The Royal Orthopaedic Hospital NHS Foundation Trust

Trust Board (Public) April

Wednesday 9th April 2025, 11:00h-15:00h

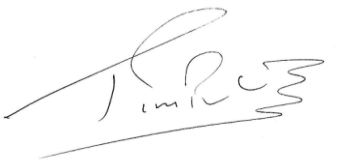
Boardroom, Trust Headquarters

Notice of Trust Board Meeting in Public on Wednesday, 9 April 2025

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 9 April 2025, in the Boardroom, Trust HQ commencing at **11:00.**

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

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



Tim Pile
Chair

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

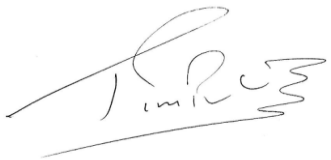
4th April 2025

Notice of a meeting of the Board of Directors

Notice is hereby given to all the members of the Board of the Royal Orthopaedic Hospital NHS Foundation Trust that the following meetings of the Trust Board will be held in the Boardroom, Trust HQ on Wednesday, 9 April 2025:

Meeting	**Timing**
Non-Executives pre-meet – Director of Finance's Office	08:00 – 08:45
Private Board Meeting – Boardroom, Trust HQ	09:00 – 10:45
Public Board Meeting – Boardroom, Trust HQ	11:00 – 12:30
Lunch	12:30 – 13:00
Public Board Meeting – Boardroom, Trust HQ (Continued)	13:00 – 15:00

The business to be transacted is provided on the private and public agendas enclosed or attached with this letter.



Tim Pile
Chair

The Royal Orthopaedic Hospital NHS Foundation Trust

AGENDA
TRUST BOARD PUBLIC

Venue Boardroom, Trust Headquarters **Date** 9 April 2025: 09:00h – 15:00h

Members attending

Mr Tim Pile	Chair	(TP)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Mr Les Williams	Non Executive Director	(LW)
Ms Ayodele Ajose	Non Executive Director	(AA)
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 Nikki Brockie	Executive Chief Nurse	(NB)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance

Ms Jude Davies	Critical Care Outreach Team Leader	(JD)	[Item 13]
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
		IN PUBLIC SESSION		
11:00	13	Patient Story –Call for Concern and 2024/25 Summary	ROHTB (4/25) 030 ROHTB (4/25) 030 (a) ROHTB (4/25) 030 (b)	JD/NB
11:20	14	Apologies: Simone Jordan, Jenny Belza, Ian Reckless	Verbal	Chair
	15	Declarations of Interest	ROHTB (4/25) 007	Chair
	16	Minutes of Board Meeting held in Public on 5th March 2025: *for approval*	ROHTB (3/25) 020	Chair
	17	Actions from previous meetings in public: *for assurance*	ROHTB (3/25) 020 (a)	SGL
	18	Questions from members of the public	Verbal	Chair
11:25	19	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (4/25) 008 ROHTB (4/25) 008 (a)	MH/TP

11:35	20	Chief Finance Officer's report: *for information and assurance*	ROHTB (4/25) 009 ROHTB (4/25) 009 (a)	SW
11:50	21	Chief Operating Officer's report: *for assurance*	ROHTB (4/25) 010 ROHTB (4/25) 010 (a)	MP
12:10	22	Chief People Officer's report: *for assurance*	ROHTB (4/25) 011	SM
12:20	23	Quality Officers' report: *for assurance*	ROHTB (4/25) 012	MR/NB/ SGL
12:30	**LUNCH**			
13:00	24	Wellbeing Update: *for assurance*	ROHTB (4/25) 013 ROHTB (4/25) 013 (a)	SM
13:15	24.1	Wellbeing Non Executive Champion Update: *for assurance*	ROHTB (4/25) 014 ROHTB (4/25) 014 (a)	AA
13:20	25	Staff Survey 2024: *for assurance*	ROHTB (4/25) 015 ROHTB (4/25) 015 (a)	SM
13:35	26	Health Inequalities: *for assurance*	ROHTB (4/25) 016 ROHTB (4/25) 016 (a)	NB
13:45	27	Patient Experience Report and Action Plan: *for assurance*	ROHTB (4/25) 017 ROHTB (4/25) 017 (a)	NB
	GOVERNANCE AND COMPLIANCE			
13:55	28	Control Drugs Accountable Officers Report: *for assurance*	ROHTB (4/25) 018 ROHTB (4/25) 018 (a)	NB
14:05	29	Quality Impact Assessment (QIA) Process: *for assurance*	ROHTB (4/25) 019 ROHTB (4/25) 019 (a)	MR/NB
14:15	30	BAF Update: *for assurance*	ROHTB (4/25) 020 ROHTB (4/25) 020 (a-f)	SGL
14:25	31	Patient Safety Incident Reporting Form (PSIRF) Annual Report: *for assurance*	ROHTB (4/25) 021 ROHTB (4/25) 021 (a)	SGL
14:35	32	Insightful Provider Board Self Assessment: *for assurance*	ROHTB (4/25) 022 ROHTB (4/25) 022 (a)	SGL
14:40	33	Freedom to Speak Up Non Executive Champion Update: *for assurance*	ROHTB (4/25) 023 ROHTB (4/25) 023 (a)	GH
	UPWARD REPORTS FROM THE BOARD COMMITTEES			
14:45	34	Upward reports from the Board Committees:		

		• Finance & Performance Committee • Quality & Safety Committee • Charitable Funds Committee	ROHTB (4/25) 024 ROHTB (4/25) 025 ROHTB (4/25) 026	LW GH AA
14:55	**MATTERS TO BE TAKEN BY EXCEPTION**			
	35	Performance Reports: *for assurance* a) Finance & Performance b) Quality Report	ROHTB (4/25) 027 ROHTB (4/25) 028	
	36	Any Other Business	Verbal	All
	37	Meeting effectiveness	Verbal	All
15:00	**CLOSE: Date of next meeting: Wednesday, 7 May 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 2024/25 UPDATED TO MARCH 2025

MEMBER	ATTENDANCE										TOTAL
	10/04/2023	01/05/2023	05/06/2023	03/07/2023	04/09/2023	02/10/2023	06/11/2023	04/12/2023	05/02/2024	05/03/2024	
Tim Pile (Ch)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Ian Reckless	✓	✓	✓	✓	✓	✓	✓	A	A	✓	
Simone Jordan	A	✓	A	✓	✓	✓	✓	✓	✓	✓	
Gianjeet Hunjan	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	
Ayodele Ajose	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	
Les Williams	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Simon Page	✓	✓	✓	A	A	✓	✓	A	✓	✓	
Jenny Belza	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	
Jan Teo	✓	✓	✓	✓	✓	✓	✓	A	A	✓	
Jo Williams	✓	✓	✓	✓	✓						
Matthew Hartland						✓	✓	✓	✓	✓	
Matthew Revell	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Nikki Brockie	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Marie Peplow	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Stephen Washbourne	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	
Sharon Malhi	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	
Simon Grainger-Lloyd	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	

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

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NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Patient and Staff Experience Stories 2024/2025**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Executive Chief Nurse**
AUTHOR:	**Emma Steele, Deputy Chief Nurse**
DATE OF MEETING:	**9th April 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Royal Orthopaedic Hospital NHS Foundation Trust is committed to improving our services and patient experiences by learning from complaints, feedback, comments, and compliments raised by our patients, their carers, family, friends, and members of public who have contact with the Trust.

The Trust is dedicated to continuously improving our services by listening to our service users and their families. We want to ensure that we learn from our patients lived experience, thus helping us to improve our care and services. Capturing and sharing patients lived experience and stories add value and support the Board to have focus on the daily experiences within the Trust.

This report provides assurance regarding the patient experience stories brought to Board in the previous financial year.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Patient stories were shared and lessons learnt	• N/A

REPORT RECOMMENDATION:

The BOARD is asked to: Note for assurance

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

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

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

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

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

Trust Strategy 2024-2025
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
None specifically.
BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)*:
N/A
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
Annual patient experience report, annual patient story 2-23/24.

FOR INFORMATION

The Royal Orthopaedic Hospital NHS Foundation Trust

Board Patient Experience Stories 2024/2025

Report to Trust Board April 2025

1 Purpose of the Report

1.1 This paper provides a summary of the patient stories presented to the Royal Orthopaedic Hospital (ROH) Trust Board throughout 2024/25.

2 Context and Background

2.1 The Royal Orthopaedic Hospital NHS Foundation Trust is committed to improving our services and learning from complaints, feedback, comments, and compliments raised by our patients, their carers, family, friends, and members of public.

2.2 The Trust is dedicated to continuously improving our services by listening to our service users and their families. We want to ensure that we learn from our patients lived experience, thus helping us to improve our care and services. Capturing and sharing patient lived experience and stories adds value and supports the Board to focus by doing the following:

- Connecting with our patients and relatives.
- Learning from lived experience and stories to help us to improve our services.
- Connecting with front line staff and understanding the impact that involvement with harm or near miss incidents can have. We should never underestimate the emotional effect on staff involved in incidents of patient harm. It can be an opportunity for staff to talk in depth about an event and discuss with senior leaders their thoughts and opinions on why it happened and how it could be avoided in future.
- Improve understanding of human factors in harm and error. Boards are advised to concentrate on strategy, but an in-depth story can give useful detail that provides a window into the workings of the system. This can be particularly useful in building understanding of what it means to have a culture that is just; one that recognises why people make mistakes and exactly what they are asking of their staff when they put them to work in their organisation.
- Make patient safety personal. When stories of patient harm appear in the media it is not uncommon for healthcare leaders to feel such an event would not happen in their organisation. Hearing stories of their patients who have been harmed or had a near miss brings it into their own sphere of accountability – 'this is here, we did this'.

2.3 The Trust have Patient or Staff Stories scheduled at each Board meeting. The stories are usually told by the subject of the story (patient or staff member) but they may choose to have a representative tell the story on their behalf. The Patient Experience Team and Executive colleagues support staff and patients to prepare for the Board meeting and to share their story. The Patient Experience Team will actively seek patients who are willing to share their stories with the Board. This paper will only focus on the patient stories for 2023/24:

3 Preparation for Presenting

3.1 Patient in preparation for presenting at Board are asked to consider the following questions:

- **Summary of their journey.**
- **Things that went well.**
- **Things that could be improved.**
- **What did we as a Trust do to improve your experience whilst in hospital (if applicable).**
- **Actions and any solution.**
- **How will we embed learning from this patient experience around the Trust?**

3.2 At the end of each financial year, the Patient Experience Team will provide a summary report to the Board of the previous year's stories, learning and actions.

4 Board stories over 2024/25

4.1 The following stories have been presented to the Board in the financial year 2024/2025

4.3 April 2024: Orthopaedic Surgery

Presented by: Christine Terry, patient and qualified nurse

Situation:
Chris has had a number of surgeries here at ROH, the most recent being a hip replacement. Chris is a registered nurse and has worked many bank shifts at ROH. Chris shared a story last year too from her experience for previous surgery.

Experience:
Chris shared that her surgery was successful, and many aspects of her journey were positive, there were however some negative aspects.

- Encouraged to administer own enoxaparin injections in preparation for discharge
- Free Wi-Fi was appreciated
- Patient permission was asked prior to any intervention
- When tearful and in pain staff provided psychological care and reassurance.

- Many other staff were noted to be kind and caring including, ward environmental cleaner, porters, physiotherapist and volunteers.
- The hospital grounds are lovely to look at and walk through
- Great environment and service at Hydrotherapy
- Poor communication from a member of staff in Imaging
- Lack of hand hygiene at times and not all staff bare below elbow
- No opening times for Café Royale on display and machine broken
- Puddings cold when served at same time as main meal

Learning:

- Imaging Leads to monitor staff behaviours and introducing themselves along with explaining what they are going to do to the patient
- In-patient team to review hand hygiene and uniform policy compliance
- Ensure patients and visitors are advised of Café Royale opening times and out of hours provisions
- Puddings should be served after the main meals to avoid them going cold.

4.4 June 2024: BOOM Update

Presented by: Mr Lee Jays – Orthopaedic Oncology Surgeon

Situation: Mr Jays provided an overview of the Birmingham Orthopaedic Oncology Meeting (BOOM)

Experience:

Following a visit to Canada Mr Jays recognised that patients are being treated differently across the world. BOOM was set up to bring Orthopaedic Oncology Surgeons together to discuss and share good practice.

Learning:

- Access to treatment for patients is discussed
- Surgeons attending the meeting are encouraged to share opinions and research
- Papers are published following discussion and input from attendees
- Global consensus supports complex work at ROH leading to improve patient experience and outcomes

4.5 September 2024: Tia's Story

Presented by: Sharon Latham, Lead for Patient Experience, on behalf of Tia and her family

Situation:

Tia is 18 years old and had surgery at ROH for an Osteoblastoma in March 2024. Tia has autism and anxiety and is supported by her Mum who is her advocate and walks her daughters journey with her.

Experience:
Tia had a difficult experience in Imaging department where she was unable to roll and get in the right position due to her wound. Tia felt unheard, not listened to and not valued which resulted in her stating that she did not want to ever return to the department. The patient experience team were made aware and supported Tia and her Mum, it was identified that Tia had not been referred to the Vulnerabilities team and that the imaging request form did not indicate her additional needs.
Once additional support was put in place Tia's experience was very good.

Learning:

- Importance of communication and listening to our patients
- Recognition of impact of vulnerabilities on patients and their treatment
- Referral to Vulnerabilities team for support for patients, carers and staff

Actions taken to address gaps:

- Introduction of communication boxes to every clinical area
- LD & Autism champions days throughout the year (video shared at the day)
- Tier 2 Oliver McGowan training rolled out. Over 90% compliance with Tier 1 training.

4.6 November 2024: David's Story
Presented by: Rachel Richards, Clinical Service Manager – Private Patients Service

Situation:
David underwent spinal surgery at ROH as his local Healthcare provider was not able to provide the surgery. He researched and sought advice and decided he would come to the Woodlands Suite for his surgery.

Experience:
The surgery was successful, Davis has been able to return to using his electric bike. The GP commented on his neat wound. David has had experience of private Healthcare elsewhere and was impressed with the Woodlands Suite, in particular the room and the service he received.

Learning:

- Consider marketing to a wider area
- Consider appropriate charges for HDU

4.7 January 2025: Elliott's Story
Presented by: Sharon Latham, Lead for Patient Experience, on behalf of Elliott

Situation:
Elliott is 27 years old and for 7 years has been the primary carer for his Father who has dementia and cancer.

Elliott was admitted to ROH in June 2024 for surgery for Cauda Equina. His symptoms included loss of power to lower limbs, and he had no bowel or bladder control.

Experience:
Elliott was advised that following surgery a full recovery was unlikely. The care and support he received on HDU and ward 1 enabled him to cope and remain positive. Elliott described that the whole team approach helped him to recover, and the staff positivity, humour and compassion lifted him. Elliott was progressing well and transferred to a rehabilitation unit.

Learning:
The impact of behaviours of all of the staff at ROH can have a profound and positive effect on our patients, many of whom are going through extremely challenging times.

Actions taken:

- The trust launched the Butterfly scheme in March 25. Training has been disseminated to the champions and wider teams. This will continue over the next few months.

5. Patient / staff story for 2025/26

5.1 Table 1. Outlines the plan for patient / stories for the coming year, focusing on ensuring the voice of the patient and staff is heard at Trust Board.

Board Date	
April 2025	Patient Story
May 2025	Staff story
June 2025	Patient Story
July 2025	Staff story
Sept 2025	Patient Story
Oct 2025	Staff story
Nov 2025	Patient Story
Dec 2025	Staff story
Feb 2026	Patient Story
Mar 2026	Staff story

5.2 The Trust Board is asked to accept and note the report.

Emma Steele
Deputy Chief Nurse
April 2025

Call for Concern & Martha's Rule
A patient safety initiative.

Jude Davies
Critical Care Outreach Team
Lead Nurse

Background

Failure to rescue first emerged in the United States back in the 1990's and has been an international debate ever since.

Recognising deterioration remains a predominant area of patient safety concern globally.

There has been widespread use of clinical systems to improve the recognition and response to deterioration in patients, including the National Early Warning Score. (NEWS2) (Royal College of Physicians 2017)

Introduction of Critical Care Outreach Teams

Despite the implementation of such initiatives there is still too many cases of failure to rescue with potentially 5 avoidable deaths in each UK Trust per month. (Welch et al 2024).

Evan Nathan Smith –Age 21
Called 999

Mia Glynn – Age 8

Martha Mill Age - 13

One resource that has been largely overlooked in the identification and escalation of deteriorating patients are patients themselves and their families. The early signs of deterioration can be subtle or soft.

Patient/relative triggered Rapid Response systems are now at the forefront of patient safety strategies within the NHS and were first introduced to the UK in 2009 at the Royal Berkshire and is widely known as Call for Conc

Call 4 Concern©
A patient safety initiative

Call for Concern Service

NHS England's Worry and Concern Collaborative.

"Ensuring patient and family concerns are central to the recognition and management of acute illness and deterioration". This programme will include Martha's include Martha's Rule:

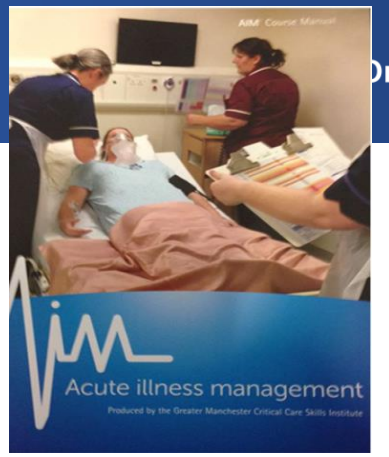
Call for Concern
PART OF MARTHA'S RULE

1. 24/7 Access to Rapid Review: All staff in NHS trusts must have around the clock have around the clock access to a Critical Care Outreach Team for rapid review if Team for rapid review if they have concerns about a patient's condition. CCOT also

2. Patient, Family and Loved Ones Access to Rapid Review: Patient's families, carers, Patient's families, carers, and advocates must also have 24/7 access to a Critical access to a Critical Care Outreach Team, through clearly advertised mechanisms.

3. Daily Wellness Information Gathering: The NHS must adopt a structured approach to adopt a structured approach to gather information about the patient's condition patient's condition directly from the patient and their family at least once a day. (NHS least once a day. (NHS England, 2024)

Prevention, Identification, Escalation and Response (PIER)



Critical Care Outreach Team (CCOT)

SUPPORT 24/7
ALWAYS ON, ALWAYS READY

Will making a C4C call affect how you or the patient you are supporting is being cared for?

Please do not feel concerned that using this system will have a negative effect on the patient's care in any way. We recognise that sometimes the patient or a close loved one can be the first to notice that something is wrong. No one knows your health care needs better than you and your family.

Patient Advice and Liaison Service (PALS)

PALS provide a confidential, patient led service. They offer on the spot advice and support, helping to resolve any concerns a patient or their family may have about the care provided. PALS:

- Is an impartial confidential Trust service that can act as a 'friend within the system' by listening and giving support.
- Listens to concerns and help to resolve them in an informal way.
- Provides information about organisations that offer help and support.
- Has access to all Trust staff to help resolve concerns.
- Explains the procedure for making a formal complaint.
- The PALS office is open Monday to Friday between 9am and 5pm.

PRH PALS

Telephone:
01444 448678

Email:
uhsussex.patient.experience@nhs.net

RSCH PALS

Telephone:
01273 696955 Ext. 64511 **or** 64973

Email:
uhsussex.patient.experience@nhs.net

This leaflet is intended for patients receiving care in Brighton & Hove or Haywards Heath

Ref number: 933.2
Publication date: 12/2021
Review date: 12/2024

CPIG
carer and patient information group approved

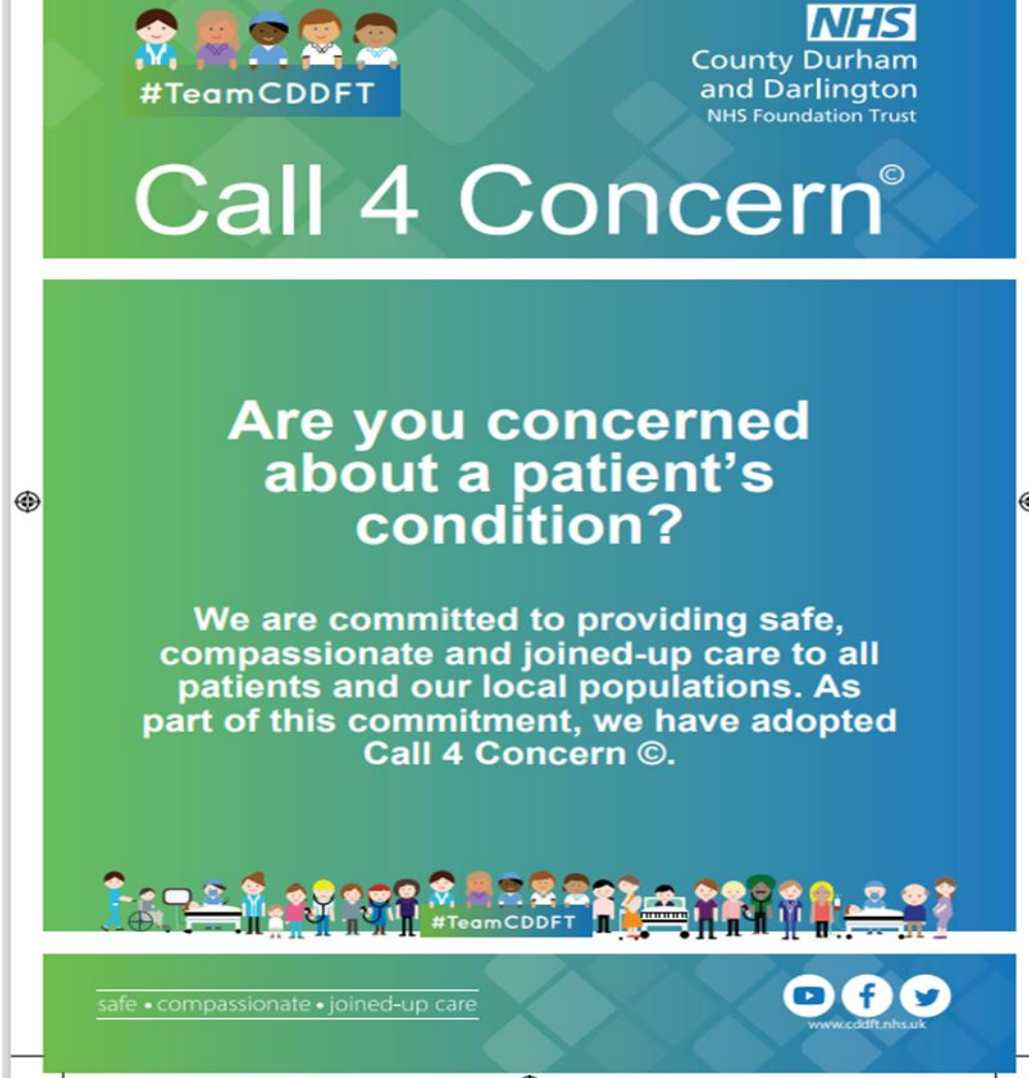
NHS
University Hospitals Sussex
NHS Foundation Trust

Are you concerned about a patient?

Call 4 Concern©

A patient safety initiative

Patient Information



Our trust is implementing Martha's Rule, a vital patient safety initiative that gives patients, their families and healthcare staff, a clear pathway to raise concerns about rapid deterioration.

Martha's Rule:

- involves staff asking, listening, recording and acting on any changes in condition reported by patients or their loved ones
- allows staff, patients or their families to request a rapid review from a different team if they notice any deterioration in the patient's condition that is not being addressed by the local care team.

Martha's Rule is saving lives, and your role is crucial to its success.

Here's what you need to do:

- ✓ **ASK regularly** Check with patients and families at least daily about how they're feeling and if their condition has changed.
- ✓ **LISTEN carefully** Value the insights of patients, families and colleagues about deterioration.
- ✓ **ACT promptly** Use our 24/7 rapid review service if your concerns about a patient aren't being adequately addressed through usual channels. Call:

Remember:

- Patient and family observations matter – they know the patient best.
- You're empowered to escalate concerns.
- Anyone can request a review – staff, patients or families.
- Early intervention saves lives.

Martha's Rule: Listening to patients to keep them safe

What is Martha's Rule?

Martha's Rule empowers you to take action if you feel that your condition or that of a loved one is getting worse and your concerns are not being addressed. You know yourself, or your loved ones, better than anyone, and may be first to notice if a condition is rapidly worsening.

It is a service for inpatients on our wards at University Hospital Lewisham and Queen Elizabeth Hospital, Woolworth.

What you can do

1. Recognise:

- Any rapidly worsening changes in condition or signs of deterioration that are not being addressed by the clinical team looking after the patient
- This could be increased shortness of breath, breathing rate, confusion, unusual behaviour, or physical symptoms like not eating or drinking
- If you spot any, you should raise it first with nurses or doctors on your ward for them to act on and keep you informed of the steps they are taking.

2. Request:

- If your condition, or that of someone you care about, is rapidly worsening and you feel you are not being listened to, or have unaddressed concerns, then Martha's Rule gives you the right to request a rapid review.
- You can do this at any time, day or night if you feel that you are not being listened to or your concerns are not being addressed
- You can do this by calling **07899 115 243** at University Hospital Lewisham or **07350 425 289** at Queen Elizabeth Hospital and ask for a rapid review under Martha's Rule

What we will do:

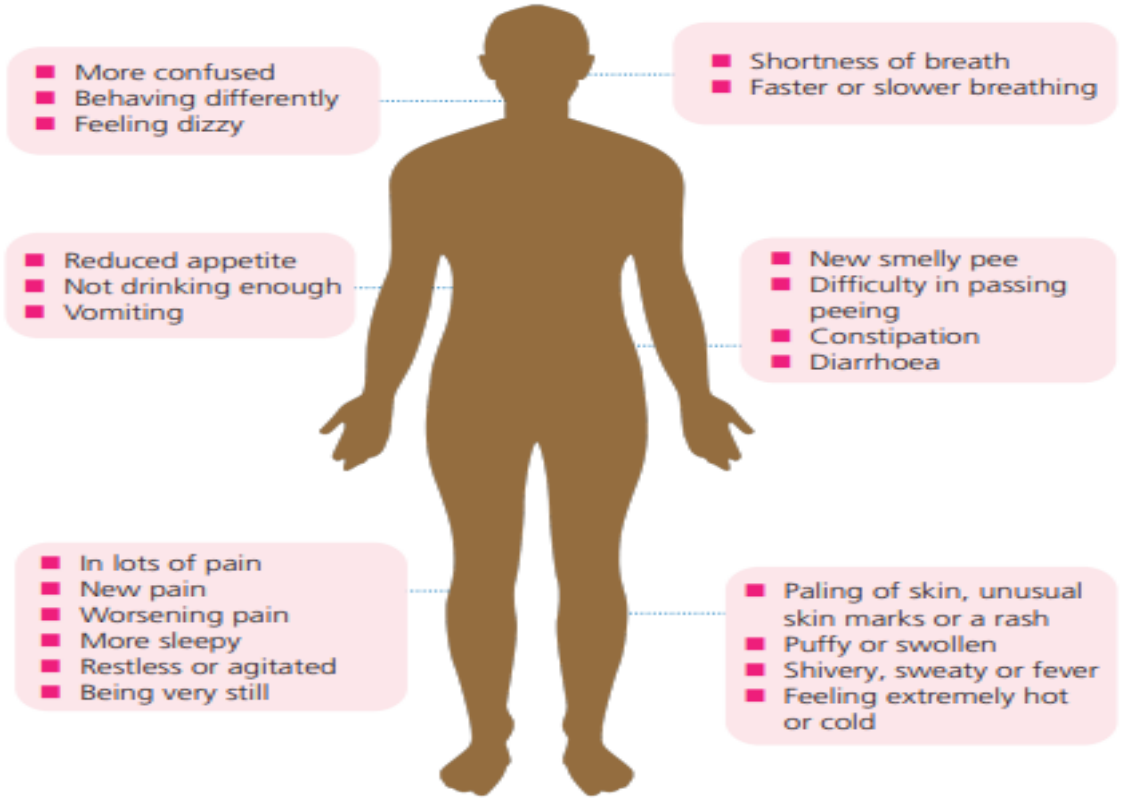
3. Review:

- A member of our Critical Care Outreach Team, doctors and nurses who specialise in the care of very unwell patients, will ask for some key information. They will need to know the patient's name and ward location, as well as your immediate concern. They will then assess the situation and take any necessary action.

Your voice matters. Martha's Rule is there to make sure that your concerns are taken seriously and that you receive the best possible care. Don't hesitate to speak up if you have any concerns.

Deterioration: What to look out for

Use this diagram as a guide to help you describe what is making you worried or concerned about yourself or your family member.



If you notice any of these signs or anything else unusual or something just doesn't feel right, make sure you tell a nurse or doctor.

They are here to help.

Daily Wellness Check: documented in patients notes

Patient label

NHS
Kettering General Hospital
NHS Foundation Trust

Date: _____
Time: _____

Patient Wellness Chart

To be completed by the registered member of staff overseeing the patient once per shift
10am and 10pm

Please tick to indicate who you are asking the questions to
Patient ☐ Relative ☐ Carer ☐

How are you feeling right now?

If being completed by relative/carer ask, How does the patient seem to you?
Circle the response

1 Very Good	2 Good	3 Fair	4 Poor	5 Very Poor

A score of 4 or 5: undertake a set of observations (escalate as per trust policy) and inform nurse in charge. If within day hours (9am-5pm) inform ward doctors. If out of hours inform Hospital at Night Team.

Any concerns identified?	Actions taken?	Signature

Do you understand your current management plan?

Does the patient understand why they are in hospital and what their current treatment plan and/or discharge plan is?
Circle the response

Yes	No

Any concerns identified?	Actions taken?	Signature

Keeping a record of your concerns

Name of patient

Your concern

Date	Time	Feeling better	Still the same	Feeling worse

Actions

Please tick

- ☐ Have you noticed that a condition is getting worse?
- ☐ Have you spoken to the care team on your ward about your concerns?
- ☐ Have these concerns been addressed?
- ☐ If not, have you requested a review through Martha's Rule?
- ☐ Has this been acted upon?

Notes

Considerations

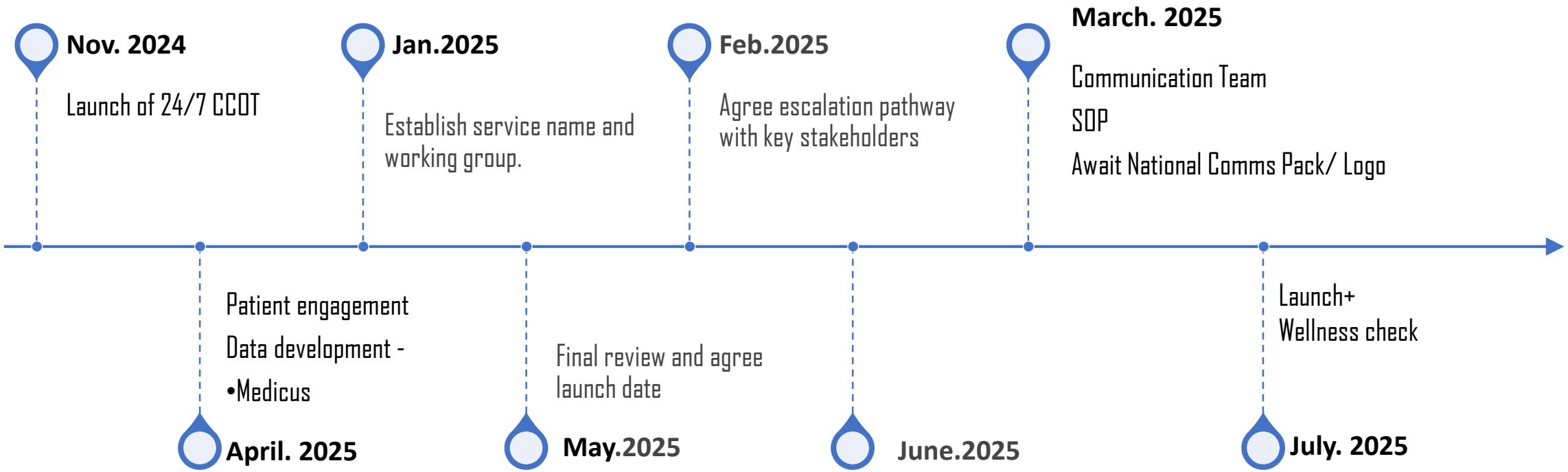
How such measures can be applied equitably to ensure all patients and families are equally empowered.

We have framed actionable insights from the discussion around the **RHO Anti-Racism Principles.**

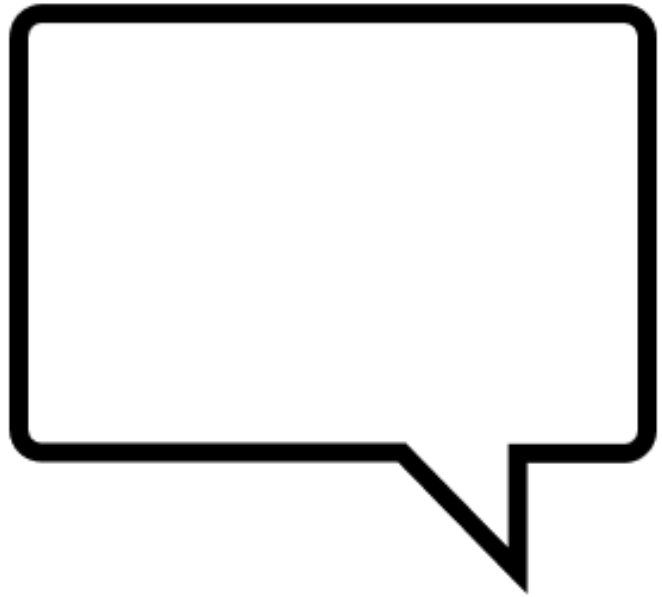
NHS RACE & HEALTH OBSERVATORY

1. **Demonstrate leadership by naming racism**, engaging seriously and continuously with the ways in which racism impacts the lives of the patients and the public, and actively working to dismantle it.
2. **Understand and acknowledge** that structural, institutional and interpersonal racism all impact on health and be clear about where accountability lies for improvement and progress. Create transparent pathways for raising concerns and tangible steps for addressing them.
3. **Meaningfully involve racially minoritised individuals and communities** in in every stage of developing a service or intervention, including ensuring that teams and decision-making structures themselves are racially diverse and fundamentally inclusive.
4. **Collect and publish data** on race inequity in its entirety, ensuring it directly informs policy, strategy, and improvement. Where data is not available, change policies to ensure that data is collected.
5. **Identify racist bias** in policies, decision making processes, and other areas within your organisation.
6. **Apply a race-critical lens** to the adoption of any interventions or improvements to be tested, and to the design and delivery of services.
7. **Evaluate and reflect** on interventions using metrics that recognise the role of racism as determinant of health. These evaluations should seek to understand the extent to which interventions mitigate the impacts of racism.

Road Map- Call for Concern ROH



Any Questions?



TRUST BOARD DECLARATIONS OF INTEREST REGISTER

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

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

Name	Interest	Voting Member
	substantive post at Milton Keynes University Hospital (0.4 WTE secondment) as of 15 April 2024 for six months.	
Name	**Interest**	**Voting Member**
Simon Page **Non Executive Director**	• Owner, Weathervane Consultancy	Yes
Jenny Belza **Non Executive Director**	• Governor, University College Birmingham	Yes
Jan Teo **Non Executive Director**	• Non Executive Director, Birmingham Community Healthcare Foundation Trust (1 March 2023 to 28 February 2026) • Company Director, 3 Castle Street (RTM) Limited • Oversight Board, K2CO (Dance Company)	Yes

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board PUBLIC - DRAFT Version 0.1

Venue Boardroom, Trust Headquarters **Date** 5 March 2025: 1230h - 1400h

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)
Mrs Jenny Belza	Non Executive Director	(JB)
Mr Simon Page	Non Executive Director	(SP)
Miss Jan Teo	Non Executive Director	(JT)
Mr Matthew Hartland	Interim 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 & Acting Chief Executive Officer	(SGL)

In attendance:

Miss Natalie Green	Senior Specialist Registrar	(NG)	[Item 16]
Mrs Clare Mair	Head of OD and Inclusion	(CM)	[Item 16]
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Alison Money	Deputy Chief People Officer	(AM)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

IN PUBLIC SESSION	
16 Staff Story (NG)	**Presentation**
Natalie Green (NG), Senior Specialist Registrar, joined the Board to tell her story of her experience of being a female trainee orthopaedic surgeon. The key points to highlight: • NG is in her final year of training.	

- Vast experience across the West Midlands and in the military.
- Experience at ROH has been hugely positive.
- The improvements to be made would be more senior role models in place. Availability of protective equipment for women, e.g. lead gowns in the right size.
- Wider improvements as a medical profession include offering flexible training, ensuring the early experiences for undergraduates and junior resident doctors are positive ones, and educating other specialities, allied health care professionals and patients who are quite often surprised to see female surgeons.

The Board was invited to comment and ask questions.

The following points were of particular note:

- NB questioned how was the transition from the military to the NHS. NG explained that it is hard to move out of the military, but the orthopaedic area provides the comradery that you experience in the military,
- TP questioned whether ROH are behind others. NG didn't believe we are but there are less around the Birmingham area. TP supported the statement that NG made about needing role models.
- SW enquired whether the gender negative barriers are they still there and if they are what can we do to make sure they are no longer there. NG explained you earn respect, and you get the support from the colleagues then. Education is key and not ignoring comments. The way you can be introduced can also be unconsciously degrading.
- JB question is there anything else at the ROH we could be doing. NG raised it is visibility, raising awareness that acknowledges how important it is to consider how we treat people, and more female orthopaedic consultants. NG also raised it is also patient awareness and improve visibility to ensure patients are aware.
- JT raised that the key to change is to not just have women supporting women but educating men as they may need support in understanding how they can support women.
- MP thanked NG for her presentation and provided assurance to NG that lead gowns will be addressed.
    - IR queried how do we ensure all trainees are provided for with the relevant protection. MR provided assurance this has been addressed.
    - SJ requested that by the next Trust Board the equipment would be suitably sourced and provided for all trainees and the Board will be updated. **ACTION MR/MP**

• NB queried whether NG felt supported by the nursing staff. NG felt it would be great to come and talk to the nursing colleagues but also confirmed that there is a good working relationship. TP thanked NG for sharing her story today.	
17 Apologies: (Chair)	**Verbal**
Apologies were received and accepted from Sharon Malhi and Ayodele Ajose	
18 Declarations of Interest (chair)	**ROHTB (3/25) 010**
There was one new declarations to record to what has been published. • Simon Page is no longer Vice Chair at South Warwickshire Foundation Trust (SWFT).	
19 Minutes of the previous meeting in public held on 5th February 2025: *for approval* (chair)	**ROHTB (2/25) 026**
The minutes of the meeting held in private on 5 February 2025 were accepted and **approved** by the board.	
20 Actions from previous meetings in public: *for assurance* (SGL)	**ROHTB (2/25) 026 (a)**
SGL provided an update on the following amber action: • ROHTBACT.269 – WRES/WDES deep dive on data has been deferred to the April Staff Experience & OD Committee due to the publication of data and timings.	
21 Questions from members of the public (Chair)	**Verbal**
There are no questions received ahead of the meeting.	
22 Chair's and Chief Executive's update: *for information and assurance* (TP/MH)	**ROHTB (3/25) 011** **ROHTB (3/25) 011 (a)**
MH presented the Chief Executive Update, and the paper was taken as read. The key highlighted are: • Change in NHS leadership, with two significant changes at NHS England. The new Chair of NHS England has been announced as Dr Penny Dash and with the announcement of Amanda Pritchard, Chief Executive of NHS England leaving the role at the end of this month it was confirmed Sir James Mackie will become transitional Chief Executive of NHS England with effective from 1 April 2025. • There have been a number of policy statements and guidance published by the	

Government, Department of Health and Social Care and NHS England recently, the impact of which are being considered in the review of the Trust Strategy. • The operational plan and review of the Strategy of 2025/2028 will be presented at the extraordinary trust board in two weeks times. • MH has undertaken a number of external visits. The purpose of the visits was to review how we can strengthen the relationship and explore strategic partnering opportunities. • It is recognised that the next financial year will be challenging. The system focus is very much on neighbourhood work, and this could affect the investment in the future. We need to understand how we fit into this. There is no doubt there will be difficult decisions that will need to come to the Board. TP will be attending a Chair's meeting that has been called by NHS England and an update will be provided at the next Board meeting.	
23 Vaccination Update: *for assurance* (NB)	**ROHTB (3/25) 012** **ROHTB (3/25) 012 (a)**
NB presented the Vaccination Update, and the paper was taken as read. The key points to highlight are: • Approximately 36% uptake and it has been very challenging to achieve even this result. • This was the first year there was no incentive to have the vaccination. • Continuing to offer the vaccination for another week. • Covid vaccination was not something we were able to offer, but conversations have commenced on next year's campaign. The Board was invited to comment and ask questions. The following points were of particular note: • TP raised how disappointing this was. NB raised that it is when in particular the number of flu cases, and people absence with this reason from work, yet it still did not encourage people to have the vaccination. The Board discussed how we would use this as a means of helping to drive the campaign next year detailing how many people we had off absent. AM agreed to review the data we capture and establish if an overall figure could be published. **ACTION AM/NB** • SGL queried the number of people who gave reason for not having the vaccination is due to allergic reaction and wondered was this a national issue. NB would need to review the wider details to understand but did not believe	

this to be the case.	
GOVERNANCE AND COMPLIANCE	
24 Gender Pay Gap Report: *for assurance* (AM)	**ROHTB (3/25) 013** **ROHTB (3/25) 013 (a)**
AM presented the Gender Pay Gap Report and the paper was taken as read. The following key points were highlighted: • This is an annual report, and a statutory requirement to publish this on the Trust website by the end of the month. • There has been a positive reduction in both the mean and the median figure. • There has been an increase in female consultants. • There is an action plan, and this was included in the pack circulated. The Board was invited to comment and ask questions. The following points were of particular point: • LW queried why the talent and succession framework is on hold. AM confirmed it is included but it has been due to capacity of the team that this has not develop, but it is a focus for the new year. • LW also queried the ERostering system and questioned why it is also on hold. NB explained that all clinical teams are on this system but due to licences it comes at a cost. Therefore, this is being currently explored as to whether this can be rolled out across the whole Trust. • IR raised that the bonus payment gap will only get worse as this has now closed so there will be no new additions to have as a comparative. The Board **approved** the publication of the Gender Pay Gap Report.	
25 Equality Delivery System (EDS): *for assurance* (AM)	**ROHTB (3/25) 014** **ROHTB (3/25) 014 (a)**
AM presented the Equality Delivery System (EDS) Report. The paper was taken as read. The key points highlighted are as follows: • The report is worked on in conjunction with the ICS. • Validation has been undertaken by UHB and a Staffside representative. The Board was invited to comment and ask questions. • TP queried what the next steps are. AM explained this now needs to be	

published on the website. • NB raised the report needs to be reviewed and redacted before publication. Subject to the redactions required, the Board **approved** the publication of the EDS report.	
UPWARD REPORTS FROM THE BOARD COMMITTEES	
26 Upward reports from the Board Committees: • **Finance & Performance Committee** • **Staff Experience & OD Committee**	**ROHTB (3/25) 015** **ROHTB (3/25) 016**
Finance and Performance Committee – LW The upward report was taken as read and the following points were highlighted in addition to the discussions that had already taken place. • The Committee noted the very challenging financial position this year, with the likelihood that the planned deficit is unlikely to be achieved. • The considerable demands on the Executives and colleagues currently were noted and it was agreed to delay receipt of the updated risk register and further deep dives until planning for 2025/26 is completed. TP queried timings of the Finance and Performance Committee meeting, being so close to the extraordinary Trust Board meeting. It was agreed that it would be a concentrated agenda on M11 position only. **Staff Experience & OD Committee – SJ** SJ presented the upward report, and the paper was taken as read. Several of the key points have been discussed today, but in addition the following points were highlighted: • Turnover and sickness are concerning. • The Committee supported the development of a strategic partnership, and this will be explored further. JB queried whether since the deep dive on sickness it had reduced. SJ explained that there has not been an improvement, and it is clear work is needed to address this.	
MATTERS TO BE TAKEN BY EXCEPTION	
27 Performance Reports: *for assurance* • **Finance & Performance**	**ROHTB (3/25) 017** **ROHTB (3/25) 018**

• **Quality Report** • **Workforce Report**	**ROHTB (3/25) 019**
The reports were taken as read.	
28 Any Other Business	**Verbal**
MH reminded the Board members of the Insightful Trust Board self-assessment that needs to be completed.	
29 Meeting Effectiveness	**Verbal**
Date of next meeting: Wednesday, 9 April 2025 @ 0900h	

PUBLIC SESSION

Next Meeting: 9 April 2025, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 2nd April 2025

Number	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT.271	Staff Story	Presentation	05/03/2025	Provide confirmation at next Board meeting that the equipment issues raised by Trainee surgeons has been resolved.	MR/MP	09-Apr-25	**Verbal assurance to be provided at the meeting.**	
ROHTBACT.269	WRES/WDES Update	ROHTB (11/24) 004 ROHTB (11/24) 004 (a) ROHTB (11/24) 004 (b) ROHTB (11/24) 004 (C)	06/11/2024	Deep dive on the WRES/WDES data, particularly around bullying and harrassment to understand what is driving the results. Report to shared with Staff Experience and OD Committee in February.	SM	~~26/02/2024~~ 30/04/2024	**Deferred to April Staff Experience & OD Committee due to publication of data.**	
ROHTBACT.272	Vaccination Update	ROHTB (3/25) 012 ROHTB (3/25) 012 (a)	05/03/2025	Review and compare the absence data for those out with flu symptoms to demonstrate the risk of not having the flu vaccine and established if this can be used as part of encouraging uptake. Provide an update of outcome to the Board.	NB/AM	02-Jul-25	**ACTION NOT YET DUE**	

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:	**9 April 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 Public Trust Board (in Public) on 9 April 2025

1. INTRODUCTION

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

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

2. NATIONAL UPDATE

2.1 NHS England Leadership

With effect from 1 April, the Transition Leadership Team is in place at NHS England led by Dr Penny Dash as Chair and Sir James Mackey as Chief Executive. Both have been hosting events and calls with Chief Executives and Chairs to inform Trusts and ICBs of their plans for the next two years which is very much focussed on in-year delivery of 2025/26 financial and operational plans and overseeing the transition of NHSE into the Department of Health and Social Care.

2.2 NHS Operating Model

Since the last Board it has been announced at NHS England will be abolished, with its functions transferred into the Department of Health and Social Care, and that both NHSE and ICBs are required to reduce running costs by 50% this year.

Whilst this is a significant change to the Operating Model published recently, the essence of ICBs having responsibility for strategic commissioning and the oversight of provider performance returning to NHSE remains the ambition. The structure of NHSE and ICBs is yet to be determined. This will be a very difficult period for our colleagues at BSOL ICB and NHSE and ROH staff have been requested to be considerate of this in their dealings with them.

We 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

Following the change in NHSE leadership there have been a number of proposed policy statements and guidance for which we are yet to receive the full details. Those most relevant to the ROH are the predicted removal of the cap on elective activity and the requirement to reduce the recent growth in corporate and infrastructure workforce. We are modelling the impact of these, and other expected changes, so we can implement as soon as possible and include them in our plans for 2025/6 where required.

3 CHIEF EXECUTIVE ACTIVITIES

3.1 Strategic Priorities

Board has previously supported a refocussing of our short-term priorities in advance of the 2025/26 financial year. The Strategic Oversight Group, and its supporting Financial Recovery Group, Productivity Improvement Group and Strategy Review Group have met in their current form for the last time and a further paper on the Board agenda updates Board on the replacement governance model to ensure oversight of 2025/26 plans.

3.2 Planning 2025/26

I have been actively involved, along with colleagues, on the finalisation of operational, workforce and financial plans for 2025/26.

I am pleased that we have been able to conclude the planning round for 2025/26 in advance of the end of the current financial year and thank the Board for supporting us to do so. I must make the Board aware, however, that this is based on the current planning guidance, and that plans may change dependent on the outcome of the revised policies.

The plan for 2025/26 will be extremely challenging. The cap on income has necessitated the need for a 6.5% cost improvement programme for next year which will be difficult to achieve however is vital for us to achieve our plans agreed with our commissioners. Our plans describe that we will achieve planning guidance performance objectives on electives, cancer and diagnostics and our workforce plan identified the reductions in workforce we are expecting from bank, agency, corporate, infrastructure and service reviews.

Delivery of the above plans is key for the trust in the current NHS environment and new oversight governance is being implemented as described above. We are very conscious, however, that the implementation of all of our plans cannot impact on the quality of service we provide to our patients, and we are currently finalising EQIA's to ensure this ambition is met.

3.3 Acute Provider Collaborative (APC)

Unfortunately, the APC in March was cancelled as all CEOs were required to attend a meeting with NHSE in London.

3.4 ICB Board

There has not been an ICB Board workshop since the last Board due to the regular discussions on planning. I continue to be the provider CEO rep on the ICB Finance & Performance Committee.

3.5 Federation of Specialist Hospitals

On 2 April I attended the launch of the report produced by members of the Federation of Specialist Hospitals titled 'The Power of Specialism' at the Houses of Parliament. The event was attended by members of FOSH, NHS Providers, Members of Parliament and Lords who heard why specialist hospitals are so important to the NHS with the aim of including as such in the forthcoming NHS 10-year plan. The MP for Northfield, Laurence Turner, attended and is very supportive of the Trust and the report.

3.5 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.

3.6 HERO Awards

It was a great pleasure to give the first three HERO awards to Jonathan Coye, Nickisha Patel, and Nicola Bremner. The nominations showed the great standing all three individuals have with their colleagues and the excellent work they do to make the ROH what it is. We also had over 600 nominations for the Blue Heart Awards which again recognises the fantastic work of our staff at the Trust.

4. ROH UPDATE

4.1 Financial Position

The underlying position for the Trust in month was a £38k surplus which continues to show that expenditure controls are impacting.

However, the impact of the non-achievement of ERF in February, for which the plan in Quarter 4 is significantly higher than in previous quarters, results in a net deficit for the month of £688k. This is against a planned surplus for the month of £19k. The year-to-date total deficit is now 4,120k against a deficit plan of £132k, generating an adverse £3,988k variance.

Whilst the Trust has not achieved ERF target in the early months of the year, mainly due to consultant vacancies, the phasing of the plan requiring significant more income to be achieved in Quarter 4 is not achievable. The Trust does, however, continue to manage costs and increase ERF activity to conclude the year in the best possible position.

4.2 Activity & Performance

Headline reported performance metrics for February include 54% Referral to Treatment Time (RTT), an improvement on our January position, a reduction in the number of patients waiting over 52 weeks, continued achievement of national cancer

standards with 62-day target achievement at 88.2% (national standard 70%), and faster diagnosis standard at 77.8% (national standard 77%) and compliance with the national diagnostic standard at 99.9%. We do, however, have a small number of patients waiting over 65 weeks due to unforeseen challenges in the spinal unit, however a rectification plan is in place.

The Trusts productivity metrics continue to show improvement with indicators such as theatre session utilisation improving, average operations per list increasing, length of stay reducing and outpatient slot utilisation increasing.

4.3 Trust Management Group

Trust Management Group (TMG) has not met since the last Board as it meets on the 7 April. There is therefore no upward report.

4.4 Trust Strategy 2023-2028 – Mid Term Review

Work of the mid-term review of the Trust strategy is progressing well and is in final draft stage. It will be presented to Board in May following a further period of engagement.

5 POLICY APPROVAL

5.1 Since the Trust Board last met, there have been no corporate policies presented to the Executive Team for approval. This reflects the focus on reviewing and updating policies is coming to its conclusion.

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
April 2025

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Finance Officer's Report M11**
SPONSOR (EXECUTIVE DIRECTOR):	**Steve Washbourne, CFO**
AUTHOR:	**Steve Washbourne**
DATE OF MEETING:	**5th February 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Month 11 Financial Report

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Underlying surplus in month Continued underspend on Pay	Continued Risk around ERF and Elective Inpatient activity delivery Unidentified 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 11

1. Summary

The Trust delivered a deficit in month of £688k against a planned surplus of £19k, generating an adverse £707k variance. The year-to-date deficit is now £4,120k against a deficit plan of £132k, generating an adverse £3,988k variance.

Income & expenditure summary	Current month				Year to date			
	Plan £000s	Actual £000s	Variance £000s	%	Plan £000s	Actual £000s	Variance £000s	%
Operating income	11,940	11,166	(775)	(6.5%)	130,286	128,524	(1,763)	(1.4%)
Agency pay	(199)	(126)	72	36.3%	(2,663)	(2,110)	552	20.7%
All other employee expenses	(6,813)	(6,630)	183	2.7%	(72,667)	(72,150)	518	0.7%
Operating non pay	(4,799)	(5,017)	(218)	(4.5%)	(53,866)	(57,471)	(3,606)	(6.7%)
Total operating surplus / (deficit)	**130**	**(607)**	**(737)**	**(6.2%)**	**1,091**	**(3,208)**	**(4,298)**	**(3.3%)**
Non operating items	(119)	(88)	31	25.7%	(1,308)	(996)	312	23.9%
Surplus/(deficit) for the period/year	**11**	**(696)**	**(707)**	**(5.9%)**	**(217)**	**(4,203)**	**(3,986)**	**(3.1%)**
Less I&E impairments/(reversals) & (gains)/losses on transfers by absorption	0	0	0		(0)	0	0	
Surplus / (deficit) before impairments and transfers	**11**	**(696)**	**(707)**	**(5.9%)**	**(217)**	**(4,203)**	**(3,986)**	**(3.1%)**
Technical adjustments	8	8	(0)	(5.3%)	85	83	(2)	(2.0%)
Adjusted financial performance surplus / (deficit)	**19**	**(688)**	**(707)**	**(5.9%)**	**(132)**	**(4,120)**	**(3,988)**	**(3.1%)**
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**19**	**(688)**	**(707)**	**(5.9%)**	**(132)**	**(4,120)**	**(3,988)**	**(3.1%)**
EBITDA as a percentage of related income	**5.8%**	**(0.9%)**	**(6.7%)**		**5.5%**	**1.7%**	**(3.8%)**	
I&E margin	**0.2%**	**(6.2%)**	**(6.3%)**		**(0.1%)**	**(3.2%)**	**(3.1%)**	

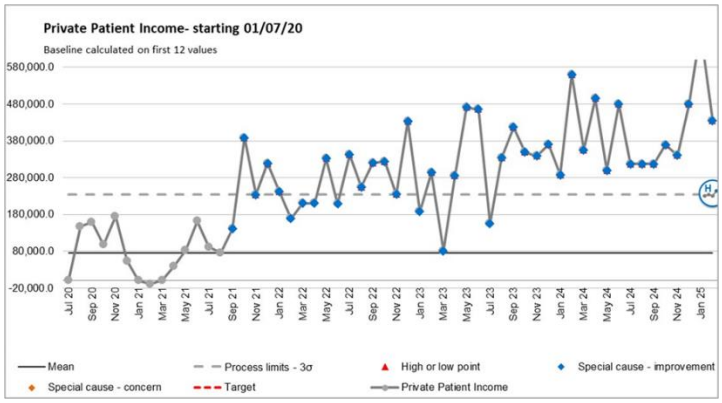
The above position is however net of a total income provision against ERF of £2m against a projected underperformance of £2.9m for the year, leaving £900k of unmitigated ERF risk that will need to be provided for in M12.

2. Income

Year to date income is now showing an under-performance of £1.7m which reflects a £491k additional provision in relation to 2023/24 ERF income following the receipt of final outturn figures, and £2m of the 2024/25 ERF income risk. Mitigating this we have higher than planned levels of allograft and bespoke prothesis which are charged to NHS England as pass through.

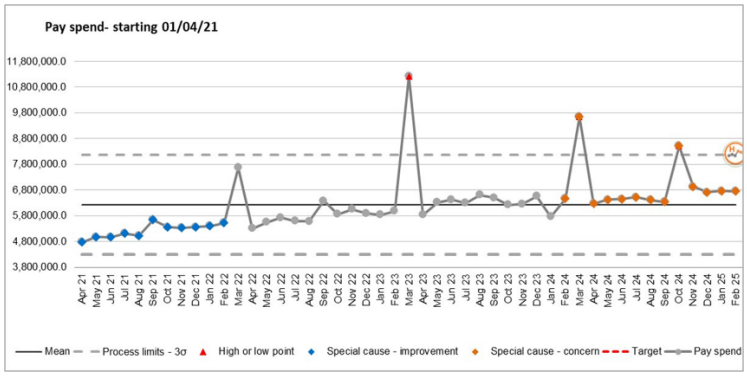
A separate briefing note on ERF has been included at Appendix A.

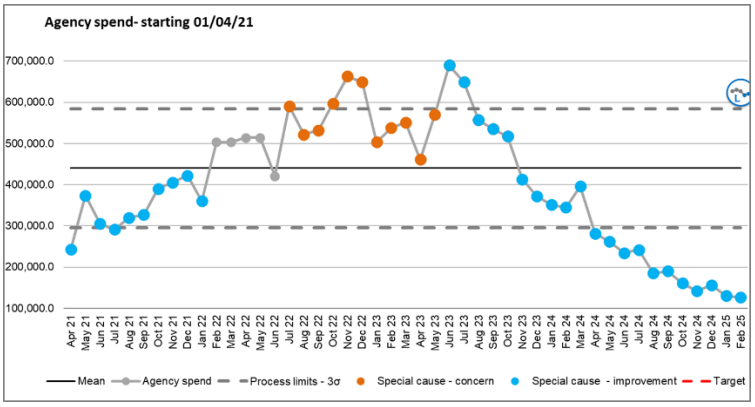
Private patients' income is £435k in month against a plan of £510k (actual YTD income of £4.7m against a plan of £4.5m). Projected income is now above the initial target of £5m but below the stretch target of £5.5m.



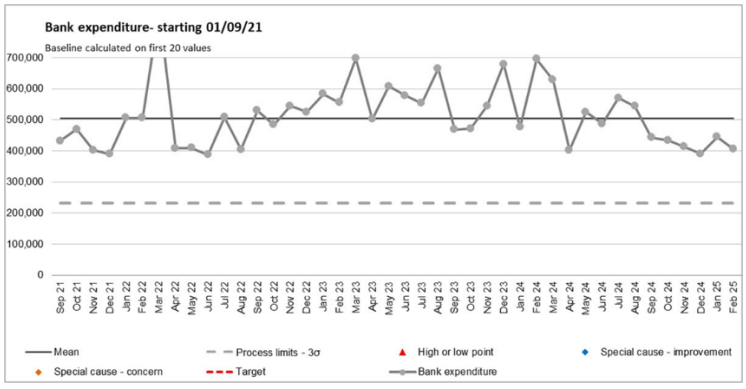
3. Pay

Pay expenditure is underspent in month by £256k, with a YTD underspend of £1m. Agency spend is £126k in M11 (£108k in M10), or 1.8% of pay (2.8% YTD). This is now the sixth month the monthly value has been below the national target of 3.2%,.



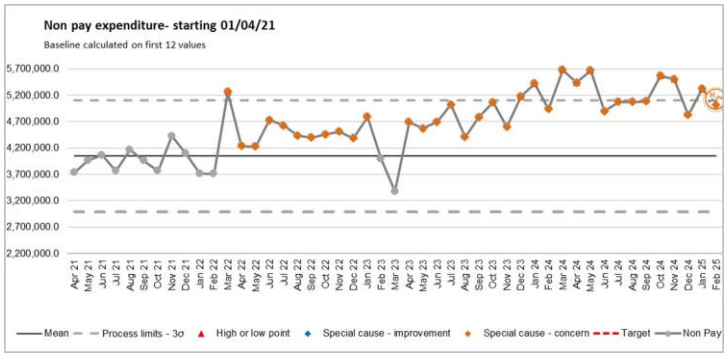


Bank expenditure has reduced from £445k in month at M10 to £405k in month at M11 (target £402k), with reductions in A&C and Ancillary staffing (£140k to £119k), and medics (£124k to £85k). Nursing increased from £92k to £110k.



4. Non-Pay

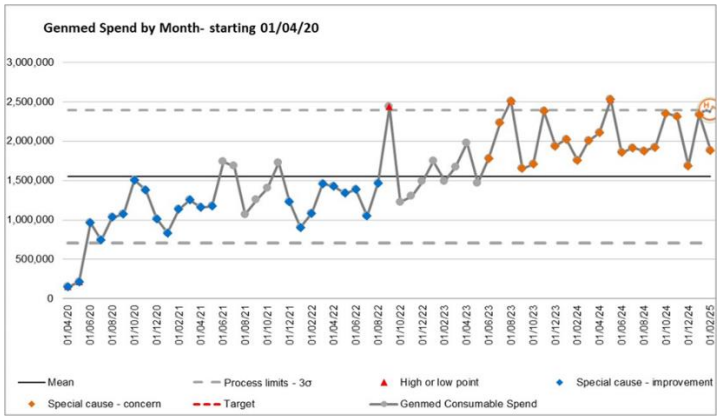
Non pay was £218k overspent in month due to continued use of LLP and unachieved CIP.



LLP spend increased from £262k (M7) to £386k (M8) and £375k (M9) and then reduced in M10 to £325k and £300k in M11 with a total expenditure of £3.2m, an increase of £1.9m to the original plan.

