Trust Board (Public) September

Wednesday 3rd September, 09:00h-13:00h

Boardroom, Trust Headquarters

Notice of Trust Board Meeting in Public on Wednesday, 3 September 2025

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 3 September 2025, in the Boardroom, Trust HQ commencing at **09:00.**

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

Simon Page
Chair

TRUST BOARD (IN PUBLIC)

Venue Boardroom, Trust Headquarters **Date** 3 September 2025: 09:00h – 13:00h

Members attending

Mr Simon Page	Chair	(SP)
Ms Simone Jordan	Vice Chair & Senior Independent Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Mr Les Williams	Non Executive Director	(LW)
Dr Ian Reckless	Non Executive Director	(IR)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mrs Jenny Belza	Non Executive Director	(JB)
Mr 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 Sikhathele Nkala	Domestic Abuse & Sexual Violence Advocate	(SN)	[Item 1]
Ms Rebecca Furnival	Head of Safeguarding and Vulnerabilities	(RF)	[Item 1]
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
		IN PUBLIC SESSION		
09:00	1	Patient Story	ROHTB (9/25) 028	SN/RF
09:30	2	Apologies: Jan Teo	Verbal	Chair
	3	Declarations of Interest	ROHTB (9/25) 001	Chair
	4	Minutes of Board Meeting held in Public on 2nd July 2025: *for approval*	ROHTB (7/25) 022	Chair
	5	Actions from previous meetings in public: *for assurance*	ROHTB (7/25) 022 (a)	SGL
	6	Questions from members of the public	Verbal	Chair
09:50	7	Chair's and Chief Executive's update: *for information and assurance*	ROHTB (9/25) 002 ROHTB (9/25) 002 (a)	MH/SP
	7.1	Board Operating Model: *for approval*	ROHTB (9/25) 003 ROHTB (9/25) 003 (a)	SGL

10:10	8	Chief Finance Officer's report: *for information and assurance*	ROHTB (9/25) 004 ROHTB (9/25) 004 (a)	SW
10:30	9	Chief Operating Officer's report: *for assurance*	ROHTB (9/25) 005 ROHTB (9/25) 005 (a)	MP
10:45	10	Chief People Officer's report: *for assurance*	ROHTB (9/25) 006	SM
11:00	11	Quality Officers' report: *for assurance*	ROHTB (9/25) 007	MR/NB/ SGL
11:15		**BREAK**		
11:25	12	Green Plan Update: *for assurance*	ROHTB (9/25) 008 ROHTB (9/25) 008 (a)	SW
11:35	13	ROH Strategy 2023-2028: Delivery Plan Update: *for assurance*	ROHTB (9/25) 009 ROHTB (9/25) 009 (a)	RL
		GOVERNANCE AND COMPLIANCE		
11:55	14	Refreshed Board Assurance Framework: *for assurance*	ROHTB (9/25) 010 ROHTB (9/25) 010 (a - f)	SGL
12:10	15	Flu Vaccination Plan 2025: *for assurance*	ROHTB (9/25) 011 ROHTB (9/25) 011 (a)	NB
12:25	16	Learning from Deaths: *for assurance*	ROHTB (9/25) 012 ROHTB (9/25) 012 (a)	MR
		UPWARD REPORTS FROM THE BOARD COMMITTEES		
12:35	17	Upward reports from the Board Committees: • Finance & Performance Committee • Staff Experience & OD Committee • Quality & Safety Committee o Infection Prevention & Control Annual Report: *for approval* • Audit Committee	ROHTB (9/25) 014 ROHTB (9/25) 015 ROHTB (9/25) 016 ROHTB (9/25) 016 (a-b) ROHTB (9/25) 017	LW SJ IR GH
12:50		**MATTERS TO BE TAKEN BY EXCEPTION**		
	18	Performance Reports: *for assurance* a) Finance & Performance b) Quality Report c) Workforce Report	ROHTB (9/25) 018 ROHTB (9/25) 019 ROHTB (9/25) 020	
	19	Any Other Business	Verbal	All
	20	Meeting effectiveness	Verbal	All

13:00	CLOSE: Date of next meeting: Wednesday, 8 October 2025 @ 09:00

Notes

Quorum:

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

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

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

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

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

KEY:

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

* Apologies tendered as attending a national event on behalf of the ROH, mandated for all NHS trusts
** Meeting moved from 02/04/2025 to 09/04/2025 due to availability of Chair and CEO.

TRUST BOARD DECLARATIONS OF INTEREST REGISTER

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

Name	Interest	Voting Member
Simone Jordan **Non Executive Director & Vice Chair**	• Non Executive Director, George Eliot Hospital NHS Trust • Member of the Chartered Institute of Personnel and Development • Vice Chair & Non Executive Director, Leicestershire & Rutland Integrated Care Board (LLR ICB).	Yes
Les Williams **Non Executive Director**	• Chair of Labour Branch, Cradley Heath	Yes
Gianjeet Hunjan **Non Executive Director**	• Non Executive Director, Black Country ICB • Lay Member, National Clinical Impact Awards - National Main Committee and West Midlands Committee • Governor, Oldbury Academy • Governor, Ferndale Primary School • Member of IHSCM • Member of HFMA • Fellow of Chartered Institute of Public Finance and Accountancy (CIPFA) • Member of Nishkam Healthcare Trust at local Gurdwara • Lay Panel Chair, Nursing and Midwifery Council	Yes
Ayodele Ajose **Non Executive Director**	• Legal Consultant to Law Firm Addleshaw Goddard LLP – Currently Assigned Full-Time to Group Lotus	Yes
Ian Reckless **Non Executive Director**	• Executive Director (Medical Director and Deputy Chief Executive), Milton Keynes University Hospital NHS Foundation Trust • Director, ADMK Limited (wholly owned subsidiary of Milton Keynes University Hospital NHS Foundation Trust) • Director, JTER Trading Limited (company involved in property services and antiques trading) • Fellow, Royal College of Physicians • Fellow, Faculty of Medical Leadership and Management	Yes

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

MINUTES

Trust Board PUBLIC - DRAFT Version 0.1

Venue Boardroom, Trust Headquarters **Date** 2 July 2025: 1115h - 1300h

Members attending:

Mr Simon Page	Chair	(SP)
Ms Simone Jordan	Vice Chair & Senior Independent Director	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Dr Ian Reckless	Non Executive Director	(IR)
Ms Ayodele Ajose	Non Executive Director	(AA)
Mr Matthew Hartland	Chief Executive	MH)
Mr Mathew Revell	Executive Medical Director	(MD)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mrs Sharon Malhi	Executive Chief People Officer	(NB)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance:

Mrs Sophie Goddard	Health and Safety Advisor	(SG)	
Mrs Alexandra Gilder	Deputy Director of Finance	(AGi)	
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

IN PUBLIC SESSION	
14 Staff Story (SG)	**Presentation**
SGL introduced Sophie Goddard (SG), Health and Safety Advisor, who joined the Trust Board meeting today to share her story since joining the Trust in November 2024. The key points to highlight include: • New to the NHS in November 2024. • Started in Environmental work after leaving university. • Moved into HSE working in the fuel industry. • Started a family and deciding a career change was needed to be nearer home. On return from maternity leave for the second time and applied for the	

position at the ROH.

- Flexible working was crucial, and other positions were not prepared to offer such flexibility that would fit around life and still allow career to progress.
- NHS comes with different risks and finding way in the organisation works.

The Board was invited to ask questions and comment.

The following points were of particular note:

- SP questioned what the NHS could learn from the outside experience. SG raised it would be good to raise awareness of Health and Safety Legislation as the NHS is not exempt from it, and it is just as important as patient and clinical safety. SG raised training could be enhanced, whilst we deliver to guidance it could be tailored. Management responsibility is something that could be enhanced. NB raised one constraint is mandatory training and how it is slow to keep up with what is happening in real time. NB agreed it is important to remind everyone of their responsibilities. SG raised it is also important to give people the capacity to undertake the training.
- SJ thanked SG for sharing her story. SJ questioned what has been the biggest surprise at the ROH and the NHS. SG explained the challenge of the estate and the work they have to undertake with the old infrastructure.
- SGL explained that this role is undertaken in three days a week. SGL highlighted that SG led the Health & Safety Inspection recently and asked what would do differently for future outside agency visits. SG explained more interrogation would be needed. Policies and procedures are in place, and it is crucial the checking and the acting part of responsibilities need to take place. Need to be more robust around assurance. SGL agreed this feedback is valuable to support other inspections we undertake.
- AA welcomed SG to the Trust and questioned what is the biggest health & safety risk to the Trust in comparison to private organisations. SG explained manual handling is a big risk to our colleagues. It has been identified those other colleagues that may have not been captured that need a higher level of training but provided assurance this is being addressed. Stress is also a risk, and this is clear it is a challenge across the NHS. This will continue and we need to establish how we do not allow it to get to this stage.
    - NB highlighted that there has been an increase in support needed to staff with stress in particular with regards to safeguarding. NB questioned how this would be addressed outside of the NHS. SG explained that the risk assessment is processed in the exactly the same way but would need to investigate further to be able share best practice from other industries.
- SM thanked SG for her involvement in the ‘Me as Manager’ programme and questioned how engagement has been with Managers. SG explained that two sessions, with a mix of clinical and non-clinical on both sessions, have

taken place. The uptake is minimal and would recommend more to attend and would encourage mandating the attendance. SM questioned if we are able to triangulate data back to areas to focus on. SG explained that this is possible. **ACTION: review the mandatory aspect of training and ensure it is right. SM** • MH questioned whether the flexibility for working is right at the Trust. SG explained that conscious not able to provide for clinical colleagues, but the flexible working provided has meant SG has been able to still undertake a job she is passionate about. SP thanked SG for sharing her story with the Board.	
15 Apologies: (Chair)	**Verbal**
Apologies were received and accepted from Les Williams, Jenny Belza, Jan Teo and Steve Washbourne.	
16 Declarations of Interest (chair)	**ROHTB (7/25) 008**
There were no new declarations to record to what has been published.	
17 Minutes of the previous meeting in public held on 4 th June 2025: *for approval* **(chair)**	**ROHTB (6/25) 021**
The minutes of the meeting held in private on 4 June 2025 were accepted and **approved** by the board.	
18 Actions from previous meetings in public: *for assurance* **(SGL)**	**ROHTB (6/25) 021 (a)**
SGL presented the action log and provided the following updates: - **ROHTBACT.272** Vaccination update – It was confirmed the data has been reviewed but due to the limitations of how the data is categorised we are unable to link the sickness to vaccination data. Propose Closure. - **ROHTBACT.274** Clinical Decision-Making Tool update will be provided as part of the wider MSK update. IR queried the capital for this sits on our plan for £2m but is a system capital. AGi to action a query on where this should sit. **ACTION AGi**	
19 Questions from members of the public (Chair)	**Verbal**
There are no questions received ahead of the meeting.	
20 Chair's and Chief Executive's update: *for information and assurance* **(TP/MH)**	**ROHTB (7/25) 009** **ROHTB (7/25) 009 (a)**
Chief Executive Update	

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MH presented the Chief Executive update, and the paper was taken as read.

The key points to highlight include:

- We are awaiting the publication of the NHS 10 Year Plan which is expected by the end of this week.
- An offer of support has been extended to Robert Jones and Agnes Hunt after the sudden loss of their Chief Nurse. Our heartfelt thoughts are with the Trust at this very sad time.
- Strategy Update and Implementation. There has been continued reinforcement through engagement with colleagues and feedback is it being recognised that there is the need to change. Service review process is underway for Corporate Services. The corporate service review process involves a data book that is prepared and requests the team consider savings that could be made. The risks of making these savings will then be reviewed by the Executives as to whether this can be supported. Reviews will be completed by 24th July and then a check and challenge review will be undertaken, with Executives reviewing over August. This will then be reported to the Strategy Delivery Board. It will then move into Clinical Review, however Spinal and Theatre Reviews have already commenced. A full report will be presented to the Board in September.
- Research & Development Innovation Work – positive conversations with a number of organisations, including hosting a visit of a group from China who are looking to developing a product and would like to consider the ROH as the base to develop this in our laboratory. IR raised concern over the risk of this, and the risk was noted.

Chair Update

- The private board provided an opportunity to discuss a number of key items that have provided assurance the Trust have control measures in place.
- The finance position is reassuring, and it is important the focus remains.

The Board was invited to ask questions and comments.

- GH queried the GetUBetter help, and MP explained the funding is currently being explored to support this in continuing.

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<tr><td>21 Chief Finance Officer's Report: for assurance (SW)</td><td>ROHTB (7/25) 010
ROHTB (7/25) 010 (a)</td></tr>
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AGi presented the Chief Finance Officer Report in the absence of Steve Washbourne. The report was taken as read.

The key points to highlight include:

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

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• The positive position is driven by an income overperformance in month, and achievement of cost improvement programmes (CIP) for the first two months. • Risk around income and the current contract positions. A number of contracts have now been agreed. MH explained that this will be escalated with the ones that have not been agreed and would look to the Board to approve this escalation. • Non pay remains an area of focus but there are noticeable improvements. • Pay focus will look to the output of the service reviews in order to deliver the cost improvement programmes. • Cash remains challenging. AGi explained the cash position and how the banking balance works. The Board was invited to comment and ask question. The following point was of particular note: • SP questioned if we are content that we are delivering everything that is needed to achieve what we have set out to achieve. MH explained that as part of the Strategy Delivery Group there will be a detailed report provided from the PMO team to show the delivery plan and highlight any areas of concern.	
22 **Chief Operating Officer's Report:** *for assurance* **(MP)**	**ROHTB (7/25) 011** **ROHTB (7/25) 011 (a)**
MP presented the Chief Operating Officer's Report. The key points to highlight include: • A suite of operational metrics are monitored weekly against the agreed trajectory. • Trust Improvement Group met for its inaugural meeting on 23rd June. This Group will deliver oversight on all key continuous improvement projects and will provide an update assurance report for the Trust Management Group. • Operational metrics are on target. • 65-week target delivered for May and June. • Activity for May +29 Cases and +129 cases YTD. There is also a positive report for June. • Exploring new markets for Private Patients. Completed walkabout sessions, where conversations with surgeons took place to gather interest. In outpatients had broader conversations with Nursing teams and had positive responses with some good ideas. • Focus on Surgery Week is scheduled to take place during week commencing 7th July.	

• Outpatients Transformation Programme will be presented to Finance & Performance Committee to share the work being undertaken as this a national priority. The Board was invited to ask questions and comment. The following points were of particular note: • SP questioned the over delivery on private patient and queried can the stretch target be amended. MP explained this is going to be discussed at Executive meeting next week. MH highlighted need to remember increase in work also includes increase in costs and we need to be mindful of that. • IR questioned if the national guidance was to be implemented where patients were not to be seen before 12 weeks would that affect us. MP explained that we do have some services that are delivering below 12 weeks and therefore could be a challenge to the Trust to slow down the work that is being done.	
23 Chief People Officer's Report: *for assurance* **(SM)**	**ROHTB (7/25) 012**
SM presented the Chief People Officer's report, and the paper was taken as read. The key points to highlight include: • Working through appraisal window, 500 appraisals to be completed by the end of the month. Full report to be provided at Staff Experience & OD Committee in August. • The Trust retained the Disability Confident Level 3. Thanks to AGi and Team. • Silver Accreditation for Thrive at Work has been achieved. Now aiming for Gold. • The NHS is facing possible industrial action, primarily centred around pay disputes. • Winter preparation letter has been received, and plans are being prepared especially if faced with industrial action. • Key risk is staff engagement across the Trust as we work through some challenging months. People pulse goes live end of the month which will provide an idea of areas that require more focus. • There has been shift in long term absence to short term absence which required support to managers in the management of the absence now.	
24 Quality Officers' Report: *for assurance* **(MR/NB/SGL)**	**ROHTB (7/25) 013**
MR, NB and SGL presented the Quality Officers Report. The paper was taken as read. The key points to highlight to include:	

• Spinal Endoscopy review completed and will be presented in detail to the Quality and Safety Committee. MR provided assurance that support has been given to the team to help digest the feedback given. An action plan has been created and a summary response to Royal College of Surgeons is required by the end August and then a detailed response within 6 months. • Children and Young Person CQC visit – NB explained this is still in progress and a full update provided once report received. • The NHS Standard Contract 2025/26 report normally goes to Quality and Safety Committee but there has now been set a zero target in every domain so highlighting to the Board as the Trust is in a positive position but area of concern as this ties into oversight framework. • IPC visit undertaken by NHSE and ICB. This was an annual engagement visit with focus being supportive and informative. • HTA Peer Review was undertaken, and we are awaiting formal report but there were no concerns raised. The Trust has been asked to share what we have done with other organisations. • The Trust held its second Nursing and Allied Healthcare Professional Conference. • Sexual Safety Charter Work, working with University of Worcester. Staff survey results show improvements. • System wide Patient Safety Group established, updates will be included in the future reports received. • Governance team supporting roll out of Patient Safety Incident Framework to system partners. • A planned Health and Safety Investigation took place on 18 th and 19th June. We are awaiting formal feedback. • The use of Artificial Intelligence to support the work of the Executive PA continues to be explored with confirmation that the Team will pilot Microsoft CoPilot towards the end of the year once licences have been allocated. • The Freedom to Speak Up Team is supporting an awareness event on 8 July to promote Civility and Respect.	
25 RACE Code Adoption: *for approval* **(SM)**	**ROHTB (7/25) 014** **ROHTB (7/25) 014 (a)** **ROHTB (7/25) 014 (b)**
SM presented the RACE Equality Code, and the paper was taken as read. The key points to highlight include: • The pack includes the compliance statements.	

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- This has been heavily supported by the Governance Team to provide the evidence required.
- Working with Comms team to ensure the information is able to be digested.
- It is presented to the Board for approval to adopt.
- SJ confirmed this has been discussed at Staff Experience & OD Committee and it is incredible powerful if the improvements were implemented. SJ emphasised this is crucial this remains under the scrutiny of SE&OD. SM provided assurance that the detail will feed into Executives and then feed into Staff Experience & OD through a number of reports already presented.
- MP provided assurance that this demonstrates the commitment to tackle the racism issues people are facing and the attendance at the network group shows just how much more comfortable people to speak up about this.

The Board approved the adoption of the RACE Equality Code that has been presented to the Trust Board today.
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<tr><td colspan="2">GOVERNANCE AND COMPLIANCE</td></tr>
<tr><td>26 Insightful Provider Board Action Plan: for assurance (SGL)</td><td>ROHTB (7/25) 015
ROHTB (7/25) 015 (a)</td></tr>
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SGL presented the Insightful Provider Board action plan, and the paper was taken as read.

The key points to highlight:

- Three actions to be worked through which are all currently in progress.
- Update to action plan to be presented in November.

The Board was invited to comment and ask questions.

- IR queried the number of Board members and questioned is it appropriate for the size of the Trust. SGL explained that a reflection of the skills of the Board would be considered, and it has been agreed to review the terms of references of Committees.
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<tr><td colspan="2">UPWARD REPORTS FROM THE BOARD COMMITTEES</td></tr>
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27 Upward reports from the Board Committees:

- **Finance and Performance Committee**
- **Staff Experience and OD Committee**
- **Charitable Funds Committee**
</td><td>ROHTB (7/25) 016
ROHTB (7/25) 017
ROTHB (7/25) 018</td></tr>
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Finance and Performance Committee – GH

The paper was taken as read.

The key points to highlight include:
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- In a full agenda, discussions focussed on Month 2 performance and progress on plans to deliver activity and financial targets, and progress on the development of the Integrated Performance Dashboard.
- The Committee received and approved the proposed Capital Plan for 2025/26, which has been presented for approval at today's meeting.
- Several positive aspects of financial, activity and waiting times performance were noted. Much of the detail has already been presented in the Chief Executive and Executive Directors' reports earlier in the agenda and so will not be repeated here.
- It was noted that future months will be more challenging for delivery, due to the continually developing national approach, the scale of the CIP challenge, and the greater authority provided to Commissioners to impose activity and financial targets in case of dispute.
- Challenges in the theatre environment were noted, and activity delivery in spite of these issues was commended, as was continued downward pressure on agency and bank costs, and stabilisation of theatre equipment spend in the GenMed contract.
- There remains uncertainty about NHS England funding for the new EPR, and discussions with NHS England are being actively pursued.
- The next stage of development of the Integrated Performance Dashboard was discussed at length, and although the need for Model Hospital measures to be included was noted, the proposed Dashboard still did not fully reflect the proposals set out by Non Executive Directors. It was agreed that NEDs remained available for further discussions to progress this to the point of being used to monitor practice and variation.
- The Committee received updates on the 2025/26 contracting process and the recent national Spending Review by the Chancellor and it was noted this would not result in further funding becoming available.

Staff Experience and OD Committee -SJ

The paper was taken as read.

- Positive story from a medical student and highlighted the wider organisations that goes into arranging this experience.

Charitable Funds Committee – AA

The paper was taken as read.

- Concern was raised of being mindful not to lose sight of spending the funds in the unallocated Charity pot was noted.
- Business development team being formed which will work with the Charity on plans around the redesign of the welcome area at the front of the hospital to house the ROC Hub.
- The second phase of Health Hacks is being developed.
- Charity Annual Report was presented and thanks to the Team for the creation of the document.

• Bid Approved for the upgrade to the Multifaith room.	
MATTERS TO BE TAKEN BY EXCEPTION	
28 Performance Reports: *for assurance* • **Finance & Performance** • **Quality Report** • **Workforce Report**	**ROHTB (7/25) 019** **ROHTB (7/25) 020** **ROHTB (7/25) 021**
The reports were taken as read.	
28 Any Other Business	**Verbal**
IR raised it should be noted the recent news where a number of executives have been arrested at Countess of Chester and should consider the risk to organisation.	
29 Meeting Effectiveness	**Verbal**
The Board Members recognised the focussed and timeliness of the meeting.	
Date of next meeting: Wednesday, 3rd September 2025 @ 0900h	

PUBLIC SESSION

Next Meeting: 3 September 2025, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 28th August 2025

Number	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT.277	Upward Reports to Board Committee - SE&OD	ROHTB (5/25) 011	07/05/2025	Provide an update from the Workforce Planner to the August SE&OD Committee and then present to the Trust Board in September.	SM	03-Sep-25	**Presentation provided to Staff Experience & OD Committee on 27th August.**	
ROHTBACT.280	Staff Story	Presentation	02/07/2025	Review the mandatory aspect of Me as a Manager training.	SM	03-Sep-25	**Interim evaulation report will be provided to Staff Experience & OD Committee in October to scope the decision around mandating this training.**	
ROHTBACT.281	Actions from previous meeting in public	ROHTB (6-25) 021 (a)	02/07/2025	Query where the cost of the clinical decision making tool should sit now that this is a BSOL system wide project.	AGi	03-Sep-25	**ICS agreement that UHB will host. Propose Closure.**	
ROHTBACT.279	Freedom to Speak Up Update	ROHTB (6/25) 014 ROHTB (6/25) 014 (a)	04/06/2025	Discuss the Freedom to Speak Up report at Staff Experience & OD Committee in connection with the previous Staff Story feedback.	SM	20-Aug-25	**Discussion took place at Staff Experience and OD Committee on 27th August 2025. Propose Closure.**	

KEY:

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

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	**Chief Executive's Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Chief Executive**
AUTHOR:	**Matthew Hartland, Chief Executive**
DATE OF MEETING:	**3 September 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

CHIEF EXECUTIVE'S REPORT

Report to the Trust Board (in Public) on 3 September 2025

1. INTRODUCTION

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

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

PERSONAL STATEMENT

1.4 I start this report by stating how much of an honour it is to be appointed as the substantive Chief Executive of the Royal Orthopaedic Hospital. This follows the appointment of Jo Williams as the Chief Executive of the Shrewsbury and Telford Hospital NHS Trust and I, and the full Board, wish Jo well in her new role in Shropshire. My priorities at the ROH in the short-term will continue to be financial sustainability, improving productivity and delivering our strategy, but I can also now plan for the longer term which includes reflecting on our strategy to ensure it, as a minimum, meets the requirements of the new NHS 10-year plan. I thank the Board, Executive Team and colleagues within the Trust and System for their support to date, and I very much look forward to working with you all ensure the ROH is the best it can be for our patients, population and staff.

2. NATIONAL UPDATE

2.1 NHS Operating Model

It has now been confirmed that Birmingham and Solihull ICB will cluster with Black Country ICB. The two organisations are already working closely together but are expected to move to a single leadership structure over the next few months. The Chief Executive of the new Cluster will be David Melbourne, currently Chief Executive of the Birmingham and Solihull system. The Chair is yet to be confirmed. I wish David well in his new role and I, and the Executive Team, will continue to support David and the wider BSOL/Black Country team on what will be a challenging period ahead.

The change in geographical footprint will also impact on ways of working for the ROH and other providers in the system. We are commencing dialogue with provider colleagues across the new system to agree the best way to operate to support the needs of the system and individual providers. This will form part of a future development session for Board to consider.

2.2 Policy – Ten Year Health Plan for the NHS

Since the last Board meeting in July the government has published the 10-year Health Plan for the NHS. We were aware of the three 'Darzi' priorities that would form the basis of the plan – Hospital to Community; Analogue to Digital; Sickness to Prevention – and had included such themes in the refresh of the ROH strategy published in April this year. The plan includes the detail and expectation behind such priorities, but also describes five 'enabling pillars' that are expected to drive the changes required to the NHS to meet the three priorities. Such enablers are changes to the NHS Operating Model; Innovation and Technology; Transparency of Care; Workforce Transformation and Finance and Productivity.

We are not required by NHSE to construct a revised strategy or formal delivery plan, however we will be reviewing our current strategy to 2028 to amend as required to meet the aims of the Plan. The Trusts Strategy Delivery Board will oversee the implementation of the 10-year plan and Board will be fully engaged and inform its development.

2.3 Industrial Action

Resident Doctors took industrial action in July. The impact at the Trust was minimal and at this stage it is now known if, or when, further industrial action will be taken. We continue to engage with staff side and will take mitigation action as appropriate as we have done previously.

3 CHIEF EXECUTIVE ACTIVITIES

3.1 Trust Strategy

I described earlier that the Strategy Delivery Board will oversee the implementation of the 10-year NHS Plan. It met for the first time in July and its first report to Board is included within these papers.

3.2 National Orthopaedic Alliance / Federation of Specialist Hospitals

The NOA Board has not met since the last Board. The Federation of Specialist Hospitals held its members meeting in July and received presentations from the National Director of Specialised Commissioning and the DHSC value-based commissioning procurement team. It also discussed the potential impact of the 10-year plan on specialist hospitals. Both the NOA and FOSH are important voices for specialist hospitals, particularly with potential changes to provider models across the country, so I am pleased to be able to contribute and use the learning at the ROH.

3.3 Birmingham Health Partners

The Board of BHP has not met recently, however I am part of the panel to interview a new chair in September following the appointment of the current chair as the chair of Health Innovation West Midlands.

3.6 Acute Provider Collaborative (APC)

The Acute Provider Collaborative met on 16th July 2025 and was attended by the Director of Strategy. The meeting reflected on how the collaborative had evolved over its first 12 months, now focusing on Elective, Cancer and Diagnostics as well as Pathology, Gynaecology and MSK/Orthopaedics. Discussion centred on how the APC can support each of the 6 localities across Birmingham and Solihull, and how pathway transformation will take place across the new Birmingham and Black Country footprint.

3.7 NHS Confederation

I have participated in a number of policy discussions in the last few weeks as part of my role on the Board of the NHS Confederation Acute Advisory Network. I will attend my first formal network meeting in September. I look forward to welcoming Rory Deighton, the Confederation's Director of Acute, Emergency and Community Care who is visiting the Trust in September.

3.8 ROH Internal Visits

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

4. ROH UPDATE

4.1 Financial Position

It is pleasing to report that the Trust remains ahead of financial plan at month 4. Whilst there was an in-month deficit to plan in July of £0.1m, we are £0.4m ahead of plan. This has been achieved through both income overperformance to date, maintaining controls on levels of operating expenditure and delivery of CIP. A huge thank you to our staff for taking the required action to achieve this. There will be more challenging months to come, however, so focus will need to remain on both income and cost.

4.2 Performance

We continue to perform well from a performance perspective. Headline reported performance metrics for July include 60.34% Referral to Treatment Time (RTT), exceeding the target trajectory of 56.54%. The number of patients waiting over 52 weeks reduced ahead of plan to 446, which is a significant achievement that supports the NHS operational priority of reducing the number of patients waiting in excess of 52 weeks to 1% of the total waiting list by March 2026.

Although activity performance for July was slightly below plan, financial performance exceeded planned income levels. The year to date activity position is 105 cases ahead of plan.

We continue to achievement all national cancer and diagnostic standards.

4.3 Segmentation

The announcement of Trust's segmentation rating as part of the new NHS National Oversight Framework has been deferred by NHSE and will be confirmed in September. We have recently received confirmation of the Provider Capability Assessment process which will run alongside the metric-based Oversight Framework. It is a self-assessment model, to be overseen by Boards, and is due to be submitted in October. Board will be fully engaged in its completion. Further detail of the provider assessment performance is detailed in a paper to be considered in a separate paper on today's agenda.

4.4 Trust Management Group

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

5 POLICY APPROVAL

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

- Security Management Policy
- Bank Worker Policy
- Emergency Preparedness, Resilience and Response (EPRR) Policy
- Business Continuity Management Policy
- Safer Staffing Policy
- Non-Medical Rostering Policy
- IT Asset Management Policy

6 RECOMMENDATIONS

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

Matthew Hartland
Chief Executive
June 2025

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	Board Operating Model
SPONSOR (EXECUTIVE DIRECTOR):	Simon Page, Chair and Matthew Hartland, Chief Executive
AUTHOR:	Simon Grainger-Lloyd, Director of Governance
DATE OF MEETING:	3 September 2025

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The ROH Trust Board has historically met every month, with the exception of January and August, for the last number of years. Each Board session has comprised an element in public and a private session for confidential matters.

Alternative models are in operation in some other trusts, such as Robert Jones & Agnes Hunt NHSFT, Birmingham Women's & Children's NHSFT and Birmingham Community Healthcare NHSFT, all of which meet formally on alternate months. Additional sessions are held for the Board as needed, including workshops and Board development events, neither of which have featured in the ROH Board cycle on a regular basis.

The meetings of the ROH Board committees, with the exception of Finance & Performance Committee, moved to an alternate monthly model in 2024, which has worked well to date.

To bring it in line with the Board committees and many other organisations, it is proposed to change the operating model for the Board from the Autumn 2025, to reduce the frequency of meetings in public to alternative months and to build in a workshop session for discussing formative ideas and concepts for a more rounded Board view. It is also proposed that the opportunity of Board members being onsite should be used for walkabouts to various areas across the Trust, a matter which will enable Board members to witness first hand some of the work of staff, meet patients and offer an improved level of visibility for Board members, a matter that has been raised by some staff previously.

Workshops

The proposed discussion topics for workshops are around a set of key themes, these being aligned to the Trust strategy and areas of focus for the ROH at present. These are:

1. Adopting and adapting to new technologies - AI, Digital, Robotics
2. Building a seamless patient experience, using benchmarking outside as well as inside the NHS.
3. Creating a better working environment for staff, one where they feel they have permission to make a difference and all at lower cost and higher quality.
4. Reducing health inequalities, including a community focus.
5. Theatre productivity and lean, given its centrality to our performance and productivity.
6. Keeping strategically relevant and on track. This might include the impact of new NHS initiatives as well as testing our own approach against a new reality.

In addition, there may be some useful discussion around some specific topics, which may or may not fit within the above, these being:

- 10 Year Health plan implications
- Charity trustee training
- Partnerships
- Role of ROH in neighbourhood/Localities
- Commercial/Business Development
- CQC Readiness
- FT application (if required)
- EPR

The schedule of Board sessions will remain unchanged in terms of dates but the model is suggested to be:

September 25	Public and Private Board
October 25	Private Board, Workshop & Walkabout
November 25	Public and Private Board
December 25	Private Board, Workshop & Walkabout
January 26	No Board meeting
February 26	Public and Private Board
March 26	Private Board, Workshop & Walkabout
April 26	Public and Private Board
May 26	Private Board, Workshop & Walkabout
June 26	Public and Private Board
July 26	Private Board, Workshop & Walkabout
August 26	No board meeting

Walkabouts

It is suggested that Board members conduct walkabouts in pairs and the Corporate Services Manager will work with individuals to agree locations and pairings. Space will be provided at the next available Board meeting to discuss the observations from the walkabouts.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Aligns well with the Trust's well led plans	• None

REPORT RECOMMENDATION:

The BOARD is asked to consider and approve the proposed revised model of Board operation.

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		**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:

Opportunity to discuss alignment with the wider System's strategic plans.

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

Other BSol providers and RJAH NHSFT.

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

None

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	Chief Finance Officer's Report M4
SPONSOR (EXECUTIVE DIRECTOR):	Steve Washbourne, Chief Finance Officer
AUTHOR:	Steve Washbourne, Chief Finance Officer
DATE OF MEETING:	3rd September 2025

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Month 4 Financial Report

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Elective Activity on target Reduced spend in Bank and Agency CIP currently being delivered	Ongoing pressure on cash management and future delivery of CIP

REPORT RECOMMENDATION:

The Committee/Board is asked to:

NOTE the Finance Report

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

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

Comments:

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

Care	x	Community	
Expertise	x	Services	x
People	x	Collaboration	X

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

Risk register and BAF

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

NA

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

NA

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

NA

CFO's Report Month 4

1. Summary

The Trust delivered a deficit in month of £164k against a planned deficit of £54k, generating an adverse variance of £110k in month. This results in a deficit of £380k YTD, a favourable variance of £352k against plan.

Income & expenditure summary	Current month				Year to date				Forecast Outturn			
	Plan £000s	Actual £000s	Variance £000s	%	Plan £000s	Actual £000s	Variance £000s	%	Plan £000s	Forecast £000s	Variance £000s	%
Operating income	12,366	11,933	(433)	**(3.5%)**	47,302	47,260	(42)	**(0.1%)**	147,169	147,089	(80)	**(0.1%)**
Agency pay	(136)	(115)	21	**15.3%**	(589)	(458)	131	**22.2%**	(1,570)	(1,284)	286	**18.2%**
All other employee expenses	(6,780)	(6,997)	(217)	**(3.2%)**	(27,315)	(27,657)	(342)	**(1.3%)**	(81,530)	(82,389)	(859)	**(1.1%)**
Operating non pay	(5,389)	(4,898)	491	**9.1%**	(19,668)	(19,173)	495	**2.5%**	(62,654)	(62,063)	591	**0.9%**
Total operating surplus / (deficit)	**61**	**(77)**	**(138)**	**(1.1%)**	**(270)**	**(28)**	**242**	**0.5%**	**1,415**	**1,353**	**(62)**	**(0.0%)**
Non operating items	(123)	(97)	26	**21.5%**	(492)	(390)	102	**20.8%**	(1,472)	(1,410)	62	**4.2%**
Surplus/(deficit) for the period/year	**(62)**	**(173)**	**(111)**	**(0.9%)**	**(762)**	**(417)**	**345**	**0.7%**	**(57)**	**(57)**	**0**	**0.0%**
Less I&E impairments/(reversals) & (gains)/losses on transfers by absorption	0	0	0		0	0	0		0	0	0	
Surplus / (deficit) before impairments and transfers	**(62)**	**(173)**	**(111)**	**(0.9%)**	**(762)**	**(417)**	**345**	**0.7%**	**(57)**	**(57)**	**0**	**0.0%**
Technical adjustments	8	9	1	**16.0%**	30	37	7	**24.7%**	92	92	0	**0.0%**
Adjusted financial performance surplus/(deficit)	**(54)**	**(164)**	**(110)**	**(0.9%)**	**(732)**	**(380)**	**352**	**0.7%**	**35**	**35**	**0**	**0.0%**

Whilst this remains a positive position YTD, driven mainly from strong elective performance and an underspend on operating costs, we need to continue the current focus on controlling expenditure and delivery against CIP and income targets as there will be more challenging months to come.

2. Income

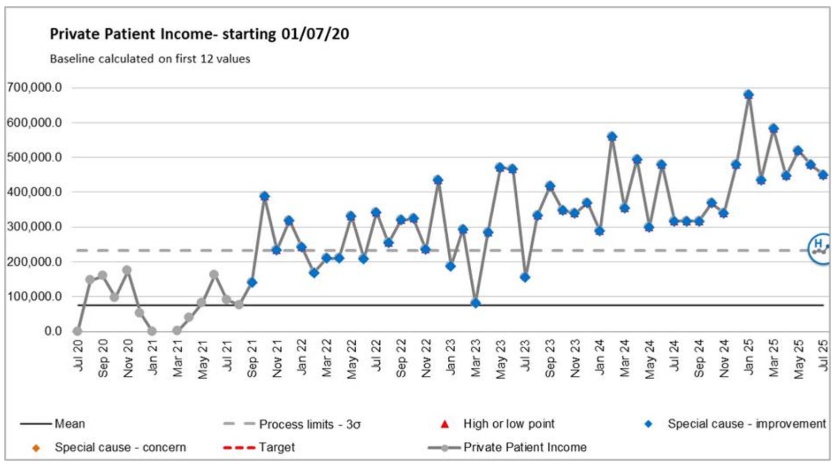
As previously discussed, the income position for 2025/26 has been reset based on activity delivered in 2024/25, and required activity to deliver the 2025/26 RTT targets. As the Trust underperformed on its elective activity during 24/25, this has resulted in a real-term reduction in income.

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

In Month 4 we continued to deliver a small overperformance on variable elective patient care income. This variable income is potentially still subject to be capped should the commissioner choose to apply an Indicative Activity Plan / Activity Management Plan, and current performance would give a notional overperformance against cap of £309k based on our planned activity profile.

Activity undertaken in Q1 will be paid for in total, but a commissioner can impose an AMP to manage the trajectory for the rest of the year back to the value stated in the IAP. As shown in appendix A there is currently a risk across all commissioners overperforming against plan.

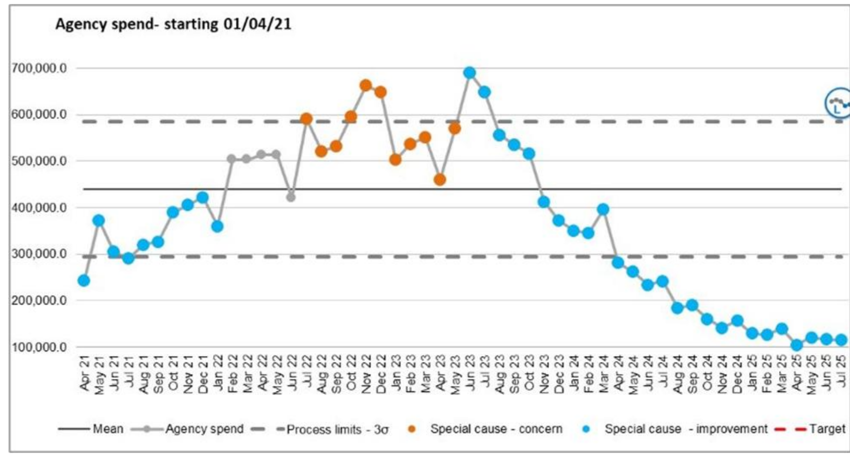
Private patients' income is £450k in month against a plan of £466k, but is still £137k overperforming YTD.

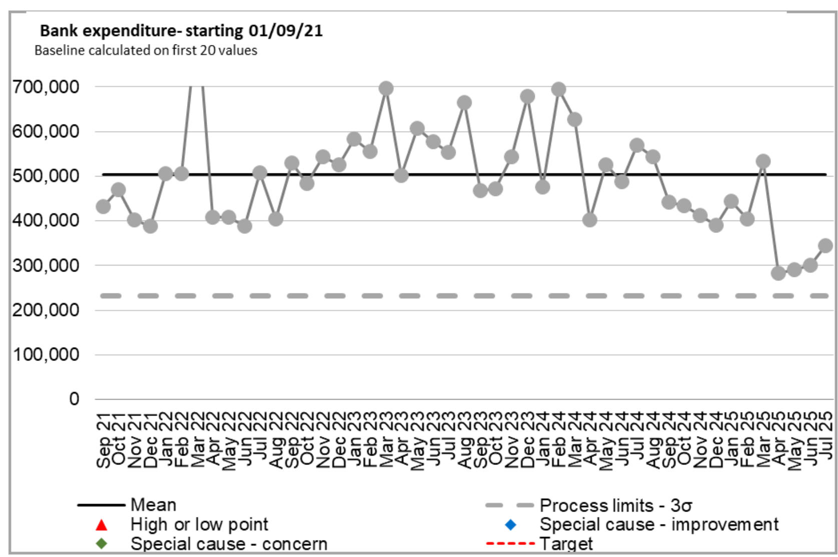


3. Pay

Pay expenditure is overspent in month by £217k contributing to an overspend YTD of £342k. However, the plan reduced by £100k from M3, whilst expenditure increased by £100k, largely related to bank spend.

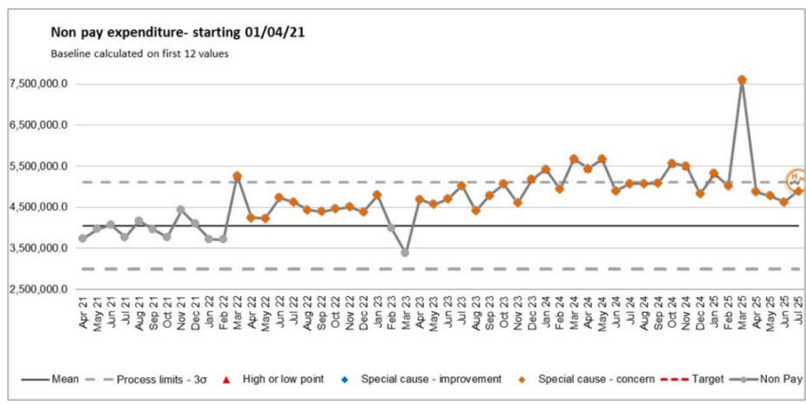
Agency spend is £115k in month (M3 £117k), or 1.6% of pay. Bank expenditure is £345k in month (M3 £301k) against a plan of £325k, with most of this increase in Medics (M4 £119k v M3 £76k) which is reflective of ADHs and on-call payments. Spend in Nursing of £48k (24/25 ave £111k) is slightly higher than M3 £39k, whilst Infrastructure spend of £95k (24/25 ave £145k) continues to be low.





4. Non-Pay

Non-pay spend increased from £4,624k in M3 to £4,898k in M4 which reflects £200k of R&D spend in month (offset by an opposite adjustment to income). The Plan also increased by £500k resulting in a £491k underspend in month.



LLP spend increased to £176k in month and now has YTD spend of £659k against a plan of £467k, with th majority of this additional spend being in spinal.

5. Cash

The cash position remains challenging, but further support payments are not currently required.

6. Capital

We have had capital spend of £282k in the first 4 months against a plan of £618k.

7. CIP and Route to Break Even

In month efficiencies of £418 has been generated increasing the year to date achieved to £1,887k against a plan of £2,270k.

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

CIP Scheme	26/27 FYE	YTD Plan	YTD Total	YTD Variance
Bank reduction 10%		0.00	279.00	106.13
Agency Reduction 30%		0.00	218.29	-6.01
LLP	-84.00	-87.80	0.00	87.80
Non pay Procurement 0.01%		0.00	0.00	-204.69
Non Pay Other	716.19	210.63	266.60	-4.98
Optimising Medicines value	100.44	33.32	28.84	-4.48
Optimising energy Value	200.00	66.67	0.00	-66.67
Activity gap	0.00	0.00	0.00	0.00
Avoid duplication and low value activity	0.00	0.00	0.00	0.00
Digital Optimisation	811.00	235.58	142.02	-0.98
Commercial income	583.00	248.63	242.37	-36.90
Service redesign	1,128.97	76.29	0.00	0.00
Bugdet management schemes	811.14	211.70	70.13	0.00
Workforce redesign	4,004.98	153.26	2.36	
Executive led schemes	1,114.87	-	0.00	
Total CIP schemes 25/26	**9,386.59**	**2,270**	**1,887**	**(383)**

8. System Position

After three months the system position has a YTD deficit of £31.3, £17.8m adverse to plan. This represents a £3.5m increase in deficit compared to month 3.

Total Performance	YTD			FOT			Prior Month variance £000s
	Current Plan £000s	Actual £000s	Variance £000s	Annual Plan £000s	FOT £000s	Variance £000s	
BSOL ICB	-2,431	-1,253	1,178	0	0	0	26
BSMHT	1,389	-2,286	-3,675	4,200	4,200	0	-3,547
BCHC	205	-1,341	-1,546	0	0	0	-1,586
BWC	0	-4,631	-4,631	0	0	0	-3,001
ROH	-732	-380	352	35	35	0	462
UHB	-11,990	-21,473	-9,483	-4,200	-4,200	0	-8,436
Total	-13,559	-31,364	-17,805	35	35	0	-16,083

Appendix A: Elective Variable Income

	Actual					Year to date		In Month		
	1	2	3	4	Year to date	Cap Limit	Variance	Actual	Cap	Variance
Armed Forces	£8,302	£9,111	£12,011	16,347	45,770			£12,011		
NHS Herefordshire and Worcestershire ICB	£443,781	£577,366	£666,307	605,901	2,301,193	£2,149,916	(£151,277)	605,901	£579,707	£26,194
NHS Birmingham and Solihull ICB	£2,042,644	£2,180,803	£2,236,175	2,328,392	8,848,567	£9,058,270	£209,703	2,328,392	£2,442,487	(£114,0950
NHS Staffordshire and Stoke-on-Trent ICB	£176,848	£165,074	£120,712	131,285	607,576	£545,806	(£61,771)	131,285	£147,172	(£15,887)
NHS Black Country ICB	£635,793	£580,007	£589,210	710,034	2,523,388	£2,557,847	£34,459	710,034	£689,702	£20,332
NHS Coventry and Warwickshire ICB	£166,192	£106,392	£86,760	124,782	487,239	£392,057	(£95,182)	124,782	£105,715	£19,067
Spec Com	£662,020	£665,704	£607,390	620,684	2,596,981	£2,397,272	(£199,754)	620,684	£646,392	(£25,708)
Grand Total	**£4,135,581**	**£4,284,457**	**£4,318,565**	4,537,426	17,410,715	£17,101,122	(£309,592)	4,537,426	£4,611,176	(£73,750)

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	**Trust Officers' Reports**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Chief Executive**
AUTHOR:	**Executive Directors**
DATE OF MEETING:	**3rd September 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.

CHIEF OPERATING OFFICERS REPORT

Report to Trust Board – September 2025

1 NATIONAL OPERATIONAL CONTEXT AND DEVELOPMENTS

1.1 Following the release of the NHS Long Term Plan, published on 3 rd July 2025, the Senior Operational Team have reviewed impact and significance from an operational perspective which will inform and shape the business planning process for Division 1 and 2 for 2026/27. Currently the Teams are completing their corporate service review documents and working towards plans to deliver the next phase of the Trust clinical service review process.

The 10-year plan focuses on driving operational efficiency, integrated care and digital transformation to sustainably meet rising demand. It prioritises prevention, early diagnosis, and personalised care, while shifting resources towards community and primary care to reduce pressure on hospitals.

The current strategic operational delivery plan is well aligned to the key messaging in the 10-year plan including:

- **Leveraging technology to streamline services** - exemplified within the Outpatient Transformation plan and the theatres improvement programme.
- **Improving workforce planning and retention** - as part of the annual operational planning cycle all areas utilise the IMAS (Interim management and support) tool to refresh demand and capacity for each service to understand current demand, develop a resource plan identifying any workforce constraints to delivery of the agreed operational imperatives.
- **left shift into the community** - The MSK programme and leadership demonstrated by the ROH in this area also aligns well with the requirement to collaborate through Integrated Care Systems (ICS) to deliver value-based care, reduce variation and enhance patient outcomes across the NHS.

As the Team commence operational planning for 2026/27 the 10-year plan will influence and shape delivery to ensure the operating model aligns well with the ambitions within the plan and the Trust strategic objectives.

1.2 The Trust continue to participate in the National Validation Sprint programme for Quarter 2. Progress to date is positive, as demonstrated by the current improvement in the RTT (Return to Treatment) position. A full update will be provided at the end of Quarter 2.

1.3 The Trust was re accredited as an Elective Hub by GIRFT (Getting It Right First Time) in July 2025 following a successful review by the National Team on the 30 th July 2025. The assessment panel highlighted our exceptional performance particularly the capped theatre utilisation rate of 87%. The Team also commented on the passion and pride demonstrated during the presentation. The meeting was highly positive reflecting the Team's continued commitment to efficiency, quality and patient-centred care.

The presentation led by the Chief Operating Officer was supported by the Medical Director , Chief Nursing Officer and Deputy Operating Officer alongside the Divisional Triumvirate from Divisions 1 and 2. The contribution of all Team members on the day and the wider Trust support in maintaining accreditation status has been celebrated internally and externally with the support of the Communications Team in order to maximise the impact of this significant achievement .

2. OPERATIONAL PERFORMANCE

2.1 As of July 2025, RTT performance reached **60.34%**, exceeding the target trajectory of **56.54**%, reflecting strong progress in improving patient access. Notably, the number of patients waiting over 52 weeks reduced ahead of plan to 446, a significant achievement that supports the NHS operational priority to ensure patients waiting over 52 weeks are 1% of the total waiting list by March 2026. The operational imperative for first appointment was also delivered in line with plan. Overall, this highlights robust performance on all the required operational imperatives relating to RTT performance.

2.2 The Team sustained delivery of all National cancer performance standards in the reported position for June 2025 and are on target for achievement in July.

2.3 The Trust sustained the 65-week breach position, with a reported position of zero 65-week patients reported in July 2025, demonstrating our continued commitment to timely patient care and effective waiting list management.

2.4 Diagnostic performance exceeded National standards retaining a 99% position in July 2025. It should be noted that retaining this exemplary performance against a backdrop of rising National demand and increased waiting times for imaging and local vacancy rates for Radiologists is challenging. It has been delivered as a result of excellent service development and improved productivity in a number of key modalities, such as MRI scanning using AI supported software to accelerate scanning

times and workforce redesign in plain film imaging.

2.5 Activity performance for July 2025 was 49 cases below plan; however, financial performance exceeded planned income levels, driven by case mix in that a higher proportion of inpatient (more complex) activity was delivered in relation to day case activity. The year-to-date position is therefore 105 cases ahead of plan YTD demonstrating strong overall performance and resilience in delivery of the operational plan.

3. PRIVATE PATIENTS

The Private Patient Service is currently £138k ahead of the £5.5m original plan and £78K behind plan YTD against the refreshed £6.1m target, whilst performance is below uplifted trajectory at this stage, it is felt this is seasonal with a lower availability of surgical capacity and demand in July and August . There is continued momentum to strengthen delivery for the remainder of the year to deliver the stretch target of £6.5m. A targeted marketing campaign is due to launch in October 2025 supported with dedicated Communications assistance now in place, designed to raise awareness and grow our Private Patient base. The Private Patient Service will be strengthened further with the support of the emerging business development framework to expand and develop the Private Patient Service as a small business unit. The Trust is also prioritising the promotion of robotic surgery. These initiatives are expected to stimulate increased interest and activity over the coming months supporting a stronger position against plan.

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

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

4.1 Theatre Improvement Group

A service review has commenced in July 2025 led by the Theatre Triumvirate Team, supported by Division 2, to deliver continued improvements in the Theatre environment aligned to the Trust Service Review Strategy. Following a successful 'Focus on Surgery Week' in June 2025, ahead of the accreditation review, learning is being shared with the Theatre Teams and this is being taken into the Service Review Programme to inform this process. Areas of focus include high intensity theatre lists standby patient expansion, training needs analysis across all specialties, real time governance, staff wellbeing initiatives, development of staff feedback forums. Progress of the review will be reported through TIG.

4.2 Outpatient Transformation

Outpatient Transformation continues at pace and a presentation of the programme and benefits realised will be presented at the September 2025 Finance and

Performance Committee. Following the GIRFT review a key area of focus is aligning all outpatient templates to the GIRFT Best Practice Go Further Faster Framework. This process is a significant piece of work and investment in this work is expected to improve productivity significantly in the outpatient setting. Detail of anticipated productivity gains will be shared in the Finance and Performance report in September.

4.3 Day Case delivery and reducing length of stay

There is a renewed focus on expanding day case activity and reducing length of stay in line with British Association of Day Case (BADS) best practice. A Working Group, led by the Director of Operations for Division 1, is now in place. This has been supported by the trial which commenced in August 2025 to create a 23 hour stay ward on one of our base Wards, led by the Deputy Director of Nursing. Early indications are extremely positive. The pilot is currently being evaluated and results will be upwardly reported at the Finance and Performance Committee.

5 KEY RISKS

5.1 The volume of Spinal patients over 52 weeks continues to be a risk to reducing the overall waiting times for the Trust. In particular unanticipated reduction in surgical capacity for July and August 2025 due to sickness has added to the challenge. A locum Consultant has been appointed and is due to commence with the Trust in September 2025.

An accelerated pathway improvement workshop led by the Chief Operating Officer is planned for September 2025. In association with the Spinal Service Review now underway this will support the mitigation of this risk and the overall reduction in waiting times for this service with a clear rectification plan to continue to deliver and exceed the National Operational imperatives for RTT developed as part of this work programme. With the input of additional surgical capacity recently the Spinal T eam are keen to harness the opportunities which service redesign presents, aligned to best practice pathways supported by the Regional Spinal Team.

5.2 As documented on the Risk Register current delays in Pathology services continue to impact our patient cancer pathways and whilst currently performance is being sustained in line with National requirements the position remains challenging and requires significant tracking and management of the patient pathway to maintain performance. The delays in Pathology services have been escalated both locally at Trust board level and on the weekly Strategic Oversight meeting Chaired by NHS England. The issue is complex and not uncommon nationally , this will continued to be monitored at the System Oversight Group and via cancer board.

6.0 MSK PROGRAMME UPDATE

6.1 The ROH continue to lead on the system MSK programme. Notable milestones in July 2025 include the agreement of funding at System Investment Committee for the

deployment of the ‘Get U Better’ app supporting self-management for MSK conditions. The App now has over 23,000 users across BSoL and data is available detailing the positive impact the app is having, particularly in supporting the inequalities agenda. Examples of the impact will be shared at the November 2025 MSK programme update to board.

The programme is now finalising data collection to deliver the workforce plan. This will inform an options appraisal for delivery of MSK across BsoL aligned to localities, improving access and outcomes for patients. This will be tabled at the Acute Provider Collaborative meeting in October 2025 for consideration.

As Phase 1 objectives of the programme are almost complete the Team are scoping Phase 2 of the programme which would aim to include the wider MSK conditions such as rheumatology, pain management and fragility services. It is intended once this is drafted it will be shared with the board as part of the MSK update at November 2025 Trust Board .

7 WORK PLANNED IN NEXT MONTH

7.1 NHS England have shared information regarding a Capital Incentive Scheme designed to support Trusts on returning to RTT standards by linking access to capital funding with elective recovery performance. Trusts that demonstrate sustained progress towards reducing long waits particularly 65 and 52 weeks breaches and improving RTT performance are prioritised for capital investment. The Scheme aims to drive efficiency, optimise capacity and accelerate the recovery of elective services, aligning financial support with operational improvement to meet the National standard of treating 92% of patients within 18 weeks. Although the Trust is on target to meet the eligibility criteria in terms of operational performance the financial framework is currently being evaluated in association with the Chief Financial Officer to understand how the Trust might be able to benefit from the scheme as it is not cash backed.

7.2 Service reviews are underway in Spinal Services and Theatres as a priority ahead of the roll out of Phase 2 of the Service Review Programme as detailed earlier in the report.

7.3 September 2025 will see the start of the Business Planning Cycle as indicated by NHS England where the 2026/27 Business Planning Cycle will come forward and it is anticipated this will be completed by the end of Quarter 3 therefore significant work will be required to deliver the operational / activity plan aligned to the Financial and Workforce Plan at pace.

8. RECOMMENDATION(S)

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

Marie Peplow - Executive Chief Operating Officer August 2025.

CHIEF PEOPLE OFFICER'S

Report to Trust Board (Public) – July 2025

1 LOCAL MATTERS FOR BOARD ATTENTION

1.1 MSK Academy

Following the presentation at Trust Board in June, the Clinical Programme Lead (Uzo Ehiogu) is proactively building on the proposals.

For Audit / QIDD in September, Uzo has planned a partnership event with Stryker. Stryker will have interactive educational stands in the library and training room, whilst also delivering enhanced training sessions for the Theatre teams.

One of the project priorities over the next 3 months is to the populate the MSK Academy website with educational content and the aim is to have 15 short videos in addition to the examination videos currently online before the formal launch of the website. The website will then become the online shop front for the MSK Academy. Currently educational videos for early career surgical trainees (1-4 years qualified) are in development and these videos are 6 mins in a range of areas for example: diagnosis of soft tissue sarcoma – what surgical trainees need to know. These are to be developed in house with support from our Comms team.

1.2 Anti Racism Statement

The Trusts Anti Racism statement has been finalised, and this can be found in the 'for information' section of the Committee pack. The plan is to launch this and the work to support achievement of the RACE Code over coming weeks.

1.3 Tackling Inequalities Leadership Programme

During July I completed the NHS Confederations Tackling Inequalities Leadership Programme. This programme has really challenged my thinking and enabled me to network with multi professional NHS colleagues from across the country. The programme, delivered as a mix of virtual and face-to-face sessions, offers leaders the opportunity to develop key strategic skills through collaborative small-group learning.

The programme has been developed through the thinking that without tackling inequality the NHS will not transform. Success is therefore dependent on a practical approach to tackling inequality as a core function for all health and care organisations, appropriately resourced and with robust strategic support from senior leadership. The programme delivery method aims to enhance the existing skills of leaders working within healthcare organisations to tackle inequality in both the workforce and the design and delivery of services.

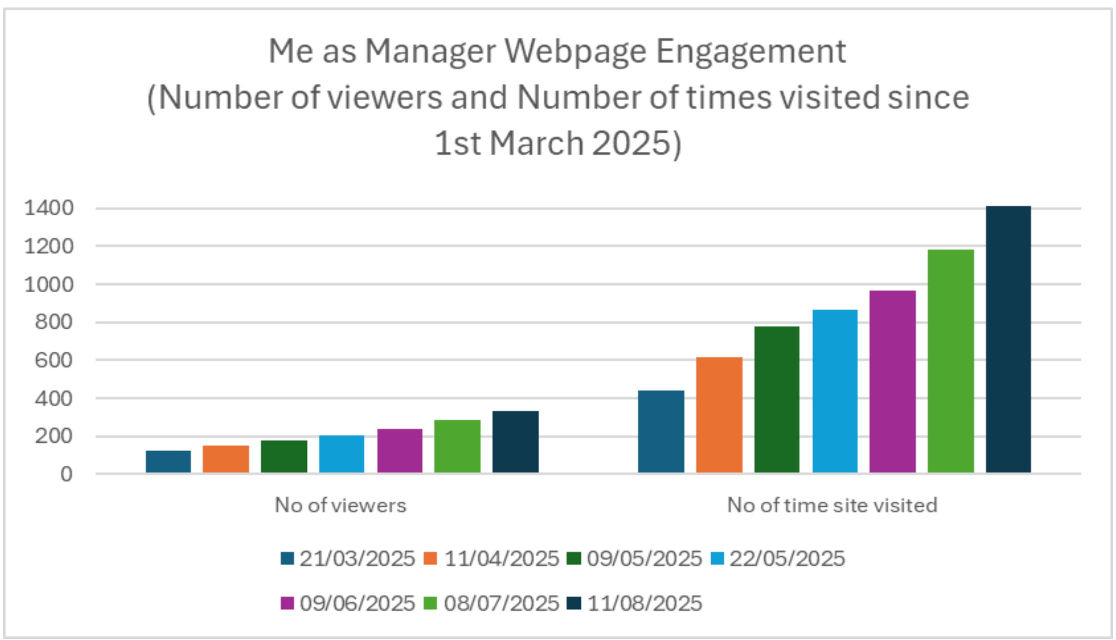
The programme has focussed on working with leaders to develop our skills, equipping us with tools, ideas and insights, and connecting us with a community of peers.

1.4 Appraisal Window

The Trusts appraisal window closed at the end of July 2025. At the time of writing the appraisal completion rate for the Trust is 78%. The team are working through data validation, and we anticipate that this number will rise.

1.5 Me as Manager: The ROH Management Development Framework

During June and July, the Trust has been focussing efforts on promoting the Me as Manager programme. On 11th August 2025, 333 individual people had accessed the Me as Manager webpage 1408 times (average of 4.23 visits per viewer). This is an increase from 21st March at which point 127 people had accessed the site 443 times (average of 3.5 visits per viewer).



Of the new "Me as an ROH Manager" workshops, all have now been successfully piloted to a range of staff. The attendance numbers and bookings for these workshops has increased by more than double in the last month. Attendance is based on individual development needs, and staff availability to attend. The calendar of courses continues to be regularly reviewed, with consolidation of programmes where appropriate, and for 2 courses, there are proposals to split into shorter 2-hour modules.

The pilot of "Developing Leaders in the ROH" (Level 5 CMI accredited) programme completed on the 10th June 2025, with their final presentations. Once they have all completed the qualification elements of the programme a graduate event will be organised. The second cohort who commenced on the 9th June 2025 are progressing well. Below are some evaluation statements from delegates of cohort 1:

"This has been an incredible process, and I feel truly grateful for the opportunity to have participated. The course has not only equipped me with new knowledge and leadership tools but has also challenged me to reflect deeply on my leadership style

and approach. The sessions were engaging, thought-provoking, and relevant to the real challenges we face in the workplace. It has been particularly valuable to connect with other leaders and hear different perspectives; this peer learning enriched the experience even further. The facilitator, Sharon, created a supportive and open environment, which encouraged honest conversations and meaningful personal growth."

"I have really enjoyed the programme; I have gained a further understanding around how my leadership style needs to be adaptable to the people I manage due to their different needs and learning styles etc. I will take away that my leadership can be applied to multiple settings not necessarily just the clinical area and this was evident when we shared some of the issues with the guys from different areas (IT, library). Please pass on my thanks to Sharon, not only a great teacher but a great facilitator of debates!"

"Thank you for all your help. I feel that I have learned different management techniques that will support me in my current role. My previous management style was learned from other managers; this had its limitations and did not benefit the organisation. Sharon has a very good teaching style and makes the students feel relaxed. The learning is not death by PowerPoint but more discussion and group interaction. I have found the course very rewarding. Thank you to you and the team."

"I really enjoyed the programme and took a lot away from it. The topics really resonated with me and a lot of the material will definitely stay with me moving forward as a developing leader. It was also great to meet others from my Trust in similar roles and share experiences. Sharon is a great tutor and led the sessions in a digestible, fun and well-structured way. Thank you!"

1.6 Learning Management System Procurement Update

Dynamic Business Solutions and the ROH are working well with the implementation plans for the new LMS. Pilots and engagement sessions are being held during August 2025 with a full launch in late September 2025. The new domain name for the LMS has been identified as: https://learning.roh.nhs.uk/ .

The Phase One launch in September will consist of:

- Core Statutory and Mandatory training activity

Role specific mandatory training activity Phase two (from December 2025) is likely to consist of:

- Clinical competencies
- APP supervision
- CPD with potential learning logs

Phase three (from March 2026 onwards) is likely to consist of:

- Preceptorship
- Care certificate

- Appraisals
- 360° feedback
- Talent management

1.7 Core Skills Training Framework (CSTF) Mandatory Training Compliance

Trust is at 87.45% compliance for the CSTF (at 30th June, up from 86.63% 31st May) This small increase is due to improved Cyber Security and IG compliance following the initial decrease at the start of the financial year due to challenges with the "Metacompliance" learning platform which have now been resolved.

The local Trust target continues to be 93%. The CSTF is comprised of 8 nationally mandated modules. The annual renewal of Fire Safety training is lowest compliance within the CSFT at around 80%, however this is the highest fire safety training has been in recent years. The other modules, Moving and Handling, Equality Diversity and Inclusion, Health and Safety, Infection Prevention and control and the Oliver McGowan Level 1 training continue to be over 90% compliant.

1.8 Staff Survey 2025

Planning work has commenced for the 2025 staff survey which will launch in October 2025. The teams are currently working through the staff engagement and communication plans for progress against last year's actions.

Four socio-economic background questions have been added to the online versions of this year's survey. These questions will provide additional demographic information and will enable NHS employers, regional and national teams to better understand the staff experience by socio-economic background, identify good practice and drive improvements.

The NHS Staff Survey questions are rigorously tested, and responses remain anonymous and confidential. The 2025 survey fieldwork period will run from Monday 6 October to Friday 28 November 2025.

1.9 Workforce Deployment Survey

The teams are currently working through the annual national Workforce Deployment System survey, which opened on Monday 4th August. The survey asks about e-rostering and e-job planning, assessing the extent these systems are implemented nationally. The survey will allow us to assess our own progress, as well as highlight actions needed to leverage the full potential of the software, whilst informing critical regional and national improvement strategies.

1.10 Apprenticeship Levy

The Trust has 13 new apprenticeships starts since April 2025;

- 2 x L3 Business Admin
- 1 x L3 Team Leader

- 1 x L5 Student Nurse Associate
- 1 x L6 Operating Department Practitioner
- 1 x L7 Accountancy and
- 6 x L7 Senior Leader
- 1 x L7 MSc Digital and Technical Specialist.

There are 8 additional in the pipeline to commence in the next 6 months and a further 6 in discussion. In summary, potential for 27 against a target of 34.

In relation to the apprenticeship levy funding investment, we have utilised 60.34%, with 2.16% of this being gifted to smaller charitable organisations. Our expired levy has dropped to under 11%, with no funds expiring since April 2024, and our remaining level has decreased from 30.76% in January 2025 to 28.19% in June 2025.

	June 2025 (£)	June 2025 (%)	Shift
Total Levy Paid	£1,997,917.25		
Levy Charges Drawn Down	£1,170,856.64	58.60%	
Gifted levy charges	£47,413.86	2.37%	
Levy Expired	£216,411.89	10.83%	
Remaining levy pot	£563,234.87	28.19%	

2 NATIONAL CONTEXT AND DEVELOPMENTS

2.1 Regulation of NHS Managers

In November 2024 the Department of Health and Social Care (DHSC) consulted on whether to introduce regulation for managers in the NHS. The proposals have been shared as part of the government's ten-year health plan, and the formal response which outlines the intention for new regulation to apply to board level members in the NHS and their direct reports, was published by DHSC on 21 July 2025.

The consultation sought views from all stakeholders on the most effective way to strengthen oversight and accountability of NHS managers in England. The consultation also invited responses on matters relating to candour, including on the possibility of introducing a professional duty of candour for NHS managers and leaders, and on making managers accountable for responding to concerns about the provision of healthcare patient safety. The consultation closed on 18 February 2025 and received strong engagement across the sector and wider public, with 4,924 responses in total.

The feedback received demonstrates widespread support for a statutory regulatory system, focusing on senior leaders. The vast majority of responses (92%) agreed that NHS managers should be regulated. Respondents largely cited improving accountability and trust in management decision making as reasons for this. Consensus for this was highest among non-managerial members of the health or care workforce, while 79% of senior managers and leaders also agreed.

The feedback gathered from this consultation has been considered to inform future policy decisions on how NHS managers and leaders will be regulated and to determine what wider support should be in place for managers and leaders.
Key messages

- There has been a decision to introduce a form of regulation, this will be a statutory barring scheme.
- This is a complex and novel form of regulation, unique for the health sector.
- It is different to other regulation that exists; in that it is not a register for which individuals must meet a set of educational and fitness standards to be able to practise in a particular role.
- It will be a register which identifies those individuals who are unfit to be appointed to a board level role or a senior direct reporting role.
- The Health and Care Professions Council (HCPC) will hold responsibility for the scheme.

Next steps

- There will be a formal consultation on the method of regulation. This is likely to happen in late 2026
- Draft legislation will be prepared which will follow the usual parliamentary passage to become legislation.
- In parallel, the HCPC will formally consult on rules and processes including a Code of Conduct as well as engaging with stakeholders on the design of the scheme.
- When the scheme infrastructure has been designed and approved, ahead of its implementation, there will be a period of up to 12 months, in which the requirements will be clearly articulated to those who will be subject to the scheme.

2.2 Industrial Relations/Pay including Resident Doctors Strikes

During July, the Trust has had 4 individuals take action as part of the Resident Drs strikes between the 25-30th July. It is unclear as to whether further action will take place however NHS Employers have advised Trusts that they should plan and prepare for monthly action. There will be no strikes in August to give time for negotiating. Therefore, it's likely that the next strike would be mid-September at the earliest (end of August, then 2 weeks' notice time).

The current mandate expires on the 6 January 2026. The BMA are likely to strike at times which would have more impact for example half term dates when resources are reduced.

In addition, many NHS workers in UNISON and Managers in Partnership (MiP) have signalled they would be willing to take industrial action to challenge this year's pay award.
Most NHS staff were awarded a pay rise of 3.6% this year following a recommendation from the NHS pay review body. UNISON asked its members, including eligible MiP members, if they would be willing to take strike action to challenge the award. 70% of members who responded to the consultation said they would support strikes.

2.3 Transforming People Services

Transforming People Services is a critical component of the 10 Year Plan:

- Staff will be able to access HR services anytime and anyplace, to book annual leave, or onboard to a new organisation digitally, with virtual assistants to improve both staff and manager experience.
- HR professionals will be more available to focus on complex issues, where human compassion matters most.
- At the same time, we will replace the old NHS payroll system with a new state of the art one.

NHS England are continuing to work with CIPD and KPMG to develop a target operating model for the future to enable the transformation of People Services, with strategic workforce plans and a business case due for approval in the autumn

2.4 Apprenticeship Funding – Level 7

Following the recent announcement of the defunding of level 7 apprenticeships from the levy, the national apprenticeship team have been able to secure investment to sustain the following level 7 apprenticeship programmes within the NHS. Funding will be available for the following apprenticeships:

- Advanced Clinical Practitioner
- Specialist Community Public Health Nurse
- District Nurse (Community Specialist Practice Qualification)
- Clinical Associate in Psychology (CAP)
- Population Health Intelligence Specialists (PHIS)

2.5 Ethnicity Pay Gap Review

An independent review into ethnicity pay gaps in the NHS in England has been announced by the NHS Race and Health Observatory.

The University of Surrey will work with the Observatory to undertake the first ever comprehensive review of an ethnicity pay gap across the National Health Service. This 18-month project – spanning July 2025 to December 2026 – will focus on examining the differences in pay, career progression, pension contributions and potential impact on cumulative financial earning between staff from different ethnicities. It will also explore potential explanations for any differences and provide recommendations, and evidence-based solutions, to reduce and eliminate unwarranted inequities where they are found to exist.

The NHS is the biggest employer of Black, Asian and minority ethnic staff in Europe. Despite becoming more ethnically diverse than ever before, staff from ethnic minority backgrounds in the NHS continue to be underrepresented in senior pay bands.

The Observatory will work with Professor Carol Woodhams (Professor of Human Resource Management at the University of Surrey), and Professor Doyin Atewologun

(Professor (Hon.) at the University of Exeter and CEO of leadership and inclusion consultancy, Delta). Both will be key leads on the review.

In September 2024, 29.5% (449,127) of staff in NHS Trusts and Core Organisations were from an ethnic minority background. This represents a 136.0% (258,784) increase from September 2014 when just 16.8% (190,343) of staff in NHS Trusts and Core Organisation were from an ethnic minority background. However, ethnic minority staff in the NHS continue to be significantly underrepresented in senior roles. In September 2024, staff from ethnic minority backgrounds made up only 7.9% of all staff in Very Senior Management (VSM) roles compared to 29.5% overall workforce representation. The gap between overall representation and representation at VSM roles has increased from 12.6% in 2014 to 21.6% in 2024.

2.6 Parental Leave and Pay

The government is conducting a review of the parental leave and pay system to better support working families, reflect the modern economy, and align with the government's Plan for Change.

The consultation is seeking views and evidence on:

- how well the current entitlements support the stated objectives
- whether these objectives are appropriate and if there are additional objectives to consider
- the strengths and weaknesses of the current system and potential areas for improvement.

2.7 Oliver McGowan Code of Practice – finalised and approved

The Oliver McGowan code of practice on statutory learning disability and autism training aims to ensure staff have the right skills to provide care and boost understanding of the needs of these groups of people. The National STATMAND review team have adopted the 3 yearly frequencies for OMMT and will not be reviewing this as part of the current review but will review again in three years' time.

It sets out the standards that providers are expected to meet to be compliant with the law and help make sure patients are kept safe.

Those with a learning disability or autistic people face poorer health outcomes than the general population, and it is crucial that health and social care staff have the right knowledge and skills to tackle these inequalities.

The training and the code of practice are named after Oliver McGowan, an 18-year-old from Bristol with a mild learning disability who died following a severe reaction to medication given to him against his and his family’s strong wishes. Under the law, health and care providers registered by the Care Quality Commission (CQC) have a requirement to ensure staff have the appropriate training.

3 KEY RISKS

3.1 There is a risk that short term absences continue to rise and will result in reduced workforce availability leading to disruption of clinical services and patient care, increased reliance on bank/agency staff and associate costs,

reduced morale/wellbeing due to additional workload and potential non compliance with safe staffing levels.

4 WORK PLANNED IN NEXT MONTH

4.1 Support teams with effective workforce planning to support the next business planning round.

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

5 RECOMMENDATION(S)

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

Sharon Malhi
Chief People Officer
September 2025

FOR ASSURANCE

QUALITY OFFICERS' REPORT

Report to Trust Board on 3 September 2025

1 MEDICAL DIRECTOR'S UPDATE

1.1 A project has commenced with Innovation Route, supported by Health Innovation West Midlands to support our IP development and process. We aim to have work completed within 3-4 months.

1.2 The Trust was successful in retaining its Getting it Right First Time (GIRFT) elective hub exemplar status in July 2025.

1.3 The review of spinal triage incident patients for harm continues with the Governance Team overseeing appropriate corporate duty of candour contact.

1.4 The Trust has been involved with supporting BSol ICB with Operation Pegasus (national simulated outbreak exercise planned for the Autumn)

1.5 Work with the Human Tissue Authority (HTA) around the Research Tissue Bank at University of Coventry and Warwick continues; this is supported by the Chief Nurse / Designated Individual for our site.

1.6 The restoration plan for Endoscopic Spinal Surgery continues. A response to the Royal College of Surgeons has been sent following a review of the report received.

1.7 I attended a Responsible Officer Reference event on 31/7/2025.

1.8 I attended a NHS Leadership Event around 10-year plan on behalf of the Trust on 10 July 2025.

1.9 The Trust received a visit from Professor Wu (Beijing Biomaterials) Aston and Sinapec (Petrochemical company) on 18 July 2025. This is promising for potential future project funding looking at polyethylene biocompatibility.

1.10 We received notification from Birmingham Health Partners that Carlos Chan, Research Development Co-ordinator had been recognised for this services and expertise. The following was received:

BIRMINGHAM HEALTH PARTNERS (BHP) PEOPLE: Recognition award

As BHP, we put people at the heart of what we do. As such we look to recognise colleagues who working in research and innovation across our member organisations through our BHP People recognition scheme.

I am writing because you have been recommended by your colleagues to receive this award.

*The member of staff we would like to celebrate is **Carlos Chan, Research Development Coordinator**.*

Carlos came to R&D at ROH after relocating his family from Hong Kong to the UK. He started with us in a Band 2 administrative role; however, his project management and IT skills were very quickly apparent. These skills have seen him successfully climb the ladder within R&D, initially as a Data Manager and now as a Research Development Coordinator, within our Governance team. Carlos has an unrivalled work ethic, a diligence and attention to detail that makes him ideally suited to research. Furthermore, his courteous manner, 'can-do' attitude and positivity make him a popular and supportive member of staff. Carlos has significantly improved our data capture and analysis capabilities, especially concerning study set up times. As a result of his work, we are seeing our processes become more efficient and set-up times reducing. We have no doubts that Carlos will continue to develop within the coming years.

On behalf of all our organisations, we would like to congratulate you on your professional achievements and for the vital role you play, not only to the Royal Orthopaedic Hospital, but to the wider partnership. Many congratulations.

With best wishes

Jonathan Pearson, Chair BHP
Prof Neil Hanley, BHP Executive Director
Prof Lorraine Harper, BHP Managing Director

2 CHIEF NURSE'S UPDATE

2.1 On 15 July, I attended the Chief Nursing Officer (England) leadership day in London. The day was opened by Sir Jim Mackey, Chief Executive Officer of NHS England, and Dr Penny Dash, the Chair of NHS England. The focus of the day was the implementation of the 10-year Health Plan for England and the development of the CNO's Professional Strategy for Nursing & Midwifery. Over the next 6 months the CNO's team aims to work with Nursing and Midwifery colleagues from across Health & Social Care sectors to develop this strategy. In October, CNO (England) has invited all the CNOs from across Health and Social Care to his annual conference in London, which I will attend.

2.2 I also attended the BSol CNO development and leadership session on 18 July with system colleagues. The day focused on workforce, specifically the current challenges being faced by newly qualified nurses and midwives. In addition, we focused on the work being undertaken to support women's health in BSol and how as a group we support the winter plan and the implementation of the localities model.

2.3 Over the last two months, the corporate nursing teams have been focused on the 'back to floor' initiative lead by Emma Steele, the Deputy Chief Nurse. Emma has led this initiative, which see senior nurses undertaking clinical shifts in various ROH wards / departments. This is a positive opportunity for the senior nursing team to engage with patients and to work with nursing staff across the organisation. The focus of this initiative is to understand the day-to-day challenges faced by clinical teams, and share best practice. As part of my clinical time, I have focused on visiting operating theatres to observe a range of surgical procedures and listening to the concerns of clinical teams and consultants. This has allowed me to gain a better understanding of working life in theatres, and to consider how we can continue to improve patient care delivery.

2.4 In August, the ROH Director of Governance and Chief Nurse introduced a new joint clinical walkabout. The first visit centred around Ward 12, specifically to explore how the ambulatory pathway was embedding. Sister Mishera Musabayana, shared with pride, how the safety huddle methodology and quality improvement boards have been embedded and contribute to improving the care of patients on the ward. Over the next year we aim to have a monthly walkabout to different areas with the intention of strengthening the governance and clinical teams.

National / Regional

2.5 On 12 August, Chief Nursing Officer (England) wrote to all Chief Nurses to share the proposed legislation change to the title 'Nurse':

> *"The proposed change will provide legal protection to the title 'nurse', whereas currently only the titles 'registered nurse', 'midwife' and 'nursing associate' are protected in law. This will provide additional legal safeguards to prevent individuals misleading the public*

by describing themselves as a nurse without the relevant registration. The government has suggested that it expects the new protection to be a summary offence for which a fine can be imposed."

This change is expected to occur within this parliament. CNOs have been asked to review all role titles within their organisations to ensure that they compliant with the proposed new legislation. This review was carried out internally, and it was confirmed that all positions in ROH with job titles containing the word 'nurse' or 'nursing' are filled by NMC registrants.

2.6 On 12 August, CNO (England) and Elizabeth O'Mahony wrote to Chief Nurses sharing that the Secretary of State had announced a Graduate Guarantee for newly qualified nurses. The offer ensures that every newly qualified nurse will have the opportunity to apply to join the Health and Social Care workforce. There are three conditions of the Graduate Guarantee that apply to ROH:

- **Proactive recruitment**: This ensures that all posts at AfC Band 5 support applications from newly qualified nurses. I can confirm that we are reviewing all Person Specifications within our nursing job descriptions are appropriate to ensure that newly qualified nurses can apply.
- **Creating new opportunities:** The biannual establishment review is currently underway, which will help to identify any appropriate new posts which might be available for newly qualified nurses.
- **Targeted reduction in agency staffing:** ROH is not currently using any agency staff. However, we will review bank activity and explore how this can be reduced further to support this national request.

3 DIRECTOR OF GOVERNANCE'S UPDATE

3.1 On 13 August, I undertook the first of a series of clinical walkabouts with the Chief Nurse. The aim is to understand how governance processes are impacting and being used in the clinical areas and identify areas for possible improvement, particularly around lessons learned.

3.2 Work continues to address the actions identified from when the Health & safety Executive visited in June. The Health & Safety Adviser has undertaken much work to create actions to address the areas of non-compliance in terms of management of sharps and dermatitis. The focus session for Team Brief this month was to encourage staff to more systematically report and investigate any incidents related to sharps injuries and other occupational injuries. Thanks to all who have contributed to this improvement and it is a positive piece of assurance to provide to the HSE to their deadline of 4 September.

3.3 Further work has been done to progress the review of the governance architecture of the Trust. This is a significant piece of work and most Executive Directors have now met with the Assistant Director of Governance to understand the process for reviewing the effectiveness of meetings within their remit and to address any duplication. This is a key piece of work aligned to the productivity and efficiency intentions for the organisation.

