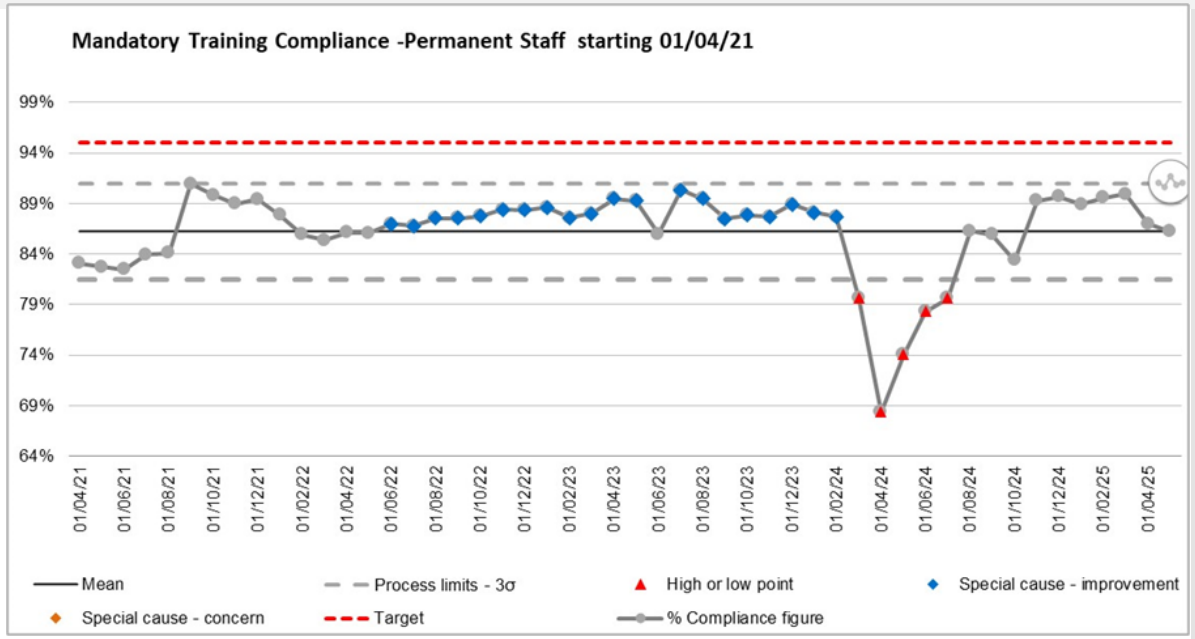
Mandatory Training

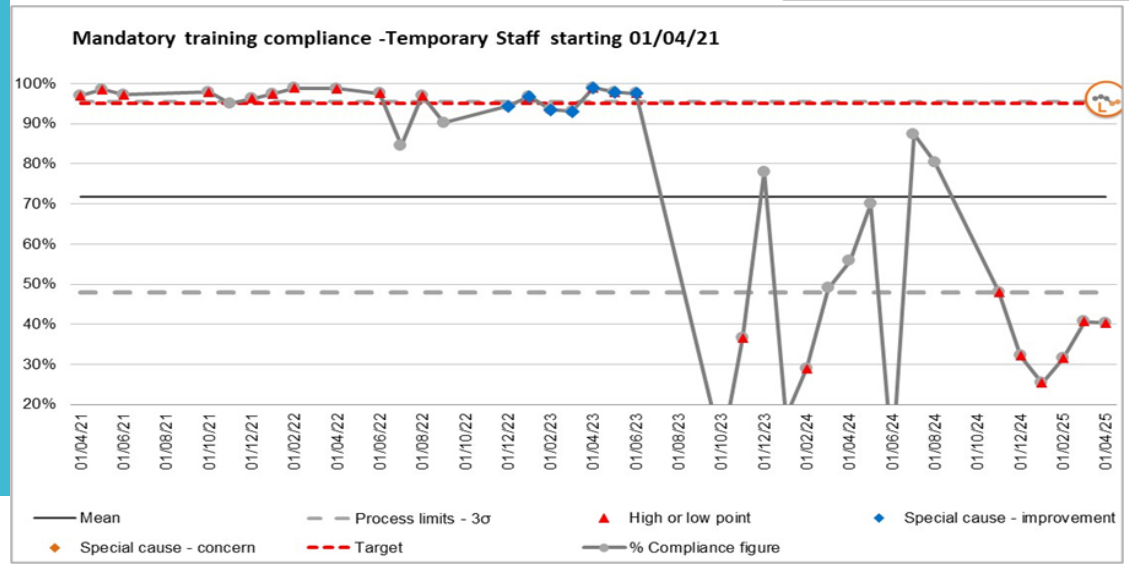
KPI	93%
May, 2025	86.63%
TREND	

Training compliance summary – 31st May 2025

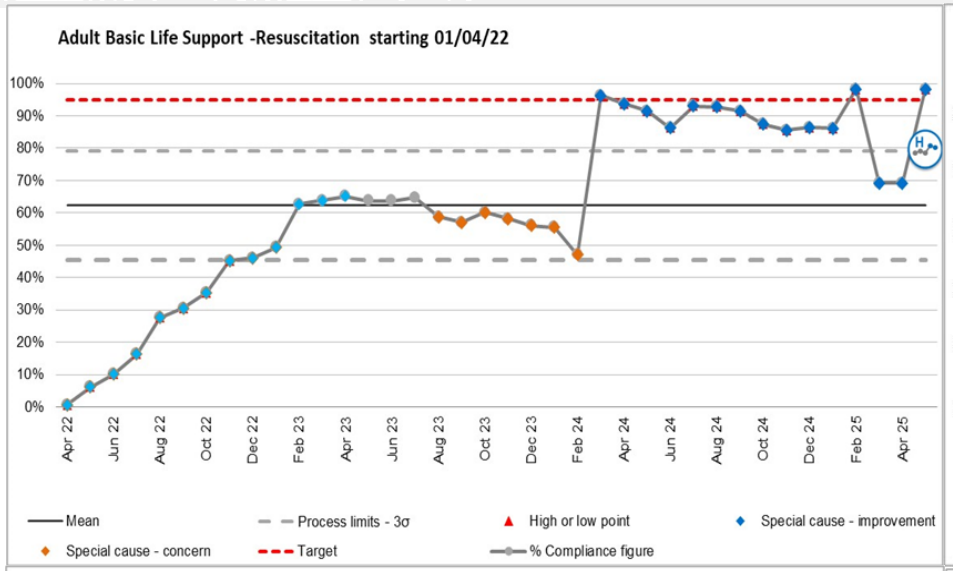
Pg.	COURSE	Compliance %age	COMMENTS	TREND
4	Core Mandatory Training – Permanent Staff	86.63%	Compliance is improving but has slightly decreased this month. If we break this down per compliance module it increases further for some elements of the Core Skills Training Framework (CSTF). % decrease due to Cyber and IG access issues. Fire chaser to go out next month.	
4	Core Mandatory Training – Temporary Staff	47%	Based on staff working on the Bank who are **compliant** with training. Bank Office have been targeting staff to complete their training. 119 staff are over 90% compliant.	
6	Cyber	78.74%	Constant slight increase month on month No new figures this month due to access issues with Meta	
6	IG	77.69%	Constant slight increase month on month No new figures this month due to access issues with Meta	
7	Basic Life Support – Level 1	98.22%	Following direct mail chasing completions this has vastly improved. Target audience – non clinical.	
7	Hospital Life Support – Level 2	80.61%	Continuing to see DNAs and need to push those out of date to book and attend f2f sessions.	
8	Immediate Life Support	84.81%	Large jump in compliance following an increase in activity	
8	Advanced Life Support	97.62%	Large increase in % this month due to a session being put on at ROH	
9	Paediatric Immediate Life Support	86.67%	Target achieved earlier this year, a few out of date. There is a session scheduled for February 2025.	
10	Patient Handling	87.29%	Good progress overall this year but less stable during the last few months; need to sustain improvement.	
10	Conflict Resolution	83.03%	Stayed the same over the last few months since the renewal period change.	
11	NEWS2	98.38%	Consistently achieving over 95% compliance since June 2022.	
11	Safe use of Insulin	89.80%	Staying the same over the last few months.	
11	VTE	94.17%	Stayed the same over the last few months.	
12	CONSENT	82.72%	Slight decrease on last months, accessed via BMJ.	
12	IPC2	78.34%	Decrease due to extra staff groups being added to complete (porters and domestic staff)	
12	Food Hygiene	95.24%	Slight decrease on last month	

