



The Royal
Orthopaedic Hospital
NHS Foundation Trust

Trust Board (In Public)

Wednesday 5 November 2025

Board Room, Trust Headquarters



AGENDA

TRUST BOARD (IN PUBLIC)

Venue Boardroom, Trust Headquarters

Date 5 November 2025: 09:00h – 12:30h

Members attending

Mr Simon Page	Chair	(SP)
Ms Simone Jordan	Non Executive Director & Vice Chair	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
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

Pete Law	Media Studio Manager & Staff Governor	(PL) [Agenda Item 1]
Mrs Rebecca Lloyd	Director of Strategy	(RL)
Mrs Mandy Wilson	Executive PA to the Chief Operating Officer	(MW) [Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
IN PUBLIC SESSION				
09:00	1	Staff Story	Presentation	PL
09:20	2	Apologies: Jan Teo	Verbal	Chair
	3	Declarations of Interest	ROHTB (11/25) 001	Chair
	4	Minutes of Board Meeting held in Public on 3 rd September 2025: <i>for approval</i>	ROHTB (9/25) 030	Chair
	5	Actions from previous meetings in public: <i>for assurance</i>	ROHTB (9/25) 030 (a)	SGL
	6	Questions from members of the public	Verbal	Chair
	7	Feedback from the Board walkabouts in October	Verbal	ALL
09:35	8	Chair's and Chief Executive's update: <i>for information and assurance</i>	ROHTB (11/25) 002 ROHTB (11/25) 002 (a)	MH/SP



09:55	9	Chief Finance Officer's report: <i>for information and assurance</i>	ROHTB (11/25) 003	SW
10:15	10	Chief Operating Officer's report: <i>for assurance</i>	ROHTB (11/25) 004	MP
10:30	11	Chief People Officer's report: <i>for assurance</i>	ROHTB (11/25) 005	SM
10:45	12	Quality Officers' report: <i>for assurance</i>	ROHTB (11/25) 006	MR/NB/ SGL
11:00	BREAK			
11:10	13	Supreme Court Ruling of Human Rights Update: <i>for assurance</i>	ROHTB (11/25) 007 ROHTB (11/25) 007 (a)	SM/NB
11:25	14	ROH Strategy 2023-2028: Strategy Update: <i>for assurance</i>	ROHTB (11/25) 008 ROHTB (11/25) 008 (a)	RL
GOVERNANCE AND COMPLIANCE				
11:40	15	WDES/WRES Actions Plans: <i>for assurance</i>	ROHTB (11/25) 009 ROHTB (11/25) 009 (a-e)	SM
11:55	16	Sexual Safety Charter: <i>for assurance</i>	ROHTB (11/25) 010 ROHTB (11/25) 010 (a)	NB
12:05	17	Annual Report for Medical Appraisal and Validation: <i>for assurance</i>	ROHTB (11/25) 011 ROHTB (11/25) 011 (a)	MR
UPWARD REPORTS FROM THE BOARD COMMITTEES				
12:20	18	Upward reports from the Board Committees: <ul style="list-style-type: none"> • Finance & Performance Committee • Staff Experience & OD Committee • Audit Committee 	ROHTB (11/25) 012 ROHTB (11/25) 013 ROHTB (11/25) 014	LW SJ GH
12:25	MATTERS TO BE TAKEN BY EXCEPTION			
	19	Performance Reports: <i>for assurance</i> <ol style="list-style-type: none"> a) Finance & Performance b) Quality Report c) Workforce Report 	ROHTB (11/25) 015 ROHTB (11/25) 016 ROHTB (11/25) 017	
	20	Any Other Business	Verbal	All
	21	Meeting effectiveness	Verbal	All
12:30	CLOSE: Date of next meeting: Wednesday, 3 December 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

ATTENDANCE											
MEMBER	** 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	✓	✓	✓	A	✓					
Simone Jordan	A	✓	✓	✓	✓	✓					
Gianjeet Hunjan	✓	✓	✓	✓	✓	✓					
Ayodele Ajose	✓	✓	✓	✓	A	✓					
Les Williams	✓	✓	✓	A	✓	✓					
Simon Page (Ch)	✓	✓	✓	✓	✓	✓					
Jenny Belza	A	✓	✓	A	✓	✓					
Jan Teo	A	✓	✓	A	A	A					
Matthew Hartland	✓	✓	✓	✓	✓	✓					
Matthew Revell	✓	✓	✓	✓	✓	A					
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.



MINUTES

Trust Board PUBLIC - DRAFT Version 0.1

Venue Boardroom, Trust Headquarters

Date 3 September 2025: 1100h - 1300h

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)
Mrs Jenny Belza	Non Executive Director	(JB)
Mr Matthew Hartland	Chief Executive	(MH)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mr Matthew Revell	Executive Medical Director	(MR)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)

In attendance:

Ms 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]

IN PUBLIC SESSION	
1 Patient Story (SN/RF)	Presentation
<p>Sikhalthele Nkala (SN), Domestic Abuse and Sexual Violence Advocate (DASV) and Rebecca Furnival (RF), Head of Safeguarding and Vulnerabilities, joined the meeting to share the story of a patient they have been supporting.</p> <p>The key points to highlight include:</p> <ul style="list-style-type: none"> • The details of the work undertaken by the Safeguarding Team to support a patient who had been experiencing domestic abuse. • The Team were alerted when the patient disclosed the abuse they had been subjected to. 	



- The support provided including rearranging appointments so the patient could attend safely.
- The DASV Advocate also completed a referral to the Multi Agency Risk Assessment Conference, a report to West Midlands Police due the risks highlighted, referral to housing support services and a referral to the Rape and Sexual Violence Project.
- It was confirmed the patient are now living safely in a refuge.
- It was highlighted that all of this has to be undertaken in a tight timeframe, which is the greatest challenge to the Safeguarding Team.

The Board was invited to ask questions and comment.

The following points were of particular note:

- A question was then asked in relation to training for Non-Clinical staff and it was clarified that this category of staff are only required to undertake Level 2 which was deemed to be acceptable although alongside this RF and the Safeguarding Team do provide monthly training and also any additional support or guidance if needed.
- It was queried what support, if any, was being provided to the Safeguarding Team. RF advised that, following the withdrawal of Practitioner Support from the ICB, no external support was currently in place. This was noted to be causing some difficulties. RF confirmed that weekly internal meetings are held to monitor staff wellbeing and provide peer support. In addition, team members have established a code word to be used should immediate support or assistance be required.
 - An option that is being explored is to create “Peer to Peer” supervision and this is something currently being looked at by NB.
- It was noted this post was funded by the Charity and the question was asked as to how this post could become permanently funded. NB explained the original aim was to show proof of concept and this is being modelled across the system. This is included in the business planning, and it is clear the role is fundamental to the team. MH explained this is part of the work that is being undertaken within the service reviews.
- A query was raised as to whether if we risk assessed our trust would our risk be quite low in comparison to other organisation, and the question was asked have we seen a large increase in cases, and is this comparative to other organisations within our system. NB explained that growth is being seen across the system and could provide an update to the Board on the data across the system. **ACTION NB.** MH explained that the principle of the service reviews is to consider should roles sit at the Trust or should they be system wide.



15 Apologies (chair)	Verbal
Apologies were received and accepted from Jan Teo, Ayo Ajose and Ian Reckless	
16 Declarations of Interest (chair)	ROHTB (9/25) 001
There were no new declarations to record to what has been published.	
17 Minutes of Board Meeting held in Public on 2nd July 2025: for approval (chair)	ROHTB (7/25) 022
The minutes of the meeting held in public on 2 nd July 2025 were accepted and approved by the board.	
18 Actions from previous meetings in public: for assurance (SGL)	ROHTB (7/25) 022 (a)
No updates to note as actions remitted to Staff Experience & OD Committee.	
19 Questions from members of the public (chair)	verbal
No questions were received in advance of the meeting	
20 Chair's and Chief Executive's update: for information and assurance (SP/MH)	ROHTB (9/25) 002 ROHTB (9/25) 002 (a)
<p><u>Chair Update</u></p> <p>SP welcomed MH as the newly appointed substantive Chief Executive and congratulated him on his role.</p> <p>SP provided an update on the recent walkabouts that he has undertaken and praised the organisation on the changes that are clearly becoming embedded across the Trust.</p> <p><u>Chief Executive Update</u></p> <p>MH presented the Chief Executive Update to the Board.</p> <p>The key points highlighted include:</p> <ul style="list-style-type: none"> • Thanked the organisation for the opportunity to lead the Trust as the newly appointed substantive Chief Executive and congratulated Jo Williams in her new post at the Shrewsbury and Telford Hospital NHS Trust. • It has been confirmed that Birmingham and Solihull Integrated Care Board (ICB) will cluster with Black Country ICB. Danielle Oum has been confirmed as the new Chair of the Cluster ICB, and David Melbourne as Chief Executive. 	



<p>Consultation is now underway for the Executives within the ICB to form a single leadership structure, and this should be concluded by December.</p> <ul style="list-style-type: none"> • The 10- year health plan for the NHS was published in July. The plan includes the detail and expectation behind such priorities as published in the ‘Darzi’ report but also includes the five ‘enabling’ pillars that are expected to drive the changes required to the NHS to meet the three priorities. The Trusts Strategy Delivery Board will oversee the implementation of the 10-year plan. • The NHS Confederation Acute Advisory Board will be meeting next week. There will be a presentation on planning guidance for next year and feedback is being sought on the plans which MH will provide from a specialist hospital lens. <p>The Board was invited to comment and ask questions.</p> <p>The following point was of particular note:</p> <p>SP queried if there is an update on the Gender Rights bill and action that needs to be taken. NB explained our policy has been reviewed and is very clear on our approach, but we are awaiting further updates.</p>	
<p>20.1 Board Operating Model: <i>for approval</i></p>	<p>ROHTB (9/25) 003 ROHTB (9/25) 003 (a)</p>
<p>SGL presented a new operating model for the Board going forward. The paper was taken as read.</p> <p>The key points to highlight include:</p> <ul style="list-style-type: none"> • The Private Board will meet every month. • The Public Board will move to alternative months. • The Private Board will give opportunity to undertake a board workshop with focus. <p>The Board was invited to comment and ask questions.</p> <p>The following points of particular note include:</p> <ul style="list-style-type: none"> • JB highlighted this works really well at other organisations and is welcomed to provide opportunity to have space to discuss in detail some of those key topics already mentioned. • GH queried is there a regulatory requirement to meet in public. SGL explained there is no set number. • SP supported this proposal and felt it will give opportunity to focus on some real key topics. <p>The Board supported the presented operating model and approved the proposal.</p>	



<p>21 Chief Finance Officer’s report: <i>for information and assurance</i></p>	<p>ROHTB (9/25) 004 ROHTB (9/25) 004 (a)</p>
<p>SW presented the CFO report, the report was taken as read.</p> <p>The key points to highlight included:</p> <ul style="list-style-type: none"> • 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. • Month 5 is planned for a deficit and then Month 6 onwards it is a surplus plan; this will provide a steeper challenge to deliver the financial position. • Elective activity remains on plan. • Pay plan reduced from Month 3 by £100k, expenditure increased which generated the variance. • There has been an increase in bank spend and with the majority of the increase was in Medics which is reflective of ADHs and on-call payments. • Contract negotiations continue, with only one unsigned contract where meetings are continuing to resolve. • Risks for the end of the year is delivery of the cost improvement programmes (CIPs). Service review process is supporting this with focus on the corporate functions within the organisations. There will be a delivery risk to these which could affect the cost reductions. <p>The Board was invited to ask questions and comments.</p> <p>The following points of particular note include:</p> <ul style="list-style-type: none"> • SP raised the organisations is in a promising place but does not come without risk. SP questioned how comfortable we are that we will deliver. MH explained that these discussions are taking place in Financial Delivery Board. In these meeting discussions around the short-term impacts and detrimental impacts that will support our long-term plans are taking place. There needs to be focus on pay, and in particular, focus on CIPs and the delivery of those and bridging the gap. It is essential we must use the ICB support when we need it, in particular with contract negotiations. There is a great focus on the delivery of the service reviews to support the financial plan. 	
<p>LUNCH</p>	
<p>22 Chief Operating Officer’s report: <i>for assurance</i></p>	<p>ROHTB (9/25) 005 ROHTB (9/25) 005 (a)</p>
<p>MP presented the Chief Operating Officer’s report, and the paper was taken as read.</p> <p>The key points to highlight include:</p>	



<ul style="list-style-type: none"> • Focus on the 10-year plan to ensure all targets and plans are aligned. • Achieved reaccreditation of GiRFT. This has received a great deal of positive feedback. • Strong start in Qtr. 1 and continues into Qtr. 2. This has been well received at the weekly oversight group hosted by NHSE. • A number of complex cases were undertaken which has supported the income generation. • Private patient income is ahead of the original plan, but slightly behind the stretch plan, work is taking place with the Communications Team to support marketing of the service. • Risks remain with spinal long waits, but a pathway improvement workshop has taken place to understand what the blockers are for the service. There are significant transformational plans in place to support the service. • The ROH continue to lead on the system MSK programme. The GetUBetter app was presented to the system and agreement of funding was given. There are 23,000 patients are using this app. • Current focus for the team is on service reviews and preparing to work through the clinical service reviews as part of the next stage. 	
<p>23 Chief People Officer's report: <i>for assurance</i></p>	<p>ROHTB (9/25) 006</p>
<p>SM presented the Chief People Officer's report, and the paper was taken as read.</p> <p>The key points to highlight include:</p> <ul style="list-style-type: none"> • The Trusts Anti Racism statement has been finalised. Engagement with MMEG has taken place with thanks to MP. It has been agreed to launch the statement during the Black History month. • Me as a Manager programme will undertake an evaluation and update provided to Staff Experience & OD Committee. • Staff survey will launch in October and focus on getting the completion rate increased. • Regulation of NHS Managers. As a Board we will move through a period of consultation, and this will support the development of the code of conduct. Updates will be provided at Staff Experience and OD Committee and also to Board as to the progress that is taking place. 	
<p>24 Quality Officers' report: <i>for assurance</i></p>	<p>ROHTB (9/25) 007</p>
<p>MR, NB and SGL presented the Quality Officers report.</p> <p>The key points to highlight include:</p> <ul style="list-style-type: none"> • A project has commenced with Innovation Route, supported by Health Innovation West Midlands to support our IP development and process. 	



<ul style="list-style-type: none"> • Work with the Human Tissue Authority (HTA) continues, an update will be provided to the Quality and Safety Committee in November. • Endoscopic Spinal services review has been discussed at Quality and Safety Committee and will be shared with the Board. • Leadership Day for Chief Nu10-years attended by NB. Focus on implementation of 10-year plan with focus on how we maintain quality whilst ensuring productivity. • Nursing and midwifery strategy launched with publication due in October. • Student nurses with a guaranteed graduate scheme being launched. Establishment review currently being undertaken to ensure we are able to support student nurses into the workplace and reviewing bank work to provide short term work. • There is a proposed change in legislation to using the term of 'Nurse' only with registration. • 'Back to the Floor' by the corporate nursing team has been taking place over the past two months. The team have been undertaking clinical work with a specific focus. Chief Nurse and Deputy Chief Nurse both undertaking this work. An update will be provided to Quality & Safety Committee on the output of this. • The Director of Governance and Chief Nurse have introduced joint walkabouts in clinical areas to bring together the governance and clinical link. • Following the Health and Safety Executive visit areas of improvement were identified. The Trusts Health and Safety Advisor is currently working through this. • Work is taking place on the governance architecture of the organisation. • The Director of Governance has met with Robert Jones and Agnes Hunt and discussed the next steps in terms of executing the strategic alliance between the two organisations. 	
<p>25 Green Plan Update: <i>for assurance</i></p>	<p>ROHTB (9/25) 008 ROHTB (9/25) 008 (a)</p>
<p>SW presented the Green Plan Update, and the paper was taken as read.</p> <p>The key points to highlight include:</p> <ul style="list-style-type: none"> • The update is a requirement of NHS England. • This has been submitted to the system and forms part of the BSOL ICS Carbon Reduction Plan. • Boiler replacements continue. The Trust will continue to apply for external 	



<p>funding to support the replacement as this is a big risk to the Trust financially.</p> <ul style="list-style-type: none"> • There is benchmark data now available that helps us keep informed of progress. <p>The Board was invited to ask questions and comment.</p> <p>The following points of particular note include:</p> <ul style="list-style-type: none"> • SP queried the updates to the Board and questioned the frequency. SW explained that a regular understanding of where we are against progress is required. MH raised this would be included as part of the wider strategy delivery updates that will be shared with the Board. • SP questioned would this form part of the conversations with RJAH. MH confirmed this could be included. 	
<p>26 ROH Strategy 2023-2028: Delivery Plan Update: <i>for assurance</i></p>	<p>ROHTB (9/25) 009 ROHTB (9/25) 009 (a)</p>
<p>RL presented the strategy delivery plan progress for quarter 1.</p> <p>The key points to highlight include:</p> <ul style="list-style-type: none"> • This is the first time the Trust has been able to present a detailed overview of the current delivery of the strategic objectives. • The Strategy Delivery Board had its first meeting, and it provided an opportunity to discuss in delivery of the strategy. • Sitting behind the delivery plan is a quality and improvement tracker which gives us oversight of all the projects being undertaken across the Trust and ensuring they are aligned to the strategic objectives. • This work has started to support the creation of the plans for 2026/27 and demonstrates how important it is to ensure the targets are not just statements of intent. • The aim is to bring the collaboration and community objective through a Board workshop to enable conversation on metrics that we want to see delivered. • There is a clear link to the Board Assurance Framework. <p>The Board was invited to ask comment and question.</p> <p>The points of particular note include:</p> <ul style="list-style-type: none"> • JB requested that key actions to be provided on those items that are not on track. ACTION RL • MH explained that this was to provide assurance of the work that is taking place by the Strategy Delivery Board. SP raised the detail is currently 	



<p>needed but it is important to bring the action that is being taken to mitigate the risks of non-delivery.</p>	
GOVERNANCE AND COMPLIANCE	
<p>27 Refreshed Board Assurance Framework: <i>for assurance</i></p>	<p>ROHTB (9/25) 010 ROHTB (9/25) 010 (a - f)</p>
<p>SGL presented the refreshed BAF.</p> <p>The key points to highlight included:</p> <ul style="list-style-type: none"> • There is now a clear link to the Strategy. • The care risk has been reviewed following feedback from the Quality and Safety Committee. • It is noted that following the conversations reference the Electronic Patient Record programme it will need to be reflected in the BAF. <p>JB raised some items around safety should also be included, such as PSRIF, shared learning, harm reviews, safety huddle, FTSU which would support the patient safety. SGL confirmed this will be added into for the next QSC paper. ACTION: SGL</p>	
<p>28 Flu Vaccination Plan 2025: <i>for assurance</i></p>	<p>ROHTB (9/25) 011 ROHTB (9/25) 011 (a)</p>
<p>NB presented the flu vaccination plan for 2025. The paper was taken as read.</p> <p>The key points to highlight include:</p> <ul style="list-style-type: none"> • This has been presented to Quality and Safety Committee. • The plan is to launch in October. • There is work underway into how we could possibly also vaccinate patients. • It will not only be nurses vaccinated but also some of our pharmacy colleagues will be supporting also. • It is known that across the system that vaccination uptake is reducing, and this is not something mandated. Therefore, we can only encourage our colleagues to take this. <p>The Board was invited to comment and ask questions.</p> <p>The points of particular note include:</p> <ul style="list-style-type: none"> • SJ recommended that a correlation to sickness and vaccinations is provided at the end of the vaccination programme to understand if there is a link. NB explained this can be provided but must ensure colleague data is protected. ACTION NB • SJ also raised it is important to show the link of increased sickness and how this 	



<p>can lead to absence management but by having the vaccination could support colleagues in being in work. An opportunity to highlight the consequence of continued absences can result in termination of position should be something we should be making clear.</p>	
<p>29 Learning from Deaths: <i>for assurance</i></p>	<p>ROHTB (9/25) 012 ROHTB (9/25) 012 (a)</p>
<p>MR presented the learning from deaths paper. The paper was taken as read.</p> <p>The key points to highlight include:</p> <ul style="list-style-type: none"> • This has been discussed in detail at Quality & Safety Committee. • There were no specific risks to highlight. <p>The paper was noted and accepted for assurance by the Board.</p>	
<p>UPWARD REPORTS FROM THE BOARD COMMITTEES</p>	
<p>30 Upward reports from the Board Committees: (cttee chairs)</p> <ul style="list-style-type: none"> a) Finance & Performance Committee b) Staff Experience & OD Committee c) Quality & Safety Committee <ul style="list-style-type: none"> ○ Infection Prevention & Control Annual Report: <i>for approval</i> d) Audit Committee 	<p>ROHTB (9/25) 014 ROHTB (9/25) 015 ROHTB (9/25) 016 ROHTB (9/25) 016 (a-b) ROHTB (9/25) 017</p>
<p>Finance and Performance Committee - LW</p> <ul style="list-style-type: none"> • Discussions focussed on Month 3 performance and plans to deliver activity and financial targets, with good progress being evident. The Board has today heard of progress in Month 4, so many of the detailed performance observations have been superseded by those reported today in the Chief Executive and Executive Director reports. • The risk of activity overperformance not being funded should Commissioners introduce Activity Management Plans was noted as a continuing issue. • The delivery of CIP remains dependent on achieving corporate service reductions by Quarter 4, although good progress continues to be made. • Concern was expressed about a significant increase in Outpatient waiting times and a review will be reported to the next Committee meeting. • The revised version of the Integrated Performance Dashboard was well-received, with a discussion on further development to be held with the Committee Chair. This discussion took place in August. • September’s meeting will receive updates on the following: <ul style="list-style-type: none"> ○ The Outpatient Transformation Programme ○ The Estates Plan ○ Commissioning and contractual arrangements 	



<ul style="list-style-type: none"> ○ Outpatient Waiting Time performance. ○ Reasons for clinical cancellations and trends ○ Impact on activity and waiting times from industrial action taken by resident doctors. <p>Staff Experience & OD Committee – SJ</p> <p>The paper was taken as read.</p> <ul style="list-style-type: none"> ● It was noted the standard of papers was outstanding with some real clear triangulation and demonstrated the desire to be an inclusive organisation. <p>Quality and Safety Committee - JB</p> <p>Many of the items provided on the agenda in meeting today.</p> <ul style="list-style-type: none"> ● Discussed the risk of histology. This is a national problem so not specific to ROH. ● Spinal endoscopy review and remedial actions were considered. ● Annual radiation safety update was provided but it was noted the risks with regards to the equipment that requires funding to replace. ● Infection Prevention and Control Annual Report was accepted and approved. <p>Audit Committee was taken as read.</p>	
Performance Reports	
<p>31 Performance Reports: <i>for assurance</i></p> <ul style="list-style-type: none"> ● Finance & Performance ● Quality Report ● Workforce 	<p>ROHTB (9/25) 018 ROHTB (9/25) 019 ROHTB (9/25) 020</p>
<p>The reports were taken as read.</p>	
<p>32 Any Other Business</p>	<p>Verbal</p>
<p>There was no further business to raise.</p>	
<p>33 Meeting Effectiveness</p>	<p>Verbal</p>
<p>The meeting ran efficiently with a great opportunity to still discuss items in detail.</p>	
<p>Date of next meeting: Wednesday, 8 October @ 0900h</p>	



PUBLIC SESSION

Next Meeting: 8 October 2025, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 8th September 2025

Number	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT.282	ROH Strategy Refresh	ROHTB (9/25) 009 ROHTB (9/25) 009 (a)	09-03-25	As part of future strategy refresh updates ensure the key actions being taken to address those items not delivering are included as part of the update.	RL	4-Feb-26	ACTION NOT YET DUE	
ROHTBACT.283	Refreshed Board Assurance Framework	ROHTB (9/25) 010 ROHTB (9/25) 010 (a-f)	09-03-25	Update the Board Assurance Framework to ensure mitigating actions being undertaken include patient safety actions.	SGL	8-Oct-25		
ROHTBACT.284	Flu Vaccination Programme Plan	ROHTB (9/25) 011 ROHTB (9/25) 011 (a)	09-03-25	Once the vaccination programme has been completed provide an update on the sickness absence rate v vaccination uptake to understand if link.	NB	1-Apr-26	ACTION NOT YET DUE	
ROHTBACT.277	Upward Reports to Board Committee - SE&OD	ROHTB (5/25) 011	05-07-25	Provide an update from the Workforce Planner to the August SE&OD Committee and then present to the Trust Board in September.	SM	3-Sep-25	Presentation provided to Staff Experience & OD Committee on 27th August. PROPOSE CLOSURE	
ROHTBACT.280	Staff Story	Presentation	07-02-25	Review the mandatory aspect of Me as a Manager training.	SM	3-Sep-25	Interim evaluation report will be provided to Staff Experience & OD Committee in October to scope the decision around mandating this training. PROPOSE CLOSURE as action moved to SE&OD Committee	

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 DECLARATIONS OF INTEREST REGISTER**

Name	Interest	Voting Member
Simon Page Chair	<ul style="list-style-type: none">• Owner, Weathervane Consultancy	Yes
Matthew Hartland Chief Executive	<ul style="list-style-type: none">• Vice Chair, Shrewsbury Colleges Group (Effective from 1 February 2025)	Yes
Simon Grainger-Lloyd Director of Governance	<ul style="list-style-type: none">• Foundation Governor, Ombersley Endowed First School (4 Year Term of Office from June 2024)	Yes
Steve Washbourne Chief Finance Officer	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• None declared	Yes
Matthew Revell Medical Director	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• None declared	Yes
Sharon Malhi Chief People Officer	<ul style="list-style-type: none">• Trustee, Victoria Academies Trust	Yes

Name	• Interest	Voting Member
Simone Jordan Non Executive Director & Vice Chair	<ul style="list-style-type: none"> • NHS Leicestershire, Northamptonshire & Rutland ICB Cluster - Non Executive Member (From 1 October 2025) • Derbyshire Community Health Services NHS Foundation Trust - Non Executive Director (From 1 December 2025) 	Yes
Les Williams Non Executive Director	<ul style="list-style-type: none"> • Chair of Labour Branch, Cradley Heath 	Yes
Gianjeet Hunjan Non Executive Director	<ul style="list-style-type: none"> • Non Executive Director, Black Country ICB • Lay Member, National Clinical Impact Awards - National Main Committee and West Midlands Committee • 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	<ul style="list-style-type: none"> • Legal Consultant to Law Firm Addleshaw Goddard LLP – Currently Assigned Full-Time to Group Lotus 	Yes
Ian Reckless Non Executive Director	<ul style="list-style-type: none"> • 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
Jenny Belza Non Executive Director	<ul style="list-style-type: none"> • Governor, University College Birmingham 	Yes

Name	Interest	Voting Member
Jan Teo Non Executive Director	<ul style="list-style-type: none">• 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



TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	Chief Executive's Update				
SPONSOR (EXECUTIVE DIRECTOR):	Matthew Hartland, Chief Executive				
AUTHOR:	Matthew Hartland, Chief Executive				
DATE OF MEETING:	5 November 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 <i>(Indicate with 'x' all those that apply):</i>					
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 <i>(Indicate with 'x' all those that apply):</i>					
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 <i>(Indicate data sources included in report IF APPLICABLE):</i>					
N/A					
PREVIOUS CONSIDERATION <i>(Indicate board/committee/group & date):</i>					
N/A					

CHIEF EXECUTIVE'S REPORT

Report to the Trust Board (in Public) on 5 November 2025

1. INTRODUCTION

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

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

2. NATIONAL/REGIONAL UPDATE

2.1 ICB Cluster leadership

The Birmingham, Black Country and Solihull ICB Cluster came into being on 1 October 2025. David Melbourne has been confirmed as Chief Executive and Danielle Oum as Chair. I wish them both success in their new roles.

An interim executive leadership structure has been implemented whilst the leadership teams of Black Country and BSOL ICBs are engaged in a management of change process. Adverts are also out for Non-Executive Directors.

It was a pleasure to welcome Danielle to the Trust on 21 October as part of her induction. Simon Page and I shared with Danielle our plans for the future, how we can support the ICB and wider system in the delivery of the NHS 10-year plan and in implementing neighbourhood health. Danielle was very supportive of the Trust, and I thank Danielle for taking the time to visit.

2.2 Policy – Model Region

NHSE has published its blueprint for the 'model region'. It is in line with expectations and aligns with the model ICB published earlier in the year. The number of regions will remain at 7, however current Regional Directors will be reassigned as Regional Chief Executives, and a new post of Regional Chair will be appointed. The Regional CEO will have responsibility for the performance of the whole system and as such have more direct access to CEO's and Boards of providers.

2.3 Policy – Planning Guidance

NHSE published its medium-term planning framework on 17 October. It is not detailed planning guidance as we have previously received, but a strategic document that describes the requirements on the NHS, and individual organisations within it, ie the 'why and what' but not necessarily the 'how' for all elements. This in some ways is helpful. The Board will receive a full briefing in due course, however headline items to note from the guidance are described below:

Strategic Priorities

- **Prevention and early intervention:** A shift toward proactive care, with increased investment in public health and community services.
- **Integrated care systems (ICSs):** Strengthening collaboration across NHS organisations, local authorities, and voluntary sectors to deliver joined-up care.
- **Workforce transformation:** Addressing staffing challenges through recruitment, retention, and new roles, with a focus on wellbeing and flexible career pathways.
- **Digital and data innovation:** Expanding digital infrastructure and data sharing to improve decision-making, patient experience, and operational efficiency.
- **Financial sustainability:** Emphasising value for money and productivity, with clear expectations for cost control and resource optimisation.

Planning Expectations

- **Three-year operational plans:** NHS organisations are expected to develop aligned plans that reflect national priorities and local needs.
- **Performance metrics:** Targets include reducing waiting times, improving access to mental health services, and increasing cancer screening rates.
- **Equity and inclusion:** Tackling health inequalities is a core requirement, with a focus on underserved populations and inclusive service design.

Collaborative Delivery

- The framework encourages **co-production with patients and communities**, ensuring services are shaped by those who use them.
- It also promotes **cross-sector partnerships**, particularly in areas like housing, education, and employment, to address wider determinants of health.

The trust is required to submit a 3-year triangulated financial, workforce and activity plan in December and a 5-year strategy in the new year. It is proposed to utilise the Board Development Session in December to agree the 3 year plan.

2.4 Neighbourhood Health

DHSC/NHSE invited bids from across the country to be 'pathfinders' for neighbourhood health. I was co-signatory for bids from the BSOL system and bids from East Birmingham and Solihull were successful. The detail of the programme is still to be finalised by NHSE, but as active members of both localities we anticipate that the learning from the programme is used across the whole of the Birmingham, Black Country and Solihull.

3 CHIEF EXECUTIVE ACTIVITIES

3.1 Trust Strategy

Strategy Delivery Board met in October to inform the paper on today's agenda. As part of the review of organisational priorities and portfolios, whilst the refreshed strategy updated earlier this year remains valid, oversight of the Trusts transformation and improvement programme will now be overseen under 3 themes: development of the

Trust Business Model, development and implementation of the Trust Operating Model and finally the Trust's Care model. This will become the oversight and reporting mechanism through the Strategy Board to Board.

3.2 NHSE Leadership Event

On 16 September I attended an NHS Leaders event in London. Sir Jim Mackey, CEO and Elizabeth O'Mahoney, CFO, reiterated the expectation of the whole NHS to maintain financial discipline and deliver its financial and operational plans for 2025/6. This was supported by the Secretary of State who also described the imperative of delivering the 10-year plan.

I also attended a Midlands Leadership event in Leicester on 16 October. These events are different to national events and promote shared learning across the Midlands. A number of speakers presented, including colleagues from UHB who graciously referenced the work done by the ROH on the development of the Decision Support Tool that is being implemented across the cluster.

3.3 National Orthopaedic Alliance / Federation of Specialist Hospitals

The NOA Board hosted a session with the Kings Fund on the potential impact of the 10-year plan for orthopaedic services. I unfortunately could not attend the event but Rebecca Lloyd, Director of Strategy, described the work we are doing locally.

3.4 Birmingham Health Partners

I attended the Board of Birmingham Health Partners on 24 September. The Board heard that a new Chair has been appointed following the appointment of Jonathan Pearson as the Chair of Health Innovation West Midlands. It has now been formally announced that the new Chair is Richard Meddings, previously Chair of NHS England.

We discussed expanding the scope of the Board to reflect the new clustering of ICB's, which could include an invite to all Trusts in the Black Country and Wolverhampton University. We discussed how providers could be more consistent in process to reduce both bidding and implementation timescales, but also considered how we compete with more prominent research partnerships across the UK.

3.5 Aston University Civic Agreement

I agreed on behalf of the ROH to be a co-signatory to the Aston University Civic Agreement and I attended the launch event on 23 September. The Agreement aims to promote Birmingham as a premier destination to study, live and do business; drive including growth by attracting investment and high-value jobs; develop a skilled workforce ready to meet the needs of today and tomorrow and support socioeconomic transformation. Signatories supported 7 pledges designed to achieve the above and I was very happy to sign on behalf of the Trust.

3.6 British Orthopaedic Research Society Annual Meeting

I had the pleasure of attending a lecture by Mr Lee Jeys, consultant surgeon at the ROH at the British Orthopaedic Research Society Annual Meeting. The lecture was entitled 'The role of innovation at the Royal Orthopaedic Hospital and the Sarcoma Unit'. It was an excellent lecture which highlighted the leading role the ROH has played in innovation in orthopaedic practice over the years, the work Lee has led personally

and research currently underway. It also showed the impact the innovation has had on patients which was a pleasure to see.

3.7 ICB Strategic Commissioning

I attended a workshop with the ICB on 22 September, designed to discuss how the ICB could/should become a strategic commissioner. The Strategy Unit were jointly commissioned by the Black Country and BSOL ICBs to interview stakeholders and we heard feedback at the session. Headlines were that the ICB role needs to be specific, clear, understood and supported by all parties for it to be successful. It was also recognised that this would need further debate.

The ICB published its initial commissioning intentions for 2026/27 in October. As the financial framework is yet to be published, we are working with the ICB on the consequences and impact for the ROH.

3.8 NHSE Quarterly System Review Meeting

I attended the new-format Quarterly System Review Meeting with NHSE on 1 October. It was chaired by new Regional Chief Executive, Dale Bywater, and reflected the new approach of direct alignment from NHSE to individual providers and Boards. In reality, it will be a joint approach with the ICB, and is likely to change with new oversight arrangements, but this was the approach deployed. It was a challenging meeting with an understandable focus on finance with the 2 joining parts of the system having different financial histories – BSOL with historic financial achievement but off-plan this year, with Black Country being on-plan this year but with £95m deficit support. It could not have been clearer that I, and the Board, are accountable for achievement of the ROH's financial plan and we are expected to delivery. This is similar with key activity metrics. Quality and workforce exceptions were discussed, recognising there is active dialogue elsewhere.

3.9 Acute Provider Collaborative (APC)

The Acute Provider Collaborative met on 17th September 2025 and was attended by myself and the Director of Strategy. The meeting received usual updates on programmes of work, however we also discussed how the collaborative should evolve in the new clustering arrangements. The view was that initially we should continue to focus on the current collaborative workplan, but engage with system colleagues where there is mutual benefit for collaboration.

3.10 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 was also pleased to welcome Rory Deighton, the Confederation's Director of Acute, Emergency and Community Care who visited the Trust on 22 September. We discussed the role, risks and opportunities for specialist Trusts in the future NHS, and the role the ROH does and could play, but also how the NHS Confederation could support us. It was a very positive visit, and we will continue the discussion in my role on the Advisory Board

3.11 ROH Internal Visits

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

3.12 Visit to Birmingham Children's Hospital

I visited Birmingham Childrens Hospital on 16 October to discuss with the CEO and Executives their experience of recently implementing an Electronic Patient Record. I left with a huge amount of advice that is important as we start our EPR implementation journey, as described below.

4. ROH UPDATE

4.1 Loss of colleague

It is with great sadness that I share the news that a colleague from our IT department passed away in October. Our condolences are with their family, friends and colleagues.

4.2 Electronic Patient Record

The procurement for an Electronic Patient Record, which has been ongoing for many months, has concluded with the announcement that InterSystems is the preferred supplier. EPR Programme Board will oversee the implementation, and I look forward to working with InterSystems to achieve the transformational for the Trust that the system, and new ways of working, will bring.

4.3 Guardian of Safe Working

There is a requirement for an update from the Guardian of Safe Working to be received by Board quarterly. It has been agreed with the Guardian, Mr McKenzie, that I will provide an update via my CEO report, with Mr McKenzie attending Board once per year and as and when required. There is currently nothing of concern to report.

4.4 Financial Position

It is pleasing to report that the Trust remains ahead of financial plan at month 6. Whilst there was an in-month deficit to plan in September of £0.2m, we remain £0.1m 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.

4.5 Performance

We continue to perform well from a performance perspective. Headline reported performance metrics for July include 62.3% Referral to Treatment Time (RTT), exceeding the target trajectory of 58.4%. The number of patients waiting over 52 weeks reduced ahead of plan to 375, 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. We continue to achievement all national cancer and diagnostic standards.

4.6 Segmentation

It was announcement in September that Trust has been rated in Segment 1 as part of the new NHS National Oversight Framework. This was excellent news for the Trust, however the methodology of the framework, and financial override, can result in significant variability as assessments are made throughout the year, impacting on league tables. We will continue to focus on improving our position on each of the applicable metrics. The deadline for Board Capability assessment has been deferred and there is a separate paper on the private agenda in this regard.

4.7 NHSE Board Development Programme

NHSE have recently launched a Board Development Programme, focussed on the use of data to support continuous improvement. The expectation is that it is provided for a 'group' of Boards rather than individual providers.

The proposal for the ROH is to do a joint application with Robert Jones and Agnes Hunt in cohort 2. This aligns with the ambition of the strategic alliance and deferring until cohort 2 will allow progress under the MOU to be demonstrated, for which demonstrating a relationship between the organisations is a requisite of the application.

4.8 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:

- Ionising Radiation Policy
- Fit & Proper Person Policy
- Medical Job Planning Policy
- Safe Surgery Policy
- Infection Prevention and Control Policy

6 RECOMMENDATIONS

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

Matthew Hartland
Chief Executive
October 2025



TRUST BOARD (PUBLIC)

DOCUMENT TITLE:		Chief Finance Officer's Report M6			
SPONSOR (EXECUTIVE DIRECTOR):		Steve Washbourne, CFO			
AUTHOR:		Steve Washbourne, CFO			
DATE OF MEETING:		5 November 2025			
PURPOSE OF THE REPORT:					
TO PROVIDE ASSURANCE	x	FOR INFORMATION ONLY		TO SEEK APPROVAL	
EXECUTIVE SUMMARY:					
Month 6 Financial Report					
ASSURANCE PROVIDED BY THE REPORT:					
POSITIVE			GAPS IN ASSURANCE/RISKS TO ESCALATE		
Still ahead of YTD plan at M6 Continued low spend across non-pay			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 <i>(Indicate with 'x' all those that apply):</i>					
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 <i>(Indicate with 'x' all those that apply):</i>					
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					

CFO's Report Month 6

1. Summary

The Trust delivered a deficit in month of £17k against a planned surplus of £47k, generating an adverse variance of £64k in month. This results in a deficit of £688k YTD, a favourable variance of £68k against plan.

Income & expenditure summary	Current month				Year to date			
	Plan £000s	Actual £000s	Variance £000s	%	Plan £000s	Actual £000s	Variance £000s	%
Operating income	12,495	12,155	(340)	(2.7%)	72,261	70,970	(1,291)	(1.8%)
Agency pay	(136)	(99)	37	26.9%	(861)	(664)	197	22.9%
All other employee expenses	(6,810)	(7,010)	(200)	(2.9%)	(41,291)	(41,548)	(257)	(0.6%)
Operating non pay	(5,387)	(4,950)	437	8.1%	(30,172)	(28,891)	1,281	4.2%
Total operating surplus / (deficit)	162	96	(66)	(0.5%)	(63)	(132)	(69)	(0.1%)
Non operating items	(123)	(123)	0	0.3%	(738)	(612)	126	17.0%
Surplus/(deficit) for the period/year	39	(27)	(66)	(0.5%)	(801)	(744)	57	0.1%
Less I&E impairments/(reversals) & (gains)/losses on transfers by absorption	0	0	0		0	0	0	
Surplus / (deficit) before impairments and transfers	39	(27)	(66)	(0.5%)	(801)	(744)	57	0.1%
Technical adjustments	8	9	1	16.0%	45	56	11	24.5%
Adjusted financial performance surplus/(deficit)	47	(17)	(64)	(0.5%)	(756)	(688)	68	0.1%
Less Non-Recurrent Deficit Support	0	0	0		0	0	0	
Adjusted financial performance surplus/(deficit) excluding non-recurrent deficit funding	47	(17)	(64)	(0.5%)	(756)	(688)	68	0.1%
Underlying position								
EBITDA as a percentage of related income	5.8%	5.2%	(0.6%)		4.6%	4.4%	(0.2%)	
I&E margin	0.4%	(0.1%)	(0.5%)		(1.0%)	(1.0%)	0.1%	

Whilst this remains a positive position YTD for H1, 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. The YTD deficit reflects an average monthly deficit of circa £115k per month and we now need to reverse that and achieve an average surplus of c£115k per month to achieve a break-even position for the year – this is an improvement of £230k per month

2. Income

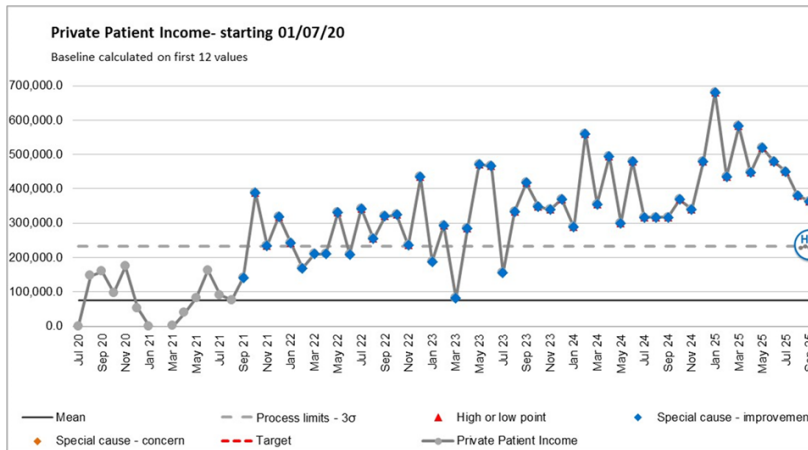
As previously discussed, the income position for 2025/26 has been reset based on activity delivered in 2024/25, and required activity to deliver the 2025/26 RTT targets. As the Trust underperformed on its elective activity during 24/25, this has resulted in a real-term reduction in income.

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 6 the Trust delivered an underperformance on variable elective patient care income of c£324k in month and £710k underperformance YTD, after correcting for application of specialist top-up, although at £4.9m this reflects the highest level of income achieved this year.

Whilst the actual performance on income is included at M6, it is the net position that is recognised. We are also assuming underperformance will be clawed back in H2.

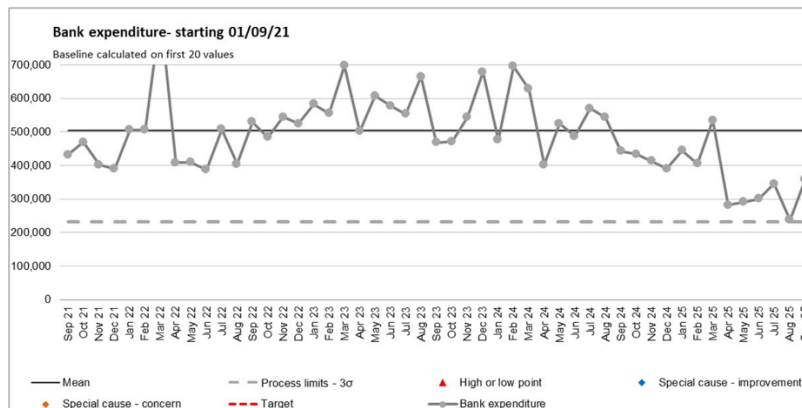
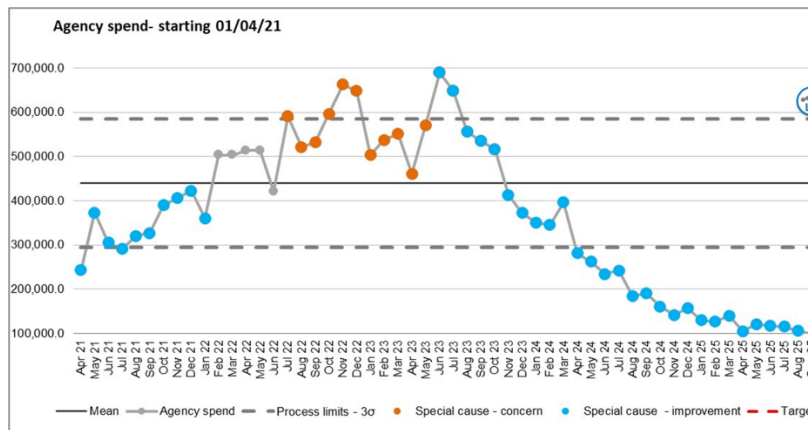
Private patients' income is £363k in month against a plan of £383k which means it is now delivering plan YTD. This is the lowest monthly PP income for the year.



3. Pay

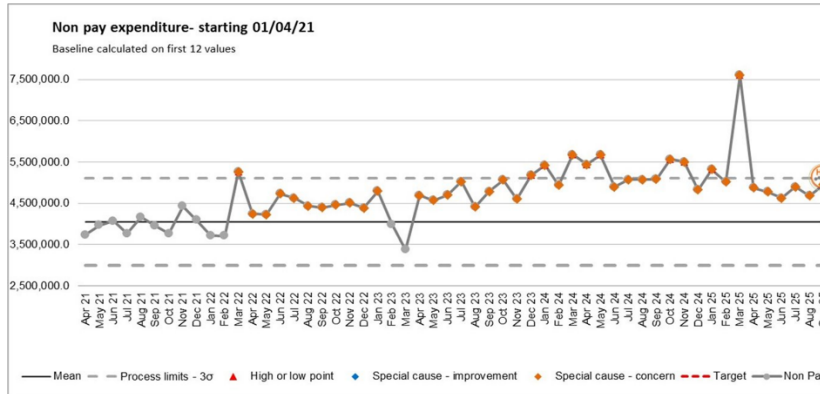
Pay expenditure is overspent in month by £200k contributing to an overspend of £257k YTD. However, actual spend was only £100k more than M5, relating primarily to an increase in Bank spend.

Agency spend is £99k in month (M5 £106k), or 1.4% of pay, the lowest this year. Bank expenditure however increased to £359k in month (M5 £238k) against a plan of £271k, with most of this increase in Medics (M6 £105k v M5 £46k) which is reflective of increased spend on ADHs and on-call payments. Spend in Nursing of £71k (24/25 ave £111k) is the highest this year and reflective of increased sickness, whilst Infrastructure spend of £118k (24/25 ave £145k) also increased although still less than last year.



4. Non-Pay

Non-pay spend of £4,950k in M6 was slightly more than the £4,768k in M5 but £437k less than plan.



LLP spend was £198k in month and now has YTD spend of £1,089k against a plan of £517k, with actual spend of £419k in spinal and £570k across arthroplasty.

5. Cash

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

6. Capital

We had low spend in month of £5k. We need to be conscious of the cash impact of increased capital spend through the rest of the year.

An additional update paper is also included this month

7. CIP and Route to Break Even

In month efficiencies of £683k have been recorded. This increases the year to date achieved to £3,301k against a plan of £3,856k, generating an underperformance of £555k. 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.

A further review of CIP performance will be undertaken at Finance Delivery Board.

8. System Position

After six months the system position is a YTD deficit of £37.5m, £21.5m adverse to plan. This represents a £0.4m decrease in deficit compared to month 5 and a £1.9m improvement in variance against plan compared to the YTD M5 variance. Four organisations have been asked to produce a financial recovery plan, BSMHT, BCHC, BWC and UHB.

ROHTB (11-25) 003

Total Performance	YTD			FOT			YTD Income / Allocation £000s	YTD Deficit as % of turnover
	Current Plan £000s	Actual £000s	Variance £000s	Annual Plan £000s	FOT £000s	Variance £000s		
BSOL ICB	-3,513	-2,233	1,280	0	-1	-1	2,149,067	-0.10%
BSMHT	2,086	-772	-2,858	4,200	4,200	0	364,145	-0.21%
BCHC	359	-998	-1,357	0	0	0	194,737	-0.51%
BWC	0	-4,740	-4,740	0	0	0	365,929	-1.30%
ROH	-756	-688	68	35	35	0	70,970	-0.97%
UHB	-14,201	-28,064	-13,863	-4,200	-4,162	38	1,329,250	-2.11%
Total	-16,025	-37,495	-21,470	35	72	37	4,474,098	

Appendix A: Elective Variable Income

	Actual									In Month		
	1	2	3	4	5	6 Total	Plan YTD	Variance	Actual	Cap	Variance	
Hereford & Worcs ICB	£446,679	£588,234	£677,735	£623,135	£604,289	£748,709	£3,688,782	£3,459,875	£228,908	£748,709	£610,563	£138,146
BSOL ICB	£2,055,993	£2,217,469	£2,299,298	£2,347,850	£2,285,500	£2,478,917	£13,685,027	£14,204,398	−£519,371	£2,478,917	£2,572,493	−£93,576
Staffs & Stoke ICB	£178,007	£168,807	£133,587	£132,149	£193,588	£119,600	£925,738	£968,261	−£42,523	£119,600	£155,005	−£35,405
Black Country ICB	£639,972	£590,798	£595,625	£724,893	£661,349	£837,983	£4,050,619	£4,093,500	−£42,881	£837,983	£726,413	£111,570
Cov & Warwick ICB	£167,332	£107,341	£90,807	£126,345	£118,022	£138,055	£747,902	£729,448	£18,455	£138,055	£111,341	£26,714
Spec Com	£563,699	£559,615	£538,132	£541,711	£655,543	£542,029	£3,400,730	£3,844,015	−£443,285	£542,029	£680,797	−£138,768
Grand Total	£4,060,038	£4,241,434	£4,347,274	£4,512,538	£4,532,285	£4,895,445	£26,589,014	£27,299,496	−£710,482	£4,532,285	£5,219,772	−£324,327

27th of October

CHIEF OPERATING OFFICERS REPORT

Report to Trust Board – October 2025

1 NATIONAL OPERATIONAL CONTEXT AND DEVELOPMENTS

- 1.1 In October there have been two significant national meetings from an operational perspective. The first meeting was held on the 2nd of October and was a face-to-face round table strategy meeting with Sir Jim Mackey. Circa 20 Chief Operating Officers (COOS) were chosen from across the UK to attend this meeting. The Chief Operating Officer attended this meeting to hear national updates from Sir Jim Mackey and the national team regarding the 10-year plan, likely changes to the financial frameworks and the focus operationally on waiting list reduction and the delivery of the forthcoming RTT plan. It was also an opportunity for COOS to share their challenges at a local level. The challenges with the elective cap framework in relation to a specialist surgical hub were shared to raise the profile of the ROH as a specialist Trust and the crucial role we can play in waiting list recovery. The session was useful, informative and supportive of the challenges Trusts are currently facing in terms of delivering the operational access imperatives whilst maintaining financial balance and a good opportunity to raise the profile of the ROH.

On the 23rd of October the inaugural national COOS meeting also took place led by Sarah Jane Marsh and was attended by one of the Associate Director of Operations from the ROH on behalf of the Chief Operating Officer. This was the first of a series of sessions to support operational leaders across the UK and share current challenges and best practice. Discussions started with a Questions and Answers session led by Sir Jim Mackey that focussed on quality and safety being hand in hand with productivity to improve overall quality. He shared examples relating to urgent care and encouraged leaders to maximise efforts around productivity.

There was a discussion around career structure and pay progression for COOS and aspiring CEOs and how these positions can become more attractive in the future with appropriate training and support. The multi-year planning guidance was discussed and the requirements to develop a 3-year detailed plan and a subsequent 2-year narrative outline plan. It was also emphasised that detailed planning is expected to be at an organisational level rather than a system level. There was a discussion around clinical job plans aligning to demand. This fits well with the launch of our newly agreed job planning policy which is launched in November at the ROH.

The Chief Operating officer had the pleasure in chairing a Black history month commemoration event on the 15th of October which was well attended by staff from across the organisation. The session organised by Jennifer Pearson hosted guest speakers including a local poet, an RAF veteran and author, an expert patient and speakers from the Trust sharing

their stories around allyship and heritage and discussed how we continue to build an inclusive culture at the ROH together. The theme this year was 'power and pride' and the session embodied these sentiments well with good feedback from all who attended. Thanks go to Jennifer who organised an uplifting thought-provoking session in association with the Trust MMEG network.

2. OPERATIONAL PERFORMANCE

- 2.1 As of September 2025, RTT performance reached **62.32%**, exceeding the target trajectory of **58.37%**, reflecting strong progress in improving patient access. Notably, the number of patients waiting over 52 weeks reduced ahead of plan to 375, 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 ahead of plan with a reported position of **66.54%** against a plan of 64.80%. 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 August 2025.
- 2.3 The Trust sustained the 65-week breach position, with a reported position of zero 65-week patients reported in September 2025, demonstrating our continued commitment to timely patient care and effective waiting list management.
- 2.4 Diagnostic performance exceeded National standards retaining a 99.8% position in September 2025.
- 2.5 Activity performance for September 2025 was 7 cases below plan. The year-to-date position is however currently 80 cases ahead of plan YTD, demonstrating strong overall performance and resilience in delivery of the operational plan.

3. PRIVATE PATIENTS

Private patients' income is £363k in month against a plan of £383k which means it is delivering plan YTD, however below the stretch plan. Targeted actions are in place to deliver the £6.1m stretch income target. The activity undertaken in September 2025 reflects a cohort of less complex patients attracting a lower tariff. Work is ongoing to increase uptake in private patient activity. An agreement has been reached with an additional Hand Surgeon who will support the expansion of our private patient services from January 2026.

Marketing continues to focus on the promotion of our robotic surgery to stimulate more interest and activity over the coming months and optimisation of the search engine. The Trust continues to progress the development of a business unit framework to expand and develop private patients as a small business unit entity. The team have just been awarded a new contract as the preferred scanning provider for an insurance

company which will expand imaging activity and are working in collaboration with Harborne hospital on a collaboration to expand overseas activity.

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

Key highlights from the September 2025 TIG meeting are outlined below:

- Following the development of the virtual Project management office (PMO), thirty active projects are now aligned to the Trust strategy with clear ownership and completion dates, strengthening governance reporting into the Strategy Delivery Group and Trust Board.
- Six projects have already been marked as complete, demonstrating that the Trust are delivering and sustaining improvement work.
- The outpatient booking innovation is progressing well, with staff describing it as transformative and teams fully engaged. The Associate Director of Operations for Outpatient Transformation presented to Finance & Performance Committee at the end of September 2025. The team have secured external funding for 3 years to continue use of Dr Doctor for unlimited use of online questionnaires to help inform clinic consultations. These forms are already adding value in Therapies.
- The outpatient transformation group have analysed data that evidences that IMD 1-3 patients are most at risk of DNAs, enabling targeted interventions such as volunteers calling patients and supporting transport for patients where appropriate as part of the wider Trust Health Inequalities work.
- The ambulatory care unit trial on Ward 12 has shown positive results, with safe same-day discharges, patient satisfaction, and early positive audit evidence. The successful implementation of this reconfiguration will support the roll out of improving day case rates across all specialties and a project team led by the Associate Director of Operations has been set up to take this forward in line with achieving the BADS GIRFT Day case target of 85%. This programme of work will report back to the Finance and Performance Committee in February 2026.
- The Imaging team have now submitted the application for working towards QSI Accreditation status. This is an external accreditation supported by the Royal College of Radiographers and Radiology and will continue to support excellence in imaging and endorse quality in this service.

5 KEY RISKS

- 5.1 Even though all national operational imperatives are currently on target the volume of Spinal patients over 52 weeks continues to be a risk to reducing the overall waiting

times for the Trust. In line with the expanded capacity to support spinal services a locum Consultant has commenced in post during September 2025.

As part of the spinal service review a workshop to accelerate progress against the GIRFT best practice was held in September, chaired by the Chief Operating Officer. Following a full demand and capacity analysis, additional capacity has been introduced utilising Advanced Pain Practitioners (APPs) to optimise patients waiting to see surgeons and to redirect appropriate patients to non-consultant led clinics. Further pathway transformation work continues with alignment of APPs to surgical clinics, and a second workshop has been agreed in November to scope opportunities to improve clinical triage and deliver best practice interface service provision for spinal services.

- 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. The delays are now starting to have an impact on the Trust's ability to continue to meet the Faster Diagnosis Standard. UHB have sourced expertise from Sweden to increase capacity. The risk will continue to be monitored at the System Oversight Group and via the Trust Cancer board, supported by the COO and Medical Director.

6.0 MSK PROGRAMME UPDATE

- 6.1 The ROH continue to lead on the system MSK programme. Notable milestones in September include the acceleration of system use of the 'Get U Better' app now system funding has been agreed. The App now has over 25,000 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.

In October the workforce plan data collection was completed, and a workshop was held to discuss outcomes agree options for workforce transformation. The options appraisal will offer potential models for the 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 November 2025 for consideration.

As Phase 1 objectives of the programme are almost complete the Team are scoping the strategy for Phase 2 of the programme which would aim to include the wider MSK conditions such as 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 A new job planning policy has now been agreed that is aligned to NHS Impact recommendations. The teams will start the data gathering element of the new job planning cycle with a view to understanding demand and capacity for next year to inform team job planning discussion in November 2025.
- 7.2 In November the team will be implementing a new patient access policy that has been developed in collaboration with system partners. This will ensure that patients are managed consistently across all BSOL providers reducing inequalities in patient access.
- 7.3 A super patient tracking list validation internal sprint is planned for November 25 to focus on reducing the overall waiting times. Meetings will be held with all subspecialties chaired by the Chief Operating officer to gain detailed insight into the challenges at subspecialty level and offer focussed support in innovations to accelerate waiting list recovery to deliver the 18-week RTT standard.
- 7.4 Momentum will be increased on mobilising standby patients for electives to backfill short notice cancellations in a systematic and planned manner to maximise capacity in theatres in line with the Trust winter plan.

8. RECOMMENDATION(S)

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

Marie Peplow - Executive Chief Operating Officer October 2025.