3.4 I have been involved in leading the process for the recruitment of the substantive Chief Executive for the ROH, with much time in August focussed on the arrangements that culminated in the interviews, stakeholder panel and selection process on 20 & 21 August. With congratulations to Matthew Hartland who was appointed into the role who will take on the substantive post from October.

3.5 On 6 August, I met with the Trust Secretary at Robert Jones & Agnes Hunt NHSFT to discuss next steps in terms of executing the strategic alliance between our organisations. The plan is to organise an initial meeting of the Chairs and Chief Executives of ROH & RJAH during late September/early October and then an Executive to Executive meeting in late October/early November to agree and discuss priority areas for joint working. A Board to Board meeting will be arranged before Christmas.

We also discussed some initial common areas for support from a governance perspective and agreed on Freedom to Speak Up and Health & Safety. The Health & Safety Advisors from the two organisations have already met and have been giving mutual support and advice on the visits from the Health & safety Executive.

3.6 On 28 August, I jointly with the Director of Strategy, met with the West Birmingham locality lead to discuss ways in which the ROH may contribute to the development of the neighbourhood agenda. Further engagement is planned as the work progresses.

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

27 August 2025

TRUST BOARD

DOCUMENT TITLE:	**Green Plan Refresh**
SPONSOR (EXECUTIVE DIRECTOR):	**Steve Washbourne, Chief Finance Office**
AUTHOR:	**Stuart Lovack, Deputy Director of Delivery**
DATE OF MEETING:	**3rd September 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The attached Green Plan provides a refreshed delivery plan and forms part of the BSOL ICS Carbon Reduction Plan. It provides an updated vision and target but also provides data on baseline usage for the first time, so future reductions can be measured.

Delivery is focused on ten workstreams; Workforce and Leadership; Clinical Transformation, Digital Transformation, Medicines, Travel and Transport, Estates and Facilities, Supply Chain and Procurement, Food and Nutrition, Adaption, and Communications. Of these the hospital estates probably provides the biggest challenge due to its age and reliance on gas fired boilers. Given access to capital funding is limited, it would be unrealistic to expect significant change or improvement unless further funding is identified.

The ROH Green Plan sets out the Trusts commitment to working towards net zero by reducing harmful emissions, improving efficiency, developing new ways of working through the transformation of the delivery of services and its estate. It clearly articulates the work that has been undertaken to date and sets out an ambitious change programme for the future

The ROH Green Board will continue to monitor progress and working towards net zero. The ten workstream plans will be reviewed regularly and will be upwardly reported to the Trust Board on an annual basis. The Finance and Performance Committee will be the sub-committee of the Board who will monitor progress against the plan.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Progress is being made against delivery plan across workstreams • Usage data in tco2e expressed for first time	• Access to appropriate capital funding

REPORT RECOMMENDATION:

The BOARD is asked to:

APPROVE the Green Plan Refresh

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	x
Clinical	x	Equality and Diversity		Workforce	x
Inequalities		Integrated Care		Continuous Improvement	x
Comments:					

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

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

N/A

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

Forms part of ICS Carbon Reduction Plan

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

N/A

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

July 2021 Board

The Royal Orthopaedic Hospital

NHS Foundation Trust

Green Plan (Refresh)

2026- 2040

September 2025

Executive Summary

The National Health Service (NHS) is one of the largest employers in the UK, providing health care to a population of over 68 million people. The NHS is also one of the UK's biggest users of energy and has a range of consumables that stretches from medical supplies to catering and cleaning products.

In 2020, the NHS became the world's first health system to commit to reaching net zero emissions. The NHS Executive set out plans to reduce the impact of the NHS on the environment and aims to be the world's first net zero national health service by 2040.

At the Royal Orthopaedic Hospital (ROH), the Trust Board of Directors are equally committed to reducing the organisation's impact on the local health economy and its population, we are actively contributing towards the NHS meeting this realistic, yet ambitious target.

This document has been revised in 2025 and forms part of the overarching Birmingham and Solihull Integrated Care System (BSOL ICS) Carbon Reduction Plan. It sets out the ROH responses and series of action plans to work towards/achieving net zero. These are challenging, innovative and mirror targets which achieve the level of ambition that has been set out nationally. The ROH is fully committed to meeting its obligation and responsibility to our population which we serve.

Matthew Hartland
Chief Executive

Simon Page
Chairman

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1. Delivering a Net Zero NHS

Climate change presents an immediate and growing threat to health. The UK is already experiencing more frequent and severe floods and heatwaves, as well as worsening air pollution. Up to 38,000 deaths a year are associated with air pollution alone, disproportionately affecting the most deprived and further exacerbating health inequalities.

The impact of climate change is expensive for society and the NHS, with the costs of heat-related mortalities from climate change alone estimated at £6.8 billion per year in the 2020s and predicted to rise to £14.7 billion per year in the 2050s.

The Health and Care Act 2022 sets out climate change duties with two clear targets to respond to the challenge:

- for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032

- for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039

The Health and Care Act 2022, further underscores the importance of the NHS's robust response to climate change, placing new duties on NHS England and all trusts, foundation trusts, and integrated care boards to contribute towards statutory emissions and environmental targets. The Act requires commissioners and providers of NHS services specifically to address:

- the UK net zero emissions target

- the environmental targets within the Environment Act 2021, and

- to adapt to any current or predicted impacts of climate change identified within the Climate Change Act 2008

Meeting this commitment will only be achievable if every part of the NHS – more than 1.3 million of us – are working together, we all have a role in delivering a net zero NHS, providing health and high-quality care for all, now and for future generations.

Nationally, significant progress towards achieving net zero has been made, over the last 3 years this includes:

- over £1 billion in funding secured by NHS trusts through the Public Sector Decarbonisation Scheme (PSDS), this is expected to reduce NHS energy costs by over £260 million a year
- NHS-wide decommissioning of desflurane, an environmentally damaging anaesthetic gas with a higher global warming potential than its readily available alternatives
- ongoing reduction in waste from nitrous oxide, responsible for the largest overall volume of emissions from anaesthetic and medical gases, saving around £5 million annually
- progressing high-quality, lower-carbon respiratory care, supporting patients to improve their lung health while reducing inhaler emissions by around 300 kilotons' of carbon (Kt/CO_2e) a year

- the introduction of requirements for NHS suppliers to disclose their emissions and publish a carbon reduction plan, in line with the NHS Net Zero Supplier Roadmap

The ROH continues to apply for external funding through the variety of government initiatives and support the local health care system with the aim to:

- prioritising interventions that support world-leading patient care and population health, reducing inequalities while tackling climate change and broader sustainability issues
- plan and make considered investments while increasing efficiencies and delivering value for taxpayers
- be ambitious to reach net zero carbon emissions and reflect on learning from our delivery to date

Workforce and Leadership

The transition to a net zero NHS will be driven by its people. The ROH will support its staff and leaders to learn, innovate and embed sustainability into everyday actions. We have:

- appointed a designated executive board-level net zero lead to oversee green plan delivery with clearly identified operational support
- assessed workforce capacity and skill requirements for delivering the green plan, considering good practice examples such as hybrid roles, apprenticeships, fellowships and NHS estates sustainability career pathways
- promoted, and consider setting uptake targets for, core training offers set out on the Greener NHS Training Hub
- promoted specialist training for staff groups who underpin the delivery of green plans, such as board members, procurement, finance, estates and facilities staff and clinicians

Clinical Transformation

The ROH supports and is committed to moving to out-of-hospital and digitally enabled care where clinically appropriate, improving prevention of ill health and reducing health inequalities. These changes also underpin our commitment to net zero.

The ROH supports net zero clinical transformation thereby ensuring high-quality, preventative, low-carbon care is provided to orthopaedic patients at every stage. We are focused on reducing emissions and improving quality of care in our clinical areas by:

- identifying a clinical lead with oversight of net zero clinical transformation, with formal links into board-level leadership and governance
- establishing a clinical lead and multidisciplinary working group responsible for reducing emissions in our clinical area(s)
- completing quality improvement project(s) in our clinical area(s) that focus on a measurable reduction in emissions, with co-benefits for outcomes and quality of care, efficiency and reducing healthcare inequalities
- sharing learning and outcomes through clinical networks, the ICB and NHS England

The two main areas of focus for the ROH are 'diagnostic tests & procedures' and 'medical pathways', with a focus on acute and/or long-term conditions.

Digital Transformation

The ROH is building strong digital foundations to transform care by improving access, quality, productivity and reducing emissions. However, digital services can also increase emissions. The ROH will work with NHS England's 'What good looks like framework' to prioritise sustainability in the procurement, design and management of digital services to meet the objectives of the 'Greening government: ICT and digital services strategy'.

The ROH is actively looking to:

- maximise the benefits of digital transformation to reduce emissions and improve patient care, for example, by reducing the use of paper and providing virtual pathways where clinically appropriate
- support the 'Digital Maturity Assessment', consider opportunities to embed sustainability in digital services by:
    - using circular and low-carbon approaches to IT hardware management, which may include longer device lifetimes, leasing models, buying refurbished or remanufactured equipment and 'PC power down' configuration
    - considering low carbon hosting, promoting good data hygiene (such as, deduplication and archiving) and engaging digital suppliers

Medicines

Medicines account for around 25% of NHS emissions. A few medicines account for a large portion of these emissions, for example, anaesthetic gases (2% of NHS emissions) and inhalers (3%). The ROH is actively reducing these "point of use" emissions, which improve patient care and reducing waste. Actions to reduce emissions from the medicines supply chain are set out under 'Supply chain and procurement'.

The ROH will:

- work with primary care to support high-quality, lower-carbon respiratory care in line with clinical guidelines for 'asthma' and 'chronic obstructive pulmonary disease'
- work in line with 'National medicines optimisation opportunities', address overprescribing and oversupply while supporting patients in greatest need, taking a shared decision-making approach and personalising care

The ROH has taken actions to:

- reduce nitrous oxide waste from medical gas pipeline systems (MGPS) by progressing the actions outlined in the updated 'nitrous oxide waste mitigation toolkit'
- cease use of the volatile anaesthetic agent desflurane in line with 'national guidance', allowing exceptional use only as published by the 'Neuro Anaesthesia and Critical Care Society'

Travel and Transport

The NHS fleet is the second largest in the country, consisting of over 20,000 vehicles. It directly contributes to harmful air pollution. The 'NHS Net zero travel and transport strategy' outlines a roadmap to decarbonise NHS travel and transport, while also providing cost-saving and health benefits.

The ROH is actively looking at:

- developing a sustainable travel plan by December 2026, to be incorporated into the green plan (for example, as an annex), focusing on active travel, public transport and zero-emission vehicles, supported by a clear understanding of staff commuting (NHS England guidance will be available in 2025)
- offering only zero-emission vehicles through vehicle salary sacrifice schemes from December 2026 onwards (for new lease agreements)
- planning to purchase, or entering new lease arrangements for, zero-emission vehicles only from December 2027 onwards
- forming partnerships with local authorities and local transport authorities to maximise funding and infrastructure opportunities

Estates and Facilities

There are significant opportunities across the NHS estate to reduce emissions and lower costs while improving energy resilience and patient care.

The ROH is focused on:

- improving energy efficiency through the installation of LED lighting, insulation and double-glazed windows
- replacing fossil fuel heating systems with lower carbon alternatives, such as heat pumps or connecting to a heat network
- increasing use of renewable energy by investing in on- or near-site renewable energy generation to meet NHS energy demand

The NHS is developing a pipeline of revenue and carbon saving projects together with:

- working with local partners to ensure estate decarbonisation planning aligns with local priorities, infrastructure plans (for example, heat networks) and funding opportunities
- identifying opportunities to support primary care estates decarbonisation, such as through the 'Boiler upgrade scheme'
- supporting Trusts that have not accessed PSDS funding previously to develop applications (this may include exploring joint bids between trusts or other partners)
- ensuring the green plan aligns with the 'ICS 10-year infrastructure strategy'

The ROH is looking into:

- developing a heat decarbonisation plan (HDP), which includes:

- identifying and prioritising the phasing out of all existing fossil-fuel primary heating systems by 2032 and seeking to remove all oil primary heating systems by 2028
    - considering 'local area energy plans' and opportunities from 'heat networks' and other low-carbon solutions
    - identifying any installations in scope of the UK Emissions Trading Scheme and outline plans to reduce emissions in line with allocated targets
- developing business cases to deliver the measures outlined in the HDP, as well as accompanying energy efficiency and renewable energy interventions, with a view to submitting a funding application through the PSDS if projects cannot be financed through internal budgets
- ensuring all applicable new building and major refurbishment projects are compliant with the 'NHS Net Zero Building Standard'

Supply Chain and Procurement

The 'NHS net zero supplier roadmap' outlines steps suppliers must follow to align with the NHS net zero ambition between now and 2030. Roadmap implementation is a shared responsibility across trusts, systems, regional procurement hubs and nationally.

The ROH will seek to embed circular solutions, such as using reusable, remanufactured or recycled solutions when clinically appropriate, which are often cost savings.

The ROH is actively looking to:

- embed the 'NHS net zero supplier roadmap' requirements into all relevant procurements and ensure they are monitored via Key Performance Indicators
- encourage suppliers to go beyond minimum requirements and engage with the 'Evergreen Sustainable Supplier Assessment' to support a single conversation between the NHS and its suppliers on sustainability priorities
- reduce reliance on single-use products, considering how to safely build this work into clinical improvement projects (see' Net zero clinical transformation')

Food and Nutrition

The ROH continues to implement the 'National standards for healthcare food and drink', this requiring NHS organisations to deliver high-quality, healthy and sustainable food and minimise waste.

The ROH is actively looking to:

- measure food waste in line with the' Estates Returns Information Collection (ERIC)' and set reduction targets
- seek opportunities to make menus healthier and lower carbon by supporting the provision of seasonal menus high in fruits and vegetables and low in heavily processed foods

Adaptation

Climate change threatens the ability of the NHS to deliver its essential services in both the near and longer term. Resilience and adaptation are built into business continuity and longer-term planning to avoid climate-related service disruptions. Partnership working between sustainability leads, public health, emergency response teams and estates leads at Trust and system level is crucial.

The ROH is actively working:

- with providers and commissioners of NHS-funded services to comply with the adaptation provisions within the 'NHS Core Standards for emergency preparedness, resilience and response (EPRR)' and the 'NHS Standard Contract' to support business continuity during adverse weather events
- with colleagues to set out actions to prepare for severe weather events and improve climate resilience of local sites and services, including digital services
- in partnership with emergency response colleagues and others, identify interdependencies between services and the necessary mutual aid requirements to prevent service disruptions
- providers and commissioners to share findings with resilience partners (for example, local resilience forums and directors of public health) to ensure critical information is integrated into broader emergency planning and climate adaptation planning practices
- to factor in the effects of climate change when making infrastructure decisions and designing new facilities, including enhancements like improved green spaces, drainage systems and passive cooling solutions
- to ensure adequate cascading of weather health alerts and relevant messaging across the organisation, in line with the government's 'Adverse Weather and Health Plan'

2. About the Royal Orthopaedic Hospital NHS FT

The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) has been providing specialist orthopaedic care at a local, regional, national and international level for over 200 years. Situated within the Birmingham and Solihull Integrated Care System (BSOL ICS), it has circa 1500 staff, 120 beds (over 6 wards) and 14 operating theatres. The hospital provides specialist care for all areas of orthopaedics including arthroplasty, arthroscopy, spinal, foot & ankle, hand, MSK, pain management and core therapies, and is a national centre for orthopaedic oncology.

The hospital is in the south of Birmingham with good transport access for patients, staff and visitors. In 2021it invested in a major capital redevelopment with a new modular build theatre and ward complex, this provided 4 new 'state of the art' operating theatres to complement the 10 existing theatres and a new 20 bedded, mainly single en-suite accommodation, ward.

3. The ROH Governance Process

The ROH Green Plan delivery is overseen by our Chief Finance Officer / SIRO / AEO who is an executive director of the Trust. This role is also supported by other executive directors and their senior leadership teams. The ROH Green Board reports through to the Finance & Performance Committee and upward to the Trust Board.

The ROH has governance arrangements in place to co-ordinate the ROH green plan delivery, we have regular green plan delivery board meetings chaired by the organisation's board-level net zero lead and attended by relevant directors/senior leaders.

The ROH Green Plan is reviewed annually where we consider progress made and any new priorities, guidance, technology and other emerging enablers. The ROH works with our ICB partner and other trusts to support the delivery of our green plan publishing data in our annual report. Metrics are also tracked through the 'Greener NHS dashboard' and 'Estates Return Information Collection' portal.

Some of our green planning actions, where benefits can be captured immediately with little requirement for financial investment are actioned, these include waste reduction, safe re-use of products and optimisation of medicines usage.

Other initiatives do require initial capital investment but also offer substantial efficiency savings, examples of this include LED lighting, systems to manage and reduce energy consumption, and the electrification of the ROH fleet in line with the 'Net Zero Travel and Transport Strategy'.

The ROH considers how net zero principles can be routinely integrated into all our business-as-usual upgrades and backlog maintenance when developing our green plan.

The ROH is actively pursuing the wider government funding to support the UK-wide transition to net zero. Nationally the NHS has already:

- secured over £1 billion in investment to cut energy costs and reduce carbon emissions through the 'Public Sector Decarbonisation Scheme (PSDS)'
- invested £40 million in LED lighting through the NHS Energy Efficiency Fund, with an additional £75 million available to support LED lighting and building management system projects in 2024/25
- identified other schemes including the 'Public Sector Low Carbon Skills Fund', the 'Workplace Charging Scheme', and the 'Boiler Upgrade Scheme' to support green heating installations in smaller properties such as primary care practices

The ROH workstreams have 'executive sponsors', roles within the ROH have also been identified as 'leads roles' for the developed ten workstreams:

- Workforce and Leadership – Executive Chief People Officer
- Clinical Transformation – Chief Nurse & Executive Medical Director
- Digital Transformation – Chief Digital Information Officer
- Medicines – Chief Pharmacist
- Travel and Transport – Deputy Director of Delivery
- Estates and Facilities – Head of Estates and Head of Facilities
- Supply Chain and Procurement – Managing Director (Procurement)

- Food and Nutrition – Head of Facilities
- Adaptation – Head of Capital and Emergency Planning Officer
- Communication – Head of Strategy and Communications

4. **The Carbon Footprint Targets**

The ROH plan is working towards achieving its key strategic targets, these being:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ROH ambition to reach an 80% reduction by 2028 to 2032

- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ROH ambition to reach an 80% reduction by 2036 to 2039

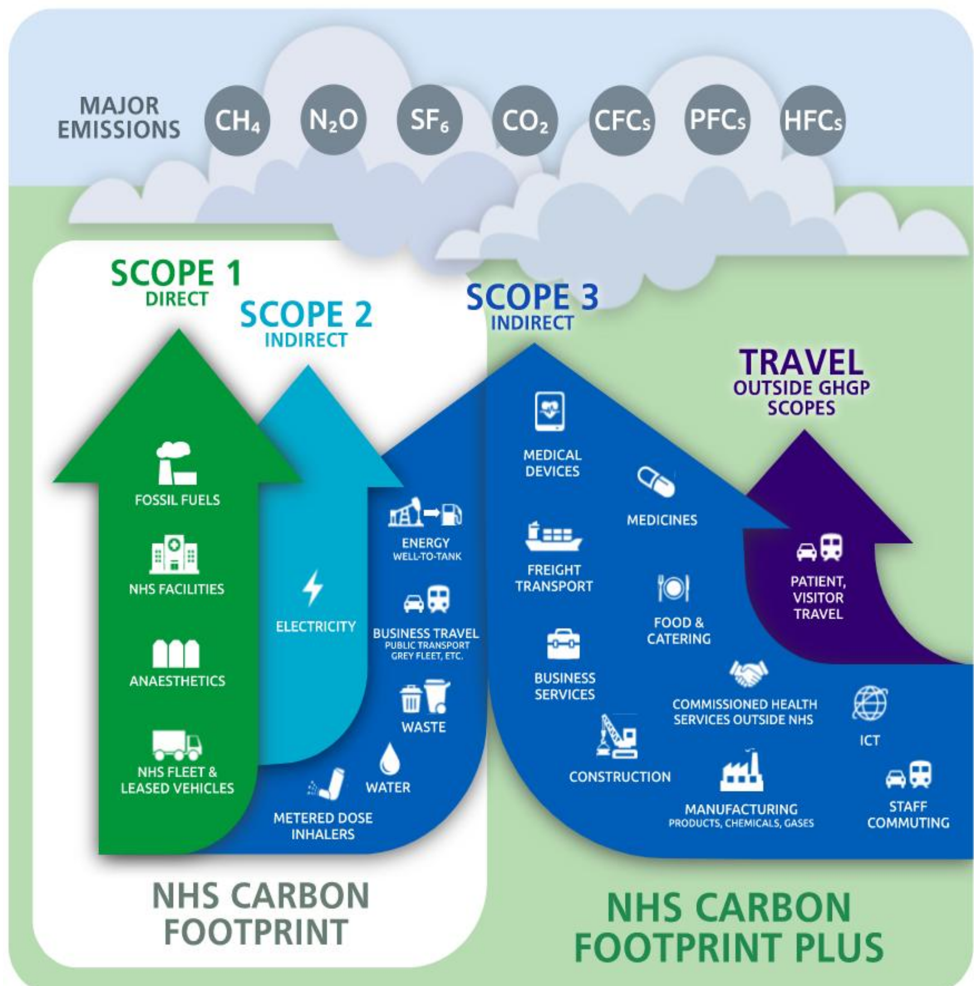


Fig. 1 NHS Net Zero Plan (2021)

5. ROH Green Plan Progress

The ROH has been actively working to reduce its carbon emissions in line with the NHS targets, We have previously lacked the ability to record our current usage form which future deductions could be made, so in 2024/25 the ICS agreed on a shared resource to measure current baseline usage:

Current Usage in Tonnes of Carbon Dioxide Equivalent (tCO_2e)

Summary (tCO_2e)	2024/25	% of tCO_2e	NHS Average
Medicines & Chemicals	30	0.3%	20%
Medical Equipment	2,456	21.8%	10%
Non-Medical Equipment	3,256	28.9%	8%
Other Supply Chain	728	6.4%	24%
Building Energy	2,620	23.2%	10%
Waste & Water	152	1.3%	5%
Anaesthetic Gases & Inhalers	56	0.5%	5%
Refrigerant Gases	282	2.5%	0%
Business Travel & NHS Fleet	83	0.7%	4%
Patient & Visitor Travel	677	6.0%	6%
Staff Commuting	451	4.0%	4%
Commissioned Health Services	491	4.3%	4%
Medicines, Medical Equipment & Other Supply Chain	6,469	57.3%	62%
Carbon Footprint	3,193	28.3%	24%
Personal Travel	1,128	10.0%	10%
Commissioned Health Services Outside NHS	491	4.3%	4%
NHS Carbon Footprint	**3,193**	**28.3%**	**24%**
NHS Carbon Footprint Plus	**8,088**	**71.7%**	**76%**
TOTAL:	**11,281**		
convert to heating this number of homes:	4,178		

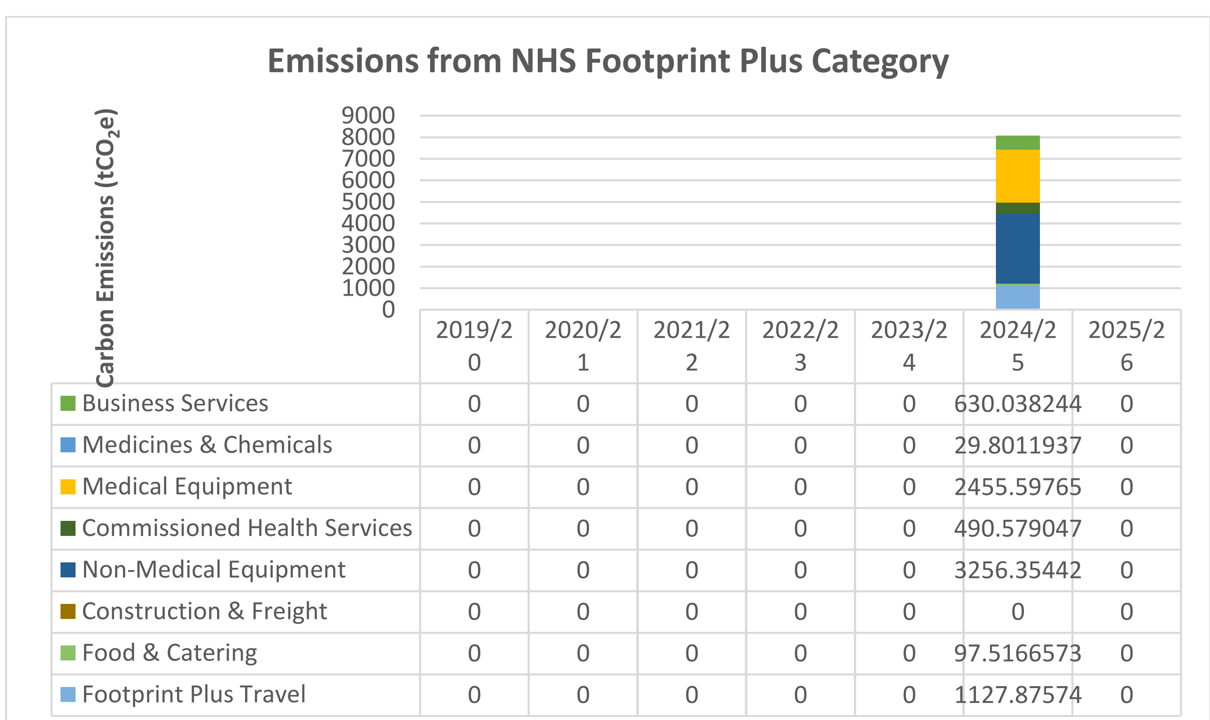
Note: Staff commuting and patient & visitor travel data have been estimated based on National NHS carbon averages (4% & 6% respectively). Inhaler data has been apportioned using MDI and DPI Greener NHS carbon factors. eClass data includes uncategorised entries, which have been re-categorised with the available data.

The ROH emissions data breaks down into our 'NHS Footprint Cateogry' and 'NHS Footprint Plus Category' as follows:

Emissions from NHS Footprint Category

Carbon Emissions (tCO_2e)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Oil						0	
Natural Gas	0	0	0	0	0	1452.88233	0
Heat	0	0	0	0	0	0	0
Electricity	0	0	0	0	0	1167.55535	0
Water	0	0	0	0	0	7.05831829	0
Waste	0	0	0	0	0	144.61698	0
Inhaler	0	0	0	0	0	4.63635	0
Anaesthetic Gases	0	0	0	0	0	51.427475	0
Refrigerant Gases	0	0	0	0	0	282.062	0
Footprint Travel	0	0	0	0	0	83.0100827	0

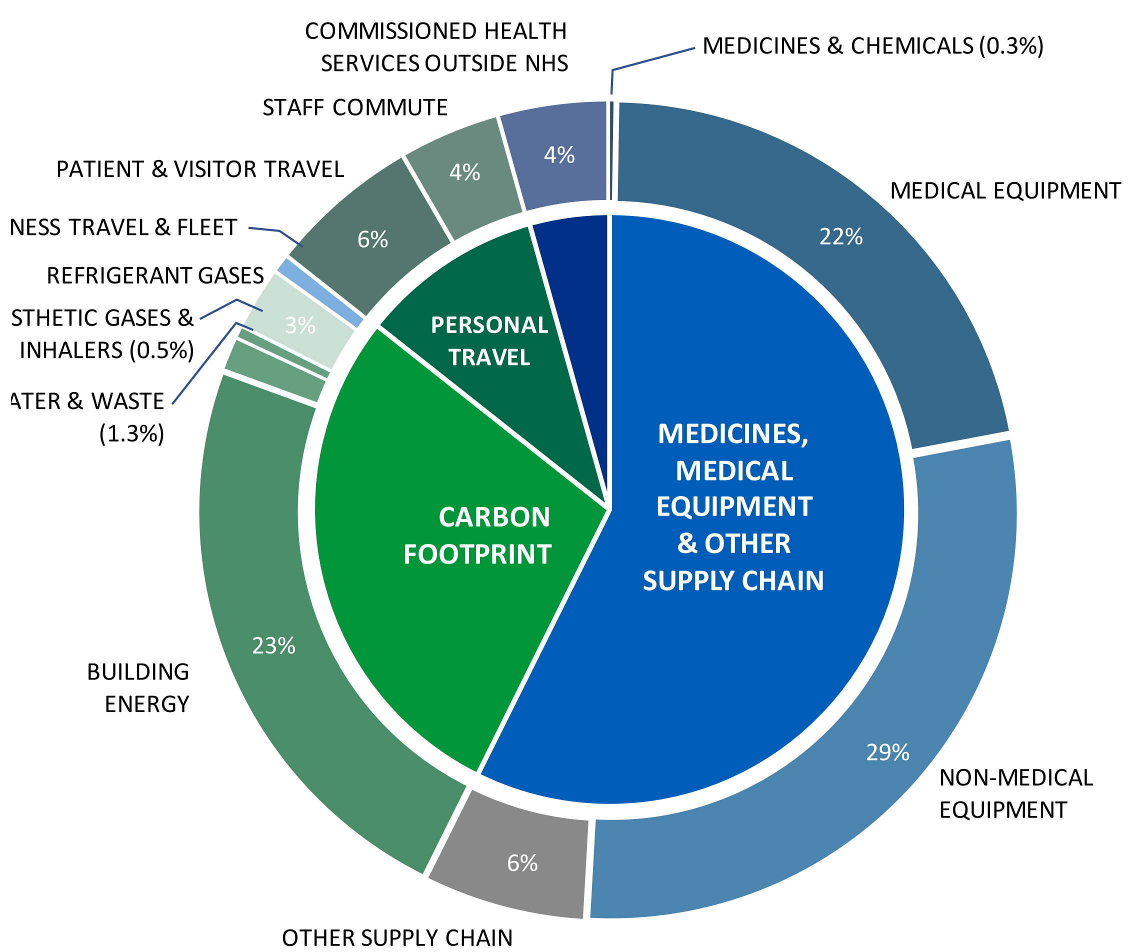


Emissions from NHS Footprint Plus Category

Carbon Emissions (tCO_2e)

	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Business Services	0	0	0	0	0	630.038244	0
Medicines & Chemicals	0	0	0	0	0	29.8011937	0
Medical Equipment	0	0	0	0	0	2455.59765	0
Commissioned Health Services	0	0	0	0	0	490.579047	0
Non-Medical Equipment	0	0	0	0	0	3256.35442	0
Construction & Freight	0	0	0	0	0	0	0
Food & Catering	0	0	0	0	0	97.5166573	0
Footprint Plus Travel	0	0	0	0	0	1127.87574	0

The above information can also be expressed in a pie chart as follows:



6. ROH Organisational Vision

In the summer of 2021, the Trust Board received the NHS Net Zero report and the aims and targets within. In 2025 the Trust Board remains committed to playing its part in achieving these aims and developing realistic plans to deliver the ROH's contribution towards a net zero NHS.

The ROH since 2022 has started to examine and question its approach to environmental factors, carbon reduction and achieving a more ecological sustainable Trust. The Trust Board is aware that these initiatives form the beginning of an extensive series of transformational improvements and has committed to developing and delivering a net zero plan alongside our ICS partners in BSOL.

Through our ROH Green Board we have developed a Net Zero Strategy, using NHS guidance we have generated 10 workstreams (which includes communication) in our bid to become a net zero NHS organisation.

The ROH Green Plan has been revised and refreshed using the latest NHS guidance. Through the ROH Green Board we continue to monitor the established and updated workstreams which have been designed around the following themes:

1. Workforce and Leadership
2. Clinical Transformation
3. Digital Transformation
4. Medicines
5. Travel and Transport
6. Estates and Facilities
7. Supply Chain and Procurement
8. Food and Nutrition
9. Adaptation
10. Communications

7. Workforce and Leadership – progress & plan

Critical to the success of the Trust's net zero ambition is ensuring our workforce feels educated and empowered to achieve our sustainability objectives. The ROH is looking to create a workplace culture where people understand how they can positively contribute to net zero and align this with supportive Trust policies and practices which enable a sustainability culture to develop, in turn, supporting the objectives of the other workstreams.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Engage with the Carbon Literacy Project to increase staff awareness and education around the impact of carbon emissions and how they can make a difference	Trust to identify a lead to expand education and awareness training on the impact of carbon emissions, additional advice and support provided by T&D	
Encourage staff to sign up to the Greener NHS Community	No progress but discussions will be started with existing staff networks to see how work can be incorporated as well as reviewing options to start a greener network group	
Link sustainability to the Trust's health and wellbeing agenda incentivising sustainability actions to increase staff engagement	In progress, information to be included in the November Wellbeing weeks with support from external partners including Living Streets. Information will also form part of the regular Wellbeing updates to Trust Board members and managers meetings	
Further embed an agile/flexible working culture across the Trust	Staff survey results indicate our staff feel that they can work more flexibly: **Flexible working** 2022: 6.40 2023: 6.47 2024: 6.66 **Work life balance:** 2022: 6.37 2023: 6.53 2024: 6.70	

	This is above national average	
Ensure that sustainability and the responsibilities of staff in terms of moving towards net zero are included within recruitment literature, Trust induction and job descriptions for all staff	Included in the Trust's induction programme, also narrative added in the recruitment literature	
Ensure all leaders are aware of their responsibilities with regards to sustainability and include this in individual's objectives and team annual plans	Included in the Trust's documentation for annual planning	

8. **Clinical Transformation – progress & plan**

The focus for the operational management team is to lead and implement a range of projects which reduces the Trust's reliance on printing and use of paper, reducing the number of patients attending the site thereby reduce transport emissions and support the reduction of waste.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Increase virtual consultations	Virtual consultations including video in June 2025 was at 9.4%, the yearly target is 19% rising to the national target of 25%. Increasing virtual appointments is challenging due to the absence of a video platform. We do encourage telephone clinics but sometimes with the nature of the speciality the patient must be physically assessed by the clinician	
Increase number of patients on a patient initiated follow up pathway	The patient is given an option to choose whether they should be followed up within a defined clinical window. If no contact during the clinical window the patient is removed from the waiting list. The intention being to reduce any unnecessary appointments In relation to PIFU the ROH are 4th best nationally at 10.3% with an aspiration of 12%	
Increase use of Advice and Guidance	Increase the electronic and virtual offer for patients by reducing paper forms / print outs and offering an online coaching app which patients can access at any time The ROH have an action plan aligned to the system action plan for advice	

	and guidance. This is monitored through the Trust primary care interface group.	
Increase uptake of electronic letters	The Trust has implemented electronic letters and text messages to reduce the number of printed letters being sent to patients. This has had the short-term effect of reducing missed appointments but in the long term will support the ambition to become a paperless Trust	
Increase virtual aspects of the Joint Care pathway	Virtual coffee catch ups are underway for patients who have taken part in our Joint Care programme Look to roll out programme beyond Joint Care	
Reduction in theatre plastic wrapping	Explore the reduction of plastic wrapping for theatre equipment kits thereby reducing unnecessary repeat sterilisation of equipment Lead to be appointed	

9. Digital Transformation – progress & plan

The Digital Programme Team work closely with operational teams from across the organisation to establish new digital processes and technologies to enhance patient care.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Electronic GP documentation	PICS deployed which has digitised all discharge letters, DNR and notification of death. Remainder will be fully digitised under EPR deployment	
Offsite printing of clinic letters	Partially complete, fully digitised under EPR deployment	
Video Consultations	Doctor Dr Programme, functionality available however was not pursued due to clinical preference. To be revisit under EPR deployment	
Digital Patient letters -reduces paper output	PICS deployed which has digitised GP documentation such as all discharge letters, DNR and notification of death. Remainder will be fully digitised under EPR deployment	

EPMA – NEWS2, Observations and Assessments captured electronically (previously paper) Introduction of digital clinical noting and operation notes	Implemented through PICS deployment	
RPA – paper processes have been redesigned to a digital process	NDL,15+ digitised forms live	
Patient SMS Appointment service	Doctor Dr Programme implemented	
Referral Management System – replaces paper-based referrals and imports referrals from Primary care via an electronic system	Implemented	
HIE/ShCR – Onboarded the Trust to the new ICS shared care record for all BSOL (Primary, Secondary and Social Care providers) with patient records access available from providers including cloud migration	Implemented through clinical portal	
Utilise Virtual/Video Consultations further to reduce journey and travel costs and reduce carbon emissions for service users Digital Care Pathway Redesign will assist reducing current paper-based processes across the trust and allow patient records to be viewed digitally • PreOp Digitisation – reduce journey and travel costs to service users • Clinical Portal – Patient record accessible digitally, Access to Shared Care record for West Midlands • Medical Record Digitisation. Convert all current paper hosted medical records to a digital version	Clinical Portal went live in 2025, shared care record implemented. Further digitisation under EPR deployment.	
Reduce the printer estate significantly by digitising as many paper-based processes as possible • The implementation of Order Comms to allow imaging requests to be conducted via the trusts EPMA solution mitigating paper processes	Order comms for imaging deployed onto PICS in 2023	
Automation – Redesign current paper processes where possible and use Robotic Process Automation to convert to digital data entry points ensuring data is captured into efficient databases and not stored on paper	Partially implemented will be completed under EPR deployment	

Expand the electronic documentation service to Primary Care further by onboarding other Trust services	To be implemented under EPR deployment	
Centralised PMO function – Implement a solution that hosts all Project / Programme related documents into a web-based repository	DDaT Triage process implemented with centralised DDaT PMO function covering all DDaT projects across ROH	
Digitally enable care pathways for service users will significantly reduce travel and journeys to the Trust with 'care closer to home' being delivered through remote consultations and monitoring	Patient engagement using Apps in certain pathways e.g. MyRecovery. Further digitisation under EPR deployment	
Front-line digitisation of clinical records, clinical and operational workflow and communications aided by digital messaging and electronic health and care record systems (EPR)	Partially complete through PICS, Clinical Portal & Theatreman. Full implementation through EPR Deployment (2026 onwards)	
Large-scale migration of Trust data centres into the cloud; reducing the need for the storage of large volumes of data on power consuming hardware	Cloud migration implementation progressing	
Replacement of the current telephony solution with a cloud-based solution reducing power consumption	Telephony project with Mytel in progress due to Go Live in October 2025	
Liaise with suppliers providing digital services/solutions to the Trust to minimise their environmental impact and adapt their solutions accordingly to support the Net Zero principle	Working with the procurement hub and suppliers to ensure they conform to the Net zero roadmap	
Enhance the electronic documentation service to Primary Care into a fully Digital "Transfers of Care" model	Partially implemented through Share Care records & GP communication, further items planned through EPR deployment	
Aspire to become a paperless Trust	To be achieved through EPR deployment and optimisation post (2026 onwards)	
Provide a Digital Front Door for service users to allow access to a Patient Portal for Applications, Data submissions	Some work done under NHS App but not fully integrated with ROH systems and don't have patient engagement platform, plan to be done under EPR deployment	

10. Medicines – progress & plan

Medicines account for about 25% of emissions within the NHS in England. There are 2 types of medicines that account for a high amount of these emissions these being Anaesthetic Gases and Nitrous Oxide at 2% and Metered Dose Inhalers at 3%.

The areas at the ROH which directly influences us is the anaesthetic gases and Nitrous Oxide usage. The inhaler usage and changes to different devices will be led by the CCG/ICS and we (ROH) will then follow their guidance.

The anaesthetic gases which we have eliminated from use at the ROH are desflurane and nitrous oxide. Desflurane has a Global Warming Potential of 2540 whereas the alternative, Sevoflurane, has a global warming potential of 130.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Reduce the use of Desflurane	Desflurane not used at the Trust	
Reduce the use of Nitrous Oxide	Nitrous oxide decommissioned at the Trust	
Reduce the use of plastic Pharmacy bags	Switched to paper bags in 2023	
Recapture system for Sevoflurane	Sevoflurane re-capture system requires investment	
Reduce Pharmacy deliveries	Robust system in place to ensure a sufficient stock holding, plus urgent ordering process in place	
Use of cool sticks instead of ethyl chloride spray	Scoping exercise completed, currently has minimal impact	
Entonox usage	Entonox usage on site is being monitored	

11. Travel and Transportation – progress & plan

The aim is to reduce local air pollution as this has a direct impact on our patients, staff and the local community. We can attribute 14% of all the NHS emissions to patient, staff, visitor, business and NHS fleet travel. In comparison, the building energy use, water and waste totals15%.

The Trust has already replaced its fleet diesel cars by purchasing two zero emission vehicles (ZEV). This has demonstrated a saving of 9,164kg of CO_2 per annum. Through the Covid pandemic, new and innovative ways of staff working and delivery of services were introduced (e.g. remote working / virtual consultation) again reducing the number of journeys to our site.

As an organisation we should be embedding active, clean and low carbon travel to reduce carbon emissions linked to our business activity. The following objectives have been set:

Action	Progress to date	Status
Reduce carbon emissions and air pollution from non-emergency patient transport	Promoted required standard with non-emergency patient transport providers.	
Develop a Healthy Travel Strategy with targets & measures to reduce single occupancy car journeys	Working towards developing a healthy travel strategy	
Use ROH/BSOL partnerships to reduce our emissions in supply chain transportation	Working with other partners and the procurement hub	

Increase the amount of people travelling to the ROH by active and sustainable travel methods	Working towards monitoring people travel to ROH	
Flexible/hybrid working for staff to reduce the workforce travelling to site	Flexible & hybrid working policy in place	
All staff having access to video & teleconferencing minimising business miles	Microsoft TEAMS system operational	
Consider the Clean Air Hospital Framework by monitoring indoor and outdoor air quality on the site to identify hotspots, with a view to improving these areas	ROH is part of the West Midlands Clean Air and NHS Air Quality Group	
All contracts to include a sustainability and travel criteria	Engaging with procurement hub	
Introduce a sitewide 'No Idling Policy'	No idling signs installed at key locations around Trust	

Staff Travel

The Trust already has a plan in place for staff travel and promotes active and sustainable transport as a mode of travel for commuting. The Trust received a Bronze Accreditation for its staff travel plan from Mode Shift Staff, working with Birmingham Council and Transport for West Midlands. The Trust has worked in partnership with the charity Living Streets to promote walking and provide Dr Bike sessions facilitated by the charity New Roots.

Through a grant application the Trust has been successful in purchasing an E-bike, two hybrid bikes and storage lockers, for staff to use for business use and to borrow for their commute. This gives staff a flavour of how their commute could be improved and encourages them to purchase their own bicycle using the Cycle to Work Scheme.

A recent travel survey indicated 60% of staff travel by single occupancy car. There is an opportunity for modal change with 45% of staff living within five miles of the site and almost 70% of staff living within ten miles.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Develop our Greener Car Park Management Policy	Under review, link to staff travel survey data	
Promote our cycling and cycle to work scheme – develop a cycle to work Lead and Cycling Club	Further promotion to be scheduled	
Provide more secure cycling storage onsite	Review current onsite cycle storage	
Provide dedicated showers / changing / locker facilities that can be accessed by patients, visitors and staff	Plans being developed to increase provision	
Organise Dr Bike sessions with teaching sessions for staff/patients to learn new skills	Re-engage with Dr Bike sessions	

Promote staff discounted public transport tickets and route planning	Discounted bus tickets available to staff	
Working with local public transport providers to offer new staff 'free public transport' on their commencement date	One-month free travel vouchers available for staff giving up their car for alternative mode of transport	
Staff Lease Car scheme to offer Ultra Low Emission (ULEV) and Zero Emission Vehicles (ZEV), enabling staff to replace their diesel/petrol vehicles	ULEV and ZEV vehicles offered under the scheme	

Patient and Visitor Travel

Reducing patient travel to our site is challenging due to the type of treatment being delivered (MSK, orthopaedic and spinal conditions). We proactively work towards decreasing the level of patient travel required through the following actions:

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Work with local transport providers to provide discounted travel for patients	Discounted West Midlands bus travel available to ROH staff	
Introduce 'How They Travelled Today' onto the booking-in systems to collect data	To be progressed	
Conduct a Travel Survey for patients and visitors	2025 travel survey to be sent out.	
Provide information to patients and visitors on active and sustainable travel options	To be progressed	

Business Travel

The Trust Zero Emission Vehicles (ZEV) fleet cars were commissioned in May 2021 and has shown a significant reduction in emissions. Individual staff business travel has reduced through video / teleconferencing, more work it to be undertaken on reasons for business travel.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Business travel to be linked to greener car park management policy	To be progressed	
Increase in Video/Teleconferencing (staff meetings)	Video and teleconferencing available to staff	
Introduce a competitive 'Cycle to Meeting' rates	To be progressed	
Promote use of Trust Pool Bicycles	Pool bicycles available, further promotion scheduled	
Collate payroll information on mileage claims and reasons for travel	To be progressed	

12. **Estates – progress & plan**

Energy Adaptation

Technological development in 'alternative energy' will play a big part in adapting our environments to meet the future needs of the service and working towards our 'Net Zero' target. The development of a 'Solar Farm' on the roof of Blocks 37 & 76 has, in part, enabled us to move over to an alternative energy solution.

The super insulating of existing buildings which are to remain on site will be a necessity in the drive to reduce energy leakage and improve the buildings thermal qualities. When existing buildings are refurbished a review of the thermal capability will be undertaken and judged against the latest Building Regulation standards for energy preservation.

The orientation of our buildings can result in solar gain, where buildings are in direct sunlight then solar shading such as 'Brise Soleir' is being investigated. The use of 'Free Heating' and 'Free Cooling' is also being considered and harnessed.

Action	Progress to date	Status
Develop a heat decarbonisation plan and business case	To be progressed	
Ensure all new build / major refurbishment projects comply with 'NHS Net Zero Building Standard'	To be reviewed during new build / major refurbishment projects	
Improving energy efficiency through the installation of LED lighting, insulation and double-glazed windows	60% of the Trust has LED lighting. Reviews are taking place on insulation levels and double glazing	
Replacing fossil fuel heating systems with lower carbon alternatives, such as heat pumps	Older boiler installations replaced for more energy efficient boilers. Heat pumps systems require large scale investment and an externally funding investment plan.	
Increasing use of renewable energy on site	Solar panels systems installed on blocks 37 & 76, further expansion to be explored.	
Review solar shading, free heating and free cooling options	Free cooling introduced to block 52	
Introduce sub-metering throughout site	Trust has engaged with supplier and roll-out underway	
Optimisation of Building Management System	Working with controls expert to optimise systems	

13. **Facilities – progress & plan**

Waste reduction is important; the Trust is looking at ways of reducing the quantities of waste sent for landfill in relation to healthcare clinical waste and general household commercial waste.

Waste is a significant cost to the NHS, with clinical waste requiring expensive methods of disposal. Disposing of waste efficiently and correctly will reduce cost, reduce the strain on

natural resources and improve the environment. Making moderate changes on how waste is managed within the Trust is evidenced by the introduction of the non-infectious waste stream, confidential waste, cardboard segregation and dry mixed recyclables segregation. These waste streams along with others waste reduction and recycling schemes will be further developed and improved.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Increase recycling rates	Introduced paper only recycling – redundant office furniture is sent to the BSOL warehouse and repurposed. Departments source from the warehouse in the first instance	
Reduce plastic waste	Introduced an ROH plastic recycling scheme that captures theatre plastic trays	
Educate users on better waste segregation	Introduced toolbox talks with staff, new intranet page for waste and segregation posters on display	
Work with clinical colleagues to reduce single use medical equipment	Introduced more stringent recycling regimes within theatres focussing on excess packaging around instrument	
Introduction of non-infectious waste stream, confidential waste stream, cardboard segregation and dry mixed recyclables segregation.	All waste streams active throughout the Trust	

Healthcare Clinical waste

While not seen as a prominent contributing factor to the reduction of carbon emissions, the introduction of the non-infectious waste stream has been a success, in relation to waste compliance and regulation. We continue to work with our clinical waste treatment providers Stericycle to pursue alternative avenues of how waste is treated and sent for final disposal.

Our infectious waste stream is currently treated via an alternative treatment process. Waste is autoclaved rather than incinerated or treated with harmful chloride substances. Once treated waste will either be used as a fuel stock in the manufacturing of cement or sent to deep landfill.

Commercial Waste

The recycling provision for dry recyclables (paper, card, glass, plastics and metals) has increased where permitted by healthcare guidance. This equates to 252 tonnes diverted from landfill, and Energy from waste incineration 27% of our total waste arising. This has been achieved by providing additional internal recycling bins, greater operational management of cardboard capture, and working closely with our commercial waste contractor Veolia. The Trust has managed to avoid a further 93 tonnes our commercial waste entering landfill.

General waste has been diverted from landfill and is used as a fuel stock to generate power that services the Birmingham region.

The specific deliverables for these workstreams are as follows:

Action	Progress to date	Status
Removal of all plastic, spoons, knives and forks – replaced by biodegradable bamboo	Complete	
Removal of plastic single use cups – replaced with bio-degradable composite materials	Complete in part, now exploring the possible of reintroducing re-usable hot drinks cups	
Removal of plastic straws- replaced with paper composite materials	Complete	
Removal of polystyrene take-away trays – replaced with bio-degradable composite materials	Complete, plus we have introduced re-useable takeaway containers	
Removal of un-recyclable take away hot drink's cups- replaced with bio-degradable composite materials" and the introduction of re-usable hot drinks cups	Exploring the reintroduction of reuseable hot drinks cups	
Confidential paper waste is 100% recycled	Complete	
Cardboard is 100% recycled	Complete	
Dry mixed recyclable bin rollout capturing paper, card, plastics and metals	Waste bins roll out 98% - OPD outstanding, reviewing requirements to enable a reduced purchase of replacement bins	
Glass only recycling bins	In part, looking to introduce glass only recycling caddies within all areas	
Battery recycling stations introduced	Complete	
Introduction of bulky scrap metal recycling	Complete	
Cleaner hazardous waste disposal (Waste electronic, electrical equipment WEEE)	In part, looking at alternative storage solutions such has storage container (waste compound 1)	
Re-useable mop and microfiber heads	Complete	

Facilities continue to undertake reviews of all waste management systems and processes to increase recycling tonnage, deploy better waste segregation and seek to reduce plastic waste through education, training and communication.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Removal of Plastic Milk bottles (Inpatient areas). Data capture analysis undertaken – It is estimated that we use over 17,000 plastic milk bottles per annum	Due to space constraints unable to action the introduction of milk pergolas. Exploring new ways on how's best to capture plastic milk bottles	
Examine other plastic waste produced and seek alternative solutions to recycle	Exploring possible plastic only bins to be cited within all areas, however	

	due to the constraints of space within most areas, may need to look at several central drop off points throughout the site	
Examine alternatives to plastic sharps boxes and waste medicine containers	Our current and projected usage of plastic sharps boxes are relatively low. We have very limited space within our internal waste holding areas, as the areas are not large enough to store reusable sharps bins	
Reduce and divert food waste to Anaerobic Digestion or composting initiates - It is estimated that we would need around 20 x 120 Eurobins to capture weekly waste quantities generated. Quotes obtained from our current waste provider Veolia has the estimated increase spend of £15,000 per annum	Complete in part, exploring the introduction of food waste caddies within office areas	
Introduce "Wood only recycling" - Quotes obtained from Veolia for this provision has been estimated @ £3,000 per annum	Complete	
Remove all "take away disposable items- replace with re-useable containers - current spend on disposable has been estimated @ £11,000 per annum	Complete	
Continue to work with our waste contractors to ensure that waste is managed and disposed of at the highest level of the waste hierarchy	Complete, new waste tender in development	
Capture all paper waste enabling the Trust to be 100% paper recyclable	Complete	
Work with our colleagues within theatres – exploring improved waste segregation and recycling	Complete	
Remove all local workstation bins – replace with dedicated recycling station alternatives This encourages recycling rates as staff are required to use centrally located recycling stations as opposed to personal bins. This will be seen as Health and Wellbeing advantages, through encouraging more frequent movement away from desks. This also benefits the facilities team, via a reduction in number of bins needing service.	Complete	
Remove where possible paper-based hand towels – replace with hygienic/micro-biological hand dryers	Not complete, reverted to paper hand towels	

Membership to the Warp-It; a public sector reuse initiative that facilitates trading of surplus assets within and between organisations	Not complete, to be explored further	
Will work to reduce single use plastic items in other areas, including gloves, gowns and hygiene products	Complete, working with IPC Team	
Reduce the number of "General waste bins" within all areas – encouraging greater recycling and ownership to the producer	Complete	

14. Supply Chain and Procurement – progress & plan

The Trust works in partnership with Birmingham and Solihull Procurement Collaborative (BSOLPC) (hosted by UHB) to provide specialist supply chain and procurement services. The Managing Director is leading the 'Supply Chain and Procurement Green Plan' for the ICS.

BSOLPC is constantly working with suppliers to ensure the Trust/NHS meet their greener agendas and monitor their carbon omissions. The BSOL ICS is looking to introduce a system where suppliers can report their carbon omissions, enabling us to focus on omission reductions as one of our key performance indicators.

In February 2022 the Trust will be moving all of our stock management to Kings Norton through the BSOLPC; all transport of stock across BSOL is through HGV Electric vehicles. This is part of the national pilot with the Department of Transport to support HVG electricalisation.

All BSOL tenders now include a Sustainability and Social Value sections which will be 10% of the overall scoring criteria ensuring Greener Procurement solutions are an integral part of supplier selection.

The Trust continues to look at onsite storage in a move to reduce the number of weekly deliveries thereby supporting the 'Think Birmingham - Buy Birmingham' Social Value priorities.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Embed the NHS net zero supplier roadmap	All suppliers are required to conform to the Net Zero roadmap and all procurements (suppliers) are mandated to produce a Carbon Reduction Plan (CRP)	
Engage with suppliers to adopt the 'evergreen sustainable suppliers assessment tool	All suppliers are required to complete the Evergreen Assessment on the ATAMIS system as part of the new procurement legislation. The team are working with all incumbent suppliers to align them with the new requirements	

Develop HVG electricalisation of fleet	The ICS is currently looking at a system wide Transport transformation strategy, including integrated route planning and systemwide transport utilisation. There is a strategy to move to a wider electrification of fleet, but this is dependent on infrastructure to support service requirements	
Removal of single use plastics	The Clinical Procurement Nurse led team are reviewing all single use plastic products to either remove or find reusable alternatives. Such as Gloves Off campaign, removal of Blue Couch roll, etc	
Move to Reuse, Remanufacture, Recycled MedTech Devices	BSOL was part of the (DHSC) Design for Life team, to shift suppliers from single use to Reuse, Remanufacture, Recycle devices. BSOL is already working with Vanguard who remanufacture devices, which are then removed from clinical waste and provide an income stream	
WARPIT reuse of equipment across BSOL	BSOL is introducing a portal "WARPIT" which allows Trusts to advertise unwanted furniture/equipment free of charge to avoid unnecessary waste costs. WARPIT will be used by procurement when requisitions for office furniture are received to check potential availability, and avoid costs of new purchases	

More sustainable procurement

The Trust alongside other NHS Trusts that form part of the Birmingham and Solihull shared Procurement Hub, has a huge amount of buying power, particularly when working together regionally, and nationally. We can therefore significantly influence improvements to farming practices as well as improving environmental outcomes and enhancing social value.

Within our hospitals, there are many elements that create a sustainable food system. We already have robust tools in place to support environmentally sustainable food in NHS hospitals such as the Hospital food review, and the Public Services (Social Value) Act [67], both of which support Part Two of the National Food Strategy. The Hospital Food Review Panel has been exploring opportunities for managing food procurement sustainably in hospitals.

They are recommending that, as part of the food standards, the BSOL shared procure hub should use Defra's 'A plan for public procurement: Food and catering: the balanced scorecard' to assess our procurement and catering practices.

Public sector procurement has long recognised the need to promote value for society, environment, and the local economy and there have been previous government initiatives to encourage public sector bodies to purchase food in a sustainable way and to help local and small businesses compete for public sector contracts.

There is also growing interest in the NHS about its role as an 'anchor institution' with considerable awareness of the economic, environmental, social and health benefits of sustainable food procurement by public bodies.

It is anticipated that the new NHS food standards (when published) will include recommendations regarding mandatory procurement standards along with the tools to support implementation. Through making food procurement and catering more sustainable and reducing the amount of food wasted by the NHS in hospital settings.

15. Food and Nutrition – progress & plan

This section of the plan will outline ways to reduce the carbon emissions generated from the food made, processed and served within the Trust.

It will evidence key objectives which will be introduced within a five-year plan focusing on the following key goals:

Action	Progress to date	Status
Work with the Procurement Hub to ensure a more sustainable procurement	Tenders are procured in line with corporate responsibility and sustainability; weighted questions embed within each tender	
Food waste minimisation -reduction of food waste inpatient and catering retail	Introduced stringent monitoring to reduce food wate both within catering retail and in-patient wards	
Introduction of "meat free Mondays and Fish Friday" (replacing meat product offerings)	Currently not implemented, it is perceived it would have a dramatic impact on revenue sales	
Reintroduce "seasonal menus" i.e. Winter and summer menu	Currently being drafted with a plan to introduce from September 2025	
Evaluate current meal provision remove where possible processed foods	Review undertaken – the processed foods used are cooked Ham, Turkey, Corned Beef, Bacon & Breakfast Sausages	
Work towards accreditation to demonstrate that the Trust commitment to the sustainability agenda (e.g. Soil Association accreditation)	Currently not implemented due to increased costs and the possible introduction of new in-patient meals	

16. Adaptation – progress & plan

Climate Change Adaptation

Climate change is one of the biggest public health challenges we face. Extreme weather conditions such as flooding and heatwaves are becoming more frequent and more intense, and we need to adapt our environment to these changing conditions. We need to be aware of these climate changes and embed strategies into our organisation to deal with any impacts on our infrastructure, services and procurement of goods/services.

We need to invest in adaptation and mitigation strategies/measures to minimise the effects of Climate Change. We have developed a Climate Change Risk Assessment (CCRA) to highlight any risks to clinical service continuity and resilience of our supply. This will ensure our adaptation and contingency strategies work together as one. We will continue to raise awareness and understanding of the causes and impacts of climate change amongst our staff and service users.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Develop climate change risk assessment	Business continuity plans developed, risk assessment are part of BPC's	
Mitigate the risks of climate change	Climate change risks are regularly reviewed; some mitigate plans in place	
Develop adverse weather plan	Adverse weather plan in circulation	
Monitor adverse weather events and update current actions/plans	Adverse weather events monitored, and any lesson learned captured, and plans updated accordingly	

Capital Design Adaptation

In the development and design of our Estate we need to embed sustainability; we will use smart design and emerging technologies to support our improvement programmes.

The aim is to take a 'Whole Life Cycle Costing' approach to our projects by considering sustainability in design, construction, commissioning, operation and decommissioning to help futureproof the Trust.

The aim to reduce the environmental impact of our buildings by developing sustainability guidelines for all our major capital developments. We will take a 'Design for Performance' approach considering the BSRIA soft landings framework and recognised methodologies such as BREEAM selecting the most appropriate measures to maximise the benefits.

We will endeavour to meet the Passivhaus Standard and BREEAM Outstanding status for new buildings. We will prioritise access to natural light, ventilation, greenspace and active travel infrastructure in the development of our Estate. We will weight 'Social Values Outcomes' when procuring new services in the design and construction of new space.

We will work with and engage with industry professionals to try and ensure all our major projects are 'Net Zero in Operation'. We will include an assessment of the energy / carbon

performance of our buildings in-use to ensure the parameters set in the design process have been achieved. We will use Sustainability Impact Assessments (SIA) as part of our Business Development Investment approval procedure.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Review emerging technologies and SMART building design	The ROH use approved architects and engineers to design their buildings, these use the most up-to-date thinking	
Consider whole life cycle costing approach to all new projects	Considered for all new build projects	
Consider sustainability guidelines and take a 'Design for Performance' approach	Considered for all new build projects	
Consider Passihaus standards and strive for BREEAM outstanding status	Considered for all new build projects	
Strive for 'Net Zero in Operation'	Considered for all new build projects	

Service Design Adaptation

The ROH has already undertaken service adaptations to address some of its clinical environmental issues such as the re-purposing of Block 37. The functional change to an outpatient type activity has reduced the operation of this building from 24 hours a day to 12 hours thereby reducing its impact on its service providers.

We have closed old Ward 10 converting it for on-call rooms and administrative functions. Ward 12, in parts, does not have a 'controlled air' environment. Currently the service users experience high temperatures in the summer months, and this is likely to increase further with climate change. Strategic plans are being developed to provide additional ward capacity, this will enable this ward to be relocated in future years.

The Hydrotherapy service is in a prime location off the main hospital street. The potential relocation of this service to a purpose built, energy efficient, stand-alone building on the site would make noticeable improvements for its service users and release the land area for future clinical development.

The Theatre service operates from a collection of buildings, some buildings are of modern design/construction, and other buildings/theatres need regular improvement. The High Dependency Unit is co-located within the Theatre complex; strategic plans are being developed to relocate our HDU service to enable a phased replacement of our aging theatre stock. The service adaptation will enable well designed, energy efficient replacement theatres to be delivered in a phased manner.

The adaptation of patterns of working is likely to result in changes to the way we use our offices/buildings, the development of 'Hot Desks' and 'Bookable Space' will assist in any future 'Agile Working' strategies.

Building Adaptation

The evolving 'Estates Strategic Development Plan' has looked at future site adaptations in the form of demolition of our older building stock. The buildings under consideration are:

- Block 02 – this building currently provides accommodation for our Human Resources Department, the building was built in circa 1925
- Block 03 – this building provides Body Storage, the building was built in circa 1925
- Block 14 – this building provides accommodation for our Hydrotherapy Department, the building was built in 1979
- Block 21 – this building provides Administration Accommodation for our Spinal Team, the building was built in 1935
- Block 28 – this building provides Theatres 1, 2 & 4, the original building dating back to circa 1925
- Block 30 – this building provides accommodation for our High Dependency Unit, the building was built in 1938
- Block 46 – this building provides our Therapy Gymnasium Service, the building was built in 1930
- Block 72 – this building provides our Theatre 9 & 10 Facilities, built in 2004 under a modular design, demolition would pave the way for future Theatre expansion

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Review of Block 02 – Human Resources Department	Linked to strategic estates review	
Review of Block 03 – decommissioned Body Store	Awaiting BCC approval to demolish	
Review Block 14 - Hydrotherapy Department	Linked to strategic estates review	
Review of Block 21 – Spinal Administration	Linked to strategic estates review	
Review Block 28 – Theatres 1, 2 & 4	Linked to strategic estates review	
Review Block 30 – High Dependency Unit	Linked to strategic estates review	
Review Block 46 – decommissioned Therapy Gymnasium Service	Awaiting BCC approval to demolish	
Review Block 72 – Theatre 9 & 10	Linked to strategic estates review	

Green Spaces & Bio-diversity Adaptation

Nurturing and improving our 'Greenspace' has benefits for Health & Wellbeing, leads to improved air quality, noise reduction and supports Biodiversity. We will maximise the quality and benefits of our greenspace, reduce biodiversity loss by protecting and enhancing our natural assets.

The ROH Trust has a long history in providing well maintained grounds & gardens for its staff and service users. The 'Woodlands Site' has a varied collection of trees which support the control of greenhouse gases. The Trust continues to maintain its green canopies, invest in the planting of new trees and is proud of its 'Green Apple' award status.

We will enhance our 'Health & Wellbeing' by maximising the quality and resilience of our 'Greenspace' to help mitigate the effects of climate change. We will work with internal and external stakeholders to ensure we have a Climate Change Adaptation Plan.

We will raise awareness of the benefits of the natural environment, encourage our staff and volunteers to get involved in gardening and food growing schemes which have the potential to incorporate the food products into our catering services.

We will continue to plant trees and shrubs to enhance our environment. We will create a 'Herb Garden' in the central wooded area of the site to provide sensory stimulation for our service users and a food source for our pollinators. The development of 'Green Roofs' and 'Living Walls' will be explored to further enhance the eco-system.

The ROH Trust will install 'Bird Boxes' around its site in its tree canopies, this will encourage birds to nest and help with the local ecology.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Develop a climate adaptation plan	To be developed	
Maintain and develop our woodland area	The Woodland site is being developed and maintained	
Develop a garden of herbs	Herb garden developed	
Install bird boxes	Bird Boxes installed	
Install bug houses	Bug houses installed	
Develop green roofs and living walls	To be reviewed/developed	

17. Communications – progress & plan

The communications team will support the delivery and promotion of the Trust's strategy work with staff to understand the work they are doing to reduce carbon emissions and help the Trust to reach the targets that have been set.

The team will assist in the delivery of a net zero strategy, communicating to staff on how they can become greener at home and at work. Provide positive publicity to ensure staff, patients, visitors and external stakeholders know the Trust are working together to create a healthier, more sustainable environment.

The specific deliverables for this workstream are as follows:

Action	Progress to date	Status
Provide communication channels to help reduce our carbon emissions	Reduced the costs associated with printing over 24 months and continues to develop a range of digital communication channels, including: • The ROH Hub (intranet) • Team Brief (delivered virtually) • Loop (communications for non-desk-based staff) • Social media Patient information hosted on the website can be accessed digitally	

Communicate the benefits of carbon reduction to our staff, patients and visitors	The Communications Team has delivered internal and external communications which promote the Trust Green Plan and celebrates initiatives associated with it. This includes: Internal comms examples: • General and Clinical Waste Management External comms and PR examples: • SBRI Healthcare awards £1 Million to pioneering innovations to support delivery of a net zero NHS	
Communicate how reduced emissions improve their lives and make the environment more sustainable	The Trust internal communications have featured opportunities for staff to understand how reduced emissions improve health and sustainability: Examples: • Vivup - Cycle to Work Scheme Transport for WM, Cycle and Scoot to promote sustainable travel	
Communicate on the Trust's progress towards net zero	The Communications Team have shared internal updates which relate to Net Zero progress. They are published via the Waste Management page.	
Develop marketing material across the Trust	The Communications Team have developed a range of marketing material promoting initiatives associated with the green plan (e.g., cycling schemes, walking schemes).	
Develop net zero on our ROH website	The ROH website features our net zero ambition and Trust Green Plan. It is accessible here: ROH Green Plan	
Communicate with schools and external partnerships to promote net zero	The Communication Team are planning green-specific communication initiatives with schools and other external partners. The Communication Team are involved in developing the prevention and health promotion agenda for the Trust and plan to integrate net zero messaging into this approach alongside our prevention-focussed messaging.	

18. Conclusions and Recommendations

The NHS is currently developing a pipeline of revenue and carbon saving NHS projects for 2025/26 and beyond, this will ensure that the NHS is optimally placed to secure any funding made available across government, as well as to bid for any future capital funding where measures have positive returns on investment.

The ROH Green Plan sets out the Trusts commitment to working towards net zero by reducing harmful emissions, improving efficiency, developing new ways of working through the transformation of the delivery of services and its estate. It clearly articulates the work that has been undertaken to date and sets out an ambitious change programme for the future.

This plan sets out how, the Royal Orthopaedic Hospital will play its part in contributing towards the NHS Net Zero plan. The work will require ongoing support of the Trust Board, the senior leadership team, the staff, patients and visitors who attend the site, alongside capital investment and behavioural change to enable long term sustainable change.

The ROH Green Board will continue to monitor progress and working towards net zero. The ten workstream plans will be reviewed regularly and will be upwardly reported to the Trust Board on an annual basis. The Finance and Performance Committee will be the sub-committee of the Board who will monitor progress against the plan.

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	ROH Strategy 2023-2028: Delivery Plan Update
SPONSOR (EXECUTIVE DIRECTOR):	Matthew Hartland – Chief Executive Officer
AUTHOR:	Rebecca Lloyd – Director of Strategy
DATE OF MEETING:	3 September 2025

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Introduction

The Board is presented with the Trust's 2025-26 Delivery Plan which was agreed in April 2025 in line with the refreshed Trust strategy. The Delivery Plan is formed of six sections; each aligned to a strategic objective (or combination of two).

The Delivery Plan was reviewed by the Strategy Delivery Board on 7th August 2025 and received constructive feedback as to how progress is reflected in the Delivery Plan, with an action to further refine the metrics associated with each of the goals listed.

Progress is rated against the following criteria, with an indication of current performance (where possible/relevant):

- Not yet started/due
- On track for delivery
- Delay but progressing
- Significant delay and risks to completion
- Completed

The Board will note that relevant delivery metrics from the National Oversight Framework are included against each section, accompanied by ROH strategic priorities.

Overview

This is the first time that the Board has reviewed an annual Delivery Plan aligned to the Trust strategy. The new PMO Manager role has been instrumental in developing this document into something that is now aligned to:

- The Board Assurance Framework – goals are linked to a specific BAF risk to highlight how our Delivery Plan mitigates the risk of not achieving our strategic objectives
- Cost Improvement Plan – major schemes within the 2025-26 Cost Improvement Programme are reflected in the Delivery Plan, acknowledging the urgency and prioritisation of cost reduction this financial year

- Quality & Service Improvement project tracker – visibility of the link between live improvement projects and how they support the achievement of the goals in our annual Delivery Plan

Timely and Equitable Access to Care

The majority of metrics/goals in this section are delivered through the Outpatient Transformation Programme and Theatre Improvement Programme, both of which report to the Trust Improvement Group on a monthly basis and are aligned to GIRFT and NHS Impact. These goals are largely driven by the NHS Operating Guidance for 25-26 and there is clear evidence that the Trust is delivering against its monthly trajectory.

Further work is underway to analyse our health inequalities data in greater depth to prioritise a small number of projects/initiatives for this year and into 26-27.

Digitally Enabled Care

Clinical Portal has been trialled in Hands, Foot and Ankle, and plans are in place to roll out to Clinical Support. This is a key enabler to support the Outpatient Transformation Programme and ultimately the transition to EPR. EPR implementation is a critical enabler of our digital transformation and digital maturity. Work is underway to produce an updated DDAT roadmap/plan that incorporates the digital ambition set out in the 10 year plan, as well as the capability that a fully functional EPR will provide.

High Quality Care and Cutting-Edge Expertise

Our Integrated Performance Dashboard now includes Quality metrics, with greater supporting narrative provided through the Quality Report. GIRFT Elective Hub accreditation was re-assessed in July 2025 and maintained. Phase 2 Service Accreditation is progressing well, as is the work towards achieving the national service accreditation for Imaging.

Recruiting research participants has been challenging this year, with the national average down by 52% and ROH recruitment down by 45% on last year.

People and Continuous Improvement

Staff Experience and OD Committee receive detailed narrative and data-driven reporting against the goals included within this section, with particular scrutiny around sickness absence, temporary workforce and the Trust’s inclusion agenda. Workforce planning is becoming integrated into business planning and a positive case study showcased this month from the Trust’s Workforce Planning lead and Head of Imaging.

Improvement huddle training is progressing well, however sustained use of huddle boards is not yet embedded.

Organisational Sustainability and Productivity

Detailed reporting against the financial and operational targets within this section is provided through Finance and Performance Committee, including progress against our 25-26 Financial Plan (including major CIP schemes) and 25-26 Activity Plan (including GIRFT performance targets). The Trust is delivering against its monthly income target due to strong activity performance year to date.

The Theatres service review will include clearly prioritised process reviews to further improve productivity.

Supporting our Community through Collaboration

The Executive Team represent the ROH on each of the six Birmingham and Solihull Locality Delivery Partnership Boards, and progress is being made to establish the ROH role in evolving locality/neighbourhood models. The MSK Transformation Programme is a key enabler to the ROH expanding its provision into each locality, based on population need and workforce reconfiguration. Successful community-based initiatives have taken place through Q1 and Q2 including the first MSK Roadshow, Community Appointment Days, and Health Hacks in schools.

Strategic partnerships are critical to the ROH leading and innovating as we shift from hospital to community. The MOU with RJAH will be a positive platform to build upon, as well as an updated MOU with Aston University.

Summary

As we approach the final month of Q2, it is positive to see that 69% of our goals are either on track for delivery or have been completed.

Those that are significantly delayed are being escalated through their relevant governance forum:

- Deploy Electronic Prescription Service – reliant on EPR implementation, escalated through Digital Data and Technology Programme Board and EPR Programme Board
- Implement framework for NHS action on digital inclusion – reliant on EPR implementation, escalated through EPR Programme Board
- Deliver a balanced net system financial position – scrutinised at BSOL System CEO/CFO meeting
- Reduce number of early finishes in Theatres – Theatre Improvement Group, reporting to Trust Improvement Group
- Deliver overall day case performance – new BADS (British Association of Day Case) Delivery Group established, reporting to Trust Improvement Group

It is acknowledged that the scale of this year's Delivery Plan means that prioritisation has been challenging. It is also recognised that some goals would be better framed as statements of intent or ambition, and are not specific nor measurable. This will be considered as we begin to prepare the 2026-27 Delivery Plan to ensure it is SMART.

ASSURANCE PROVIDED BY THE REPORT:	
POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• 56 out of 81 goals are on track to be delivered by the planned completion date, or have been completed • New Strategy Delivery Board meets bi-monthly to monitor progress and provide support and challenge where required • New PMO Manager role is working well, and has given this process the structure and rigour it requires • All goals are clearly aligned to the Board Assurance Framework • The refreshed corporate governance meeting structure enables the strategy to be clearly tracked on a monthly basis	• 5 goals are significantly delayed (see detail above) • 20 goals are delayed but progressing • Some metrics still to be refined to provide greater assurance

REPORT RECOMMENDATION:					
The BOARD is asked to receive the update against 2025-26 delivery of the Trust's five year strategy (year 3) for assurance					
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:
Aligned to BAF
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
Trust Strategy aligned to ICS Strategy
BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)*:
N/A
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
Trust Board – April 2025

2025-2026 DELIVERY PLAN: RESET & TRANSFORM

Objectives	Goals (All Metrics)	Current Progress	Current Performance Metric Actual	Monthly Metric Target	Target for March 2026	Date for completion	Executive Lead	BAF Risk
	Targets set in the NHS Operating Guidance 2025-26 / Elective Reform Plan/NHS Performance Assessment Framework							
	60% of our patients treated within 18 weeks (RTT) by 31.03.2026	On Track for Delivery	60.07%	55.00%	60%	31-03-2026	MP	
	67% of our patients receive 1st Outpatient appointment within 18 weeks by 31.03.2026	On Track for Delivery	60.3%	58.00%	67%	31-03-2026	MP	
	Patients waiting over 52 weeks reduced to below 1% by 31.03.2026	On Track for Delivery	3.6%	3.97%	<1%	31-03-2026	MP	
	75% performance against 62-day cancer target by 31.03.2026	On Track for Delivery	75.0%	75.0%	75%	31-03-2026	MP	
	80% performance against Faster Diagnosis Standard (cancer diagnosis within 28 days) by 31.03.2026 (Current Target is 77%)	On Track for Delivery	77.5%	77.0%	80%	31-03-2026	MP	
	Validate patients on an RTT waiting list every 12 weeks	On Track for Delivery	99.0%	Greater than 90%	Greater than 90%	31-03-2026	MP	
	Percentage of people waiting over 6 weeks for a diagnostic procedure or test	On Track for Delivery	99.0%	95%	95%	31-03-2026	MP	
Timely and Equitable Access to CARE	**ROH Priorities**							
	Interactive patient led booking and rescheduling of clinic appointments	Not Yet Started/Due			Patient-led	30-06-2025	MP	SR1
	Align all outpatient clinic templates to GIRFT Further Faster	On Track for Delivery			Templates all aligned to GIRFT Further Faster and NHS Impact guidelines	31-03-2026	MP	SR1
	Approval of system wide clinical decision support tool for orthopaedics and MSK	Completed			Reduction in inappropriate referrals Increase in surgical conversion rates Reduced rejection of referrals to primary care	30-04-2025	MP	SR1
	Align outpatient scheduling process to NHS Impact best practice	On Track for Delivery			Alignment with NHS Impact best practice scheduling recommendations	30-06-2025	MP	SR1
	Reduce the number of missed appointments	On Track for Delivery	6.4%		Stretch target of 6%	31-03-2026	MP	SR1
	Implement digital PIFU as standard in all appropriate pathways	On Track for Delivery	9.78%		National target of 5% ROH stretch target - 15%.	31-03-2026	MP	SR1
	Reduce inequalities for patients accessing ROH services	Delay but Progressing			Delivering 25-26 action plan	31-03-2026	NB	SR1
	Targets set in the NHS Operating Guidance 2025-26 / Elective Reform Plan							
	70% elective care appointments available by NHS App	Completed			70%	31-03-2026	MP	
	Adoption of Federated Data Platform	On Track for Delivery			85% Trusts	31-03-2026	SW/MP	
	Complete EPR procurement	Delay but Progressing			100% complete and transition to implementation	31-12-2025	SW	
	Deploy Electronic Prescription Service	Significant Delay and risks to completion				31-03-2026	SW	
	Full integration with eRS to include Oncology	On Track for Delivery				31-03-2026	MP	
Digitally enabled CARE	Maintain compliance with NHS Multi-Factor Authentication Policy	On Track for Delivery			All core requirements	31-03-2026	SW	
	Implement framework for NHS action on digital inclusion	Significant Delay and risks to completion			Level 4 HiMMs	31-03-2026	SW	
	ROH Priorities							
	Clinical Portal fully embedded across all services	Delay but Progressing				31-07-2025	SW	SR1
	Deliver high priority digital transformation schemes to support national imperatives	Delay but Progressing			Delivery of EPR Programme	31-03-2026	SW/MP	SR1
	Trust-wide engagement to refine pathways ahead of EPR (EPR Readiness)	On Track for Delivery				31-12-2025	SW	SR1
	Quarterly review of health inequalities data	Delay but Progressing				31-03-2026	NB	
	Expand use of technology and Artifical Intelligence	Delay but Progressing			Delivery of EPR Programme	31-03-2026	SW	SR1
	NHS Performance Assessment Framework							
	NHS staff survey raising concerns sub-score	Not Yet Started/Due				31-03-2026	SGL	
	CQC safe inspection score	On Track for Delivery	Good		Good/Outstanding	31-03-2026	NB	
	Rate of inpatients to suffer a new pressure ulcer	On Track for Delivery	0	0	0	31-03-2026	NB	
	Rates of MRSA, C-Difficile and E-Coli	On Track for Delivery	1	0	0	31-03-2026	NB	
	CQC inpatient survey satisfaction rate	On Track for Delivery	Achieved (not yet published)		>85%	31-03-2026	NB	
	Percentage of patient-facing staff to receive a flu vaccination	Not Yet Started/Due			40%	31-03-2026	NB	
	ROH Priorities							
	Delivery of 2025-26 Quality Priorities	On Track for Delivery				31-03-2026	NB	SR2
	Deliver Phase 2 Service Accreditation	On Track for Delivery			Phase 2 complete	31-03-2026	NB	SR1
	Reduce to zero hospital acquired infections	On Track for Delivery	1	0	0	31-03-2026	NB	SR1
	Increased engagement and representation with patients, young people, children, transition patients and carers	Delay but Progressing				31-03-2026	NB	SR2
	Maintain GIRFT accreditation	Completed	Accreditation updated - July 2025			31-07-2025	MP	SR2
High quality CARE and cutting-edge EXPERTISE	Obtain Imaging national service accreditation (QSI)	On Track for Delivery	Working to 'Working Towards' Status			31-03-2026	MP	SR2
	Deliver year 1 objectives for MSK Academy	On Track for Delivery				31-03-2026	MR	SR2
	Implement new PROMS system	On Track for Delivery			£25k cost reduction	31-12-2025	MR	

	Increased patient participation in research	Delay but Progressing	160		350 patients	31-03-2026	MR	SR2
	Increased ROH authored publications	Delay but Progressing	155		200 publications	31-03-2026	MR	SR2
PEOPLE and continuous improvement	**Targets set in the NHS Operating Guidance 2025-26 / Elective Reform Plan/NHS Performance Assessment Framework**							
	Achieve close to 100% planned core capacity before accessing premium capacity	Not Yet Started/Due			100%	31-03-2026	ALL	
	Reduction in agency spend	On Track for Delivery	35%	30%	30% reduction on last year	31-03-2026	ALL	
	Reduction in bank spend	On Track for Delivery	17%	10%	10% reduction on last year	31-03-2026	ALL	
	Reduce corporate function spend to April 2022 levels	On Track for Delivery			WTE reduction in line with planning guidance	30-09-2025	SM	
	Reduce voluntary turnover with a key focus on first year leavers. Percentage of NHS Trust staff to leave in the last 12 months	Delay but Progressing	11.29%	10.5%	<10.5%	31-03-2026	SM	
	Reduce sickness absence rate	Delay but Progressing	5.99%	4.0%	<4.98%	31-03-2026	SM	
	Increase staff engagement score in Staff Survey	On Track for Delivery	7.13	N/A - annual	7.4	31-03-2026	SM	
	National Education and Training Survey Satisfaction rate	On Track for Delivery	85.59%	N/A - annual	88%	31-03-2026	SM	
	ROH Priorities							
	PAUSED: Increase establishment supported by workforce planning approach	Not Yet Started/Due			>90%	31-03-2026	SM	SR3
	Implement Me As Manager programme	Completed			Me as a Manager Programme fully delivered	31-03-2026	SM	SR3
	Embed the race equality code	On Track for Delivery			Improvements in WRES and staff survey scores	31-03-2026	SM	SR3
	Reduce the gender pay gap	On Track for Delivery	31.69% (2024 result)	30.69% (Target)	1% improvement	31-01-2026	SM	SR3
	Refresh inclusive workforce approach	On Track for Delivery			1% improvement in both WRES / WDES staff survey scores	31-03-2026	SM	SR3
	Implement High Performing Teams framework	Delay but Progressing			Integrated empowerment, improvement & performance approach	31-03-2026	SM	SR3
	Implement all domains of the People Promise Programme by April 2026	On Track for Delivery			Delivered plan	31-03-2026	SM	SR3
	Advanced Clinical Practitioner Oversight	Completed			Governance embedded	31-03-2026	NB	SR3
	Enhanced Occupational Physiotherapy provision for staff	On Track for Delivery				31-12-2026	SM	SR3
	Improvement Huddles running in 100% teams	Delay but Progressing	45%		100% teams delivering	31-12-2026	RL	SR3
Organisational SUSTAINABILITY & Productivity	**Targets set in the NHS Operating Guidance 2025-26 / Elective Reform Plan/ NHS Performance Assessment Framework**							
	Deliver a balanced net system financial position	Significant Delay and risks to completion	(£31,364) YTD	(£13,559) YTD	£0	31-03-2026	ALL	
	Recruitment of Consultant capacity to deliver 50 weeks elective activity in Theatre.	On Track for Delivery	Recruitment underway - current deficit relating to unplanned consultant absence.		250.1 cases per year per surgeon wte	31-03-2026	MP	
	Optimise medicine and prescribing value	Delay but Progressing	£16k	£25k	£100k cost reduction	31-03-2026	NB	
	Optimise energy value	Delay but Progressing	£0	£50k	£200k cost reduction	31-03-2026	SW	
	Variance year to date to financial plan	On Track for Delivery	(£380K) YTD	(£732K) YTD	£0	31-03-2026	SW	
	ROH Priorities							
	5% cost improvement target across all budgets	Completed	5% target across all budgets		5% reduction	31-03-2026	ALL	SR5
	Deliver total efficiencies of 6.5% (£9.453m)	Delay but Progressing	£1469k	£1576k	6.5% total CIP	31-03-2026	ALL	SR5
	Deliver NHS commissioned income levels	On Track for Delivery	£17,410,715	£17,101,122	100% on plan (risk relating to over delivery)	31-03-2026	MP	SR5
	Implementation of nurse led pre-operative pathway	On Track for Delivery	Delivered pathway		Full implementation including CIP delivery	31-03-2026	NB/MP/MR	SR5
	Reduce number of early finishes in Theatres	Significant Delay and risks to completion	12.60%	11.30%	11.3% (Model Hospital Peer Median)	31-03-2026	MP	SR5
	Commission dedicated day case pathway and bed modelling to deliver overall day case performance, including joint replacements.	Significant Delay and risks to completion	50.60%	>85%	>85%	31-03-2026	MP/NB	SR5
	95% of individuals job planned - NHS IMPACT action plan	Delay but Progressing	90%		95%	31.4.25	MR/MP	SR5
	Reduction in LLP spend	Delay but Progressing	£363k	£731k	As per agreed in CIP plan	31-03-2026	MP	SR5
	Theatre tray rationalisation	On Track for Delivery			£50k cost reduction	Q2 2025	MP	SR5
	Commercialisation of Private patients aligned to ring-fenced theatre capacity	On Track for Delivery	£450k	£466k	Plan £5.5m, Aspirational target £6.5m	31-03-2026	MP	SR5
	Repatriation of orthopaedic activity from the Independent Sector	Not Yet Started/Due	BSOL Contract Negotitations to start in September		£500k income generation	31-03-2026	MP	SR5
	Generate new commercial income opportunities	On Track for Delivery	Creation of BDU		£0.5m R&D income £0.72m Commercial income	31-03-2026	MR/RL	SR5
	Future proofing theatre estate (1,2,4)	Delay but Progressing				31-03-2026	SW	SR5
	ROH Priorities							

Supporting our COMMUNITY through COLLABORATION	Expand ROH services available in BSOL localities through Neighbourhood Health Service Model through an agreed workforce model for BSOL MSK & Orthopaedics	Delay but Progressing	1		ROH services available across 6 localities	31-03-2026	MP/RL	SR4
	Review of demand and capacity requirements for orthopaedics and spinal services across Bsol	On Track for Delivery			Proposal for operating framework agreed at APC	31-03-2026	MP	SR6
	Deliver year 1 of the new Health Promotion & Prevention Plan (including MSK Roadshow, Health Hacks)	On Track for Delivery			Delivery of MSK Roadshow	31-03-2026	MP/RL	SR4
	Secure minimum 3 formal Strategic Partnerships (Healthcare, Industry, Academia)	On Track for Delivery	2		3	31-03-2026	MH/RL	SR6

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Helen Genders, Corporate Governance Lead and Executive Team**
DATE OF MEETING:	**3 September 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 was refreshed earlier this year to reflect the mid-term review of the Trust's strategy, including the reframed priorities.