LLP spend by specialty	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	ytd
Oncology	£18,900	£20,318	£14,332	£26,660	£26,138	£12,867	£10,395	£37,050	£34,637	£3,313			£204,609
Spinal	£39,210	£95,776	£55,420	£55,397	£95,585	£82,685	£91,897	£123,915	£86,700	£135,883	£51,332		£913,800
Arthroplasty	£124,333	£130,070	£113,690	£136,737	£127,084	£134,585	£137,815	£153,001	£152,390	£126,317	£161,000		£1,497,021
Spinal staffing								£30,936					£30,936
	£182,443	**£246,164**	**£183,442**	**£218,794**	**£248,806**	**£230,137**	**£240,107**	**£344,901**	**£374,974**	**£265,513**	**£212,332**		**£2,747,613**
Financial plan	£77,039	£77,039	£77,039	£77,039	£77,039	£77,039	£77,039	£77,039	£77,039	£77,039	£77,039	£77,039	£847,429
Variance to plan	**(£105,404)**	**(£169,125)**	**(£106,403)**	**(£141,755)**	**(£171,767)**	**(£153,098)**	**(£163,068)**	**(£267,862)**	**(£297,935)**	**(£188,474)**	**(£135,293)**		**(£1,900,184)**
Anaes	£132,346	(£30,625)	£37,025	£34,134	£46,265	£51,883	£22,687	£41,322	£42,102	£59,950	£88,102		£525,192
Financial plan	£48,510	£48,510	£48,510	£48,510	£48,510	£48,510	£48,510	£48,510	£48,510	£48,510	£48,510	£48,510	£533,610
Variance to plan	(£83,836)	£79,135	£11,485	£14,376	£2,245	(£3,373)	£25,823	£7,188	£6,408	(£11,440)	(£39,592)		£8,418
TOTAL LLP spend	**£314,789**	**£215,539**	**£220,468**	**£252,928**	**£295,071**	**£282,020**	**£262,794**	**£386,223**	**£374,974**	**£325,463**	**£300,434**		**£3,230,703**
TOTAL LLP VARIANCE	**(£189,240)**	**(£89,990)**	**(£94,919)**	**(£127,379)**	**(£169,522)**	**(£156,471)**	**(£137,245)**	**(£260,674)**	**(£291,527)**	**(£199,914)**	**(£174,885)**		**(£1,891,766)**

Theatre spend continues to fluctuate but is reduced in month and certainly showing that recent annual increases have been curtailed in year.



5. Cash

The cash position remains challenging to manage given current I&E pressures but remain above de-minimus levels

6. Capital

We now have a total capital allocation of £7.1m for 2024/25 with anticipated spend to match.

7. CIP and Route to Break Even

To date efficiencies of £4,802k has been generated against a plan of £5,572. The focus for the remaining months is to hold discretionary spend, vacancies and reduce premium rate working costs.
Planning for 2025/26 has identified a total of c.£13m of schemes to be delivered over two years with £9.4m (6.5%) expected to be delivered during 2025/26.

Scheme	Recurrent/ Non Recurrent	FYE Plan	YTD Actual	Forecast Outturn
Procurement –ROH and BSOL procurement	Recurrent	£528	£1,525	£1,664
Minimise overall agency spend	Non Recurrent	£2,194	£3,040	£3,316
Private patient service expansion	Recurrent	£440	£0	£500
Discretionary spend hold	Non Recurrent	£751	£61	£200
Contracts and SLA review	Recurrent	£0	£134	£134
Pharmacy - Generic switches	Recurrent	£154	£0	£50
Non clinical admin, vacancy and bank hold	Recurrent	£334	£30	£140
Consultant premium rate working (LLP spend reduction)	Recurrent	£564	£0	£100
ERF additional income	Non Recurrent	£607	£12	£12

8. System Position

The BSOL ICS headline performance at M11 was a deficit of £42.4m, a £38m adverse variance to the £4.4m deficit plan.

Total Performance	YTD				FOT				Prior Month variance £000s
	June Plan £000s	Current Plan £000s	Actual £000s	Variance £000s	June Plan £000s	Annual Plan £000s	FOT £000s	Variance £000s	
BSOL ICB	9,983	9,970	12,871	2,901	11,405	11,405	16,203	4,798	517
BSMHT	2,046	2,046	2,602	556	2,069	2,069	10,736	8,667	-419
BCHC	-26	-26	1,995	2,021	0	0	2,600	2,600	1,992
BWC	2,750	2,750	-72	-2,822	3,000	3,000	5,200	2,200	-4,742
ROH	-132	-132	-4,120	-3,988	0	1	0	-1	-3,280
UHB	-19,026	-19,026	-55,711	-36,685	-16,474	-16,474	-34,700	-18,226	-29,615
Total	-4,405	-4,418	-42,434	-38,016	0	1	39	38	-35,548

As an ICS we are still forecasting a break-even forecast for the year.

Appendix A: ERF

Month 11 Position

Based on NHSE data for M1-8 and ROH data for M9-11 the underperformance against the revised targets is shown below:-

	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
NHSE Target	**57,208,277**	4,389,353	4,714,360	4,543,279	4,746,278	3,947,029	4,478,513	4,973,961	4,860,342	4,297,829	4,711,157	5,543,855	51,205,956
Actual		4,163,273	4,694,054	4,183,494	5,003,505	4,364,521	4,513,054	4,718,283	4,422,929	*4,232,299*	*4,769,099*	*4,670,460*	49,734,971
Variance		(226,080)	(20,306)	(359,785)	257,227	417,492	34,541	(255,678)	(437,413)	(65,530)	57,942	(873,395)	(1,470,985)
NHSE rephased target	**57,208,277**	4,508,804	4,750,078	4,655,830	4,900,874	4,640,751	4,900,874	5,142,148	4,866,945	4,471,105	4,998,891	4,471,105	52,307,405
Variance		(345,531)	(56,024)	(472,336)	102,631	(276,230)	(387,820)	(423,865)	(444,016)	(238,806)	(229,792)	199,355	(2,572,434)
Breakeven Target	**60,599,277**	4,776,062	5,031,637	4,931,803	5,191,371	4,915,829	5,191,371	5,446,947	5,155,431	4,736,128	5,295,199	4,736,128	55,407,906
Variance		(612,789)	(337,583)	(748,309)	(187,866)	(551,308)	(678,317)	(728,664)	(732,502)	(503,829)	(526,100)	(65,668)	(5,672,935)

Note: M9-11 are estimates

This shows a YTD underperformance against NHSE Target of £1,471k which is a significant increase due to the size of the Feb target.
The NHSE target for Months 11 and 12 increases significantly with 20% target expected to be delivered in these months. Rephasing this target to align with the activity plan shows a YTD underperformance of £2,572k YTD at Mth 11

	YTD Actual	YTD Target	Variance	M12 forecast actual	M12 pro rata forecast	Change
NHS Herefordshire and Worcestershire	£6,606,604	£6,067,765	£538,839	£7,207,204	£409,614	(£129,225)
Birmingham and Solihull ICB	£25,720,857	£26,148,748	(£427,891)	£28,059,117	(£1,365,776)	(£937,885)
Staffordshire and Stoke-on-Trent ICB	£1,661,895	£1,978,100	(£316,205)	£1,812,977	(£366,807)	(£50,602)
Black Country ICB	£7,643,204	£7,991,386	(£348,183)	£8,338,040	(£571,122)	(£222,939)
Coventry and Warwickshire ICB	£1,130,605	£1,567,360	(£436,755)	£1,233,388	(£598,945)	(£162,191)
Spec Comm	£6,749,965	£7,288,936	(£538,971)	£7,363,598	(£519,552)	£19,420
Armed Forces	£205,753	£143,744	£62,009	£224,458	£64,715	£2,706
Health and Justice	£16,088	£19,916	(£3,828)	£17,551	(£4,072)	(£244)
	£49,734,972	£51,205,956	(£1,470,985)	£54,256,333	(£2,951,945)	(£1,480,960)

Performance in M11 whilst significantly down on plan was also significantly up against anticipated income based on a straight-line profiling of M1-10 activity adjusted for working days. This gives a slightly higher forecast position for M12 of £54.2m against the NHSE Target of £57.2m.

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Trust Officers' Reports**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Chief Executive**
AUTHOR:	**Executive Directors**
DATE OF MEETING:	**9th April 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

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

ASSURANCE PROVIDED BY THE REPORT:

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

REPORT RECOMMENDATION:

The BOARD is asked to receive and note the updates

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

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

Comments:

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

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

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

Financial sustainability and recovery

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

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

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

None specifically

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

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

FOR ASSURANCE

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

CHIEF OPERATING OFFICERS REPORT

Report to Trust Board – April 2025

1 LOCAL MATTERS FOR BOARD ATTENTION

1.1 The operational team has focused its priorities to ensure delivery of the 2025/26 national operational imperatives supporting the revised financial plan. The focus for this year will be ensuring that the activity delivered aligns to the income trajectory by proactive assessment of forecasted income on a weekly basis. The operational plan will be monitored weekly against the key performance indicators and early rectification plans developed to resolve any deviations from plan.

The Trust Productivity improvement group continues to meet fortnightly chaired by the Chief Operating Officer. In April, the group will collate the learning from the five focus areas delivered over Q4 to support the Trust financial recovery, ensuring they are embedded in the 2025/26 operational delivery plan. A report is being prepared to demonstrate the improvements made as a result of the 5 working groups reporting to the Trust Productivity Improvement Group, which will be tabled at the April Finance and Performance committee.

2 NATIONAL CONTEXT AND DEVELOPMENTS

2.1 The teams continue to focus on the delivery of national waiting times with a specific focus on reducing the number of patients waiting more than 52 weeks and ensuring 0 patients wait over 65 weeks. The final validated position for February 2025 for the 65-week target had reduced to 5 patients. The March 2025 position had forecasted 0 patients waiting over 65 weeks, however there is 1 patient that has breached the 65-week standard patient due to a delayed first outpatient appointment. This related to patient choice and a late conversion to theatre for complex surgery. The 65-week forecast position continues to show significant improvement in April and the trajectory for 65 weeks is to meet the 0, 65-week target. (This is dependent on patient availability and choice as most of the patients are complex and require significant diagnostics and preoperative preparation for their procedures).

Daily meetings continue to be chaired by the Deputy COO and a recovery plan remains in place to help mitigate the loss in capacity within the spinal team. Extra additional capacity will continue to ensure that the team remains on track for delivery of the revised RTT targets. The specialty is also trying to source locum support to mitigate the risk of lost capacity. The Deputy COO will be providing further strategic support to the specialty in Quarter 1.

2.3 The February RTT position closed at 53.58% an increase of 1.47% on the January reported position of 52.01%. The number of patients waiting over 52 weeks continues to reduce with a reduction of 63 from the January reported position. The forecasted position for all specialties other than spinal is 0 patients waiting over 52 weeks by the end of March 2025.

3 TRUST PRODUCTIVITY IMPROVEMENT GROUP – KEY HIGHLIGHTS

3.1 Dual Scoliosis lists have now been regularly job planned for 2 Spinal Deformity surgeons.

3.2 2 Spinal consultants performed a posterior and anterior scoliosis procedure as a single procedure rather than a 2 staged procedure avoiding the need for the patient to have 2 General Anaesthetics a week apart and improving patient experience. This will now move into business as usual as clinically appropriate.

3.3 The introduction of the block area has seen a positive impact on the turnaround time between hand cases, which was 7 minutes in February 25 compared to 12 minutes in December 24.

3.5 The daily activity huddles have supported an increase in activity for both January and February 2025 by backfilling short notice cancellations utilising the standby patient process.

3.6 A gap analysis has been conducted against all 3 NHSE Impact guidance documents and action plans are in place to support alignment to best practice, this will be shared in the Productivity improvement group evaluation report in detail.

3.7 Job planning is underway and a draft revised job planning policy has been submitted to the Joint Local Negotiating Committee for consideration. The new policy will include the introduction of a job planning consistency committee to ensure that job plans are aligned to best practice and meet the needs of both the service and the Trust.

3.8 2 specialty deep dives have now been reported to the Finance and Performance committee with the next deep dive focussing on the Hands service due in May 2025.

3.9 The private practice group are developing an enhanced year 2 plan for the 3-year strategy to deliver the aspirational 20% increase in income in 2025/26. Events planned though April include a number of engagement meetings with consultants,

private patient secretaries, other private providers hosted at the ROH to showcase facilities and encourage expansion of services. There is also a sports medicine workshop being planned in May to develop a vision for maximising opportunities in this area.

4 DAY CASE WEEK HIGHLIGHTS

4.1 A Day case week was held w/c 24th February 2025 to promote the British Association of Day case principles and ensure that appropriate support services were in place to promote a 'day case first approach' for clinically appropriate patients receiving a total hip or knee replacement.

4.2 The intention of the day case week was to provide dedicated day case lists to improve productivity and reduce length of stay. The focussed week was also used to understand the barriers to patients going home on the same day following a routine Total Hip or Knee replacement.

4.3 During the week 19 patients were identified as being suitable to have a day case total hip or total knee replacement. Out of the 19, 8 patients were successfully treated and sent home the same day, and 7 further patients had a 23-hour length of stay. (Detailed evaluation report to be tabled at April Finance and Performance Committee.)

4.4 At the February 2025 Finance and Performance Committee, the team reported a reduction in length of stay with total hips being reported at 2.4 days and total knees being reported at 2.6 days. All length of stay KPIS were lower than the national benchmark of 2.7 days.

5 KEY RISKS

5.1 The activity delivered in February was **1,340** against a stretch plan **1,219**, **121** cases ahead of the Trust plan for February 2025. However, whilst this demonstrates an improvement the overall activity target is behind plan by -117 patients YTD (February 25 reported position). This is an improvement of 122 patients from the January 2025 reported position. The team continue to hold twice daily huddles to manage last minute cancellations and work closely with the surgical teams to improve the position.

The team have experienced a significant loss of theatre capacity from the 10th of March 2025 due to the breakdown of the motor servicing 3 theatres. The loss of capacity in 3 theatres has impacted on the team's ability to deliver the Trust plan for March 2025. The impact has been reduced by a continued focus on productivity and maximising the use of all theatres available, including the emergency theatre. To help mitigate a loss in activity for April 2025, the planned maintenance for the Easter period has been brought forward. Assuming the motor can be repaired all 14 theatres are expected to be available week commencing 21st April 2025. Repair will

be confirmed once work has commenced, and the motor has been inspected by the repair company.

6 WORK PLANNED IN NEXT MONTH

6.1 Reconfiguration of the theatre baseline to provide 50 weeks cover from Quarter 2 with the introduction of the recent consultant appointments.

6.2 Productivity improvement groups continue at pace delivering positive improvements in metrics monitored at the Trust's Finance and Performance committee.

6.3 Promotion of ROH services through the introduction of directly bookable slots for Arthroplasty, Arthroscopy and Young Adult Hips. This is currently in place for 2 Arthroscopy surgeons and the intention is to have more slots open by the middle of April 2025 in line with the waiting list reduction. This will enable the trust to publish its shorter waits in some specialties to ensure ROH is promoted in primary care as a provider of choice for patients for access and quality. (An update will be included in next month's report.)

6.4 In April the Trust will host the system lead for the primary care interface Steering group Dr Renata Rowe at the ROH primary care interface Group chaired by the Chief Operating Officer. This group supports locally the ambitions of the system to strengthen partnerships with our primary care colleagues and create an active two-way dialogue to support the 'left shift ambition' and improve patient experience developing seamless patient access across the BSol System.

6.5 The BSol MSK transformation programme continues at pace. The group have led the national initiative 'Go Further Faster' for the reduction of community MSK waits supported by a £200k Funding. Due to the ongoing success of the programme the ROH have presented nationally, demonstrating significant reductions in waiting times and transformation to embed efficiency and productivity in future care models.

The Clinical Decision-Making tool has now been agreed for implementation across the whole of the BSol system as a result of the approval of a business case presented at the System Investment Committee in January 2025 by the Chief Operating officer. In April, the business case for the self-management digital app will be presented to the system investment committee for approval, delivering the 2nd key ambition of the transformation programme. Work is ongoing to develop the workforce transformation element of the programme with a vision to have a Single point of Access across BSol for MSK / Orthopaedic services as part of the lead provider Acute Collaborative Provider model. Progress in on target for presentation of this work to the system in June 2025.

7 RECOMMENDATION(S)

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

Marie Peplow - **Executive Chief Operating Officer**

2nd April 2025.

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

CHIEF PEOPLE OFFICER'S REPORT

Report to Trust Board (in Public) – 9 April 2025

1 LOCAL MATTERS FOR ATTENTION

1.1 Formal launch of the Me As A Manager development programme has taken place. And This framework is for all existing and new line managers within the Trust. It is proposed that all managers will be provided with a Me as Manager Self-assessment workbook to complete, and to discuss the outcomes as part of annual appraisal using the outcomes to create a Personal Development plan (PDP) from the training resources and solutions available within 3 distinct development pathways. 52 delegates have booked on the 12 courses planned in Q1 (April to June) and over 100 managers from a total of 250 have been briefed on the framework.

1.2 Work has begun to review the quality of appraisals following Phase 1 of the appraisal refresh work which took place last year. As a result of the changes to the Trusts Appraisal process we have seen appraisal completion increase to above 90% against a KPI of 95% or above completion indicating that there is still work to undertaken to ensure that all of our colleagues receive a quality appraisal with their line managers each year.

1.3 The Trust has been progressing work towards adoption of the RACE Equality Code alongside other Trusts within the Birmingham and Solihull Integrated Care System (BSOL ICS). The RACE Equality Code aims to promote equality and inclusion within organisations by assessing current practices and identifying areas for improvement. The Trust has undertaken all key parts of the assessment process including participation of Board members in the assessment workshops, surveys and all relevant departments within the Trust have uploaded key documents for review. This analysis will inform a report and action plan outlining key areas for improvement in relation to compliance with the RACE Code which will further support our work to further embed inclusion at the Royal Orthopaedic Hospital NHs Foundation Trust (ROH).

1.4 Following a request made by the Royal College of Nursing (RCN) and the Royal College of Midwives (RCM) to the NHS Staff Council in 2021, the NHS Job Evaluation Group has been undertaking a review of the national job matching profiles for nursing and midwifery (band 4 and above). The purpose of the review is to ensure that the profiles accurately reflect current nursing and midwifery practice, training, and role development.

NHS Staff Council Job Evaluation Group (JEG) consulted on proposed revisions to the job evaluation matching profile for nursing and midwifery - bands 4, 5 and 6 earlier in the year and have also consulted on proposals for bands 7 to 9. Revised profiles are expected to be published by May 2025.

We are undertaking work locally to understand the impact of this review on us liaising with nursing and finance colleagues. Once this initial scoping has taken place we will have a clearer understanding of any impact for the Trust.

1.5 The Trust have completed the Organisational Readiness Survey, which will help the NHS Business Services Authority (NHSBSA) gather critical information about our organisation, which will inform the development of implementation plans of the Future NHS Workforce Solution across England and Wales. Over the coming weeks the NHSBSA will review all submissions and then generate insights into the Trust's readiness for the Future Workforce Solution.

1.6 The Trust has published its Gender Pay Gap Report on our Trust website complying with our duties in relation to the Public Sector Equality Duty. The Trust has reduced its mean gender pay gap since 2018 and has also narrowed its gap in relation to the median gender pay gap. The report acknowledges that there is more work to be done in attracting females into orthopaedics and that the gap is driven by a higher degree of males in senior medical roles. Work continues to develop our ethnicity and disability pay gap reports.

2 RECOMMENDATION(S)

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

Sharon Malhi
Chief People Officer
April 2025

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY OFFICERS' REPORT

Report to Trust Board – 9 April 2025

1 MEDICAL DIRECTOR'S UPDATE

1.1 Medical and Nursing

- Quality Impact Assessment (QIA) scheme in place for Cost Improvement schemes, which is detailed in a separate paper to the Board
- Civility and Respect focussed work is underway in theatres to reinforce a positive working culture in clinical areas

Medical

- A 5% Cost Improvement Programme (CIP) from the leadership budget has been identified and is undergoing QIA
- Job planning work is being lead from within the directorate and is being prioritised
- The Arthroplasty team is working through review of National Joint Registry (NJR) and Patient Reported Outcome Measures (PROMS) reports, as an outcome of the Day Case surgery week
- The response to the Preventing Future Deaths report response has been presented at the BSol Quality Committee and was supported
- A Consensus document has been agreed by the Chief Medical Officers of BSol, ROH, UHB and the Medical Director for elective care for BSol is recommending repatriation of private sector work commissioned by the ICB to go to system leads
- The close down of Health Innovation sprint exercise has been completed – all pilots are leading to further work/enquiries and explorations with our teams.
- Birmingham City University Artificial Intelligence (AI) predictor tool work is being demonstrated in April
- The Associate Medical Director for Division 1 is leading a campaign to bring the European Society for Paediatric Surgery conference to Birmingham
- The Trust has supported a Getting It Right First Time (GIRFT) accreditation visit as a panel member to North Allerton

R&D

- A 5% CIP has been identified and QIA has been approved by at the QIA panel
- Birmingham Health Partners (BHP) supported some work around project approval process – there is a recognised risk around timeliness and resilience of feasibility assessment and the remedial plan includes reassignment of a post internally to support
- The latest Staff survey results for the areas have been reviewed, understood and engagement work is starting around "You Said, We Did" with the team
- The application to fund the ALIGN partnership (ROH and UoB) has been submitted, to undertake a large evidence synthesis for joint replacement.
- BACPAK study (with 3 co-apps from ROH) has received NIHR sign off and moves to set up next week (£2 million Human Tissue Authority grant looking at effectiveness of ACB following Total Knee Replacement on persistent pain at 6-months).
- There has been significant interest in the lab via Professor Jun Wu (Lead for the Engineering and Physical Studies faculty from Aston University and Deputy Pro Vice Chancellor) with a collaboration from Beijing. Good progress has been made on securing a grant or private sector support.
- There has been a visit (Chief Medical Officer and Director of Research) to Professor Hall at University of Birmingham to see their implant wear simulation labs and a potential location for a Birmingham Retrieval centre

2 CHIEF NURSE UPDATE

2.1 On 6 March 25, I had the privilege of being invited to attend a BSol Oliver McGowan celebration, recognising all that has been achieved to date as a system. BSol data shared outlined that BSol has 84,000 staff in health and social care that are required to attend the two tiers of training. At the end of year 1, around 6,000 staff had attended Tier 1 (one hour Teams session) and around 20,000 staff have completed tier 2 (face-to-face). The target set for the system was 30% and this demonstrated a commitment to achieving that target.

2.2 The Trust was inspected in May 2024 by the Human Tissue Authority. This inspection highlighted three Corrective and Prevention Actions (CAPAs). Over the last six months the HTA team has worked with partners to implement change. On the 6 March, all three CAPAs were closed by HTA as they were satisfied with the improvements.

2.3 **P**atient-**L**ed **A**ssessments of the **C**are **E**nvironment (PLACE) are an annual national self-assessment programme, which is managed by NHS Digital on NHS England's behalf. Under PLACE, organisations make an in-depth assessment of the non-clinical, patient-related aspects of the care environment for all qualifying inpatient settings. Domains included are: *cleanliness, food (meal services preparation), organisational food, ward food (taste and quality), privacy, dignity, condition, appearance, dementia, disability.*

Our annual PLACE assessment was performed in October 2024. Official scoring shows that the Trust achieved 99.35% within the element of cleanliness, which is above the national score of 98.31%. Table 1. Provides benchmarking against our peer groups.

Table 1.

NHS Trust	Cleanliness	Combined food	Organisational food	Ward food	Privacy	Condition	Dementia	Disability
ROH	**99.35%**	**93.69%**	**89.93%**	**94.65%**	**91.67%**	**99.00%**	**91.49%**	**91.91%**
RNOH	96.99%	90.90%	99.31%	85.98%	86.98%	93.63%	78.44%	81.29%
RJAH	100.00%	94.82%	86.88%	100.00%	87.97%	98.71%	76.76%	78.35%
BWC	99.84%	93.78%	88.76%	96.31%	96.10%	99.86%	92.05%	97.47%
UHB	98.88%	94.07%	93.34%	94.27%	83.08%	97.80%	88.05%	91.11%
BCHC	98.91%	90.78%	89.52%	92.29%	84.51%	95.80%	78.80%	80.38%

2.5 **Service Accreditation**: Phase 2 of the service accreditation is due to commence in April 25. The Service Accreditation system is a quality assurance programme that follows a structured approach using a uniformed set of standards to measure quality of care delivered across clinical/ service units or areas. It is a key driver to improving patient care and celebrating good practice. The next areas included are: Main Outpatients, Lordswood House and Griffins Brook surgery, Phlebotomy, Children and Young Persons Outpatients, Topography, Pre-Operative Assessment Centre (POAC), Discharge Lounge, College Green and Royal Orthopaedic Community Scheme (ROCS).

2.6 Evelyn 'O'Kane, Lead for Safeguarding has retired from the ROH after 31 years of service. Evelyn has undertaken a variety of role over the years here at ROH, but more notability is her work in the Safeguarding setting. Evelyne has been instrumental in establishing the Safeguarding team and has been a pro-active lead locally and regionally in responding to the changes in legislation and local needs over the years. Evelyn will be greatly missed. In the short-term Rebecca Furnival will be acting into the Head of Nursing for Safeguarding and Vulnerability post, while a review of the services is undertaken.

2.7 Rebecca Furnival in her previous capacity as Named Nurse and Domestic Abuse lead for ROH has been invited to the House of Lords; this is to share her work on Domestic Abuse, having been recognised for her considerable contribution within the region.

2.8 Jennifer Pearson Head of Nursing for Division 2 has been accepted onto Florance Nightingale development programme. This programme will commence in May 25. In addition to this achievement, Jennifer recently represented the Midlands and the CNO & CMidO BME SAG (group) as well as the wider nursing communities at the COVID-19 Day of Reflection 2025 in the House of Parliament.

2.9 A CQC engagement session is planned for 4 April 25. Details of the meeting will be provided next month.

3 DIRECTOR OF GOVERNANCE UPDATE

Clinical Governance

3.1 Never Events

Two Never Events have been declared, as previously notified to the Board:

#1 Wrong sided prosthesis. Anticipated harm non or low. Immediate learning and early actions around mindful application of safety checks and the role of company representatives in theatres. Sources of assurance: identified and corrected in theatre, clear coverage in the existing Safe Surgery Policy of both these issues, reflection and undertaking to lead on corporate learning by those involved.

Feedback on the final report has been received from the Divisional Governance meeting and Executive Governance meeting. The feedback, comments and suggested amendments are currently being incorporated into the report before it is re-circulated to Divisional Governance and Executive Directors for final sign off and sharing. The learning outcomes will be shared within the April 2025 Quality Report.

#2 Wrong site surgery. Anticipated harm non or low. Central theme around appropriate delegation and communication. Sources of assurance: identified and reported in theatre.

The final report for this incident has been approved. The learning outcomes will be shared within the April 2025 Quality Report.

3.2 Ulysses Upgrade Work

The Governance Team has now completed training which has provided the necessary skills and knowledge to enable the team to begin work on completing the planned upgrades to the risk and incident modules on Ulysses. These changes have been identified as a significant cost saving against the costs of procuring and implementing a new system. A summary of key planned changes are as follows:

- Department & committee mapping
- Link to ESR for up-to-date staff data to improve data quality and security
- Refined incident cause groups
- Tailored dashboard reporting
- Improved automated risk reports
- Amended incident and risk forms
- Improved risk and incident notifications
- Mandatory sections in risk form to ensure quality of data held within risks

3.3 Risk Management & BAF and Patient Safety Incident Response Framework (PSIRF) Internal Audits

The Trust's internal auditors, KPMG, have recently completed audits of our Risk Management & BAF processes and our implementation of PSIRF. We have received a provisional rating of 'significant assurance with minor learning opportunities' for both audits. Once final versions of the report are received, they will be considered by the Audit Committee and by the relevant Board committees.

Health & Safety

3.4 **Training** - 'Health and Safety for Managers' module added to 'Me as Manager' training programme. First session launching 23rd April. Content designed to cover key elements of 'IOSH Managing Safely', and with specific focus on working in Healthcare sector. Condensed into 1 day. For Managers at all levels.

Currently reviewing training offering for Manual Handling (inanimate load handling) with Trust Moving and Handling lead. Will refresh current manual handling mandatory training and look to develop enhanced training offering for certain job roles (e.g. Portering, housekeeping).

3.5 **Audit & Assurance** - Launched Health and Safety 'pre-audit questionnaire' for trial across Divisions 1 and 2. Currently being completed by department leads. To help raise awareness among Managers of H&S requirements and in preparation for H&S annual audits across 2025 - 2026. Aim to cover all departments in Trust.

3.6 **Risk Assessment and support** - Continuing to offer support in development of workplace risk assessments. Recently engaged with following areas:

- Facilities (waste portering)
- Facilities (kitchens / catering)
- Facilities (housekeeping / environmental cleaning)
- Undertaking review of Ligature Point Risk Assessment for Trust (in conjunction with clinical teams) - in progress

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

April 2025

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NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Wellbeing priorities update**
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:	**9th April 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This report gives an update and shows progress made on the ROH Wellbeing plan particularly around the four priority areas that were identified in April 2024. These priorities were confirmed following an evaluation of existing wellbeing initiatives, a review of the NHS Health and Wellbeing framework and an analysis of key data (including staff survey data and HR metrics). The four areas identified were:

- Upskilling Managers to support team wellbeing
- Access to Musculoskeletal (MSK) support
- Managing Stress and Anxiety
- Cost of Living support

There is also an update on the priorities identified for 2025. Using the same review as last year, work will continue on the original four priorities, however there will be additional focus on Musculoskeletal (MSK) issue and stress and anxiety which are both significantly impacting sickness levels.

This work continues to be aligned to the following areas:

- ROH Trust Strategy
- People Plan with five year progress targets
- Work being undertaken by the People Promise Manager
- NHS Health and Wellbeing Diagnostic tool – mid year review to commence in September 2025
- Thrive at Work Silver accreditation
- BSol and National NHS initiatives

Next steps

- Share two priority areas with colleagues across the Trust
- Confirmation of funding available for future initiatives to include external funding options

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE

• Progress has been made across the four priorities areas at different levels • Colleagues and managers from across the Trust continue to support this work and are key to successful delivery • External recognition has been received for the work undertaken in Wellbeing	• Continuing to ensure the work is focussed in the correct areas needed by staff • Resource available to support the delivery of the priority areas • Uncertainty on continuing funding available on current initiatives

REPORT RECOMMENDATION:

The BOARD is asked to: review for assurance

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

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

Comments:

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

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

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

Risk Strategy

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

ICS Wellbeing plan

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

Staff survey and HR metrics

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

Trust Board May 2024

Wellbeing priorities update – March

Background

This document gives an update on the wellbeing priorities that were agreed and undertaken in 2024. It also gives an overview of the wellbeing priorities for 2025. This information complements the Wellbeing Guardian assurance report which has also been submitted for Trust Board in March 2025.

The work for 2024 was separated into the four priorities of:

- Confident and competent managers
- Access to MSK services
- Managing Stress and Anxiety
- Cost of Living provision

These priorities were identified following a review of:

- NHS Health and Wellbeing framework, completed by colleagues across the Trust
- Feedback from the National Staff survey (NSS)
- Priorities as part of the Wellbeing plan and People Plan
- Staff data and HR metrics

The table below outlines the four wellbeing priorities and provides an update on the actions and staff survey questions that were identified when the plan was confirmed. For the staff survey questions, the percentage in brackets () shows the score for 2023. Actions that are still being progressed form part of the 2025 action plan.

Priorities 2024	What	Measure and Impact -	Update
Confident and competent managers to support teams and colleagues for wellbeing	**1. Embedding wellbeing conversations**	1. Increase in managers trained in wellbeing conversations	**Update:** There has been an increase in the number of managers training in wellbeing conversations and this work is ongoing. We have also seen a positive improvement in staff survey results in key questions from 2023 to 2024, detailed below: 9g My manager listens to me when I have challenges - **73.2%** (70.8%) 9h My manager cares about my concerns – **71.2%** (69.9%) 11a My organisation takes positive action on health and wellbeing – **66.7%** (65.3%)
	2. Support Managers awareness of policies (HR)	2. Reduction in sickness rates to 4%	**Update:** There is a new sickness absence policy implemented by the HR Team which includes a training package. The sickness rate has reduced by **0.31%** in 2024 compared to 2023 with a rolling rate of **5.78%**
	3. Manager upskilling	3. Improvement in NSS learning scores and WDES and WRES scores	**Update:** We have seen a positive improvement from NSS q24e 'I am able to access the right development when I need to'. Positive improvement from 58.9% to **61.9%** for ROH with a higher increase for BME staff (WRES) at **64.1%** **Update:** Across the Trust there are 4 colleagues participating in the BSol Possibilities Beyond Limits (PBL)

			to support the careers for colleagues from ethnic minority background or who are neurodivergent
Access to MSK support for all colleagues	**1. Enhanced process for accessing MSK support** **2. Review feasibility of Get U Better app rollout**	1. Reduction of MSK related sickness cases in line with sickness rate (shown above) 2. Colleague friendly app launched as part of new EAP provision	**Update:** MSK is now the 4th top reason for sickness absence which has improved from being in the top 3 in the last 12 months - We have seen a negative decline in NSS q11 - 'Experiencing MSK problems as a result of work **25.6%** (23.4%) **Update** Following a review of sickness stats with the senior Physiotherapy team a bid was submitted for a 12 month MSK Triage role to Charitable Funds. This was approved in March 2025 and planning for this project **Update:** Now in place and used as part of support to staff and metrics currently being collated **Update:** Delay in this work but MSK Triage role now approved as mentioned above
Managing Stress and Anxiety	**1. Stress policy and awareness launched**	1. Policy completed with a new stress risk assessment template.	**Update:** Policy to be launched with stress awareness event in May 2025 Reduction in sickness rates for work related stress (in line with over figure of 4%) **Update** Limited Progress but agreed as a 2025 priority We have seen a decline in NSS q11 - 'have you felt unwell as result of work related stress?' 35.0% (33.9%) 9h My manager cares about my concerns – **71.2%** (69.9%)

	2. Mental Health Focus Group with clear outcomes ongoing work funding with MIND to upskill managers **3. Review counselling services (to align to Occupational Health review)**	2. Training integrated into Me as Manager programme to increase numbers of managers attending 3. Counselling service integrating into EAP provision	**Update: -** Me as Manager programme started in April 2025 **Update:** BSol service confirmed until March 2026 for counselling
Cost of Living support	**1. Review of EAP programme and cost of Living provision**	1. Metrics for EAP usage Review stats	**Update:** Procurement process to start in April 2025 We have seen a positive improvement on NSS q11a - 'My organisation takes positive action on health and well-being – **66.7%** to 65.1% **Update**: Extra £4000 funded by ICS, which will enable us to continue with our Cost-of-Living initiatives across the Trust.

Additional progress in 2024

Work has also continued on accreditations, awards and key initiatives in addition to the wellbeing action plan above. The key work is highlighted below:

- Submission of Thrive at Work Silver accreditation in March 2025. External accreditation run by West Midlands Combined Authority (WMCA). Currently awaiting confirmation of accreditation
- Supporting staff through awareness sessions including wellbeing week (bi annual) and stress awareness week (April)
- Updated format and training for Wellbeing conversations which is currently being rolled out
- Improvement in Inclusive Companies ranking to 8 for Top 50 UK companies and No 1 NHS Trust
- Continuation of initiatives with a successful bid for ICS funding
    - Period Dignity – Blue Bags
    - Free porridge
    - ROH Pantry
    - £1 meals
    -

Priorities for 2025

Work will continue in the four priority areas listed above to ensure ongoing progress, however there will be more focussed interventions in two of the priority areas: **MSK** and **Stress and Anxiety**. To identify priorities for 2025, the same approach was undertaken using:

- NHS Health and Wellbeing framework, completed by colleagues across the Trust
- Feedback from the National Staff survey
- Priorities as part of the Wellbeing plan
- Staff data and HR metrics

The table below outlines the key actions that will be undertaken for the two priorities relating to MSK and Stress Anxiety using the same staff survey questions as in 2024 to assess progress.

Priorities 2025	What	How	Date

Access to MSK support for all colleagues	**Enhanced process for accessing MSK support**	1. Development of MSK Triage role (Charitable Funds successful bid). This role will be part of the Physiotherapy team and work closely with the Wellbeing team 2. Wellbeing activities concentrated on MSK issues during key interventions such as wellbeing week and senior leaders wellbeing trollies 3. Continuation of 2024 actions including 'Get You Better' **4.** Review of EAP provision	July 2026
Managing Stress and Anxiety	**Reducing stress and anxiety to support improvement of staff sickness (by a further 1%)**	1. Enhanced HR metrics and support (Business partnering) at departmental level to highlight issues with stress related sickness and ensure effective action planning is undertaken 2. Wellbeing activities concentrated on stress and sickness management such as wellbeing week (May 2025), stress awareness month (April 2025) and other related inclusion awareness sessions 3. Me as Manager sessions for all managers to upskill and offer support	March 2026

Progress will again be assessed by the key information used in Wellbeing priorities for 2024 including staff survey results and HR data .

Work alignment

The Wellbeing priorities are aligned to following work and will continue to support accessibility and relevance for all staff members

- People Plan with five-year progress targets
- Wellbeing Plan
- Work being undertaken by the People Promise Manager
- Current strategic objectives focussed on productivity and high performance
- Wellbeing Guardian work

Alison Money – Deputy Chief People Officer

Clare Mair - Head of OD and Inclusion

April 2025

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TRUST BOARD

DOCUMENT TITLE:	**Wellbeing Guardian Assurance report**
SPONSOR (EXECUTIVE DIRECTOR):	**Ayodele Ajose – Non Executive Director and Wellbeing Guardian**
AUTHOR:	**Ayodele Ajose – Non Executive Director and Wellbeing Guardian** **Clare Mair – Head of OD and Inclusion**
DATE OF MEETING:	**9th April 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This document outlines the second assurance report for the Health and Wellbeing Guardian. The report includes:

- Definitions and scope of responsibility
- Operational and Executive Leads
- Activity and progress
- Status of relevant strategies and policies
- Key priorities
- Monitoring and review approaches
- Matters of escalation/key points of assurance to the Board

Next steps

- Confirmed action plan based on 2 priority areas identified through HR metrics and staff feedback
- Continued support of the Cost of Living initiative provided through the Trust and with external funding
- Implementation of Musculoskeletal Triage role as a priority
- Continued review of the Employee Assistance Programme (EAP)
- Bi annual review of the NHS Health and Wellbeing framework to identify any gaps as part of action planning

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Clear progress has been made over the last 12 months particularly around cost of living • Progress has been highlighted in results from the NHS National staff survey in questions focussed around Health and Wellbeing	• Ensure staff have access to a range of Health and Wellbeing interventions to support varying needs particularly with current financial and resources challenges • Ensure metrics are developed further to identify outcomes and impact

REPORT RECOMMENDATION:					
The BOARD is asked to: review for assurance					
KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***					
Financial	**X**	Environmental	x	Communications & Media	**X**
Business and market share		Legal & Policy	X	Patient Experience	
Clinical		Equality and Diversity	**x**	Workforce	**X**
Inequalities	**x**	Integrated Care		Continuous Improvement	**X**
Comments:					

ALIGNMENT TO TRUST STRATEGY ***(Indicate with 'x' all those that apply):***			
Care	**x**	**Community**	
Expertise		**Services**	**X**
People	**x**	**Collaboration**	**X**

ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Trust Strategy
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
ICS Wellbeing work
BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)***:**
Staff survey and HR metrics
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)***:**
March 2024

The Royal Orthopaedic Hospital NHS Foundation Trust

ASSURANCE REPORT FROM NON- EXECUTIVE CHAMPION

FOR HEALTH AND WELLBEING

Definitions and scope of responsibility with latest national updates	**Role** The role of the Health and Wellbeing Guardian in the NHS is clearly defined and supports the following points: • NHS England has committed to regularly reviewing the health and wellbeing guardian function and the supporting guidance • Health and wellbeing guardians are to champion a health and wellbeing culture, seek assurance and hold to account their senior leadership team A key part of the role is to seek assurance that: - The organisation understands the diverse health and wellbeing needs of its employees - There is a holistic strategy for improving occupational health and wellbeing for all employees - Senior leaders continually review and act on employee health and wellbeing data and metrics - There is an inclusive approach to providing occupational health and wellbeing services and support for all employees **Key updates** Regional Health and Wellbeing Guardians attended a Midlands meeting in November 2024 which highlighted the importance of • Creating a community of practice • Aligning work to the Long-Term Workforce plan (LTWP) • Utilising the Health and Wellbeing Framework and Diagnostic tool (HWB Framework and DT) • Continuing support and sponsorship for Health and Wellbeing at Trusts • Ensuring staff survey feedback is central to identifying Wellbeing priorities
Operational and Executive Leads with responsibility for Health and Wellbeing Management	• Sharon Malhi, Chief People Officer • Alison Money – Deputy Chief People Officer • Clare Mair – Head of OD and Inclusion • Laura Tilley-Hood, Engagement and Wellbeing Officer • Operational support – Human Resources, Health and Safety and Wellbeing champions

Activity this period (March 2024 – March 2025)	**Reviewing progress** The information below gives an update on progress in 2024 where the focus was around 4 wellbeing priorities with overarching aims to: • embed key wellbeing initiatives • improve access for all colleagues. As part of the review to identify the priorities, the Trust utilised the NHS HWB Framework and Diagnostic Tool (DT). This review enabled the Trust to set a baseline of metrics against the framework, to use with staff survey results, for future monitoring. In 2024 the following areas were identified: • Confident and competent managers to support teams and colleagues for wellbeing* • Managing Stress and Anxiety • Access to MSK support for all colleagues • Cost of Living support * This was the key priority to ensure that managers are equipped to support their team members with their varying wellbeing needs, in order to provide outstanding patient care. An action plan was put in place and the work was also aligned to the ROH People Plan actions and elements of the People Promise (PP) programme. The PP work continues to be focussed on: • Working flexibly • Staff Engagement • We are Learning • Civility and Respect **Key progress** Key progress in the four priorities includes: • The development of the Me as Manager programme for all managers, which has a focus on inclusive leadership and wellbeing. This programme is starting in April 2025. The purpose of the programme is to equip all managers with the knowledge, skills and expected behaviours to support each team member individually and to help them understand their role in the team. To also ensure they accountably lead and maximise the performance of their teams and individuals. Supporting staff with wellbeing in an inclusive environment is at the heart of this the programme • A separate accredited Managers development programme commenced in November 2024 for key departments to support team leaders; 12 colleagues have started on the first cohort • Continued rollout of wellbeing conversations training

	• Continued support provided for stress and anxiety through counselling services and wellbeing interventions • Continued awareness of stress and anxiety support at regular team level interventions, support material and wellbeing week activities • Launch of the 'Get You Better' Musculoskeletal (MSK) app • Successful Charitable Funds bid (March 2025) for a 12-month MSK Physiotherapy Triage role to develop a best practice framework to support staff with Musculoskeletal MSK issues. This role will also focus on preventative support • Continued support of staff through the Hardship fund and other cost of living initiatives • Enhancing different ways for staff to get equal access to Wellbeing initiatives with support for departmental managers Additional progress • Submission of Thrive at Work Silver accreditation. External accreditation run by West Midlands Combined Authority (WMCA). Awaiting confirmation of accreditation • Updated format and training for Wellbeing conversations • Continuation of initiatives with successful bid for ICS funding - Period Dignity – Blue Bags - ROH Pantry - Wellbeing Dome - £1 meals - Free porridge - School uniform donation for local community This work has been achieved through collaborative working with managers and colleagues across the Trust including: - Human Resources - Safeguarding team - Learning Disability team - Network Chairs - Regional and National NHS Wellbeing Leads - Wellbeing champions Staff survey progress The progress made in the last 12 months (listed above) links to some of the changes seen in staff survey 2024 results for questions around 'Wellbeing' and 'colleague support'. The highlights are in the following areas with 2023 result in brackets (): Sub theme – We are always learning – **5.7** (5.58) Sub theme – Support for work life balance – **6.7** (6.53) Sub theme – Work stressor – **6.07** (5.99) 9g My manager listens to me when I have challenges - **73.2%** (70.8%) 9h My manager cares about my concerns – **71.2%** (69.9%)

	11a My organisation takes positive action on health and wellbeing – **66.7%** (65.3%) 23a Have you had an appraisal? - **92.1%** (76.3%) 24e I am able to access the right L&D opportunities when I need to – **61.8%** (58.9%) Key decline areas from staff survey are shown below. This feedback has been central to confirming priority areas for 2025 11b Have you experienced MSK issues as a result of work **25.6%** (23.4%) 11c Have you experienced stress as a result of work **35.0%** (33.9%)
Status of relevant strategies and policies	• Stress and Health and Wellbeing policy and new Stress Risk Assessment Template are at final sign off • Annual Wellbeing action plan confirmed to support Trust priorities • NSS, Health and Wellbeing Framework and Diagnostic tool updated
Matters of escalation/key points of assurance to the Board	• Ensure staff have access to a range of Health and Wellbeing interventions to support varying needs • Ensure metrics are developed further to identify outcomes and impact • Budget for Wellbeing initiatives - limited budget identified • Time for colleagues to attend/engage with current financial pressures
Actions planned for next period	• Further review of the NHS Health and Wellbeing framework to identify any gaps as part of ongoing action planning with focus on MSK and Stress, to support productivity and high performance • The work on the framework will also ensure that the impact of changes in the previous year can be review and therefore inform priorities moving forward • Development of MSK Triage role (Charitable Funds successful bid) • Continued support of the Cost-of-Living initiatives provided through the Trust with small amount of ICS funding secured for next 12 months • Targeted interventions included wellbeing weeks and departmental work to support key priorities • Procurement process to start for the Employee Assistance Programme (EAP) to ensure the service is fit for purpose with changing Wellbeing needs of our staff • Complete actions identified as part of the Thrive at Work Silver accreditation recommendations • Support the review of Hardship funding options to include possible support from external funding • Continued development of metrics to demonstrate impact on initiatives including sickness data and staff survey feedback

Ayodele Ajose – Non Executive Director

March 2025

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TRUST BOARD

DOCUMENT TITLE:	**Staff Survey Update**
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:	**9th April 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This report gives an overview of the latest National NHS staff survey (NSS) results for 2024.

The NSS staff survey was run from the 4th October – 25th November 2024 using a mixed mode of paper (10%) and online (90%) copies.

The survey was run in partnership with IQVIA. This is the first year that IQVIA have run the survey for all Trusts in BSol which will allow better reporting across the region.

The information in the report includes:

- Comparisons for ROH against BSol Trusts
- Comparisons for ROH against the Acute Specialist Trust group
- An overview of the staff engagement scores from NSS staff survey and People Pulse results
- Work to date following publication of the results
- Overview of next steps

This work is integral to the Trust's ambition to be rated in the top 5% of Trusts to work for by our people, recognising our commitment towards inclusivity and wellbeing for all. Success in this will be measured by the staff engagement score in this NSS survey which consists of 9 key questions around Involvement, Motivation and Advocacy.

Next steps

- Ensure results are shared across all the departments
- Support colleagues to be a part of next steps including attending focus groups and action planning
- Contact other Trusts to learn from best practice
-

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

• Good progress has been made in some areas particularly in areas identified for specific focus in 2024 e.g. Sexual safety and Appraisals • Work is well underway by Executive Directors to cascade information to their teams with a clear brief of what is required	• Ensuring progress can made in identified areas during the current financial and resource challenges • Ensuring correct actions are identified at team level to enable improvement

REPORT RECOMMENDATION:

The BOARD is asked to: review for assurance

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

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

Comments:

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

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

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

Risk register

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

People Plan

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

Staff survey and HR metrics

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

Executive Director meeting – 18th March 2025

National Staff Survey Results 2024

Trust Board March 2025

Background information

- The National staff survey 2024 (NSS) ran from the **4th October – 25th November 2024**
- A mixed mode was implemented with paper (10%) and online (90%) copies
- The survey was run in partnership with **IQVIA** for the 4th year
- This is the first year that an **ICS NSS contract** is in place with IQVIA
- Changes to NHS reporting has meant that it is possible to receive a **higher number of reports** (up to 42) at departmental level if 10 responses are reached in each area
- **836 staff surveys** were completed in 2024 compared to 793 response in 2023
- The response rate was **59%** compared to 60% in 2023
- The ROH is still aligned to the Acute Specialist Group which is 13 Trusts in total
- This report contains information for substantive staff only as NHS Bank staff reporting will be available in April 2025
- The information is still reported in People Promise themes along with Staff Engagement and Morale – 9 areas in total

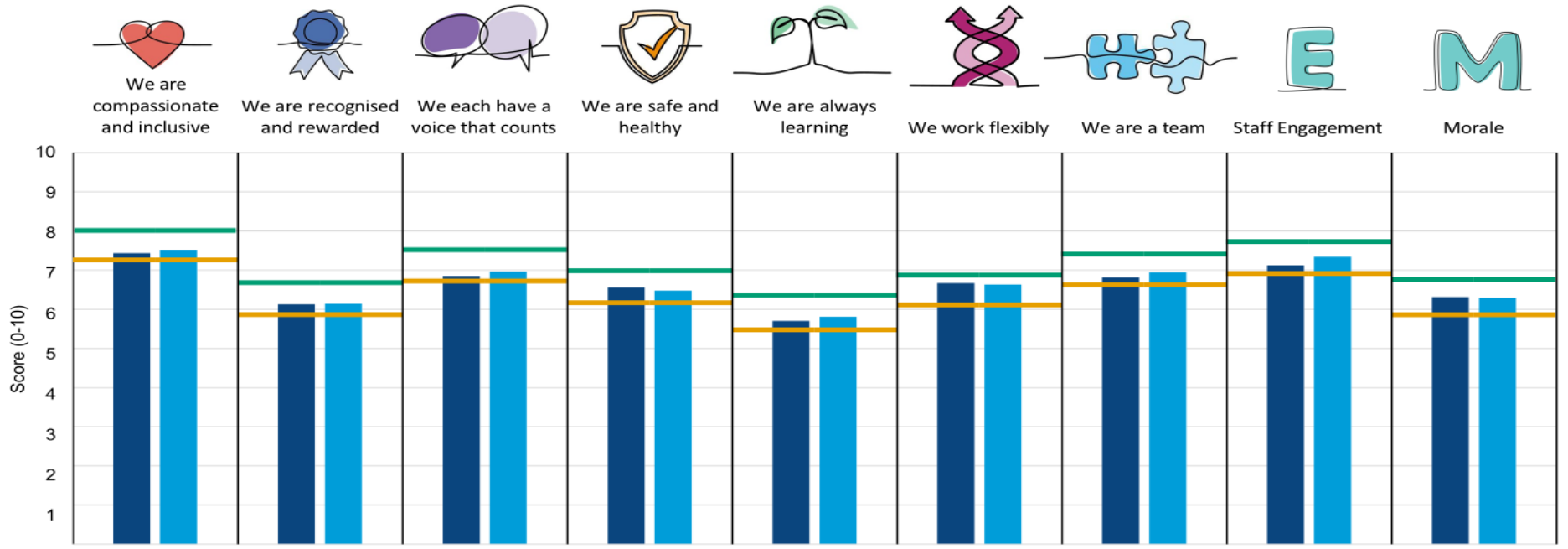
Key information

This table gives an overview of 9 themes that the survey is reported under; 7 People Promise themes in addition to Staff Engagement and Morale. The scores shown below are a comparison for the Acute Specialist Trust Group

People Promise elements and themes: Overview

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.43	6.13	6.84	6.55	5.70	6.66	6.81	7.12	6.31
Best result	8.01	6.67	7.51	6.98	6.35	6.87	7.40	7.72	6.75
Average result	7.52	6.14	6.96	6.47	5.81	6.63	6.94	7.34	6.28
Worst result	7.25	5.86	6.71	6.16	5.47	6.10	6.63	6.90	5.86
Responses	831	834	826	822	804	826	830	834	833

IQVIA analysis of ROH Theme Scores

This table is part of IQVIA analysis and shows the 9 themes with an indication of any significant changes. There are two comparisons shown:
ROH score for 2023 and 2024
ROH score against Acute Specialist Trusts (named as 'Sector Score' for this table)

People Promise/Theme/Question	2023 Score	Significance	2024 Score	Significance	Sector Score
Theme - Staff engagement	7.18	Not Significant	7.12	Significantly Worse	7.26
Theme - Morale	6.28	Not Significant	6.31	Not Significant	6.19
People Promise 1 - We are compassionate and inclusive	7.47	Not Significant	7.43	Not Significant	7.53
People Promise 2 - We are recognised and rewarded	6.09	Not Significant	6.12	Not Significant	6.13
People Promise 3 - We each have a voice that counts	6.88	Not Significant	6.84	Not Significant	6.92
People Promise 4 - We are safe and healthy	6.56	Not Significant	6.54	Significantly Better	6.39
People Promise 5 - We are always learning	5.57	Not Significant	5.70	Not Significant	5.84
People Promise 6 - We work flexibly	6.47	Not Significant	6.66	Significantly Better	6.39
People Promise 7 - We are a team	6.78	Not Significant	6.81	Not Significant	6.91

ICS and Acute Specialist data

This table gives a comparison of response rates and engagement scores for ICS Trusts in BSol. It also includes the information for the Acute Specialist Trust average scores. ROH currently has the highest engagement score in BSol

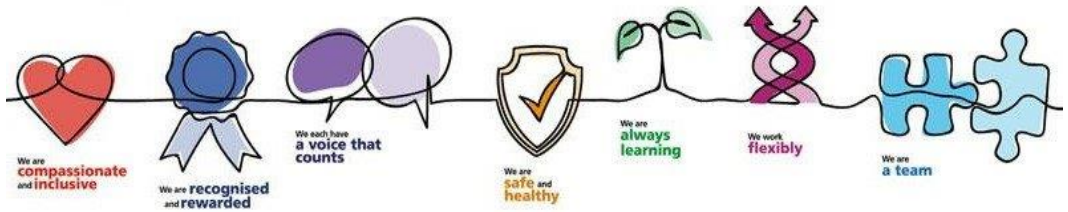
Organisation	2023 Response rate	2024 Response rate	2023 Engagement score	2024 Engagement score
ROH	60%	59.0%	7.18	**7.12** (not sig)
BSMHT	55%	57.0%	7.02	**7.07** (not sig)
BW&C	45%	47.1%	7.04	**6.98** (not sig)
BCHC	57.5%	62.2%	6.89	**6.87** (not sig)
UHB	29.4%	37.6%	6.53	**6.61** (sig)
Average Acute Specialist Trust	54.7%	57.2%	7.35	**7.34** (not sig)

People Promise Themes across ICS Trusts

This table shows the information for BSol in more detail against the 9 themes. The highest scores for each area is highlighted in **Yellow**. The ROH has the highest score in 3 out of the 9 themes.

Trust	Response rate %	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Engagement	Morale
The Royal Orthopaedic Hospital NHS Foundation Trust	59.0%	7.43	6.13	6.84	6.55	5.70	6.66	6.81	7.12	6.31
Birmingham and Solihull Mental Health NHS Foundation Trust	57.0%	7.43	6.38	6.86	6.42	6.12	6.91	7.21	7.07	6.34
Birmingham Women's and Children's NHS Foundation Trust	47.1%	7.40	5.94	6.79	6.01	5.48	6.41	6.87	6.98	5.79
Birmingham Community Healthcare NHS Foundation Trust	62.2%	7.30	6.00	6.75	6.12	5.61	6.63	6.88	6.87	5.83
University Hospital Birmingham NHS Foundation Trust	37.6%	6.97	5.69	6.45	5.97	5.40	6.09	6.57	6.62	5.80

Key information



Following a review of data with support from IQVIA analysis, the following has been highlighted as areas of improvement and areas to focus on in 2025:

Improvements

- Significant improvement in people receiving appraisals following work to redesign the approach
- Significant improvement in people feeling they can work flexibly following work in this area
- Significant improvement in staff feelings of sexual safety at work following development of a Trust charter

Areas to focus on

- Professional development
- More opportunities to show potential and initiative
- More training opportunities
- Ensuring colleagues get the best experience from appraisal conversations
- Working with staff groups experiencing discrimination because of their ethnic background
- Working with teams where staff engagement is low to identified support is needed – see next slide for key questions in this theme

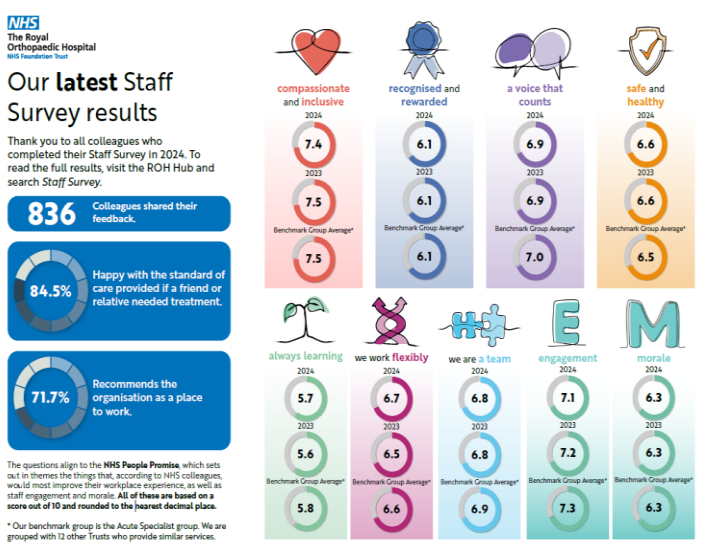
ROH Staff Engagement scores

This table shows the information for the ROH staff engagement in 2023 and 2024 which is collated from the National Staff survey and the quarterly People Pulse surveys. The ambition of the ROH is to be rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey, recognising our commitment towards inclusivity and wellbeing for all. This is directly linked to the staff engagement score. The results from these surveys will continue to inform on areas of improvement to achieve this ambition

Comparison of People Pulse and National Staff Survey results	National Staff Survey 2023	*National Staff Survey 2024*	People Pulse Quarter 4 2024/2025	People Pulse Quarter 2 2024/2025	People Pulse Quarter 1 2024/2025	People Pulse Quarter 4 2023/2024	People Pulse Quarter 2 2023/2024	People Pulse Quarter 1 2023/2024	People Pulse Quarter 4 2022/2023	People Pulse Quarter 2 2022/2023	People Pulse Quarter 1 2022/2023
Overall Staff Engagement	7.18	7.12	7.55	7.40	6.76	7.19	7.06	7.01	7.03	7.04	7.00
Q1. I often/always look forward to going to work.	57%	54.8%	67.4%	54.5%	66.7%	60%	56%	56%	52%	55%	54%
Q2. I am often /always enthusiastic about my job.	69%	66.5%	81.4%	70.5%	71.4%	71%	69%	69%	66%	68%	67%
Q3. Time often/always passes quickly when I am working.	68%	68.0%	72.1%	72.7%	66.7%	67%	68%	68%	69%	68%	68%
Q4. There are frequent opportunities for me to show initiatives in my role.	70%	71.9%	81.4%	79.5%	57.1%	70%	69%	69%	66%	63%	66%
Q5. I am able to make suggestions to improve the work team/department.	71%	70.3%	81.4%	79.5%	57.1%	70%	70%	70%	69%	67%	66%
Q6. I am able to make improvements happen in my area of work.	57%	57%	62.8%	68.2%	52.4%	66%	62%	61%	62%	59%	59%
Q7. Care of patients /service users is my organisations top priority.	83%	82.9%	88.4%	86.4%	85.7%	80%	85%	83%	80%	81%	78%
Q8. I would recommend my organisation as a place to work.	73%	71.4%	83.7%	68.2%	66.7%	75%	71%	66%	70%	68%	66%
Q9. If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation.	85%	84.7%	95.3%	84.1%	71.4%	86%	85%	84%	86%	87%	86%

Work to date

- Communications plan in place to ensure all staff access the results and discuss within their teams
- Following the embargo lifting, staff survey results have been shared with staff via messaging, online, managers briefings, department
- IQVIA has presented key findings to the Executive Director team
- Each Executive Director has received a briefing pack to be cascaded to their team with expectations of next steps
- Network chairs have been updated with key findings to support next steps



Overview of Next Steps

As part of the Trust Strategy, our ambition is to be rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey, recognising our commitment towards inclusivity and wellbeing for all. This will be increasing challenging in the changing financial climate. However, the Trust will continue to work to this ambition and the key steps to be undertaken in 2025 towards this are:

- Executive Directors to continue cascade of information to all departments with a clear guide on how information should be shared, how staff can feedback and when action plans need to be confirmed
- Additional reporting to be provided for teams where results highlight significant improvements needed
- Focus groups run across the Trust to understand issue and therefore actions that staff recommend
- Each Directorate to update actions and 'You Said We Did'
- Link staff results to other key work including appraisal window rollout (1st April to 31st July)
- ROH to link in with other Trust with best practice both in Acute Specialist Trust group and nationally
- Trust to work with colleagues across BSol on key initiatives to promote improvements across the region
- Trust to focus work on staff engagement scores and work with teams where scores are particularly low

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TRUST BOARD

DOCUMENT TITLE:	**Health Inequalities update**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland Chief Executive Officer**
AUTHOR:	**Nicola Brockie, Chief Nurse**
DATE OF MEETING:	**9 April 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This paper provides an update to the Trust Board about Health inequalities action plan and progress made to date. Over the next quarter the action plan will be refreshed and brought in line with the refreshed Trust Strategy. The refreshed action plan will be shared with Trust Board in the next quarter.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• CNO & CPO attend NHS Conf programme. • BLACHIR – good engagement. Exploring the development of clinically sensitive action plan. • LD & Autism annual benchmarking – patients and staff. Good uptake.	• Poor update of training on ESR

REPORT RECOMMENDATION:

The Board is asked to: note and accept.

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

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

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

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

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

Our care risk, our communities risk

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

Contribute to the wider determinants of health.

BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)*:
N/A
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
Health Inequalities paper in September 2024

HEALTH INEQUALITIES PLAN 2023 - 2028

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2024-25 ACTION PLAN

DATA AND INSIGHT

Introduce a clear framework for collecting health inequalities data and create a dashboard to support insight and improvement.

GOVERNANCE AND MONITORING

Ensure that our governance supports consistent monitoring of health inequalities data to enable improvement.

SYSTEM ALIGNMENT

Ensure that the data we collect and actions we take, aligns with the strategic approach of BSol ICS in tackling health inequality.

CAPACITY AND SUPPORT

Build adequate leaderhsip, capacity, support and resources to deliver our health inequalities agenda.

IMPROVEMENT INTERVENTIONS

Create a high impact action plan that prioritises measureable improvement interventions that reduce health inequality.