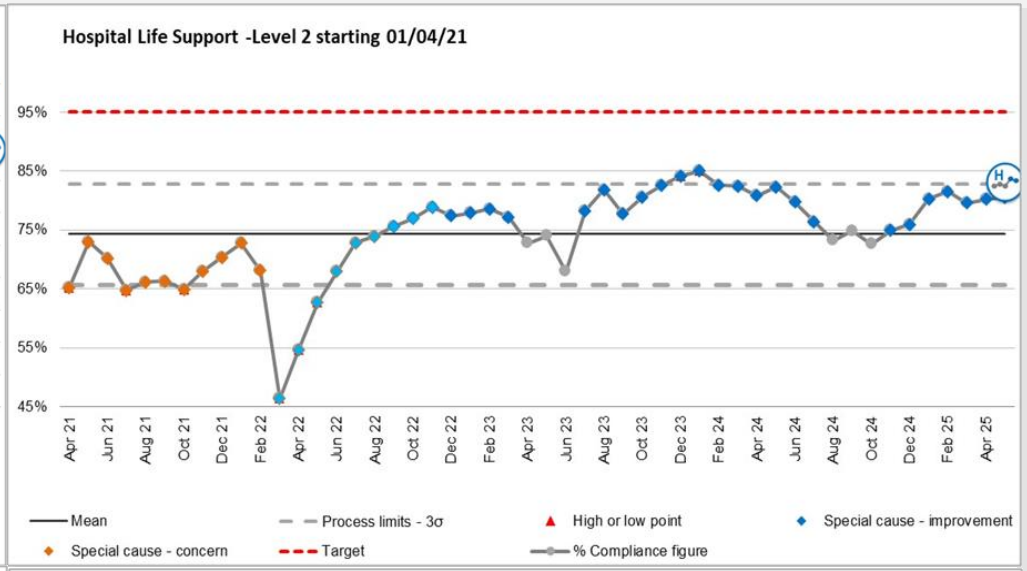
Core Mandatory Training: Permanent and Temporary Staff