FOR ASSURANCE
FOR INFORMATION



CHIEF PEOPLE OFFICER'S

Report to Trust Board (Public) – October 2025

1 LOCAL MATTERS FOR BOARD ATTENTION

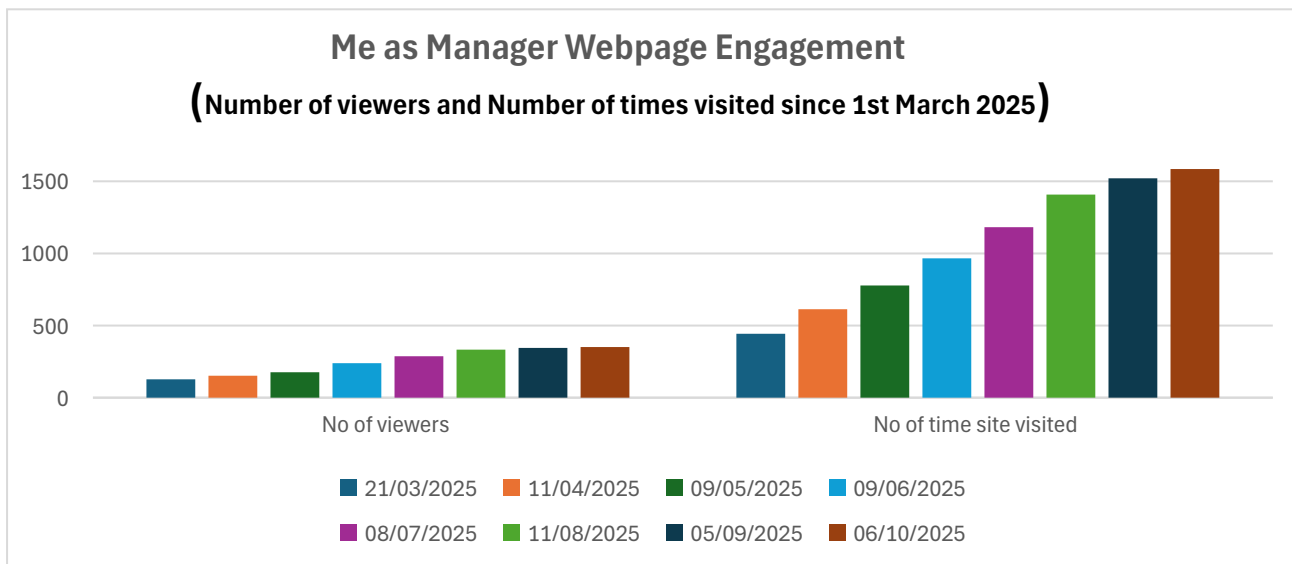
1.1 Anti Racism Statement & RACE Equality Code Launch

The Trusts Anti Racism statement has been finalised and the launch alongside the launch of the Trusts RACE Equality Code Action Plan has taken place during Black History Month in October 2025. There has been positive engagement with the launch.

1.2 Me as Manager: The ROH Management Development Framework

Me as Manager: The ROH Management Development Framework was launched during March 2025 with high levels of engagement, and positive verbal feedback. Find out more about the framework here: [Me As Manager](#)

On 6th October 2025, 351 individual people had accessed the Me as Manager webpage 1585 times.(Average of 4.52 visits per viewer) This is an increase from 8th July at which point 287 people had accessed the site 1182 times (average of 4.12 visits per viewer).



The pilot of “Developing Leaders in the ROH” (Level 5 CMI accredited) programme completed on the 10th June 2025, with their final presentations. A graduation event was held on 6th October 2025. The second cohort who commenced on the 9th June 2025 are progressing well, and applications have opened for Cohort 3 commencing in January 2026.

A 6-month review of the Me as Manager Framework is currently in progress with a feedback questionnaire circulated on the 30th September, which will be open until the 16th November 2025. Initial survey results are extremely positive.

1.3 Learning Management System Procurement Update

Dynamic Business Solutions and the ROH delivered a soft launch of the new LMS on the 2nd October, with a full launch which took place on the 15th October. The new domain name for the LMS is: <https://learning.roh.nhs.uk/> Initial feedback about the new platform has been extremely positive and we are anticipating that this will improve mandatory training compliance as we know from staff feedback accessibility of the ESR system was a major barrier. The courses are more user friendly and engaging which should support staff completion rates.

1.4 Core Skills Training Framework (CSTF) Mandatory Training Compliance

Trust compliance for the CCSTF is at 83.13% on 30th September 2025 (down from 87.43% in July). This decrease was due the annual renewal requirements for Cyber Security, Information Governance and Fire not being maintained. Other areas of focus are Infection Prevention Control Level 2 and Oliver McGowan Mandatory Training Part 2 Tier 1 (for Non-clinical staff).

With the launch of the new Learning Management System (LMS) it is envisaged that this will impact positively upon future completion rates.

1.5 Apprenticeship Activity

At 6th October 2025, the Trust has 23 new apprenticeships starts, up from 13 in July. There are 4 additional in the pipeline to commence in the next 3 months; and there are currently an additional 6 in discussion. So there is potential for 33 new starts against our annual target of 34.

In relation to the apprenticeship levy funding investment, we have utilised 62.66%, with 2.9% of this being gifted to smaller charitable organisations. Our expired levy has dropped to under 10.5%, with no funds expiring since April 2024, and our remaining level has seen a positive decreased from 30.76% in January 2025 to 26.69% in May 2025.

1.6 MSK Academy

The MSK Academy website was launched on the 3rd October 2025, which contains a range of free, on-demand learning resources. Ranging from bite-size courses to patient examination guidance to expand practitioner knowledge on diagnosing, treating and managing MSK conditions. The website and video have been developed in house in partnership with the communications team.

[Royal Orthopaedic Hospital | MSK Academy - Home](#) This website will become our online shop front for the MSK Academy.

During QIDD in September, a partnership event took place with Stryker. Stryker had interactive educational stands in the library and training room for Consultants to

explore, whilst they also delivered enhanced training sessions in Theatres for the Theatre teams.

1.7 Staff Survey 2025

The 2025 National Survey has launched during the month of October 2025. At the time of writing, we have a 27% response rate which is lower than this time last year. We will continue to ensure that we drive the importance of feeding back and staff sharing their voice so we can continue to drive improvements for our patients and staff.

1.8 Strategic Workforce Forum

During October I attended the Strategic Workforce Forum on Day 2. It was a great day with presentations about evidence-based HR, transforming people services and closing remarks from Jim Mackey, Chief Executive NHS England.

In addition to some great speakers, some of the key discussion was about the next steps and plans for the implementation of the Target Operating Model for People Services which sets out to transform the way in which People Services are delivered in the NHS by 20230.

2 NATIONAL CONTEXT AND DEVELOPMENTS

2.1 Pay & Terms and Conditions/Industrial Relations

The British Medical Association (BMA) announced resident doctors strikes Friday 14 November to Wednesday 19 November. We anticipate that the impact for the ROH will be minimal.

The NHS Pay Review Body (PRB) process for 2026/27 pay has now begun. NHS Employers will submit evidence on behalf of employers. The oral evidence session with the PRB is planned for November 2025.

The job evaluation task and finish group (TFG) has been reconvened with a refreshed membership and updated terms of reference and will initially begin on an enabling agreement.

The nursing career progression TFG led by DHSC has also been reconvened to support the delivery of the non-pay recommendations and have agreed that the publication of resources will be done in stages over the next two years, with the priority to begin work on supporting the career progression of BAME nurses.

The NHS Terms and Conditions of Service (TCS) Handbook review steering group has also set up a TFG to look specifically at the non-pay recommendations. Annex 20 (development of professional roles) and recognition of overseas experience are being worked on as a priority area.

2.2 National Education and Training Key Highlights

- NHS England has secured mitigation funding for five key [Level 7 apprenticeships](#) starting in 2026, with details on the expression of interest (EOI) and payment process to be shared in September.
- The government has launched a [Graduate Guarantee](#) to ensure every newly qualified nurse and midwife in England has access to a job.
- NHS England has announced it will not fund any further cohorts for the [medical doctor degree apprenticeship](#), in line with the DfE's Level 7 review outcomes.
- The [NHS Procurement & Commercial Digital Academy](#) is now accepting applications for Level 3–6 apprenticeships in data and analytics.

2.3 NHS Workforce Plan

We still await the NHS Workforce Plan and the call for evidence is still live until 7th November 2025. Further updates will be provided when available. The call for evidence is keen to understand

- the professions, roles and skills, including skills included and emphasised in training curricula, that will be critical to successfully implement the three shifts
- how specific professions, roles and skills may be impacted by the implementation of the three shifts and the wider policy ambitions of the 10 Year Health Plan, while maintaining quality care for patients
- how the 10 Year Workforce Plan can support the government growth and opportunity missions

2.4 NHS Workforce Solution

The NHS Business Services Authority (NHSBSA) has announced it has awarded a £1.2 billion contract to Infosys to deliver a new and enhanced workforce management solution for the NHS.

The solution is intended to support NHS organisations and their employees by providing a complete employment lifecycle platform, generating significant benefits for the NHS over the 15-year contract duration. It will support everything from recruitment and onboarding to career development, workforce management, payroll and retirement.

The Future NHS Workforce Solution will succeed the Electronic Staff Record (ESR) and continue to pay 1.9 million NHS employees, which is 5% of the UK workforce, over £55 billion in payroll each year.

NHS people will be at the heart of the design of the future solution and the NHSBSA has listened to over 15,000 people across the NHS workforce, to understand their needs.

Implementation is expected to be completed by 2030. Using the latest technology and artificial intelligence, the future solution is intended to allow employees to connect more easily with other digital systems and will empower them to manage their personal information more efficiently. It will also aim to give the NHS improved data about its

workforce so managers can make better planning decisions, which will drive cost reduction and enable productivity improvements.

3 KEY RISKS

3.1 Lower engagement with staff survey completion compared to previous years.

3.2 Continued short term absence and impact on productivity.

4 WORK PLANNED IN NEXT MONTH

4.1 Continue to drive staff survey response rates.

4.2 Continue with medium term planning work.

4.3 Continue to focus on 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
October 2025



QUALITY OFFICERS' REPORT

Report to Trust Board on 5 November 2025

1 MEDICAL DIRECTOR'S UPDATE

External meetings

- 1.1 On 16 Oct 2025, I attended the Regional Responsible Officers Event (Virtual). The key elements of the agenda covered – NHSE/DoH integration and amendments to RO regulations 2025, Sexual Safety, Higher Level Responsible Officer Quality assurance and Compassion in Leadership.
- 1.2 On 10 Oct 2025, I joined the BSol Localities meeting on behalf of CEO/Exec team (focus on East) following a visit to South Locality 25 Sept 2025. The meeting focussed on progress in informatics and central reporting. All localities are progressing with care coordination centres and most are prioritising respiratory pathways for this winter. There is varying readiness with these and roll out of Integrated Neighbourhood Teams with localities planning roll out over 2025-2026 (require negotiation with PCNs)
- 1.3 The Regional Research Delivery network stakeholder meeting was held on 15 Oct 2025. This looked at current finances and funding, as well as potential future models being considered nationally. Support was given for a 150 day study set up target (ROH has been working with BHP for some months on this with improving trajectory). Discussions focussed on data and future strategy where the ROH contributed.



- 1.4 I had a meeting with Chief Nurse with Chair and project lead for BLACHIR, in the context of Black History month – focus on data and access

Internal focus

- 1.5 The theatre and divisional triumvirate is working through the theatre service review and with the Chief Nurse I am exploring commissioning of Association for Perioperative Practice (AfPP) to work towards accreditation, potentially.
- 1.6 Genomics – a meeting was held with the Oncology and Research teams to define more clearly how the Trust will manage and record decisions to enter adults for genomics and our longer-term ambition (linking with Research Tissue lab)
- 1.7 Spinal Harm reviews around outpatient breaches are nearing completion and an update on the investigation process will be presented to Quality & Safety Committee at its November meeting, with an update to Board in December.
- 1.8 The Oncology team is working with UHB regard to pathology service performance and support.
- 1.9 The Medical Education team is completing a Medical faculty with key posts and wider educational team is progressing strongly on MSK Academy launch (fuller presentation estimated for Dec 25 / early 26)
- 1.10 The third QIDD day was held and there was positive feedback around quality improvement discussions and training opportunities.

2 CHIEF NURSE'S UPDATE

National / Regional updates

- 2.1 On the 18 October 25, the Department of Health and Social Care announced its intention to launch a public consultation in 2026 on Liberty Protection Safeguards. The Liberty Protection Safeguards (LPS) were introduced through the Mental Capacity (Amendment) Act 2019, which aimed to reform the Deprivation of Liberty Safeguards (DoLS) system. The move toward Liberty Protection Safeguards began with the *Mental Capacity (Amendment) Act 2019*, which amended the original *Mental Capacity Act 2005*. This legislation was passed to address growing concerns that DoLS was overly complex, bureaucratic, and unable to keep pace with increasing demand. However, implementation has been delayed due to the pandemic and logistical challenges.

The 2019 amendment introduced LPS as a more streamlined and flexible framework for authorising deprivations of liberty for individuals aged 16 and over who lack capacity to consent to their care arrangements. Key changes are:

- **Age lowered:** Applies to people aged 16+ (DoLS was 18+).
- **Wider settings:** Covers hospitals, care homes, and community settings.
- **Simplified process:** Care home managers can coordinate authorisations.

- **New test:** Must be necessary, proportionate, and the person must lack capacity.
- **AMCP role:** Independent review for complex or contested cases.
- **Integrated planning:** Aligns with existing care and treatment plans.

2.2 On the 9th / 10th October, I attended the Chief Nursing Officer for England Conference focused on 'Shaping the future of nursing and midwifery through strategic collaboration and professional development'. The Conference focused on shaping the new Professional Strategy for Nursing and Midwifery, with key themes including workforce retention, leadership development, and improving student placement experiences. Strategic actions being explored included a national standard for quality metrics, greater visibility of winter pressures and social care, and stronger collaboration with the Royal College of Nursing.

Following the conference Prof Nina Morgan the Midlands Regional CNO is exploring the following concepts: regional network for new Chief Nurses, enhancing communication through specialty-based WhatsApp groups, and launching a regional social media hashtag to share positive stories, coaching senior teams, involving early career nurses in leadership spaces. Additionally, there is a renewed focus on embedding research in Chief Nurse portfolios, including relaunching the Executive Nurse Research Forum designed to connect leadership in communities.

Internal

2.3 The pharmacy team held their annual CQC pharmacy engagement meeting in month. Early feedback is the meeting was positive with good practice around patient information being noted.

2.4 Vicky Clewer, Head of IPC, is the Deputy Chair of the National Shared Professional Decision-Making Council for IPC. Vicky summarises the impact her role has nationally in the following statement: *'As Deputy Chair of the National Shared Professional Decision-Making Council for IPC, my role is to support and partner the Chair in providing strategic and operational leadership to the council. This includes ensuring robust governance, facilitating the council's work to deliver on its objectives around IPC and shared decision-making, engaging key stakeholders, translating decisions into practice, and maintaining continuity of leadership when required. The Chief Nursing Officer's Shared Professional Decision-Making Councils aim to empower nursing, midwifery, and allied health professionals by ensuring that staff voices are heard, leadership is distributed, and decisions are made collaboratively to drive quality improvement and excellence in patient care. As part of this professional council, I help ensure that shared decision-making is embedded in practice, that improvement initiatives are co-produced, and that the council remains an effective forum for influencing national IPC priorities.'*

2.5 On the 29 October, the Trust will be hosting the first study day for Person Designate (P.D), (Human Tissues Management). Matt Coombe P.D for the Royal Orthopaedic

Hospital and Barney Pitt P.D from Robert Jones and Agnes Hunt using the MOU, have collaborated to develop the day. The day is designed to be the forerunner for a 'P.D's Communities of Practice' forum that would meet quarterly to share learning and lessons. The initiative has been strongly supported by the Human Tissue Authority, with the Authority providing a speaker on the day.

- 2.6 On the 22 October, Mr Mehta, Ryan McComb Clinical Services Support Manger for private patients, and I visited the Harborne Hospital. The meeting was designed to foster relationships and to shared learning from a patient perspective around standards of care in a private provider. Over the coming months we will be working with the team to explore how this learning can be best incorporated into practice.
- 2.7 The Mary Seacole leadership programme for Global Majority Nurses and Midwives is a regionally funded initiative designed to offer a structured, evidence-based pathway into leadership. There are 23 place available this year with ROH hoping to supporting two nurses applications. Applicants will be awarded an NHS Academy Award in Healthcare Leadership, as well as the being supported with career progression / talent development.
- 2.8 At the beginning of October, the Nursing Council celebrated Black History Month, by inviting colleagues to share stories / lived experiences about Black healthcare leaders who have helped shape the NHS. Jennifer Pearson, Head of Nursing for Division 2, continued to amplify this work throughout the month with a celebration in the Knowledge Hub for Black history month titled 'Power and Pride'. This was followed regionally with Jennifer chairing a webinar with Professor Nina Morgna on '*Midlands Regional Career Progression*'.
- 2.9 Executive and NED walkabout – Jenny Belza and I visited College Green in month. During the visit we observed a group post-operative session and the team explained the value of key equipment that supports patient back to sport after surgery.
- 2.10 Emme Steele the Deputy Chief Nurse, has been shortlisted in the Nursing Times Workforce awards for a workforce initiative reducing vacancies and reliance on temporary staffing. She presented to the judging panel at the Nursing Times Head Office on 15th October and awaits the outcome.
- 2.11 The Catering team supported 'Black History Month' with a Caribbean food theme, which was greatly welcomed and supported by staff across the trust.
- 2.12 The Facilities team welcomed Matt Hartland, Chief Executivem, to the team on the 23 October. Matt worked with two Domestic staff on Ward 3 (Oncology), learning about how the hygiene code is put into practice. The team really enjoyed working with Matt.



2.13 On 6th October the annual flu campaign was launched, this was supported by the Trust Board during that week. The target set by NHSE is 41.3%, which is an increase of 5% on the previous year. At the time of writing this paper the following has been achieved:

Total HCW (all) = 1,385
 Total vaccinated = 400
 % of all HCW vaccinated: 28.8%

Total Frontline HCW = 836
 Total Frontline HCW vaccinated = 228
 % Frontline HCW vaccinated = **27.3%**

2.14 Quality Priorities for FY 25/26 update for quarter 1.

Domain	Priority	Progress
Safe (QP1)	Reducing Surgical Site Infection (SSI) risk rates for total knee replacement (TKR) and spinal surgeries undertaken at The Royal Orthopaedic Hospital (ROH) from 2024/25 onwards. (Rollover – year 2)	On-track
Caring (QP2)	Art for health – Holistic approach to managing patient's pain	On-track
Effectiveness (QP3)	Delivering Safe, Effective and Inclusive Care - Minimising the risks and potential impact of medical neglect among children and young people with limited engagement in health services due to existing health-related barriers.	On-track
Responsive (QP4)	Reduction in length of time for patients to wait for access to the Spinal Service	On-track

Well-led (QP5)	Year 2 of roll out of Service Accreditation	On-track
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2.15 The Trust has completed its first years Veterans Accreditation review and has successfully been re-awarded. Over the coming months events are planned to acknowledge key dates such as Remembrance Day. The trust is now working toward silver level accreditation, which involves increased training and awareness of the health inequalities associated with veterans and their families.



3 DIRECTOR OF GOVERNANCE'S UPDATE

3.1 On 27 October, I, together with Claudette Jones, Freedom to Speak Up Guardian and Gianjeet Hunjan, Non Executive Lead for Freedom to Speak Up, celebrated FTSU month, with a listening session with Ward 2 staff who are currently deployed into other areas while the ward is temporarily closed.

The FTSU team offered samosas to staff who were happy to discuss with them thoughts around the theme of the event, this being 'We are LISTENING, let's work together to take ACTION and BUILD TRUST'.

3.2 The Trustwide governance review continues and good progress has been made to map out the corporate governance architecture of the organisation, with a view to identifying areas of duplication and opportunities to streamline the information flows across the organisation.

3.3 Work is underway to undertake a self-assessment against the new and refreshed Violence Prevention and Reduction Standards (VPRS). The work is being lead by Sophie Goddard, Health & Safety Advisor, who will report on this through to Health & Safety Group but also into Staff Experience & OD Committee, given the impact of this work on the Trust's staff.

3.4 On 6 November, the Chief Nurse and I, will join the next scheduled engagement meeting (virtual) with our CQC relationship manager, Jessica Huntley.

3.5 A significant part of the previous month, has been taken by preparing for our submission of the evidence to support our Provider Capability Assessment, a key element of the National Oversight Framework. The Board will consider this as part of its private session and following its submission and consideration by NHS England, this will be reported in public. Thanks to all colleagues who have supported this significant piece of work.

3.6 An Internal Audit into the Trust's arrangements to comply with the national Fit and Proper Persons Test arrangements is currently underway. The annual declaration, signed by the Chair, was submitted earlier this year to NHSE, to the required deadline of 30 June 2025. The declaration did not highlight any areas of concern and all were declared compliant with the regulations. Following the recent recruitment into the Non Executive post, vacated by Les Williams, this gives an opportunity to refresh and strengthen our compliance with the FPPT as they embed into the organisation.

On 20 November, the Council of Governors will additionally be updated as to the FPPT status of Board members and Non Executive colleagues.

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

October 2025



TRUST BOARD

DOCUMENT TITLE:		Gender Rights Supreme Court Ruling briefing – Update			
SPONSOR (EXECUTIVE DIRECTOR):		Nikki Brockie, Executive Chief Nurse Sharon Malhi, Executive Chief People Officer			
AUTHOR:		Emma Steele, Deputy Chief Nurse Clare Mair, Head of OD and Inclusion			
DATE OF MEETING:		5 th November 2025			
PURPOSE OF THE REPORT:					
TO PROVIDE ASSURANCE	x	FOR INFORMATION ONLY	x	TO CREATE DISCUSSION	TO SEEK APPROVAL
EXECUTIVE SUMMARY:					
<p>This paper provides an update on the work being undertaken following the 2025 UK Supreme Court ruling, which clarified that the terms "woman" and "sex" in the Equality Act 2010 refer to biological sex. The decision, arising from the 'For Women Scotland case', has far-reaching consequences for the National Health Service (NHS), legislative clarity, and policy development.</p> <p>Following the Gender Rights Supreme Court ruling in April 2025, the Trust undertook initial actions to ensure compliance with the legal requirements for staff, patients and visitors. This work is ongoing and includes engagement with ICS EDI colleagues, through an ICS Taskforce group, to adopt a system-wide approach. This work will continue to ensure ongoing momentum in the absence of final guidance.</p> <p>Progress has been delayed due to the absence of national NHS guidance, which was originally anticipated in July 2025, as well as the pending publication of the Equality and Human Rights Commission (EHRC) guidance following their consultation, which closed on 30 June 2025.</p> <p>This paper outlines the progress achieved to date and sets out an action plan for the next phases.</p>					
ASSURANCE PROVIDED BY THE REPORT:					
POSITIVE			GAPS IN ASSURANCE/RISKS TO ESCALATE		
<ul style="list-style-type: none"> The Trust is working with ICS colleagues as part of a Taskforce group to ensure a consistent approach to support colleagues, patients and visitors in understanding the legal implications of the Supreme ruling Colleagues from Nursing, Estates and OD and Inclusion continue to work locally at the Trust to review changes needed and the communication needed for all parties 			<ul style="list-style-type: none"> The lack of national guidance from NHSE and the EHRC expected earlier in the year is causing a delay in confirming final guidance Changes arising from the final guidance for the Supreme Court ruling are expected to have financial implications for the Trust, particularly in relation to potential alterations to existing facilities. 		
REPORT RECOMMENDATION:					
The BOARD is asked to: review for assurance and information					
KEY AREAS OF IMPACT (Indicate with 'x' all those that apply):					

ROHTB (11-25) 007

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

Comments:

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

Care	x	Community	x
Expertise		Services	x
People	x	Collaboration	x

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

Equality Act 2010

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

ICS Taskforce group

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

EHRC code of practice still to be approved

PREVIOUS CONSIDERATION

Executive Team meeting April 25th, 2025
 Trust Board meeting – May 7th, 2025
 Executive Team meeting – September 23rd, 2025
 Executive Team meeting – October 27th, 2025



Gender Rights Supreme Ruling

Trust Board – Wednesday 5th November 2025

1. Background

Following the Gender Rights Supreme Court ruling in April 2025, the Trust undertook initial actions to ensure compliance with the legal requirements for both staff and patients. This work also included engagement with ICS EDI colleagues to adopt a system-wide approach.

Progress on implementing the recommendations has been delayed due to the absence of national NHS guidance, which was expected in July 2025, and the pending publication of the Equality and Human Rights Commission (EHRC) guidance following their consultation, which closed on 30th June 2025.

The EHRC has now withdrawn its interim guidance, advising organisations that, until a new code of practice is in place, they must seek specialist legal advice. This follows the EHRC sending the code of practice document for approval to the Minister for Women and Equalities on 4th September with a further request for approval sent again on 15th October 2025. The EHRC have stated that 'following ministerial approval, the UK government will still need to lay the updated code of practice before Parliament for 40 days before it can become statutory guidance'.

This paper is a follow up on from the report provided to the Executive Team and Trust Board in May 2025 (Appendix I) and September 23rd, 2025. It includes updates based on the latest information from EHRC, as highlighted above.

2. Actions Completed

Since the Supreme ruling in April the following actions have been completed at the Trust and previously reported to the Executive Team:

- During May, a communication to all staff was issued by the Chief People Officer, explaining the ruling, its implications, and available support
- One-to-one support sessions offered to staff via comms messaging with a small number of staff taking the opportunity to share their thoughts/concerns
- Manager briefings conducted to share key information received
- Initial audit of toilet and changing facilities completed by the Estates and OD and Inclusion departments (undertaken with support from a volunteer) to identify current configurations and signage.

In addition, an ICS Taskforce group has now been formed, and meets fortnightly to look at the legal implications, structure of guidance needed, information on facilities and an agreement on specific wording for signage. Any materials produced from this work will be designed to enable customisation at Trust level.

3. Key Points to Note

ICS Collaboration

- An ICS EDI Leads Taskforce has started to collaborate on a system-wide approach as detailed above
- The legal clarity of the Supreme Court ruling has led the group to determine that the risk of incorrect action, in the absence of national guidance is minimal. However, it is noted that the EHRC have advised individual organisations to continue to seek their own legal advice which the Trust will do as required.

Facilities Audit

- Initial audits have highlighted varying levels of compliance across the site
- The focus of the audits has been to identify adequate toilet, changing and ward spaces for male, female and unisex (gender neutral) with appropriate signage, for patients and staff
- Communal areas used by patients, staff and visitors provide access to suitable toilet facilities, but signage will need to be standardised and clear
- Areas of concern highlighted for staff include:
 - Theatres – currently single sex changing facilities
 - Wards – need to clearly identify facilities
 - Outpatient Departments (OPD) – need to clearly identify facilities
 - Hydrotherapy – all staff use same changing room/shower/toilet
- Audits of off-site locations e.g. College Green are still to be undertaken (see action plan)
- In some clinical areas staff members have self-designated unisex (gender neutral) toilets to male or female with new signage. To ensure compliance with the ruling, these toilets may need to be reinstated to unisex (gender neutral). This will require sensitive communications with the teams affected.
- Appropriate facilities signage

Additional Facilities issues identified with no direct impact on the ruling

- The audit highlighted inconsistent standards across staff changing facilities.
- For example, a lower standard for shared male/female facilities was observed in Hydrotherapy when compared to the new Porters/Housekeeping change areas
- Inconsistent signage was noted, which may present accessibility challenges for individuals with language or literacy barriers.

Patient focus

- It is important to respect patients gender identity in communications and documentation and maintain a patient centred approach; biological sex will be relevant for some elements of care.
- In clinical settings we will need to consider appropriate accommodation spaces i.e. side rooms
- Will need to review mixed sex breach policy
- Need to review how we understand and document if patient is identifying as a gender different from that at birth as this may impact clinical care

Financial Implications

- Upgrading of some facilities will be required to meet Supreme ruling requirements
- Standardising and upgrading signage is needed to ensure all individuals can safely and clearly identify appropriate facilities.
- Costs may also be incurred to update patient information materials and external information sources for patients such as AccessABLE.

Risks to Staff and Patients

- Lack of appropriate facilities and allocation of appropriate bed space (male, female, and unisex/gender neutral) may result in individuals feeling unsafe.
- Absence of designated non-gender facilities may place transgender individuals at risk of non-compliance with the ruling, should they be forced to use facilities aligned with their birth sex.

Risk to the Trust

- Potential for legal claims against the Trust if individuals (staff or patients) are not provided with adequate and safe facilities. This risk applies to all those with protected characteristics.
- There may be an impact on Trust reputation due to patient and staff experience and poor media reporting

Training and Support

- Guidance materials are being developed for staff, patients and visitors
- Briefings will be undertaken to ensure that managers are able to support staff and patients with an update scheduled at the next ward managers meeting
- The Trust will continue to work with ICS EDI colleagues

Communications and Consultation

- Ongoing engagement with staff side, unions, staff networks, patient groups, and other stakeholders will continue to give updates and identify any concerns across diverse groups. This will include sharing a draft proposal with networks and groups for comment and feedback.

- A communications plan will be finalised to ensure key messages and support information is accessible for all. Work through the ICS EDI Leads Taskforce group will ensure a consistent message across the system

4. Action Plan

Action	Date
Phase 1 (September to November 2025)	
Complete information and support materials for staff and patients based on ICS standard materials	Mid November 2025
Complete further facilities audit with key stakeholders to identify appropriate facilities and required signage	End of November 2025
Consult with staff and patient groups with a draft proposal	End of November 2025
Confirm comms plan to include staff briefings	Mid November 2025
Liaise with BSol ICS Comms and EDI colleagues to collaborate on future work and implications through the Taskforce group	Ongoing, with fortnightly meetings
Phase 2 (December 2025 – February 2026)	
Financial report to be submitted to Executives once facilities costings are confirmed	January 2026
Review work completed when National and EHRC guidance is released	TBC due to delay in national guidance
Review and update relevant policies based on National and EHRC guidance	TBC due to delay in national guidance
Phase 3 (March 2026 onwards)	
Complete any structural changes need to facilities	Following approval of costings

Trust Board is asked to:

- Note the update from the EHRC website indicating that there has been no response to the Code of Practice submitted to the Minister for Women and Equalities in September 2025. This delay affects the timeline of related work currently underway at the Trust.
- Note that the ECHR is now advising organisations to seek independent legal advice due to the lack of response from the Minister for Women and Equalities; the Trust will do so when required
- Acknowledge the potential financial implications involved in ensuring compliance.
- Note the actions outlined in the three-phase plan to mitigate the risks with dates reflecting the delay in guidance being issued by NHSE and the EHRC.

Clare Mair – Head of OD and inclusion

Emma Steele – Deputy Chief Nurse

October 2025

Appendix I - Gender rights Supreme Court ruling briefing

Interim Report to Trust Board May 2025

1 Purpose of the Report

1.1 This paper examines the 2025 UK Supreme Court ruling¹, which clarified that the terms "woman" and "sex" in the Equality Act 2010 refer to biological sex. The decision, arising from the For Women Scotland case, has far-reaching consequences for the National Health Service (NHS), legislative clarity, and policy development.

1.2 By exploring the context and outcomes of this ruling, this paper highlights its influence on gender rights, healthcare practices, legal frameworks and inclusive practices for patients and staff at the Royal Orthopaedic Hospital NHS Foundation Trust (ROH).

2 Context and Background

2.1 The 2025 UK Supreme Court case, *For Women Scotland Ltd v The Scottish Ministers*, stemmed from a legal challenge to the Scottish government's interpretation of the Equality Act 2010.

The dispute centred on whether the terms "woman" and "sex" in the Act included transgender women with Gender Recognition Certificates (GRCs). The case originated from Scotland's Gender Representation on Public Boards Act 2018, which aimed to increase female representation but included trans women in its definition of "woman." After losing in Scottish courts, the gender-critical advocacy group For Women Scotland escalated the matter to the Supreme Court.

2.2 On April 16, 2025, the court ruled that "woman" and "sex" in the Equality Act refer to biological sex providing clarity on the Act's interpretation while maintaining protections for transgender individuals under other provisions.

2.3 While the ruling has been welcomed by some as providing clarity, it has also raised concerns among transgender rights groups about potential exclusions from single-sex spaces and services.

2.4 At the time of writing this report there has been no guidance produced from NHS England.

¹ UKSC/2024/0042 [For Women Scotland Ltd \(Appellant\) v The Scottish Ministers \(Respondent\) - UK Supreme Court](#)

3 Patient facing services

3.1 In April 2011, NHSE² introduced the reporting of same-sex accommodation (ss breaches) and the following guiding principles:

- A breach occurs at the point a patient is admitted to mixed-sex accommodation outside the guidance.
- Patients should not normally have to share sleeping accommodation with members of the opposite sex.
- Patients should not have to share toilet or bathroom facilities with members of the opposite sex.
- Patients should not have to walk through an area occupied by patients of the opposite sex to reach toilets or bathrooms; this excludes corridors.
- Women-only day rooms should be provided in mental health inpatient settings.

Note:

- *Sleeping accommodation includes all areas where patients are admitted and cared for on beds or trolleys, even when they do not stay*
- *An admitted patient is one who undergoes a hospital's admission process to receive treatment and/or care.*

3.2 The NHS's same-sex accommodation policies are designed to uphold patient privacy, dignity, and safety by ensuring that individuals are placed in wards or spaces designated for their biological sex. These policies, guided by the NHS Constitution³ and Equality Act 2010⁴, aim to prevent mixed-sex accommodation breaches, except in specific clinical circumstances such as critical care.

3.3 In 2014 MSA was included in Care Quality Commission (CQC) Regulations 201 *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10: Paragraph 10(2)(a)*.⁵

3.4 Within the current guidance of Mixed Sex Assessment (MSA), Annex B outlined that *'Those who have undergone transition should be accommodated according to their gender presentation.'*

Transgender patients are protected under the Equality Act 2010, which clarifies 'individuals who have proposed, begun or completed reassignment of gender enjoy legal protection against discrimination.' Therefore, until the ruling outlined previously the ROH MSA policy complied with transgender women being nursed in female bays.

3.5 This decision has necessitated adjustments to ensure compliance with legal definitions while balancing the rights of transgender individuals and safeguarding the privacy and dignity of all patients.

3.6 As outlined in section 2.3. there remains no clear guidance from NHSE, however the website does provide assurance that NHSE are currently reviewing the guidance. The website does remind all NHS-Funded care providers on the following: *All providers of NHS-funded care continue to be expected to provide high quality care that meets all patients' clinical needs,*

² NHS (2011) [NHS England » Delivering same-sex accommodation](#)

³ NHS (2023) The NHS Constitution for England. [The NHS Constitution for England - GOV.UK](#)

⁴ Equality Act (2010) [Equality Act 2010: guidance - GOV.UK](#)

⁵ CQC (2014) [20150510_hsc_a_2008_regulated_activities_regs_2104_current.pdf](#)

safeguards them from the risk of harm and ensures their privacy and dignity when they are admitted to hospital.

3.7 Steps taken at ROH (Clinical)

While the NHSE guidance is awaited the following action are being undertaken:

- An understanding of current demand has been explored.
- all transgender patients will be provided a third space 'side room' if required.
- Policies to be reviewed and take into consideration the clarification and ruling.
- All patient facing documentation to be reviewed to ensure the 'right questions is asked', to safeguard all patients.

4 Staff facing services

Whilst the NHSE guidance is awaited, the ruling does highlight the need to ensure compliance with the updated information on legal definitions, while maintaining inclusive practices. The key areas to review in line with the compliance are:

4.1 Facilities

The Supreme Court stated that the terms 'man', 'woman' and 'sex' in the Equality Act 2010 refer to biological sex of an individual. The "proper functioning" of the Equality Act 2010's provisions on separate spaces and single-sex services (including changing rooms) should be aligned to the biological interpretation of sex¹.

In addition, the initial briefing from Equality and Human Rights Commission (EHRC) stated that 'in workplaces, it is compulsory to provide sufficient single-sex toilets, as well as sufficient single-sex changing and washing facilities where these facilities are needed⁶.

Relevant steps that will be taken are:

- Confirmation of arrangements for staff changing rooms and toilets to ensure individuals use the facilities aligned to their biological gender e.g. a biological female will be required to use a female changing room.
- Confirmation of gender-neutral facilities at the Trust that can be used by individuals, including transgender staff members.

4.2 Policies Review and Adjustment

- Assessment of existing policies related to single-sex spaces, such as toilets and changing facilities, to ensure they align with the legal definition of "woman" as a biological female.
- Inclusion policy to clarify that the supreme ruling is specific to the protected characteristic for gender in the Equality Act 2010 and not gender reassignment.
- Work with staff, union colleagues and staff network chairs to review and understand guidance as provided by NHS England.

⁶ Equality and Human Rights Commission (2025) [An interim update on the practical implications of the UK Supreme Court judgment | EHRC](#)

4.3 Communication and awareness

- The Trust will establish clear messaging and support systems for all staff (with particular focus for transgender employees) to address any questions or concerns they may have, following the ruling.
- The Trust will work closely with local and regional NHS providers to ensure there is a consistent message shared with staff, patients and the community on the guidance and support available.

4.4 Advice and guidance for staff members

- All staff members may be required at some point to support and speak to transgender patients, visitors and staff members who are looking for clarification. Guidance must be readily available with clear signposting to additional information and support.

5. Next steps

Action	Date
Chief People Officer announcement to be sent to staff member via email, intranet and noticeboard posters. This will outline the Supreme ruling, what it means, and support available	2nd May
One to one support sessions offered as part of the above announcement	From 5 th May
Managers briefings to share information to date	9 th May (first session)
Hospital signage to be reviewed to ensure female, male and non-gender facilities are clearly marked for patients, staff and visitors	9 th May
Share information at Wellbeing week as part of staff network work	w/c 12 th May
Liaise with BSol ICS Comms and EDI colleagues to collaborate on future work and implications	Ongoing

6. The Trust Board is asked to note this report at this time.

Nikki Brockie, Chief Nurse

Sharon Malhi, Chief People Officer

Clare Mair, Head of OD & Inclusion

May 2025



TRUST BOARD

DOCUMENT TITLE:	ROH Strategy 2023-2028: Strategy Update
SPONSOR (EXECUTIVE DIRECTOR):	Matthew Hartland, Chief Executive
AUTHOR:	Rebecca Lloyd, Director of Strategy
DATE OF MEETING:	5 November 2025

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE	x	FOR INFORMATION ONLY		TO CREATE DISCUSSION		TO SEEK APPROVAL	
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EXECUTIVE SUMMARY:

The ROH is now over half-way through year 3 of its five-year strategy, refreshed in April 2025.

The attached paper provides an overview of progress with delivery of the key objectives of the strategy; positive progress has been made across all areas.

The paper also highlights the renewed focus on the ROH role as a knowledge leader in MSK, and its role within an emerging neighbourhood health model across Birmingham and Solihull as a result of the publication of the 10 Year Health Plan.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
<ul style="list-style-type: none"> Good progress with delivery across all domains, with no significant delay in any areas 	<ul style="list-style-type: none"> None

REPORT RECOMMENDATION:

The BOARD is asked to:

- RECEIVE and ACCEPT the progress update with the delivery of the refreshed strategy

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:

MSK Transformation programme and participation in collaborative mechanisms

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

None specifically

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

Progress with relevant areas is shared with Committees on an ongoing basis.



ROH Strategy 2023-2028: Strategy Update

Trust Board | 5 November 2025

1. Introduction

STRATEGIC OBJECTIVES	CARE	EXPERTISE	PEOPLE	COMMUNITY	SUSTAINABILITY	COLLABORATION
	By 2028, we will maintain outstanding, high-quality care across all services and improve access, experience and outcomes for our patients.	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.	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.	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.	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.	By 2028, we will have transformed MSK and orthopaedic services for our patient population through our strategic partnerships across healthcare, third sector, industry, research and academia.

The ROH is now over half-way through year 3 of its five-year strategy, refreshed in April 2025. The publication of the NHS 10 Year Health Plan has since prompted even greater focus on the ROH role as a knowledge leader in MSK, and its role within an emerging neighbourhood health model across Birmingham and Solihull.

The Trust Board workshop held on 8 October 2025 generated clear direction as to how we prioritise our ambition to improve access, experience and outcomes, as well as leading MSK prevention across our communities. This will inform how we frame our delivery plan for year 4 of the Trust strategy.

2. Delivery Plan – 2025/26

The Strategy Delivery Board met on 20 October 2025 and reviewed the 2025-26 Trust Delivery Plan, which includes a combination of national planning guidance imperatives and ROH priorities. This year is the first year in which there is a detailed plan underpinning delivery of the Trust strategy.

Progress has been positive across Q2, much of which has been explored in detail at relevant Board sub-committee meetings. Section 2 includes a summary of progress against each of the six domains, with further context behind those priorities which are delayed or at risk.

3. Progress – end of Quarter 2 (2025/26)

The PMO team work closely with each Executive Director to update progress against respective priorities within the Trust’s delivery plan. This is reported to Strategy Delivery Board (chaired by the CEO) on a bi-monthly basis.

Timely and equitable access to CARE	Completed: <ul style="list-style-type: none"> Approval of system wide clinical decision support tool for orthopaedics and MSK (now ‘IPP’ - Integrated Patient Pathway)
	On track for delivery: <ul style="list-style-type: none"> All national operational targets for Referral to Treatment (RTT) targets are on track for delivery by March 2026 (greater detail provided at FPC) The Outpatient Transformation Programme continues to drive best practice, aligned to GIRFT and NHS Impact – particular progress noted against reduction in DNA rate
	Delay but progressing: <ul style="list-style-type: none"> Reduce inequalities for patients accessing ROH services – as discussed at the Board workshop on 8 October 2025, the organisation is beginning to use data for insight to prioritise where to make the most impact improving access to ROH services. Updated population health data across ICB is essential to make progress against this domain.
	Significant delay and risks to completion: <ul style="list-style-type: none"> None

Digitally enabled CARE	Completed: <ul style="list-style-type: none"> 70% elective care appointments available by NHS App
	On track for delivery: <ul style="list-style-type: none"> EPR readiness Trust-wide engagement to refine pathways
	Delay but progressing: <ul style="list-style-type: none"> EPR procurement delayed (latest update reported to Trust Board in October 2025). Suppliers notified of procurement outcome. FBC will be concluded by the end of November 2025. National priority to deploy electronic prescription service – this will be delivered as part of EPR. Standalone solution ahead of EPR implementation would be cost prohibitive and include implementation timescales which may conflict with EPR. Inpatient prescribing delivered via PICS. Implement framework for NHS action on digital inclusion – improved access to data with further rollout of patient portal and NHS App functionality. Designing user-centred solutions with expert by experience input, particularly the new EPR. Clinical portal not yet fully embedded
	Significant delay and risks to completion: <ul style="list-style-type: none"> None

High quality CARE and cutting-edge EXPERTISE	<p>Completed:</p> <ul style="list-style-type: none"> • Maintain GIRFT Accreditation (July 2025)
	<p>On track for delivery:</p> <ul style="list-style-type: none"> • 2025-26 Quality Priorities are on track for delivery, as well as Phase 2 Service Accreditation (reported via QSC) • Achieved positive CQC inpatient survey (further discussion has taken place at QSC) • Imaging team on track to meet ‘working towards’ status for national QSI (Quality Standard for Imaging) accreditation • MSK Academy website launched in October 2025, first GP education sessions run at College Green and partnership event held with Stryker as part of QIDD. • 155 ROH authored research publications against target of 200 • On track to implement new PROMS system
	<p>Delay but progressing:</p> <ul style="list-style-type: none"> • Zero hospital acquired infections will not be achieved in-year (currently 1 case) - this is the same for achieving a zero rate of MRSA, C-Difficile and E-Coli • Nationally-recognised challenge increasing patient participation in research – currently 160 patients recruited against annual target of 350
	<p>Significant delay and risks to completion:</p> <ul style="list-style-type: none"> • None

PEOPLE and continuous improvement	<p>Completed:</p> <ul style="list-style-type: none"> • Me as Manager programme implemented • Advanced Clinical Practitioner oversight in place, led by Corporate Nursing and Consultant Physiotherapist
	<p>On track for delivery:</p> <ul style="list-style-type: none"> • A number of key priorities featured within the Trust’s Inclusion Plan are on track for delivery, including embedding the race equality code (reviewed at October SE&OD meeting) and reducing the gender pay gap (2024 result shows improvement against 2023) • A new MSK Occupational Health Physiotherapy role to support staff MSK related sickness absence is being recruited to in November 2025
	<p>Delay but progressing:</p> <ul style="list-style-type: none"> • Reducing sickness absence – internal audit report and HR-led ‘deep-dive’ scrutinised at Staff Experience & OD Committee (October 2025). Chief People Officer established working group across HR&OD, Strategy & Communications to design internal campaign.

	<ul style="list-style-type: none"> • Patient Safety Team and Service Improvement Team have refreshed improvement huddle rollout plan, to reinvigorate uptake and regular use. Executive Team to undertake huddle training as part of weekly meeting in November 2025.
	<p>Significant delay and risks to completion:</p> <ul style="list-style-type: none"> • None

<p>Organisational SUSTAINABILITY and productivity</p>	<p>Completed:</p> <ul style="list-style-type: none"> • 5% cost improvement target in place for all services, with Phase 1 Service reviews realising 7.5% in some areas
	<p>On track for delivery:</p> <ul style="list-style-type: none"> • Financial plan achieved for Month 6 (and Q2) • 94% Consultants job-planned (against 95% target) • New Consultants commenced in Hand and Arthroplasty - delivering 50 weeks elective activity in Theatres • Private patient income target on track, as is overall commercial income target included in financial plan • Progress continues to be made with rationalising theatre trays • Dedicated day case pathway rolled out in Arthroplasty – new 23 hour ward operational and actively being audited as part of BADS (British Association of Day Surgery) Delivery Group
	<p>Delay but progressing:</p> <ul style="list-style-type: none"> • CIP programme is behind plan, but is compensated by other savings within the Trust. Financial Delivery Board is reviewing all CIPs. • Future proofing of Theatres 1,2 and 4 remains on the Corporate Risk Register • Continuing to reduce the number of early finishes in Theatres and this remains a focus as part of GIRFT/Model Hospital metrics on weekly basis
	<p>Significant delay and risks to completion:</p> <ul style="list-style-type: none"> • None

<p>Supporting our COMMUNITY through COLLABORATION</p>	<p>Completed:</p> <ul style="list-style-type: none"> • None
	<p>On track for delivery:</p> <ul style="list-style-type: none"> • Chief Operating Officer leading review of demand and capacity requirements for Orthopaedics and Spinal services across BSOL, reported through Acute Provider Collaborative • Increased community impact through first MSK Roadshow, further rollout of Health Hacks, Community Appointment Days and reduction of community physiotherapy waiting lists for BSOL. • Strategic partnerships with Robert Jones & Agnes Hunt and Aston University progressing well. Strategy Delivery Board to review 'Strategic Partnership Plan' in December 2025.

	Delay but progressing: <ul style="list-style-type: none"> Limited focus on MSK/Orthopaedics through Community Care Collaborative neighbourhood health service model. Board workshop on 8 October 2025 gave focus to ROH community presence at neighbourhood level, with support for a pilot to demonstrate impact of high street presence, and enhanced community-based expertise across primary care, schools etc.
	Significant delay and risks to completion: <ul style="list-style-type: none"> None

4. Planning for 2026/27 and beyond

The recent publication of the NHS England Medium Term Planning Framework (2026/27 – 2028/29) will inform how the Trust shapes its delivery plan for 2026-27, recognising the focus on multi-year planning and submission of a 5-year strategic plan by January 2026. The existing Trust strategy will be reviewed and scrutinised against the planning framework, and recommendations for further adjustments/refresh will be presented to the Board meeting in December 2025.

Rebecca Lloyd – Director of Strategy

27 October 2025



TRUST BOARD

DOCUMENT TITLE:	Workforce Disability Equality standard (WDES) update
SPONSOR (EXECUTIVE DIRECTOR):	Sharon Malhi, Chief People Officer
AUTHOR:	Alison Money, Deputy Chief People Officer Clare Mair, Head of OD and Inclusion
DATE OF MEETING:	5th November 2025

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE	x	FOR INFORMATION ONLY		TO CREATE DISCUSSION		TO SEEK APPROVAL	x
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EXECUTIVE SUMMARY:

This report gives an update on the Workforce Disability Equality Standard (WDES) data report that was submitted online to NHS England in May 2025 and reported at Staff Experience and OD in June 2025, August 2025 and October 2025 and Trust Board in July 2025. The additional information provided in this report is an updated action plan aligned to each indicator and the four identified priorities:

1. To ensure the Trust has a **diverse workforce** bringing lived experience and unique skills to reflect and better serve our patients and community
2. To ensure staff feel **safe and empowered in the workplace** - to speak up to share concerns or ideas
3. To ensure **opportunities** are in place and accessible to all for staff to develop, progress and reach their full potential
4. To ensure **robust data analysis** is in place to identify areas of focus, track progress to provide assurance and achieve KPIs

The WDES action plan is targeting the work to support the improvement of experiences, opportunities, and outcomes for our disabled staff.

In line with NHSE requirements, this report is required to be published on the ROH website following approval at Trust Board.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVES	GAPS IN ASSURANCE/RISKS TO ESCALATE
<ul style="list-style-type: none"> - The reaccreditation of Disability Confident Leader status has provided a valuable assessment of the progress achieved to date and has identified key areas for further development - The ABLE network remains actively engaged in supporting and contributing to the WDES action plan, ensuring that staff voices are heard and that efforts positively influence both staff experience and patient care 	<ul style="list-style-type: none"> - The experience of staff is being directly impacted by the current challenges within in the NHS

- Several actions have been initiated, and good progress is being made					
REPORT RECOMMENDATION:					
To review the report for assurance and approve publication on the ROH website					
KEY AREAS OF IMPACT <i>(Indicate with 'x' all those that apply):</i>					
Financial		Environmental		Communications & Media	x
Business and market share		Legal & Policy		Patient Experience	x
Clinical		Equality and Diversity	x	Workforce	x
Inequalities	x	Integrated Care		Continuous Improvement	X
Comments:					
ALIGNMENT TO TRUST STRATEGY <i>(Indicate with 'x' all those that apply):</i>					
Care	x	Community			x
Expertise	x	Services			
People	x	Collaboration			x
ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
Corporate risk register					
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:					
ICS Inclusion work					
BENCHMARKING SOURCE <i>(Indicate data sources included in report IF APPLICABLE):</i>					
BSol ICS WDES Indicator data					
Specialist Acute Trust WDES indicator results					
PREVIOUS CONSIDERATION <i>(Indicate board/committee/group & date):</i>					
Executive meeting 14 th October 2025					
Staff Experience and OD Committee October 22 nd 2025					



The Royal
Orthopaedic Hospital
NHS Foundation Trust

Workforce Disability Equality Standard (WDES)

Report and Action Plan
October 2025

Summary

- Workforce Disability Equality Standards (WDES) standards were introduced to monitor data of employees with disabilities to ensure they have equal access to career opportunities and receive fair treatment in the workplace
- Full information on the WDES standard can be found on the NHS link [NHS England » NHS Workforce Disability Equality Standard](#)
- Data covers the period 1st April 2024 to 31st March 2025 and is taken from Electronic Staff Record (ESR) and National Staff Survey sources. The data has been submitted to NHS England in May 2025
- WDES data shows a decline in 7 indicators, improvement in 4 indicators and no change in 1 indicator
- Areas of focus identified from WDES data are bullying and harassment, discrimination, inclusive recruitment and career opportunities
- Limitations to note: non-disclosed data is reducing but there is still more work to do particularly on disability declaration rates

Progress since October 2024

- Declaration rates improved across WDES data (6.9%)
- Reaccreditation of the Disability Confident – Leader status
- Rollout of the Staff Health passport
- Shortlisted for the Scope awards – Innovation award
- Birmingham and Solihull (BSol) Coaching and Mentoring network launched
- ROH participants on the ICS ‘Possibilities beyond Limits’ programme
- Enhanced appraisal training to include inclusive conversations for diverse groups
- Equality and Diversity annual report published
- Improved Inclusive Companies Top 50 UK ranking to number 8 (No 1 NHS) and CEO award
- Final report published for ‘Seeing Beyond the Stigma’ exhibition by University of Canterbury

Priorities highlighted by latest data submission

Following the review of the data across WDES in May 2025, results show that work in the following areas must be prioritised.