	What are we trying to deliver?	Quarter 1 (2024-25) actions	Update	RAG rating
Data & Insight	Introduce a **clear framework** for collecting health inequalities (HL) data and create a **dashboard** to support insight and improvement	• Patient progress dashboard update to Q&SC • Business Intelligence team building v1 of Health Inequalities dataset. • Data Quality Group – to scope & agree KPI'S • System to support with benchmarked data	• Medical Director leading wider stakeholder engagement on patient progress dashboard • Waiting list profile presented to Board in Dec 24. • Proposal to implement HEART clinical tool across system – remains outstanding. • Limited progress due to operational pressures.	Behind target
Governance & Monitoring	Ensure that our governance supports **consistent monitoring of health inequalities data** to enable improvement.	• Refine ROH Health Inequalities Plan • Reporting structure agreed - QSE then direct to Board. • BAF updated to highlight Health Inequalities	• Reporting structure embedded. • BAF work completed and incorporated Health Inequalities • Trust strategy to now have HI incorporated. Action plan refresh for FY 25/26 to follow.	On track
System Alignment	Ensure that the data we collect and actions we take, aligns with the **strategic approach of BSol ICS** in tackling health inequality	• Build brief for Versus Arthritis – 'State of MSK Health for BSOL' • Work with 'I can' to support recruitment form local population – acting as anchor institute	• Working in partnership with VA to promote MSK education sessions to primary care colleagues • 'I Can' approach has been embed into ROH, with entry level roles being fielded through the team. The work is expanding to included universal carers. Established at ROH and wider system partners. • Worked in collaboration with ICB to submit £500k bid to DWP for dedicated Employment Advisers for MSK patients. • Community Appointment Day established. • MSK project awarded £210K to support waiting list reduction. • System CYP Board established. Focussed on HI, information to follow. • Oliver McGowan tier 2 training rolled-out across the system. Target in year 1 - 30% (system), on target to achieve.	On track

	What are we trying to deliver?	Quarter 1 (2024-25) actions	Update	RAG rating
Capacity & Support	Build **adequate leadership, capacity, support and resources** to deliver our health inequalities agenda.	• Finalise Health Inequalities training offer for staff (Health disparities & Health inequalities module on e-learning)	• CNO & CPO are attending Executive level Health Inequalities training with NHS Conf over the coming year. • Health inequalities training is available on ESR, poor uptake due to clinical commitments. Exploring alternatives approaches.	Being reviewed.
Improvement Interventions	Create a **high impact action plan** that prioritises **measurable improvement interventions** that reduce health inequality	• Launch of bi-monthly MSK Health Prevention Programme in schools • Patient information improvements • Undertake a waiting list profile v's opportunities to improve access to people from deprived areas. • LD & Autism Strategy	• MSK Health Prevention Programme established. • Quality priority 2 (Patient Information) - focusing on easy read material. This work is progressing. Digital team are now supporting. • Waiting list profile for Total Knee Replacement being analysed as part of Masters level research –completed. • LD & Autism national benchmarking – good uptake this year.	On target

Focus for FY25/26

- In quarter 1. Aim to refresh the action plan in line with the new trust strategy.
- Strengthen the trust HI action plan by working with BLACHIR. Exploring the development of a clinical action plan to address inequalities in the Black and ethnic minority patients.
- Explore educational approaches to addressing staff understanding of HI.

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TRUST BOARD

DOCUMENT TITLE:	**Thematic Review of Feedback, Compliments and Concerns and Action Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Executive Chief Nurse**
AUTHOR:	**Sharon Latham, Head of Patient Experience**
DATE OF MEETING:	**9th April 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This Thematic review examines the feedback, compliments and concerns received from patients in the period between 01/01/2024 – 31/12/2025.
The objective was to identify the primary themes of concerns raised and determine actions to address concerns and proactively shape and improve patient care for the future.
The review studied all feedback received by the Patient experience team from various sources including national and local surveys, complaints, Patient Advice and Liaison Service (PALS), Friends and Family Test (FFT), compliments, online comments and via Healthwatch.

An Action plan has been developed with input from Operational and Nursing Teams and will be shared and updated.
Ongoing monitoring and evaluation of patient feedback is crucial to shape services and strategies that enhance quality of care, accessibility and communication.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Overall patient, family and carer feedback has an overwhelming theme of positivity with “excellent care” “great treatment” “service delivery was excellent” “friendly, helpful, professional staff” “absolutely amazing” being some of the very many comments received Despite the marked increase in contacts via PALS or complaints all those contacts received where there is a cause for concern equate to less than 0.5% of overall footfall to ROH	From the review of PALS, Complaints, and external feedback 5 primary themes were identified. • Appointments 36% • Referrals 11% • Communication 12% • Values and Behaviours/Attitude of Staff – 10% • Delays in Follow up – 11%

The ROH are one of the few organisations within the ICB that has an overall rating of 4.5 stars out of 5, 439 reviews were left in 2024 for the Royal Orthopaedic Hospital and of those 96% were 3 stars and above	The largest number of contacts for PALS and Complaints were for the Spinal Specialty

REPORT RECOMMENDATION:

The Committee/Board is asked to: Accept the report as assurance and approve the action plan.

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

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

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

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

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

Improve Patient Experience

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

BSol vision is to work as a partnership, for the people of Birmingham and Solihull to live longer healthier and happier lives. They will be supported from birth to the end of life in ways that are culturally safe and give them control, dignity and choice.

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

None

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

Quality & Safety Committee March 2025

THEMATIC REVIEW OF FEEDBACK, COMPLIMENTS AND CONCERNS RECEIVED – 01/01/2024 TO 31/12/2024

1. EXECUTIVE SUMMARY

1.1 This paper provides a summary of all feedback received and monitored via the Patient Experience Department directly and indirectly.

1.2 The thematic review aims to identify the primary themes of concerns expressed by our patients and their families and carers and to enable the continuous improvement of patient experience by addressing those issues to reduce concerns received and to proactively shape care for future patients.

1.3 Both PALS and formal complaints have risen throughout 2024 by 21% in the number of contacts from the 2023 calendar year to the 2024 calendar year.

1.4 In the calendar year 2024, 743 contacts regarding concerns were received

- 11% were formal complaints. This includes 4 Private Suite Complaints, 1 withdrawn complaint and 5 re-opened complaints. 75% of complaints received were for Division 1 which includes the Private Suite, 20% were for Division 2 and remaining 5% were either Corporate or withdrawn.
- 87% were managed as PALS cases. 548 cases were for Division 1, 108 were for Division 2 and the remaining 8 cases were either Corporate or not aligned to a division.
- The remaining 2% were either provided as feedback only or were withdrawn.

1.5 The review identified that 80% of all concern contacts received were comprised of the following five themes

- Appointments – 36%
- Communication – 12%
- Delays in follow up – 11%
- Referrals – 11%
- Values and Behaviours – 10%

The remaining case types received less than ten contacts per case type.

1.6 Compliments were recorded separately and have not been included as part of this review as the focus for this piece of work was on areas for improvement.

2. BACKGROUND

2.1 The Royal Orthopaedic Hospital is renowned for delivering exceptional patient care, with a reputation built on quality, compassion, and excellence in specialised elective services. Central to maintaining and enhancing this standard is the hospital's commitment to gathering, analysing, and acting upon patient experience feedback. As a cornerstone of our operational ethos, patient feedback is not only valued but actively used to shape and improve the care we provide.

The Royal Orthopaedic Hospital has a proven history of effectively gathering and acting upon a wide range of patient feedback sources. These include:

- **National and local surveys**, such as the Care Quality Commission (CQC) In-Patient Survey and bespoke In-Patient and Out-Patient surveys.
- **Friends and Family Tests (FFT)**, which provide valuable insight into how likely patients are to recommend our services.
- **Compliments**, which highlight areas of excellence and provide opportunities for staff recognition and morale building.
- **Patient Advice and Liaison Service (PALS) cases and formal complaints**, which help identify areas for improvement and refine service delivery.
- **Healthwatch Birmingham** comments and other feedback from social media platforms, offering real-time and often unfiltered perspectives on patient experiences.

By leveraging these rich sources of data, we aim to identify patterns, address challenges proactively, and amplify practices that enhance the patient experience.

3. FEEDBACK REVIEW

3.1 Methodology

All PALS, Complaints, direct feedback, and online information from 01/01/24 – 31/12/24 was collated and reviewed to identify the main themes of all concerns raised with The Royal Orthopaedic Hospital Birmingham. Findings from the 2023 CQC inpatient survey were also reviewed, however, as this survey focuses on inpatient experience, and as a Trust we do not have any overriding themes involving inpatient concerns the full themes are not brought through. There are, however, over nine hundred patient comments within the Inpatient survey results and we can see that where these are concerns, they correlate to the themes that we see throughout the PALS and Complaints data.

3.2 Overall patient, family and carer feedback has an overwhelming theme of positivity with "excellent care" "great treatment" "service delivery was excellent" "friendly, helpful, professional staff" "absolutely amazing" being some of the very many comments received, however, it is important for us to continue to collate feedback and

review where we can continue to improve our patient care, experience and service delivery.

3.3 Both PALS and formal complaints have risen throughout 2024 in comparison to previous years by 21% in the total number of contacts from the 2023 calendar year to the 2024 calendar year.

- PALS cases have increased by 20% from 521 cases in 2023 to 647 cases in 2024
- Formal Complaints have increased by 55% from 36 cases in 2023 to 79 cases in 2024.

Despite the marked increase in numbers for PALS and Complaints it should be noted that all contacts received where there is a cause for concern equate to less than 0.5% of patient footfall into the Trust.

Footfall Data to ROH for the 2024 Calendar Year is shown here.

Outpatients Data	
Appointment Type / Name	**Count**
Follow-up telephone or telemedicine consultation	8974
Follow-up attendance face to face	73921
First telephone or telemedicine consultation	2211
First attendance face to face	27723
Inpatient Data	
Total inpatient admissions	14935
Tiara Data	
Profession Name	
Physiotherapy Face to face	44573
Podiatry Face to face	1927
Physiotherapy Virtual	80
Podiatry Virtual	178
Total Telephone or Virtual	11,443
Total Face to Face	163,079
Total Footfall	**174,522**

4. PALS AND COMPLAINTS

4.1 From the review of PALS, Complaints, and external feedback the following five primary themes were identified, these themes combine to make 80% of all contacts received.

- Appointments 265 – 36%
- Referrals 82 – 11%
- Communication 86 – 12%

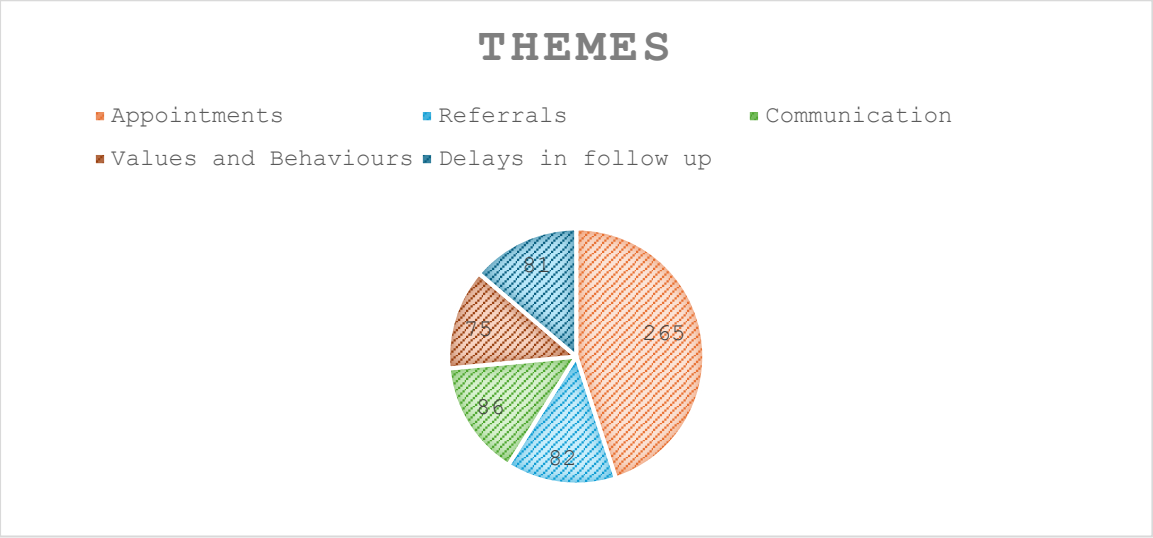
- Values and Behaviours/Attitude of Staff 75 – 10%
- Delays in Follow up – 81 - 11%

Work is already ongoing around many of these identified themes, and this is reflected in the Patient Experience Action Plan.

4.2 The other case types which received less than 10 contacts per category across both PALS and Complaints are shown below.

- Admissions
- Access to Treatment or Drugs
- Nursing
- Trust Administration/Corporate
- Discrimination / Protected characteristics
- Discharge query
- Inadequate pain management
- Injury sustained during procedure.
- Prescribing Error
- Policies
- Surgery Cancellation
- Unsatisfactory Treatment
- Estates
- Hygiene/cleanliness

Table 1 – Primary themes across PALS and Complaints



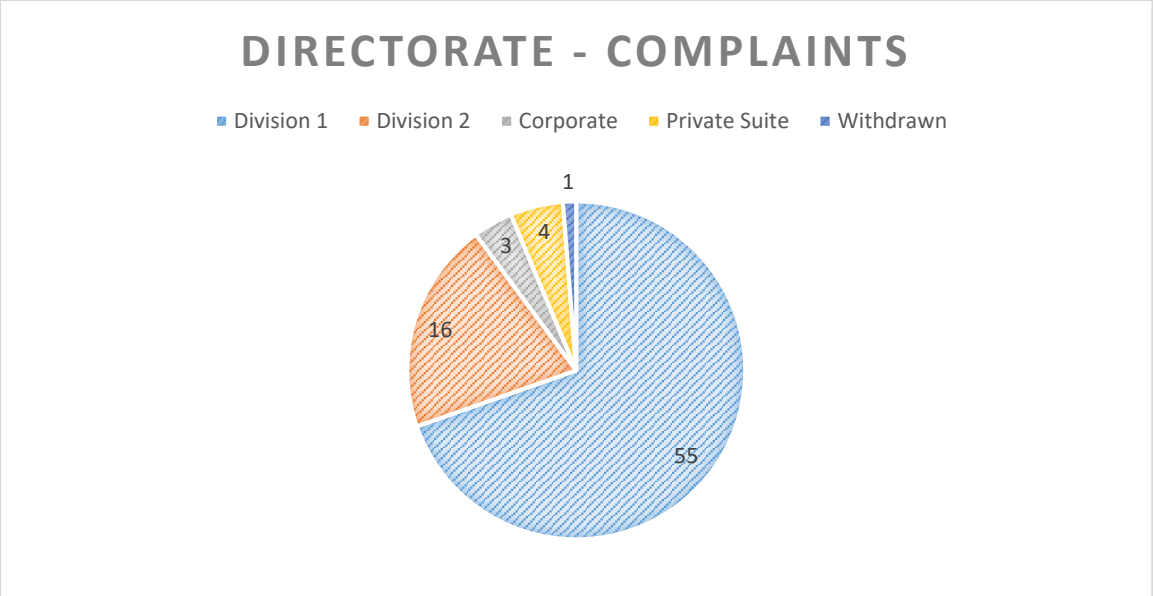
5. COMPLAINTS

In 2024 we received 743 contacts of which 79 (10.63%) were formal complaints. This includes 4 Private Suite Complaints, one withdrawn complaint and five re-opened complaints.

As can be seen below 75% of complaints received were for Division 1 which includes the Private Suite, 20% were for Division 2 and remaining 5% were either Corporate or withdrawn.

5.1 Formal complaints are shown by Directorate and Department in the tables below. As can be seen the departments with the highest number of complaints are Spinal – to include degeneration and deformity and Large Joints who received 20 and 16 Formal Complaints respectively. The primary causes for concern for Spinal Complaints were around Delays in appointments and treatment whereas in Large Joints the concerns were predominantly raised around clinical queries.

Tables 2 and 3 - Formal Complaints by Directorate and Department



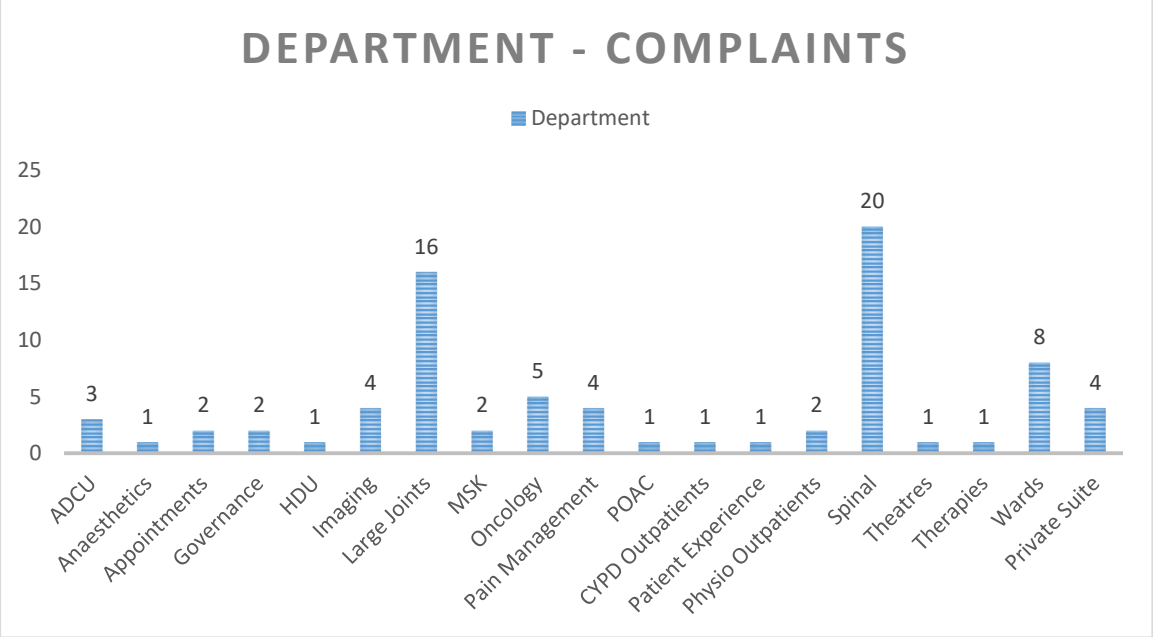


Table 4 – Concern Type

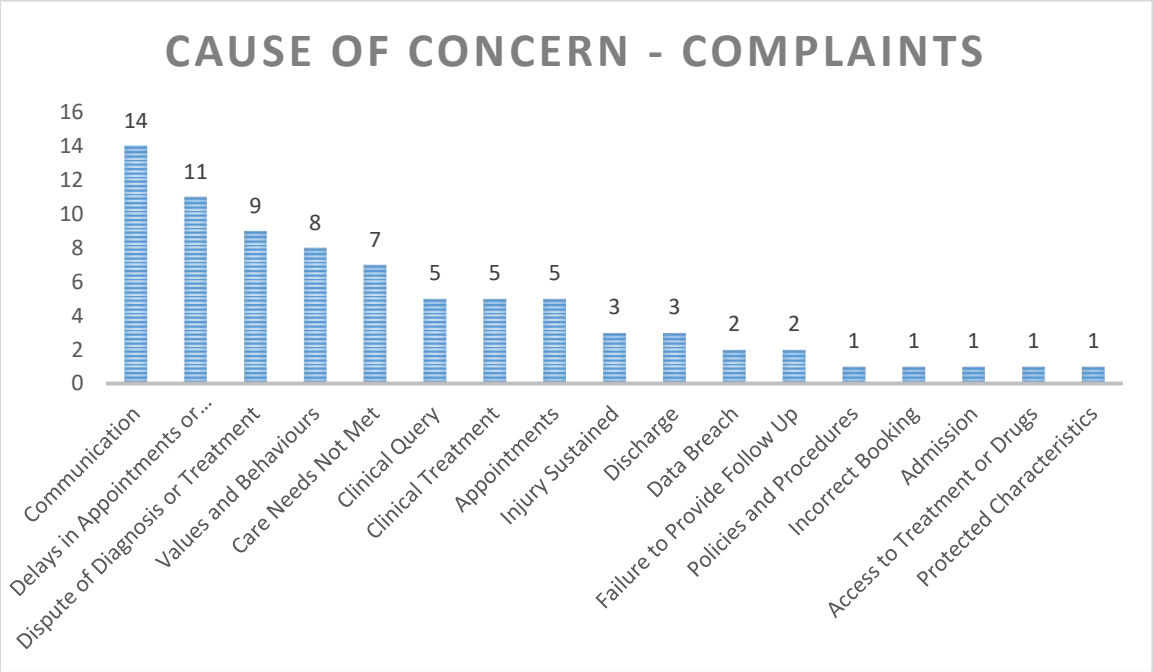
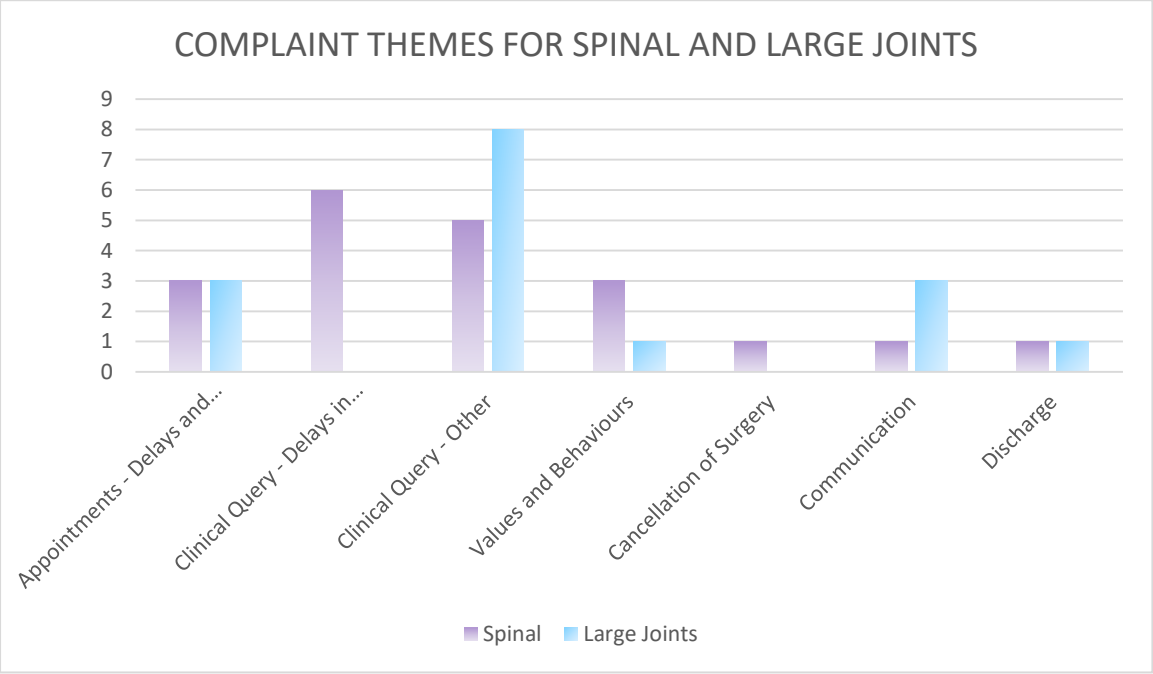


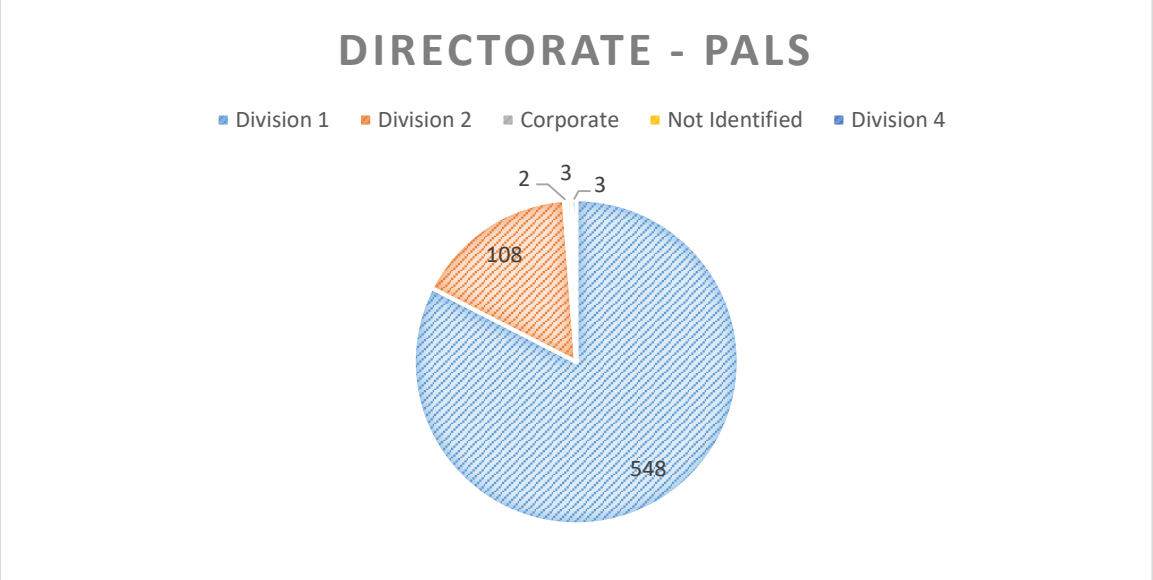
Table 5– Complaint themes for Spinal and Large Joints

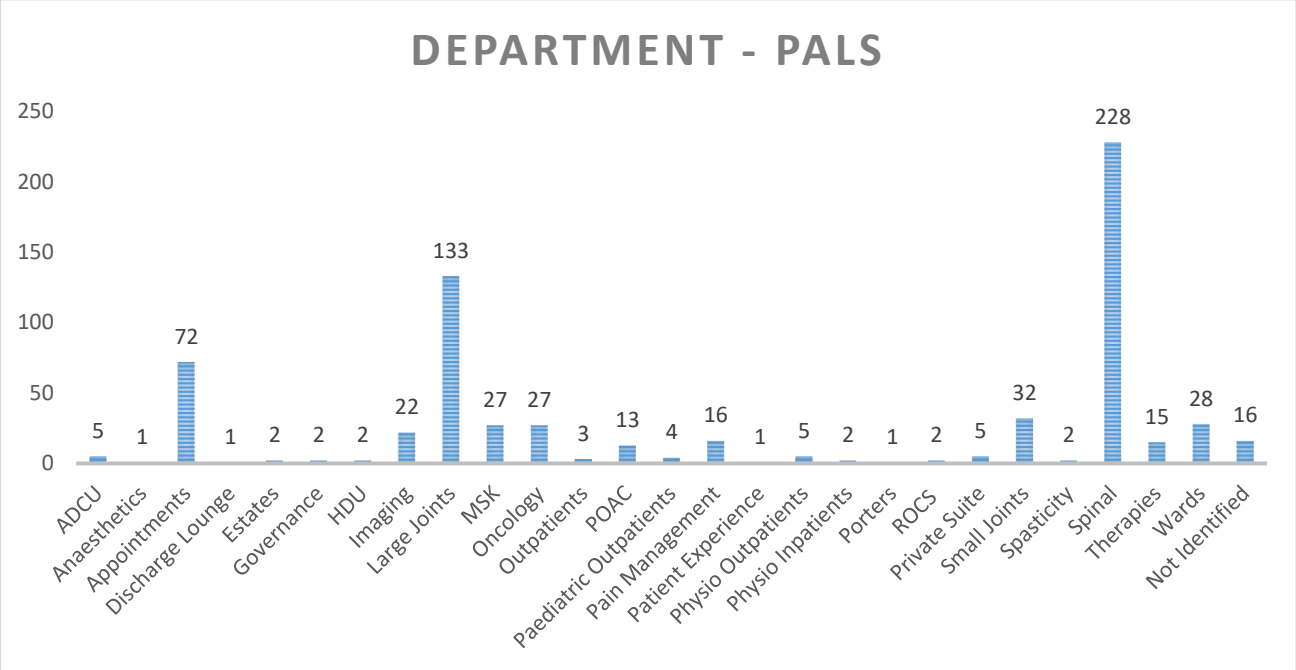


6. PALS

6.1 Of the remaining 664 cases 648 were managed as PALS cases, eleven were withdrawn and five were provided as feedback only. 82% of PALS cases were for Division, 16% were for Division 2 and the remainder were divided between corporate, Division 4 or no division identified.

Tables 5 and 6 – PALS Cases by Directorate and Department

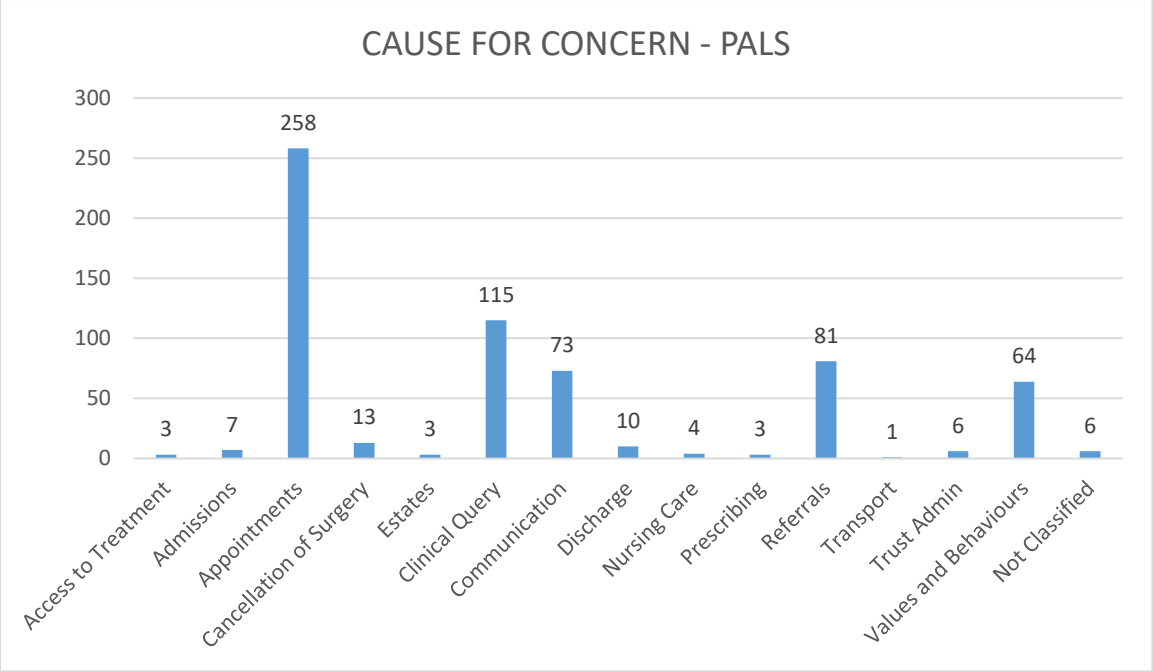




6.2 The primary themes shown below demonstrate where the majority of our patient concerns are focused, it is important to note that where Clinical Query is cited that 40 of those 115 concerns are regarding delays in follow up appointments and 8 were

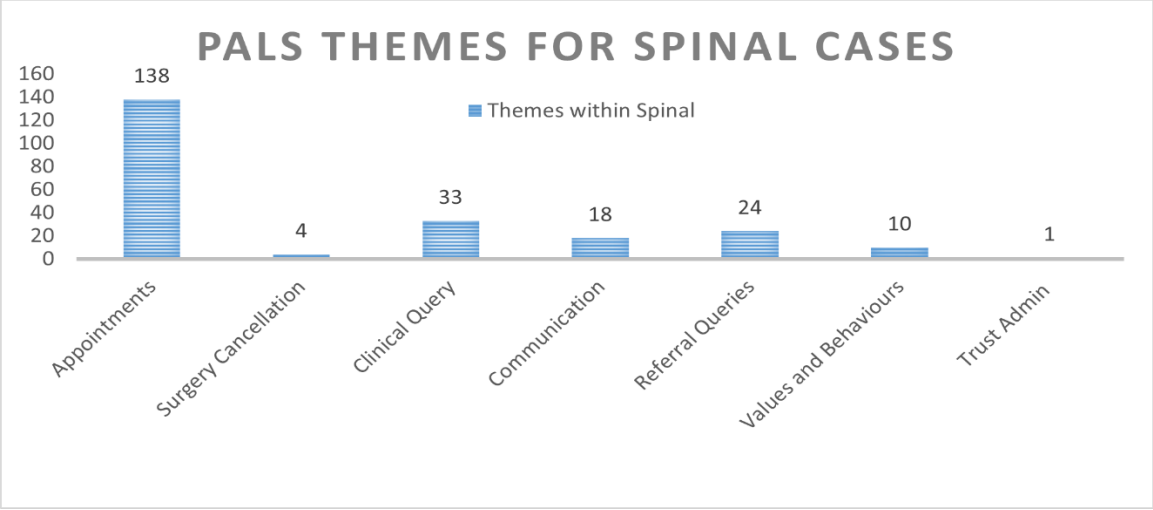
regarding delay in obtaining results due to failure to get a follow up appointment, and the potential impact on patient wellbeing which would increase the appointment concerns to nearly 50% of all PALS cases (306 of 648)

Table 7– PALS Cases Primary Themes



6.3 As is reflected in Complaints the largest number of PALS (33%) were raised for the Spinal Specialities. The Primary themes are shown below however, it should be noted that of the thirty-three cases where the primary concern was a clinical query twenty-three of those cases were regarding delays in receiving results where an appointment was required. Therefore, making delays and cancellations of appointments responsible for 70% of all Spinal PALS concerns.

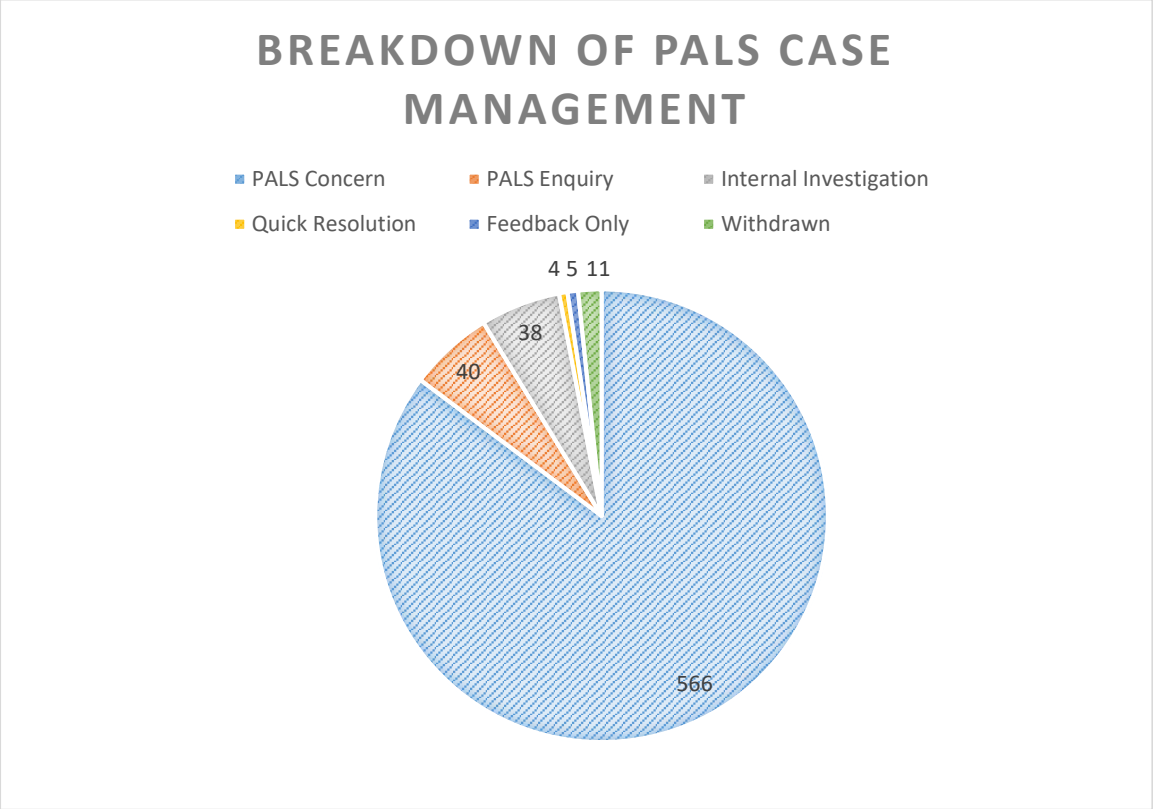
Table 8 – Themes for Spinal Department: PALS cases



7. PALS CASE MANAGEMENT TYPE

7.1 When a PALS case is received into the Trust it is triaged by the Patient Experience Team who will assess the most appropriate means of management in order to gain a successful and timely outcome for the patient, this can include resolution being managed by Patient Experience directly with the patient or escalation to the speciality or department. Where a case is shown as Internal Investigation this is where a case has been managed directly by Patient Experience from commencement to closure, the responsible divisions are updated as to these cases via the 2 weekly Governance meetings.

Table 9 – Case Management Types for PALS



8. HEALTHWATCH BIRMINGHAM

8.1 Feedback via HealthWatch

Healthwatch Birmingham is independent of NHS and social care services and provides patients and the public with ways to feedback and have a stronger say about the services they use. Healthwatch Birmingham feedback is overwhelmingly positive and The ROH are one of the few organisations within the ICB that has an overall rating of 4.5 stars out of 5, 439 reviews were left in 2024 for the Royal Orthopaedic Hospital and of those 96% were 3 stars and above, however, we have received a small number (18) of 1 and 2 star reviews in the last 12 months of which (13) 72% cited appointment issues of either delays or cancellations as the reason for the low score review.

8.2 Healthwatch comments;

You wait over a year for an appointment, still no appointments your informed, told could be another 6 months, yet others are getting appointments within weeks????

Appointment booking here is awful. Three consecutive times I've been told that my next appointment would be sent it me in 4 months time. 3 times it wasn't sent and 3 times I had to contact PALS to get an appointment. Apparently the appointment system has changed. Change it back because the system isn't working.

It's been a long wait to see them.

I have been waiting a year now for my follow up, from my last consultation. Both my GP and my oncologist have written to my consultant at the ROH 3 times asking for my appointment to be expedited as soon as possible, as they believe due to my deterioration I need to be seen, and as been a year it's been way too long also, a total of 3 letters have been sent, as well as phone calls made, yet when I chase my appointment I am told the likelihood of me been seen in 2024 is highly unlikely, this is appalling as if I'm not seen say for example till Jan 2025 that is 17 months after my last appointment, and that's only if in January. I went to the hospital outpatients with all the letters, and was told absolutely nothing they can do, you have to go through the appointment line.

After waiting 5 months I finally got an outpatient appointment for 28 November. On 11 November I was notified this had been changed to 16 November. A long standing commitment meant I could not attend on this day. After phoning and waiting for 30 minutes I got through to someone in appointments who said nothing else was available. After some pleading, explaining that I was out of the country for 7 weeks from 31 December, I was offered an appointment on 19 December which I gratefully accepted and which was confirmed online by the hospital. 24 hours later I got another online letter telling me the appointment was now on 9 January - when I am out of the county. After waiting another 20 minutes on the phone I was told there was nothing available and I should ring in a couple of weeks to book for February.

9. ONLINE FEEDBACK

9.1 Online feedback via ROH Social media posts are monitored by the Comms Team, however, when there is negative feedback or commenting these are then shared with the Patient Experience Team for us to attempt to contact the patient and reach a resolution to their concern.

These comments include.

"Still waiting for an appointment over 12 months".

"a pity I've been waiting over a year for an appointment."

"I have chosen ROH but with over years wait just for a first appointment it's heartbreaking."

"I have been waiting over 20 weeks and was told I have another 40 weeks plus".

"He could start with the problem of cancelling appointments again and again."

9.2 Where this feedback is received the comment is replied to on the online platform asking the commenter to contact the Patient Experience Team, if the commenter can be definitively identified from their online profile, then the team will reach out to them to try to help resolve their concern.

10. CONCLUSION

The thematic review of feedback, compliments, and concerns for patient experience at The Royal Orthopaedic Hospital Birmingham in 2024 highlights the hospital's ongoing commitment to delivering high-quality care and ensuring patient satisfaction. The data gathered from multiple sources, including surveys, PALS, complaints, and Healthwatch Birmingham, has provided valuable insights into both areas of excellence and opportunities for improvement.

Overall, the feedback remains overwhelmingly positive, with patients frequently praising the professionalism, compassion, and effectiveness of the care they receive.

The recognition of excellence through compliments contributes significantly to staff morale and reinforces the high standards maintained by the Trust.

However, the increase in PALS and formal complaints, while remaining a small fraction of the overall patient footfall, underscores the importance of continued efforts to address recurring concerns. Key themes such as appointment scheduling, referrals, communication, staff attitude, and delays in follow-up care have been identified as primary areas for improvement. These insights align with feedback and local survey findings and have been incorporated into the ongoing Patient Experience Action Plan to drive targeted interventions and service enhancements.

The Royal Orthopaedic Hospital remains dedicated to fostering a culture of continuous improvement by proactively addressing patient concerns and refining service delivery.

By maintaining an open and responsive approach to feedback, the Trust aims to uphold its reputation for excellence and ensure that every patient's experience is as positive and seamless as possible.

Moving forward, ongoing monitoring and evaluation of patient feedback will be crucial in shaping strategies that enhance care quality, accessibility, and communication. The Trust's commitment to patient-centred care remains steadfast, ensuring that all patients, families, and carers receive the highest standard of service and support.

SHARON LATHAM
HEAD of PATIENT EXPERIENCE
January 2025

PATIENT EXPERIENCE ACTION PLAN

JANUARY 2025

Background

The Royal Orthopaedic Hospital is renowned for providing exceptional patient care, and as a specialised, elective service, the importance of gathering and acting upon patient experience feedback cannot be underestimated.

By implementing evidence-based practices and leveraging patient feedback, this plan seeks to ensure that every interaction with the hospital, from the first consultation to post-operative care and recovery, reflects our commitment to quality, compassion, and excellence. This action plan helps to outline our strategic approach to promoting an environment that prioritises patient-centred care, operational efficiency, and empathetic communication.

The Royal Orthopaedic Hospital has a successful history of gathering, analysing and acting upon patient experience and feedback from a wide range of sources including CQC In-Patient Survey, in depth In-Patient and Outpatient surveys, Friends and Family Tests (FFT), Compliments, the joint care ‘coffee catch up programme ,’ Patient Advice and Liaison Service (PALS) cases and Complaints raised. Alongside these and other targeted surveys we also gain information from comments left on Healthwatch Birmingham and other social media platforms.

Following the thematic review of all feedback received into the Trust the following key areas and themes were highlighted as the main areas for improvement.

1. **Referrals:** Patient perception of long wait times for referrals to be processed and appointment to be offered or referral rejected. Patient not aware of outcome if referral is rejected. Internal referrals to other Consultant specialties not received/ actioned.
2. **Appointments:** Delays in accessing initial appointments, Inability or delay to access follow up appointments. Multiple cancellations and rescheduling of appointments once offered.
3. **Communication:** Difficulty in being able to contact Trust departments by telephone, lack of clarity in communication regarding appointment venues.
4. **Staff Attitude:** Instances of perceived unprofessional or dismissive behaviour.
5. **Follow-Up:** Delays or lack of follow-up after procedures or consultations.

This action plan aims to provide a framework to align the Trust service delivery with the needs and expectations of its patients, cultivating trust and enhancing our reputation for excellence in orthopaedic care. By fostering collaboration among healthcare professionals, administrative staff, and patients, the hospital strives to establish a new benchmark for exceptional patient experiences in orthopaedic healthcare.

No.	Area of concern	Assurance	Action	Responsibility	Measure of Success	Timescale	Progress (RAG)
1.1	Patients raising concern regarding waiting time from referral received to outcome of triage.	Patients with a pending referral are monitored through a twice weekly outpatient KPI report. The report identifies any delays in the referral process. This is escalated to the Division 1 triumvirate to have targeted conversations with the individuals to reduce the time from referral to triage outcome.	The Trust is to continue working with the ICB via the Primary care interface steering group to improve clinical pathways and reduce poor quality referrals. (Delays are often associated with requests for additional information during the triage process to ensure the right patient is seen in the appropriate clinic with all the necessary information available.)	Divisional triumvirate - division 1	Reduction in PALS and Complaints cases raised where referral delays are cited as the primary concern.	30/06/2025	Current performance has seen considerable improvement with all areas within KPI. This will be monitored for Q1 to ensure BAU hence timescale attached.
1.2	Patients raising concern that they are not aware that their referral has been rejected and is not progressing with the ROH. Patients unhappy that they have not	The reason for rejecting referral is communicated to the GP. The rejection may include advice for the GP to action and communicate to the patient.	Consider use of Dr Doctor or the NHS App for improving communication with patients with regards to referral status in line with best practice and direct them to the GP for further advice.	MP / OP	Reduction in concerns and complaints where the patient believes they are waiting for an appointment, but their	30/04/2025	

	received information regarding the reason for the rejection of their referral.				referral has been rejected.		
1.3	Patient is advised that they are being transferred to an alternative clinician or speciality within the ROH this referral is then not received and cannot be tracked	Internal referrals are sent from the secretarial team to the appointments team via email and then uploaded to RMS. There is a risk if this is not actioned at source.	An electronic internal referral form has been requested from the Trust IT team as a priority. This will be completed by the consultant at point of referral and will be fully auditable.	MP/OP/AR	Robust audit process for tracking referrals in place. Reduction in concerns related to time delays / action for internal referrals	June 2025	Awaiting IT development. Identified as a trust priority scheme.
2.1	Patient raising concerns over length of wait for initial appointment when their NHS app states an average of 18 week wait at ROH	Waits to be seen will vary from specialty to specialty and the NHS App can only serve as a guide	DCOO to continue ensure waiting lists are equalised within all subspecialties to ensure the wait is equalised – (unless specialist and reliant on individual clinicians).	DCOO	Reduction in patients raising concerns regarding average wait time across a subspecialty.	Quarterly Review	Last review undertaken March 25
2.2	Delay or failure to access follow up appointments due to capacity within specialities	Continuation of the outpatient transformation programme to re-direct patients on appropriate surveillance follow up to a patient initiated follow up creating capacity for patients to be seen.	Recruitment to additional consultants in specialities with significant outpatient backlogs will generate more capacity.	Head of services / Clinicians	Reduction in concerns regarding failure to access a follow up appointment.	June 2025 - phased introduction of expansion of consultant posts.	Opportunities to provide follow ups via alternative workforce is also being explored

						June 2025 implementation of Digital PIFU	
2.3	Patients receiving multiple cancellations and rescheduling of appointments	ROH Patient Access Policy to be followed when a patient is cancelled by the hospital on more than two occasions.	Regular report to be generated to audit the number of cancellations made by the hospital to identify any key themes to support additional training for appointment staff as required. Cross referencing existing patient access policy vs. proposed system access policy – standardised processes across the system	MP SR/MH	Multiple cancellations avoided leading to a reduction in concerns being raised by patients and carers	Weekly report in place April 2025	IT support requested to enable an alert flag on the system to alert the member of staff changing the appointment that the appointment has been changed twice already by the hospital and to escalate prior to proceeding.
3.1	Patients reporting difficulty in being able to contact departments by telephone and being unable to leave messages for some secretary teams as mailboxes are full	Comms sent to all Team Leaders to ensure that voice mails are checked daily and cleared to avoid the box from being full. Reminders that buddying systems should be in place in all areas to ensure that phones are answered promptly during staff absence.	Upgrade telephone access systems – Telephony Project will assist with call logging and monitoring of response times.	IT	Reduction in patients contacting PALS when unable to access departments	June 2025	Project progressing in line with timelines. Communication sent to all team leaders March 2025
3.2	Patients reporting lack of clarity in written and text communication regarding appointment	Letter templates are reviewed at the patient information group. An action log is in place for this group to reflect feedback from patients.	Patient Information Group actions to update and quality assure the written information sent to patients	KH- Patient information group	Reduction in DNA. Reduction in late attendance.	Quarter 2	Ongoing work with Synertec to ensure that letter templates reflect the correct information for the venue.

	venues for outpatient appointment.				Reduction in concerns raised.		
4	Complaints raised by patients or families regarding the attitudes and behaviours of staff. This is not limited to any individual staff group.	Share themes of patient feedback with all staff. In specific cases, staff member informed, supported and encouraged to reflect. Use of appraisal and supervision process to share feedback and learning. Share Information on Team Brief. Respect and Civility Workstream.	Learning on one Page (LOOP) to be developed and shared	Head of Patient Experience Heads of Service People Promise Manager	All staff to portray the values and behaviours expected of staff at the ROH Reduction in complaints raised regarding attitudes, values and behaviours of staff.	March 2025	
5	Patients advised that they will require a follow up appointment in a specified time period and then do not receive a follow up appointment and are unable to access one when contacting the appointments department.	The Trust has a BI report indicating when follow ups are due for renewal. The challenge in some specialities is that capacity outstrips demand. New consultants have been recruited that will help improve the capacity challenge.	Continuation of the outpatient transformation programme to re-direct patients on appropriate surveillance follow up to a patient initiated follow up creating capacity for patients to be seen. Recruitment to additional consultants in specialities with significant outpatient backlogs will also generate more capacity.	MP / OP / IT	Reduction in concerns raised about this issue	Quarter 2	

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual CDAO Report 2024**
SPONSOR (EXECUTIVE DIRECTOR):	**Nikki Brockie, Chief Nurse, CDAO**
AUTHOR:	**Sulthana Begum, Chief Pharmacist**
DATE OF MEETING:	**9th April 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The purpose of this paper is to give assurance that the Controlled drugs accountable officer at the Trust is fulfilling the role to QSC. Key highlights in 2024:

- There has been a significant decrease in the number of CD related incidents reported in the past 12 months (89 compared to 106 in 2023 and 177 in 2022). Controlled drugs still make up the majority of medicines incidents however, this decline has been partially attributed to fewer liquid CD losses as more tablet forms are used, greater use of electronic registers and fewer incidents reported by pharmacy after conducting CD audits as actions place are in place.
- Vast majority of incidents were low harm which indicates a positive reporting culture.
- No serious incidents of diversion/ harm have been reported externally via the CDLIN in 2024.
- There were a cluster of incidents related to broken and damaged ampoules of fentanyl and alfentanil in theatres which were investigated and guidance issued around handling. There have been no further incidents has since December 2024 after correct handling instructions were sent and pharmacy inspected all stock received into the Trust.
- We continue to see small number of liquid morphine losses, a trial of an oral dispersible equivalent 'Actimorph' tablets is underway on wards which will help to mitigate against these losses.
- Pharmacy quarterly audits of all clinical areas continue to provide high levels of assurance against standard for safe and secure handling of CDs. Most areas perform over 95% compliance. There is a good level of engagement between pharmacy and clinical areas to improve practice via action plans.
- The new authorised witness for witnessing CD destruction of stock is Sophie Goddard (H&S manager)
- ROH has shared good practice with the CQC and is compliant with the 2023 annual report suggestions.
- ADIOS benchmarking data highlights a higher use of Opiates at ROH compared to RJAH and RNOH. Further work is needed to understand how our acute pain management can be optimised., The Acute pain guidance is due for review in 2025.
- An audit looking at patients opiate use post discharge is underway and will be used to optimise information provided to patients on pain medication.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• No cases of diversion or staff investigation in 2024. Clear impact of Omnicell's in improving CD	• Ongoing work to improve pain management and reduce reliance on long -acting opiates.

documentation compliance through electronic registers. • Evidence of quality improvement following on from Audits by pharmacy. high levels of compliance to CQC /legal standards for CDS across theatres and wards. • MDT working to maximise learning and innovation in acute pain	

REPORT RECOMMENDATION:

The Committee is asked to: note and accept the report.

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

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

Comments:

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

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

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

Patients & Process elements of the Trust's strategy
Evidence of safe and secure medicines management for CQC KLOE on patient safety

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)***:**

Quality & Safety Committee March 2025

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Update from the Accountable Officer for Controlled Drugs

Report to Quality & Safety Committee –Jan 2024- Dec 2024

1. Purpose of this Paper

The purpose of this paper is to give assurance that the Controlled Drugs Accountable Officer at the Trust is fulfilling the role and provide that assurance to the Quality & Safety Committee. The paper is not designed to provide detailed analysis of Controlled Drugs at the Trust. This is provided to the Drugs & Therapeutic Committee via the Controlled Drugs Accountable Officer Assurance Group which reports exceptions to the Quality & Safety Committee.

2. Legislative Requirement for Controlled Drug Accountable Officer

Following the end of the Shipman enquiry in 2005, The Health Act 2006 outlined improvements in Controlled Drugs (CD) governance by introducing required designated bodies to appoint a Controlled Drugs Accountable Officer (CDAO). There have been a variety of legislative changes and introductions around CDs but the requirement to have a CDAO has not been amended. The latest legislation is The Controlled Drugs (Supervision of Management and Use) Regulations 2013 which came into force in England on 1st April 2013.

The Royal Orthopaedic Hospital (ROH) as an NHS Foundation Trust fulfils the descriptor of "designated body" therefore has an appointed CDAO.

Within the Trust the CDAO is the Chief Nurse

The CDAO has attended a recognised CDAO two-day training course to discharge this role in November 2022.

Care Quality Commission (CQC) Regulation

It is also a statutory requirement that the CQC are aware of the name and role undertaking the role of CDAO, which is within the public domain of the CQC website.

The CQC website was updated with the named CDAO as Nicola Brockie (Chief Nurse).

3. Role of the CDAO

The CDAO role has a set of generic responsibilities summarised as:

- To ensure the safe and effective use and management of CD within their organisation.
- That adequate and up to date Standard Operating Procedures (SOPs) are in place.
- There are adequate destruction and disposal arrangements for CD; (Sophie Goddard (H&S advisor) is the designated authorised witness for stock CD destruction)
- Monitoring and auditing of the management and use of CD.

- Assessment & investigation of concerns with appropriate action taken.
- The establishment of arrangements for sharing information both externally and internally.

The CDAO at the Trust confirms these generic responsibilities are discharged within the Trust via close collaboration with the Chief Pharmacist and pharmacy team.

4. <u>Controlled Drug Local Intelligence Networks (CDLIN).</u>

Outside of the Trust, NHS England have a local area team CDAO to which the designated body CDAO accounts usually through the CDLIN. Outside of these meetings the CDAO at the Trust must notify the local area team CDAO of any issues which cause concern or actions being taken in relation to CD, in addition to any other responsible bodies such as the police.

It is a statutory requirement of the Trust's CDAO that a quarterly report is provided to the CDLIN. In brief, Regulation 29 requires CDAO to give an occurrence report to the accountable officer for the local area team that is leading their local intelligence network (LIN). This should contain details of any concerns that their designated body has regarding its management or use of controlled drugs (or confirmation that it has no concerns to report). Attendance at the CDLIN is also required. The Chief Pharmacist may attend these meetings on behalf of the CDAO.

Table 1 - Number of Incidents reported to CD Lin over last 3 years

Jan 22-Dec 22	Jan 23-Dec 23	Jan 24-Dec24
177	**106**	**89**

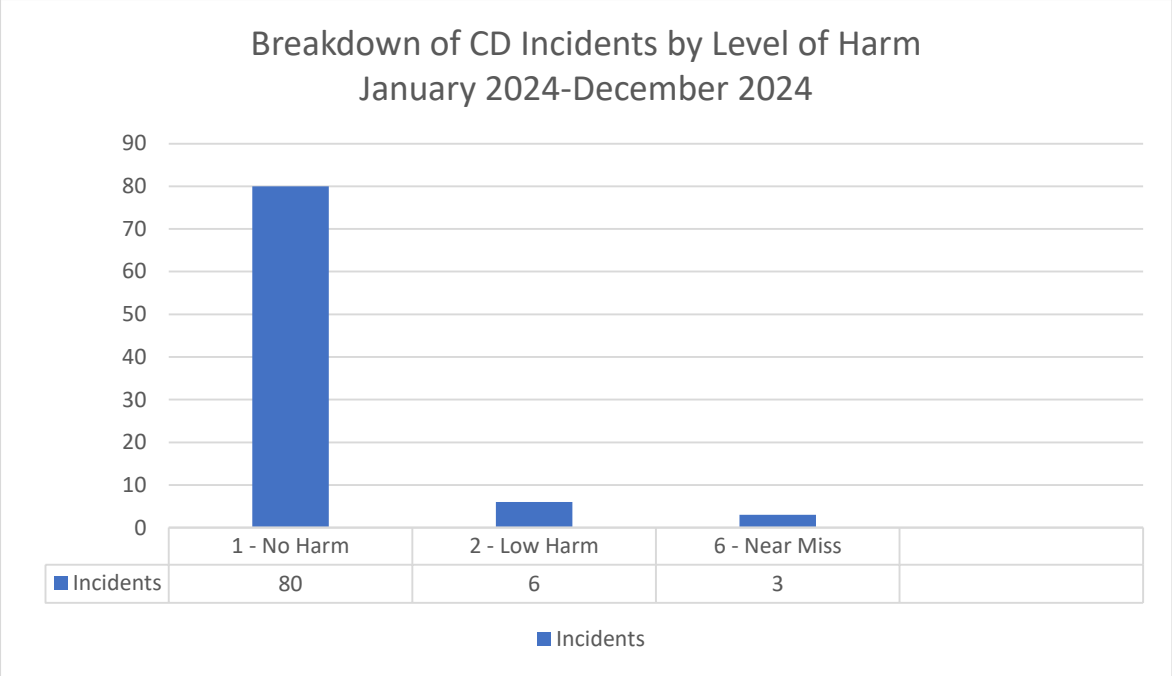
A more detailed analysis on the reported incidents is in section 8 (CD Incidents) below.

There has been a significant decrease in the number of CD related incidents reported in the past 12 months. Controlled drugs still make up for the majority of medicines incidents however this decline has been partially attributed to fewer liquid CD losses as more tablet forms are used, greater use of electronic registers and fewer incidents reported by pharmacy after conducting CD audits as actions place are in place.

Vast majority of incidents were low harm which indicates a positive reporting culture.

No serious incidents of diversion/ harm have been reported externally via the CDLIN in 2024.

There were a cluster of incidents related to broken and damaged ampoules in theatres which are detailed in section 5.



5. <u>CD Incidents</u>

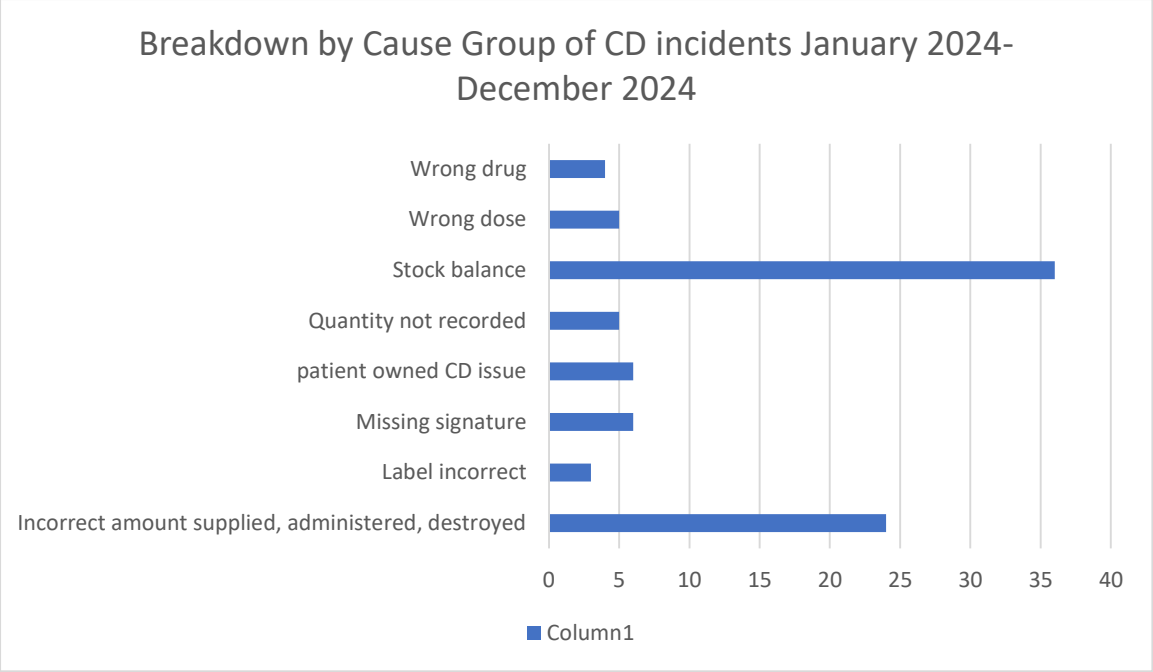
All incidents with CD are logged on ULYSSES and the system sends an automatic notification to the CDAO at the Trust.

Each month an analysis of incidents is undertaken, and this is captured within a CDLIN quarterly upward report. This is used at the CDAO assurance group for scrutiny and also submitted on the required quarterly basis to the CDLIN.

All incidents are reviewed in detail at the Medicines Safety Group to ensure they are both closed and lessons are learnt within the Trust. Any trends or incidents of concern relating to CD are discussed in detail at the CDAO assurance meeting. Learning is also disseminated via the Medicines newsletter which pharmacy create bimonthly.

<u>5.2 Incidents by cause</u>

The vast majority of incidents relate to Omnicell stock balance issues due to incorrect booking out / user error and handwritten omissions in theatre registers which are on paper. These are recurrent themes and actions are in place to continue education for healthcare staff involved in CD administration. There were no incidents of diversion / unaccounted for CDS.



6. CD Lin incidents for Jan -Dec 2024

Q1 Jan – March 2024

There were four Oramorph liquid discrepancies, two on ward 3 for 18.5mls and 16mls respectively. Two on ward 2 – 9mls and 10mls respectively. All incidents above a 5% loss are reported and investigated and documented accordingly. A switch to an oral preparation such as Actimorph will help mitigate against liquid transfer loss.

A patient on ward 12 did not administer drugs as witnessed and had been storing doses inappropriately which caused issues around timing of doses. Learning was shared around safe custody of medicines.

Ward 3 Omnicell discrepancies, a number of transactions were incorrectly entered and were investigated by pharmacy and corrected using PICS admin records and a number of Oramorph doses administered had no admin record in PICS -potentially unaccounted for but were investigated and resolved.

There were recurrent themes around incorrect Omnicell register entries and Oramorph losses for this period. Further training was delivered by pharmacy and an improvement in these incidents was seen over the next two quarters.