The attached presents the updated BAF which is presented quarterly to the Board to provide updates on the mitigations to the risks identified. Updates from relevant Executive leads in August, have been built into the version considered at today's meeting.

A key change from the previous version is the allocation of the various programmes of work and key mitigations to address the risks to individual Executive Directors.

Following the recent meeting of the Strategy Delivery Board, some changes to the timing of some of the elements of the delivery plan were agreed and so these revised timings will be reflected in the BAF mitigations, including delivery programmes in the next iteration.

Following consideration at the last meeting of the Audit Committee and the Quality & safety Committee, the mitigations to address the risks associated with the 'Our Care' domain have also been strengthened.

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, mitigated and updated where relevant.

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)***:**

Relevant extracts at each Committee meeting.

Board Assurance Framework (BAF): SR1 - CARE - August 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 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.
Improvement Targets	• Achieve a CQC rating of Outstanding • Achieve a CQC Inpatient Survey Score of over 85% (should be broader than Inpatient only?) • Achieve the RTT target by 2027 (two years ahead of the national Elective Recovery Plan) • Reduce our hospital acquired infections to zero. • Maintain GIRFT Accreditation as a Surgical Hub
Strategic objective:	**CARE - By 2028, we will maintain outstanding, high-quality care across all services and improve access, experience and outcomes for our patients.**

		Risk Rating	**Current Risk Score**	**Target Risk Score**
Lead Committees	Quality & Safety Committee, SE & OD Committee, Finance & Performance Committee & Trust Board	**Consequence**	4	4
Executive Lead:	Chief Nurse & Chief Operations Officer	**Likelihood**	3	1
Initial Date of Assessment	January 2024	**Risk Rating**	12	4
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			

RISK ASSURANCE RATING
TBC

RISK HISTORY	
July 2024	12 (3lX4c)
October 2024	12 (3lX4c)
January 2025	12 (3lX4c)
April 2025	12 (3lX4c)
August 2025	12 (3lX4c)

KEY PRIORITY IMPROVEMENT PROGRAMMES

Continuously improve our inpatient experience through our Service Accreditation Programme
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 replacement patients, increasing the
Mobilise a suite of meaningful outcome targets that are actively used to improve the quality of care we delivery (including PROMS, National Joint Registry - Support and Embedd clinical outcome metrics as core reporting PROMS and Patient Progress Dashboard
Optimise referral management to improve waiting times and access to our services
Digital transformation programmes to facilitate new, innovative models of care

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS for 2025-26
(full details of key controls are set out within the Delivery Plan)

Key Action/Metric	**Executive Lead**
Deliver Phase 2 of the Service Accreditation Programme	Chief Nurse
Deliver high priority digital transformation schemes to support national imperitives -	Chief Operations Officer & Chief Financial
Clinical Portal fully imbeded across all services	Officer
Expand use of technology and AI (to include implementation EPR)	Chief Financial Officer
Improve referral management and access to clinic booking June 2025 COO	Chief Operations Officer
Align all outpatient clinic templates to GIRFT Further Faster March 2026 COO	Chief Operations Officer
Approval of system wide clinical decision support tool for orthopaedics and MSK April 2025 COO	Chief Operations Officer

Review and update outpatient schedulng process - June 2025 COO - complete	Chief Operations Officer
Reduce no of missed appointments - March 2026 COO	Chief Operations Officer
Implement digital PIFU as standard in all appropriate pathways March 2026 COO	Chief Operations Officer
Reduce inequalities for patients accessing ROH services March 2026 CN	Chief Nurse
70% elective care appointments available by NHS App March 2026 COO	Chief Operations Officer
Full adoption of Federated Data Platform March 2026 CFO	Chief Financial Officer
Complete EPR procurement Dec 2025 CFO	Chief Financial Officer
Deploy Electronic Prescription Service March 2026 CFO	Chief Financial Officer
Full integration with eRS to include Oncology March 2026 CFO	Chief Financial Officer
Maintain compliance with NHS Multi-Factor Authentication Policy March 2026 CFO	Chief Financial Officer
Implement framework for NHS action on digital inclusion March 2026 CFO	Chief Financial Officer
Trust-wide engagement to refine pathways ahead of EPR (EPR Readiness) Dec 2025 CFO	Chief Financial Officer
Trust to support and embed clinical outcome metrics as core reporting - PROMS and Patient Progress Dashboard Dec 2025 MD	Medical Director
Quarterly review of health inequalities data Dec 2025 CN	Chief Nurse
Delivery of 2025-26 Quality Priorities March 2025 - CN	Chief Nurse
Reduce to zero hospital acquired infections March 2025 - CN	Chief Nurse
Increased engagement and representation with patients, young people, children, transition patients and carers March 2025 CN	Chief Nurse

Corporate Risk Register Risks aligned to BAF Risk SR1 - Our Care

Aligned Clinical Risks	Target Score	Current Score
Risk MD1 - If a patient develops a clinical condition that is outside the scope or level of organ system support they need, there may be harm as a result of delay or a ceiling on the care offered at the ROH site. The impact will be clinical and may be financial, reputational, and legal.	5 (1Lx5C)	10 (2Lx5C)
Risk MD3 (also see CE2) - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required in the context of mutual aid. The wait may be due to intrinsic factors within the Trust or the Trust may inherit a risk transferred from other providers as part of mutual aid arrangements. This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	6 (2Lx3C)	9 (3Lx3C)
1918 - Risk relating to patients no longer having access to specialist speech and language assessment and support	4 (1Lx4C)	12 (3Lx4C)
Risk 1759 - risk relating to abilty to meet the national standard of having access to a senior children's nurse for advice at all times throughout the 24 hour period.	4 (1Lx4C)	4 (1Lx4C)
Risk 1467 - Risk relating to non-compliance with blood transfusion standards as a result of no Transfusion Practitioner dedicated to ROH.	5 (1Lx5C)	10 (2Lx5C)
Risk 1573 - risk relating to patient outcomes and consequent risk of harm due to ongoing backlog and increased waiting times for physiotherapy.	3 (1Lx3C)	9 (3Lx3C)
Risk 1938 (MD4) - risk of patient harm when novel techniques and devices are used in care provision, as happens in research and in service evaluation of a new technology. The cause is that all procedures and devices carry a risk of harm; in the case of new technology the level of uncertainty about the outcome is higher and there is a possibility of a cohort of patients experiencing harm before a pattern is identified. The consequences of patient harm would be clinical, reputational, and financial.	10 (2Lx5C)	12 (3Lx4C)

Risk 2070 - Non-compliance with National Patient Safety Alert NatPSA/2024/004/MHRA Reducing risk for transfusion-associated circulatory overload. Actions due completion date 04/10/2024. Oustanding: A TACO risk assessment is underatken utilising the SHOT risk assessment tool prior to infusions and regular audit of its use.	4 (1Lx4C)	8 (2Lx4C)
Risk 2041 - NHSBT Amber alert status for group O may impact non urgent elective surgery.	4 (1Lx4C)	8 (2Lx4C)

Aligned Operational Risks	Target Score	Current Score
Risk CE2 - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required. The wait may be due to intrinsic factors within the Trust or inherited as part of mutual aid . This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	8 (2Lx4C)	12 (3Lx4C)
Risk 1893 - Risk of patient harm due to delays in receiving histology results which may impact patients treatment and/or outcomes Turnaround times as described in the Service Level Agreement with UHB are not being met and result in Cancer target breaches and poor patient experience	8 (2Lx4C)	12 (3Lx4C)

Aligned Workforce Risks	Target Score	Current Score
Risk 2059 - People Priority 5: Planning	8 (2Lx4C)	12 (3Lx4C)
Risk 2057 - People Priority 3: Improving	4 (1Lx4C)	12 (3Lx4C)
Risk 1917 Risk relating to patients not having their dietary needs assessed and met as a result of lack of suitabilty skilled and trained staff employed by the Trust	4 (1Lx4C)	12 (3Lx4C)

Risk	Target Score	Current Score
Risk 2058 - People Priority 4: Engaging	8 (2Lx4C)	16 (4Lx4C)
Risk 2060 risk relating to Healthcare Support Workers job profile review	6 (2Lx3C)	9 (3Lx3C)
Risk 1809 - Risk relating to potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	6 (2Lx3C)	9 3Lx3C)

Aligned Estates Risks	Target Score	Current Score
Risk 770 - risk relating to aged theatre plant	5 (1Lx5C)	12 (3Lx4C)
Risk CL8 - There is a risk that as a result of insufficient capital funding to replace parts of the ageing Estate, there is limited capacity to treat additional cohorts of patients and increase productivity.	4 (1Lx4C)	12 (3Lx4C)

Aligned Digital/IT Risks	Target Score	Current Score
Risk 1648 - Risk of non-delivery of Quality Improvement Projects due to problems with clinical informatics projects	3 (1Lx3C)	12 (4Lx3C)
Risk 1181 - risk relating to lack of abilty for IT systems to flag safeguarding alerts	6 (2Lx3C)	12 (4Lx3C)
Risk 1089 - There is a risk that a fully integrated and fully interoperable electronic patient record (EPR) will not be achieved in the required timelines. This will impact on an ability to meet the national Healthcare Information and Management Systems Society required level 5 be met, and we will fail to achieve Digital Capable Framework Compliance. This would put at risk the financial sustainability by restricting our ability to transform processes and deliver efficiencies.	9 3Lx3C)	20 5Lx4C)

Aligned Governance Risks	Target Score	Current Score

791 - risk relating to number of Trust policies overdue for review	6 (2Lx3C)	12 (4Lx3C)

Aligned Finance Risks	Target Score	Current Score
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	12 (3Lx4C)	16 (4Lx4C)

Aligned risk
Estates: [2]
Digital [3]
Operational: [2]
Clinical [9]
Workforce: [6]
Finance [1]
Governance [1]

Board Assurance Framework (BAF): SR2 - EXPERTISE - August 2025

Risk Reference: SR2 - Our Expertise	Strategic Risk: OUR EXPERTISE - There is a risk that the Trust will fail to increase 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	Improvement Targets	>700 participants recruited to NIHR funded studies • 200 ROH authored publications • Increased R&D income: - NIHR grants with ROH applicants = £9m - NIHR grants with ROH lead = £5m - Commercial income = £1m • Minimum of 3 Post Graduate qualifications (level 6/7) developed in partnership with Birmingham higher education institutions	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**

			Current Risk Score	Target Risk Score		RISK HISTORY	
Lead Committees	SE & OD Committee, Finance & Performance Committee, Quality & Safety Committee & Trust Board	**Risk Rating** / **Consequence**	3	3	**RISK ASSURANCE RATING**	**July 2024**	9 (3Lx3C)
Executive Lead:	Medical Director	**Likelihood**	3	2		**October 2024**	9 (3Lx3C)
Initial Date of Assessment	Jan-24	**Risk Rating**	9	6	TBC	**January 2025**	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.					**April 2025**	9 (3Lx3C)
						August 2025	9 (3Lx3C)

PRIORITY IMPROVEMENT PROGRAMMES

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
Leadership in MSK and Orthopaedics

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS for 2025-26

(full details of key controls are set out within the Delivery Plan)

Key Action/Metric	Executive Lead
Maintain GIRFT accreditation (complete and maintained for 2025)	Chief Operations Officer
Obtain Imaging national service accreditation (QSI)	Chief Operations Officer
Deliver year 1 objectives for MSK Academy	Medical Director
Increased patient participation in research	Medical Director
Increased ROH authored publications	Medical Director

Corporate Risk Register Risks aligned to BAF Risk SR2 - Our Expertise

Aligned Clinical Risks	Target Score	Current Score
Risk 1938 - risk of patient harm when novel techniques and devices are used in care provision, as happens in research and in service evaluation of a new technology. The cause is that all procedures and devices carry a risk of harm; in the case of new technology the level of uncertainty about the outcome is higher and there is a possibility of a cohort of patients experiencing harm before a pattern is identified. The consequences of patient harm would be clinical, reputational, and financial.	10 (2LX5C)	12 (3LX4C)
Risk MD3 - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required in the context of mutual aid. The wait may be due to intrinsic factors within the Trust or the Trust may inherit a risk transferred from other providers as part of mutual aid arrangements. This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	6 (2LX3C)	9 (3LX3C)

Aligned Operational Risks	Target Score	Current Score
OP1 There is a ris that the Trust will not meet its speciality targets in Spinal services due to the size of the local, regional and national backlog. This is due to growth in demand and gaps in the workforce.	8 (2LX4C)	12 (3LX4C)

Aligned Workforce Risks	Target Score	Current Score
Risk 1809 - Risk relating to potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	6 (2LX3C)	9 (3LX3C)
Risk 2057 - People Priority 3: Improving	4 (1LX4C)	12 (3LX4C)

Aligned Finance Risks	Target Score	Current Score
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years	12 (3LX4C)	16 (4LX4C)

Aligned risk
Estates: [0]
Digital [0]
Operational: [1]
Clinical [2]
Workforce: [2]
Finance [1]
Governance [0]

Board Assurance Framework (BAF): SR3 - PEOPLE - August 2025

<table>
<tr><td>Risk Reference: SR3 - Our People</td><td>Strategic Risk:
OUR PEOPLE - There is a risk that the Trust will fail to meet its objective of being 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, by 2028</td><td>Causes</td><td colspan="2">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.</td><td>Consequence</td><td>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.</td><td>Improvement Targets</td><td>• Reduce MSK and mental health related sickness absence by below 4%
• Turnover rate <10.5%
• Establishment >90%
• Improve WRES/WDES scores on annual basis
• Reduce the gender pay gap</td><td>Strategic objective:</td><td>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</td></tr>
<tr><td rowspan="2">Lead Committees</td><td rowspan="2">SE & OD Committee & Trust Board</td><td>Risk Rating</td><td colspan="3">Current Risk Score</td><td>Target Risk Score</td><td colspan="2" rowspan="3">RISK ASSURANCE RATING</td><td colspan="2">RISK HISTORY</td></tr>
<tr><td>Consequence</td><td colspan="3">5</td><td>5</td><td>July 2024</td><td>20 (4Lx5C)</td></tr>
<tr><td>Executive Lead:</td><td>Chief People Officer</td><td>Likelihood</td><td colspan="3">4</td><td>2</td><td>October 2024</td><td>20 (4Lx5C)</td></tr>
<tr><td>Initial Date of Assessment</td><td>Jan-24</td><td>Risk Rating</td><td colspan="3">20</td><td>10</td><td colspan="2" rowspan="3">TBC</td><td>January 2025</td><td>20 (4Lx5C)</td></tr>
<tr><td rowspan="2">Risk appetite Statement</td><td colspan="6" rowspan="2">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.</td><td>April 2025</td><td>20 (4Lx5C)</td></tr>
<tr><td>August 2025</td><td>20 (4Lx5C)</td></tr>
</table>

Priority Improvement Programmes

- Implementation of Me As Manager and assessment of impact
- New Talent & Succession Framework
- Women in Orthopaedics education & engagement programme
- Embed new High Performing Teams accountability framework
- Embed the Race Equality Code

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS for 2025-26

(full details of key controls are set out within the Delivery Plan)

Key Action/Metric	Executive Lead
Increase establisment supported by worlforce plannng approach	Chief People Officer
Implement Me as Manager programme	Chief People Officer
Embed Race Equality Code	Chief People Officer
Reduce Gender Pay Gap	Chief People Officer
Refresh inclusive workforce approach	Chief People Officer
Implement high performing teams framework	Chief People Officer
Advanced Clinical Practitioner strategy development	Chief Nurse
Enhanced occupational physiotherapy provision for staff	Chief People Officer
Improvement Huddles running in 100% of teams	Strategy Director

Board Assurance Framework (BAF): SR4 - COMMUNITY - August 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**	• ROH MSK service provision in each of the six BSOL localities • Improve waiting times for patients in our 20% most deprived communities • Increase the number of people accessing entry level posts from our local population via schemes such as 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		**July 2024**	12 (3Lx4C)
Executive Lead:	Chief Executive Officer	**Likelihood**	3	2		**October 2024**	12 (3Lx4C)
Initial Date of Assessment	Jan-24	**Risk Rating**	12	8	TBC	**January 2025**	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.�					**April 2025**	12 (3Lx4C)
						August 2025	12 (3Lx4C)

Priority Improvement Programmes

- Support the development of neighbourhood health models and community care collaboratives
- Deliver our Health Inequalities action plan, including greater visibility of data
- 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
- 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)

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS for 2025-26

(full details of key controls are set out within the Delivery Plan)

Key Action/Metric	Executive Lead
Expand ROH services available in BSOL localities through neighbourhood health service model, through an agreed workforce model for BSOL MSK and orthopaedic	Chief Operations Officer & Strategy Director
Deliver Year 1 of the new health promotion and prevention plan	Chief Operations Officer & Strategy Director

Corporate Risk Register Risks aligned to BAF Risk SR4 - Our Community

Aligned Clinical Risks	Target Score	Current Score
MD5 - There is a risk that patients may come to harm within the Trusts referral and treatment pathways as a result of inequities of access based on protected characteristics. Patients failing to access or having reduced access to the care they need due to patient, cultural, social, politcal, structural, process or bias factors.	6 (2Lx3C)	9 (3Lx3C)

Aligned Workforce Risks	Target Score	Current Score
Risk 1809 - potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	6 (2Lx3C)	9 (3Lx3C)
Risk 2059 People Priority 5: Planning	8 (2Lx4C)	12 (3Lx4C)

Aligned Finance Risks	Target Score	Current Score
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	12 (3Lx4C)	16 (4Lx4C)

Aligned risk
Estates: [0]
Digital: [0]
Operational: [0]
Clinical: [1]
Workforce: [2]
Finance: [1]
Governance: [0]

Board Assurance Framework (BAF): SR5 - SUSTAINABILITY - August 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 sustainability 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.	**Improvement Targets**	• Achieve financial break-even position on recurrent basis • Achieve annual activity plan (aspiring to 18k patients treated each year by 2028) • Achieve Private Patient annual growth target	**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		**July 2024**	N/A
Executive Lead:	Chief Operating Officer	**Likelihood**	3	1		**October 2024**	N/A
Initial Date of Assessment	Jan-24	**Risk Rating**	15	5	TBC	**January 2025**	N/A
Risk appetite Statement	The Trust has a low tolerance 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.					**April 2025**	15(3L x 5C)
						August 2025	15(3L x 5C)

Priority Improvement Programmes

- Outpatient and Pre-Operative Transformation
- Productivity in Theatres (aligned to NHS Impact / GIRFT best practice)
- Growth of Private Patient service and additional commercial opportunities
- 7 day working
- Cost improvement scheme delivery, focussing on reducing waste
- Support NHS Carbon Net Zero plan by 2032

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS for 2025-26

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

Key Action/Metric	Executive Lead
Deliver a balanced net system financial position	All
Achieve activity plan in line with 2025/2026 agreed funding gap	Chief Operations Officer
Optimise medicine and prescribing value	Chief Nurse
Optimise energy value	Chief Finance Officer
Variance year to date to financial plan	Chief Finance Officer
5% cost improvement target across all budgets	All
Deliver total efficiencies of 6.5% (£9.453m)	All
Deliver NHS commissioned income levels in line with 2025/2026 agreed funding gap	Chief Operations Officer
Implementation of new pre-operative pathway	Chief Nurse, Chief Operations Officer, Medical Director
Reduce number of early finishes in Theatres	Chief Operations Officer

Commission dedicated day case pathway and bed modelling	Chief Operations Officer, Chief Nurse
Improve overall day case performance, including joint replacements	Chief Nurse, Chief Operations Officer, Medical Director
95% of individuals job planned - NHS IMPACT action plan	Chief Operations Officer, Medical Director
Reduction in LLP spend	Chief Operations Officer
Theatre tray rationalisation	Chief Operations Officer
Commercialisation of Private patients aligned to ring-fenced theatre capacity - complete August 2025	Chief Operations Officer
Repatriation of orthopaedic activity from the Independent Sector	Chief Operations Officer
Generate new commercial income opportunities	Diretor
Transition of BCH services (initial scoping underway)	Chief Operations Officer
Future proofing theatre estate (1,2,4)	Chief Finance Officer

Corporate Risk Register Risks aligned to BAF Risk SR5 - Our Services

Aligned Clinical Risks	Target Score	Current Score
Risk MD1 - If a patient develops a clinical condition that is outside the scope or level of organ system support they need, there may be harm as a result of delay or a ceiling on the care offered at the ROH site. The impact will be clinical and may be financial, reputational, and legal.	5 (1Lx5C)	10 (2Lx5C)
Risk OP2 - There is a risk that there will be insufficient rotating and substantive ward based medical staff to cover the rota. This may lead to shortfalls in patient care and patient harm. The impact may be clinical, financial, reputational and legal.	4 (1Lx4C)	8 (2Lx4C)
Risk 1759 - risk relating to abilty to meet the national standard of having access to a senior children's nurse for advice at all times throughout the 24 hour period.	4 (1Lx4C)	8 (2Lx4C)
Risk 1938 (MD4) - risk of patient harm when novel techniques and devices are used in care provision, as happens in research and in service evaluation of a new technology. The cause is that all procedures and devices carry a risk of harm; in the case of new technology the level of uncertainty about the outcome is higher and there is a possibility of a cohort of patients experiencing harm before a pattern is identified. The consequences of patient harm would be clinical, reputational, and financial.	10 (2Lx5C)	12 (3Lx4C)
Risk MD3 - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required in the context of mutual aid. The wait may be due to intrinsic factors within the Trust or the Trust may inherit a risk transferred from other providers as part of mutual aid arrangements. This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	6 (2Lx3C)	9 (3Lx3C)

Aligned Operational Risks	Target Score	Current Score
Risk 1573 - risk relating to patient outcomes and consequent risk of harm due to ongoing backlog and increased waiting times for physiotherapy.	3 (1Lx3C)	9 (3Lx3C)
Risk 1893 - Risk of patient harm due to delays in receiving histology results which may impact patients treatment and/or outcomes Turnaround times as described in the Service Level Agreement with UHB are not being met and result in Cancer target breaches and poor patient experience	8 (2Lx4C)	12 (3Lx4C)

Aligned Workforce Risks	Target Score	Current Score
Risk 2059 - People Priority 5: Planning	6 (3Lx2C)	12 (3Lx4C)

Risk	Target Score	Current Score
Risk 2057 - People Priority 3: Improving	4 (2Lx2C)	9 (3Lx3C)
Risk 2058 - People Priority 4: Engaging	6 (2Lx3C)	12 (4Lx3C)
Risk 1809 - Risk relating to potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	6 (2Lx3C)	9 (3Lx3C)

Aligned Estates Risks	Target Score	Current Score
Risk 770 - risk relating to aged theatre plant	12 (4Lx3C)	5 (1Lx5C)
Risk CL8 - There is a risk that as a result of insufficient capital funding to replace parts of the ageing Estate, there is limited capacity to treat additional cohorts of patients and increase productivity.	12 (3Lx4C)	4 (1Lx4C)

Aligned Digital/IT Risks	Target Score	Current Score
1298 - cyber security risk	16 (4Lx4C)	8 (2Lx4C)
Risk 1181 - risk realting to lack of abilty for IT systems to flag safeguarding alerts	12 (4Lx3C)	6 (2Lx3C)
Risk 1902 - There is a risk that a fully integrated and fully interoperable electronic patient record (EPR) will not be achieved in the required timelines. This will impact on an ability to meet the national Healthcare Information and Management Systems Society required level 5 be met, and we will fail to achieve Digital Capable Framework Compliance. This would put at risk the financial sustainability by restricting our ability to transform processes and deliver efficiencies.	4 (1Lx4C)	12 (3Lx4C)

Aligned Governance Risks	Target Score	Current Score
791 - risk relating to number of Trust policies overdue for review	9 (3Lx3C)	3 (1Lx3C)

Aligned Finance Risks	Target Score	Current Score
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	12 (3Lx4C)	16 (4Lx4C)

Aligned risk
Estates: [2]
Digital [3]
Operational: [2]
Clinical [5]

Workforce: [4]
Finance [1]
Governance [1]

Board Assurance Framework (BAF): SR6 - COLLABORATION - August 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	**Improvement Targets**	• Single point of access for MSK & Orthopaedics in BSOL • Improved referral quality and conversion to surgery • Increased proportion of population accessing self-management and MSK support in communities	**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		**July 2024**	12 (3L x 4C)
Executive Lead:	Chief Operating Officer	**Likelihood**	3	2		**October 2024**	12 (3L x 4C)
Initial Date of Assessment	January 2024	**Risk Rating**	12	8	TBC	**January 2025**	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					**April 2025**	12 (3L x 4C)
						Augusy 2025	12 (3L x 4C)

Priority Improvement Programmes
Leadership of the BSOL MSK Transformation Programme
Develop strategic partnerships with the Federation of Specialist Hospitals (FOSH) and the National Orthopaedic Alliance (NOA)
Develop strategic alliance with Robert Jones and Agnes Hunt as specialist Orthopaedic hospitals in the Midlands
Develop strategic alliances with Birmingham Higher Education Institutions to achieve our research and academic ambition
Develop strategic alliances with industry to maximise our productivity and lean processes
Charitable partnerships with our own Charity (ROC) to enhance MSK services regionally and nationally

SUMMARY OF PLANNED MITIGATIONS & ACTIONS for 2025-26

(full details of key controls are set out within respective plans)

Key Action/Metric	Executive Lead
Expand ROH services available in BSOL localities through Neighbourhood Health Service Model through an agreed workforce model for BSOL MSK & Orthopaedics	Chief Operations Officer, Strategy Director
Review of demand and capacity requirements for orthopaedics and spinal services across BSOL	Chief Operations Officer
Deliver year 1 of the new Health Promotion & Prevention Plan (including MSK Roadshow, Health Hacks)	Chief Operations Officer, Strategy Director
Secure minimum 3 formal Strategic Partnerships (Healthcare, Industry, Academia)	Chief Executive, Strategy Director
Develop and implement a Mutual Aid Strategy	Chief Operations Officer

Corporate Risk Register Risks aligned to BAF Risk SR6 - Our Collaboration

Aligned Clinical Risks	Target Score	Current Score
Risk MD1 - There is a risk of harm as a result of patients receiving care on an isolated single specialty site. This may be from patients developing a clinical condition outside the expertise of the clinicians on site or requiring organ support at a level above that provided on the ROH site. This may result in delays in treatment or a ceiling of care. The impact would be clinical, financial, reputational and legal.	5 (1Lx5C)	10 (2Lx5C)
Risk MD3 - If the Trust accepts large numbers of long waiter patients (eg via system mutual aid) there is a risk that patients may come to harm as a result of their wait if there is insuficient capacity to deliver the work required, which could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	6 (2Lx3C)	9 (3Lx3C)

Aligned Operational Risks	Target Score	Current Score
Risk CL8 - There is a risk that as a result of insufficient capital funding to replace parts of the ageing Estate, there is limited capacity to treat additional cohorts of patients and increase productivity.	4 (1Lx4C)	12 (3Lx4C)

Aligned Workforce Risks	Target Score	Current Score
Risk 1809 - Risk relating to potential rise in sickness absence due to staff burnout caused by staff not taking full quota of annual leave entitlement	6 (2Lx3C)	9 (3Lx3C)

Aligned Finance Risks	Target Score	Current Score
Risk CE1 - Current Financial Modelling suggests that the Trust (and ICS) has a significant run-rate pressure over the next four years.	12 (3Lx4C)	16 (4Lx4C)

Aligned risk
Estates: [0]
Digital [0]
Operational: [1]
Clinical [2]
Workforce: [1]
Finance [1]
Governance [0]

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	**2025/26 Flu Vaccination Plan – Briefing Paper**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Chief Nurse , DIPC**
AUTHOR:	**Victoria Clewer, Head of Infection Prevention & Control, TV & Deputy DIPC**
DATE OF MEETING:	**3 September 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This briefing paper outlines the 2025/26 seasonal influenza vaccination campaign strategy for healthcare workers (HCWs) at The Royal Orthopaedic Hospital NHS Foundation Trust (ROH). The campaign is aligned with NHS England objectives, aiming to safeguard staff, patients, and service resilience during the winter season.

The Trust achieved a total of 35% vaccination uptake during the 2024/25 campaign (508/1440).

36% of all frontline healthcare workers were vaccinated (373/1028).

For 2025/26, provider vaccination campaigns must include a stretch target of a 5% increase in vaccination uptake amongst frontline healthcare workers compared to 2024/25 final uptake total.

In addition to this, further external scrutiny will be given to provider vaccination campaigns. As stated in the NHS Performance Assessment Framework 2025/26, Trusts are required to externally report the percentage of patient-facing staff that receive the annual flu vaccination between the 1st of October 2025 and 31st of March 2026.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
A clear plan has been described for promoting uptake of the flu vaccine with ongoing monitoring and engagement.	Senior leadership support and promotion of the campaign. Ownership by senior managers and departments to ensure maximum offer and uptake by frontline healthcare workers.

REPORT RECOMMENDATION:

The Committee is asked to review the plan within the briefing paper and approve its implementation.

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

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

Comments:

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

Care	X	Community	
Expertise		Services	
People	X	Collaboration	

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

The contents of this report align to the:

- Health and Adult Social Care Act; code of practice on the prevention and control of infections and related guidance (DH 2012).
- National Infection Prevention and Control Board Assurance Framework.
- National flu immunisation programme 2025 to 2026 letter - GOV.UK
- NHS England » The NHS Performance Assessment Framework for 2025/26

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

This report identifies how ROH contributes to the BSOL ICB shared objective 'Protect people from harm'. The contents of this report are shared at ICB IPC committee meetings and operational groups.

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

Seasonal influenza vaccine uptake in frontline healthcare workers in England: winter season 2024 to 2025 - GOV.UK

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

Quality & Safety Committee July 2025

R	Red – No Progress
A	Amber – On Track
G	Green - Complete

INFLUENZA VACCINATION ACTION PLAN

Formatted to incorporate the NICE assessment tool NG103 and ICB/NHSE KLOE for 2025/26.

Priority Area	Action	Lead	Timeframe	Progress update	Status
Strong leadership	To appoint a named Executive 'Winter Director' responsible for staff vaccination and flu monitoring.	ES	31/07/2025	Nicola Brockie is the named exec lead for the ROH winter vaccination programme.	Green
	Flu campaign management group to be created.	ES	31/07/2025	Core members identified and regular meetings scheduled.	Green
	To identify 'flu champions' within clinical areas to help share campaign messages and influence uptake.	ES	31/07/2025		Amber
	Campaign resources to be developed – print and digital to myth-bust, promote informed decision making and raise awareness of campaign. E.g. Weekly myth-busting updates, disseminated via internal communication channels, tackling common concerns with facts.	YB	31/08/2025		Amber
	Campaign resources to be developed to promote the availability of the vaccine, inform staff of clinic timings etc.	YB	31/08/2025		Amber
	Create staff testimonials (written word and video), share across digital and print media to share personal stories, increase relatability, and promote a culture of informed decision-making.	YB	31/08/2025		Amber
	'Flu Fighters' media campaign to highlight individual and team engagement with the campaign.	YB	31/08/2025		Amber
	Flu campaign resources on intranet to be visible on the landing page throughout the vaccination period (Oct 25 to March 26).	YB	30/09/2025		Amber
	Standard slide about the flu vaccination campaign to be created for inclusion in all team briefs between August 2025 and March 2026.	VC	31/07/2025		Amber
		MH, ES	31/07/2025		Amber

DRAFT

Raising awareness	CEO to incorporate updates from the flu vaccination campaign into their weekly updates from start of August 2025.				
	Vaccine uptake to be discussed at divisional governance meetings to keep clinical leaders appraised of progress and areas for improvement.	KH, JP	31/10/2025		
	To arrange drop-in sessions with campaign leads to discuss vaccine hesitancy and raise awareness of need for vaccination.	ES, VC	30/09/2025		
	To update the flu consent form for the 2025/26 campaign.	VC	31/07/2025	Consent form updated. Now captures vaccination and those that have declined or cannot receive the vaccine.	
	Identify core business hours for bookable clinics to cover vaccine campaign period (6th Oct 25 to 31st Mar 26).	ES, VC	31/07/2025		
	Identify best location for booked clinics to be run from and book these areas if required.	ES, VC	31/07/2025		
	Identify hours to provide a walk-in clinic to cover vaccine campaign period (6th Oct 25 to 31st Mar 26).	ES, VC	31/07/2025		
	Arrange rotas for the bookable and walk-in clinics to cover vaccine campaign period (6th Oct 25 to 31st Mar 26).	ES, VC	31/07/2025		
	Create a rota for roving vaccinators to cover vaccine campaign period (6th Oct 25 to 31st Mar 26).	ES, VC	31/07/2025		
	Arrange to attend QIDD and core mandatory training days between October 2025 and March 2026 to deliver vaccination to consultants and new starters.	ES	31/07/2025		
	To contact existing peer vaccinators to confirm support for the 2025/25 campaign.	VC	31/07/2025	Email sent to all existing peer vaccinators. Names added to vaccinator Excell spreadsheet once confirmation received.	
	To identify x2 peer vaccinators within clinical areas.	TN, VB, SC, KD	31/07/2025		
	To identify the training requirement for peer vaccinators.	VC	31/08/2025		
		VC	31/08/2025		

DRAFT

	Create a training presentation to help consolidate eLearning and give opportunity to practice vaccination.			
Offering vaccination	Arrange a training day for vaccinators – provide direction on eLearning and face to face training.	VC	31/07/2025	Provisional date booked – Wednesday 17th of September 09:00 to 11:00hrs in the boardroom.
	To identify what vaccine will be used for the 2025/26 campaign, order enough stock, and identify how they are to be administered.	NP, JB	30/06/2025	TIVr : recombinant trivalent influenza vaccine has been ordered via pharmacy.
	Written Instruction to be signed by Medical Director and vaccinators who have completed training.	NP, JB, MR	30/09/2025	
	Identify number of anaphylaxis packs that will be required.	NP, JB	30/09/2025	
	Make available cool bags/blocks to maintain cold chain in clinics and during roving vaccination.	NP, JB	30/09/2025	
	To organise and make available consumables for vaccination. • Small plasters • Sharps bin • Gauze	MF, VC	30/09/2025	
	Department leads to keep record of staff vaccination – to compare against total head count on a monthly basis. Template provided by Head of IPC.	TN, VB, SC, KD	31/03/2026	Monthly data to be provided to Head of IPC.
	Ensure all vaccinators have access to the NHS RAVS system.	VC, RP	30/09/2025	
	Frontline staff details on ESR are correct to enable accurate reporting on FDP	MD	30/09/2025	
	HR to provide Head of IPC with a monthly update of: • Total No. of trust staff • Total No. of frontline healthcare workers This must not include staff on long term sick or maternity leave for the whole of the vaccine campaign period (6th October 2025 to 31st March 2026).	MD	30/09/2025	Initial numbers needed by 30/09/2025 – will require monthly update.
	Head of IPC to submit data to the UKHSA ImmForm database between November 2025 and March 2206.	VC	31/06/2026	Reminders set on outlook calendar.

DRAFT

DRAFT

Data capture, monitoring & feedback	Create a 'flu league table' to show uptake across departments.	VC	30/09/2025		
Increasing uptake	Trust Board and senior leaders to lead by example and have vaccinations during campaign launch week (6-12 Oct 2025).	ES	08/10/2025	Trust board meeting on 08/10/2025	
	Complete application to ROC for incentive support.	ES	20/07/2025		
	Create a staff survey to be used at the end of the campaign (March 2026) to, inform future campaigns.	VC	31/03/2026		

Key:

ES – Emma Steele	VC – Victoria Clewer	NB – Nicola Brockie	MH – Matthew Harland	YB – Yasmin Brown	KH – Karen Hughes
JP – Jennifer Pearson	NP – Nickisha Patel	JB – John Bloomfield	MF – Matt Ford	RP – Rachel Powell	MD – Matt Dingle
TN – Talitha Neville	VB – Vicki Butler	SC – Sue Cox	KD – Kristian Duce		

TRUST BOARD

DOCUMENT TITLE:	**Learning from Deaths & Mortality Review- April 2024 to March 2025**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Revell, Executive Medical Director**
AUTHOR:	**John Va Faye – Associate Medical Director** **Adam Roberts – Assistant Director of Governance** **Hayley Phillips - Informatics Analyst** **Sally Breecher – Clinical Governance Lead**
DATE OF MEETING:	**3 September 2025**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This report provides assurance on mortality management and governance within The Royal Orthopaedic Hospital NHS Trust for the period April 2024 – March 2025. Overall, mortality remains stable, within historical control limits, and compares favourably with national specialist peer benchmarks.

A Learning from Deaths Review Panel (LfDRP) has been formalised and meets monthly to scrutinise cases, supporting the Associated Medical Director, improving resilience, communication, enhancing objectivity and insight from a multidisciplinary perspective.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Mortality rates stable and within historical limits • Meeting of monthly multidisciplinary Learning from Deaths Panel • Robust benchmarking against specialist peers • No significant quality issues identified from structured judgement reviews • Clear thematic learning with identified actionable improvements	• Transition to electronic AMaT will have a learning curve and will need some process adjustment. Ultimately process will be strengthened

REPORT RECOMMENDATION:

For approval.

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

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

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

BAF Risk SR1: Our Care.

MD1: Isolated Site

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

Learning from Deaths and System Quality Meetings

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

HED Data

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

Quality and Safety Committee July 2025

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Introduction

The Learning from Deaths (LfD) framework demonstrates ROH's commitment to patient safety, clinical transparency, and continuous improvement. It augments divisional governance structures, offering an additional layer of scrutiny and reflection in instances where a patient has died under our care.

Nationally, NHS Trusts adopt the Structured Judgement Review (SJR) methodology to support this process—triaging inpatient deaths and identifying those warranting more detailed evaluation. At ROH, all deaths occurring within 30 days of discharge are captured and evaluated. Where presentation does not meet the threshold for judgment review the case is de-escalated; all others proceed to structured assessments, ensuring that opportunities for clinical learning and improvements are neither missed nor diluted.

Oversight and accountability are embedded within the process. The Governance Team maintains a dedicated tracker and dashboard—publicly accessible and updated. Clinical leadership is provided by the Associate Medical Director (Corporate), who also plays a central role in the regional Learning from Deaths collaborative, helping to ensure that local insights inform broader system learning.

The LfD programme is shaped by four strategic aims:

- Refinement of clinical practice through robust mortality review findings.
- Proactive prevention—targeted interventions to mitigate mortality linked to chronic disease and cancer.
- Operational integration—embedding learning into training and decision-making processes to foster a culture of quality improvement.
- Stakeholder engagement—ensuring continued dialogue with clinical and operational teams to align practice with evolving standards and front-line feedback.

The Audit Quality Improvement Learning and Analysis group (AQILA) receives all LfD outputs and provides routine oversight, with monthly mortality data monitoring and thematic triangulation to support strategic governance.

Governance Update

The integration of the Audit Management and Tracking Tool (AMaT) is continuing, aiming to enhance efficiency and analysis capabilities.

The Trust is active within the regional Birmingham and Solihull Learning from Deaths network, ensuring local practice and learning aligns with broader regional and national standards.

An enhancement has been the establishment of a formal monthly Learning from Deaths Review Panel, providing multidisciplinary oversight of Structured Judgement Reviews (SJRs), related PSIRF investigations and regular thematic reviews. The panel, established following a recent Regulation 28 – Preventing Future Deaths Report, demonstrates the Trust's commitment to robust governance. An illustrative example includes revising an avoidability score in a complex postoperative infection case, demonstrating improved scrutiny, fairness, and transparency.

Quantitative Analysis

Rolling 12-month Mortality (April 2024 – March 2025)

Overview

Total mortality: 22

- Trauma & Orthopaedics: Reduced to 12 deaths (previous peak 18)
- Clinical Oncology: Stable at 9 deaths
- Spinal Surgery: Stable at 1 death
- General Medicine: No deaths

Monthly Mortality Patterns:

- Deaths predominantly occurred post-discharge (8–30 days), consistent with patient complexity and chronic disease burden.
- In-hospital deaths remain rare (max 2 per month).

Cause of Death Patterns:

- Predominantly malignancies (lung, bone, unknown primary sites).
- Cardiac and respiratory complications noted, with low incidence of procedural/device complications.
- No significant clustering or new emerging risks.

Benchmarking:

- ROH maintains a favourable mortality profile compared with peer hospitals RNOH and RJAH
    - Note RJAH have a palliative unit which will affect figures and data entry for RNOH appears to be incomplete
- No indicators of excess or avoidable mortality identified.

See Tables 1&2, Figures

Benchmarking – Historical Comparators

ROH Rolling 12 Month 30 Day Mortality Numbers by Treatment Function Code

Treatment Function	Apr 23-Mar 24	May 23-Apr 24	Jun 23-May 24	Jul 23-Jun 24	Aug 23-Jul 24	Sep 23-Aug 24	Oct 23-Sep 24	Nov 23-Oct 24	Dec 23-Nov 24	Jan 24-Dec 24	Feb 24-Jan 25	Mar 24-Feb 25
T&O	18	16	17	16	17	15	11	14	14	13	14	12
Spinal Surgery	1	2	2	2	2	2	2	1	1	1	1	1
General Medicine	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Oncology	9	9	9	10	9	10	11	10	9	9	9	9
TOTAL	**28**	**27**	**28**	**28**	**28**	**27**	**24**	**25**	**24**	**23**	**24**	**22**

Table 1

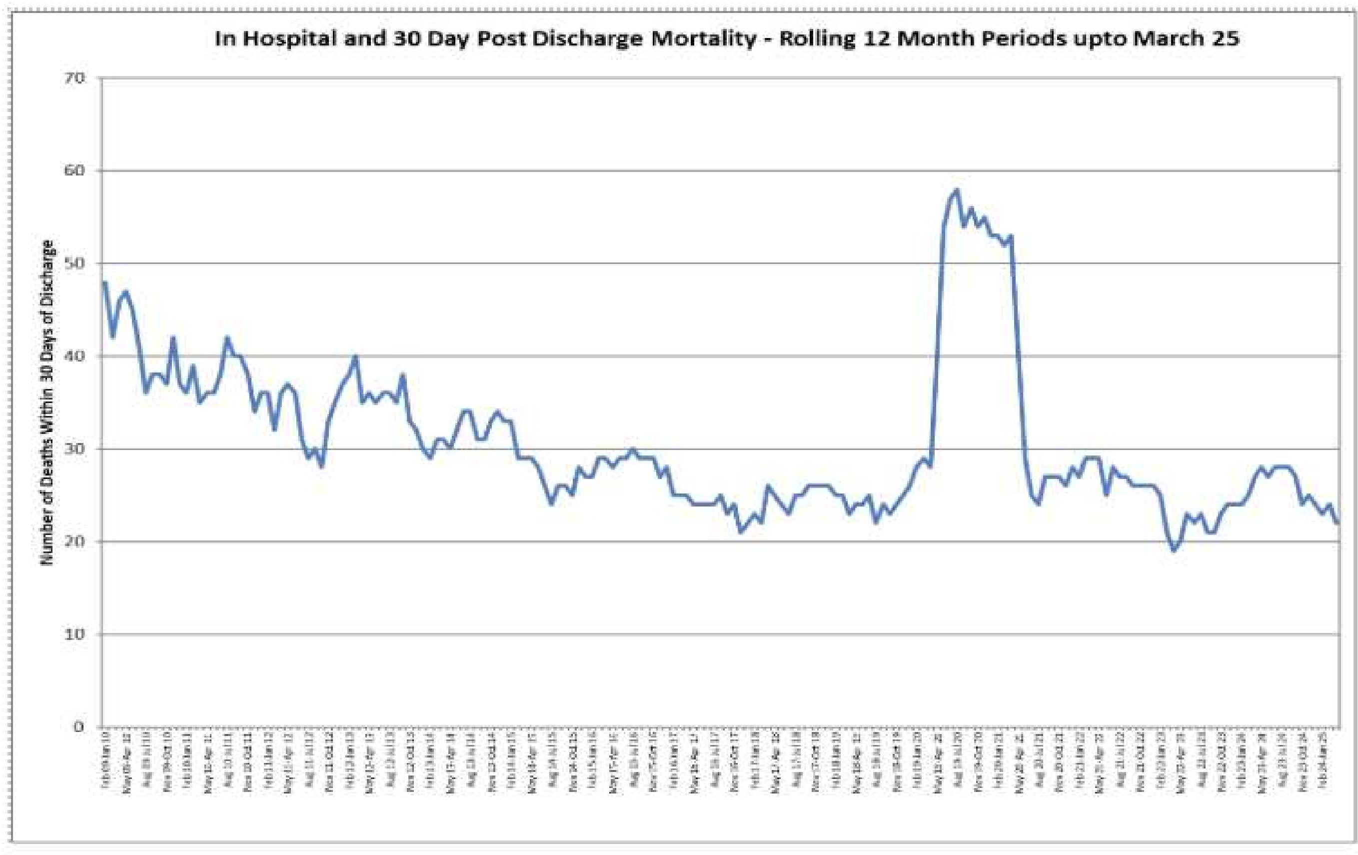


Figure 1

30 Day Mortality by Month April 24 – March 25

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Deaths In Hospital	2					1	1				2	
1-7 Days from discharge	1	1						1				
8-30 Days from discharge		1	3	1	2			3	1	1		1
Total	**3**	**2**	**3**	**1**	**2**	**1**	**1**	**4**	**1**	**1**	**2**	**1**

Table 2

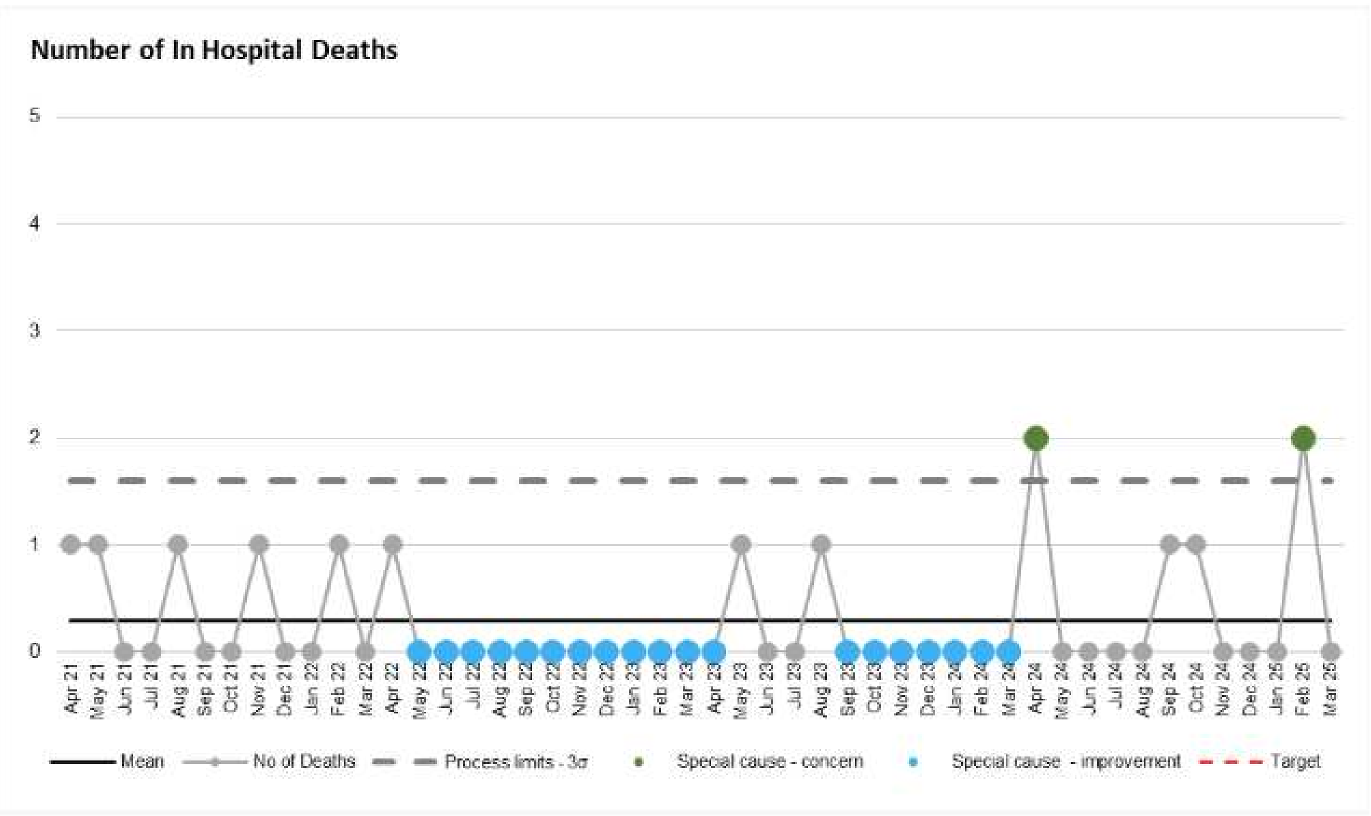


Figure 2

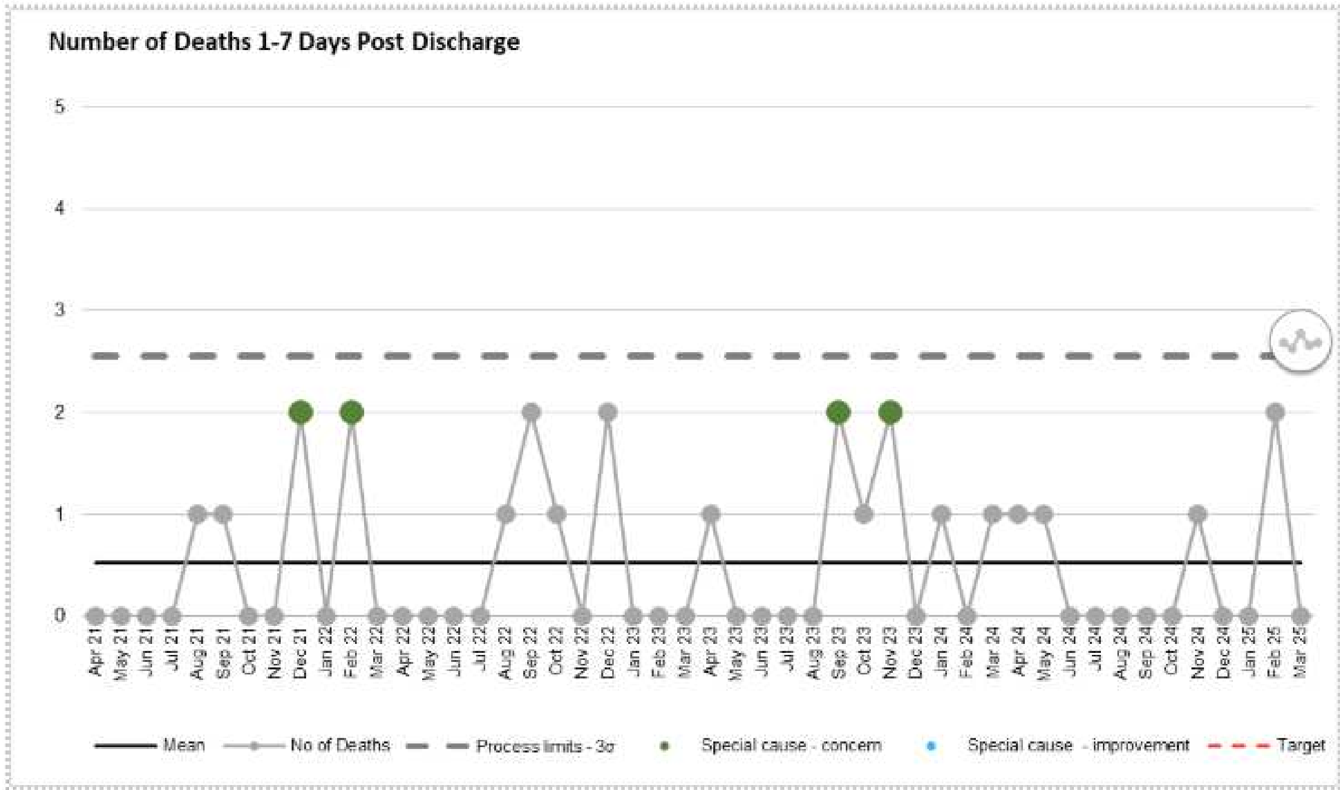


Figure 3

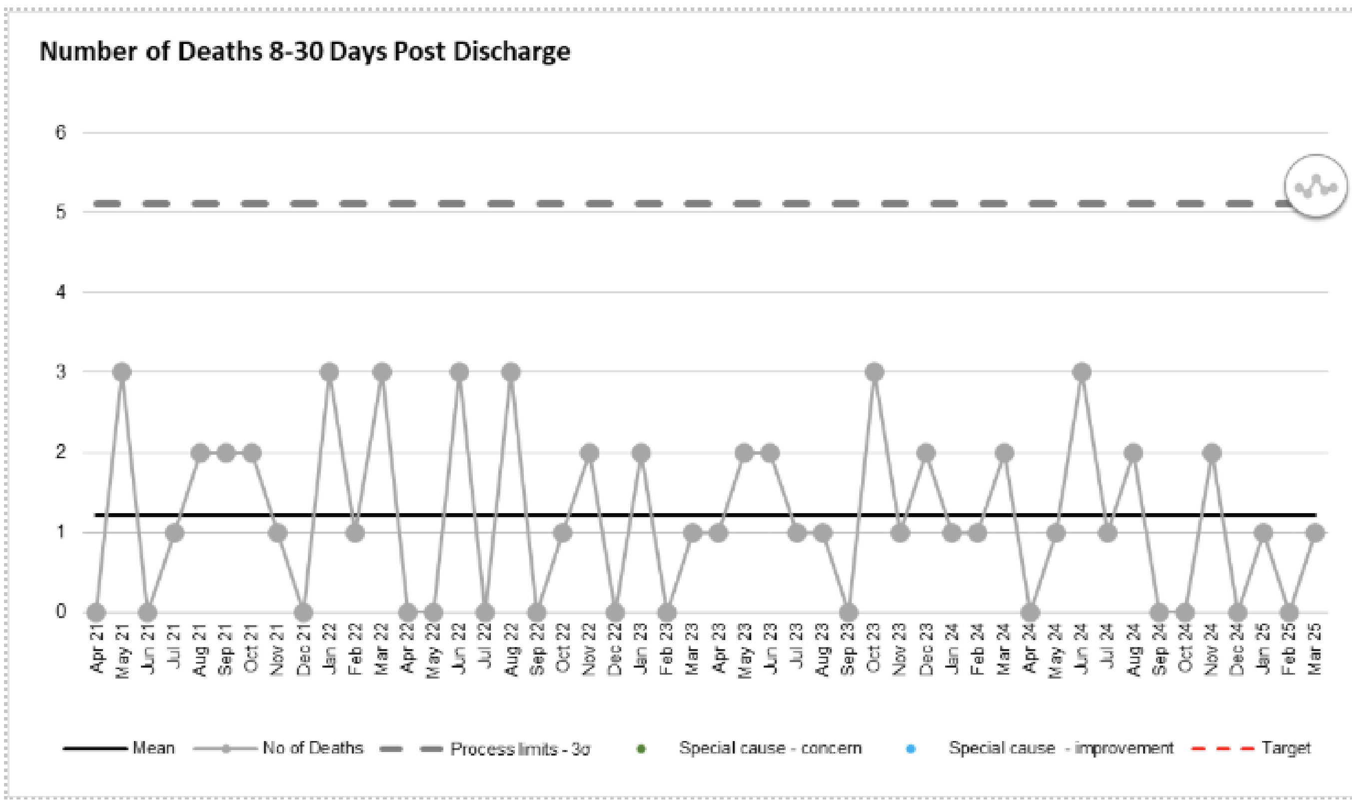


Figure 4

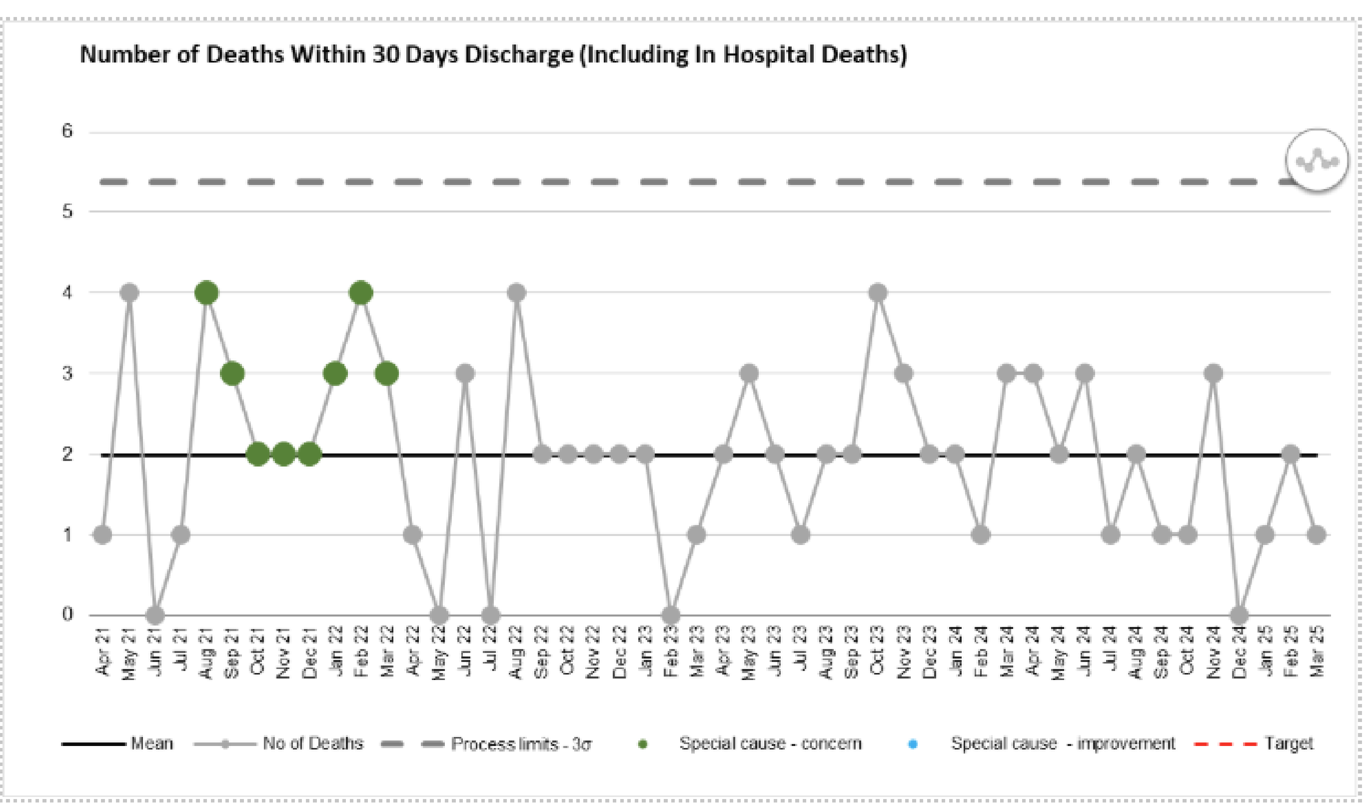


Figure 5

Custom Indicator Set: - Mortality Dashboard	Trust Performance			Benchmarking		
Indicator	Current	Previous	Change	Peer	National	Position
Number of mortalities (12 mth rolling) HES Inpatients (Jun 2025)	148 (Apr 2024 - Mar 2025)	162 (Mar 2024 - Feb 2025)	-14 ↓	178*	2,723*	
Number of in-hospital mortalities (12 mth rolling) HES Inpatients (Jun 2025)	6 (Apr 2024 - Mar 2025)	6 (Mar 2024 - Feb 2025)	No Change	9*	1,223*	
Number of out-of-hospital mortalities (12 mth rolling) HES Inpatients (Jun 2025)	142 (Apr 2024 - Mar 2025)	156 (Mar 2024 - Feb 2025)	-14 ↓	169*	1,526*	
HSMR (monthly) HES Inpatients (Jun 2025)	-	-	No Change	-	101.69	Within expected range
HSMR (12 mth rolling) HES Inpatients (Jun 2025)	57.10 (Apr 2024 - Mar 2025)	56.03 (Mar 2024 - Feb 2025)	1.07 ↑	73.17	99.96	Within expected range
HSMR - Without adjustment for specialist palliative care (12 mth rolling) HES Inpatients (Jun 2025)	44.56 (Apr 2024 - Mar 2025)	44.51 (Mar 2024 - Feb 2025)	0.05 ↑	50.47	99.88	Within expected range
HSMR - Weekday mortality (12 mth rolling) HES Inpatients (Jun 2025)	75.27 (Apr 2024 - Mar 2025)	73.82 (Mar 2024 - Feb 2025)	1.45 ↑	73.05	98.45	Within expected range
HSMR - Weekend mortality (12 mth rolling) HES Inpatients (Jun 2025)	0.00 (Apr 2024 - Mar 2025)	0.00 (Mar 2024 - Feb 2025)	No Change	-	104.75	Very low (>99.8%)
NRLS - Incidents resulting in severe harm or death (biannual) NRLS (Oct 2022)	0.00 (Oct 2019 - Mar 2020)	0.16 (Apr 2019 - Sep 2019)	-0.16 ↓	0.19	0.23	
Crude mortality rate in low-risk diagnosis groups (12 mth rolling) HES Inpatients (Jun 2025)	0.00% (Apr 2024 - Mar 2025)	0.00% (Mar 2024 - Feb 2025)	No Change	0.00%	0.04%	Within expected range
Crude in-hospital mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Jun 2025)	0.04% (Apr 2024 - Mar 2025)	0.04% (Mar 2024 - Feb 2025)	No Change	0.06%	1.05%	
Crude mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Jun 2025)	1.06% (Apr 2024 - Mar 2025)	1.15% (Mar 2024 - Feb 2025)	-0.09 ↓	1.16%	2.44%	
Crude mortality rate (monthly) HES Inpatients and HES-ONS Linked Mortality Datasets (Jun 2025)	0.26% (Mar 2025)	0.57% (Feb 2025)	-0.31 ↓	-	2.09%	
Crude out-of-hospital mortality rate (12 mth rolling) HES Inpatients and HES-ONS Linked Mortality Datasets (Jun 2025)	1.01% (Apr 2024 - Mar 2025)	1.11% (Mar 2024 - Feb 2025)	-0.10 ↓	1.10%	1.39%	

Table 3: Benchmarked mortality metrics against stand-alone orthopaedic Trusts Source Health Evaluation Data 9/7/2025

Case 1: E. Coli Bacteraemia and COVID-19 in Hip revision patient

Review Status: Closed – Final Avoidability Score: 6 (Definitely Not Avoidable)

Summary

• Complex elderly patient transferred for recurrent hip dislocations; significant comorbidities increased risks.
• Received thorough multidisciplinary preoperative assessment and postoperative HDU care.
• Developed unavoidable complications: hospital-acquired COVID-19 and E. coli bacteraemia, leading to multi-organ failure.
• Rigorous review (initial SJR, infection control, LfD panel) revised avoidability score to 'definitely not avoidable,' affirming high-quality care.
• Key learning: Emphasised rapid escalation pathways, adherence to infection control, and compassionate family communication.

Case Details

The patient was an elderly patient transferred to ROH from a district general hospital (DGH), re-presenting with recurrent left hip dislocations following multiple previous surgeries. Significant comorbidities—including chronic respiratory disease, long-term corticosteroid treatment, prior cerebrovascular accident with dysphasia, and recent pneumonia—markedly increased surgical risks which prompted a meticulous preoperative assessment and pre-optimisation.

Following thorough multidisciplinary evaluation, the patient underwent a carefully considered revision arthroplasty in March 2025. Postoperative care commenced appropriately within the High Dependency Unit (HDU), and initial postoperative progress allowed for transition to ward-level care. However, the patient subsequently developed systemic deterioration, complicated by hospital-acquired COVID-19 and E. coli bacteraemia, confirmed through postmortem return of positive blood cultures. Despite rapid identification, timely escalation back to HDU, and comprehensive multidisciplinary support, her condition continued to deteriorate, culminating in multi-organ failure and the initiation of compassionate end-of-life care, resulting in her death.

Assessment

Governance and Infection Review Findings an initial Structured Judgement Review (SJR) concluded that the care provided across all clinical domains—surgical, anaesthetic, HDU, and ward-based—was very good, characterised by prompt escalation, effective communication with family members, and compassionate end-of-life management.

Subsequently, an infection control review and a Learning from Deaths panel assessment were conducted in line with national guidance due to the mandatory reporting of hospital-onset Gram-negative bloodstream infections. These additional reviews concluded definitively that the E. coli bacteraemia was unavoidable, amending the initial avoidability score from 4 (possible avoidability) to 6 (definitely not avoidable). No coronial referral was required, with the death being categorised unequivocally as resulting from natural causes without further recommendations or actions required by the Trust.

Learning

1. Prompt recognition and escalation of clinical deterioration, supported by clearly defined multidisciplinary care pathways.

2. A balance of adherence to infection control protocols and revision arthroplasty best practices together with diligent clinical management during perioperative periods, especially for patients with complex comorbidities.

3. Ongoing commitment to clear, empathetic communication with families throughout critical care transitions, particularly during end-of-life care.

The ultimate outcome reflected the severity of her clinical presentation and unavoidable physiological compromise rather than any shortcomings in clinical care.

Case 2: Qualitative Case Review- interhospital transfer

Review Status: Currently with UHB team with the ROH contribution completed

Summary

- Patient with periprosthetic fracture experienced significant delays in transfer from UHB to ROH.
- Clinical deterioration due to systemic infection prevented immediate surgical intervention upon arrival.
- Exemplary multidisciplinary management at ROH, but systemic delays impacted overall care trajectory.
- Coroner explicitly excluded ROH from criticism, identifying natural causes.
- Key learning: Highlighted importance of robust inter-hospital escalation, timely information transfer, and proactive multidisciplinary care for frail or very ill patients

Case Details

This patient sustained a periprosthetic hip fracture associated with a fall, complicating a previous successful total hip replacement performed at ROH in March 2022. Initially admitted to UHB on 01/12/2024, the patient's subsequent transfer to ROH experienced notable delays due to incomplete information sharing and outstanding anaesthetic clearances. Despite diligent follow-up by the ROH team through the Refer-a-patient portal, the eventual transfer occurred 17 days later.

After transfer, the patient's deteriorating clinical condition was characterised by frailty and emergent systemic infection indicators. The clinical picture precluded immediate surgical intervention. Instead, a multidisciplinary care strategy was developed involving orthopaedic, anaesthetic, geriatric, microbiology and radiology expertise. Despite this, the patient's health deteriorated further, prompting a subsequent transfer back to University Hospitals Birmingham (UHB) Trust for intensive therapy. There was a surgical intervention at another UHB site, after which the patient sadly died.

Assessment

Coronial

The coroner's assessment concluded that the primary cause of death was sepsis and multi-organ failure precipitated by the underlying non-MSK infection and ensuing complications. The coronial review clearly stated the natural causes of death and explicitly excluded ROH from criticism or designation as an interested party.

LFD Panel

The structured review highlighted exemplary multidisciplinary coordination and proactive clinical management following patients' admission to ROH. Although the delays prior to transfer posed significant challenges and potentially limited earlier surgical intervention opportunities, the internal clinical response at ROH was judged as consistently good to excellent. This appraisal reinforces the ROH team's commitment to patient-centred, clinically robust care.

Learning

1. The necessity of escalation for delayed inter-hospital patient transfers, especially where surgical urgency is paramount.
2. The essential role of accurate, timely information transfer via shared digital platforms such as Refer-a-patient.
3. Recognition and reinforcement of proactive multidisciplinary input, particularly in managing medically complex, frail orthopaedic patients.

The review demonstrates that while the clinical deterioration leading to patients death was influenced by systemic infection and intrinsic comorbidities and lifestyle choices, the care provided by ROH was diligent, clinically sound, and aligned with best practices. Nevertheless, the inter-hospital delays serve as an important reminder of the imperative for seamless inter-institutional cooperation. Continued emphasis on collaborative communication and comprehensive documentation standards across institutions remains vital to mitigating similar risks in the future.

Conclusion

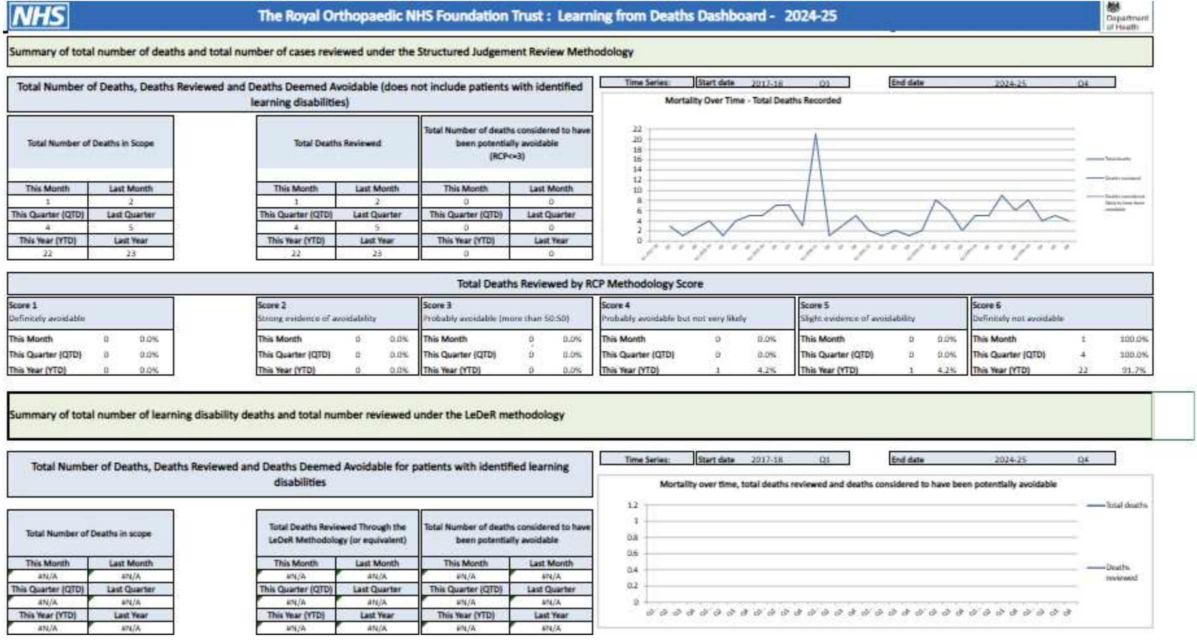
Mortality management and governance remain robust at The Royal Orthopaedic Hospital NHS Trust. Outcomes remain consistently within safe and expected limits. The establishment of a formal Learning from Deaths Review Panel enhances clinical oversight, adding transparency and rigour to governance processes.

Qualitative case reviews for this period demonstrated excellent patient care and proactive management of identified issues.

The Trust's approach remains aligned with national best practices, ensuring continuous quality improvement and patient safety.

Appendix

Mortality Dashboard from Q4:



Headline Mortality Data for Q4 2024–25

Metric	This Month	This Quarter (Q4)	This Year (YTD)
Total Deaths (in-scope)	1	4	22
Deaths Reviewed Using SJR Methodology	1	4	22

This shows full review compliance: 100% of reported deaths reviewed using SJR.

Avoidability Scoring (Structured Judgement Review - RCP Framework)

Avoidability Score	This Year (YTD)	Interpretation
Score 1 – Definitely avoidable	0	None identified
Score 2 – Strong evidence avoidable	0	None identified
Score 3 – Probable avoidability	0	None identified
Score 4 – Possible avoidability	1 (revised)	Initially assigned to the E. coli/COVID case
Score 5 – Slight evidence avoidable	0	None identified
Score 6 – Definitely not avoidable	21	Includes the revised E. coli/COVID case

The case with E. coli bacteraemia and COVID-19 was revised from score 4 to 6 following PSII and panel review, reflecting accurate updates in the dashboard.

Summary Interpretation of Dashboard

- Mortality volume is low and consistent with the Trust's risk-adjusted case mix.
- All deaths have been reviewed, reflecting strong compliance with governance expectations.
- No deaths were judged avoidable, and only one initially required reconsideration—now resolved.
- The SJR outcomes support a position of high-quality care delivery with appropriate escalation and end-of-life decision-making.

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 29 July 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was highlighted that despite the motors being replaced in the plant that in terms of resilience of services in Theatres 1,2 and 4 there is still a residual risk of failure. A review of the risk will be undertaken by the Chief Finance Officer and Chief Operating Officer to ascertain whether the current risk score associated with this position is appropriate and will align with the Chief Nurse from an IPC point of view. • Despite a positive performance in elective activity, with over performance year to date, there is a potential risk that commissioners could introduce an activity management plan to reduce the trajectory of our performance. Proactive conversations are taking place with all commissioners. • It was noted the delivery of the cost improvement programme (CIP) is slightly adverse to plan, with much of the delivery weighted on the achievement of corporate service reductions by Q4. • There has been a significant increase in outpatient waiting times and a review is taking place by the Associate Director of Operations who is responsible for Outpatients to understand the reasons. • Performance against workforce establishments remains an issue but once the service review process has been concluded this should improve. • It was noted that short term sickness absence in June had been particularly high, with a possible link to the hot weather. However, it was highlighted that long term absence is reducing.	• The Estates plan is being considered, and a further update will be provided at the September meeting with regards to the next steps, if this timing is appropriate. • An update will be provided at the September Finance and Performance Committee on the commissioning conversations. • The QIA update to be included in the Chief Finance Officer report each month going forward as an overview of the schemes that have been reviewed and approved or rejected. • Discussion with Committee Chairs need to be scheduled in to discuss the integrated performance dashboard, including an overview meeting with the Chair of the Audit Committee. • An update will be provided to the Finance and Performance Committee in September on the findings from the review of Outpatient waiting time performance. • A trend analysis of reasons for clinical cancellations to be provided at a future meeting. • A summary will be provided at the next Finance and Performance Committee on the impact on activity and waiting times from the industrial action that has taken place by the resident doctors.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The BAF is currently being updated to include timescales and responsibilities and will be presented to the Strategy Delivery	• The Committee agreed to defer the presentation on the Outpatient Transformation Programme to the September Finance and Performance Committee.

Board next week and will then follow through to the Committee and the Trust Board. • The Trust is ahead of its financial plan in Q1. Despite a deficit of £216k YTD the plan was actually £678k YTD, so this places the Trust ahead of plan by £462k. This has been driven by income and activity overperformance. • It was highlighted that pay and non-pay remained stable throughout Quarter 1. • The Committee was presented with a further updated version of the integrated performance dashboard that now pulls together the finance, performance, workforce and quality metrics. The Committee praised the work undertaken by the BI team in the creation of this report and asked for its thanks to be communicated to the team. • The Committee received the upward report from the Financial Delivery Board. • RTT performance remains ahead of target by 4.9%. • 65 weeks waits remain at zero, and 52-week position is in line with the plan. • Outpatient activity has increased, and this is being delivered at a lower cost with a reduction in the amount of additional duty hours spent. • The Trust remains one of the highest in the country for PIFU rates, which is currently 9.78%. • Theatre utilisation continues to improve and is currently at 87%, which is the highest it has been seen. Physiotherapy waits have reduced from 33 weeks to 16 weeks, and this is an output of the MSK Further Faster Programme implemented by the GiRFT Team. • The Committee received an update on how the ambulatory care unit will support conversion rates going forward and also improve the British Association of Data (BADS) score.	

Chair's comments on the effectiveness of the meeting: The Chair was commended on a successful meeting that enabled the opportunity to gain assurance of the positive progress being made.