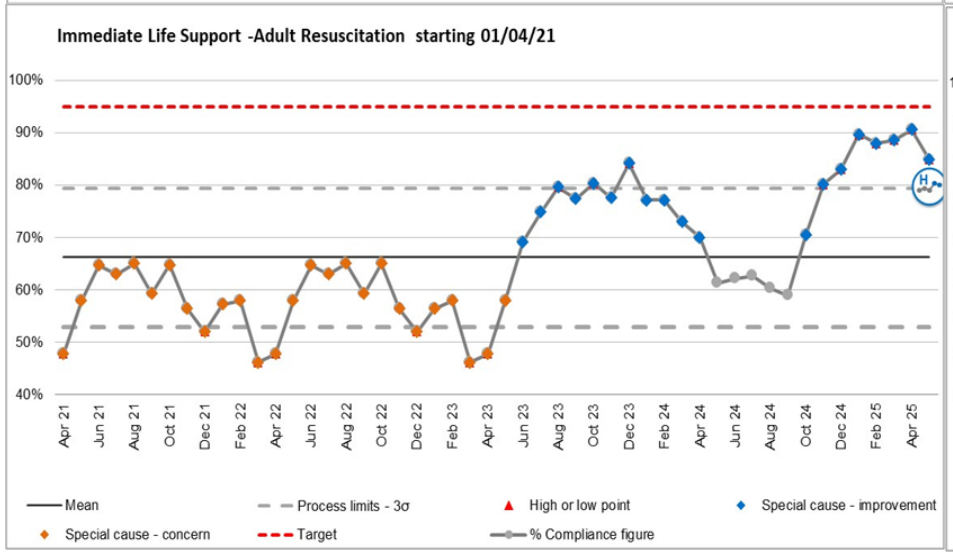


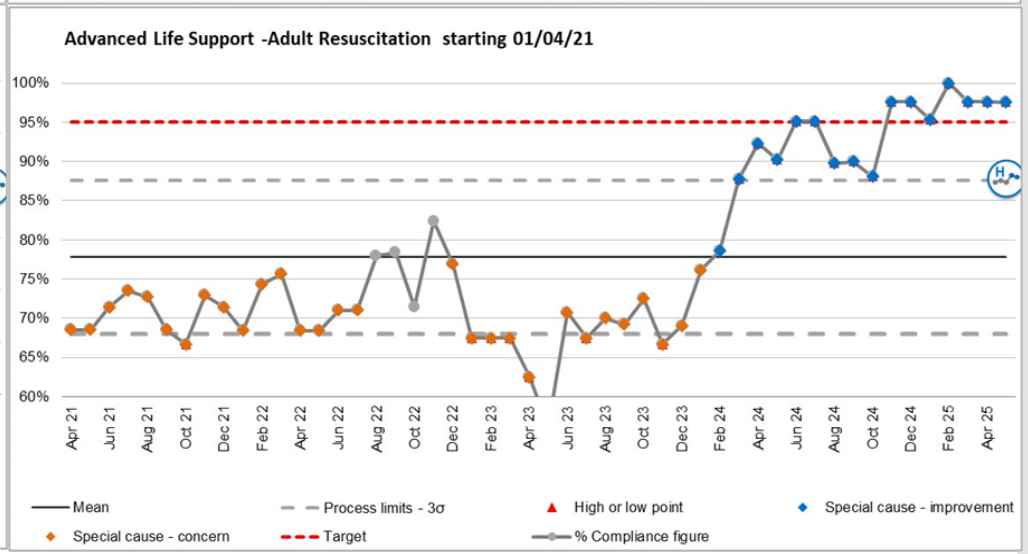


Resuscitation Training: Adult