Q2 April -Jun 24

There were 4 incidents of broken ampules of CDs – none of these cases were suspicious and were witnessed appropriately and retrospectively reviewed by pharmacy. A log was created to monitor these and this was discussed with the regional CDAO.

There were 6 incidents on ward 3 relating to missing entries on PICS or Omnicell discrepancies. All were investigated and learning and re- training opportunities shared with the ward team.

One incident related to a patient who had incorrectly been issues ward stock and his own CD medicines on discharge. The patient was issued with 20 Zomorph 60mg capsules and 50 gabapentin 400mg capsules by 2 nurses. This was on top of the patient's actual own CDs which were 38 600mg Gabapentin and 28 of 30mg Zomorph. The patient was contacted to take the excess stock to his local chemist for destruction and his GP notified. The ward undertook some additional learning around the process of temporary CD stock storage. This was reported to the CDLIN.

There was one incident involving incorrect issue of gabapentin on ward 2, however, there has been a decline in incidents involving pregabalin and gabapentin which is positive as this was previously a recurrent theme.

Q3 Jul- Sept 24

There were 4 cases of broken glass ampoules of fentanyl and alfentanil in theatres. One case of broken midazolam amps in pharmacy during dispensing. Upon further correlation from previous incidents, regional procurement was contacted, and these were isolated to ROH. Advice was issued to handle with care and use scissors for opening which improved practice.

Pharmacy had an unaccounted for loss of 21mls of Pregabalin oral solution. This is dispensed infrequently and is thought to be from spillage as the bottle was laying on its side.

One incident involved discharge lounge. The patients' relatives claimed they could not locate 10 oxycodone capsules which were booked out by two nurses at the point of discharge. This was not found on site. The patient did not return for this to be re-dispensed. Therefore, it was not thought to be missing and was not re issued.

An incident on ward 3 involved a patient who received Oramorph PRN within 1 hour of oxycodone immediate release which was prescribed 'regularly.' This was a source of confusion and guidance on prescribing opiates is being devised for clinical staff.

Q4 Oct-Dec 24

There were 6 incidents of unaccounted for loss – 4 were linked to liquid morphine losses and 1 was a 13ml loss of pregabalin liquid in pharmacy. The roll out of actimorph tablets his being piloted to help mitigate against these incidents.

There were 6 incidents of accounted for losses- 1 smashed oramorph 3 broken fentanyl amps (2 duplicated incidents) and 1 smashed midazolam ampoule in pharmacy. This was in addition to the 4 cases of broken glass ampoules of fentanyl and alfentanil in theatres in the previous quarter. These were all reviewed and appropriately witnessed and documented. No further broken amps have been found since sending comms out regarding handling and pharmacy have inspected all of the stock on arrival.

There were 6 incidents involving patient administration/prescription which is a rise compared to previous quarters. These are listed below:

2 patients received MR morphine tabs against an 'MR caps' prescription due to stock switching from a shortage. No harm to patients as these were the same dose.

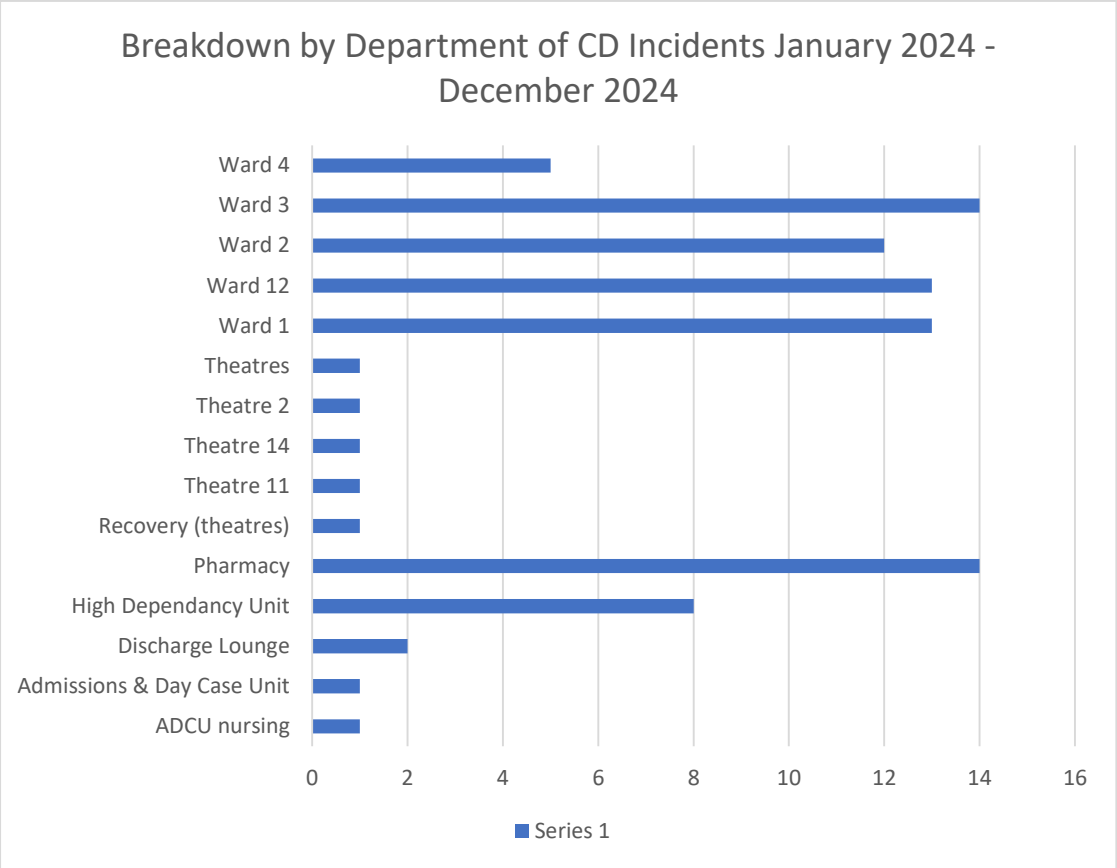
A patient was given MR morphine and MR oxycodone within 6 hours and 3 doses of short acting oxycodone in that time period and became drowsy, however further investigation confirmed no harm to the patient.

A ward 3 patient given 2 oxycodone IR doses with morphine PCA in situ with no harm however a separate patient was given a morphine PCA and oral morphine administered concurrently requiring naloxone.

An action plan is being devised by the medicines safety group to address the rise in incidents concerning patients understanding of medicines and co-prescribing of opiates.

7. Where the Incidents Occurred.

Most incidents were split amongst wards. Pharmacy had a high number reported under them but these were not linked to pharmacy but rather labelled as such under the incident reporting system.



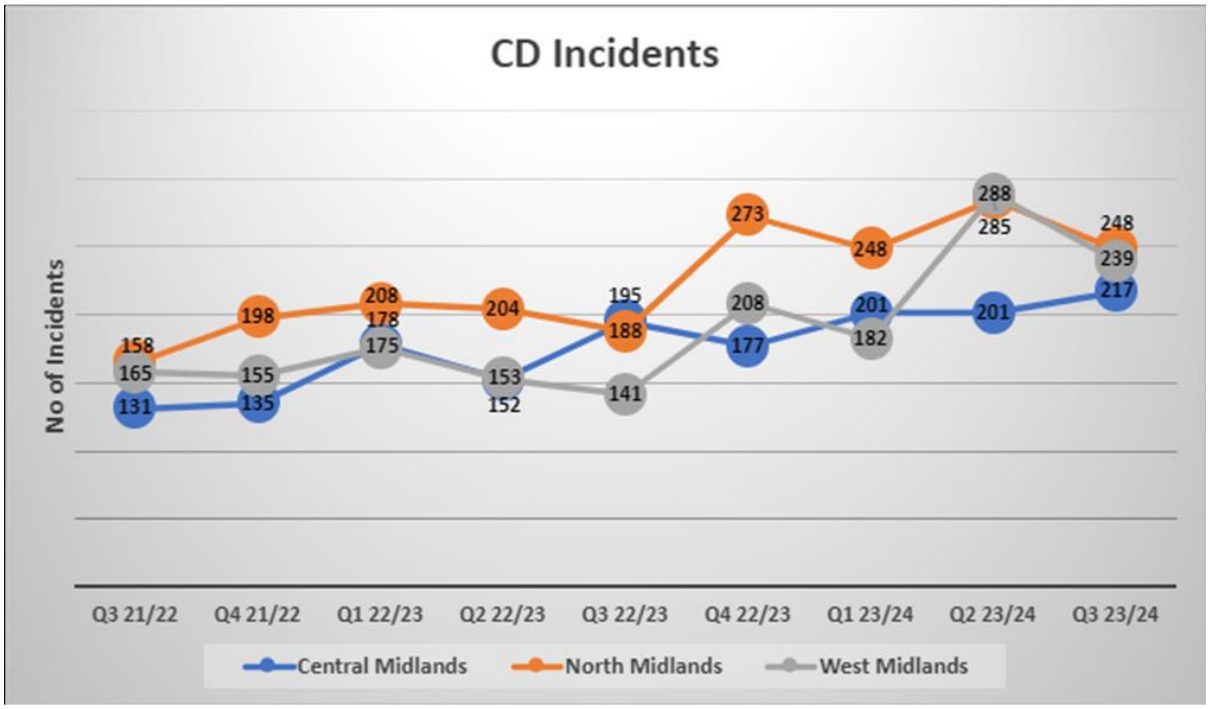
8. Pharmacy Controlled Drug audits for Division 1 and Division 2.

Pharmacy undertake detailed audits on all aspects of controlled drug storage and handling which is based on a regional tool. This provides assurance on CQC and legal requirements. Action plans are agreed on AMAT by each area. These are reported to the Medicines safety group and to the CDAO group for oversight and assurance. Both Divisions consistently report a very low discrepancy and error rate and a high compliance which is considered to be over 95% to all standards. See tables 1 and 2(appendix 1) for combined results by quarter for each division. These provide consistent positive assurance of compliance to regulations by both divisions.

9. CDLIN key learnings from Annual summary 2023

The below graph shows the trend in incidents reports across the three CD areas of the Midlands region.

The data in the second graph shows the total number of incidents submitted over the past 2 years. There has been a slight decrease in incident reported for Q3 23-24 compared to the previous quarter but a significant increase has been seen compared to the same quarter in previous years.



Key Learnings from NHS Trusts - Acute, Non-Acute, Mental Health and Ambulance

- Use of liquid bottle stoppers / bungs and oral syringes have reduced the number of unaccounted and accounted for losses. In house outpatient dispensing service resumed in Q2 and since then the use of FP10 prescriptions has reduced which in turn has reduced our reliance on FP10 prescriptions and their unaccounted for loss.

- There have been several incidents where prescribing has been incorrect and patients have had an underdose or medications missed off their regular prescriptions. MSO is working with the EPMA team to do teaching sessions for prescribers to ensure they have a better understanding of prescribing. There was feedback that the newer doctors didn't know how to access certain parts of the EPMA prescribing and not using order sets that prevent errors. There have also been several incidents where CDs were not signed into the CD registers correctly causing governance issues. This has been highlighted to the meds safety team who will share this with the wards to improve understanding of processes.

- Removal of authorisation for all CD Authorised Witnesses; development of new in-house CDAW training; development of CDAW application process; development of CDAW monitoring and governance processes; training and designation/authorisation of new CDAWs
- T28 waste exemption certificates in place for all relevant sites.
- Implementation of new processes for application and recording of CD destruction.

10.CQC annual report update 2024

The CQC make recommendations to help ensure that the arrangements for managing controlled drugs safely in England continue to be effective and outline this in their annual report.

Key points include new legislative changes for some medicines.

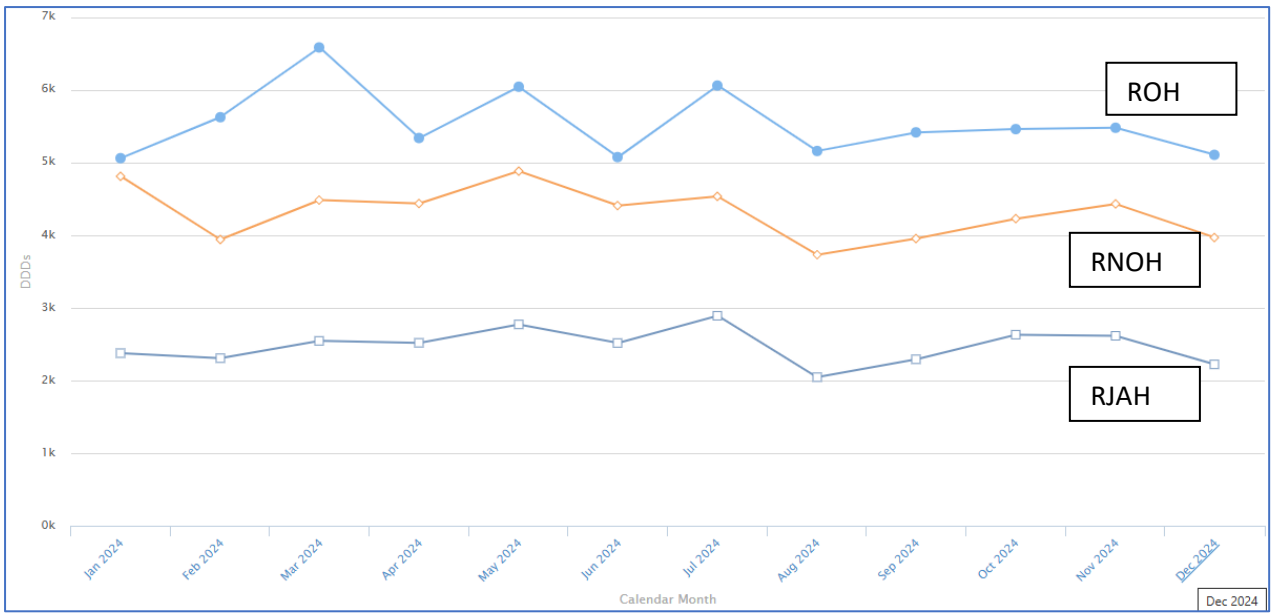
- Awareness of security measures needed for PIN numbers and controlled stationary
- Drug errors with alfentanil and morphine sulphate in paediatrics. ROH is complaint with the suggestions for these.
- A review of how CDs are destroyed / rendered irretrievable may be needed.
- Governance and roll out of e-cd registers for organisations for which ROH was an early adopter and shared lots of learning with other Trusts.
- ROH is largely complaint with the learning and findings if the CQC report. A review of how resin / destruction of CDs on wards will be undertaken. Ongoing audits on remote prescribing in OPD and use of Fp10s will be undertaken. Trend analysis of CD usage will be shared for ongoing monitoring at CDAO meetings.
- Security service was shared by the regional team due to increased theft of local pharmacies. The ROH pharmacy is alarmed and secure with CCTV the only additional measure needed for assurance

11. CD usage trend analysis – Adios

CD usage is monitored using Adios which is a benchmarking tool and issues alerts when there is an increase in usage compared to baseline activity. These are all investigated by pharmacy on a monthly basis and reported to the CDAO group.

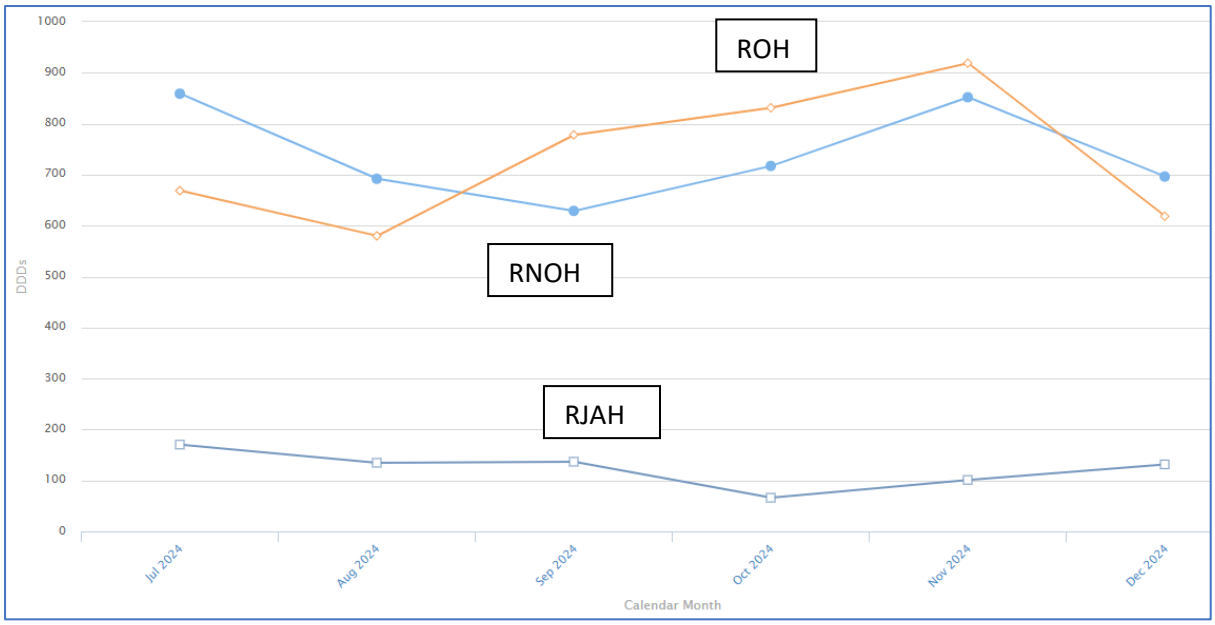
The Graphs below indicate the total opioid prescribing at ROH compared to Rhah and RNOH as peers.

Total opioid consumption ROH vs other specialist Orthopaedic Trusts in DDDs in 2024.

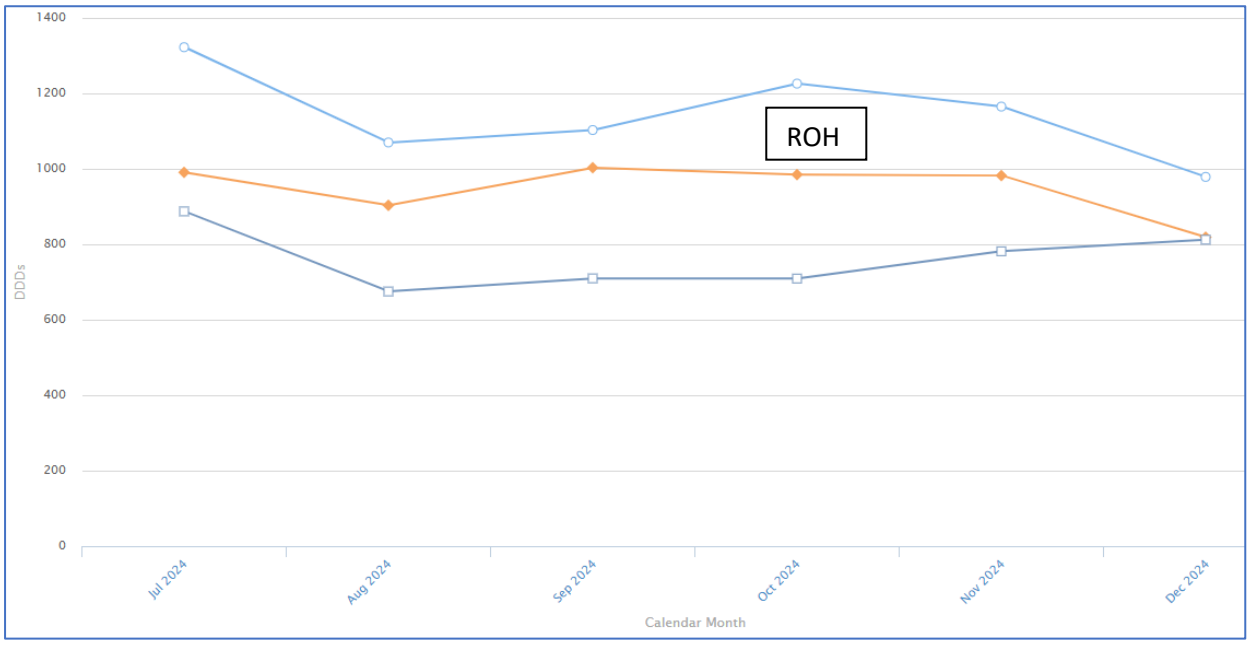


ROH has the highest total opiate consumption compared to the other Orthopaedic hospitals. This may be due to differences in pain guidelines and types of procedures. A review into the use of non- opiate analgesia such as NSAIDS is underway by Pharmacy.

Oxycodone issued at ROH in DDDs



Morphine – DDD's last 6 months.



These graphs indicate a drop in oxycodone use and morphine for the last quarter. Ongoing reviews are needed and input from the acute pain team to de-escalate patients' opioids ahead of discharge. The acute pain guidelines are due to be reviewed in 2025 and will present an opportunity to revise current practice on opiates.

12. Standard Operating Procedures & Policies

The Trust has SOPs for CDs which are within date, and other details of the management of CDs are contained in the Medicines Management Policy which was updated to include all the Omnicell SOP changes in December 2023. Ongoing changes are made to the Pharmacy Omnicell SOPs to improve current processes and reporting of discrepancies on digital registers.

13. Destruction and Disposal Arrangements for CDs

The Trust has a process for the destruction of CDs, this is incorporated into the Medicines Management Policy. A T28 Certificate has been renewed in December 2023 and will last for a period of 3 years.

The regulatory requirement is that the person witnessing destruction is not involved in the destruction of CD in any way, therefore the witnessing of destruction is undertaken at the Trust by the Health & Safety Manager, who has received training and been DBS checked which also fulfils the requirement. The Trust is therefore compliant in its destruction of CD requirements. The new authorised witness is Sophie Goddard.

14. Conclusion

The Accountable Officer confirms that the Trust fulfils legislation and CQC requirements by having a named CDAO who has received appropriate training who as part of their duties does not routinely become involved in CD.

The Accountable can provide assurance on the safe and effective management of controlled drugs at ROH by:

- Maintenance of professional knowledge of the CDAO by attendance at professional updates;
  - Attendance at the CDLIN and sharing through the CDLIN occurrence report issues around CD within the Trust;
  - A Governance framework which allows the Trust Board to be aware of the use and management of CD within the Trust by audits of management and usage of CD; The use of Adios has allowed benchmarking and interventions to be implemented to reduce opiate use such as the switch to Morphine tablets on discharge.
  - An incident reporting mechanism that allows the CDAO to be aware of all CD incidents and unaccounted for CDs within the Trust and evidence escalation to the Local Area Team CDAO;
  - Mechanisms for destruction and disposal of CD take place in pharmacy in a risk assessed environment;
  - A detailed audit programme exists within the Trust with frequent reviews of action plans for all clinical areas
  - The roll out of automated CD cabinets and e-cd registers has improved documentation standards and security of CDS and reduced liquid discrepancies.
  - Continued engagement with pharmacy and various departments and escalation via MSG CDAO group to DTC to QSE.

Ongoing actions highlighted from DTC/ CDAO group

1. To audit controlled drug prescribing activity at least 6 monthly and feedback trends to CDAO group.
2. Audit on post discharge opiate requirements of patients to determine whether this was appropriate and required to reduce unnecessary prescribing – due Q1 2025
3. Enhanced education and training for all clinical staff groups including nurses and prescribers, both at induction n and via mid- year updates
4. Review of acute pain guidelines and update on opioid selection at ROH.
5. Ongoing rollout of Actimorph orodispersible tablets. This may reduce the risk of unintentional overdosing and allow better control on the quantity of controlled drugs issued on discharge. These products would be schedule 2 and therefore the requirement of 2 witnesses needs to be monitored for impact.
6. An action plan needs to be developed by all relevant stakeholders to better understand local controlled drug prescribing practices and a process implemented to prevent excessive controlled drug prescribing on TTO's in conjunction with BSol Pain network.

Sulthana Begum Chief Pharmacist for Nicola Brockie CDAO and Chief Nurse

Appendix 1- Annual summary of Pharmacy Controlled drug audits . Division 2▲ Table 1: Highlights the percentage compliance for all Division 2 areas from April 2024 to January 2025

Theatre	Overall Compliance (%) April 2024	Overall Compliance (%) July 2024	Overall Compliance (%) October 2024	Overall Compliance (%) January 2025
Th 1	92	100	97	100
Th 2	94	100	97	100
Th 3	97	92	94	97
Th 4	94	100	100	100
Th 5	92	100	100	97
Th 6	94	97	97	97
Th 7	92	94	94	97
Th 8	94	94	100	100
Th 9	97	97	97	97
Th 10	92	94	94	92
Th 11	94	92	97	94
Th 12	100	97	97	94
Th 14	100	92	94	94
Th 15	97	94	94	92
Main Rec	97	100	100	97
ADCU	97	97	94	100
Imaging	100	100	94	100
HDU	97	100	92	94

April 2024	**July 2024**	**October 2024**	**January 2025**
86%	92%	92%	95%
94%	97%	92%	86%
97%	89%	92%	92%
92%	97%	92%	89%
94%	89%	94%	96%

Table 2 – Division 1 audit results for ward 1,2,3,4,12 combined

REPORT REF: ROHTB (4/25) 019/019 (a)

TRUST BOARD

DOCUMENT TITLE:	**Quality Impact Approach for CIP/QIS 2025-2026**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Revell, Executive Medical Director**
AUTHOR:	**Matthew Revell, Executive Medical Director** **Nikki Brockie, Executive Chief Nurse** **Steve Washbourne, Executive Chief Finance Officer** **Amanda Gaston, Deputy Director of Finance**
DATE OF MEETING:	**9 April 2025**

PURPOSE OF THE REPORT:

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

Executive Summary:

The paper outlines the approved QIA process for Cost Improvement Schemes 2024-2025
A new electronic system is being piloted using the AMAT platform
Reporting of signed off schemes will be to Quality and Safety Committee in May and July 2025. The Trust will report progress to BSol Quality Committee in addition.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
The Trust has a QIA process in place to ensure that clinical quality is not impacted by cost improvement schemes The electronic proforma complies with BSol requirements and preserves two important domains from the Trusts existing proforma – staff experience and EDI	Pace and engagement from CIP and budget holders will be reported through Quality and Safety committee

REPORT RECOMMENDATION:

The Committee is asked to: Check & Challenge. Draw assurance and draw attention to areas for improvement.

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:

The CIP programme applies to a number of major schemes and also all budget lines and therefore QIA will impact on all areas of the Trust.

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:

Our care, sustainability Touches on all BAF areas

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

Key objectives:

Improve health outcomes

Patient centred services

Strategic priorities:

Reducing inequalities

System wide efficiency

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

QIA approach is aligned with BSol Partners – tracking progress through BSol medical directors and formal reporting through to Quality Committee

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

Previous CIP discussions at F&P and Board and QIA process presented at Quality and Safety Committee in 2024

Background:

The Trust has an ambitious 6.5% CIP target for 2025-2026

Hitherto the trust has run a paper system with an effective and well understood paper template

The Trust now has a requirement to report QIAs through BSol Quality committee

The following approach has been approved at Executive Committee on 25th March 2025, and is now in progress

Approach

An automated / electronic QIA form has been developed using AMAT (see appendix). There is an electronic link which has been cascaded through executives.

The form was approved through the financial recovery group and integrates the best of BSol (**) and ROH templates (*), maintaining our values and rigour as well as balancing need for brevity, clarity and simplicity for scheme owners. Impact areas to record:

- Clinical effectiveness *
- Patient safety *
- Patient experience *
- Impact on system / health economy *
- Longer term (eg 5-year impact) *
- Staff experience **
- EDI **

CMO and CNO have scheduled weekly meetings for QIAs to be presented by the scheme owners and formally signed off

Summary of approved schemes will come to Executives meeting on Tuesdays

Upward reporting will be to Quality and Safety committee in May and July 2025 and to BSol Quality Committee as requested.

Appendix: QIA Proforma Fields:

Link to proforma requires straightforward Amat registration: https://roh.amat.co.uk/t/3EMa9etIxi

NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

Trust EQIA Tracker V1-1

1. Scheme Name *

2. Scheme Description *

3. Executive Owner (Circle all that apply) *

CEO / CMO / CNO / CPO / CFO / COO / Executive Director of Governance / Director of Strategy

4. Division (Circle one) *

Division 1 / Division 2 / Corporate

5. Department / Service *

6. Clinical Effectiveness Impact / Risk / Mitigation *

7. Clinical Effectiveness Initial Likelihood Score (0-5) *

8. Clinical Effectiveness Initial Consequence Score (0-5) *

9. Clinical Effectiveness Initial Risk Score (0-25) *

10. Clinical Effectiveness Mitigated Likelihood Score (0-5) *

11. Clinical Effectiveness Mitigated Consequence Score (0-5) *

12. Clinical Effectiveness Mitigated Risk Score (0-25) *

13. Patient Safety Impact / Risk / Mitigation *

2

14. Patient Safety Initial Likelihood Score (0-5) *

15. Patient Safety Initial Consequence Score (0-5) *

16. Patient Safety Initial Risk Score (0-25) *

17. Patient Safety Mitigated Likelihood Score (0-5) *

18. Patient Safety Mitigated Consequence Score (0-5) *

19. Patient Safety Mitigated Risk Score (0-25) *

20. Patient Experience Impact / Risk / Mitigation *

21. Patient Experience Initial Likelihood Score (0-5) *

22. Patient Experience Initial Consequence Score (0-5) *

23. Patient Experience Initial Risk Score (0-25) *

24. Patient Experience Mitigated Likelihood Score (0-5) *

25. Patient Experience Mitigated Consequence Score (0-5) *

26. Patient Experience Mitigated Risk Score (0-25) *

27. System / Health Economy Impact / Risk / Mitigation *

AMaT

3

28. System / Health Economy Initial Likelihood Score (0-5) *

29. System / Health Economy Initial Consequence Score (0-5) *

30. System / Health Economy Initial Risk Score (0-25) *

31. System / Health Economy Mitigated Likelihood Score (0-5) *

32. System / Health Economy Mitigated Consequence Score (0-5) *

33. System / Health Economy Mitigated Risk Score (0-25) *

34. Five Year Look Forward Impact / Risk / Mitigation *

35. Five Year Look Forward Impact Initial Likelihood Score (0-5) *

36. Five Year Look Forward Impact Initial Consequence Risk Score (0-5) *

37. Five Year Look Forward Impact Initial Risk Score (0-25) *

38. Five Year Look Forward Impact Mitigated Likelihood Score (0-5) *

39. Five Year Look Forward Impact Mitigated Consequence Score (0-5) *

40. Five Year Look Forward Impact Mitigated Risk Score (0-25) *

41. Staff Experience Impact / Risk / Mitigation *

4

42. Staff Experience Initial Likelihood Score (0-5) *

43. Staff Experience Initial Consequence Score (0-5) *

44. Staff Experience Initial Risk Score (0-25) *

45. Staff Experience Mitigated Likelihood Score (0-5) *

46. Staff Experience Mitigated Consequence Score (0-5) *

47. Staff Experience Mitigated Risk Score (0-25) *

48. Equality Diversity & Inclusion Impact / Risk / Mitigation *

49. Equality Diversity & Inclusion Initial Likelihood Score (0-5) *

50. Equality Diversity & Inclusion Initial Consequence Score (0-5) *

51. Equality Diversity & Inclusion Initial Risk Score (0-25) *

52. Equality Diversity & Inclusion Mitigated Likelihood Score (0-5) *

53. Equality Diversity & Inclusion Mitigated Consequence Score (0-5) *

54. Equality Diversity & Inclusion Mitigated Risk Score (0-25) *

55. Relevant risks on the risk register (Risk number) *

AMaT

56. Lead 1 *

57. Lead 2 *

58. Lead 3 *

59. Form Completed by / Sign off on behalf of the team *

Sign to confirm accuracy of information and sign of by department and executive leads

60. Date of EQIA From Completion *

(dd/mm/yyyy):

61. Comments / Known Risks to Delivery *

62. CMO Sign off (Circle one)

No / Yes

63. Date of CMO sign off

(dd/mm/yyyy):

64. CNO Sign off (Circle one)

No / Yes

65. Date of CNO sign off

(dd/mm/yyyy):

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Adam Roberts, Assistant Director of Governance and Executive Team**
DATE OF MEETING:	**9 April 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Board Assurance Framework is designed to provide an overview of the key risks to the delivery of the Trust's organisational strategy.

The BAF has been refreshed to reflect the mid-term review of the Trust's strategy, including the reframed priorities. They remain very similar in theme to the first iteration of the strategy, published in 2023, but have been refreshed in order to align with the shifts in the local and national environment.

The attached presents the refreshed BAF which will be presented quarterly to the Board to provide updates on the mitigations to the risks identified.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Refresh aligns to the reframed strategy	• None

REPORT RECOMMENDATION:

The BOARD is asked to:

- RECEIVE and ACCEPT the assurances provided that the risks to the delivery of the Trust strategy have been identified and mitigated

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	**Sustainability**	x
People	x	**Collaboration**	x

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

Board Assurance Framework – all domains

ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
Takes into account the duty to collaborate, including through System processes
BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)*:
None
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
Executive Team - 1 April 2025

Board Assurance Framework (BAF): SR1 - OUR CARE - APRIL 2025

Risk Reference: SR1 - Our Care	Strategic Risk: There is a risk that the Trust will fail to meet its objective of maintaining outstanding, high-quality care across all services and meeting the needs of our patients through continuously improving our services.	**Causes**	As a result of the Trust:- Not being able to maintain current standards of service and patient care; Not being able to optimise pathways to ensure they are seamless and patient centred; Not being enabling patient-led booking via implementation of innovative digital technologies; Not having enough staff and resources; Not having a suitable physical estate or environment	**Consequence**	With the consequence of detriment to:- Patient safety, The quality of service we provide; and Our reputation and rating as a Trust.	**Priorities**	• Achieve a CQC rating of Outstanding • Achieve a CQC Inpatient Survey Score of over 85% (should be broader than Inpatient only?) • Reduce RTT waiting times to 12 weeks • (Agree metric around harm free care) • (Agree top level metric from GIRFT accreditation indicating high quality care)	**Strategic objective:**	**CARE - By 2028, By 2028, we will maintain outstanding, high-quality care across all services and will meet the needs of our patients through continuously improving our services.**
Lead Committees	Quality & Safety Committee, SE & OD Committee, Finance & Performance Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	4		4			**January 2024**	12 (3lX4c)
Executive Lead:	Chief Nurse & Chief Operations Officer	**Likelihood**	3		1			**April 2024**	12 (3lX4c)
Initial Date of Assessment	January 2024	**Risk Rating**	12		4	TBC		**July 2024**	12 (3lX4c)
Risk appetite Statement	The Trust has a low/no tolerance to risks that have the potential to negatively impact the quality of care we provide and the safety of our patients							**October 2024**	12 (3lX4c)
								January 2025	12 (3lX4c)

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS

(full details of key controls and priority improvement programmes are set out within the Delivery Plan)

Continuously improve our inpatient experience through our Service
Embed seamless, connected, efficient processes and pathways in readiness for a fully integrated Electronic Patient Record
Evolve our JointCare pathway to meet the needs of our joint
Mobilise a suite of meaningful outcome targets that are actively used
Implement centralised booking and improved access for patients

Board Assurance Framework (BAF): SR2 - OUR EXPERTISE - APRIL 2025

Risk Reference: SR2 - Our Expertise	Strategic Risk: OUR EXPERTISE - There is a risk that the Trust will fail to increased our influence as the leading centre for orthopaedic surgery and MSK care through our cutting-edge research and MSK Academy	**Causes**	Shortfalls in the ability to: Research and innovate, teach and train, continuously improve May have underlying cause in:- Insufficient capital and/or resource, insufficient infrastructure or resillience, insufficient agility and dynamic capability to adapt to rapid change rapidly enough to keep up with changes in the Trust's external environment	**Consequence**	Consequences include: Failure to keep pace or ahead of technological gains which would benefit patients Failure to teach and train our staff Failure to continuously improve the quality of our work or maintain and monitor standards	**Priorities**	>1000 participants recruited to NIHR funded studies. 30-35% increase in publications (compared with 21/22)	**Strategic objective:**	**OUR EXPERTISE - Innovate, improve, research and teach - By 2028, we will have increased our influence as the leading centre for orthopaedic surgery and MSK care through our cutting-edge research and MSK Academy**
Lead Committees	SE & OD Committee, Finance & Performance Committee, Quality & Safety Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	3		3			**January 2024**	9 (3Lx3C)
Executive Lead:	Medical Director	**Likelihood**	3		2			**April 2024**	9 (3Lx3C)
Initial Date of Assessment	Jan-24	**Risk Rating**	9		6	TBC		**July 2024**	9 (3Lx3C)
Risk appetite Statement	The Trust has a higher level of tolerance to risks that involve innovation and service improvement which would enable us to grow and expand our expertise and our reputation as a specialist provider of orthopaedic care. The Trust needs to be brave and at the forefront of change. This has to be balanced with a no/low tolerance of risk to patient harm.							**October 2024**	9 (3Lx3C)
								January 2025	9 (3Lx3C)

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS

(full details of key controls and priority improvement programmes are set out within the Delivery Plan)

Building ROH into a leading centre for cutting edge innovation, including robotic assisted surgery, Osseointegration, Metastatic Bone Disease
Deliver years 3-5 of Research & Development Plan
Accreditation as a Major Revision Centre
Growing the ROH MSK Academy, designing and delivering education for NHS colleagues, patients and communities
Supporting the professional development of ROH staff
Excellence in HVLC and maintaining GIRFT accreditation
Leadership in MSK and Orthopaedics (APC/FSH/NOA)

Board Assurance Framework (BAF): SR3 - OUR PEOPLE - APRIL 2025

Risk Reference: SR3 - Our People	Strategic Risk: OUR PEOPLE - There is a risk that the Trust will fail to meet its objective of being rated iBy 2028, we will be rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey, recognising our commitment towards inclusivity and wellbeing for all	**Causes**	As a result of the Trust:- Having difficulties in recruiting and retaining staff at both a trust/local level and is also impacted upon by the difficulties the NHS is experiencing with recruitment and retention at a national level.	**Consequence**	With the consequence of detriment of:- The culture within the Trust and also potential impact on our abilty to deliver large aspects of the Trust's Strategy (for example our ability to provide outstanding care, our ability to continue to provide our current level of service, our abilty to expand and innovate, our inability to addres health inequalities within our region and our ability to collaborate and contribute to wider system work.	**Priorities**	Turnover rate <10% Establishment >90% Specific target for WRES/WDES Reduce the gender pay gap National accreditation	**Strategic objective:**	**OUR PEOPLE - Rated as among the best NHS hospitals to work for by our team - By 2028, we will be rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey, recognising our commitment towards inclusivity and wellbeing for all**
Lead Committees	SE & OD Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	5		5			**January 2024**	20 (4Lx5C)
Executive Lead:	Chief People Officer	**Likelihood**	4		2			**April 2024**	20 (4Lx5C)
Initial Date of Assessment	Jan-24	**Risk Rating**	20		10	TBC		**July 2024**	20 (4Lx5C)
Risk appetite Statement	The Trust has a low tolerance for risks relating to our people and the recruitment and retention of staff, as being able to attract and retain staff is absolutely essential to not only our abilty to achieve our stategic objectives but also to our continued day to day delivery of services and care.							**October 2024**	20 (4Lx5C)
								January 2025	20 (4Lx5C)

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS (full details of key controls and priority improvement programmes are set out within the Delivery Plan & People Plan)

Me As Manager programme
Talent & Succession Framework
Flexible Working
Performance Management
Embed Race Equality Code

Board Assurance Framework (BAF): SR4 - OUR COMMUNITY - APRIL 2025

Risk Reference: SR4 - Our Community	Strategic Risk: There is a risk that the Trust will fail to meet its objective of being leaders in MSK Prevention across our communities, improving access to our services and increasing the provision of MSK expertise at locality level.	**Causes**	This could potentially be caused by:- a lack of quality data to help identify this cohort of patients; a lack of a framework for the necessary outreach and engagement work; and a lack of resource to fund the work required to achieve this objective, especially in the current financial situation the Trust and the wider NHS are operating within and an inabilty to work collaboratviely within the BSOL ICB to ensure there is a jointed up system based arrpoach to talking regional health inequalities,.	**Consequence**	This could potentially have the consequence of:- No change or improvement in obtaining access or earlier access to health care for those within our community who would benefit from earlier access to health services, which in turn would help reduce the long term burden and cost to the NHS if treated earlier.	**Priorities**	Improve waiting times for patients in our 20% most deprived communities. Increase the number of people accessing entry level posts through iCAN	**Strategic objective:**	**OUR COMMUNITY - Work with our community to reduce health inequality and support prevention - By 2028, we will be leaders in MSK Prevention across our communities, improving access to our services and increasing the provision of MSK expertise at locality level.**
Lead Committees	Finance & Performance Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	4		4			**January 2024**	12 (3Lx4C)
Executive Lead:	Chief Executive Officer	**Likelihood**	3		2			**April 2024**	12 (3Lx4C)
Initial Date of Assessment	Jan-24	**Risk Rating**	12		8	TBC		**July 2024**	12 (3Lx4C)
Risk appetite Statement	The Trust has a higher tolerance for risk in regards to tackling regional health inequalities. Earlier access to treatment for this cohort of patients is important in terms of reducing health inequalities within the region and thus in turn also helping reduce the long term cost and burden on the NHS. However, it is key to balance this with the reality of the current ecomnomic situation we as a Trust and the wider NHS are operating in and the pressure to prioritise the need to mainatian current levels and standards of service with the same/or less levels of resource and income.							**October 2024**	12 (3Lx4C)
								January 2025	12 (3Lx4C)

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS

(full details of key controls and priority imporvment programmes are set out within the Delivery Plan)

Deliver our three-year Health Promotion and Prevention Plan, using our orthopaedic and MSK expertise to build tools and develop services for our partners and communities
Deliver a rolling programme of Community Appointment Days and Community Roadshows to provide condition and community specific MSK advice & signposting
Implemented a new MSK workforce model through the MSK Transformation Programme
Embed engagement and co-production into our services to ensure people help design and deliver the services they need
Utilise digital technology to optimise how patients access ROH services (Clinical Decision Support, Self-Management, AI, Triage)

Board Assurance Framework (BAF): SR5 - OUR SUSTAINABILITY - APRIL 2025

Risk Reference: SR5 - Our Sustainability	Strategic Risk: There is a risk that the Trust will fail to meet its objective to By 2028, the ROH will be financially sustainable, having increased the number of people we treat through continuously improving our processes, standardising pathways and improving productivity	**Causes**	As a result of the Trust:- current financial sustanability and productivity levels; breakdown of aged theatre plant/estates; increased costs associated with staffing and retention levels; mutual aid and collaborative work within the BSOL system to ease waiting list pressure; increased demand for services via health inequality work plans; the risk of breaches of our cyber security defences; further financial controls imposed by NHS E and/or BSOL ICB due to current national and system financial positions.	**Consequence**	With the consequence of detriment to:- increased restrictions on ability to make strategic and operational management decisions independantly; further financial controls; detrimental impact on the achievement of the 6 strategic priorities, reputational damage; and enhanced internal and external reporting and governance requirements; an increase in patient safety incidents; as well as financial and reputational loss and poor compliance with national targets.	**Priorities**	Financial target. Activity target. Private Patient target. GIRFT	**Strategic objective:**	**OUR SUSTAINABILITY - Efficient, effective and sustainable- By 2028, the ROH will be financially sustainable, having increased the number of people we treat through continuously improving our processes, standardising pathways and improving productivity**
Lead Committees	Finance & Performance Committee, Quality & Safety Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	5		5			**April 2025**	15(3L x 5C)
Executive Lead:	Chief Operating Officer	**Likelihood**	3		1			**July 2025**	
Initial Date of Assessment	Jan-24	**Risk Rating**	15		5	TBC		**October 2025**	
Risk appetite Statement	The Trust has a low tolernance for this risk due to the potential negative impact on our activity levels, the quality of our patient care and the potential impact on the autonomy to make operational and strategic decisions in regards to the current and future management of the Trust.							**January 2026**	
								April 2026	

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS

(full details of key controls and priority improvement programmes are set out within the Delivery Plan)

Ambulatory Care Unit – additional theatre capacity
Private Patient growth
7 day working
Commercialising innovation
Specialised service development
Delivering Elective Reform Plan?

Board Assurance Framework (BAF): SR6 - OUR COLLABORATION - APRIL 2025

Risk Reference: SR6 - Our Collaboration	Strategic Risk: There is a risk that the Trust will fail to meet its objective of transforming MSK and Orthopaedic services for our wide-reaching patient population through our strategic partnerships across healthcare, third sector, industry, research and academia.	**Causes**	As a result of the system not having the agreed framework for a single point of access for orthopaedic referrals and stanadrdised pathways agreed across ptimary and secondary care. Not having the neccesary capital and/or resource to enable growth, expansion and innovation in terms of our ability to establish the Trust as a Major Revision Centre (MRC) and deliver additional capacity required across the system to suport standardised access in terms of waiting times . Also the logistical and/or political and operational difficulties of trying to embed new pathways and processes across the system	**Consequence**	With the consequence of detriment to:-financial impact and quality differential , as well as a reputational impact in terms of our allignment, position and standing within BSOL ICB	**Priorities**	GIRFT metric. Strategic Partnership Agreements. Commercial income growth.	**Strategic objective:**	**OUR COLLABORATION - Collaborate to support improvement, locally, regionally and nationally - By 2028, we will have transformed MSK and Orthopaedic services for our wide-reaching patient population through our strategic partnerships across healthcare, third sector, industry, research and academia.**
Lead Committees	Finance & Performance Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	4		4			**January 2024**	12 (3L x 4C)
Executive Lead:	Chief Operating Officer	**Likelihood**	3		2			**April 2024**	12 (3L x 4C)
Initial Date of Assessment	January 2024	**Risk Rating**	12		8	TBC		**July 2024**	12 (3L x 4C)
Risk appetite Statement	The Trust has a higher tolerance for risk in regards to our ability to engineer improvement to system wide pathways and services and our abilty to influence and have a strong voice within the BSOL ICB system							**October 2024**	12 (3L x 4C)
								January 2025	12 (3L x 4C)

SUMMARY OF PLANNED MITIGATIONS & ACTIONS

(full details of key controls and priority improvement programmes are set out within respective plans)

Healthcare – leading MSK & Orthopaedics as part of Acute Provider Collaborative
Industry
R&D
Academia
Charity
VFSCE

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**PSIRF Annual Review**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Adam Roberts, Assistant Director of Governance & Risk**
DATE OF MEETING:	**9th April 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This report provides an organisational overview of the first year of implementation of the Patient Safety Incident Response Framework (PSIRF). It includes how the implementation of framework has evolved over the last year and identifies the further planned areas of implementation and improvement, as we continue to embed PSIRF into our culture and governance practices.

The report will review the implementation of PSIRF to demonstrate how the organisation meets the four key aims of PSIRF.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Strong start with implementation of PSIRF, especially in regard to aims relating to proportionality of PSIRF responses and cultural maturity • Recognition of work regionally and within BSOL ICB • Positive (provisional) assurance rating from Internal PSIRF Audit	• Work remains to be done in regard to training and compassionate engagement

REPORT RECOMMENDATION:

The Board is asked to: note and accept this report as assurance

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

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

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

Care	x	Community	
Expertise	x	Services	x
People		Collaboration	

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

Aligned to clinical risks on BAF, CRR and Divisional level

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

Aligned to BSOL ICB Quality objectives, CRM review meetings and PSIRF working group

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

N/A

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

Quality & Safety Committee – March 2025

ROH Patient Safety Incident Response Framework (PSIRF) – Annual Review 2025

Executive Summary

This report provides an organisational overview of the first year of implementation of the Patient Safety Incident Response Framework (PSIRF). It includes how the implementation of framework has evolved over the last year and identifies the further planned areas of implementation and improvement, as we continue to embed PSIRF into our culture and governance practices.

The report will review the implementation of PSIRF to demonstrate how the organisation meets the four key aims of PSIRF, which are:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

Background

PSIRF, the national replacement for the Serious Incident Framework (SIF), went live at ROH on 6th November 2023.

Under the previous SIF, approaches to managing patient safety incidents were based on the premise that safety is the absence of harm. This approach, which focused on identifying the root cause of patient safety incidents and fixing these to eliminate future adverse events, has been shown to be limited in scope; and the focus on root cause analysis and elimination of harm has tended to result in ineffective and narrowly focused investigations and actions that emphasised individual staff member errors and training needs, rather than systems and processes that require change and improvement.

PSIRF recognises that healthcare is highly complex. It takes place in constantly evolving environments that consist of interacting components including the people, processes and procedures, the tasks required, the tools and technology available and the setting and environment in which the care is taking place. All these elements impact on each other and can affect outcomes for people receiving care, staff providing care, and the organisation as a whole.

PSRIF focuses on understanding how outcomes occur within this complex system of challenging and changing conditions. Under PSIRF, ROH is aiming to become an exemplar in patient safety, reflected through a mature culture of safety and a desire for continuous improvement. We aim to improve safety by; increasing the capacity of staff who are trained and supported to use proportionate, system-based approaches to learning from safety events; by creating a culture of safety and openness; by bringing the patient perspective and voice into the centre of patient safety; and by ensuring that safety is considered a core activity by all within the Trust.

This report will describe how the implementation of PSIRF at ROH reflects the key aims of using systems-based approaches to learning, proportionate responses, engaging and involving those affected by safety events and supportive oversight. It will highlight the key areas of good practice as well as the aspects of implementation that we continue to strive to improve and embed in our governance practices under PSIRF.

Analysis of performance against the four aims of PSIRF

This report sets out key measures and indicators of the embodiment of the principles of PSIRF and its long-term sustainability.

A rating for each key measure and indicator will be given using the following key:-

A) Established
B) In progress

Following each rating, a narrative summary will be provided to evidence achievement or set out the proposed plan of action for improvement and future sustainability.

1. <u>Compassionate Engagement of those affected by patient safety issues</u>

   a) Difference between Duty of Candour (DoC) and compassionate engagement is understood – **In Progress**

      Over the course of the Trust's transition from the previous SIF to PSIRF, we have retained our strong levels of compliance and adherence to the DoC. The Trust and its staff have a well embedded culture of openness and honesty and an organisational desire to learn and continuously improve to make our services safer and of a higher quality for our patients.

      We also acknowledge there is more we can do as a Trust to ensure that we are fully engaging in compassionate communication with patients who are involved in patient safety incidents and PSIRF investigations. A review of our existing DoC policy is currently being undertaken. A summary of the planned changes to the policy are set out below:-

      - Policy to be entitled "Engaging Patients & Families following Patient Safety Incidents (inc. Duty of Candour) Policy"

- Reiterate and re-educate staff on three step legal test for application of Corporate DoC
- Inclusion of an additional step in DoC process to ensure better communication with patient/family etc, with the aim of seeking feedback and/or offering the opportunity for engagement in any investigation process.

b) Dedicated organisational resources for compassionate engagement are available - **In Progress**

The provision of additional resources and services to support improved compassionate engagement are planned as follows:-

- Revised template DoC letters and communication flow chart, with an emphasis on compassionate engagement and communication.
- Implementation of a support service and mechanisms to provide psychological and well-being support for members of staff involved in patient safety incidents. It is recognised that being involved in a PSIRF investigation, whether as the investigator or as a member of staff involved in a patient safety incident can be emotionally challenging. It is therefore seen as essential to have a peer support practice, alongside step-by-step guidance and support around the practical governance processes that take place as part of PSIRF investigations (as well as claims and coroner cases etc) for staff involved in patient safety incidents. The governance team is working with the newly appointed clinical wellbeing lead to develop this service and resources.

c) Patient Safety Partners (PSP) are engaged - **In Progress**

Initial attempts to recruit a PSP were unsuccessful, therefore it is necessary to revisit this work to ensure that we are able to recruit, support and embed the role within our governance and PSIRF practices.

The challenge of recruiting a PSP was not unique to ROH, with reports of difficulties nationally as well as regionally.

d) Alignment with patient feedback services (e.g. PALS) and learning responses - **In Progress**

To close the loop on PSIRF investigations we plan to develop a means of collating both staff and patient feedback, using existing methods and processes already in place via the PALS team. Seeking the views of staff and patients will allow us to continue to evolve and improve our PSIRF investigation processes and ensure staff feel psychologically safe and not blamed and our patients feel compassionately engaged and involved in driving patient safety and quality improvements.

2. <u>Application of a range of system-based approaches to learning from patient safety incidents</u>

a) Adaptable and flexible learning response methods – **Established**

A range of learning response methods have been implemented and can be used in a proportionate way, depending on the complexity of the patient safety event and the depth of potential learning. These methodologies adhere to national guidance and are described in our PSIRF Policy and PSIRF Response Plan.

b) Training for staff – **In Progress**

The provision of training for staff has been challenging and is an area identified as a priority going forwards. Training was initially to be provided/procured at a Birmingham and Solihull Integrated Care System (BSOL ICS) level to ensure consistency, however this did not materialise. Focus has now shifted to exploring the option of

procuring initial external provided training for key staff involved in PSIRF investigations and also developing a suite of in-house training and guidance.

c) No indication of intention to blame individuals for incidents occurring – **Established**

The key cultural concepts and principles of PSIRF are strongly aligned to the need to adopt a human factor and just culture approach to the management of patient safety incidents. PSIRF advocates focusing on what could be done differently rather than what went wrong and why, seeking to move away from the need to identify a root cause that was seen as key under the SIF.

The Trust has always had a strong no blame culture in patient safety incidents and that has remained. The Trust has been successful in adopting and embedding this cultural change into its PSIRF investigations. We have seen a shift away from actions arising from patient safety investigations that are individualised regarding the need for specific members of staff and/or teams to be trained and be competency/performance managed. Under PSIRF our investigations and actions are focused instead on systems, process and practices rather than human factors and human errors.

We have also seen consistent levels of the number of incidents reported (which is tracked via the Quality Report) since the implementation of PSIRF. This is evidenced in our recent staff survey results, which show that there is not a culture of blame and that staff feel safe, confident and encouraged to report incidents; that the Trust treats people involved in patient safety incidents fairly; and that the Trust takes action to make improvements.

A summary of the highlights from the staff survey relating to incident reporting are below:-

- 61.8% of staff who completed the survey saying they feel that the Trust treat staff involved in patient safety incidents fairly (increase from 58.7%)
- 85.7% of staff said the trust promotes and encourages the reporting of incidents; and
- 71.2% of staff said the trust takes action to ensure incidents do not happen again

d) Appropriate stakeholder engagement in learning responses – **Established**

On review of PSIRF investigations commissioned since implementation, there is clear evidence that we have collaborated and engaged well with appropriate stakeholders, both internally and externally, via cross team working within the Trust or working with colleagues and governance departments at other providers within the BSOL ICS system.

A good example of this can be found in the MDT PSIRF review that was commissioned into the incident relating to a vascular bleed during hemi-pelvectomy surgery and the subsequent emergency transfer out. An MDT review to identify the key issues and learning was held, involving representatives from several internal teams and departments within ROH, as well as representatives from both the vascular team and the ITU team at the University Hospitals Birmingham (UHB) and the Midlands regional Adult Critical Care Transfer Service (ACCOTS).

e) Systems thinking is in place for actions as well as investigations – **Established**

As alluded to above, PSIRF advocates focusing on what could be done differently rather than what went wrong and why, seeking to move away from the need to identify a root cause that was seen as key under the SIF.

The Trust has fully embraced the cultural shift from investigation to improvement. Our decision-making processes for our response to patient safety incidents, and which PSIRF investigation methodologies to use, are more focused on systems and processes that can be improved, instead of this being dictated by levels of harm and the root cause.

Again, this can be evidenced in the shift from individualised training and performance-based actions to actions that strive to change and improve systems and processes.

3. <u>Considered and proportionate responses to patient safety incidents</u>

a) Focus on proportionality – **Established**

PSIRF promotes an emphasis and focus on learning, and provides autonomy to proportionately respond to safety incidents. Under the previous SI framework, the only available means to investigate were Root Cause Analysis investigation reports, which were timely to produce, resource intensive and focused on the investigation process rather than identifying learning based actions.

A strong example of the significant improvements made to the proportionality of our responses to patient safety incidents can be evidence in the changes we have made to how we apply PSIRF to VTE related incidents.

Under the previous SI framework all VTE incidents underwent RCA investigation. Via PSIRF, a VTE triage assessment process has been gradually introduced. The VTE triage assessment allowed a timely review of VTE related incidents in order to determine the potential avoidability of the VTE. Following review, where there was no indication of potential avoidabilty, no further action is taken. If there is indication of potential avoidability, then a full PSIRF investigation is commenced.

This approach has significantly lessened the time and resource used to review and investigate VTE related incidents. We have also trialled introducing this approach to the management of Pressure Sore related incidents.

b) Appropriate resources available – **Established**

Under PSIRF we have introduced a suite of investigation methodologies, such as After Action Reviews (AARs), MDT reviews, Thematic Reviews and Patient Safety Incident Investigations (PSIIs). Tailored templates are available for AARs and PSIIs with guidance for investigators included within the template.

Furthermore, we have developed a Learning On One Page (LOOP) template, which is used to share the outcomes and learning from PSIRF investigations.

4. <u>Supportive oversight focused on strengthening response system functioning and improvement</u>

a) PSIRP and PSIRF policy match the aspirations for the organisation – **Established**

As was required under NHS England guidance on the implementation of PSIRF, our local PSIRF Response plan was drafted following data analysis of incident reports over at least a five-year period.

The approved PSIRF Response plan was reflective of the data analysis, as well as the known risks and complications of surgery associated with the specialist orthopaedic services provided at ROH.

b) Local priorities are well understood by relevant stakeholders – **Established**

The incident categories contained within the Trust PSIRF Response Plan are well understood and embedded within our divisional governance processes. The incident categories are used to guide escalation for review and discussion at the bi-weekly divisional governance meetings and allow the divisional triumvirate to make proportionate and systems-based decisions on which incidents to investigate using the variety of PSIRF investigation methodologies.

The strength of our divisional governance processes and practices were highlighted in the recent KPMG Internal audit of PSIRF. The PSIRF Audit Report is currently in draft form and will be subject to internal review at Quality & Safety Executive, Quality & Safety Committee and Trust Board once it has been finalised.

c) Oversight and assurance focusses on evidence of improvement – **Established**

Following the implementation of PSIRF, work has been undertaken to adapt and evolve the Trust's Quality Report to ensure it reflects and adopts the principles of PSIRF, aligns to the focus on learning and improvement and is reflective of the incident priorities set out in the Trust's PSIRF Response Plan. Amendments to the report have been made to reflect comments and suggestions from members of the Quality & Safety Committee.

A summary of the key changes made to the report are listed below:-

- Dashboard overview of key quality and patient safety metrics
- Statistical and numerical tracking of no. of incidents and types of PSIRF investigations commissioned
- Dedicated section of the report for each incident category contained within the PSIRF Response Plan
- Run chart and SPC charts used to provide assurance and trend/theme monitoring
- Narrative focus on learning and improvements implemented as a result of concluded PSIRF Investigations

d) Governance processes have been redesigned to facilitate PSIRF – **Established**

The implementation of PSIRF has not necessitated any changes to our governance processes. Our divisional governance structure and bi-weekly divisional governance meetings are well established, experienced and highly effective at managing and monitoring patient safety incidents. The Terms of Reference, as well as the roles and responsibilities of the divisional governance meetings are clearly defined with good level of assurance and oversight provided by Divisional Management Board, Executive Governance Forum, Clinical Quality Group, Quality & Safety Committee and Trust Board.

The governance structures in place for the application and management of patient safety incidents under PSIRF were acknowledged as an area of good practice in the KPMG Internal Audit of PSIRF. The PSIRF Audit Report is currently in draft form and will be subject to internal review via Quality & Safety Executive, Quality & Safety Committee and Trust Board once it has been finalised.

e) Leadership culture and governance functions are supportive of PSIRF – **Established**

Along with the significant progress made to improve the proportionality of our responses to patient safety incidents under PSIRF, the way in which the executive and non-executive directors, the senior leaders and key stakeholder within our governance structures have embraced and supported the implementation of PSIRF and the cultural changes to the way in which we manage patient safety incidents has been a real strength and a key success.

The cultural maturity of the Trust's approach to PSIRF has been recognised at BSOL ICS system level and was also evidenced in the collaborative and united way in which the Trust responded to concerns raised by the coroner

over our investigation processes in the Regulation 28 Preventing Future Deaths Report that was issued followed a recent coronial inquest.

f) ICB and other stakeholders are engaged and supportive of organisation's safety work – **Established**

As alluded to previously, the strength of the Trust's cultural maturity with the implementation of PSIRF has been recognised at ICB system level.

BSOL ICB has held monthly PSIRF learning groups for system providers since before PSIRF went 'live' across the system in November 2023. Representatives from the Trust have regularly attended to provide feedback and insight into the progress made with the implementation and embedding of PSIRF. We have regularly received positive comments and feedback on the presentations we have delivered, which transpired into being invited to be guest speaker at a recent Heath Innovation East & West Midlands Sustainability in PSIRF Event, attended by colleagues and peers from system providers and ICBs from across the Midlands as well as by staff from NHS England, where we were asking to talk about our PSIRF journey and the successes and challenges we have faced as a Trust with the implementation of PSIRF.

g) Culture of PSIRF sustainability and alignment to CI/QI – **In Progress**

The Trust has made a strong start on the implementation and embedding of PSIRF into our patient safety culture and practices. Good progress has been made towards the proportionality and systems-based approaches to patient safety incidents.

The reduction in the volume of investigations and a focus on improving processes and systems is good assurance that we manage and mitigate the risks and known complications of surgery that relate to the patient safety incidents categories that were included in our initial PSIRF Response Plan very well.

The next stage of our PSIRF journey is to identify a set of patient safety incident categories that align to and reflect the current climate and environment in which the Trust is operating in.

The next version of the PSIRF Response plan needs to be reflective of the current issues, be based on analysis and triangulation of data relating to incidents, claims, PALS and complaints, be aligned to our current strategic priorities and business plans and in the knowledge and awareness of the current continuous improvement work that is already underway within the Trust, in order to ensure we are able to make continuous improvements to the safety and the quality of the services we provide to our patients.

h) PSIRF Internal Audit – **Established**

The Trust's internal auditors, KPMG, have recently conducted an audit into our PSIRF policy and governance practices.

A provisional audit rating of *"significant assurance with minor improvement opportunities'* has been awarded. The PSIRF Audit Report is currently in draft form and will be subject to internal review via Quality & Safety Executive, Quality & Safety Committee and Trust Board once it has been finalised.