UPWARD REPORT FROM THE STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 27 August 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- It was noted that there is high level of ‘did not attend’ rates on mandatory training and ‘Me as a Manager’ courses despite the positive feedback being received about the courses. A deep dive is being undertaken to understand the reasons people are not attending.
- There has been a noticeable spike in sickness absence, in particular short-term absence which is unusual for this time of year. There has however been progress on sickness cases through absence stages and leading to final hearings which demonstrates the absence management process being adhered to.
- The Committee received the WDES/WRES update, and it was noted that there had been a number of declines in both areas. A number of actions have been prioritised to help address these.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- An interim evaluation report on the Me as a Manager programme is being produced for the next Staff Experience and OD Committee in October.
- Further work is being undertaken on the workforce risks to ensure there is triangulation with other teams and departments to ensure the mitigations are clear.
- Updates to be made to the WDES/WRES action plan to ensure it reflects the high impact actions that need to be addressed with actions that are targeted and measured regularly.
- Work to take place on providing feedback following incident reporting to those individuals who report using the system so that the individuals feel confident their feedback has been investigated.
- Freedom to speak up concerns to be shared more at divisional level.
- A report to be produced on education funding allocation across the Trust to enable more transparency about this issue to the Staff Experience & OD Committee in October.

POSITIVE ASSURANCES TO PROVIDE

- The Committee welcomed the Librarian Team Leader to the meeting who provided a wonderful explanation of how their role supports the Trust and the personal development journey they are undertaking.
- The workforce risks have been reviewed and realigned to the people priorities.
- It was noted that turnover is below the Trust target and has been a positive decrease this month.
- The annual appraisal window has now closed with 83% currently recorded as completed and it is expected that the Trust will deliver the target expected.

DECISIONS MADE

- The Committee agreed the WDES/WRES action update would not be presented at the next Trust Board meeting but would be updated further and shared at the November Trust Board.

• There has been an increase in staff members declaring they have a disability which is encouraging, and this will be linked to the WDES actions plans. • The Committee received an update from the Workforce Planner on the work that is being undertaken at the Trust, with a particular focus on the Radiography department. • The Committee received an information update on the triangulation work that has taken place to understand where there may be an issue with bullying and harassment in the workplace and to work through how the information is used to create improved staff experience. • The Committee discussed the improvement, performance and workforce empowerment approach that is being undertaken. • The Committee received an update on the Safer Learning Environment Charter Review. • The Committee was presented with the ROH/NHSE Education Funding Review.	
Chair's comments on the effectiveness of the meeting: The Committee agreed that the papers demonstrated an improving level of organisational maturity and it was good to see some cross portfolio working. It was noted that some of the papers addressed some issues that had been raised for some time and there was good assurance that plans and actions were being taken to improve the position where possible. It was suggested that additional time could have been afforded for the guest presentation given the complexity of the subject being discussed. Overall, however the meeting was seen to be positive and there was good pace.	

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE

Date Group or Board met: 30 July 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- It was noted that risk number 1893, the delay to Histology reporting remains a great concern. There are now bi-weekly meetings in place with key stakeholders to minimise the delays and escalate where necessary. It was not affecting the overall compliance with cancer targets at this point.
- It was highlighted that Risk No 2401 (NHSBT amber alert status for Blood Group 0) has been downgraded to a local risk at national level.
- A Patient Safety Incident Investigation (PSII) has commenced to investigate the issues identified in spinal services. Once the investigation has concluded an update will be provided to the Committee and Trust Board.
- It was noted that the British Association of Day case Surgery (BADS) data remained below the national target but there is a plan to introduce the 23h day case unit from w/c 4th August which should see a positive impact to this score.
- It was noted the Spinal Endoscopy Review undertaken by the Royal College of Surgeons had been received and there a number of recommendations that will need to be addressed before the service can commence.
- Following the presentation of the annual radiation safety update, it was noted that the aging kit does carry a risk to the delivery of the service. Capital monies have been allocated to support the replacement of the CT Scanner, and a number of funding bids have been submitted to further support the updates required on the equipment to ensure they are fit for the future.
- Following an Infection Prevention and Control Visit from NHS England and Birmingham and Solihull ICB, it was highlighted the need to update the Outpatient procedure room. An action plan has been created to address the concerns raised.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- An updated patient experience report will be presented at the September meeting which will include an update on the spinal complaints.
- The updated BAF will be presented at the September meeting following a refresh of the BAF aligned to the strategic actions taken place to support delivery.
- An update to be provided at the September Quality and Safety Committee on the outcome of the most recent Coroner's Inquest.
- Provide a one-page summary for all members to understand the current issues/challenge within spinal services.
- The Endoscopic Spinal Review restart and evidence of completed recommendations to be presented at a future Quality and Safety Committee.
- Provide an update on the progress made in the Outpatient Procedure Room and present to the Quality and Safety Committee in November 2025.

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- It was noted that the Trust received a focussed Health and Safety Inspection on 19th June on sharps and dermatitis and has since been issued with an improvement notice. An action plan has been created to address the points raised by 4th September.

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POSITIVE ASSURANCES TO PROVIDE

- The Committee was provided with an update on the current work that is taking place with the BAF to ensure it lists the details the supporting action plans, including completion dates.
- The Quality Report now includes an update on any Reporting of Injuries, Diseases and Dangerous Occurrences Regulations incidents.
- It was noted complaints responses had moved to 70% and demonstrated a positive trajectory in responding to our patients.
- The risk assessment for the CAS alert with regards to bed rails has now been completed and will resolve the issues when patients return back into the community.
- The Committee received the quarterly learning from deaths report which provided the assurance of the learning and actions taken.
- The Committee received an update on the current state of the spinal service.
- The Committee received an update from the Head of Imaging on the Radiation Safety in the Trust, with confirmation that following the Radiation Protection Specialist audit all recommendations has been completed and there are no other concerns with compliance.
- It was noted that a comprehensive workforce review has taken place in Radiology to ensure a robust workforce plan has been created and a clear recruitment plan is now in place to fulfil the current vacancies.
- The Committee received the Infection Prevention and Control (IPC) Annual Report, and the team was commended on the comprehensive report provided.
- The Committee was presented with the action plan to deliver the 'flu vaccination requirements for 2025, which includes a 5% increase to the previous year's target.
- The Committee received an update on the current progress being made with the CQC 'Safe' Self-Assessment Action Plan.

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DECISIONS MADE

- The Committee agreed to share the Spinal Endoscopic Royal College of Surgeons report with the Trust Board in public.
- The Committee recommended the Infection Prevention and Control Annual Report is presented to the Trust Board for approval to publish.
- The Committee agreed for the flu vaccination plan to be shared with the Trust Board in September.
- The Committee agreed to hold the Quality and Safety Committee in September in person.

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• The Committee was provided with the assurance that all Quality Impact Assessments (QIAs) are signed off clinically by the Chief Nurse and Medical Director. • The Committee was presented with the Birmingham Health Partners' reporting dashboard and there were no concerns to highlight from this report.	

Chair's comments on the effectiveness of the meeting: A very thorough meeting with a number of key items to focus on which allowed for assurance to be provided.

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	2024/25 IPC Annual Report
SPONSOR (EXECUTIVE DIRECTOR):	Nicola Brockie, Chief Nurse and DIPC
AUTHOR:	Victoria Clewer, Head of Infection Prevention and Control, TV and Deputy DIPC
DATE OF MEETING:	3rd September 2025

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This annual report outlines the key achievements, challenges, and performance outcomes of the Infection Prevention and Control (IPC) service over the past year. The IPC team has continued to deliver a robust and responsive programme, ensuring patient safety, staff protection, and compliance with national guidance.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Compliance with regulated activities set out in Regulations for service providers and managers - Care Quality Commission and Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK	None.

REPORT RECOMMENDATION:

The Committee is asked to: review and approve the report.

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

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

Comments:

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

Care	X	Community	
Expertise		Services	
People		Collaboration	

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

The contents of this report align to the:

- Health and Adult Social Care Act; code of practice on the prevention and control of infections and related guidance (DH 2012).
- National Infection Prevention and Control Board Assurance Framework.
- Trust KPIs for; MRSA, Clostridioides difficile and Gram-negative blood stream infections.

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

This report identifies how ROH contributes to the BSOL ICB shared objective 'Protect people from harm'. The contents of this report are shared at ICB IPC committee meetings and operational groups.
BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)*:
ROH HCAI surveillance spreadsheets. Integrated dashboard. UK Health Security Agency (UKHSA) Data Capture System. UKHSA Surgical Site Infection Surveillance Programme.
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
2023/24 Annual IPC Report submitted to the Q&S committee during January 2025. Quality & Safety Committee July 2025

Infection Prevention and Control

Annual Report 2024/25

LEAVE BLANK

Foreword

I am pleased to introduce the annual Infection Prevention and Control (IPC) Report for The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) for the financial year 2024/25.

Infection prevention and control remains a core priority for our Trust. Our patients, many of whom undergo complex orthopaedic procedures, place immense trust in us to provide care that is not only excellent but also safe. This year, our teams have continued to demonstrate an unwavering commitment to maintaining the highest standards of infection prevention across all areas of our organisation.

Throughout 2024/25, we have built upon our strong foundations, ensuring that IPC is embedded into every aspect of patient care and Trust operations. Key highlights this year include continued low rates of healthcare-associated infections, successful delivery of key national IPC targets, and further development of our IPC surveillance and audit programmes. We have responded proactively to emerging challenges, such as the evolving antimicrobial resistance agenda and seasonal infection pressures, by strengthening our stewardship initiatives and enhancing our staff education programmes.

Importantly, our success is a direct result of the collaborative efforts of our multidisciplinary teams. IPC is everyone’s responsibility, and I would like to thank all colleagues across the Trust — from clinical staff and support services to leadership teams — for their consistent dedication to best practice. The leadership of our Infection Prevention and Control Team has been instrumental in driving continuous improvement, providing expert guidance, and promoting a positive culture of safety.

Looking ahead, we remain committed to evolving our IPC strategy to ensure that we can meet future challenges, support national ambitions and continue delivering outstanding, safe care for our patients.

I commend this report to you and invite you to join me in recognising the achievements of the past year, while maintaining our collective focus on sustaining excellence in infection prevention and control.

Nicola Brockie

Executive Chief Nursing Officer

Director of Infection Prevention and Control (DIPC)

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Acknowledgements for their input and support:

Nicola Brockie – Chief Nursing Officer and DIPC
Wendy Jones – IPC Administrator
Nickisha Patel – Antimicrobial Pharmacist
Steve Harnett – Head of Facilities
Tracy Price – Logistics and Sterile Services Manager
Stuart Lovack – Deputy Director of Estates

Abbreviations

AMS	Antimicrobial stewardship
BAF	Board assurance framework
BSI	Bloodstream infection
BSOL	Birmingham and Solihull
CPE	Carbapenemase-producing Enterobacterales
CQUIN	Commissioning for quality and innovation
CVAD	Central venous access device
DIPC	Director of infection prevention and control
HCAI	Healthcare associated infection
HCAI DCS	Healthcare associated infections data capture system
HDU	High dependency unit
ICB	Integrated Care Board
IPC	Infection prevention and control
MDR	Multidrug-resistant
MDT	Multidisciplinary Team
MRSA	Methicillin-resistant *Staphylococcus aureus*
MSSA	Methicillin-susceptible *Staphylococcus aureus*
NHSE	National Health Service England
NIPCM	National infection prevention & control manual
PIVC	Peripherally inserted venous catheter
PPE	Personal protective equipment
PSIRF	Patient safety incident response framework
PSIRP	Patient safety incident response plan
RCN	Royal College of Nursing
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital
RNOH	Royal National Orthopaedic Hospital NHS Trust
ROH	Royal Orthopaedic Hospital NHS Foundation Trust
RSV	Respiratory Syncytial Virus
SSI	Surgical site infection
SSIS	Surgical site infection surveillance
UC	Urinary catheter
UHB	University Hospitals Birmingham
UKHSA	UK Health Security Agency
UTI	Urinary tract infections
VAD	Vascular access device
VRE	Vancomycin-resistant Enterococci

Executive summary

- ROH ended 2024/25 below the NHS England threshold for bloodstream infections (BSI) attributable to *Escherichia coli* (*E.coli*). However, equal to the NHS England threshold for healthcare associated *Clostridioides difficile* (*C. difficile*) *infections*, and BSI attributable to *Klebsiella species* and *Pseudomonas aeruginosa*.
- The Trust reported zero bloodstream infections attributable to Methicillin-resistant *Staphylococcus aureus* (MRSA). No MRSA BSI have been reported by ROH for the last 13 years.
- When compared with national data for participating hospitals, the ROH surgical site infection (SSI) risk rate for spinal surgery was identified as a 'higher outlier' during Q2 2024 (April to June).
- The number of SARS CoV-2 cases and associated outbreaks decreased during 2024/25.
- A muti-disciplinary Surgical Site Infection Prevention Group was established which monitors SSI data and reviews evidence-based guidance to ensure this is embedded at the ROH.
- The annual closure, decanting, planned preventative maintenance and deep cleaning of clinical areas continues to be prioritised, significantly supporting efforts to keep HCAIs a low as possible.
- The Trust IPC study day was held in November 2024, which involved internal and external speakers. The day was well attended and evaluated positively by attendees.
- The IPC team Implemented an annual skin check assessment based on guidance related to occupational dermatitis and caring for the skin health of our workforce.
- Organised and celebrated several key events in the IPC calendar across ROH, this included World Hand Hygiene Day, World Antimicrobial Awareness Week, and International Infection Prevention Week 2024.
- Refreshed and reimplemented department cleaning schedules and records.
- Supported and delivered the annual healthcare worker vaccination programme.
- The IPC team became core members of the Trust Green Board, supporting efforts to reduce the carbon footprint of healthcare.
- Set up an 'IPC in Orthopaedics' collaborative pathway with Robert Jones and Agnes Hunt Orthopaedic Hospital, sharing knowledge, support, data and resources to improve IPC and SSI prevention practices.
- Continued to deliver and innovate services in relation to decontamination, water, and ventilation safety.
- Strengthened governance and assurance arrangements to ensure compliance with contractual requirements.
- During November 2025, successfully recruited a band 3 IPC auditor to support the Trusts IPC audit and surveillance programme.
- This report includes a summary of the IPC annual business plan and programme of work for 2025/26.

About The Royal Orthopaedic Hospital NHS Foundation Trust

The ROH is one of the largest providers of elective orthopaedic surgery in the UK and is one of five specialist orthopaedic centres. It offers three tiers of service:

- Routine orthopaedic operations for a local population of 4 million people in Birmingham and North Worcestershire;
- Specialist services such as spinal surgery to 5 million people who live in greater Birmingham and the West Midlands;
- and diagnosis and treatment of malignant bone tumours.

The Trust has 14 operating theatres, 6 wards and 117 beds, including 8 beds for private treatment and 6 being on a High Dependency Unit. Of these, 56 are single occupancy rooms with en-suite and 3 are single occupancy rooms without en-suite. The Trust employs in excess of 1,200 staff. Only a small amount of emergency and urgent activity is undertaken, generally in the field of spinal disorders; the core business of the ROH is elective surgery. The main elective surgery activities are joint replacement surgery (arthroplasty), joint arthroscopy and reconstruction (keyhole surgery and ligament repairs), plus hand and foot surgery.

We are guided by our values in everything we do and reflect the diversity, opportunity and ambition of our communities and the people we serve.

<u>ROH IPC Vision:</u>

Preventing harm from infection by delivering clean, safe care.

<u>ROH IPC Mission:</u>

To deliver a patient focused, expert infection prevention service that supports and empowers staff and patients through education, innovation, and role modelling, to ensure harm free care for all.

Healthcare-associated infection (HCAI) surveillance

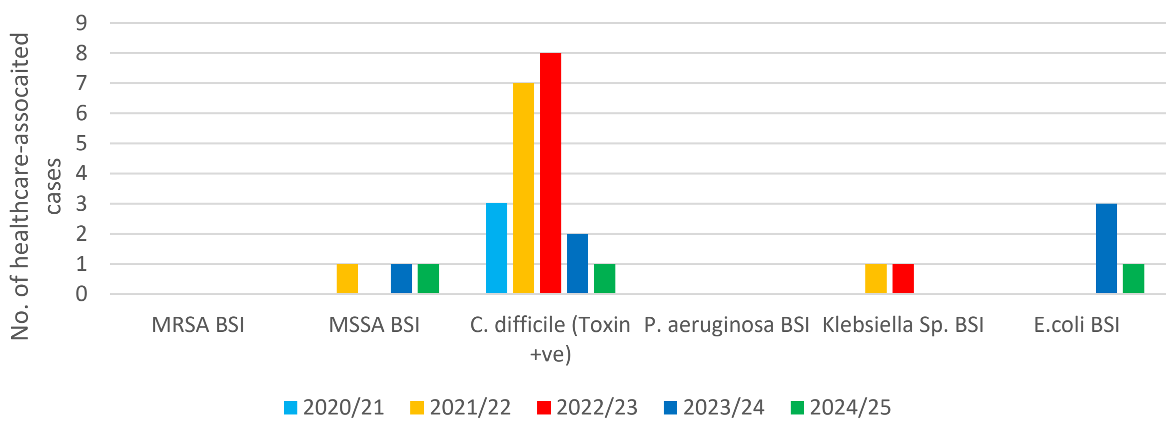
The Trust participates in the mandatory HCAI surveillance programme facilitated by the UK Health Security Agency (UKHSA) including:

- *Clostridioides difficile* infection (CDI) – toxin positive cases
- Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia
- Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia
- *Escherichia coli* (*E. coli*) bacteraemia
- *Klebsiella species* bacteraemia
- *Pseudomonas aeruginosa* (*P. aeruginosa*) bacteraemia
- Quarterly Mandatory Laboratory Return (QMLR)

Performance is monitored by Birmingham and Solihull Integrated Care Board (BSOL ICB).

The NHS Standard Contract includes quality requirements for NHS trusts to minimise rates of both *C. difficile* and of Gram-negative bloodstream infections to threshold levels set by NHS England. Objectives have been set for five of the six HCAI included in mandatory surveillance. MSSA is the only HCAI without a national objective.

Trust-wide mandatory healthcare-associated surveillance case numbers over the last five financial years:

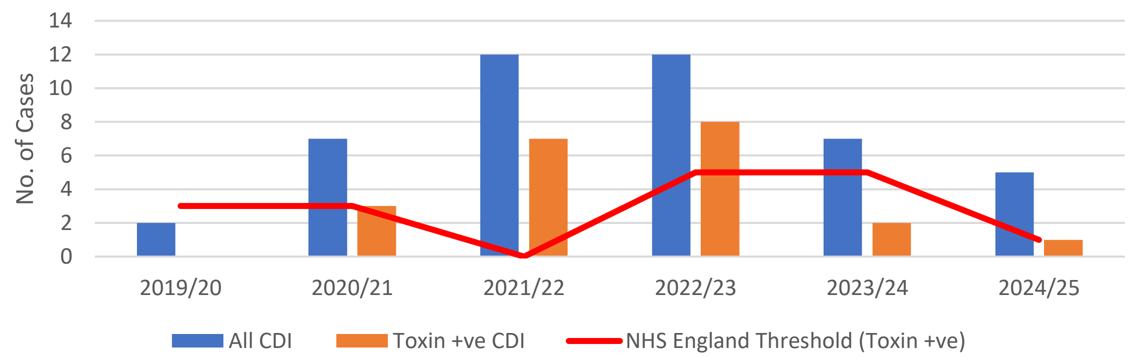


ROH contributes relatively few cases of HCAIs to the overall Birmingham and Solihull (BSOL) system totals – monthly data for ROH and other Trusts within BSOL are available here: MRSA, MSSA, Gram-negative bacteraemia and CDI: monthly data, 2024 to 2025 - GOV.UK

***Clostridioides difficile* infection**

- During 2024/25 there was 1 healthcare-associated *C.difficile* toxin-positive (reportable), against the NHS England threshold of 1.
- There has been a 50% decrease in toxin positive cases and a 33% decrease in all cases since 2023/24.
- An IPC review using the Patient Safety Incident Response Framework (PSIRF) approach is undertaken for each healthcare-associated reportable infection; no lapse in care or quality due to cross-transmission or antibiotic choices were identified.

Total number of C. difficile cases reported by ROH annually:



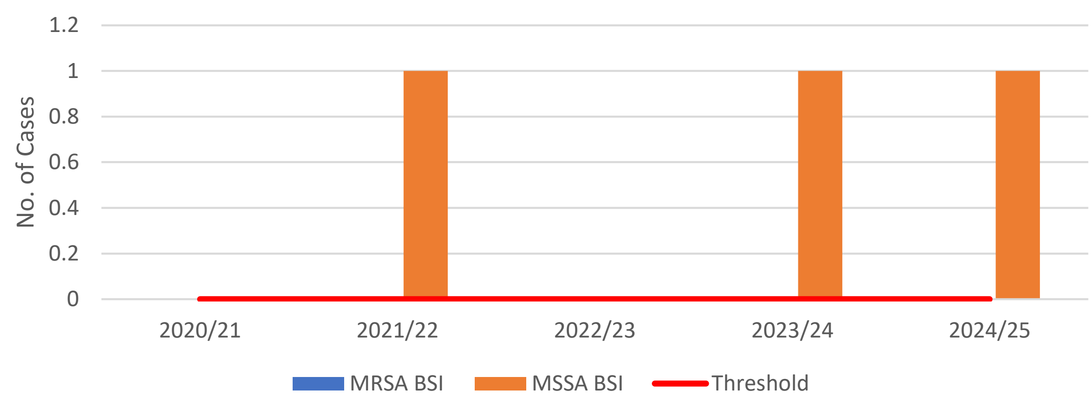
Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections

- During 2024/25 there was 0 healthcare-associated MRSA BSI. There remains a zero-tolerance approach for MRSA BSIs nationally.
- ROH have not reported an MRSA BSI for the last 13 years (last case reported during 2011/12).

Methicillin-sensitive *Staphylococcus aureus* (MSSA) bloodstream infections

- During 2024/25 there was 1 hospital-onset, healthcare associated MSSA BSI and 1 community-onset, healthcare associated MSSA BSI; there is currently no national threshold provided by NHS England.
- This is equal to the number of cases reported during 2023/24 (1 HOHA case).

Total number of HOHA MRSA and MSSA BSI cases reported by ROH annually:



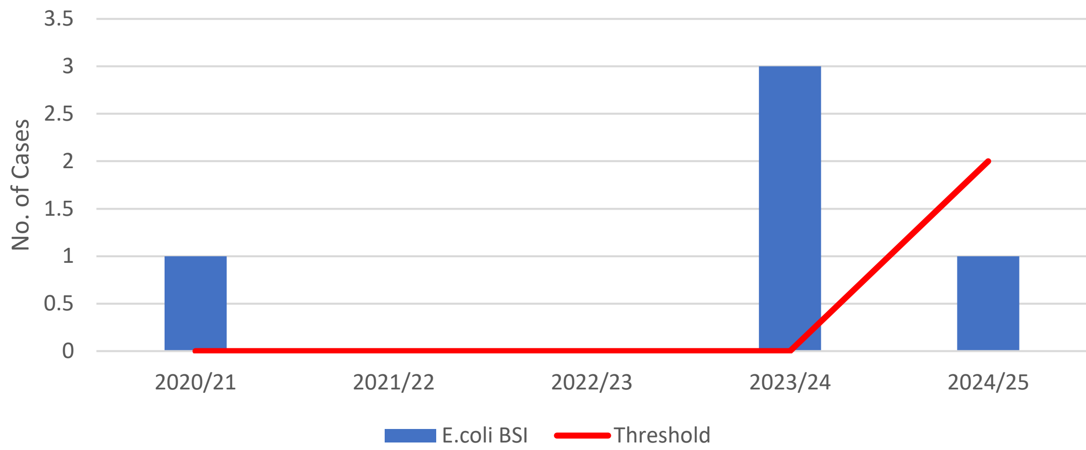
Gram-negative bloodstream infections

Gram-negative bacteria such as *E. coli*, *Klebsiella sp.,* and *P. aeruginosa* are the leading causes of healthcare-associated BSI. Each healthcare-associated Gram-negative associated BSI is individually reviewed to identify source (if possible), risk and contributing factors.

Escherichia coli bloodstream infections

- During 2024/25 there was 1 healthcare-associated *E.coli* BSI, against the NHS England threshold of 2.
- There has been a 67% decrease in cases reported during 2024/25 (1 case), compared to 2023/24 (3 cases).
- IPC review highlighted no care or management concerns that are believed to have contributed to this blood stream infection whilst the patient was under the care of the ROH.

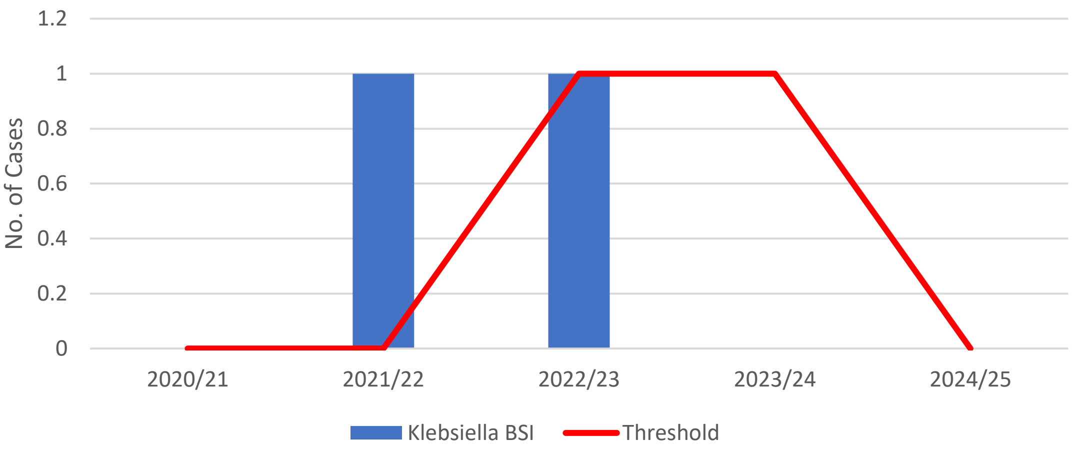
Total number of *E.coli* BSI cases reported by ROH annually:



Klebsiella species blood stream infections

- During 2024/25 there was 0 healthcare-associated *Klebsiella sp.* BSI, against the NHS England threshold of 0.
- This is equal to the number of cases reported during 2023/24 (0 cases).

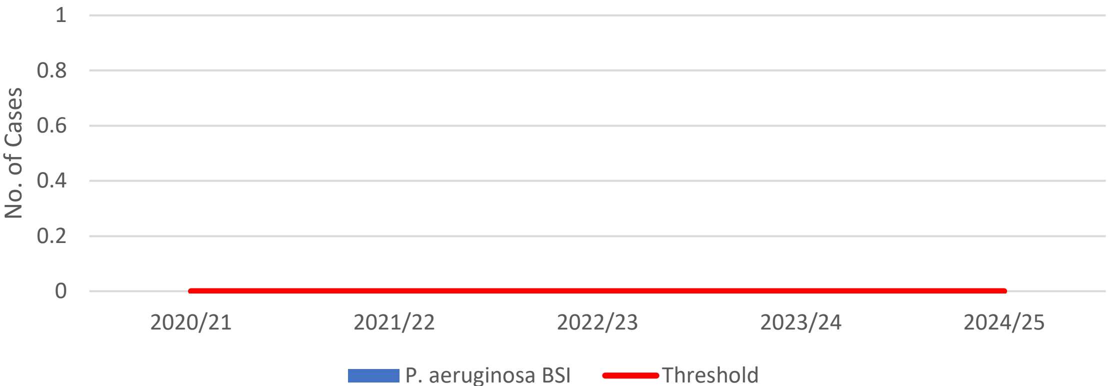
Total number of *Klebsiella sp.* BSI cases reported by ROH annually:



Pseudomonas aeruginosa bloodstream infections

- During 2024/25 there were 0 healthcare-associated *P. aeruginosa* BSI, against the NHS England threshold of 0.
- This is equal to the number of cases reported during 2023/24 (0 cases).

Total number of Pseudomonas aeruginosa BSI cases reported by ROH annually:

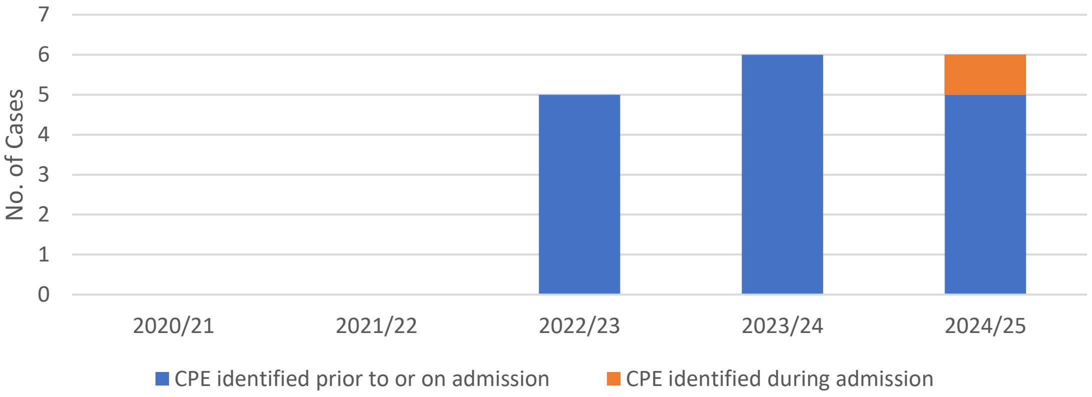


Carbapenemase-producing Enterobacterales (CPE)

CPE is considered a high-risk transmission hazard and in healthcare settings can lead to poor clinical outcomes due to limited therapeutic options. Increased incidence of CPE has significant cost and operational implications for healthcare providers. The Trust closely monitor for CPE by undertaking screening based on risk factors to promptly identify and isolate patients who are colonised with the organism. During 2022/23, ROH CPE screening guidance was updated to reflect changes to the national CPE screening guidance as described in Framework of actions to contain Carbapenemase-producing Enterobacterales (UKHSA, 2022).

- During 2024/25, A total of 7 CPE cases were identified compared to 7 in 2023/24.
- 3 of the cases were identified prior to admission, from pre-admission screening. 3 cases were identified on admission following transfer from another acute NHS Trust. 1 case was identified as an acquisition, positive tissue sample identified 72 days following admission to the ROH.
- Whole ward screening was conducted over a period of 4 weeks on the ward where the acquisition was identified, this yielded no additional positive CPE results.

Total number of CPE identified via screening prior to, on or during admission to ROH annually:

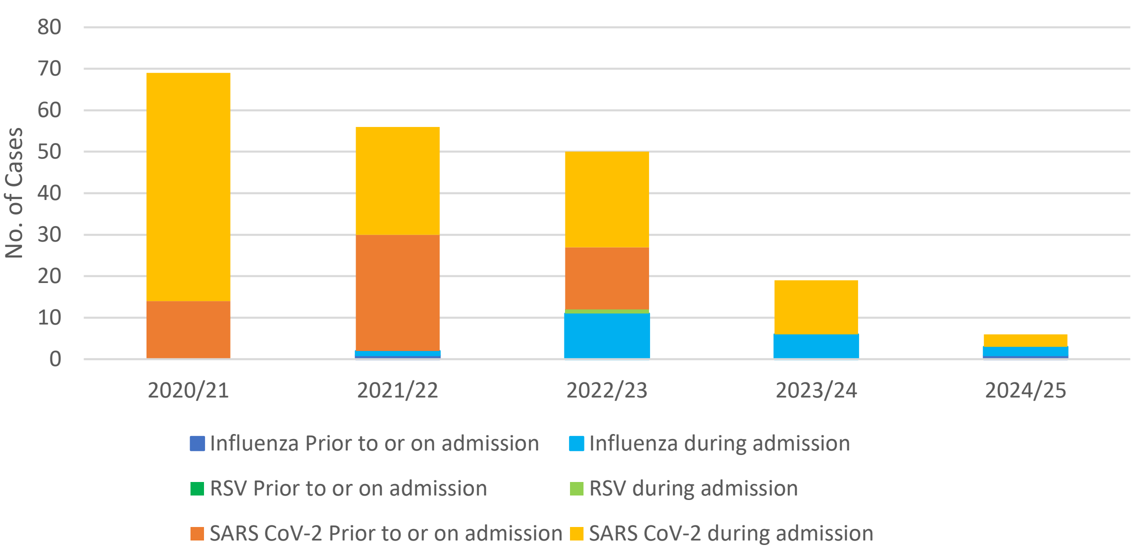


Respiratory virus infections

Respiratory viral infections such as Influenza and Respiratory Syncytial Virus (RSV) typically peak during the winter months, however, cases can arise throughout the year depending upon community prevalence.

- During 2024/25, a total of 3 Influenza A, 0 RSV and 3 SARS CoV-2 cases were identified, compared to 6 Influenza A, 0 RSV and 13 SARS CoV-2 cases identified in 2023/24.

Total number of respiratory viral infections identified prior to, on and during admission to ROH annually:

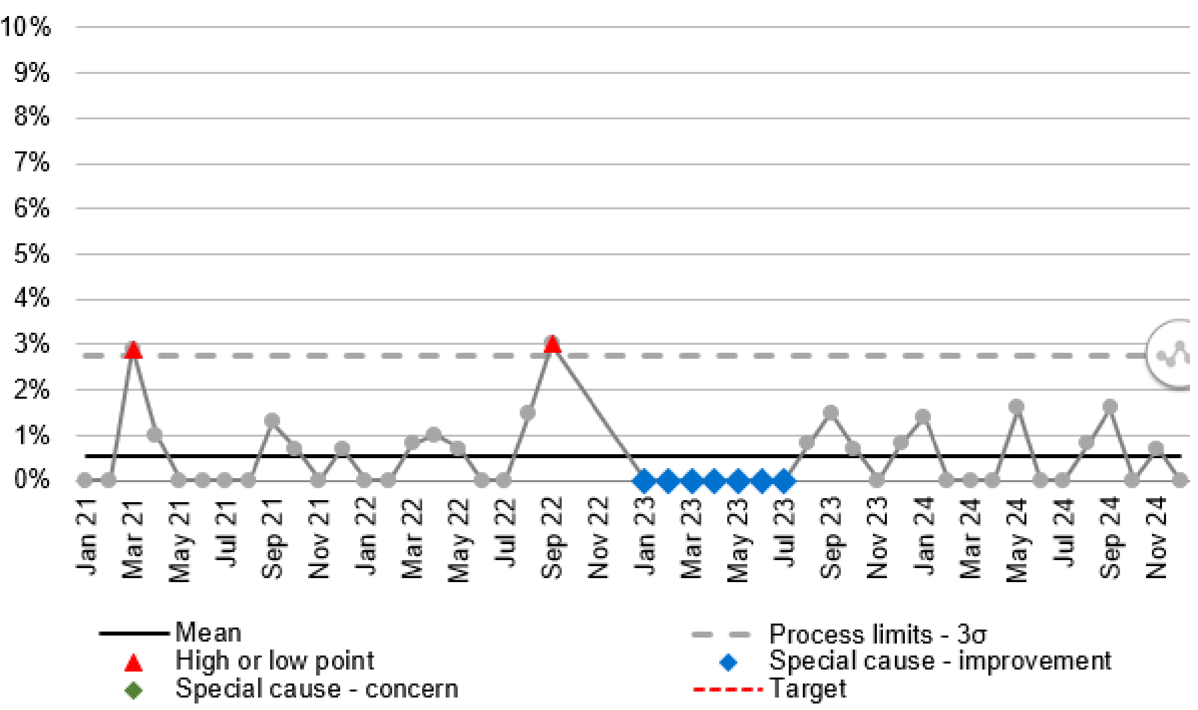


Surgical Site Infection Surveillance (SSIS)

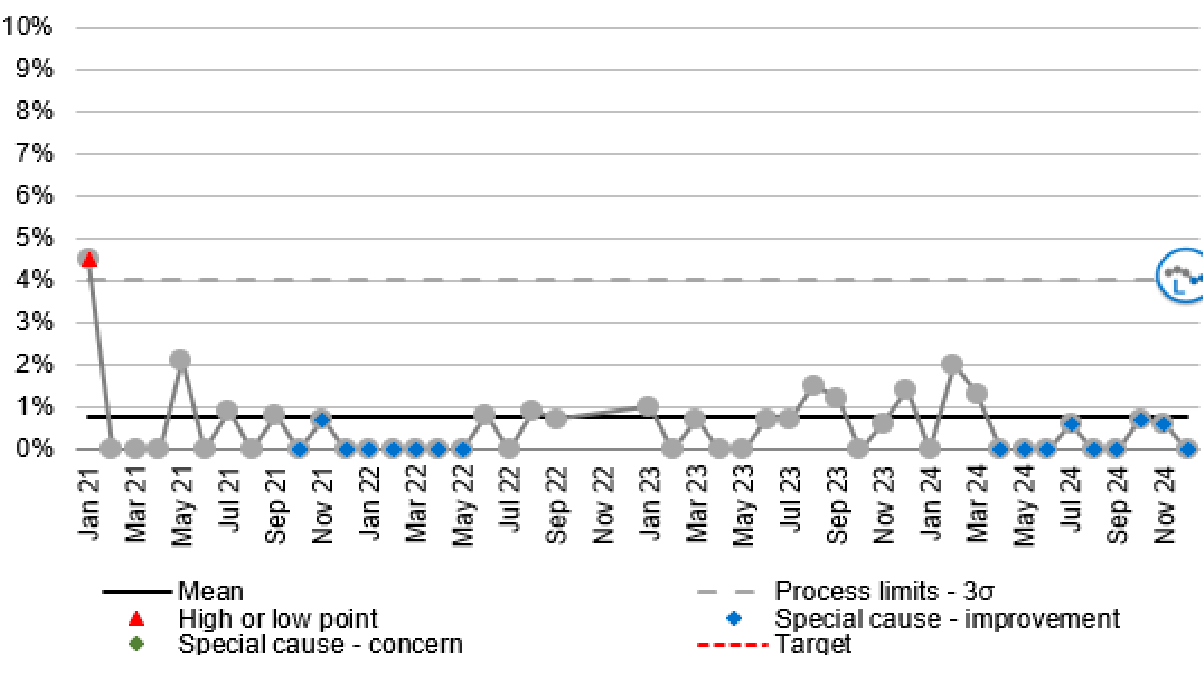
- Rates of SSI are monitored by the IPC team for arthroplasty surgery (total hip and knee replacement – mandatory) and spinal surgery (voluntary).
- During February 2025 we reduced from 2 SSI coordinators to 1. We were still able to continue with the surveillance programme as planned and there are no anticipated issues or plans to fill this vacancy.
- When compared with national data for participating hospitals, the ROH SSI risk rate for spinal surgery was identified as a 'higher outlier' during Q2 2024 (April to June).
- The main risk factors for SSI continue to be raised BMI. Work continues to pre-optimise patients for surgery with a focus on education and support pre-operatively whilst awaiting a surgery date.
- The reduction of SSI risk rate for total knee replacement and spinal surgery was made a Trust quality priority for 2024/25.
- The existing 'Theatre Focus Group' was developed into a multi-disciplinary Surgical Site Infection Prevention Group (SSIPG) to monitor SSI data, review current practice against evidence-based guidance (NICE NG125 SSI prevention and treatment), and identify actions and interventions to help minimise the risk of SSI.

- As part of the quality priority, the SSIPG has been working on developing a ROH bespoke SSI prevention bundle. This work is still currently underway, and the quality priority will continue into 2025/26. It is anticipated the bundle will be ready for implementation at the end of Q1 (June) 2025.

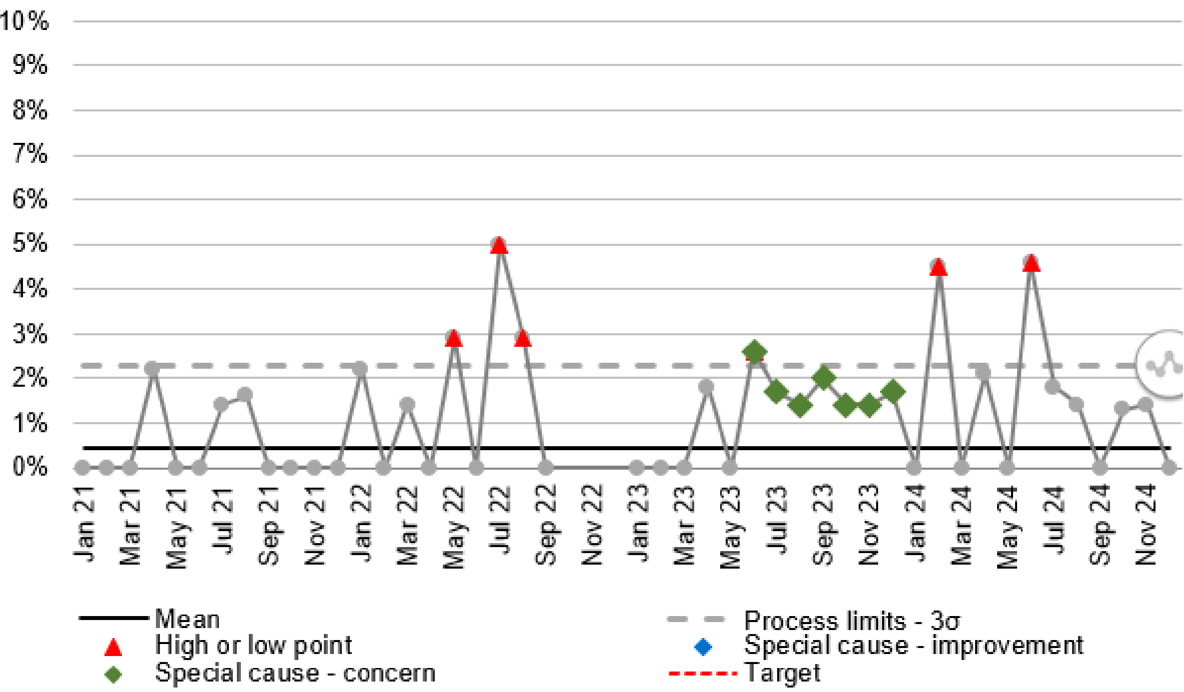
Total hip replacement surgery SSI risk rate per month, identified from inpatients or on readmission - January 2021 to December 2024:



Total knee replacement surgery SSI risk rate per month, identified from inpatients or on readmission - January 2021 to December 2024:



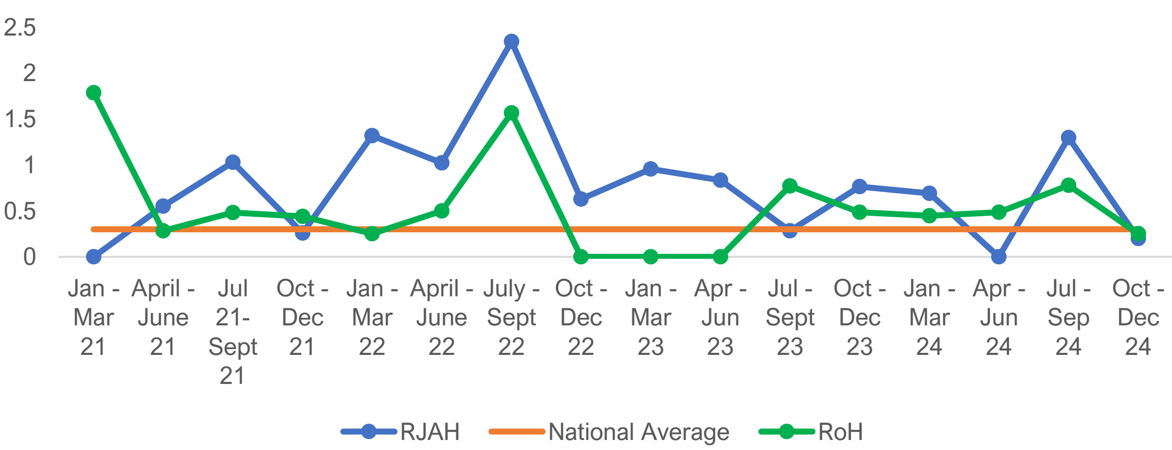
Spinal surgery SSI risk rate per month, identified from inpatients or on readmission – January 2021 to December 2024:



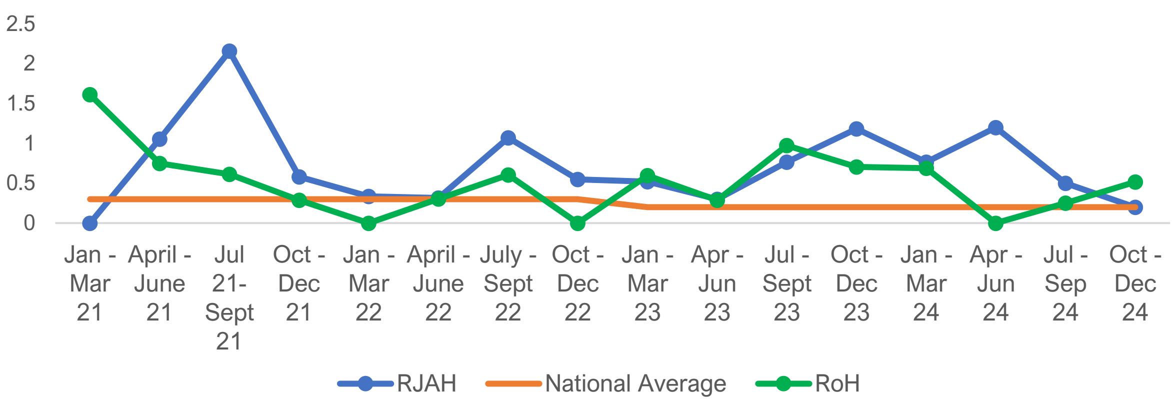
Note: we withdrew from SSI surveillance for Q4 2022 due to lack of surveillance team personnel due to sickness.

Inpatients and readmission SSI risk rates benchmarked with other specialist orthopaedic trusts:

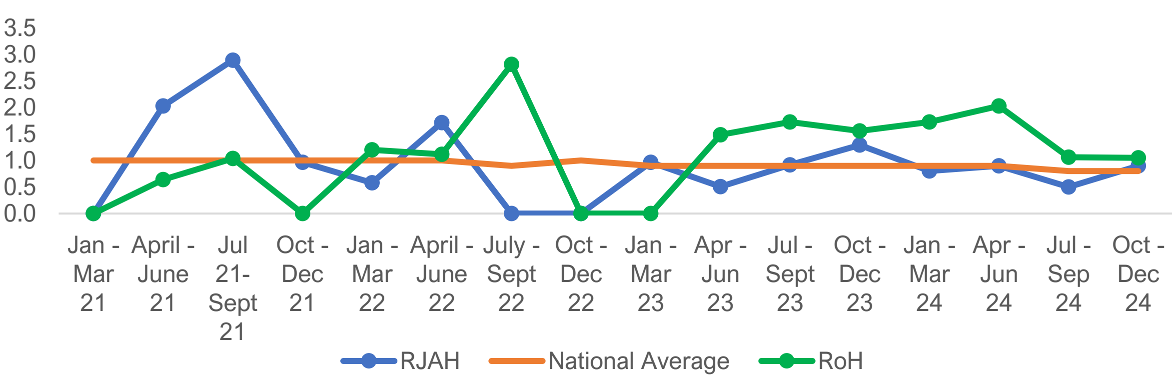
Total hip replacement:



Total knee replacement:



Spinal surgery:



Note: Only data from The Robert Jones and Agnes Hunt Orthopaedic Hospital was shared.

Clinical Activity and Incidents

The IPC team continues to support the development of guidance for managing the risk of infectious diseases that are updated in response to changes in local prevalence and national guidance.

Incidents:

- During May 2024, a SARS CoV-2 outbreak was declared on ward 3 involving 3 patients. The outbreak was recognised and responded to efficiently, minimising the impact and duration of the outbreak. Peer reviews of the Trust response by UKHSA and ICB IPC team reported that the response to the outbreak was comprehensive.
- During October 2024, routine 6-monthly legionella and *Pseudomonas aeruginosa* testing identified several outlets were positive for *Pseudomonas aeruginosa*. Remedial work and retesting was carried out in accordance with HTM 04:01 Safe

water in healthcare premises, this included the use of point of use filters whilst pending negative results. All outlets were cleared and returned to use.

Clinical activity:

- Governance process for investigations into SSIs were updated, in line with the ROH PSIRF. This enables more timely feedback to clinical service leads and a structured approach to thematic reviews if there are higher or lower outlier notifications received for any quarter.
- All in patient wards and theatres were deep cleaned as part of the annual shut down and planned preventative maintenance schedule.
- An annual skin check assessment and guidance related to occupational dermatitis was created and implemented. This provides staff and line managers with guidance on how to manage and monitor skin health of our workforce.
- Organised and celebrated several key events in the IPC calendar across ROH, this included World Hand Hygiene Day, World Antimicrobial Awareness Week, and International Infection Prevention Week 2024.
- Refreshed and reimplemented department cleaning schedules and records. This project was done in conjunction with the facilities team and department staff to ensure they are user friendly and provide assurance of cleaning taking place.
- The IPC team became core members of the Trust Green Board, supporting efforts to reduce the carbon footprint of healthcare.
- An ‘IPC in Orthopaedics’ collaborative pathway with Robert Jones and Agnes Hunt Orthopaedic Hospital was created to share knowledge, support, data and resources to improve IPC practices. During August 2024, ROH IPC lead Nurse and Senior IPC Nurse visited RJAH to observe their theatres and practices.
- The Trust IPC study day was held in November 2024, which involved internal and external speakers. The day was well attended and evaluated positively by attendees.
- Supported the annual Patient led assessment of the care environment (PLACE) assessment.
- Support was provided to the theatre department through auditing activities and direct engagement with theatre staff. Several spinal surgery lists were observed, during which aspects of clinical practice were identified that require improvement.

Antimicrobial Stewardship Programme 2024/25

The Trust Antimicrobial Stewardship Steering Group (AMSSG) continues to meet quarterly and includes representatives from pharmacy, microbiology, nursing, and medical staff. This group produces and manages policies regarding AMS and responds to concerns in this area. The group produces upward reports and escalates concerns via the Drugs and Therapeutics Committee (DTC) and IPCC. The Trust’s Antimicrobial Pharmacist reports quarterly antimicrobial consumption which is then reported at DTC and IPCC.

Antimicrobial Consumption Report 2024/25

Consumption of antibiotics is monitored by the Chief Pharmacist and analysed for trends by the Antimicrobial Pharmacist. The audits outlined above were conducted during 2024/25 for oversight on antimicrobial stewardship activities.

Since 2019 the NHS Standard Contract, set out by NHSE has contained a requirement on trusts to make 1% year-on-year reductions in their rate of total antibiotic usage per 1000 admissions – in accordance with the direction set in the UK's five-year national action plan (NAP) tackling antimicrobial resistance 2019-2024. ROH has continued to work towards this outside of the renewal of this requirement for the NAP 24/25 action plan. The UK 5-year action plan for Antimicrobial Resistance 2024-2029, outlines that by 2029, we should aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline. The 2024/2025 standard contract outlines the aim to reduce 10% of total use of antibiotics from the Watch and Reserve categories (UK 2024 categorisation) across the secondary healthcare system, from the 2017 baseline. The consumption report from Q1 2025/26 will outline the progress to monitor the above.

ROH antimicrobial baseline data for the year 2018/19:

2018/19 Baseline Data	Total DDD	42008
	DDD / 1000 patients	3239
NHSE target (2022/23)	Target DDD / 1000 patients	3093

DDD = Defined daily doses

The pharmacy team continue to undertake interventions relating to inappropriate antibiotic usage with prescribing teams to maintain good antimicrobial stewardship. Total antibiotic usage is monitored quarterly and ROH continues to maintain usage below the England average.

All antibiotics

Total Antibiotic consumption data in defined daily doses (DDDs) and DDD per 1000 admissions compared to the 2018 reference year (Jan to Dec) for all antibiotics including those prescribed by the Bone Infection Service (BIS):

All antibiotics including BIS Abx

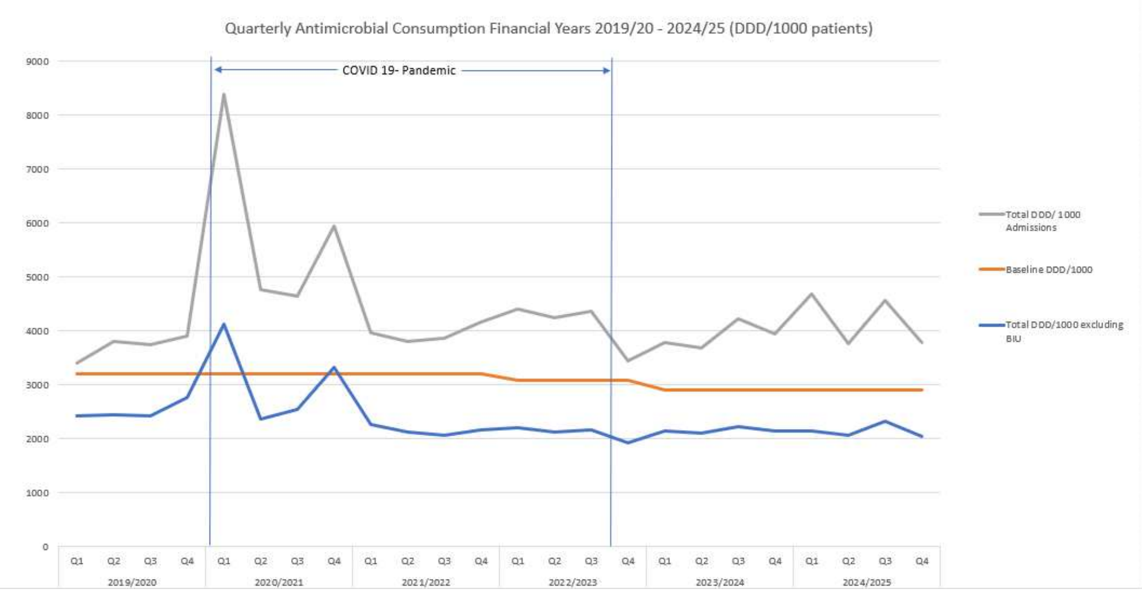
Year	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Total Antimicrobial consumption (DDD)	48607	39194	50179	54639	53814	61351
Target Total DDD	41587.9	41587.9	41587.9	40117	37807.2	41732
Antimicrobial consumption Per 1000 admission	3719	5518	3947	4114	3892	4292
Target DDD/ 1000	3206	3206	3206	3093	2915	2888

All antibiotics excluding BIS Abx

Year	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Total Antimicrobial consumption (DDD) (Excluding BIS)	27647	20549	27400	27984	29813	31410
Target Total DDD	41587.9	41587.9	41587.9	40117	37807.2	41732
Antimicrobial consumption Per 1000 admission (Excluding BIS)	2115	2894	2159	2107	2156	2197
Target DDD/ 1000	3206	3206	3206	3093	2915	2888

The table above provide a breakdown of overall antimicrobial consumption for each financial year since 2018. Both graphs show we have reached back to pre-pandemic levels, however with an overall incline can be seen in total consumption but aligns with an increased in bone infection unit patients, as excluding BIS the consumption remains consistent over the past 2 years.

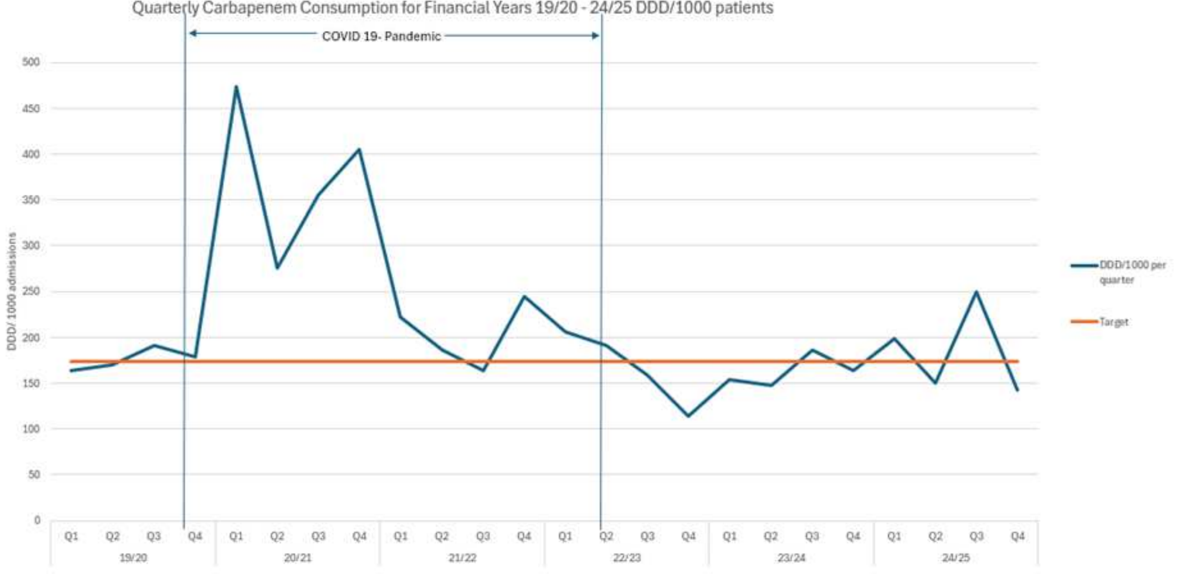
Total antimicrobial consumption (DDD) 2019/20 to 2024/25:



Carbapenem Usage

Total Carbapenem consumption data in DDDs and DDD per 1000 admissions compared to the 2018 reference year:

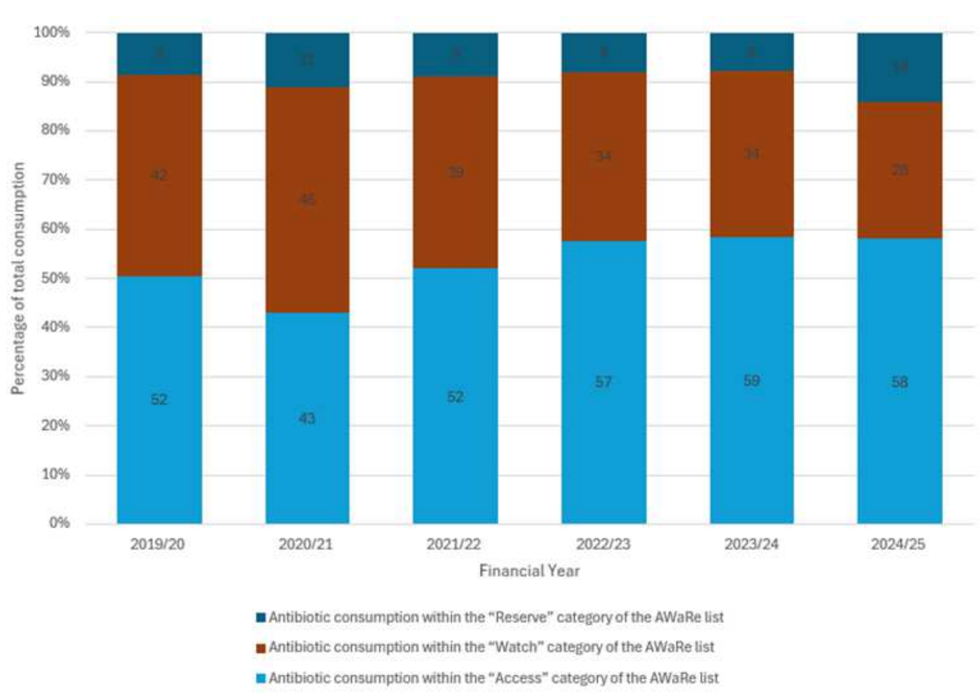
Year	2018	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Carbapenem consumption (DDD)	2420.8	2300.5	2548.8	2586	2202	2258	2677
Carbapenem consumption (DDD Per 1000 admission)	177.5	176.01	358.9	204	166	163	187
Target DDD/ 1000		173.9	173.9	173.9	173.9	173.9	173.9



The graph above shows quarterly carbapenem usage has decreased significantly over the last quarter.

A scoping exercise was carried out to help focus on the stewardship activities that are required outside of bone infection services. Additional work around monitoring carbapenem usage has been carried out this quarter and de-escalated appropriately.

Yearly usage of antimicrobials within the WHO “Access” category of the AWaRe list financial years 2019/20 – 2024/25:

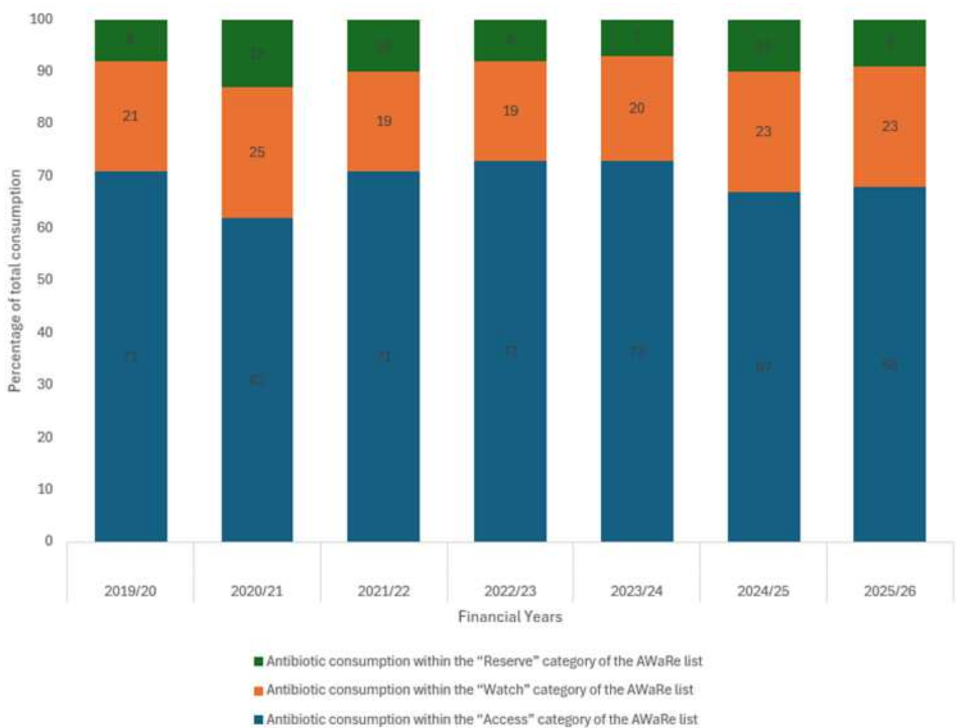


The percentage of antibiotics within the Access group category has been steady over the past 5 years. An increase in the reserve category antimicrobials is outlined below.

The NAP target for 2024-2029, states we should aim to achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system- this is not isolated to the hospital settings. We sit below this target when excluding BIS for 2024/25 YTD.

It is important to note antibiotics routinely used for BIS MDT are mostly found within either the Reserve or Watch categories; therefore, as activity remains high for BIS Outpatient then this impacts on the percentage consumption of Access antibiotics.

Excluding BIS antibiotics causes the Trust to comfortably achieve the CQUIN targets as evidenced below:



Care and Management of the Healthcare Environmental and Equipment

Decontamination

- No decontamination of critical devices is undertaken onsite at ROH. This is contracted out to Steris who deliver an accredited decontamination service and oversee the process and management of all decontamination of surgical instruments. No other equipment used onsite or offsite as part of ROH services requires sterile decontamination.
- Steris have taken over from BBraun for ROH's reprocessing of surgical instruments since November 2024. The transition included lots of meetings to implement the new processes, training for Steris staff and theatre personnel and exchange of tray data. The transition was not without issues but have now settled down and ROH will

be in contract with Steris for the next 20 years or 10 years if Pan-Birmingham Trusts and Steris decide to not renew.

- ROH have an appointed Sterile Services Manager (SSM) who takes responsibility for coordinating activity between the theatre, decontamination, and supply/purchase teams. They ensure that the inventory of surgical instruments is proactively reviewed and managed in accordance with Health Technical Memorandum (HTM) 01-01, which offers best practice guidance on the whole decontamination cycle including the management and decontamination of surgical instruments used in acute care as well as local guidance, clinical requirements, and industry best practice.
- The SSM reports to the Trust's Decontamination lead. In the absence of a formal Decontamination Lead, this responsibility is held by the DIPC. The SSM provides an upward report on decontamination at the IPC committee.

Water

- The Water Safety Group (WSG) continues to meet bi-monthly and reports upwardly to the IPC Committee. The group is chaired by the Deputy Director of Delivery (Estates). The Trust continues to monitor and review work and actions undertaken toward the water safety plan (WSP). The plan was developed based on the peer review and reflects the status and identified risks of the Trust's water systems. This is monitored at the WSG.
- The Estates Department carried out planned preventive maintenance in accordance with the relevant water safety guidance documentation. Every two years the Trust commissions an independent Legionella risk assessment to be completed across the site, the outcome/actions from the assessment are discussed at the WSG.
- Six monthly Legionella water sampling to several fixed and random points was undertaken. Following an in-depth *Pseudomonas aeruginosa* risk assessment, from January 2024, this also included testing for *P. aeruginosa* in 'higher risk' areas which include ward 1, ward 3 and HDU. The results are reported through the WSG. As noted in the clinical activity section, during October 2024, routine 6-monthly water testing identified several *Pseudomonas aeruginosa* positive outlets. Remedial work and retesting was carried out in accordance with HTM 04:01 Safe water in healthcare premises, this included the use of point of use filters whilst pending negative results. All outlets were cleared and returned to use.
- The water quality in our hydrotherapy pool is tested on a weekly basis, the tests are undertaken and monitored by our hydrotherapy staff and exceptions are reported to the WSG.

Ventilation

- The ventilation safety group (VSG) continues to meet bi-monthly and reports via upward report to the IPC committee. The DIPC is responsible for reporting on activities and recommendations of the VSG to the Quality and Safety Committee which feeds into Trust Board.

- As per the requirements set out in HTM 03:01 specialised ventilation for healthcare premises, the VSG is a multidisciplinary group whose remit is to assess all aspects of ventilation safety and resilience required for the safe development and operation of the ROH healthcare premises.
- The Trust have 15 operating theatres, 14 of which have ultra clean air (UCA) enclosures, these are serviced and maintained by the Estates Department, the UCAs are serviced/validated twice yearly by a specialist external provider.

Estate

The IPCT continue to advise and support estates with refurbishments and new building projects within the Trust. This has required attendance at key design and planning meetings and the review of plans and minimum build standards.

During 2024/25 the IPCT have advised on:

- Routine programme of ward and theatre closures to allow routine maintenance and deep cleaning to take place.
- Replacement of worn theatre flooring within theatres 5, 6 and 7 as well as the corridor outside theatre 8.
- The creation of a staff wellbeing room on HDU.
- Repair of Hydrotherapy roof.
- Male theatre changing room refurbishment and maintenance of theatre 1, 2 and 4.
- Estate challenges are ongoing throughout the theatre complex and orthotics department. These areas are historic buildings that require investment to ensure prolonged use.

Environmental Hygiene (Cleanliness)

Cleaning and environmental decontamination services provided at ROH are undertaken by an in-house team within the Facilities department. These services are provided by a dedicated team of environmental cleaners and an enhanced cleaning team. Environmental cleaners provide cover in all patient areas from 06:00 to 22:00hrs Monday to Friday and 08:30 to 19:00hrs Saturday & Sunday. The enhanced cleaning team undertake all enhanced cleaning and terminal cleaning requests which includes ultraviolet light cleaning (UV-C) and Bioquell (hydrogen peroxide vapour misting) between the hours 08:30 to 05:30hrs (split over two long shifts) Monday to Sunday.

Training for domestic staff continues to be provided by the housekeeping coordinators which includes the completion of a training manual. The training manual was updated during 2024/25 to reflect greater narratives and training in relation to control of substance hazardous to health (COSHH) and health and safety.

Environmental cleaners are responsible for ensuring that cleaning methodologies are rigorously applied, and frequencies are maintained. All cleaning staff play an essential role in ensuring that the Trust maintain low incidence of HCAI which helps to promote confidence in patients and visitors.

Facilities audit programme:

Auditing Principles and Frequencies		
Functional Risk Category	**Frequency of Audit**	**Outcome Required %**
FR 1 – Theatres & supporting areas	Weekly	98% or above
FR 2 - General Wards & Clinics	Monthly	95 % or above
FR 3 – Outpatients & public access areas	Bi-Monthly	90% or above
FR 4 – Offices	Every 3 Months	85% or above
FR 5 – Not introduced	Every 6 Months	80% or above
FR 6 – Not introduced	Every 12 Months	75% or above

Star ratings

Star ratings are displayed to give patients, staff, and the public an easily understood visual score of the standard of cleanliness being met. It reflects the cleanliness of a functional area regardless of which staff group is responsible for cleaning each element. Our star ratings are derived from the original audit score at the time of audit. Scores can only be updated following the next full re-audit. The monthly star ratings are displayed within all patient facing locations displays. This system enables easier administration and allows monitoring to take place. All areas achieved 5 stars at each audit during 2024/25.

Efficacy audits

Annual efficacy audits are designed to assess the process of cleaning and infection prevention and control practices related to cleaning. The audit is carried out by Facilities Management, Infection Prevention and Control and Clinical teams.

Location	Date performed	Scoring %
X-Ray	May 24	86%
MRI	May 24	100%
Hydro pool	June 24	79%
HDU	July 24	100%
Discharge Lounge	June 24	93%
OPD / CYPD	Jan 25	98%
Ward 1	Jan 25	98%

Patient led assessment of the care environment (PLACE)

PLACE assessments assist organisations to understand how well they are meeting the needs of their patients and identify where improvements can be made. Assessments were performed over a one-day period with Trust volunteers and uses information gleaned directly from patient assessors to report how well our trust has performed – in terms of national standards and against other similar trusts. Assessments were undertaken on our wards, clinics, out-patient departments, and public areas.

Discipline	National Average	ROH 2024/25	Comment
Cleanliness	98%	99%	Above National Average
Food	91%	94%	Above National Average

Organisational Food	92%	90%	Below National Average
Ward Food	91%	95%	Above National Average
Privacy, Dignity	88%	92%	Above National Average
Condition/Appearance	96%	99%	Above National Average
Dementia	84%	91%	Above National Average
Disability	85%	92%	Above National Average

Successes:

- Revised local cleaning manual currently being rolled out.
- Cleanliness policy has been reviewed and update.
- Additional staff have been training on the safe use of the Bioquell system.

Future Plans:

- Continue to explore possible chemical free alternatives to cleaning chemical materials, that has limited or zero impact on the environment.
- Exploring new technologies and innovation, trialling new digital cleanliness audit system.
- To increase staff training with the safe use of the decontamination Bioquell system.

IPC Training and Education

- The IPC team deliver training sessions year-round according to a training needs analysis.
- Mandatory IPC training continues to be delivered in-person (level 1 – all staff) and online (level 2 – clinical staff). Trust compliance is monitored at the IPC Committee.
- Ad-hoc, turbo tutorials are delivered by the IPC team in clinical settings to share updates, important messages, and target education on specific subjects.
- The IPC team has a dedicated full time FFP3 respirator fit tester that delivers the fit testing programme for the Trust. Much work has gone into ensuring clinical staff are tested on at least one UK manufactured respirator as well as providing training on the use of the Trusts respirator hoods.
- There is an active link champion programme in place with good engagement from clinical departments. Quarterly in-person link champion meetings are held by the IPC team.
- Engagement and training undertaken by the IPCT during 2024/25:
  - Facilitated quarterly meetings for IPC link champions (from each ward and department).
  - Continued to utilise educational 'grab packs' for hand hygiene, Influenza, MRSA, PPE, and CPE across ROH to support staff with effective application of theory into practice within their areas of work.
  - Continued to work collaboratively with suppliers, estates, and facilities teams to ensure that infection risk is considered and managed when commissioning works, new equipment, or processes.

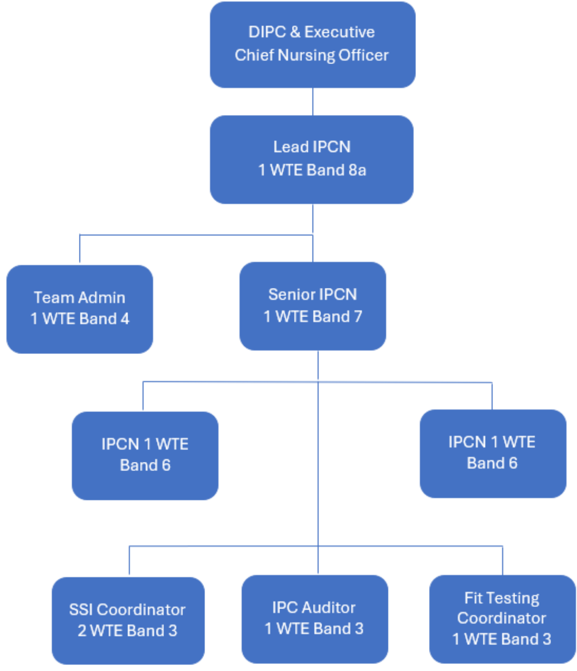
- Continued to facilitate communication of key messages via several media methodologies including social network, newsletters, and emails.
- Facilitated the national antibiotic awareness and hand hygiene days across ROH.
- Supported new and updated policy roll out and dissemination utilising external industry partners.

Governance and Assurance Arrangements

The IPC team support the Trust in meeting its obligations under the Health and Social Care Act 2008 code of practice for prevention and control of infections and related guidance and other relevant legislation and guidance from, for example, the Department of Health and Social Care, UKHSA, and the Care Quality Commission. The service is led by the Lead Specialist IPC Nurse, (holding a formal qualification in IPC) with the Chief Nursing Officer as director of IPC (DIPC) and executive lead.

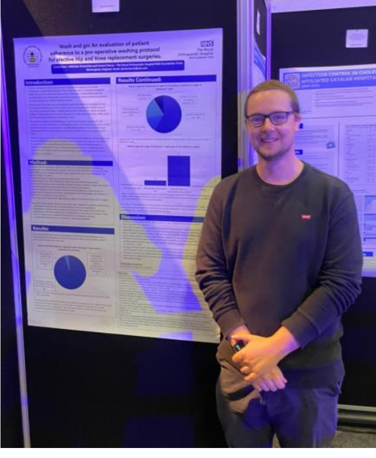
- The team operates between the hours of 08:30 and 16:30hrs Monday to Friday (except bank holidays). The Trust has 24-hour access to expert Consultant Microbiology advice and support via a Service Level Agreement (SLA) with the University Hospitals Birmingham NHS Foundation Trust (UHB).
- A Consultant Microbiologist is the designated Infection Prevention and Control Doctor (IPCD) which is also provided via an SLA with UHB. This allows for the weekly allocation of 2 programmed activities (PAs) of Infection Control Doctor time. Cover for leave of absence of the IPCT and out of hours service is provided by the on-call Microbiology team at UHB which is covered in the SLA.
- ROH do not have access to an onsite laboratory. Laboratory services are provided by UHB which has purpose-built laboratories onsite at both The Queen Elizabeth Hospital and Heartlands Hospital where ROH samples are processed. The UHB microbiology laboratory has full (UKAS) accreditation ISO Standard 15189. ROH has electronic access to microbiology results to facilitate prompt identification and response.
- Occupational Health services are provided via an SLA by UHB. Occupational Health (OH) staff from UHB provide one session (1 day) per week to support the OH requirements of ROH staff. The OH team carry out preplacement health assessment and immunisation checks, skin health surveillance (from line manager referral) and management of inoculation injuries.
- The IPC service is provided through a structured annual business plan and associated programme of work which includes expert advice, audit, teaching, education, surveillance, policy development and review as well as advice and support to staff, patients, and visitors. The main objective of the annual programme is to maintain the high standards already achieved and enhance or improve on other key areas. The programme addresses national and local priorities and encompasses all aspects of healthcare provided across the Trust. The annual programme is agreed at the IPC committee.

ROH Infection Prevention and Control Service Structure 2024/25:



During 2024/25, the IPC team took part in the following development opportunities:

- Lead IPC Nurse continued to pursue a master's degree in IPC at Dundee University.
- Lead IPC Nurse continued to undertake a DIPC development course.
- Senior IPC completed the internal nurse leaders development programme.
- IPCN presented a poster on QI work at the annual Infection Prevention Society Conference which was held in Birmingham during November 2024.
- An away day to review previous year's performance and plan for the year ahead.
- Several Infection Prevention Society study days attended focusing on key topics that benefit service provision at ROH.
- SSI team undertook annual SSI surveillance training refresher provided by UKHSA.
- Continued to hold monthly journal clubs to discuss new and emerging research evidence related to IPC to inform continuous improvement.



Governance

- A bi-monthly Trust Infection Prevention and Control Committee (IPCC) is chaired by the Chief Nursing Officer and reports to the Trust Board. It receives regular reports and updates from each Clinical Group and the following sub-committees:
  - Water Safety Group
  - Ventilation Safety Group
  - Antimicrobial Stewardship Steering Group
  - Surgical Site Infection Prevention Group
- The IPCC also receives updates from our regional UKHSA Advanced Health Protection Nurse, Integrated Care Board IPC lead, estates, facilities, and UHB Occupational Health team.
- Assurances associated to Trust IPC matters is provided three times a year by the DIPC to the Quality and Safety committee, which reports directly to Trust Board. Any interim exceptional reporting to the Trust board is undertaken via existing reports from the Chief Nurse's Office.
- As part of the Trusts PSIRF approach, the IPCT supports timely reviews of reportable HCAI and IPC incidents which are presented and discussed at divisional governance meetings.
- To keep IPC high on the agenda the IPCT regularly attend and champion IPC at relevant groups, committees, and forums.
- Improved communication and patient flow lead to positive outcomes for patients and their families when the system works together. The IPCT have been actively engaged in maintaining and expanding networks locally, regionally, and nationally. This has included:
  - Regional and national meetings with NHS England.
  - Birmingham and Solihull system IPC Meetings.
- No external reviews of IPC practice were undertaken during 2024/25.

Assurance

The IPC audit programme demonstrates compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections. Audits are undertaken by both clinical teams, as self-assessments and the IPCT, as assurance of practice and data validation. Where additional risks are identified or upon the declaration of a period of increased incidence/outbreak, the IPCT undertake additional audits, outside of the routine programme, in accordance with risk requirement.

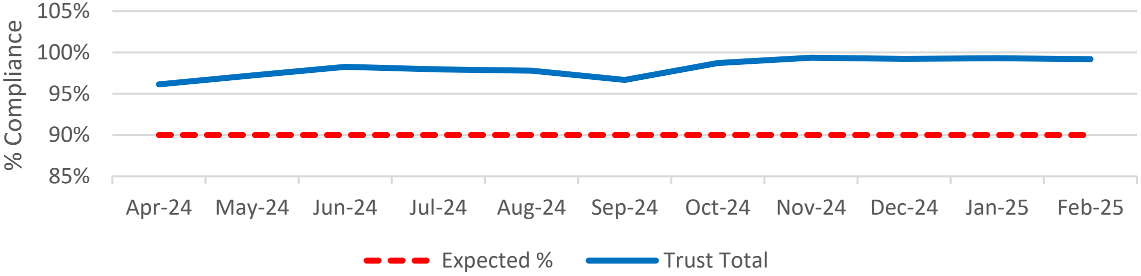
Action plans are devised by the departments where issues are highlighted, and completion of these are monitored within the responsible division and reported on at fortnightly divisional governance meetings. Details of audits undertaken by clinical

areas and associated actions are upwardly reported by the divisional Head of Nursing to IPCC by exception or to champion good practice. Details of audits undertaken by the IPCT are included in the IPC summary report provided by the Lead IPC Nurse at the IPCC.

Hand hygiene (inc. bare below the elbows) and Personal Protective Equipment:

Overall compliance from hand hygiene auditing was 99%, this is a 3% increase from 2023/24. Audits undertaken by IPC nurses showed a lower level of overall compliance rate at 91%. This is in part due to the competence of those undertaking the audit and audit bias (observation, observer, and selection bias). Overall compliance from PPE audits undertaken by the IPC team was 91%. Work to address hand hygiene and PPE compliance was a 2024/25 priority for the IPC team, with the intention of introducing formal hand hygiene and PPE training for all staff and audit training for link champions. An application was made to the Training and Development committee to make hand hygiene and PPE training mandatory; however, this approval was denied by the group due to changes being made to mandatory training at a national level. The absence of mandated hand hygiene and PPE training has been added as a risk to the IPC risk register.