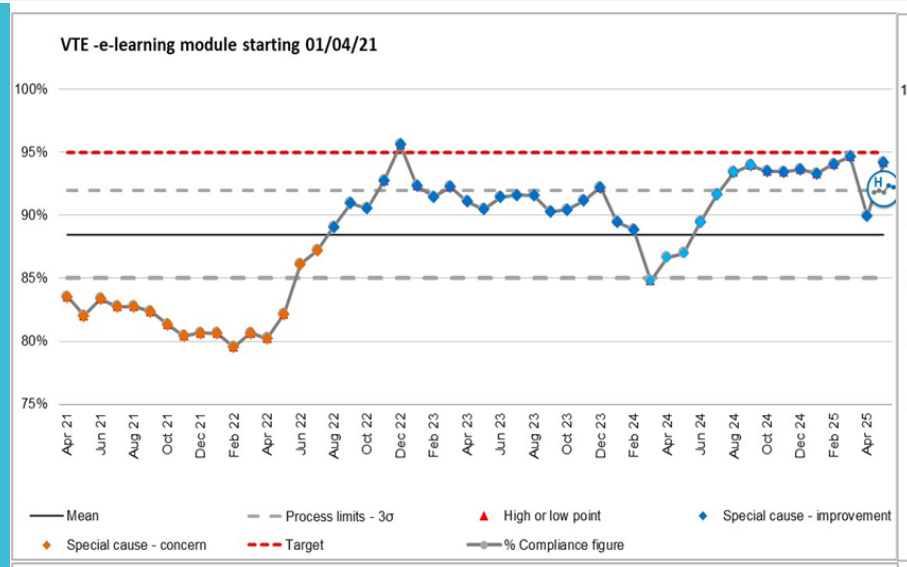


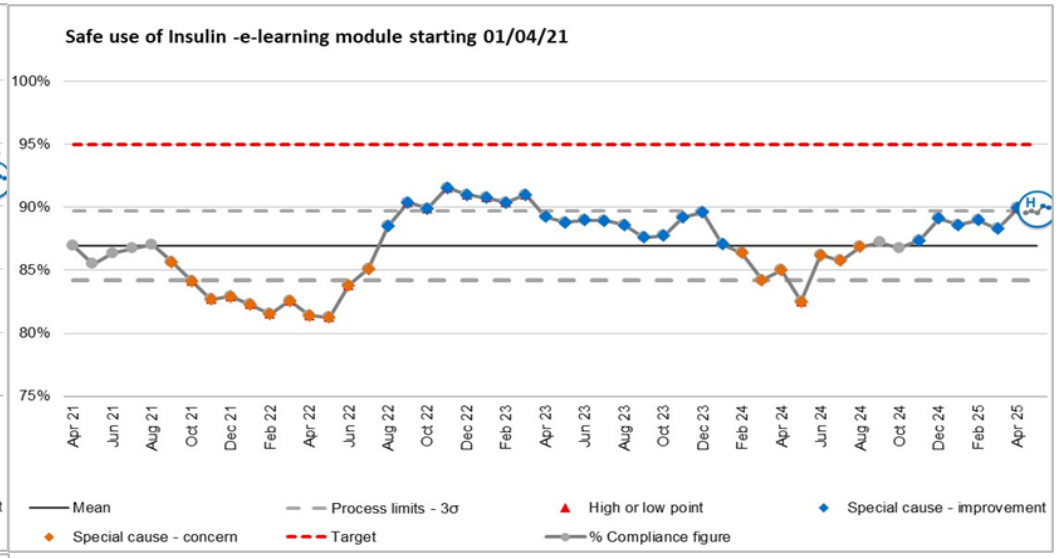


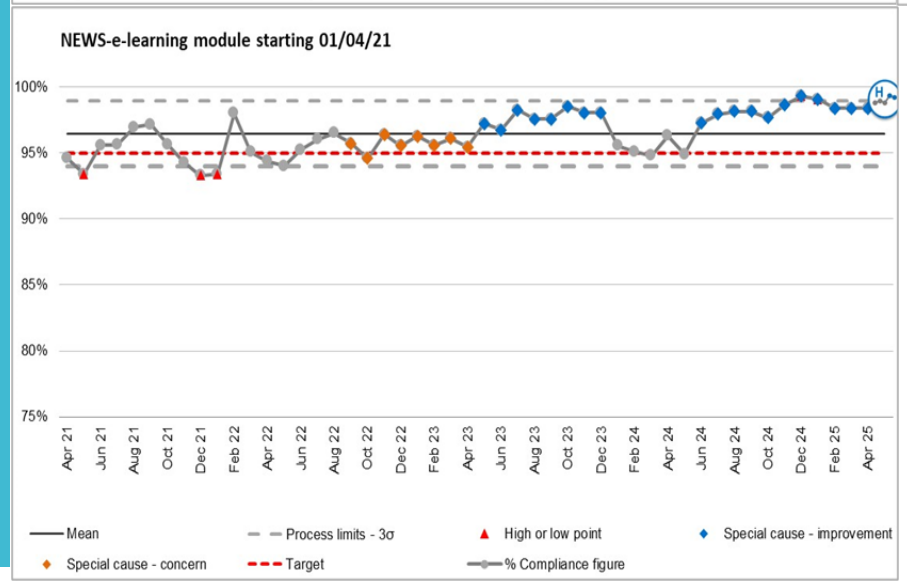