Next Steps

Following this report and approval of the Internal PSIRF Audit Report, we plan to draft and consult on the following 2 key pieces of work:-

1. Draft version of our 2nd PSIRF Response Plan
2. Detailed PSIRF Implementation Action Plan (incl. timescales for delivery)

Adam Roberts

Assistant Director of Governance & Risk

March 2025

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TRUST BOARD

DOCUMENT TITLE:	**Insightful Provider Board**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Tammy Ferris, Corporate Services Manager**
DATE OF MEETING:	**9th April 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 all Board members were invited to complete the self-assessment to help evaluate how insightful the Trust Board at ROH is.

The results were collated, and it was clear Board members felt we can demonstrate we run an insightful Trust Board, but there are always things we can do to improve on.

The following points were highlighted:

- Freedom to Speak Up (FTSU) information is discussed at the board and considered alongside other sources of information on organisational culture.
- The role of each committee is clear, including what areas and organisational risk it covers.
- A great deal of information is shared at the Board, but it is not always clear why it is there.
- The amount of data received does not always allow time for the analysis and focused attention.
- Financial, operational, quality and people performance need to be equally balanced.

Next Steps:

With the feedback received, and a review of the gap analysis undertaken an action plan will be 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.

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 – February 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 from NHSE Chair Expressions of Interest material	*Refresh required for the Board and Council of Governors*
Rigorous skills-based recruitment and appointment process for non-executives, and they are independent	Recruitment Packs Non Executive CVs	
The size of the board, the committee structure and processes reflect the size, services and complexity of the organisation	Comparison to peer organisations	
The board receive the right information, presented in the right way and at the right time	Board workplan Performance dashboard Standardised templates	*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 reporting lines Revised governance paper to Board in April 2025	*Overall governance review to be concluded by May/June 2025*
The right structures are in place to escalate information through the organisations from the point of care to the board	Governance structure Upward reports	
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' walkabouts	
The roles and responsibilities of the Senior Independent Director are clear and agreed by the board	Code of Governance Paper received by the Board in 2021 around roles	*Refresh required for the Board and Council of Governors*
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.
- Refresh of key roles and responsibilities for the Board and Council of Governance
- Completion of meetings and governance review

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 minutes	
The Board understand when to seek external review and independent input	Committee minutes (Quality & Safety Committee as an example)	
Most of the discussions are at the public board, and with clear justifications for any items discussed in private	Board agendas Board minutes	*Further review of agendas to ensure appropriate material is considered in public*
Issues are appropriately escalated from executives and the information is presented transparently	Committee meeting packs Board Packs Upward reports	
The board balances operational performance with people performance at all levels of the organisation	Board agendas Committee agendas Board packs Committee meeting packs	
All board members have undertaken a 360-degree feedback	PDR paperwork	
The board proactively seek views, listens to them and demonstrably follow up, and promote the value of 'speaking up' culture	Twice yearly FTSU Reports to Trust Board Staff survey results	

	NED and Executive leads in place for FTSU	
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 Patient Safety & Quality report includes section on FTSU	
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	
Areas and functions of the trust operations that require specific governance groups is established	Governance structure	*Overall governance review to be concluded by May/June 2025*
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	
There is a balance between strategy – developing and delivering it – and day-to day operations	Board agendas	
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 stating purpose of report	
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	
The board also receives information showing wider system performance across the provider's key operational areas	System updates included within the CFO update	*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	Chief Officer Reports	*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 focuses the attention on meaningful data rather than expected variation and statistical noise	Performance Packs	*The roll out of the integrated performance report and dashboard is desperately needed to allow the attention to be focused in the right place.*
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	Chief Officer Reports. Performance Packs	

The information supports the board to ensure a focus on continuous improvement across the organisation	Continuous and Quality Improvement discussions and presentations Challenge in minutes of Board and Committee minutes	*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 reflect 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 Alignment of the strategy to the ICB strategy and national guidance	
The trust is working collaboratively with system partners and its provider collaborative for the overall good of the system and population served	System meetings Acute Provider Collaborative papers Mutual aid	
The board is assured that it is overseeing the delivery of its organisational strategy	Board Strategy Refresh Delivery plan Cover sheets	

effectively and that this is responding to the needs of the local system strategy		
The organisation is meeting, and will continue to meet, any regulatory direction placed on it or undertakings	Planning submissions CQC preparedness work	
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 Safety Incident Reporting CQC Assessment Clinical and internal audit outcomes Staff survey Patient survey Complaints, PALs and compliments Health & Safety self-assessments and action plans	
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 Patient safety & Quality report	
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 and action plans WRES Action Plan FTSU actions Staff stories	
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 Mandatory Training suite	
Staff are able to express concerns in an open and constructive environment	FTSU data Staff survey results	
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 Vacancies Turnover and leaver rates Diversity Workforce plan for 2025/26	

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 Plan 2025/26 Financer & Performance meeting packs	
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*
Appropriate population health targets have been agreed with the Integrated Care Board		*This is not clearly evidenced*
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	

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	FPC self-assessment Robust operation of FPC evidence good challenge and follow up Annual Governance Statement Annual audits by external audit	*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 Finance extracts of BAF and Corporate Risk Register Audit Committee minutes	
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 Meetings System FPC meetings	
KEY ACTIONS REQUIRED TO ADDRESS GAPS		
• Review of the contract management process		

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TRUST BOARD

DOCUMENT TITLE:	**Annual Assurance Report from the Non Executive Champion for Freedom to Speak Up**
SPONSOR (EXECUTIVE DIRECTOR):	**Gianjeet Hunjan, Non Executive Director**
AUTHOR:	**Gianjeet Hunjan, Non Executive Director** **Claudette Jones, FTSU Guardian** **Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**9 April 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

National guidance was received in 2022 which rationalised the number of Non Executive champion roles to five: Freedom to Speak Up; Security Management; Wellbeing; Doctors' Disciplinary; Maternity Safety (not relevant to ROH).

When the new guidance was presented to the Board, it was agreed that the assigned Non Executive champions would provide an assurance report to the Board by rotation.

Attached is the usual annual report from the Non Executive Champion for Freedom to Speak Up, Gianjeet Hunjan.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• FTSU Team now has a dedicated room that is used as a safe space for raising concerns, provide support and resources for staff, facilitates consultations, small team meetings and attending FTSU virtual conferences.	• Track completion of FTSU modules being completed on ESR. Completion of FTSU modules has increased. Although uptake is still low

REPORT RECOMMENDATION:

- The BOARD is asked to: RECEIVE and NOTE the update and assurance within the report.

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

Financial		Environmental		Communications & Media	**X**
Business and market share		Legal & Policy	X	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		Community	
Expertise		Services	
People		Collaboration	

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

NHS E guidance on Non Executive championships

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)*:

Report to Trust Board in April 2024.

ASSURANCE REPORT FROM THE NON-EXECUTIVE DIRECTOR

FOR FREEDOM TO SPEAK UP - 2025

Definitions and scope of responsibility	NHS England has committed to promoting Freedom to Speak Up, wanting all workers to feel valued and respected and to know that their views are welcomed, to enable them to provide the best possible care. NHS is committed to providing a working environment where FTSU is valued as an opportunity to learn and improve. FTSU statistics are reviewed regularly and fed back through the staff survey. The role of the Senior Lead for FTSU is defined as supporting the FTSU Guardian. This person should be considered: • A credible role model of the behaviours that encourage speaking up. • Clear about their role and responsibility. • Able to evidence that they help improve the organisation's speaking up culture. • They should be accountable for these aspects of the FTSU's guardian role: - Fair, inclusive recruitment - Capacity - Evaluating speaking up arrangements • They should also be able to explain to oversight bodies the rationale for decisions around: - Ringfenced time, as well as the checks and balances put in place to show this. - Time is sufficient and effective. - How the guardian was appointed. - How the organisation reviews its speaking-up arrangements. The role of the Non-Executive Director (NED) for FTSU in the NHS is defined as providing a senior, independent lead role specific to organisations with boards. In this context, the NED is predominantly a support for the guardian: a fresh pair of eyes to ensure that investigations are conducted with rigor and to help escalate issues, where needed.

	They should have an in-depth knowledge of FTSU and be able to readily articulate: • Why a healthy speaking-up culture is vital. • The indicators of a healthy speaking-up culture. • The indicators that there is sufficient support for speaking up and wider culture transformation. • The red flags that should trigger concern. They challenge the most senior people in the organisation to reflect on whether they could do more to create a healthy, effective speaking-up culture. This might involve constructively raising awareness about poor behaviours. Function responsibilities include: • Promoting an open and honest reporting culture within the NHS, where people can speak up and have their suggestions listened to and acted upon. • Raising concerns to support and encourage improvement. The role of the Guardian is defined as • Supporting colleagues, providing an alternative route for workers to speak up about issues that prevents them from providing good care – empowering them and breaking down barriers to speaking up. • Worker Experience – work to enhance the experience of workers. • Ensuring those who speak up are thanked. • Ensuring that issues raised are responded to. • Ensuring those speaking up receive feedback on the actions taken. • Patient safety and quality of care – contribute to protecting patient safety and improving quality of care. • Promoting learning and improvement – matters raised by staff are used as opportunities for learning and continuous improvement. • Contribute to the work of the National Guardian's Office by providing speaking up data, responding to surveys and passing on FTSU stories to share the impact of FTSU on health.

	• Complete the NGO's programme of training and maintain currency. • Recruit and support FTSU Champions. The role of the Champion is defined as • A voluntary role aiming to support colleagues to speak up. • Offer encouragement and signpost workers to avenues to speak up or receive support. • Raise awareness of the importance of speaking up. • Promote the value of speaking up. • Compliment the work of guardians by supporting a culture where open communication is encouraged.
Operational and Executive Leads with responsibility for Security Management	Simon Grainger Lloyd – Executive Lead for FTSU Gianjeet Hunjan – Non-Executive Lead for FTSU Claudette Jones – FTSU Guardian Champions: • Jane Bevan, Clinical Audit & Effectiveness Facilitator • Asif Kabala, Finance Assistant • Uzo Ehiogu, Senior Physiotherapist • Eunice Butler, Healthcare Assistant • Petros Mikalef, Consultant Surgeon • Symeon Hopkins, Oncology Admin Manager • Wilson Thomas, Consultant Anaesthetist • James Jones, Research Healthcare Technician • Kirsty Hindley, Clinical Site Manager • Vicky Butler, Matron
Activity this period (March 2024 – March 2025)	• Confirmed that the FTSU Plan is in line with the FTSU Strategy and NHS People Plan • Oversaw the implementation of triangulation document which is shared at divisional level, providing information regarding number of cases raised and themes, to be used to promote shared learning, change and improvement. • Worked collaboratively with managers and colleagues across the Trust including: - Network Chairs - Engagements and Wellbeing Officer - Managers for reporting and following up of concerns.

	- Human Resources - Regular 1:1 meetings with Director, senior leaders, managers and staff as appropriate. • Taken assurance that training sessions for new starters and junior doctors in FTSU (in response to issues raised) are taking place • Attended meetings with new and existing champions to understand progress, discuss strategy and plans for associated events. • Undertook regular walkabouts to meet and support staff. • Participated in Awareness Events: - Awareness Day - Awareness Month • Supported the production and distribution of quarterly newsletters (provided updates across the Trust regarding FTSU activity) • Acted as a sounding board for the creation of resources around the site, maintenance and updating of associated publicity i.e. posting boxes (as a result of workers requests) • Supported the creation and distribute leaflets and posters regarding Awareness of FTSU. • Supported the FTSUG to provide reports: - Biannually to Trust Board - Annual assurance report to the Trust Board • Sought assurance on the follow up of concerns raised and outcomes. • Supported the creation of Thank You cards to ensure those speaking up are thanked. • Supported the recruitment of champions from diverse backgrounds and roles across the organisation. • Had oversight to ensure that Champions completed bespoke training endorsed by NGO, delivered by FTSUG. • Participated in bespoke induction for FTSU Champions delivered by FTSU Guardian, Executive Director with certificate to induct Champions in their role. • Sought assurance that the FTSU page on the Intranet is updated regularly and when required. And that FTSU modules are currently on ESR for everyone to complete (not mandatory) - Freedom to speak up – all staff - Freedom to listen up – managers

	- Freedom to follow up – Boards member and senior managers. • Sought administrative support and a designated office for the FTSU function which has been recently provided.
Status of relevant strategies and policies	• FTSU policy inline with FTSU template and NHSE was completed November 2022 (deadline was January 2024) and is not due to be updated until 2025. • FTSU – A guide for leaders in the NHS and organisations delivering NHS services: reflection tool (for the Board) is a task commenced and awaiting final review. • Detriment document completed and rolled out across the Trust through awareness activities, delivered to all departments, and promoted during new staff training sessions held monthly • FTSU policy and detriment documents are up to date and in line with NHSE People Promise and staff voice. Rolled out across the Trust and workers made aware of the information through awareness sessions, walk about and training sessions. The documents also distributed across the Trust.
Matters of escalation/key points of assurance to the Board	• FTSU Team now has a dedicated room that is used as a safe space for raising concerns, provide support and resources for staff, facilitates consultations, small team meetings and attending FTSU virtual conferences. • Track completion of FTSU modules being completed on ESR. Completion of FTSU modules has increased. Although uptake is still low • Use ESR data to inform actions to promote completion of training, to aid learning and improvement of culture change. • Ensure awareness of FTSU is consistently at the forefront of meetings. • Share further triangulation data at division level to foster training and development, so that senior managers are aware of themes and can develop or prioritise any necessary training. Training and outcome to be fed back to safety group. • Due to local and national cost pressures, identifying administration to support FTSU process is challenging.

Actions planned for next period	• FTSU – A guide for leaders in the NHS and organisations delivering NHS services: reflection tool, (for the Board) to be completed. • FTSU handbook launched; currently in its final stage of completion • Complete recruitment and induction process for two additional champions. • Relaunch a 'Survey Monkey' questionnaire, asking if workers feel safe & confident to speak up and if they have experienced detriment following speaking up. Previous survey showed that workers felt safe to speak up, no detriment was reported • Complete embedding of FTSU 'thank you' cards across the organisation. • Continued FTSU Team 1:1 meetings with Executive and Non-Executive for team support • Continue recording and monitoring of worker concerns and providing feedback. • Continue formation of reports for Board, NGO and Safety Team. • Issue quarterly FTSU newsletters. • Investigate FTSU Case Management System • Introduce eFTSU form for FTSU Champions • Implement eFTSU response form for Guardian • National FTSU October month awareness month planning and preparation and July FTSU week planning

Gianjeet Hunjan
Non Executive Director

March 2025

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UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 25 March 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It is unlikely the Trust will be able to deliver the March activity target due to the loss of three theatres for essential maintenance. • The absence and turnover rates continue to increase. There is a real focus on the wellbeing plan to help ensure we are supporting our colleagues to remain or return to work. • The Trust will need to deliver a very challenging financial plan in 2025/26. It was noted how important it is to ensure that mechanisms are in place throughout the Trust to ensure that this is being delivered from the very beginning of the financial year, and if possible, performing above the planned level.	• The evaluation of the 'Day Case Week' that was held in February will be shared at the next Finance & Performance Committee in April.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• It was recognised that there had been a significant amount of work to develop the 2025/26 plan in order to achieve the submission deadline. • The Committee was provided with an update on the positive performance in February, with activity above the monthly plan, RTT at 53.8%, and the intention still being to deliver zero patients waiting more than 65 weeks by year end. • The Trust's theatre utilisation % sits in the top quartile nationally on Model Hospital. • Despite a slight increase on agency spend in Month 11 it remains at 1.9%, which is below the target 3.2%. This is the 7th consecutive month this has been achieved. • The appraisal window will open from 1st April 2025 and the focus this year is on the quality of the appraisals. • The Committee received an update on the considerable and high quality 2025/26 planning work that has taken place since the Board met on 19th March 2026. A credible plan had been developed in	• There were no significant decisions made.

challenging circumstances and Executive colleagues were thanked for their efforts. • There has been a revised Quality Impact Assessment (QIA) process devised to help support the delivery of the cost improvement programme (CIP) in 2025/26. This will be presented to the Trust Board in April. • The Committee received the CQC 'Effective' self-assessment and action plan which highlighted good compliance with the quality statements.	

Chair's comments on the effectiveness of the meeting: It provided an opportunity to have good discussions on key items that affect the end of this year and the next financial year.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 26 March 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- It was noted that there were four risks to be added to the corporate risk register. Risk Number 1758 Psychiatric Liaison Support, risk number 1817 Safeguarding database, risk number 2041 NHSBT ambers status for Blood Group O, and risk number 2070 NPSA for TACO will be added to the register.
- It was noted that there had been two inpatient deaths, and both are currently being investigated. One case has been listed for inquest.
- It was noted that the number of incidents had dropped this month, however the number of low and no harm incidents remain high so there is confidence that the good reporting culture remains in place.
- The Committee received an update on the Environmental Agency inspection that took place in November 2024 and were presented with the action plan to resolve the areas of improvement required.
- It was noted opioid usage at ROH is higher than Robert Jones and Agnes Hunt and work it taking place to try and reduce this and to change the prescribing practices at the ROH.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- Review to be undertaken on harm reviews for spinal cases and update to be provided a future Quality & Safety Committee.
- Update the Environmental Agency Action plan to ensure the Lead Officer and due date for each action is clear.
- Produce a document that details the output of the 'Coffee Catch Ups', describing its purpose and impact to support the CQC 'Safe' work that is taking place.
- Review the national list of clinical audits and provide assurance the ROH is completing all that are relevant, and if not ensure a reason is given.
- Provide to the Board an overview of the Quality Impact Assessment (QIA) process, and then to future Quality & Safety Committee share a worked example.

POSITIVE ASSURANCES TO PROVIDE

- The Committee received a presentation on 'Call for Concern', also known as 'Martha's Rule', from the Lead Nurse of the Critical Care Outreach Team.
- It was highlighted that the number of patients waiting over 65 weeks has now reduced, with the aim to achieve zero 65-week cases by the end of March.
- It was noted that the response time for issuing complaints had improved.
- The Committee received the patient experience action plan following the thematic review that has been undertaken.
- The Committee received the CQC 'Safe' self-assessment and action plan.

DECISIONS MADE

- The Committee agreed that the patient experience report would be presented at Trust Board with an updated version showing the activity volumes included.
- The Committee agreed that the Environmental Agency Report and Action Plan should be presented to the Board.
- The Committee received and approved the revised terms of reference for the Safeguarding Committee.
- The Committee agreed that the QIA process should be shared with the Board so that all members are aware of the process.
- It was agreed that the annual PSIRF report be presented to the Board at its next meeting.

• The Committee received, and accepted, the Controlled Drugs Accountable Officers Annual Report. • The Deputy Chief Pharmacist presented the Missed Medicine Report and provided assurance to the Committee that the audit undertaken did not highlight any concerns. • The Committee received the Patient Reported Outcome Measures (PROMs) report which highlighted that the Trust reports highly in comparison to our peer organisations. • The National Joint Registry report was presented to the Committee and assurance given that following peer reviews, there are no outliers at the Trust. • The Committee was provided with assurance that the Trust is compliant with the requirements of the Human Tissue Authority (HTA) regulations. • The Committee received and accepted the Clinical Audit Update. • The Assistant Director of Governance & Risk presented the Patient Safety Incident Reporting Form (PSIRF) Annual Report, and it was warmly received by the Committee.	
Chair's comments on the effectiveness of the meeting: The meeting focused on several key agenda items that allowed for good discussion on the subjects presented.	

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM CHARITABLE FUNDS COMMITTEE

Date Group or Board met: 20 March 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Discussions took place around utilising the funds more effectively and the need to focus on bid generation.	• In relation to bid #320 entitled Digital Wayfinding Solution, it was agreed to rework the paper, linking in all options, including AccessAble and further work would take place to represent this bid. • Extended discussions took place around the redesign of the front of the hospital to house the ROC Hub. A Business Case is being prepared for further consideration.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• A comprehensive Charity Report was received which included numerous upcoming events, an update on the Charity Team and fundraising and grant successes. • Positive changes were presented by the Director of Strategy around bid #318 entitled 'Community Fundraiser' including assurance around mitigating the temporary depleted staff numbers in the Charity Team. • In the financial update, there was nothing significant to report in terms of fund balance. A productive meeting took place following December's Board with Cazenove around the performance of the Charity's investment portfolio and risk appetite. • Members of the Committee received for information bid updates which included 6 month review updates of the previously approved bids. The Chair thanked the Charity Team for providing these updates which were most helpful.	• The following seven bids were approved by the Committee: #312 Audit Fee 2023/24 #313 Admin Fee 2024/25 #316 eTapestry (for a further three years) #318 Community Fundraiser #319 Grants & Trust Consultant #321 MSK Occupational Health Physiotherapist Role #323 MR Artwork – agreed to approve this bid in principle, subject to alternative artwork being proposed not exceeding the requested budget. • An additional fourth meeting per year of the Charitable Funds Committee was agreed to take place. • It was agreed to keep the current structure around bids for approval as the articulation works well.

Chair's comments on the effectiveness of the meeting: The Chair shared how she enjoys these meetings and highlighted the amount of challenge and the numerous areas covered. The Chair referred to the excellent discussion with Cazenove following December's Trust Board meeting and the need to change direction in terms of utilising funds more effectively and focus on bid generation. The Chair thanked members for their contributions and attendance.

Finance and Performance Report

Month 11

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.

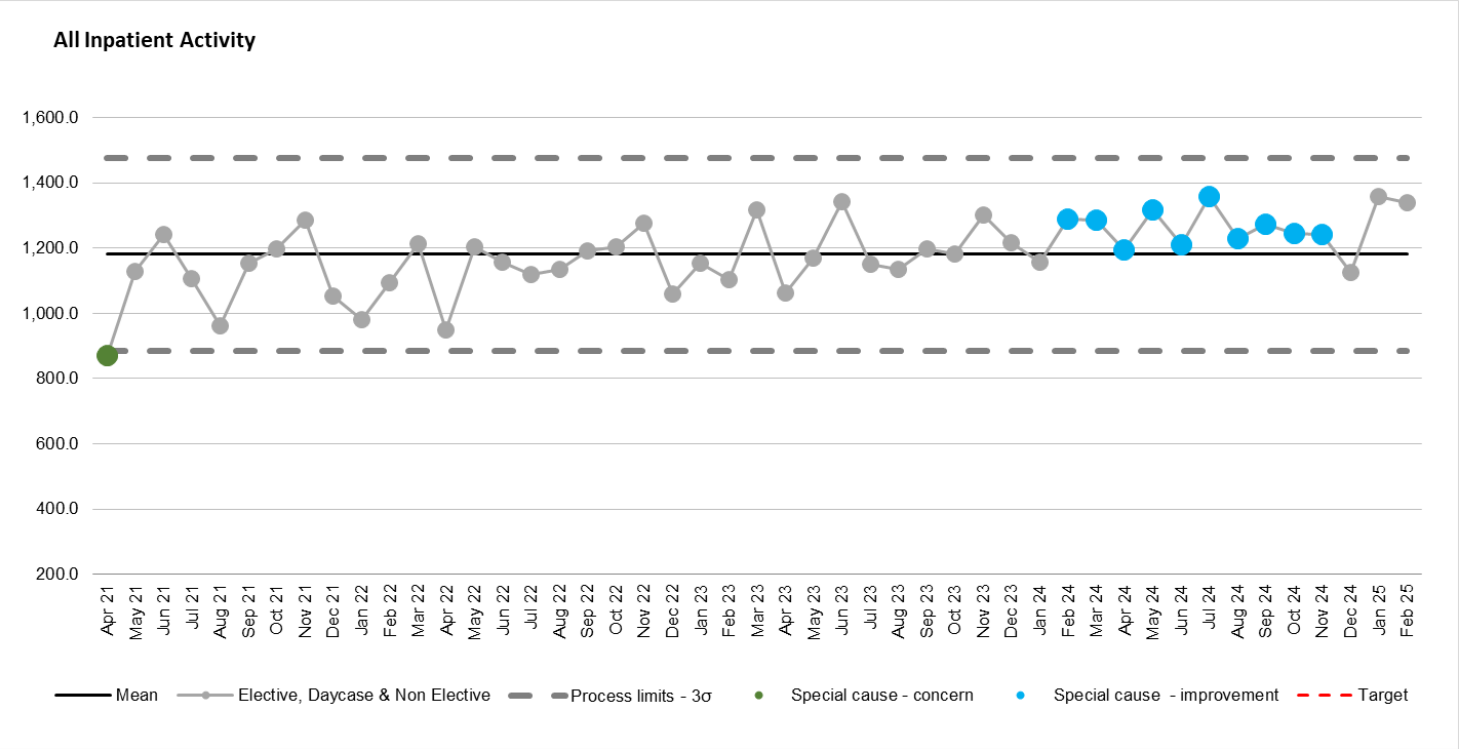
Operational Performance Summary

Performance to end February 25	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	53.58%	52.01%	92%		F
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	5	19	0	L	F
52 week waits (52 – 64 Weeks)	664	727	0	H	F
All activity YTD (compared to plan)	13,897	12,557	14,014		F
Outpatient activity YTD (compared to plan)	66,679 108.7% Cumulative	60,701 108.6% Cumulative	61,339 YTD Target		P
Outpatient Did Not Attend (YTD)	8.0%	8.2%	8%		P
PIFU (trajectory to 5% target)	674 11.8%	711 10.99%	403 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	9.3%	9.9%	19%		F
FUP attendances(compared to 19/20)	99.97%	101.1%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	113.4%	113.2%	N/A		F
Diagnostics volume YTD (compared to plan)	23,500 Cumulative	21,544 Cumulative	24,862 YTD Target		F
Diagnostics 6 week target	99.92%	99.89%	99%		P

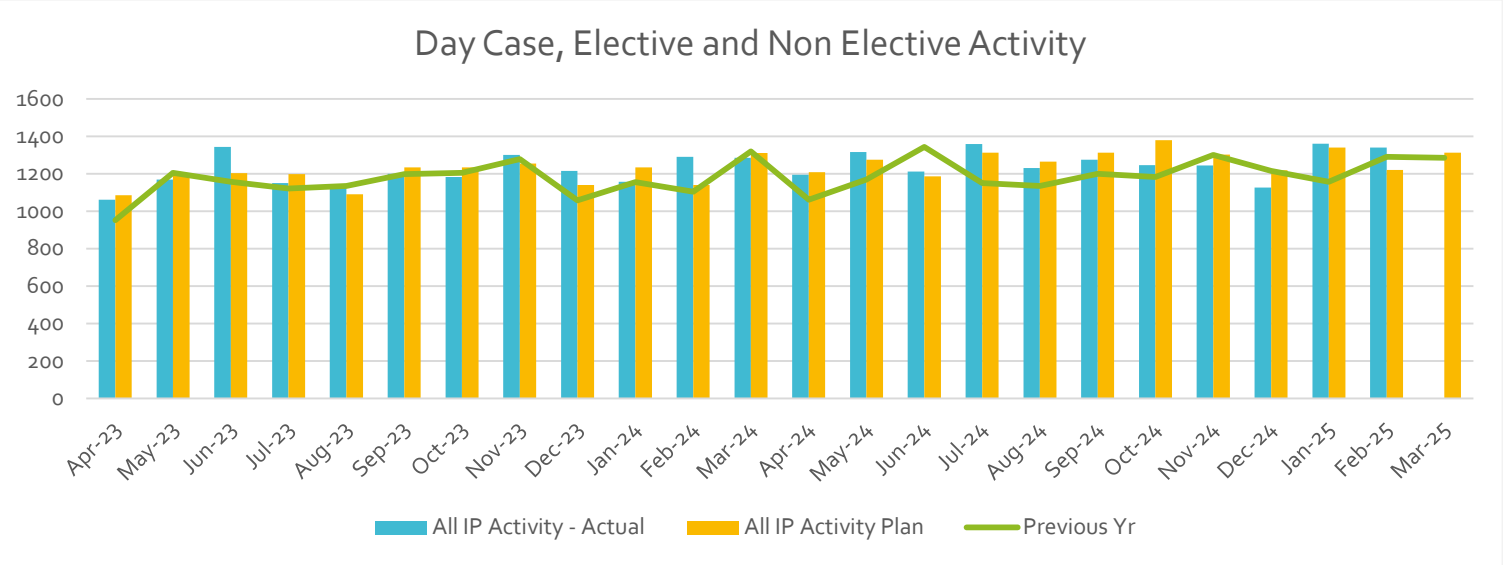
Operational Performance Summary

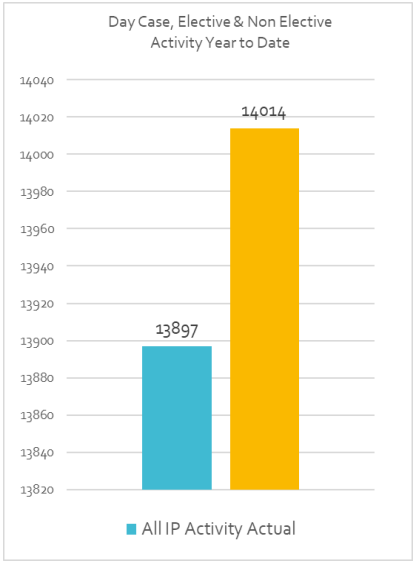
Performance to end February 25	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (Uncapped)	89.23%	93.1%	85%		P
Theatre In Session Utilisation (Uncapped)	83.64%	82.5%	85%		F
Cancer - 31 day first treatment	100%	100%	96%		P
Cancer - 62 day (traditional)	88.2%	90.9%	70% Nat 85% Trust		P
28 day FDS	77.8%	80.5%	75%		P
Patients over 104 days (62 day standard)	0	0	0		No Target
POAC activity volume (YTD)	23,312 Cumulative	21,447 Cumulative	21,184 Cumulative		P
Bed Occupancy (excluding CYP and HDU)	74.1%	70.6%	82-85%		F
LOS - excluding Oncology, Paeds,YAH, Spinal	3.03	3.1	n/a		No Target
LOS - elective primary hip	2.40	3.0	2.7		P
LOS - elective primary knee	2.60	3.0	2.7		P
BADS Orthopaedic: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period) Nov 24	53.7%	56.0%	85%		F
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Nov'24)	37.3%	37.4%	-		No Target

1. Activity Summary



1. Activity Summary





	Activity Type	Plan Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Plan Year to Date	Actual Year to Date	% Achieved against plan	Variance Year to Date
Trust Plan	Inpatient	554	584	542	602	580	602	632	598	560	614	560	602	6428	6099	95%	-329
	Daycase	642	677	631	697	673	697	733	691	647	712	648	697	7448	7577	102%	129
	NEL	12	13	13	13	11	13	14	13	11	14	11	13	138	221	160%	83
	All Activity	**1208**	**1274**	**1186**	**1312**	**1264**	**1312**	**1379**	**1302**	**1218**	**1340**	**1219**	**1312**	**14014**	**13897**	**99%**	**-117**

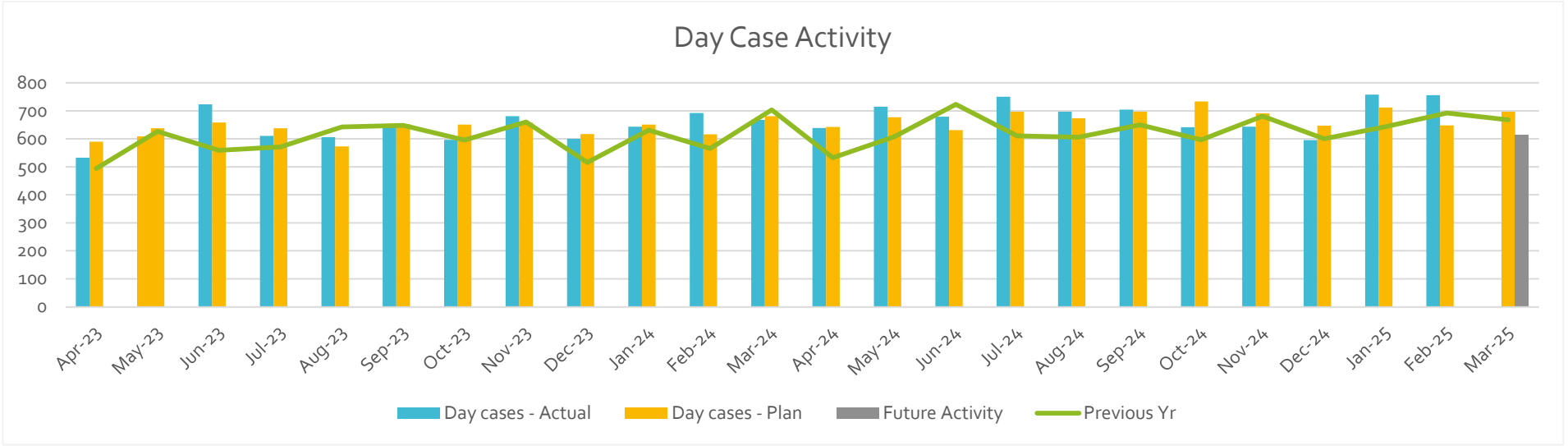
February 25

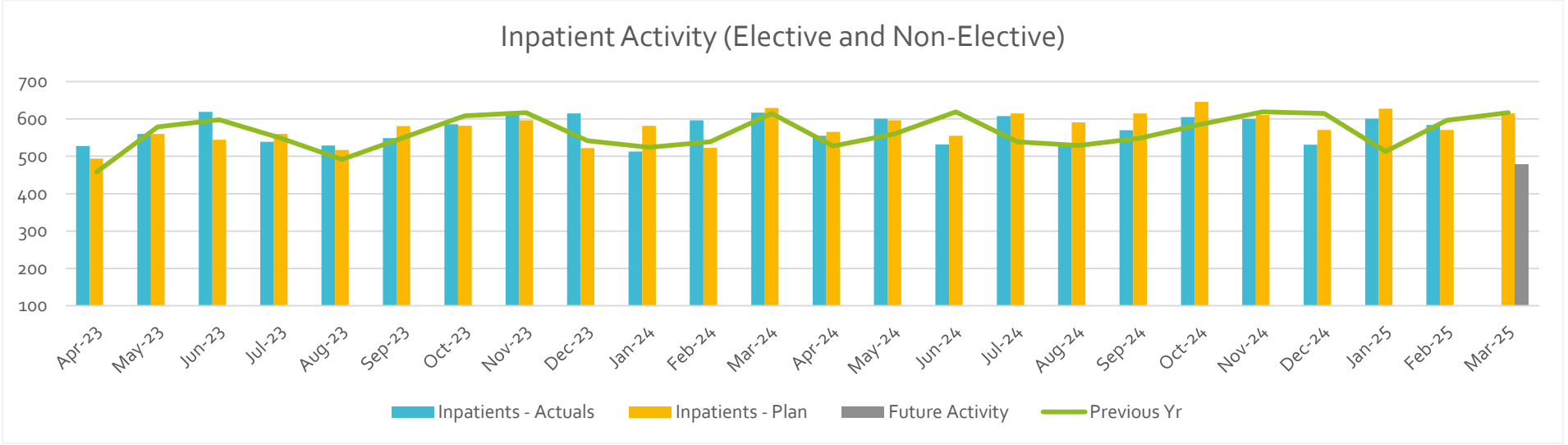
In month performance: We treated 1340 patients against a plan of 1219. 121 cases ahead of the plan for the month

YTD: As a result of over performance in February we have improved our YTD position to 117 behind the YTD plan.

The Trust plan includes the 6% amended target to deliver 15,326 cases.

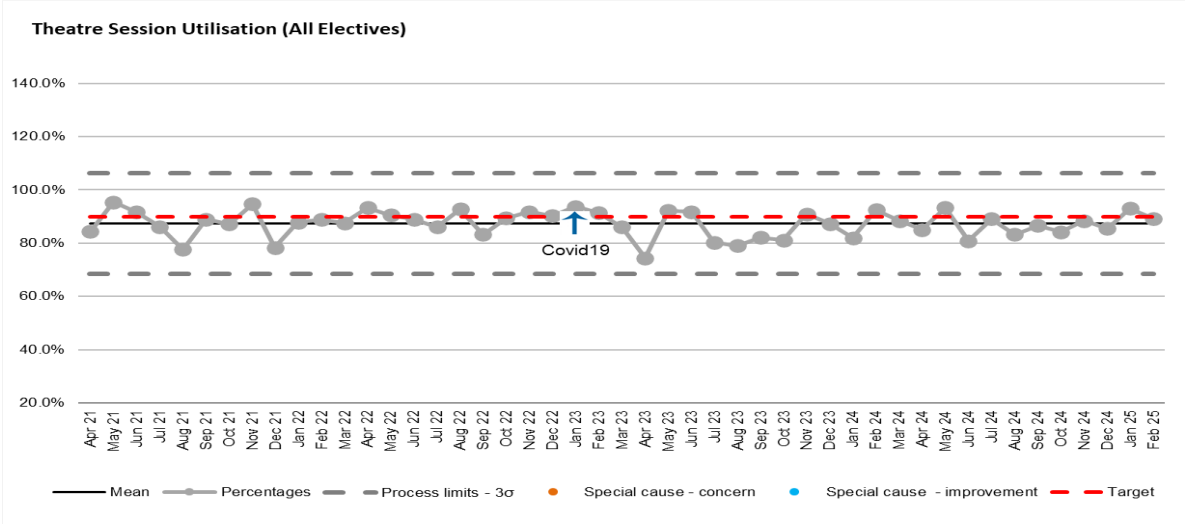
1. Activity Summary

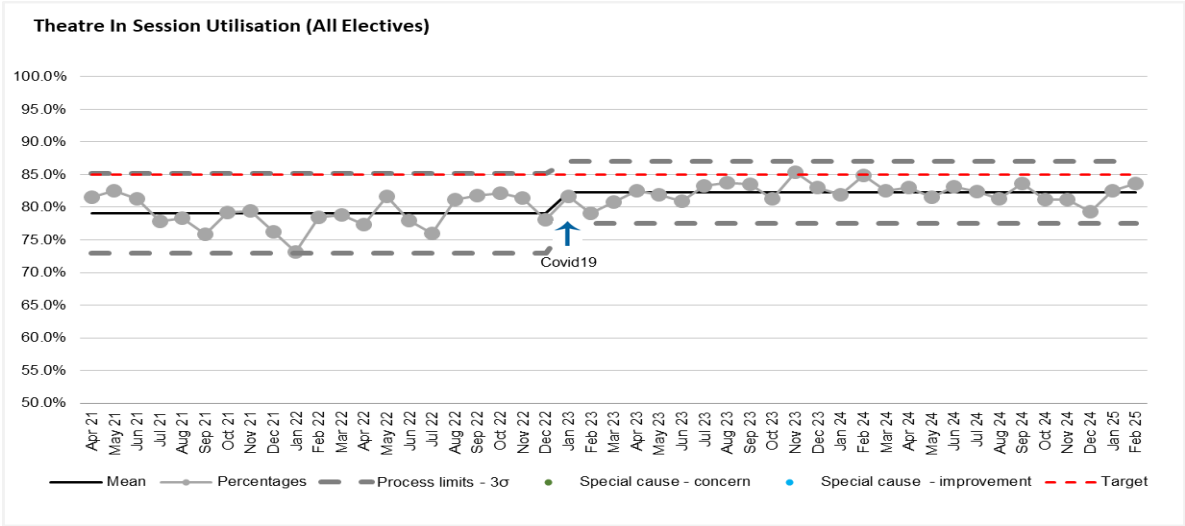




2. Theatre Utilisation

DATA QUALITY KITEMARK

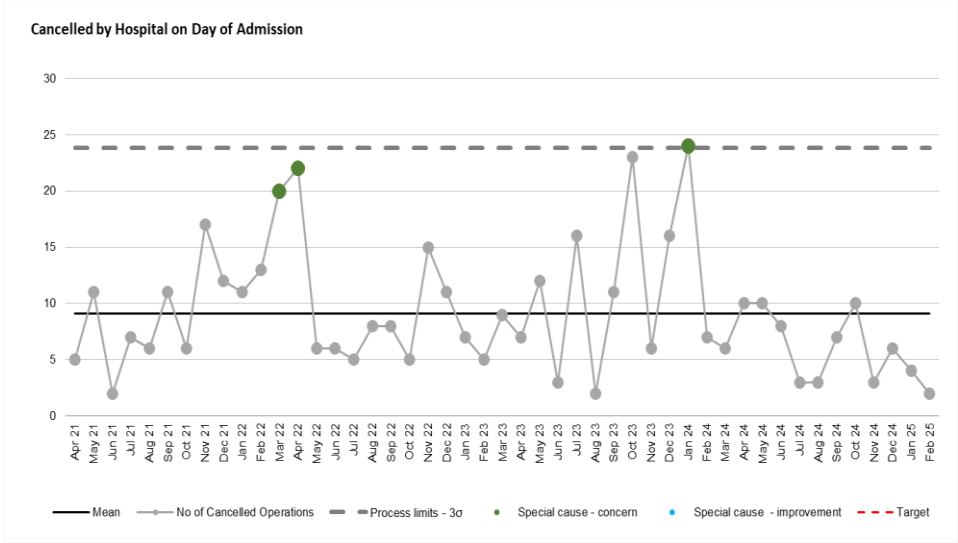


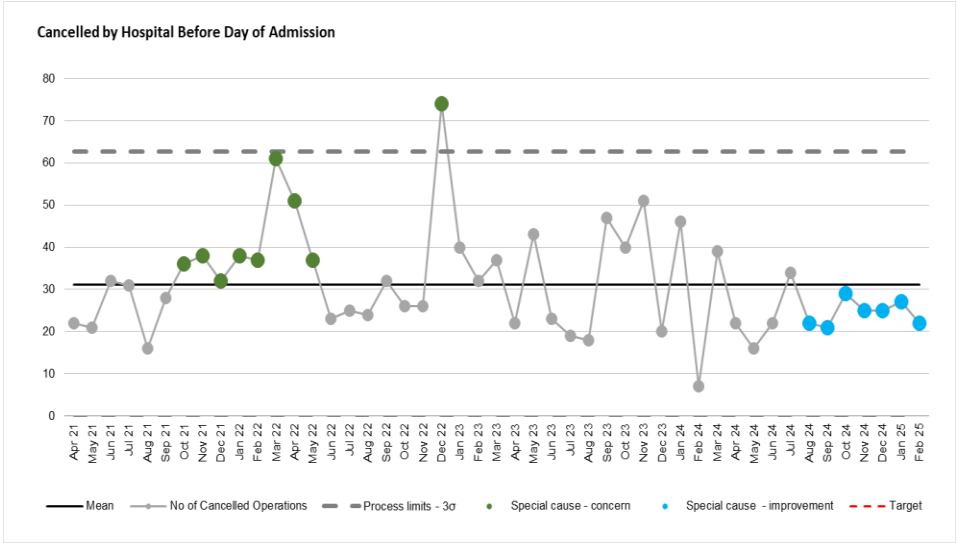


Elective Session Utilisation (February 2025)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	492	441	51	89.63%
UHB	28	23	5	82.14%
Totals	**520**	**464**	**56**	**89.23%**

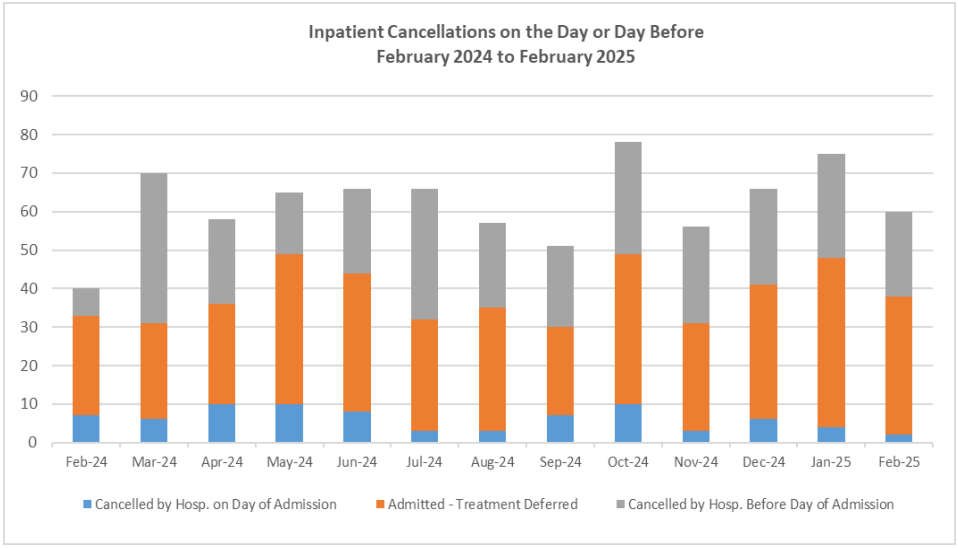
Elective In Session Utilisation (February 2025)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1921	1617	304	84.19%
UHB	103	76	27	73.48%
Totals	**2024**	**1693**	**331**	**83.64%**

2. Theatre Utilisation/ Hospital Led Cancellations

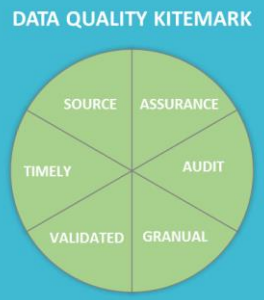




Year - Month	Cancelled by Hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by Hosp. Before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
Feb-24	7	26	7	40	0
Mar-24	6	25	39	70	0
Apr-24	10	26	22	58	0
May-24	10	39	16	65	0
Jun-24	8	36	22	66	0
Jul-24	3	29	34	66	0
Aug-24	3	32	22	57	0
Sep-24	7	23	21	51	0
Oct-24	10	39	29	78	0
Nov-24	3	28	25	56	0
Dec-24	6	35	25	66	0
Jan-25	4	44	27	75	0
Feb-25	2	36	22	60	0
Total	**79**	**418**	**311**	**808**	**0**



2. Theatre Utilisation



SUMMARY

Overall theatre session utilisation for February was 89.23%. The overall in-session utilisation for February was 83.64%.

AREAS FOR IMPROVEMENT

Theatre utilisation was 89.23%, slightly lower when compared to January which was 93%. This was mainly driven by half term week and the higher level of annual leave taken during these 2 weeks. However, activity delivered was above the monthly activity target (+117 cases) .

On time starts of theatre lists continue to improve, with average delays being 27 minutes over the month. Initiatives are being introduced to reduce this further including 'automatic sends' for all day oncology cases. The team is introducing the 'golden patient' process to reduce the number of changes in list order. All of which will be monitored via the productivity improvement group.

Tray / implant rationalisation work continues which is being supported by the Arthroplasty CSL in reducing the number of 'systems' currently available.

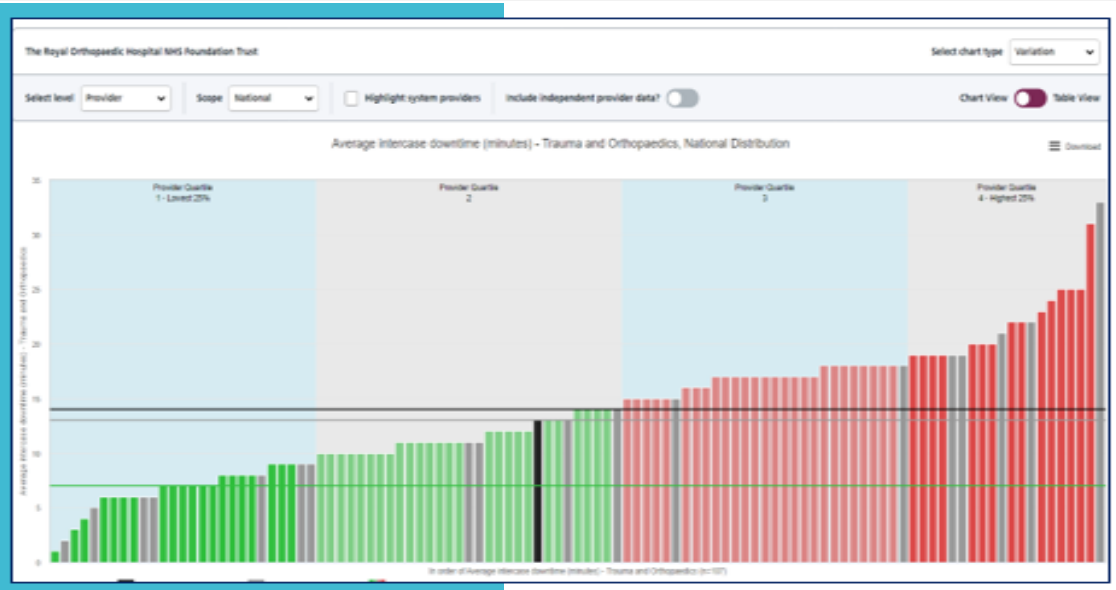
The introduction of the block area has seen a positive impact on the turnaround time between hand cases, which was 7 minutes in February 25 compared to 12 minutes in December 24.

Early finish times remain a challenge and clinically led cancellations on the day are a key factor in driving this KPI . Work is underway led by the Divisional 2 Medical Director to reduce this level of cancellations and the standby patient is embedded to try and reduce the impact of 72-hour cancellations . Theatre where early finishes are as a result of underfilled lists are being tracked and individual discussions with surgical teams are exploring opportunities for improvements

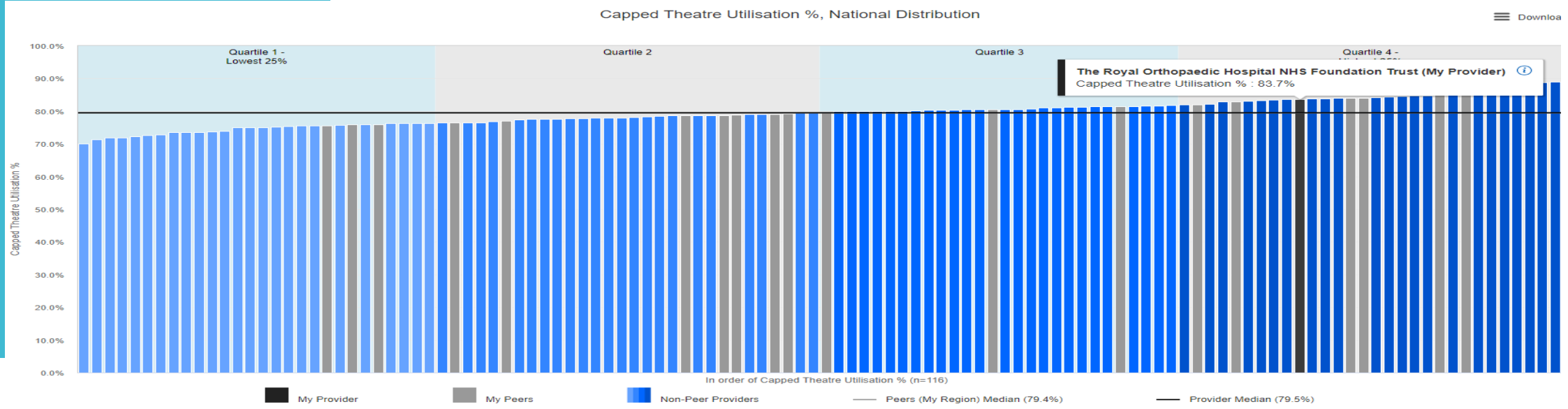
The 'Day Case Week' took place w/c 24th February with multiple teams involved throughout the entire pathway Detailed outcome report to follow. (April 2025)

RISKS / ISSUES

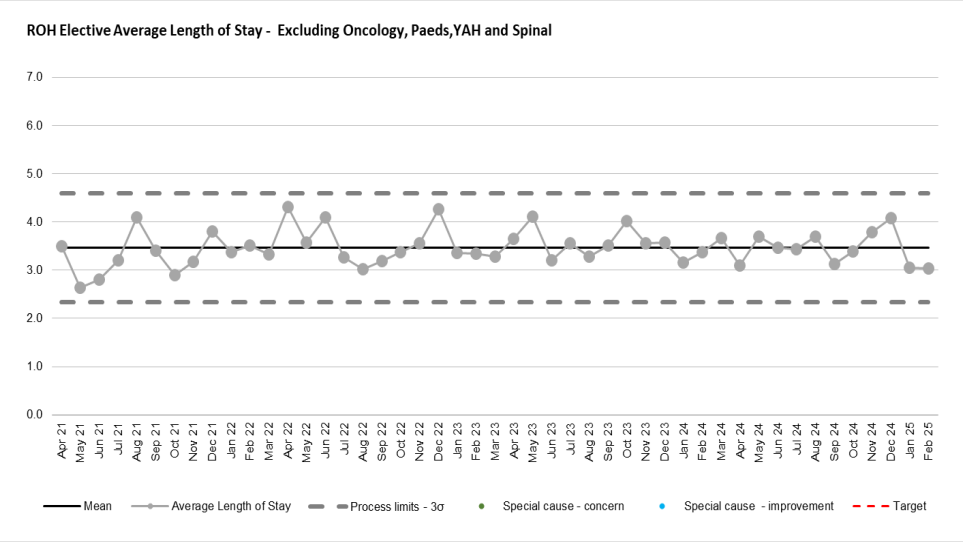
The intensified focus on filling theatre lists by creating a greater pool of ' fit to list' patients has resulted in an increased requirement for pre-operative assessments, placing extra challenge for the POAC team. This is being reviewed as a part of the POAC improvement group, to enhance the pre-operative process further and streamline the pathway pre-operatively.

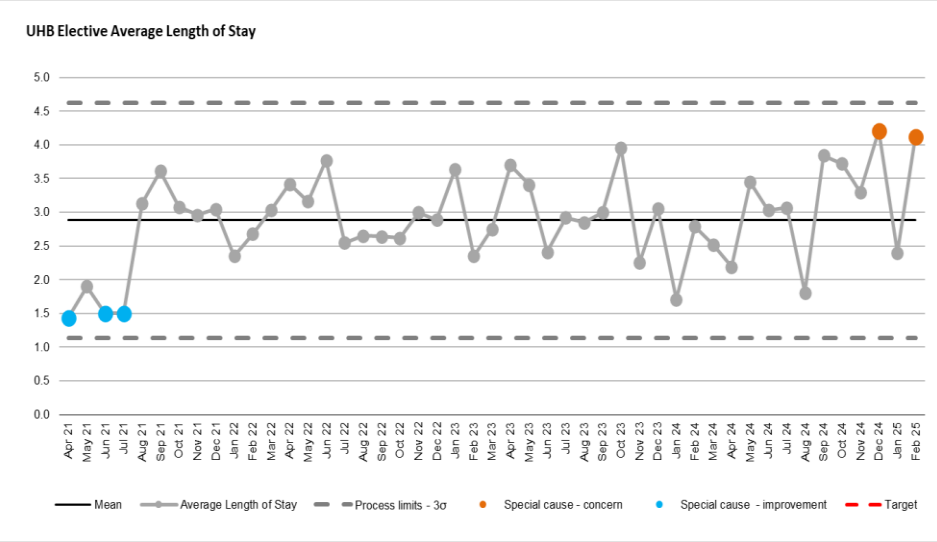

The Royal Orthopaedic Hospital NHS Foundation Trust
Select chart type
Variation
Select level
Provider
Scope
National
Highlight system providers
Include independent provider data?
Chart View
Table View
Average intercase downtime (minutes) - Trauma and Orthopaedics, National Distribution
Download
Provider Quartile 1 - Lowest 25%
Provider Quartile 2
Provider Quartile 3
Provider Quartile 4 - Highest 25%

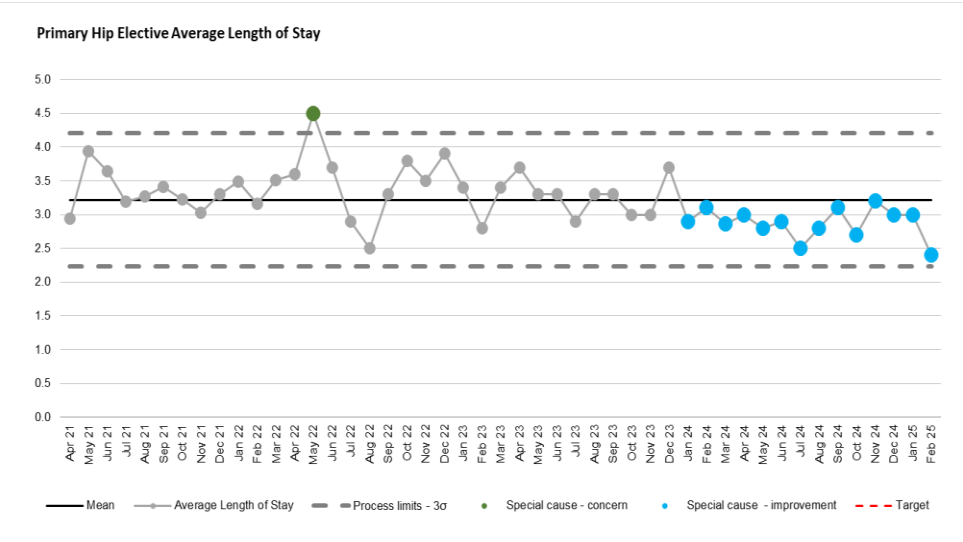

Average early finish (of all valid elective sessions) (minutes), National Distribution
Download
Provider Quartile 1 - Lowest 25%
Provider Quartile 2
Provider Quartile 3
Provider Quartile 4 - Highest 25%
Average early finish (of all valid elective sessions) (minutes)
In order of Average early finish (of all valid elective sessions) (minutes) (n=116)
My Provider
My Peers
Non-Peer Providers
Peers (My Region) Median (43)
Provider Top/Best Decile (29)
Provider Median (40)

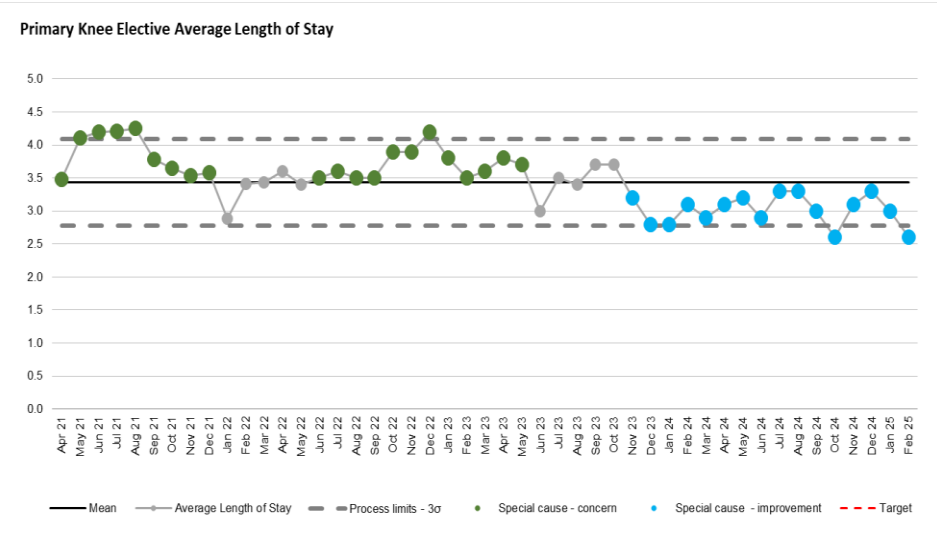

Capped Theatre Utilisation %, National Distribution
Downloa
Quartile 1 - Lowest 25%
Quartile 2
Quartile 3
Quartile 4 -
The Royal Orthopaedic Hospital NHS Foundation Trust (My Provider)
Capped Theatre Utilisation % : 83.7%
Capped Theatre Utilisation %
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
In order of Capped Theatre Utilisation % (n=116)
My Provider
My Peers
Non-Peer Providers
Peers (My Region) Median (79.4%)
Provider Median (79.5%)

3. Length of Stay









3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips has decreased at 2.4 days (3.0 days January 25) and primary Knees has decreased at 2.6 days (3.0 days January 25).
The average length of stay for ROH patients excluding Oncology, Young Adult Hip and Spinal has decreased to **3.03 days** (3.05 days January 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 9 (31 Jan) 2 Oncology Arthroplasty, 7 arthroplasty; All had an ASA score of 2 (mild systemic disease).

LOS >/=8 days as 5 (6 January), 1 Oncology arthroplasty (0 January) and 4 arthroplasty (6 January) . All had an ASA score of 2 (mild systemic disease). On review of clinical noting for patients with LOS >/=8 days all had clinical, physio/OT or social care needs preventing earlier discharge.

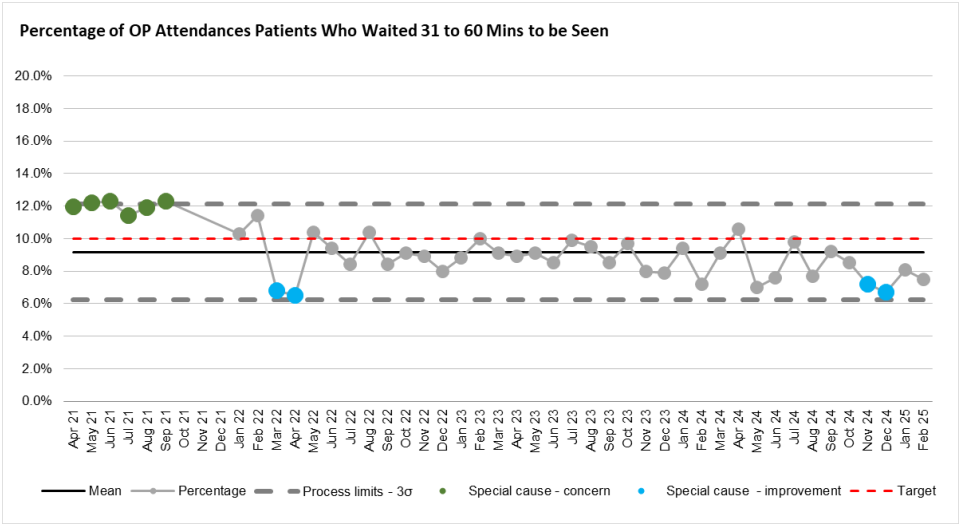
A review of all arthroplasty and oncology arthroplasty patients, identifies the number of patients with LOS >/= to 8 days as 27 (20 Jan).
15 were Oncology Arthroplasty, and 12 were Arthroplasty. These included revisions, EPRs and other more complex surgeries.
Review of the 9 long stay patients with LOS >15 days, 3 were Arthroplasty and 6 Oncology arthroplasty.
Longest stay 42 days (25 Jan), was an 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.