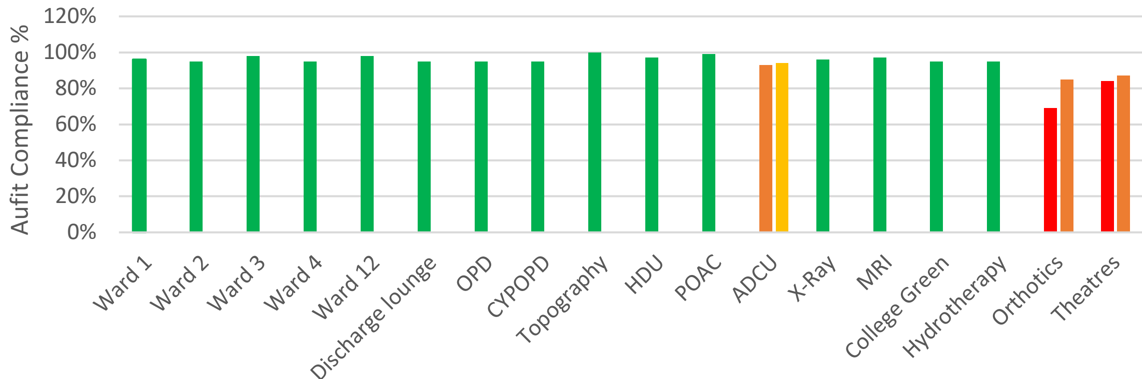
Trust Hand Hygiene Audits - % Monthly Average:



IPC Practice Audit:

All clinical areas are audited by the IPCT in conjunction with the facilities team, every year. A RAG based scoring system is used and a formal process for audit escalation followed should an audit fail. This involves escalation to senior management within the division, re-audit within a specified time frame (dependent upon severity of findings) and feedback of corrective actions/measures taken to address issues. All audits that fail (<95%) have improvement recommendations made. There are ongoing estates issues within the theatre, orthotics and ADCU departments that continue to bring down the departments IPC audit compliance scores.

Annual IPC Audits Scores:



Policy

All IPC policies and guidelines are available for staff to view via the Trust intranet. There is a formal governance structure in place for reviewing and ratifying such documents within the Trust and the corporate governance team produce a directory of documents alerting lead authors when policies are due for review. Policies are also updated prior to review date if national guidance or evidence base is updated/changed. All polices are agreed and approved for use at the IPCC (if minor or no change) or Quality and Safety Committee (if the changes are major or introduction of new policy).

The Trust has adopted the new NHS England National Infection Prevention and Control Manual (NIPCM) to guide its policies and procedures.

During 2024/25 the IPCT reviewed and/or updated the following polices and documents:

- Carbapenemase-producing Enterobacterales Policy
- Blood and Body Fluid Spillages Policy
- Isolation Policy
- Outbreak Policy
- Standard Infection Control Precautions Policy
- Personal Protective Equipment for Clinical Use Policy
- Communicable Diseases and Notification Policy
- Respiratory Illnesses Policy
- IPC risk assessment during construction or refurbishment of a healthcare facility Procedure
- Staff Immunisation Policy
- UKHSA SSI Surveillance Guide
- Procedure for the Management of Occupational Dermatitis
- ROH Audit Programme
- Patient Safety Incident Response Plan for Infection Prevention and Control Related Incidents
- *Clostridioides difficile* Standard Operating Procedure

The following polices/documents were removed as they were deemed no longer relevant, superseded or included within existing polices:

- ROH SSI SOP
- Influenza Policy
- Major Outbreak Policy
- High Impact Interventions SOP

Risk

- The IPC board assurance framework has been updated throughout 2024/25. Actions arising from the framework are monitored via the IPC committee.
- IPC risks are included on a risk register which is reviewed bi-monthly at the IPC committee.
- 5 risks were closed during 2024/25:
  - February 2025 – risk relating to the exposure of staff, visitors and patients to respiratory illnesses. This risk was closed as mitigated as far as is reasonably possible with ongoing monitoring in place.
  - January 2025 – risk relating to the lack of a staff immunisation policy. This was closed as a policy was written and implemented.
  - November 2024 – risk relating to the IT issues within the ROH and the IPC team not being able to access the UKHSA data capture website from Trust computers. This was closed as the issue was resolved.
  - November 2024 – risk relating to insufficient access to respiratory protective equipment. This risk was closed as there was a good supply of FFP3 respirators and the Trust had procured 28 respirator hoods for clinical use.
  - June 2024 – risk relating to UHB microbiology staff (Consultants and Registrars) not being able to access the ROH PICS. This was closed as access was arranged by the lead IPC nurse and a process implemented to endure this is kept up to date with new starters and leavers.
- 1 new risk was added to the IPC risk register:
  - February 2025 - risk relating to the use of Excel spreadsheets to store patient information for surveillance purposes. Data can be easily inputted incorrectly, overwritten or deleted. Surveillance database solution required to provide better digital solution to monitoring HCAI trends and alerting new issues.

Annual Plan

Below is a snapshot of the IPC business plan priority objectives and programme of work for 2025/26, mapped against our [Trust strategic objectives] (1=Care, 2=Expertise, 3=People, 4=Community, 5=Services, 6=Collaboration).

🔷 Quality & Continuous Improvement

📋 Decontamination Processes - Conduct a comprehensive review to assess effectiveness and compliance. (1, 2, 5)

🤝 SSI Prevention Bundle - Collaborate with SSIPG to develop and implement a tailored ROH-specific bundle. (1, 2, 5, 6)

🎓 IPC Training Review - Use the NHS England IPC Education Framework to assess current training and explore innovative delivery methods. (1, 2, 3, 5)

🗣️ Patient Feedback - Develop and roll out an inpatient IPC survey. Use insights to drive improvements and audits. (1, 2, 4, 5)

🎥 Lived Experience Videos - Partner with Comms and Patient Experience to create videos highlighting inpatient HCAI stories. (2, 4, 6)

🌱 Sustainability via Bed Linen QI - Apply QI methods to assess frequency of changes and analyse carbon footprint reduction. (2, 5, 6)

🔷 Productivity

💻 Digital SSI Data Collection - Move fully from paper to digital systems for UKHSA SSIS submissions. (2, 5)

📊 Enhanced Outpatient Surveillance - Collaborate to improve SSI data collection in OPD & ROCS settings. (2, 5, 6)

🏥 Reactive Duty Role Evaluation - Refine this role to support bed management and improve isolation resource use. (2, 5)

📚 Journal Club & CI Huddles - Integrate both to promote QI workstream development. (2, 5)

🔷 Financial Control

📋 Staffing & Service Review - Streamline IPC structure to optimise efficiency. (3, 5)

🖨️ Reduce Printing - Cut printing and laminating reliance to align with sustainability goals. (5)

🧪 Consumables Standardisation - Align with UHB on fit testing supplies and use joint procurement to reduce costs. (1, 3, 5, 6)

Conclusion

Overall, our performance in infection prevention and control is measured by our adherence to the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. This code underpins all elements of our IPC programme, including governance systems, environmental cleanliness, decontamination, staff training, and robust policies—all designed to protect patients, staff, and visitors.

Throughout 2024/25, the IPC team has continued to lead with innovation and professionalism, successfully delivering the IPC programme with measurable progress in reducing healthcare-associated infections.

The Trust's ongoing priority is to maintain and improve IPC standards across all care settings, supporting safe and effective patient care pathways throughout the wider health economy. The IPC team remains committed to undertaking detailed reviews of every case of infection in collaboration with clinical teams, ensuring that learning is captured and translated into practice improvements.

It is evident that our IPC specialists play a critical leadership role in safeguarding the health of both patients and staff. As we move forward, it is essential that we continue to evaluate our practices with rigour, placing patient safety and staff wellbeing at the heart of everything we do. The dedication and resilience of our teams remain the foundation of our success.

Related Documents

Department of Health (DOH) The Health and Social Care Act 2008 Code of Practice of the prevention and control of infections and related guidance. Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK

WHO access, watch, reserve, classification of antibiotics for evaluation and monitoring of use. 2021 AWaRe classification (who.int)

Confronting antimicrobial resistance 2024 to 2029. UK 5-year action plan for antimicrobial resistance 2024 to 2029 - GOV.UK

Protocol for the Surveillance of Surgical Site Infection Surgical Site Infection Surveillance Service Version 6 (June 2013) Protocol for the Surveillance of Surgical Site Infection version 6 (publishing.service.gov.uk)

NHS England (2022) National Infection Prevention and Control Manual for England. NHS England » National infection prevention and control manual (NIPCM) for England

The Royal Orthopaedic Hospital
NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 18th July 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that the internal audit recommendation tracker had been updated with a number of revised dates to the completion of actions. There are currently 19 actions that have been delayed. • It was noted that work is currently taking place on fixed asset register to tighten the reconciliation process. • It was highlighted that declarations of interest position was detailed on the Counter Fraud self-assessment as amber rated, but it was noted that there is a plan in place to engage more closely with the Medical Director and Clinical Service Leads to raise awareness with the medical staffing teams.	• The Artificial Intelligence session that is being arranged for the Trust Board will take place following the completion of the internal audit report that is currently being undertaken. The session will be planned with support from KPMG. • The internal audit action to be updated to provide reason for delays in actions not being completed and this will be shared monthly with the Executive team. • Following the audit lessons learned meeting with Deloitte an action plan will be devised with clear timescales and responsible owners will be shared with the Committee in October.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee received a comprehensive progress update from internal audit, including contract management review, update to 25/26 plan, the artificial intelligence review and absence management review that are all taking place at the moment. • The Committee received an update on the key financial controls annual review that had been undertaken that focused on the fixed asset register and single tender waiver process. • The Committee received confirmation that the adjustments that were required to the annual accounts had taken place to reclassify the accrued income and deferred income due to a prior year misstatement. • The Committee was assured that the value for money work had been concluded, and the auditors annual report was issued on 10th July 2025. • The Committee received the Counter Fraud Annual report, and it was noted that there had been an improvement in the assessment against the NHS Counter Fraud Authority 12 standards.	• There were no decisions made by the Committee.

• The Committee received the breaches and waivers report, and assurance was provided on the action being taken to address any issues. • The Committee was presented with the revised Board Assurance Framework.	

Chair's comments on the effectiveness of the meeting: The meeting maintained good pace but allowed for good conversation on some key topics.

Finance and Performance Report

Month 4

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

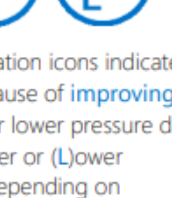
Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually 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.

N/A to SPC

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.

Report

Operational Performance Summary

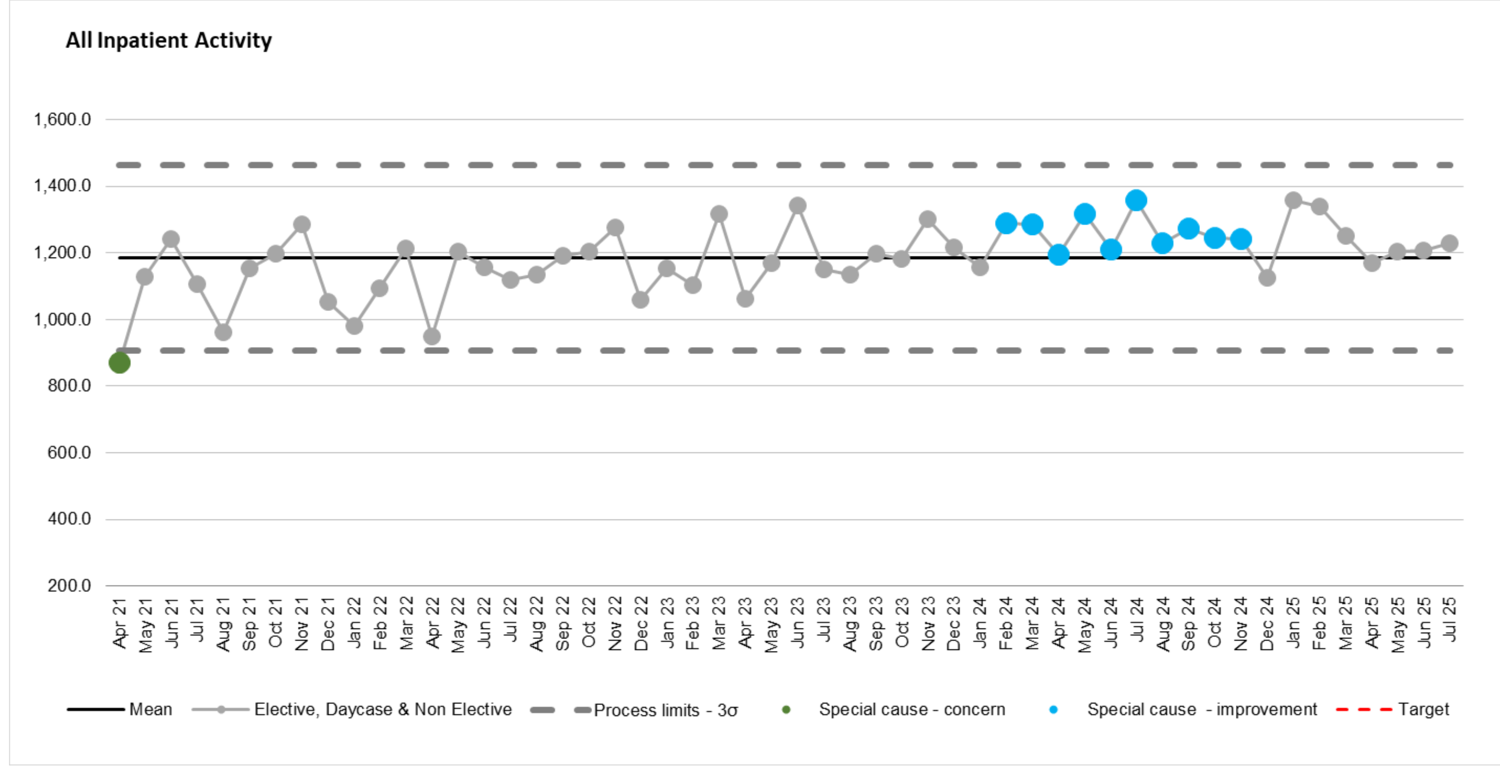
Performance to end July 25	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	60.34%	60.07%	56.54%		P
65 Week waits (65-77 weeks)	0	0	0	L	P
52 week waits (52 – 64 Weeks)	446	466	493	L	P
RTT Proportion of Patients Waiting 52 weeks	3.34%	3.60%	3.64%	L	P
RTT First Appointment Waiting List	62.03%	61.78%	61.63%		P
RTT Waiting List Size	13,345	12,952	13,536		P
All activity YTD (compared to plan)	4,810	3,581	4,705		P
Outpatient activity YTD (compared to plan)	24,538 102.8% Cumulative	18,072 104.5% Cumulative	23,878 YTD Target		P
Outpatient Did Not Attend (YTD)	5.9%	6.8%	8%		P
PIFU (trajectory to 5% target)	657 10.62%	575 9.78%	588 5%	H	P
Virtual Consultations	9.7%	9.2%	N/A		F
FUP attendances(compared to 19/20)	106.6%	108.2%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	119.6%	118.3%	120%		F
Diagnostics volume YTD (compared to plan)	8,700 Cumulative	6,440 Cumulative	8,472 YTD Target		P
Diagnostics 6 week target	99.8%	99.9%	99%		P

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

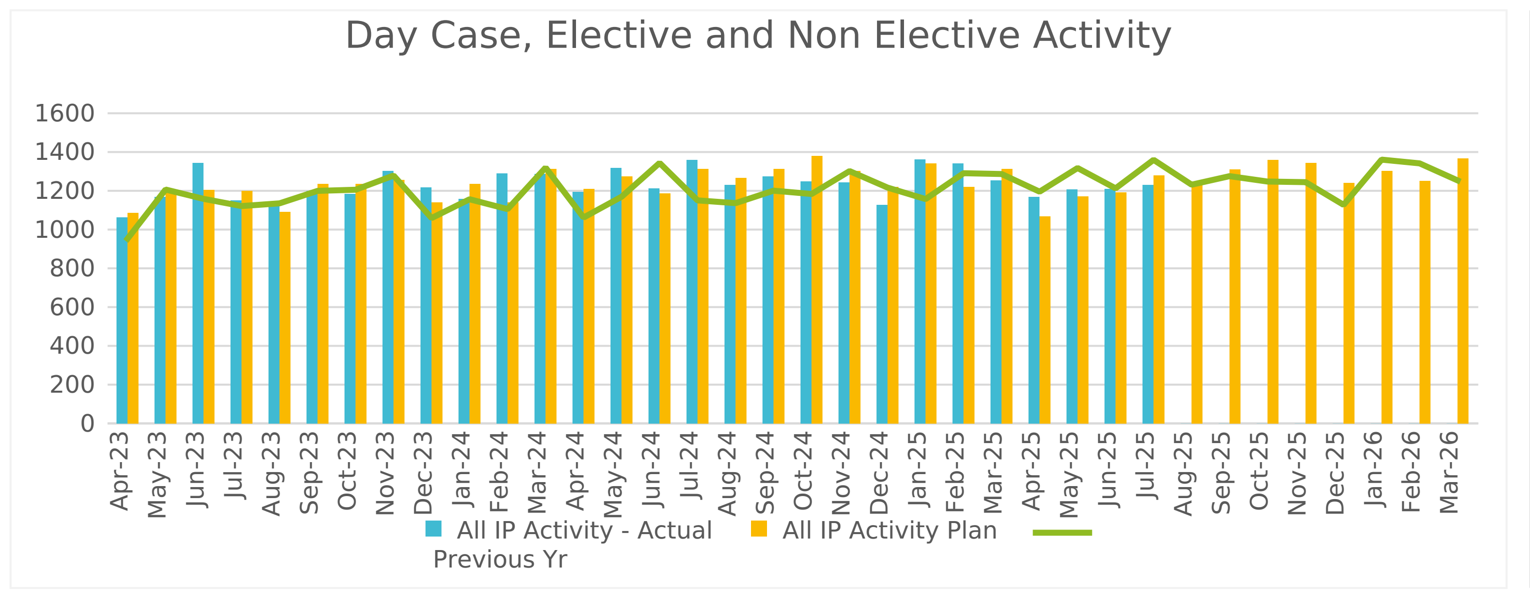
Operational Performance Summary

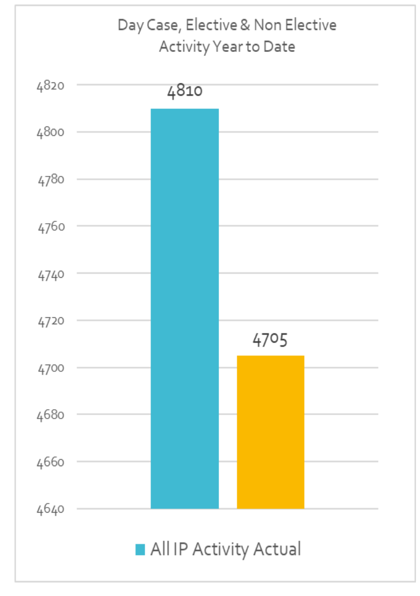
Performance to end July 25	In month	Previous month	Target	Variation	Assurance
Theatre utilisation	85.0%	83.1%	85%		P
Theatre In Session Utilisation	81.7%	82.4%	85%		F
Cancer - 31 day first treatment	100%	100%	96%		P
Cancer - 62 day (traditional)	75%	88.2%	70% Nat 85% Trust		P
28 day FDS	79.1%	80.6%	75%		P
Patients over 104 days (62 day standard)	0	0	0		No Target
POAC activity volume (YTD)	7,905 Cumulative	5,600 Cumulative	7,712 Cumulative		P
Bed Occupancy (excluding CYP and HDU)	79.1%	74.7%	82-85%		F
LOS - excluding Oncology, Paeds,YAH, Spinal	3.03	3.45	N/A		No Target
LOS - elective primary hip	2.8	2.70	2.7		F
LOS - elective primary knee	2.8	2.50	2.7		F
BADS Orthopaedic: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period) Apr 25	52.40%	53.0%	85%		F
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Mar 25)	35.6%	37.5%	-		No Target

1. Activity Summary



1. Activity Summary





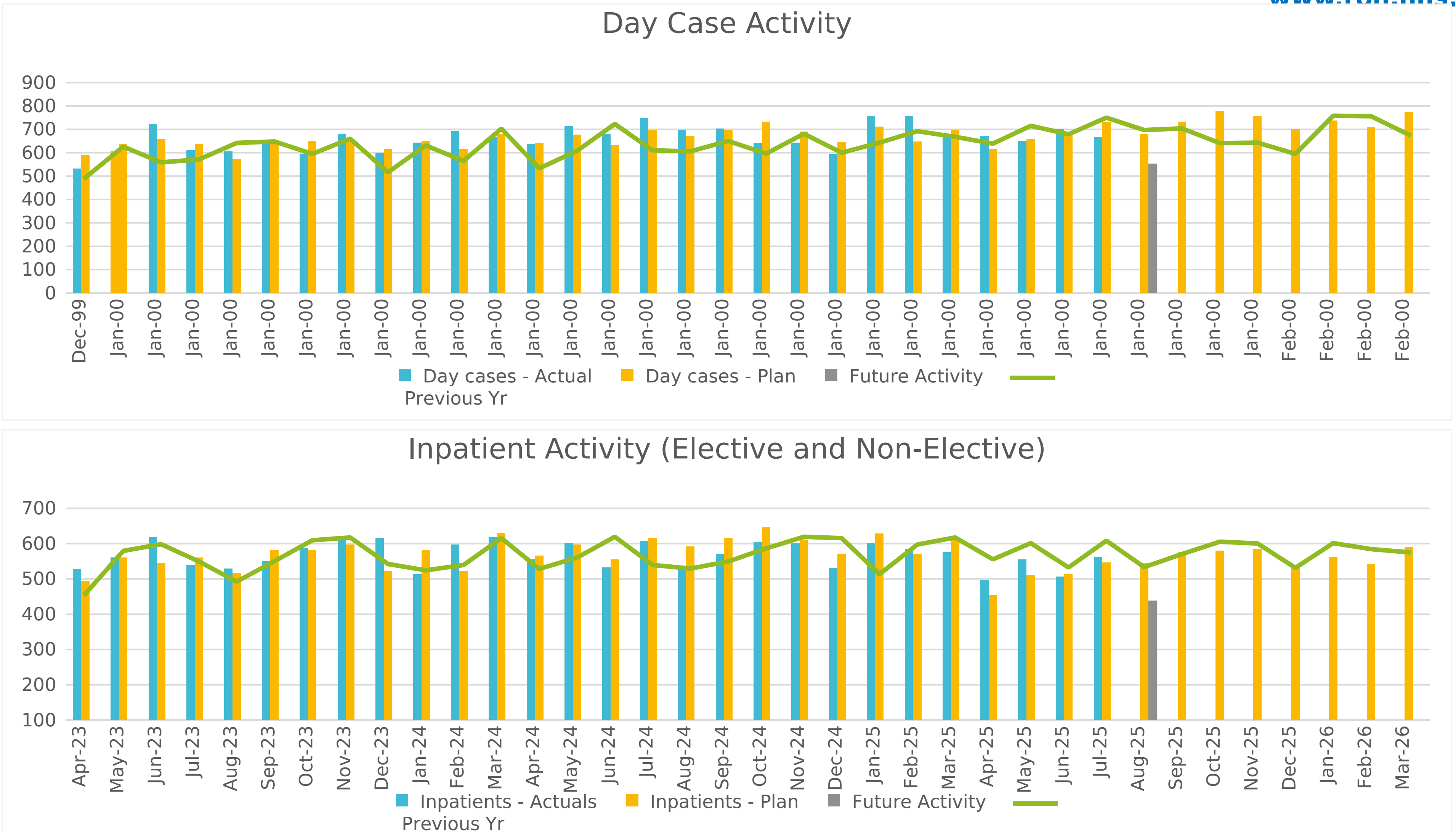
	Plan													Plan	Actual	% Achieved	Variance
	Activity Type	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Year to Dat	Year to Date	against plan	Year to Da
Trust Plan	Inpatient	434	488	492	525	523	553	557	563	513	540	520	567	1939	2041	105%	102
	Daycase	615	659	676	731	680	731	777	758	702	739	708	775	2681	2692	100%	11
	NEL	19	22	22	22	22	23	23	22	23	22	21	23	85	77	90%	-8
	All Activity	**1068**	**1169**	**1190**	**1278**	**1225**	**1308**	**1357**	**1342**	**1238**	**1300**	**1249**	**1365**	**4705**	**4810**	**102%**	**105**

July 2025

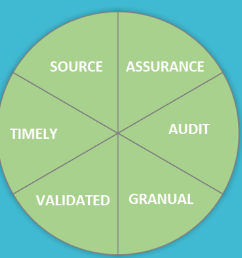
The inpatient activity for the month of July 25 was 1,229 cases that translated to an in-month under performance of 49 cases (-3.83%) against the agreed target of 1,278 cases.
YTD we are **105 cases** (2%) ahead of the agreed YTD plan of 4,705 cases.

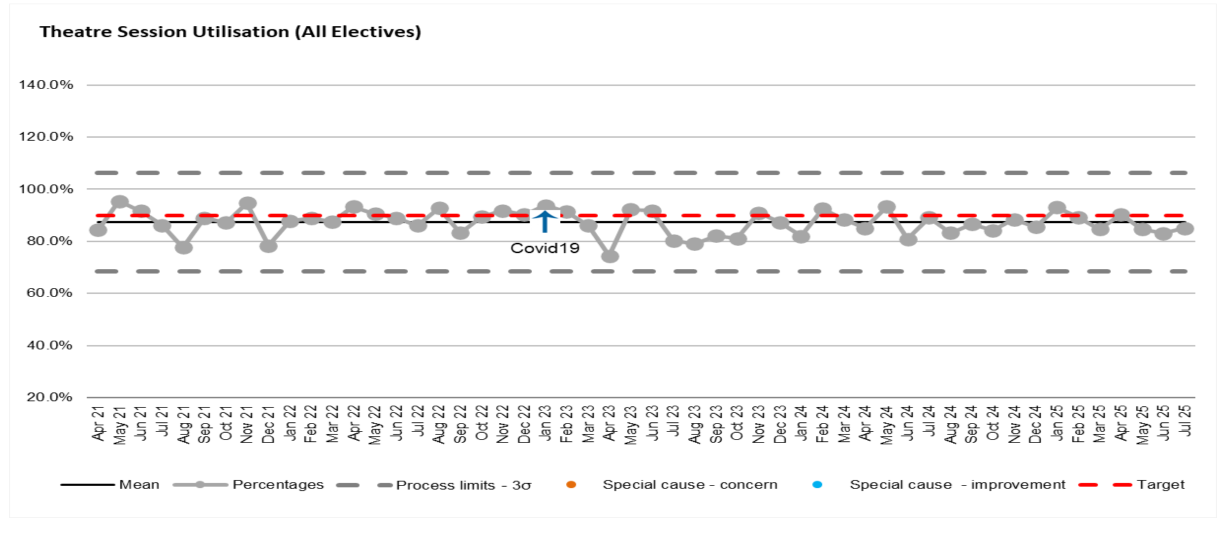
The next slides demonstrates an overperformance in elective activity for July 25 attracting a higher financial tariff and a slight reduction in day cases tending to be shorter surgical procedures. The drop-in overall activity was offset by an overperformance financially.

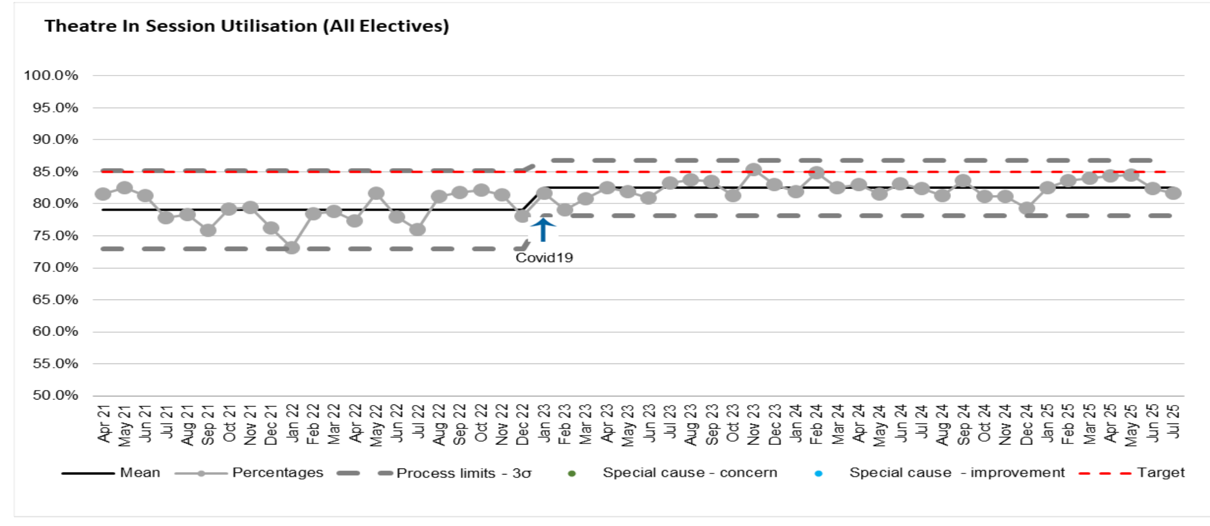
1. Activity Summary



2. Theatre Utilisation





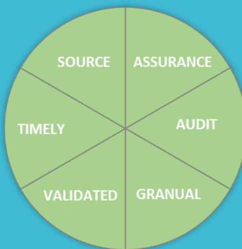


Elective Session Utilisation (July 2025)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	529	455	74	86.01%
UHB	32	22	10	68.75%
Totals	**561**	**477**	**84**	**85.03%**

Elective In Session Utilisation (July 2025)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	1955	1597	358	81.69%
UHB	99	80	18	81.37%
Totals	**2053**	**1677**	**376**	**81.68%**

2. Theatre Utilisation

DATA QUALITY KITEMARK



SUMMARY

Overall theatre session utilisation for July 25 was 85.03% with an overall in-session utilisation of 81.68%**.** The uncapped utilisation is based on the theatres that were physically available to the teams.

AREAS FOR IMPROVEMENT

Theatres held its Surgery focus week between the 7th -11th July with planned session utilisation captured at 90.55% and in session utilisation recorded as 83.31%. Activity during this week was the highest in July 25 with 183 operations completed.

A lessons learnt event post-Surgery Focus week has identified some key improvements and an associated action plan will be incorporated into the theatre service review. The recommendation is to regularly hold surgery focus weeks with the next one being scheduled for Nov 25.

POAC provided an extra review of theatre activity the week before surgery with a view to preventing cancellations on the day. The 3pm theatre huddle was enhanced to include a review of theatre staff skill mix and equipment checks for the next day. These initiative will continue as business as usual.

The team are refocusing efforts on the reduction of early finish times to fully maximise the theatre capacity available.

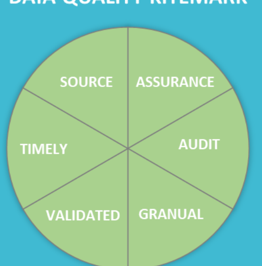
A comprehensive process and SOP is being compiled for all ward-based patients following the successful trial of the Auto send process throughout June & July 25.

RISKS / ISSUES

Complex revisions and theatre staff skill mix are reducing the ability to fully utilise lists in Arthroplasty. Additional training was completed during the Quality Improvement Day (QIDD) 14th July 25 to help upskill the team.

2. Theatre Utilisation Model Hospital

DATA QUALITY KITEMARK



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

Capped elective theatre utilisation %, National Distribution

Download

Provider Quartile 1 - Lowest 25% | Provider Quartile 2 | Provider Quartile 3

The Royal Orthopaedic Hospital NHS Foundation Trust (My Provider)
Capped elective theatre utilisation % : 87.0%

100.0% 90.0% 80.0% 70.0% 60.0% 50.0% 40.0% 30.0% 20.0% 10.0% 0.0%

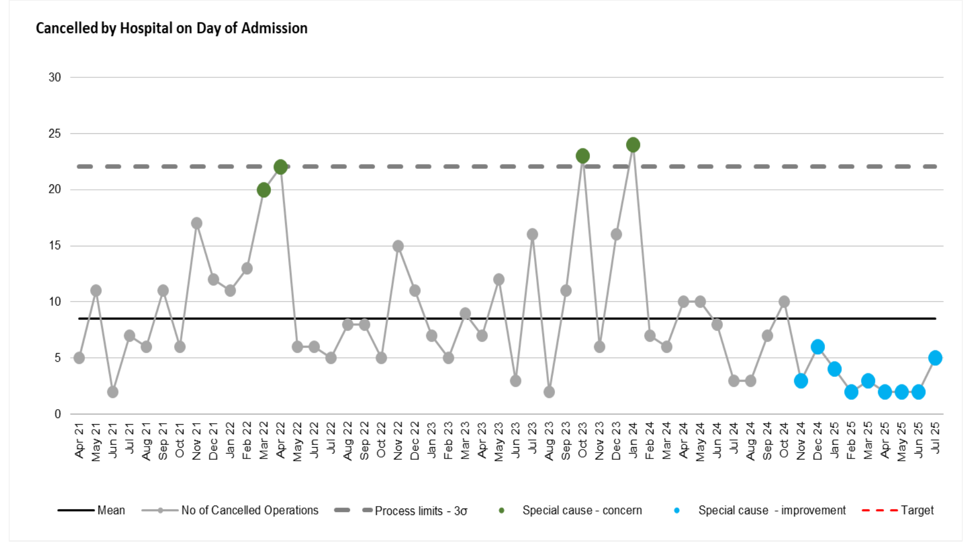
In order of Capped elective theatre utilisation % (n=113)

My Provider | My Peers | Non-Peer Providers | Peers (My Region) Median (81.1%) | Provider Top/Best Decile (85.8%) | Provider Median (81.1%)

SUMMARY

The model hospital capped theatre utilisation for July 25 reached 87% (Top 7 nationally and ahead of all orthopaedic peers).

2. Theatre Utilisation/ Hospital Led Cancellations

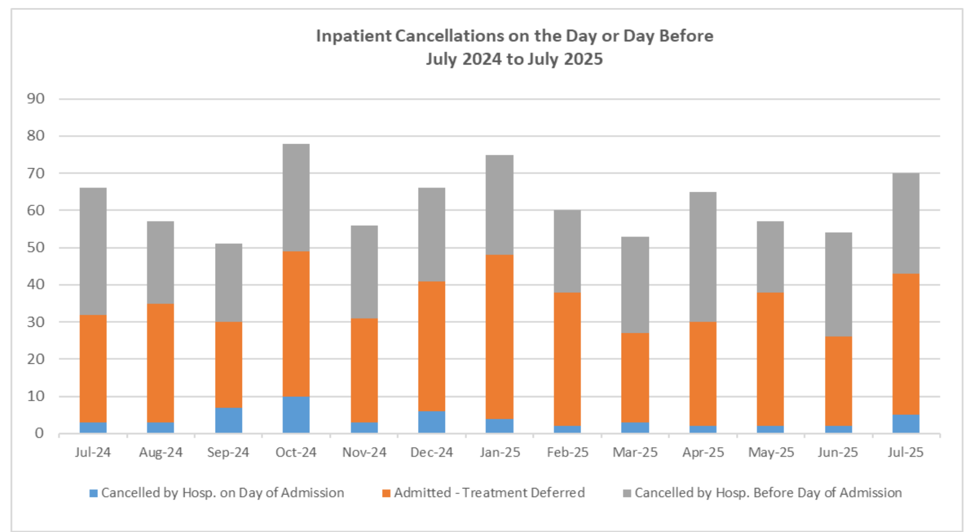


Cancelled by Hospital Before Day of Admission

Mean — No of Cancelled Operations — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Year - Month	Cancelled by Hosp. Day of Admissior	Admitted - Treatm Deferred	Cancelled by Hosp Before Day of Admission	Grand Total
Jul-24	3	29	34	66
Aug-24	3	32	22	57
Sep-24	7	23	21	51
Oct-24	10	39	29	78
Nov-24	3	28	25	56
Dec-24	6	35	25	66
Jan-25	4	44	27	75
Feb-25	2	36	22	60
Mar-25	3	24	26	53
Apr-25	2	28	35	65
May-25	2	36	19	57
Jun-25	2	24	28	54
Jul-25	5	38	27	70
Total	**52**	**416**	**340**	**808**

Cancelled Op Not Seen Within 28 Day
0
0
0
0
0
0
0
0
0
0
0
1
0
1



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 July 2025:

Patients cancelled on the day x 5	Patients admitted and had treatment deferred x 38	Patients cancelled by the hospital the day before the date of admission x 27
Total Clinical Cancellation: x 3 1 x Long Haul Flight 1 x D&V 1 x Medically Unfit **Total Non-Clinical Cancellation: x 2** 1 x Skill Mix Issues – Complex case 1 x UHB Listing Error	**Clinical Total - 25** 5 x Medically unfit 8 x Not Stopped Meds, Safeguarding, Change In Procedure, Further Investigations 12 x Skin integrity - insect bites/dog bites/ulcer etc. **Non-Clinical Total - 13** 2 x Surgeon/Staff unavailable. 3 x lack of specialist equipment / hole in tray 3 x lack of theatre time 5 x Self Cancelled	**Total Clinical Cancellation: 14** 9 x Medically unfit/further tests required 5 x Replaced by more urgent case due to theatre closures. **Total Non-Clinical Cancellation: 13** 5 x Surgeon/staff unavailable 6 x Lack of specialist equipment 2 x HDU oversubscribed – pts reallocated to ease flow

AREAS FOR IMPROVEMENT/ RISKS/ ISSUES

Daily monitoring of cancellations for non-clinical reasons that must be approved by Deputy COO, COO or Exec on call with the Escalation process re-emphasised to all staff. The Ops team continue to work with and support the 72hr call team in identifying medically unfit patients.

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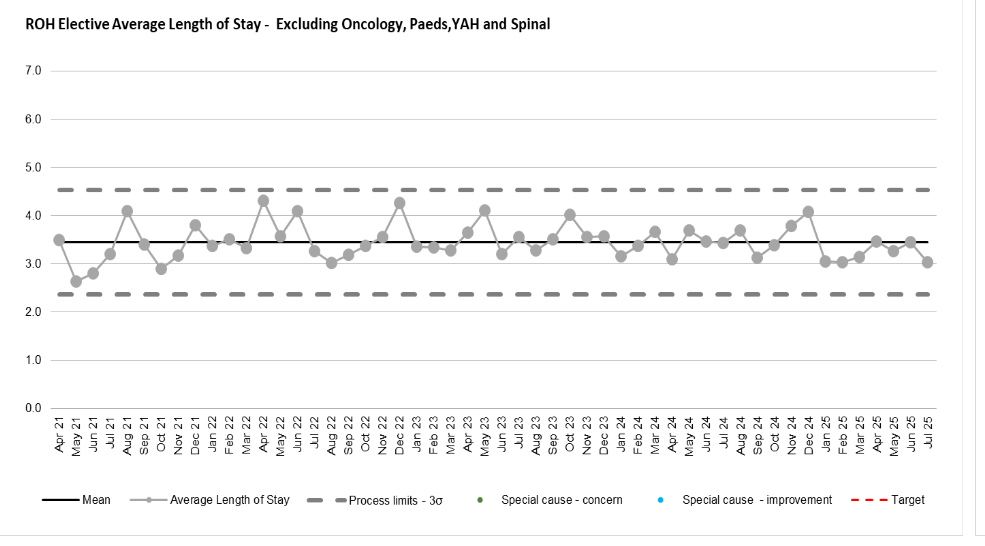
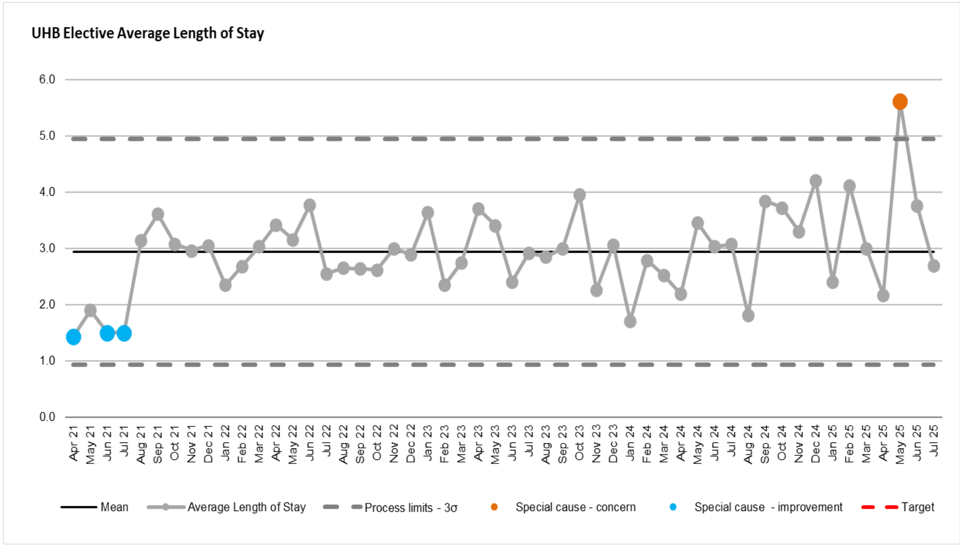
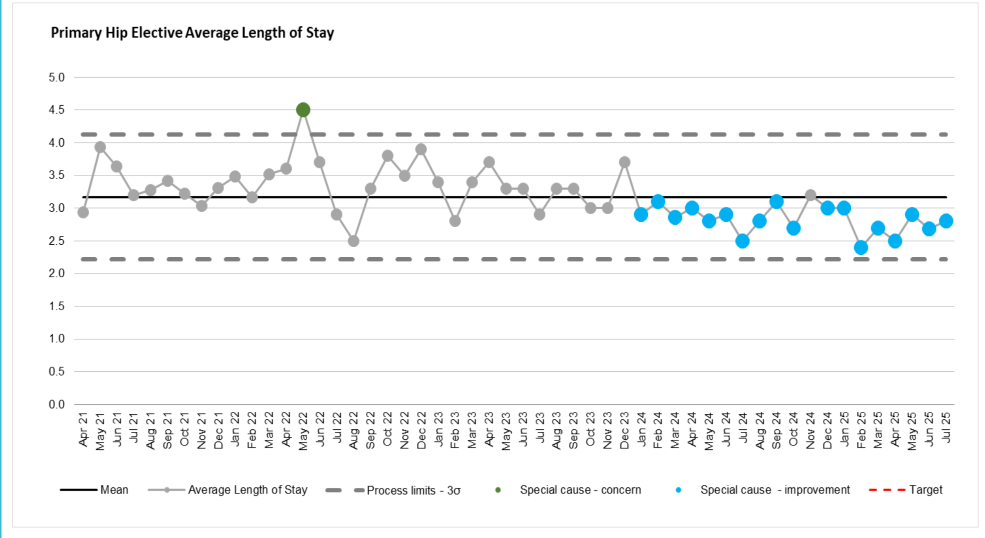
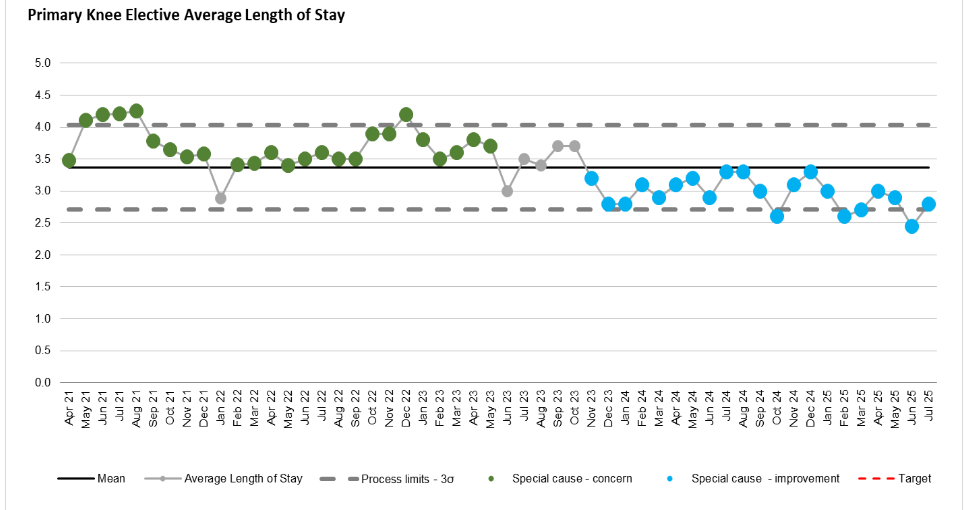
3pm Huddle forward look at the next day activity/issues enhanced as a recommendation from Surgery Focus Week. (5 Cancellations prevented via this daily MDT during surgery focus week).

3. Length of Stay









3. Length of Stay

SUMMARY

The average length of stay for ROH primary Hips has increased to 2.8 days (2.7 days June 25) and primary Knees has increased to 2.8 days (2.5 days June 25). The average length of stay for ROH patients excluding Oncology, Young Adult Hip and Spinal has decreased to **3.03 days** (3.45 days June 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 24 (14 June) 9 Oncology Arthroplasty (7 June) , 15 arthroplasty (7 June); 1 had an ASA score of 1 (A normal healthy patient) 17 had an ASA score of 2 (mild systemic disease); 6 had an ASA score of 3 (a patient with severe systemic disease);

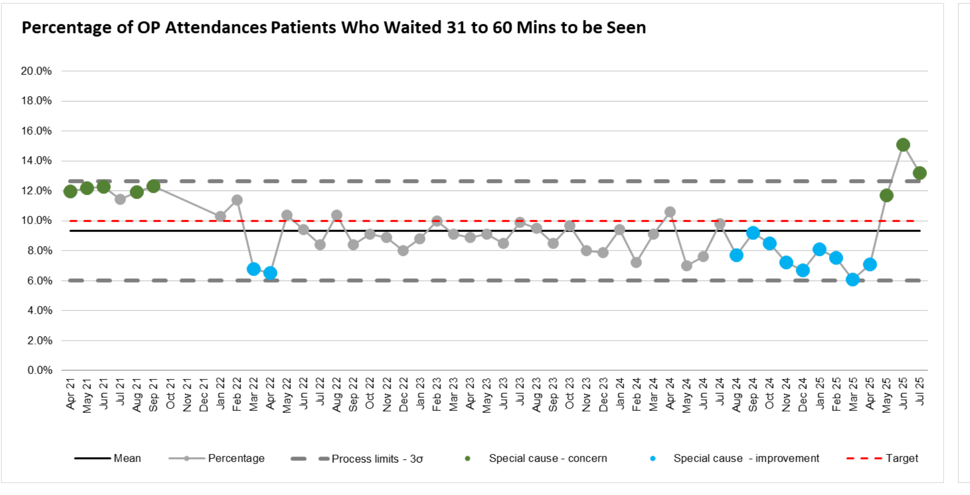
LOS >/=8 days as 9 (6 June), 3 Oncology arthroplasty and 6 arthroplasty . 7 had an ASA score of 2 (mild systemic disease). 2 had an ASA score of 3 (a patient with severe systemic disease; On review of clinical noting for patients with LOS >/=8 days . All had on going therapy, clinical needs,

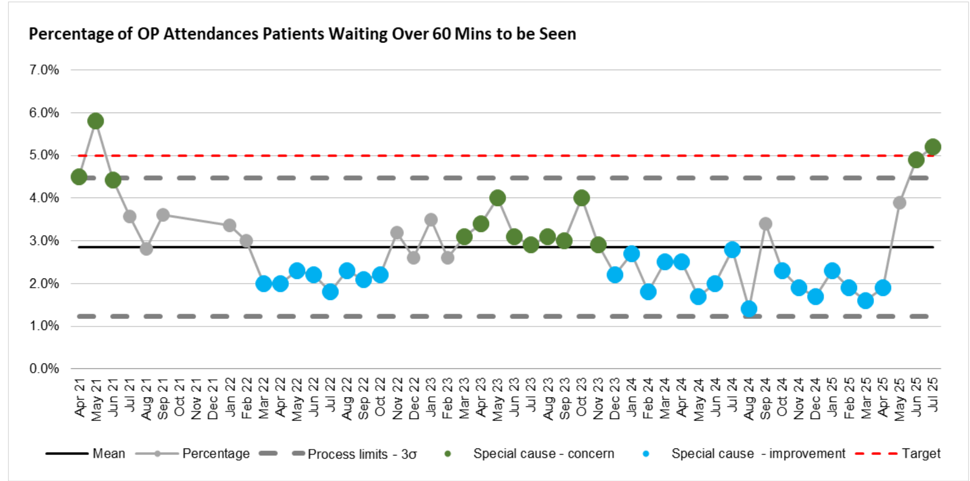
A review of all arthroplasty and oncology arthroplasty patients, identifies the number of patients with LOS >/= to 8 days as 29 (28 June).
8 were Oncology Arthroplasty, and 20 were Arthroplasty. This data included revisions, EPRs and other more complex surgeries.
Review of the 10 long stay patients with LOS >15 days, 6 were Arthroplasty and 4 Oncology arthroplasty.
Longest stay 31 days (59 June), was an Oncology arthroplasty patient. Complex who developed post op delirium and pneumonia requiring an extended HDU stay. Clinically appropriate LOS.

AREAS FOR IMPROVEMENT / ACTION PLAN

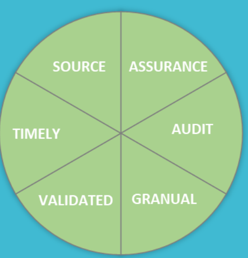
- Review scope of data included within report to ensure it aligns with what is being included by other organisations
- To note Bone infection, revision MRC and complex Oncology arthroplasty patients contribute considerably to the longer length of stays.
- Number of patients converting from day case to overnight stay for non-clinical reasons. Outcome of Division 2 review
- Alignment of support services to 7 day working, if arthroplasty lists to continue Saturdays. Avoiding the need to use on-call support services to enable timely discharges..
- Ambulatory unit for co-horting of all primary joint patient's proof-of-concept trial commenced 4th August 2025.
- Review LOS data by consultant to enable analysis of themes/trends.

4. Outpatient efficiency



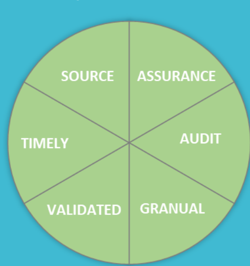


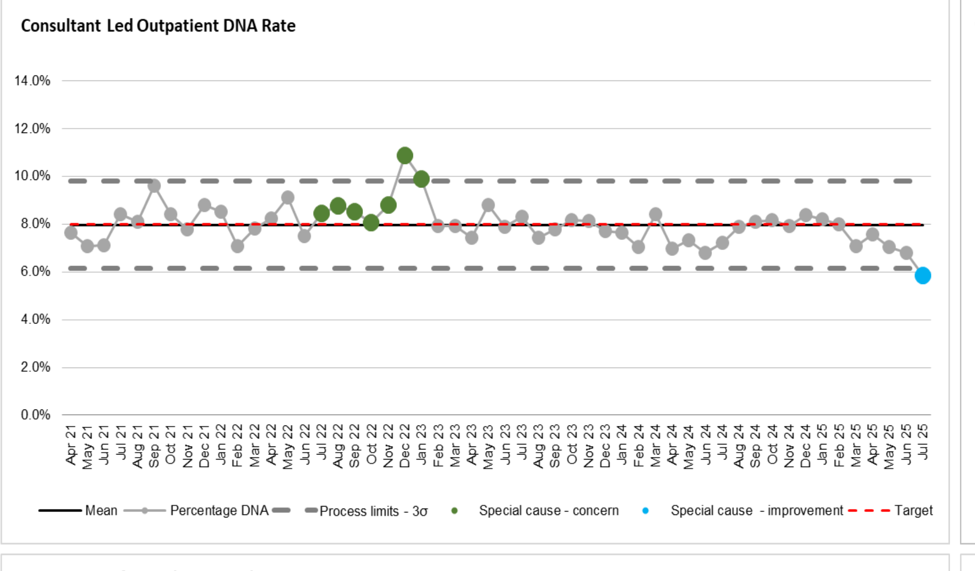
DATA QUALITY KITEMARK

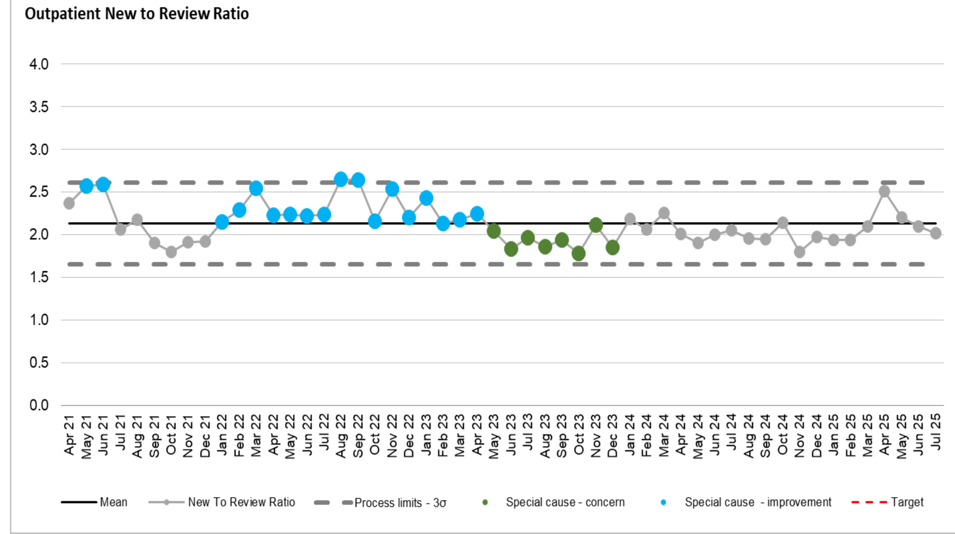


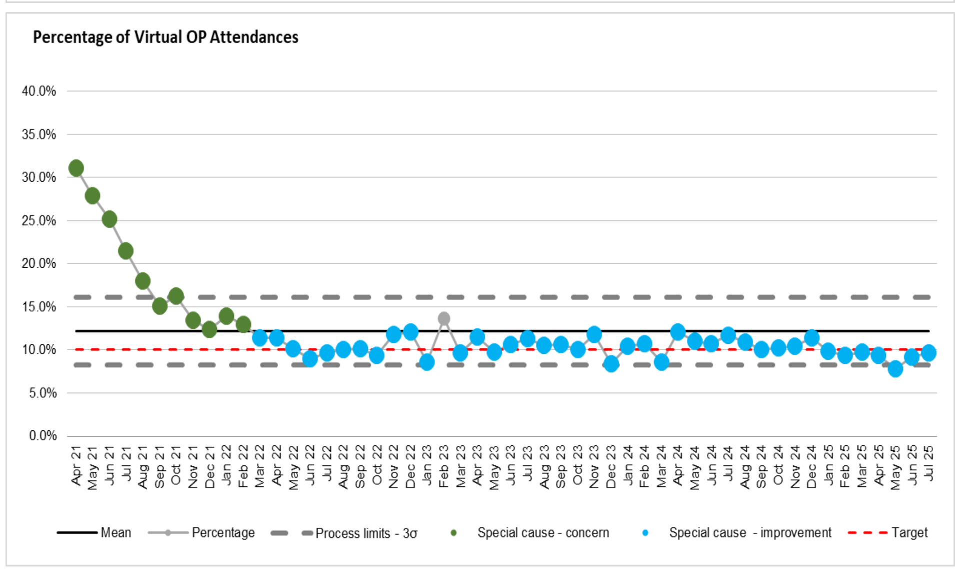
4. Outpatient efficiency

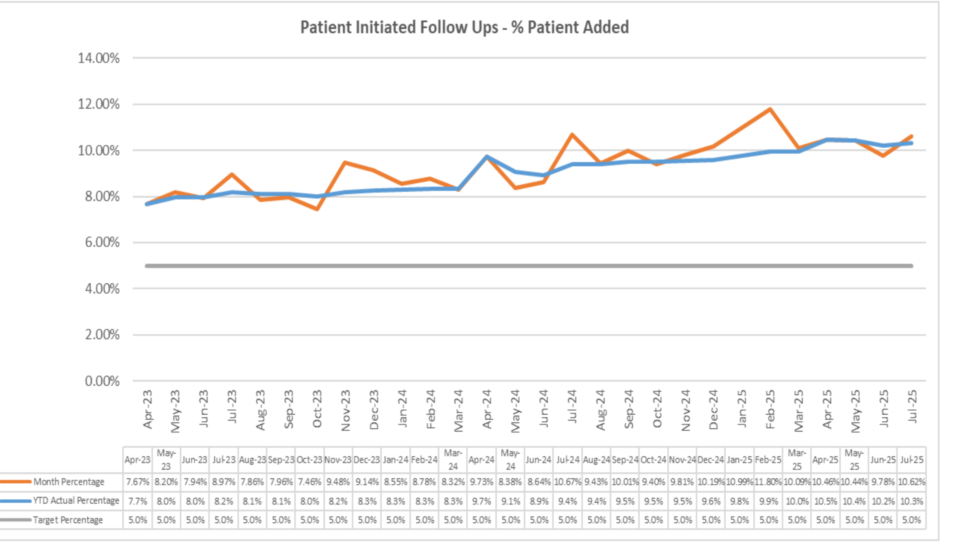
DATA QUALITY KITEMARK









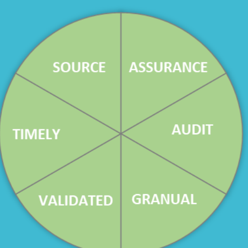


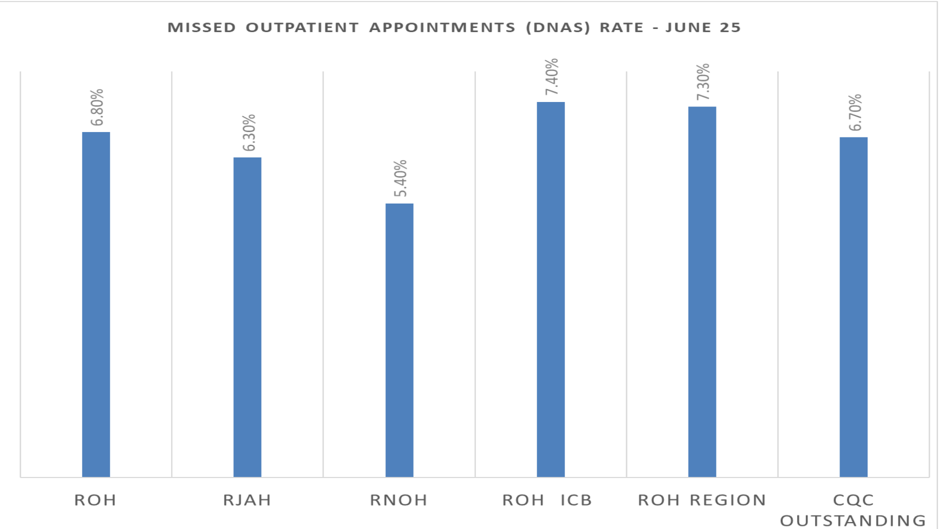
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24
Month Percentage	7.67%	8.20%	7.94%	8.97%	7.86%	7.96%	7.46%	9.48%	9.14%	8.55%	8.78%	8.32%	9.73%	8.38%
YTD Actual Percentage	7.7%	8.0%	8.0%	8.2%	8.1%	8.1%	8.0%	8.2%	8.3%	8.3%	8.3%	8.3%	9.7%	9.1%
Target Percentage	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

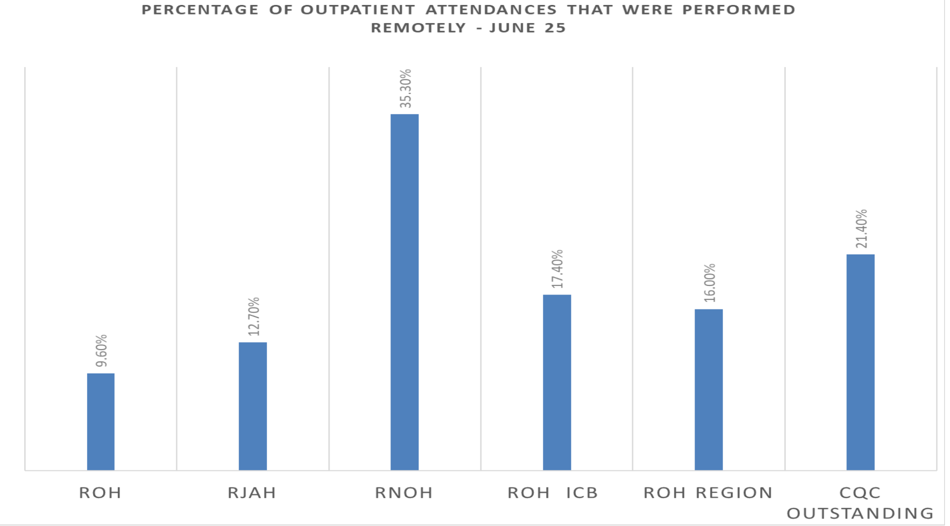
	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Month Percentage	8.64%	10.67%	9.43%	10.01%	9.40%	9.81%	10.19%	10.99%	11.80%	10.09%	10.46%	10.44%	9.78%	10.62%
YTD Actual Percentage	8.9%	9.4%	9.4%	9.5%	9.5%	9.5%	9.6%	9.8%	9.9%	10.0%	10.5%	10.4%	10.2%	10.3%
Target Percentage	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%

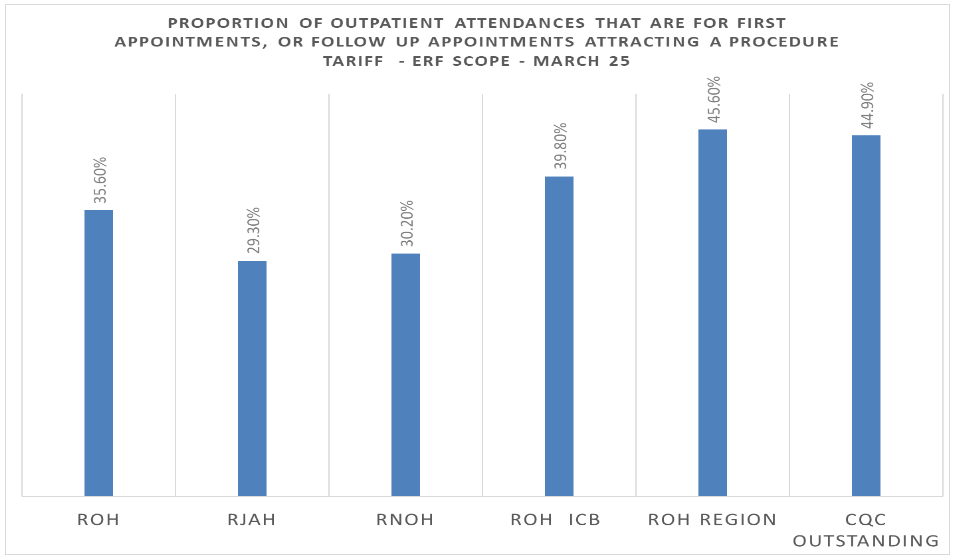
4. Outpatient efficiency

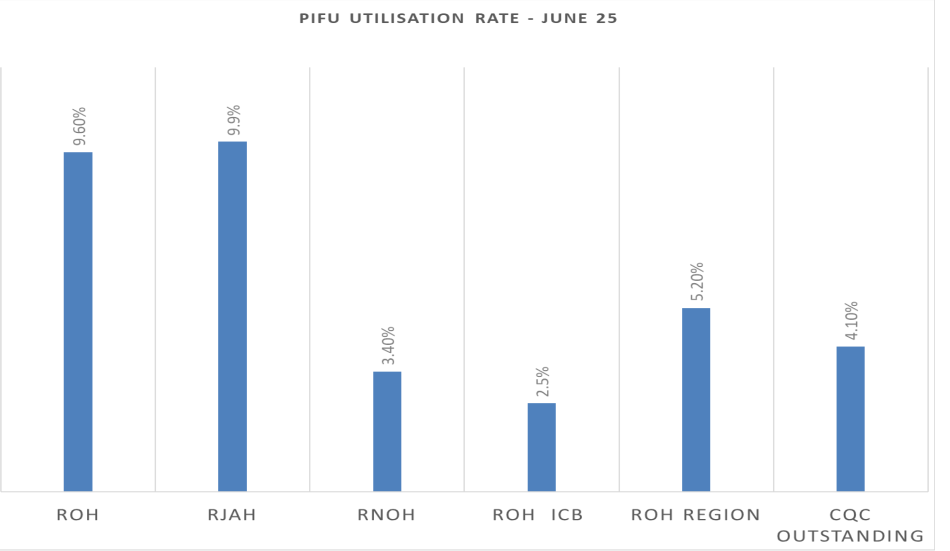
DATA QUALITY KITEMARK





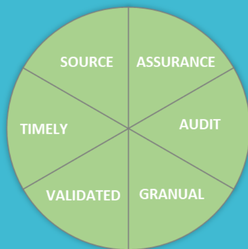






4. Outpatient efficiency

DATA QUALITY KITEMARK



SUMMARY

July 2025 performance is as follows:

- 5,841 face to face and 625 virtual appointments
- 9.67% virtual in total.
- 10.62% of outpatient attendances moved to the PIFU waiting list. The overall YTD position is 10.3%.
- 5.86% missed appointment (DNA) rate – exceeding Trust target of 8% and an improvement on June 25 position of 6.80%

Clinic Waiting Times

- 30-minute delays – not meeting Trust Target at **13.2**% **(Target 10%) -** improvement on the previous month of 15.1% -The team have identified some data quality instances that are being reviewed as potentially negatively impacting on performance
- 60-minute delays – not meeting trust target at **5.2**% **(Target 5%) - YTD on track: 4.3%**

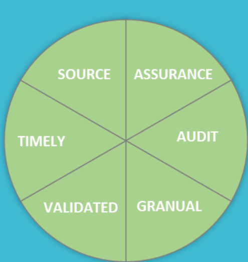
AREAS OF IMPROVEMENT

Outpatient Utilisation

- Outpatient activity is **9% under plan** for new appointments **and 3% over plan** for follow ups in July 25
    - YTD position is 9% under for new appointments and 10% over for follow ups.
- The cashing up process has been reviewed and is now managed by the appointments team.
- A project kick off meeting is being set up to upgrade the InTouch system which will allow implementation of electronic outcomes. InTouch can also be interfaced with PAS automatically updating the outcome of clinic appointments reducing uncashed clinics and administrative burden.
- Delays in outpatients over 30 minutes has reduced slightly from the previous month but waits over 60 minutes have slightly increased. The data shows the majority of these longer waits have been in Arthroplasty, Foot and Ankle, Oncology, Hands and Young Adult Hips. These issues are collated throughout the week and discussed with the relevant operational managers at the check and challenge meeting on a Friday
- Clinical Portal has been rolled out to hands and foot and ankle. This trial is going well, and an Exec paper is being drafted and will be submitted in the next 1 – 2 weeks
- DNA rates have also dropped in July demonstrating good communication with our patients
- The Trust’s rate of PIFU pathways also remains high

5. Referral to Treatment -

DATA QUALITY KITEMARK



SUMMARY

The Referral To Treatment (RTT) position for July 25 was 60.34%, surpassing the 25/26 operational target for June 2025 of 56.54%, by 3.80%. This represents a 0.27% increase compared to the June 25 reported position of 60.07%.

As with April, May and June, no patients waited over 65 weeks in July 2025

446 patients were waiting over 52 weeks in July 25 that is a decrease from the trust wide position for June 25 that was 466 patients. This was ahead of the operational July target to ensure we had no more than 493 patients waiting over 52 weeks (or 3.64% of the total incomplete pathways).

Additionally, the LUNA report for data quality validation continues to demonstrate consistent performance, maintaining a rate above 98%. We are proud to be the only trust in the Midlands consistently achieving 100% validation for patients waiting to be seen every 12 weeks.

During July 25, ROH received 3,017 referrals (111.58%) compared to pre covid levels. 2,704 is the average monthly referrals received Pre-Covid.

AREAS FOR IMPROVEMENT

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

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

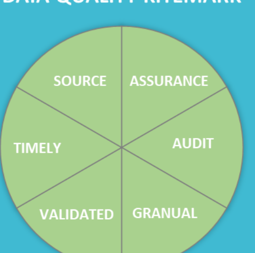
Sprint Validation Performance: As of the most recent data, we are ahead of our Year-To-Date baseline position by 749, representing a 21% lead. This positive momentum reflects the continued success of our sprint initiatives, and we are focused on maintaining this trajectory for the remainder of the quarter.

RISKS / ISSUES

Spinal backlogs continue to be a national challenge and members of the team attended a Midlands workshop to discuss innovative opportunities to reduce backlogs. The team have however, delivered against the required trajectory for July 2025

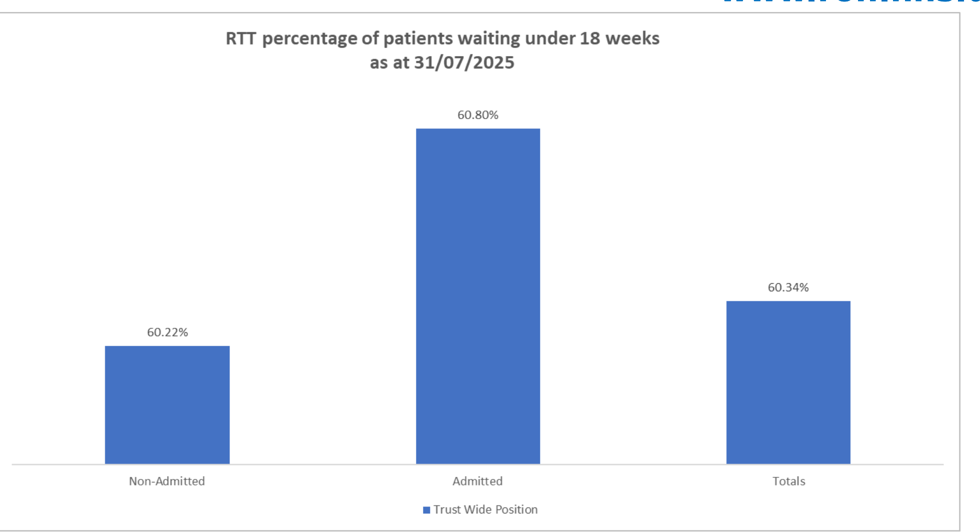
5. Referral to Treatment

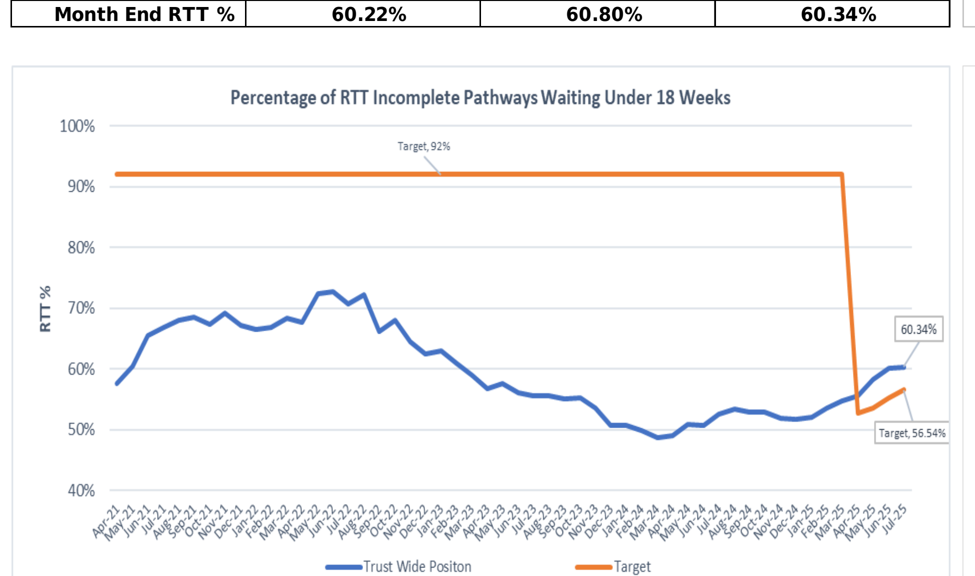
DATA QUALITY KITEMARK

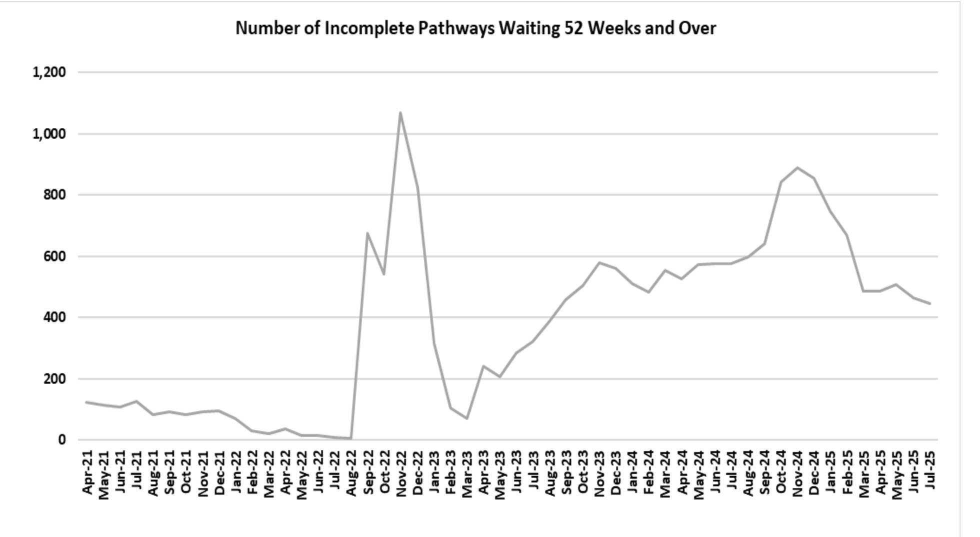


	Trust Wide Position		
Weeks Waiting	**Non-Admitted**	**Admitted**	**Totals**
0-6	3,302	749	4,051
7-13	2,174	635	2,809
14-17	901	291	1,192
18-26	1,741	534	2,275
27-39	1,301	394	1,695
40-47	538	107	645
48-51	219	13	232
52 weeks and over	414	32	446
Total	10,590	2,755	13,345

Weeks Waiting	Non Admitted	Admitted	Totals
Under 18	6,377	1,675	8,052
18 and over	4,213	1,080	5,293
Month End RTT %	**60.22%**	**60.80%**	**60.34%**





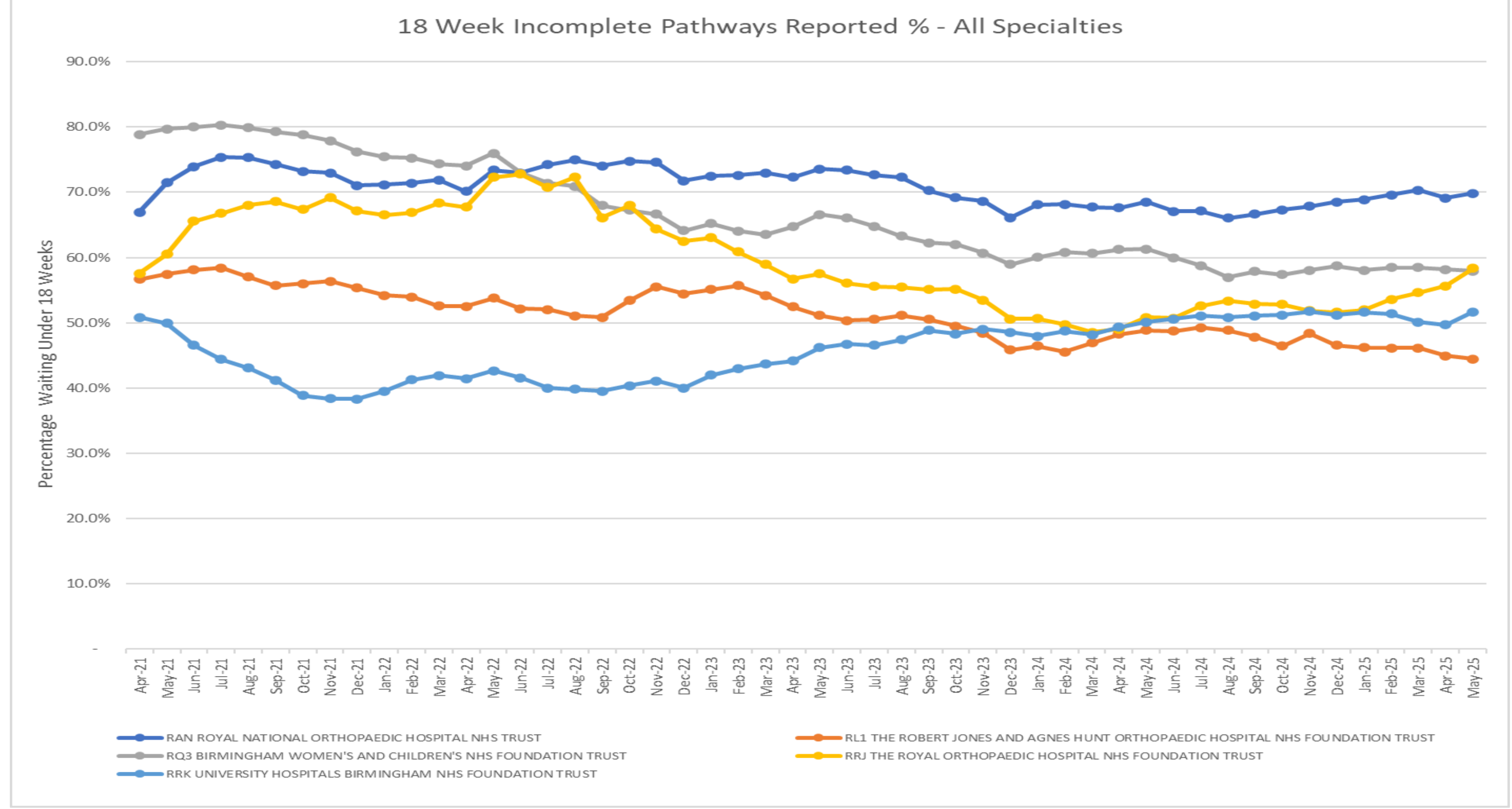


5. Referral to Treatment

DATA QUALITY KITEMARK

SOURCE
ASSURANCE
TIMELY
AUDIT
VALIDATED
GRANUAL

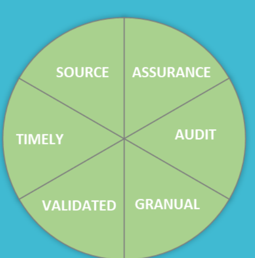
18 weeks Incomplete pathways Benchmarking against other providers:



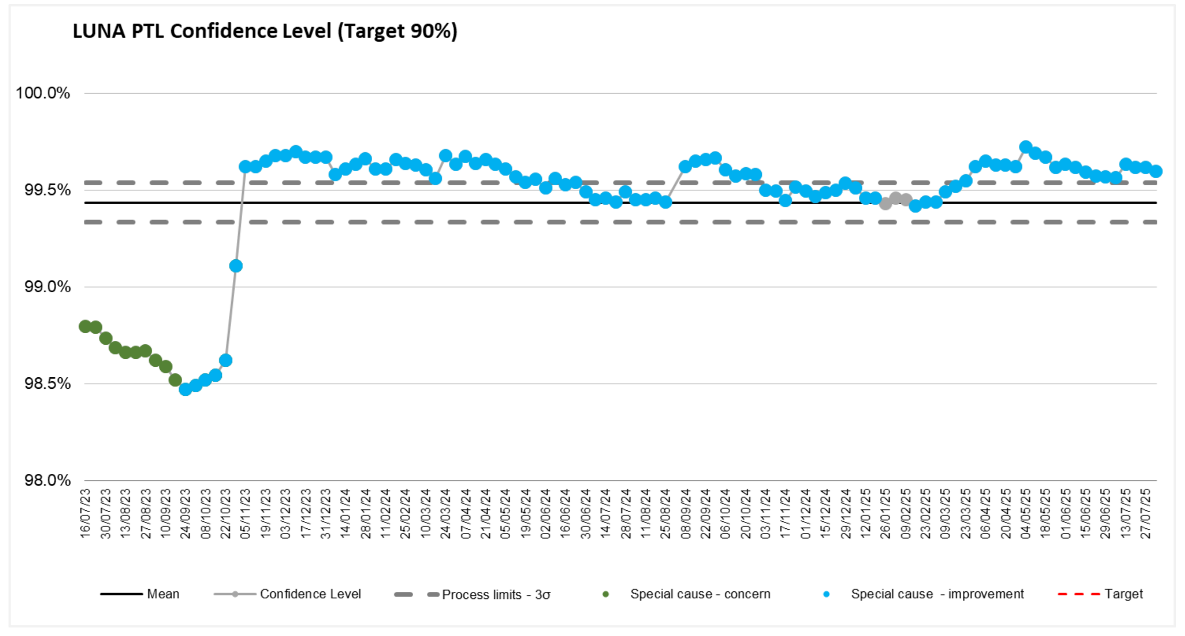
5. Referral to Treatment

Luna Data

DATA QUALITY KITEMARK



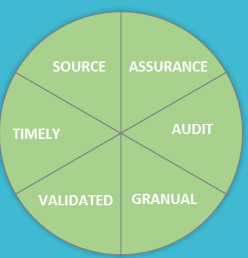
The chart below shows LUNA National Data Quality report data for the Trust, and our average confidence levels for our RTT data has consistently remained above 98% against a target of 90%. Over the last 24 months, the average confidence levels in our weekly data submissions have remained above 98%, with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

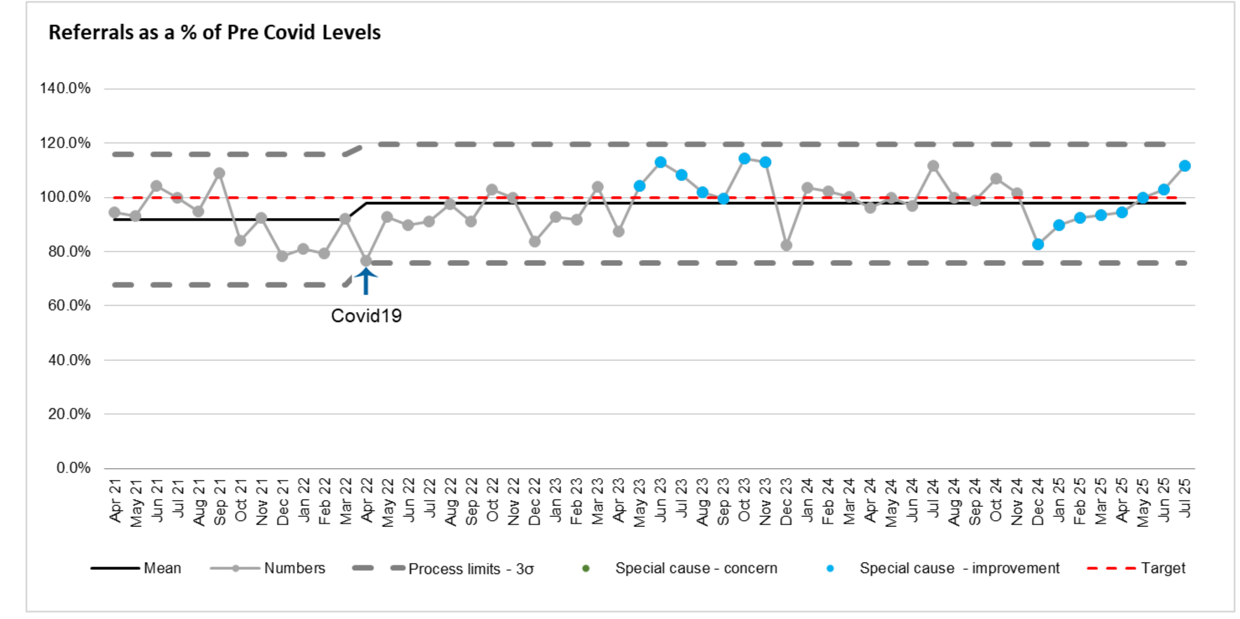


It is important to note the significant improvement from the data quality team utilising the LUNA data to continue to drive improvements. The latest chart suggests that the Trust has minimal errors identified by LUNA with a confidence rate in excess of 99.5%.