Priority areas

Progress the approach to inclusive recruitment

Introduce Civility and Respect approach

Implement Inclusive Talent and Succession approach to inclusive coaching and mentoring

Provide specific support for departments highlighted with low scores in staff survey results for 'treating staff'

The networks including ABLE (Disability) will support and feedback on this work

Overview of WDES indicators

The figures in () indicates percentages for non disabled staff member

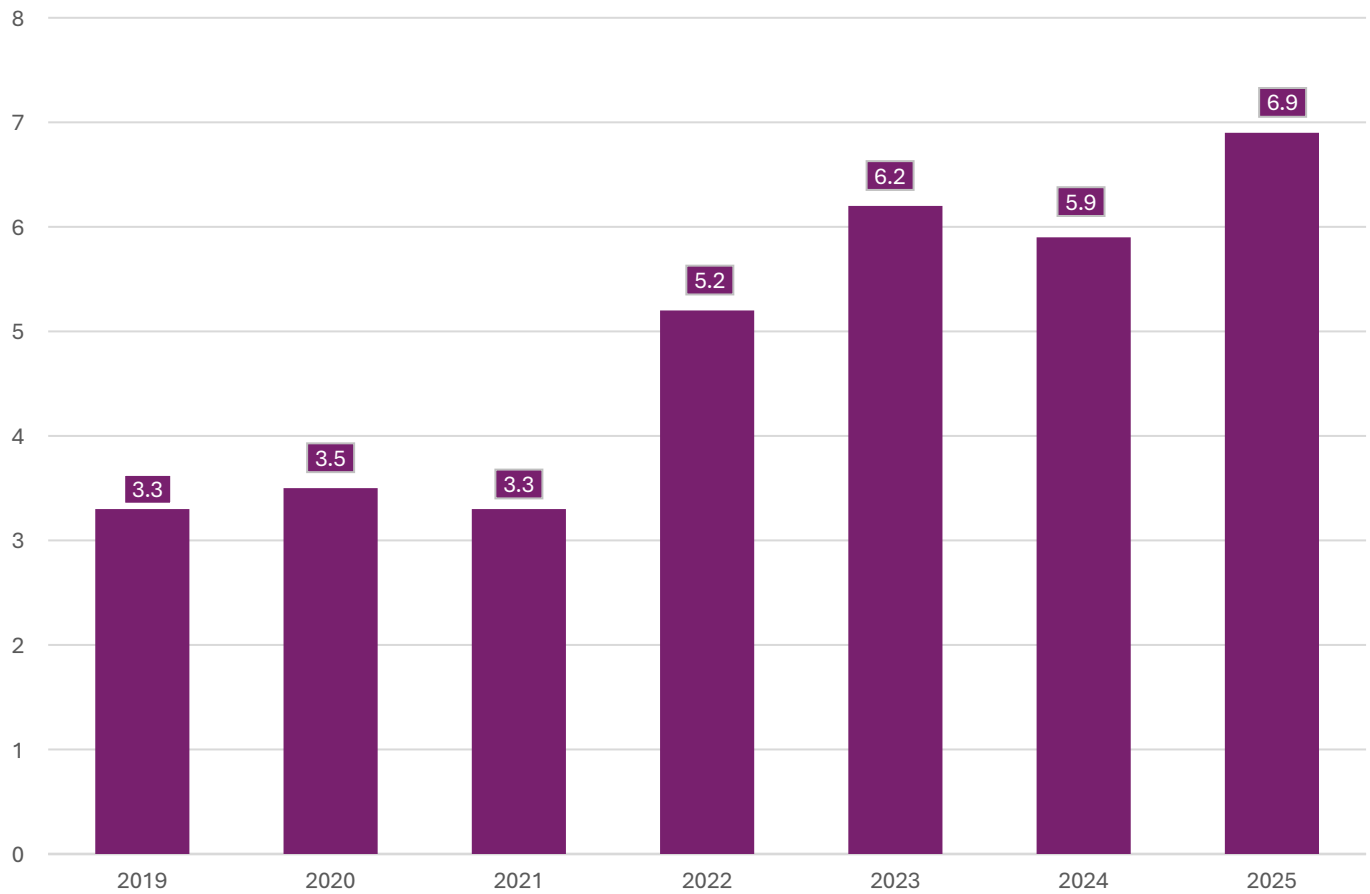
Indicator	Indicator Definition	2024	2025	Change since 2024
1	% of disabled staff	5.9	6.9	Improvement
2	Relative likelihood of non-disabled staff being appointed from shortlisted candidates compared to non-disabled staff	1.01	1.3	Decline
3	Relative likelihood of disabled staff entering formal capability (average of 2-year period)	0.00	1.58	Decline
4a	% of disabled staff experiencing harassment, bullying or abuse from patients or public in last 12 months	22.56 (14.12)	23.62 (14.05)	Decline
4b	% of disabled staff experiencing harassment, bullying or abuse from managers in last 12 months	12.27 (8.26)	15.66 (10.16)	Decline
4c	% of disabled staff experiencing harassment, bullying or abuse from staff in last 12 months	23.17 (17.45)	24.62 (16.07)	Decline
5	% of disabled staff believing the trust provides equal opportunities for Career progression or promotion from staff in the last 12 months	52.44 (58.47)	49.75 (55.75)	Decline
6	% of disabled staff have felt pressure from their managers to come to work, despite not feeling well enough to perform duties	25.66 (18.84)	20.67 (17.25)	Improvement
7	% of staff saying they are satisfied with the extent to which the organisation values their work	41.92 (53.76)	41.50 (53.17)	Minimal change
8	% of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	74.73	76.80	Improvement
9	The staff engagement score for disabled staff compared to non-disabled staff and the overall engagement score for the organisation	6.75 (7.16)	6.82 (7.13)	Improvement
10	% Total Board members	13.33	12.5	Decline

Comparison for BSol and Specialist summary

This table shows the comparison percentages for Trusts across the BSol ICS and also key organisations in the Specialist Acute sector

NHS Staff Survey WDES Metrics 2024	Group of Staff	BCHC	BSMH	BWC	ICB	ROH	UHB	ICS	RNOH	RJAH	LHC
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Disability	26.0%	35.9%	24.3%	13.9%	23.6%	26.8%	27.3%	28%	27.8%	16.4%
	No Disability	19.3%	30.0%	18.6%	5.8%	14.1%	21.9%	21.4%	19.6%	16%	11.7%
Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	Disability	12.1%	14.2%	13.1%	20.8%	15.7%	16.4%	14.9%	18.3%	9%	6.7%
	No Disability	7.0%	7.8%	7.2%	8.7%	10.2%	9.2%	8.4%	9.3%	7.9%	3.9%
Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months	Disability	22.5%	23.1%	23.3%	27.0%	24.6%	27.9%	25.4%	28.2%	25.1%	19.7%
	No Disability	13.5%	15.3%	14.9%	8.4%	16.1%	18.7%	16.5%	17.8%	16.2%	11%
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	Disability	59.7%	63.5%	62.9%	42.5%	61.3%	53.5%	57.7%	57.6%	50%	59.4%
	No Disability	58.0%	70.0%	57.9%	44.2%	54.9%	47.6%	54.2%	55.7%	55.8%	50%
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	Disability	45.9%	50.9%	52.6%	37.0%	49.8%	44.2%	46.9%	54.3%	53.6%	60.7%
	No Disability	53.5%	55.4%	57.7%	49.3%	55.2%	52.6%	54.0%	55%	61.8%	71.5%
Percentage of staff have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Disability	21.1%	18.4%	23.9%	16.4%	20.7%	28.3%	24.4%	28.3%	28.7%	20%
	No Disability	14.0%	10.6%	14.8%	14.4%	17.3%	17.6%	15.6%	18.2%	16.1%	16.7%
Percentage of staff satisfied with the extent to which their organisation values their work	Disability	33.9%	43.1%	33.7%	40.2%	41.5%	30.8%	34.3%	45.6%	36.4%	50.9%
	No Disability	45.8%	53.8%	44.4%	56.6%	53.2%	43.4%	46.0%	53.2%	48.4%	62.3%
Percentage of staff with a long lasting health condition or illness saying their employer has made reasonable adjustments to enable them to carry out their work	Disability	78.0%	80.6%	72.8%	74.2%	76.8%	71.8%	74.6%	77.7%	74%	83.2%
Staff engagement score (0-10)	Disability	6.52	6.74	6.66	6.33	6.82	6.10	6.39	7.3%	7.3%	7.7%
	No Disability	7.00	7.23	7.09	6.82	7.23	6.79	6.95	7.2%	6.9%	7.3%

WDES indicator 1 % of Disabled Staff

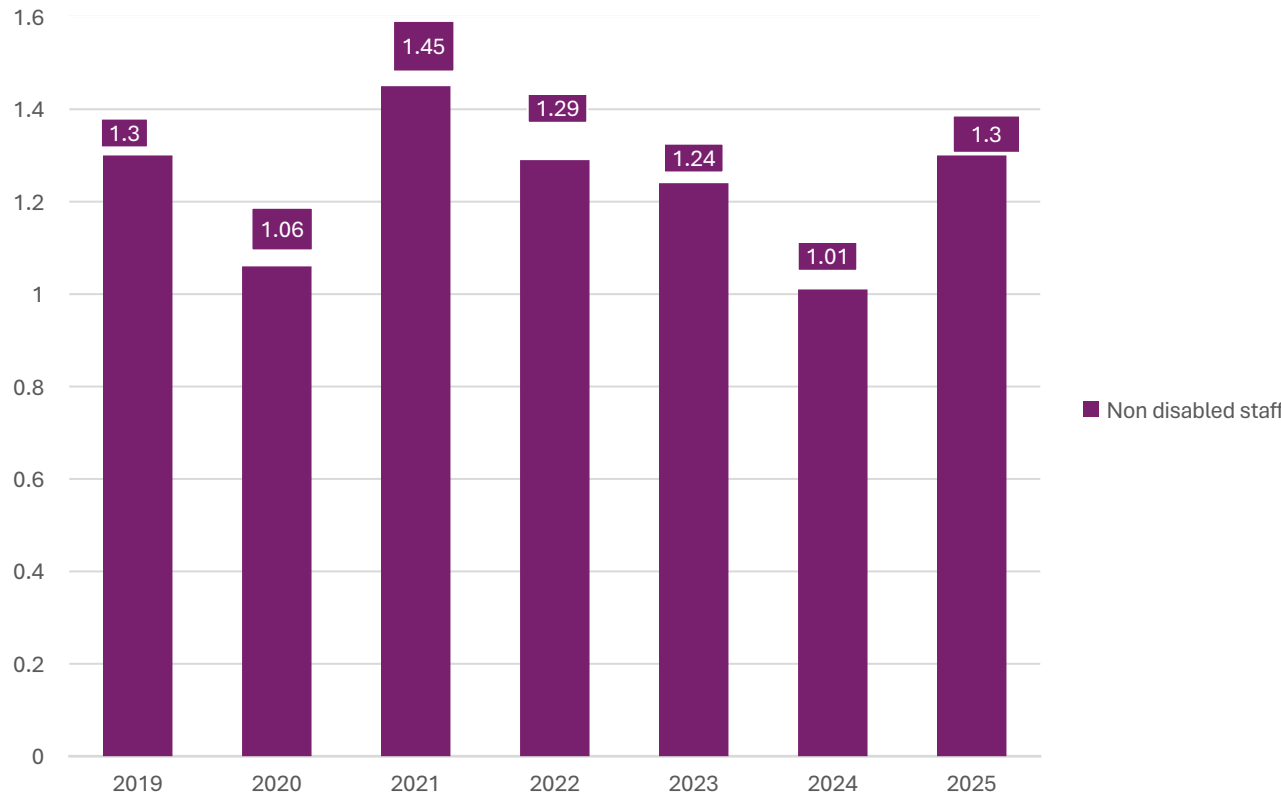


Key analysis

- We have seen a positive **increase** in staff members declaring a disability from 5.9 to 6.9%
- Data as at 31st March 2025
- This percentage has changed over the year with starters and leavers and reached the highest percentage at 8.1%
- The national NHS average for disability declaration is 4.9%
- The Staff Health passport was introduced in 2024 to encourage staff members to disclose disabilities
- In the NHS staff survey 23.8% of respondents declared a long-term condition

WDES indicator 2

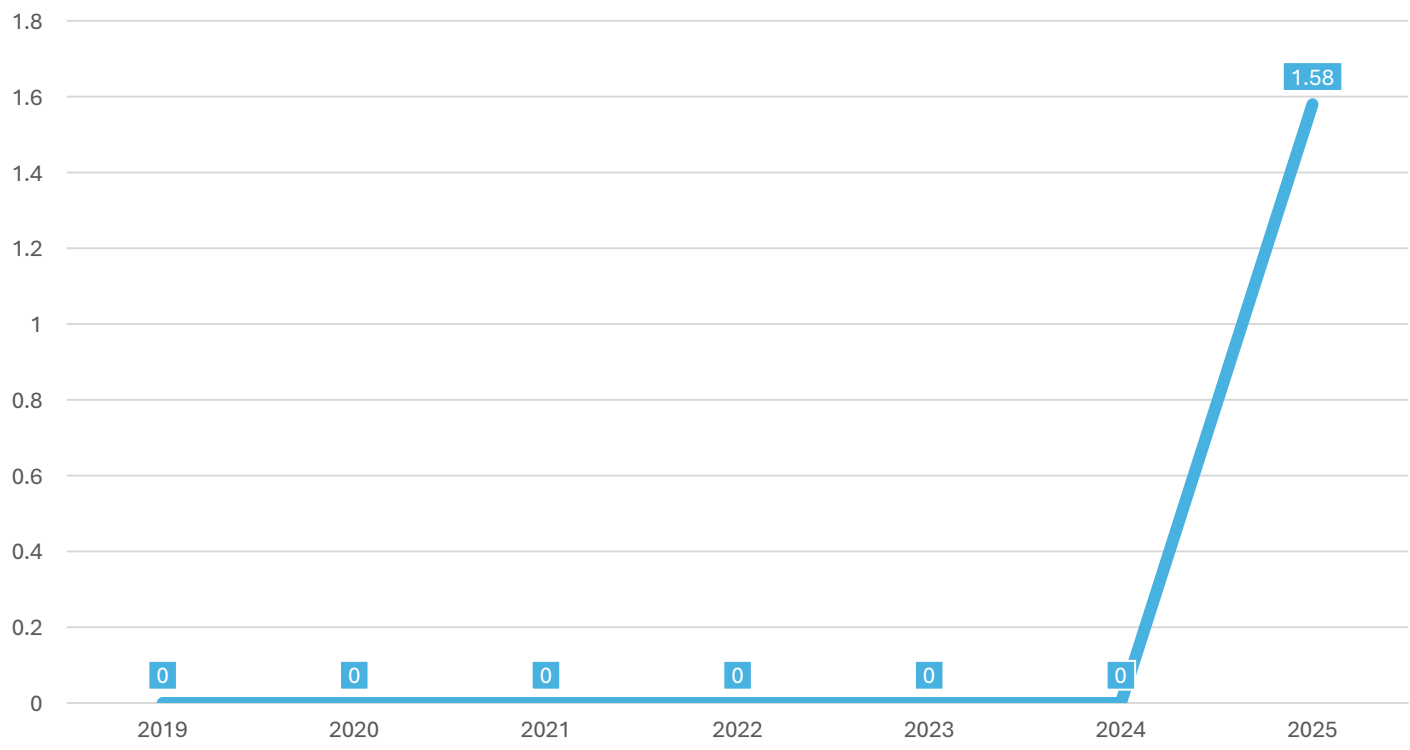
Relative likelihood of non disabled staff being appointed from shortlisted candidates compared to non-disabled staff



Key analysis

- There has been a **decline** in this indicator from 1.01 to 1.3
- This indicator means that it is 1.3 times more likely for a non-disabled staff member to be appointed from shortlisting than an applicant with a disability
- No diversity information is shared at the shortlisting phase
- Further analysis will be undertaken as a priority, as part of the WDES action plan to look at data in more details to identify the differences in staff groups
- Work and actions from the reaccredited Disability Confident Leader status accreditation will impact this indicator which actions already impacting some pois

WDES indicator 3 Relative likelihood of disabled staff entering formal capability

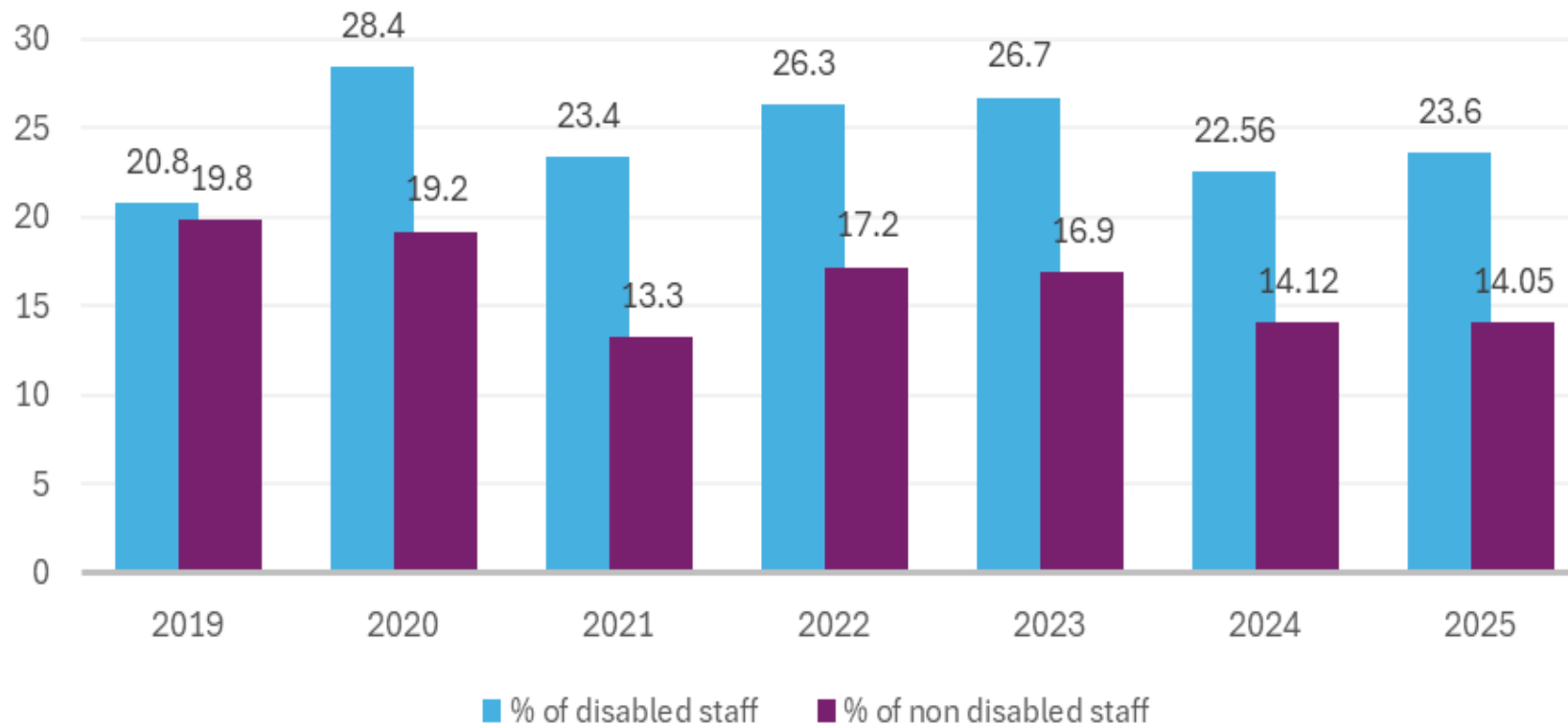


Key analysis

- There has been a **decline** in this indicator from 0 to 1.58
- This indicator means that it is 1.58 times more likely for a disabled staff to enter formal capability than a non disabled person
- The national average for this indicator is 1.98
- This is the first time since the start of WDES data collection that the Trust has had any cases for disabled staff
- This indicator is calculated by taking the average over a two year period. There were 9 cases over this time

WDES indicator 4

% of disabled staff experiencing harassment, bullying or abuse from patients or public in last 12 months

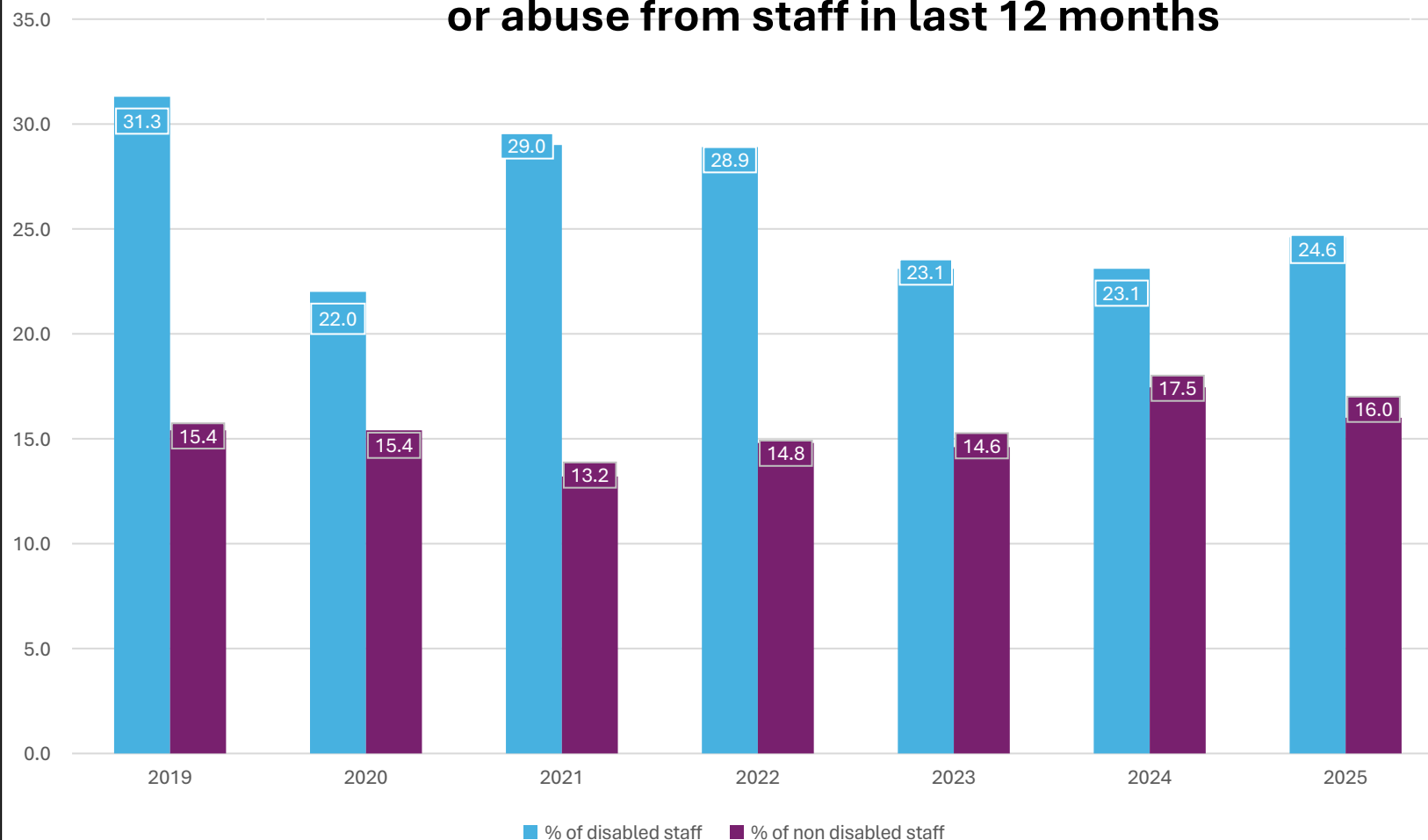


Key analysis

- There has been a **decline** in this indicator from 22.56% to 23.6%
- This is lower than the average score for disabled staff in the Specialist Acute sector which is 24.24%
- There has been a slight improvement for non-disabled staff from 14.12 to 14.05

WDES indicator 4a

% of disabled staff experiencing harassment, bullying or abuse from staff in last 12 months

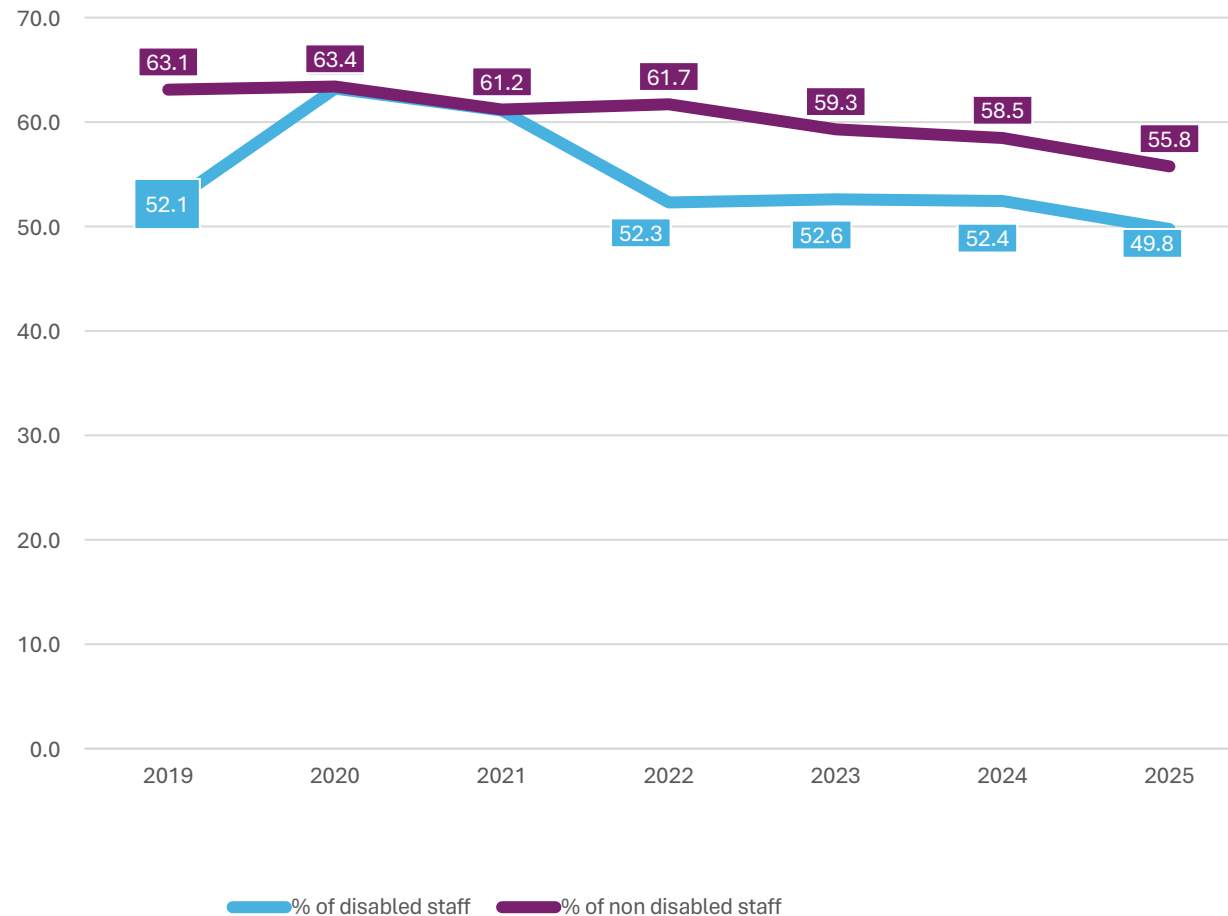


Key analysis

- There has been a **decline** in this indicator from 23.1% to 24.6%
- This is lower than the average score for disabled staff in the Specialist Acute sector which is 25.12%
- There has been a slight improvement for non-disabled staff from 17.5% to 16%
- There was an increase in responses from staff with long term health conditions

WDES indicator 5

% of disabled staff believing the trust provides equal opportunities for career progression or promotion from staff in the last 12 months

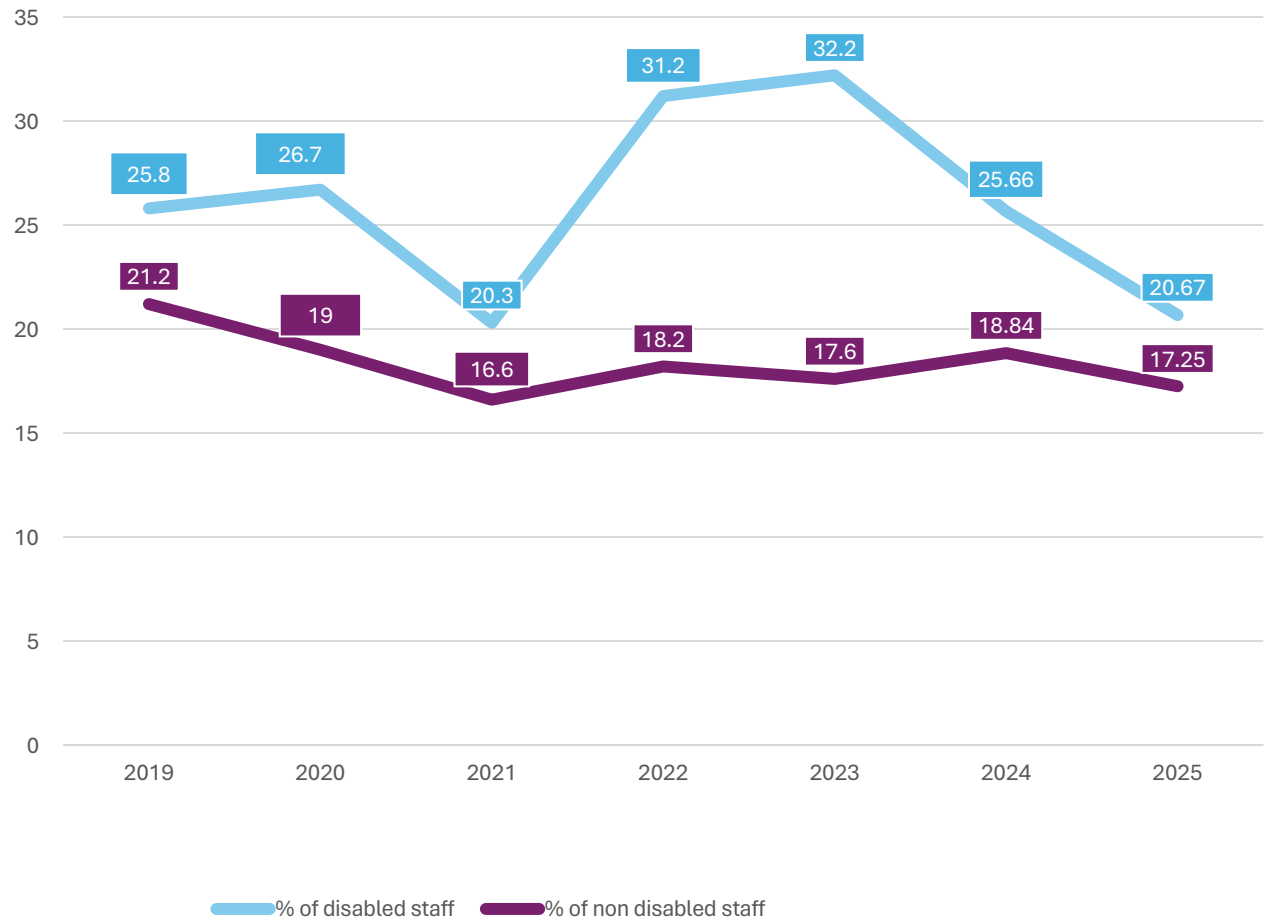


Key analysis

- There has been a **decline** in this indicator from 58.47% to 55.25%
- There has also been a decline for non-disabled staff members
- The average score for disabled staff in the Specialist Acute sector is 52.5%
- Changes to the appraisal approach which include an emphasis on development conversations will help to improve this indicator.
- The ICS 'Possibilities Beyond Limits' course is an example of new programmes available to staff with disabilities

WDES indicator 6

% of disabled staff have felt pressured from their managers to come to work, despite not feeling well enough to perform duties

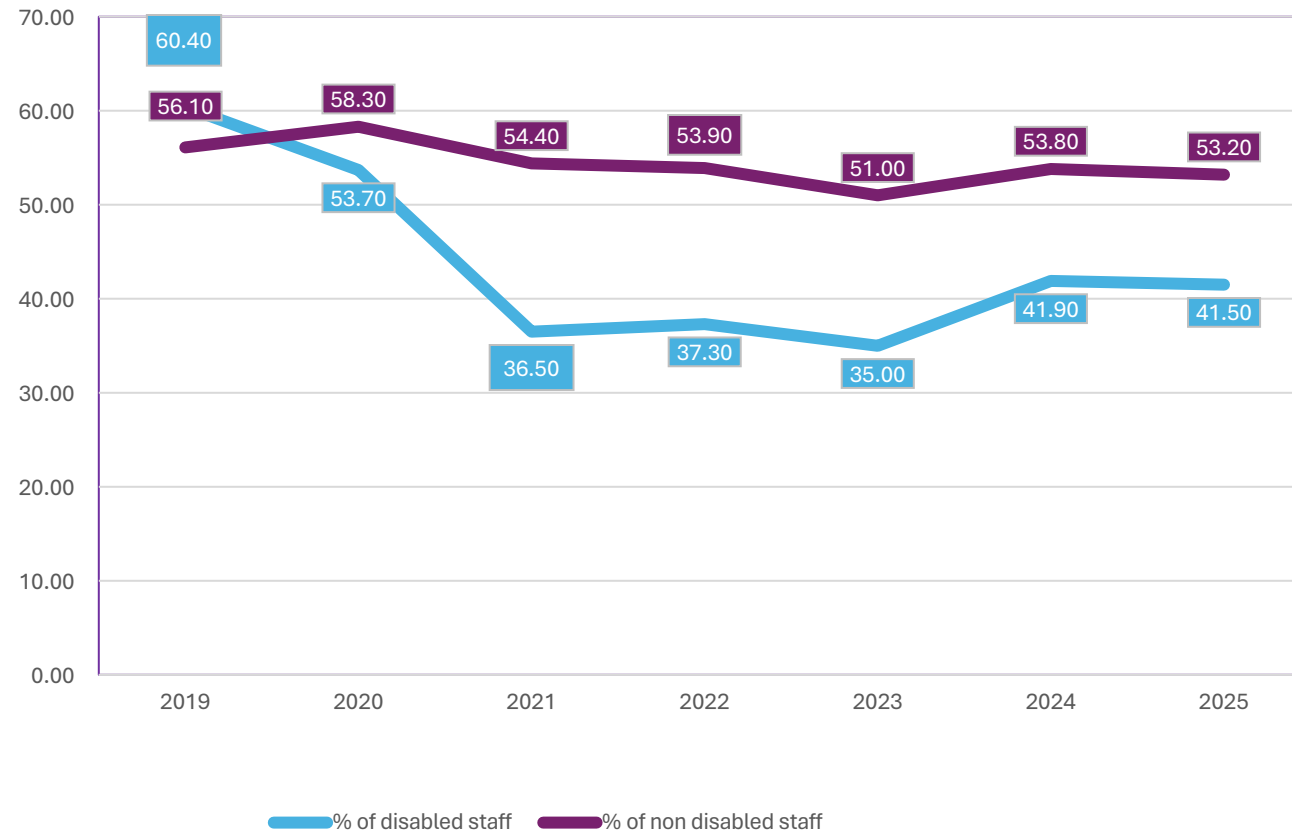


Key analysis

- There has been an **improvement** in this indicator from 25.66% to 20.67%
- There has also been an improvement for non-disabled staff members
- This is more positive result than the average score for disabled staff in the Specialist Acute sector which is 24.4%
- The work on managers training for wellbeing conversations and the rolling out of the Staff Health Passport has been undertaken to support improvements in this areas

WDES Indicator 7

% of staff saying they are satisfied with the extent to which the organisation values their work

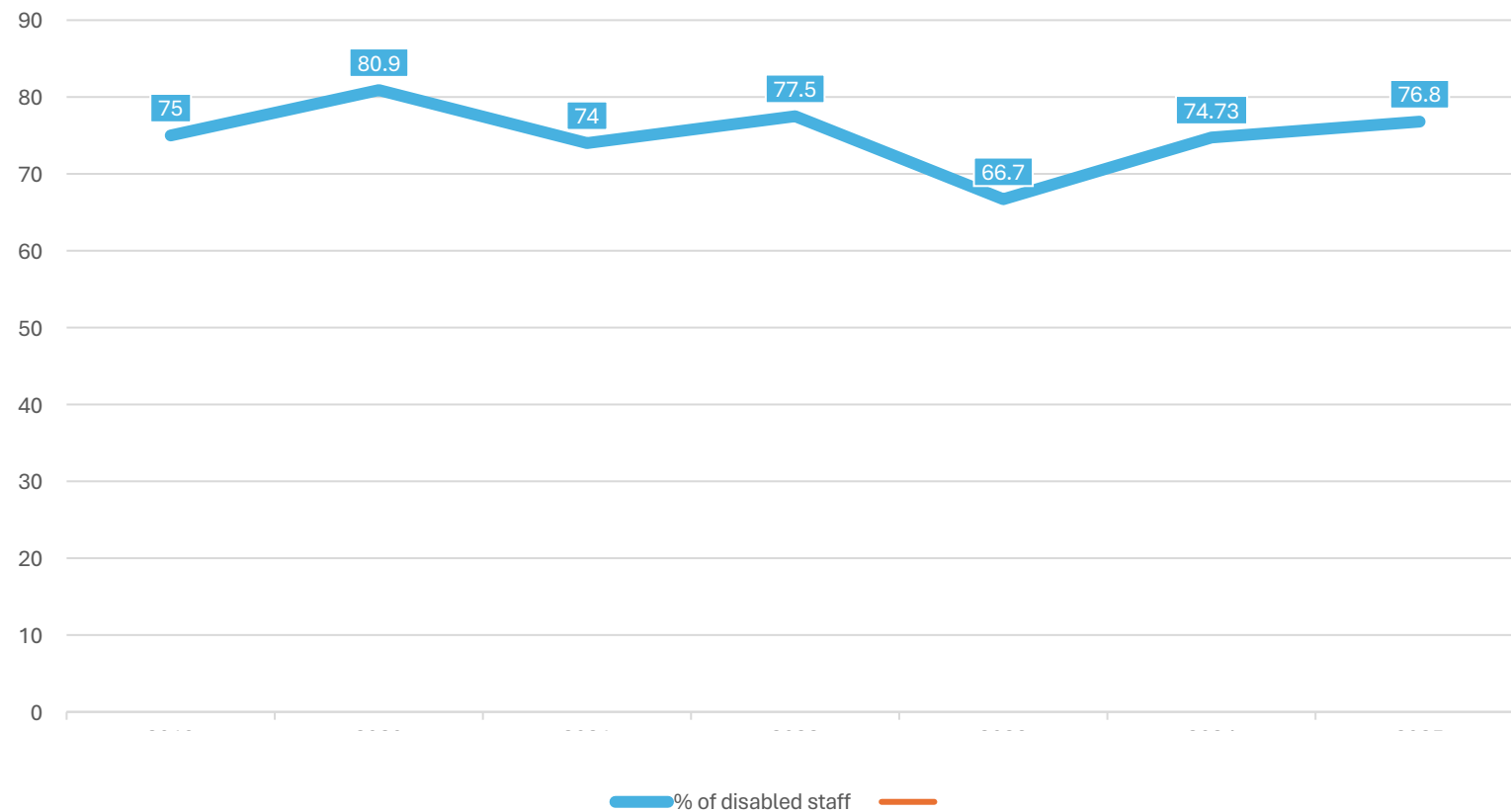


Key analysis

- There has been a small change to this indicator from 53.8% to 53.2%
- There has also been a small change for non-disabled staff members from 41.90% to 41.50%
- This is more positive result than the average score for disabled staff in the Specialist Acute sector which is 40.67%

WDES indicator 8

% of disabled staff saying employer has made adequate adjustment(s) to enable them to carry out their work

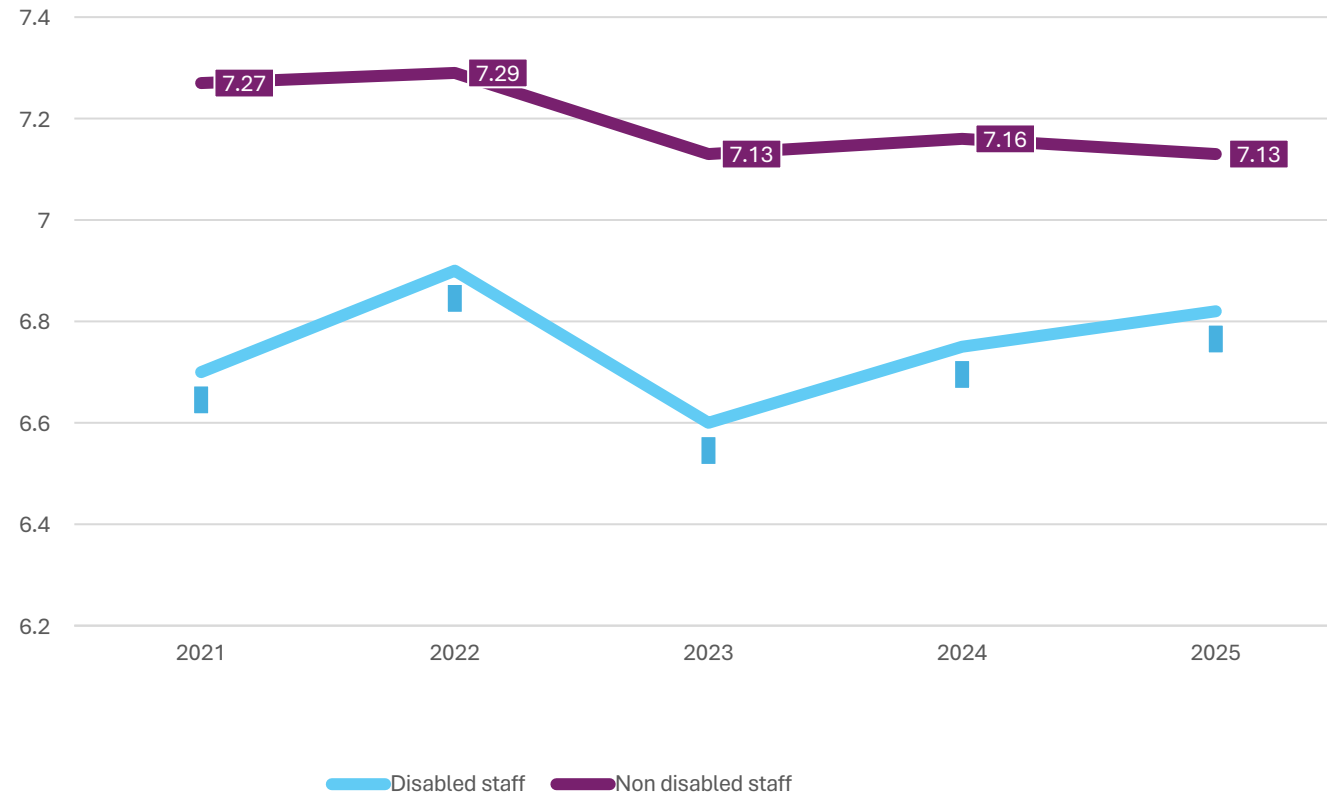


Key analysis

- There has been an **improvement** from 74.73% to 76.8% for disabled staff members
- This is a lower result than the average score for disabled staff in the Specialist Acute sector which is 77.67%
- The continued work with the Staff Health passport will help to further conversations on reasonable adjustments and extra support that staff with disabilities may need

WDES indicator 9

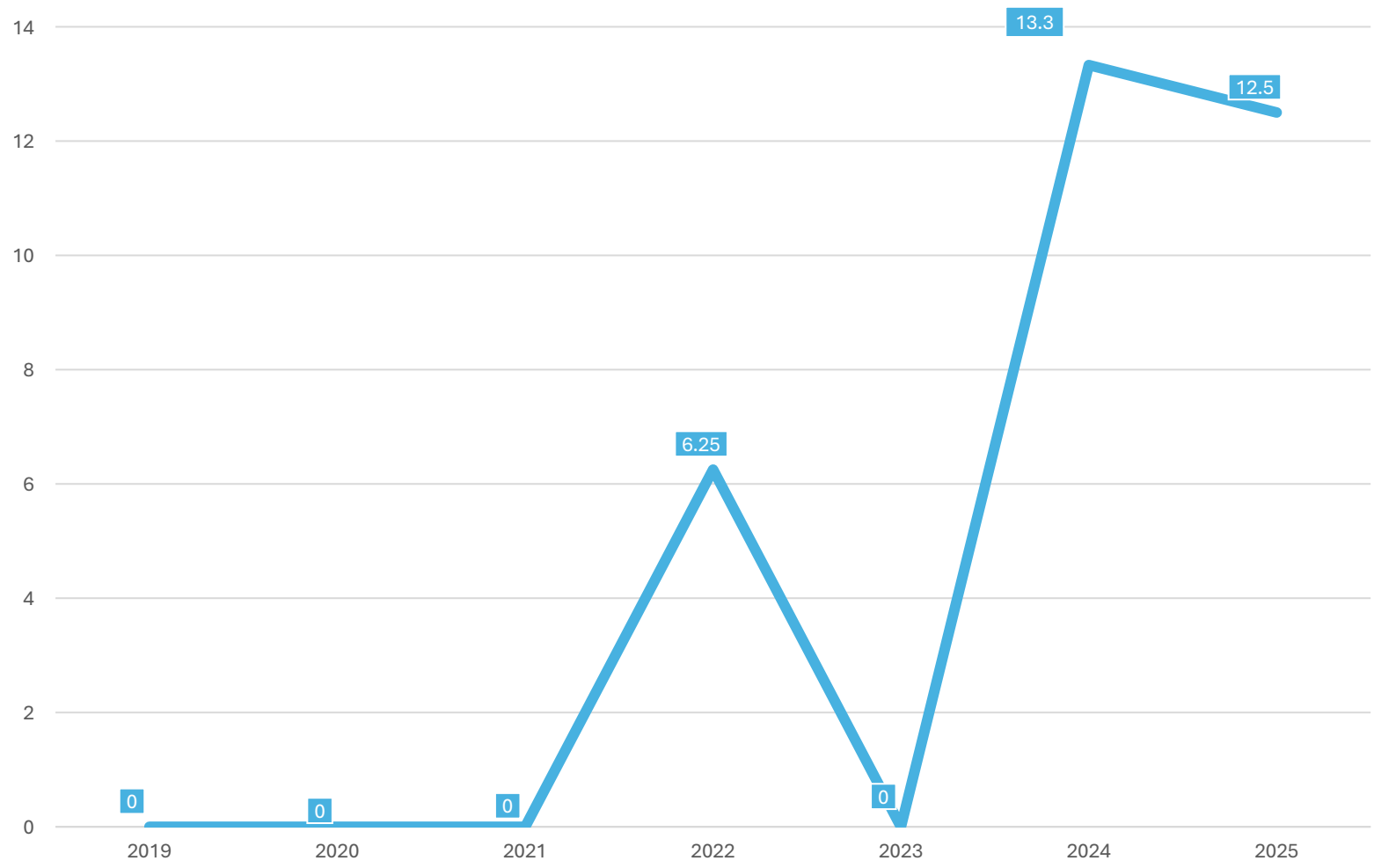
The staff engagement score for disabled staff compared to the overall engagement score for the organisation



Key analysis

- There has been an **improvement** from 6.75% to 6.82% for disabled staff members
- For non-disabled staff members there has been a decline from 7.16 to 7.13
- This is a slightly lower result than the average score for disabled staff in the Specialist Acute sector which is 6.96%

WDES Indicator 10 - % Total Board members by disability



Key analysis

- There has been a **decline** in this indicator from 13.3% to 12.5%

Is are small number of undeclared

- The NHS national average for Board members is 5.7%

- Work will continue across the Trust to ensure that all staff members update the disability declaration on ESR

Workforce Disability Equality Standard (WDES) Action Plan by Priorities

Following a comprehensive review of the WDES indicators, a set of key priorities has been identified to support the ongoing improvement of experiences, opportunities, and outcomes for our disabled staff. These priorities form an integral part of the annual WDES report.

The four priorities are listed below:

- 1.To ensure the Trust has a **diverse workforce** bringing lived experience and unique skills to reflect and better serve our patients and community
- 2.To ensure staff feel **safe and empowered in the workplace** - to speak up to share concerns or ideas
3. To ensure **opportunities** are in place and accessible to all for staff to develop, progress and reach their full potential
- 4.To ensure **robust data analysis** is in place to identify areas of focus, track progress to provide assurance and achieve KPIs

Please note: All quarterly completion dates are be based on the calendar year (i.e., Q1: January–March, Q2: April–June, Q3: July–September, Q4: October–December).

Priority	Indicator	Action	Date	KPI	Outcome for 2028	Alignment to reports
1. To ensure the Trust has a diverse workforce bringing lived experience and unique skills to reflect and better serve our patients and community	WDES Indicator 2 Shortlisting to appointment	<ol style="list-style-type: none"> 1. Monitor appointment ratios quarterly 2. Introduce mandatory inclusive recruitment training for all panel members covering unconscious bias, cultural competence and reasonable adjustments 3. Maintain Disability Confident level accreditation 	<p>Commence: October 2025 - ongoing on Quarterly basis</p> <p>Commence: December 2025 Complete: Q4 2026</p> <p>Commence: April 2026 ongoing with biannual review</p>	KPI: Likelihood of shortlisting to appointment for non disabled staff to decrease from 1.3 to 1 (parity) by 2026	<p>Percentage of disabled staff representative of Birmingham communities</p> <p>Census 2021: 17% disability in Birmingham's population</p>	<p>WRES reporting</p> <p>Disability Confident Leader accreditation</p> <p>Equality Monitoring tool</p> <p>EDI Improvement plan - High Impact Action 2</p>
2. To ensure staff feel safe and empowered in the workplace - to speak up to share concerns or ideas	WDES Indicator 3 Formal capability	<ol style="list-style-type: none"> 1. Introduce pre-capability Wellbeing conversation 2. Include OH early intervention 3. Conduct EQIA for all capability cases 4. Promote Access to work programme 	<p>In place</p> <p>In place</p> <p>Commence: January 2026</p> <p>Commence: December 2025 and on-going</p> <p>All actions to be completed: Q1 2026</p>	KPI Reduction in likelihood of formal cases from 1.58 to 1 (parity) by 2026	1:1 likelihood of formal capability action for disabled staff members	<p>WRES report</p> <p>Equality Monitoring Tool</p> <p>EDI Improvement plan - High Impact Action 6</p>
	WDES Indicator 4a Bullying, Harassment and Abuse - Patients	Rollout out of Civility and Respect (C&R) phase 2 awareness to include:	<p>Commence: November 25 Complete: Q4 2026</p>	<p>KPI: Improvement in Indicator – 23.62% to 22.5% by 2026</p>	20% positive improvement in the national staff survey score	WRES Report

		1. Zero tolerance campaign in clinical areas 2. Poster and education campaign on disability and neuro diversity to raise awareness			and above the average score for Specialist Acute Trust	Bullying and Harassment report Aug 2025 EDI Improvement plan - High Impact Action 6
WDES Indicator 4b Bullying, Harassment and Abuse – Managers	Rollout out of Civility and Respect (C&R) phase 2 awareness to include: 1. Focus on microaggressions, Active Bystander and Allyship training 2. Ensure manager attendance at Me as Manager Inclusion modules	Commence: November 25 Complete: Q4 2026	KPI: Improvement in Indicator – 15.66% to 13.87% by 2026	20% positive improvement in the national staff survey score and above the average score for Specialist Acute Trust	WRES Report Bullying and Harassment report - August 2025 Aligned to ICS EDI priority – Anti racism programme EDI Improvement plan - High Impact Action 6	
WDES Indicator 4c Bullying, Harassment and Abuse - Staff	Rollout out of Civility and Respect (C&R) phase 2 awareness to include: 1. Focus on microaggressions, Active Bystander and Allyship training 2. Run quarterly listening sessions as part of ABLE network 3. Share work on Bullying and Harassment report with colleagues	Commence: November 2025 Complete: Q4 2026 Commenced Complete: Q2 2026	KPI: Improvement in Indicator – 24.62% to 23% by 2026	20% positive improvement in the national staff survey score and above the average score for Specialist Acute Trust	WRES Report Bullying and Harassment report - August 2025 Aligned to ICS EDI priority – Anti racism programme EDI Improvement plan - High Impact Action 6	
WDES Indicator 4d - Reporting	1. Review and implement findings from reporting and manager feedback section of Bullying and Harassment report	Commenced: Complete: Q2 2026	KPI: Improvement in Indicator – 61.25% to 65% by 2026	20% positive improvement in the national staff survey score and above the average score for Specialist Acute Trust	WRES Report Bullying and Harassment report - August 2025 Aligned to ICS EDI priority – Anti racism programme EDI Improvement plan - High Impact Action 6	
WDES Indicator 6 Pressure to come to work	1. Relaunch Staff Health Passport with ABLE network and managers 2. Ensure sickness policy is explicit about hidden disabilities 3. Include wellbeing data in the workforce performance dashboard	Commence: December 2025 In progress Commence: December 2025	KPI: Improvement in Indicator – 20.67% to 18% by 2026	20% positive improvement in the national staff survey score and above the average score for Specialist Acute Trust	WRES Report Aligned to ICS EDI priority – Anti racism programme	

			All actions to be completed: Q1 2026			EDI Improvement plan - High Impact Action 4
	WDES Indicator 7 Feeling valued	1. Comms campaign on disabilities 2. Appraisals to include enhanced wellbeing check ins to support disabilities	Commence: December 2025 Commence: December 2025 All actions to be completed: Q1 2026	KPI: Improvement on Indicator – 41.50% to 45.65% by 2026 Current KPI aligned to Best in Specialist Acute Trust category for NSS survey	20% positive improvement in the national staff survey score, and above the average score for Specialist Acute Trust	WRES Report EDI Improvement plan - High Impact Action 4
	WDES Indicator 8 Reasonable Adjustments	1. Further develop Staff Health Passport to include wellbeing element and invisible disabilities 2. Further promote Access to Work 3. Audit experience of staff with reasonable adjustments	In progress Commence: December 2025 Commence: January 2026 All actions to be completed: Q1 2026	KPI: Improvement in Indicator 6 – 76.80% to 80% by 2026	20% positive improvement in the national staff survey score and above the average score for Specialist Acute Trust	WRES Report EDI Improvement plan - High Impact Action 4
	WDES Indicator 9 Staff Engagement	1. Ensure the Chair of the ABLE network is a member of the workforce group 2. Comms campaign to promote different disabilities with ABLE network 3. Run quarterly listening sessions as part of ABLE network	Commence: December 2025 Commence: December 2025 Commence: October 2025 All actions to be completed: Q1 2026	KPI: Improvement on Indicator – 6.92 to 6.96 by 2026	20% positive improvement in the national staff survey score and above the average score for Specialist Acute Trust	WRES Report EDI Improvement plan - High Impact Action 4
3. To ensure opportunities are in place and accessible to all for staff to develop, progress and reach their full potential	WDES Indicator 5 Equal Opportunities	1. Implement career tracker to include -New Talent framework -Career pathway review to identify barriers to progression and access to Leadership programmes and mentoring - Analyse internal promotions by disability status - Review acting up and secondment 2. Train managers in having inclusive career conversations	Commence: February 2026	KPI: Improvement in Indicator – 49.75% to 51% by 2026 Current KPI aligned to Best in Specialist Acute Trust category for NSS survey	20% positive improvement in the national staff survey score and above the average score for Specialist Acute Trust	WRES Report

		<p>3. Promote targeted leadership development and mentoring programmes</p> <p>4. Promote current learning opportunities including ICS Possibilities Beyond Limits (PBL) to diverse groups</p>	<p>In progress</p> <p>Commence: October 2025</p> <p>All actions to be completed: Q3 2026</p> <p>Commenced and ongoing</p>			<p>EDI Improvement plan - High Impact Action 6</p>
<p>4. To ensure robust data analysis is in place to identify areas of focus, track progress to provide assurance and achieve KPIs</p>	<p>WDES Indicator 1 % Staff</p>	<p>1. Regular ESR data cleansing</p> <p>2. 'Confidence to declare' campaign</p> <p>3. Quarterly review of workforce representation by band</p> <p>4. Completion of Disability Pay Gap report</p>	<p>Commence: December 2025</p> <p>Commence: January 2026</p> <p>Commence: January 2026 - ongoing</p> <p>Commence: December 2026</p> <p>All actions to be completed: Q2 2026</p>	<p>KPI: Improvement of declaration rate of disabled staff to from 6.9% to 10% 2026</p>	<p>Percentage of disabled staff, representative of Birmingham communities</p> <p>Census 2021: 17% disability in Birmingham's population</p>	<p>WDES reporting</p> <p>Disability Confident Leader accreditation</p> <p>Equality Monitoring tool</p> <p>EDI Improvement plan - High Impact Action 2</p>
	<p>WDES Indicator 10 Board representation</p>	<p>1. Board to be open in sharing their lived experience in Comms campaign</p> <p>2. Encourage disabled colleagues to consider shadow board opportunities</p> <p>3. Increase Board diversity profile</p>	<p>Commence: December 2025</p> <p>Commence: Next ICS campaign</p> <p>Commence: December 2025</p> <p>All actions to be completed: Q1 2026</p>	<p>KPI: Full declaration for all diversity information for all Board members by 2026</p>	<p>Percentage of disabled Trust Board members representative of disabled ROH staff members</p>	<p>WDES reporting</p> <p>Equality Monitoring tool</p> <p>EDI Improvement plan - High Impact Action 1</p>



TRUST BOARD

DOCUMENT TITLE:	Workforce Race Equality standard (WRES) Report
SPONSOR (EXECUTIVE DIRECTOR):	Sharon Malhi, Chief People Officer
AUTHOR:	Alison Money, Deputy Chief People Officer Clare Mair, Head of OD and Inclusion
DATE OF MEETING:	5th November 2025

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE	x	FOR INFORMATION ONLY		TO CREATE DISCUSSION		TO SEEK APPROVAL	x
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EXECUTIVE SUMMARY:

This report is an update on the Workforce Race Equality Standard (WRES) data report that was submitted online to NHS England in May 2025 and reported at Staff Experience and OD in June 2025, August 2025 and October 2025 and Trust Board in July 2025. The additional information provided is an updated action plan aligned to each WRES indicator and the four identified priorities:

1. To ensure the Trust has a **diverse workforce** bringing lived experience and unique skills to reflect and better serve our patients and community
2. To ensure staff feel **safe and empowered in the workplace** - to speak up to share concerns or ideas
3. To ensure **opportunities** are in place and accessible to all for staff to develop, progress and reach their full potential
4. To ensure **robust data analysis** is in place to identify areas of focus, track progress to provide assurance and achieve KPIs

The WRES action plan is targeting the work to support the improvement of experiences, opportunities, and outcomes for our staff from an ethnic minority.

In line with NHSE requirements, this report is required to be published on the ROH website following approval from Trust Board.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVES	GAPS IN ASSURANCE/RISKS TO ESCALATE
<ul style="list-style-type: none"> - The MMEG network remains actively engaged in supporting and contributing to the WRES action plan, ensuring that staff voices are heard and that efforts positively influence both staff experience and patient care - A number of actions have been initiated, and good progress is being made 	<ul style="list-style-type: none"> - The experience of staff is being directly impacted by the current challenges within the NHS

REPORT RECOMMENDATION:

To review the report for assurance and approve publication on the ROH website

KEY AREAS OF IMPACT <i>(Indicate with 'x' all those that apply):</i>					
Financial		Environmental		Communications & Media	x
Business and market share		Legal & Policy		Patient Experience	x
Clinical		Equality and Diversity	x	Workforce	x
Inequalities	x	Integrated Care		Continuous Improvement	X
Comments:					
ALIGNMENT TO TRUST STRATEGY <i>(Indicate with 'x' all those that apply):</i>					
Care	x	Community			x
Expertise	x	Services			
People	x	Collaboration			x
ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
Corporate risk register					
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:					
ICS Inclusion work					
BENCHMARKING SOURCE <i>(Indicate data sources included in report IF APPLICABLE):</i>					
BSol ICS WRES Indicator data					
Specialist Acute Trust WRES indicator results					
PREVIOUS CONSIDERATION <i>(Indicate board/committee/group & date):</i>					
Executive meeting 14 th October 2025					
Staff Experience and OD Committee 22 nd October 2025					



The Royal
Orthopaedic Hospital
NHS Foundation Trust

Workforce Race Equality Standard (WRES)

Report and Action plan
October 2025

Summary

- Workforce Race Equality Standards (WRES) was introduced to monitor data of employees from an ethnic minority background to ensure they have equal access to career opportunities and receive fair treatment in the workplace
- Full information on the WRES standard can be found on the NHS link [NHS England » NHS Workforce Race Equality Standard](#)
- Data covers the period 1st April 2024 to 31st March 2025 and is taken from Electronic Staff Record (ESR) TRAC recruitment and National Staff Survey sources. The data has been submitted to NHS England in May 2025
- WRES data shows a decline in 4 indicators, improvement in 5 indicators
- Areas of focus identified from WRES are bullying and harassment, discrimination and inclusive recruitment and career opportunities
- Work is aligned to RACE Equality Code and Ethnicity Pay gap for the WRES data

Progress since October 2024

- Declaration rates improved for WRES to 35%
- Recruitment of Chair and Deputy chair for the Multi Minority Ethnicity group (MMEG)
- Increase number of staff members joining the MMEG network
- Birmingham and Solihull (BSol) Coaching and Mentoring network launched
- ROH participants on the ICS 'Possibilities beyond Limits' programme
- Enhanced appraisal training to include inclusive conversations for diverse groups
- Equality and Diversity annual report published
- Improved Inclusive Companies Top 50 UK ranking to number 8 (No 1 NHS) and CEO award
- Continued involvement in the Birmingham and Lewisham African and Caribbean Health Inequalities (BLACHIR) programme
- Anti racist statement confirmed and launch started
- Work started on the RACE Equality code in partnership with the Governance Forum
- Completion of the Trust's first Ethnicity Pay gap report
- Launch of Active Bystander training

Priorities highlighted by latest data submission

Following the review of the data across WRES May 2025, results show that work in the following areas must be prioritised.