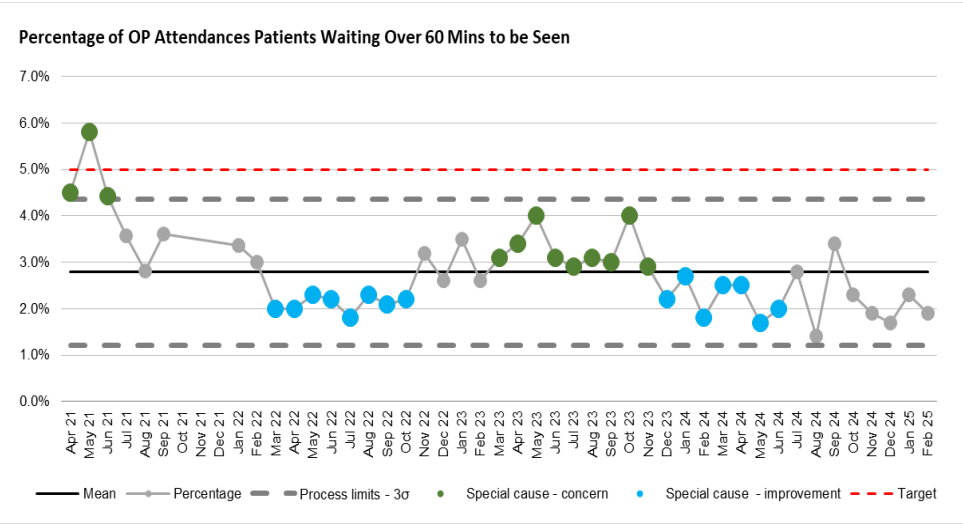
AREAS FOR IMPROVEMENT / ACTION PLAN

- Bone infection, revision and MRC patients contribute considerably to the longer length of stays. MRC terms of reference being finalised, which should aid management plan decisions post-surgery.
- Number of patients converting from day case to overnight stay for non-clinical reasons. Findings of Division 2 review awaited.
- Alignment of support services to 7 day working, if arthroplasty lists to continue on Saturdays. Avoid need to use on-call support services to enable timely discharges..
- Demand and capacity delivered as part of annual business planning to identify any workforce challenges.
- Renewed focus on BADS data reporting to productivity improvement group following changes to dataset.
- ‘Day case’ pathway refresh week – confirmed importance of ensuring patients are prepared pre-operatively in accordance with other day case criteria and that it works well provided this is done.
- Need to revisit joint care as a project and make day case jointcare business as usual for clinically appropriate patients .
- Consider producing primary LOS data by consultant to enable analysis of themes/trends.

4. Outpatient efficiency

DATA QUALITY KITEMARK





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 January 2025: January saw a high number of patient led cancellations relating to clinical conditions and a slight rise in lack of cancellations due to lack of theatre time relating to booking of lists to 100% .

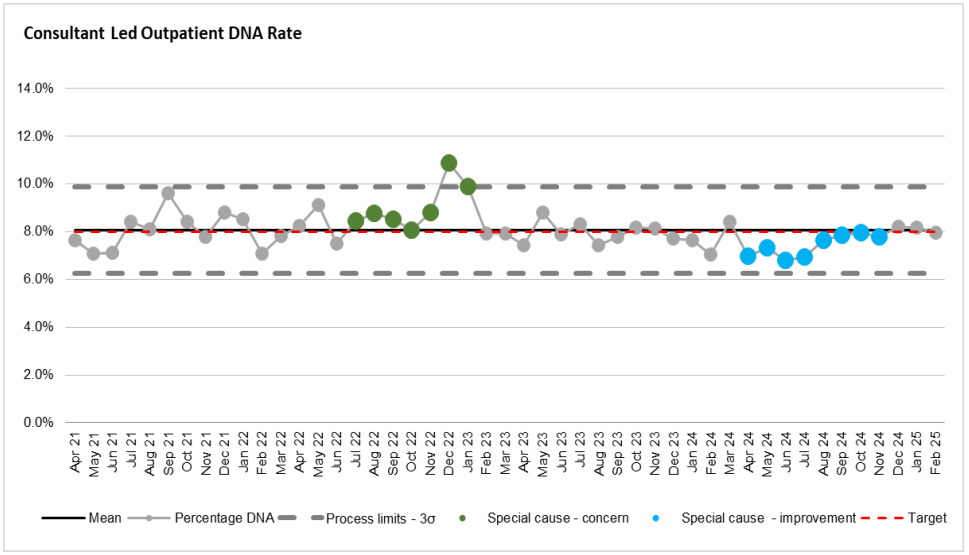
Patients cancelled on the day x 2	Patients admitted and had treatment deferred x 36	Patients cancelled by the hospital the day before the date of admission x 22
Clinical 0 Non-Clinical 1 x Equipment failure 1 x Lack of theatre time – due to complex cases	Clinical 12 x Medically unfit 3 x Skin integrity - insect bites/dog bites/ulcer etc. 6 x Patient self-cancelled / unwell / Change in plan / pt declined procedure 6 x Procedure abandoned/no longer required Non-Clinical 1 x Lack of equipment 5 x Lack of theatre time – due to complex cases 2 x Patients did not follow fasting rules 1 x Lack of HDU capacity	Clinical 7 x Medically unfit/further tests required 4 x Patient self-cancelled / unwell / Change in plan / pt declined procedure Non-Clinical 6 x TCI date not convenient for patient/change in TCI date before procedure date. 4 x Surgeon unavailable 1 x Equipment unavailable

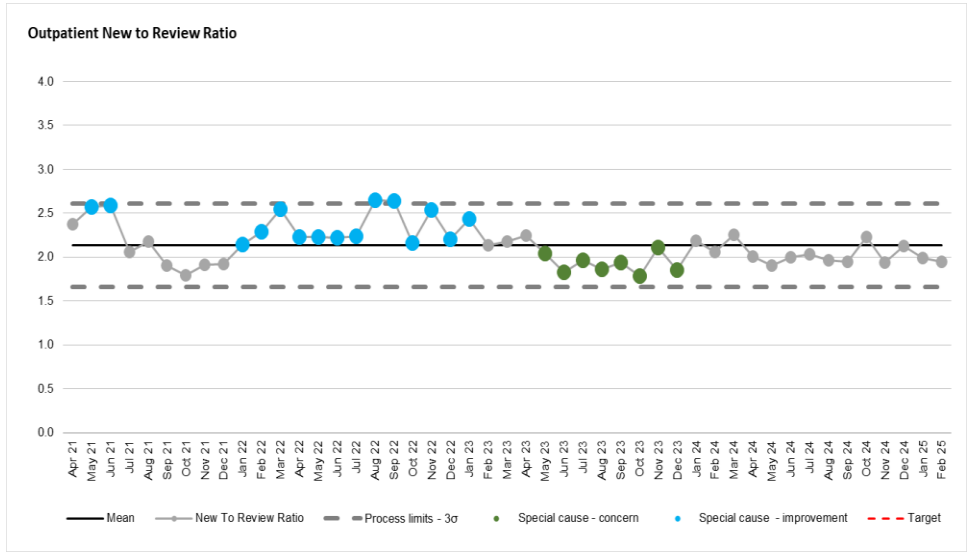
AREAS FOR IMPROVEMENT/ RISKS/ISSUES

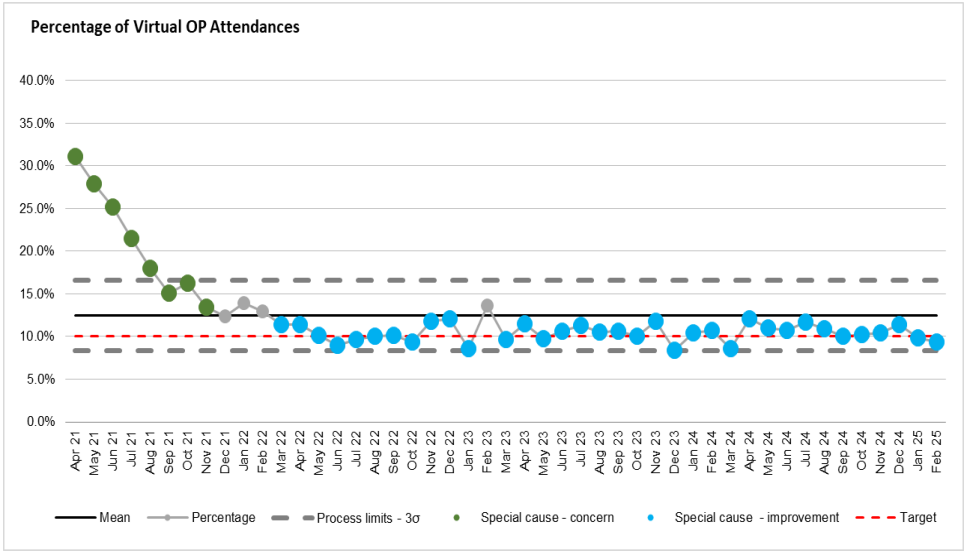
Daily monitoring of cancellations for non-clinical reasons that must be approved by Deputy COO, COO or Exec on call.

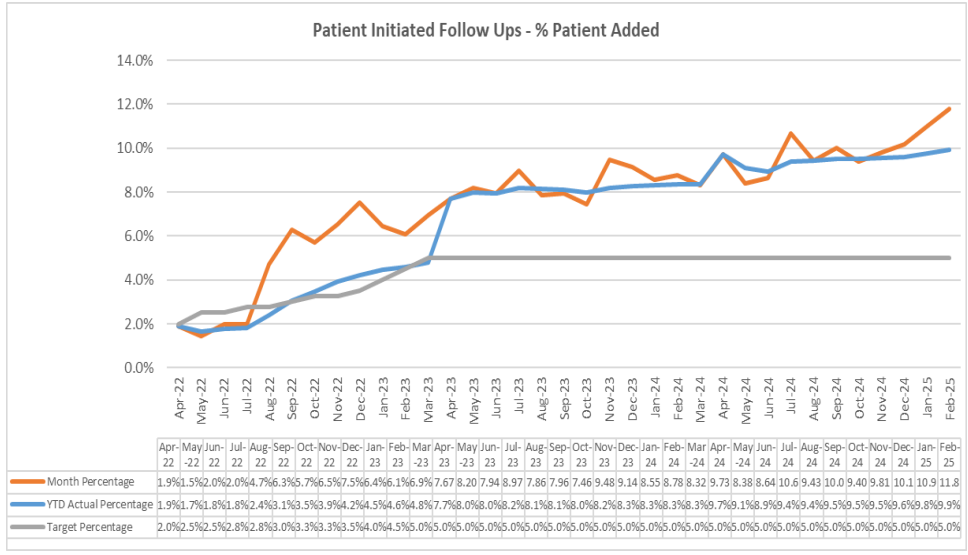
4. Outpatient efficiency

DATA QUALITY KITEMARK



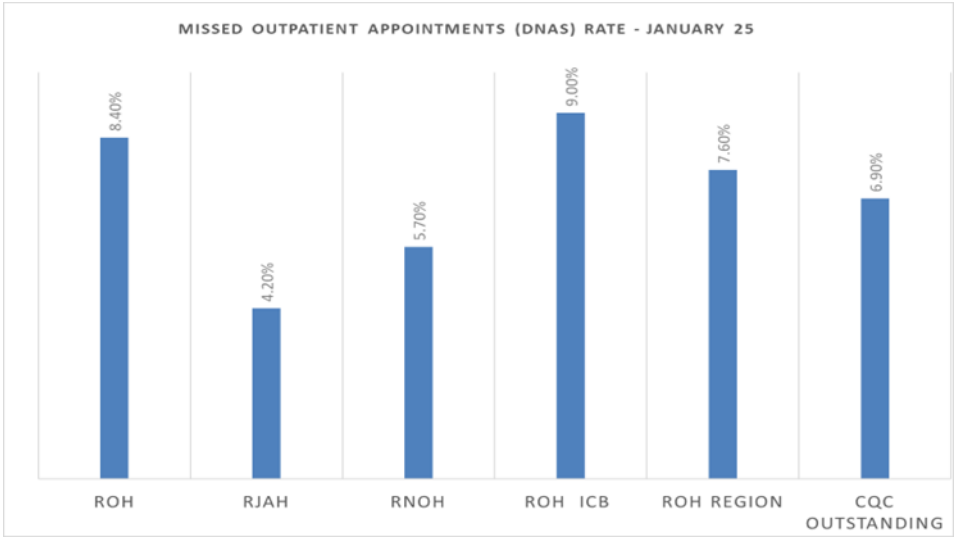


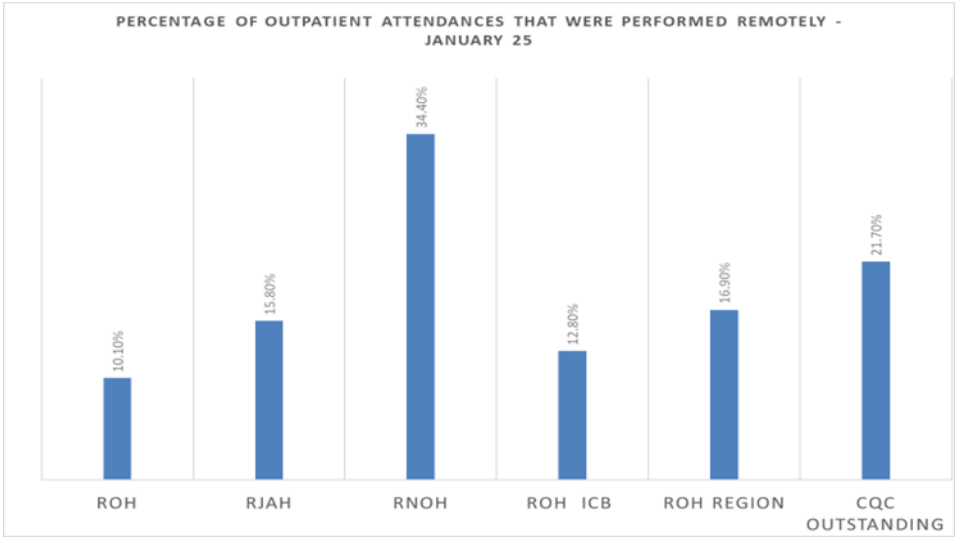


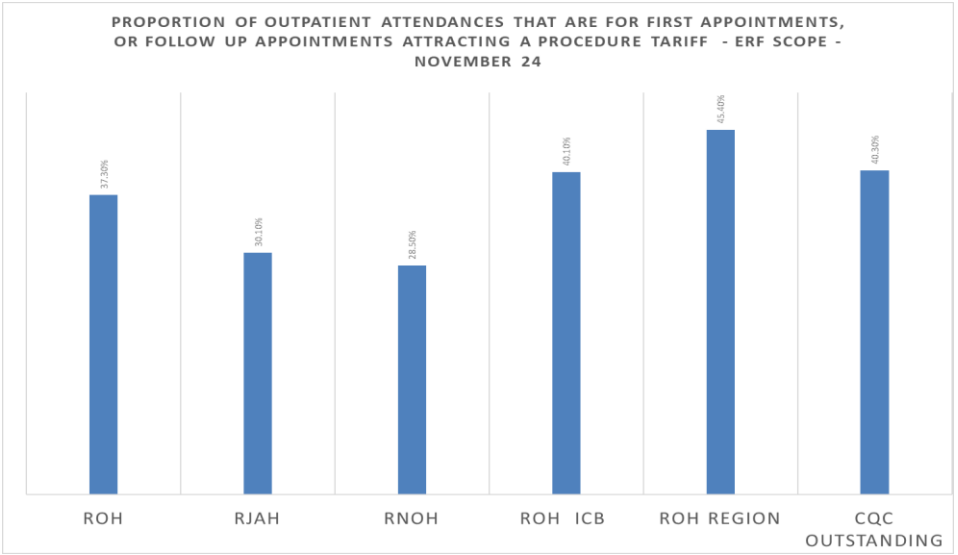


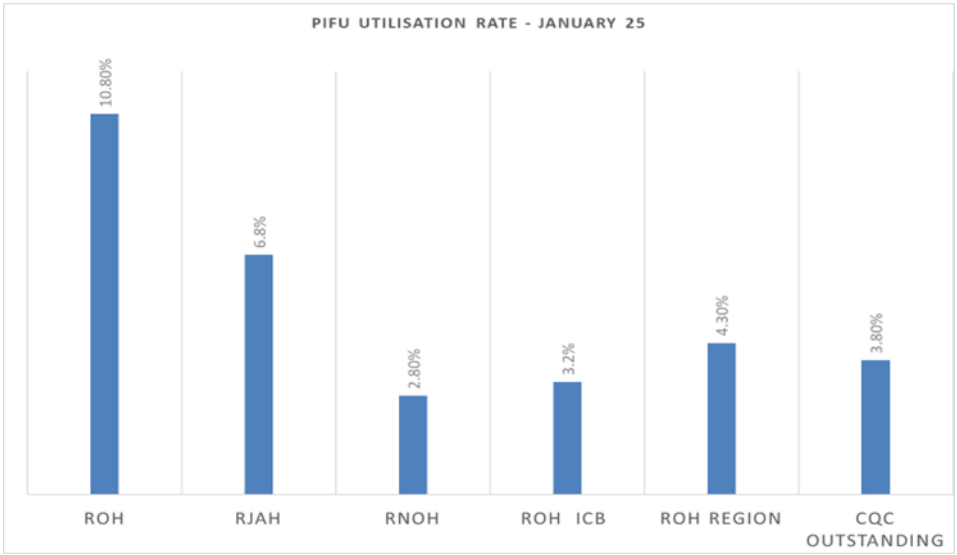
4. Outpatient efficiency

DATA QUALITY KITEMARK









4. Outpatient efficiency

DATA QUALITY KITEMARK

SUMMARY

February 2025 performance is as follows:

- 5,420 face to face and 558 virtual appointments
- 9.33% virtual in total.
- 11.8% of outpatient attendances moved to the PIFU waiting list. The overall YTD position is 9.9%.
- 7.97% Achieved Appointment (DNA) rate – lower than the Trust target of 8% an improvement on January 24 position of 8.15%

- **Clinic Waiting Times**
- 30-minute delays – meeting Trust Target at **7.5**% **(Target 10%)**
- 60-minute delays – meeting trust target at **1.9**% **(Target 5%)**

AREAS OF IMPROVEMENT

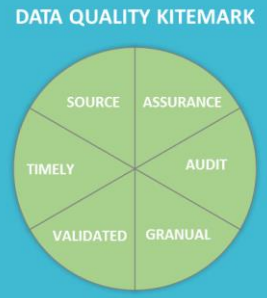
Outpatient Utilisation

Outpatient activity is **11% over plan** for new appointments **and 6% over plan for follow** ups year to date. Activity is monitored closely, and work is underway to align clinic templates across the Trust. The InTouch business case has been agreed, and the order will be placed before the end of the financial year. Once launched the new InTouch system will allow utilisation to be available.

The appointments Key Performance Indicator report that is produced twice a week continues to demonstrate the good performance of the appointments team. The KPI relating to the clinical triage of referrals met the KPI for the first time in week commencing 3 March 2025. Room allocation continues to be managed through excel spreadsheets which allow all managers to view room availability and request extra clinics.

Missed Appointments (MA)
The Trust continues to work with the ICB on reduction of missed appointments. Work is continuing to introduce text reminders to patients booked via the TIARA system. That was planned to roll out by the end of February 25 but unfortunately this deadline has had to be moved back to The end of April. Work is ongoing with RJAH to chare best practice in op metrics and the use of the digital platform to enhance productivity is key to delivery of 25/26 operational imperatives therefore work is ongoing with the IT team to prioritise urgent high priority projects to enable delivery.
Appointments
KPI data is monitored weekly by the Div 1 ADOPs at the weekly Ops meeting. Exceptions are escalated to the Deputy COO. The Outpatient Performance and Activity Group and Check and Challenge meetings are being reviewed to ensure a robust agenda to drive forward efficiencies in outpatients. A business case is being written to ensure the staffing levels are sufficient in the appointments team. Currently there are challenges with having to use bank staff who are temporary and move on quickly. Recently 2 permanent vacancies have been authorised, and these are being recruited to.
The new Associate Director of Operations – Operational Lead for System Integration and Outpatient transformation starts on 17 March 25.

4. Outpatient Transformation



SPECIALTY PRIORITY UPDATES / HIGHLIGHTS

PIFU

The ROH continues to be a national exemplar for PIFU (6th nationally and top of peer group).

Coding is being scoped for the Dr Doctor PIFU module to automate validation of the waiting list and create a record for patient requests to be seen.

Missed Appointments

Messaging to be rolled out to MSK with a predicted go live of the end of Apil 25

NHS Way finder has gone live for stage 2. A renewed focus on patient access to the NHS app will be in place in line with the Elective reform planning guidance operational imperatives.

E-meet and greet module in Dr Doctor being explored.

Arthroplasty continues to show best practice with a 4.9% Missed Appointment rate. Learning being utilised for other sub-specialties .
Work underway with RJAH to share best practice for OP pathways as there are areas of best practice in both providers where sharing seeks to improve performance at both providers.

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.

Productivity gains included in OP trajectory as per planning assurance pack presented at board review March 25.

Clinical Pathways (e.g. Specialist Advice)

Referral criteria needs to be confirmed for Primary Care. Internal primary care interface group now in place supported by COO /CMO attending system steering group with good collaboration and two-way communication channels now in place across a number of clinical and non-clinical development programmes

The Clinical support decision making tool has been agreed by the system investment committee developed tested and concept proven via the ROH MSK steering group.

Activity has been confirmed for A&G via national reporting team.

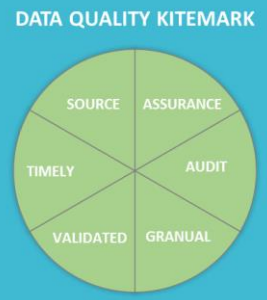
Productivity & Efficiency

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

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

Evaluation report to be table at April FPC for productivity improvement groups including action plan and delivery framework for 25/26 .

5. Referral to Treatment -



SUMMARY

The Referral To Treatment (RTT) position for February 25 was 53.58% against the National Constitutional Target of 92%. This represents a 1.57% increase compared to the January reported position of 52.01% that includes patients transferred from other providers. The LUNA report for data quality validation is consistently above 98%.

5 patients breached 65 weeks in February due to an unanticipated loss of capacity in mid-December due to a reduction in Consultant capacity in the spinal team. 669 patients were waiting over 52 weeks in February, a decrease from the trust wide position for January that was 746 patients. The majority of the patients sit within the Spinal Service, and referrals are currently being triaged, and additional support is in place from MSK team as per outcomes of the spinal 'deep dive' and patient tracking monitoring of the 65 weeks position.

During February 25, ROH received 2,454 referrals (90.75%) 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

The trust validation team are completing an enhanced validation on all Patients pathways that are due to breach 52 weeks up until March 2025.

The 65 weeks position for Q4 remains our priority with additional capacity in place from March 2025 with a new consultant appointment in spinal deformity to support the ongoing delivery.

Large and Small joints and Oncology are all now working to Zero 52 weeks in March.

RISKS / ISSUES

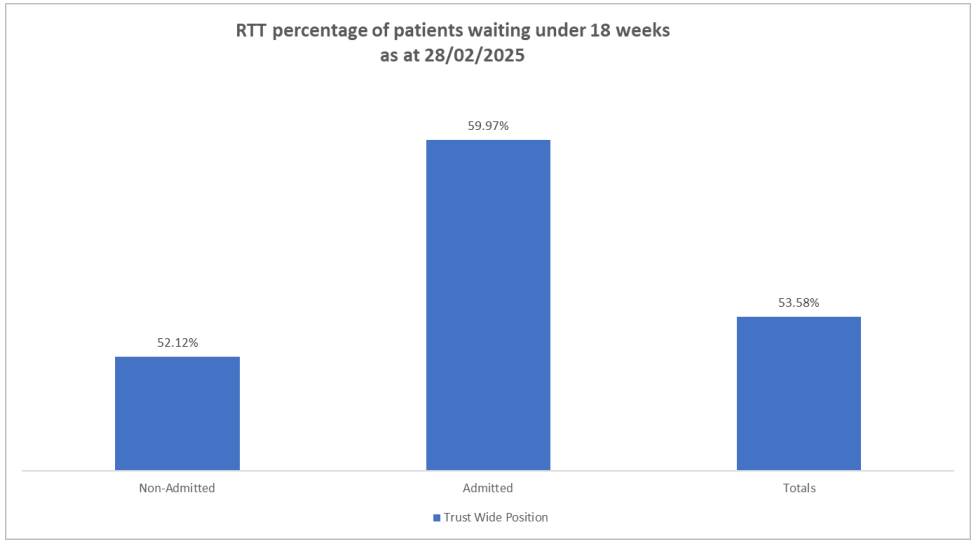
Spinal backlogs continue to be a concern with the team focussing on managing all patients currently over 60 weeks and preventing breaches of the 65 weeks standard. Spinal have lost capacity due to x2 consultants being unavailable at short notice. Replacement consultant in place from March 2025 and locum currently being sourced.

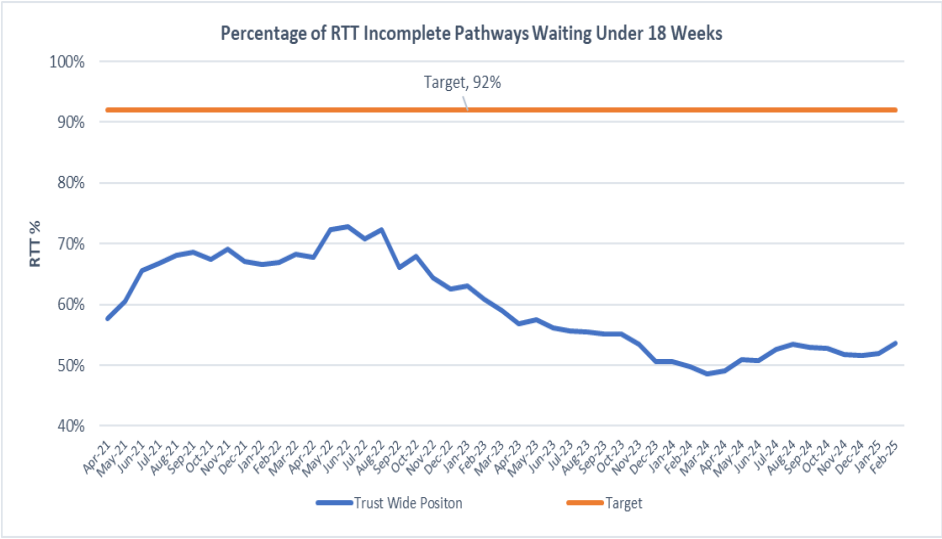
5. Referral to Treatment

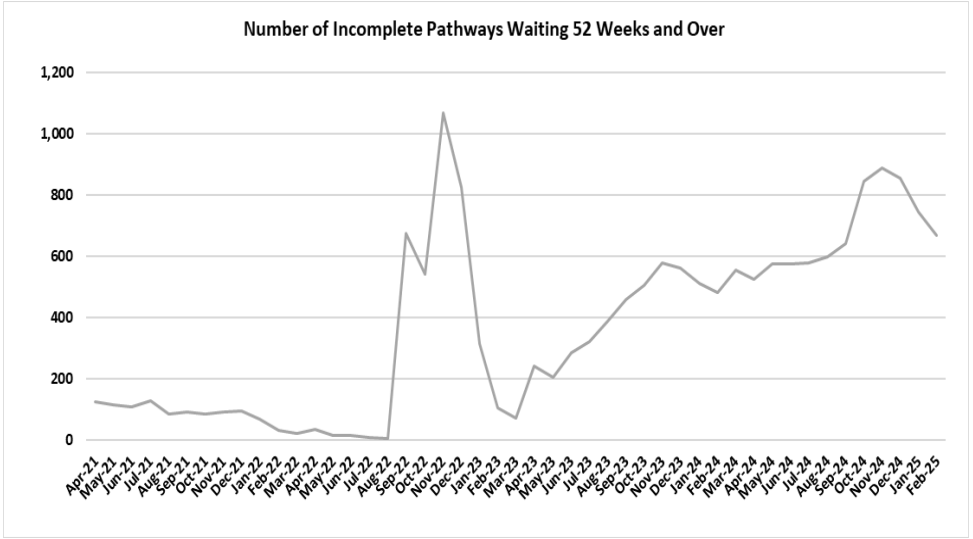
DATA QUALITY KITEMARK

	Trust Wide Position		
Weeks Waiting	Non-Admitted	Admitted	Totals
0-6	2,803	725	3,528
7-13	1,736	512	2,248
14-17	1,092	246	1,338
18-26	1,781	483	2,264
27-39	1,802	318	2,120
40-47	688	110	798
48-51	283	29	312
52 weeks and over	619	50	669
Total	10,804	2,473	13,277

Weeks Waiting	Non Admitted	Admitted	Totals
Under 18	5,631	1,483	7,114
18 and over	5,173	990	6,163
Month End RTT %	**52.12%**	**59.97%**	**53.58%**



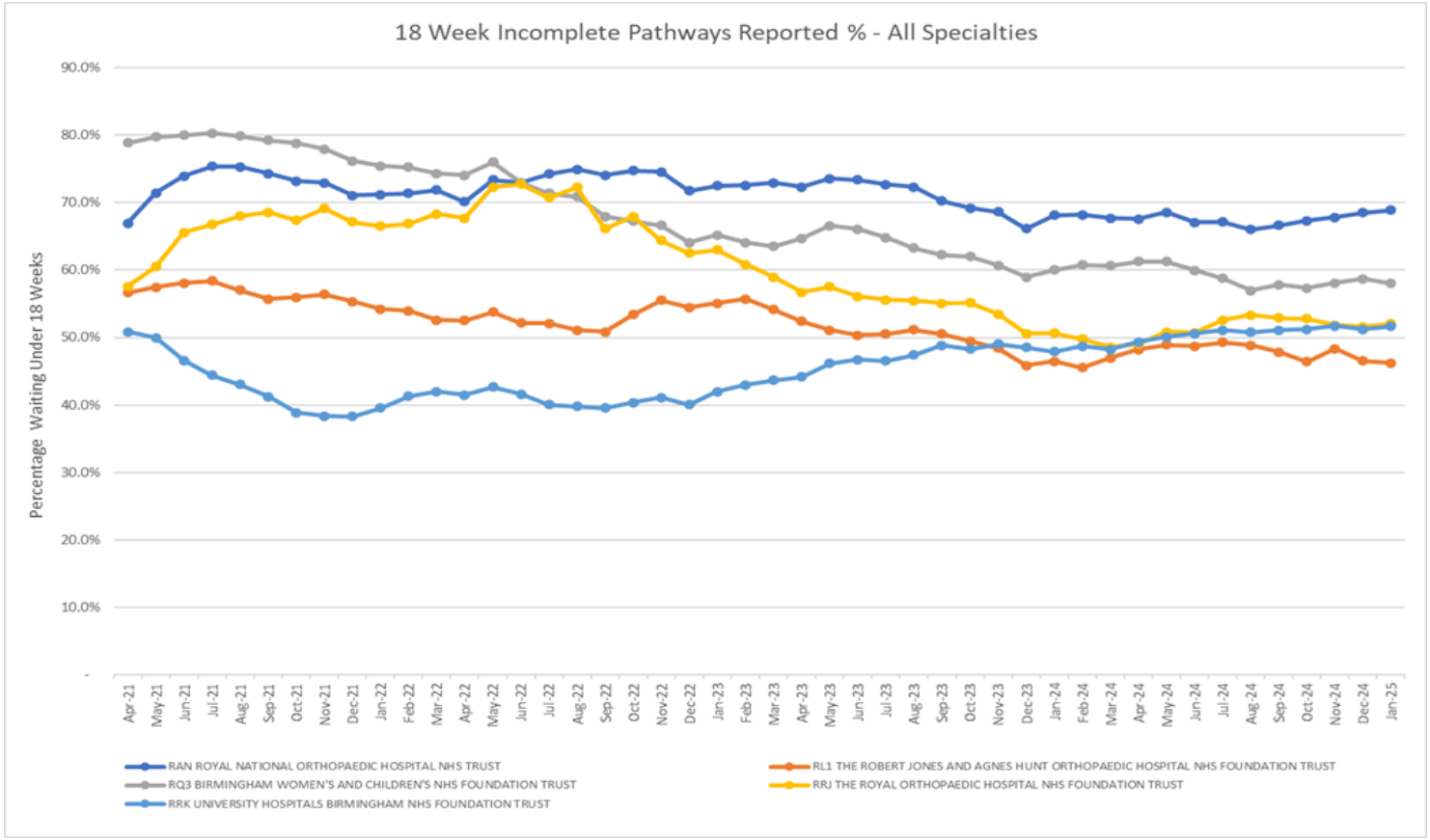




5. Referral to Treatment

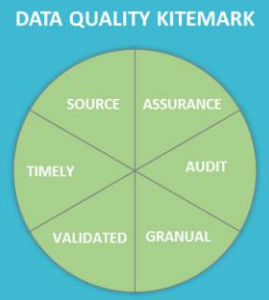
DATA QUALITY KITEMARK

18 weeks Incomplete pathways Benchmarking against other providers:

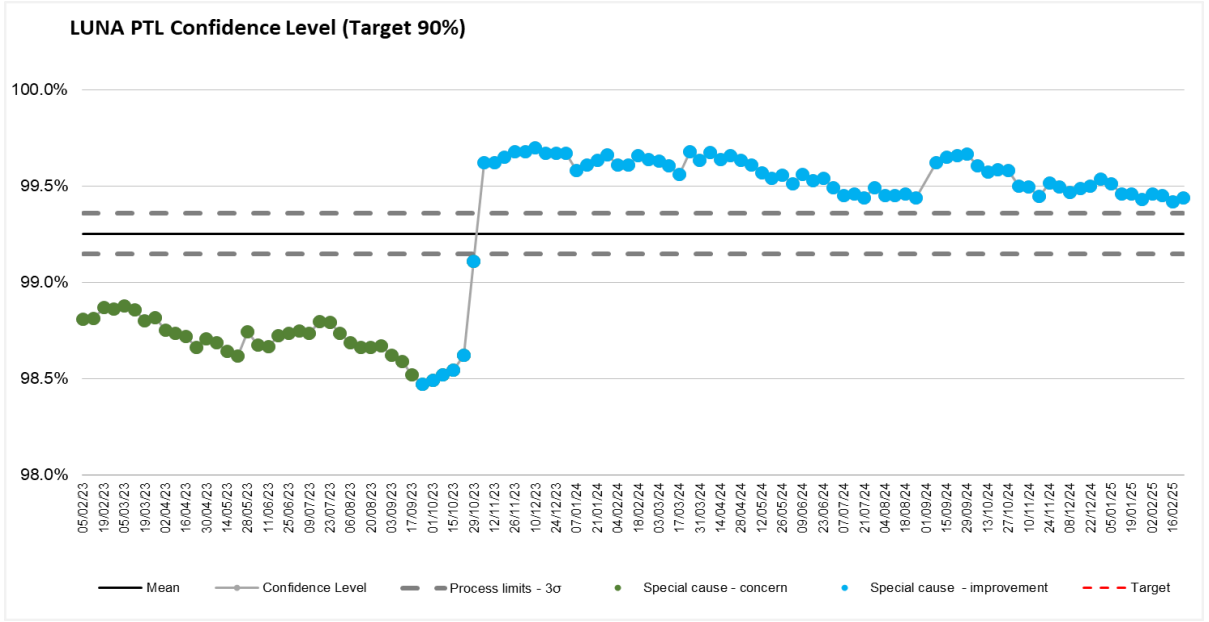


5. Referral to Treatment

Luna Data



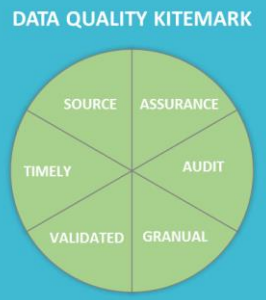
The chart below shows LUNA National Data Quality report data for the Trust, and our average confidence levels for our RTT data has consistently remained above 98% against a target of 90%. Over the last 24 months, the average confidence levels in our weekly data submissions have remained above 98%, with 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.

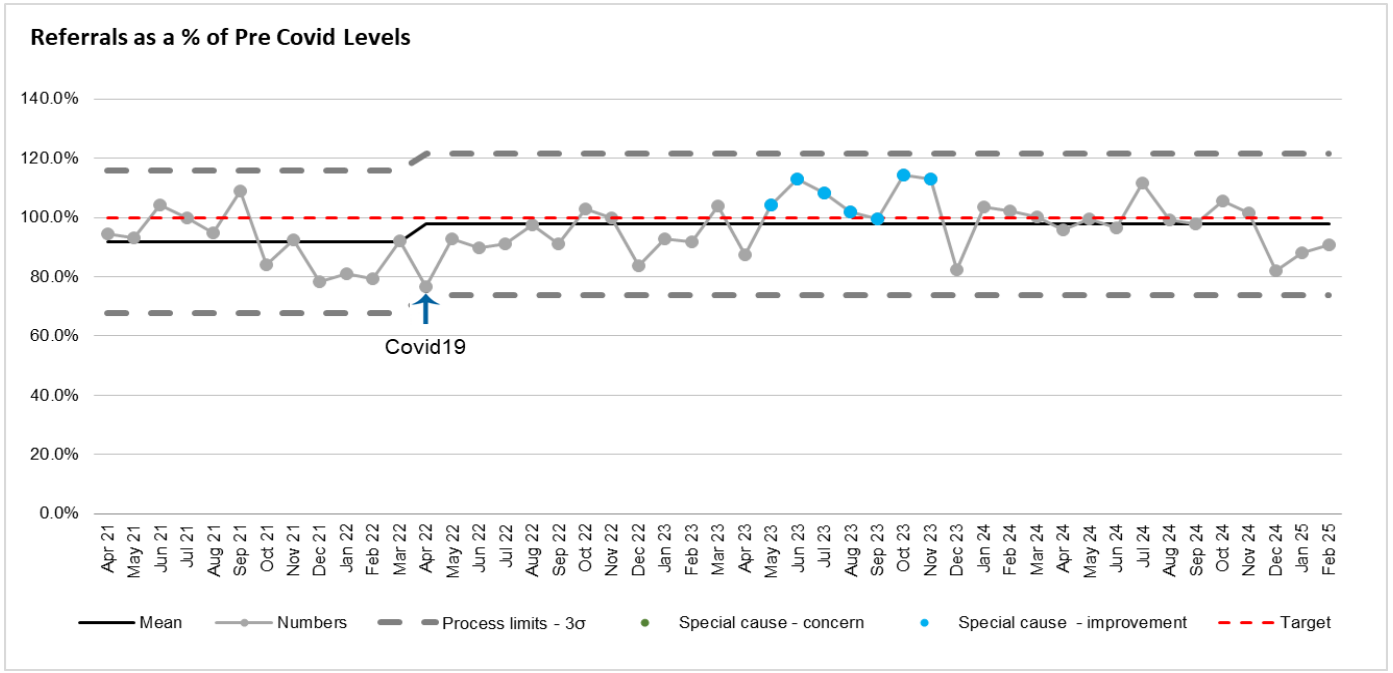


It is important to note the significant improvement from the data quality team utilising the LUNA data to continue to drive improvements. The latest chart suggests that the Trust has minimal errors identified by LUNA with a confidence rate in excess of 99.5%.

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





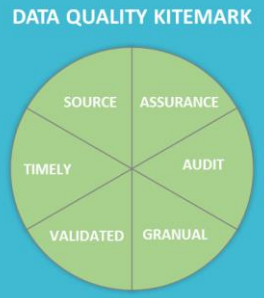
Pre Covid Level	2704

Month	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Number of Referrals	2557	2521	2815	2704	2567	2941	2273	2495	2113	2236	2249	2516	2082	2522	2479	2573	2681	2515	2820	2728	2282	2532	2513	2835
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%	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	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Number of Referrals	2363	2818	3059	2926	2752	2693	3093	3056	2224	2802	2760	2707	2587	2694	2613	3021	2678	2645	2854	2743	2216	2377	2454	
Referrals as a % of Pre Covid Levels	87.39%	104.22%	113.13%	108.21%	101.78%	99.59%	114.39%	113.02%	82.25%	103.62%	102.07%	100.11%	95.67%	99.63%	96.63%	111.72%	99.04%	97.82%	105.55%	101.44%	81.95%	87.91%	90.75%	

5. Referral to Treatment

Specialty Breakdown



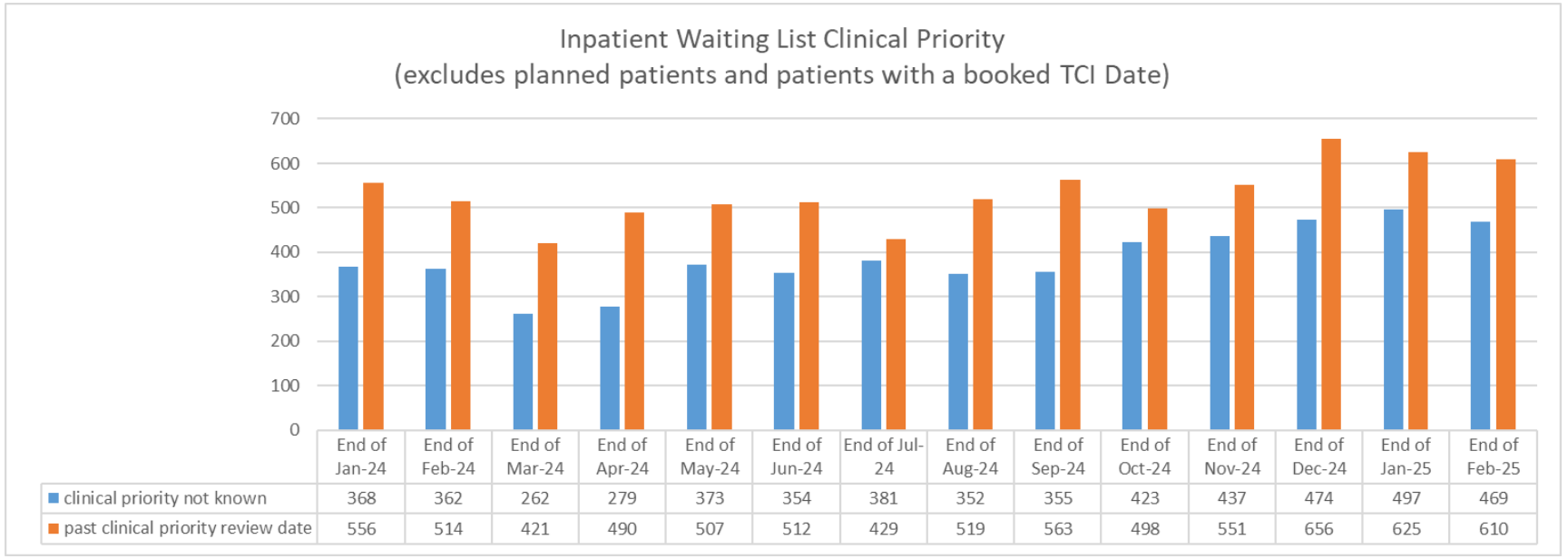
The national RTT target is for 92% of patients to be treated within 18 weeks. The table below highlights the current performance against this target by specialty. It also includes the number of patients currently waiting over 52 weeks prior to any tip ins. This will be used to support focussed intervention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

Specialty	Number of patients over 52 weeks with an incomplete RTT pathway	RTT % as of 12.02.25
Arthroplasty	4	67.0%
Arthroscopy	31	61.3%
Clinical Support	1	61.0%
Foot and Ankle	5	52.5%
Hands	22	42.8%
Oncology	0	89.3%
Oncology Arthroplasty	0	74.88%
Spinal	403	26.2%
Spinal Deformity	318	30.09%
Young Adult Hips	2	63.0%

5. Referral to Treatment

DATA QUALITY KITEMARK

Overdue Clinical Priority:



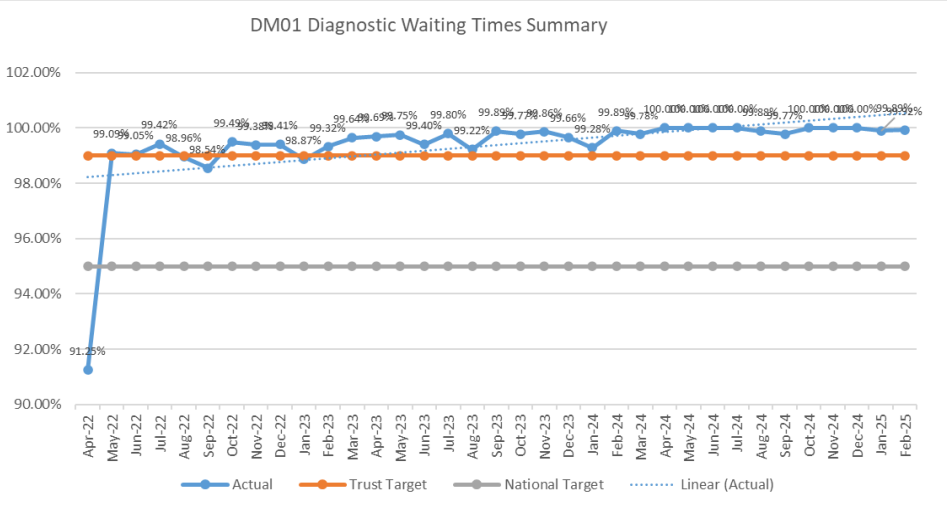
	End of Jan-24	End of Feb-24	End of Mar-24	End of Apr-24	End of May-24	End of Jun-24	End of Jul-24	End of Aug-24	End of Sep-24	End of Oct-24	End of Nov-24	End of Dec-24	End of Jan-25	End of Feb-25
clinical priority not known	368	362	262	279	373	354	381	352	355	423	437	474	497	469
past clinical priority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

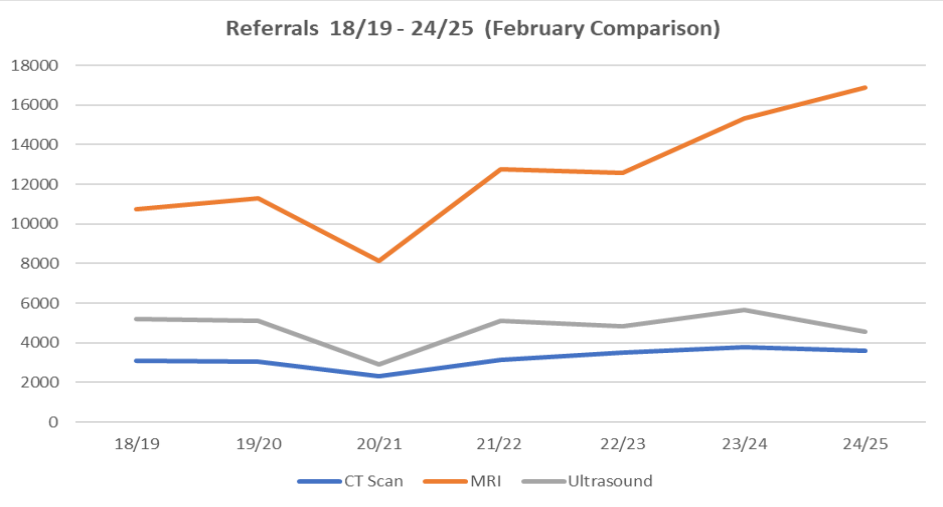
The number of patients with an unknown clinical priority has increased by 68 patients, however, the numbers that have past the clinical priority review date has reduced by 65 patients. The information continues to be shared monthly with individual services and clinicians to manage individual clinical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

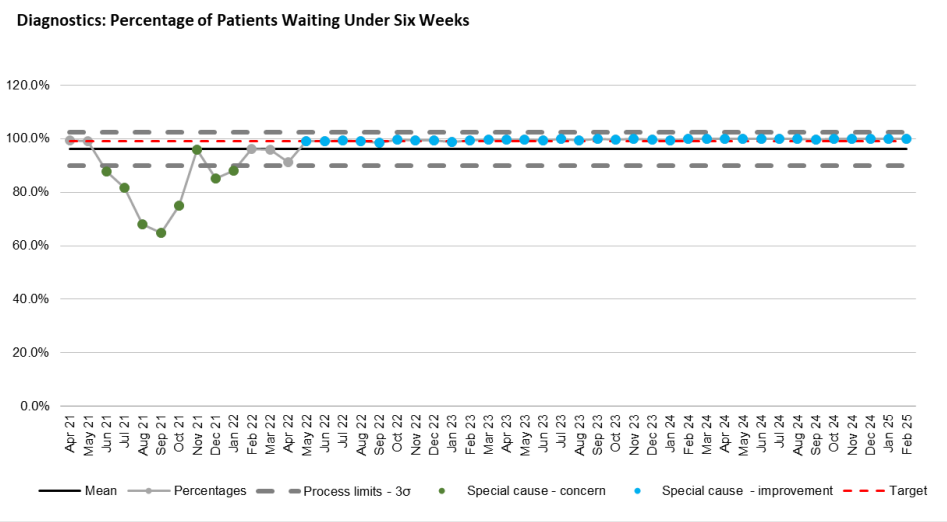
The team are liaising with the business intelligence team to test the validity of the data in response to clinical review of the current position.

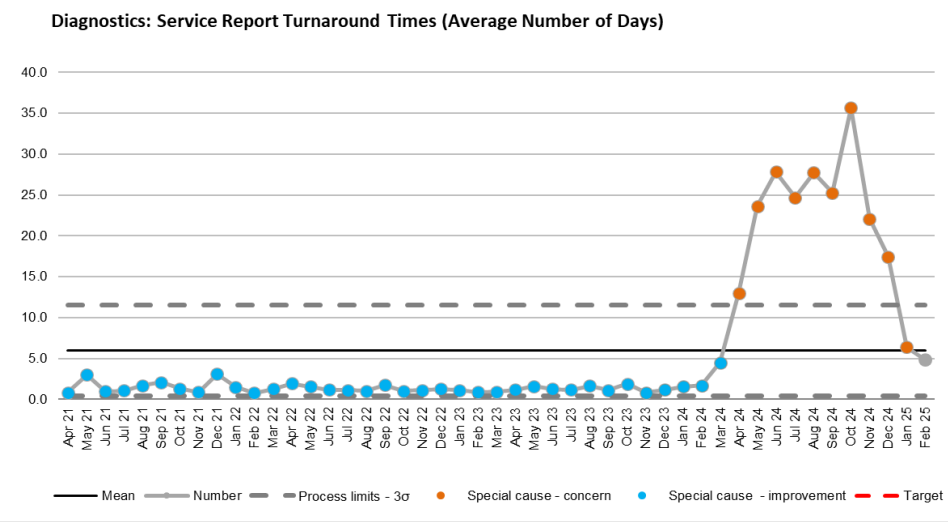
6. Diagnostic Performance

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









7. Diagnostic Performance

SUMMARY

The Imaging Department achieved the 99% DM01 target in February 2025 closing the month at 99.9%.

The National 24/25 operational target remains at 95% which ROH continues to achieve consistently despite reduced capacity in ultrasound.

Newly appointed Clinical Service Support Manager and Junior Operations Manager started 06/01/2025

AREAS FOR IMPROVEMENT

The team continue to outsource Radiology Reporting – Currently reporting MRI's from February 2025. Turnaround time for outsourcing is 72 hours. All Oncology and non-medical referrer x-rays continue to be prioritised by the in-house Radiological team.

Demand and Capacity modelling has been reviewed, additional posts requested within budget setting for 2025/2026.

Business planning for 2025/2026 is complete. Capital plans include discussions to replace the CT scanner and 2 x X-ray rooms in the next financial year.

Discussions to begin regarding an interim provision of Interventional CT service during CT scanner refurbishment.

2 x replacement mobile x-ray machines delivered + installed. Staff training booked for 14/03/2025.

1 x WTE Sonographer started 17/02/25, 2nd x WTE will start 01/04/2025, increasing capacity and improving resilience for the ultrasound service

RISKS

There is a current risk with Consultant Radiologist workforce vacancies. New Consultant appointed due to commence in March 2025. however, 1 x Consultant Radiologist leaving the Trust 16/02/2024.

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

8. Cancer Performance

Summary Performance Figures – January 25 (February 2025 Submission)

		January 25 (complete)			
Target Name	National Standard	%	In target	Breach	Total
31 DTTD to Treatment	96%	100%	16.0	0.0	16.0
62 day RTT to treatment	70%	88.2%	7.5	1.0	8.5
28 day FDS REPORTED	77%	77.8%	56	16	72
Patients over 104 days (62 day standard)					

Performance

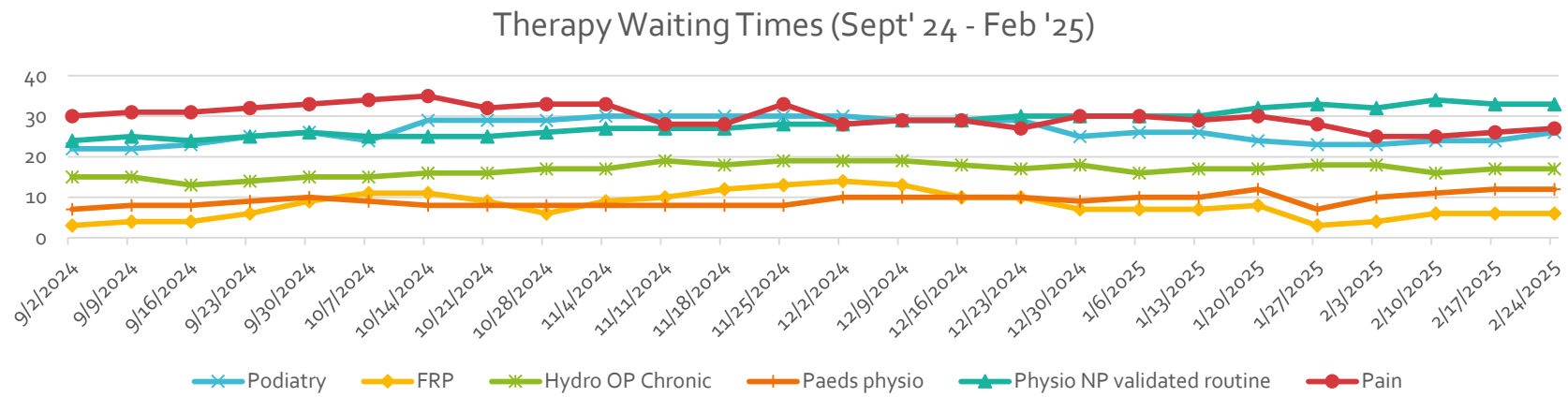
The trust was compliant against all three cancer waiting time targets for January 24.

The 62-day metric was achieved at 88.2%. A total of 9 treatments were applicable to the trust, 7.5 of those were compliant and the remaining two patients breached.
X1 0.5 shared Breach, this was due to ROH being the middle trust. The patient was referred into ROH on day 22 and required full diagnostic work, ROH diagnosed 33 days later and referred to treating trust for chemotherapy on day 55. Breach was shared with ROH as we held the patient longer than the original referring trust.
X1 0.5 Shared breach IPT received Day 18, shared breach as ROH was middle trust and patient required full diagnostic work up, ROH held 32 days due to pathology requiring additional molecular work.

Risks /actions ongoing

The team continues to monitor performance at the cancer PTL meetings, actively participating and engaging with the weekly System Oversight Group for cancer recovery and receives positive feedback against overall performance standards. Ongoing concerns regarding histological reporting resulting in delays in patient pathways. Pathology delays have been raised at the System Oversight Group, as an area of concern. Histology delays continue to be escalated to UHB COO for an expedited resolution and to explore possibility of outsourcing work.
Workforce challenges in Radiology are impacting on interventional capacity this is being mitigated through communication and early escalation between oncology and radiology, additional sessions and mutual aid continue to be explored. We continued to see an increase of late tertiary referrals during January 25 received after day 38. Patients that require full diagnostic work up are challenging to schedule treatment within the 24-day target and we expect these breaches to impact in February performance. Any risk to pathways are escalated to Dov 1 Director of Ops and communication is ongoing with centres who refer patients late in their pathway to encourage earlier referral wherever possible.

9. MSK Waits



Summary – data as per 28/02/25

The chart above shows changes in waiting times over recent months. The physio waits are increasing due to reduced workforce, active recruitment is ongoing. ROH are receiving funding to reduce physiotherapy waiting times via the Physio 'go further faster programme' which commenced in January 2025. A number of initiatives are underway to reduce patients waiting over 18 weeks in line with national initiatives to support return to work for people with MSK related conditions.

• Risks /actions ongoing

- Recruitment continues to be a challenge for physiotherapists and occupational therapists.
- Administrative workforce challenges remain in managing a PTL of over 3,500 pts.

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10. Private Patients

SUMMARY

- The service has a £5m turnover planned for 24/25 with a stretch target of an additional £500k in months 10, 11 and 12.
- The service is predicted to meet its original £5m target and at mid-point of month 11 is £58,867 over plan'. The team continue to work towards delivering the stretch plan .

Private Patients Income Plan Against £5m target	Jan-25	Feb-25	YTD (M1 to M11)
Plan	425000	510000	4487000
Inpatient actual	381026	421000	4398867
Imaging actual	14700	TBC	147000
Total income	395726	421000	4545867
Variance	-29274	-89000	58867

***The above figures are based on activity and income through the service which may not have been invoiced yet. This does not include income for private imaging.

Finance figures are based on the income received ***.

AREAS FOR IMPROVEMENT

The service core objective for the last quarter is to secure an additional £500k over plan to support the Trust financial position. The service reports to the Productivity Improvement Group fortnightly and has identified the below as the actions and areas to invest effort to maximise financial opportunity:

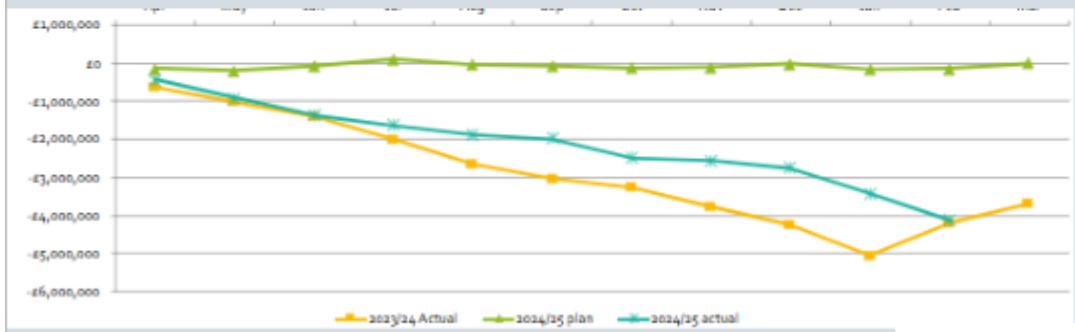
AXA contract – currently paused due to internal AXA process change. Expected April 2025.
Increase in self-funding fees - Benchmarking against competitor prices continue alongside Trust internal procedure and profitability workstreams.
Concentrated effort on invoicing. Imaging invoicing YTD of £147k has been captured. The service is working with the finance team to develop a weekly reporting dashboard to capture all private activity not just inpatients as reported above.
Support to maximise contracts – There are 6 insurance contracts in place and specialist expertise is being sought to ensure that these contracts are being maximised in terms of billing opportunity.

11. Finance on a Page

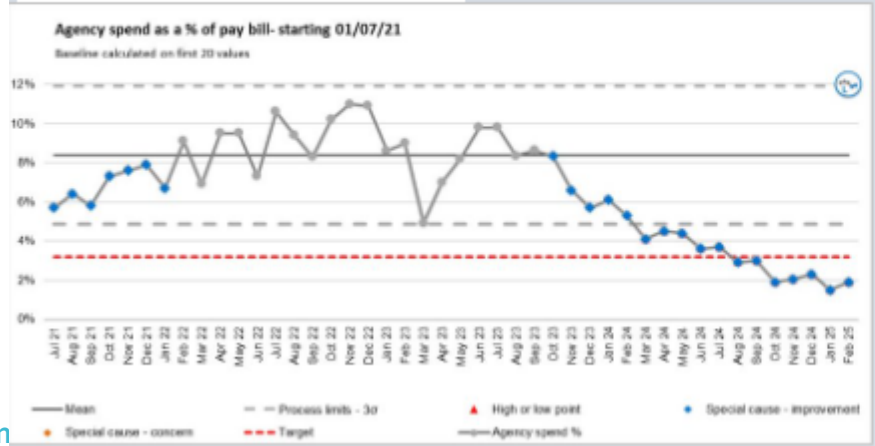
Month 11

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	£11,405	£10,664	-£741	£124,386	£122,650	-£1,736	£135,653	£133,682	-£1,971
Other income	£536	£501	-£35	£5,900	£5,874	-£26	£6,432	£6,228	-£204
Pay	-£7,012	-£6,756	£256	-£75,330	-£74,260	£1,070	-£82,050	-£78,543	£3,507
Non Pay	-£4,799	-£5,017	-£218	-£53,866	-£57,471	-£3,605	-£58,692	-£60,377	-£1,685
Non operating costs	-£119	-£88	£31	-£1,308	-£996	£312	-£1,435	-£1,082	£353
Remove capital donations	£8	£8	£0	£85	£82	-£3	£92	£92	£0
TOTAL	£19	-£688	-£707	-£133	-£4,121	-£3,988	£0	£0	£0



Agency as a % of paybill =1.9%



Efficiencies	YTD	Forecast
Plan	£4,942	£6,484
Actual	£4,109	£6,484
Variance	-£833	£0

Capital	YTD	Forecast
Plan (exc IFRS16)	£3,141	£5,035
Actual	£3,128	£5,035
IFRS 16	£465	£465
Variance	£304	£0

Better Payment practice code	YTD	% move't prev month
Non-NHS		
By number	83.7%	-0.2%
By Value	84.6%	-2.2%
NHS		
By number	51.4%	-4.0%
By Value	19.6%	-0.9%
Total		
By number	83.1%	-0.3%
By Value	80.3%	-2.4%

12. Overall Financial Performance

SUMMARY

The Trust delivered a deficit in month of £688k, with the in month variance again relating to ERF performance. Year to date deficit totals £4,203k deficit against a deficit plan of £217k, generating an adverse £3,986k variance.