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

5. Referral to Treatment





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

Month	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	2082	2522	2479	2573	2681	2515	2820	2728	2282	2532	2513	2835
Referrals as a % of Pre Covid Levels	77.00%	93.27%	91.68%	95.16%	99.15%	93.01%	104.29%	100.89%	84.39%	93.64%	92.94%	104.84%

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

Month	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	2595	2705	2617	3018	2702	2676	2888	2744	2235	2428	2500	2527
Referrals as a % of Pre Covid Levels	95.97%	100.04%	96.78%	111.61%	99.93%	98.96%	106.80%	101.48%	82.66%	89.79%	92.46%	93.45%

Month	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of Referrals	2555	2696	2784	3017								
Referrals as a % of Pre Covid Levels	94.49%	99.70%	102.96%	111.58%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

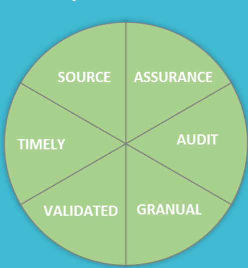
5. Referral to Treatment

Specialty Breakdown

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

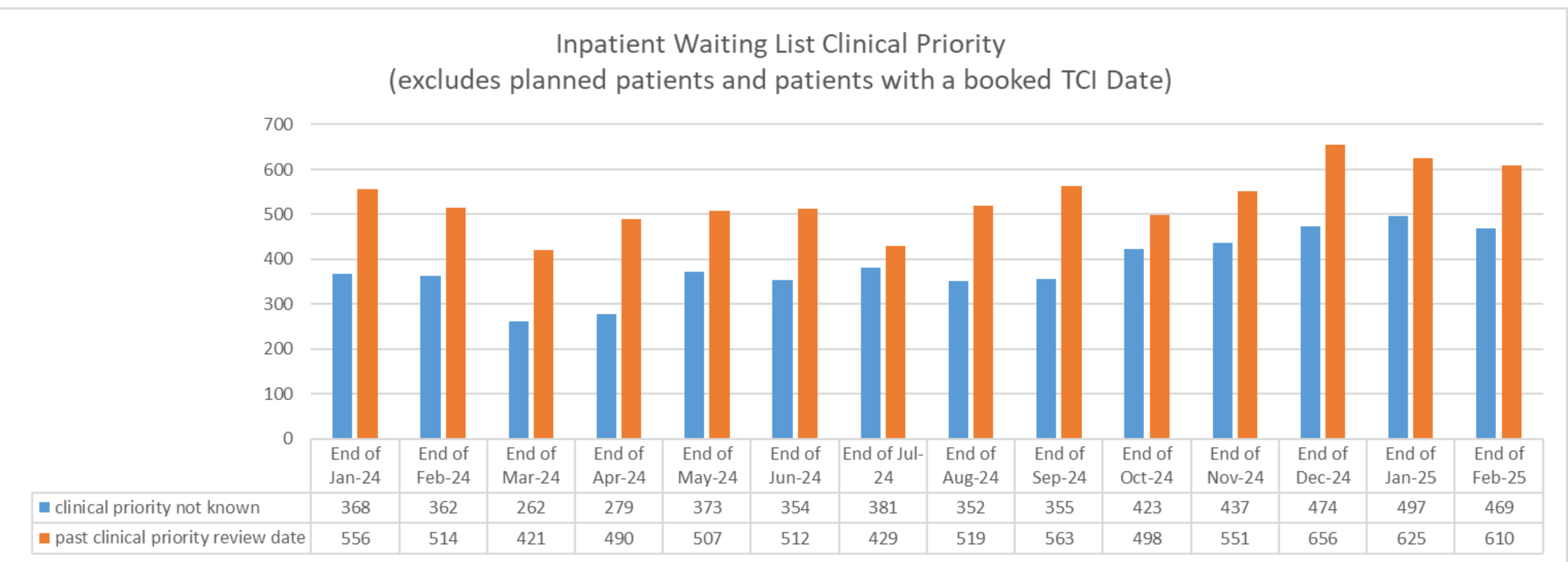
Specialty	Number of patients over 52 weeks with an incomplete RTT pathway	RTT % as of 19.08.25
Arthroplasty	0	66.40%
Arthroscopy	1	64.86%
Clinical Support (Pain Management)	2	61.35%
Foot and Ankle	0	75.13%
Hands	1	54.11%
Oncology	0	90.62%
Oncology Arthroplasty	0	70.02%
Spinal	229	39.64%
Spinal Deformity	285	33.76%
Young Adult Hips	0	57.04%

DATA QUALITY KITEMARK



5. Referral to Treatment

Overdue Clinical Priority:

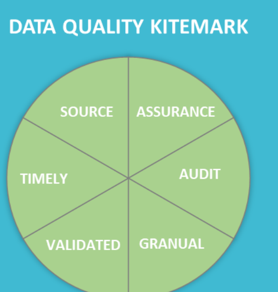


	End of Jan-24	End of Feb-24	End of Mar-24	End of Apr-24	End of May-24	End of Jun-24	End of Jul-24	End of Aug-24	End of Sep-24	End of Oct-24	End of Nov-24	End of Dec-24	End of Jan-25	End of Feb-25
clinical priority not known	368	362	262	279	373	354	381	352	355	423	437	474	497	469
past clinical priority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

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

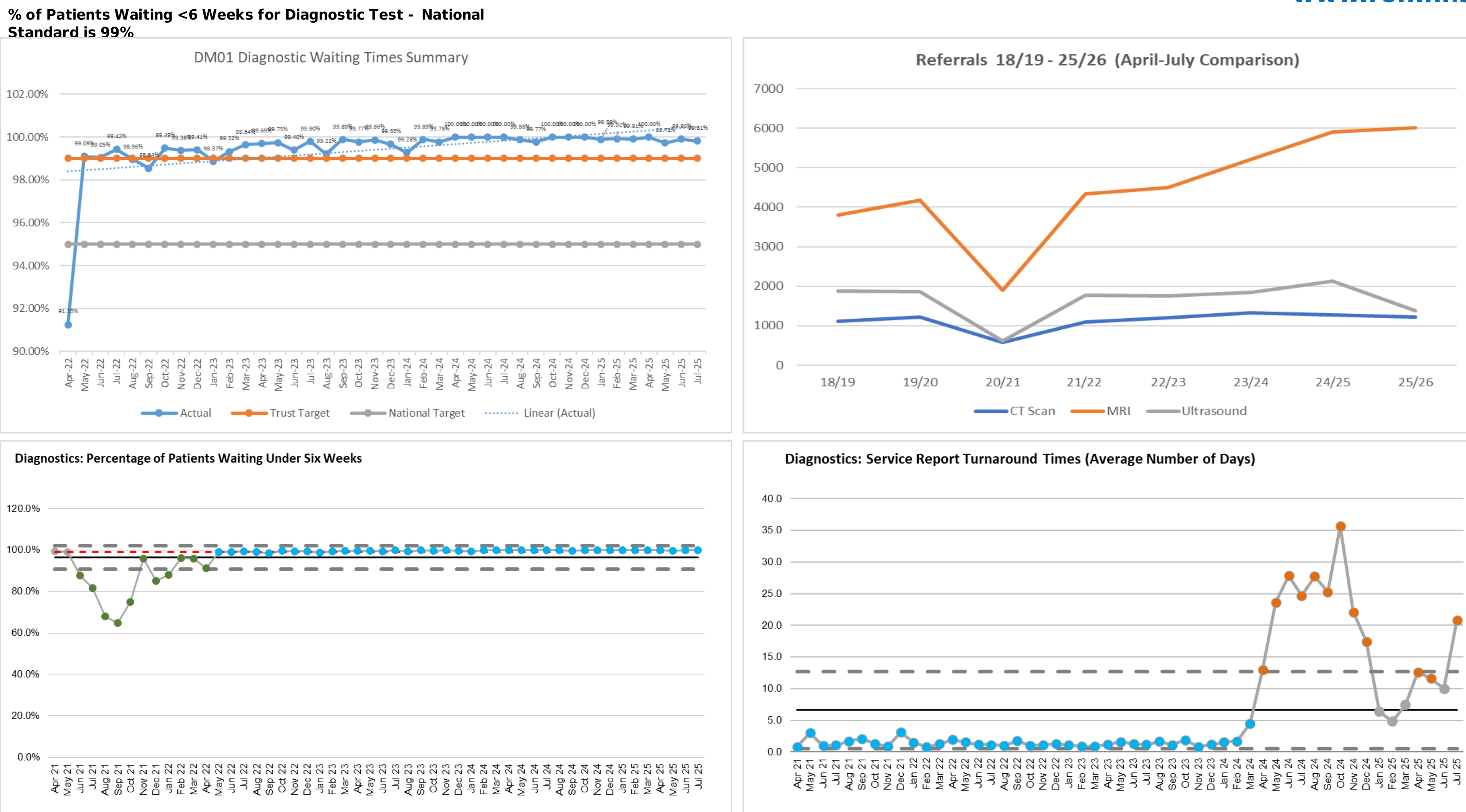
Large Joints and Small Joints team will pilot a focussed process review of all patients marked 'clinical priority not known' to ensure these are appropriately clinically prioritised.

DATA QUALITY KITEMARK



6. Diagnostic Performance

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



7. Diagnostic Performance

SUMMARY

The Imaging Department achieved the 99% DM01 target in July 2025 closing the month at 99.8%. The National 24/25 operational target remains at 95% which ROH continues to achieve consistently despite reduced capacity in ultrasound.

AREAS FOR IMPROVEMENT

Reporting - The team continues to outsource Radiology Reporting – Turnaround time for outsourcing is 72 hours from receipt for MRI. Oncology and Young Adult Hips (YAH) MRI's need to be reported in house due to the speciality. All Oncology and non-medical referrer x-rays continue to be prioritised.

Capital plans for 25/26 include replacing the CT scanner and 2 x X-ray rooms, as these are out of full-service cover from December 2025. Requested funding from BSol towards these capital replacement schemes. CT refurb will take 12 weeks, therefore, the team is scoping the use of a modular scanner on-site which should help maintain capacity. Conversions are underway. Business case to be drafted outlining the options that have been considered. Hoping to start CT refurb in October 25.

Successfully appointed into 2 x WTE Band 5 X-ray Radiographer vacancies. 2 x WTE X-ray B6 Radiographer and 1.37 WTE x MRI B6 Radiographer posts have been advertised.

Restarted QSI application – currently reviewing all existing SOP's and patient information leaflets. Team have surpassed 50% progress,;therefore the team will be submitting the application for "Working Towards" status. Regular progress updates are provided to the Trust Improvement group (TIG)

RISKS

There is an ongoing risk with Consultant Radiologist workforce vacancies. The team are undertaking a workforce review and scoping the option of further auto-reporting to support the reduced workforce and improve turnaround times. Additional lists are being provided for CT Biopsies to support maintenance of cancer targets.

8. Cancer Performance

Summary Performance Figures – June 25 (Aug 2025 Submission)

Target Name	National Standard	June 25 (complete) %	In target	Breach	Total
31 DTTD to Treatment	96%	100%	21.0	0.0	21.0
62 day RTT to treatment	70%	75%	7.5	2.5	10
28 day FDS REPORTED	77%	79.1%	68	18	86
Patients over 104 days (62 day sta				0	

Performance

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

The 62-day metric was achieved at 75%. A total of 10 treatments were applicable to the trust, 7.5 of those were compliant and the remaining 2.5 patients breaching. The root cause of the delays for the 62-day breaches were due to patient choice and complex diagnosis.

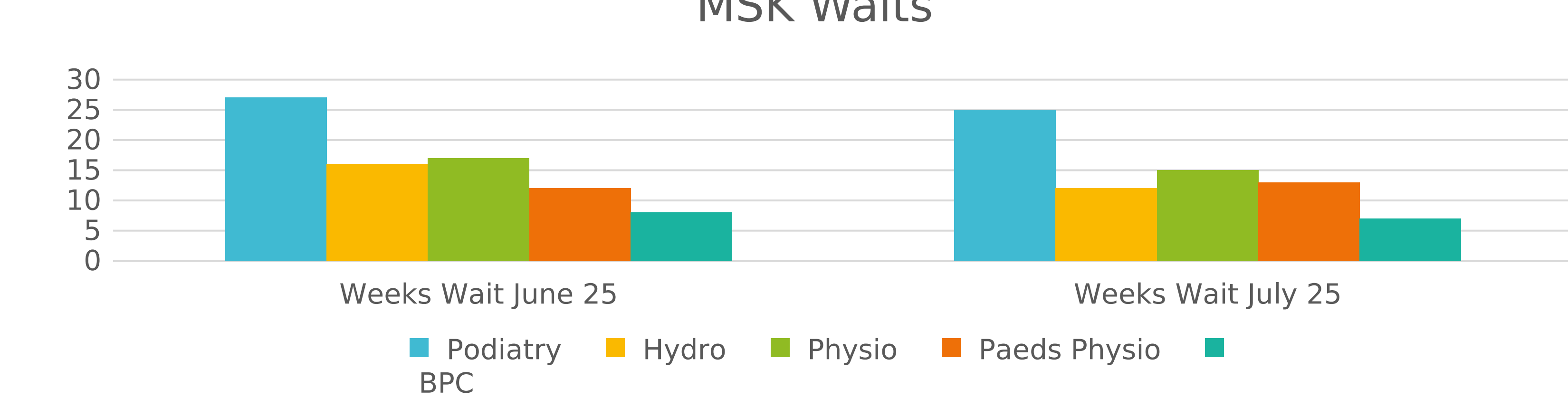
- 1 full Breach. 2ww referral direct from GP. Patient declined two biopsy dates and therefore diagnostic was not performed until day 40 of their pathway. Resulting in surgery being performed after their 62 day target. Root cause of delay was patient choice.
- 1 full Breach. 2ww referral directly from GP. Late tertiary out to oncologist as patient required 3 diagnostics scans before biopsy was performed, pathology then took 22 days due to additional molecular work. Patient sent out for Radiotherapy on day 52. Root cause of delay complex diagnostic pathway.
- 0.5 shared breach. 2ww referral from GP. Patient was seen in clinic with MRI and listed for a soft tissue biopsy, patient then declined biopsy for 3 weeks due to summer holiday. IPT sent out day 47, root cause of delay patient choice.

Risks /actions ongoing

The team continues to receive positive feedback on cancer pathways and remains compliant against all three metrics for the past 12 months. Interventional radiology capacity is still limited for CT guided biopsies currently due to a reduction in workforce. The risk is being mitigated locally with biopsies being performed in theatre, where possible. Waits for interventional have reduced back down to 12 days compared to last month but remain outside the usual 10-day KPI.

Challenges remain with Histopathology turnaround times, resilience and unity within the UHB Histopathology dept continues to be raised. Turnaround times remain poor, and it is becoming challenging for ROH to achieve the standard. Twice weekly escalation continues to the Director of Pathology at UHB. Specimens requiring next generation sequencing is becoming more frequent and has an average turnaround time of 28 days. UHB colleagues have notified us they have a temporary reduction in workforce due to an unforeseen absence. Discussions are ongoing to provide ROH assurance of maintaining continuity of the service. Bi-Weekly meetings are now in place with ROH and UHB Ops colleagues to discuss turnaround times and quality improvement projects. Further escalation raised at SOG on pathology waits and impact reviewed within cancer board.

9. MSK Waits



Summary – July 25

The chart above shows changes in waiting times from June to July 25. Waiting times remain challenging for Podiatry, however, the waits have reduced from 27 weeks to 25 weeks. Physiotherapy waiting times have reduced significantly from 17 weeks to 15 weeks. The main drivers for this are waiting list initiatives and funding from GIRFT. Initiatives have included validation, assessment clinics for approximately 800 patients, recruitment to vacancies and additional resources, caseload and template reviews and a further Mini Community Appointment Day with 867 patients attending on 14th June 25.

• Risks / Actions Ongoing

- Recruitment continues to be a challenge for physiotherapists, and a locum is in place to support whilst on going recruitment continues.
- There is a risk regarding sustaining waiting time improvement now that GIRFT funding has ceased with a 23% increase in physio referrals compared to previous years. The team continue to follow the GIRFT methodology to help mitigate.
- Administrative workforce challenges remain managing a PTL of circa 3,000 pts. Future automation is being scoped thorugh the outpatient transformation programme.
- The team is working on modernising and digitising the self-referral form.
- Text messaging is currently on hold due to HL7 live feed issue. Discussions in place with IT and Dr Doctor.

10. Private Patients

SUMMARY

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

- July revenue was behind target; however, the team achieved the activity plan from a volume perspective. This was due to case mix of procedures booked attracting a lower value.
- The service is currently £196k behind plan to achieve the revised plan of £6.1m (YTD)
- Aviva non network tariff, BUPA tariff and AXA imaging contracts are all currently under negotiation
- 11 in week theatres utilised during July. (April 9, May 10, June 12)

	Apr-25	May-25	Jun-25	Jul-25	YTD
Revised revenue plan 2025/26 (£6.1m)	**£385,000**	**£546,000**	**£552,000**	**£486,000**	**£1,969,000**
Revenue Actual	£384,773	£541,749	£407,554	£438,560	**£1,772,636**
Variance	-£227	-£4,251	-£144,446	-£47,440	**-£196,364**

AREAS FOR IMPROVEMENT

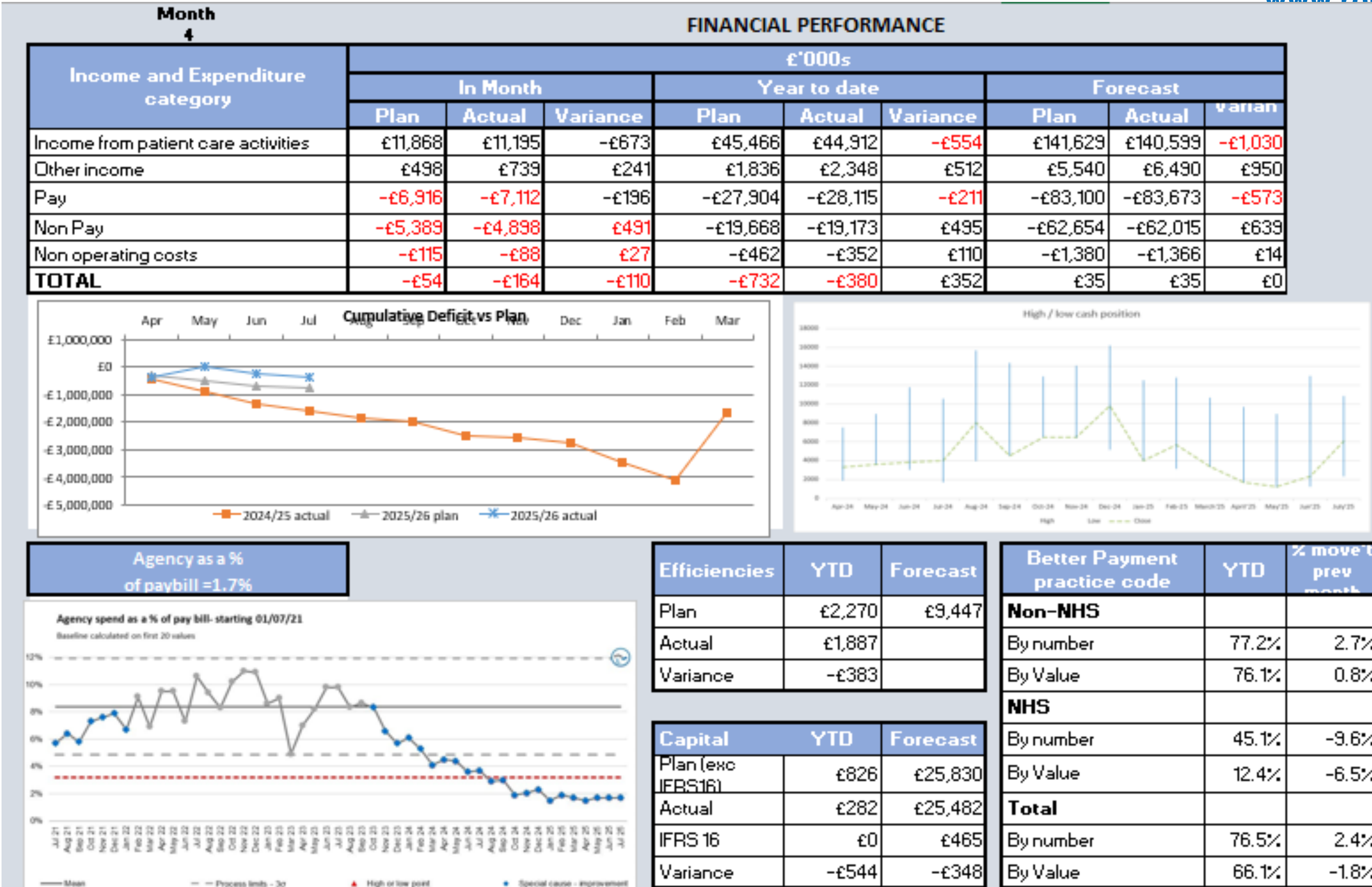
An investment of £70k has been approved by the Executive team to secure search engine optimisation specialists and continue local marketing campaigns.

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

- Secure an in-year revenue of £6.1m to £6.5m (stretch)
- Utilise one theatre per day for private cases – protected theatres in place
- Secure updated tariffs and assess self-funding fees
- Marketing / SEO/ local /international campaigns
- PLICS assessment of profit / total contribution and maximise contract values
- Expand overseas service
- Develop patient offer (amenity beds / customer care)

A high level progress overview will be provided in the September 2025 F&P pack.

11. Finance on a Page



Month 4

FINANCIAL PERFORMANCE

Income and Expenditure category	£'000s								
	In Month			Year to date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Varian
Income from patient care activities	£11,868	£11,195	-£673	£45,466	£44,912	-£554	£141,629	£140,599	-£1,030
Other income	£498	£739	£241	£1,836	£2,348	£512	£5,540	£6,490	£950
Pay	-£6,916	-£7,112	-£196	-£27,904	-£28,115	-£211	-£83,100	-£83,673	-£573
Non Pay	-£5,389	-£4,898	£491	-£19,668	-£19,173	£495	-£62,654	-£62,015	£639
Non operating costs	-£115	-£88	£27	-£462	-£352	£110	-£1,380	-£1,366	£14
TOTAL	-£54	-£164	-£110	-£732	-£380	£352	£35	£35	£0

Efficiencies	YTD	Forecast
Plan	£2,270	£9,447
Actual	£1,887	
Variance	-£383	

Capital	YTD	Forecast
Plan (exc IFRS16)	£826	£25,830
Actual	£282	£25,482
IFRS 16	£0	£465
Variance	-£544	-£348

Better Payment practice code	YTD	% move't prev month
Non-NHS		
By number	77.2%	2.7%
By Value	76.1%	0.8%
NHS		
By number	45.1%	-9.6%
By Value	12.4%	-6.5%
Total		
By number	76.5%	2.4%
By Value	66.1%	-1.8%

12. Overall Financial Performance

SUMMARY

The Trust delivered a deficit in month of £173k, generating a year to date deficit of £380k which is £352k better than plan.

Income performed better than plan by £42k year to date. Commissioner income overperforming against commissioner cap by £309k, Private patient income overperformed by £137k, Research and Development income by £206k and other income by £122k.

Pay expenditure is overspent by £211k year to date. Agency spend in month was 1.6% of paybill year, with an underspend of £21k. Bank expenditure reduced in month with a year to date underspend of £248k.

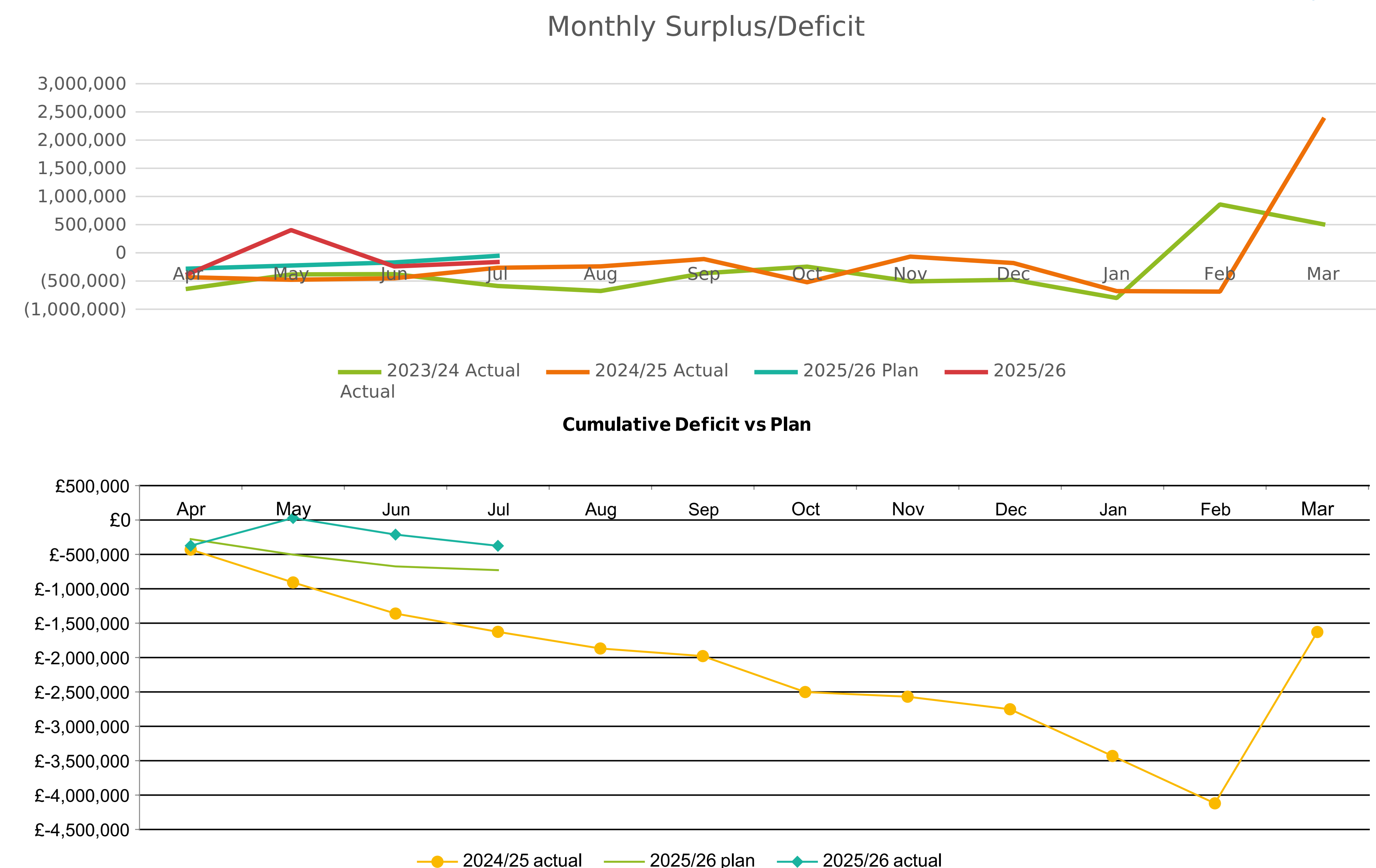
Non pay expenditure underspent in month by £491k improving the non pay variance to £503k underspent. This is primarily driven as a result of; better performance on non pay CIP schemes and clinical supplies.

	In Month £'000s			YEAR TO DATE £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance
Income	12,366	11,933	(433)	47,302	47,260	42
Pay	(6,916)	(7,112)	(196)	(27,904)	(28,115)	(211)
Non pay	(5,389)	(4,898)	491	(19,638)	(19,135)	503
Non operating items	**(123)**	**(97)**	**26**	**(492)**	**(390)**	**102**
TOTAL SURPLUS/(DEFICIT)	**(62)**	**(173)**	**(111)**	**(732)**	**(380)**	**352**

12. Overall Financial Performance

	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	45,466	44,912	(554)
Other Operating Income (Excluding top up)	1,836	2,348	512
Employee Expenses (inc. Agency)	(27,904)	(28,115)	(211)
Other operating expenses	(19,668)	(19,173)	495
Operating Surplus	**(270)**	**(28)**	**(242)**
Net Finance Costs	(492)	(390)	102
Net surplus/(deficit)	**(762)**	**(417)**	**345**
Remove donated asset I&E impact	30	37	7
Adjusted financial performance	**(732)**	**(380)**	**352**

12. Overall Financial Performance



13. Income

SUMMARY

Income performed better than plan by £42k year to date. CCommissioner income overperforming against commissioner cap by £309k, Private patient income overperformed by £137k (agaisnt original plan), Research and Development income by £206k and other income by £122k.

Elective activity overperformed against plan by £309k with £17.4m delivered against a plan of £17.1m.

AREAS FOR IMPROVEMENT

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

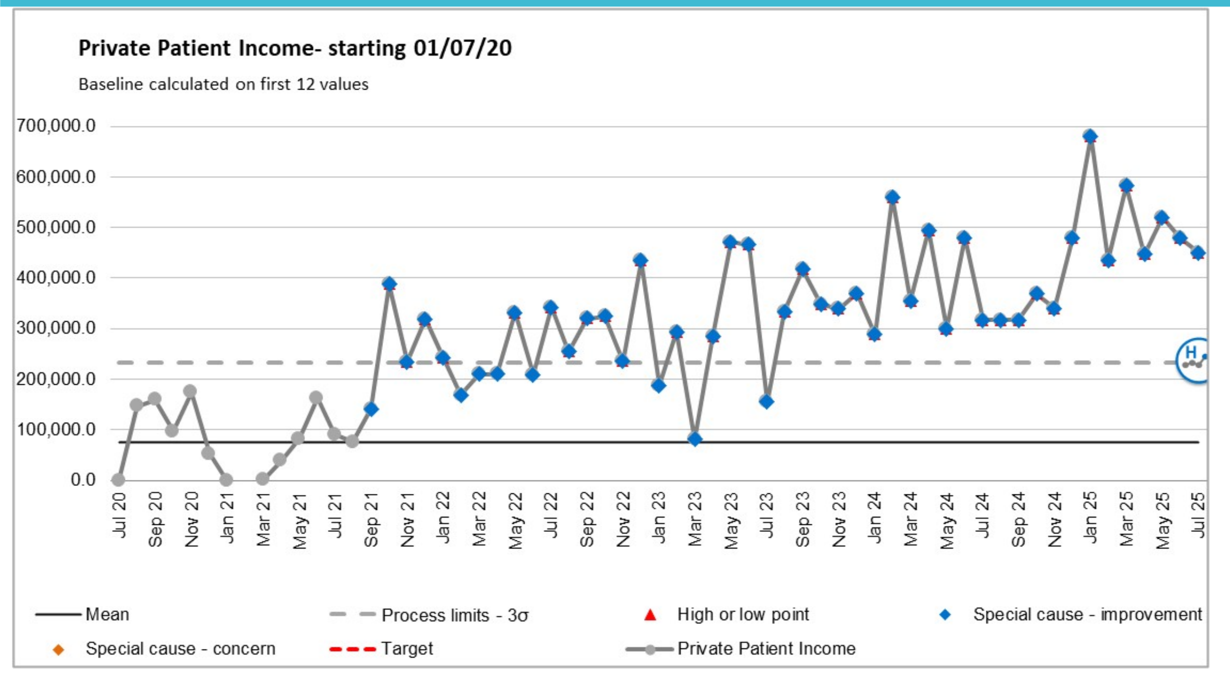
RISKS / ISSUES

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

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

13. Income

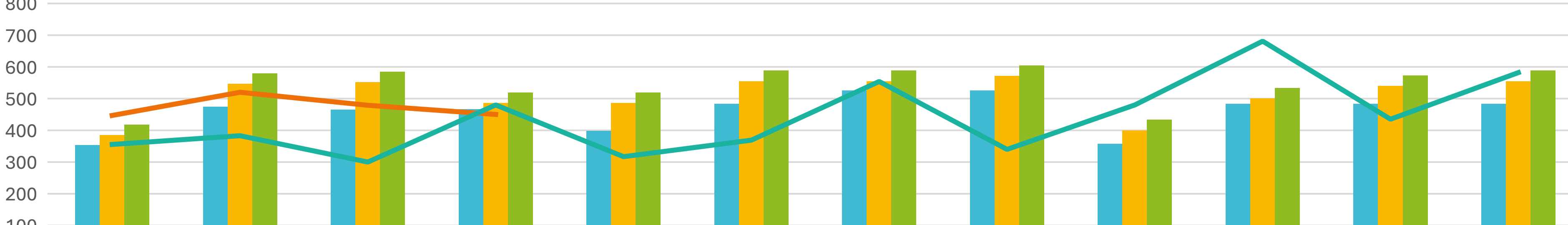
Private patient income



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

	Year to date (£'000s)
Plan (£5.5m)	1,758
Increased plan to £6.1m	1,969
Stretch plan £6.5m	2,102
Actual	1,896

Private patient income vs plan



13. Income

NHS income

Performance in chargeable elective activity compared to the payment cap limit by commissioner is shown below;

	Actual					Year to date		In Month		
	1	2	3	4	Year to date	Cap Limit	Variance	Actual	Cap	Variance
Armed Forces	£8,302	£9,111	£12,011	16,347	45,770			£12,011		
NHS Herefordshire and Worcestershire ICB	£443,781	£577,366	£666,307	605,901	2,301,193	£2,149,916	(£151,277)	605,901	£579,707	£26,194
NHS Birmingham and Solihull ICB	£2,042,644	£2,180,803	£2,236,175	2,328,392	8,848,567	£9,058,270	£209,703	2,328,392	£2,442,487	(£114,0950
NHS Staffordshire and Stoke-on-Trent ICB	£176,848	£165,074	£120,712	131,285	607,576	£545,806	(£61,771)	131,285	£147,172	(£15,887)
NHS Black Country ICB	£635,793	£580,007	£589,210	710,034	2,523,388	£2,557,847	£34,459	710,034	£689,702	£20,332
NHS Coventry and Warwickshire ICB	£166,192	£106,392	£86,760	124,782	487,239	£392,057	(£95,182)	124,782	£105,715	£19,067
Spec Com	£662,020	£665,704	£607,390	620,684	2,596,981	£2,397,272	(£199,754)	620,684	£646,392	(£25,708)
Grand Total	**£4,135,581**	**£4,284,457**	**£4,318,565**	**4,537,426**	**17,410,715**	**£17,101,122**	**(£309,592)**	**4,537,426**	**£4,611,176**	**(£73,750)**

There is a net overperformance against payment cap limit of £309k which has been included within the year to date position. The financial risk for overperformance against cap totals £507k.
Payment cap limit performance will be managed by individual commissioner, as such there is risk with commissioners where we have an overperformance against the limit.

14. Expenditure

SUMMARY

Pay expenditure is overspent by £211k year to date. Agency spend in month was 1.6% of paybill year, with an underspend of £21k. Bank expenditure reduced in month with a year to date underspend of £248k. A slight increase in medical agency and bank spend in M4 was seen as a result of industrial action.

Non pay expenditure underspent in month by £491k improving the non pay variance to £503k underspent. This is primarily driven as a result of; better performance on non pay CIP schemes and clinical supplies.

LLP expenditure against plan has overspent by £150k in month and contributing to a year to date overspend of £192k. This is offset in part by the reduction in ADH spend which is underspent against plan by £17k year to date.

AREAS FOR IMPROVEMENT

- Identification of CIP
- Delivery of planned CIP schemes

RISKS / ISSUES

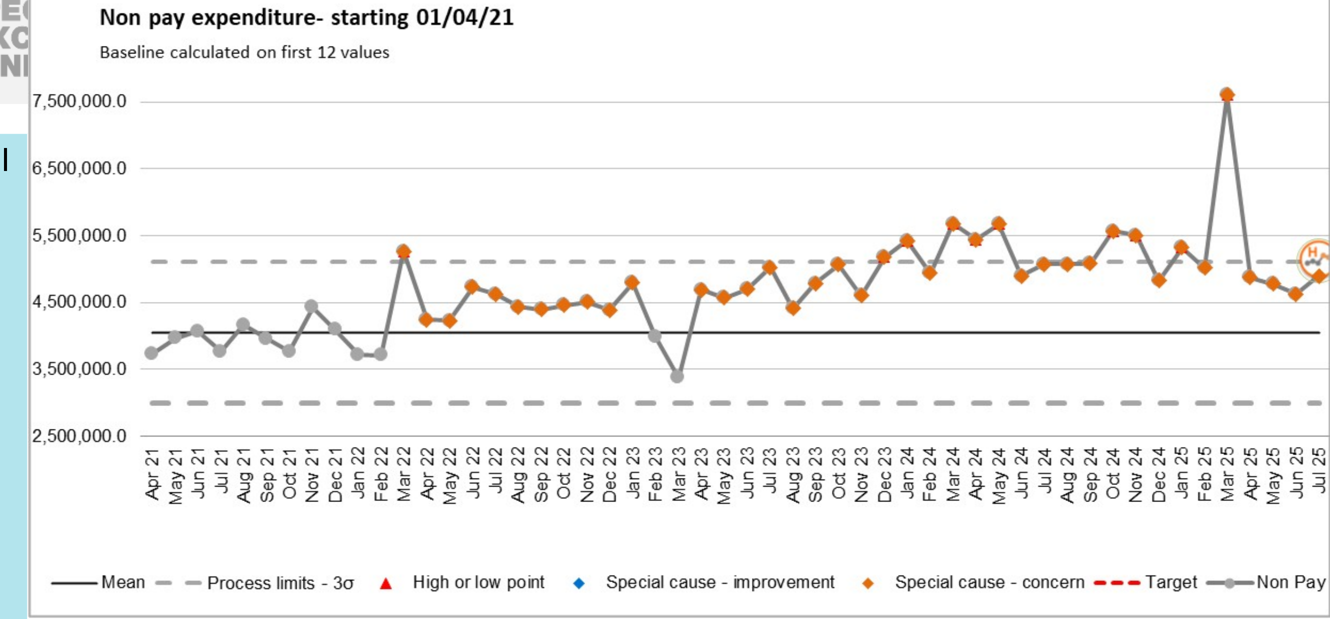
- CIP delivery risk

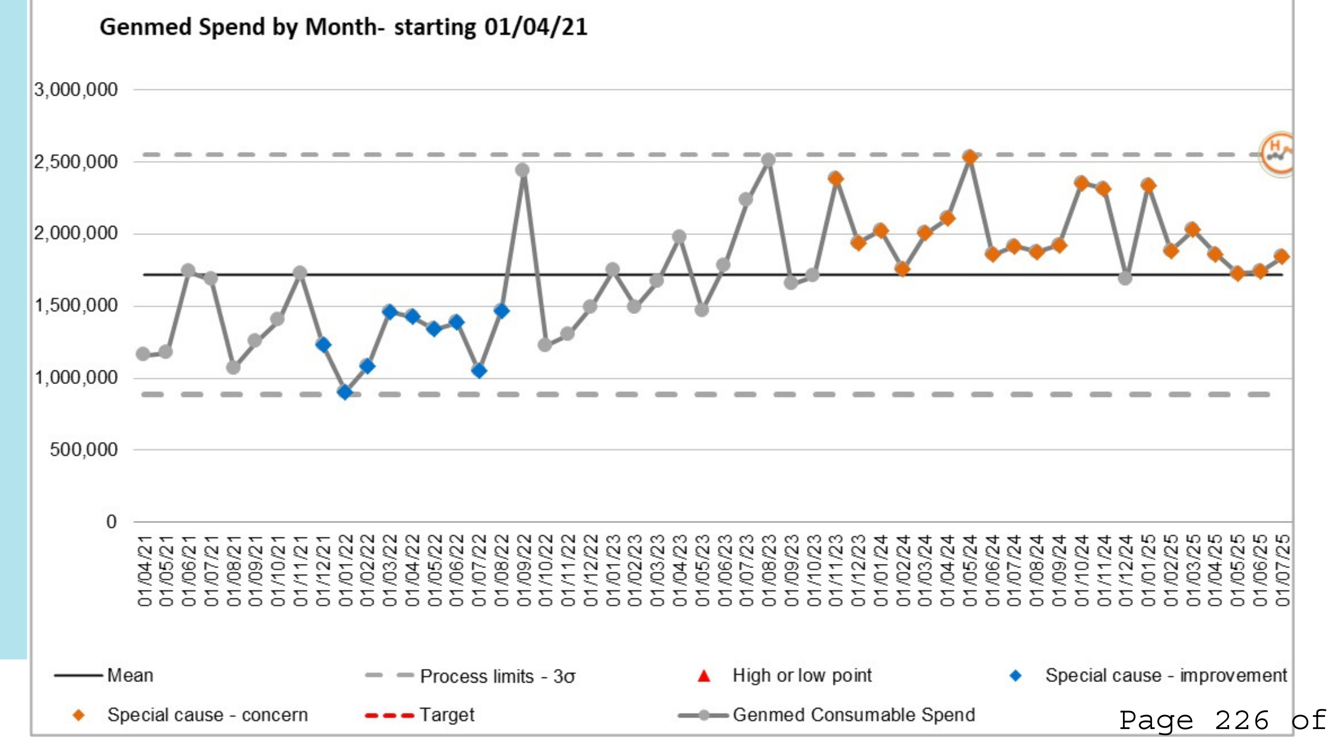
14. Non Pay Expenditure

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

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

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





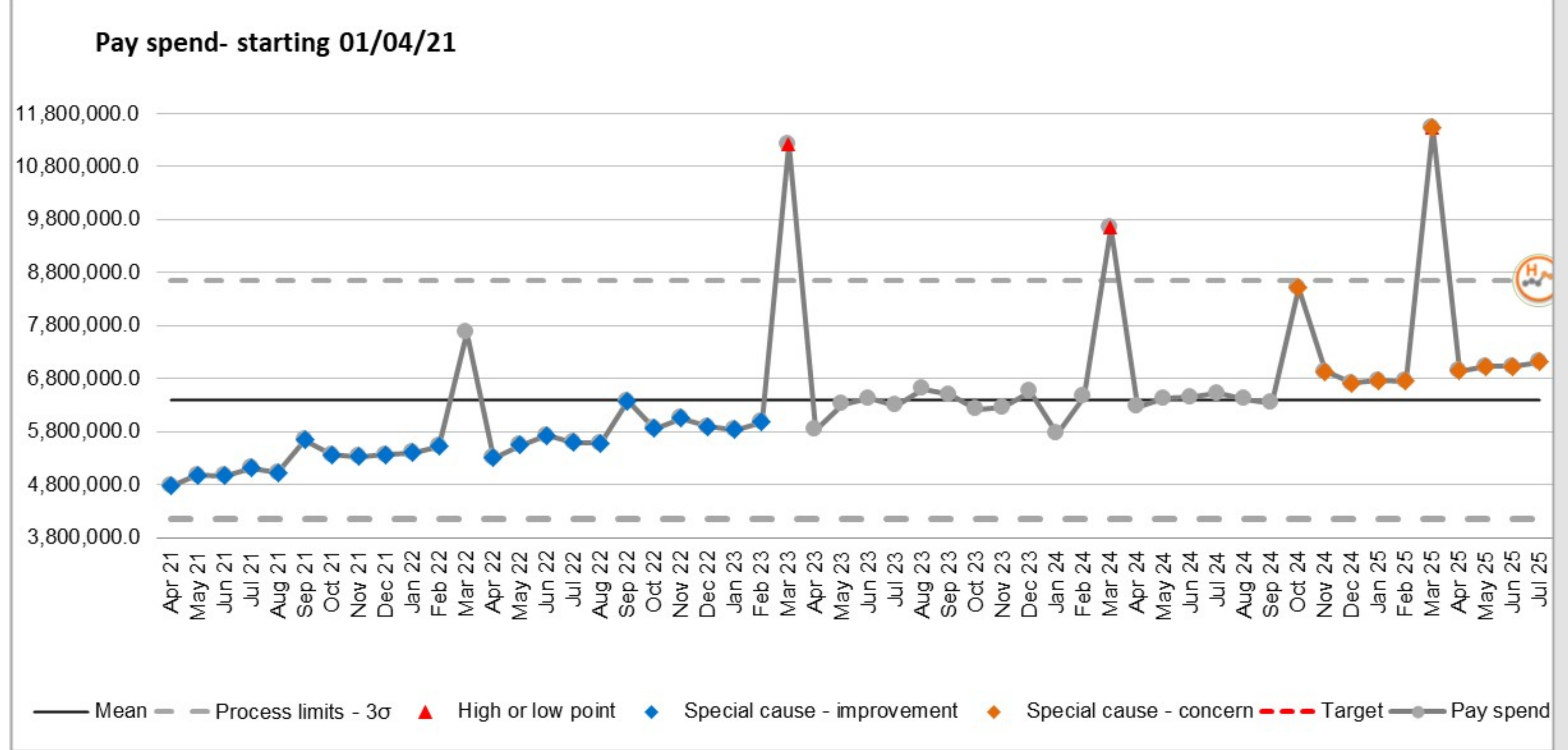
15. Non Pay Expenditure

SUMMARY

Premium rate additional sessions remain a key element of the cost improvement plan, with a reduction in LLP expenditure planned of £2.4m. LLP expenditure in month of £176k causing an overspend of £150k, which increases the year to date overspend to £192k. Ths is offset in part by the reduction in ADH spend which is underspent against plan by £17k year to date.

	£'000s			Substantive wte surgeons and anaethetists
Year	LLP	ADH	Total	
17-18		1,672	1,672	63.28
18-19		1,950	1,950	61.57
19-20	274	1,503	1,777	64.48
20-21	271	432	703	70.22
21-22	1,460	438	1,898	75.58
22-23	1,865	882	2,747	71.66
23-24	3,382	1,067	4,449	70.22
24-25	3,629	1,307	4,936	77.66
25-26	659	220	683	78.62

16. Pay Expenditure



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

17. Agency Expenditure

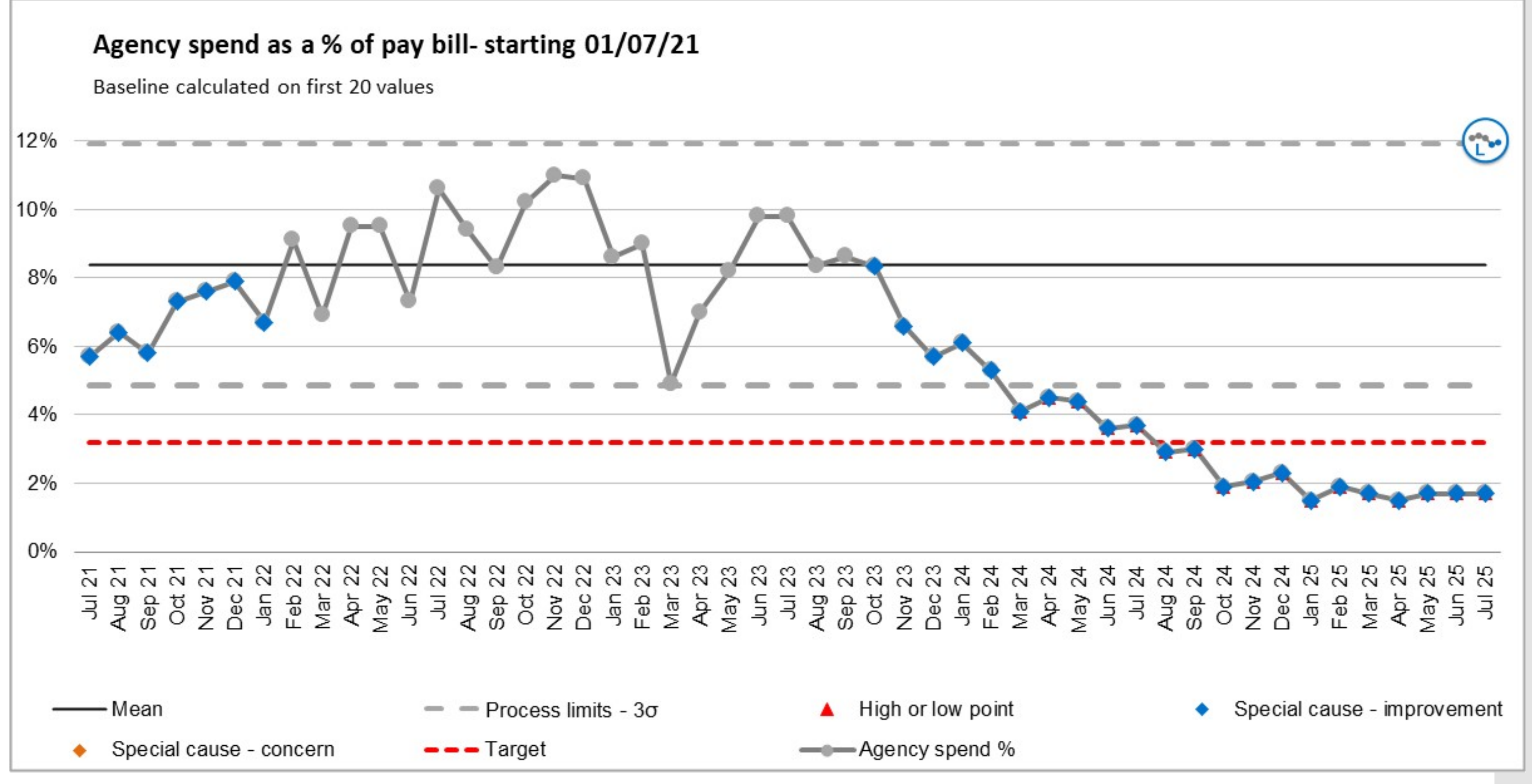
Agency spend- starting 01/04/21

700,000.0
600,000.0
500,000.0
400,000.0
300,000.0
200,000.0
100,000.0

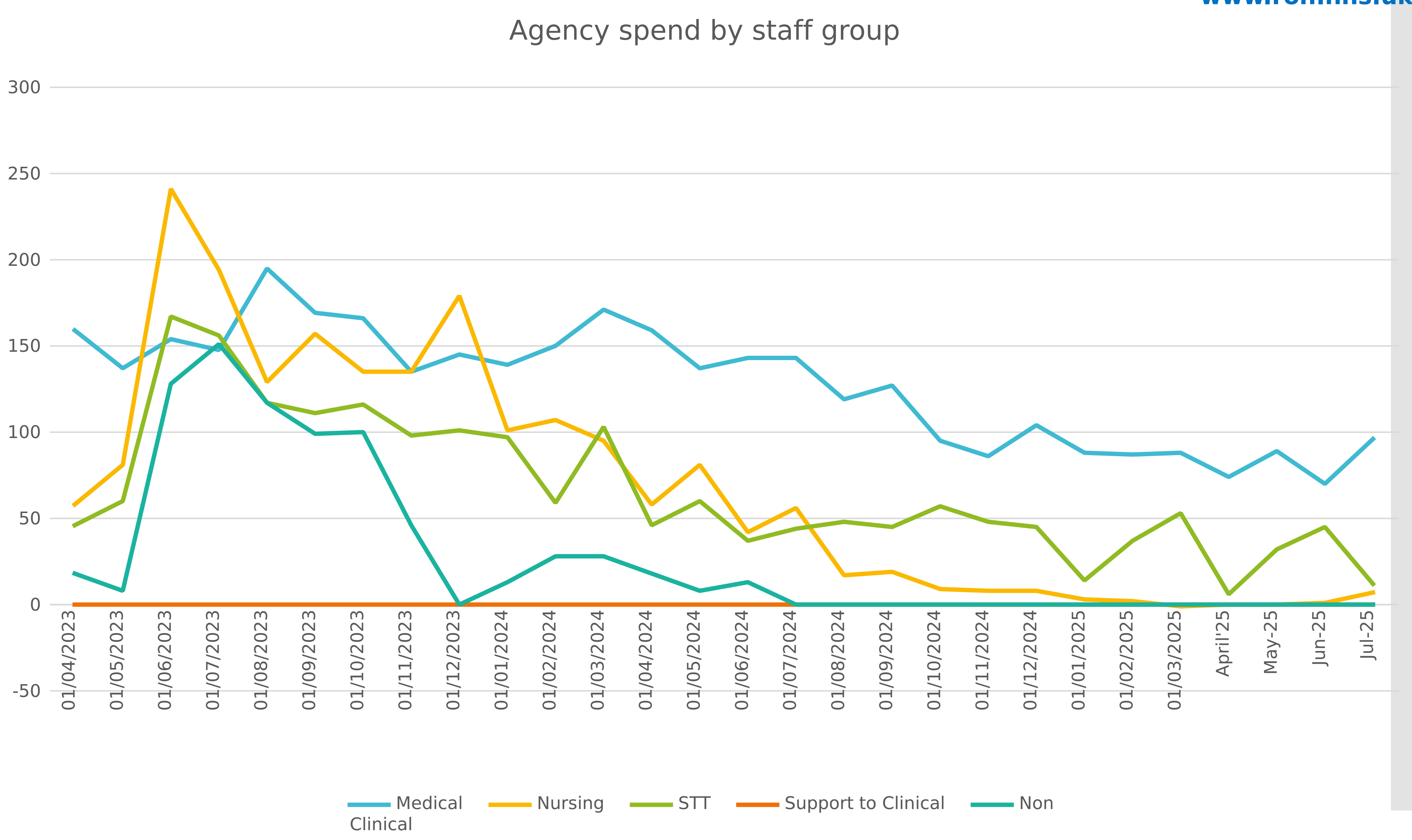
Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22, Apr 22, May 22, Jun 22, Jul 22, Aug 22, Sep 22, Oct 22, Nov 22, Dec 22, Jan 23, Feb 23, Mar 23, Apr 23, May 23, Jun 23, Jul 23, Aug 23, Sep 23, Oct 23, Nov 23, Dec 23, Jan 24, Feb 24, Mar 24, Apr 24, May 24,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

Mean — Agency spend — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

17. Agency Expenditure



17. Agency Expenditure



Note: nursing agency spend in month relates to a 24/25 VAT adjustment and not shifts worked in month

17. Bank Expenditure

Bank expenditure	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr'25	May'25	Jun'25	Jul'25
Registered nursing	110	136	116	101	95	112	118	92	109	108	48	41	39	48
Healthcare scientists and Scientific, therapeutic and tech	32	47	25	33	41	38	38	34	35	38	39	38	38	40
Support to clinical	60	86	78	55	56	61	69	55	38	94	26	20	34	32
Total medical and dental staff bank	51	61	107	88	117	85	52	124	88	142	58	97	76	119
NHS infrastructure support	155	189	200	151	125	117	111	140	119	157	110	95	115	95
TOTAL	487	570	543	443	434	413	390	445	404	534	282	291	301	334

Bank expenditure- starting 01/09/21

Mean ···· Process limits - 3σ ▲ High or low point ◆ Special cause - improvement ◆ Special cause - concern ······ Target

Bank expenditure

18. Cost Improvement Plan

SUMMARY

In month efficiencies of £418k has been generated increasing the year to date achieved to £1,887k against a plan of £2,270k, generating an underperformance of £383k. A target for the year has been set at £9.4m with plans fully identifying the target. Quality Impact Assessments (QIAs) for schemes are in progress with the panel meeting weekly to review assessments.

	Actual	Actual	Actual	Actual	Forecast								Actual	Forecast Y/end	Full Year Effect
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	YTD		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pharmacy	0	16	0	12	8	8	8	8	8	8	8	8	28	92	96
Premium rate working reduction	241	66	273	174	225	225	232	232	232	232	232	339	754	2,703	4,068
Non pay procurement plan delivery	58	82	55	43	35	35	35	35	35	51	51	51	237	565	612
Energy savings	0	0	0		17	17	17	17	17	17	17	17	0	136	204
Digital Optimisation	0	72	0	70	67	67	67	67	67	67	67	67	141	677	804
Commercial Income	75	155	26		127	61	61	61	61	61	61	61	257	811	732
Service Redesign	0	0	0		83	83	90	90	90	101	101	101	0	739	1,212
Budget management control	9	43	0		9	54	54	54	54	112	112	376	52	877	1,344
Temporary staffing - bank expenditure reduction	26	141	130	120	88	108	123	123	85	95	95	0	418	1,135	0
Corporate team redesign	0	0	0		146	146	148	148	148	329	329	329	0	1,723	3,948
	409	**575**	**484**	**418**	**805**	**804**	**835**	**835**	**797**	**1,073**	**1,073**	**1,349**	**1,887**	**9,459**	**13,020**

19. Statement of Financial Position

SUMMARY

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

The cash position remains challenging, with challenging points in the month and the necessity to manage payments accordingly. Despite this, further support payments are not currently expected to be needed in 2056-26.

	2024/25 M12	2025/26 M4	Movement
Intangible Assets	933	808	(215)
Tangible Assets	66,859	65,339	(1,520)
Total Non Current Assets	**67,792**	**66,147**	**(1,645)**
Trade and other current assets	18,580	17,289	(1,291)
Cash	3,293	3,258	(35)
Total Current Assets	**21,873**	**20,547**	**(1,326)**
Trade and other payables	(18,235)	(15,733)	2,502
Borrowings	(13,722)	(12,718)	1,004
Provisions	(3,014)	(3,014)	0
Other Liabilities	(6,332)	(7,282)	(950)
Total Liabilities	**(41,303)**	**(38,747)**	**2,556**
Total Net Assets Employed	**48,362**	**47,947**	**(415)**
Total Taxpayers’ and Others’ Equity	**48,362**	**47,947**	**(415)**

20. 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.

High / low cash position

21. System Position

The year to date system position is a deficit of £31.3m, £17.8m adverse to plan. This represents a £3.5m increase in deficit compared to month 3 and a £1.7m deterioration in variance against plan compared to YTD M3 variance.

Total Performance	YTD Current Plan £000s	YTD Actual £000s	YTD Variance £000s	FOT Annual Plan £000s	FOT FOT £000s	FOT Variance £000s	Prior Month variance £000s
BSOL ICB	-2,431	-1,253	1,178	0	0	0	26
BSMHT	1,389	-2,286	-3,675	4,200	4,200	0	-3,547
BCHC	205	-1,341	-1,546	0	0	0	-1,586
BWC	0	-4,631	-4,631	0	0	0	-3,001
ROH	-732	-380	352	35	35	0	462
UHB	-11,990	-21,473	-9,483	-4,200	-4,200	0	-8,436
Total	-13,559	-31,364	-17,805	35	35	0	-16,083

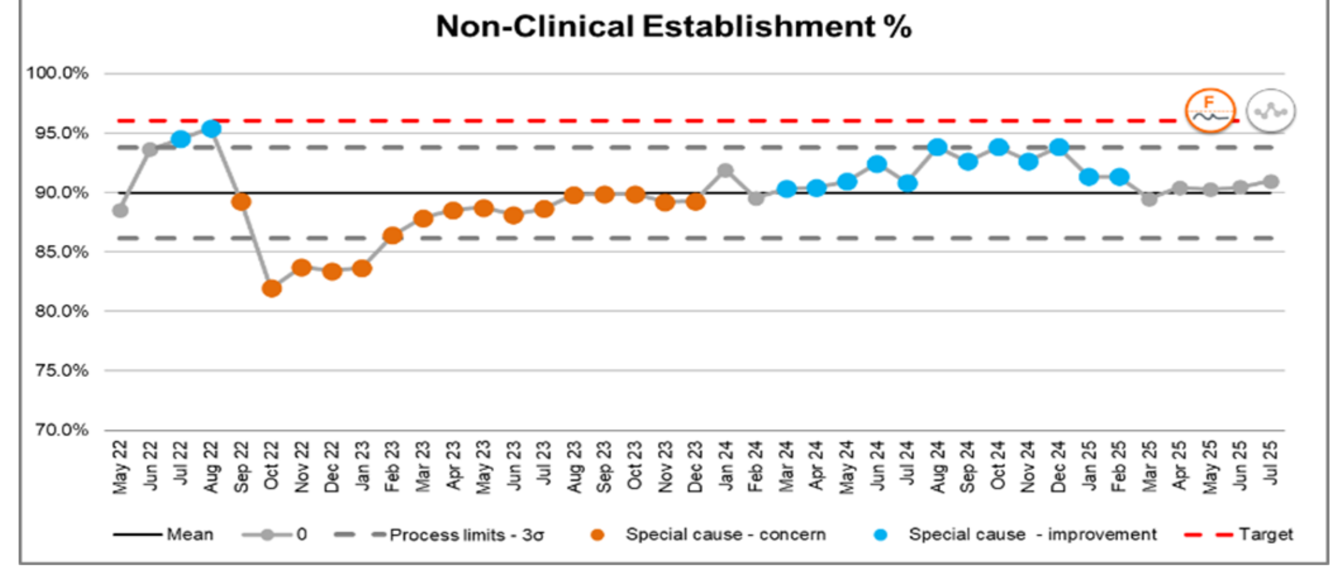
Total Actual Surplus/(Deficit)	Trend M1 £000s	Trend M2 £000s	Trend M3 £000s	Trend M4 £000s	YTD £000s
BSOL ICB	-627	-555	-679	608	-1,253
BSMHT	-1,086	-1,496	77	220	-2,286
BCHC	-604	-585	-294	142	-1,341
BWC	-1,081	-698	-1,222	-1,630	-4,631
ROH	-377	403	-242	-164	-380
UHB	-11,221	-2,753	-4,833	-2,666	-21,473
	-14,997	-5,685	-7,193	-3,489	-31,364

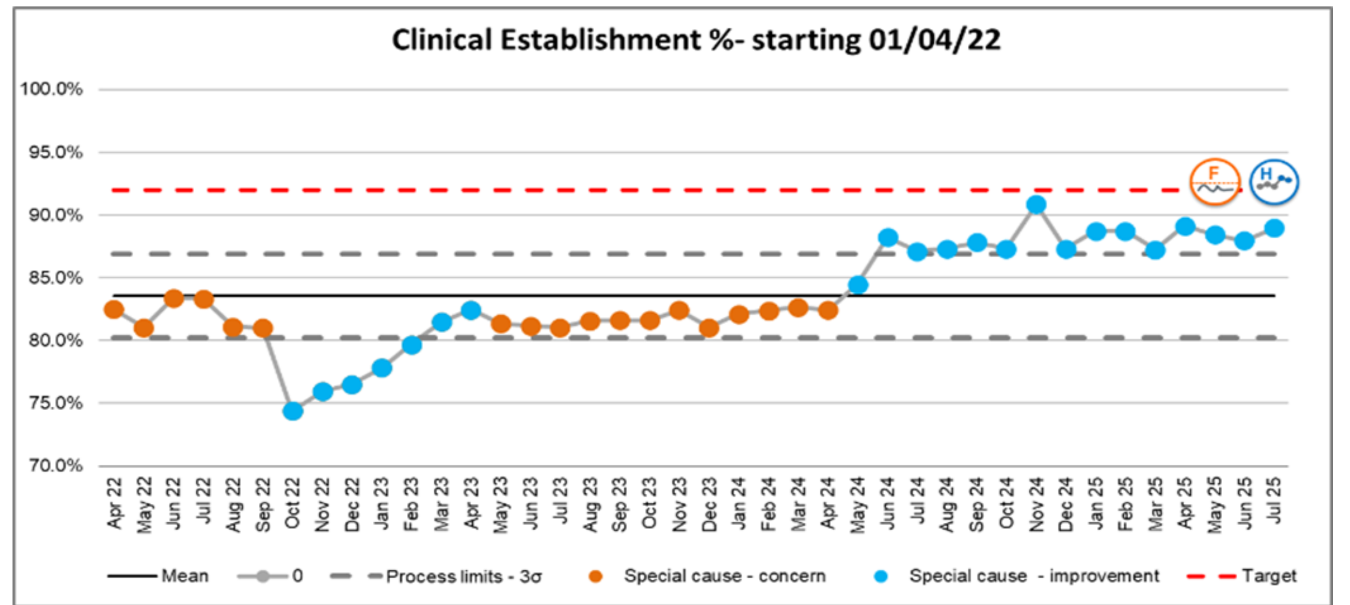
	BSMHT £000s	BCHC £000s	BWC £000s	ROH £000s	UHB £000s	Provider Total £000s	ICB £000s	**System Total £000s**
YTD Plan	11,807	6,132	10,072	2,270	37,425	67,706	34,086	**101,792**
YTD Actual	8,383	4,349	6,438	1,887	32,466	53,523	33,973	**87,496**
YTD Variance	-3,424	-1,783	-3,634	-383	-4,959	-14,183	-113	**-14,295**
% of YTD achieved	71%	71%	64%	83%	87%	79%	100%	**86%**

22. Workforce

Occupied Establishment	93%		
Turnover (adjusted)	10.5%		
Staff in post - FTE	N/A	1306.34	-
Sickness absence	4%		
Appraisals	95%		
Disability declaration rate	7.5%		
Workforce Wellbeing – A/Leave	N/A		N/A
Mandatory Training	93%		

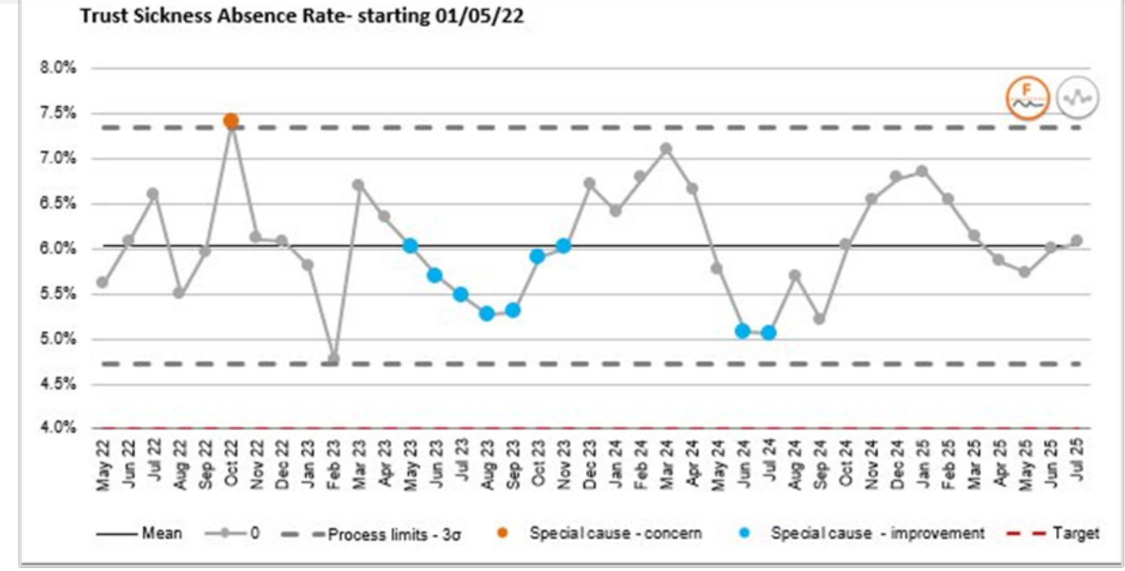
22. Workforce

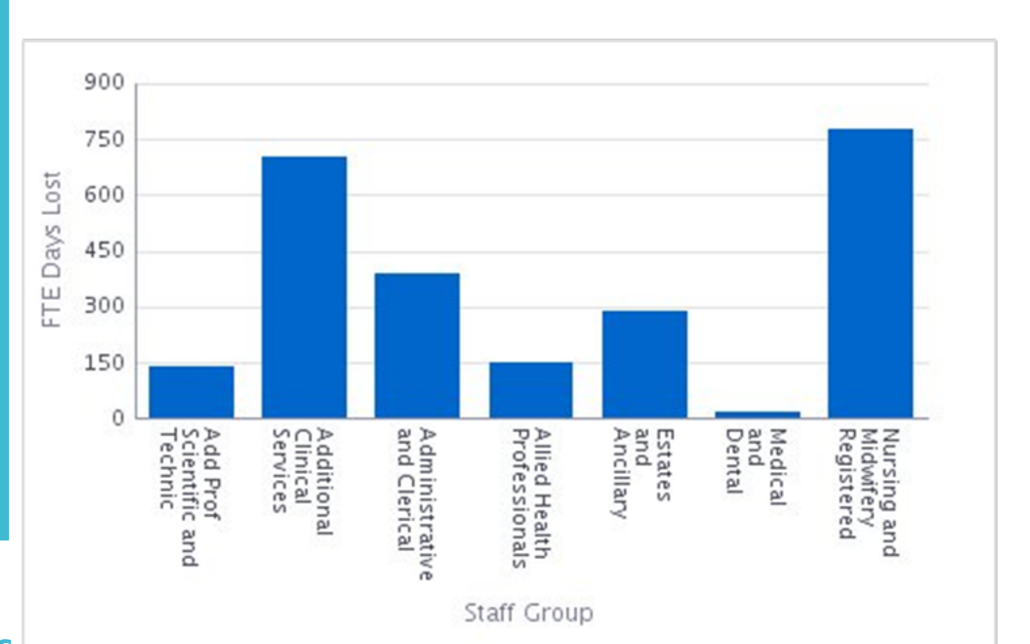


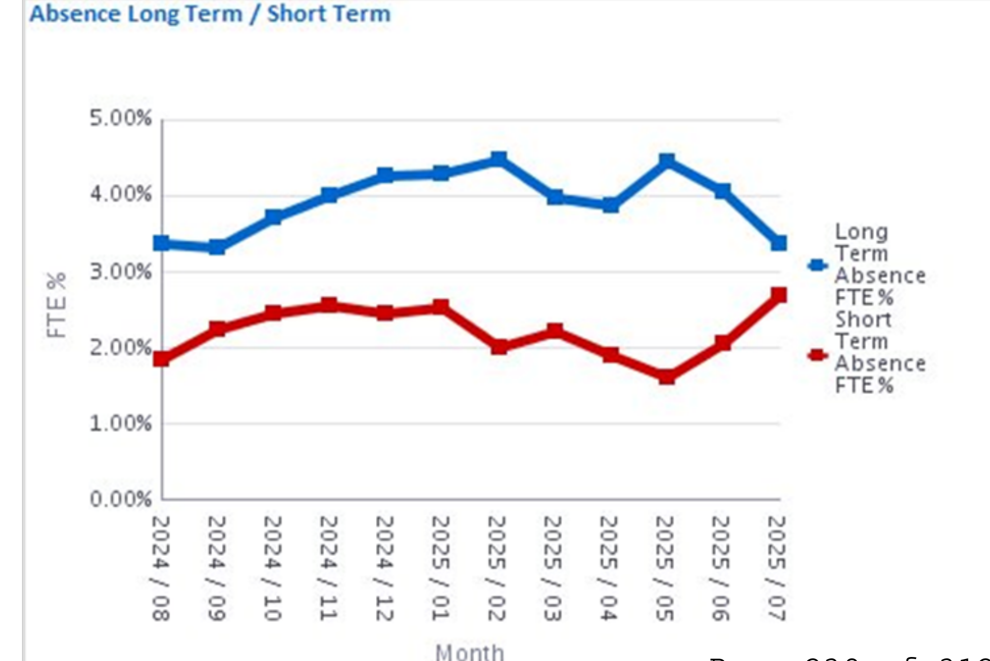


22. Workforce

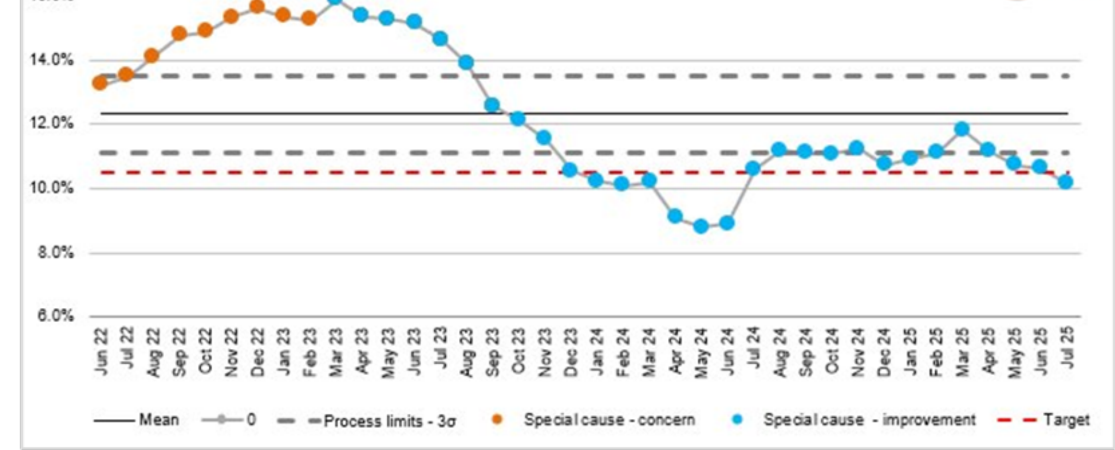
Absence cost is linked to the pay of the individual absent from work, rather than the overall cost of sickness absence

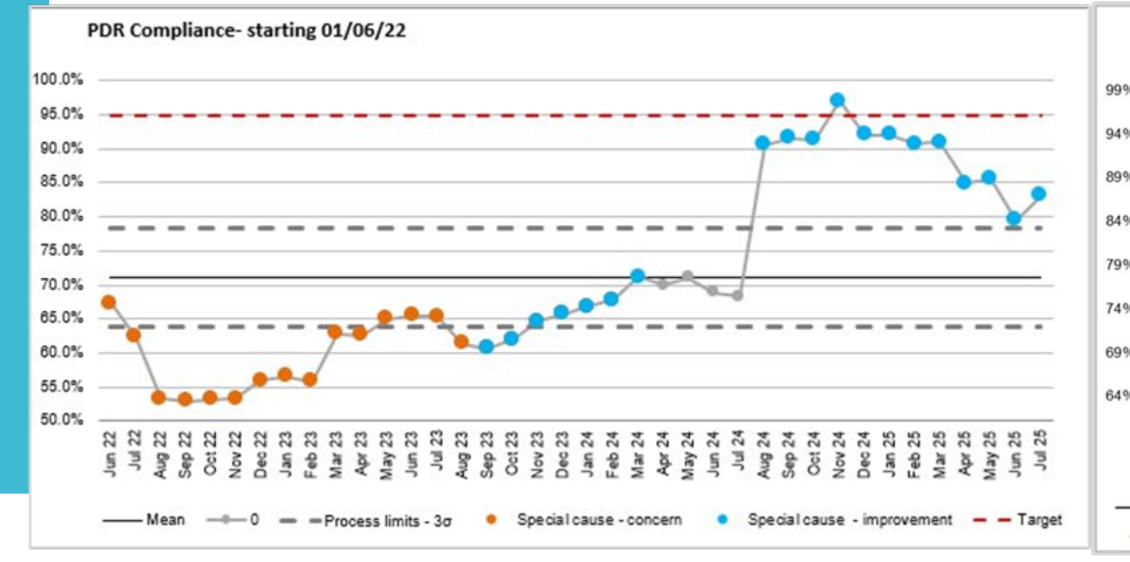


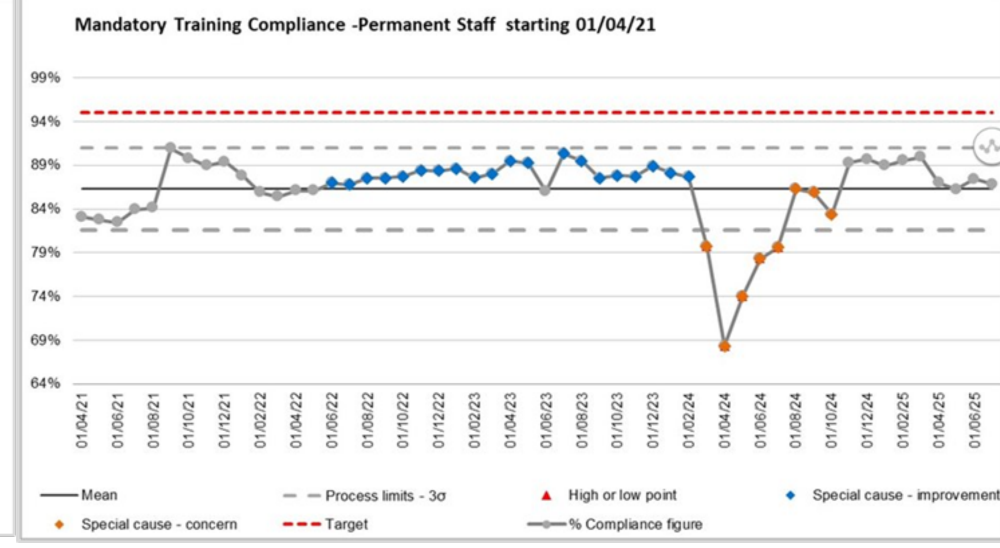




22. Workforce







Integrated Performance Dashboard

Metric Grouping	Metric Name	Reporting Period	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend	Latest Variation	Latest Assurance	Target
Inpatients	IP Activity YTD Plan	YTD	1,312	2,576	3,888	5,267	6,569	7,787	9,127	10,346	11,658	1,068	2,237	3,427	4,705	-	-	-	-
Inpatients	IP Activity YTD Actuals	YTD	1,358	2,588	3,862	5,108	6,351	7,477	8,836	10,176	11,428	1,168	2,373	3,581	4,810	-	-	-	-
Inpatients	IP Activity YTD Performance %	YTD	103.5%	100.5%	99.3%	97.0%	96.7%	96.0%	96.8%	98.4%	98.0%	109.4%	106.1%	104.5%	102.2%	-	-	-	-
Inpatients	IP Activity YTD Variance	YTD	46	12	-26	-159	-218	-310	-291	-170	-230	100	136	154	105				-
Inpatients	IP Activity Electives YTD Plan	YTD	602	1,182	1,784	2,416	3,014	3,574	4,188	4,748	5,350	434	922	1,414	1,939	-	-	-	-
Inpatients	IP Activity Electives YTD Actuals	YTD	593	1,108	1,656	2,237	2,811	3,317	3,896	4,467	5,014	485	1,015	1,502	2,041	-	-	-	-
Inpatients	IP Activity Eletives YTD Performance %	YTD	98.5%	93.7%	92.8%	92.6%	93.3%	92.8%	93.0%	94.1%	93.7%	111.8%	110.1%	106.2%	105.3%	-	-	-	-
Inpatients	IP Activity Electives YTD Variance	YTD	-9	-74	-128	-179	-203	-257	-292	-281	-336	51	93	88	102				-
Inpatients	IP Activity Daycases YTD Plan	YTD	697	1,370	2,067	2,800	3,491	4,138	4,850	5,498	6,195	615	1,274	1,950	2,681	-	-	-	-
Inpatients	IP Activity Daycases YTD Actuals	YTD	750	1,447	2,151	2,792	3,435	4,030	4,788	5,544	6,221	672	1,322	2,024	2,692	-	-	-	-
Inpatients	IP Activity Daycases YTD Performance %	YTD	107.6%	105.6%	104.1%	99.7%	98.4%	97.4%	98.7%	100.8%	100.4%	109.2%	103.8%	103.8%	100.4%	-	-	-	-
Inpatients	IP Activity Daycases YTD Variance	YTD	53	77	84	-8	-56	-108	-62	46	26	57	48	74	11				-
Inpatients	IP Activity Non-Electives YTD Plan	YTD	13	24	37	51	64	75	89	100	113	19	41	63	85	-	-	-	-
Inpatients	IP Activity Non-Electives YTD Actuals	YTD	15	33	55	79	105	130	152	165	193	11	36	55	77	-	-	-	-
Inpatients	IP Activity Non-Electives YTD Performance %s	YTD	115.4%	137.5%	148.7%	154.9%	164.1%	173.3%	170.8%	165.0%	170.8%	57.7%	87.6%	87.1%	90.2%	-	-	-	-
Inpatients	IP Activity Non-Electives YTD Variance	YTD	2	9	18	28	41	55	63	65	80	-8	-5	-8	-8		-	-	-