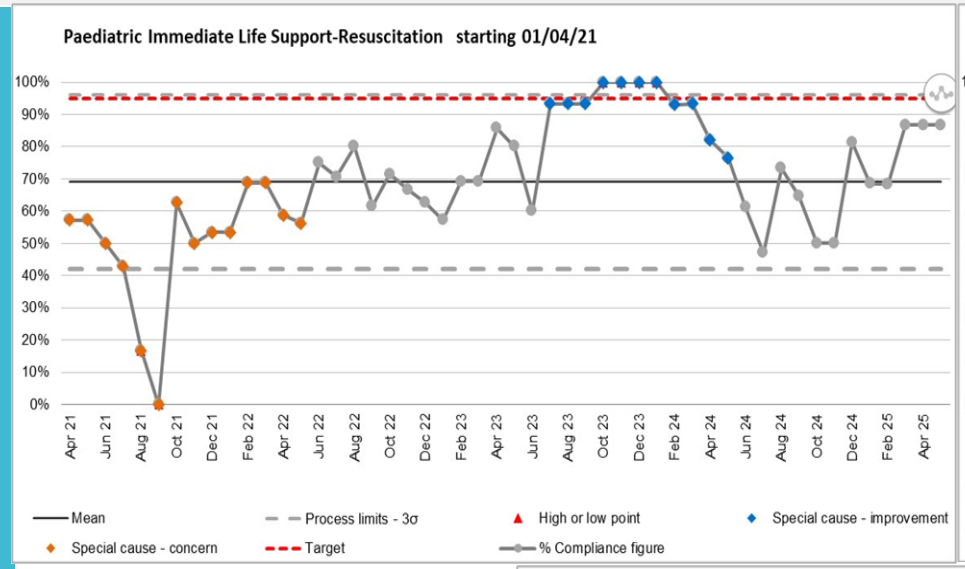
VTE, Safe use of Insulin, NEWS2

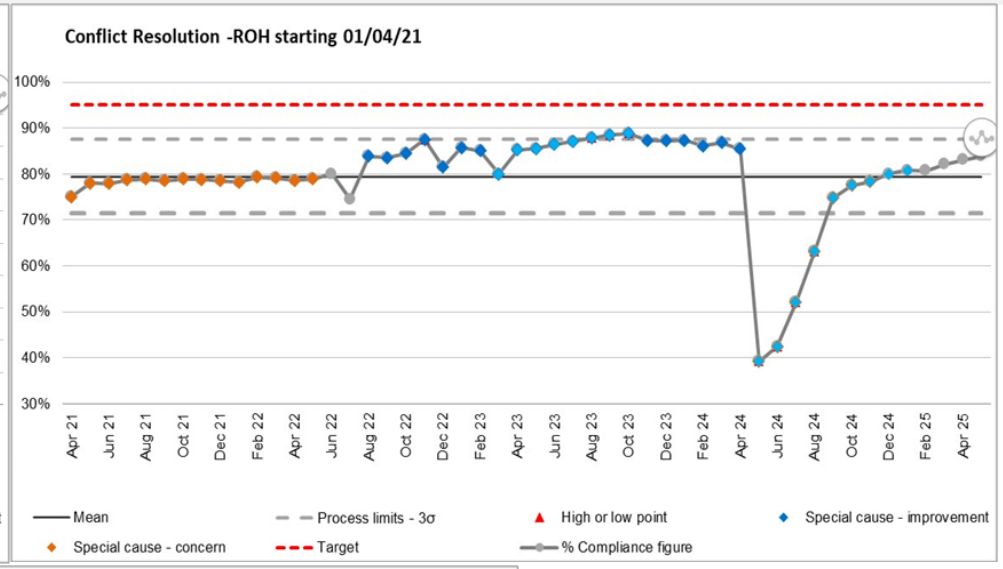