Income year to date adverse variance of £1,763kk. This primarily relates to underperformance in commercial income and Elective recovery adjustments for 23/24 and in year performance.

Pay expenditure is underspent year to date of £1,070k. Agency spend in month was 1.9% of paybill year and year to date 1.9%. Agency spend year to date underspend of £552k.

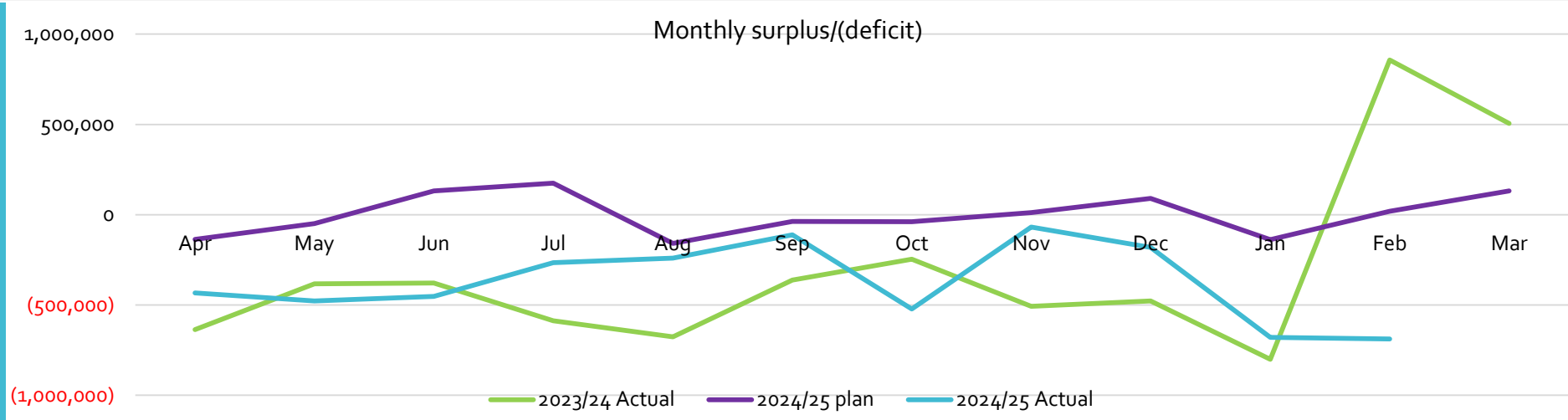
Non pay expenditure year to date adverse variance of £3,606k. This is primarily driven as a result of LLP expenditure above plan and unidentified CIP not identified.

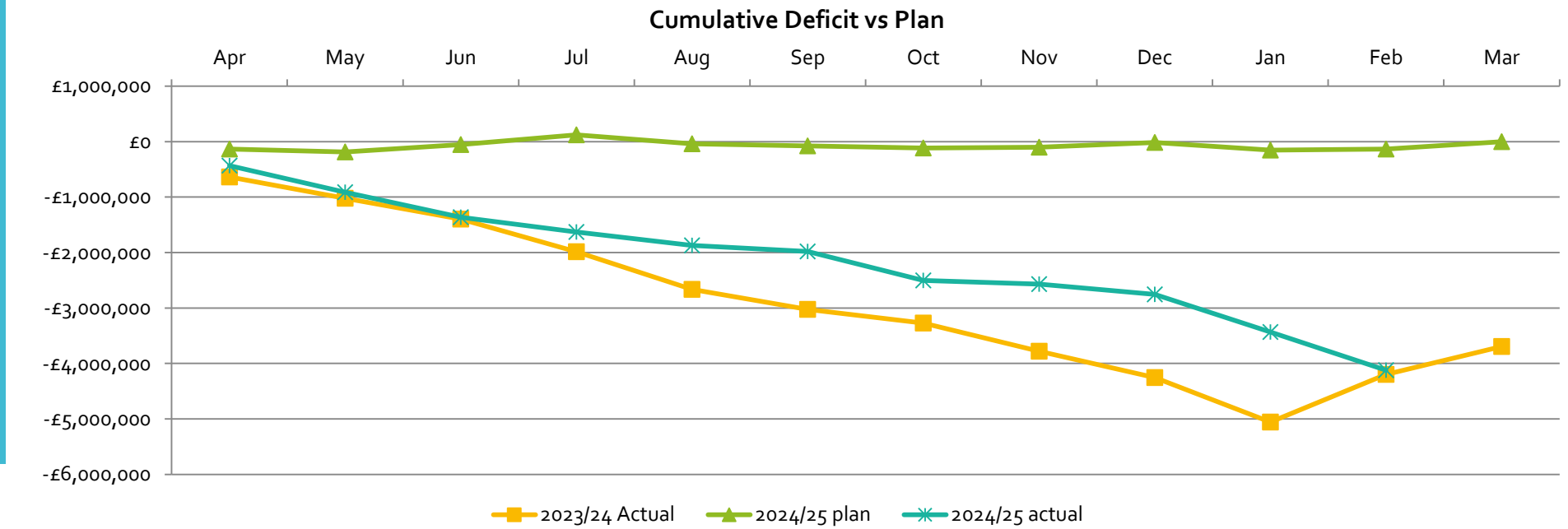
	£'000s				
	Income	Pay	Non Pay	Finance costs and capital donation	Total
Year to date Variance	(1,763)	1,070	(3,606)	311	(3,988)
Year to date plan	130,286	*(75,330)*	*(53,866)*	(1,223)	(132)
Year to date actual	128,524	(74,260)	(57,471)	(913)	(4,120)
Variance compared previous month	↓	↑	↓	↑	↓

12. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	124,386	122,650	(1,737)
Other Operating Income (Excluding top up)	5,900	5,874	(26)
Employee Expenses (inc. Agency)	(75,330)	(74,260)	1,070
Other operating expenses	(53,866)	(57,471)	(3,606)
Operating Surplus	**1,091**	**(3,208)**	**(4,298)**
Net Finance Costs	(1,308)	(996)	312
Net surplus/(deficit)	**(217)**	**(4,203)**	**(3,986)**
Remove donated asset I&E impact	85	83	(2)
Adjusted financial performance	**(132)**	**(4,120)**	**(3,988)**

12. Overall Financial Performance





13. Income

SUMMARY

Income year to date under performed by £1,763kk. This primarily relates to underperformance in commercial income and Elective recovery adjustments for 23/24 and in year performance.

Elective Recovery Fund (ERF) target performance against NHSE target is an underperformance of £1.47m year to date. Due to the phasing of the ERF target the forecast underperformance at year end is expected to be £2.9m underperformance. An income provision of £2m had already been made, which leaves £0.9m of unmitigated risk.

Commercial income is underperforming year to date by £378k

Private patient Income is overperforming year to date by £218k.

AREAS FOR IMPROVEMENT

Elective recovery target delivery during the year to maximise income generation.

Private patient income to deliver a stretch target of £5.5m

RISKS / ISSUES

Elective recovery target delivery remains a risk. Notification that the ERF payment mechanism will change for Q4 has created uncertainty.

ERF target baseline phasing does not align to the Trusts activity plan with significant increase in ERF target set by NHSE in Q4.

Non recurrent funding has been included within plans for 2024/25, generating an underlying financial risk for 2025/26 and beyond.

13. Income

Elective Recovery Fund (ERF)

Based on NHSE data for M1-8 and ROH data for M9-11 the underperformance against the revised targets is shown below:-

	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
NHSE Target	**57,208,277**	4,389,353	4,714,360	4,543,279	4,746,278	3,947,029	4,478,513	4,973,961	4,860,342	4,297,829	4,711,157	5,543,855	51,205,956
Actual		4,163,273	4,694,054	4,183,494	5,003,505	4,364,521	4,513,054	4,718,283	4,422,929	*4,232,299*	*4,769,099*	*4,670,460*	49,734,971
Variance		(226,080)	(20,306)	(359,785)	257,227	417,492	34,541	(255,678)	(437,413)	(65,530)	57,942	(873,395)	(1,470,985)
NHSE rephased target	**57,208,277**	4,508,804	4,750,078	4,655,830	4,900,874	4,640,751	4,900,874	5,142,148	4,866,945	4,471,105	4,998,891	4,471,105	52,307,405
Variance		(345,531)	(56,024)	(472,336)	102,631	(276,230)	(387,820)	(423,865)	(444,016)	(238,806)	(229,792)	199,355	(2,572,434)
Breakeven Target	**60,599,277**	4,776,062	5,031,637	4,931,803	5,191,371	4,915,829	5,191,371	5,446,947	5,155,431	4,736,128	5,295,199	4,736,128	55,407,906
Variance		(612,789)	(337,583)	(748,309)	(187,866)	(551,308)	(678,317)	(728,664)	(732,502)	(503,829)	(526,100)	(65,668)	(5,672,935)

Note: M9-11 Actual performance is an estimate.

This shows a YTD underperformance against NHSE Target of £1,471k which is a significant increase given the size of the Feb target.

The NHSE target for Months 11 and 12 increase significantly with 20% target expected to be delivered in these months. Rephasing this target to align with the activity plan shows a YTD underperformance of £2,572k YTD at Mth 11

Consideration has been given to how the level of unmitigated risk there currently is related to underperformance of ERF target. The following slides summarises this along with some recovery options that have been considered.

13. Income

Elective Recovery Fund (ERF)

The most likely forecast of year end ERF performance is a £2.9m underperformance at M12. A provision of £2m has been included in the year to date position, this leaves an unmitigated risk of £0.9m.

	YTD Actual	YTD Target	Variance	M12 forecast actual	M12 pro rata forecast	Change
NHS Herefordshire and Worcestershire	£6,606,604	£6,067,765	£538,839	£7,207,204	£409,614	(£129,225)
Birmingham and Solihull ICB	£25,720,857	£26,148,748	(£427,891)	£28,059,117	(£1,365,776)	(£937,885)
Staffordshire and Stoke-on-Trent ICB	£1,661,895	£1,978,100	(£316,205)	£1,812,977	(£366,807)	(£50,602)
Black Country ICB	£7,643,204	£7,991,386	(£348,183)	£8,338,040	(£571,122)	(£222,939)
Coventry and Warwickshire ICB	£1,130,605	£1,567,360	(£436,755)	£1,233,388	(£598,945)	(£162,191)
Spec Comm	£6,749,965	£7,288,936	(£538,971)	£7,363,598	(£519,552)	£19,420
Armed Forces	£205,753	£143,744	£62,009	£224,458	£64,715	£2,706
Health and Justice	£16,088	£19,916	(£3,828)	£17,551	(£4,072)	(£244)
	£49,734,972	£51,205,956	(£1,470,985)	£54,256,333	(£2,951,945)	(£1,480,960)

13. Income

Patient level income split between ERF vs Non ERF

	1	2	3	4	5	6	7	8	9	10	11	Total
ERF Criteria	£4,176,744	£4,702,586	£4,217,677	£5,003,945	£4,368,114	£4,524,722	£4,723,374	£4,504,010	£4,243,063	£4,769,099	£4,670,460	£49,903,795
Non ERF Criteria	£3,245,073	£3,285,053	£3,008,220	£3,362,946	£3,050,961	£3,093,040	£3,911,716	£4,011,339	£3,294,240	£3,221,519	£2,442,709	£35,926,815
Grand Total	**£7,421,817**	**£7,987,639**	**£7,225,898**	**£8,366,891**	**£7,419,075**	**£7,617,762**	**£8,635,090**	**£8,515,350**	**£7,537,303**	**£7,990,617**	**£7,113,169**	**£85,830,611**
% erf	56%	59%	58%	60%	59%	59%	55%	53%	56%	60%	66%	58%

Activity split between ERF vs Non ERF

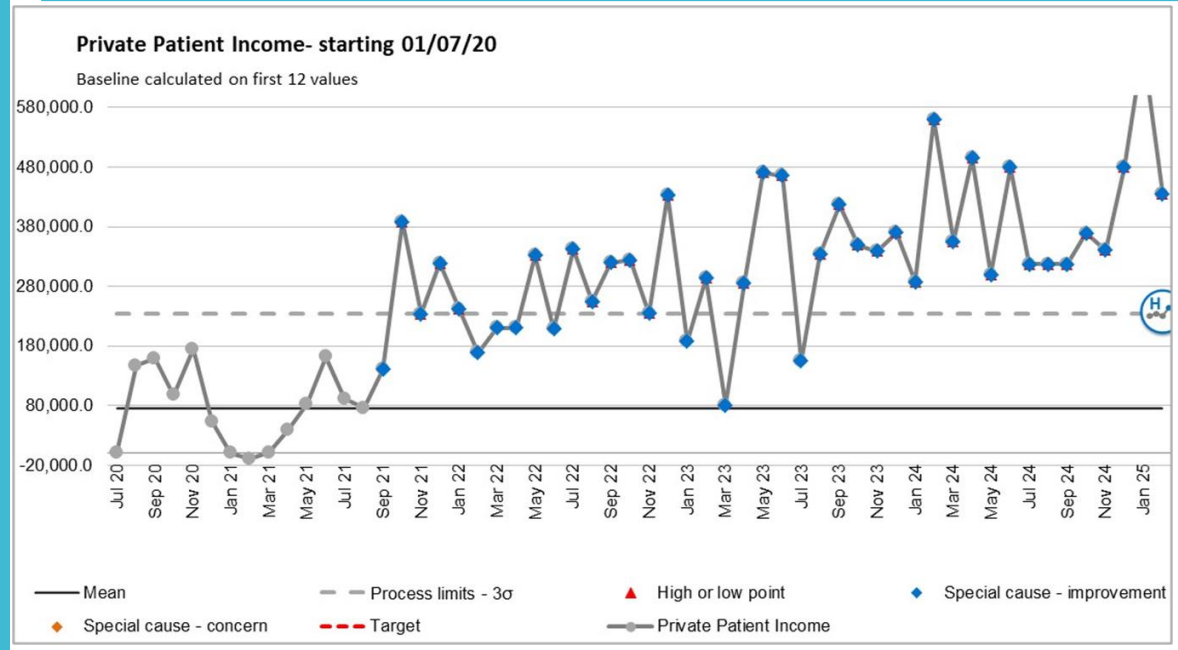
Row Labels	1	2	3	4	5	6	7	8	9	10	11	Grand Total
ERF Criteria	988	1088	1028	1165	1039	1083	1037	1016	912	1132	1117	11605
Non ERF Criteria	177	197	161	168	173	166	183	196	189	204	210	2024
Grand Total	**1165**	**1285**	**1189**	**1333**	**1212**	**1249**	**1220**	**1212**	**1101**	**1336**	**1327**	**13629**
% erf	85%	85%	86%	87%	86%	87%	85%	84%	83%	85%	84%	85%

Average tariff ERF vs Non ERF

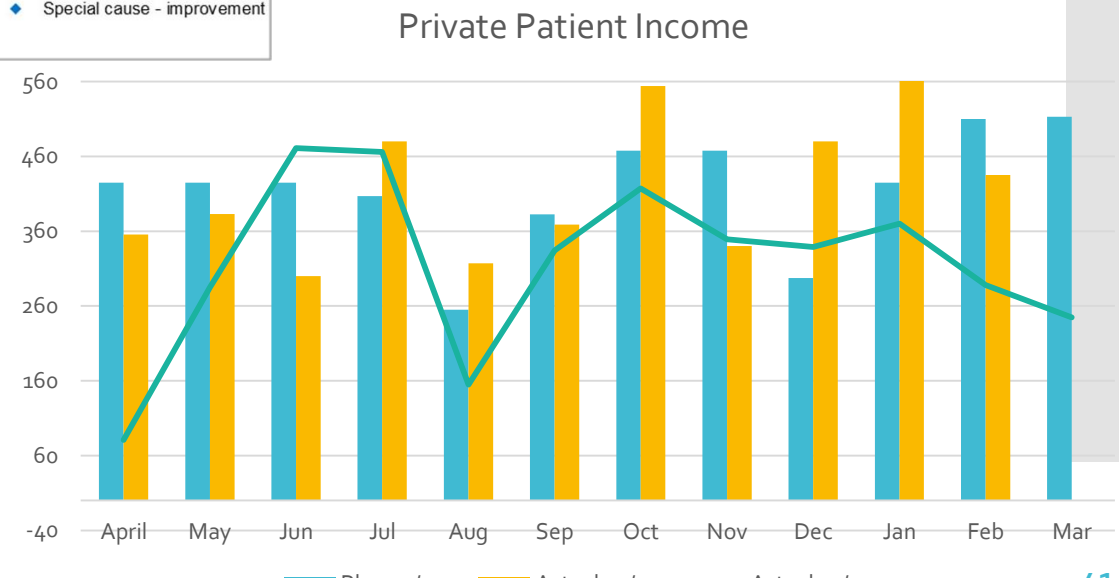
Row Labels	1	2	3	4	5	6	7	8	9	10	11	Grand Total
ERF Criteria	3706	3826	3570	3803	3725	3701	4033	3859	4078	3718	3726	3791
Non ERF Criteria	5164	5018	5436	5353	5470	5603	4973	6269	5976	4336	4753	5289
Grand Total	**3928**	**4009**	**3823**	**3999**	**3974**	**3954**	**4174**	**4249**	**4403**	**3813**	**3889**	**4014**

13. Income

Private patient income



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



14. Expenditure

SUMMARY

Pay expenditure is underspent year to date of £1,070k. Agency spend in month was 1.9% of paybill year and year to date 1.9%. Agency spend year to date underspend of £552k.

Non pay expenditure year to date adverse variance of £3,606k. This is primarily driven as a result of LLP expenditure above plan and unidentified CIP not identified.

Additional premium rate LLP spend year to date is an overspend of £2.3m with spend of £3.4m.

There continues to be high spend in theatres which is £2.8m overspent YTD. An additional contract performance meeting with Genmed has further strengthened controls and actions to militate further cost increases have been agreed and are being tracked. Additional reporting is now in place, providing more information on which further decisions can be taken. The spend was higher than planned in month due to the purchase of some power tools which are below the threshold for capitalisation.

CIP performance to date totals an underperformance of £770k.

AREAS FOR IMPROVEMENT

- LLP expenditure reduction
- Bank expenditure above plan
- Identification of CIP
- Theatre consumable spend reducing to planned levels.

RISKS / ISSUES

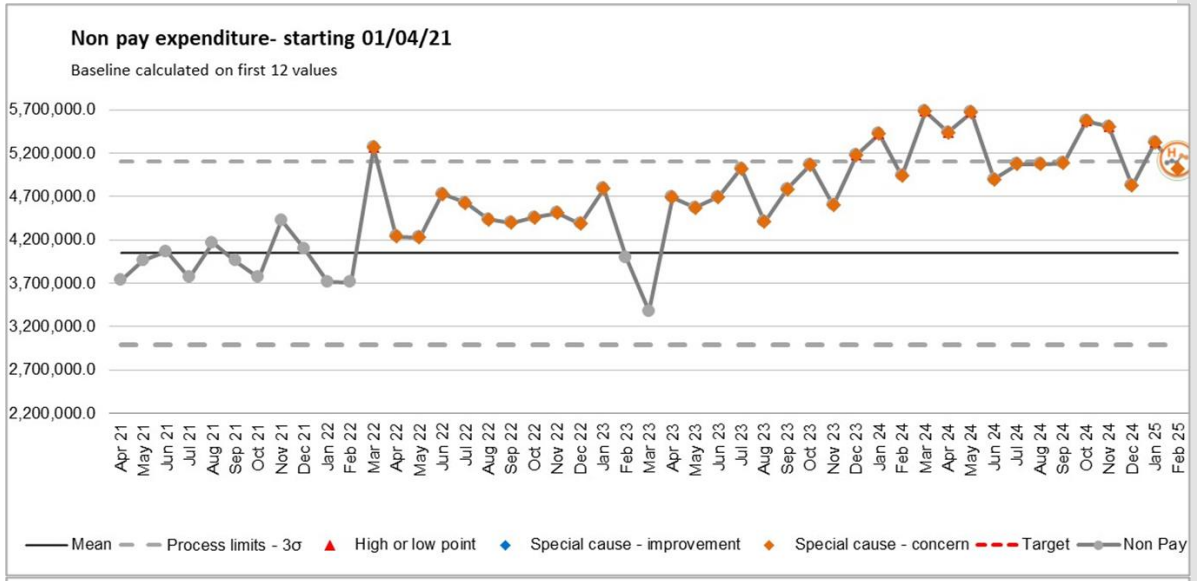
Agency spend remains high causing a cost pressure during the year

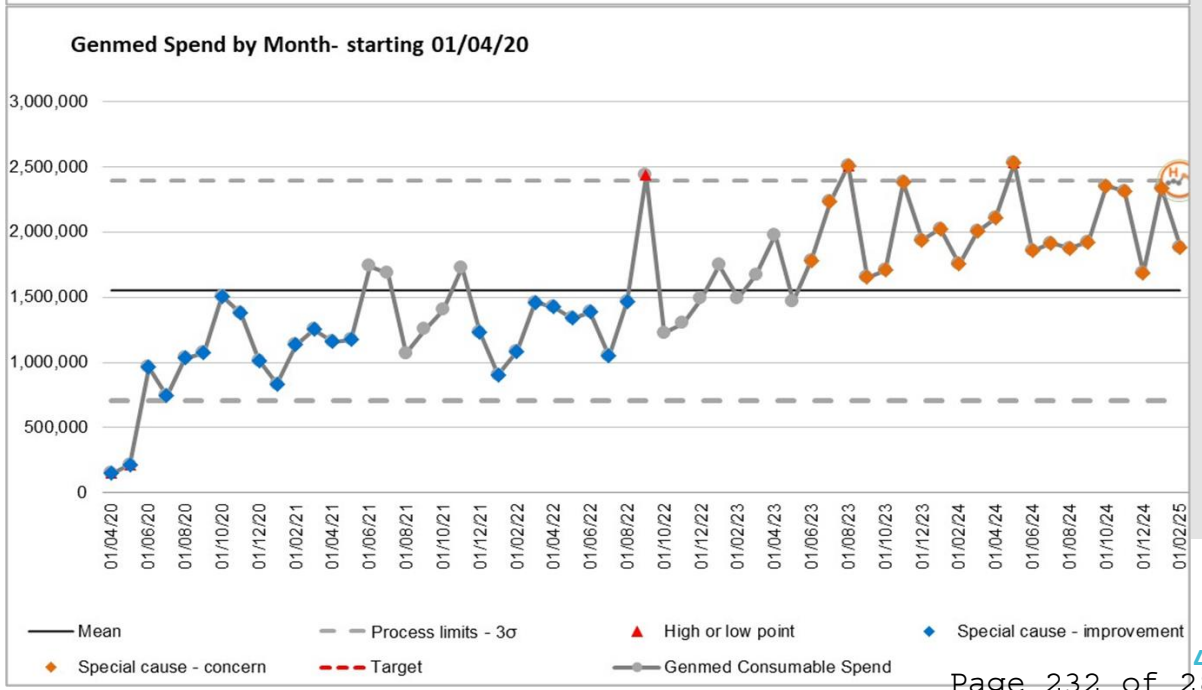
14. Non Pay Expenditure

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.



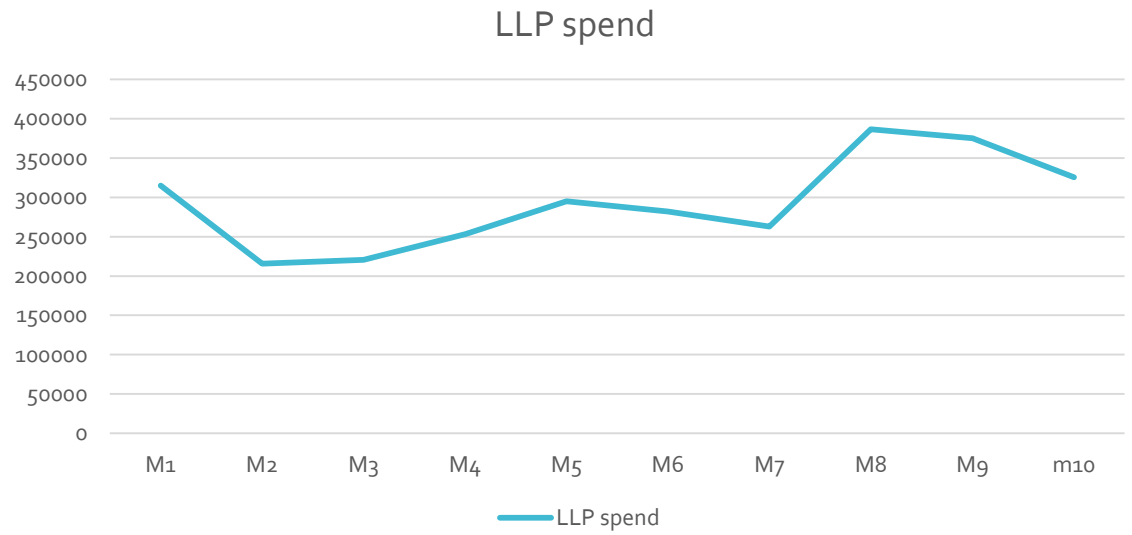


15. Non Pay Expenditure

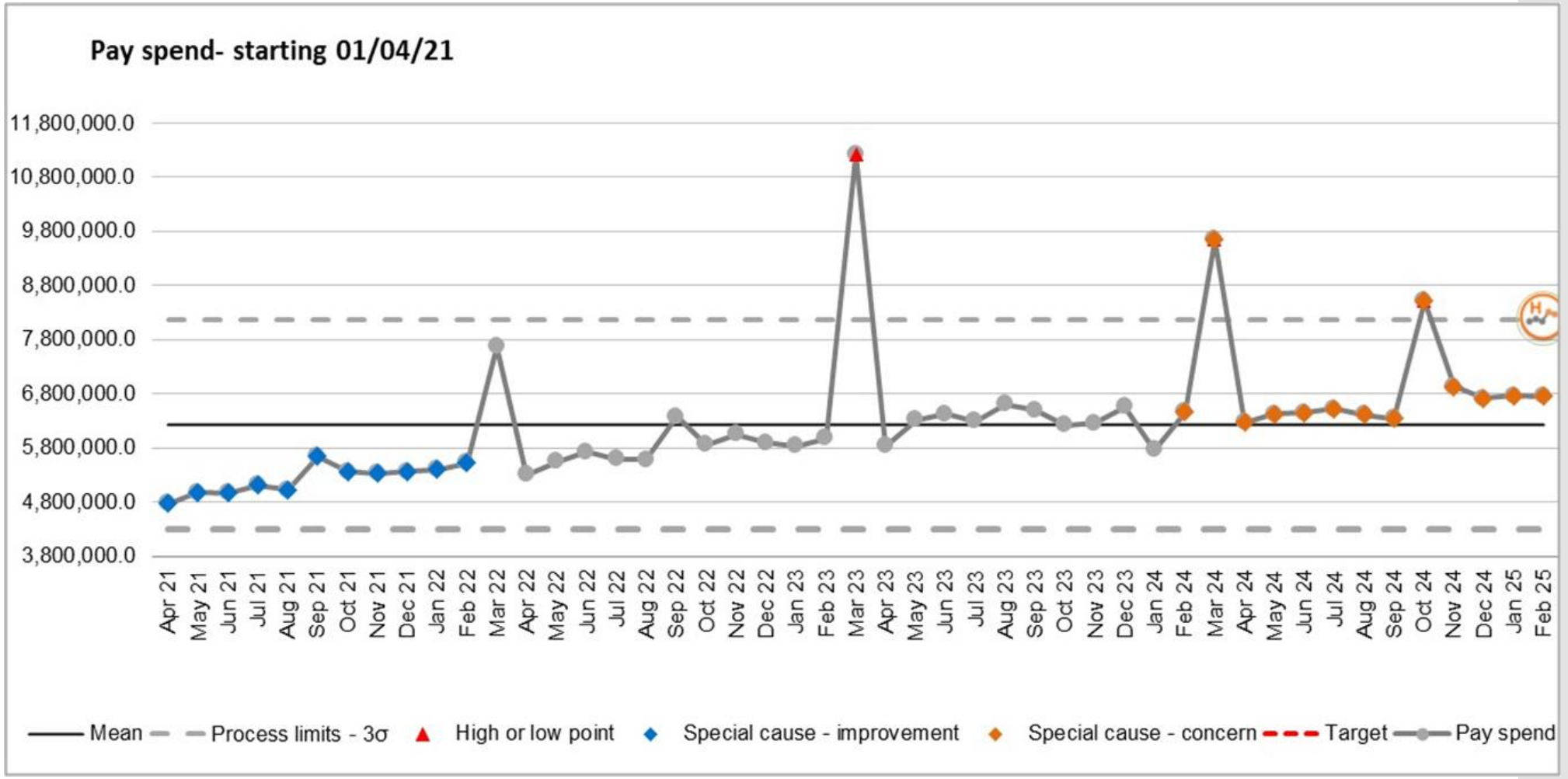
SUMMARY

Premium rate additional sessions remain a focus of the financial recovery plan, with a reduction in LLP expenditure planned from October'24 – March'25. Additional premium rate LLP spend year to date is an overspend of £1.4m with spend of £2.6m

	£'000s			Substantive wte surgeons (excludes anaes and radiologist)
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	3,429	1,171	4,599	73.11

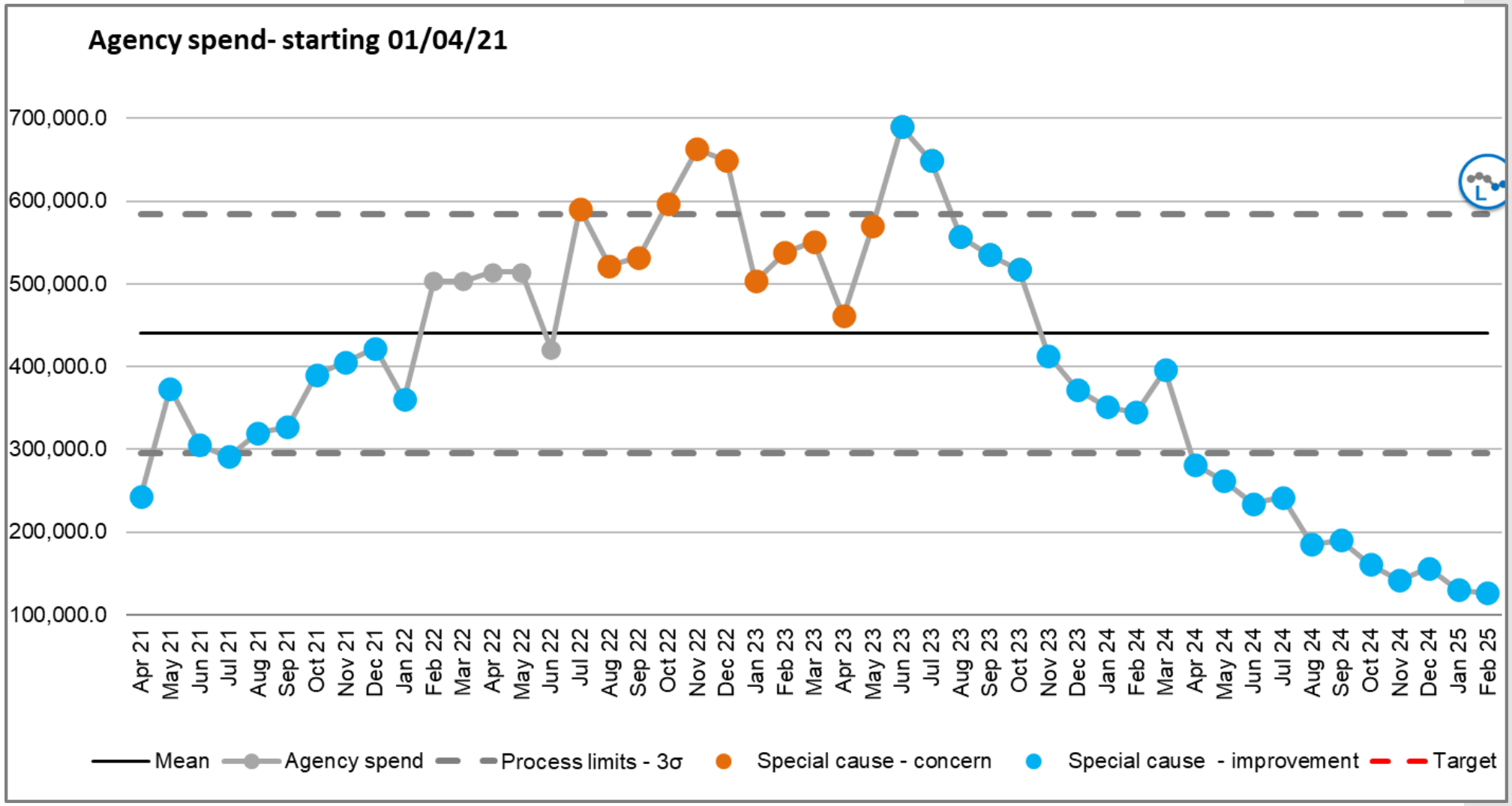


16. Pay Expenditure

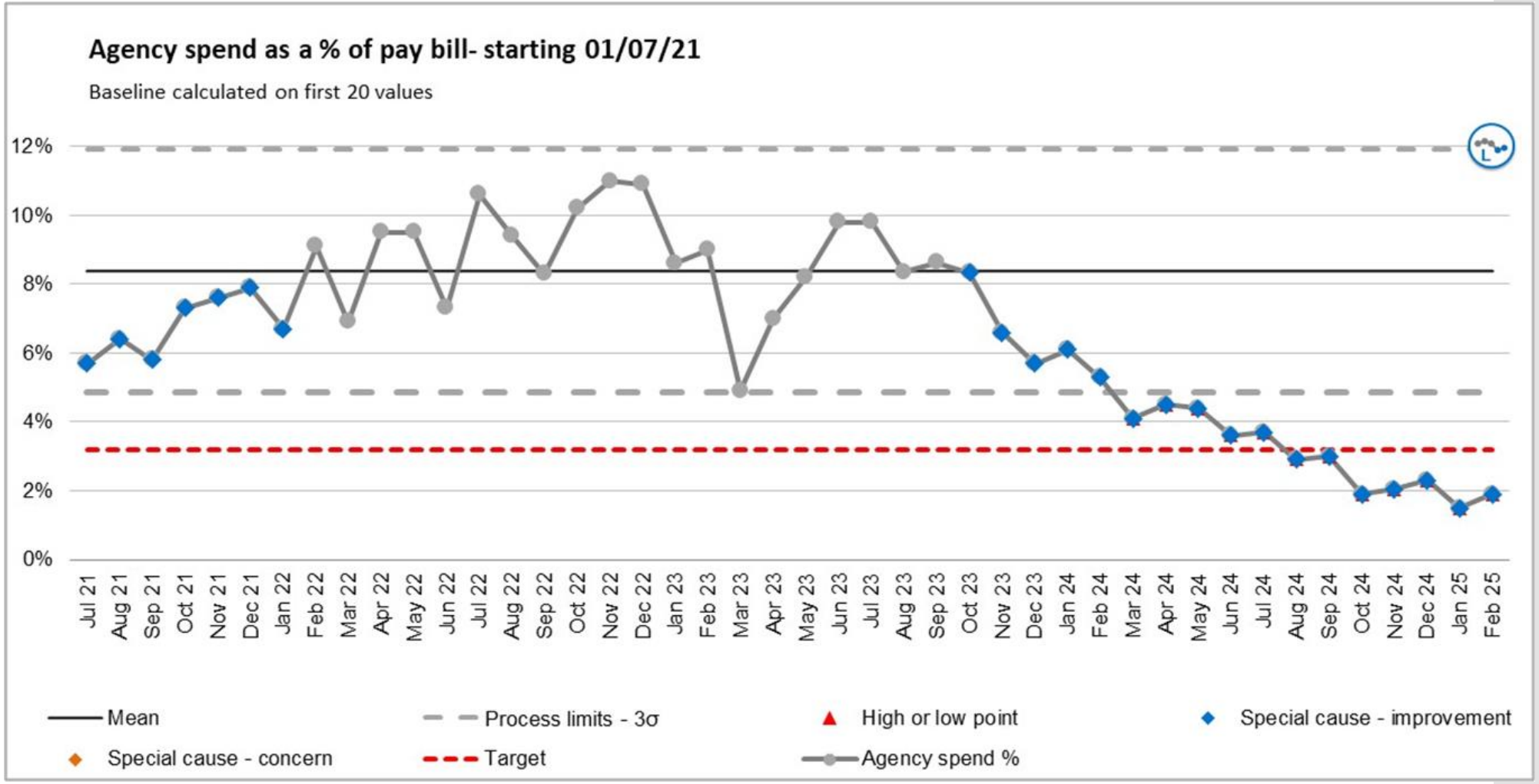


October'24 pay value includes back dated pay award

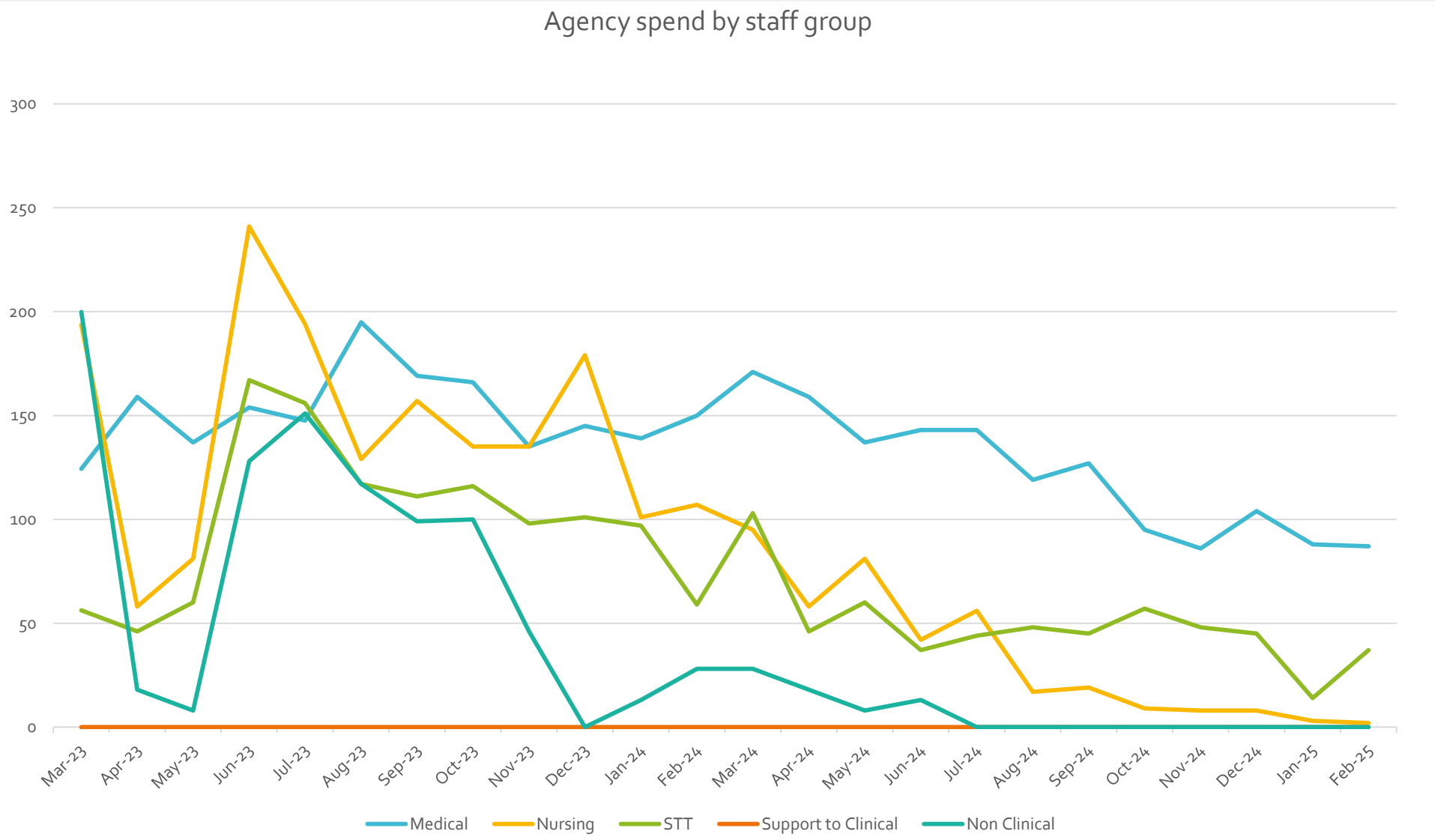
17. Agency Expenditure



17. Agency Expenditure

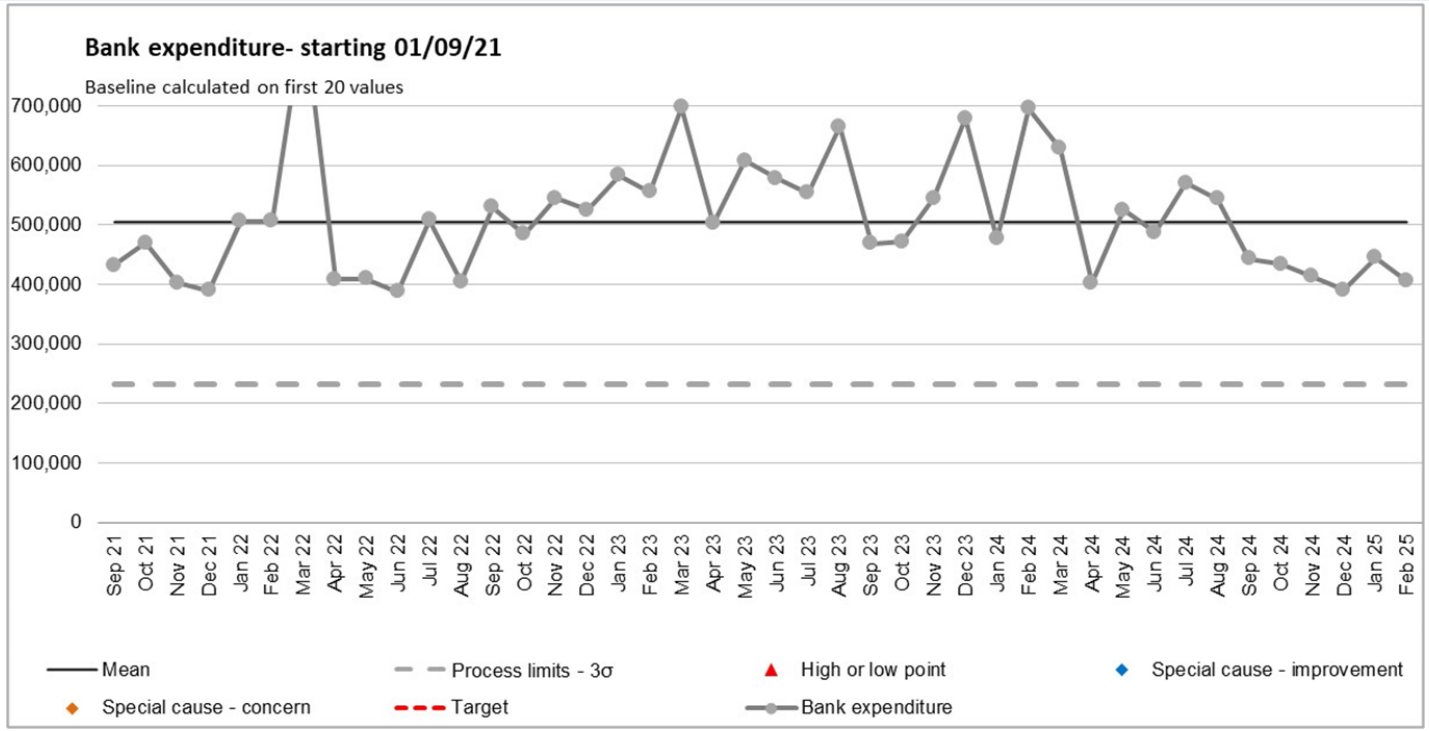


17. Agency Expenditure



17. Bank Expenditure

Bank expenditure	£'000s										
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Registered nursing, midwifery and health visiting staff	108	122	110	136	116	101	95	112	118	92	110
Healthcare scientists and Scientific, therapeutic and tech	26	35	32	47	25	33	41	38	38	34	35
Support to clinical	52	70	60	86	78	55	56	61	69	55	56
Total medical and dental staff bank	56	91	51	61	107	88	117	85	52	124	85
NHS infrastructure support	138	136	155	189	200	151	125	117	111	140	119
TOTAL	402	525	487	570	543	443	434	413	390	445	405



18. Recovery plan

	£'000s							
	Month 6	**Month 7**	**Month 8**	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Full year**
Recovery plan monthly improvements	0	501	464	464	571	587	594	3180
Year to date deficit (including M6 forecast)	-250							-2030
Current monthly plan		-39.0	11.0	89.0	-139.0	19.0	134.0	75.0
Current CIP monthly plan		-636	-664	-690	-717	-744	-818	-4267.9
Continuation of existing CIP								
Agency reduction		242	269	295	322	350	424	1902.0
Procurement - ROH		44	44	44	44	44	44	264.0
Procurement - BSOL		16	16	16	16	16	16	96.0
Associate bad debt recovery							401.5	401.5
Energy savings							51	51.0
Clinical negligence saving		11	11	11	11	11	11	64.0
Pharmacy savings		13	13	13	13	12	12	76.0
Private patient expansion		36	37	37	37	37	37	221.0
Revised financial plan	**-250**	**187**	**201**	**279**	**157**	**332**	**906**	**33**
Actual	**-110**	**-522**	**-78**	**-181**	**-679**	**-554**		
Variance	**140**	**-709**	**-279**	**-460**	**-836**	**-886**		
Revised trajectory to breakeven				**563**	**442**	**615**	**787**	**2407**
Variance to revised trajectory				**-744**	**-1,121**	**1,169**		

18. Cost Improvement Plan

SUMMARY

To date efficiencies of £4,802k has been generated against a plan of £5,572k. The focus for the remaining months is to hold discretionary spend, vacancies and reduce premium rate working costs.
Planning for 2025/26 has identified a total of c.£13m of schemes to be delivered recurrently over the next 2 years, with £9.4m expected to deliver in 2025/26.

Scheme	Recurrent/ Non Recurrent	FYE Plan	YTD Actual	Forecast Outturn
Procurement –ROH and BSOL procurement	Recurrent	£528	£1,525	£1,664
Minimise overall agency spend	Non Recurrent	£2,194	£3,040	£3,316
Private patient service expansion	Recurrent	£440	£0	£500
Discretionary spend hold	Non Recurrent	£751	£61	£200
Contracts and SLA review	Recurrent	£0	£134	£134
Pharmacy - Generic switches	Recurrent	£154	£0	£50
Non clinical admin, vacancy and bank hold	Recurrent	£334	£30	£140
Consultant premium rate working (LLP spend reduction)	Recurrent	£564	£0	£100
ERF additional income	Non Recurrent	£607	£12	£12

18. Financial Recovery – Financial Recovery Group

SUMMARY

- Financial Recovery Group (FRG) held on 19th March focused on planning for 2025/26
- Membership consists of representatives from many of the teams within this hospital including Operational management, nursing, medical, HR, Estates, Facilities, IT, Procurement and Finance.
- Key areas of focus;

Decelopment of CIP schemes into delivery plans

Staffing reduction with bank expenditure and corporate service redesign a key focus
Discretionary spend hold
LLP expenditure reduction

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 sustaiability

• Actions

- 25.26 CIP plans to be finalised
- Bank reduction confirm and challenge action plans to be monitored
- Impact of LLP reductions on ERF forecast

19. Capital summary (YTD)

SUMMARY

Year to date spend of £3,764k against planned spend of £4,476k generating an underspend to date of £712k. Forecast total spend has increased to £7.1m due to additional capital allocation to support backlog maintenance schemes.

Stream	Scheme Name	Plan	YTD Spend	Variance	Forecast	Variance
Strategic Estates	Oncology office refurbishment/relocation	1,196,222	1,156,342	39,880	1,162,222	34,000
Strategic Estates	Retention - Relocation of Facilites to the Old Pharmacy building	6,582	1,246	5,336	1,246	5,336
Strategic Estates	Retention - Replacement for room 3 from a fluoroscopy room to a digital x-ray room	2,771	1,726	1,045	1,726	1,045
Strategic Estates	Retention - Café Royale Refurbishment	2,000	3,000	(1,000)	2,000	0
Strategic Estates	Replacement boiler knowledge hub	400,000	175,742	224,258	459,059	(59,059)
Strategic Estates	Replacement boiler theatres	100,000	0	100,000	0	100,000
Strategic Estates	Remote ability to connect to mobile Generator for 2	95,000	104,637	(9,637)	104,637	(9,637)
Strategic Estates	Roof Replacement inc Large and Small Joint Medical Secretary block / Plaster room / Theatre 3, Hydrotherapy roofs	70,000	74,374	(4,374)	74,374	(78,748)
Strategic Estates	Male Changing Room Refurbishment	0	11,722	(11,722)	84,238	(95,960)
Strategic Estates	Demolition of Rabone Hall	0	8,732	(8,732)	24,000	(32,732)
Strategic Estates	Remote ability to connect to mobile Generator for 3	0	0	0	175,000	(175,000)
Strategic Estates	Replacement boiler theatres 1,2&4 / Nurses Home- Design Fees	0	0	0	154,534	(154,534)
Green estate	Pool allocation for scheme prioritisation by budget holder	50,000	560	49,440	35,615	14,385
Estates Maintenance	Pool allocation for scheme prioritisation by budget holder	150,000	156,254	(6,254)	411,708	(261,708)
Equipment	Pool allocation for scheme prioritisation by budget holder	200,000	73,263	126,737	1,530,764	(1,330,764)
Equipment	Image intensifiers x 5	804,000	659,160	144,840	659,160	144,840
Information Technology	Pool allocation for scheme prioritisation by budget holder	100,000	111,949	(11,949)	725,251	(625,251)
Information Technology	EPR	200,000	123,273	76,727	200,000	0
Information Technology	Networking	0	890,576	(890,576)	890,576	(890,576)
Reserve		122,425	(244,879)	367,304	(52,109)	174,534
TOTAL EXCL. IFRS16 ADJ		**3,499,000**	**3,307,677**	**191,324**	**6,644,000**	**(3,239,828)**
	IFRS 16 Adjustment for revaluation of Modular theatres and other leases	756,000	456,000	300,000	456,000	300,000
TOTAL CDEL		**4,255,000**	**3,763,677**	**491,324**	**7,100,000**	**(2,939,828)**

BAU	3,499
System Capital Bonus	1,545
Capital Infrastrucure Risk	1,600
IFRS Adjustment	456
	7,100

20. Statement of Financial Position

SUMMARY

The main movements in the balance sheet have been in relation to the increase in cash and PDC following the support payment received from the Department of Health.

The cash position is challenging as more is spent on recovering the capital slippage from earlier in the year=.

Continued focus is being places on ensuring that cash is being managed robustly, whilst also trying to maximise Better Payment Practice Performance.

	2023/24 M12	2024/25 M11	Movement
		(£'000)	
Intangible Assets	981	690	(291)
Tangible Assets	65,398	64,038	(1,360)
Total Non Current Assets	**66,379**	**64,728**	**(1,651)**
Inventories	1	24	23
Trade and other current assets	8,193	9,781	1,588
Cash	1,699	5,570	3,871
Total Current Assets	**9,893**	**15,375**	**5,482**
Trade and other payables	(13,896)	(16,409)	(2,513)
Borrowings	(16,145)	(13,578)	2,567
Provisions	(1,187)	(1,209)	(22)
Other Liabilities	(1,233)	(3,908)	(2,675)
Total Liabilities	**(32,461)**	**(35,104)**	**(2,643)**
Total Net Assets Employed	**43,811**	**44,999**	**1,188**
Total Taxpayers' and Others' Equity	**43,811**	**44,999**	**1,188**

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 month 11 position is a deficit of £42.4 million, £38m adverse compared to plan. The systems is still expecting to deliver its forecast break-even position.

Total Performance	YTD				FOT				Prior Month variance £000s
	June Plan £000s	Current Plan £000s	Actual £000s	Variance £000s	June Plan £000s	Annual Plan £000s	FOT £000s	Variance £000s	
BSOL ICB	9,983	9,970	12,871	2,901	11,405	11,405	16,203	4,798	517
BSMHT	2,046	2,046	2,602	556	2,069	2,069	10,736	8,667	-419
BCHC	-26	-26	1,995	2,021	0	0	2,600	2,600	1,992
BWC	2,750	2,750	-72	-2,822	3,000	3,000	5,200	2,200	-4,742
ROH	-132	-132	-4,120	-3,988	0	1	0	-1	-3,280
UHB	-19,026	-19,026	-55,711	-36,685	-16,474	-16,474	-34,700	-18,226	-29,615
Total	-4,405	-4,418	-42,434	-38,016	0	1	39	38	-35,548

20. Workforce

SUMMARY

Attendance improved mildly this month but remains well below target. This follows a yearly trend of improvements in February, with fewer winter illnesses leading to a decrease in short term absence.

Turnover worsened slightly, however this data was impacted by two dismissals and five retirees. There was also one individual who sadly passed away in service.

Note: February data for the establishment was not available at the point of writing this report, however with an increase in establishment, this is expected to have improved in February.

Risks/Issues

Our high sickness absence rate will be having an impact on productivity and higher temporary staffing spend. This is a priority area of focus.

Actions

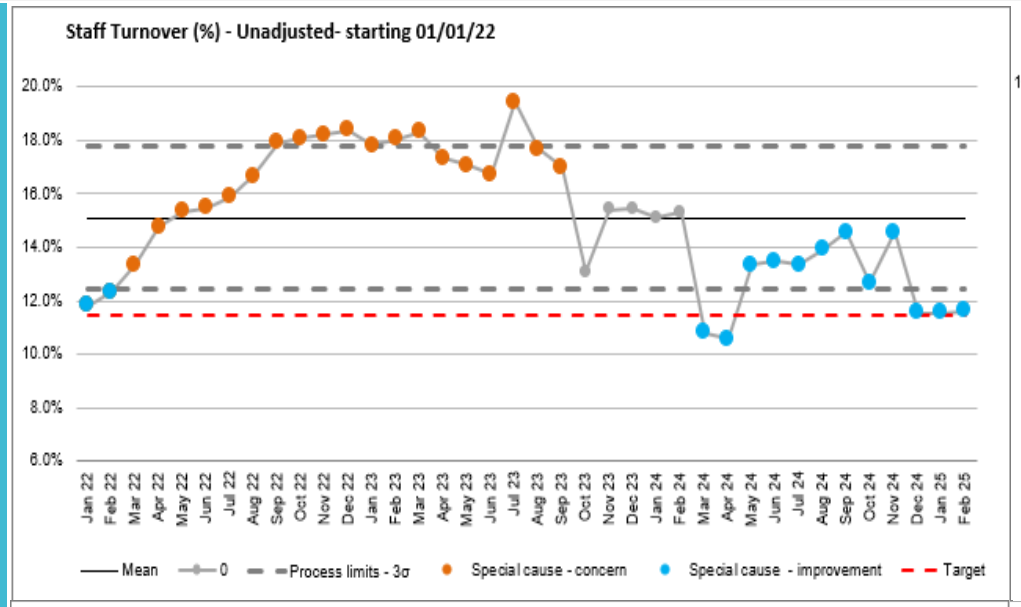
Policy compliance is our main area of focus in relation to sickness absence and 60 audits have been completed this year, highlighting areas of improvement and good practice.

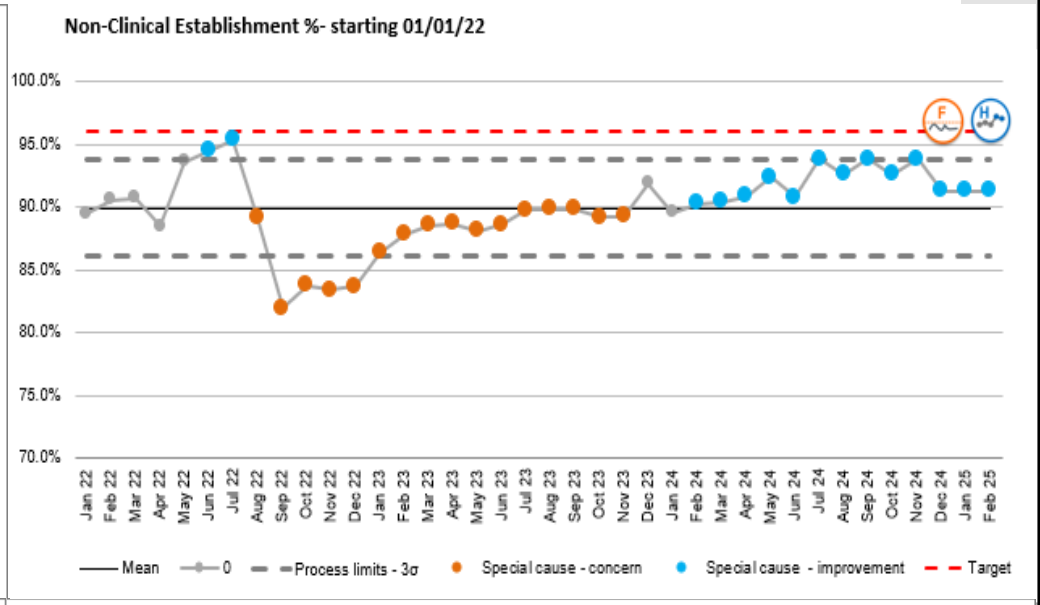
We are approaching the Appraisal window opening in April and will expect a drop off in compliance rates until the window closes in July. We are working with managers to provide coaching and education around appraisals, to support improving quality.