Metric Grouping	Metric Name	Reporting Period	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend	Latest Variation	Latest Assurance	Target
Inpatients	IP Activity Monthly Plan	Monthly	1,312	1,264	1,312	1,379	1,302	1,218	1,340	1,219	1,312	1,068	1,169	1,190	1,278	-	-	-	-
Inpatients	IP Activity Monthly Actuals	Monthly	1,358	1,230	1,274	1,246	1,243	1,126	1,359	1,340	1,252	1,168	1,205	1,208	1,229	-	-	-	-
Inpatients	IP Activity Monthly Performance %	Monthly	103.5%	97.3%	97.1%	90.4%	95.5%	92.4%	101.4%	109.9%	95.4%	109.4%	103.1%	101.5%	96.2%	-	-	-	
Inpatients	IP Activity Monthly Variance	Monthly	46	-34	-38	-133	-59	-92	19	121	-60	100	36	18	-49				-
Inpatients	IP Activity Electives Monthly Plan	Monthly	602	580	602	632	598	560	614	560	602	434	488	492	525	-	-	-	-
Inpatients	IP Activity Electives Monthly Actuals	Monthly	593	515	548	581	574	506	579	571	547	485	530	487	539	-	-	-	
Inpatients	IP Activity Electives Monthly Performance %	Monthly	98.5%	88.8%	91.0%	91.9%	96.0%	90.4%	94.3%	102.0%	90.9%	111.8%	108.6%	98.9%	102.8%	-	-	-	
Inpatients	IP Activity Electives Monthly Variance	Monthly	-9	-65	-54	-51	-24	-54	-35	11	-55	51	42	-5	14				
Inpatients	IP Activity Daycases Monthly Plan	Monthly	697	673	697	733	691	647	712	648	697	615	659	676	731	-	-	-	-
Inpatients	IP Activity Daycases Monthly Actuals	Monthly	750	697	704	641	643	595	758	756	677	672	650	702	668	-	-	-	
Inpatients	IP Activity Daycases Monthly Performance %	Monthly	107.6%	103.6%	101.0%	87.4%	93.1%	92.0%	106.5%	116.7%	97.1%	109.2%	98.6%	103.9%	91.4%	-	-	-	
Inpatients	IP Activity Daycases Monthly Variance	Monthly	53	24	7	-92	-48	-52	46	108	-20	57	-9	26	-63				
Inpatients	IP Activity Non-Electives Monthly Plan	Monthly	13	11	13	14	13	11	14	11	13	19	22	22	22	-	-	-	-
Inpatients	IP Activity Non-Electives Monthly Actuals	Monthly	15	18	22	24	26	25	22	13	28	11	25	19	22	-	-	-	
Inpatients	IP Activity Non-Electives Monthly Performance %	Monthly	115.4%	163.6%	169.2%	171.4%	200.0%	227.3%	157.1%	118.2%	215.4%	57.7%	157.7%	157.7%	157.7%	-	-	-	
Inpatients	IP Activity Non-Electives Monthly Variance	Monthly	2	7	9	10	13	14	8	2	15	-8	3	-3	0		-	-	-

Metric Grouping	Metric Name	Reporting Period	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend	Latest Variation	Latest Assurance	Target
Outpatients	OP Activity YTD Plan	YTD	6,377	10,021	15,790	22,167	28,544	32,795	39,172	44,638	51,014	5,685	11,371	17,057	22,744	-	-	-	-
Outpatients	OP Activity YTD Actuals	YTD	6,465	12,082	18,012	24,495	30,625	36,216	43,029	49,064	55,312	5,995	11,846	18,072	24,538	-	-	-	-
Outpatients	OP Activity YTD Performance %	YTD	101.4%	120.6%	114.1%	110.5%	107.3%	110.4%	109.8%	109.9%	108.4%	105.5%	104.2%	106.0%	107.9%	-	-	-	-
Outpatients	OP Activity YTD Variance	YTD	88	2,061	2,222	2,328	2,081	3,421	3,857	4,426	4,298	310	475	1,015	1,794		H	P	-
Outpatients	OP Activity First YTD Plan	YTD	2,038	3,202	5,046	7,083	9,121	10,480	12,517	14,264	16,301	1,992	3,985	6,077	8,369	-	-	-	-
Outpatients	OP Activity First YTD Actuals	YTD	2,084	3,943	5,917	7,958	10,117	11,973	14,257	16,254	18,218	1,674	3,445	5,390	7,489	-	-	-	-
Outpatients	OP Activity Eletives YTD Performance %	YTD	102.3%	123.1%	117.3%	112.3%	110.9%	114.3%	113.9%	114.0%	111.8%	84.0%	86.5%	88.7%	89.5%	-	-	-	-
Outpatients	OP Activity First YTD Variance	YTD	46	741	871	875	996	1,493	1,740	1,990	1,917	-318	-540	-687	-880		L	F	-
Outpatients	OP Activity Follow Up YTD Plan	YTD	3,969	6,236	9,827	13,795	17,764	20,410	24,378	27,780	31,748	3,446	6,891	10,510	14,472	-	-	-	-
Outpatients	OP Activity Follow Up YTD Actuals	YTD	4,073	7,585	11,282	15,486	19,219	22,696	26,913	30,685	34,723	4,051	7,868	11,890	15,980	-	-	-	-
Outpatients	OP Activity Follow Up YTD Performance %	YTD	102.6%	121.6%	114.8%	112.3%	108.2%	111.2%	110.4%	110.5%	109.4%	117.6%	114.2%	113.1%	110.4%	-	-	-	-
Outpatients	OP Activity Follow Up YTD Variance	YTD	104	1,349	1,455	1,691	1,455	2,286	2,535	2,905	2,975	605	977	1,380	1,508		H	P	-
Outpatients	OP Activity Procedures YTD Plan	YTD	371	582	918	1,288	1,659	1,906	2,276	2,594	2,964	247	494	753	1,037	-	-	-	-
Outpatients	OP Activity Procedures YTD Actuals	YTD	308	554	813	1,051	1,289	1,547	1,859	2,125	2,371	270	533	792	1,069	-	-	-	-
Outpatients	OP Activity Procedures YTD Performance %s	YTD	83.1%	95.1%	88.6%	81.6%	77.7%	81.2%	81.7%	81.9%	80.0%	109.3%	107.9%	105.2%	103.1%	-	-	-	-
Outpatients	OP Activity Procedures YTD Variance	YTD	-63	-28	-105	-237	-370	-359	-417	-469	-593	23	39	39	32		H	P	-

Metric Grouping	Metric Name	Reporting Period	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend	Latest Variation	Latest Assurance	Target
Outpatients	OP Activity Monthly Plan	Monthly	6,377	3,644	5,769	6,377	6,377	4,251	6,377	5,466	6,377	5,685	5,686	5,686	5,687	-	-	-	-
Outpatients	OP Activity Monthly Actuals	Monthly	6,465	5,617	5,930	6,483	6,130	5,591	6,813	6,035	6,248	5,995	5,851	6,226	6,466	-	-	-	-
Outpatients	OP Activity Monthly Performance %	Monthly	101.4%	154.1%	102.8%	101.7%	96.1%	131.5%	106.8%	110.4%	98.0%	105.5%	102.9%	109.5%	113.7%	-	-	-	
Outpatients	OP Activity Monthly Variance	Monthly	88	1,973	161	106	-247	1,340	436	569	-129	310	165	540	779				-
Outpatients	OP Activity First Monthly Plan	Monthly	2,038	1,164	1,844	2,038	2,038	1,358	2,038	1,747	2,038	1,992	1,992	2,093	2,292	-	-	-	-
Outpatients	OP Activity First Monthly Actuals	Monthly	2,084	1,859	1,974	2,041	2,159	1,856	2,284	1,997	1,964	1,674	1,771	1,945	2,099	-	-	-	
Outpatients	OP Activity First Monthly Performance %	Monthly	102.3%	159.7%	107.1%	100.2%	106.0%	136.6%	112.1%	114.3%	96.4%	84.0%	88.9%	92.9%	91.6%	-	-	-	
Outpatients	OP Activity First Monthly Variance	Monthly	46	695	130	3	121	498	246	250	-74	-318	-221	-148	-193				
Outpatients	OP Activity Follow Up Monthly Plan	Monthly	3,969	2,268	3,591	3,969	3,969	2,646	3,969	3,402	3,969	3,446	3,446	3,618	3,962	-	-	-	-
Outpatients	OP Activity Follow Up Monthly Actuals	Monthly	4,073	3,512	3,697	4,204	3,733	3,477	4,217	3,772	4,038	4,051	3,817	4,022	4,090	-	-	-	
Outpatients	OP Activity Follow Up Monthly Performance %	Monthly	102.6%	154.9%	103.0%	105.9%	94.1%	131.4%	106.3%	110.9%	101.7%	117.6%	110.8%	111.2%	103.2%	-	-	-	
Outpatients	OP Activity Follow Up Monthly Variance	Monthly	104	1,244	106	235	-236	831	248	370	69	605	371	404	128				
Outpatients	OP Activity Procedures Monthly Plan	Monthly	371	212	335	371	371	247	371	318	371	247	247	259	284	-	-	-	-
Outpatients	OP Activity Procedures Monthly Actuals	Monthly	308	246	259	238	238	258	312	266	246	270	263	259	277	-	-	-	
Outpatients	OP Activity Procedures Monthly Performance %	Monthly	83.1%	116.2%	77.3%	64.2%	64.2%	104.4%	84.2%	83.7%	66.4%	109.3%	106.5%	100.0%	97.5%	-	-	-	
Outpatients	OP Activity Procedures Monthly Variance	Monthly	-63	34	-76	-133	-133	11	-59	-52	-125	23	16	0	-7				
Outpatients	Outpatient Did Not Attend	Monthly	7.2%	7.9%	8.1%	8.2%	7.9%	8.4%	8.2%	8.0%	7.1%	7.5%	7.0%	6.8%	5.9%				8%
Outpatients	PIFU	Monthly	10.7%	9.4%	10.0%	9.4%	9.8%	10.2%	11.0%	11.8%	10.1%	10.5%	10.4%	9.8%	10.6%				5%
Outpatients	Virtual Attendances	Monthly	11.7%	11.0%	10.0%	10.2%	10.5%	11.4%	9.9%	9.3%	9.8%	9.4%	7.9%	9.2%	9.7%				
Outpatients	OP Attendances Patients Who Waited 31 to 60 Mins to be Seen	Monthly	9.8%	7.7%	9.2%	8.5%	7.2%	6.7%	8.1%	7.5%	6.1%	7.1%	11.7%	15.1%	13.2%				
Outpatients	OP Attendances Patients Waited Over 60 Mins to be Seen	Monthly	2.8%	1.4%	3.4%	2.3%	1.9%	1.7%	2.3%	1.9%	1.6%	1.9%	3.9%	4.9%	5.2%				

Metric Grouping	Metric Name	Reporting Period	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend	Latest Variation	Latest Assurance	Target
referral to treatment	RTT Total Waiting List Under 18 weeks	Month Ending	52.58%	53.36%	52.90%	52.81%	51.84%	51.61%	52.01%	53.14%	54.66%	55.63%	58.33%	60.07%	60.34%		H	P	56.54%
referral to treatment	RTT First Appointment Waiting List Under 18 weeks	Month Ending	52.73%	53.57%	53.28%	53.08%	52.11%	52.79%	53.62%	53.06%	54.06%	54.61%	57.78%	61.78%	62.03%		H	P	61.63%
referral to treatment	RTT Total Waiting List Size	Month Ending	15,486	15,709	15,069	14,901	14,561	14,517	13,777	13,291	12,738	12,739	12,798	12,952	13,345		L	P	13,536
referral to treatment	RTT Patients Waiting 65 Week waits	Month Ending	18	9	0	1	0	13	19	6	1	0	0	0	0		L	P	0
referral to treatment	RTT Patients Waiting 52 week waits (52-64 weeks)	Month Ending	560	590	641	843	889	842	727	672	487	486	507	466	446		L	P	493
referral to treatment	RTT Proportion of Patients Waiting 52 weeks and over	Month Ending	3.73%	3.81%	4.25%	5.66%	6.11%	5.89%	5.41%	5.10%	3.83%	3.82%	3.96%	3.60%	3.34%		L	P	3.64%

Metric Grouping	Metric Name	Reporting Period	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend	Latest Variation	Latest Assurance	Target
Workforce	Staff In Post - Headcount	Monthly	1,451	1,449	1,457	1,456	1,463	1,461	1,468	1,481	1,479	1,483	1,486	1,483	1,480		-	-	-
Workforce	Staff In Post - Full Time Equivalent	Monthly	1,285	1,280	1,287	1,286	1,291	1,291	1,296	1,309	1,309	1,314	1,315	1,312	1,306		-	-	-
Workforce	Staff Turnover Percentage - Adjusted	Monthly	10.58%	11.18%	11.07%	10.70%	11.20%	11.50%	10.90%	11.11%	11.83%	9.28%	10.73%	10.64%	10.15%		H	P	11.5%
Workforce	Total Whole Time Equivalent Employed as a Percentage of Establishment - Clinical	Monthly	90.85%	87.32%	87.32%	87.30%	87.30%	87.30%	87.30%	88.74%	88.74%	89.14%	88.43%	87.97%	88.40%		L	F	92%
Workforce	Total Whole Time Equivalent Employed as a Percentage of Establishment - Non Clinical	Monthly	92.64%	93.83%	93.83%	93.80%	91.30%	91.30%	91.30%	91.34%	91.34%	90.40%	90.25%	90.44%	90.20%		L	F	96%
Workforce	Percentage of Attendance	Monthly	94.14%	94.82%	94.72%	93.90%	93.40%	93.20%	93.10%	93.47%	93.78%	94.32%	94.27%	94.01%	93.93%		L	F	96.3%
Workforce	Percentage of Staff Received Mandatory Training last 12 months	Monthly	79.62%	86.28%	86.91%	87.20%	89.20%	89.60%	88.90%	89.56%	89.92%	86.99%	86.63%	87.43%	86.82%		L	F	93%
Workforce	Percentage of Staff Received Formal PDR/Appraisal last 12 months	Monthly	90.58%	91.62%	91.30%	97.00%	92.00%	92.00%	90.60%	90.96%	90.17%	84.92%	85.58%	79.52%	83.10%		L	F	95%
Workforce	Percentage of Sickness Trust Wide Long Term	Monthly	3.86%	3.76%	3.70%	3.30%	3.41%	3.69%	3.38%	3.79%	3.49%	3.17%	3.57%	3.34%	3.38%		-	-	-
Workforce	Percentage of Sickness Trust Wide Short Term	Monthly	2.17%	2.17%	2.25%	2.70%	3.12%	3.09%	3.47%	4.15%	4.43%	2.66%	2.16%	2.64%	2.69%		-	-	-
Workforce	Return to Work Completion %	Monthly	63.08%	56.83%	67.65%	63.90%	60.80%	55.80%	66.00%	62.33%	61.32%	67.44%	61.22%	66.24%	69.33%		L	F	80%

Metric Grouping	Metric Name	Reporting Period	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend	Latest Variation	Latest Assurance	Target
Finance	I&E Surplus / (Deficit) (£k)	Monthly	(266)	(241)	(111)	(522)	(69)	(181)	(679)	(688)	2,490	(377)	402	(242)	(164)		-	-	
Finance	I&E Margin (%)	Monthly	(2.30%)	(2.10%)	(1.00%)	(3.80%)	(0.60%)	(1.60%)	(5.90%)	(6.20%)	11.40%	(3.30%)	3.30%	(2.10%)	(0.90%)		-	-	
Finance	I&E Variation from Plan	Monthly	(440)	(82)	(73)	(482)	(80)	(271)	(541)	(707)	2,357	(102)	635	(71)	(110)		-	-	
Finance	EBITDA (%)	Monthly	2.00%	2.80%	4.00%	0.50%	4.00%	3.90%	(0.90%)	(0.90%)	15.10%	2.30%	8.40%	3.40%	(1.10%)		-	-	
Finance	CIP Value	Monthly	295	278	946	498	375	308	321	691	553	409	575	484	418		-	-	
Finance	CIP Plan (don't show)	Monthly	304	333	406	438	466	492	519	546	620	494	544	538	694		-	-	
Finance	CIP Performance	Monthly	97.04%	83.59%	232.92%	113.70%	80.47%	62.60%	61.85%	126.54%	89.12%	82.79%	105.70%	89.96%	60.23%		-	-	
Finance	Agency Expenditure	Monthly	242	185	190	161	142	157	105	126	140	105	121	117	115		-	-	
Finance	Agency % of total pay bill	Monthly	3.70%	2.90%	3.00%	1.90%	2.00%	2.30%	1.50%	1.90%	1.20%	1.50%	1.70%	1.70%	1.60%		-	-	
Finance	Capital - Variation to Plan (including impact of IFRS 16)	Monthly	319	564	(215)	(833)	643	(1,014)	184	408	(507)	65	65	275	111		-	-	
Finance	Cash Balance at end of month	Monthly	4,070	7,651	4,332	6,666	6,379	8,139	6,173	5,570	3,293	1,578	835	4,034	3,258		-	-	
Finance	BPPC Invoices Paid < 30 days (Volume %)	Monthly	82.30%	81.30%	82.20%	82.80%	83.00%	83.40%	83.10%	83.70%	82.80%	72.20%	73.00%	74.10%	76.50%		-	-	
Finance	BPPC Invoices Paid < 30 days (Value %)	Monthly	81.20%	81.10%	82.00%	83.60%	82.20%	82.60%	80.30%	79.40%	78.30%	67.10%	68.50%	67.90%	66.10%		-	-	
Finance	Creditor Days	Monthly	93	87	89	110	119	117	125	105	113		113	121	113		-	-	
Finance	Debtor Days	Monthly	35	38	37	33	43	31	30	35	55		64	48	54		-	-	
Finance	Operating Expenditure Days	Monthly	11	22	12	15	16	23	17	14	6		2	11	9		-	-	

Metric Grouping	Metric Name	Reporting Period	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend	Latest Variation	Latest Assurance	Target
Governance	Number of Incidents Reported	Monthly	374	292	355	351	349	249	313	360	318	398	284	316	337		-	-	
Governance	Number of PSII (Patient Safety Incident Investigations)	Monthly	0	0	0	2	1	1	1	0	1	0	1	1	1		-	-	
Governance	Number of Inpatient Deaths	Monthly	0	0	1	0	0	0	0	2	1	1	0	1	1		-	-	
Governance	Number of Inpatient Deaths within 30 days of discharge	Monthly	4	1	1	2	1	3	1	0	0	0	0	4			-	-	
Governance	Number of Never Events	Monthly											1	0	0		-	-	
Governance	Number of VTE (Avoidable)	Monthly	0	0	1	0	1	0	0	0	0	0	0	0	0		-	-	
Governance	Number of Category 2 Pressure Ulcer Incidents (Avoidable)	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0		-	-	
Governance	Number of Category 3 Pressure Ulcer Incidents (Avoidable)	Monthly	0	1	0	0	0	0	0	0	0	0	0	0	0		-	-	
Governance	Number of Inpatient Falls	Monthly	9	9	5	9	10	9	6	7	7	8	10	5	4		-	-	
Governance	Number of Infection Incidents (Reportable)	Monthly	0	0	0	0	0	1	0	0	0	0	0	0	0		-	-	
Governance	Number of Complaints	Monthly	9	4	6	11	3	7	8	8	6	8	5	6	9		-	-	
Governance	Number of PAL contacts	Monthly	49	63	53	36	59	36	63	60		52	56	41			-	-	
Governance	Number of Claims	Monthly	0	0	0	0	0	0	0	0	0	0	2	1			-	-	
Governance	Number of Inquests	Monthly	0	0	0	0	0	1	0	0	0	0	0	0	0		-	-	

Metric Grouping	Metric Name	Reporting Period	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend	Latest Variation	Latest Assurance	Target
Infection Control	Total MRSA cases identified on or during admission	Monthly	0	0	0	0	0	0	0	0	0	1	0	0	1				
Infection Control	MRSA Acquisitions	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0				
Infection Control	MRSA bacteraemias	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0				
Infection Control	Total MSSA cases identified on or during admission	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0				
Infection Control	MSSA bacteraemias	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0				
Infection Control	Total C. difficile GDH +ve cases identified on or during admission	Monthly	1	0	0	0	0	0	0	0	1	0	0	0	1				
Infection Control	Total C. difficile Toxin +ve - Hospital Onset - Healthcare Associated (HO-HA)	Monthly	0	0	0	0	0	0	0	0	1	0	0	0	0				
Infection Control	Total Escherichia coli bacteraemia	Monthly	0	0	0	0	0	0	0	0	0	1	0	0	0				
Infection Control	Klebsiella species bacteraemia	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0				
Infection Control	Pseudomonas aeruginosa bacteraemia	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0				
Infection Control	Total Influenza cases identified on or after admission	Monthly	0	0	0	0	1	2	0	0	0	1	0	0	0				
Infection Control	Influenza Outbreaks	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0				
Infection Control	Total SARS CoV-2 cases identified on or during admission	Monthly	0	0	0	0	0	0	0	0	0	1	1	0	0				
Infection Control	SARS CoV-2 Onset classification Definite - identified >14 days after admission	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0				
Infection Control	SARS CoV-2 Onset classification Probable - identified 8-13 days after admission	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0				
Infection Control	SARS CoV-2 Onset classification indeterminate - identified 3-7 days after admission	Monthly	0	0	0	0	0	0	0	0	0	1	0	0	1				
Infection Control	SARS CoV-2 Outbreaks	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0				
Infection Control	Monthly Hand Hygiene Audit Data - Trust total %	Monthly	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	91.00%	99.00%	100.00%				
Infection Control	Surgical Site Infections Per Month (inpatient & readmission - month of surgery)	Monthly	2	2	0	2	3	0	2	3	0	2	2	1	2				

Metric Grouping	Metric Name	Reporting Period	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend	Latest Variation	Latest Assurance	Target
Headline Producitivity	Implied Productivity Growth (v 19/20)	Monthly	-16.20%	-14.80%	-14.40%	-15.70%	-15.80%	-15.10%	-14.20%	-14.20%	-12.00%						-	-	
Headline Producitivity	Implied Productivity Growth (V previous year)	Monthly	-2.10%	-0.30%	0.70%	0.20%	-1.30%	-1.20%	0.20%	0.60%	0.00%						-	-	
Workforce Productivity	Implied Workforce Productivity Growth (v19/20)	Monthly	-21.30%	-15.90%	-15.70%	-12.80%	-14.10%	-13.10%	-10.90%	-9.50%	-8.20%						-	-	
Workforce Productivity	Elective Admissions per clinical WTE	Monthly	3.10	2.91	2.92	2.90	2.91	2.67	3.25	3.15	2.89	2.86	2.88	2.84	2.99				
Workforce Productivity	Elective Admissions per WTE	Monthly	1.05	0.96	0.99	0.96	0.96	0.87	1.06	1.04	0.95	0.90	0.92	0.90	0.96		-	-	
Workforce Productivity	Outpatient Attendances per consultant wte	Monthly	75.11	75.48	73.41	80.32	76.67	74.70	92.71	77.52	77.87	75.31	70.83	74.92	78.64		-	-	
Workforce Drivers	Total Temporary Staff Spend as % of Total Spend	Monthly	12.00%	12.00%	11.00%	11.00%	10.00%	10.00%	10.00%	10.00%	10.00%	5.60%	5.90%	6.00%	6.40%		-	-	
Workforce Drivers	Reg Nurses Sickness Absence Rate	Monthly	6.80%	5.90%	6.40%	6.10%	7.80%	7.80%	8.40%	8.60%	6.90%	6.36%	7.71%	7.10%			-	-	
Workforce Drivers	Medical Sickness Absence Rate	Monthly	0.70%	0.80%	1.20%	1.00%	1.10%	1.10%	0.80%	0.50%	1.10%	0.75%	0.12%	0.30%			-	-	
Workforce Drivers	Turnover (Adjusted)	Monthly	10.58%	11.18%	11.07%	10.70%	11.20%	11.50%	10.90%	11.10%	11.83%	9.28%	10.73%	10.64%	10.50%		-	-	
Workforce Drivers	Care Hours per Patient Day (Reg Nurses)	Monthly	5.60	6.00	5.40	5.30	5.20	5.80	5.50	4.77	4.59	5.26	5.19	6.34			-	-	

Metric Grouping	Metric Name	Reporting Period	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Trend	Latest Variation	Latest Assurance	Target
Operational Productivity	Theatre Number of Sessions Planned	Monthly	622	537	546	581	543	511	563	520	558	533	528	536	561		-	-	
Operational Productivity	Theatre Session Utilisation	Monthly	89.18%	83.24%	86.52%	84.19%	88.40%	85.48%	93.07%	89.23%	84.64%	90.42%	84.63%	83.05%	85.03%				85%
Operational Productivity	Theatre In-Session Utilisation Upcapped	Monthly	82.35%	81.33%	83.59%	81.19%	81.21%	79.36%	82.47%	83.64%	84.04%	84.38%	84.54%	82.37%	81.68%				85%
Operational Productivity	Theatre Touchtime Utilisation Upcapped	Monthly	77.42%	78.47%	80.94%	77.33%	78.27%	75.85%	75.86%	80.29%	81.12%	81.76%	80.48%	79.21%	77.34%		-	-	
Operational Productivity	Average Number Of Operations Per List	Monthly	2.93	2.97	2.90	2.64	2.84	2.78	3.05	3.08	2.96	3.15	3.19	3.12	3.00			-	
Operational Productivity	Average Mins Late Starts(minutes) *Based on 9pm Start Time	Monthly	0	0	2	1	1	0	1	0	0	0	0	0	0			-	
Operational Productivity	Average Early Finishes (minutes)	Monthly	90	86	87	94	92	117	94	85	83	82	84	84	92			-	
Operational Productivity	Average Patient Turnaround (minutes)	Monthly	14	13	12	17	14	13	14	13	11	13	16	13	16			-	
Operational Productivity	Total Cancellations	Monthly	66	57	51	78	56	66	75	60	53	65	57	54	70		-	-	
Operational Productivity	Admitted Treatment Deferred	Monthly	29	32	23	39	28	35	44	36	24	28	36	24	38			-	-
Operational Productivity	Cancelled By Hospital On Day of Admission	Monthly	3	3	7	10	3	6	4	2	3	2	2	2	5			-	-
Operational Productivity	Cancelled By Hospital Day Before Day of Admission	Monthly	34	22	21	29	25	25	27	22	26	35	19	28	27			-	-
Operational Productivity	LOS - Trust Wide All Services	Monthly	3.9	4.1	3.5	3.8	4.3	4.5	3.3	3.4	3.7	4.1	3.7	3.9	3.8			-	-
Operational Productivity	LOS - Excluding Oncology, Paeds,YAH, Spinal	Monthly	3.43	3.69	3.13	3.39	3.78	4.08	3.05	3.03	3.15	3.46	3.27	3.45	3.03			-	-
Operational Productivity	LOS - Elective Primary Hip	Monthly	2.5	2.8	3.1	2.7	3.2	3.0	3.0	2.4	2.7	2.5	2.9	2.7	2.8				2.7
Operational Productivity	LOS - Elective Primary Knee	Monthly	3.3	3.3	3.0	2.6	3.1	3.3	3.0	2.6	2.7	3.0	2.9	2.5	2.8				2.7
Operational Productivity	BADS Daycase rate	Monthly	0.57%	57.30%	54.80%	53.70%	51.70%	51.50%	52.40%	51.10%	53.40%	54.60%	53.50%	53.00%	52.40%		-	-	
Operational Productivity	OP for first or follow-up Attendances attracting a procedure tariff	Monthly	36.59%	37.33%	37.36%	34.51%	38.66%	37.44%	37.95%	37.35%	37.50%	38.00%	38.00%	37.50%	35.60%				

Quality Report

August 2025 (July 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

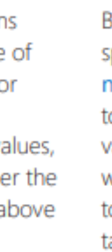
Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually 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.

N/A to SPC

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.

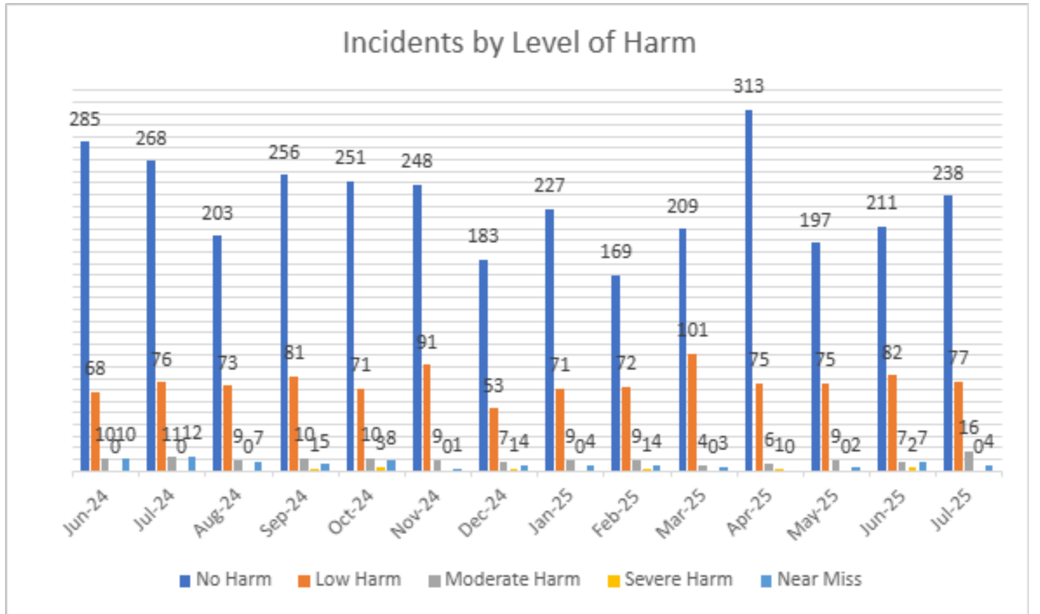
Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

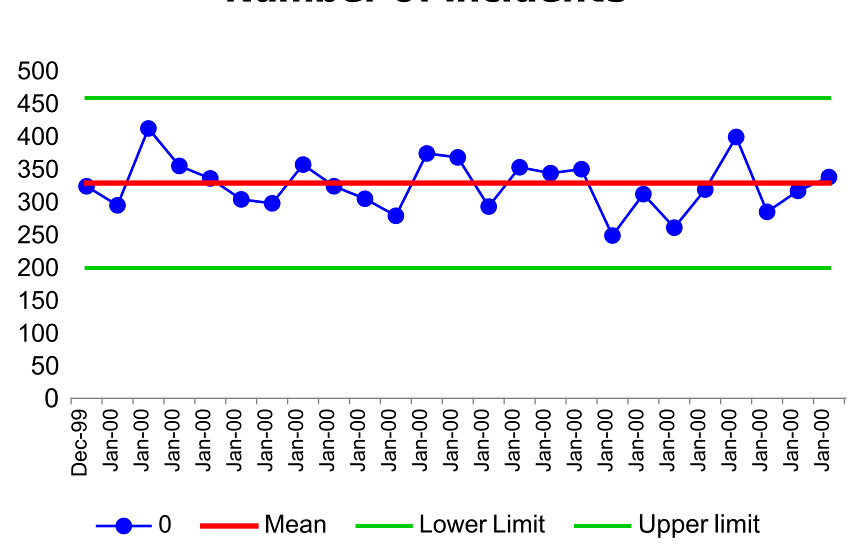
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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

Governance Performance Summary Dashboard

Performance to end July 2025	In month	Previous month	Variation	Assurance
Total No of Incidents Reported	337	316	H	P
Inpatient Deaths	1	1		P
PSII's (Patient Safety Incident Investigations)	1	1		P
Never Events	0	0		P
VTE Incidents (Avoidable)	0	0		P
Category 2 Pressure Ulcer Incidents (Avoidable)	0	0		P
Category 3 Pressure Ulcer Incidents (Avoidable)	0	0	H	P
Falls (Total No of Inpatient Falls)	4	5	L	P
Infection Incidents (Reportable)	0	0		P
Complaints	9	6	H	P
Claims	1	1		P
Inquest	0	0		P
RIDDOR Reportable Incidents	0	0		P

Incidents Reported





Quality Improvement & Learning

There were 337 incidents reported within the Trust during July 2025.

Incidents Reported...(continued)

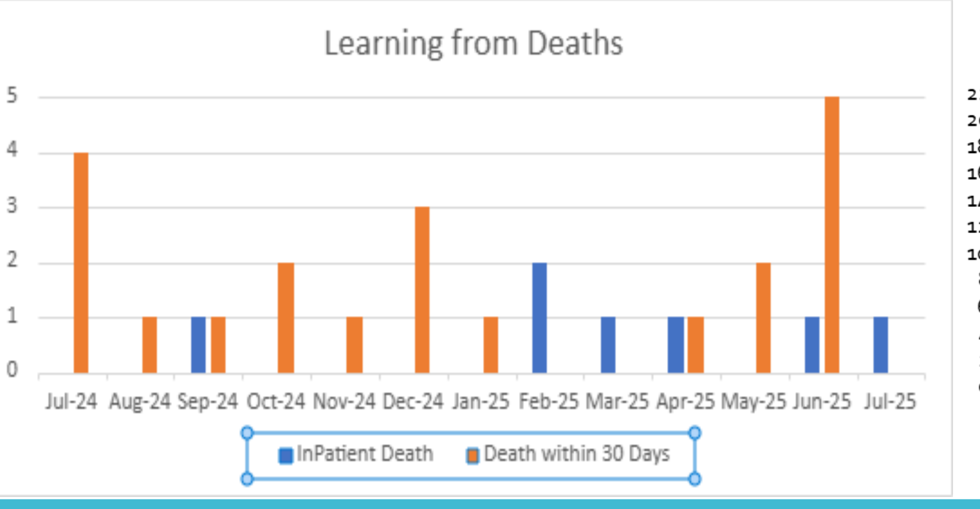
Financial Year 2025-2026

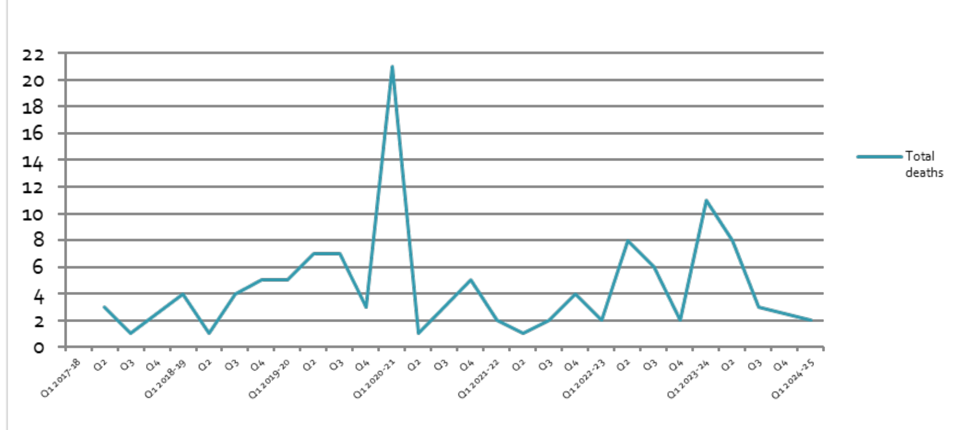
PSIRF Investigation Method	In Month	Last month	Year to Date
PSII	1	1	3
AAR	2	1	4
MDT	0	0	0
Thematic Review	0	0	1

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

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

Learning from Deaths





Quality Improvement & Learning

There was 1 inpatient death reported in July 2025. Structured judgement review has been completed with no further action required. Shared for noting with the Divisional Governance Committee and this will remain open for review pending Coronial closure.

Infection Prevention & Control

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

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

	CDI (Toxin +ve)	E.coli BSI	P. *aeruginosa* BSI	*Klebsiella* Sp. BSI	MRSA BSI
2023/24	5	0	0	1	0
2024/25	1	2	0	0	0
2025/26	0	1	0	0	0

QUALITY IMPROVEMENT WORK

E.coli BSI:

1 case to date since 1 st of April 2025. This is 1 more than the NHS England threshold of 0 cases.

Themes and learning:

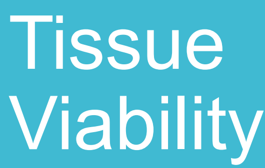
SSI prevention group continues work to create and implement a bespoke ROH orthopaedic SSI prevention bundle.
Delays to this work are ongoing due to the finalisation of interventions within some of the bundle elements (decision on pre-op washing and interventions to monitor and improve pre and intraoperative patient warming).

Recommendations:

- Note SSI risk rates and continue to monitor.

SSI:

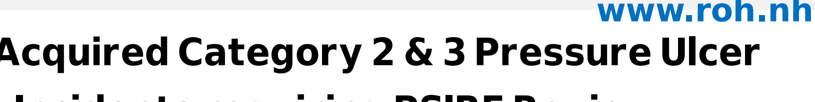
Note: data is subject to change as the reporting period has not closed.
7 SSI reported to date since the 1 st of April 2025 (2 hip, 4 knee, 1 spine)
Data for Q1 January to March 2025 was shared with speciality leads and the SSI prevention group at the end of June 2025.

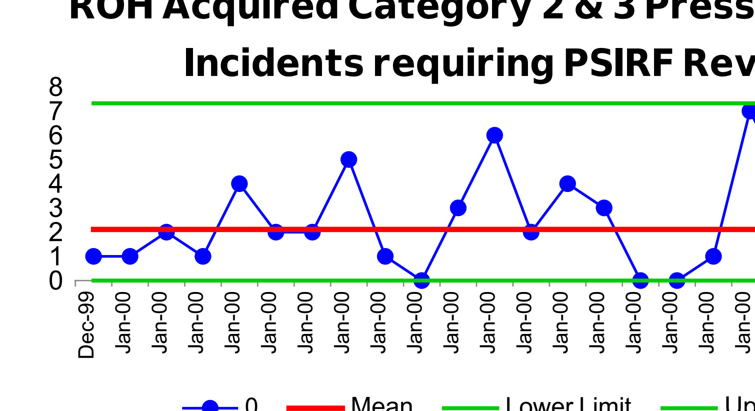


Tissue Viability

Category 2 & 3 Pressure Sore Incidents

PSII, AAR, MDT, Thematic Review, Locally Managed





Quality Improvement & Learning

There was 1 hospital acquired category 2 pressure ulcer incident reported in July 2025.

There was 1 skin tear incident reported in July 2025

AAR's have been commissioned to review the above incidents. An update on the identified learning will be provided in a future report.

Key Themes
Drape removal in theatres causing skin damage.

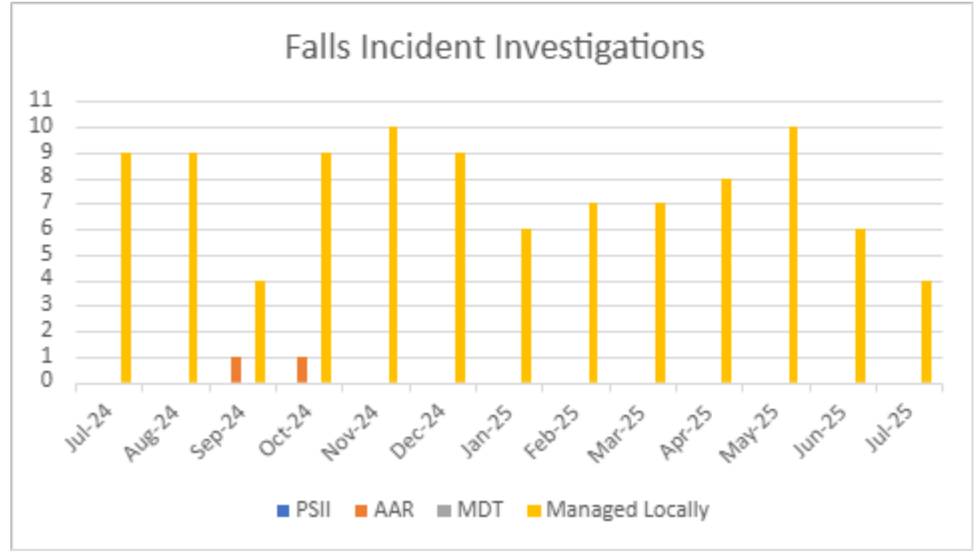
Quality Improvements
PURPOSE-T fully implemented.
TV Assurance audits to be undertaken

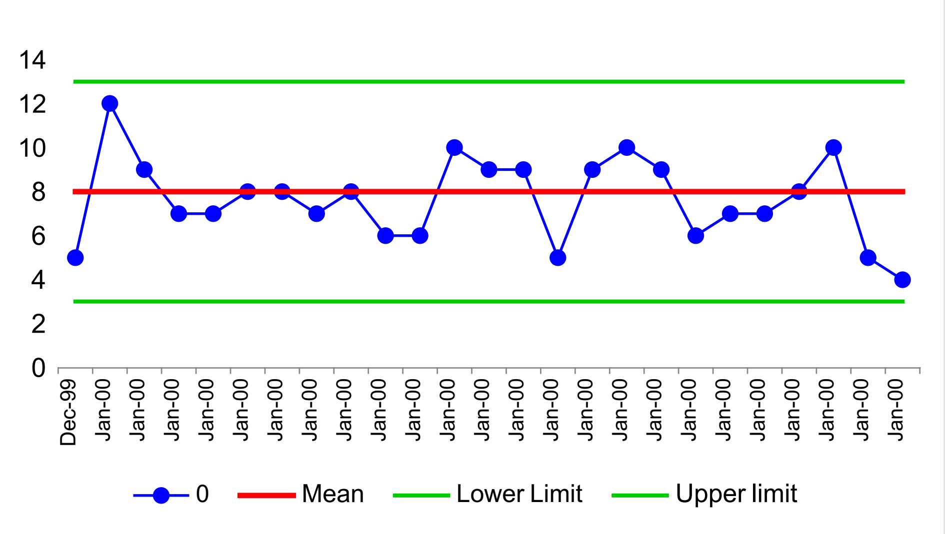
ROH Registered Nurses Education Review
Underway – in progress

Pressure Ulcer Policy
Amendments regarding PURPOSE – T in progress

Report

Falls





Quality Improvement & Learning

There were 4 inpatient falls reported in July 2025. All incidents were managed locally.

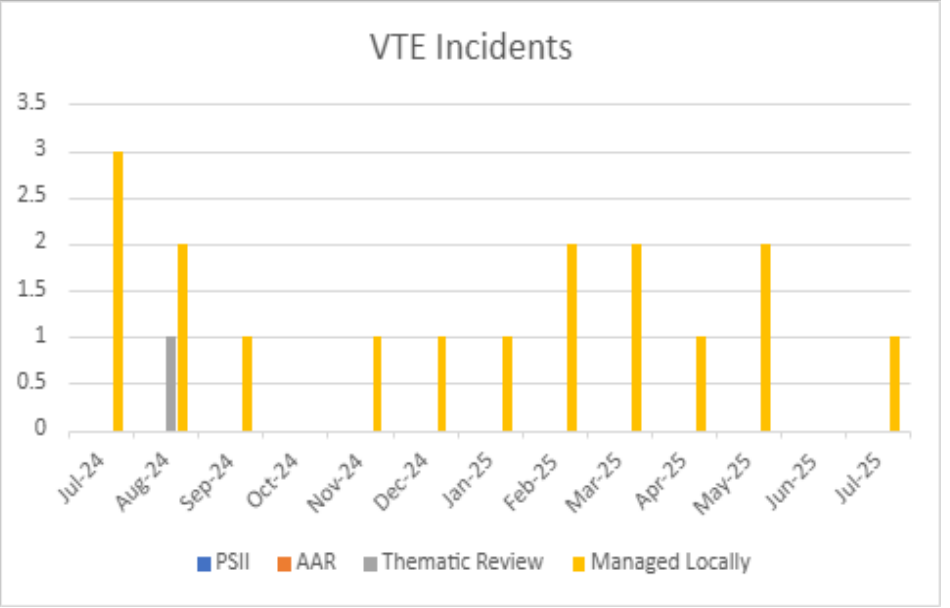
Themes

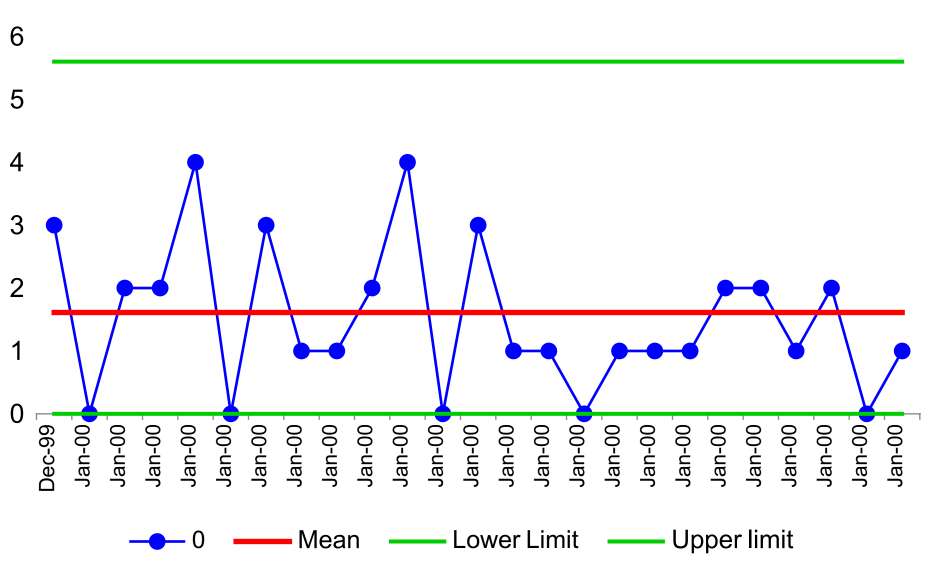
- 2 of the reported falls involved patients mobilising against advice
- 2 of the reported falls were unwitnessed

Quality and Improvement Work

- Falling leaves usage audit to be added to AMaT to monitor and improve compliance, this will be audited on quarterly basis initially.
- Identified that currant bed rails policy needs updating, renaming and extending to incorporate additional areas, looking to form a working group to review/update.
- Updated NICE falls guidance – plan to review at next Falls/Dementia meeting.
- BSoL ICS Falls Prevention Strategy 2025-2028 launched, need to review Trust against the strategy.
- Estates work still outstanding in relation to ward 4 bathrooms and falls risk. Estates manager looking to commission fabrication of free- standing toilet roll holders and install as a priority. Head of Nursing has requested an update on when this work will commence.

VTEs





Quality Improvement & Learning

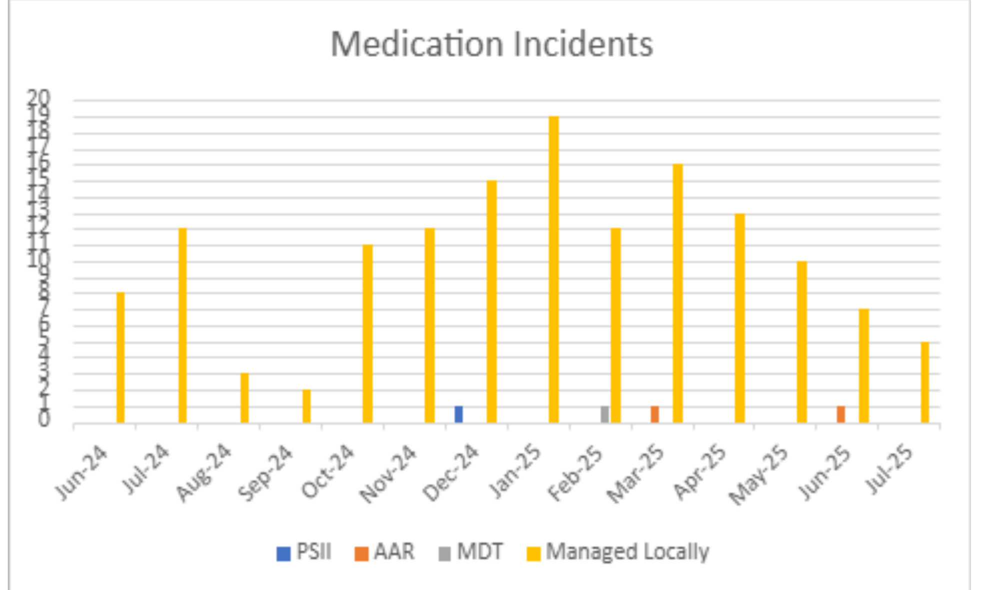
There was 1 confirmed VTE incident reported in July 2025. A triage questionnaire will be completed with an update provided in a future report.

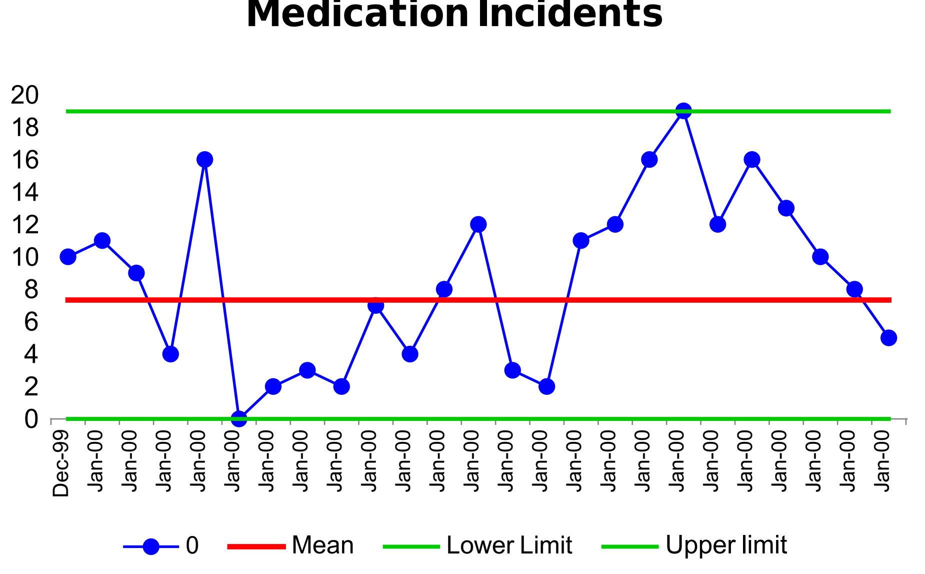
All recent VTE incidents have been deemed unavoidable after review.

VTE On Admission Assessment Compliance

Compliance figure for July 2025: 99.59%

Medication Errors





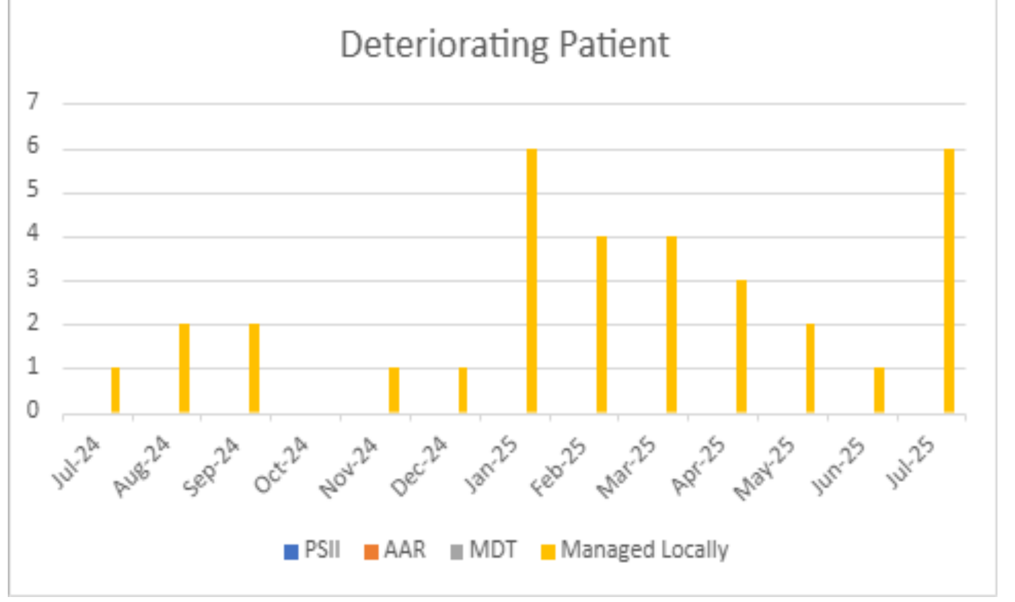
Quality Improvement & Learning

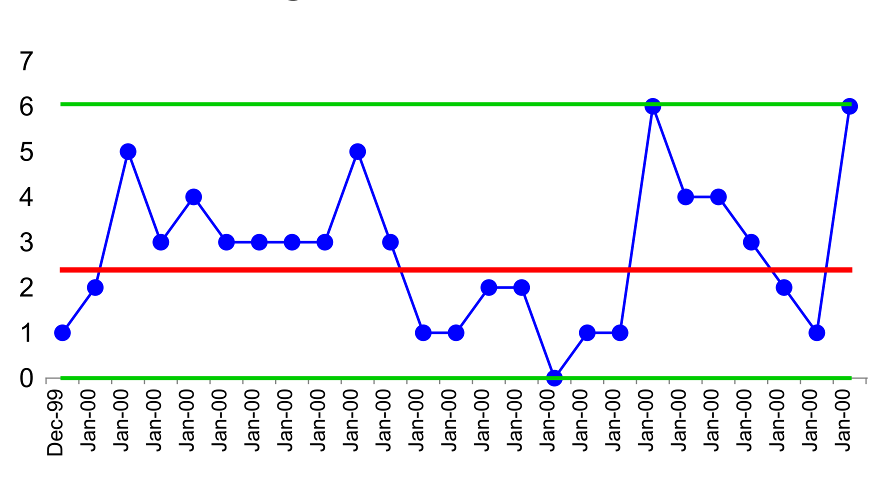
There were 5 Medication incidents reported in July 2025. All incidents were managed locally.

Quality Improvements

Pharmacy have undertaken a review of antibiotic stockholding in ward areas and reprinted a poster highlighting the locations of all antibiotics that may be prescribed for sepsis.

Deteriorating Patients



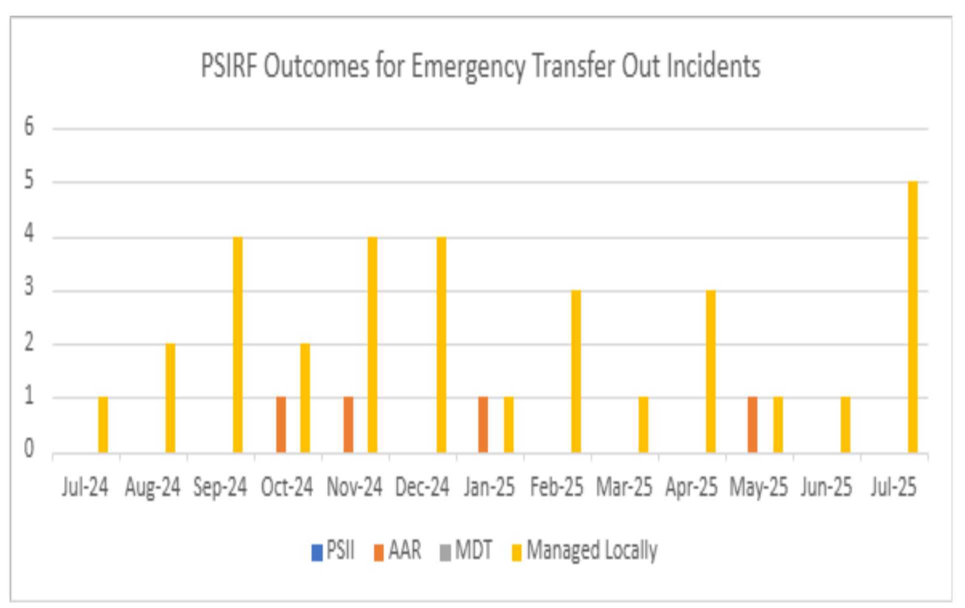


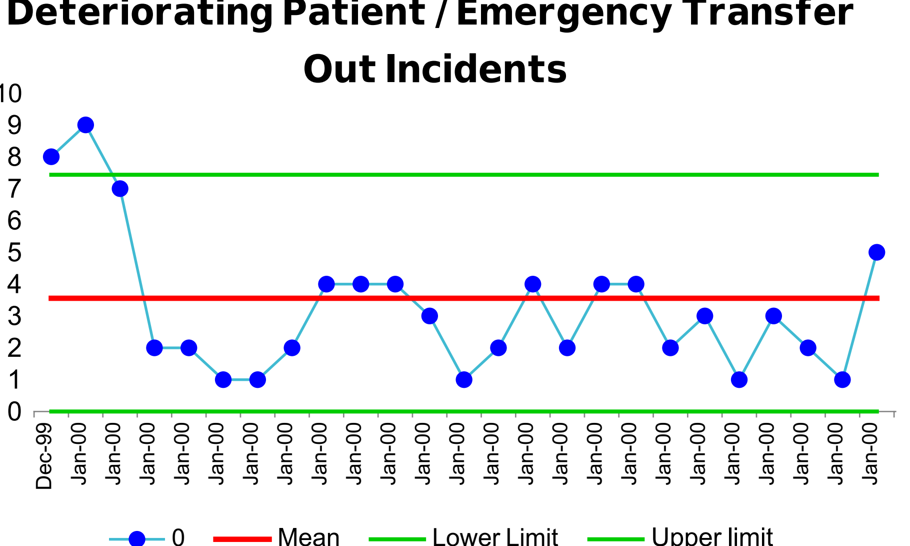
Quality Improvement & Learning

There were 6 deteriorating patient incidents reported in July 2025. All incidents were reported as no or low harm and were managed locally. All incidents were managed appropriately, with timely transfer to HDU for closer observation.

There are no identifiable themes to explain the rise in incidents this month.

Emergency Transfers Out





Quality Improvement & Learning

There were 5 emergency transfer out of Trust incidents reported in July 2025. All incidents were managed locally. The transfers out were all managed appropriately, with quick escalation and timely transfer for further care.

Complaints

Complaint Information

The Trust received **9** complaints in July 2025

Below are the departments that received complaints

- Small Joints
- Oncology
- Appointments
- Private Care
- HDU
- Imaging
- ROCS
- Spinal
- Theatres

In July 2025, the complaints team closed **8** formal complaints, 4 complaints breached the timeframe agreed with the complainant.

KPI = 50%

At the time of producing this report (11.08.2025) we currently have **23** formal complaints open
4 are reopened complaints **, 2** of these are in relation to the Private Service.

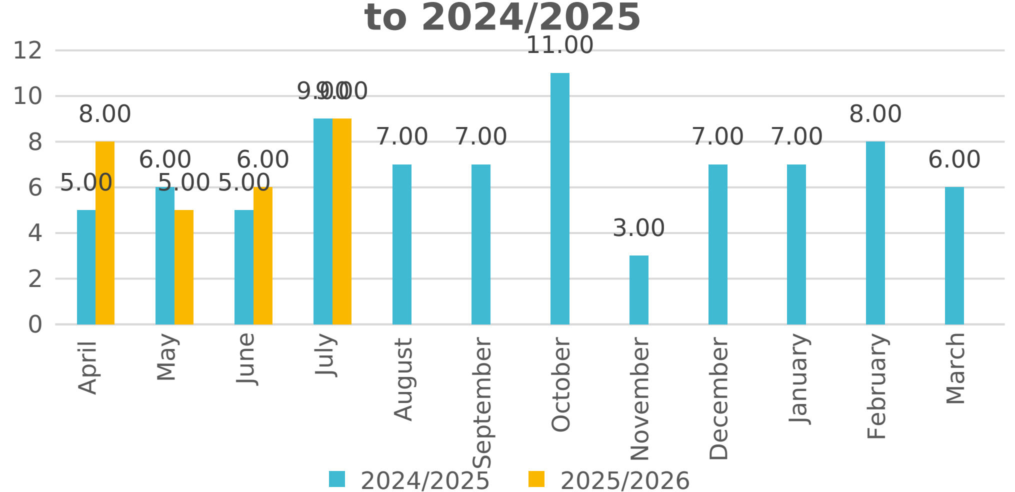
Complaints are reviewed in Divisional Governance meeting and weekly by HoPE, ADoD and HoN. A thematic review is also underway to review the recent Private Patient complaints.

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 July 2025 the Trust received 1 request for a resolution meeting.

Complaints



KPI's

KPI	Complaints %
April 2024	43%
May 2025	40%
June 2025	70%
July 2025	50%

0%-79%
80%-90%
91%-100%

4/8 complaints breached the agreed timeframe with the complainant

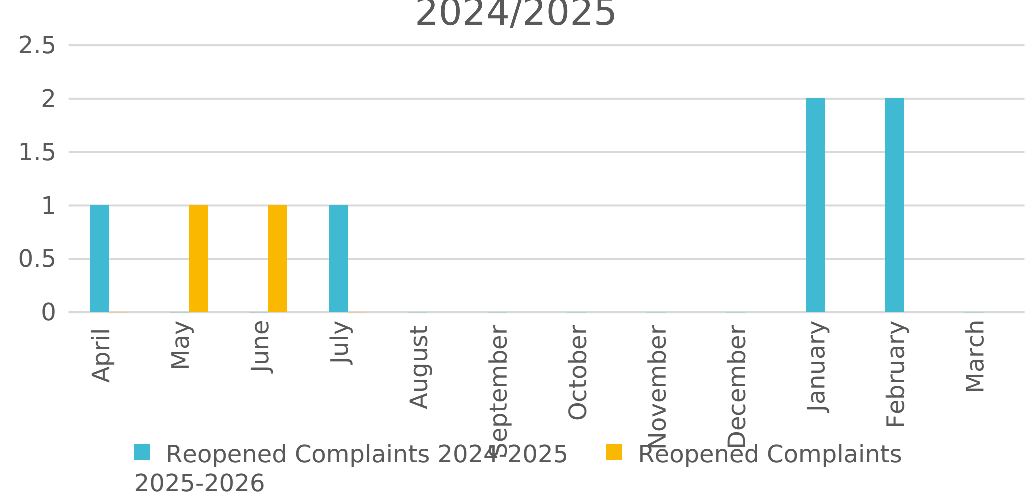
Complaint Year Totals	
April 2023 - March 2024	42
April 2024 – March 2025	92
April 2025 – July 2025	28

Themes of complaints received

- Appointment not satisfactory
- Care needs not adequately met
- Catheter Care
- Conflicting Information
- Dispute over diagnosis / treatment
- Failure to provide follow up
- Referral not actioned
- Unsatisfactory Care provided

Report

Complaint Themes



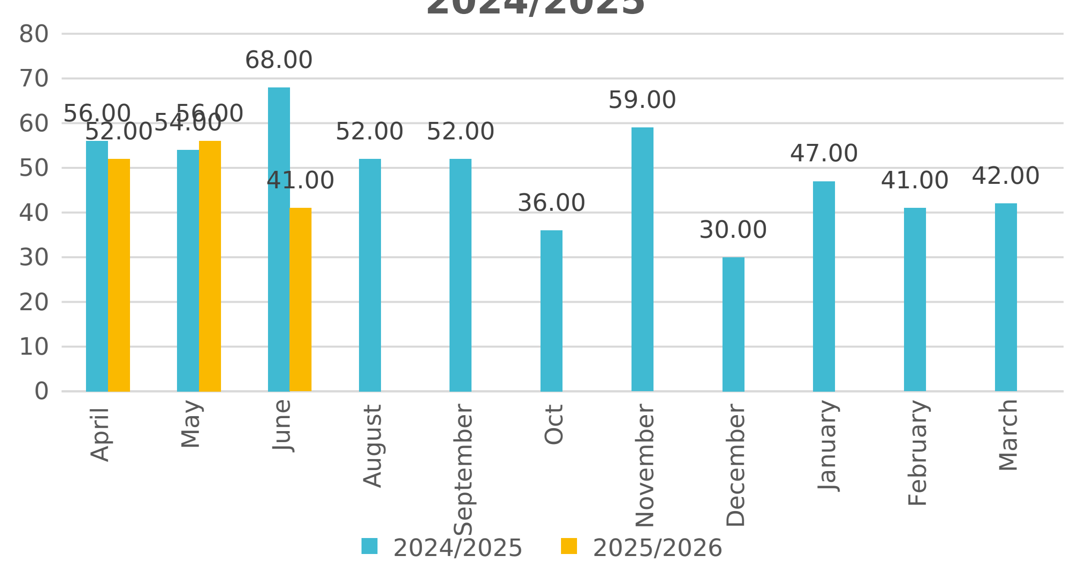
Reopened complaints

The Trust received 0 request to reopen a complaint in July 2025

What We Did / Are Doing

1. Raised in divisional governance meeting to track themes.
2. Tracked in Executive Governance Meeting
3. Ensuring actions are created and entered to Ulysses and action plans.
4. Ensuring relevant departments are aware of concerns
5. Requesting updates on outstanding actions in bi-weekly governance meetings
6. HoPE sending out weekly reminders to triumvirate, executives and identified leads
7. Internal investigations – PALS department is making it more clear which cases they have resolved before reaching the divisions.

Patient Advice and Liaison Service - PALS



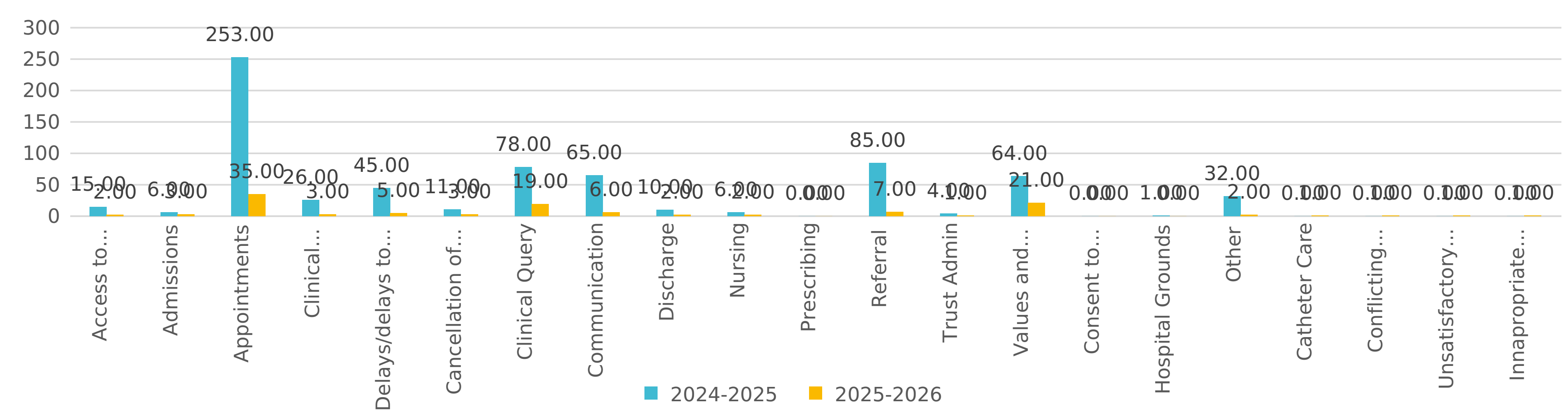
KPI's

KPI	
April 2025	83%
May 2025	74%
June 2025	81%
July 2025	70%

12 PALS Concerns breached in July 2025

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

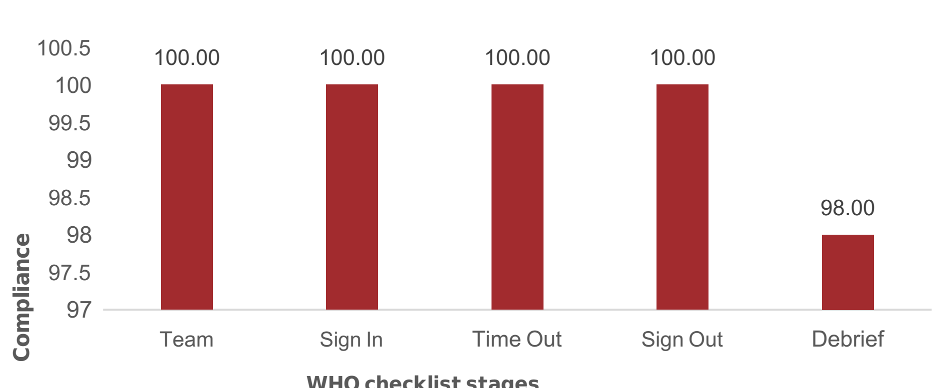
PALS Themes

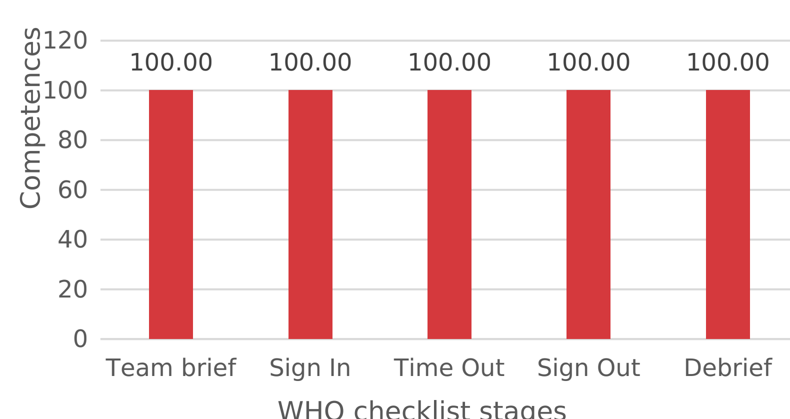


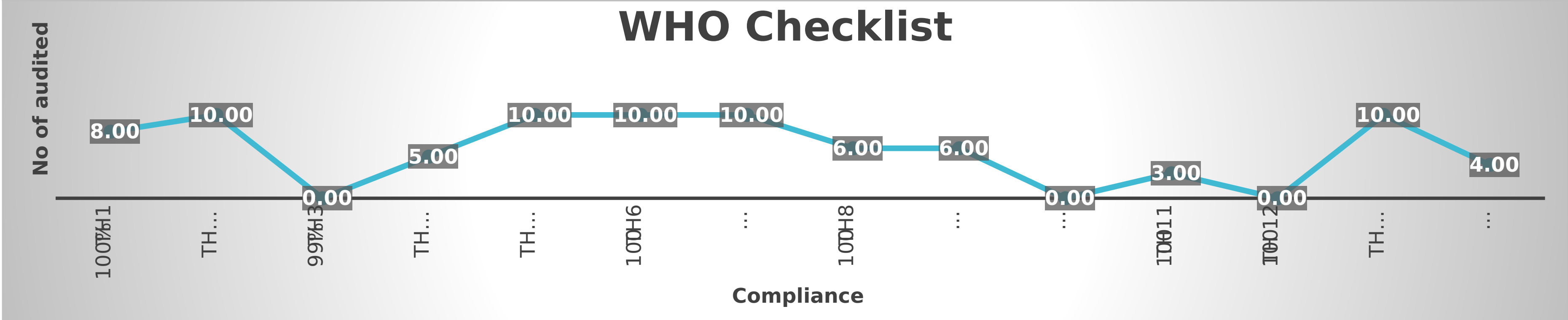
What we have done / are doing:

- Tracked in Executive Governance Meetings and via bi-weekly divisional governance meetings
- Tracked and discussed at weekly meetings between Head of Patient Experience, Head of Nursing and Associate Director of Ops.
- Escalation to ensure PALS cases are responded to.
- Head of Patient Experience sending out individual reminders on outstanding PALS alongside the weekly reminders and is meeting with leads to support resolution.
- PALS Team are managing and resolving PALS contacts within their remit.

WHO Audits







Quality Improvement & Learning

Total Number of Patients = 847

Work in Progress –A new team brief document was introduced to team leads in July's QUIDD and is currently being piloted within the oncology cluster. Further work is planned for the remaining stages of the WHO checklist.

CAS Alerts – New Alert

CAS Alerts Received 1- 31 JULY 2025

Reference	Alert Title	Originated By	Issue date	Response	Deadline
NatPSA/2025/004/MVA	Shortage of Antimicrobial Agents Used in Tuberculosis (TB) Treatment. The following antimicrobial medicines used to treat tuberculosis (TB) will be intermittently available until at least the end of 2025: •Rifampicin 150mg and 300mg capsules •Rifampicin 600mg IV solution for infusion •Rifampicin 100mg/5ml oral suspension •Rifinah® 300 tablets (rifampicin 300mg / isoniazid 150mg) •Rifater® tablets (rifampicin 120mg / isoniazid 50mg/ pyrazinamide 300mg) •Voractiv® tablets (rifampicin 150mg/ isoniazid 75mg / pyrazinamide 400mg / ethambutol 275mg) •Pyrazinamide 500mg tablets Ethambutol tablets, Isoniazid tablets, and Rifinah® 150 tablets (rifampicin 150 mg / isoniazid 100 mg) and Mycobutin® (rifabutin) 150mg capsules remain available but cannot support a full increase in demand. The supply disruption is caused by a combination of factors.	DHSC	29 Jul 2025	Acknowledged. Assessing relevance – request sent to pharmacy and patient safety team to determine relevance.	15 Aug 2025
NatPSA/2025/003/DHSC	Shortage of bumetanide 1mg tablets. Bumetanide 1mg tablets are out of stock until mid-August 2025. Bumetanide 1mg tablets are out of stock until mid-August 2025. The supply disruption is caused by a combination of manufacturing issues and a resulting increase in demand to other suppliers. Bumetanide 1mg/5ml oral solution and bumetanide 5mg tablets remain available, however cannot support any increase in demand. Furosemide 20mg and 40mg tablets remain available and can support increased demand. This National Patient Safety Alert provides further background, clinical information and actions for providers.	DHSC	3 Jul 2025	Actions Complete Pharmacy confirmed stock levels sufficient - no further action required.	11 July 2025

CAS Alerts Continued

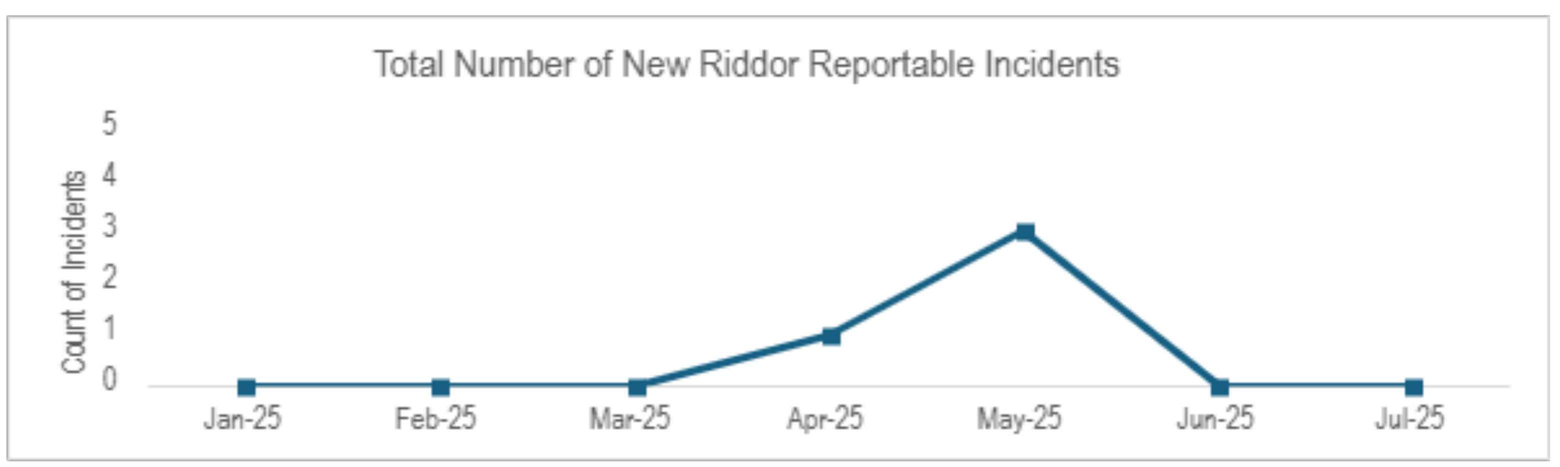
Reference	Alert Title	Originated By	Issue date	Response	Deadline
NatPSA/2025/002UKHSA	Potential contamination of non-sterile alcohol-free skin cleansing wipes with Burkholderia spp: measures to reduce patient risk UKHSA is investigating an outbreak of Burkholderia stabilis involving individuals across the UK, linked to wipes. Following testing, Burkholderia spp. (full identification pending) has been recovered from several non-sterile alcohol-free skin cleansing wipes, including those used for wound care and included in first aid kits.	UKHSA	26 Jun 2025	Acknowledged. Currently assessing relevance – IPC enquiring with stores to review whether any non-sterile wipes sourced or used across Trust.	29 Aug 2025

CAS Alerts Continued

Alerts from Previous Months (Outstanding)

Reference	Alert Title	Originated By	Issue date	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 within divisional governance'.* **Estates:** Beds tagged to aid compilation of Estates inventory. Beds & bedrails now to be serviced by our in-house engineers. Update from Patient Safety Team (16.04.25): Progress made. Policy being updated, waiting for bed rail risk assessment to be updated within the community. Ongoing…. Awaiting confirmation regarding bed rails in community risk assessment (updates) – Therapies MDSO developed action plan for closing out remaining actions	1 Mar 2024. On-going…

RIDDOR reportable staff incidents



Quality Improvement & Learning

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

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

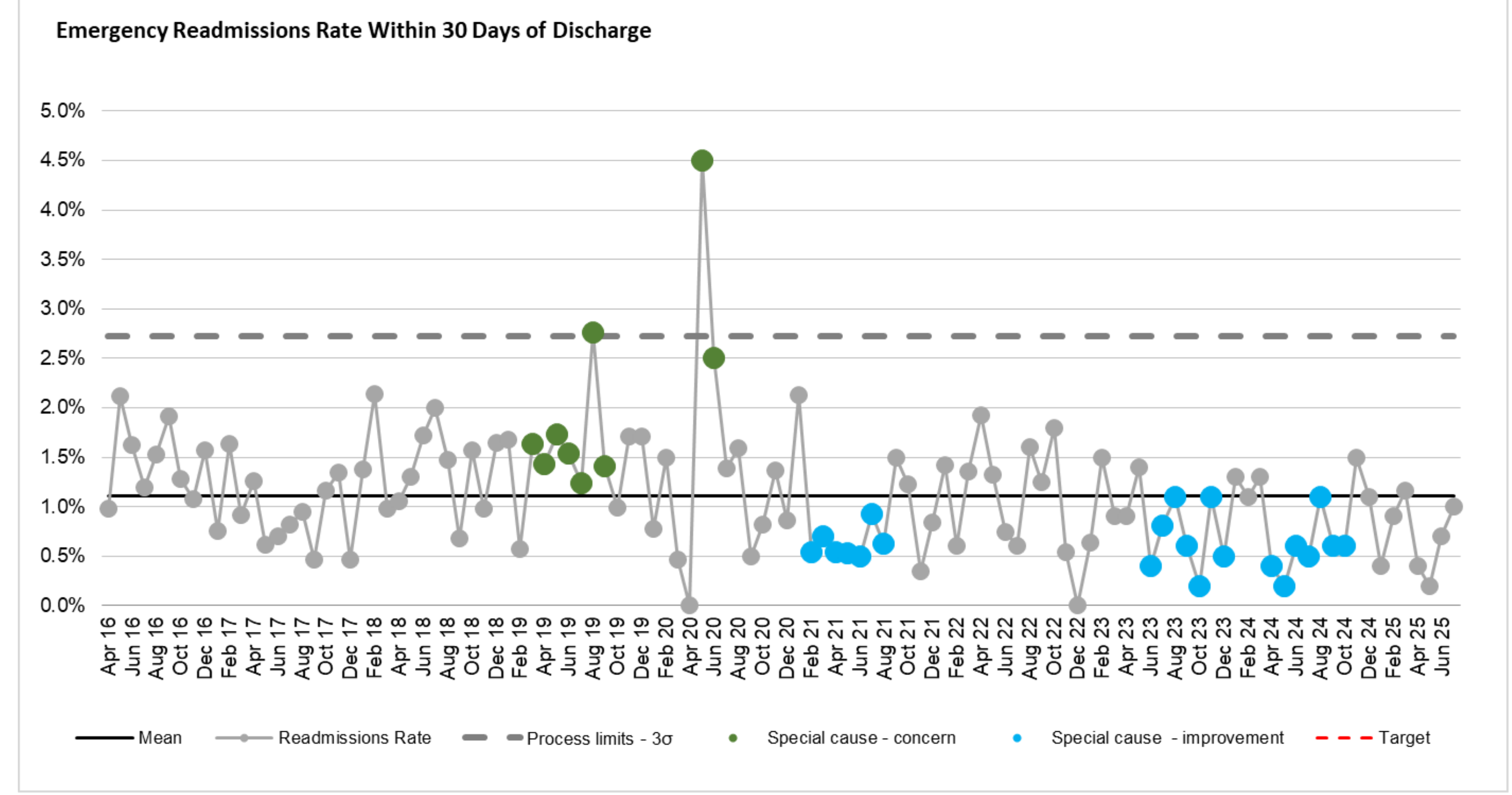
Safeguarding Training Compliance

KPI	July 2025
Safeguarding Adult Notifications	71
Safeguarding Children and Young People Notifications	39
Adults Level 1- Target 90%	93.91%
Adult Level 2 -Target 85%	93.30%
Adult Level 3- Target 85%	85.89%
Level 4- Target 90%	80.0%
Child Level 1 -Target 90%	93.68%
Child Level 2- Target 85%	92.85%
Child Level 3- Target 85%	85.89%
Mental Capacity Act MCA- Target 85%	94.29%
Deprivation of Liberty Safeguards DoLs	94.29%
Prevent Awareness- Target 95%	91.42%
WRAP (prevent level 3)- Target 90%	85.06%
Domestic Abuse	21
FGM	4
DOLS	14
MCA	4
PIPOT cases	1
PREVENT Notifications	0

Actions underway:

- Raised by Executive lead with individual leads address with teams.
- Increase access to session
- DNA reports sent to managers
- Level 4 compliance - in order to be compliance it requires over 24 hours on training, this is a new person in post, who is working towards this.