Priority areas

Progress the approach to inclusive recruitment

Introduce Civility and Respect approach including the anti-racist commitment

Implement Inclusive Talent and Succession approach to inclusive coaching and mentoring

Provide specific support for departments highlighted with low scores in staff survey results for 'treating staff'

These priorities align to work identified and actions confirmed through the Ethnicity Pay gap and RACE Equality Code assessment. The networks, particularly MMEG (Multi Minority ethnic group) will support and feedback on this work

Comparison for BSol and Specialist sector summary

This table shows the comparison percentages for Trusts across the BSol ICS and also key organisations in the Specialist Acute sector

NHS Staff Survey WRES Metrics 2024	Group of Staff	BCHC Birmingham Community	BSMH Birmingham Mental Health	BWC Birmingham Women and Children's	ICB Integrated Care Board	UHB University Hospital Birmingham	ROH	RNOH Royal National Orthopaedic Hospital	RJAH Robert Jones Agnes Hunt	LHC Liverpool Heart and Chest
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Ethnic Minority	22.6%	34.9%	20.3%	6.0%	23.9%	15.1%	19.4%	29.8%	13.7%
	White	20.2%	29.0%	20.1%	9.8%	22.8%	17.2%	23.1%	17.7%	12.4%
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Ethnic Minority	22.6%	22.9%	24.8%	17.9%	28.3%	27.0%	26.2%	24.6%	16.6%
	White	17.3%	21.7%	19.2%	18.6%	24.1%	22.0%	23.9%	21.4%	13.8%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	Ethnic Minority	45.2%	50.6%	43.6%	34.6%	43.8%	45.9%	49.6%	51.8%	68%
	White	56.0%	57.7%	62.6%	54.4%	54.8%	57.9%	62.6%	60%	70.3%
Percentage of staff experiencing discrimination at work from manager/team leader or other colleagues in last 12 months	Ethnic Minority	14.2%	13.1%	15.3%	12.9%	17.7%	17.99%	13.6%	18.5%	5.6%
	White	6.7%	8.7%	6.3%	8.1%	8.3%	7.9%	9%	4.2%	3.4%

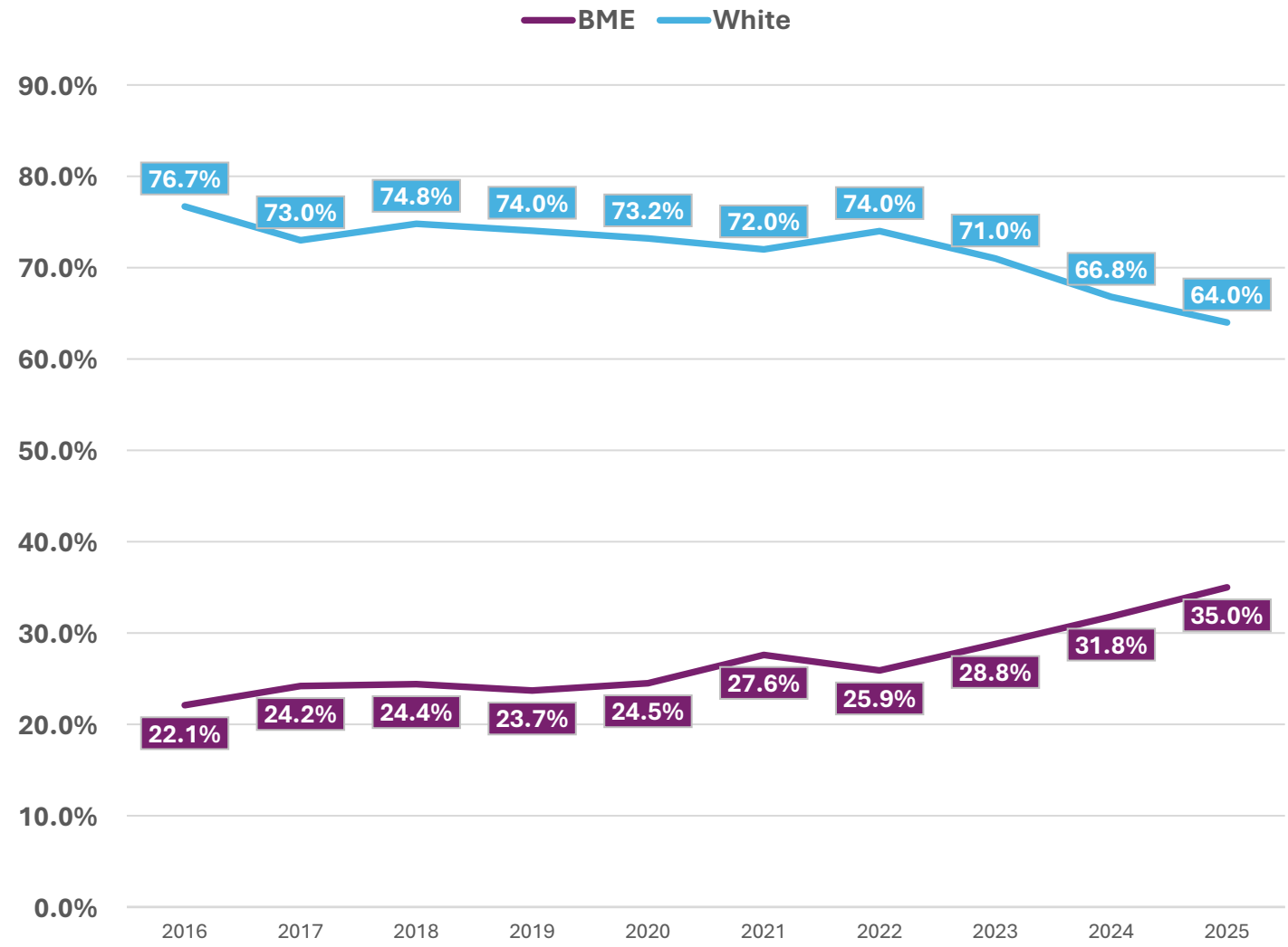
Overview of ROH WRES indicators

The figures in () indicate percentages for white staff members

WRES Indicator	Indicator Definition	2024	2025	Change since 2024
1.	% of BME staff	31.8	35.0	Improvement
2.	Relative likelihood of white staff being appointed from shortlisted candidates compared to BME staff	1.71	2.31	Decline
3.	Relative likelihood of BME staff entering formal disciplinary	2.1	0.67	Improvement
4.	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	0.91	0.86	Improvement
5	% of BME staff experiencing harassment, bullying or abuse from patients or public in last 12 months	11.44 (17.99)	15.08 (17.15)	Decline
6	% of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months	22.17 (20.9)	29.98 (22.04)	Decline
7	% of BME staff believing the trust provides equal opportunities for career progression or promotion	45.54 (62.01)	45.88 (57.88)	Slight Improvement
8	% of BME staff personally experienced discrimination at work from a manager /team leader or other colleague member of staff	12.06 (8.10)	17.86 (7.88)	Decline
9.	% of BME Total Board members	20%	25%	Improvement

WRES indicator 1

Percentage of BME staff compared to White staff



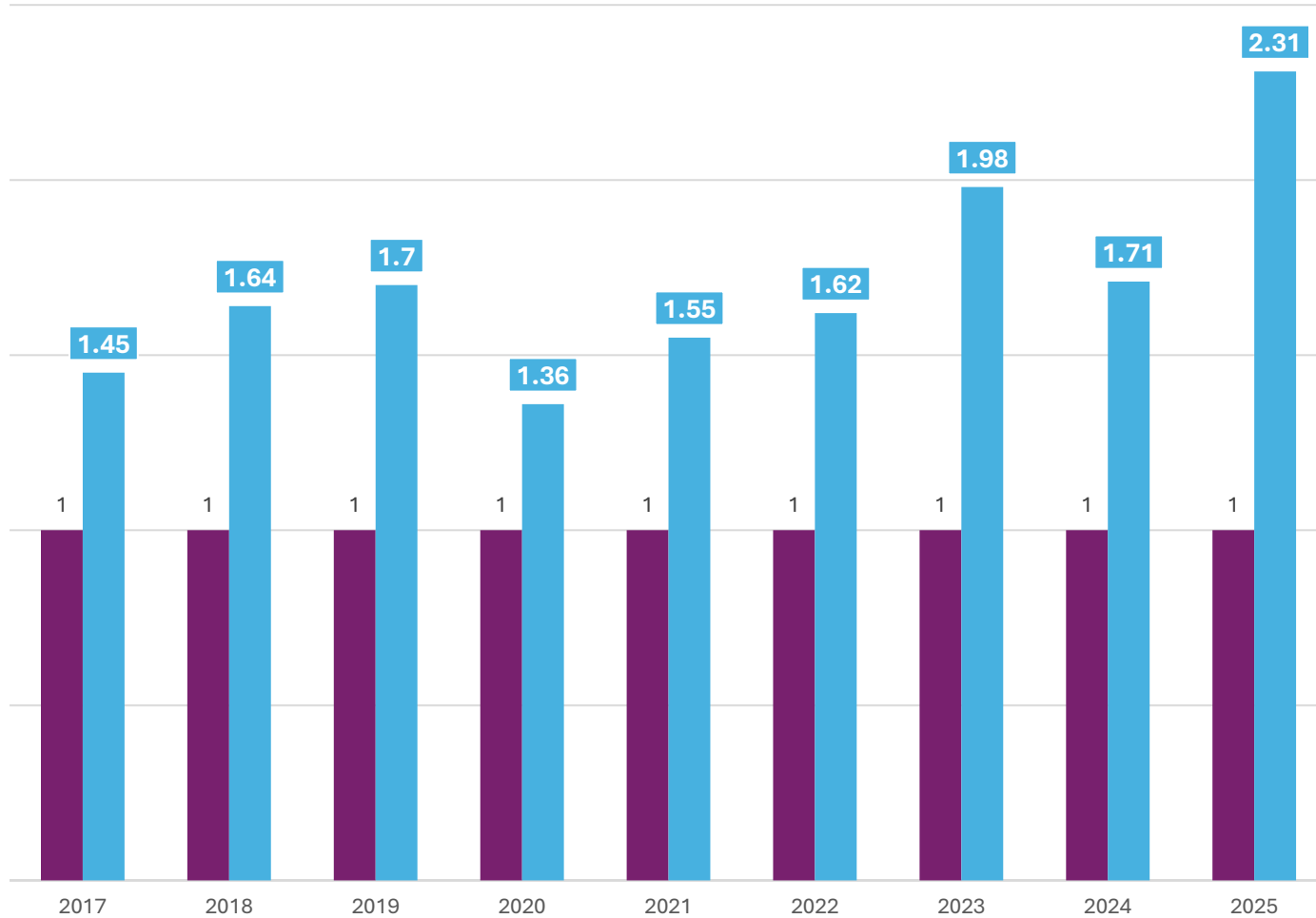
Key analysis

- We continue to see a **positive increase** in staff members from a BME background at the Trust from 31.8% to 35.0%.
- The percentage of BME staff is above the national NHS average of 26.4%
- White staff members have moved from 66.8% to 64%
- The unknown category which equates to 0.5% is 7 staff members across clinical and non-clinical staff groups
- Further analysis will be undertaken to highlight any areas or staff groups where representation is particularly low (aligned to Ethnicity Pay Gap work)

WRES indicator 2

Likelihood of a White applicant being appointed once shortlisted compared to a BME applicant

■ BME ■ White

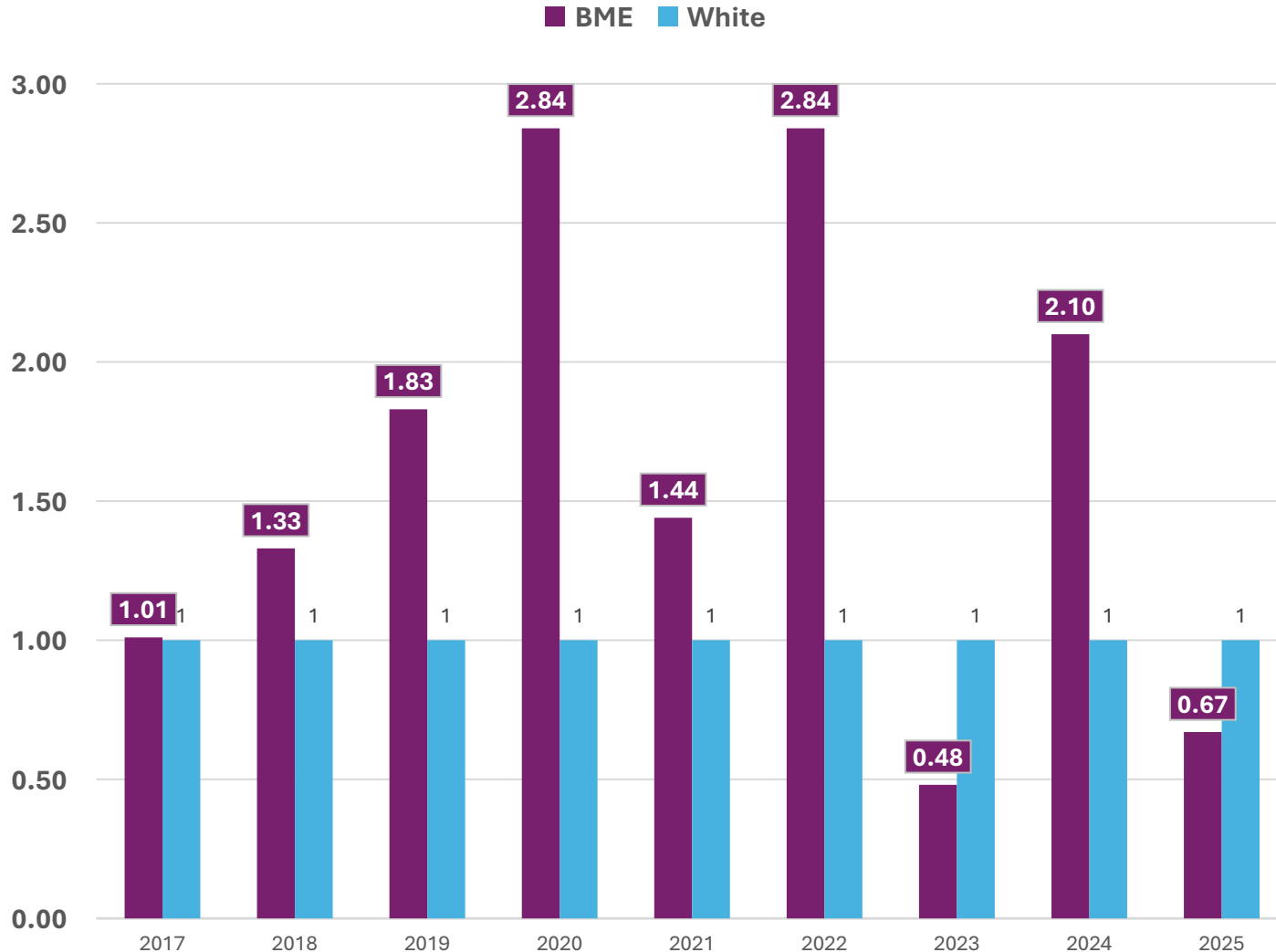


Key analysis

- There has been a further **decline** in this indicator from 1.71 to 2.31
- This indicator means that it is 2.31 times more likely for a white applicant to be appointed from shortlisting than a BME applicant
- Further analysis will be undertaken as a priority, as part of the WRES action plan to look at the data in more detail to identify the differences in staff groups
- This indicator has declined however it should be noted that the overall percentage of BME staff members employed at the Trust has increased from 31.8% to 35% overall in the last 12 months

WRES indicator 3

Likelihood of BME staff entering formal disciplinary compared to White staff

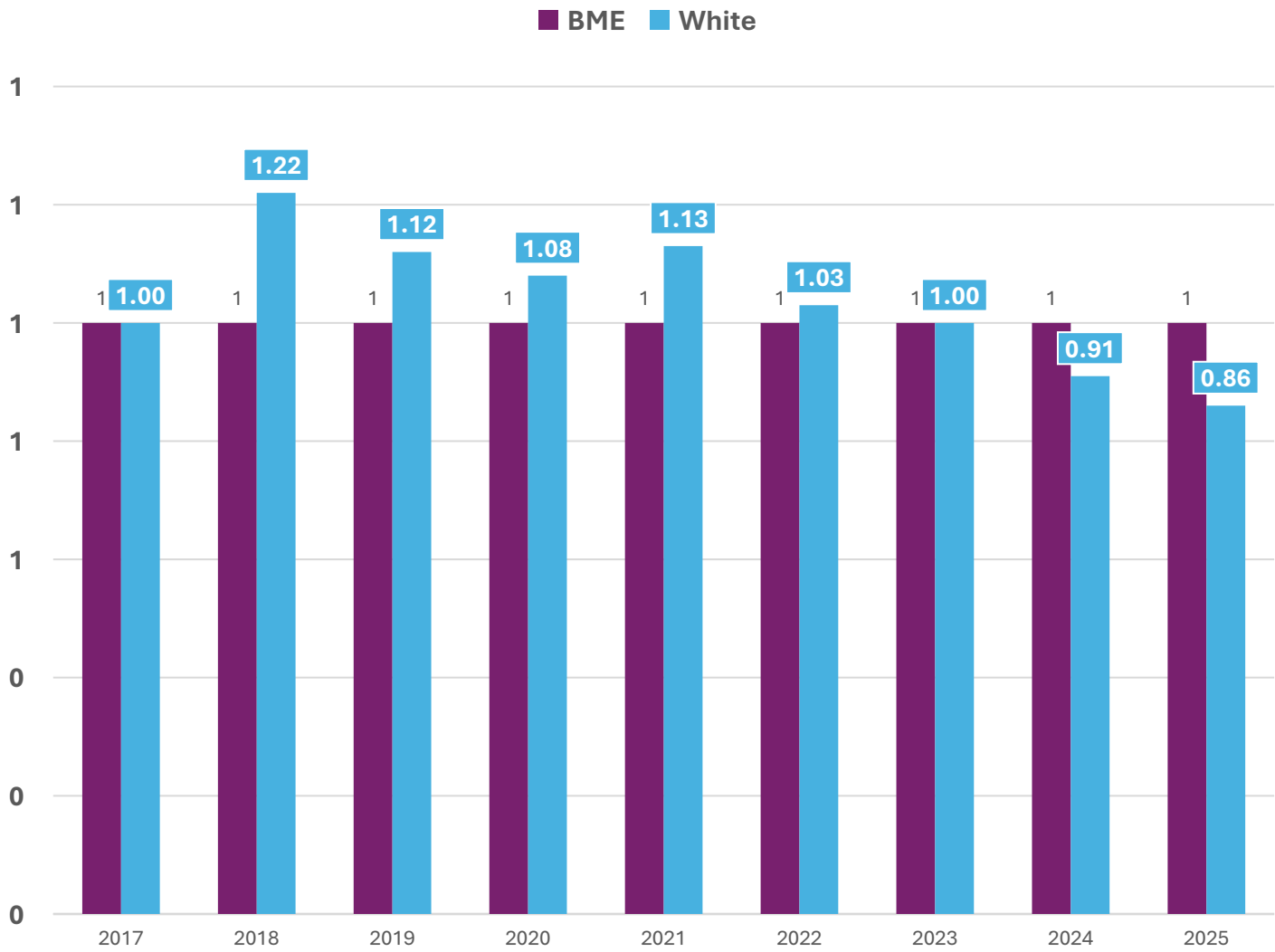


Key analysis

- There has been a significant **improvement** from 2.10 to 0.67
- This indicator means that it is 0.67 times more likely for a BME staff member to enter formal disciplinary compared to 2.10 last year
- Any number at or below 1 (parity) is seen as positive
- Further analysis will be undertaken as part of the action plan to look at data in more details and identify the differences in staff groups
- There were only a small number of formal cases – 15 in total during the data period

WRES indicator 4

Relative likelihood of White staff accessing non-mandatory CPD compared to BME staff

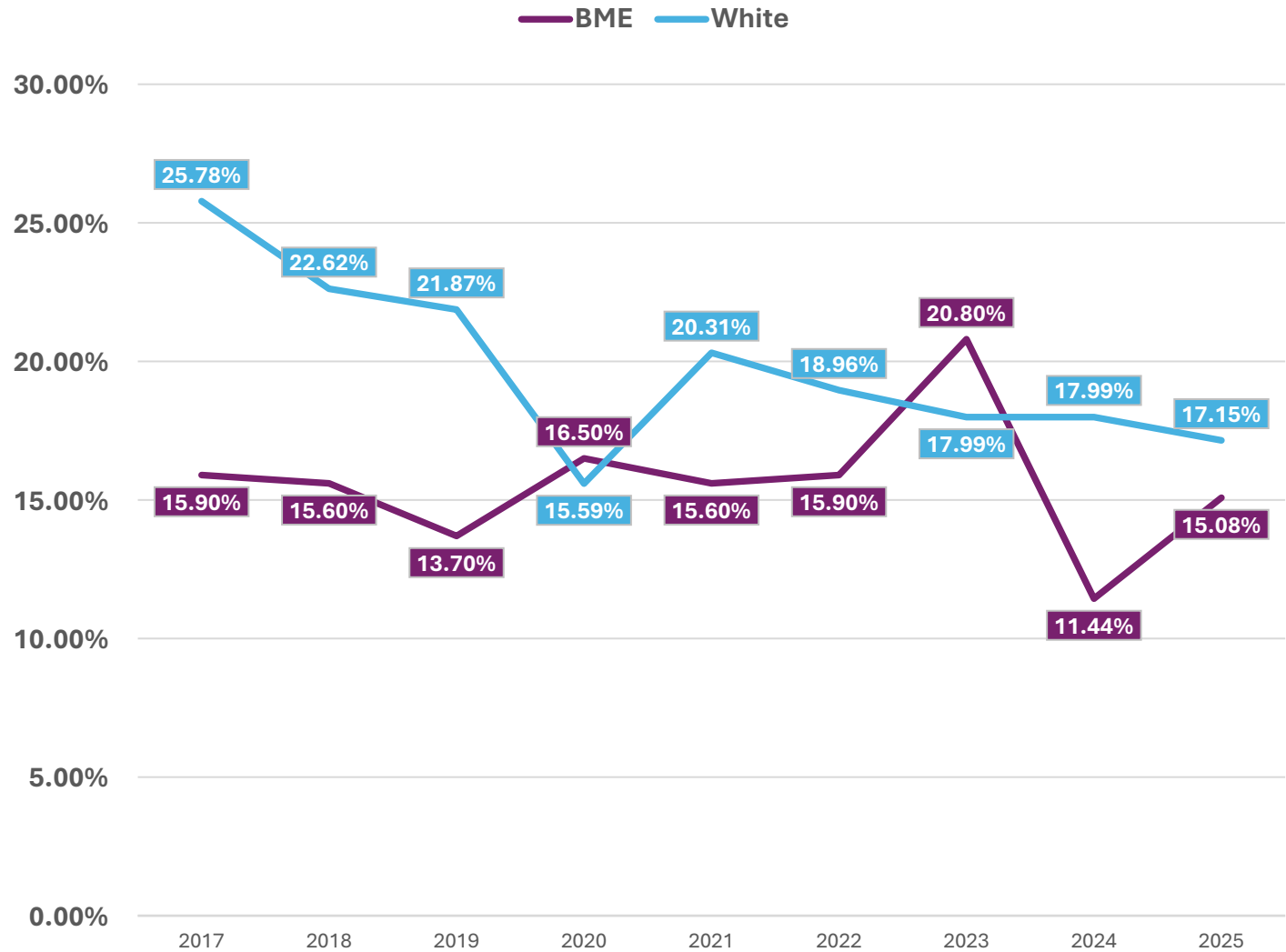


Key analysis

- There has been a further **improvement** from 0.91 to 0.86
- This indicator means that it is 0.86 times more likely for white staff members to access non mandatory training of CPD than BME staff. This means that it is more likely for BME staff to access opportunities
- The new appraisal approach has concentrated on a good quality appraisal conversation with development as a key element
- Staff networks continue to support in ensuring staff are aware of learning opportunities and offer support if they need help to access
- There have been opportunities for BME staff members to attend diverse ICS management training programmes
- The data highlights that attendees are from all staff groups and pay bands across the Trust

WRES indicator 5

Percentage of Staff Experiencing Harassment, Bullying or Abuse from Patients or Public in Last 12 Months

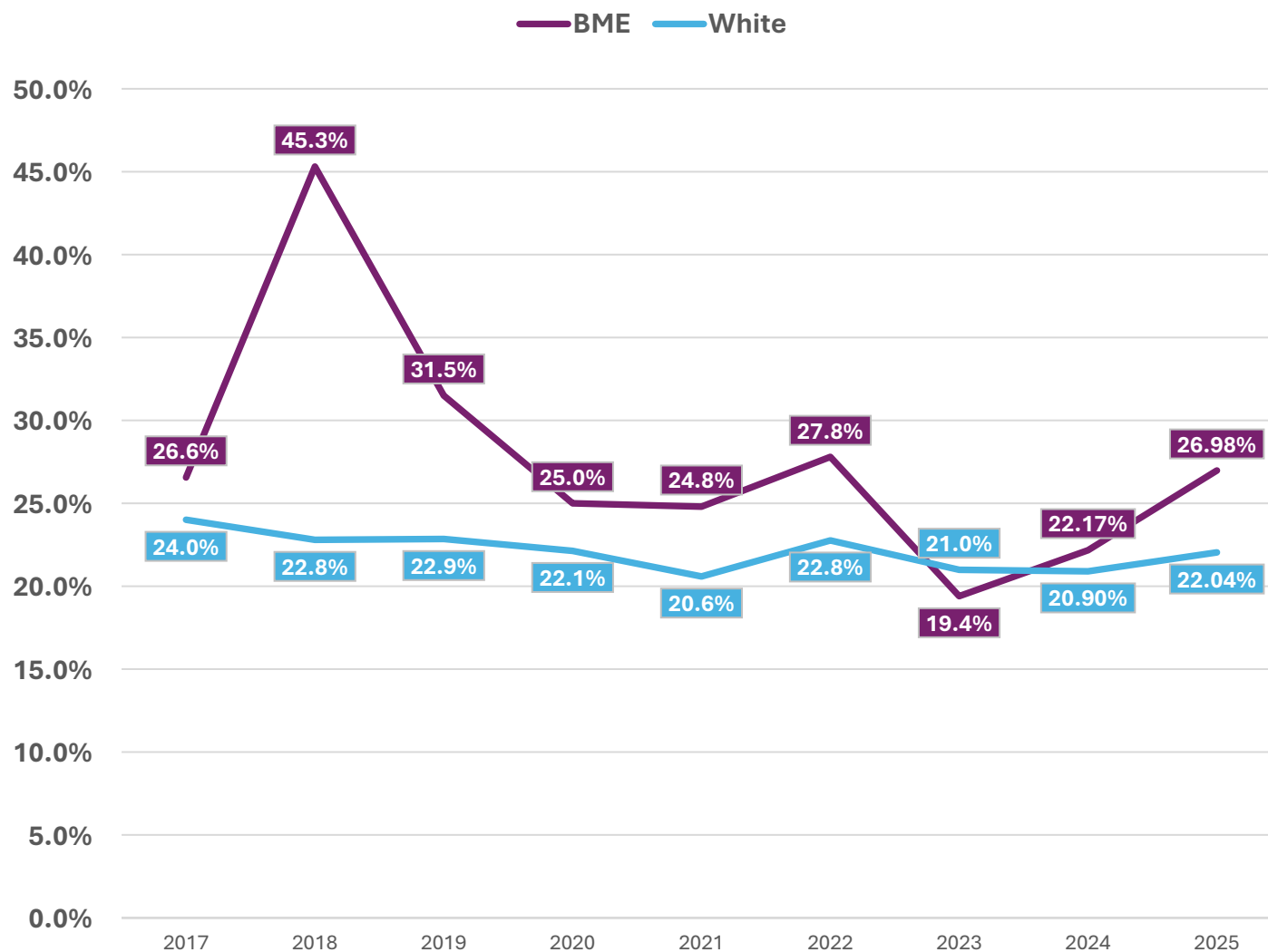


Key analysis

- There has been a **decline** in the indicator from 11.44% to 15.08% for BME staff
- The average BME score from the Specialist Acute sector is 19.43% which is worse than the percentage for ROH
- The percentage for white staff has improved slightly from 17.99% to 17.15% however this is still higher than for BME staff
- Additional focus is needed for this indicator to ensure there is an improvement all staff, and BME staff in particular

WRES indicator 6

Percentage of Staff Experiencing Harassment, Bullying or Abuse from Staff in Last 12 Months



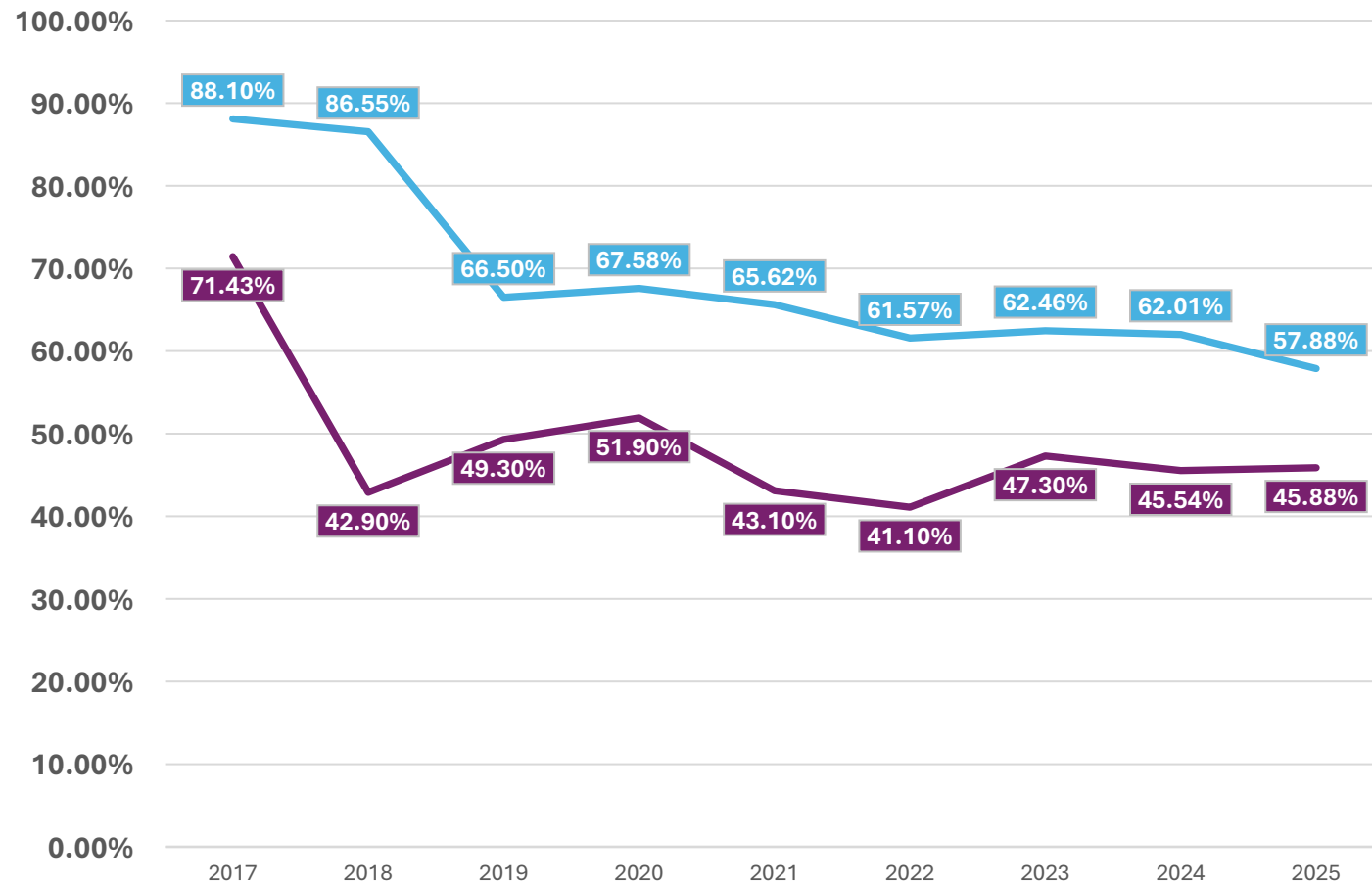
Key analysis

- There has been a further **decline** in this indicator from 22.17% to 26.98% for BME staff members
- This is higher than the average score for BME staff in the Specialist Acute sector which is 25.20%
- There has also been an increase for white staff members from 20.9% to 22.04% which is higher than the Specialist Acute average at 20.22%
- Further analysis is currently being undertaken as part of the action plan to look at data in more detail and identify the differences in staff groups or departments

WRES indicator 7

Percentage of staff believing the trust provides equal opportunities for career progression or promotion

— BME — White



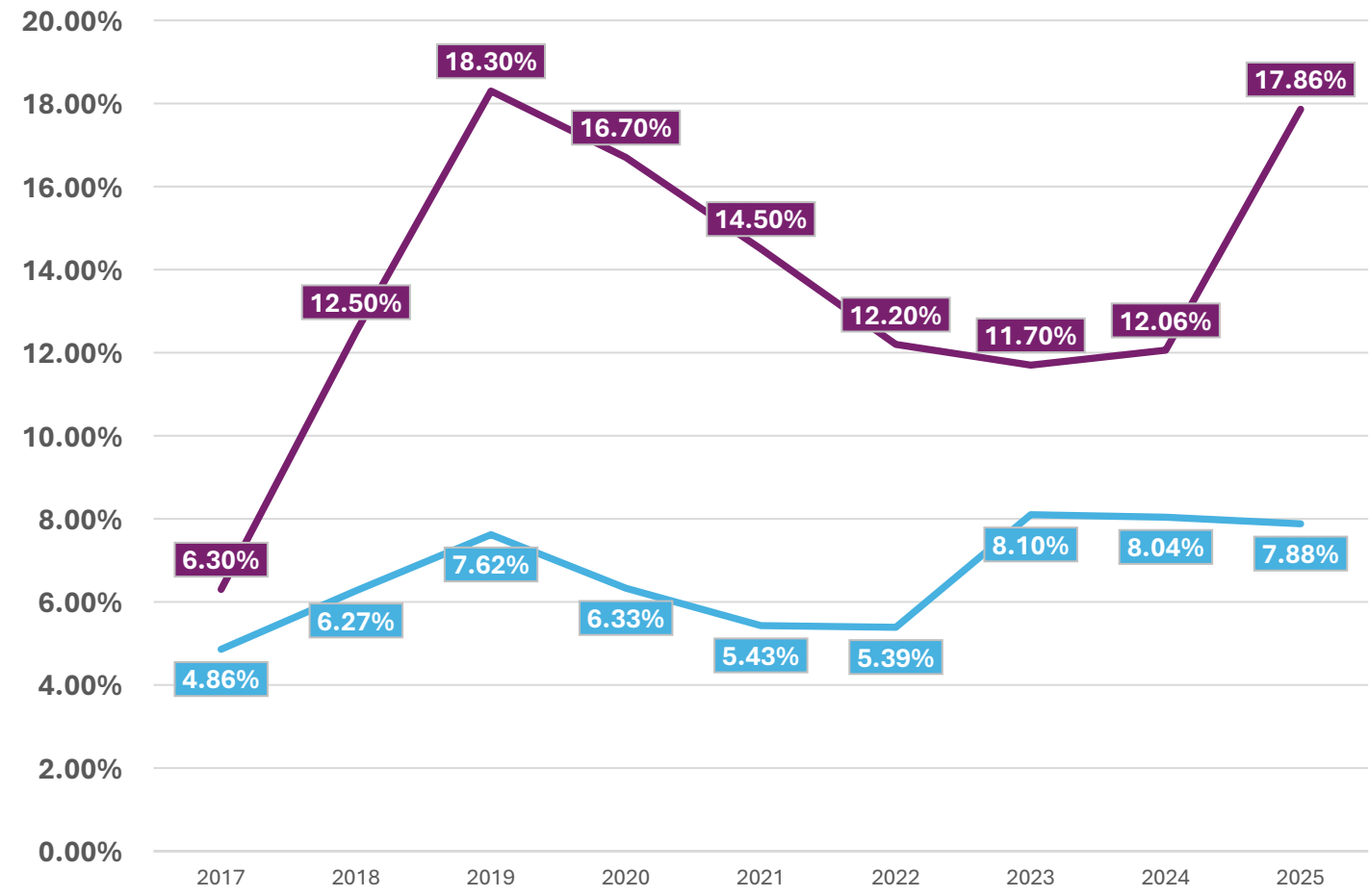
Key analysis

- There has been a slight **improvement** in this indicator from 45.54% to 45.88%
- This is a lower percentage than the average score for BME staff in the Specialist Acute sector which is 54.9%
- The percentage for BME staff is lower than white staff which is 57.88%

WRES indicator 8

Percentage of staff personally experiencing discrimination from a manager/team leader or other colleague

— BME — White

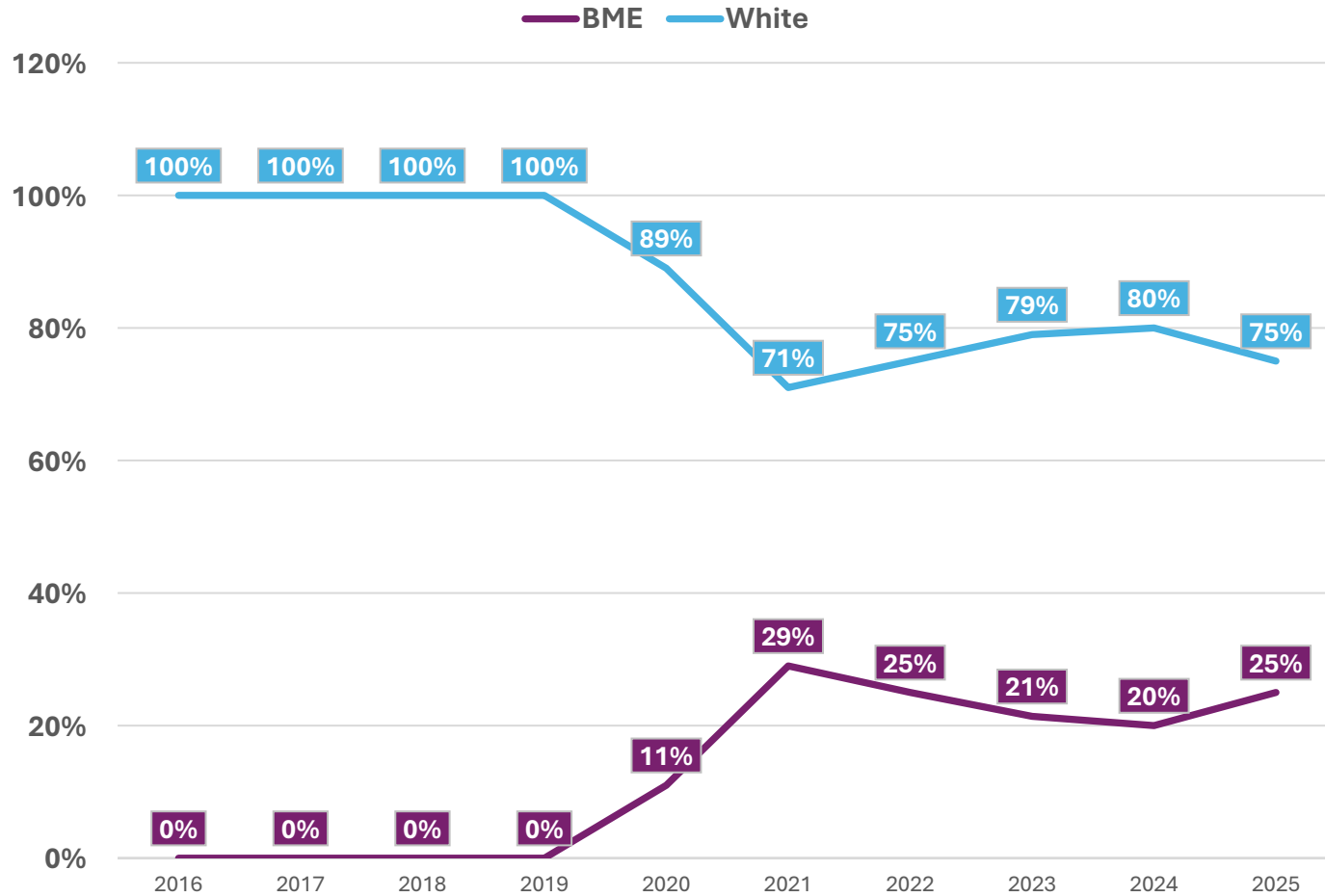


Key analysis

- There has been a significant **decline** in this indicator from 12.06% to 17.86%
- It is in comparison to the percentage of white staff which has seen a positive decrease from 8.04% to 7.88%
- This is higher than the average score for BME staff in the Specialist Acute sector which is 13.65%
- Further analysis is currently being undertaken as part of the action plan and staff survey work to look at the data in more detail and identify differences in staff groups or departments

WRES indicator 9

Percentage of full board members identifying as BME vs White



Key analysis

- There has been a positive **increase** in this indicator from 20% to 25%
- The average percentage for NHS Trust Board member from a BME background is 15.6%

Workforce Race Equality Standard Action plan (WRES) by Priorities

Following a comprehensive review of the WRES indicators, a set of key priorities have been identified to support the ongoing improvement of experiences, opportunities, and outcomes for our ethnic minority staff. These priorities form an integral part of the annual WRES report and are listed below

1.To ensure the Trust has a **diverse workforce** bringing lived experience and unique skills to reflect and better serve our patients and community

2.To ensure staff feel **safe and empowered in the workplace** - to speak up to share concerns or ideas

3. To ensure **opportunities** are in place and accessible to all for staff to develop, progress and reach their full potential

4.To ensure **robust data analysis** is in place to identify areas of focus, track progress to provide assurance and achieve KPIs

***Please note:** All quarterly completion dates are be based on the calendar year (i.e., Q1: January–March, Q2: April–June, Q3: July–September, Q4: October–December).

Priority	Indicator	Action	Date	KPI	Outcome by 2028	Alignment to EDI reporting
1.To ensure the Trust has a diverse workforce bringing lived experience and unique skills to reflect and better serve our patients and community	WRES Indicator 2 Shortlisting to appointment	1.Monitor appointment ratios quarterly 2. Introduce mandatory inclusive recruitment training for all panel members covering unconscious bias, cultural competence and reasonable adjustments	Commence: October 2025 - ongoing on Quarterly basis Commence: December 2025 Complete: Q4 2026	KPI: Improvement of Indicator – Likelihood to improve from 2.31 to 1.7 by 2026	Percentage of ethnic minority staff representative of Birmingham communities Birmingham Census 2021: 51.4% ethnic minority people	WDES report Equality Monitoring Tool EDI Improvement plan - High Impact Action 2
2.To ensure staff feel safe and empowered in the workplace - to speak up to share concerns or ideas	WRES Indicator 3 Formal disciplinary	1.Introduce pre-disciplinary Wellbeing conversation 2.Include OH early intervention 3.Conduct EQIA for all capability cases	In progress In progress Commence: January 2026 All actions to be completed: Q1 2026	KPI Maintain positive Indicator likelihood in formal cases currently 0.67 against target of 1 (parity) by 2026	1:1 likelihood of formal disciplinary action for ethnic minority staff members	WDES report EDI Improvement plan - High Impact Action 6
	WRES Indicator 5 Bullying, Harassment and Abuse - Patients	1.Rollout out of Civility and Respect (C&R) phase 2 awareness to include: -Anti Racist statement and Comms campaign -RACE Equality Code implementation	Commence: November 25 Complete: Q4 2026	KPI: Improvement in Indicator - 15.8% to 14.9% 2026	20% positive improvement in the national staff survey score and above the average score for Specialist Acute Trust	WDES Report Bullying and Harassment report Aug 2025 Aligned to ICS EDI priority – Anti racism programme

		-Zero tolerance campaign 2. Review data from Bullying and Harassment report to include feedback loop and staff debrief support	Commenced Complete: Q2 2026			EDI Improvement plan - High Impact Action 6
	WRES Indicator 6 Bullying, Harassment and Abuse - Staff	1.Rollout out of Civility and Respect (C&R) phase 2 awareness to include: -Anti Racist statement -RACE Equality Code implementation -Focus on microaggressions, Active Bystander and Allyship training -Ensure manager attendance at Me as Manager Inclusion modules 2.Share work on Bullying and Harassment report with colleagues	Commence: November 25 Complete: Q4 2026 Commenced Complete: Q2 2026	KPI: Improvement in Indicator - 29.98% to 27.0% by 2026	20% positive improvement in the national staff survey score and above the average score for Specialist Acute Trust	WDES Report Bullying and Harassment report Aug 2025 Aligned to ICS EDI priority – Anti racism programme EDI Improvement plan High Impact Action 6
	WRES Indicator 8 Discrimination	1.Rollout out of Civility and Respect (C&R) phase 2 awareness to include: -Anti Racist statement -RACE Equality Code -Focus on microaggressions, Active Bystander and Allyship training -Ensure manager attendance at Me as Manager Inclusion modules 2. Ensure the Chair of the MMEG network is a member of the workforce group	Commence: November 2025 Complete: Q4 2026 Commence: December 2025 Complete: Q1 2026	KPI: Improvement in Indicator - 17.86% to 16.01% by 2026	20% positive improvement in the national staff survey score and above the average score for Specialist Acute Trust	WDES Report Bullying and Harassment report Aug 2025 Aligned to ICS EDI priority – Anti racism programme EDI Improvement plan - High Impact Action 6
3. To ensure opportunities are in place and accessible to all for staff to develop, progress and reach their full potential	WRES Indicator 4 Non mandatory training	1.Implement career tracker to include -New Talent framework -Career pathway review to identify barriers to progression and access to Leadership programmes and mentoring -Analysis internal promotions by ethnic minority status - Review acting up and secondment	Commence: February 2026	KPI Likelihood of 1. Maintain current positive likelihood of 1.12 by 2026	1:1 likelihood of non-mandatory training for ethnic minority staff members	WDES Report Equality monitoring tool

		<p>2.Train managers in having inclusive career conversations</p> <p>3.Promote targeted leadership development and mentoring programmes</p> <p>4.Promote current learning opportunities including ICS Possibilities Beyond Limits (PBL) to diverse groups</p>	<p>In Progress</p> <p>Commence: October 2025</p> <p>All actions to be completed: Q3 2026</p> <p>Commenced</p> <p>Complete: Q4 2025</p>			EDI Improvement plan - High Impact Action 2
	WRES Indicator 7 Equal Opportunities	<p>1.Implement career tracker to include -New Talent framework</p> <p>-Career pathway review to identify barriers to progression and access to Leadership programmes and mentoring</p> <p>-Analysis internal promotions by ethnic minority status</p> <p>- Review acting up and secondment</p> <p>2.Train managers in having inclusive career conversations</p> <p>3.Promote and increase uptake in targeted leadership development and mentoring programmes</p> <p>4. Promote current learning opportunities including ICS Possibilities Beyond Limits (PBL) to diverse groups</p>	<p>Commence: February 2026</p> <p>In progress</p> <p>Commence: October 2025</p> <p>All actions to be completed: Q3 2026</p> <p>Commenced and ongoing</p>	KPI: Improvement from 45.8% to 50.38% to 2026	20% positive improvement in the national staff survey score and above the average score for Specialist Acute Trust	<p>WRES report</p> <p>Equality monitoring tool</p> <p>EDI Improvement plan - High Impact Action 2</p>
4.To ensure robust data analysis is in place to identify areas of focus, track progress to provide assurance and achieve KPIs	WRES Indicator 1 % Staff	<p>1. Quarterly review of workforce representation by band and staff group</p> <p>2.Enhancement to Ethnicity Pay Gap report</p>	<p>Commenced - ongoing on Quarterly basis</p> <p>Commence: February 2026</p> <p>Complete: Q2 2026</p>	KPI: % increase of ethnicity minority clerical roles – 20.8% to 22.8% by 2026	<p>Percentage of ethnic minority staff representative of Birmingham communities</p> <p>Birmingham Census 2021: 51.4% ethnic minority residents</p>	<p>Ethnicity Pay Gap</p> <p>Equality monitoring tool</p> <p>WDES reporting</p> <p>EDI Improvement plan- High Impact Action 2</p>
	WRES Indicator 9 Board representation	<p>1.implement RACE Equality Code.</p> <p>2.Monitor Board diversity</p> <p>3.Equality Objectives confirmed for each Trust Board member with reference to race</p>	<p>Commenced - ongoing on Quarterly basis</p> <p>Commence: December 2025</p> <p>Commence: September 2025</p>	KPI: Maintain current Board diversity	Percentage of ethnic minority Trust Board members representative of ROH staff members	<p>WDES Report</p> <p>Equality Monitoring Tool</p> <p>RACE Equality Code action plan</p>

		<p>4.Share Board recruitment data with Board members</p> <p>5.Board to be open in sharing their lived experience in Comms campaign</p> <p>6.Encourage ethnic minority applicants to consider shadow board opportunities</p>	<p>Commence: February 2026</p> <p>Commence: December 2025</p> <p>Commence: Next ICS campaign All actions to be completed: Q1 2026</p>			<p>EDI Improvement Plan- High Impact Action 1</p>
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STAFF EXPERIENCE & OD COMMITTEE

DOCUMENT TITLE:	Sexual Safety Charter Assurance Framework Self-Assessment & Action Plan
SPONSOR (EXECUTIVE DIRECTOR):	Nikki Brockie Chief Nurse
AUTHOR:	Nikki Brockie Chief Nurse
DATE OF MEETING:	September 25

PURPOSE OF THE REPORT:

TO PROVIDE ASSURANCE	x	FOR INFORMATION ONLY	x	TO CREATE DISCUSSION		TO SEEK APPROVAL	
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EXECUTIVE SUMMARY:

In September 2023, the Sexual Safety Charter was published by NHS England with the aim of promoting a zero-tolerance approach towards sexual misconduct in the workplace. All NHS Trusts and integrated care boards (ICBs) signed the Charter and committed to delivery of the 10 principles. In August 25, NHSE re-affirmed its commitment to the charter and asked all providers to undertake a self-assessment against the sexual safety charter assurance framework.

Within the letter, Trust Boards have been requested to ensure that they have oversight of the work being undertaken to ensure a sexually safe environment for our staff and patients.

Next steps:

While this report focuses on compliance of the principles, further reports are planned regarding the impact of the work. Exploring staff survey data, SG disclosure, HR disclosure and incident reporting. Though the engagement of the wide team, we are aware that staff are starting to feel safe to come forward and raise concerns. This is being monitored via the working group, and a further report will be presented after this year's staff survey results are released.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
<p>Compliance with principle overall is positive with clear work identified to ensure overall compliance.</p> <p>Key areas of delivery:</p> <ul style="list-style-type: none"> • Development and implementation of reporting mechanism • Dedicated webpage • Roll out of bystander training • Annual engagement programme • Engagement with wider trust teams, raised awareness (FSG, HG, medical team, training teams, SG) • DASVA post to support victim • Working with Worcester university a audit will be undertake to understand the impact o the bystander training. 	<ul style="list-style-type: none"> • Sexual safety policy to be launched by HR • Develop and share case studies • Complete an EIA • Review the Chaperoning policy / training is underway. • Explore eLearning now LMS is embedded • EPR – reporting of access to system

REPORT RECOMMENDATION:

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

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

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy	x	Patient Experience	x

ROHTB (11-25) 010

Clinical	x	Equality and Diversity	x	Workforce	X
Inequalities	x	Integrated Care		Continuous Improvement	X

Comments:

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

Care	X	Community	x
Expertise		Services	
People	x	Collaboration	

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

x

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



Sexual Safety Charter Assurance Framework

Self-Assessment & Action Plan

1. Executive Summary:

- 1.1 In September 2023, the Sexual Safety Charter¹ was published by NHS England with the aim of promoting a zero-tolerance approach towards sexual misconduct in the workplace. All NHS Trusts and integrated care boards (ICBs) signed the Charter and committed to delivery of the 10 principles. In August 25, NHSE re-affirmed its commitment to the charter and asked all providers to undertake a self-assessment against the sexual safety charter assurance framework².
- 1.2 Within the letter, Trust Boards have been requested to ensure that they have oversight of the work being undertaken to ensure a sexually safe environment for our staff and patients.

2. Self- Assessment & Action Plan

Principles	Action	Outcome	Progress	Outstanding actions Partially Achieved/ Achieved
1. We will actively work to eradicate sexual harassment and abuse in	<ul style="list-style-type: none"> have clear plans to focus the organisation on prevention and culture change set clear standards of behaviour in policies and enforce them core training for 	<ul style="list-style-type: none"> sexual misconduct, its prevalence, impact and how to eradicate it, is discussed openly and appropriately within the organisation 	<ul style="list-style-type: none"> The Trust has a Named Executive lead in place – Nicola Brockie Chief Nurse supported by an operational Working Group with a cross section of representative from the Trust. This was established in September 23 and continues to 	Partial Achieved

¹ [NHS England » Actions to tackle sexual misconduct in the NHS](#)

² <https://www.england.nhs.uk/long-read/sexual-safety-charter-assurance-framework/>

Updated: October 25

Owner: Nicola Brockie, Chief Nurse



<p>the workplace.</p> <p>2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.</p>	<p>all staff and specialist training for those who need it</p> <ul style="list-style-type: none"> communications campaign shared with all staff establish a structured risk management and escalation process for sexual misconduct, including defined risk thresholds for escalation to executive and board levels board-level ownership and accountability for cultural issues, prevention strategies, and oversight embed tackling sexual misconduct and protecting the sexual safety of our workforce into all relevant business as usual areas – for example, training, contracts, induction and equality, diversity and inclusion (EDI) improvement plans clear signposting to policies and support services, which are easily accessible to all staff visible, senior leadership appoint domestic abuse and sexual violence lead 	<ul style="list-style-type: none"> the executive board has agreed a suitable governance process to understand prevalence rates, staff experience and the outcomes of cases in their organisation data about prevalence, actions taken and learning from cases is shared across the organisation reduction in cases (recognising likely to be an initial increase due to increased confidence in reporting reduction in staff saying in annual staff survey they have experienced sexual misconduct in the workplace The Board proactively governs and escalates emerging sexual misconduct risks, ensuring accountability, oversight, and early intervention across the organisation increased confidence in the organisation at tackling sexual misconduct and improving safety for all staff 	<p>meet quarterly. The working group is support by the HON of SG/ FSG/ HR and other key members.</p> <ul style="list-style-type: none"> Executive lead attends national executive training / briefing in May 24. HON for SG & Vulnerabilities is the DA & SV lead. The trust also has a DASVA post support by the charity. ROH values a culture of openness which is supported by a strong Freedom to Speak culture (FSGU). FSGU is well embedded and supported by Champions. Human Resources and safeguarding, managers support individuals, teams, and line managers. There are several FSUG & OD comments boxes deployed across the trusts to allow anonymous feedback. A review (Jan 24) was undertaken into incidents related to sexual harassment to identify themes or trends. This has been triangulated with the staff survey data from 23/24 to gain a deep understanding of issues (themes / areas / issues), which has informed the working groups scope and targeted actions. Awareness campaign rolled out over the last 18 months: <ul style="list-style-type: none"> Charter signed and shared via comm’s Leadership charter launched – set of expectation and behaviours. Human factors training delivered with model uploaded to LMS New appraisal system aligned to Trust values and behaviours. Quality & Safety walkabout 	
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			<ul style="list-style-type: none"> ○ 100 days and Team brief raise awareness. ○ Preceptorship training. ○ Junior Doctor induction – Dr Jo Thomas provide a 20-minute talk on raising concerns around sexual safety. ○ Shared at admin Matter and Women’s network ○ Executive walkabout /tea trolley engagements programme, supported by FSG, SG lead, DSVA and HS lead in Dec 24. ○ Trust internet page with flow diagram of how and who can support. ○ Stands outside Café Royal ● Campaign continues throughout the year. Stands, tea & coffee trolley focusing on the awareness. ● Bystander training rolled out and available to all on the internet. Recorded locally as ESR doesn’t support. <p>Actions planned:</p> <ul style="list-style-type: none"> ● Sexual safety policy to be launched by HR (Expected Nov 25) ● Develop and share case studies (Planned for Dec 25) ● Executive walkabout /tea trolley engagements programme – planned for Dec 25 	
<p>3. We will take an intersectional approach to the sexual safety of our workforce,</p>	<ul style="list-style-type: none"> ● complete equality impact assessment of sexual safety and misconduct work (including policies) 	<ul style="list-style-type: none"> ● a clear understanding of the prevalence of sexual misconduct within different workforce groups 	<ul style="list-style-type: none"> ● Sexual safety has been aligned to the Equality, Diversity, and Inclusive action plan. Work is targeted through the year to raise awareness and target staff groups and areas that have been highlighted as areas of concern. 	<p>Achieved</p>



<p>recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.</p>	<ul style="list-style-type: none"> engage through staff networks, EDI officials and experts by experience to ensure all cohorts of our staff are represented appropriately and robustly as part of this work use data from NHS staff surveys, cut by EDI metrics, to understand staff experience and inform iterative development of key products tailor responses to ensure they are appropriate for groups that experience sexual misconduct at a disproportionate rate 	<ul style="list-style-type: none"> support is tailored, appropriate and effective in tackling intersectional experience of sexual misconduct 	<ul style="list-style-type: none"> Regular engagement throughout the year at staff engagement network. Staff survey data has been reviewed within the working group, and the insight has been used to inform activities. SG committee also review all data relating to DA and DASVA work and use this to target actions. (Example – roll out of the bystander training to all teams) Actions underway: An annual plan has been developed to raise awareness, using cafe royal focal point to capture staff, case studies, the group is scoping easy read materials and developing leaflets to reach all teams. Team aids will be developed that can be shared at team briefs and will be deployed to teams. <p>Actions planned:</p> <ul style="list-style-type: none"> Complete an EIA (planned with HR for Nov 25) Governance are currently review all incidents for the last 18 months. This will support targeted work for the next 12 months. 	
<p>4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.</p>	<ul style="list-style-type: none"> Confidential information and resources are available on the intranet and staff are signposted to them regularly staff support structures, like the Employee Assistance Programme, have guidance on sexual misconduct processes 	<ul style="list-style-type: none"> staff have knowledge of and access to a range of support tools and mechanisms that are iteratively reviewed and based on a growing evidence base specific and specialist support for those who experience sexual misconduct is embedded into 	<p>Support is currently offered via the following avenues:</p> <ul style="list-style-type: none"> Website – flow chart that outlines how staff can get support. Appendix A. line managers Human resources Safeguarding team Occupational Health 	<p>Partially Achieved</p>



	<p>and pathways to specialist support</p> <ul style="list-style-type: none"> the support offer is monitored to inform continuous improvement and ensure appropriateness. Offsite support can be offered relevant policies are evidence based and informed by data and subject matter expertise 	<p>organisational staff support structures</p>	<ul style="list-style-type: none"> Risk assessments and action plans put in place when required. FSUG DA&SVA post in post and feed back to Board. Develop a safe feedback loop to staff who report concerns. – Boxes in each department. – FSG boxes. – List of boxes, Staff are signposted to support, such as counselling and third sector support. Annual awareness campaign and Safeguarding month – share information. Bystander training on LMS. The trust also has access to mental health support via the BSOL hub. 	
<p>5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.</p>	<ul style="list-style-type: none"> sexual misconduct policy is clear on standards of behaviour, the role of those who witness inappropriate behaviour, and any interactions with other relevant policies roll out communications campaign to all staff sexual safety and misconduct are comprehensively addressed in induction and all staff training 	<ul style="list-style-type: none"> staff are clear about the standards of behaviour required in the organisation the organisation adheres to policies and applies them consistently staff feel empowered to take action should they witness or experience unwanted and/or harmful sexual behaviour 	<ul style="list-style-type: none"> National sexual safety policy was launched in October 24. This policy will be adopted by the trust(expected delivery date Nov 25). Associated policies have been updated. Communication campaign is on-going. Webpage and bystander training embedded. <p>Actions planned:</p> <ul style="list-style-type: none"> Sexual safety policy to be launched by HR (Expected Nov 25) 	<p>Partially Achieved</p>



<p>6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.</p>	<ul style="list-style-type: none"> publish a policy on sexual misconduct in line with the NHS national policy framework sexual misconduct policy is supported by flowchart and easy-read version and is easily accessible to all staff conduct/competence policies should take account of complexities in cases where it may initially be unclear whether behaviours and actions should be considered as conduct or capability policies set out roles and responsibilities of people in the organisation, for example, HR and people professionals, safeguarding teams, freedom to speak up guardians, mental health first aiders, leadership, line managers provide tools and support for line managers to understand their responsibilities and how to follow escalation processes consistently policies are clear about action that needs to be taken against perpetrators, by whom, when and how 	<ul style="list-style-type: none"> action is always taken against perpetrators, and in line with policies clear, evidence-based and trauma informed processes are documented in policies all staff are clear on roles and responsibilities line managers are clear on their responsibility to escalate potential sexual misconduct issues and the processes for doing so HR and people professionals are clear on the necessary steps required to take timely action against alleged perpetrators and this is part of their induction and ongoing training HR and people professionals are clear about when information needs to be shared with future employers relating to sexual misconduct complaints and investigations Chaperones should clearly establish the purpose for any sensitive examination and record this in an auditable way 	<ul style="list-style-type: none"> The domestic abuse policy is in place and is supported by Freedom to Speak Guardians. Flowchart developed and available on the internet – sexual safety webpage. Appendix B. Me as manager – supports the development of line managers. Managers support staff with support of HR and SG team, DASVA. Civility and respect programme has also been rolled out. Grievance policy has been updated with a section on sexual harassment. <p>Actions planned:</p> <ul style="list-style-type: none"> Review the Chaperoning policy / training is underway. Civility policy is planned for early 26. Sexual safety policy expected Nov 25. 	<p>Partially Achieved</p>
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	<ul style="list-style-type: none"> • policies are clear about investigation processes and standards • policies are clear about the circumstances in which complaints and investigations about staff should be shared with future employers and police • chaperoning policies are clear about the role of chaperones in relation to sensitive examinations 			
<p>7. We will ensure appropriate, specific, and clear training is in place.</p>	<ul style="list-style-type: none"> • training is available for all staff to recognise and report sexual misconduct and to understand how to support colleagues (victims and witnesses) • specialist training is available for those who need it to ensure effective support, reporting and investigations (for case managers, investigators and responsible officers) • training is developed for managers to support culture change • all staff have undertaken national eLearning on sexual misconduct 	<ul style="list-style-type: none"> • training on sexual misconduct and sexual safety are accessible to all staff • specialist training is accessible to those who need it • staff knowledge and awareness of issues relating to sexual misconduct increases 	<ul style="list-style-type: none"> • Awareness talks have been introduced and are being delivered to junior doctors at induction. Booklets / case studies are being developed and will be shared with teams, to raise awareness. • Bystander training has been rolled out (Appendix C) Clips are on the trust internet for all staff. • ROH is working with Worcester university to assess and monitor our improvement. <p>Planned actions:</p> <ul style="list-style-type: none"> • Explore elearning now LMS is embedded 	<p>Achieved</p>



<p>8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.</p>	<ul style="list-style-type: none"> • policy outlines sexual misconduct reporting mechanisms, including anonymous reporting • reporting mechanisms are widely communicated to ensure awareness • Freedom to Speak Up infrastructure and training for guardians updated to include sexual misconduct • there is a clear safeguarding process for identifying unusual patterns of patient record access (where an electronic patient record is in place) 	<ul style="list-style-type: none"> • staff can report an instance of alleged sexual misconduct through multiple routes, including anonymously • staff have confidence their disclosure will be treated confidentially (and understand where it might need to be shared for safeguarding reasons) and escalated appropriately • disproportionate and inappropriate access of patient records is picked up earlier 	<ul style="list-style-type: none"> • Reporting flowchart has been developed and launched on the webpage. • Policy being developed and expected to be ready by Nov 25. • FSG is a core member of the working group and feeds back to the champions. Specific training will be scoped. <p>Actions planned:</p> <ul style="list-style-type: none"> • Policy remains outstanding • Ensuring FSGU training includes sexual safety training. • Explore monitoring mechanisms for monitoring staff accessing patient record inappropriately. 	<p style="text-align: center;">Achieved</p>
<p>9. We will take all reports seriously and appropriate and timely action will be taken in all cases.</p>	<ul style="list-style-type: none"> • clear actions and action-owners set out in the sexual misconduct policy • timeframes for action set out in sexual misconduct policy • ensure access to external investigators • ensure access to external subject matter experts • executive / board reporting, including on relevant data and learning from surveys, reports and investigations of sexual misconduct, FTSU, complaints • establish a governance and risk oversight process for 	<ul style="list-style-type: none"> • sexual misconduct is identified in a timely way, all reports are actioned following organisational policies, and incidents are escalated appropriately • staff have increased confidence to report concerns • patterns of behaviour are spotted sooner by triangulating all available information • complex cases have Board and executive scrutiny, aiding the identification of systemic and organisation-wide issues 	<p>The following process are in place to raise concerns:</p> <ul style="list-style-type: none"> • Safeguarding & risk assessment process • Position of Trust process • Human Resources • Freedom to speak-up guardians. • Line managers • Reporting chains • FSG <p>Planned actions:</p> <ul style="list-style-type: none"> • Policy – ensure timeframes are incorporated. • Reporting to Board. 	<p style="text-align: center;">Partially Achieved</p>



	<p>serious and complex sexual misconduct cases, with defined escalation thresholds for executive and Board review</p> <ul style="list-style-type: none"> • there are timely routes to share with HR concerns raised through professional and clinical avenues that could have a sexual component plus data from FTSU and sexual misconduct reporting is triangulated to support • there is a process for investigations to move from competence to conduct 	<ul style="list-style-type: none"> • concerns that are initially identified as relating to clinical capability are effectively recognised and dealt with as potential sexual misconduct 		
<p>10. We will capture and share data on prevalence and staff experience transparently.</p>	<ul style="list-style-type: none"> • staff survey results are published and shared, with actions taken/to be taken to address issues and risks raised in the results • executive / board reporting on cases, including relevant data and learning 	<ul style="list-style-type: none"> • executive board understands prevalence rates, staff experience and the outcomes of cases in their organisation, including impacts and any differences between different groups of staff and required actions • staff have access to data on sexual misconduct prevalence in their organisation 	<ul style="list-style-type: none"> • Audit of incident in the last 12 months complete • Review staff survey data Yr 24/25 reviewed and action put in place. • Snapshot reporting complete and shared • FSG reporting – complete and shared • Awareness campaign – on-going • Webpage set up 	<p>Achieved</p> <p>Aim to start to roll out case studies in 25/26</p>

3.0 Additional areas in the August 2025 NHS letter

Updated: October 25

Owner: Nicola Brockie, Chief Nurse



Area	Action	Work underway	Time line
Chaperoning policies	Policies should ensure chaperones understand the purpose of procedures; that the purpose is documented; and that they are empowered to act on or report concerns when necessary	Full review of the policy is underway and training provision	Initial report due end October. Action plan to follow
Electronic patient records	Trusts should work with suppliers to audit and monitor access patterns, and – where they are in implementation or pre-implementation – ensure this capability is built into new systems from the outset.	Requested CINO clarifies current availability and ensure this is factored into EPR plan	Underway
DBS	NHS organisations should remind themselves of the NHS Employers guidance on disclosure, which is clear that an enhanced DBS check may not reveal all relevant concerns, and a lack of information should not be taken as reassurance	This forms part of the section 11 audit and was reviewed by SG in Sept 25. HR to ensure compliance	Underway
Board level assurance & complete self-assessment /	Trust Boards to assess compliance with the Sexual safety actions	Selfe assessment completed. Action plan in place. SE&OD in Oct 25, Trust Board Dec 25.	Planned for Dec 25 Board
Sexual safety audit	Trust to ensure the audit is completed by 1 Sept by HR teams.		Complete – closed

4.0 Conclusion

4.1 In conclusion, since its launch in September 2023, the Sexual Safety Framework Self-Assessment has demonstrated that work undertaken to date to encourage, empower and prompt a culture of safety and openness to speak up and seek help is positive. Overall compliance against the self-assessment domains is strong; however, it must be noted work is on-going and the campaign continues to evolve with no end date planned.