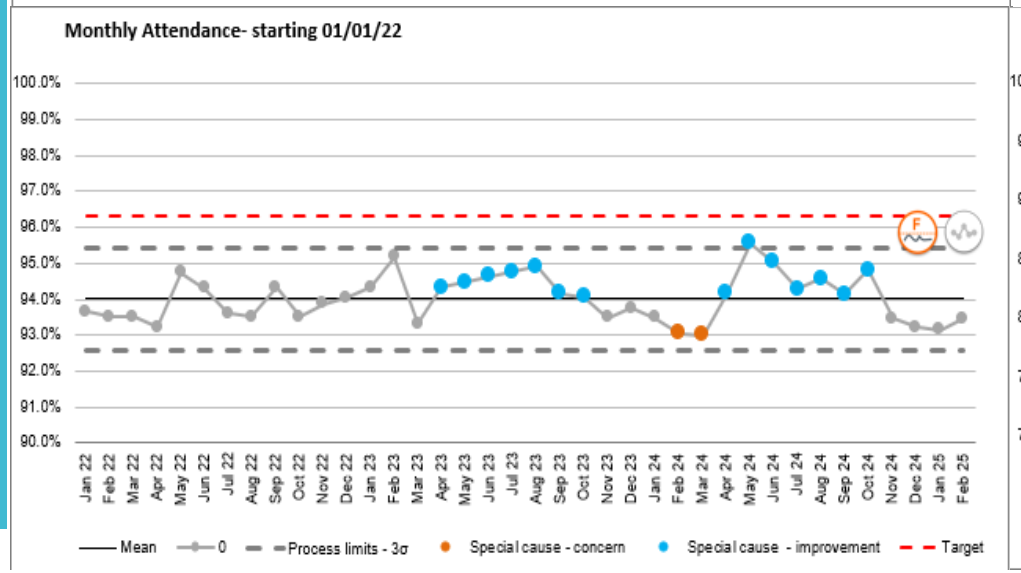
20. Workforce

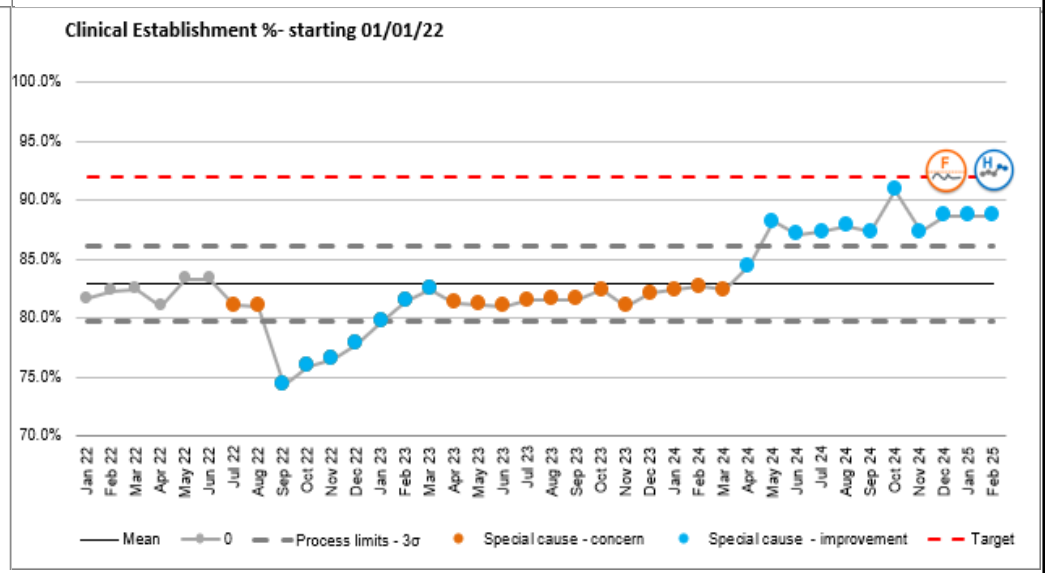
Trust Workforce Metrics	Jan-25	Feb-25	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1468	1481	13	-	-
Staff In Post - Full Time Equivalent	1295.84	1309.10	13.26	-	-
Staf Turnover % - Unadjusted	11.55%	11.63%	0.08%	↑	<=11.5%
Staf Turnover % - Adjusted	10.93%	11.11%	0.18%	↑	<=11.5%
Total WTE Employed as % of Establishment	89.69%	89.69%	0.00%		>=93%
Total WTE Employed as % of Establishment - Clinical	88.74%	88.74%	0.00%		>=92%
Total WTE Employed as % of Establishment - Non-Clinical	91.34%	91.34%	0.00%		>=96%
% Of Attendance	93.15%	93.47%	0.32%	↑	>=96.3%
% Of 12 mth MAA Attendance	94.19%	94.12%	-0.07%	↓	>=96.3%
% Staff received mandatory training last 12 months	88.93%	89.56%	0.63%	↑	>=93%
% Staff received formal PDR/appraisal last 12 months	90.67%	90.96%	0.29%	↑	>=95%
% of Sickness - Trust wide Long-term	3.38%	3.79%	0.41%	↑	-
% of Sickness - Trust wide Short-term	3.47%	2.74%	-0.73%	↓	-
Return To Work Completion %	66.03%	62.33%	-3.70%	↓	>=80%

20. Workforce

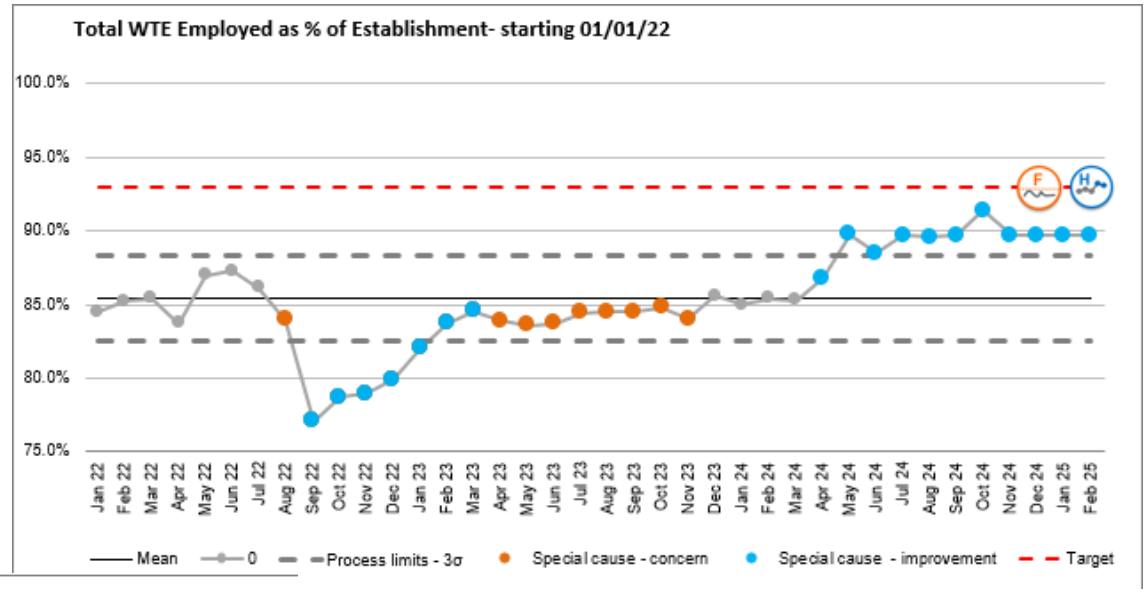


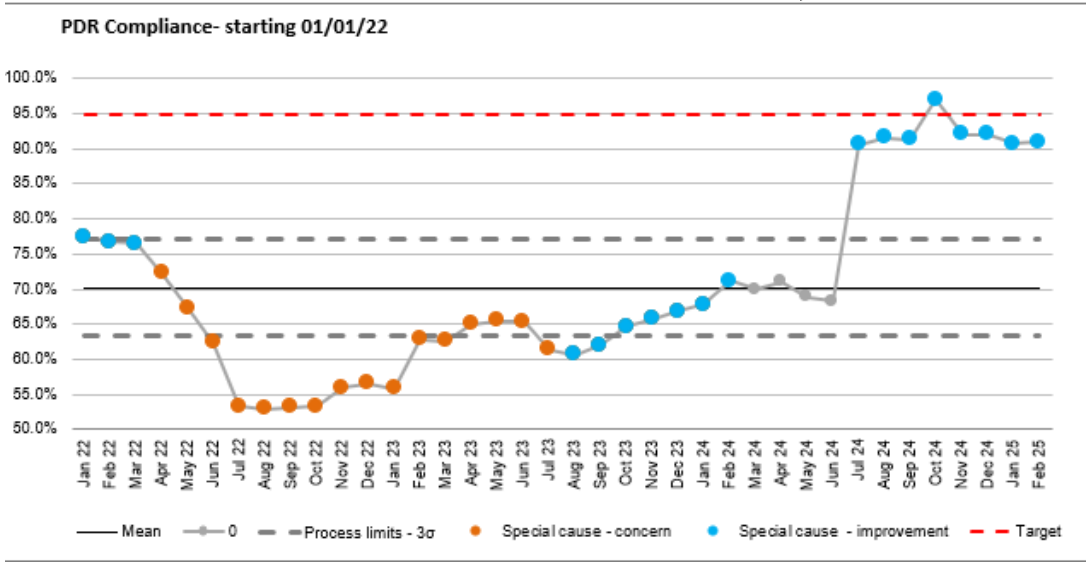






20. Workforce





Quality Report

March 2025 (February 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.

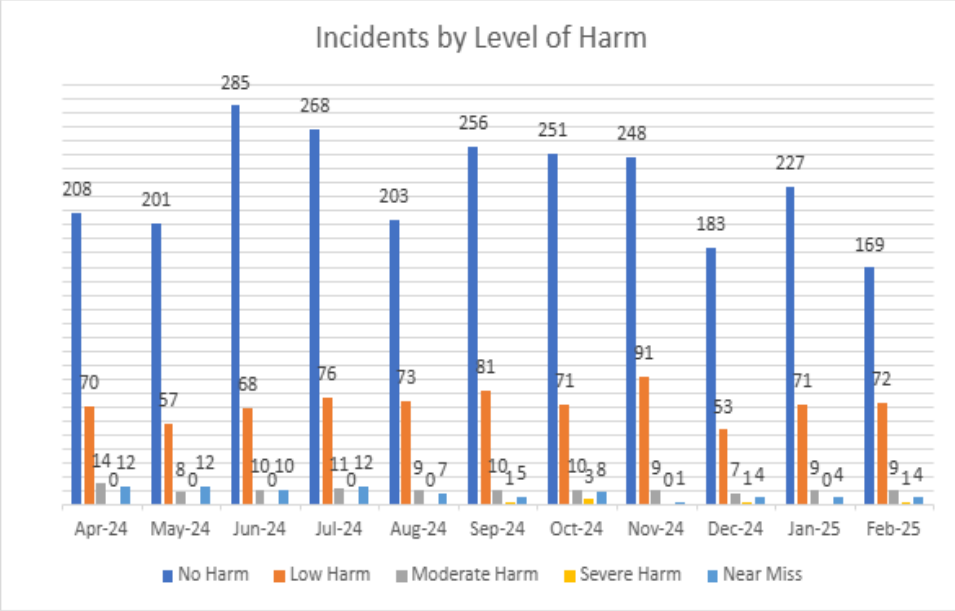
Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

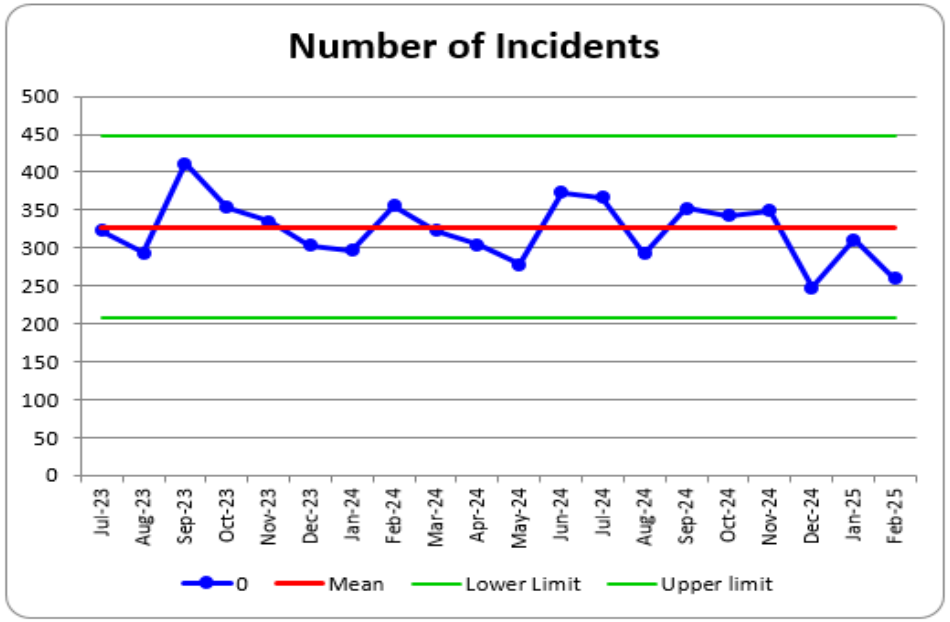
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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

Governance Performance Summary Dashboard

Performance to end February 2025	In month	Previous month	Variation	Assurance
Total No of Incidents Reported	260	313		
Inpatient Deaths	2	0		
PSII's (Patient Safety Incident Investigations)	0	1		
Never Events	0	0		
VTE Incidents (Avoidable)	0	0		
Category 2 Pressure Ulcer Incidents (Avoidable)	0	0		
Category 3 Pressure Ulcer Incidents (Avoidable)	0	0		
Falls (Total No of Inpatient Falls)	7	6		
Infection Incidents (Reportable)	0	0		
Complaints	8	8		
Claims	0	0		
Inquest	0	0		

Incidents Reported





Quality Improvement & Learning

There were 260 incidents reported within the Trust during February 2025.

There was 1 severe harm incident reported., this incident relates to a patient admitted from home with category 4 pressure damage. Immediate care was provided, and further assessment and treatment has been arranged.

Incidents Reported - continued

Quality Improvement & Learning

Quality Improvement

A plan is currently being devised to improve the sharing of the outcome of patient safety incidents, whether the incident is managed locally or whether the incident is taken through the Trusts governance process and managed in accordance with our PSIRF Response Plan.

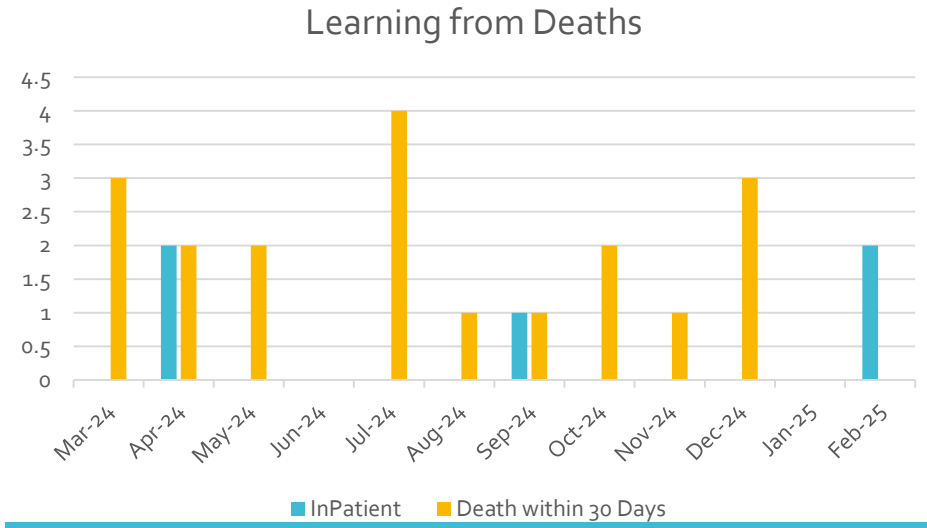
With locally managed incidents the proposed plan is to provide regular reports to local managers on closed incidents that can then be used to feedback to incident reporters on a 1 to 1 basis and also be used to share outcomes wider at local team/department meetings. The governance team are currently undertaking technical training on the incident management system, which once completed will mean we have the inhouse knowledge and skills necessary to make improvements and amendments to the system. A key identified improvement that will be implemented will be the standard and quality of the incident reports generated by the system. Once the training and system improvement work has been completed the team can then look to develop new and improved service level reports to aid knowledge of incidents and the sharing of learning and improvements within team and departments across the Trust.

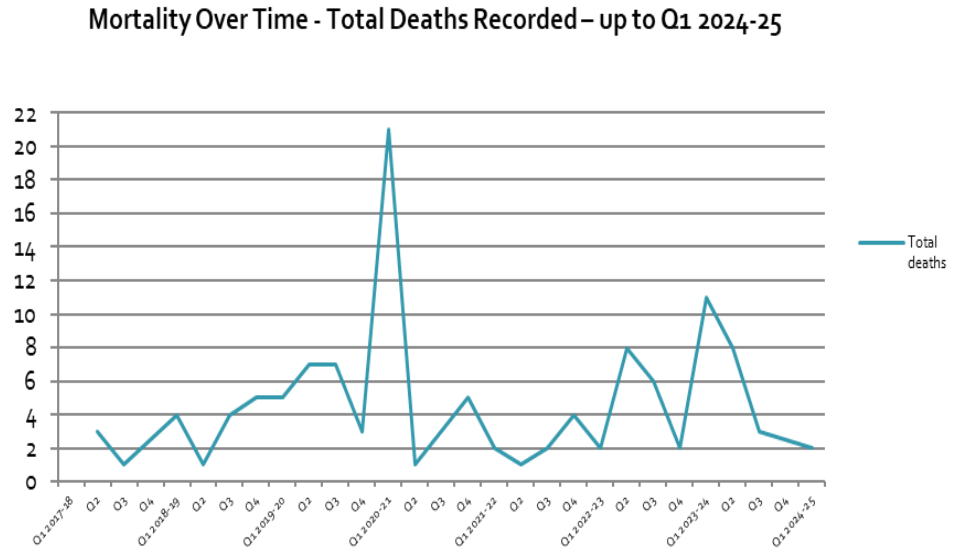
With incidents that are managed and investigated via divisional governance process, LOOP (Learning on one page) templates are used to share the learning with key internal stakeholders and the governance team provides regular monthly articles and updates on clinical governance related issues and incidents for the 'Clinical News' publication.

Incidents Reported... (continued)

PSIRF Investigation Method	In Month	Last month	Year to Date
PSII	0	1	8
AAR	0	1	18
MDT	0	0	1
Thematic Review	0	1	3

Learning from Deaths





Quality Improvement & Learning

There were 2 inpatient deaths in February 2025. Both deaths were referred to the coroner by the medical examiner.

Infection Prevention & Control

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

*Financial year running from April to March.

NHS Standard Contract 2024/25 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

QUALITY IMPROVEMENT WORK IPC Safety Priorities

IPC safety priorities for 2024/25 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.

IPC safety priorities for 2025/26

The IPC team have reviewed their IPC safety priorities for 2025/26. Full objective details have been included in the review of the IPC patient safety incident and response plan for 2025/25.

Surgical Site infection Prevention:

Minimising incidence of Surgical Site Infections in patients undergoing Arthroplasty (total hip/knee replacements) and Spinal surgery.

Cleanliness:

Improving the standard of cleaning of the physical healthcare environment and healthcare equipment.

In addition to this, other quality improvement works have been identified and included within the IPC business plan and annual programme of work.

Infection Prevention & Control – continued…

Quality Improvement & Learning - continued

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 implementation.

1. Pre-op patient information and engagement
2. Pre-operative washing
3. Perioperative warming
4. Surgical prophylaxis
5. Surgical practice standards
6. Incision management

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.

<u>Invasive Devices [Criterion 1 & 4]</u>
Appropriate care and management of devices inserted into patients.
Appropriate insertion of a device.
Documentation of appropriate device insertion.
Accurate and timely completion of device management care plans.
Timely and appropriate removal of devices.

In response to an MSSA BSI related to a PIVC and in addition to concerns regarding the PIVC and CVAD high impact intervention audit data, a short-life vascular access device (VAD) group was set up to review practice and implement quality improvement work to address any issues. The groups work concluded at the end of March 2024, however there are a few ongoing actions that are monitored at the IPC committee.

Promoting the completion of invasive device insertion documentation from theatre (point of insertion) to ensure accurate records and evidence of care taking place. The peripherally inserted devices (PID) care record has been updated – this now includes space to document midline insertion and care. It has been approved at HRAG and is going to Harlow for printing.

Infection Prevention & Control – continued…

Quality Improvement & Learning - continued

Reintroduction of needle free connectors is being led by the Head of Nursing for division 1, this will help to improve safe practices associated with PIVC and CVAD use.

Reintroduced and training provided by the company.
Consistent use to be monitored in the audit of PID by departments.

Antimicrobial Stewardship [Criterion 3]

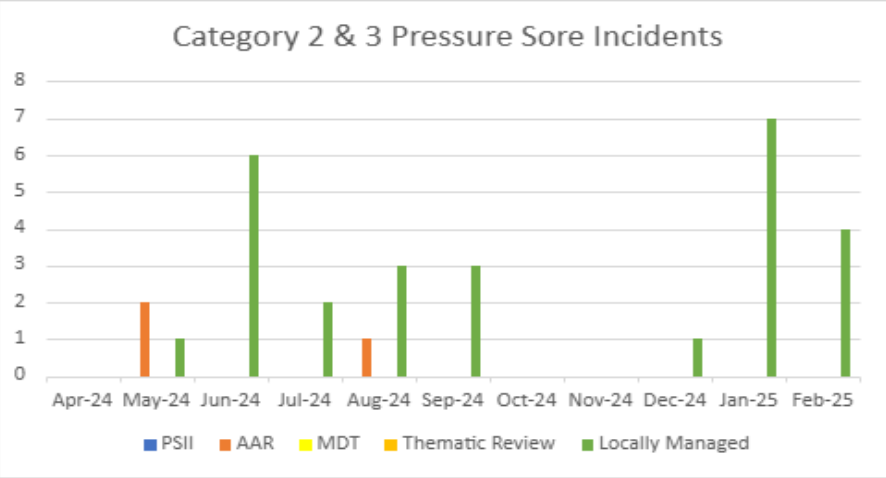
Much work has been undertaken to review surgical prophylaxis as has been described under the SSI IPC priority.

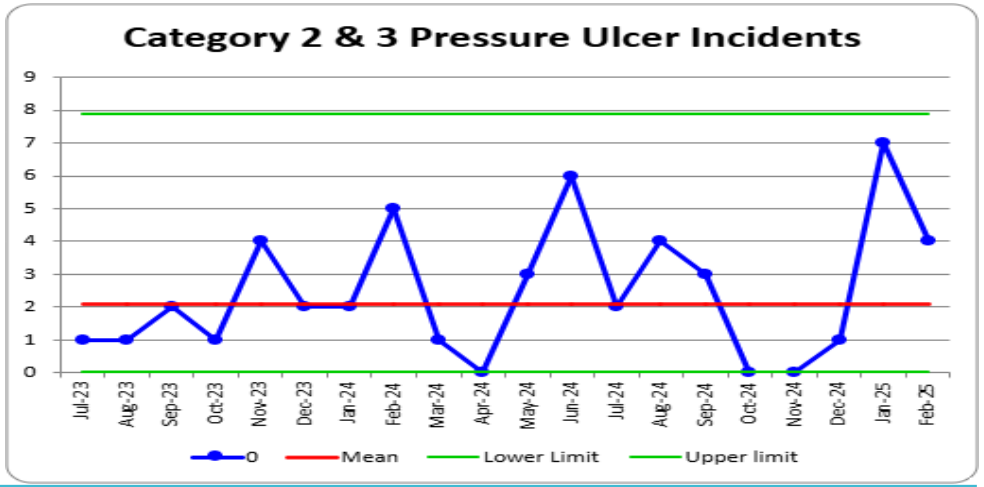
In addition to this, there is a focus on the judicious use of antimicrobials, monitoring consumption and prescribing practices. This is actioned through:

AMS training and education for prescribers and Nurses.
Implementing AMS ward rounds.
Ensuring up to date and accessible information and guidance on antibiotics for staff and patients.

AMS quality improvement initiatives and programme of work is monitored via the antimicrobial stewardship group, chaired by the Antimicrobial Pharmacist. A four-box report is submitted to the IPCC for review and information.

Tissue Viability





Quality Improvement & Learning

There were 3 category 2 Pressure sore incidents, and 1 category 3 pressure sore incident reported in February. All were managed locally and deemed unavoidable, with no lapses in care identified.

Quality Improvement

Purpose T implementation plan in progress – launch date 01/04/2025.

Stand, ward visits – planned for Wednesday 19th March 2025. Documentation approved at Health Records Advisory Group, now with Harlow for proofing and coding – codes for ordering to be circulated by TV team when available.

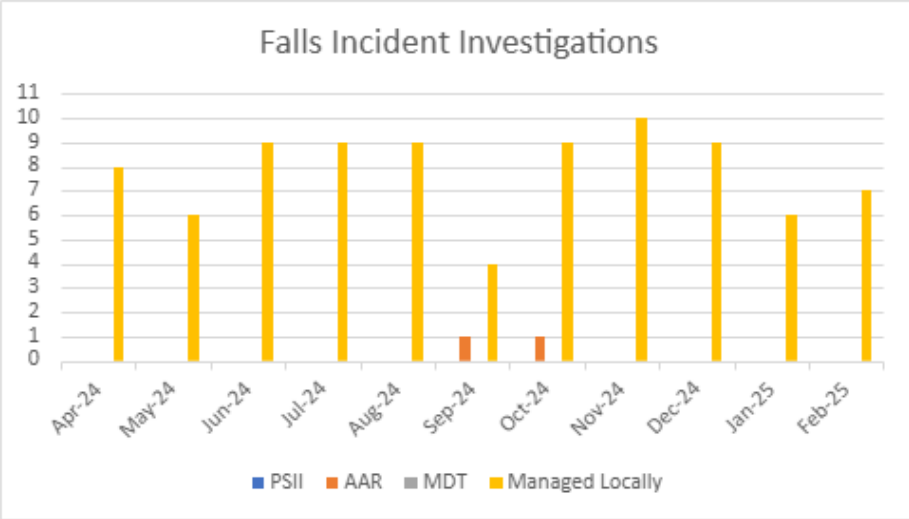
Registered nurses and NA's will be completing the NWCSP – PURPOSE – T module. This is a mandatory module for all registered staff and is now available via ESR. Training figures not available from ESR yet. Clinical managers advised of launch date and need for staff to be trained.

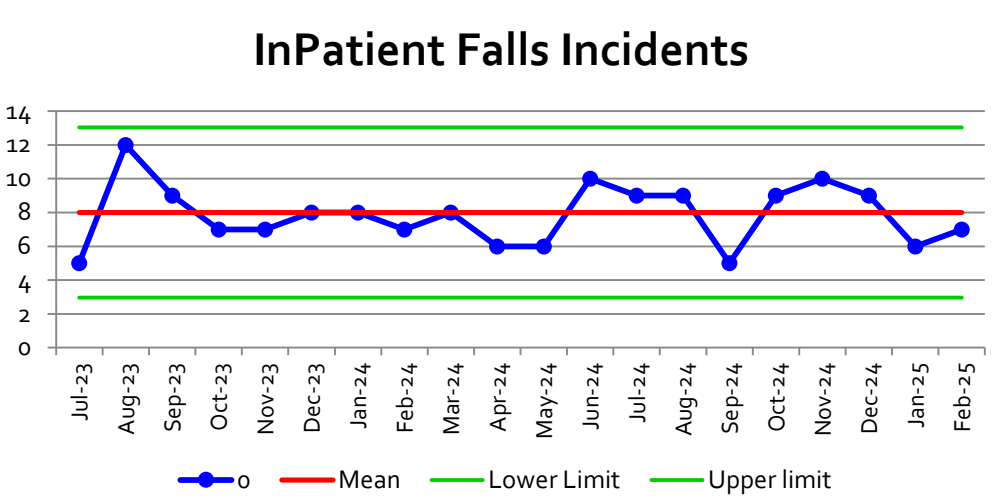
Mattress audit

Mattress and pump spot audit planned for March 2025

Report on the Quantity and Cost of Mattresses, Pumps, and Parts Required to Maintain an Up-to-Date Fleet for ROH Patients – sent to Chief Nurse. Report demonstrates if every ROH bed space (excluding HDU – 109) was filled there is a shortfall of 6 mattresses. Need to urgently purchase components – to make up complete current mattress (Soft form Premier Active – SPA) or purchase new foam only mattresses in the short term to fill this gap.

Falls





Quality Improvement & Learning

There were 7 inpatient falls reported in February 2025. All incidents were managed locally.

Themes

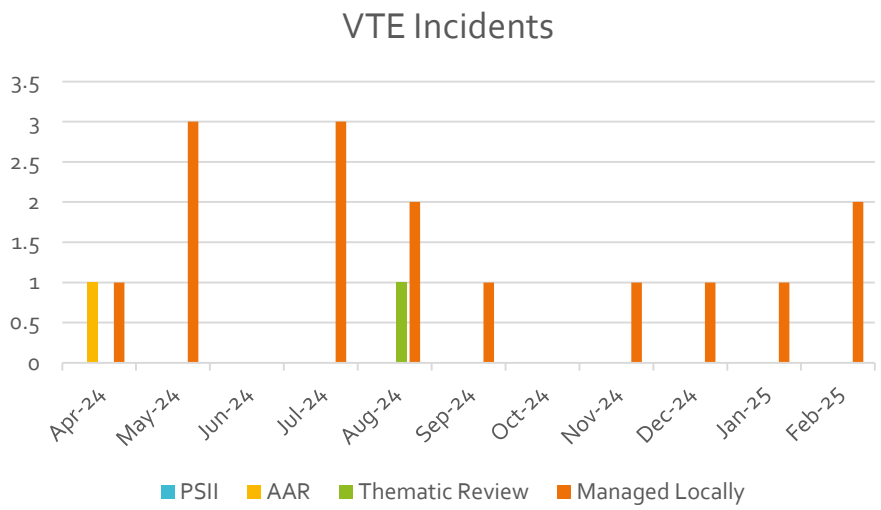
5 of the reported falls were reported on ward 1

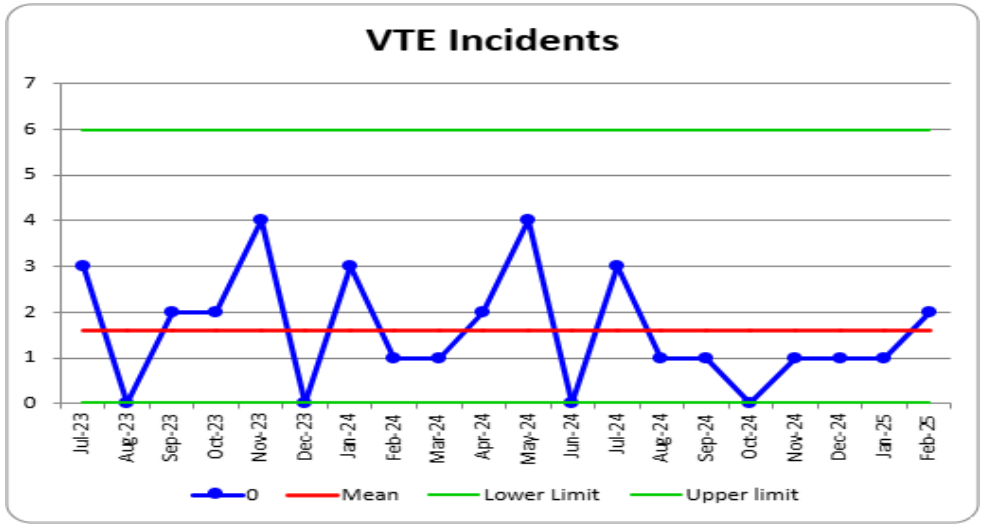
4 of the reported falls were unwitnessed

Quality and Improvement Work

- Audit of falling leaves usage ongoing
- Mini audit to review why patients are falling after mobilising against advice now live – will run until Mar 25
- New and updated falls risk assessment tool on PICS for use across all inpatient areas – still awaited.
- Estates work still outstanding in relation to ward 4 bathrooms and falls risk.
- Attendance at BSol falls group

VTEs





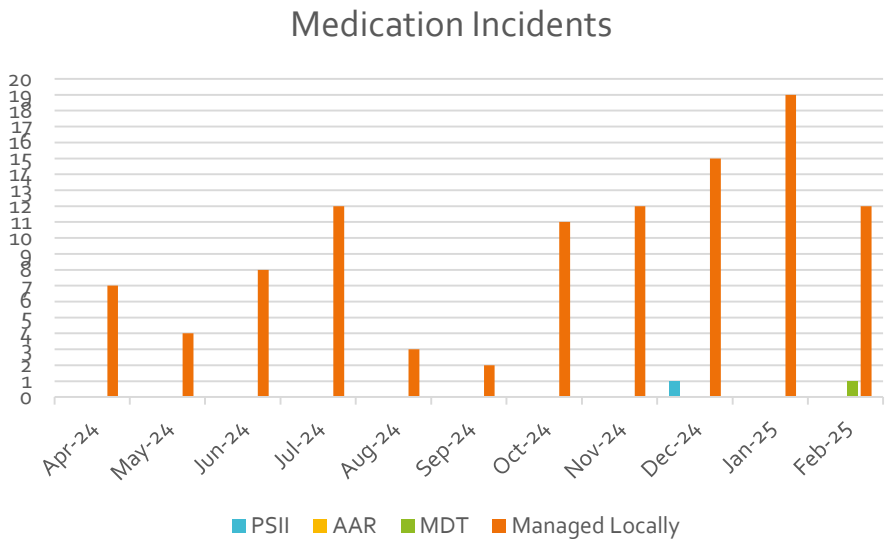
Quality Improvement & Learning

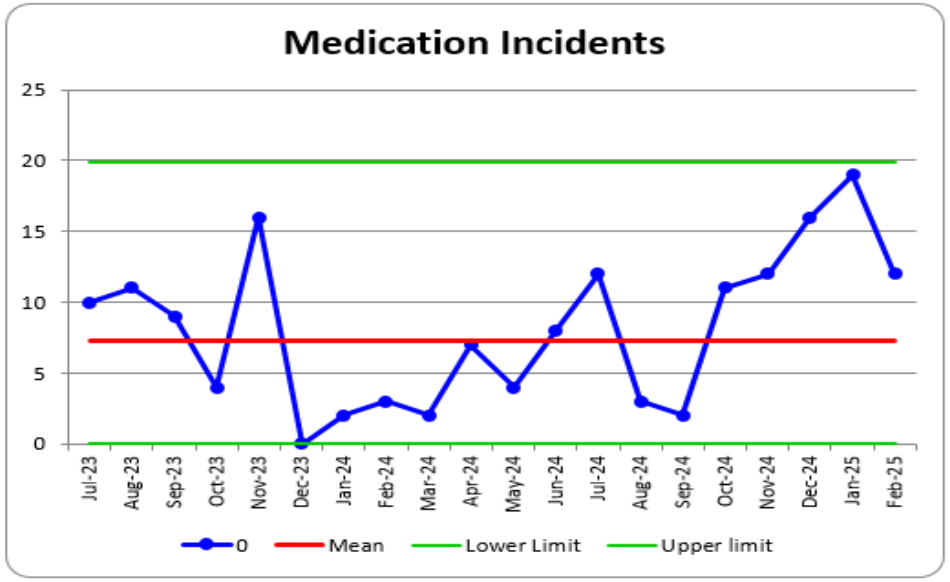
There were 2 VTE incidents reported in February 2025. VTE triage assessment to be completed to determine avoidability and will manage in line with the current PSIRF Framework should further investigation be required.

<u>VTE On Admission Assessment Compliance</u>
Compliance figure for February 2025: 98.18%

<u>Update on previously reported Thematic Review (Reported in August 2024 Quality Report)</u>
Thematic review has now been signed off by the divisional governance committee. The report did not find any themes and concluded, all VTE's reported were unavoidable and patients receiving specialist orthopaedic care are at more risk of developing VTE's due to lack of mobility, medication and co-morbidities.
All recent VTE triage assessments have concluded, and all incidents have been deemed unavoidable.

Medication Errors



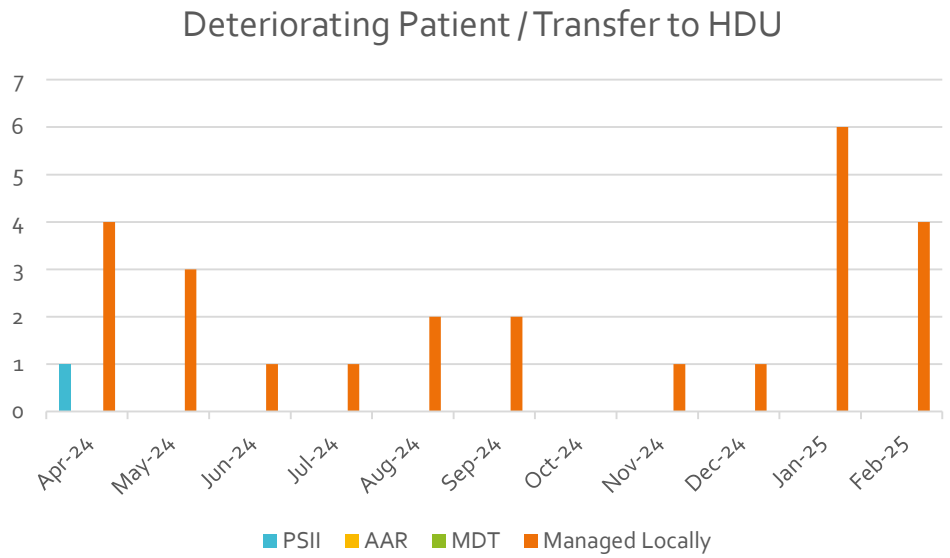


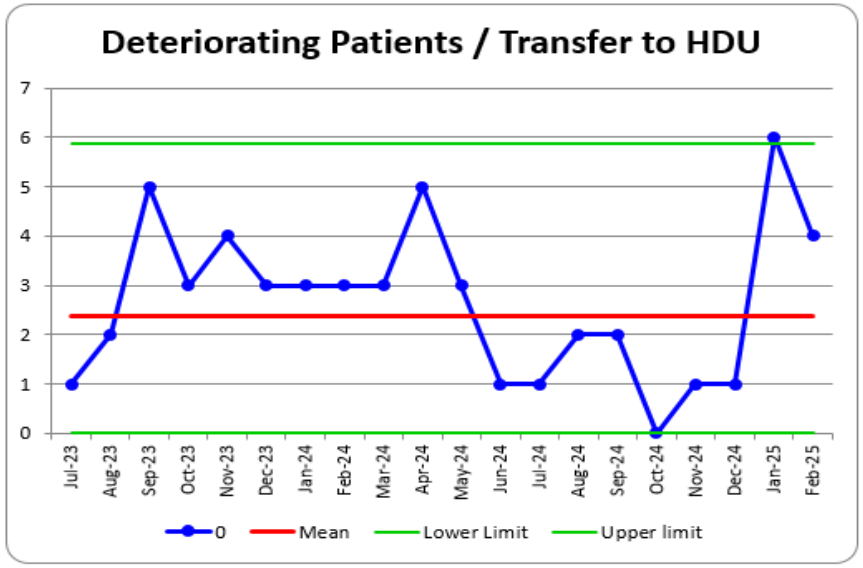
Quality Improvement & Learning

There were 12 Medication incidents reported in February 2025.
Out of these incidents 7 were due to a medication error.

In response to the increased number of medication incidents relating to inpatient and discharge pain management a thematic review has been commissioned and is being led by the DCP. This will be triangulated with prescribing data from PICS, patient experience surveys and ADIOS benchmarking. Further information on themes and identified learning and improvements will be included in a future report.

Deteriorating Patients



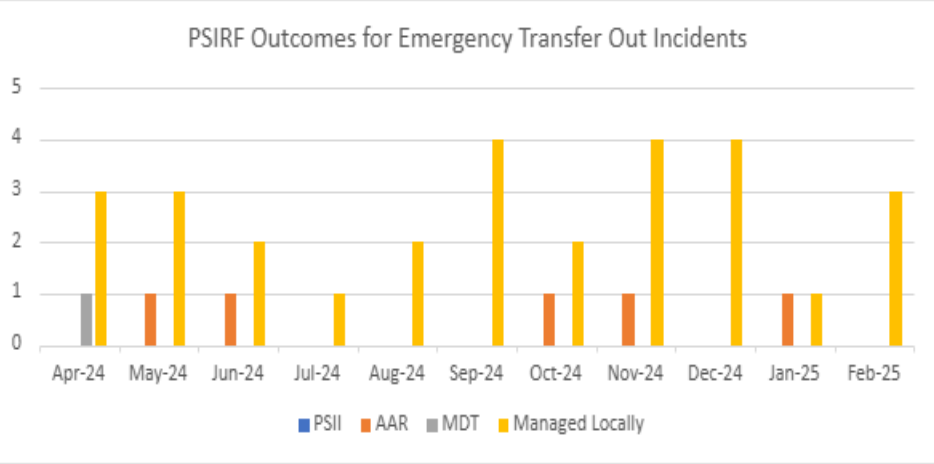


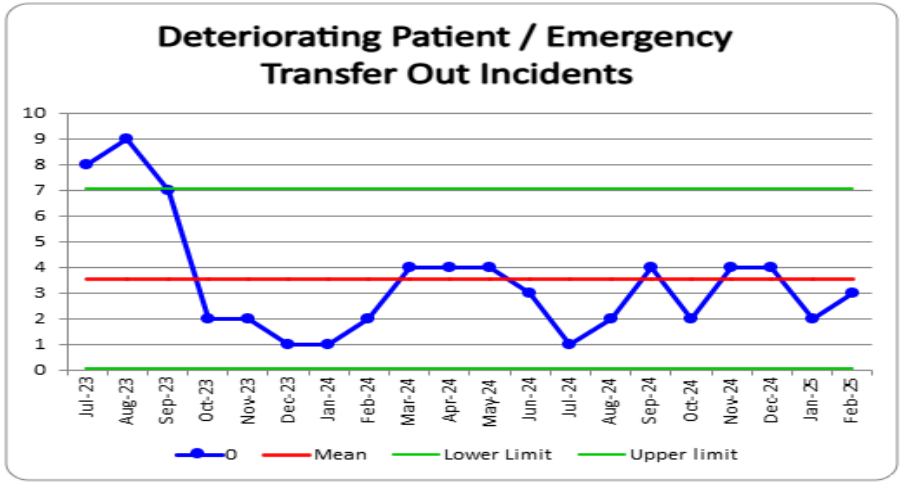
Quality Improvement & Learning

There were 4 deteriorating patient incidents reported in February 2025. All were managed locally

Within the incidents reported, the patients were transferred to HDU due to clinical deterioration that required close monitoring. Medical deterioration was escalated and managed appropriately, all incidents have been discussed and managed through the divisional governance process with no concerns raised.

Emergency Transfers Out





Quality Improvement & Learning

There were 3 emergency transfer out incidents reported in February 2025. All incidents were managed locally. The incidents have been discussed and managed through the divisional governance process, with no concerns raised.

Complaints

Complaint Information

The Trust received **8** complaints in February 2025.

Below are the departments that received complaints in February 2025.

- Oncology
- Spinal
- Ward 3
- Large Joints
- Spasticity
- Pain Management (2)
- Small Joints

In February 2025, there were **3** formal complaint closed. **1** complaint breached the timeframe agreed with the complainant. **KPI = 88%**
At the time of producing this report, (11.03.2025) we currently have **15** formal complaints open and **1** formal complaint that is paused awaiting confirmation from the complainant.

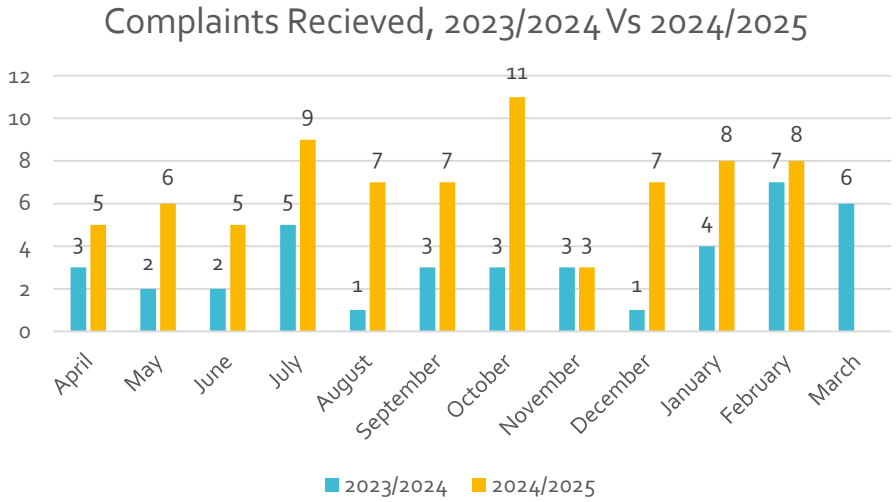
Departments that have open complaints at the time of writing report

- MSK(2)
- Estates
- Large Joints(3)
- Ward 12
- Ward 1
- Spinal
- Spasticity
- Pain Management (2)
- Small joints (3)

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 February 2025 the Trust received **4 requests for a resolution meeting.**

Complaints

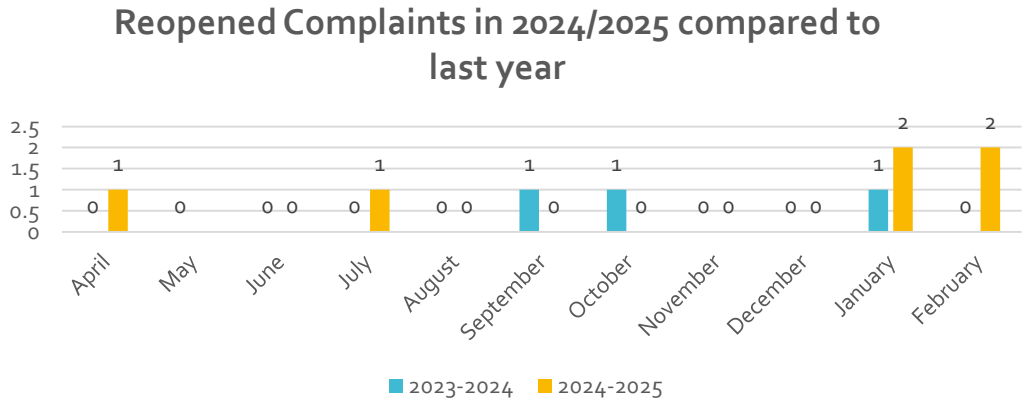


KPIo	Complaints %
April 2024	100%
May 2024	57%
June 2024	0%
July 2024	50%
August 2024	40%
September 2024	50%
October 2024	50%
November 2024	0%
December 2024	46%
January 2025	63%
February 2025	88%

Complaint Year Totals	
April 2023 - March 2024	42
April 2024 – February 2025	76

The Complaints KPI in February 2025 is 88% because 1 complaint out of 8 received breached the timeframe agreed with the complainant

Complaint Themes



Reopened complaints

The Trust received 2 requests to reopen a complaint in February 2025.

The Trust currently has 1 PHSO complaints case open – At present, the PHSO are currently investigating the complaint

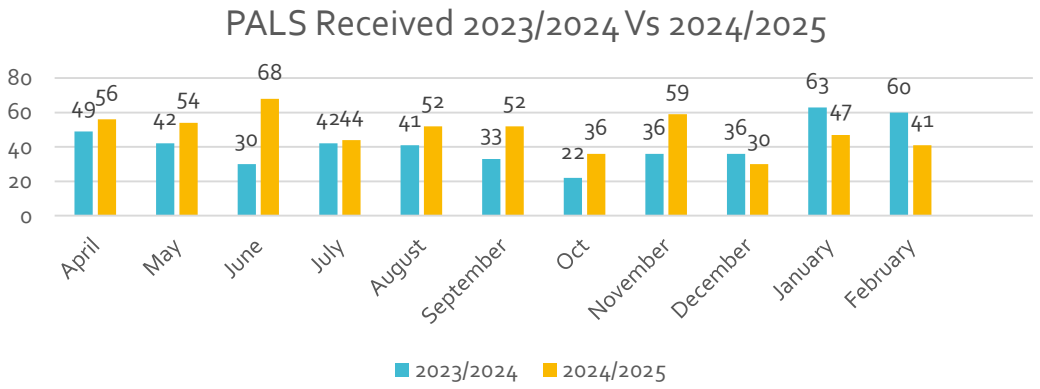
Themes of complaints currently open

1. Cancellation of surgery
2. Car parking
3. Clinical Query
4. Nursing
5. Referral

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



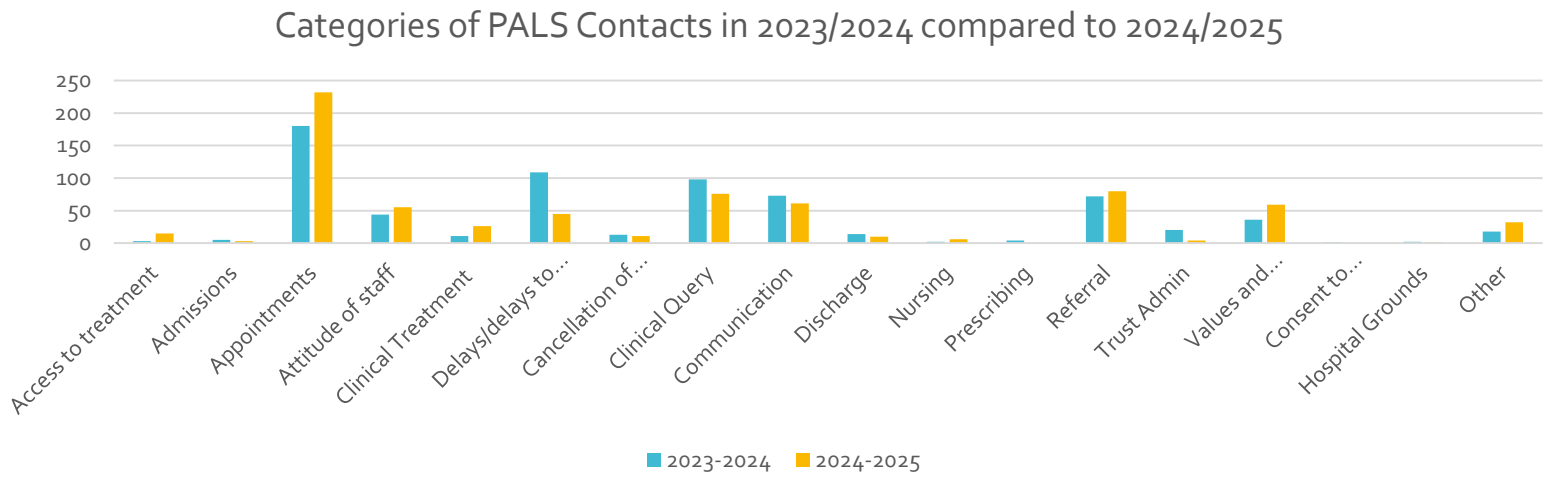
KPI	
April 2024	34%
May 2024	48%
June 2024	58%
July 2024	86%
August 2024	76%
September 2024	59%
October 2024	61%
November 2024	52%
December 2024	77%
January 2025	58%
February 2025	54%

The above graph shows that this financial year The Trust has received more PALS contacts overall in comparison to last year.
PALS Team are now formally documenting cases dealt with within the department on Ulysses to enable them to be reported on to the Divisions they originate from.

PALS Cases breached in February 2025
The KPI of 54% for PALS Contacts was not met

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

PALS Themes



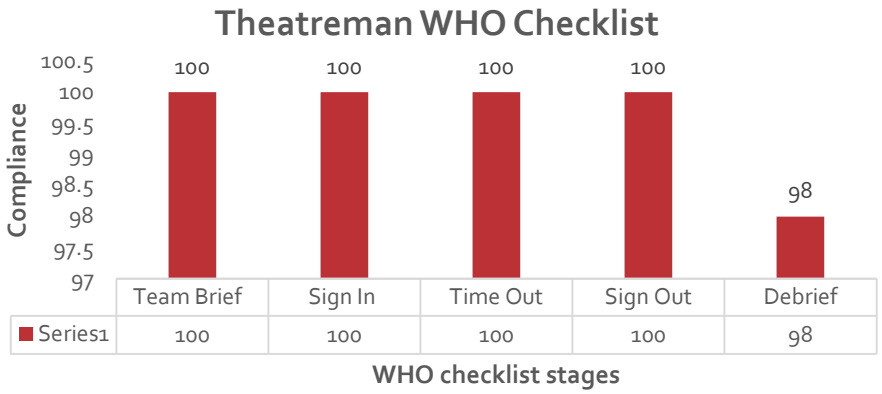
Themes

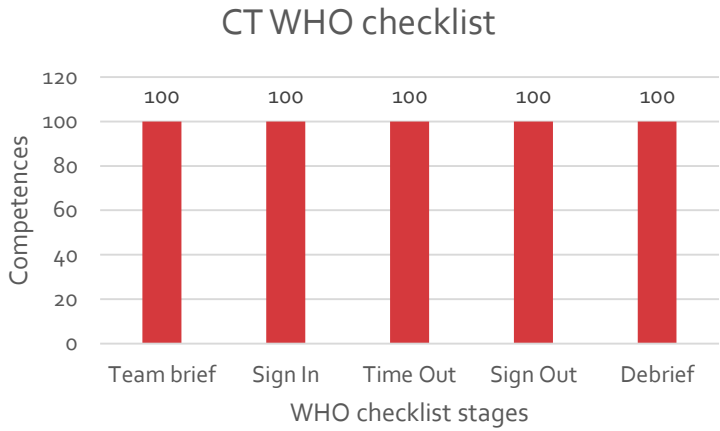
Appointments – 18 out of 41 received
Clinical Query– 12 out of 41 received

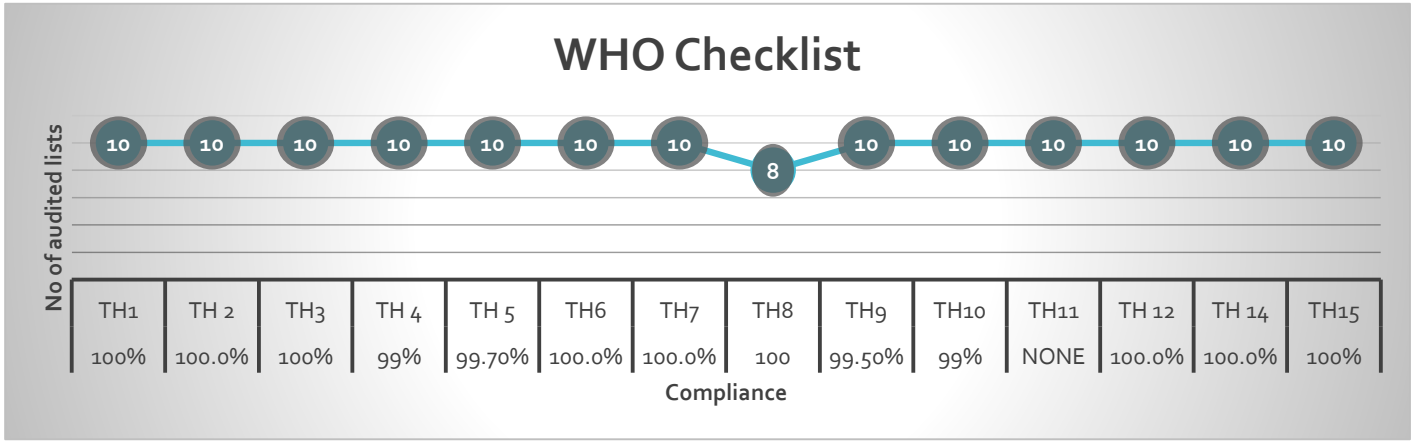
What we have done / are doing:

Tracked in Executive Governance Meetings and via bi-weekly divisional governance meetings
Also 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

Theatre 11 did not submit any audits.
Cluster leads continue working with their respective teams in ensuring that audits are completed in a timely manner.

Work in Progress – Still awaiting new date for review WHO checklist.

CAS Alerts – January 2025

There has not been any new CAS Alerts in February 2025

Ongoing and Open Alerts

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2024/002/NHSPS	Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks. This National Patient Safety Alert, issued by the NHS England National Patient Safety Team, and co-badged by the Association of Anaesthetists, Royal College of Anaesthetists and the Safe Anaesthesia Liaison Group, instructs all relevant NHS funded providers to complete the transition to NRFit connectors for all intrathecal and epidural procedures, and delivery of regional blocks by 31 January 2025.	National Patient Safety Alert	31-Jan-24	Assessed – relevant to organisation's services. **Patient Safety Team advised on 26.02.25 that all Actions are now completed, and they are satisfied to close off:** Email from J.D. (26.02.25) outlines all completed actions (Actions 1 – 3) and concludes: *"....Now that Jess has responded regarding the new ODP starters training, I am happy that we have completed all actions."*	Complete

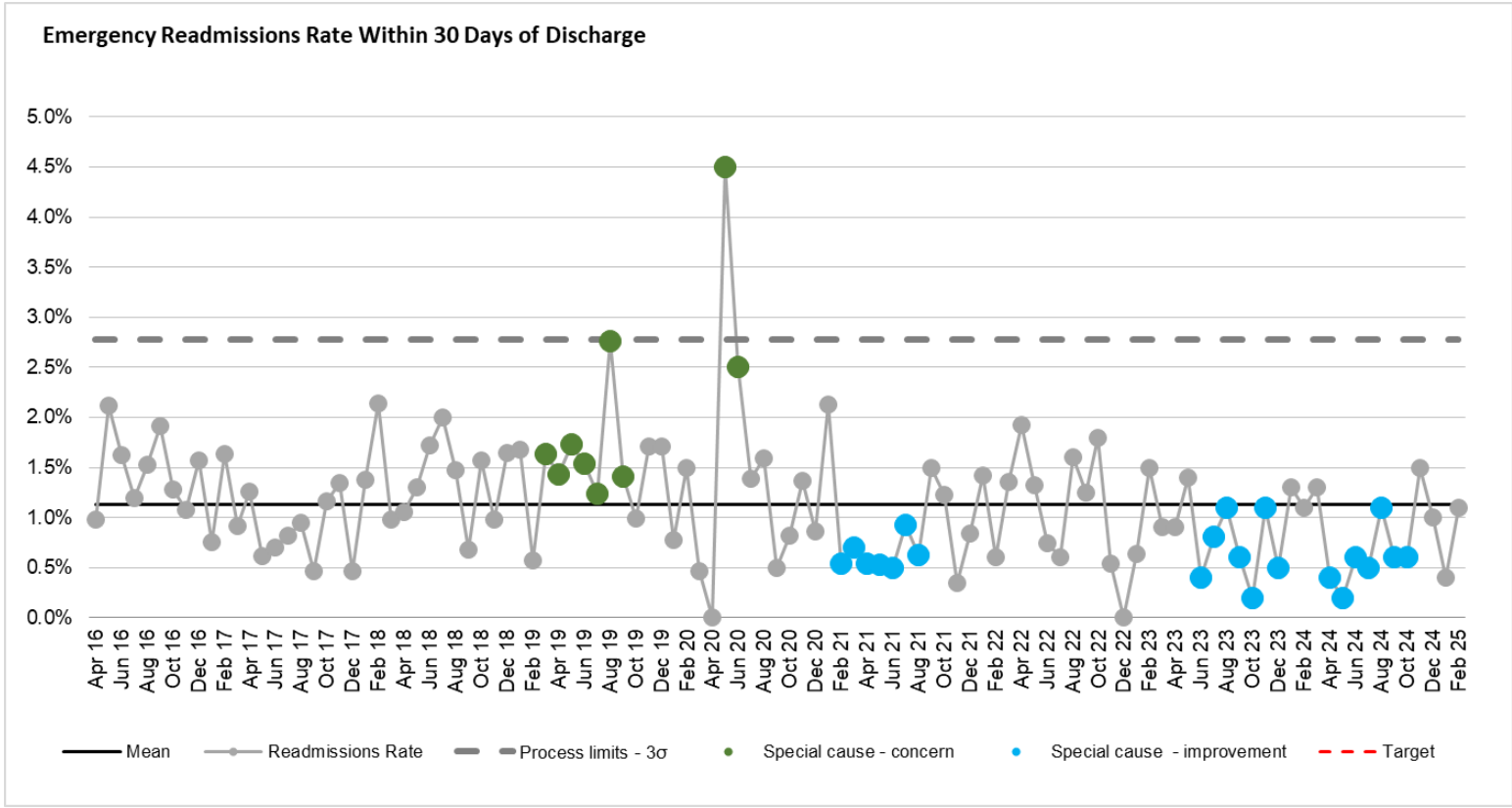
CAS Alerts – Open alerts from previous months

Reference	Alert Title	Originated By	Issue date by MHRA	Response	Deadline
NatPSA/2023/010/MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls. The MHRA continues to receive reports of deaths and serious injuries from entrapment or falls relating to medical beds, bed rails (also known as bed safety rails), trolleys, bariatric beds, lateral turning devices and bed grab handles (also known as bed levers or bed sticks). Chest or neck entrapment in bed rails is currently listed (number 11; 2018) as a 'Never Event' according to the NHS. This National Patient Safety Alert provides further background and clinical information and actions for providers.	MHRA	31 Aug 23	**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 iaw Arjo's service schedule. On-going…	1 Mar 2024. On-going…

Safeguarding Training Compliance

KPI	Feb 2025
Safeguarding Adult Notifications	55
Safeguarding Children and Young People Notifications	59
Adults Level 1- Target 90%	97.66%
Adult Level 2 -Target 85%	93.50%
Adult Level 3- Target 85%	86.78%
Level 4- Target 90%	80.0%
Child Level 1 -Target 90%	97.28%
Child Level 2- Target 85%	93.27%
Child Level 3- Target 85%	86.33%
Mental Capacity Act MCA- Target 85%	93.35%
Deprivation of Liberty Safeguards DoLs	93.35%
Prevent Awareness- Target 95%	92.21%
WRAP (prevent level 3)- Target 90%	88.59%
FGM	3
DOLS	5
MCA	9
PIPOT cases	0
PREVENT Notifications	0

Readmissions



	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25
No of Readmissions	7	2	1	3	3	5	3	3	8	5	2	6
Denominator	548	495	534	472	559	458	510	535	544	476	552	530
% Readmissions	1.3%	0.4%	0.2%	0.6%	0.5%	1.1%	0.6%	0.6%	1.5%	1.1%	0.4%	1.1%

Freedom to Speak Up

There were 2 concerns raised to FTSU in February 2025.

The themes from concerns raised were in relation to:-

Attitude and behaviour
Staff wellbeing
Bully and Harassment

Both concerns were from the same area and are being managed locally within the department.

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Quality Improvements & Learning

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

- Increase Network of Champion to 12.
- Develop FTSU team structure.
- Improve Board report to include case studies.
- Improve FTSU data collection spread sheet.

Safe Staffing

February data for March 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	Total WTE as % establishment (%)	Turnover (%)	Sickness (%)	Maternity (%)	Cumulative count of pts at 23.59 per day	Actual CHPPD	Red Flags Opened	Red Flags Closed	Enhanced Care Hours	Hand Hygiene Audit	Medication Administration Incidents	Pressure Ulcers Category 2,3 & 4	All Reported Falls	No. of PALs Contacts	No. of New Complaints	No. of FFT
Ward 1	83%	122%	101%	175%	91.29 %	11.14 %	91.69 %		477	7.9	0	0	504	98.8 %	0	0	6	0	0	60%
Ward 2	77%	107%	100%	129%	99.28 %	15.75 %	92.67 %		507	7.3	0	0	183	100.0 %	3	0	2	3	0	77%
Ward 3	85%	104%	99%	118%	95.41 %	16.04 %	92.19 %		563	6.5	0	0	125	100.0 %	0	1	0	0	1	61%
Ward 4	95%	117%	104%	158%	78.08 %	17.89 %	93.54 %		381	9.9	0	0	373.5	100.0 %	3	1	0	0	0	46%
Ward 12	73%	100%	100%	106%	85.96 %	17.50 %	90.67 %		61	11.7	0	0	0	100.0 %	0	0	0	0	0	-
HDU	109%	115%	108%	100%	52.38 %	0.00%	90.94 %		113	21.5	0	0	67.5	100.0 %	0	1	0	0	0	56%
Outpatients	100%	85%	100%	76%	88.70 %	10.12 %	92.08 %				3	0	-	91.0 %	0	0	0	0	0	2%
ADCU														100.0 %	0	0	0	0	0	31%
POAC														100.0 %	0	0	0	0	0	18%
Theatres														99.5 %	0	0	0	0	0	57%
Total/Combined											3	0		98.9 %	6	3	8	3	1	45%

Operational Performance Report

Month 11

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 February 25	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	53.58%	52.01%	92%		F
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	5	19	0	L	F
52 week waits (52 – 64 Weeks)	664	727	0	H	F
All activity YTD (compared to plan)	13,897	12,557	14,014		F
Outpatient activity YTD (compared to plan)	66,679 108.7% Cumulative	60,701 108.6% Cumulative	61,339 YTD Target		P
Outpatient Did Not Attend (YTD)	8.0%	8.2%	8%		P
PIFU (trajectory to 5% target)	674 11.8%	711 10.99%	403 5%	H	P
Virtual Consultations (target is plan, operational planning guidance is 25%)	9.3%	9.9%	19%		F
FUP attendances(compared to 19/20)	99.97%	101.1%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	113.4%	113.2%	N/A		F
Diagnostics volume YTD (compared to plan)	23,500 Cumulative	21,544 Cumulative	24,862 YTD Target		F
Diagnostics 6 week target	99.92%	99.89%	99%		P

Operational Performance Summary

Performance to end February 25	In month	Previous month	Target	Variation	Assurance
Theatre utilisation (Uncapped)	89.23%	93.1%	85%		
Theatre In Session Utilisation (Uncapped)	83.64%	82.5%	85%		
Cancer - 31 day first treatment	100%	100%	96%		
Cancer - 62 day (traditional)	88.2%	90.9%	70% Nat 85% Trust		
28 day FDS	77.8%	80.5%	75%		
Patients over 104 days (62 day standard)	0	0	0		
POAC activity volume (YTD)	23,312 Cumulative	21,447 Cumulative	21,184 Cumulative		
Bed Occupancy (excluding CYP and HDU)	74.1%	70.6%	82-85%		
LOS - excluding Oncology, Paeds,YAH, Spinal	3.03	3.1	n/a		
LOS - elective primary hip	2.40	3.0	2.7		
LOS - elective primary knee	2.60	3.0	2.7		
BADS Orthopaedic: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period) Nov 24	53.7%	56.0%	85%		
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Nov'24)	37.3%	37.4%	-		