Readmissions



	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
No of Readmissions	5	3	3	8	5	2	5	6	2	1	3	5
Denominator	458	510	535	544	476	552	531	516	445	508	455	510
% Readmissions	1.1%	0.6%	0.6%	1.5%	1.1%	0.4%	0.9%	1.2%	0.4%	0.2%	0.7%	1.0%

Freedom to Speak Up

There were 10 concerns raised to FTSU in July 2025.

The themes from concerns raised were in relation to:-

Inappropriate attitude and behaviour
Worker safety and wellbeing
Lack of Inclusion within team
Learning and Improvement:

Quality Improvements & Learning

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

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

Safe Staffing

Nursing

	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 Night-Non reg	RNA Day Hours	RNA Night Hours	Total WTE as % establishment (%)	Turnover (%)	Sickness (%)	Maternity (%)	Cumulative count of pts at 23.59 per day	Actual CHPPD	Red Flags Opened	Red Flags Closed	Enhanced Care Hours	Medication Administration Error or concern	Pressure Ulcers Category 2,3 & 4	All Reported Falls	No. of PALs Contacts	No. of New Complaints	No. of FFT
Ward 1	76%	90%	100%	88%	192	0	12%	12%	0.00%	0.00%	13.35	6.6	0	0	0	1	0	1	0	0	0%
Ward 2	74%	80%	85%	100%	218	66	6%	6%	0.00%	0.00%	14.29	7.6	0	0	256.5	0	2	0	0	0	0%
Ward 3	97%	115%	108%	159%	151.5	11	16%	16%	0.00%	0.00%	19.32	7.3	0	0	534.5	0	3	1	0	0	0%
Ward 4	99%	106%	102%	124%	60	0	15%	15%	0.00%	0.00%	14.38	8.3	0	0	175.5	1	0	1	0	0	0%
Ward 12	82%	108%	103%	135%	119	0	17%	17%	0.00%	0.00%	8.45	9.1	0	0	134.5	2	0	2	0	0	0%
HDU	89%	46%	87%	100%	0	0	9%	9%	0.00%	0.00%	3.16	25.9	0	0	22	0	0	0	0	0	0%
Total/Combined/Average	86.17%	90.83%	97.50%	117.67%	123.42	12.83	12%	12%	0.0%	0.0%	73	64.63	0	0	1123	4	5	5	0	0	0%

Quality Improvements & Learning

Dashboard continues to be developed and forms part of discussion in the Nursing and Workforce Group
Throughout July a series of ward closures have taken place. To support vacancies or enhanced observations staff have been redeployed and this has reduced the requirement for bank staff.
Establishment review is in progress, posts are being review using the QIA process.

Safe Staffing

Core Services

Ward Name	Fill Rate (KPI >90%=Green, 80-90%=Amber, <79%=Red)				Workforce						Roster Safe Care Indicators			Nurse Sensitive Indicators			Patient Satisfaction		
	Fill Rate Day-Nurses	Fill Rate Day-Non reg	Fill Rate Night-Nurse	Fill Rate Night-Non reg	RNA Day Hours	RNA Night Hours	Total WTE as % establishment (%)	Turnover (%)	Sickness (%)	Maternity (%)	Red Flags Opened	Red Flags Closed	Enhanced Care Hours	Medication Administration Error or concern	Pressure Ulcers Category 2,3 & 4	All Reported Falls	No. of PALs Contacts	No. of New Complaints	No. of FFT
Outpatients	67%	73%	100%	100%	0	0	21%	21%	0.00%	0.00%	0	0	-	0	0	0	0	0	0%
CYP OPD	30%	85%	100%	100%	0	0	-	-	-	-	-	-	-	0	0	0	0	0	0%
ADCU	50%	60%	100%	100%	192.33	0	5%	5%	0.00%	0.00%	0	0	-	0	0	0	0	0	0%
POAC	83%	96%	100%	100%	0	0	5%	5%	0.00%	0%	0	0	-	0	0	0	0	0	0%
Theatres	78%	69%	100%	100%	95.5	0	11%	11%	0.00%	0.00%	1	0	-	1	0	0	0	0	0%
Theatres recovery	75%	81%	100%	100%	0	0	-	-	-	-	0	0	-	0	0	0	0	0	0%
Discharge Lounge	102%	96%	100%	100%	0	0	-	-	-	-	0	0	-	0	0	0	0	0	0%
Total/Combined	69.29%	80.00%	100.00%	100.00%	41.12	0.00	10%	10%	0.00%	0.00%	1	0	-	1	0	0	0	0	0%

Allied Health Professionals

Ward Name	Fill Rate (KPI >90%=Green, 80-90%=Amber, <79%=Red)				Workforce						Nurse Sensitive Indicators		
	Fill Rate Day-Nurses	Fill Rate Day-Non reg	Fill Rate Night-Nurse	Fill Rate Night-Non reg	RNA Day Hours	RNA Night Hours	Total WTE as % establishment (%)	Turnover (%)	Sickness (%)	Maternity (%)	Medication Administration Error or concern	Skin Damage	All Reported Falls
In-patient Physio	100%	100%	100%	100%	0.00%	0.00%	-	-	-	-	-	-	-
Outpatient Physio	100%	100%	100%	100%	0.00%	0.00%	-	-	-	-	-	-	-
Radiology MRI	100%	100%	100%	100%	0.00%	0.00%	-	-	-	-	-	-	-
Radiology X-Ray/CT	100%	100%	100%	100%	0.00%	0.00%	-	-	-	-	-	-	-
Total/Combined	100%	100%	100%	100%	0.00%	0.00%	-	-	-	-	-	-	-

Operational Performance Summary

Performance to end June 25	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	60.07%	58.33%	55.17%		P
104 week waits	0	0	0	L	P
78+ week waits	0	0	0	L	P
65 Week waits (65-77 weeks)	0	0	0	L	P
52 week waits (52 – 64 Weeks)	466	507	539	L	P
All activity YTD (compared to plan)	3,575	2,371	3,427		P
Outpatient activity YTD (compared to plan)	17,978 103.7% Cumulative	11,845 102.9% Cumulative	17,340 YTD Target		P
Outpatient Did Not Attend (YTD)	6.4%	6.5%	8%		P
PIFU (trajectory to 5% target)	575 9.78%	579 10.4%	537 5%	H	P
FUP attendances(compared to 19/20)	107.4%	104.3%	75%		P
Diagnostics volume YTD (compared to 19/20) – All Modalities	115.6%	113.4%	120%		F
Diagnostics volume YTD (compared to plan)	6,440 Cumulative	4,192 Cumulative	6,152 YTD Target		P
Diagnostics 6 week target	99.9%	99.7%	99%		P

Operational Performance Summary

Performance to end June 25	In month	Previous month	Target	Variation	Assurance
Theatre utilisation	83.1%	84.6%	85%		F
Theatre In Session Utilisation	82.4%	84.5%	85%		F
Cancer - 31 day first treatment	100%	100%	96%		P
Cancer - 62 day (traditional)	88.2%	85.7%	70% Nat 85% Trust		P
28 day FDS	80.6%	77.3%	75%		P
Patients over 104 days (62 day standard)	0	0	0		No Target
POAC activity volume (YTD)	5,574 Cumulative	3,555 Cumulative	5,600 Cumulative		F
Bed Occupancy (excluding CYP and HDU)	74.7%	73.0%	82-85%		F
LOS - excluding Oncology, Paeds,YAH, Spinal	3.45	3.27	n/a		No Target
LOS - elective primary hip	2.70	2.9	2.7		P
LOS - elective primary knee	2.50	2.9	2.7		P
BADS Orthopaedic: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period) Mar 25	53.0%	53.5%	85%		F
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Mar 25)	35.6%	37.5%	-		No Target

Workforce Performance Report

Prepared by:
Matt Dingle, Head of Human Resources
Clare Mair, Head of OD & Inclusion
David Richardson, Head of Education & Training
Ref: August 2025/ HR&OPS

Scorecard

Topic	KPI	July 2025	TREND
Occupied Establishment	93%	89.7%	↑
Turnover (adjusted)	10.5%	10.15%	↓
Staff in post - FTE	N/A	1306.34	-
Sickness absence	4%	6.07%	↑
Appraisals	95%	83.10%	↑
Disability declaration rate	7.5%	8.02%	↑
Workforce Wellbeing – A/Leave	N/A	-	N/A
Mandatory Training	93%	86.82%	↓

Section One:
HR, OD and Inclusion

Prepared by: Matt Dingle, Head of Operational HR

Presented by: Clare Mair, Head of OD & Inclusion

Ref: August 2025 / HR & OPS

HR Operations

Summary:

The Appraisal window is now closed, and work is ongoing to achieve 95% compliance. Turnover is reporting positive decreases. The sickness absence rate has increased and information about why and HR actions are included in this data pack. Bank expenditure has seen a mild increase mainly attributed to vacancies. Mandatory training data showed a slight decrease in compliance in month.

Areas for Improvement:

There has been an increase in appraisal completions since last reporting, however, additional support is ongoing with appraisal compliance and identifying areas where appraisals are outstanding. Whilst positive assurances are provided around long-term sickness absence, more focus is needed on short-term sickness which is an anomaly and increasing.

Risks / Issues:

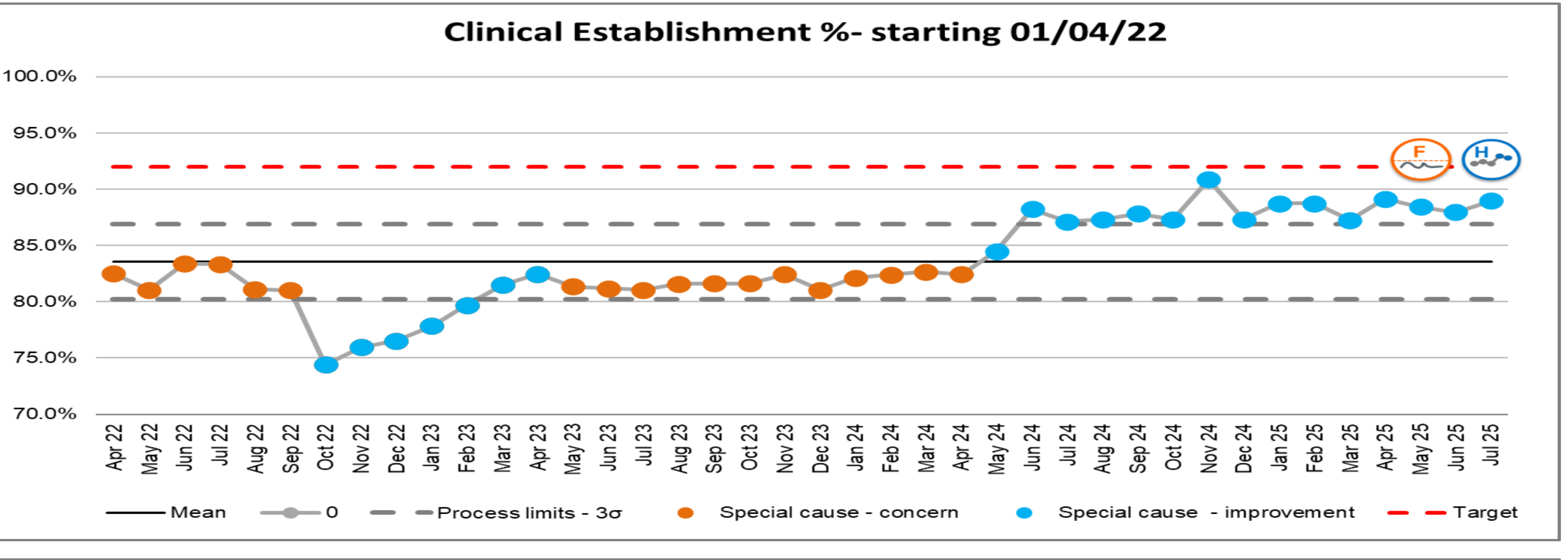
Review to be undertaken on cascade approach to appraisals to ensure timely completion through good planning in 2026.

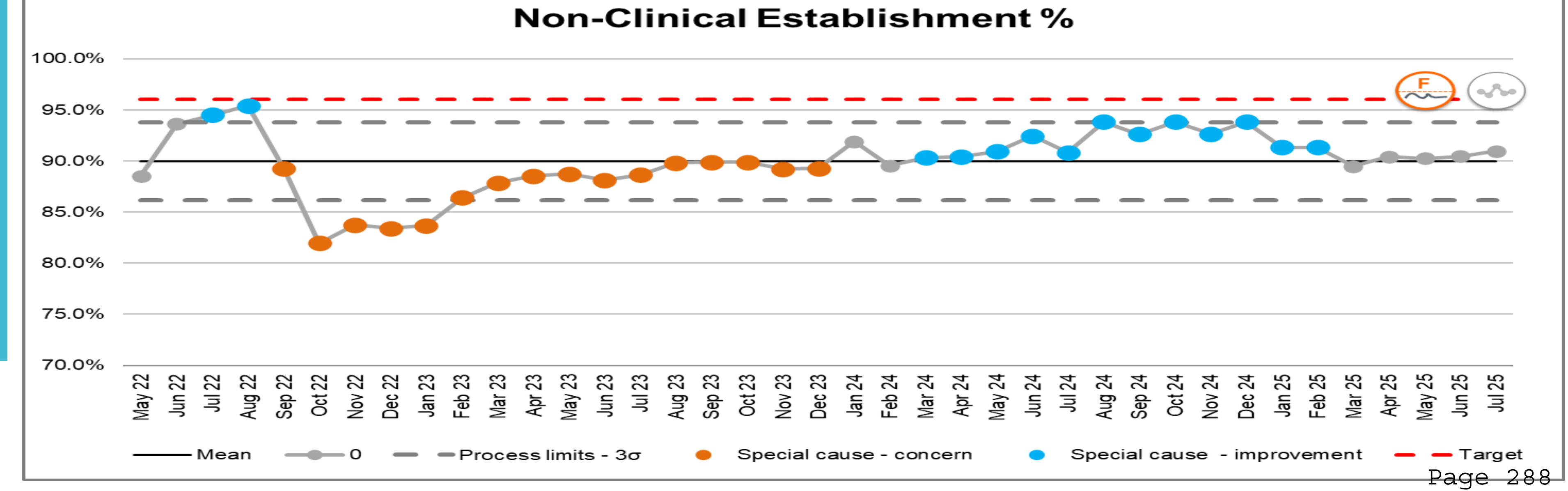
Action Plan:

Actions related to sickness absence management are included in this pack.
Conclusion of Phase 1 of the service reviews will aid vacancy and bank utilisation rates.

Occupied Establishment

KPI	93%
August, 2025	89.7%
Trend	↑





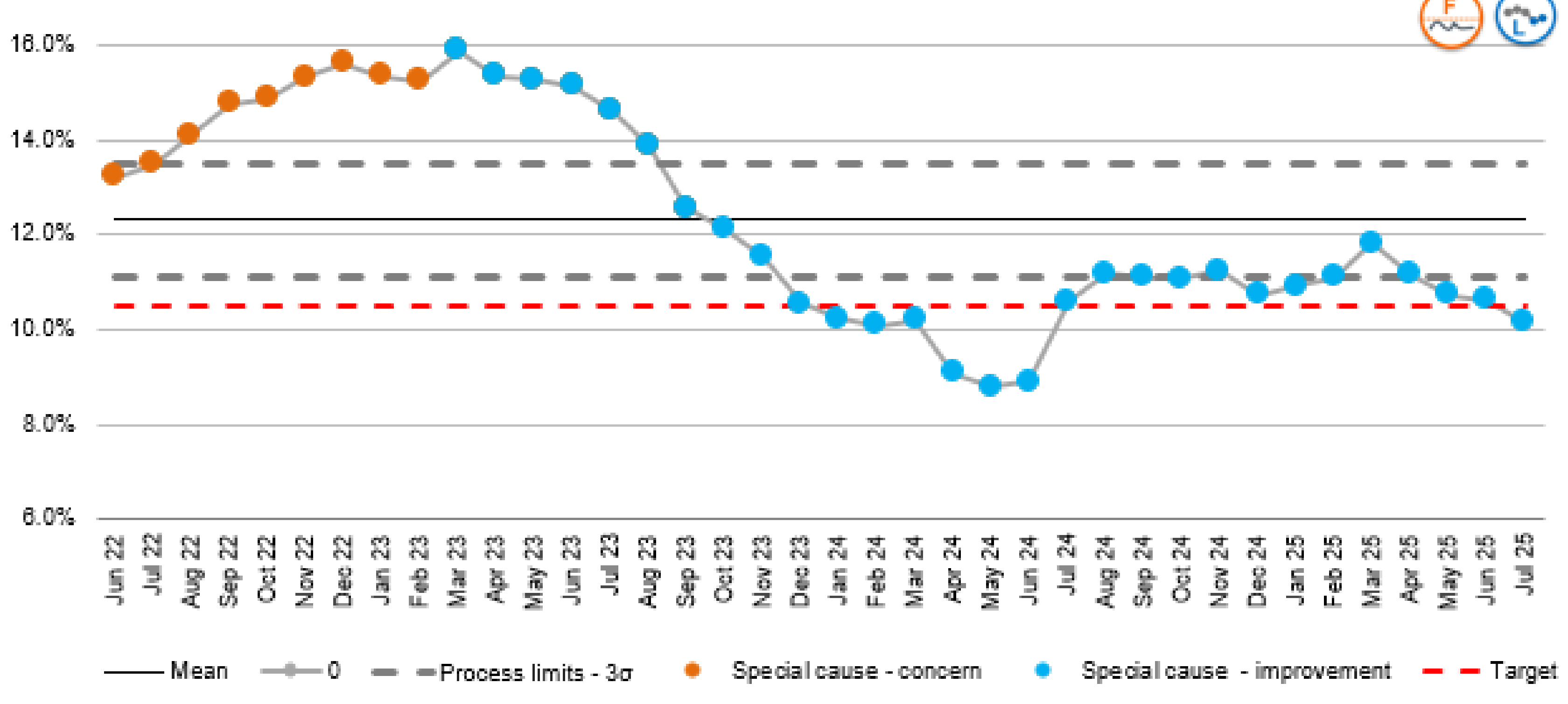
Turnover (adjusted)

KPI	10.5%
July 2025	10.15%
Trend	↓

Adjusted turnover *is all turnover minus:*

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

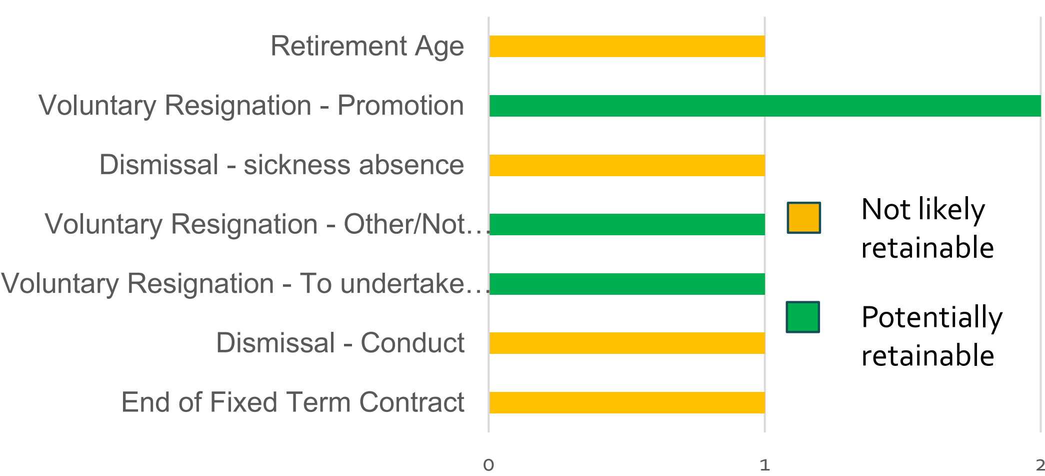
Adjusting turnover provides more meaningful data around Trust performance



Leavers – August 2025

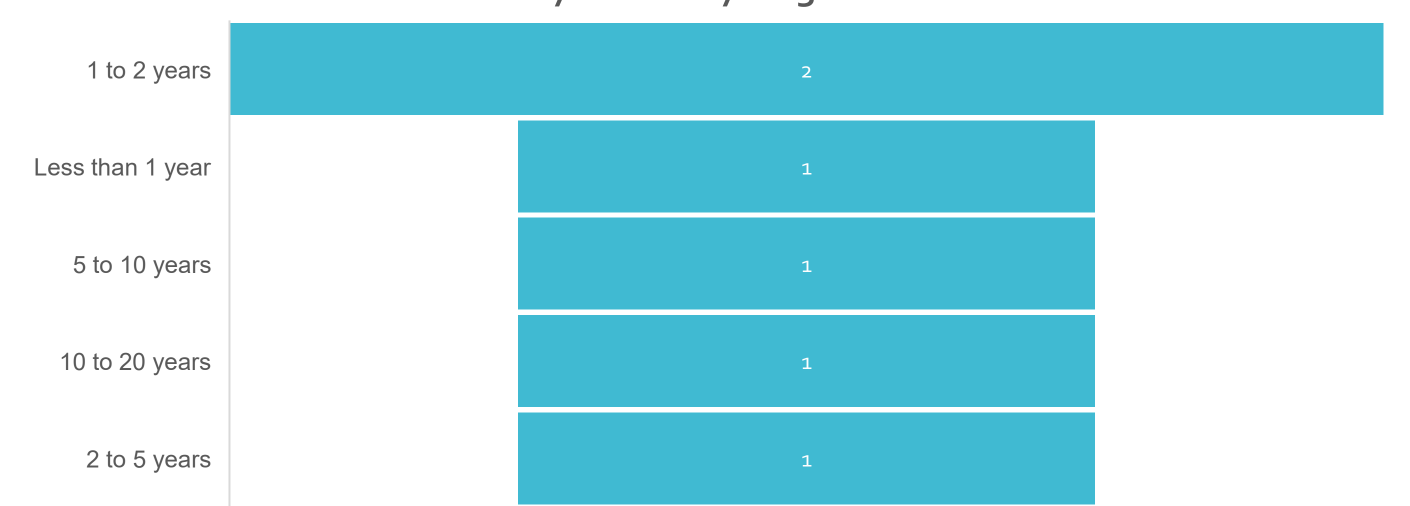
There has been a small number of voluntary leavers. Our rate was impacted by involuntary leavers (2 x dismissals)

Despite this the rate is below Trust target



Voluntary leavers by role

Job Role	WTE
Health Care Support Worker	1
Clerical Worker	2
Staff Nurse	2
Technician	1



Starters – August 2025

August represented a further lean month in terms of recruitment activity.

This data excludes honorary contracts and rotational posts

Job role	WTE
Physiotherapist	1
Domestic	0.4
Ward Clerk	0.53
Theatre Assistant	1
Staff Nurse	1.8
Nurse Associate	1
Theatre Practitioner	0.8
Consultant	1
Foundation year Pharmacist	1
Bank	3 (headcount)

A reasonable time for recruitment could be:
Time to approve – 7 days
Advertisement – 14 days
Shortlisting – 7 days
Interview – 7 days
Clearances – 20 – 30 days (depends on role)
Total = 55 to 65 days

Employee Relations

45% of ER case work has been closed since the last workforce report in June but levels remain high with new cases commencing.

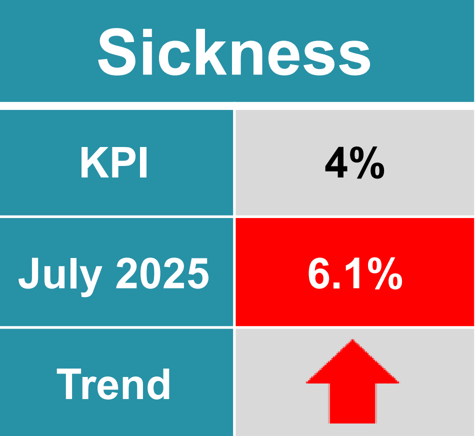
Final stage sickness cases in Q4 and Q1 had been largely LTS cases, we are seeing more STS escalations following a robust central monitoring of STS triggers since December 2024

New Disciplinary Policy signed off and due to be launched in the Autumn.

Case Type	Cases open			Total	Suspended/ Excluded	Cases Closed in Jun/July/ Aug to date
	<8 Weeks	8- 12 Weeks	>12 Weeks	19		10
Disciplinary	2	2	2	6	2	2
Grievance		1	1	2		1
Formal Capability			2	2		3
MHPS	1		1	2	1	0
Final Stage Sickness	5			5	0	4
Appeals	2			2	N/A	0

Key Themes:

- The >12-week capability cases have had monitoring extended, 1x due to improvement in some but not all competences, 1x to allow for OH assessment before stg 2 progression
- The >12 week conduct cases 1x is due for closure by mid-August, 1x final report in development
- MHPS 1x was delayed due to external agency, 1x case is scheduled for closure by week 12
- Final Stage Sickness Outcomes: 3x terminations, 1x resigned, 2x target extended
- Based on current trajectories, there are a further 7x sickness cases which will reach final stage in Aug/Sept
- Suspensions are risk assessed and reviewed on a four-weekly basis.
- Review of Civility and Respect policy is underway to reduce formal investigations, support early resolution and embed restorative just and learning culture.
- Review of Trust Sickness Policy to provide stronger clarity with STS trigger points



Sickness	
KPI	4%
July 2025	6.1%
Trend	↑

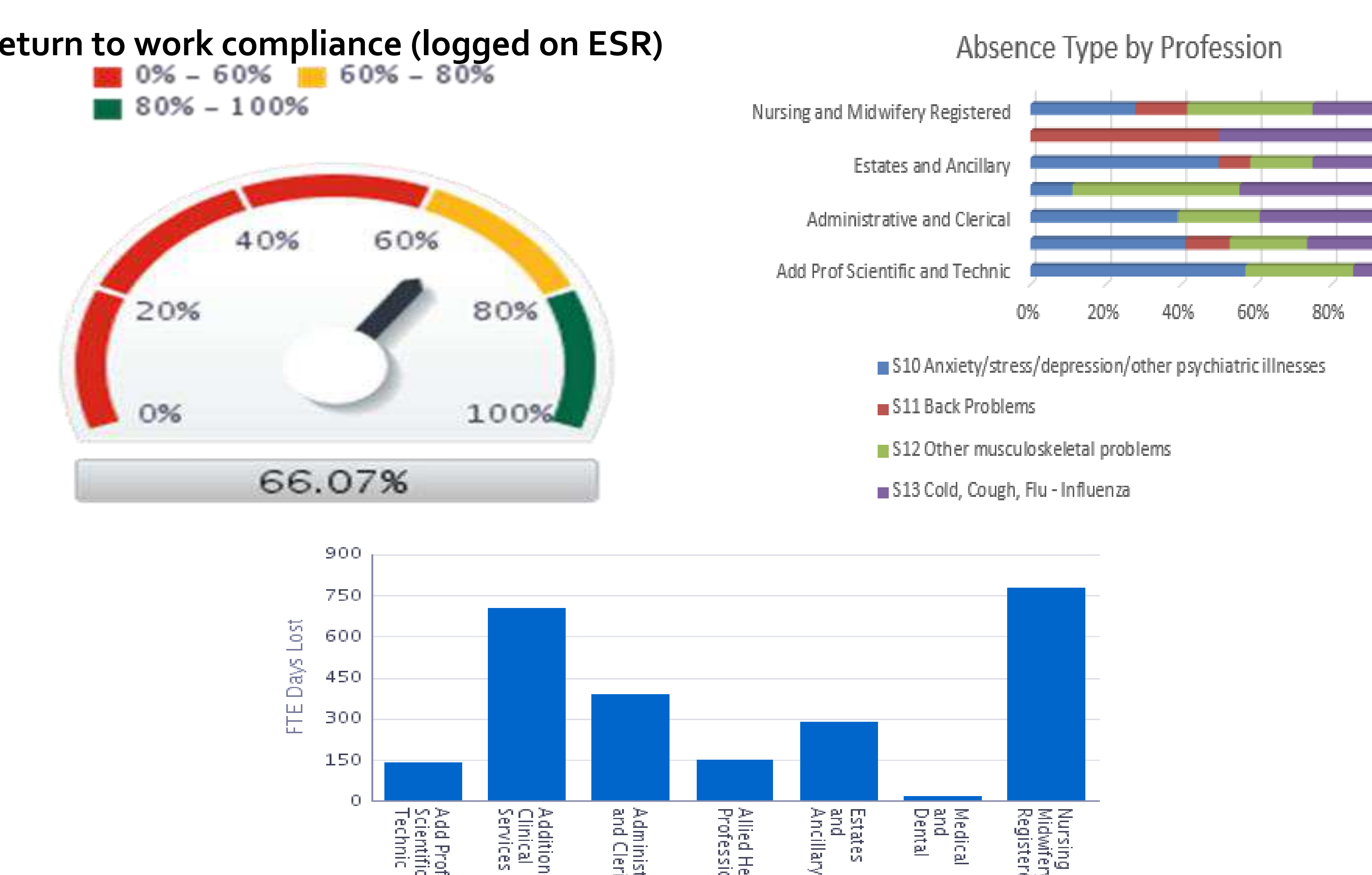
Trust Sickness Absence Rate- starting 01/05/22

8.0%
7.5%
7.0%
6.5%
6.0%
5.5%
5.0%
4.5%
4.0%

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

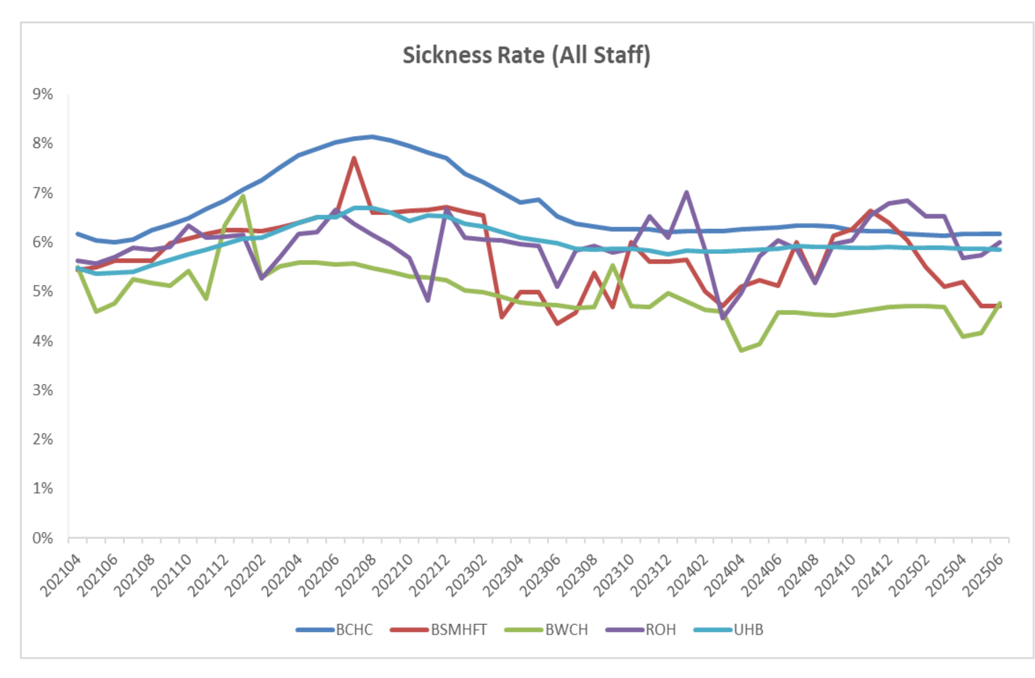
Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

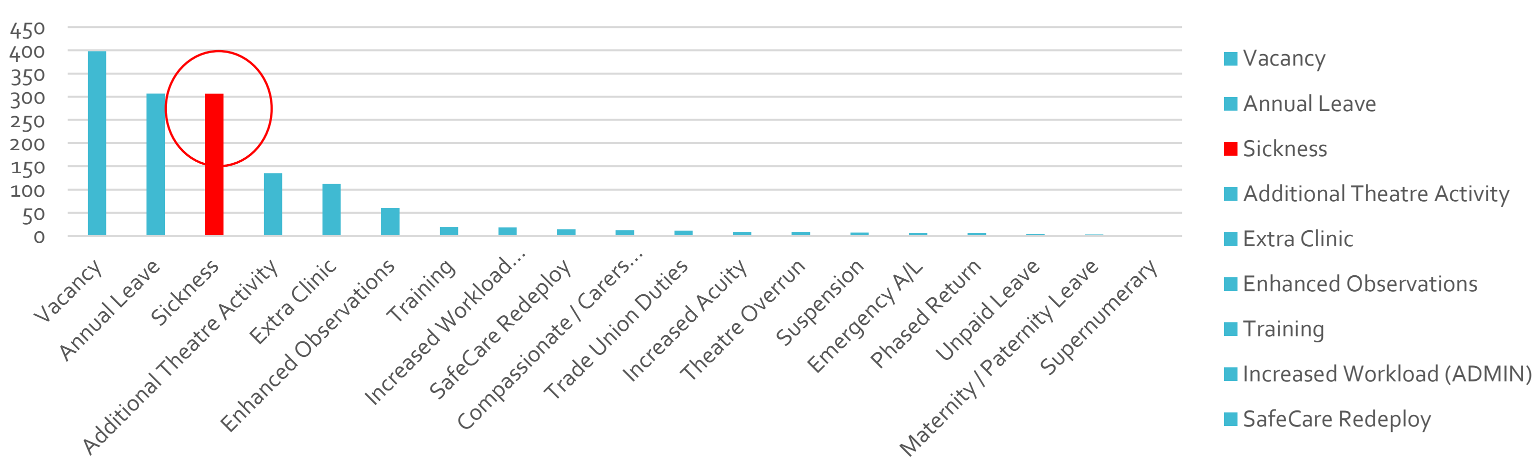
Sickness absence



Sickness Absence

The Trust sickness absence rate increased in July to above 6%. There is a varied trend across the ICS with increases and decreases in performance across each BSOL Trust.



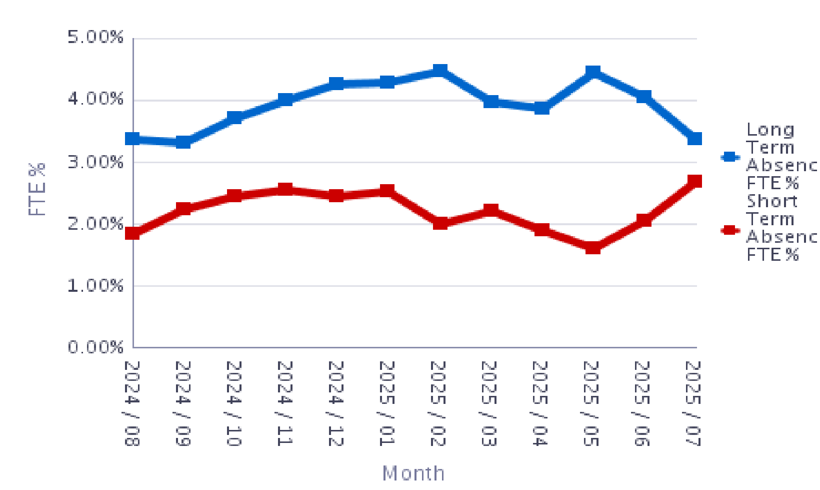


Sickness absence

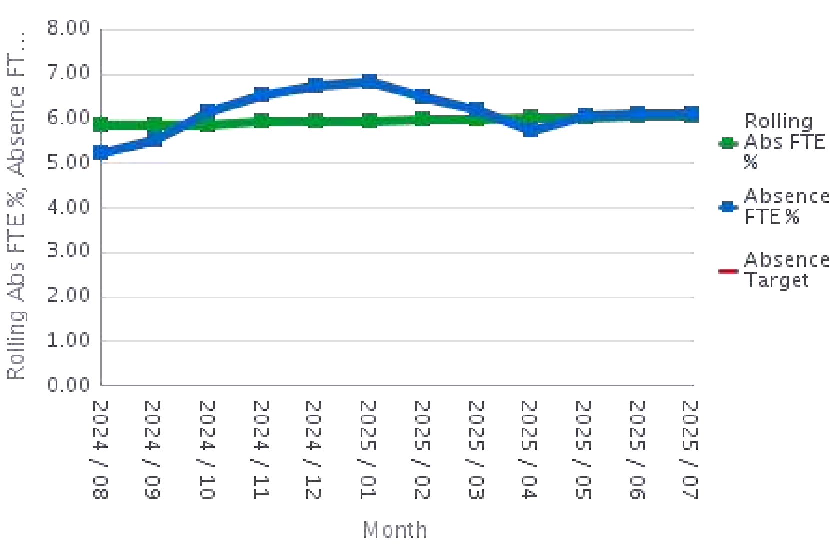
We are making good traction with long term sickness absence management. However short-term sickness absence is increasing, which is unusual for the time of the year. This is related to higher amounts of MSK, Gastro and short-term mental health issues.

What is stopping the sickness absence rate from improving?

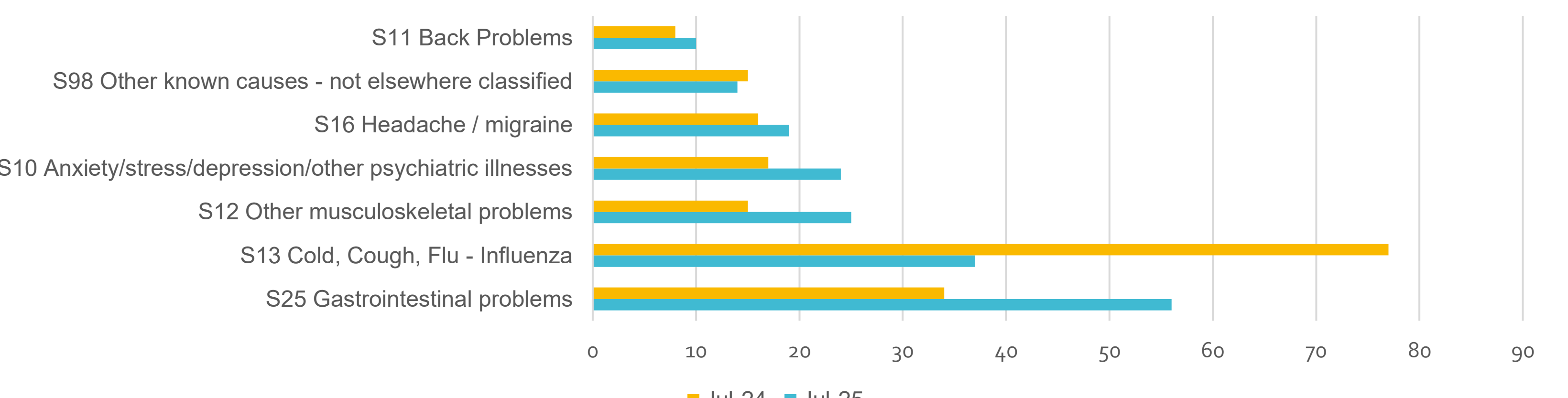
Short-term vs Long-term



Rolling absence FTE



Main short-term absences - July 24 vs July 25



Sickness Absence – Actions

What are we doing to improve the rate?:

1. We review data by department to establish hotspots where we need to provide additional support and intervention.
2. We hold a short-term sickness absence tracker and absentees with high numbers of short-term absence are monitored for compliance and a review of support is enacted.
3. We have continued high numbers of sickness hearings, reviewing if termination is appropriate or action plans put in place
4. We are conducting a deep dive on absence related to mental health absences to evaluate if we can improve the support in place or if more training is required. This will be concluded in September
5. Closer links formed with Health and Safety who work to spot MSK-related patterns where an assessment may be required.

June – July Hearings	Outcome
Individual 1	Dismissal
Individual 2	Dismissal
Individual 3	Dismissal - appealed
Individual 4	Resigned
Individual 5	Targets for improvement

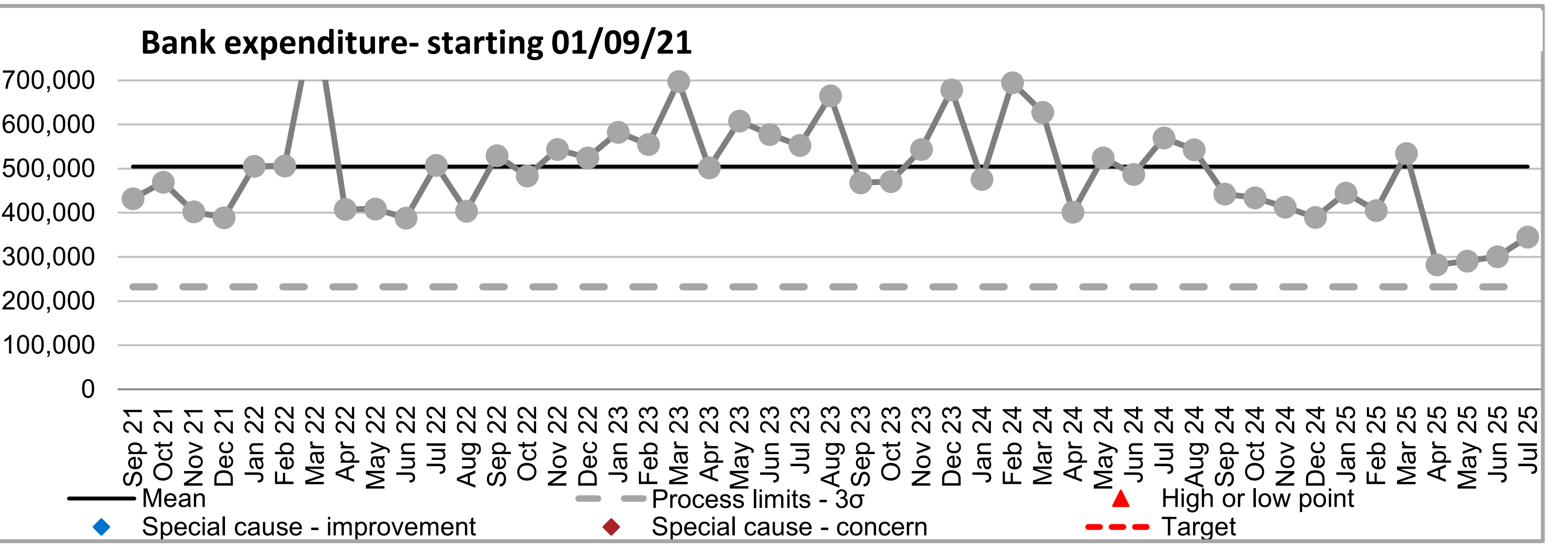
There are 5 hearings planned in September, and we are anticipating a further 7 cases will progress to a final stage in October/November. These are mostly related to persistent short-term absences

Temporary Workforce

Bank expenditure has increased mildly and the main reason is due to vacancy. One reason for this is that some posts are being held to keep them for redeployment to ensure our redundancy costs are low.

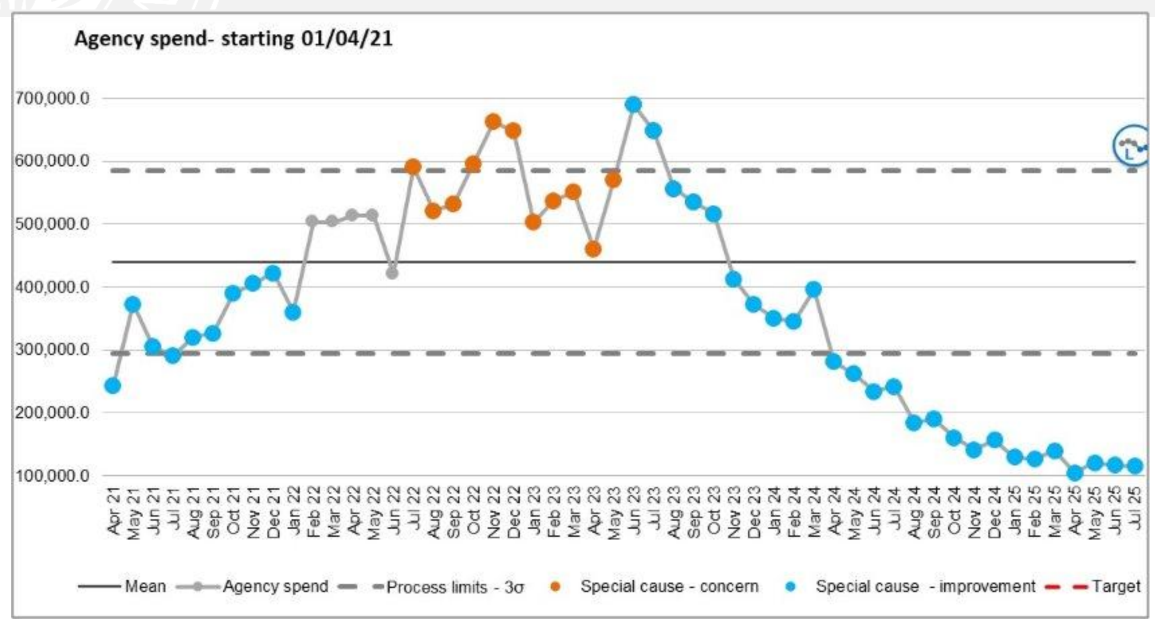
Phase 1 service reviews will conclude in September and then lead into implementation phase.

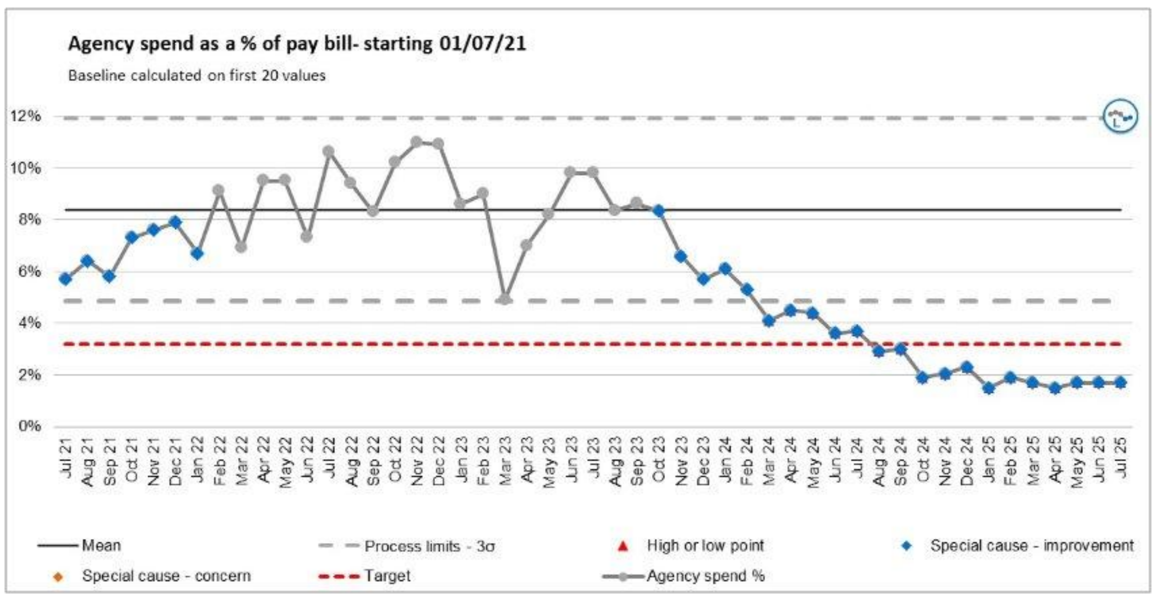
Bank expenditure														
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr'25	May'2 5	Jun'2 5	Jul'25
Registered nursing	110	136	116	101	95	112	118	92	109	108	48	41	39	48
Healthcare scientists and Scientific, therapeutic and tech	32	47	25	33	41	38	38	34	35	38	39	38	38	40
Support to clinical	60	86	78	55	56	61	69	55	38	94	26	20	34	32
medical and dental staff bank	51	61	107	88	117	85	52	124	88	142	58	97	76	119
NHS infrastructure support	155	189	200	151	125	117	111	140	119	157	110	95	115	95
TOTAL	487	570	543	443	434	413	390	445	404	534	282	291	301	334

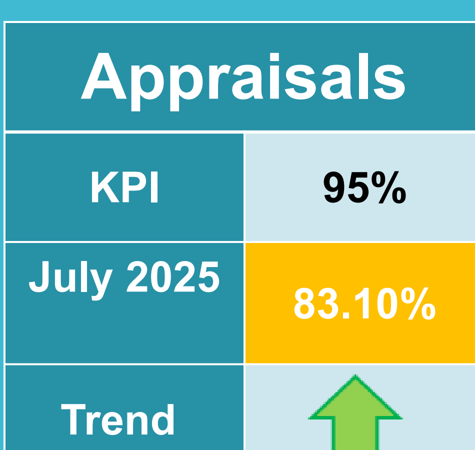


Temporary Workforce

There are small amounts of agency spend linked to some key roles for medics. One individual is due to enter a bank arrangement which will help decrease the percentage while a substantive solution is being implemented







Appraisals	
KPI	95%
July 2025	83.10%
Trend	↑

Appraisal window closed on July 31 with compliance at 83.10%. This is an improvement on June figure. Appraisal completion compliance reports continue to be shared with Executive Directors & Deputies. Managers have also been reminded to complete outstanding appraisals & upload to ESR. Monitoring and Comms will continue during August and September to ensure compliance is achieved

PDR Compliance- starting 01/06/22

100.0% 95.0% 90.0% 85.0% 80.0% 75.0% 70.0% 65.0% 60.0% 55.0% 50.0%

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

Mean — 0 — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

It is encouraging to see a continuing increase in disability declaration which is aligning to work being run with the Staff Reasonable Adjustments Health Passports

Disability Declaration rate

Category	Rate
Yes - Unspecified	1.66%
Unspecified	2.98%
Sensory Impairment	0.66%
Prefer Not to Answer	0.60%
Physical Impairment	0.60%
Other	0.33%
Not Declared	2.98%
No	85.62%
Mental Health Condition	0.73%
Long-standing illness	2.39%
Learning disability/difficulty	1.46%

Section Two:
Education and Training

Prepared by: Claire Felkin, Training & Development Manager

Presented by: Claire Felkin, Training & Development Manager

Ref: <August 2025

Education and Training

Summary:

This month has seen a slight decrease in compliance to 86.82%. The figure continues to hover around 86/87% despite continuous reminders from Execs in addition to reminders built into ESR. We are achieving the mean (average) but continue to sit below the target of 93% overall. The yearly modules are still in the 80% region whereas the average figure for the 3 yearly modules is just under 91%.

The new STAT and MAND review may see a change in frequencies, but this will not be until sometime in 2026.

Quarter 1 has seen a strong start for new apprenticeship qualifications with 16 staff commencing qualifications, with an additional 5 in sign up, 2 in recruitment and 9 in discussion (working towards 32). Of the 32 engaged this year, 11 are seeking the Level 7 Senior Leader Apprenticeship before access closes later this year.

Areas for Improvement:

- Oliver McGowan Tier 1 & 2 sessions for 2026 are now available to book via ESR. These continue to be delivered through the ICS who provide OMMT facilitators and individuals with lived experience of Autism and Learning Disabilities. We achieved our target of 33% for March and there is a slight increase month on month due to the frequency of sessions. Non-clinical teams have been slow to take up the 1 hour MANDATORY training session.

Risks / Issues:

- The yearly renewal competencies continue to be around 80%.
- Oliver McGowan Tier 1 & 2 dates were launched in July, some delays due to ICS planning window for the new financial year (now bookable via ESR).

Action Plan:

- Oliver McGowan Tier 2 will be held on site monthly for the rest of 2025 making it easier for staff to access.
- We have 100 places available for Oliver McGowan Tier 1 online 1 hour workshop on MS teams, also bookable via ESR.
- Convert the 16 apprenticeship qualifications in discussion into starts.

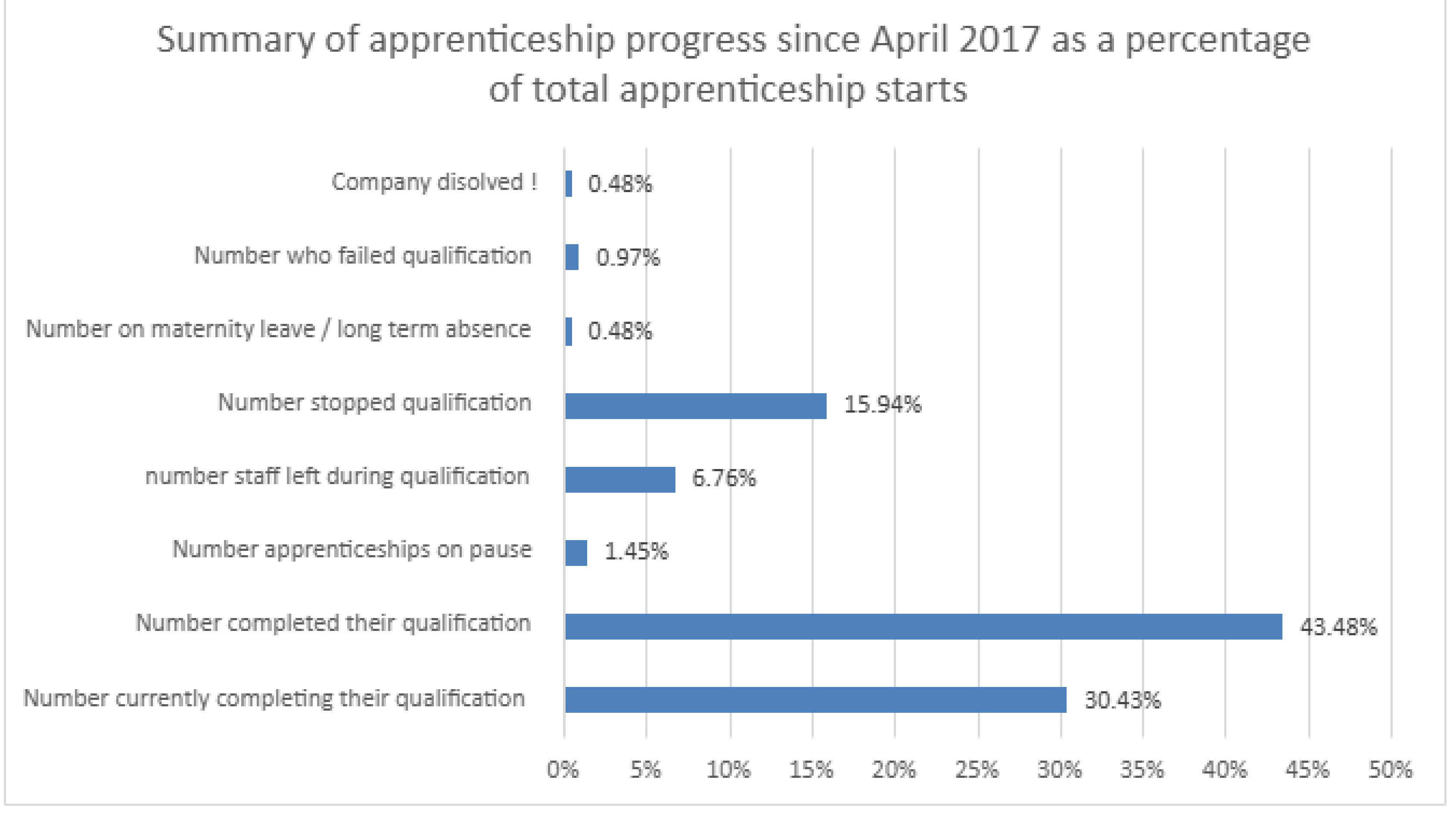
Apprenticeship Activity

KPI	34
Current YTD	16
2024/25	29/33
2023/24	36/29

Apprenticeship Qualifications At 31st July 2025	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	Total	%age
Number currently completing their qualification	0	0	0	0	1	2	19	25	16	63	30.43%
Number completed their qualification	6	17	17	9	16	13	11	1	0	90	43.48%
Number apprenticeships on pause	0	0	0	0	0	0	2	1	0	3	1.45%
number staff left during qualification	1	1	2	1	4	2	2	1	0	14	6.76%
Number stopped qualification	0	6	7	7	5	6	1	1	0	33	15.94%
Number on maternity leave / long term absence	0	0	0	0	0	0	1	0	0	1	0.48%
Number who failed qualification	0	1	0	0	0	1	0	0	0	2	0.97%
Company disolved !	0	0	1	0	0	0	0	0	0	1	0.48%
Number of GIFTED qualifications						6	8	8	1	23	207
Number of apprenticeships in discussion phase							0	0	9	9	
Number external apprenticeship in pre-employment							0	0	0	0	
Number internal apprenticeships in sign up stage							0	0	5	5	
Number internal apprenticeships in recruitment							0	0	2	2	
Number new apprenticeship qualifications commenced during the year	**7**	**25**	**27**	**17**	**26**	**24**	**36**	**29**	**16**	**207**	23
potential apprenticeships in progress	*7*	*25*	*27*	*17*	*26*	*24*	*36*	*29*	*32*	223	
Applications that didn't progress following initial interest	*0*	*7*	*9*	*11*	*6*	*11*	*8*	*15*	*15*	82	39.61%
recruited substantive instead				*1*						1	
Annual Target: 2.3% of workforce	24	23	25	26	28	28	29	33	34	250	28
Percentage of qualifications to national annual target	29.66%	107.51%	109.71%	64.27%	93.73%	84.22%	122.09%	88.30%	47.13%	82.66%	
Trust headcount	1026	1011	1070	1150	1206	1239	1282	1428	1476	10888	1210
Apprenticeships as a percentage of workforce headcount (2.3% target)	0.68%	2.47%	2.52%	1.48%	2.16%	1.94%	2.81%	2.03%	1.08%	1.90%	1.90%

The table above details the numbers of apprenticeship qualifications, by year of commencement, and their progress towards completion. The annual target is set at 2.3% of Trust head count. On average, since 2017, the trust has achieved 1.9% of headcount.

Apprenticeship Activity:



The graph above details the progress towards completing all apprenticeship qualifications since 2017. Of the 207 qualifications that have commenced, 43.5% have now completed their qualification. Only 6.67% left the Trust whilst completing their qualifications. Of the 16% that withdrew from finishing their qualification, 55% of these (18/33) was due to the implications during the COVID pandemic.

Apprenticeship Levy Funding

Total Levy	£2,025,287.87
Levy Charges	59.18%
Gifted Levy	2.58%
Levy Expired	10.69%
Remaining Levy	27.56%

Cumulative Apprenticeship Levy Utilisation (£)

Utilisation of Levy funding as a percentage of levy funds paid during the year.

Year	Utilisation
2017-18	1.29%
2018-19	24.94%
2019-20	68.81%
2020-21	51.88%
2021-22	58.22%
2022-23	66.72%
2023-24	64.54%
2024-25	106.74%
2025-26	105.21%

The graphs above detail the utilisation of the Trust Levy funding since 2017.
In July 2025, the Trust has invested just over £2 million into the Levy. Of this, 61.76% has been invested in providing qualifications (2.6% of this has been gifted to other local charitable organisations), and only 10.69% has expired. The Trust started expiring funding during the COVID pandemic and has not expired any funds since April 2024.
In 2024, the Trust utilised 107% of its invested levy for that year, and this year to date we are at 105%.

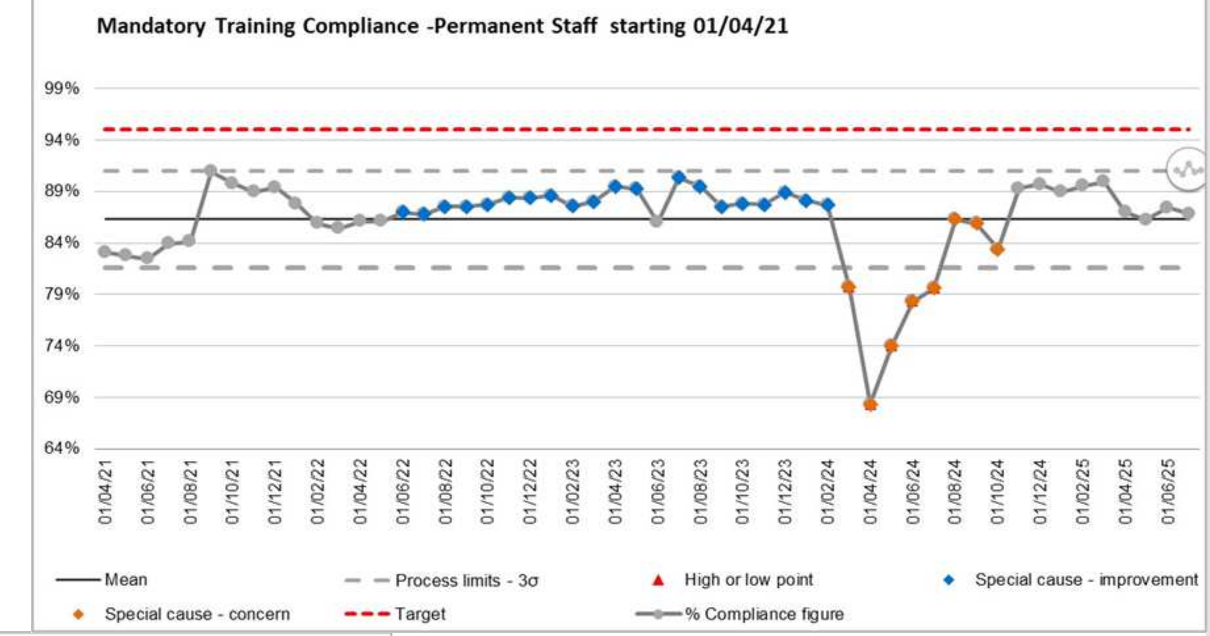
Mandatory Training

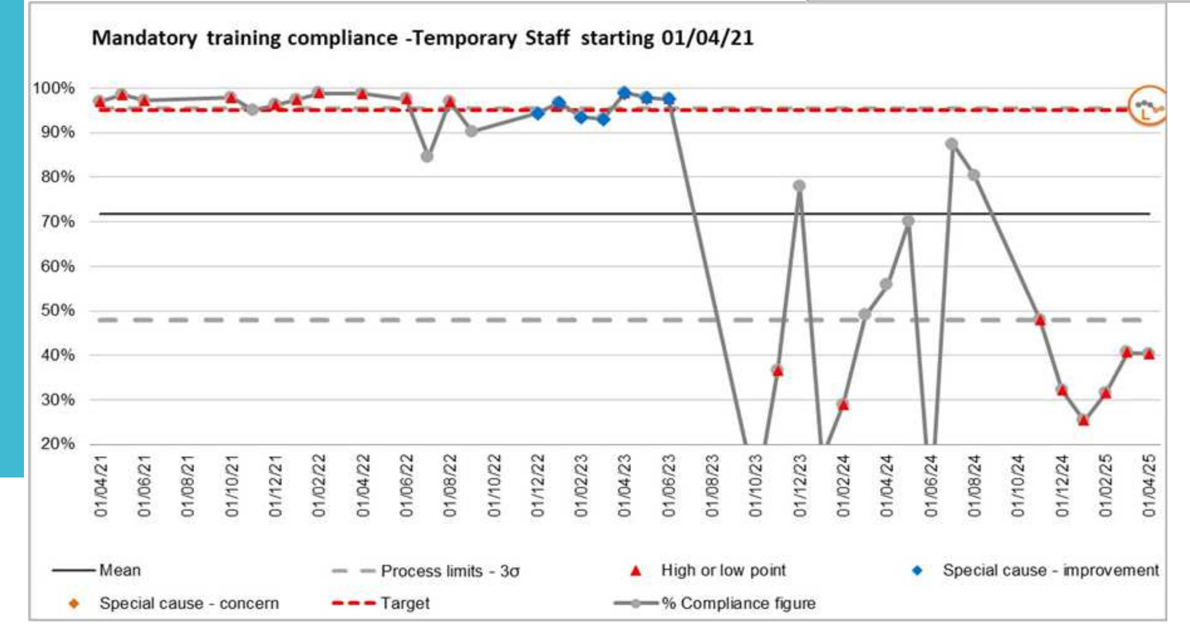
KPI	93%
June, 2025	86.82%
TREND	Down

Training compliance summary – 30th July 2025

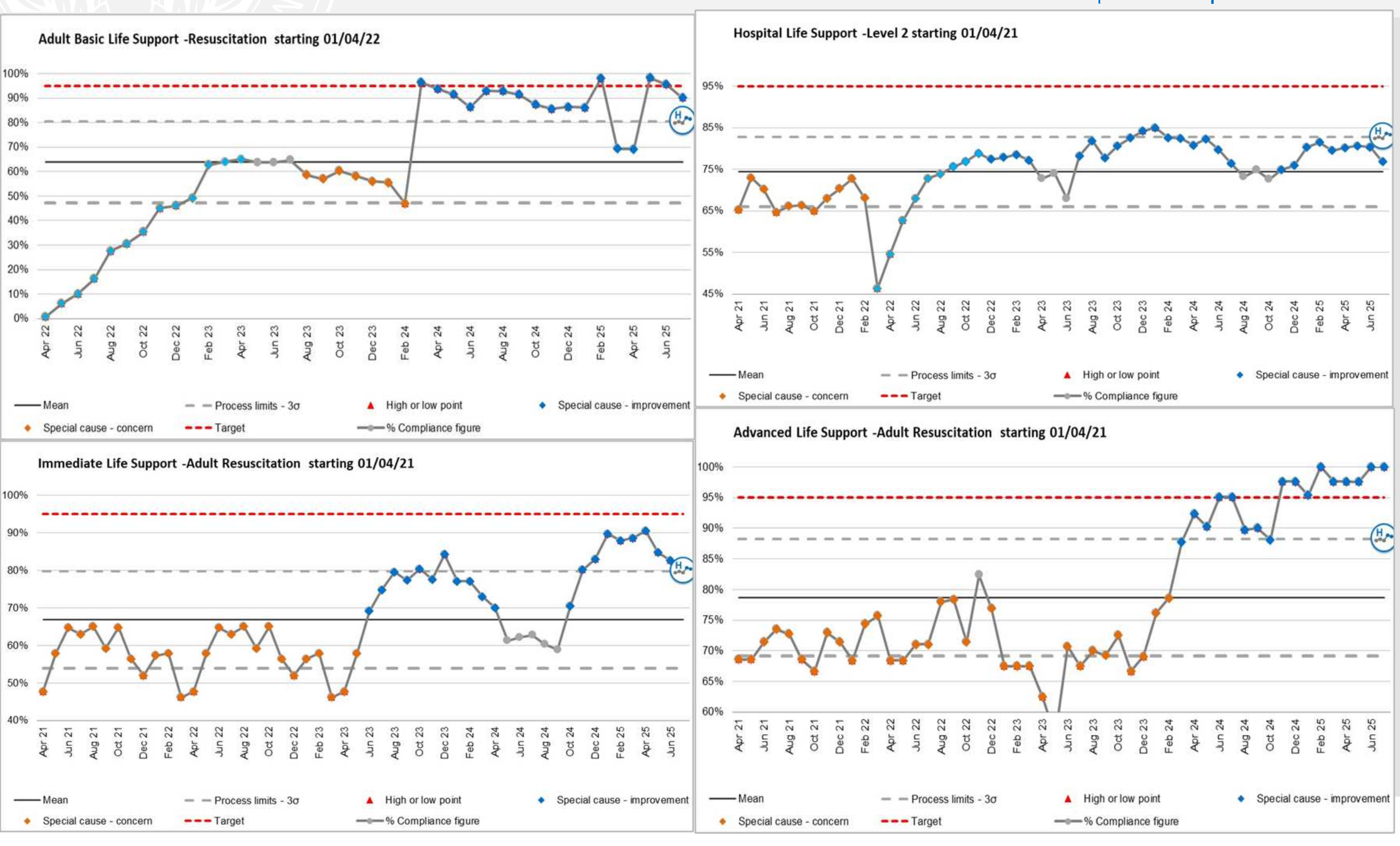
Pg.	COURSE	Compliance %age	COMMENTS	TREND
4	Core Mandatory Training – Permanent Staff	86.82%	If we break this down per compliance module it increases further for some elements of the Core Skills Training Framework (CSTF). Continually staying around this figure.	↔
4	Core Mandatory Training – Temporary Staff	47%	Based on staff working on the Bank who are **compliant** with training. Bank Office have been targeting staff to complete their training. **119 staff are over 90% compliant**.	↑
6	Cyber	76.87%	Annual renewals from April this year. Compliance is improving now that the access issues are resolved. This module is not available from ESR and are not accessible until they have expired.	↓
6	IG	75.07%	Annual renewals from April but recovering well, as per Cyber. ROH requires both modules to be completed.	↓
7	Basic Life Support – Level 1	90.03%	Regular direct chasers are keeping this requirement above target. Audience is non-clinical staff.	↔
7	Hospital Life Support – Level 2	76.77%	Continuing to see DNAs and need to push those out of date to book and attend f2f sessions.	↔
8	Immediate Life Support	81.99%	Consistently improving now over a number of months for targeted staff. In specific job roles.	↔
8	Advanced Life Support	100%	Consistent significant improvement since February 2024, helped by in-house delivery/Saturday courses and targeting attendance.	↔
9	Paediatric Immediate Life Support	71.43%	Challenging due to our small numbers to maintain compliance but Resus Officer is looking at ways to improve this through commercial offer which will also support our learners with a wider network.	↓
10	Patient Handling	84.90%	Consistent improvement since February. New dates scheduled and available to book.	↔
10	Conflict Resolution	84.16%	Incremental improvements each month, since 3 year renewal dip back in May 2024.	↔
11	NEWS2	97.91%	Consistently achieving over 95% compliance.	↔
11	Safe use of Insulin	89.09%	Dipped having been very near to target last month.	↓
11	VTE	93.89%	Target achieved	↔
12	CONSENT	82.93%	Static requires intervention to target those consultants out of date.	↓
12	IPC2	78.90%	Decrease due to extra staff groups being added to complete (porters and domestic staff)	↔
12	Food Hygiene	92.11%	Slight decrease on last month	↔

Core Mandatory Training: Permanent and Temporary Staff

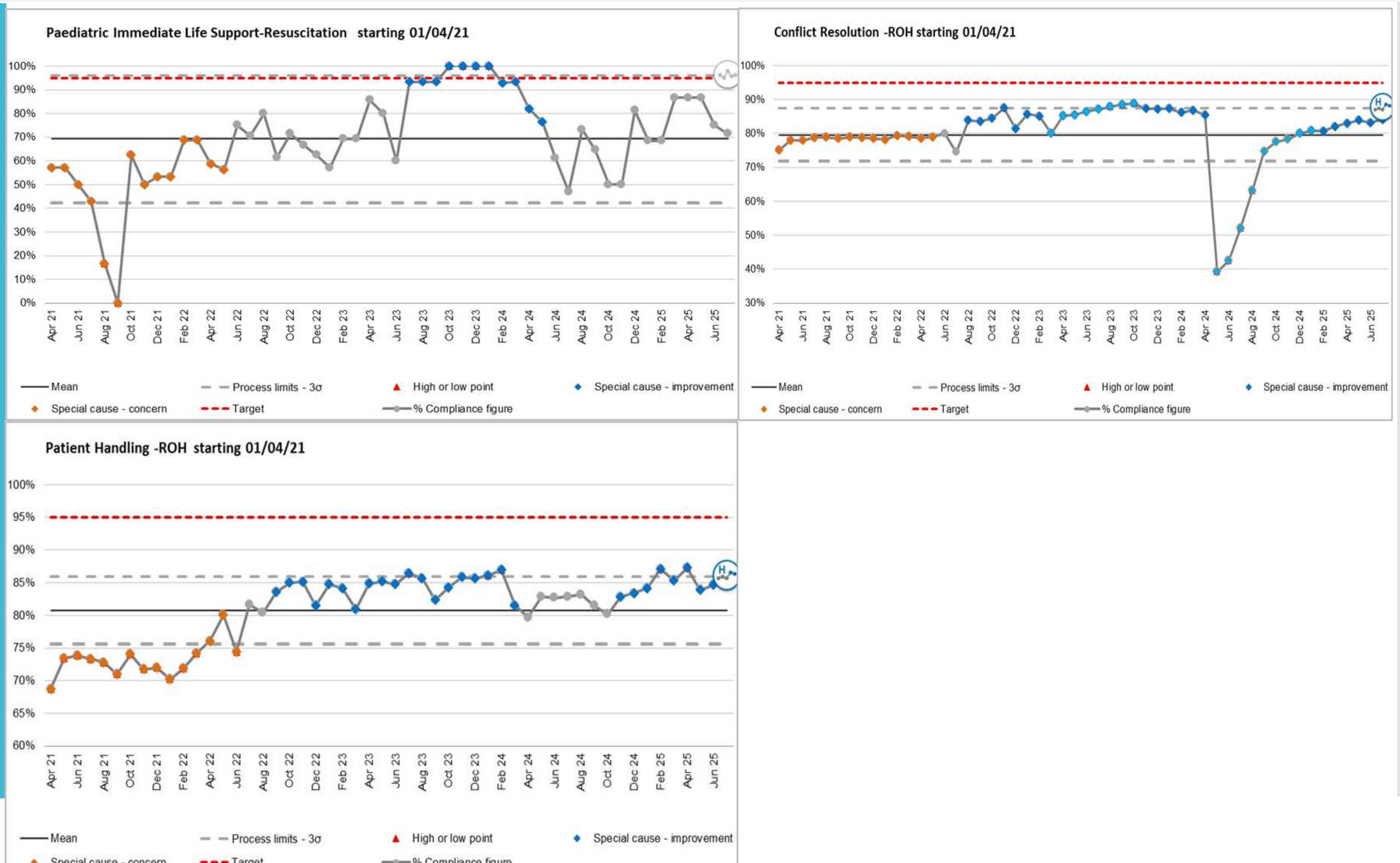




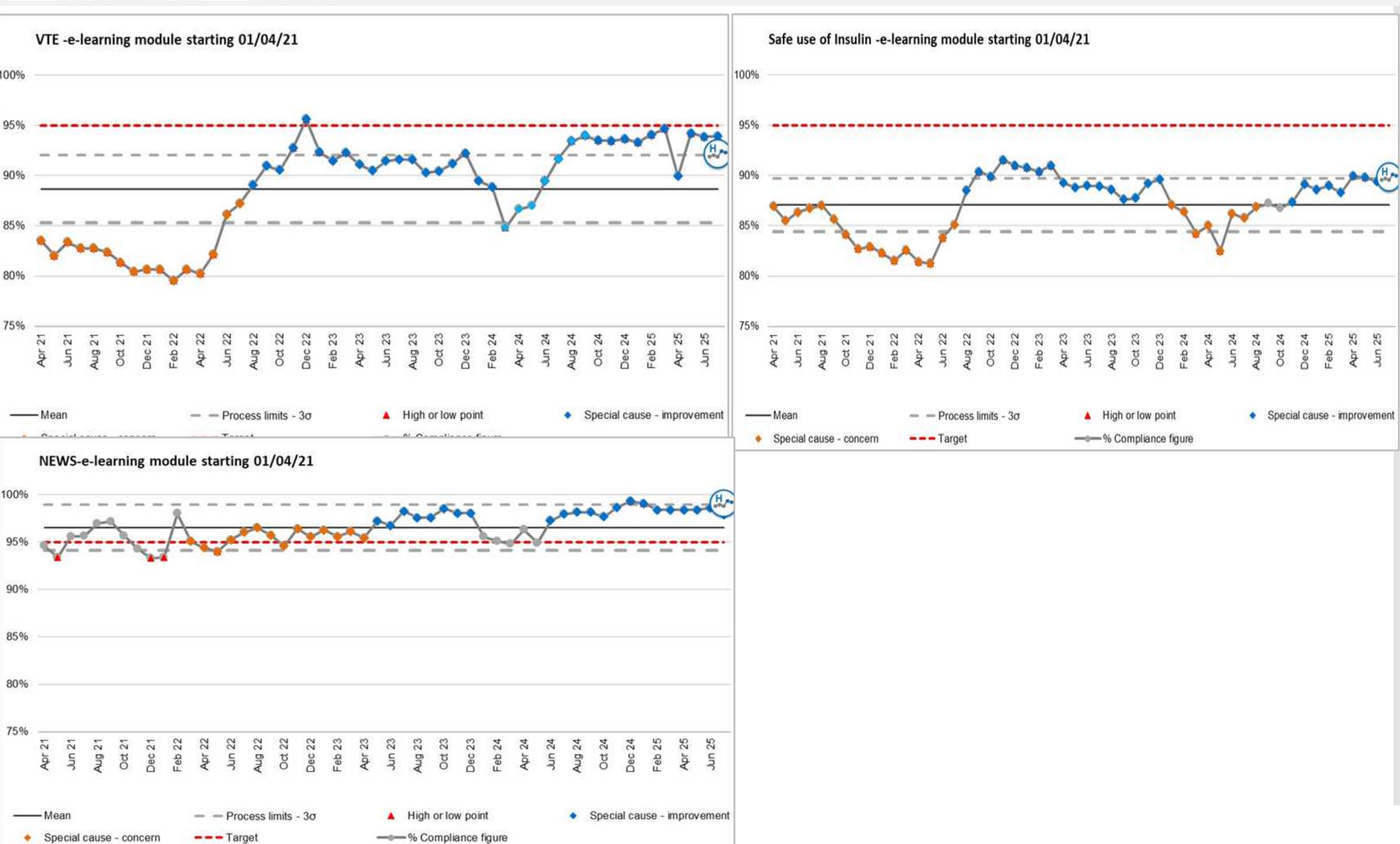
Resuscitation Training: Adult



PILS, Conflict Resolution Patient Handling



VTE, Safe use of Insulin, NEWS2



IPC Level 2, Food Hygiene Consent