Updated: October 25

Owner: Nicola Brockie, Chief Nurse



5.2 One of its most notable impacts has been the creation of a safer, more open culture where staff feel increasingly confident to speak up about concerns and access support when needed. The group have experienced this shift during the walkabout and engagement events, often with staff making disclosure and sharing lived experience sharing that they feel safe and support by the approach taken. This shift reflects a growing sense of shared responsibility and trust across trust. Sustaining this momentum will be key to embedding long-term improvements in sexual safety and staff wellbeing.

Appendix A. Trust internet



Sexual Safety

Those who work, train and learn within the healthcare system have the right to be safe and feel supported at work.

We all have a responsibility to ourselves and our colleagues and must act if we witness these behaviours.

The Royal Orthopaedic Hospital is committed to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce.

Bystander intervention training

Bystander intervention in sexual safety involves empowering staff to intervene in situations where sexual harassment or sexual assault may occur. The Sexual Safety Bystander training encourages a culture where individuals feel empowered to speak up and challenge harmful behaviours.

All colleagues are encouraged to complete the short video training clips, they are aimed at both clinical and non-clinical. Each video is between 5-10 minutes and can be completed at your own pace.

Once you have completed all videos, please notify your line manager of completion.

[Scenario 1 - Inappropriate Image](#)

[Scenario 2 - Sexist Comments](#)

[Scenario 3 - We're Just Joking](#)

[Scenario 4 - Unwanted Touching](#)

[Scenario 5 - Sexual Harassment](#)

[Scenario 6 - Online Behaviour](#)



Appendix B. How to safely raise concern

Raising a concern of Sexual Safety in the workplace



On 4 September 2023, NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. The Royal Orthopaedic Hospital commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the Trust. Sexual misconduct can happen to anyone anywhere – it is crucial that when our staff come to work, they feel safe and supported.

Raise the concern with someone you trust, however we would recommend approaching your line manager in the first instance.

Where your line manager is not immediately available or where you are less comfortable speaking to your line manager, we would also suggest you contact Human Resources or a Freedom to Speak up Champion

The line manager or Freedom to Speak Up Champion will escalate the concerns initially to Human Resources who will seek support from the Safeguarding team to ensure the staff members risks are reduced whilst at work and a safety plan put in place. The concerns will be treated as confidential and will be notified throughout the investigation of any actions completed.

An incident form will be completed by a member of the safeguarding Team or Human Resources. Victim or perpetrators identifiable information will NOT be included within the incident form.

A suitable manager will be nominated to investigate the concerns.

Weekly check ins to commence with between nominated person and victim for six weeks. This is to ensure that any emerging risks are reduced and access to support services are available. All discussions must be documented and shared with HR and safeguarding if new risks are identified.

An outcome of the investigation to be shared with victim by the investigator/Human Resources and incident form closed and updated.

STAFF MEMBER DISCLOSES A SEXUAL SAFETY CONCERN

A sexual safety concern is identified. The disclosure must be documented in full using the victims own words. This should include dates, times and location of the inappropriate sexual behaviours, gathering as much details as possible. The full name and role of the perpetrator and department they work for. If the disclosure includes sexual assault or rape, this must be immediately escalated to a member of the safeguarding team on ext 55822. Out of hours contact the clinical site managers. A consideration for a referral to sexual assault referral centre (SARC) to provide medical, practical and emotional support nhs.uk/sarcs and the Police. However, consent must be gained from the victim.

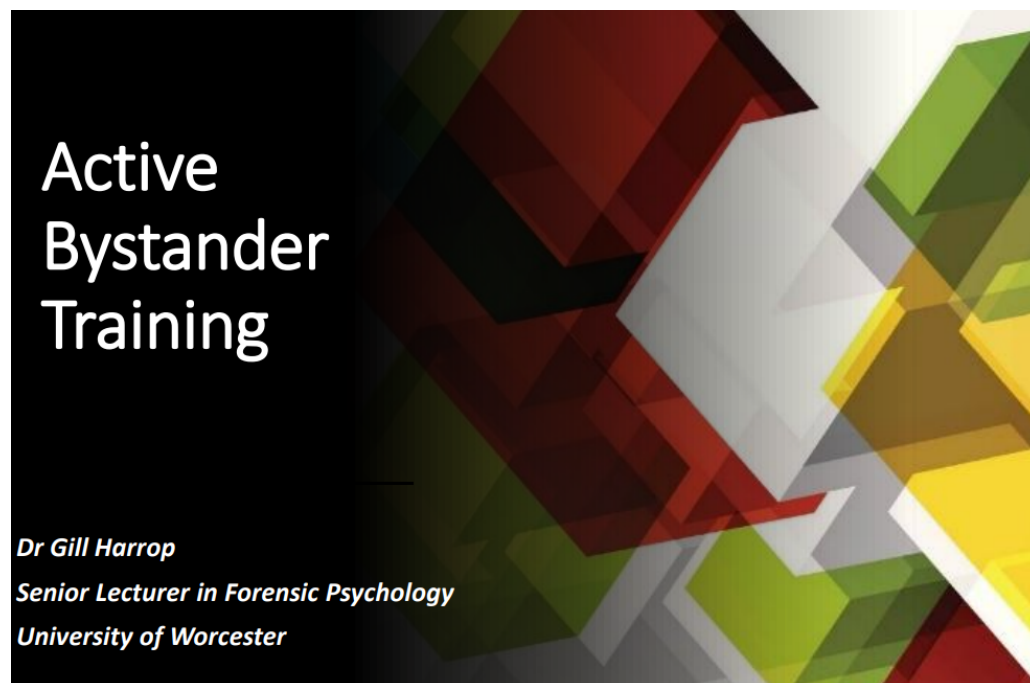
Once the disclosure has been documented, staff member to be reassured that a support is available and safety plan will be completed. Disclosure to be escalated to HR within 24 hours, who will arrange a meeting with a member of the safeguarding team Safeguarding Lead Nurse (PiPoT Lead) or Senior Named Nurse (Domestic Abuse Lead) within 48 hours.

A meeting will take place between victims line manager, HR and Safeguarding Team who will complete a risk assessment and safety plan for the victim. The safety plan will be shared with the victim. The victim maybe contacted by the Safeguarding team initially to gather further information required for safety planning, this will be completed in a supportive environment. The Safeguarding Team will provide the victim with external services that they can access for support. As part of safety planning the safeguarding team will ask the victim to nominate a senior member of staff who they would like to access for weekly check ins for the first six weeks. This will provide the victim with a safe space and they will receive updates regarding actions taken within the Trust.





Appendix C. Bystander training





TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	Designated Body Annual Board Report						
SPONSOR (EXECUTIVE DIRECTOR):	Matthew Revell, Chief Medical Officer and Responsible Officer						
AUTHOR:	Angharad MacGregor, Medical Directorate Manager Alison Newman, Revalidation Support Assistant						
DATE OF MEETING:	5 November 2025						
PURPOSE OF THE REPORT:							
TO PROVIDE ASSURANCE	<input type="checkbox"/>	FOR INFORMATION ONLY	<input type="checkbox"/>	TO CREATE DISCUSSION	<input type="checkbox"/>	TO SEEK APPROVAL	<input checked="" type="checkbox"/>
EXECUTIVE SUMMARY:							
The report is the annual submission for medical appraisal and revalidation for 2024/2025. The questions and format are mandated by NHS England.							
ASSURANCE PROVIDED BY THE REPORT:							
POSITIVE			GAPS IN ASSURANCE/RISKS TO ESCALATE				
Actions identified in the previous annual report were completed, new appraisers have been identified and trained and the Professional Practice Advisory Group has been strengthened in terms of membership, agenda, and reports.			There is a resource pressure within the Medical Directorate Team and a review of resources is required between the Medical Directorate, HR and Operations.				
REPORT RECOMMENDATION:							
The BOARD is asked to: Approve this report for submission to NHS England revalidation team							
KEY AREAS OF IMPACT <i>(Indicate with 'x' all those that apply):</i>							
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 <i>(Indicate with 'x' all those that apply):</i>							
Care	X	Community					
Expertise	X	Services			X		
People	X	Collaboration			X		
ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:							
Aligned to the performance metrics for annual appraisal							
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:							
N/A							
BENCHMARKING SOURCE <i>(Indicate data sources included in report IF APPLICABLE):</i>							
N/A							
PREVIOUS CONSIDERATION <i>(Indicate board/committee/group & date):</i>							
Staff Experience and OD Committee – October 2025							

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward.

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of: The Royal Orthopaedic NHS Hospital Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	No actions required
Comments:	Mr Matthew Revell, Medical Director is the Responsible Medical Officer and supported in this role by the Clinical Lead for Appraisals; Mr James McKenzie and the Medical Director's PA; Mrs Alison Newman.
Action for next year:	No actions required

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	No
Action from last year:	To compile a business case to support the creation of a post to support revalidation, appraisal and job planning.
Comments:	The business case was not developed to support the cost improvement initiatives. The current support for appraisals and revalidation equates to 1.5 days per week. Benchmarking suggests this is a low outlier position. The number of connected doctors has increased across the last 2 years and a review of resources to meet demand is now required.
Action for next year:	To review the resources required to support revalidation and also medical workforce functions.

1A(iii) An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	No action required
Comments:	Yes, our information is triangulated with the Trust's electronic appraisal system (currently PREP) , Electronic Staff Record and GMC Connect
Action for next year:	No action required

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	None
Comments:	Appropriate policies to support medical revalidation are in place and are reviewed by the Responsible Officer when required. The revalidation policy was reviewed in 2024.
Action for next year	No action required

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	Request peer review from similar sized Trusts
Comments:	There is currently a peer review underway between ourselves and Robert Jones and Agnes Hunt NHS Trust.
Action for next year:	Complete the peer review and implement actions from the findings.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	Further development of a locally employed doctors induction programme
Comments:	<p>Locum Consultants and Clinical Fellows are supported through a specialty structure by the Clinical Service Lead and Clinical Service Manager who supports their induction.</p> <p>Locally employed doctors have an identified academic tutor.</p> <p>Our Locally employed doctors and Locum ward doctors meet bi-weekly with a senior consultant to review issues/development needs.</p>
Action for next year	Create a checklist that can be followed for induction of all medical staff. Lead for locally employed doctors is currently out to advert with strong interest

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practise (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	No actions identified
Comments:	<p>The Annual appraisal covers a doctor's whole practice and doctors must include information from work undertaken outside the Trust, such as other NHS providers, private practice and voluntary roles.</p> <p>Appraisal documentation must include information regarding complaints and significant events and doctors need to provide data from national outcome registries where appropriate such as National Joint Registry data.</p>
Action for next year:	No actions identified

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	Formalise the escalation pathways and add to the revalidation policy.
Comments:	<p>The Appraisal Lead, Directorate Manager and Revalidation Support Assistant meet on a monthly basis to review appraisal figures and plan action for overdue appraisals, following the agreed escalation pathway.</p> <p>Escalation process is the Appraisal lead first informally, then progresses to formal communication and if that continues is escalated to the Medical Director who meets with the doctor to discuss the reason and the rectification.</p>
Action for next year:	This will be added to the policy when it is next reviewed.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	No actions identified
Comments:	There is an Appraisal and Revalidation Policy in place which was last reviewed in 2024.

Action for next year:	No actions identified
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1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	New appraisers are to be identified and trained in the next 12 months.
Comments:	New appraisers were identified and trained
Action for next year:	No additional actions required

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Yes
Action from last year:	Appraiser refresher training to be arranged for early 2025. Deliver annual presentation in the October Medical Audit and Governance meeting about appraisals and quality.
Comments:	The Appraisal lead delivered a presentation to the whole medical body about the quality of appraisals and how to get the best out of them. The appraisal lead review the quality of the appraisals via our digital platform (PReP). Refresher training was planned for August but due to availability was cancelled. The refresher training is now being arranged for 2025 to take place during our QIDD development day.
Action for next year:	Refresher training to be held in January 2026

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

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1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	No action identified
Comments:	The Medical Appraisal lead carries out an audit of appraisals via PREP and provides direct feedback to the appraisers.
Action for next year:	No action identified

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	No actions identified
Comments:	Recommendations to the GMC are made in a timely manner. No issues have been identified by the GMC Liaison Officer as part of quarterly meetings with the Trust.
Action for next year:	No action identified

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	No actions identified
Comments:	All revalidation recommendations made to the GMC, including reasons for deferral, are recorded by the Trust.
Action for next year:	No action identified

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	No action identified
Comments:	<p>Serious incidents, complaints, learning from deaths and key risks are discussed at the fortnightly Executive Triumvirate Governance meetings and monthly Executive Quality and Safety Meetings.</p> <p>There is a bimonthly Quality Improvement and Development Day where the content is learning from PSIRF investigations, M&M presentations and Clinical Audit presentations.</p> <p>Outcome and performance data is reviewed as part of the Model Hospital Club and AQILA (Audit, Quality Improvement, Learning and Analysis Group).</p>
Action for next year:	No action identified

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	The regional group; The Partnership Assurance Group was under review and the ROH will support the new iteration.
Comments:	<p>This group has been reformed and is now the Practitioner and Partnership Assurance Group (PPAG) and the ROH remains engaged.</p> <p>Appraisal packs are issued to doctors which include information regarding activity data, incidents and complaints.</p> <p>Conduct and performance is monitored via our internal Professional Practice Group meeting and the external Partnership Assurance Group (with other Trusts).</p>
Action for next year:	No action identified

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	No action identified
Comments:	Standardised appraisal information packs are provided to Trust doctors for any information that they cannot access themselves. Doctors are expected to provide individual and external information such as data.
Action for next year:	No actions identified

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	No identified actions
Comments:	The Trust applies the national MHPS Policy. A Professional Practice Advisory Group meeting now meets quarterly to advise the Responsible Officer. The Trust has a GMC Liaison advisor who we can discuss issues with. Plus, a contact within NHS Resolution (PPA) who supports us.
Action for next year:	No identified actions

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	No actions identified

Comments:	<p>The Professional Practice Advisory Group (PPAG) includes representation from Human Resources, meets quarterly by default and meetings added more frequently according to need.</p> <p>An upward report is submitted to the Executive Quality and Safety Group which is included in the upward report to the Quality and Safety Committee.</p>
Action for next year:	Additional fields required to the case tracking

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	No action identified
Comments:	<p>There is direct contact with Responsible Officers at other Providers to discuss concerns.</p> <p>Information is shared with NHS Trusts via MPIT forms when doctors move organisations or if there is an issue.</p>
Action for next year:	No action identified

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	No action identified
Comments:	<p>The Head of Human Resources and Business Partnering is a member of the Professional Practice Advisory Group. Doctors can raise issues via the Freedom to Speak up Process and Guardian of Safe Working</p>

	We have good industrial relations with BMA via Joint Local Negotiating Committee and in the context of case management
Action for next year:	No actions identified

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	No action identified
Comments:	<p>NICE Guidance and National Audit reports are reviewed as part of the AQILA meeting and recommendations discussed at the appropriate forum to consider incorporation into policies and processes.</p> <p>Dissemination of national reviews and reports is usually via our Quality Improvement Days and Clinical Newsletter.</p>
Action for next year:	No action identified

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	No actions identified
Comments:	<p>The ROH has recently introduced the 'Me as Manager' development programme. Consisting of a self-assessment and accompanying guidance to access support and training in identified topics following the self-review. This programme is for all managers from all professions.</p> <p>The Trust has supported a small number of people to apply for the 100 leader's programme, to support their development to achieve director level positions.</p> <p>The appraisal process for non-medical staff was reviewed last year, simplified and rolled out in a tight 4-month window. This increased the number of appraisals and improved the</p>

	appraisal scores within the staff survey. This year the priority has been focusing the quality of these appraisals.
Action for next year:	No action identified

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	No action identified
Comments:	<p>The Head of Human Resources has reviewed the medical staff recruitment process. The policy has been updated and accompanying SOP</p> <p>Pre-employment checks for locum staff are carried out by locum agencies which are part of the NHS Framework. Trust requirements for locum staff are overseen by a consultant lead.</p>
Action for next year:	No action identified

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	No action identified
Comments:	<p>Professional standards are central to learning from incidents. The PSIRF framework is used to review incidents.</p> <p>Learning from incidents is within the Clinical Audit and Divisional Governance meetings. In addition, the sharing of findings and improvements are discussed at the bimonthly Quality, Improvement and Development Days.</p>

Action for next year:	No action identified
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1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	No action identified
Comments:	<p>Compassion, fairness, respect, diversity and inclusivity are embedded within the Trust Values, which form the basis of the Trust strategy cascading into business plans and personal development plans.</p> <p>A central theme within the People Promise Workstream is the implementation of the Civility Saves Lives Initiative across the Trust with a focus on the medical staff.</p> <p>Staff Networks are active within the Trust to support inclusivity and diversity at all levels.</p>
Action for next year:	No action identified

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	No action identified
Comments:	<p>There is a named Non-Executive Director for Freedom to speak up.</p> <p>Freedom to Speak Up and Guardian of Safe Working roles are actively promoted within the Trust and regular update reports are submitted to the Trust Board.</p>
Action for next year:	No action identified

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	No action identified
Comments:	<p>Feedback is encouraged through HR, Freedom to Speak up and directly to the Medical Director.</p> <p>Feedback from BMA representative at JLNC</p> <p>The Trust's Medical Staffing Committee has been re-established and feeds into the JLNC</p> <p>Colleagues who wish to do so may use the grievance process in place</p>
Action for next year:	No action identified

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes
Action from last year:	<p>Given the Trusts small size the numbers for analysis are low. Review of recent suspensions indicates they have included both genders, a mix of ethnic backgrounds and different grades of doctor.</p> <p>Use of a monitoring proforma for cases discussed at the Professional Practice Advisory Group (PPAG) meeting Equality and diversity section added to PPAG agenda for HR to report onto.</p>
Comments:	A case tracker has been developed and is used for the PPAG cases.
Action for next year:	No action identified

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	No action identified
Comments:	<p>Responsible Officer attendance at Regional Higher Level RO Meetings.</p> <p>Attendance at MMC Partnership Assurance Group meeting led by UHB.</p> <p>Participation in GMC Responsible Officer Reference Events.</p>
Action for next year:	No action required

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	126
Total number of appraisals completed	103
Total number of appraisals approved missed <ul style="list-style-type: none"> • Sabbatical x1 • Appraisal not completed in previous overseas post x 9 • Sickness/personal x2 • New starter, needed more time x1 • Overseas Doctor, offered appraisal but declined as not required in their home country x1 	14
Total number of unapproved missed <ul style="list-style-type: none"> • Fellow – left without undertaking their appraisal x 2 • Missed appraisal which is now booked x1 • Appraisal was late and fell outside the 12-month window x6 	9
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	46
Total number of late recommendations	0
Total number of positive recommendations	30
Total number of deferrals made <ul style="list-style-type: none"> • Appraisal activity • Patient and colleague feedback 	16
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	5
Total number of trained case managers	3

Total number of concerns received by the Responsible Officer ²	7
Total number of concerns processes completed	2
Longest duration of concerns process of those open on 31 March (working days)	6 months
Median duration of concerns processes closed (working days) ³	35 days
Total number of doctors excluded/suspended during the period	2
Total number of doctors referred to GMC	1
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	NA
Total number of new doctors joining the organisation	39
Total number of new employment checks completed before commencement of employment	36
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld ⁴	NA

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report

- The Peer review with Robert Jones and Agnus Hunt has started, our clinical lead for appraisal has been to RJAH, and the medical directorate team at ROH has had online meetings with the equivalent personnel at RJAH. The return visit date is currently being scoped.

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

- New appraisers have started which has been welcomed. A presentation was delivered to all the doctors about the importance of appraisals and how to get the most of appraisals by the clinical lead for appraisals.
- Our internal PPAG meeting has been held more frequently to support the processing of concerns

Actions still outstanding

- Complete the peer review and report findings into SE&OD committee
- Additional resource to support medical revalidation and appraisal
- Refresher appraiser training – currently proposed for January 2026 QIDD

Current issues

The number of prescribed connections has increased over the last few years from 108 to 126. This includes our new posts of junior research fellows; these roles were previously locums that have been converted into Locally Employed Doctors and consequently require appraisals from the ROH.

The software for medical appraisals has reached the end of its license and following a review it was agreed to move to the system that our doctors use already for job planning. This software has a stronger reporting module to support the oversight of appraisals.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

- To review the resources required to support medical workforce tasks between the Medical Directorate, Operations team and Human Resources, to consider the potential for a role to be developed across these portfolios.
- Complete the peer review and implement actions from the findings.
- Create a checklist that can be followed for induction of all medical staff
- Refresher training to be held in January 2026
- Additional fields required to the case tracking spreadsheet

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

The ROH has delivered the appraisal and revalidation portfolio within 2024/25 and is currently working towards improvements to enhance the quality of the internal processes to maintain effectiveness.

The software to support medical appraisal is changing in January 2026 and this should enable easier reporting.

The Peer review is RJAH is underway and both organisations are learning a lot from each other. Once the review is concluded a report will be presented to SE&OD.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	The Royal Orthopaedic Hospital NHS Foundation Trust
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Name:	Mr Matthew Hartland
Role:	Chief Executive Officer
Signed:	
Date:	

Name of the person completing this form:	Mr Matthew Revell Chief Medical Officer and Responsible Officer
Email address:	Matthew.revell@nhs.net



UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board met: 28th October 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
<ul style="list-style-type: none"> • EPR programme: Preferred supplier confirmed and FBC in development, with challenging timescales to complete by February and draw down funding. Delegated authority will be requested for November F&P approval of FBC. NHS England will conduct a parallel assessment prior to Board sign-off. Major transformation project with significant delivery and resource risk. • Financial performance: £17k deficit in-month against a £47k planned surplus, maintaining a small favourable YTD variance (£668k deficit vs plan). 38% of CIPs delivered in H1; £230k monthly improvement required to meet year-end target. • Income risk: Case-mix variance driving lower-than-expected value despite activity delivery. Diagnostic income remains an issue, discussions ongoing on recovery options. • Private Patient income achieving original plan but not stretch plan; focus now on pricing review and marketing to deliver stretch target. • Cash position: Still challenging, though pressure eased by lower spend and delayed capital. • Sickness absence: Currently 4.7% vs target 4.1%. Mental health-related absence remains a key focus area. • Block contract reforms: Move towards volume-based commissioning presents potential risk to income stability for specialist services. The inclusion of the Black Country system may add further allocation pressure. Risk to be added to risk register. 	<ul style="list-style-type: none"> • Deep dive review on non-clinical cancellations, including analysis of theatre capacity, patient DNAs, and equipment reliability. • 23-hour stay ward pilot completed successfully; findings to inform new BADS delivery programme. • Workshop in November to accelerate RTT improvement in spinal specialties, exploring innovative follow-up approaches. • Theatre utilisation improvement plan underway (currently 86.2%); actions to reduce early finishes and maximise productivity through improved standby processes. • Continued monitoring of corporate and clinical service reviews, to be aligned with the new 3-year business planning framework. Phase 1 of corporate reviews approved by executive team.
POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
	<ul style="list-style-type: none"> • There were no decisions made by the Committee.



- **Operational delivery:** The Trust delivered its activity plan for the month and remains ahead overall. Diagnostic performance is above target, and outpatient DNAs have reduced to 6.2%, supporting better clinic utilisation.
- **PIFU and patient flow:** The Trust continues to perform among the best nationally for PIFU, and the successful 23-hour ward pilot has provided a strong foundation for the wider BADS improvement programme.
- **Productivity:** Theatre utilisation has improved to 86.2%, with further actions in place to reduce early finishes and strengthen standby arrangements to offset late cancellations.
- **Financial management:** Despite a small in-month deficit of £17k against a £47k planned surplus, the position remains ahead of plan at the end of H1 supporting the Trust's oversight rating. Pay remains stable, agency spend continues to fall, and the Trust maintains one of the strongest financial positions in the system.
- **DSPT Toolkit:** The Trust achieved a Standards Met compliance with the DSPT Toolkit for the first time, confirming strong cyber and data protection arrangements and positive external assurance.
- **Les Williams** was thanked for his dedication, challenge and support over the years he has been working with the Trust and been chair of the committee. **Sharon Thompson** was welcomed as the incoming Chair.

Chair's comments on the effectiveness of the meeting: The meeting was felt to have been effective, and gave good consideration to the matters presented.



UPWARD REPORT FROM THE STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 22 October 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- The Sickness Absence Audit report was presented. The outcome was partial assurance with some key actions required to support managers in applying the policy and further detail about management of long term absences.
- Short term absences were up within month due to seasonal sickness.
- Mandatory training compliance remains a risk however it is anticipated that the launch of the LMS will make training more accessible and achievable.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- The National Staff Survey is now live until 28th November. Response rates are lagging compared to previous years which is reflective of the climate externally too.
- Nursing managers are currently reviewing and updating Nursing Job Descriptions against the National Profiles, this is expected to be completed by the end of March 26.
- Final recommendations are being reconciled for the Phase 1 of the Service Reviews for Corporate areas.
- A deep dive is being undertaken to understand mental health related absences further alongside additional work about the uptake and impact of special leave within the Trust E & OD

POSITIVE ASSURANCES TO PROVIDE

- The Committee welcomed the Facilities Officer to the meeting who provided an insightful account of his career experiences and how this has helped him to develop his team at the ROH.
- The Executive team have been visiting areas with the Wellbeing Trolley and taking the opportunity to promote the importance of completing the staff survey.
- The Anti-Racism Pledge has been launched this month, and engagement has been good.
- The Black History Month event was well attended throughout the day, with a variety of speakers attending.
- Apprenticeship Activity is at 33 with a target of 34 for this year.
- The Resident Doctors 10-point plan was presented which provided positive assurance on the actions being taken locally to meet with national ask around improving doctors working lives.
- Positive assurance received with regards to embedding the actions related to the sexual safety charter.

DECISIONS MADE

- The Committee reviewed and agreed to publish the WRES and WDES action plans by the 31st October 2025 subject to inclusion of completion dates for key actions.
- A review of workforce risks and accompanying scores to be presented at the next SE&OD meeting in December.
- Strengthen the narrative within the risk register to ensure that it fully captures key risks around high levels of absence within the Trust.
- Undertake an interim review of the Trusts wellbeing plan ensuring that it meets key targets around prevention of absence and supporting people to stay well at work.
- Ensure that there is a proactive comms plan to support dissemination of the 2025 staff survey results across the Trust.



Chair's comments on the effectiveness of the meeting: The meeting was seen as positive with good pace. The Committee noted it was good to have the staff story in the middle of the meeting as members were more receptive. It was suggested that staff story moves to the middle of the meeting moving forward.



UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 17th October 2025

<p style="text-align: center;">MATTERS OF CONCERN OR KEY RISKS TO ESCALATE</p> <ul style="list-style-type: none">• Absence management: Internal audit found that while the policy framework and HR support are sound, local application is inconsistent. An action plan is in place led by the Chief People Officer, with updates to return to Committee and F&P early in 2026.• Counter fraud: One case remains with the CPS from last year. The Committee noted the need to formalise a Fraud Prevention Action Plan and publish a fraud statement on the Trust website.• VAT (COS 45): The Committee discussed HMRC's consultation on VAT relief for managed contracts, which could have implications for the GenMed arrangement.	<p style="text-align: center;">MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY</p> <ul style="list-style-type: none">• Internal Audit continuing reviews on Controlled Drugs and Cancellations, with findings due at the January meeting.• AI and Digital Governance: A focused discussion on artificial intelligence to be scheduled at a future meeting, building on KPMG's national insights into the risks and opportunities.• Revised Counter Fraud Action Plan to be developed between KPMG and the CFO for January 2026.• Work underway to improve invoicing processes in catering and podiatry to support compliance and enable better call-off ordering.• Progress continuing on SLA with UHB, with final agreement expected before the next meeting.
<p style="text-align: center;">POSITIVE ASSURANCES TO PROVIDE</p> <ul style="list-style-type: none">• Internal Audit: Reports on GenMed contract management and absence management both provided significant assurance. The GenMed review highlighted strong practice in on-site support and reporting, with further improvements identified around KPIs and monitoring. Forecast savings of £2m compared to last year demonstrate the impact of stronger procurement and contract controls.• Management engagement: The internal audit tracker shows 90% of actions implemented or near completion, with continued strong engagement across teams.• Financial control: Procurement oversight remains robust, and controls around single-tender waivers and contract extensions are being refined.• Counter Fraud: Three new referrals closed this year and good engagement with awareness initiatives. Fraud Awareness Month activities planned for November will support a continued culture of vigilance.	<p style="text-align: center;">DECISIONS MADE</p> <ul style="list-style-type: none">• There were no decisions made by the Committee.



- External Audit: Deloitte confirmed completion of the NAO file review and reported early planning underway for the 2025/26 audit. Preparatory work on EPR-related accounting treatment has begun.
- Governance and assurance: Updated Board Assurance Framework reviewed, and the Trust achieved “standards met” status on the DSPT for the first time, marking a notable improvement in cyber and data protection compliance.
- The Committee received the breaches and waivers report, and assurance was provided on the action being taken to address any issues.

Chair’s comments on the effectiveness of the meeting: The meeting maintained good pace and covered a broad range of assurance areas. Discussion was constructive, particularly around the internal audit findings and fraud prevention agenda, with clear actions agreed to strengthen oversight and follow-up.



Finance and Performance Report

Month 6

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 exception if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

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

Variation Icons

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



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



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



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

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

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

Assurance Icons

Can we expect to reliably hit the target?



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



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



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



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



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

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



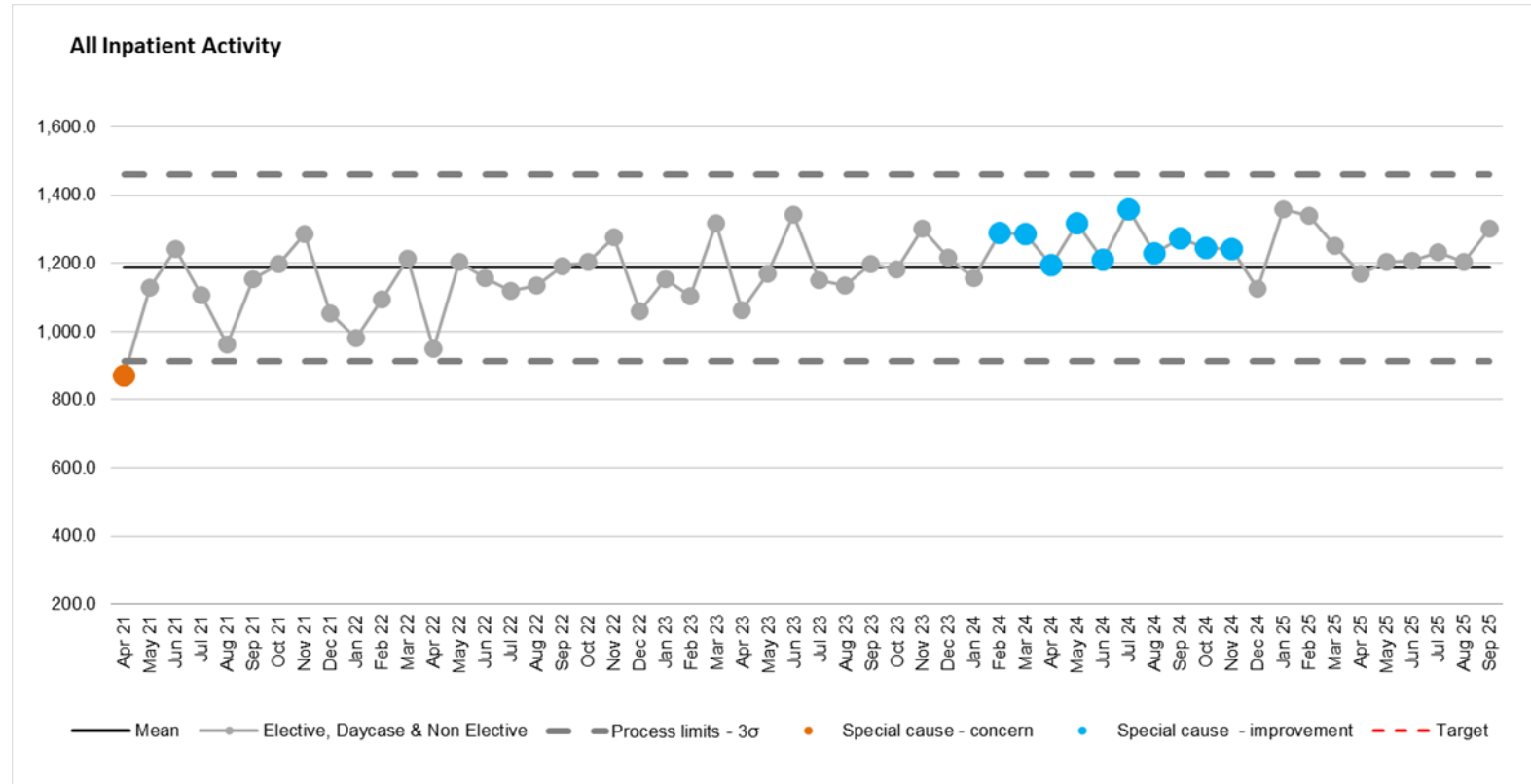
Operational Performance Summary

Performance to end September 25	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	62.32%	61.47%	58.37%		
65 Week waits (65-77 weeks)	0	0	0		
52 week waits (52 – 64 Weeks)	375	427	397		
RTT Proportion of Patients Waiting 52 weeks	2.81%	3.18%	2.98%		
RTT First Appointment Waiting List	66.54%	64.55%	64.80%		
RTT Waiting List Size	13,351	13,447	13,304		
All activity YTD (compared to plan)	7,318	6,017	7,238		
Outpatient activity YTD (compared to plan)	36,871 102.9% Cumulative	30,213 102.2% Cumulative	35,817 YTD Target		
Outpatient Did Not Attend (YTD)	6.2%	7.1%	8%		
PIFU (trajectory to 5% target)	720 11.37%	584 11%	563 5%		
Virtual Consultations (target is plan, operational planning guidance is 25%)	8.8%	10.4%	19%		
Diagnostics volume YTD (compared to plan)	13,293 Cumulative	11,042 Cumulative	12,707 YTD Target		
Diagnostics 6 week target	99.8%	99.8%	95%		

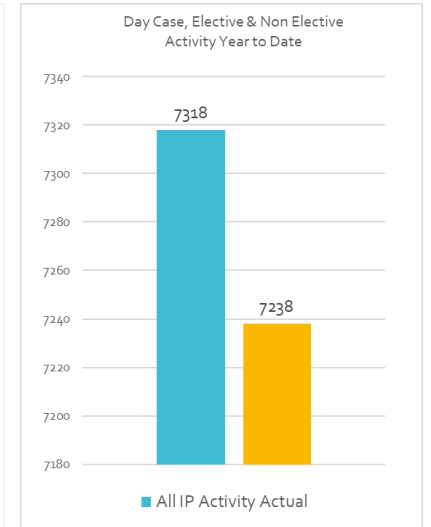
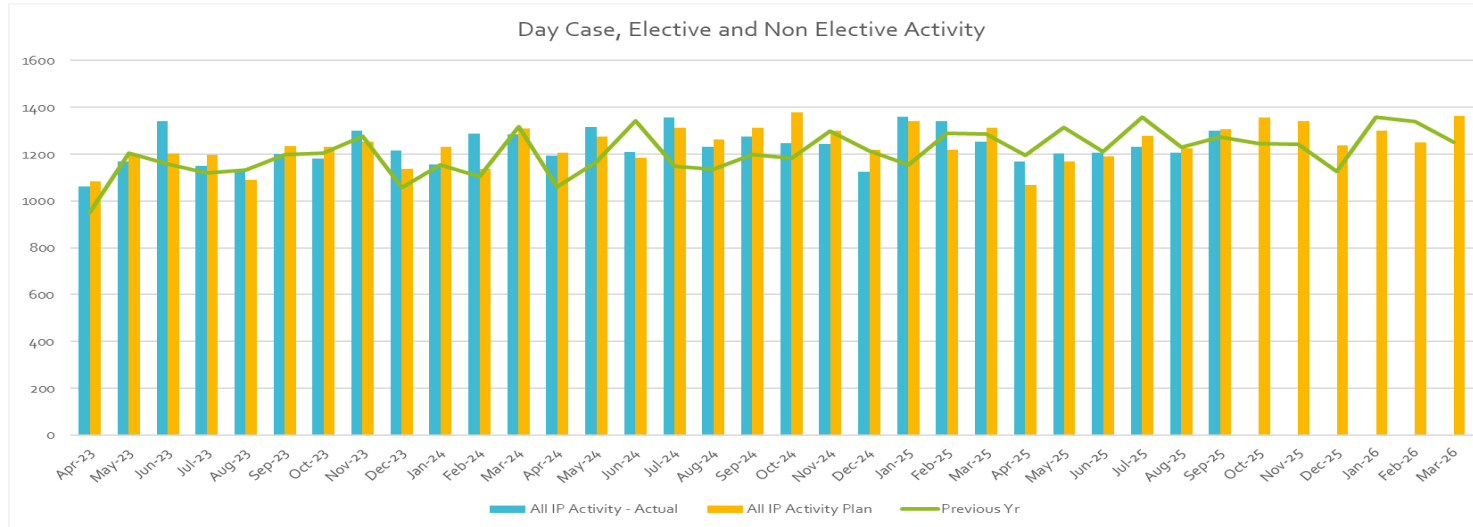
Operational Performance Summary

Performance to end September 25	In month	Previous month	Target	Variation	Assurance
Theatre Session Utilisation	87.9%	84.2%	85%		
Theatre In Session Utilisation	83.6%	85.4%	85%		
Cancer - 31 day first treatment	100%	100%	96%		
Cancer - 62 day (traditional)	77.6%	84.2%	70% Nat 85% Trust		
28 day FDS	77.4%	80.3%	75%		
Patients over 104 days (62 day standard)	0	0	0		
POAC activity volume (YTD)	11,904 Cumulative	9,859 Cumulative	11,335 Cumulative		
Bed Occupancy (excluding CYP and HDU)	69.01%	76.9%	82-85%		
LOS - excluding Oncology, Paeds, YAH, Spinal	3.03	3.74	n/a		
LOS - elective primary hip	2.9	2.7	2.7		
LOS - elective primary knee	2.6	2.7	2.7		
BADS Orthopaedic: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period) June 25	56.3%	53.60%	85%		
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Mar 25)	35.6%	37.5%	-N/A		

1. Activity Summary



1. Activity Summary



		Plan											
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
Trust Plan	Inpatient	434	488	492	525	523	553	557	563	513	540	520	567
	Daycase	615	659	676	731	680	731	777	758	702	739	708	775
	NEL	19	22	22	22	22	23	23	22	23	22	21	23
	All Activity	1068	1169	1190	1278	1225	1308	1357	1342	1238	1300	1249	1365

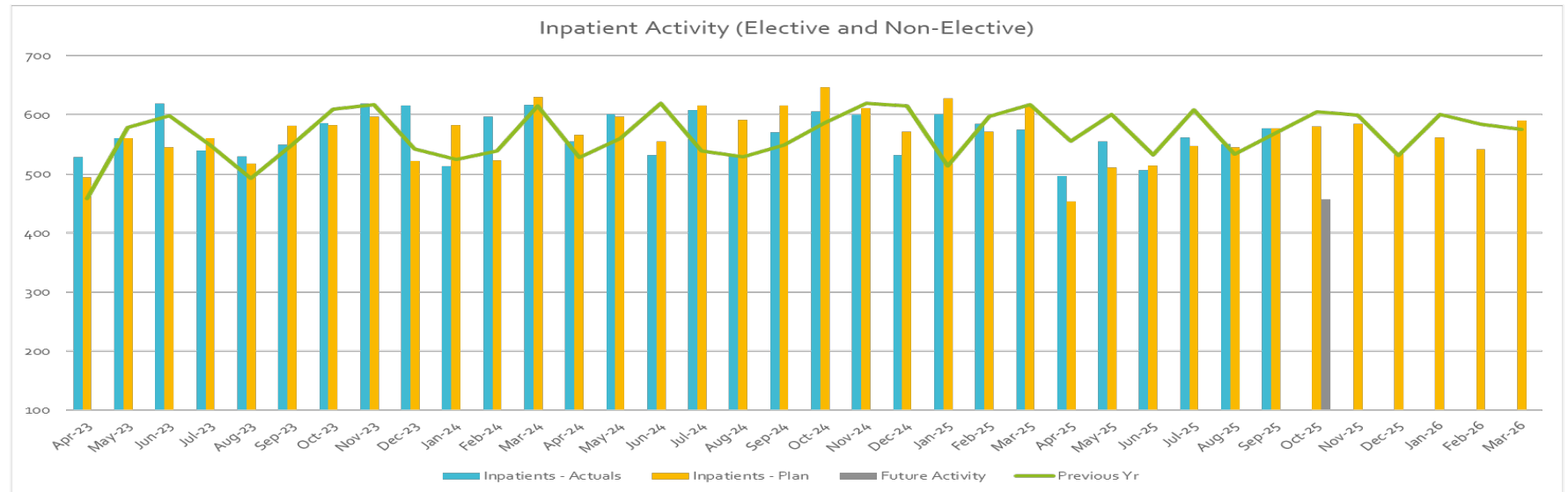
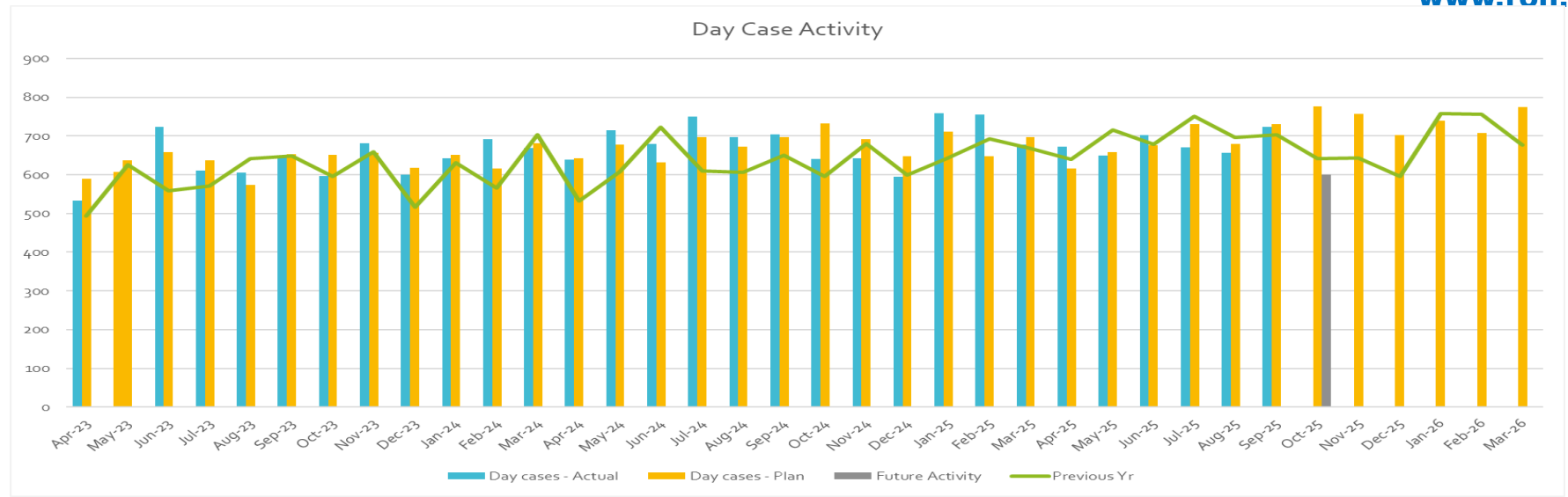
Plan	Actual	% Achieved	Variance
Year to Date	Year to Date	against plan	Year to Date
3015	3133	104%	118
4092	4073	100%	-19
131	112	86%	-19
7238	7318	101%	80

September 2025

Inpatient activity reached 1,301 cases, falling 7 cases short of the monthly target of 1,301 (-0.5%).

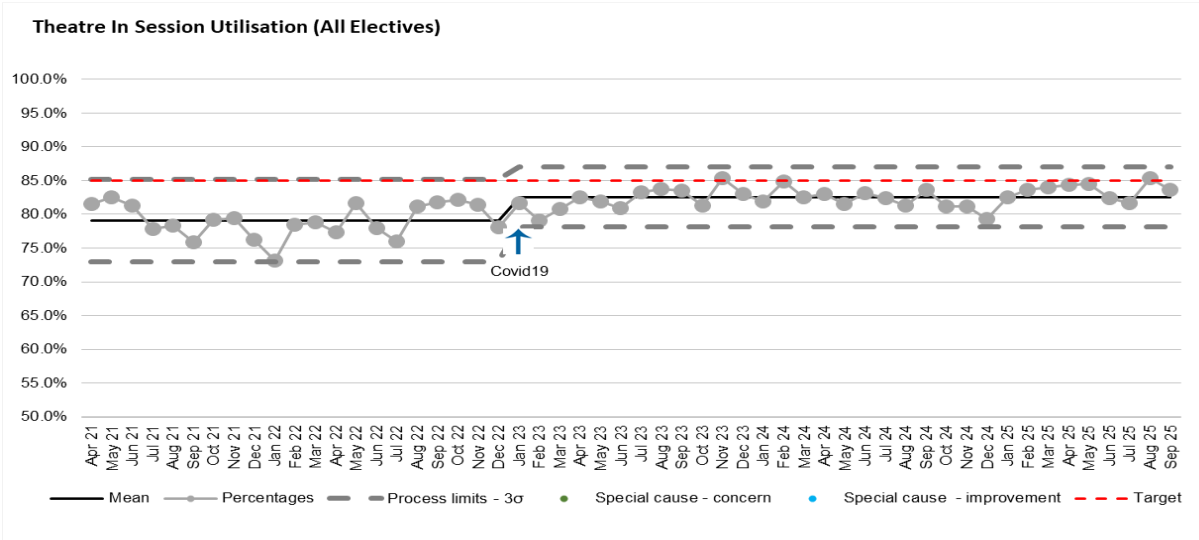
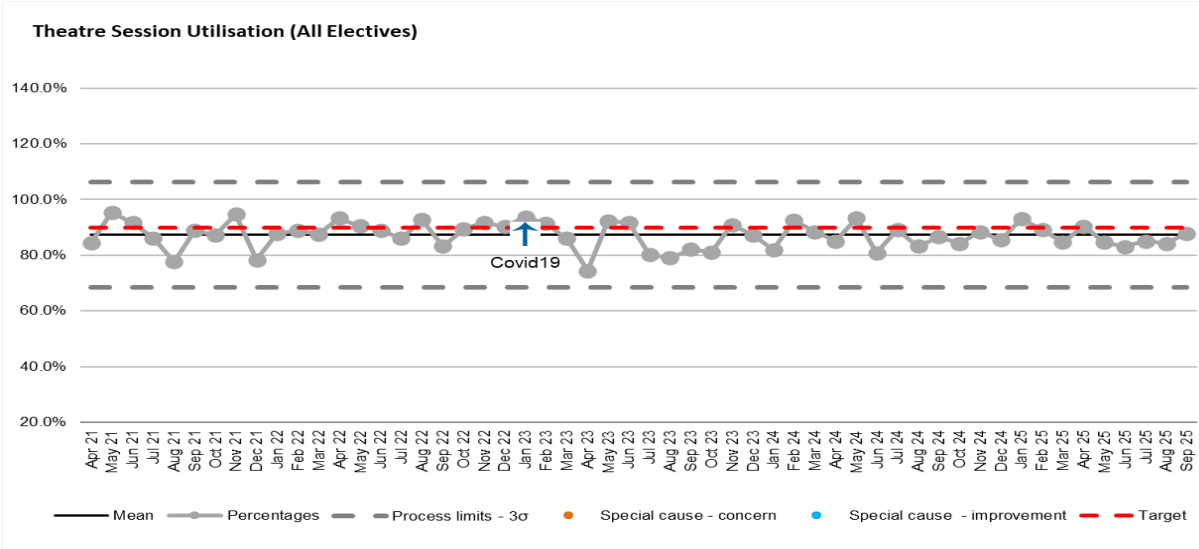
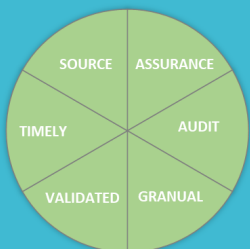
Year-to-date, the Trust remains ahead of plan by 80 cases (1%), with 7,318 cases delivered against a target of 7,238.

1. Activity Summary



2. Theatre Utilisation

DATA QUALITY KITEMARK

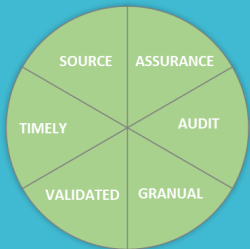


Elective Session Utilisation (September 2025)				
Trust	Planned Sessions	Utilised Sessions	Unused Sessions	% Utilisation
ROH	552	484	68	87.68%
UHB	24	22	2	91.67%
Totals	576	506	70	87.85%

Elective In Session Utilisation (September 2025)				
Trust	Planned Hours	Utilised Hours	Unused Hours	% In Session Utilisation
ROH	2085	1745	340	83.70%
UHB	97	79	18	81.82%
Totals	2182	1825	358	83.61%

2. Theatre Utilisation

DATA QUALITY KITEMARK



SUMMARY

Overall theatre session utilisation for September 25 was 87.85% with an overall in-session utilisation of 83.61%. The uncapped utilisation is based on the theatres that were physically available to the teams. Model Hospital data now focusses on capped theatre utilisation as the overall metric. Please review the next slide for the latest Model Hospital performance data.

AREAS FOR IMPROVEMENT

During September 25, the team continued to drive elective activity with an increase in the number of procedures completed within the Theatre environment (across all specialities). The team recorded the highest number of cases through theatres during this financial year.

The team continue to provide peer challenge at scheduling meetings to ensure that theatres are booked up to 100% (540 minutes – standard all day list).

Currently the department is adapting a standardised framework for standby patients to support backfilling short notice cancellations that in turn become late list additions. A stakeholder group has been formed, and it is agreed that this framework will improve list utilisation, whilst maintaining safety in line with GIRFT and NHS Impact recommendations.

The team is continuing to modify theatre scheduling in line with NHS Impact guidance, identifying potential issues earlier on in the process avoiding cancellations. A live action log is in place to ensure that issues are resolved or escalated in a timely manner. This is having a positive effect on list fulfilment with input from both operational and clinical colleagues.

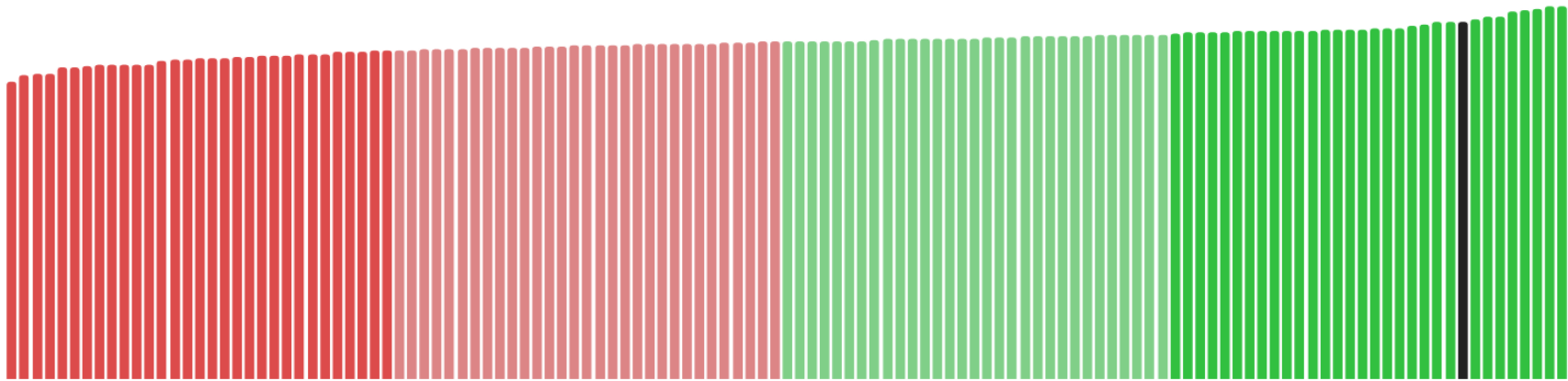
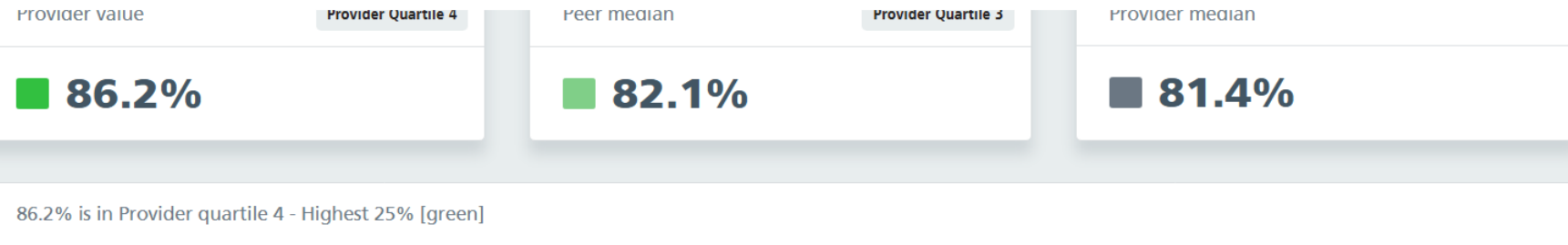
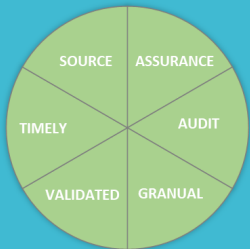
The team are currently creating an automatic send and hold SOP for all ward-based patients that are 1st on the list. All ward-based patients undergoing surgery the following day will automatically be transferred into the recovery unit at 08:15am which will act as a holding bay. As soon as the theatre is set up and the team have confirmed that they are ready for the patient, the patient will be called for from the holding bay that is in a closer proximity to the actual theatre. Trials have resulted in cases starting earlier by an average of 25 minutes in comparison to patients waiting on the wards.