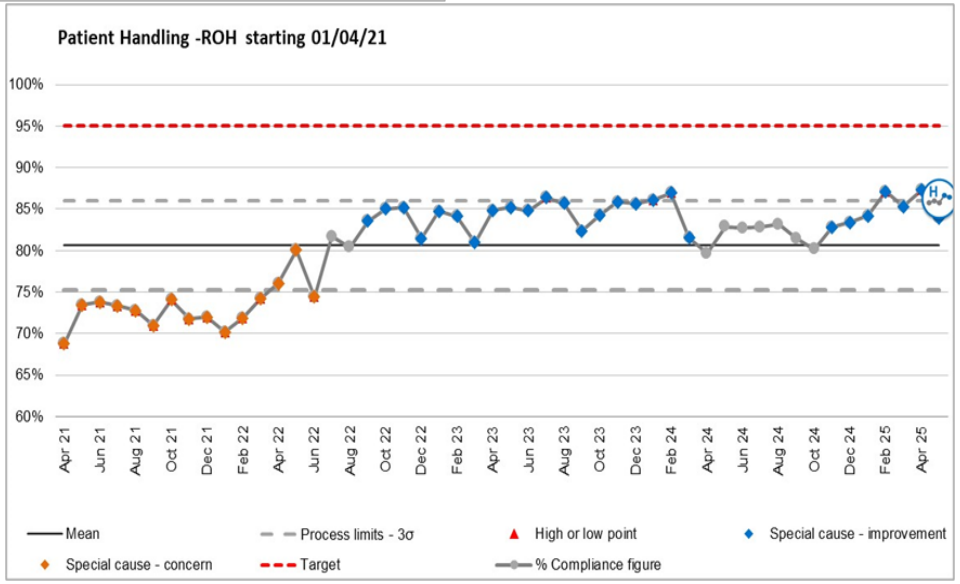




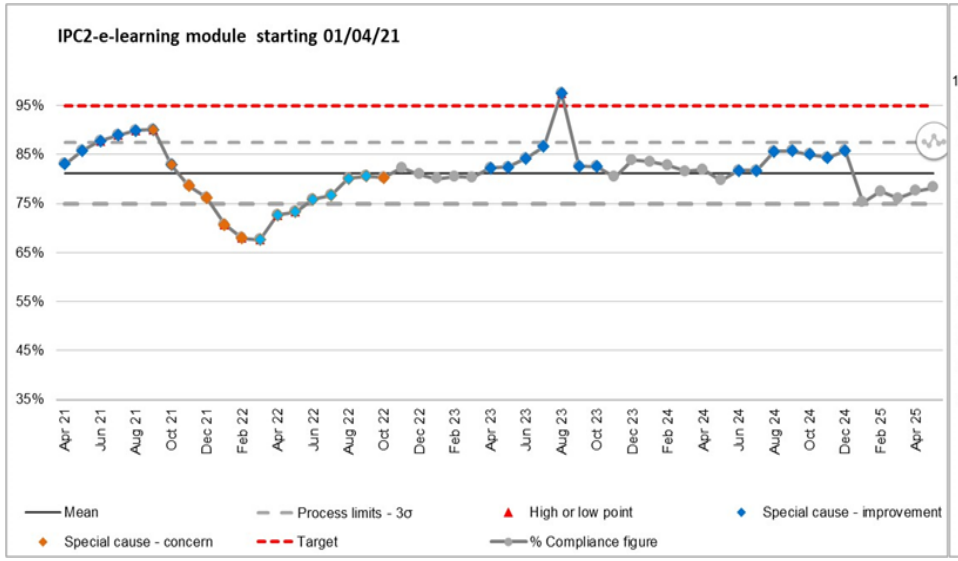
PILS, Conflict Resolution Patient Handling