RISKS / ISSUES

Sickness absence within the theatre and Anaesthetic workforce has increased throughout September due to winter viruses circulating earlier in autumn this year. This has resulted in an impact on the workforce skill mix and this will be monitored closely throughout the winter period.

2. Theatre Utilisation Model Hospital

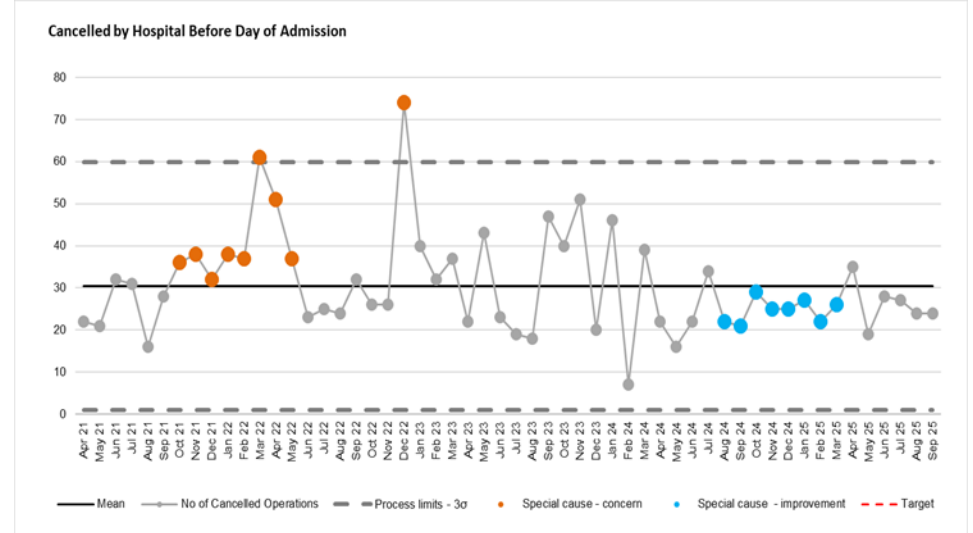
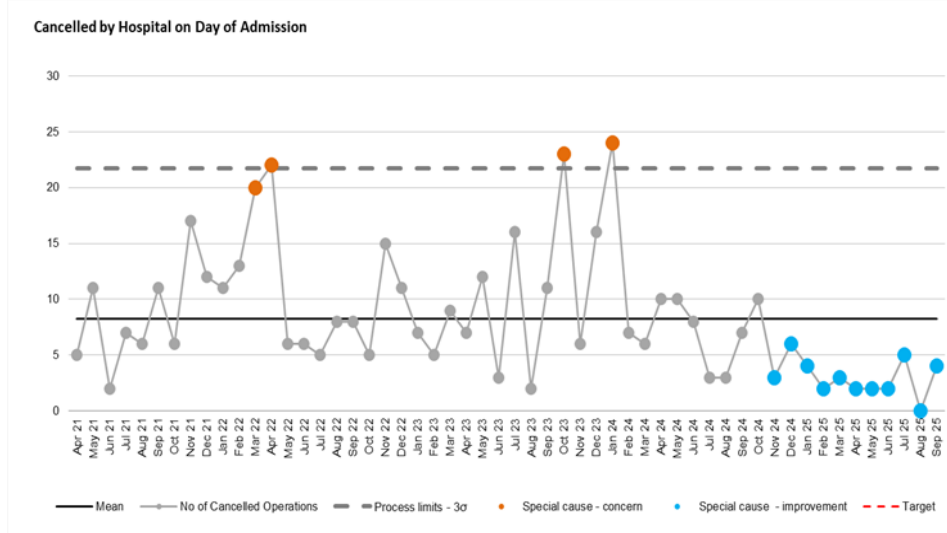
DATA QUALITY KITEMARK



SUMMARY - Full month August 25 - Model Hospital Data - 1 month behind.

The overall performance for elective capped theatre utilisation for the month of August 25 was 86.2%. The Trust ended the month in the top quartile and number 9 nationally. This performance demonstrates the teams ongoing commitment to continuously improve and maximise the funded capacity available.

2. Theatre Utilisation/ Hospital Led Cancellations



Year - Month	Cancelled by Hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by Hosp. Before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
Sep-24	7	23	21	51	0
Oct-24	10	39	29	78	0
Nov-24	3	28	25	56	0
Dec-24	6	35	25	66	0
Jan-25	4	44	27	75	0
Feb-25	2	36	22	60	0
Mar-25	3	24	26	53	0
Apr-25	2	28	35	65	0
May-25	2	36	19	57	0
Jun-25	2	24	28	54	1
Jul-25	5	38	27	70	0
Aug-25	0	24	24	48	0
Sep-25	4	34	24	62	1

2. Theatre Utilisation/ Hospital Led Cancellations

SUMMARY

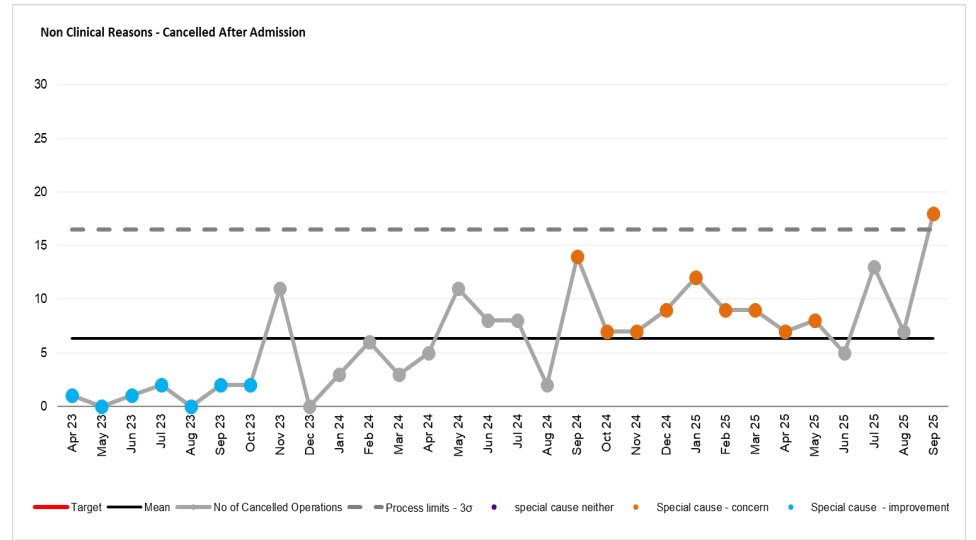
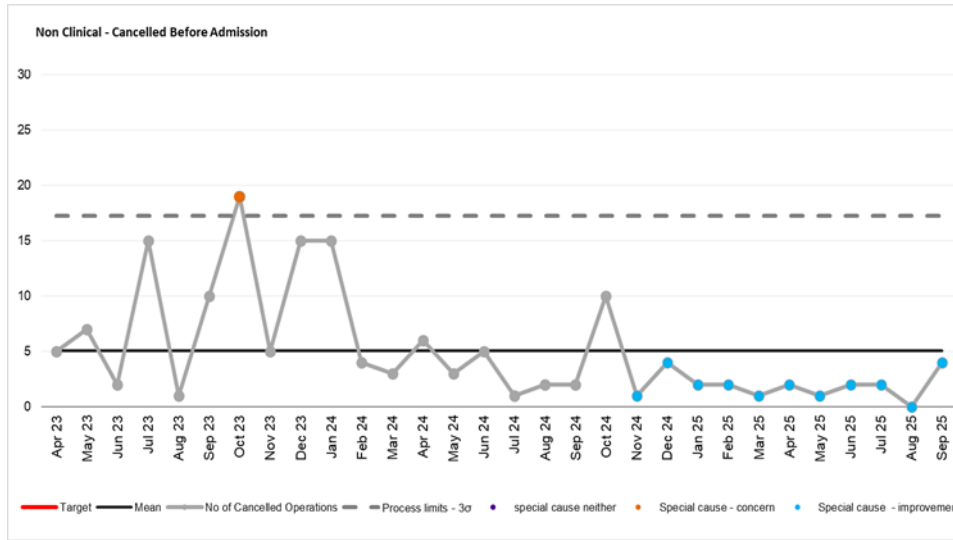
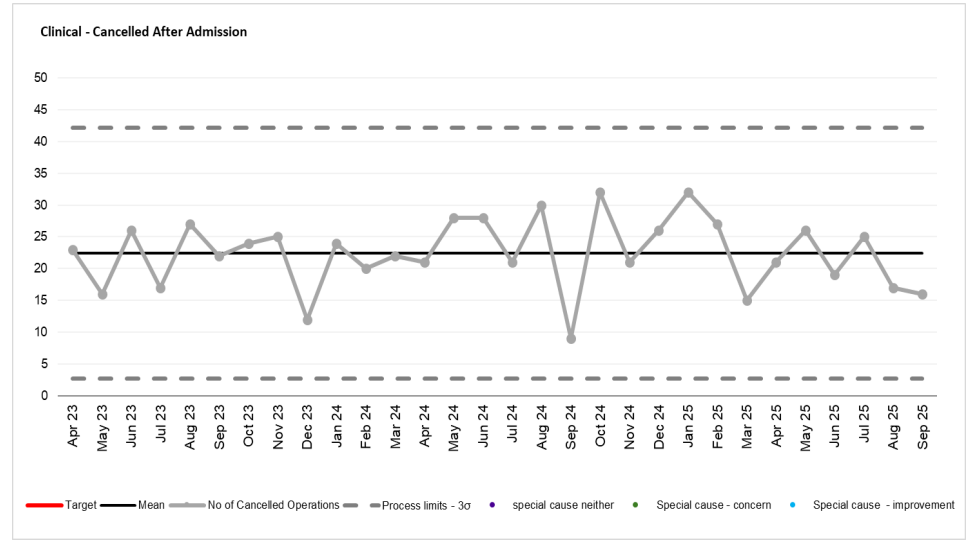
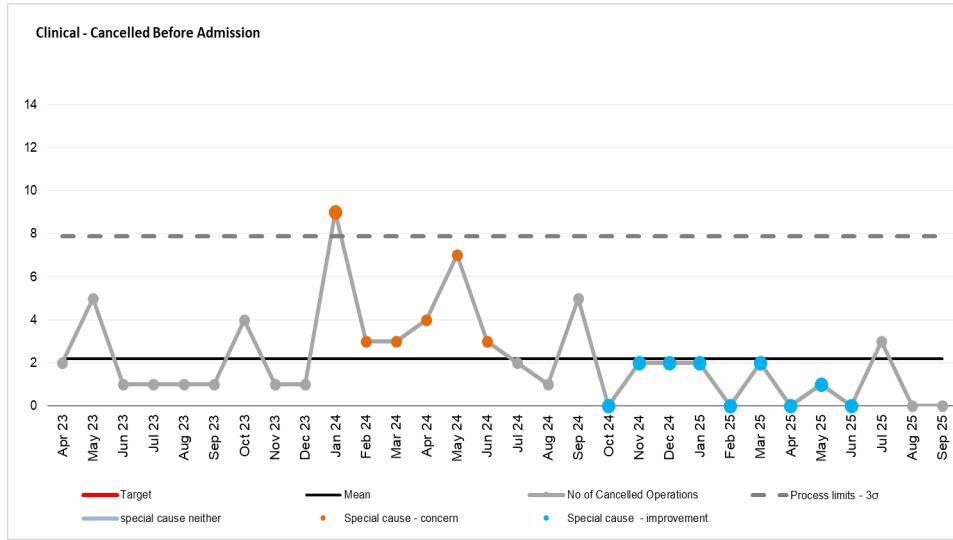
The number of cancellations / deferrals detailed on the previous slide do not include patients who were either emergency or urgent cases. These cases are more difficult to avoid due to very short notice bookings. The table below provides details of the cancellations for September 2025:

Patients not formally admitted and cancelled on the day x 4	Cancelled on the day - Admitted treatment deferred x 34	Patients cancelled by the hospital the day before the date of admission x 24
<p>Clinical Cancellation: 0</p> <p>Non-Clinical Cancellation: 4 2 x Patient self-cancelled 1 x lack of theatre time due to complexity of previous case – (this was a standby patient) 1 x Surgeon/Anaesthetist/Theatre staff unavailable</p>	<p>Clinical: 16 14 x Medically unfit 1 x Skin integrity - insect bites/dog bites/ulcer 1 x Procedure no longer required/change in clinical plan/abandoned</p> <p>Non-Clinical: 18 2 x lack of specialist equipment due to decontamination issues on the day. 7 x lack of theatre time due to complexity of previous case 6 x Patient self-cancelled/declined procedure/change in plan 3 x Replaced by more urgent case</p>	<p>Clinical Cancellation: 9 6 x Medically unfit/further tests required 1 x Procedure no longer required/change in clinical plan 2 x Skin integrity - insect bites/dog bites/ulcer</p> <p>Non-Clinical Cancellation: 15 1 x Change in TCI date 2 x Patient self-cancelled/declined procedure/change in plan 7 x Replaced by more urgent case 3 x patient returned from a long-haul flight 2 x lack of specialist equipment</p>

AREAS FOR IMPROVEMENT/ RISKS/ ISSUES

Please refer to the next slide for SPC charts providing a historic view of cancellations for non-clinical reasons. The next slide also provides themes and a high-level action plan.

2. Theatre Utilisation/ Hospital Led Cancellations



2. Theatre Utilisation/ Hospital Led Cancellations

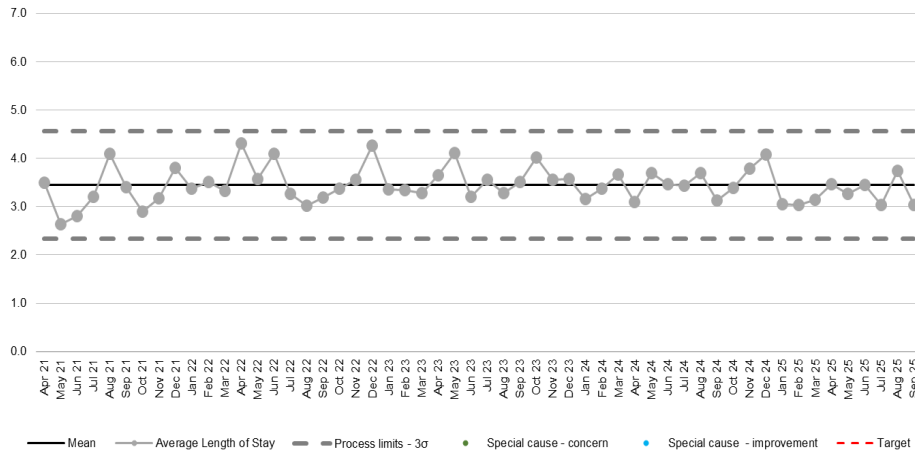
The SPC charts on the previous slide have been split into 2 main categories, 'clinical' and 'non-clinical' and sub-categorised into 'cancelled before admission' and 'cancelled after admission' to help demonstrate areas of focus to support a reduction in the number of cancellations on the day.

The key reasons for patient cancellations post admission are highlighted below, with actions in place to reduce cancellations.

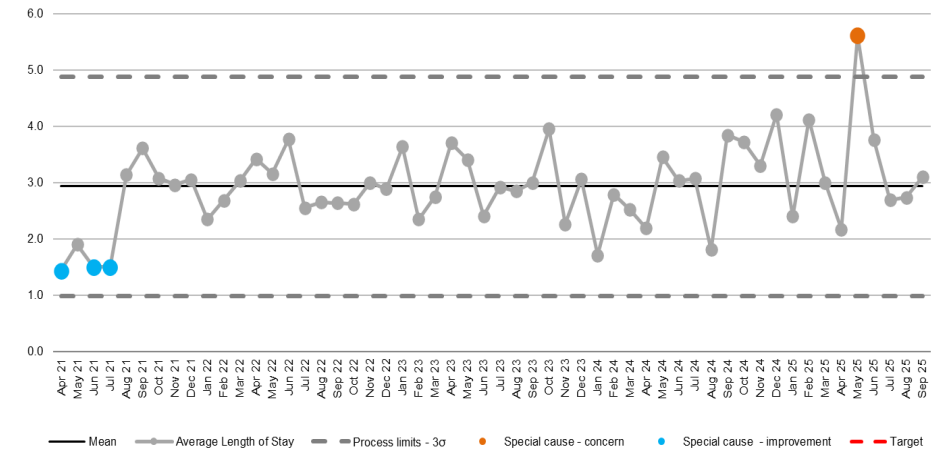
Theme – Admitted/Deferred	Action	Timescales
<ul style="list-style-type: none"> Lack of theatre time 	Planned v's actual data used to support peer challenge at theatre scheduling meetings to ensure the theatre lists more accurately reflect the likely procedure times based on learnt procedure times. As a result of this, Improvements have been made in early finish times.	Weekly monitoring at Theatre Scheduling meetings
<ul style="list-style-type: none"> Patient DNA'd/chose not to proceed – (The patients were contacted 72 hours before the procedure to confirm that they are still happy to proceed and attend as planned). 	Health inequality data is being obtained and analysed to understand if this relates to a specific patient group(s)	Q4
<ul style="list-style-type: none"> Lack of equipment/specialist equipment/holes in trays 	A daily huddle takes place to ensure availability of equipment and implants for the next day. Any issues that arise are managed by logistics and Gen Med	Themes collated and reviewed with associated action plans as a part of the theatre lookback process.
<ul style="list-style-type: none"> Staff availability 	Regular review of staffing numbers/skill mix, led by Theatre Matron and Head of Nursing	Ongoing monitoring

3. Length of Stay

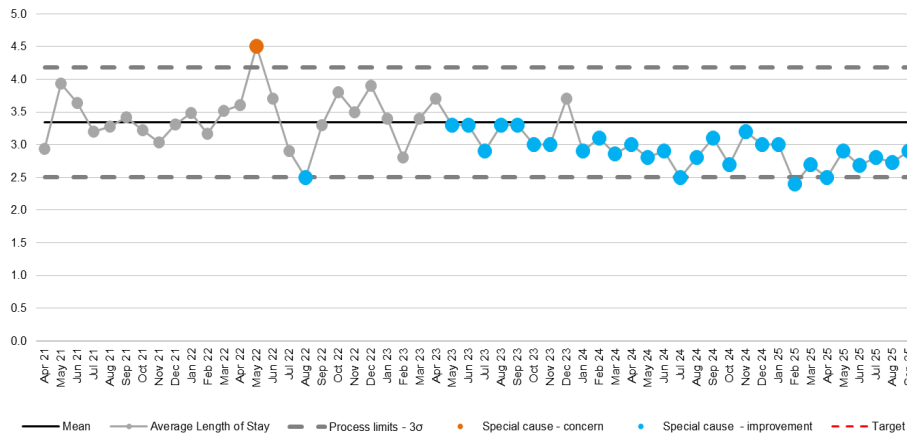
ROH Elective Average Length of Stay - Excluding Oncology, Paeds, YAH and Spinal



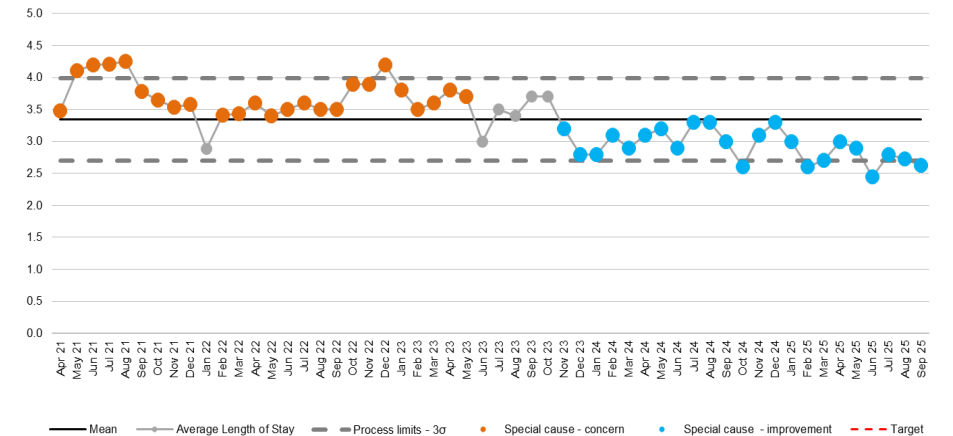
UHB Elective Average Length of Stay



Primary Hip Elective Average Length of Stay



Primary Knee Elective Average Length of Stay



3. Length of Stay

SUMMARY

The average length of stay for ROH primary hips has increased to 2.9 days (2.7 days August 25) and primary knees has decreased to 2.6 days (2.7 days August 25). The average length of stay for ROH patients excluding Oncology, Young Adult Hip and Spinal has decreased to **3.03 days** (3.74 days August 25).

A review of the ROH data for arthroplasty and oncology arthroplasty primary hips and knees identifies the number of patients with LOS \geq 5 days as 28 (17 August) 8 Oncology Arthroplasty (2 August) , 20 arthroplasty (15 August); 1 had an ASA score of 1 (normal healthy patient) 25 had an ASA score of 2 (mild systemic disease); 2 had an ASA score of 3 (a patient with severe systemic disease);

LOS \geq 8 days as 4 (10 Aug), 0 Oncology arthroplasty and 4 arthroplasty . 1 had an ASA score of 1 (normal healthy patient), 3 had an ASA score of 2 (mild systemic disease). On review of clinical noting for patients with LOS \geq 8 days some were complex joint replacements, all had on going clinical or social needs including for example post op delirium and Rehab.,

A review of all arthroplasty and oncology arthroplasty patients, identifies the number of patients with LOS \geq to 8 days as 27 (33 Aug).10 were Oncology Arthroplasty, and 17 were Arthroplasty. This data included revisions, EPRs and other more complex surgeries.

Review of the 7 long stay patients with LOS $>$ 15 days, 2 were Arthroplasty and 6 Oncology arthroplasty.

Longest stay 36 days (58 Aug), was an Oncology arthroplasty patient.. Complex prosthetic replacement of knee joint under the bone infection service.

AREAS FOR IMPROVEMENT / ACTION PLAN

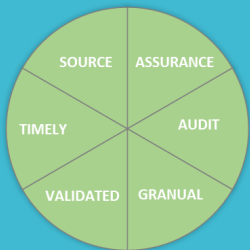
- Bone infection, revision MRC and complex Oncology arthroplasty patients continue to contribute considerably to the longer length of stays. Recommend review of acceptance, repatriation and management of long-term therapy criteria for these patients
- Number of patients converting from day case to overnight stay for non-clinical reasons appears to have reduced. To continue to monitor.
- Ambulatory unit proof of concept continues on Ward 12 until end of October, low identification of patients for this pathway from the listing stage. Continue to audit and troubleshoot
- **Day Case Surgery – Please note that the** BADS metrics have not updated on Model Hospital yet. The latest data is June 25.
- A working group has been established to improve the Trust's performance against the British Association of Day Case Surgery (BADS) metrics. The group is systematically reviewing waiting list data across all specialties to identify and transition procedures suitable for day care delivery in line with BADS and GIRFT standards.

Key Assurance Points

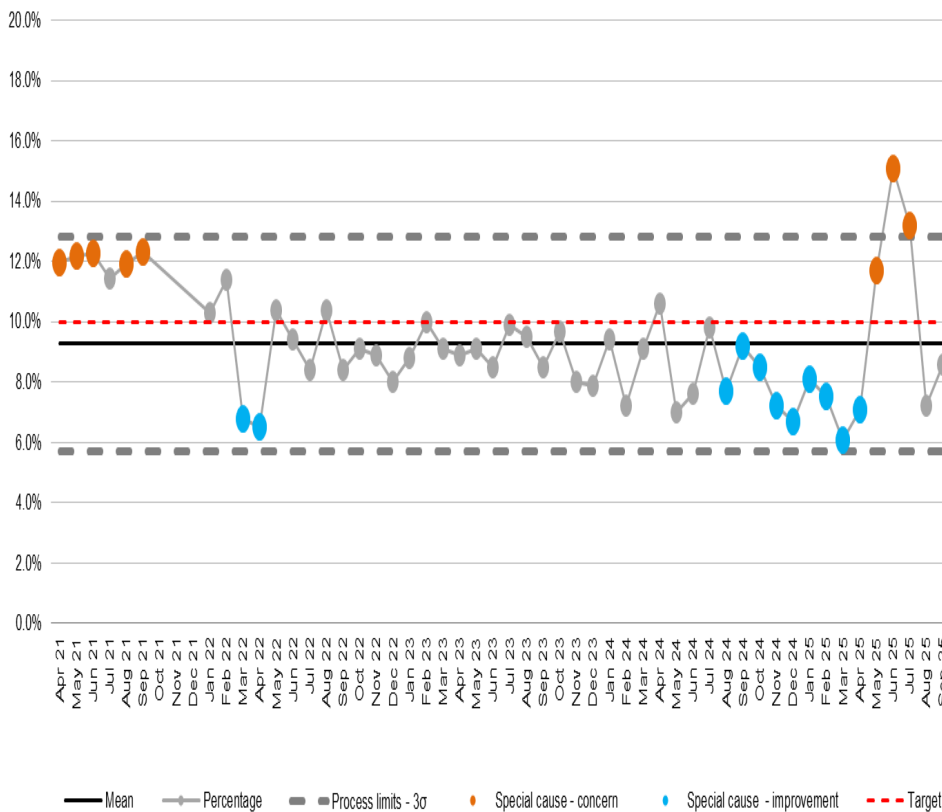
- A structured programme of work is in place, with clear specialty-level milestones.
- Progress will be tracked monthly and escalated through divisional governance.
- A consolidated position statement will be provided to the Executive Team in December 2025, evidencing measurable improvement against BADS benchmarks.

4. Outpatient efficiency

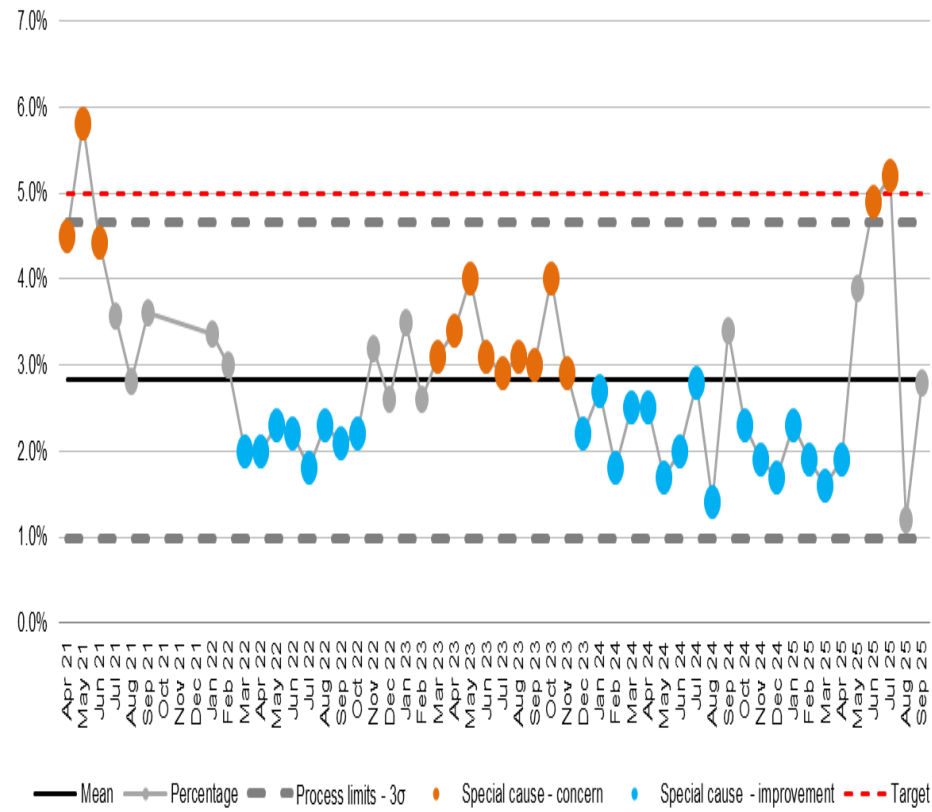
DATA QUALITY KITEMARK



Percentage of OP Attendances Patients Who Waited 31 to 60 Mins to be Seen

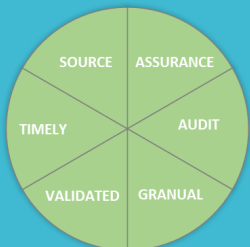


Percentage of OP Attendances Patients Waiting Over 60 Mins to be Seen

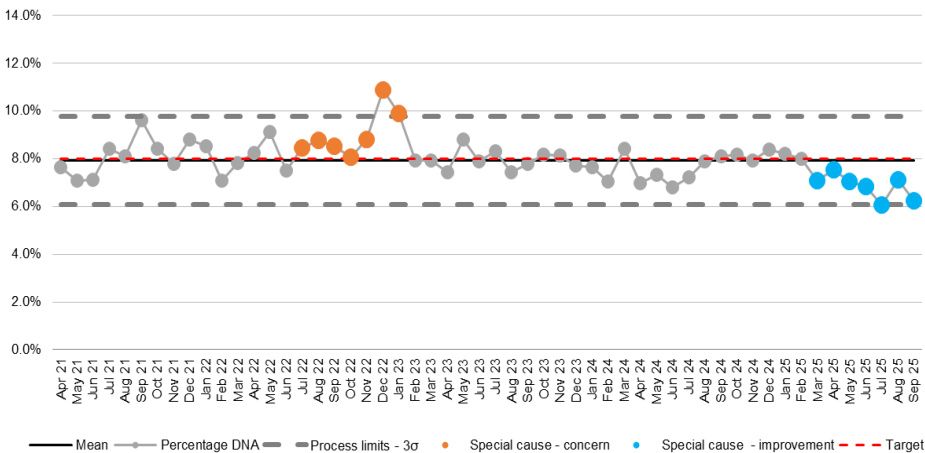


4. Outpatient efficiency

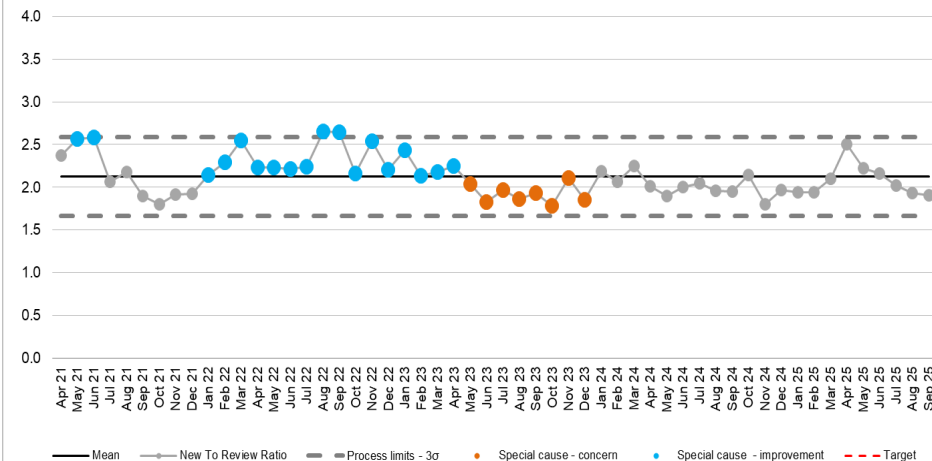
DATA QUALITY KITEMARK



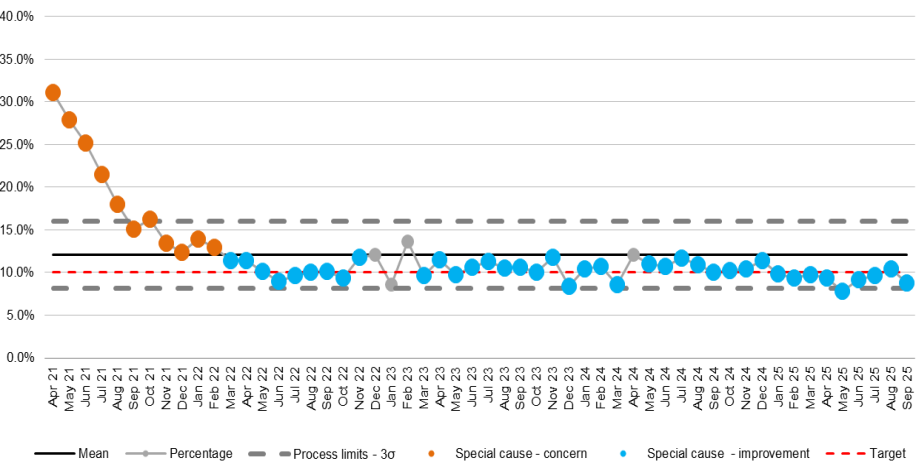
Consultant Led Outpatient DNA Rate



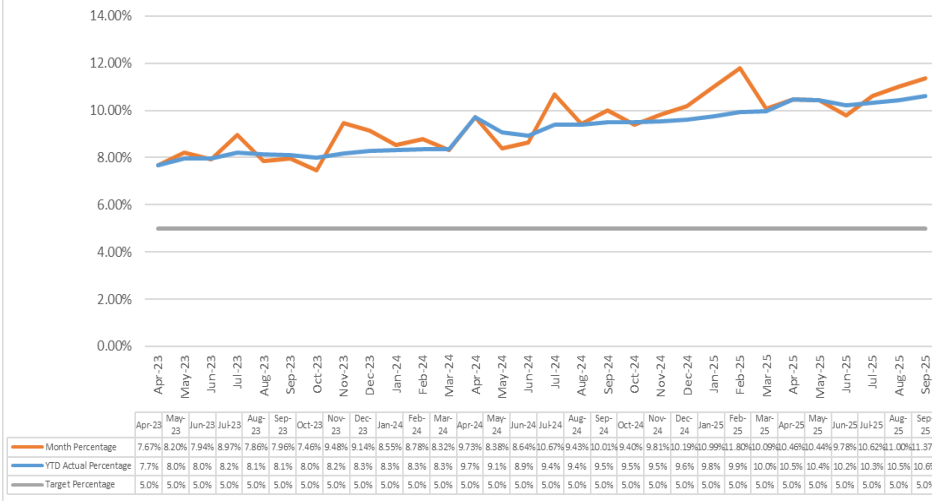
Outpatient New to Review Ratio



Percentage of Virtual OP Attendances

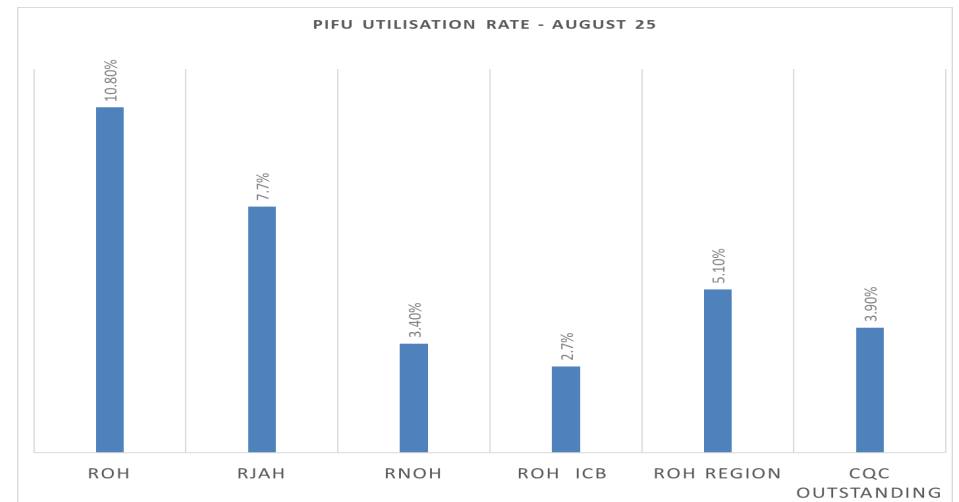
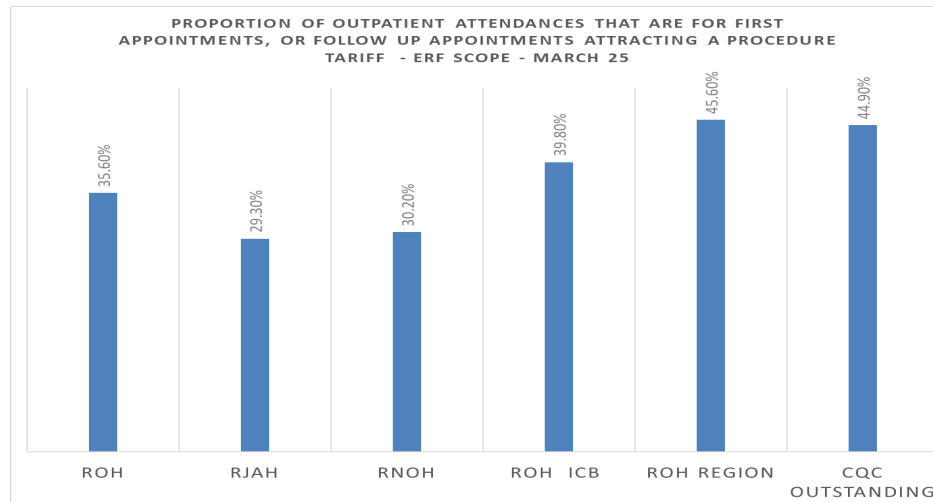
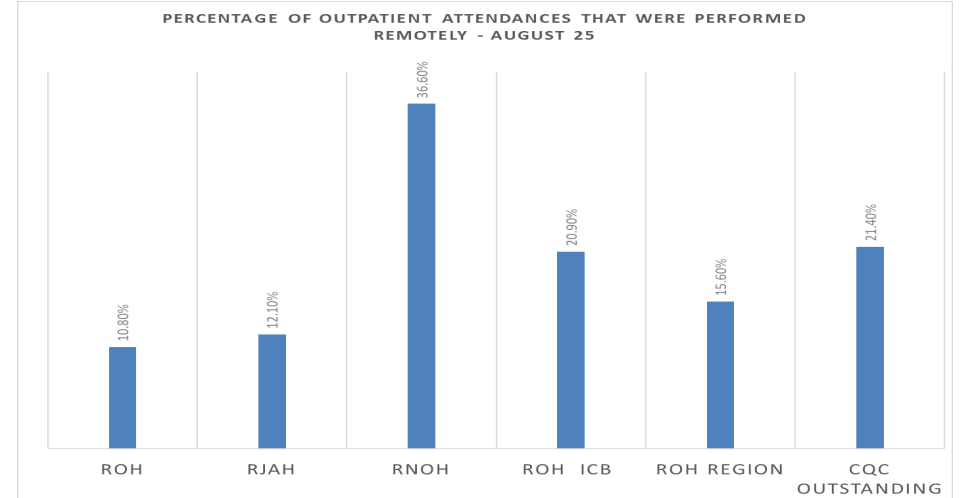
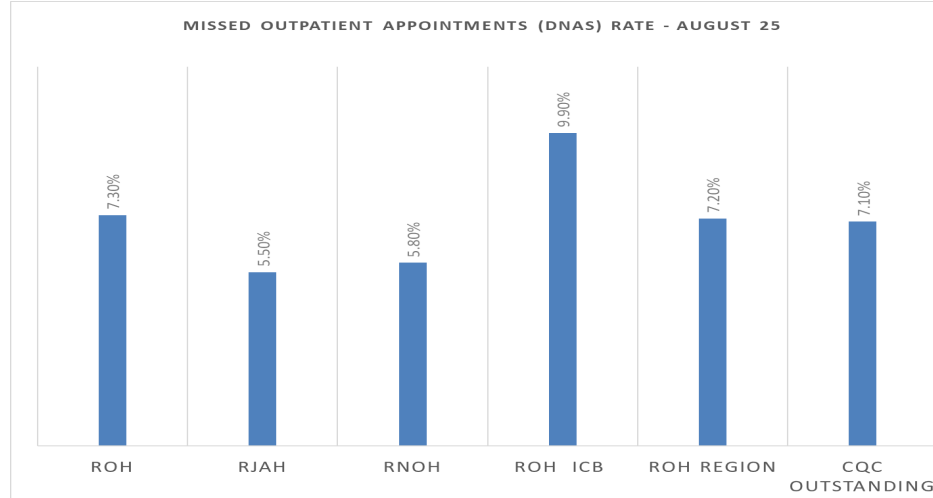
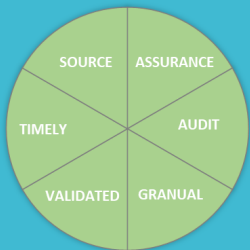


Patient Initiated Follow Ups - % Patient Added



4. Outpatient efficiency

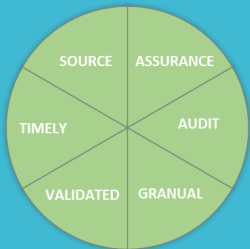
DATA QUALITY KITEMARK



The charts above benchmark the latest model hospital data (published Aug 25)

4. Outpatient efficiency

DATA QUALITY KITEMARK



SUMMARY

September 2025 Outpatient performance is as follows:

- 6,074 face to face and 584 virtual appointments undertaken - 22% increase on the previous month
- 8.77% of the overall appointments were provided virtually – slightly below the previous month (10.43%)
- 11.37% of outpatient attendances converted to the PIFU waiting list. The overall YTD position for PIFU is 10.6%. - improvement on last month
 - The Trust is 5th nationally and is currently performing higher than natural peers.
- 6.2% missed appointment (DNA) rate – meeting target, and continuing positive trajectory as we aim to get under 6% consistently

Clinic Waiting Times

- 30-minute delays – is ahead of the Trust Threshold at **8.6% (Threshold 10%)** – Data control continues to be a challenge due to manual input requirement, but this will be addressed with the implementation of electronic outcomes and the clinical team using the Flow Manager system
- 60-minute delays – the department is performing well and exceeding the Trust target with a reported position of **2.8% (Threshold 5%)**
 - **YTD** on track with a performance of **3.3%**

AREAS OF IMPROVEMENT

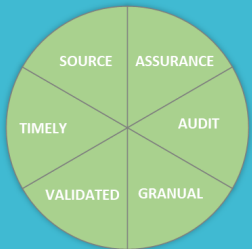
Missed Appointment rates remained under 8% in September with a reported position of 6.2%. The department is continuing its positive trajectory to achieve below 6% consistently. Further details on Missed Appointments were provided in last month's Outpatient Transformation Update paper.

Outpatient Department Flow:

- Outpatient delays: Waiting time breaches (>30 minutes) remain ahead of the Trust threshold. The recent variance from target is attributed to manual data-entry constraints over the summer period.
- Electronic outcomes (data quality & flow): Timelines are confirmed for the Phase 1/Phase 2 rollout of electronic outcoming in Outpatients.
 - Phase 1 (by mid-November 2025): Transition from paper to digital inputting in clinic, resolving key data entry delays in outcoming of appointments.
 - Phase 2: Full automation – Expected to be complete early 2026.
- Workforce capability: Targeted training and development for reception staff is underway to strengthen support to the Appointments team and increase operational flexibility across functions.
- Patient engagement (access & equity): We have strengthened outbound communications - proactive telephone calls and SMS surveys - with a focus on patients from areas of higher deprivation, to support attendance and reduce avoidable non-attendance.

5. Referral to Treatment -

DATA QUALITY KITEMARK



SUMMARY

The Referral To Treatment (RTT) position for September 25 was 62.32%, surpassing the 25/26 operational target for September 2025 of 58.37, by 3.95%. This represents a 0.85% increase compared to the August 25 reported position of 61.47%.

The Trust has maintained a zero patients waiing over 65 weeks position since April 25.

375 patients were waiting over 52 weeks in September 25 that is a decrease from the trust wide position for August 25 that was 427 patients. This performance is ahead of the trajectory for September by 22 patients against a target of 397 patients waiting over 52 weeks (or 2.98% 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 September 25, ROH received 2,855 referrals (105.58%) compared to pre-covid levels. 2,704 is the average monthly referrals received Pre-Covid.

AREAS FOR IMPROVEMENT

Spinal Services: The 65-week position 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 specialities are now aligned with the Zero 52 weeks target which continues to be maintained

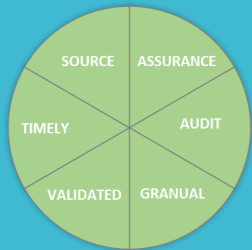
Sprint Validation Performance: The most recent reported data suggests that the Trust is ahead of our Year-To-Date baseline position by 749, representing a 21% lead. This positive momentum reflects the continued success of our sprint initiatives, and we are focused on maintaining this trajectory for the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

RISKS / ISSUES

Spinal waits continue to be a challenge both regionally and nationally. Workshops to date have been positive with opportunities identified to work differently through the use of a blended workforce. A follow up workshop has been scheduled.

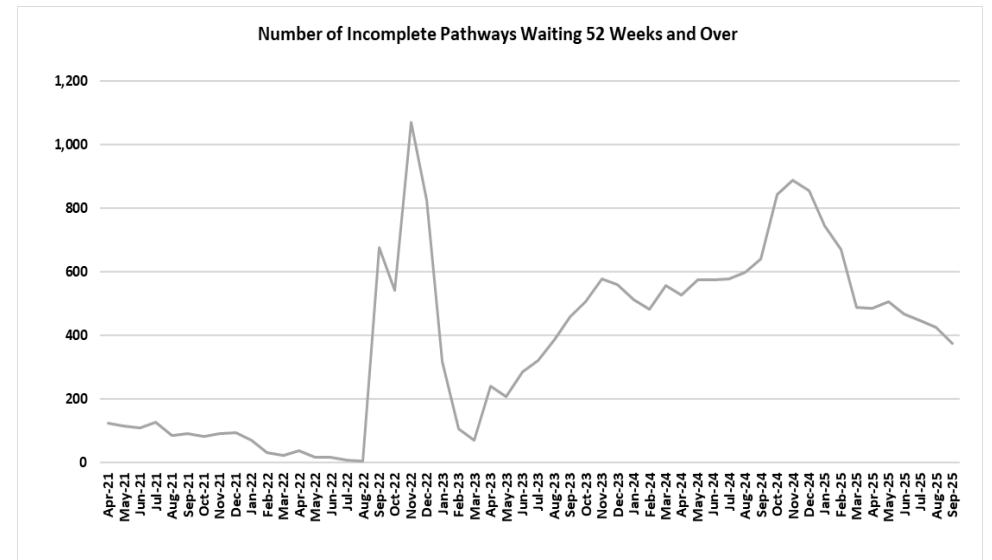
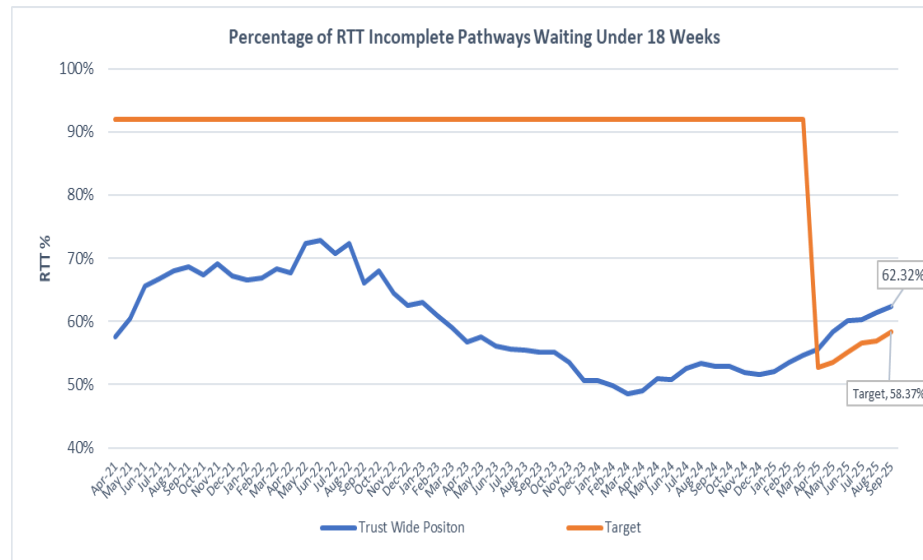
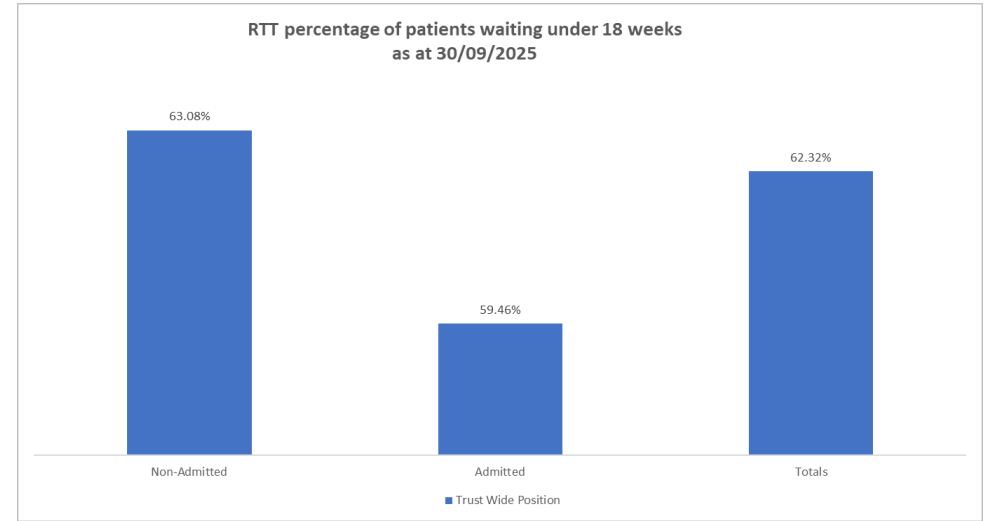
5. Referral to Treatment

DATA QUALITY KITEMARK



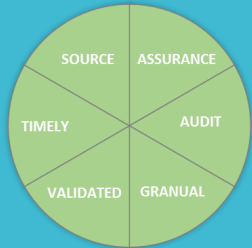
Trust Wide Position			
Weeks Waiting	Non-Admitted	Admitted	Totals
0-6	3,279	690	3,969
7-13	2,206	676	2,882
14-17	1,154	315	1,469
18-26	1,599	547	2,146
27-39	1,311	463	1,774
40-47	449	90	539
48-51	183	14	197
52 weeks and over	343	32	375
Total	10,524	2,827	13,351

Weeks Waiting	Non Admitted	Admitted	Totals
Under 18	6,639	1,681	8,320
18 and over	3,885	1,146	5,031
Month End RTT %	63.08%	59.46%	62.32%

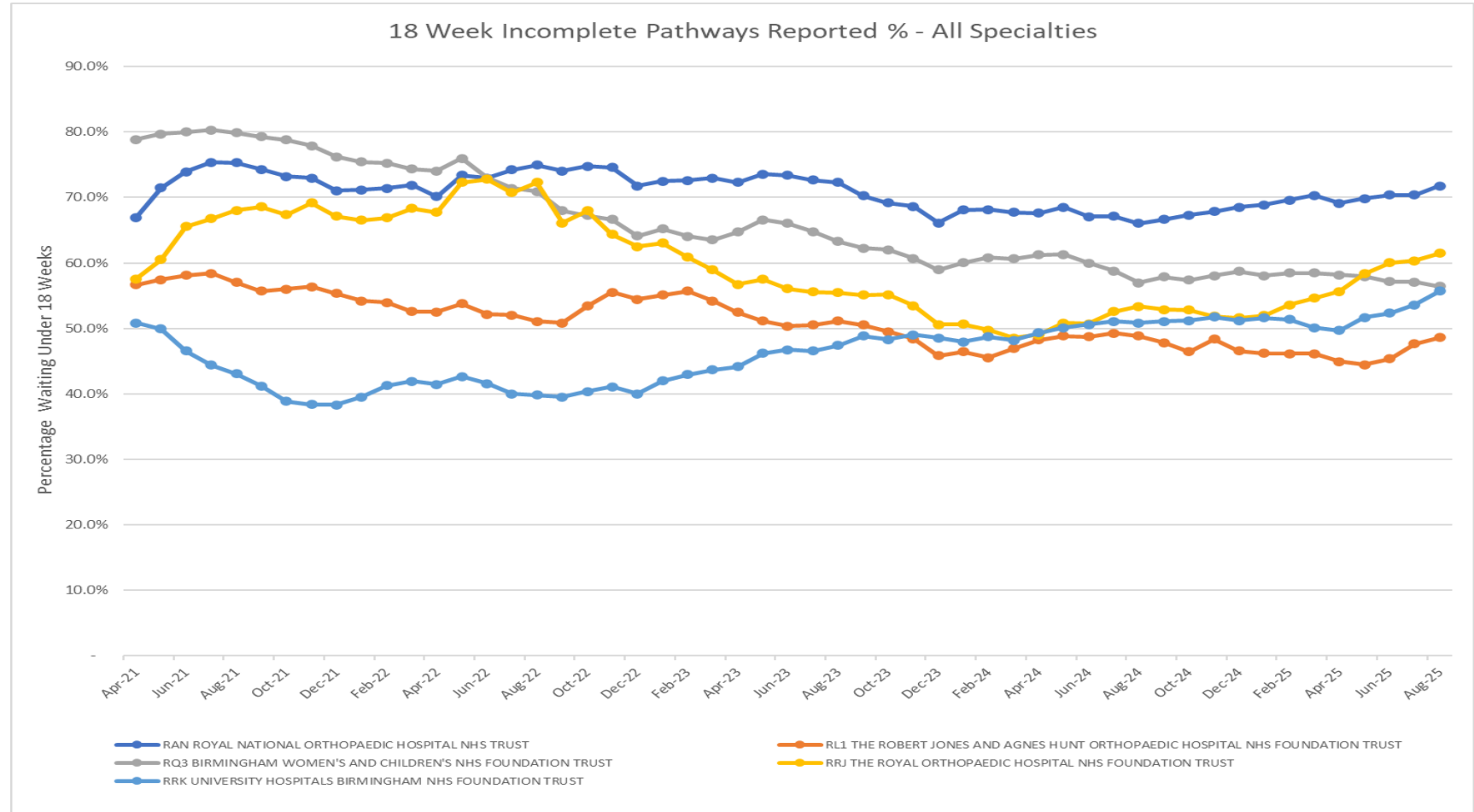


5. Referral to Treatment

DATA QUALITY KITEMARK

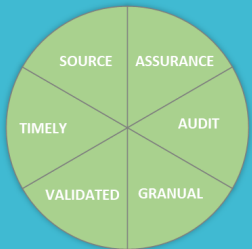


18 weeks Incomplete pathways Benchmarking against other providers:

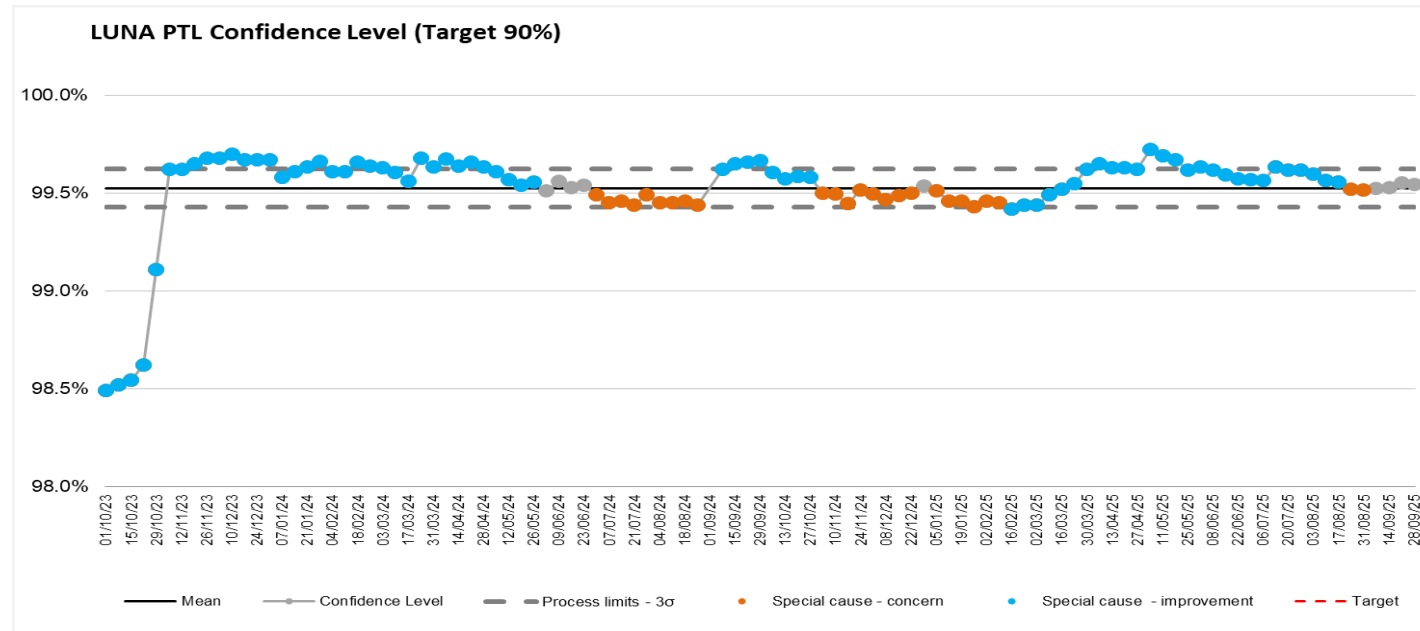


5. Referral to Treatment Luna Data

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 inconsistencies, which has demonstrated a further improvement of our waiting list data quality.

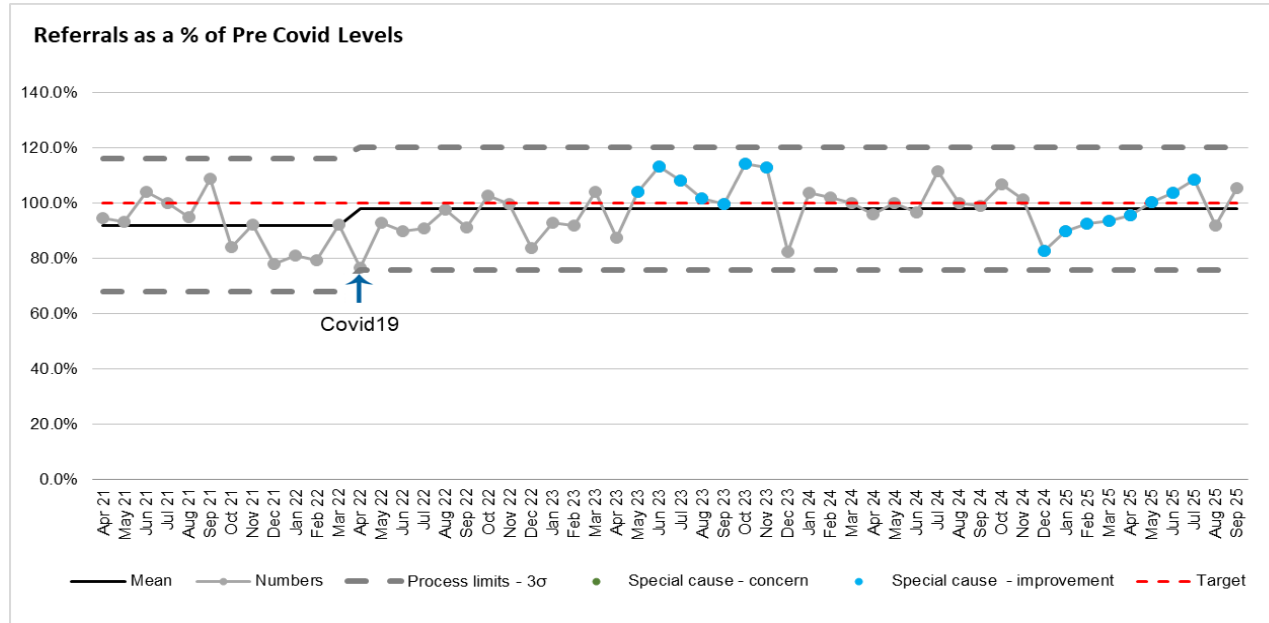
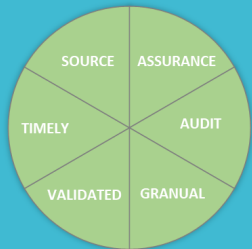


It is important to note the significant improvement from the data quality team utilising the LUNA data to continue to drive improvements. The latest chart suggests that the Trust has minimal errors identified by LUNA with a confidence rate in excess of 99.5%.

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

5. Referral to Treatment

DATA QUALITY KITEMARK



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

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%

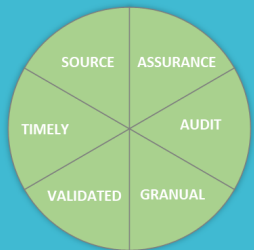
Month	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Number of Referrals	2363	2818	3059	2926	2752	2693	3093	3056	2224	2802	2760	2707
Referrals as a % of Pre Covid Levels	87.39%	104.22%	113.13%	108.21%	101.78%	99.59%	114.39%	113.02%	82.25%	103.62%	102.07%	100.11%

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	2581	2713	2805	2929	2483	2855						
Referrals as a % of Pre Covid Levels	95.45%	100.33%	103.74%	108.32%	91.83%	105.58%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

5. Referral to Treatment Specialty Breakdown

DATA QUALITY KITEMARK



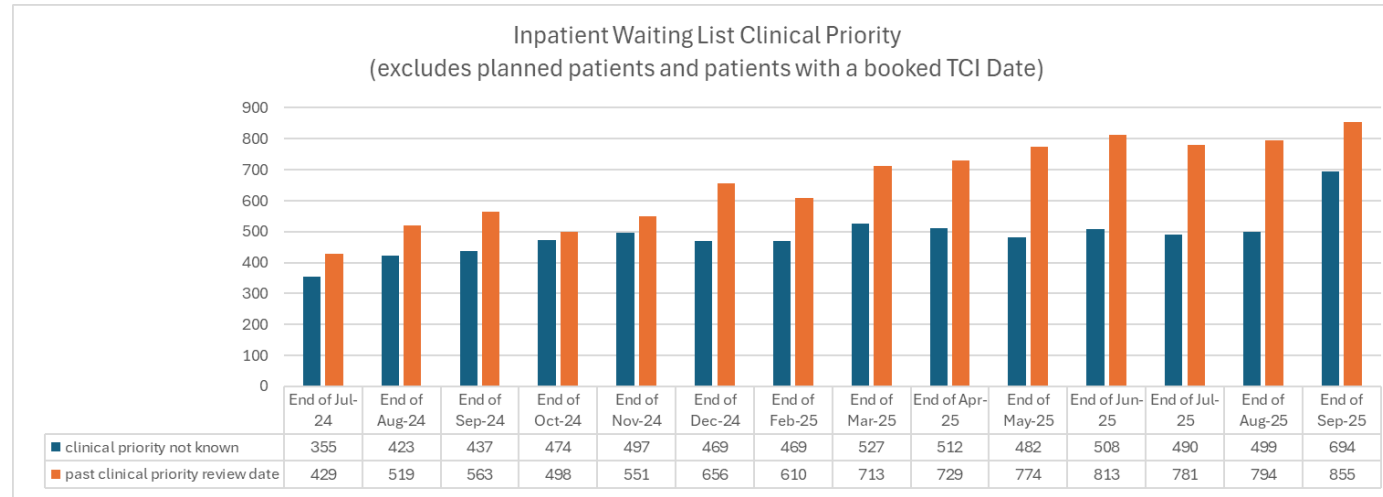
The national RTT target is for 92% of patients to be treated within 18 weeks. The table below highlights the current performance against this target by specialty. It also includes the number of patients currently waiting over 52 weeks prior to any tip ins. This will be used to support focused intervention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

Specialty	Number of patients over 52 weeks with an incomplete RTT pathway	RTT % as of 17.10.25
Arthroplasty	0	64.16%
Arthroscopy	0	61.43%
Clinical Support (Pain Management)	4 (late Spinal referrals)	64.32%
Foot and Ankle	0	84.78%
Hands	0	60.62%
Oncology	0	92.72%
Oncology Arthroplasty	0	62.34%
Spinal	153	39.64%
Spinal Deformity	235	36.74%
Young Adult Hips	0	62.53%
Paediatrics & Young Adults	2	75.71%

Hands and YAH performance is in line with the expected Trust RTT trajectory for delivery of over 60%. Additional clinics have been provided to help improve this position further. Spinal strategic review is underway, and workshops have commenced to improve the overall RTT position.

5. Referral to Treatment

Overdue Clinical Priority:



The number of patients with an unknown clinical priority has increased by 195 patients and total numbers that have past the clinical priority review date has increased by 61 patients. The information continues to be shared monthly with individual services and clinicians to manage individual clinical practice and at the Monthly CSLS meeting.

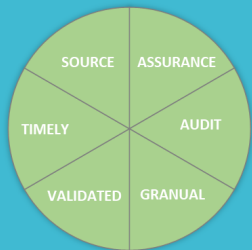
From September 2025, operational service managers will lead a structured process to strengthen oversight of surgical waiting lists. The following actions are being implemented to provide assurance:

- **Weekly review of patients without a defined priority** - Services to identify and update clinical priorities where possible or liaise directly with the responsible surgeons to confirm accuracy.
- **Monitoring overdue patients** - Services to review and escalate (to responsible clinicians) any patients whose operative timeframe has passed, in line with their original clinical priority.
- **Mandatory priority capture** - With the introduction of the electronic Patient Listing Form in August 2025, recording a surgical priority has become a mandatory requirement. and places increased emphasis on our clinical & administrative teams to ensure priorities are accurately captured when patients are added to the elective waitlist

Assurance and Oversight

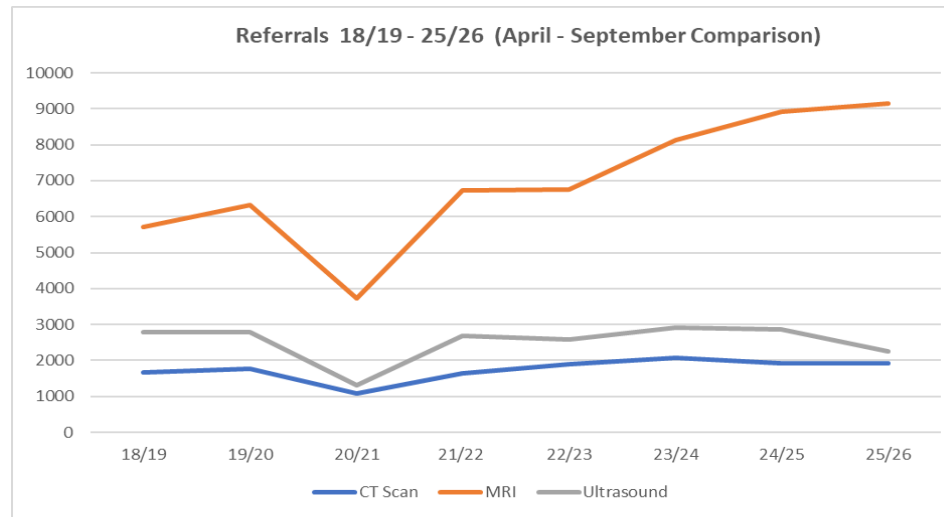
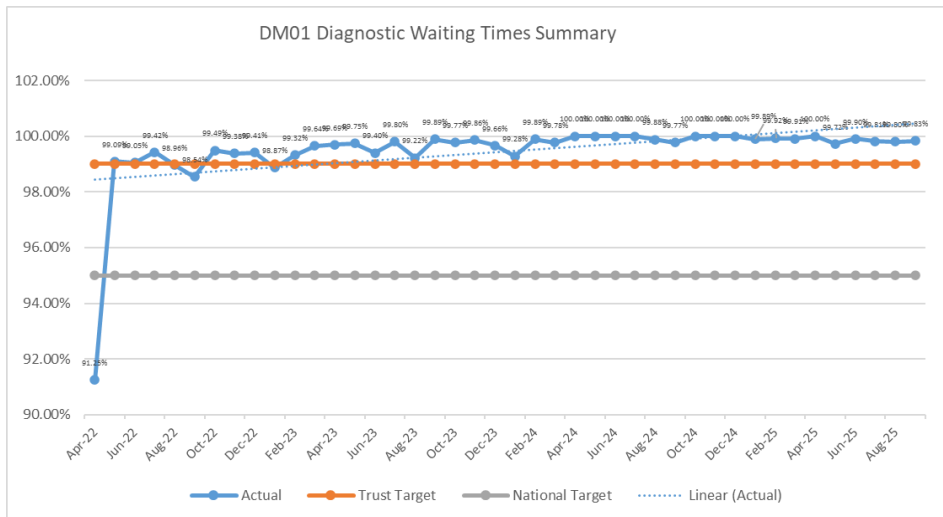
- Compliance with weekly reviews and updates will be tracked and reported to divisional leadership.
- The overall effectiveness of the new process, including its impact on booking and waiting list accuracy, will be monitored over the next 12 weeks, with outcomes reported to the Executive Team to evidence demonstrable improvements.

DATA QUALITY KITEMARK

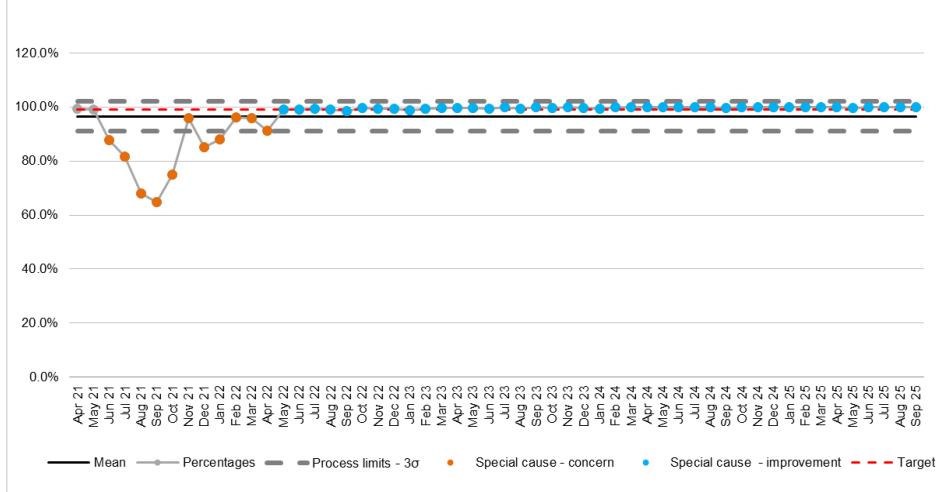


6. Diagnostic Performance

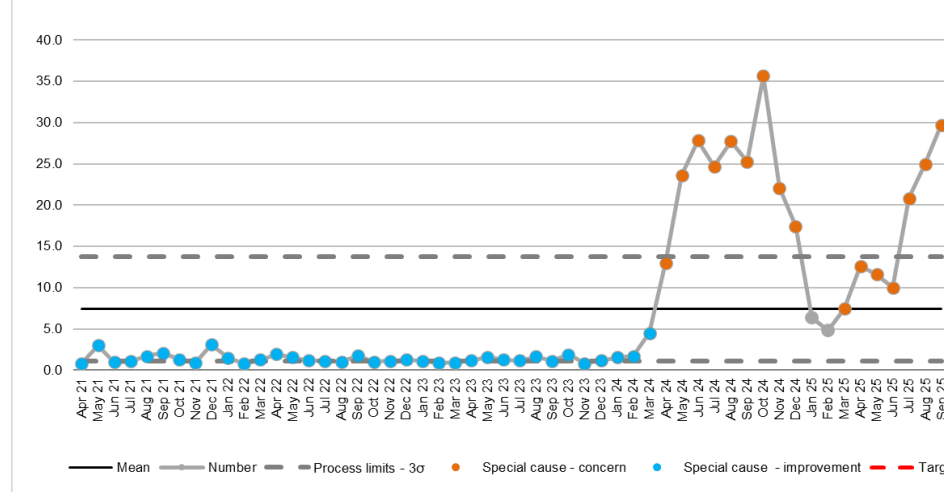
% of Patients Waiting <6 Weeks for Diagnostic Test - National Standard is 99%



Diagnostics: Percentage of Patients Waiting Under Six Weeks



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



SUMMARY

The Imaging department achieved the 99% DM01 target in September 2025 closing the month at 99.8%. The National 25/26 operational target remains at 95% which ROH continues to achieve consistently.

AREAS FOR IMPROVEMENT

Imaging Reporting

The team continue to outsource Radiology Reporting – MRI average reporting turnaround time is 72 hours from receipt. Following the recent introduction of a new auto-reporting policy the outsourcing of x-rays will begin to reduce.

The reporting of Oncology and Young Adult Hips (YAH) MRIs remain in house due to the nature of the services.

All Oncology and non-medical referrer x-rays continue to be prioritised. Additional sessions have been completed and YAH reporting times have improved significantly. This will continue to be monitored.

Equipment

Business plans for 25/26 included replacement of the CT scanner and 2 X-ray rooms, that will be out of full-service cover from December 2025.

X-ray - Only Room 4 has been allocated funds in capital plans. Room 1 and 2 are continuing to have intermittent issues/downtime due to age.

CT – allocated funding in capital plans. An options appraisal paper has been completed outlining contingency plans to provide continuity of service delivery during the project works (~12 weeks). Funding for this needs to be approved to progress the replacement.

QSI application – currently reviewing all existing SOP's and patient information leaflets. Team have surpassed 50% progress; therefore, will be submitting the application for "Working Towards" status as soon as the order has been placed and funding agreed. Regular progress updates are provided to the Trust Improvement Group.

RISKS

There is an ongoing risk with Consultant Radiologist workforce vacancies. 2 posts have been advertised, and 2 fellows have recently joined the team. The introduction of the fellows has bolstered support and resilience to the existing consultant body. Additional lists are being provided for CT Guided Biopsies to support ongoing maintenance of cancer targets.

7. Diagnostic Performance

Summary Performance Figures – August 25 (Oct 2025 Submission)

Target Name	National Standard	August 25 (complete)			
		%	In target	Breach	Total
31 DTTD to Treatment	96%	100%	26.0	0.0	26.0
62 day RTT to treatment	70%	78.6%	11.0	3.0	14.0
28 day FDS REPORTED	77%	77.4%	82	24.0	106
Patients over 104 days (62 day standard)				0	

Performance

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

The 62-day metric was achieved at 78.6%. A total of 14 treatments were applicable to the trust, 11 of those were compliant and the remaining 3 patients breaching. The root cause of the delays for the 62-day breaches were due to patient choice and complex diagnosis.

- 1 full Breach. IPT received from Addenbrookes day 47, however surgery required plastics and due to unforeseen circumstances, a plastic surgeon was unable to support the list resulting in surgery being rescheduled after the breach date. .
- 1 Full breach. Direct 2ww into the ROH. Root cause of delay was due to complex diagnosis, patient required multiple scans before a diagnosis could be reached. This resulted in a late tertiary out to UHB for radiotherapy.
- 1 Full breach. Direct 2ww into the ROH. Patient seen in clinic and consented to biopsy, however, the patient declined their biopsy for 38 days due to work commitments. Root cause was patient choice.

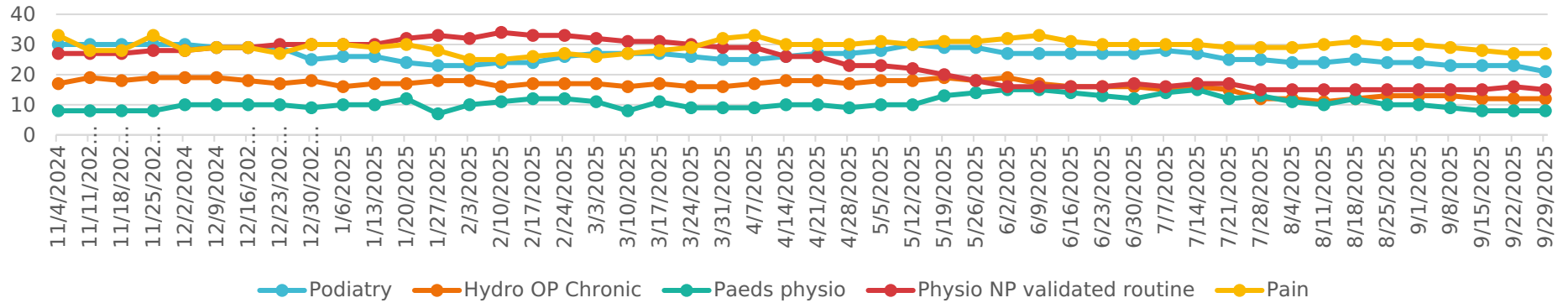
Risks /actions ongoing

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, however additional weekend sessions have been agreed to minimise delays and capacity will resume to normal levels Mid November. The risk is also being mitigated locally with biopsies being performed in theatre, where possible.

Histopathology turnaround times remain poor, and it is becoming challenging for ROH to achieve the national standards. The current 62-day prediction for September is below 70% compliance due to Histopathology delays. Regular tracking and escalation of potential breaches is in place to help mitigate impact on future performance. Twice weekly escalations continue 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 notified us that they have a temporary reduction in workforce due to an unforeseen absence. The additional support provided by Professor LarzGunner (an expert in Sweden) has not yet impacted turnaround times as predicted and the service remains fragile. The risk is discussed weekly at the System Oversight Group chaired by NHSE and the UHB COO is overseeing the action plan.

8. Cancer Performance

Therapy Waiting Times (November 24 - September 25)



9. MSK Waits

Summary - September 25

Waiting times continue to slowly reduce in Podiatry with locum support, reducing from 29 to 27 weeks since August 25. The waiting time for adult physiotherapy is 17 weeks as at end of September 25. Paediatric Physiotherapy waiting times remain in a good position at 8 weeks. Additional capacity provided for increasing waiting times in Hip Triage.

Risks / Actions Ongoing

- Ad hoc assessment clinics are being used within existing resources to manage the risk of increasing adult physiotherapy waiting times due to workforce changes and no longer having the additional funding from GIRFT.
- Cover has been arranged for Paediatric Team Leader role but will impact slightly on capacity for adult patients.
- Recruitment continues to be a challenge for physiotherapists, and a locum is in place to support whilst ongoing recruitment continues. HR processes are in progress to convert current agency to bank roles.
- The team continues to progress modernising and digitising the self-referral form for adult physiotherapy within the GetUBetter app which will now be rolled out across BSol following an initial pilot with College Green Medical Practice scheduled for November. An equivalent form for non-BSol patients had been delayed due to IT concerns however is now making further progress.
- Work now progressing for text message reminders using Ethitec (Tiara system) and Dr Doctor.

10. Private Patients

SUMMARY

The service has agreed a revised planned revenue of £6.1m for 25/26, with an ambitious stretch target of £6.5m.

- September activity levels were just below the planned volume (55 plan vs 51 actual), due to less complex procedures and case mix.
- Imaging performance in September increased with £17k invoiced activity.
- Year-to-date performance stands at £2.56m, reflecting a -£445k variance against plan, with targeted actions in place to recover and drive towards the £6.1m target. SLIC and SLAM leads to a differential in internal recording vs finance formal reported position.

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	YTD
Revised revenue plan 2025/26 (£6.1m)	£385,000	£546,000	£552,000	£486,000	£486,000	£555,000	£3,010,000
Revenue Actual	£384,773	£541,749	£407,554	£438,560	£422,500	£369,386	£2,564,522
Variance	£227	£4,251	£144,446	£47,440	£63,500	£185,614	£445,478

PROGRESS OVERVIEW

Objectives	Benefits	Progress	Next Steps / Mitigation
Secure an in-year revenue of £6.1m to £6.5m	Strengthens Trust income plan and supports financial sustainability	£2.56m YTD achieved (variance to plan, -£445k)	Targeted marketing campaigns launching to accelerate activity and revenue growth. Increase in self funding fees in alignment with the market
Utilise one theatre per day for private cases	Demonstrates commitment to growing private practice at ROH	Steady growth with 13 lists utilised in September	Ongoing promotion of weekday sessions and encouragement of longer-term bookings
Secure updated tariffs and assess self-funding fees	Contributes directly to increased revenue streams	Tariffs with major insurers under review	Negotiation with insurers to take place. Vitality network contract renewed at same value as Aviva.
Marketing / SEO / local & international campaigns	Raises awareness of both NHS and private services	SEO partner commissioned; robotics campaign planned for Autumn 2025	Detailed keyword analysis underway to maximise search visibility; campaign development progressing with surgeon input
PLICS assessment of profit / contribution to maximise contract values	Strengthens marketing case and tariff negotiations	Finance team conducting detailed review of cost data to support a robust pricing structure	Benchmarking continues to ensure pricing remains competitive and aligned to market needs
Expand overseas service	Enhances visibility in overseas markets and drives new revenue	Early stages - pipeline building with SEO support	Overseas patient acquisition to be supported through enhanced SEO and market-specific outreach; mitigating London competition with niche service promotion

11. Finance on a Page

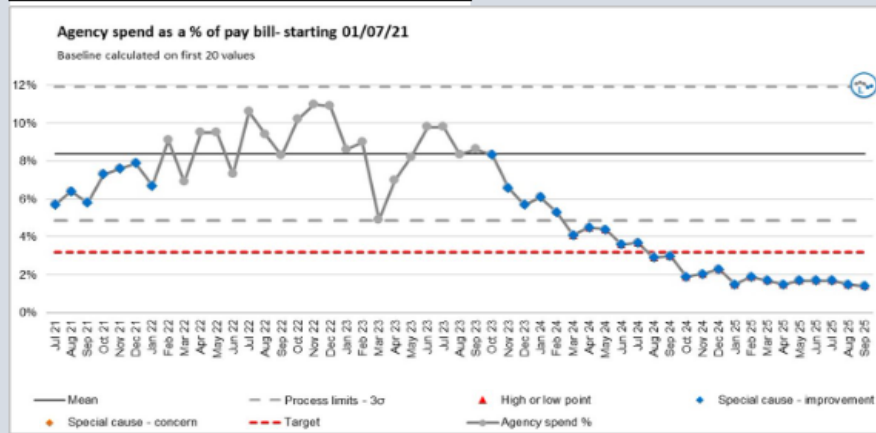
Month
6

FINANCIAL PERFORMANCE

Income and Expenditure category	£'000s								
	In Month			Year to date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Income from patient care activities	£12,028	£11,960	-£68	£69,507	£67,779	-£1,728	£141,629	£136,269	-£5,360
Other income	£467	£194	-£273	£2,754	£3,192	£438	£5,540	£6,712	£1,172
Pay	-£6,946	-£7,109	-£163	-£42,152	-£42,211	-£59	-£83,100	-£83,673	-£573
Non Pay	-£5,387	-£4,950	£437	-£30,172	-£28,891	£1,281	-£62,654	-£57,946	£4,708
Non operating costs	-£115	-£112	£3	-£693	-£557	£136	-£1,380	-£1,327	£53
TOTAL	£47	-£17	-£64	-£756	-£688	£68	£35	£35	£0



Agency as a % of paybill = 1.6%



Efficiencies	YTD	Forecast
Plan	£3,856	£9,447
Actual	£3,301	
Variance	-£555	

Better Payment practice code	YTD	% move't prev month
Non-NHS		
By number	79.5%	0.0%
By Value	78.9%	2.5%

Capital	YTD	Forecast
Plan (exc IFRS16)	£1,430	£25,365
Actual	£699	£23,017
IFRS 16	£0	£465
Variance	-£731	-£2,348

NHS	YTD	% move't prev month
By number	42.9%	-0.8%
By Value	26.5%	0.4%
Total		
By number	78.7%	0.0%
By Value	71.2%	3.7%



12. Overall Financial Performance

SUMMARY

The Trust delivered a deficit in month of £17k, generating a year to date deficit of £688k which is £68k better than plan.

Income performed below plan by £1,291k year to date. Commissioner income underperforming against elective commissioner cap by £710k, and diagnostic variable income by £613k. There are some areas of income performing better than plan; Research and Development income by £212k and other income by £211k. Private patient income is performing on plan against original plan, but underperforming against stretch plan.

Pay expenditure is overspent by £163k in month and £59k year to date. Agency spend reduced in month, being 1.6% of paybill year to date, with an underspend of £197k year to date. Bank expenditure has the highest it has been this year at £359k, up £121k against prior month, although there remains a year to date underspend of £194k.

Non pay expenditure underspent in month by £437k improving the non pay variance to £1,281k underspent. This is primarily driven as a result of better performance on non pay CIP schemes and clinical supplies reduced spend.

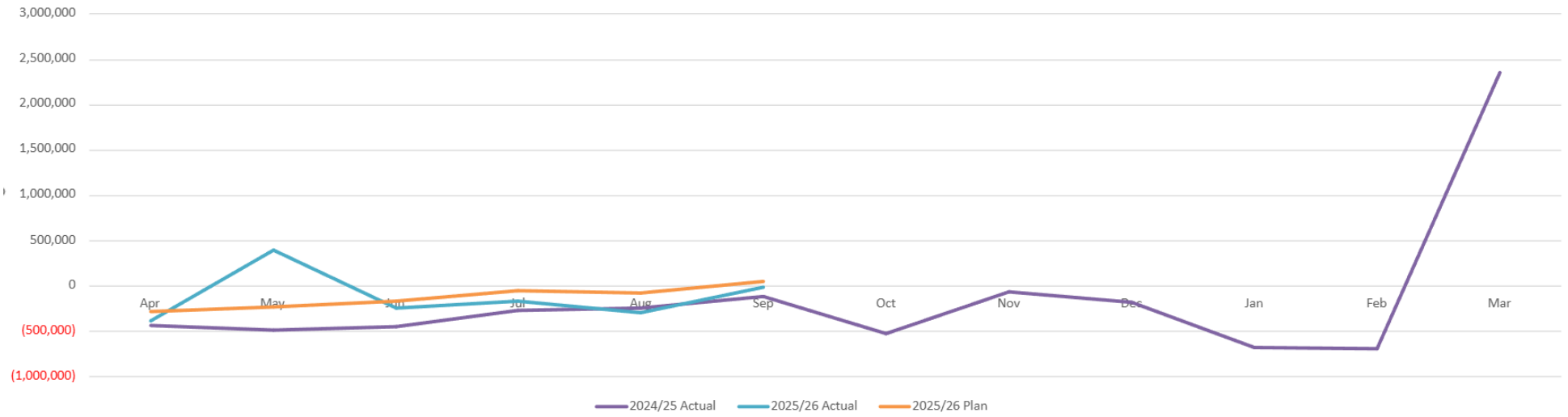
	In Month £'000s			YEAR TO DATE £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance
Income	12,495	12,155	(340)	72,261	70,970	(1,291)
Pay	(6,946)	(7,109)	(163)	(42,152)	(42,211)	(59)
Non pay	(5,387)	(4,950)	437	(30,172)	(28,891)	1,281
Non operating items	(115)	(113)	2	(693)	(557)	136
TOTAL SURPLUS/ (DEFICIT)	47	(17)	(64)	(756)	(688)	68

12. Overall Financial Performance

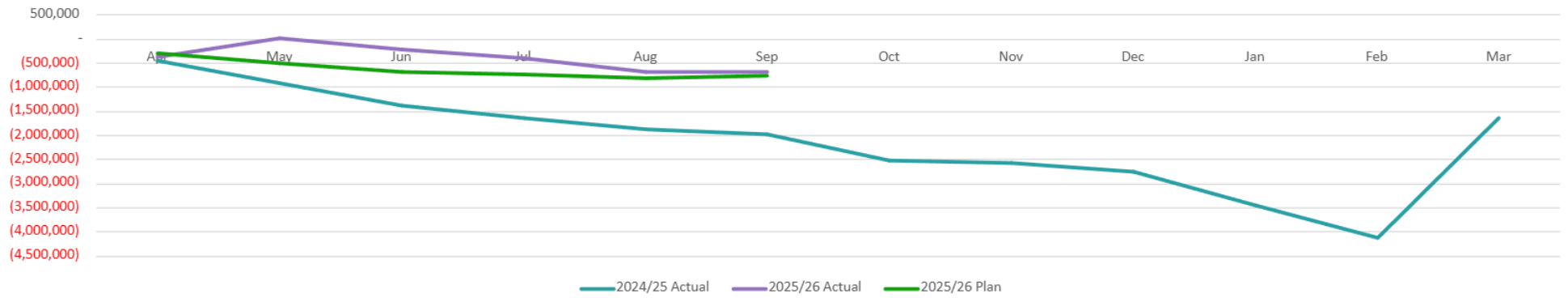
	Plan	Actual	Variance
	Year to date (£'000)		
Operating Income from Patient Care Activities	69,507	67,779	(1,728)
Other Operating Income (Excluding top up)	2,754	3,192	438
Employee Expenses (inc. Agency)	(42,152)	(42,211)	(59)
Other operating expenses	(30,172)	(28,891)	1,281
Operating Surplus	(63)	(132)	(69)
Net Finance Costs	(738)	(612)	126
Net surplus/(deficit)	(801)	(744)	57
Remove donated asset I&E impact	45	56	11
Adjusted financial performance	(756)	(688)	68

12. Overall Financial Performance

Monthly Surplus/Deficit



Cumulative Plan vs Actuals



13. Income

SUMMARY

Income performed below plan by £1,291k year to date. Commissioner income underperforming against elective commissioner cap by £710k, and diagnostic variable income by £613k.

There are some areas of income performing better than plan; Research and Development income by £212k and other income by £211k.

Private patient income is performing on plan against original plan, but underperforming against stretch plan.

AREAS FOR IMPROVEMENT

Ensuring elective activity remains within the commissioned income cap.

Daily activity estimated income reporting.

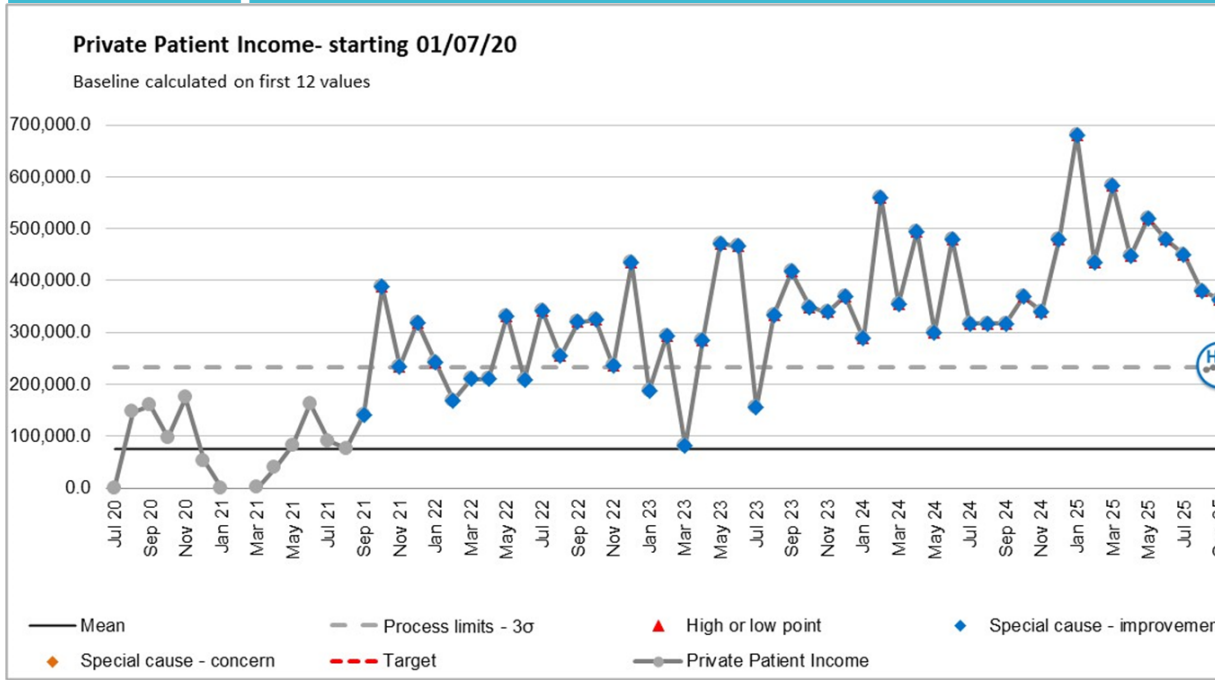
RISKS / ISSUES

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.

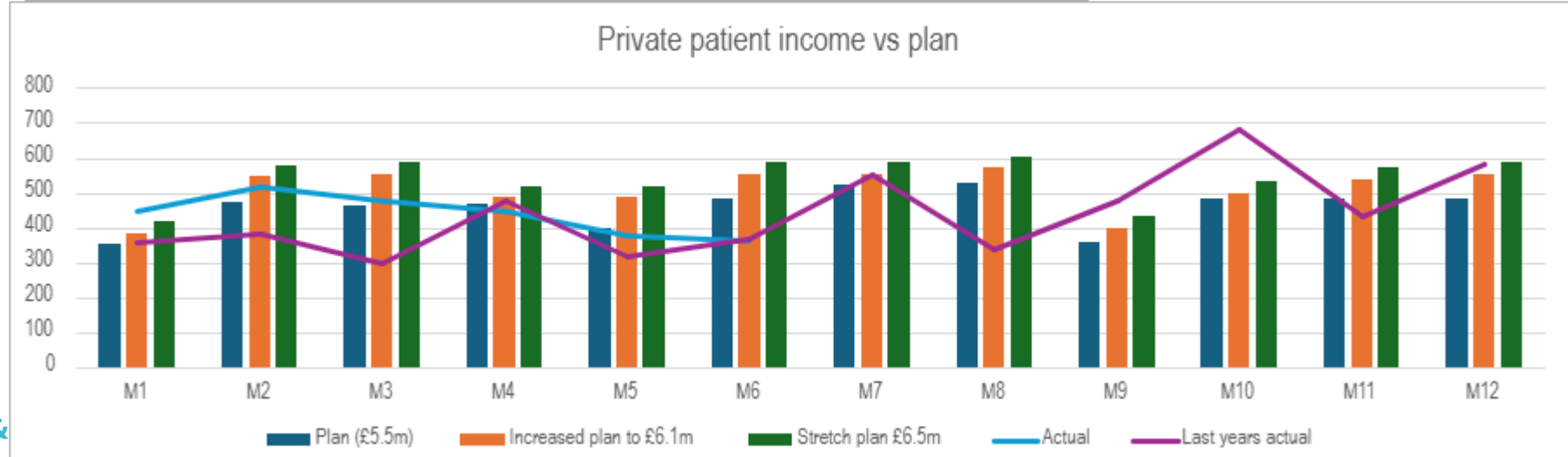
13. Income

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)	£2,587
Increased plan to £6.1m	£2,946
Stretch plan £6.5m	£3,146
Actual	£2,639



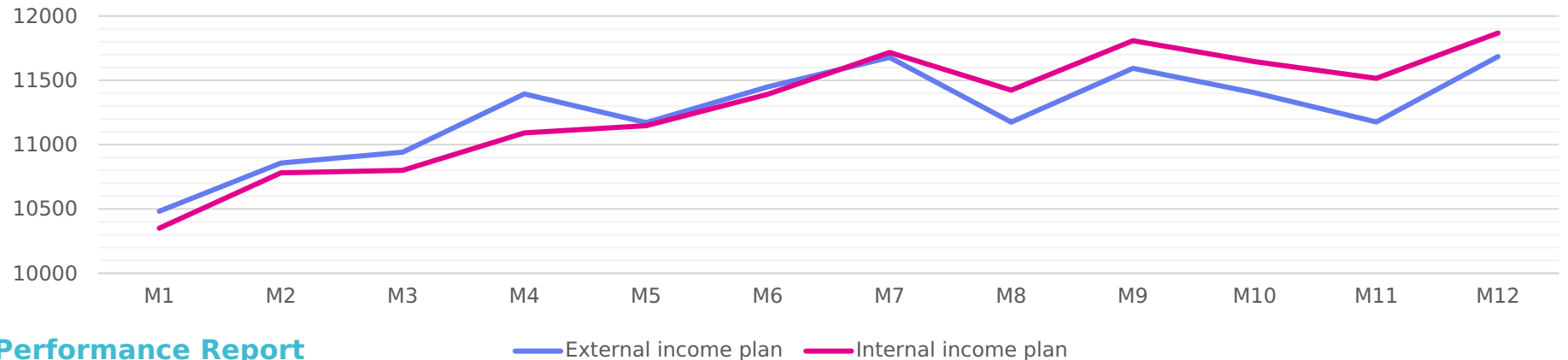
13. Income

NHS income

NHS commissioned income performance to date is an underperformance of £1.7m. The underperformance can be categorised as follows;

	£'000s	
Plan phasing year to date	-£416	The income phasing for the internal plan is phased differently to the externally reported income plan
Variable ERF underperformance	-£710	Income generated for elective, day case and outpatient activity performance against commissioner cap
Passthrough income	£93	Recharge for passthrough devices is lower than planned
Diagnostic variable	-£613	Other chargeable income is lower than planned.
Performance variance	-£1,646	

Commissioner income phasing



NHS income

Performance in chargeable elective activity compared to the payment cap limit by commissioner is shown below;

	Actual									In Month		
	1	2	3	4	5	6	Total	Plan YTD	Variance	Actual	Cap	Variance
Hereford & Worcs ICB	£446,679	£588,234	£677,735	£623,135	£604,289	£748,709	£3,688,782	£3,459,875	£228,908	£748,709	£610,563	£138,146
BSOL ICB	£2,055,993	£2,217,469	£2,299,298	£2,347,850	£2,285,500	£2,478,917	£13,685,027	£14,204,398	£-519,371	£2,478,917	£2,572,493	£-93,576
Staffs & Stoke ICB	£178,007	£168,807	£133,587	£132,149	£193,588	£119,600	£925,738	£968,261	£-42,523	£119,600	£155,005	£-35,405
Black Country ICB	£639,972	£590,798	£595,625	£724,893	£661,349	£837,983	£4,050,619	£4,093,500	£-42,881	£837,983	£726,413	£111,570
Cov & Warwick ICB	£167,332	£107,341	£90,807	£126,345	£118,022	£138,055	£747,902	£729,448	£18,455	£138,055	£111,341	£26,714
Spec Com	£563,699	£559,615	£538,132	£541,711	£655,543	£542,029	£3,400,730	£3,844,015	£-443,285	£542,029	£680,797	£-138,768
Grand Total	£4,060,038	£4,241,434	£4,347,274	£4,512,538	£4,532,285	£4,895,445	£26,589,014	£27,299,496	£-710,482	£4,532,285	£5,219,772	£-324,327

There is a net underperformance against payment cap limit of £324k in month and £710k year to date which has been included within the year to date position.

The financial risk for overperformance against cap totals £228k with Hereford, Staffs and Cov ICBs all overperforming to date, and BSOL and Spec comm underperforming by £962k.

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.

13. Income

14. Expenditure

SUMMARY

Pay expenditure is underspent by £315k in month and £104k year to date. Agency spend reduced in month with 1.5% of paybill year, with an underspend of £161k year to date. Bank expenditure reduced in month with a year to date underspend of £281k.

Non pay expenditure underspent in month by £349k improving the non pay variance to £844k underspent. This is primarily driven as a result of; better performance on non pay CIP schemes and clinical supplies reduced spend.

LLP expenditure against plan has overspent by £173k in month and contributing to a year to date overspend of £572k.

AREAS FOR IMPROVEMENT

- Identification of CIP
- Delivery of planned CIP schemes

RISKS / ISSUES

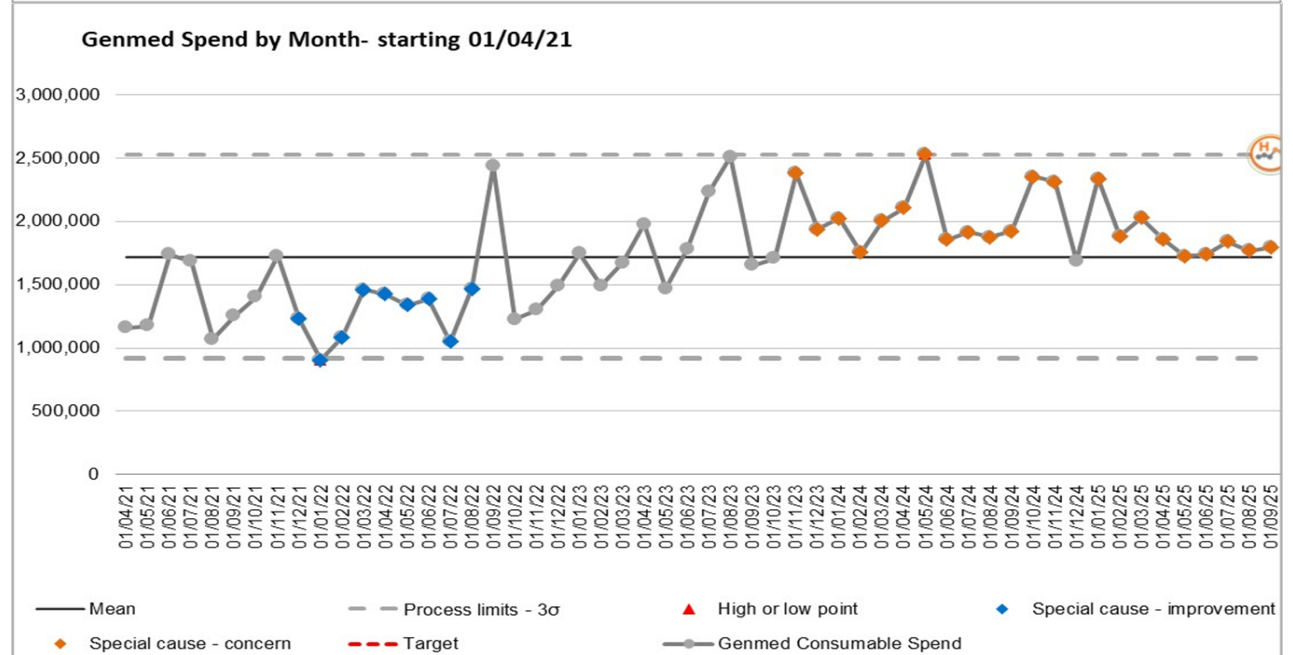
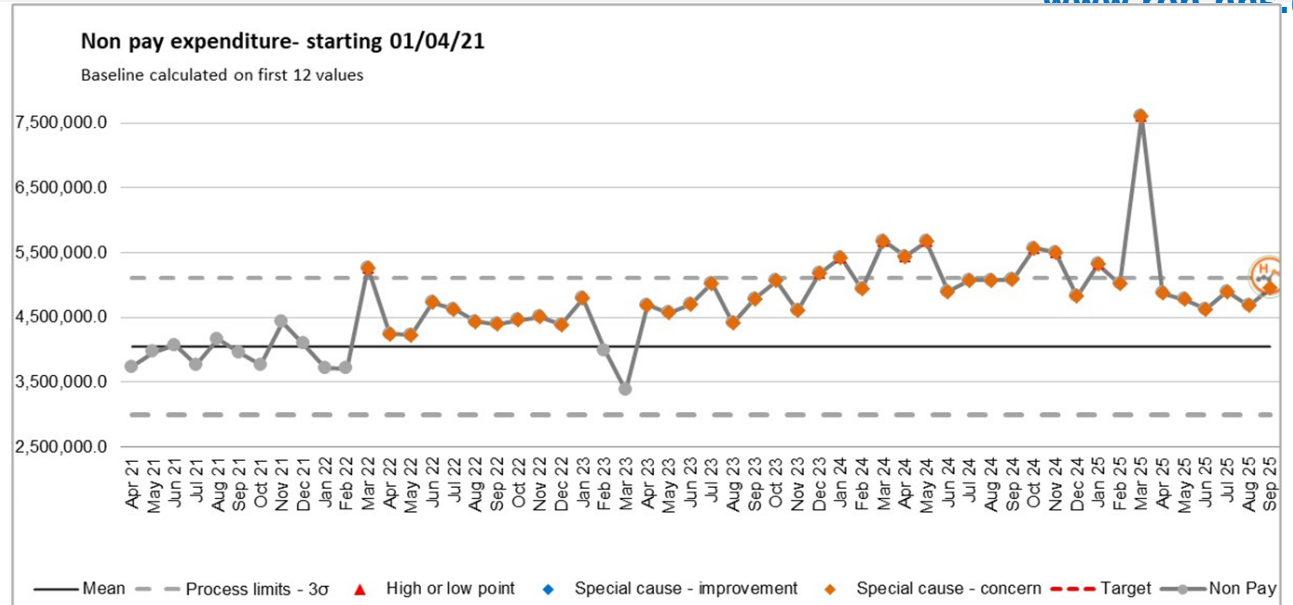
- CIP delivery risk

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.





15. Non Pay Expenditure

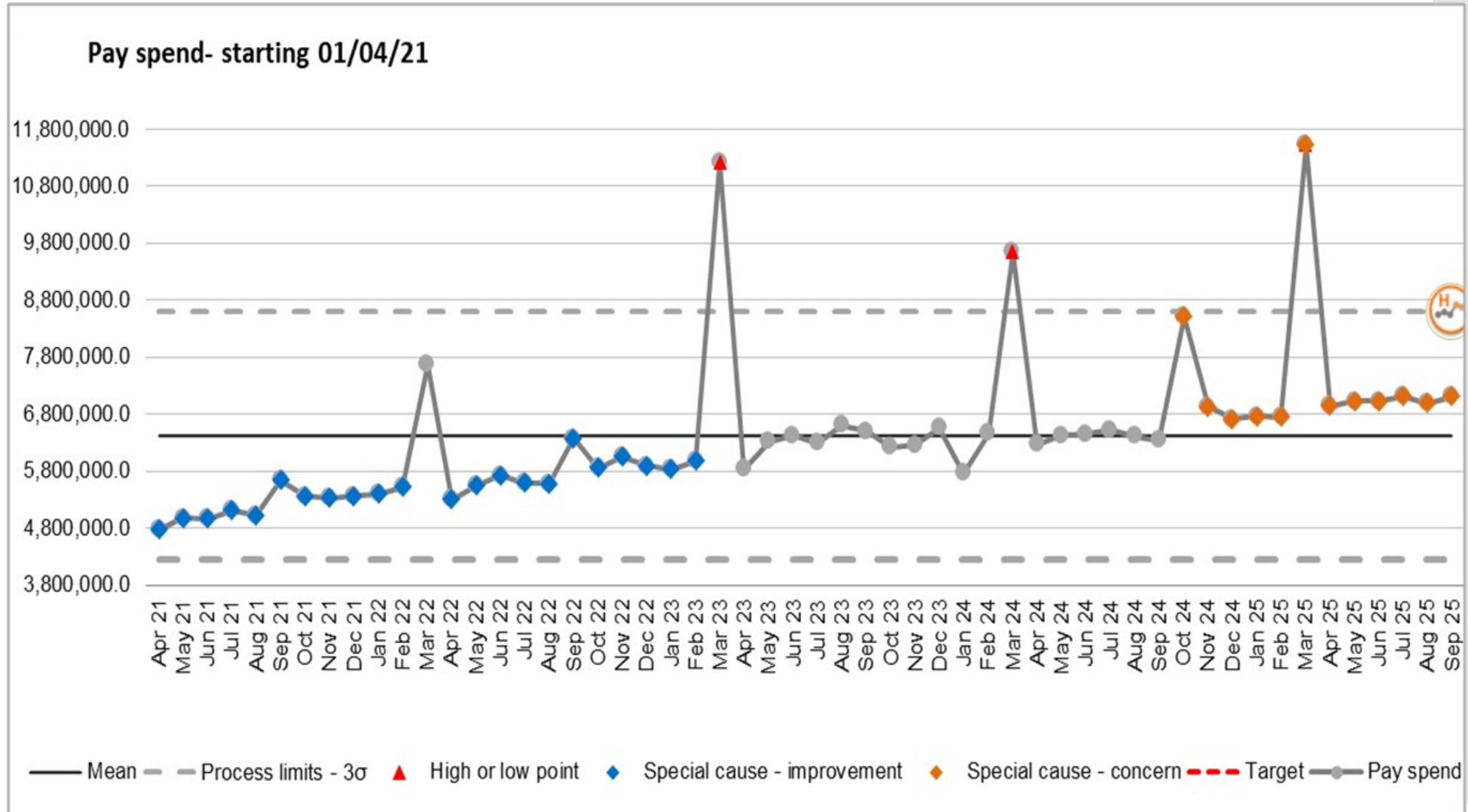
SUMMARY

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 against plan has overspent by £173k in month and contributing to a year to date overspend of £572k.

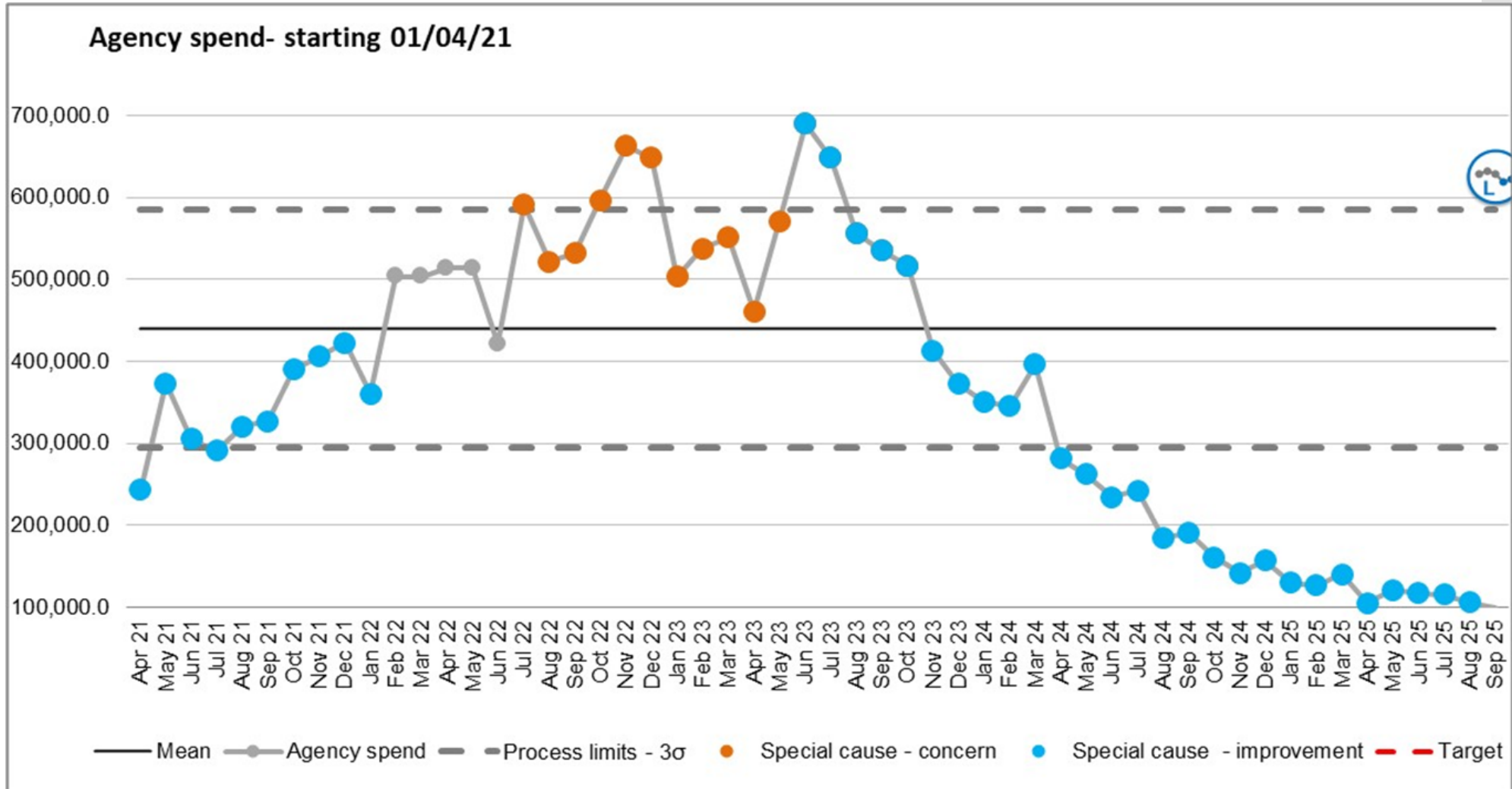
Year	£'000s			Substantive wte surgeons and anaesthetists
	LLP	ADH	Total	
17-18		1,672	1,672	63.28
18-19		1,950	1,950	61.57
19-20	274	1,503	1,777	64.48
20-21	271	432	703	70.22
21-22	1,460	438	1,898	75.58
22-23	1,865	882	2,747	71.66
23-24	3,382	1,067	4,449	70.22
24-25	3,629	1,307	4,936	77.66
25-26	1,089	305	1,394	78.62

16. Pay Expenditure

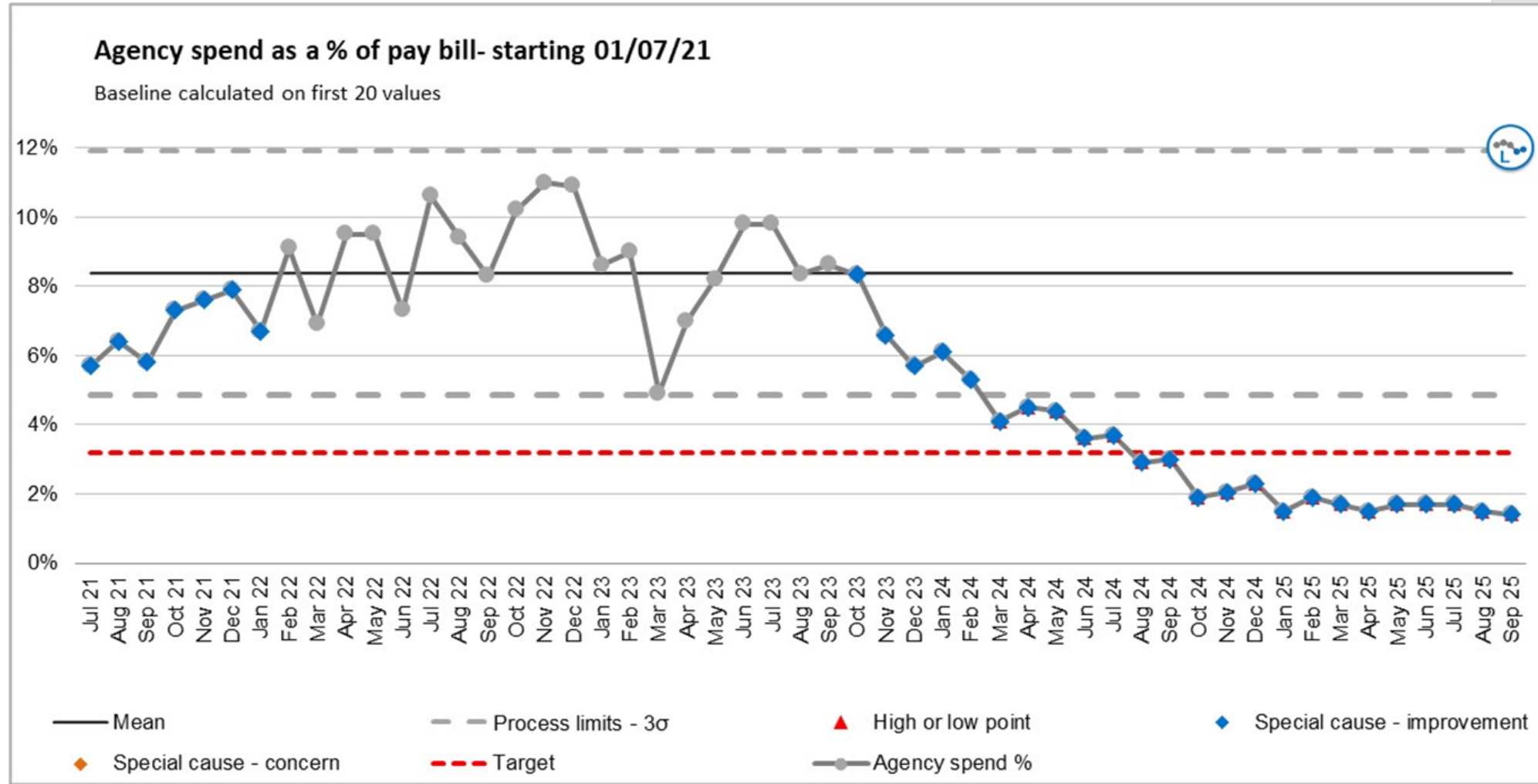


March'25 value includes pension adjustment
 October'24 pay value includes back dated pay award

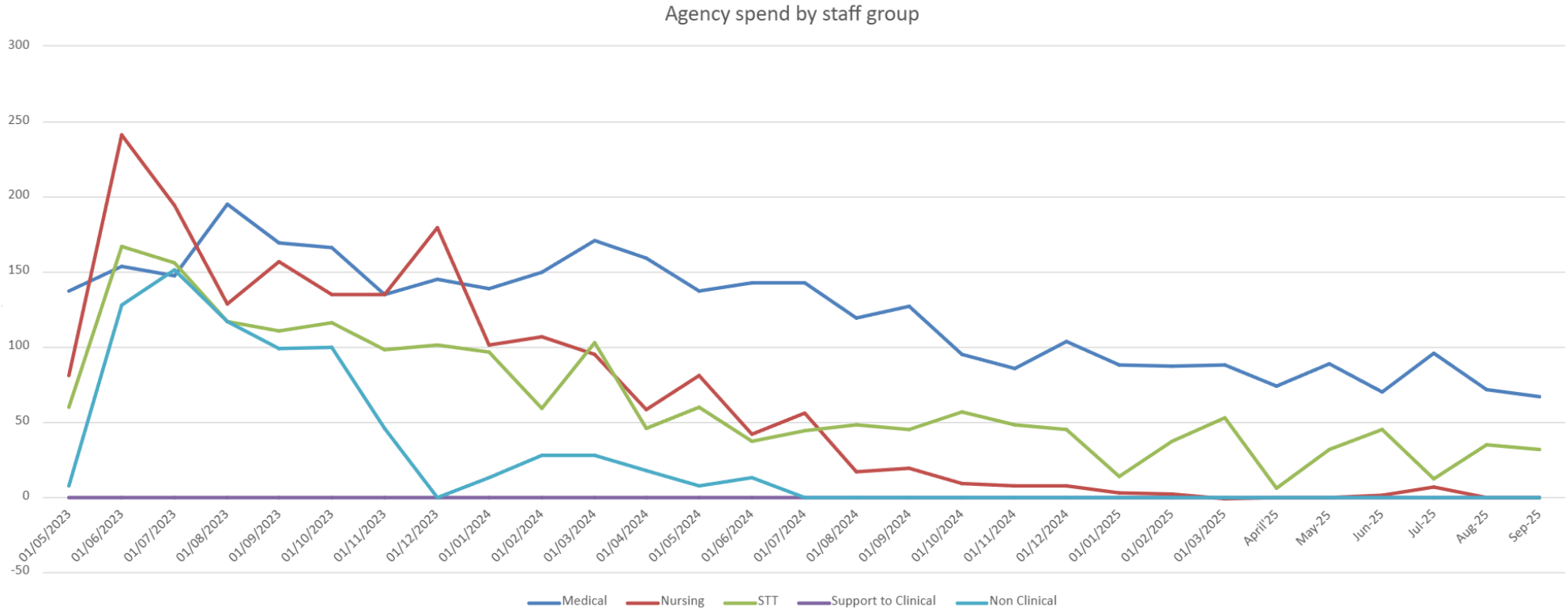
17. Agency Expenditure



17. Agency Expenditure



17. Agency Expenditure

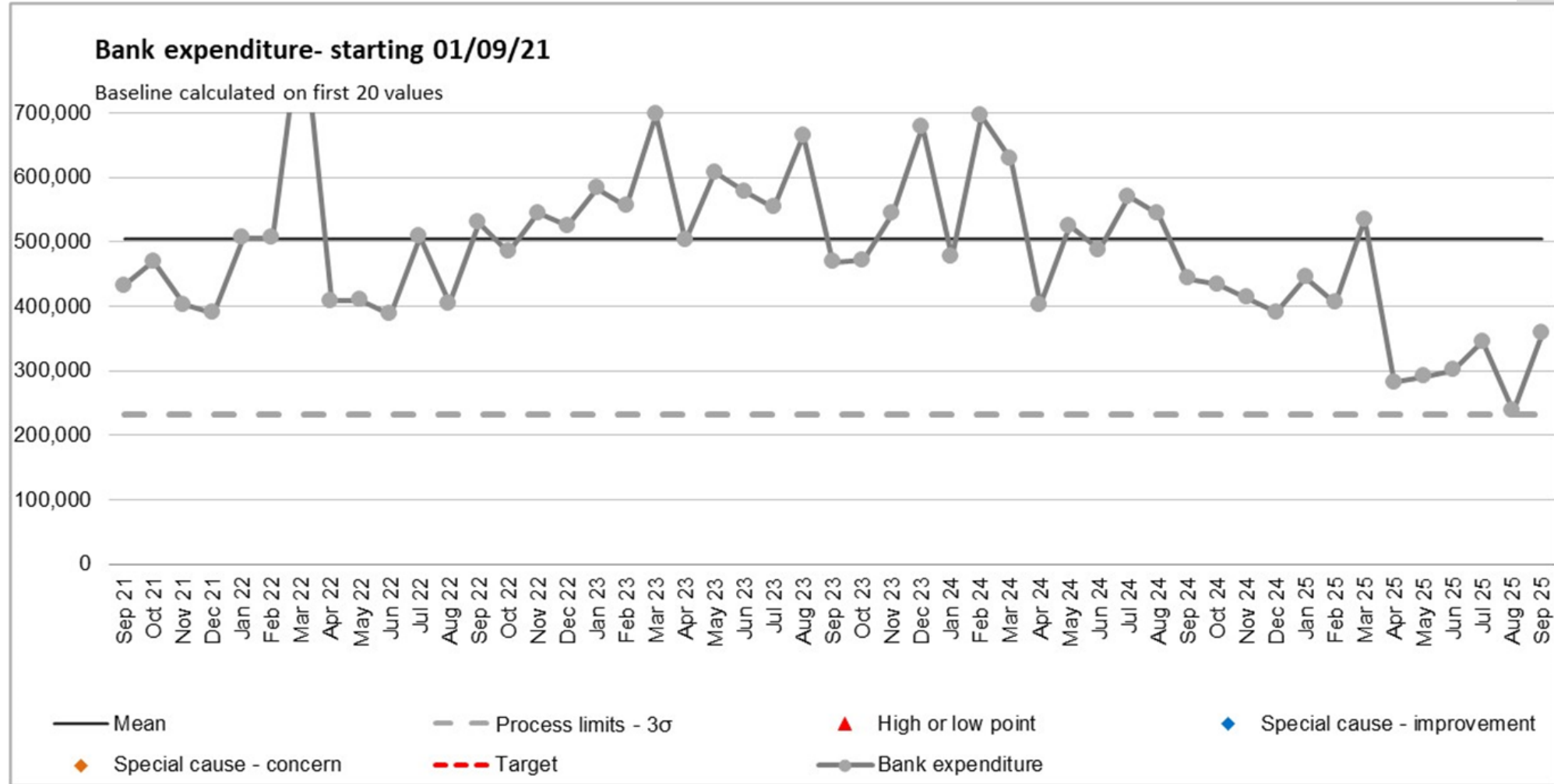


Note: nursing agency spend in July 25 relates to a 24/25 VAT adjustment and not shifts worked in month

17. Bank Expenditure

Bank expenditure														
	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25
Registered nursing	116	101	95	112	118	92	109	108	48	41	39	48	56	71
Healthcare scientists and Scientific, therapeutic tech	25	33	41	38	38	34	35	38	39	38	38	40	23	30
Support to clinical	78	55	56	61	69	55	38	94	26	20	34	32	24	35
Total medical and dental staff bank	107	88	117	85	52	124	88	142	58	97	76	119	46	105
NHS infrastructure support	200	151	125	117	111	140	119	157	110	95	115	95	90	118
TOTAL	543	443	434	413	390	445	404	534	282	291	301	334	238	359

17. Bank Expenditure



18. Cost Improvement Plan

SUMMARY

In month efficiencies of £683k has been generated increasing the year to date achieved to £3,301k against a plan of £3,856k, generating an underperformance of £555k.