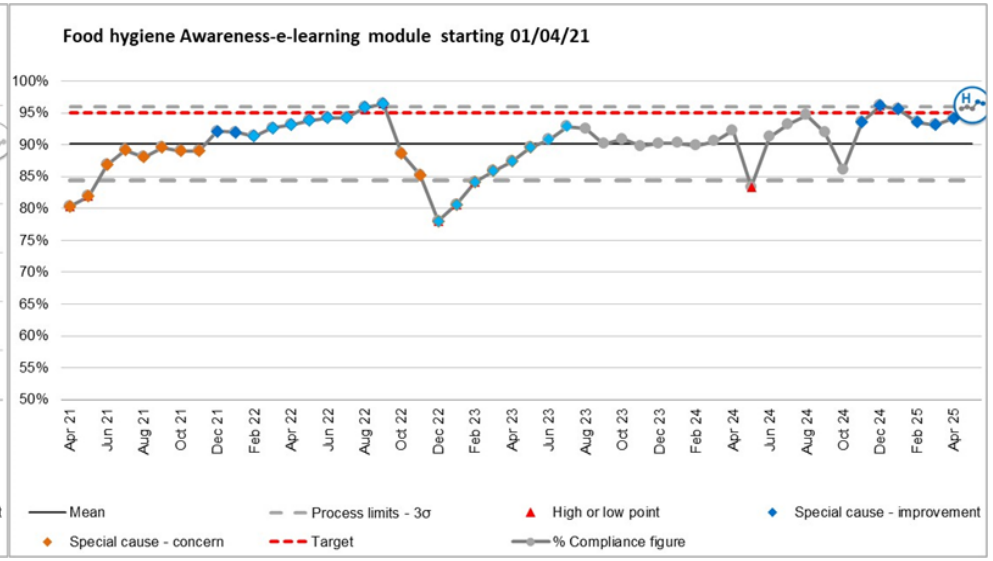




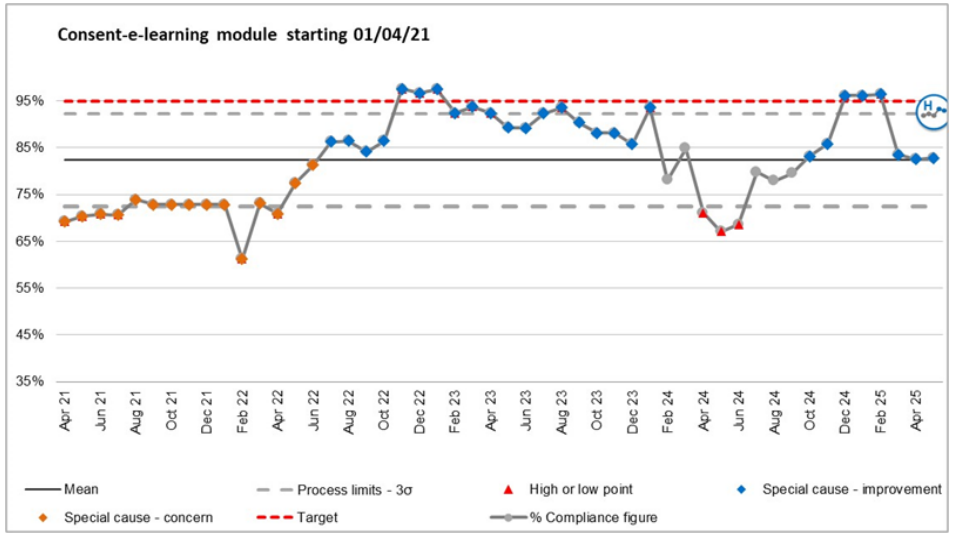


IPC Level 2, Food Hygiene, Consent





IPC level 2 has dropped significantly since August 2023. This compliance has also been extended to other staff groups, ie Facilities.



Significant drop off for **Consent** training, tracking the mean, dropping from 95% in February – consultants need to access this module via the BMJ