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						Forecast						YTD	Full year
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12		
TOTAL	409	575	484	419	730	683	925	925	887	1,105	1,105	1,010	3,301	9,447
Non-Pay - Medicines efficiencies	-	16	-	12	6	10	8	8	8	8	8	8	44	92
Premium rate working reduction	241	66	273	174	178	60	246	246	246	246	246	246	992	2,470
Non-Pay - Procurement	58	82	55	43	55	60	35	35	35	51	51	51	353	611
Energy savings	-	-	-	-	-	16	17	17	17	17	17	17	16	118
Non-Pay - Digital transformation	-	72	-	70	36	2	67	67	67	67	67	67	181	583
Commercial Income	75	155	26	-	26	58	61	61	61	61	61	61	340	706
Service re-design	-	-	-	-	-	3	90	90	90	101	101	101	3	576
Budget Management	9	43	-	-	9	22	130	130	130	130	130	130	83	864
Temporary staffing reduction	26	141	130	120	238	452	160	160	122	132	132	-	1,107	1,815
Corporate services transformation	-	-	-	-	-	-	148	148	148	329	329	329	-	1,431
Other historic schemes	-	-	-	-	181	-	-	-	-	-	-	-	181	181

19. Statement of Financial Position

SUMMARY

The main movements in the balance sheet have been in relation to the reduction in debtors, increase in cash and reduction in payables.

Whilst much improved, due to the recent receipt of a large debtor balance, the cash position will need to remain closely watched, particularly as the capital slippage is corrected.

Despite the challenging cash position at times in month, support payments are not currently expected to be needed in 2056-26.

	2024/25 M12	2025/26 M6	Movement
Intangible Assets	933	749	(184)
Tangible Assets	66,859	64,527	(2,332)
Total Non Current Assets	67,792	65,276	(2,516)
Trade and other current assets	18,580	12,537	(6,043)
Cash	3,293	6,696	3,403
Total Current Assets	21,873	19,233	(2,640)
Trade and other payables	(18,235)	(12,414)	5,821
Borrowings	(13,722)	(12,067)	1,655
Provisions	(3,014)	(3,014)	-
Other Liabilities	(6,332)	(9,395)	(3,063)
Total Liabilities	(41,303)	(36,890)	4,413
Total Net Assets Employed	48,362	47,619	(743)
Total Taxpayers' and Others' Equity	48,362	47,619	(743)

20. Cash

SUMMARY

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.



21. System Position

After 6 months the system position is a YTD deficit of £37.5m, £21.5m adverse to plan. This represents a £0.4m decrease in deficit compared to month 5 and a £1.9m improvement in variance against plan compared to the YTD M5 variance. The system is behind plan by £21.5m year to date, with month 6 showing a £1.9m favourable variance, a £7.5m deterioration on the £5.6m variance delivered in month 5. Four organisations have been asked to produce a financial recovery plan, BSMHT, BCHC, BWC and UHB.

Total Performance	YTD			FOT			YTD Income / Allocation £000s	YTD Deficit as % of turnover
	Current Plan £000s	Actual £000s	Variance £000s	Annual Plan £000s	FOT £000s	Variance £000s		
BSOL ICB	-3,513	-2,233	1,280	0	-1	-1	2,149,067	-0.10%
BSMHT	2,086	-772	-2,858	4,200	4,200	0	364,145	-0.21%
BCHC	359	-998	-1,357	0	0	0	194,737	-0.51%
BWC	0	-4,740	-4,740	0	0	0	365,929	-1.30%
ROH	-756	-688	68	35	35	0	70,970	-0.97%
UHB	-14,201	-28,064	-13,863	-4,200	-4,162	38	1,329,250	-2.11%
Total	-16,025	-37,495	-21,470	35	72	37	4,474,098	

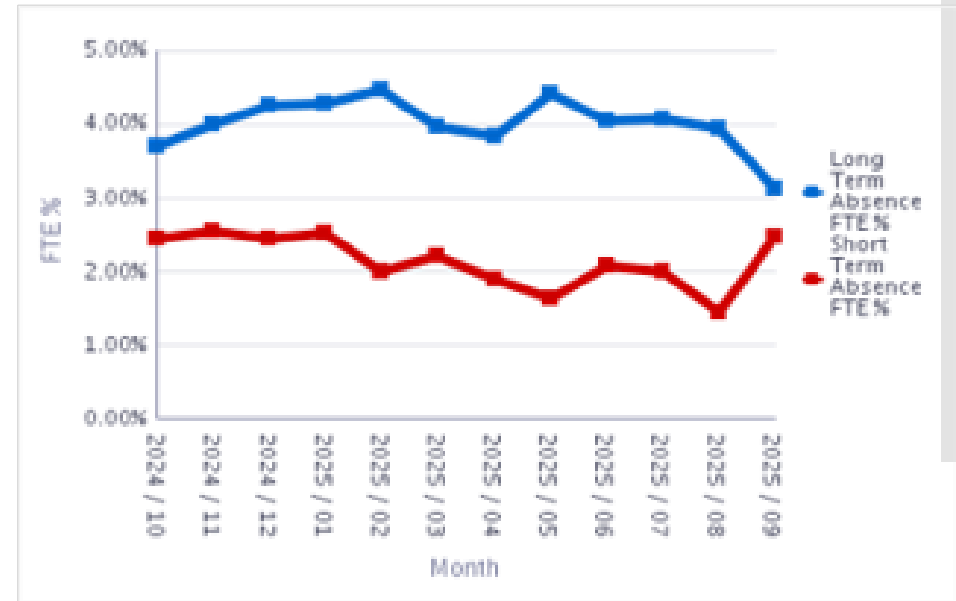
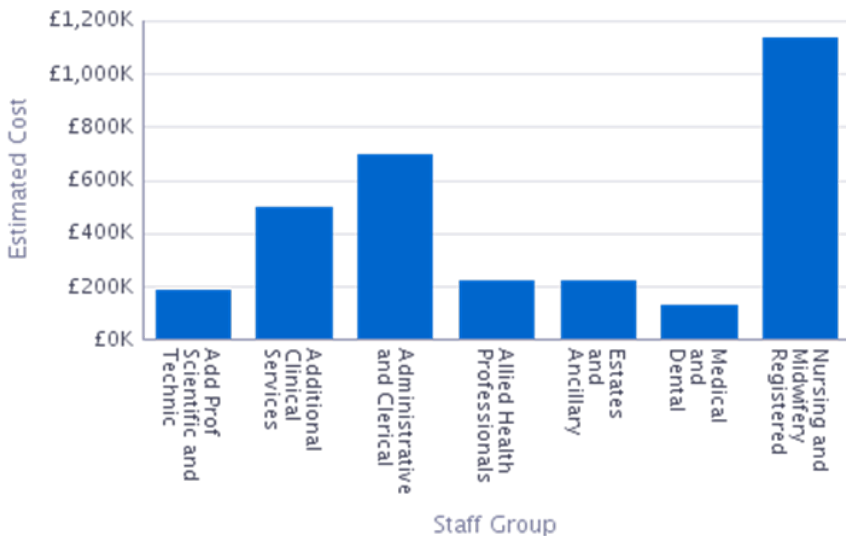
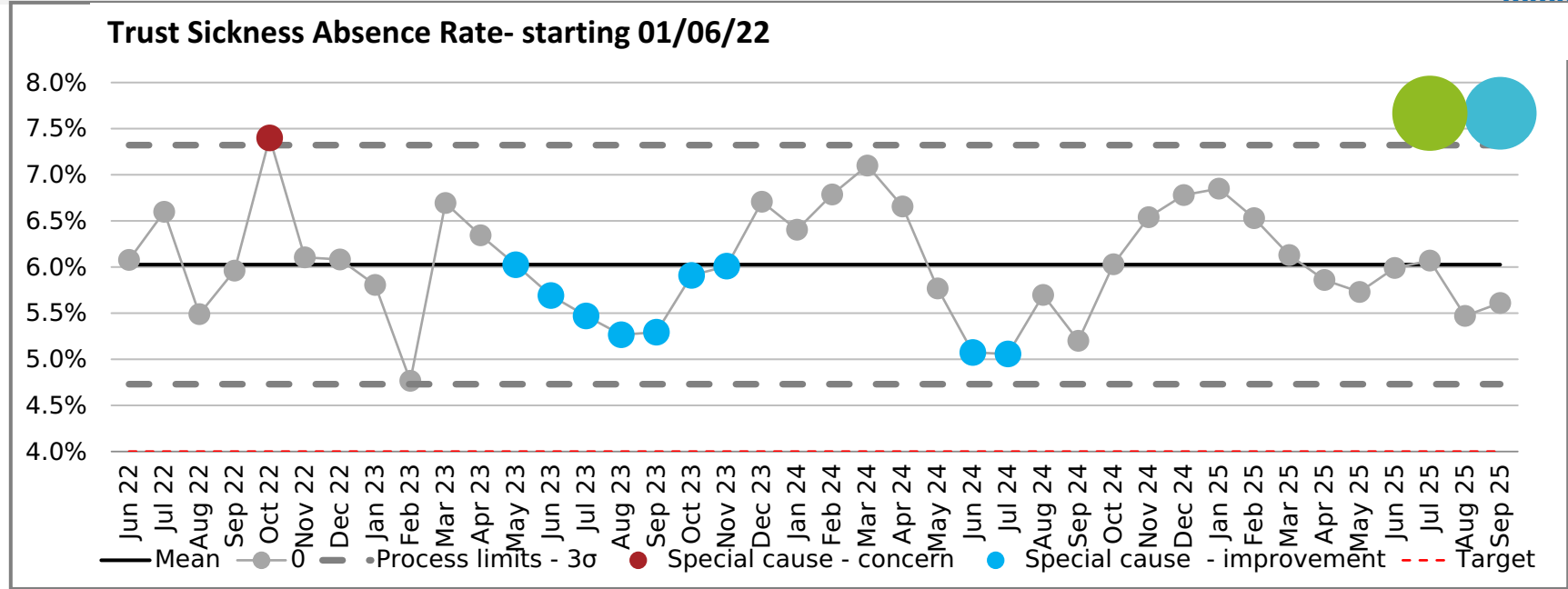
Total Variance	Trend						YTD £000s
	M1 £000s	M2 £000s	M3 £000s	M4 £000s	M5 £000s	M6 £000s	
BSOL ICB	0	78	-52	1,152	-269	371	1,280
BSMHT	-1,433	-1,843	-270	-128	77	740	-2,858
BCHC	-496	-688	-402	39	119	71	-1,357
BWC	-1,081	-698	-1,222	-1,630	-69	-40	-4,740
ROH	-96	629	-71	-110	-220	-64	68
UHB	-7,268	654	-1,822	-1,047	-5,243	863	-13,863
Total	-10,375	-1,869	-3,839	-1,723	-5,605	1,941	-21,470

22. Workforce

Trust Workforce Metrics	Aug-25	Sep-25	This Month vs Last Month	Trend	KPI
Staff In Post - Headcount	1471	1486	15	-	-
Staff In Post - Full Time Equivalent	1301.32	1294.75	-6.57	-	-
Staff Turnover % - Adjusted	10.10%	8.88%	-1.22%	↓	≤11.5%
Total WTE Employed as % of Establishment - Clinical	87.97%	91.17%	3.20%	-	≥92%
Total WTE Employed as % of Establishment - Non-Clinical	90.44%	91.62%	1.18%	-	≥96%
% Of Attendance	94.53%	94.38%	-0.15%	↓	≥96.3%
% Staff received mandatory training last 12 months	82.85%	83.13%	0.28%	↑	≥93%
% Staff received formal PDR/appraisal last 12 months	86.61%	90.00%	3.39%	↑	≥95%
% of Sickness - Trust wide Long-term	3.50%	3.14%	-0.36%	↓	-
% of Sickness - Trust wide Short-term	1.98%	2.48%	0.50%	↑	-
Return To Work Completion %	65.37%	67.01%	1.64%	↑	≥80%

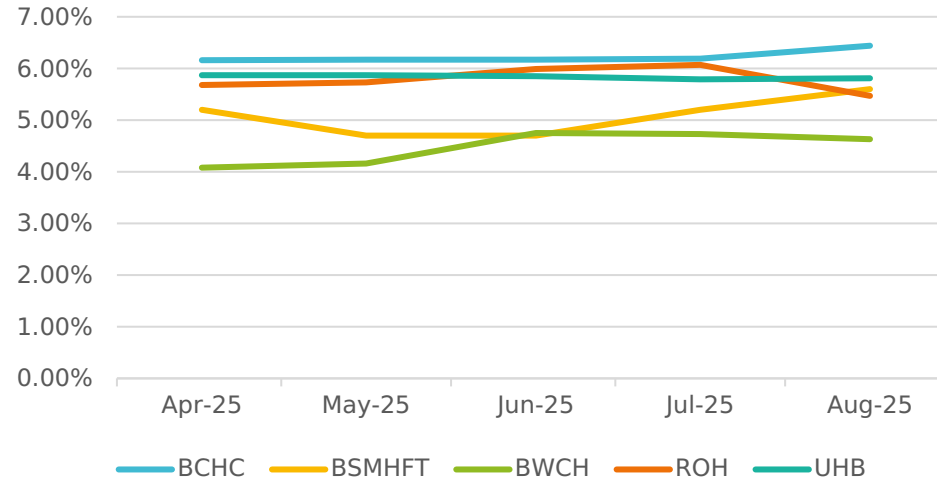
22. Workforce

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

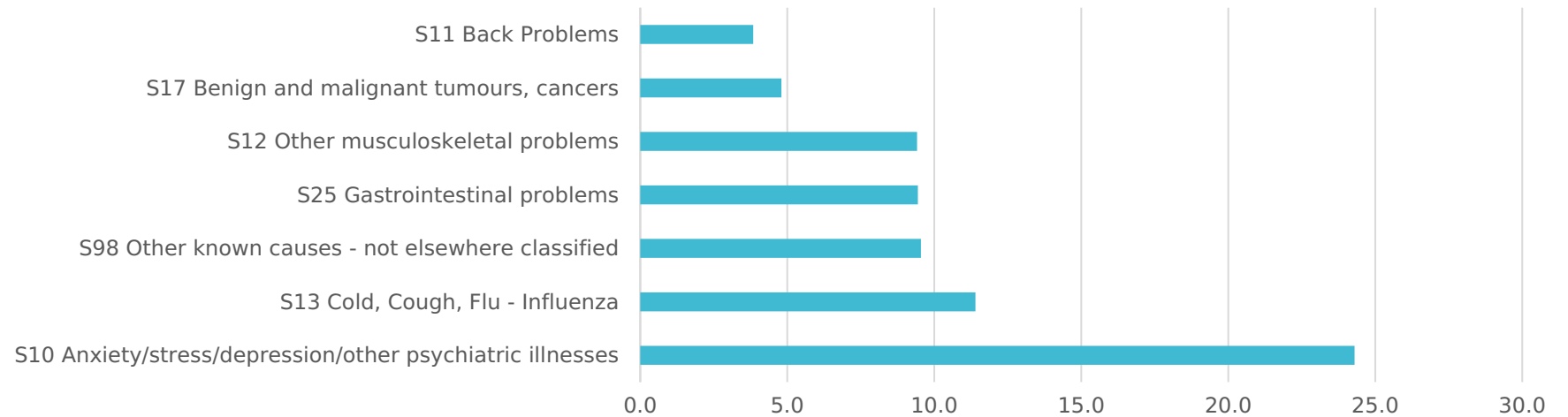


22. Workforce

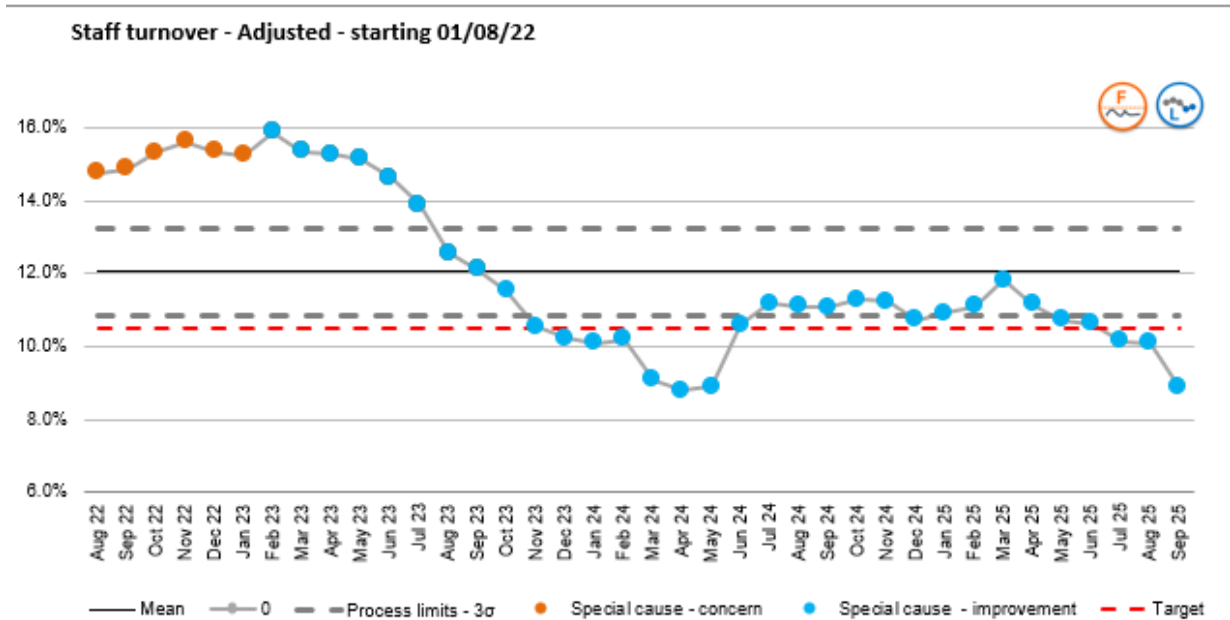
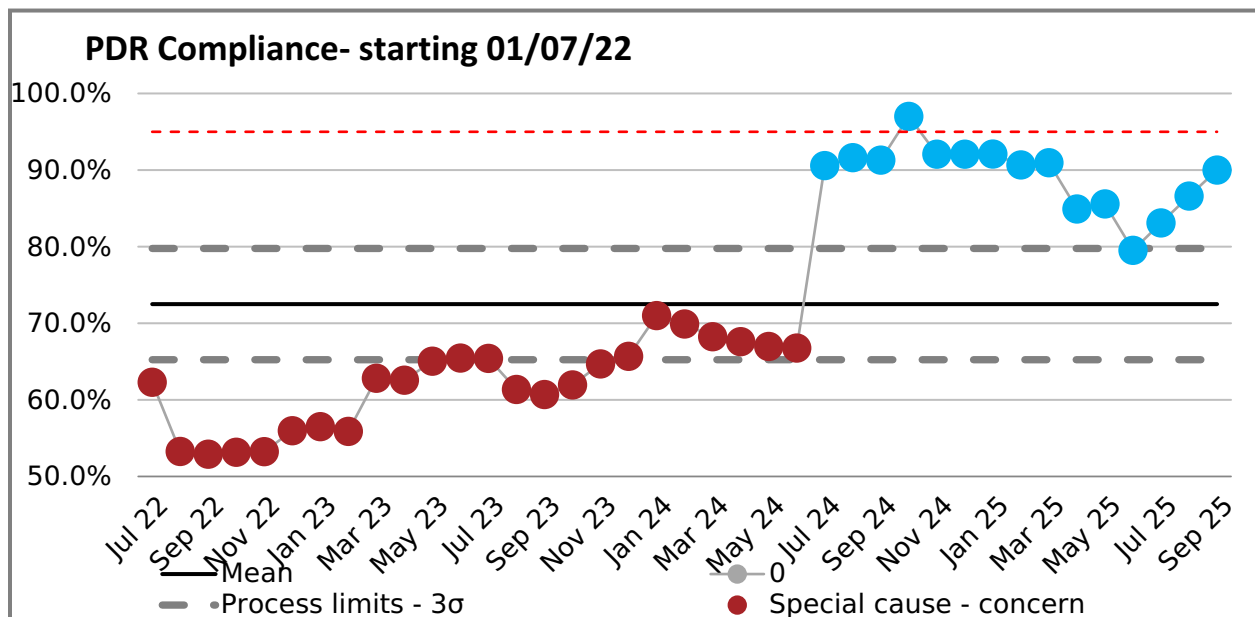
BSOL sickness benchmark



Highest absence reasons - Sept 2025



22. Workforce





The Royal
Orthopaedic Hospital
NHS Foundation Trust

Integrated Performance Dashboard



Metric Grouping	Metric Name	Reporting Period	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Inpatients	IP Activity Monthly Performance %	Monthly	97.3%	97.1%	90.4%	95.5%	92.4%	101.4%	109.9%	95.4%	109.4%	103.0%	101.5%	98.3%	98.4%	99.5%	101.1%		high is good			100%
Inpatients	IP Activity Electives Monthly Performance %	Monthly	88.8%	91.0%	91.9%	98.0%	90.4%	94.3%	102.0%	90.9%	111.8%	108.6%	98.9%	102.8%	100.9%	101.9%	104.4%		high is good			100%
Inpatients	IP Activity Daycases Monthly Performance %	Monthly	103.6%	101.0%	87.4%	93.1%	92.0%	106.5%	116.7%	97.1%	109.2%	98.5%	103.9%	91.6%	96.4%	99.0%	99.6%		high is good			100%
Inpatients	IP Activity Non-Electives Monthly Performance %	Monthly	163.6%	169.2%	171.4%	200.0%	227.3%	157.1%	118.2%	215.4%	57.7%	113.4%	86.2%	99.1%	99.8%	56.2%	92.2%		-	-	-	-
Inpatients	IP Activity Monthly Discharges	Monthly	1,230	1,274	1,246	1,243	1,126	1,359	1,340	1,252	1,168	1,204	1,208	1,231	1,206	1,301	7,318		high is good	-	-	-
Inpatients	IP Activity Elective Discharges	Monthly	515	548	581	574	506	579	571	547	485	530	487	539	528	564	3,133		high is good	-	-	-
Inpatients	IP Activity Daycase Discharges	Monthly	697	704	641	643	595	758	756	677	672	649	702	670	656	724	4,073		high is good	-	-	-
Inpatients	IP Activity Non-Elective Discharges	Monthly	18	22	24	26	25	22	13	28	11	25	19	22	22	13	112		-	-	-	-
Outpatients	OP Activity Monthly Performance %	Monthly	154.1%	102.8%	101.7%	96.1%	131.5%	106.8%	110.4%	98.0%	108.4%	103.3%	104.5%	99.1%	98.1%	106.5%	102.9%		high is good			100%
Outpatients	OP Activity First Monthly Performance %	Monthly	159.7%	107.1%	100.2%	106.0%	136.6%	112.1%	114.3%	96.4%	84.4%	89.2%	93.0%	91.8%	93.0%	102.3%	92.5%		high is good			100%
Outpatients	OP Activity Follow Up Monthly Performance %	Monthly	154.9%	103.0%	105.9%	94.1%	131.4%	106.3%	110.9%	101.7%	117.5%	111.0%	111.4%	103.3%	100.4%	107.9%	108.5%		high is good			100%
Outpatients	OP Activity Procedures Monthly Performance %	Monthly	116.2%	77.3%	64.2%	64.2%	104.4%	84.2%	83.7%	66.4%	127.5%	108.9%	101.9%	98.2%	107.7%	120.2%	110.5%		high is good			100%
Outpatients	OP Activity Monthly Attendances	Monthly	5,617	5,930	6,483	6,130	5,591	6,813	6,035	6,248	6,046	5,872	6,240	6,478	5,577	6,658	36,871		high is good	-	-	-
Outpatients	OP Activity First Monthly Attendances	Monthly	1,859	1,974	2,041	2,159	1,856	2,284	1,997	1,964	1,681	1,778	1,947	2,105	1,853	2,243	11,607		high is good	-	-	-
Outpatients	OP Activity Follow Up Monthly Attendances	Monthly	3,512	3,697	4,204	3,733	3,477	4,217	3,772	4,038	4,050	3,825	4,029	4,094	3,458	4,088	23,544		high is good	-	-	-
Outpatients	OP Activity Procedures Monthly Attendances	Monthly	246	259	238	238	258	312	266	246	315	269	264	279	266	327	1,720		high is good	-	-	-
Outpatients	Outpatient Did Not Attend	Monthly	7.9%	8.1%	8.2%	7.9%	8.4%	8.2%	8.0%	7.1%	7.5%	7.0%	6.8%	6.0%	7.1%	6.2%	6.9%		low is good			8%
Outpatients	PIFU	Monthly	9.4%	10.0%	9.4%	9.8%	10.2%	11.0%	11.8%	10.1%	10.5%	10.4%	9.8%	10.6%	11.0%	11.4%	10.5%		high is good			5%
Outpatients	Virtual Attendances	Monthly	11.0%	10.0%	10.2%	10.5%	11.4%	9.9%	9.3%	9.8%	9.4%	7.9%	9.2%	9.7%	10.4%	8.8%	9.30%		high is good			
Outpatients	OP Attendances Patients Who Waited 31 to 60 Mins to be Seen	Monthly	7.7%	9.2%	8.5%	7.2%	6.7%	8.1%	7.5%	6.1%	7.1%	11.7%	15.1%	13.2%	7.2%	8.6%	10.88%		low is good			
Outpatients	OP Attendances Patients Waited Over 60 Mins to be Seen	Monthly	1.4%	3.4%	2.3%	1.9%	1.7%	2.3%	1.9%	1.6%	1.9%	3.9%	4.9%	5.2%	1.2%	2.8%	3.42%		low is good			



Outpatients	Outpatient Did Not Attend	Monthly	7.9%	8.1%	8.2%	7.9%	8.4%	8.2%	8.0%	7.1%	7.5%	7.0%	6.8%	6.0%	7.1%	6.2%	6.9%		low is good			8%
Outpatients	PIFU	Monthly	9.4%	10.0%	9.4%	9.8%	10.2%	11.0%	11.8%	10.1%	10.5%	10.4%	9.8%	10.6%	11.0%	11.4%	10.5%		high is good			5%
Outpatients	Virtual Attendances	Monthly	11.0%	10.0%	10.2%	10.5%	11.4%	9.9%	9.3%	9.8%	9.4%	7.9%	9.2%	9.7%	10.4%	8.8%	9.30%		high is good			
Outpatients	OP Attendances Patients Who Waited 31 to 60 Mins to be Seen	Monthly	7.7%	9.2%	8.5%	7.2%	6.7%	8.1%	7.5%	6.1%	7.1%	11.7%	15.1%	13.2%	7.2%	8.6%	10.86%		low is good			
Outpatients	OP Attendances Patients Waited Over 60 Mins to be Seen	Monthly	1.4%	3.4%	2.3%	1.9%	1.7%	2.3%	1.9%	1.6%	1.9%	3.9%	4.9%	5.2%	1.2%	2.8%	3.42%		low is good			
referral to treatment	RTT Total Waiting List Under 18 weeks	Month Ending	53.36%	52.90%	52.81%	51.84%	51.61%	52.01%	53.14%	54.66%	55.63%	58.33%	60.07%	60.34%	61.47%	62.32%	NA		high is good			58.37%
referral to treatment	RTT First Appointment Waiting List Under 18 weeks	Month Ending	53.57%	53.28%	53.08%	52.11%	52.79%	53.62%	53.06%	54.06%	54.61%	57.78%	61.78%	62.03%	64.55%	66.54%	NA		high is good			64.80%
referral to treatment	RTT Total Waiting List Size	Month Ending	15,709	15,069	14,901	14,561	14,517	13,777	13,291	12,738	12,739	12,798	12,952	13,345	13,447	13,351	NA		low is good			13,304
referral to treatment	RTT Patients Waiting 65 Week waits	Month Ending	9	0	1	0	13	19	6	1	0	0	0	0	0	0	NA		low is good			0
referral to treatment	RTT Patients Waiting 52 week waits (52-64 weeks)	Month Ending	590	641	843	889	842	727	672	487	486	507	466	446	427	375	NA		low is good			397
referral to treatment	RTT Proportion of Patients Waiting 52 weeks and over	Month Ending	3.81%	4.25%	5.66%	6.11%	5.89%	5.41%	5.10%	3.83%	3.82%	3.96%	3.60%	3.34%	3.18%	2.81%	NA		low is good			2.98%
Workforce	Staff In Post - Headcount	Monthly	1,449	1,457	1,456	1,463	1,461	1,468	1,481	1,479	1,483	1,486	1,483	1,480	1,471	1,468	1,479			-	-	-
Workforce	Staff In Post - Full Time Equivalent	Monthly	1,280	1,287	1,286	1,291	1,291	1,296	1,309	1,309	1,314	1,315	1,312	1,306	1,301	1,295	1,307			-	-	-
Workforce	Staff Turnover Percentage - Adjusted	Monthly	11.18%	11.07%	10.70%	11.20%	11.50%	10.90%	11.11%	11.83%	9.28%	10.73%	10.64%	10.15%	10.10%	8.88%	9.96%		low is good			11.5%
Workforce	Total Whole Time Equivalent Employed as a Percentage of Establishment - Clinical	Monthly	87.32%	87.32%	87.30%	87.30%	87.30%	87.30%	88.74%	88.74%	89.14%	88.43%	87.97%	88.40%	91.17%	91.17%	89.38%		high is good			92%
Workforce	Total Whole Time Equivalent Employed as a Percentage of Establishment - Non Clinical	Monthly	93.83%	93.83%	93.80%	91.30%	91.30%	91.30%	91.34%	91.34%	90.40%	90.25%	90.44%	90.20%	91.62%	91.62%	90.76%		high is good			96%
Workforce	Percentage of Attendance	Monthly	94.82%	94.72%	93.90%	93.40%	93.20%	93.10%	93.47%	93.78%	94.32%	94.27%	94.01%	93.93%	94.53%	94.38%	94.24%		high is good			96.3%
Workforce	Percentage of Staff Received Mandatory Training last 12 months	Monthly	86.28%	86.91%	87.20%	89.20%	89.60%	88.90%	89.56%	89.92%	86.99%	86.63%	87.43%	86.82%	82.85%	83.13%	85.64%		high is good			93%
Workforce	Percentage of Staff Received Formal PDR/Appraisal last 12 months	Monthly	91.62%	91.30%	97.00%	92.00%	92.00%	90.60%	90.96%	90.17%	84.92%	85.58%	79.52%	83.10%	86.61%	90.00%	84.96%		high is good			95%
Workforce	Percentage of Sickness Trust Wide Long Term	Monthly	3.76%	3.70%	3.30%	3.41%	3.69%	3.38%	3.79%	3.49%	3.17%	3.57%	3.34%	3.38%	3.50%	3.14%	3.35%		low is good	-	-	-
Workforce	Percentage of Sickness Trust Wide Short Term	Monthly	2.17%	2.25%	2.70%	3.12%	3.09%	3.47%	4.15%	4.43%	2.66%	2.16%	2.64%	2.69%	1.98%	2.48%	2.44%		low is good	-	-	-
Workforce	Return to Work Completion %	Monthly	56.83%	67.65%	63.90%	60.80%	55.80%	66.00%	62.33%	61.32%	67.44%	61.22%	66.24%	69.33%	65.37%	67.01%	66.10%		high is good			80%

Finance	I&E Surplus / (Deficit) (£k)	Monthly	(241)	(111)	(522)	(69)	(181)	(679)	(688)	2,490	(377)	402	(242)	(164)	(291)	(17)	(689)		high is good	-	-	(803)
Finance	I&E Margin (%)	Monthly	(2.10%)	(1.00%)	(3.80%)	(0.60%)	(1.60%)	(5.90%)	(6.20%)	11.40%	(3.30%)	3.30%	(2.10%)	(0.90%)	(2.50%)	(0.10%)	1.10%		high is good	-	-	-1%
Finance	I&E Variation from Plan	Monthly	(82)	(73)	(482)	(80)	(271)	(541)	(707)	2,357	(102)	635	(71)	(110)	(220)	(64)	68		low is good	-	-	0
Finance	EBITDA (%)	Monthly	2.80%	4.00%	0.50%	4.00%	3.90%	(0.90%)	(0.90%)	15.10%	2.30%	8.40%	3.40%	(1.10%)	3.00%	5.20%	4.30%		high is good	-	-	4%
Finance	CIP Value	Monthly	278	946	498	375	308	321	691	553	409	575	484	418	549	683	3,118		high is good	-	-	3,052
Finance	CIP Performance	Monthly	83.59%	232.92%	113.70%	80.47%	62.60%	61.85%	126.54%	89.12%	82.79%	105.70%	89.96%	60.23%	70.20%	84.95%	(617)		high is good	-	-	0
Finance	Agency Expenditure	Monthly	185	190	161	142	157	105	126	140	105	121	117	115	106	99	663		low is good	-	-	752
Finance	Agency % of total pay bill	Monthly	2.90%	3.00%	1.90%	2.00%	2.30%	1.50%	1.90%	1.20%	1.50%	1.70%	1.70%	1.60%	1.50%	1.40%	1.60%		low is good	-	-	1.60%
Finance	Capital - Variation to Plan (including impact of IFRS 18)	Monthly	564	(215)	(833)	643	(1,014)	184	408	(507)	65	65	275	111	245	371	841		low is good	-	-	1,128
Finance	Cash Balance at end of month	Monthly	7,651	4,332	6,666	6,379	8,139	6,173	5,570	3,293	1,578	835	4,034	3,258	8,158	6,696	8,158		high is good	-	-	4,976
Finance	BPPC Invoices Paid < 30 days (Volume %)	Monthly	81.30%	82.20%	82.80%	83.00%	83.40%	83.10%	83.70%	82.80%	72.20%	73.00%	74.10%	76.50%	78.70%	78.70%	78.70%		high is good	-	-	100%
Finance	BPPC Invoices Paid < 30 days (Value %)	Monthly	81.10%	82.00%	83.60%	82.20%	82.60%	80.30%	79.40%	78.30%	67.10%	68.50%	67.90%	66.10%	67.60%	71.20%	67.60%		high is good	-	-	100%
Finance	Creditor Days	Monthly	87	89	110	119	117	125	105	113	0	113	121	113	108	89	108		low is good	-	-	30
Finance	Debtor Days	Monthly	38	37	33	43	31	30	35	55	0	64	48	54	43	41	43		low is good	-	-	30
Finance	Operating Expenditure Days	Monthly	22	12	15	16	23	17	14	6	0	2	11	9	23	17	23		high is good	-	-	n/a
Governance	Number of Incidents Reported	Monthly	292	355	351	349	249	313	360	318	398	284	316	337	295	267	1,897		high is good	-	-	
Governance	Number of PSII (Patient Safety Incident Investigations)	Monthly	0	0	2	1	1	1	0	1	0	1	1	1	1	1	5		low is good			0
Governance	Number of Inpatient Deaths	Monthly	0	1	0	0	0	0	2	1	1	0	1	1	0	0	3		low is good			0
Governance	Number of Inpatient Deaths within 30 days of discharge	Monthly	1	1	2	1	3	1	0	0	0	0	4	1	1	1	7		low is good			0
Governance	Number of Never Events	Monthly									0	1	0	0	1	1	3		low is good			0
Governance	Number of VTE (Avoidable)	Monthly	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0		low is good			0
Governance	Number of Category 2 Pressure Ulcer Incidents (Avoidable)	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good			0
Governance	Number of Category 3 Pressure Ulcer Incidents (Avoidable)	Monthly	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good			0
Governance	Number of Inpatient Falls	Monthly	9	5	9	10	9	6	7	7	8	10	5	4	7	9	43		low is good	-	-	-
Governance	Number of Infection Incidents (Reportable)	Monthly	0	0	0	0	1	0	0	0	0	0	0	0	1	0	1		low is good			0
Governance	Number of Complaints	Monthly	4	6	11	3	7	8	8	6	8	5	6	9	12	0	40		low is good	-	-	-
Governance	Number of PAL contacts	Monthly	63	53	36	59	36	63	60		52	56	41	41	44	0	234		low is good	-	-	-
Governance	Number of Claims	Monthly	0	0	0	0	0	0	0	0	0	2	1	1	0	0	4		low is good			0



Operational Productivity	Theatre Number of Sessions Planned	Monthly	537	546	581	543	511	563	520	558	533	528	536	561	518	572	3,248		-	-	-	
Operational Productivity	Theatre Session Utilisation	Monthly	83.24%	86.52%	84.19%	88.40%	85.48%	93.07%	89.23%	84.64%	90.42%	84.63%	83.05%	85.03%	84.17%	87.85%			high is good			85%
Operational Productivity	Theatre In-Session Utilisation Upcapped	Monthly	81.33%	83.59%	81.19%	81.21%	79.36%	82.47%	83.64%	84.04%	84.38%	84.54%	82.37%	81.68%	85.30%	83.61%			high is good			85%
Operational Productivity	Theatre Touchtime Utilisation Upcapped	Monthly	78.47%	80.94%	77.33%	78.27%	75.85%	75.88%	80.29%	81.12%	81.76%	80.48%	79.21%	77.34%	82.67%	79.88%			high is good			85%
Operational Productivity	Average Number Of Operations Per List	Monthly	2.97	2.90	2.64	2.84	2.78	3.05	3.08	2.96	3.15	3.19	3.12	3.00	3.16	3.07	3.12		high is good	-	-	-
Operational Productivity	Average Mins Late Starts(minutes) *Based on 9pm Start Time	Monthly	0	2	1	1	0	1	0	0	0	0	0	0	0	0	0		low is good	-	-	-
Operational Productivity	Average Early Finishes (minutes)	Monthly	86	87	94	92	117	94	85	83	82	84	84	92	81	83	84		low is good	-	-	-
Operational Productivity	Average Patient Turnaround (minutes)	Monthly	13	12	17	14	13	14	13	11	13	16	13	16	14	16	15		low is good	-	-	-
Operational Productivity	Total Cancellations	Monthly	109.00	75.00	70.00	69.00	145.00	54.00	61.00	116.00									low is good	-	-	-
Operational Productivity	Admitted Treatment Deferred	Monthly	32	23	39	28	35	44	36	24	28	36	24	38	24	34	184		low is good	-	-	-
Operational Productivity	Cancelled By Hospital On Day of Admission	Monthly	3	7	10	3	6	4	2	3	2	2	2	5	0	4	15		low is good	-	-	-
Operational Productivity	Cancelled By Hospital Day Before Day of Admission	Monthly	22	21	29	25	25	27	22	26	35	19	28	27	24	24	157		low is good	-	-	-
Operational Productivity	LOS - Trust Wide All Services	Monthly	4.1	3.5	3.8	4.3	4.5	3.3	3.4	3.7	4.1	3.7	3.9	3.8	4.3	3.4	3.9		low is good	-	-	-
Operational Productivity	LOS - Excluding Oncology, Paeds, YAH, Spinal	Monthly	3.69	3.13	3.39	3.78	4.08	3.05	3.03	3.15	3.46	3.27	3.45	3.03	3.74	3.03	3.3		low is good	-	-	-
Operational Productivity	LOS - Elective Primary Hip	Monthly	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	2.9	2.8		low is good			2.7
Operational Productivity	LOS - Elective Primary Knee	Monthly	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	2.6	2.8		low is good			2.7
Operational Productivity	BADS Daycase rate	Monthly	57.30%	54.80%	53.70%	51.70%	51.50%	52.40%	51.10%	53.40%	54.60%	53.50%	53.00%	52.40%	53.60%	56.30%	53.90%		high is good	-	-	-
Operational Productivity	OP for first or follow-up Attendances attracting a procedure tariff	Monthly	37.33%	37.36%	34.51%	38.66%	37.44%	37.95%	37.35%	37.50%	38.00%	38.00%	37.50%	35.60%	37.50%	35.60%	37.03%		high is good	-	-	-



Quality Report

October 2025 (September 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 exception if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

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

Variation Icons

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



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



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



A grey graph icon tells us the variation is common cause, and there has been no significant change.
For measures that are not appropriate to monitor using SPC you will see the "N/A to SPC" icon instead.

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

Assurance Icons

Can we expect to reliably hit the target?



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



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



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



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



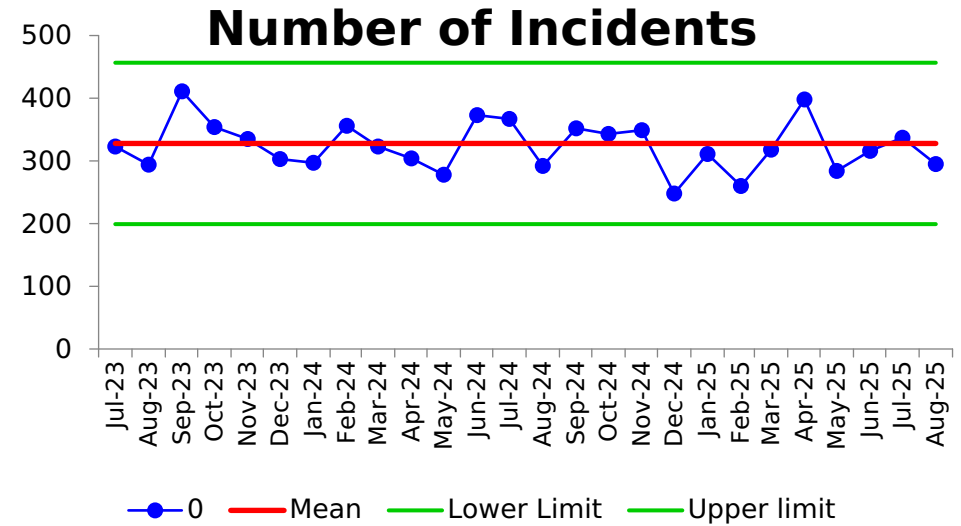
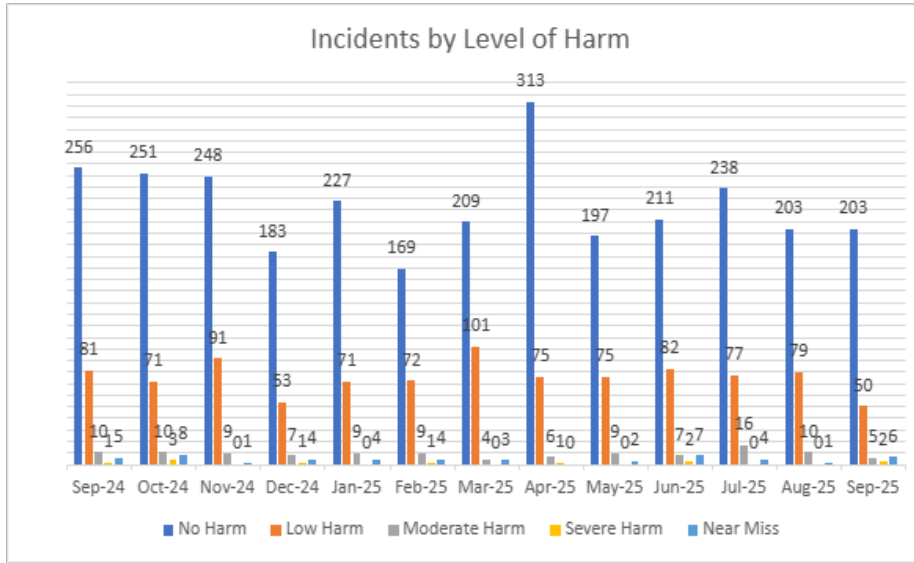
Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

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

Governance Performance Summary Dashboard

Performance to end September 2025	In month	Previous month	Variation	Assurance
Total No of Incidents Reported	267	295		
Inpatient Deaths	0	0		
PSII's (Patient Safety Incident Investigations)	1	1		
Never Events	1	1		
VTE Incidents (Avoidable)	0	0		
Category 2 Pressure Ulcer Incidents (Avoidable)	0	0		
Category 3 Pressure Ulcer Incidents (Avoidable)	0	0		
Falls (Total No of Inpatient Falls)	9	7		
Infection Incidents (Reportable)	0	1		
Complaints		12		
Claims	0	1		
Inquest	0	0		
RIDDOR Reportable Incidents	0	1		

Incidents Reported



Quality Improvement & Learning

There were 267 incidents reported within the Trust during September 2025.

In September 2025 there was a Retained Foreign Object Never Event incident reported. A PSII has been commissioned and an update on identified learning and improvements will be provided in a future report

Incidents Reported...
(continued)

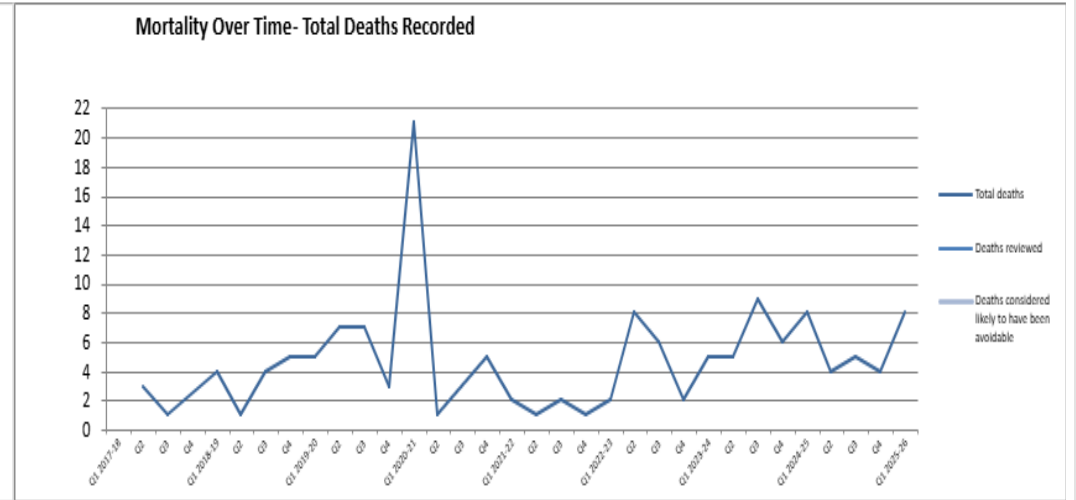
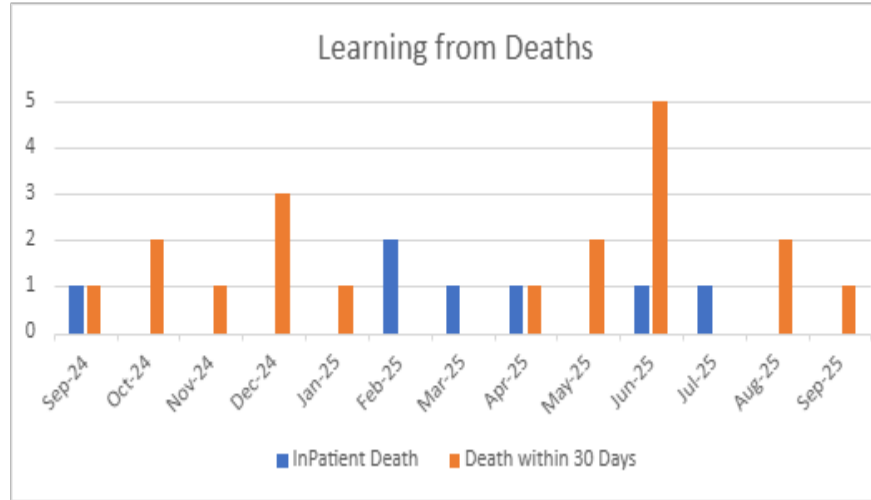
Financial Year 2025-2026

PSIRF Investigation Method	In Month	Last month	Year to Date
PSII	1	1	4
AAR	0	2	4
MDT	0	0	0
Thematic Review	1	1	3

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

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

Learning from Deaths



Quality Improvement & Learning

There were no inpatient deaths reported in September 2025.

There was 1 death within 30 days of discharge reported in September 2025.

There are 3 upcoming Inquest hearings during October and November 2025. Updates on the outcomes will be included in a future report

Infection Prevention & Control

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

Note: Toxin positive cases of CDI are reportable, and all healthcare associated (HOHA and COHA) toxin positive cases count towards the ROH threshold.

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

	CDI (Toxin +ve)	<i>E.coli</i> BSI	<i>P. aeruginosa</i> BSI	<i>Klebsiella Sp.</i> BSI	MRSA BSI
2023/24	5	0	0	1	0
2024/25	1	2	0	0	0
2025/26	0	0	0	0	0

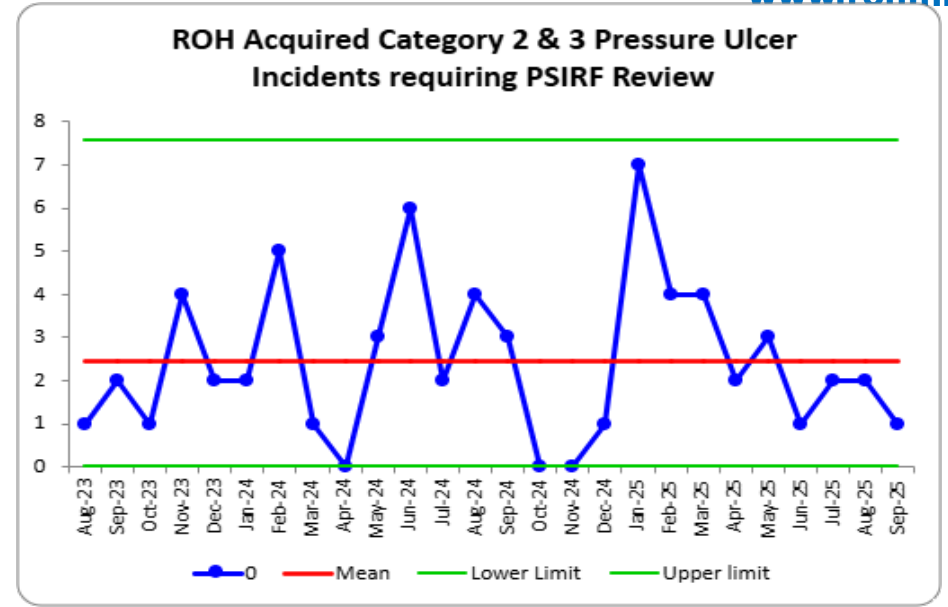
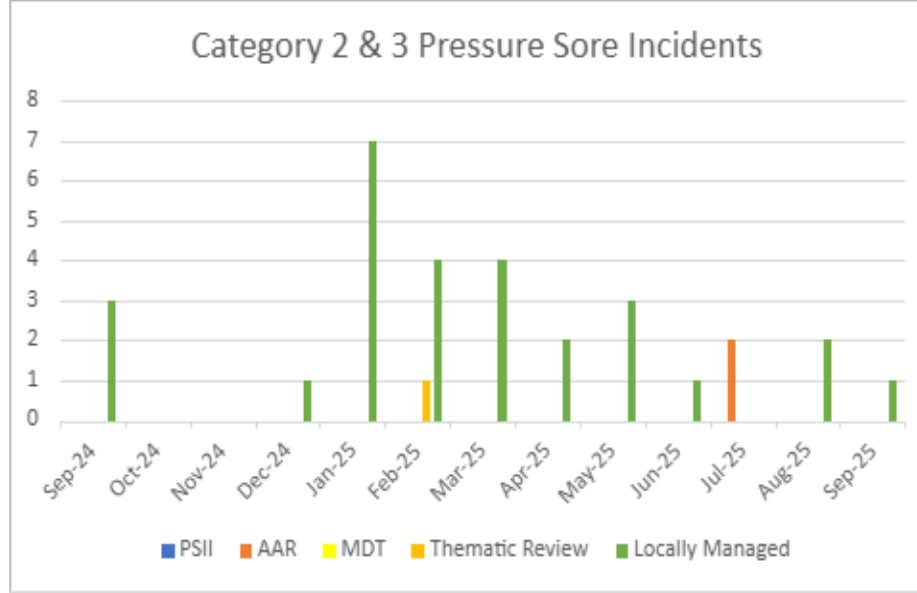
QUALITY IMPROVEMENT WORK

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).

Tissue Viability



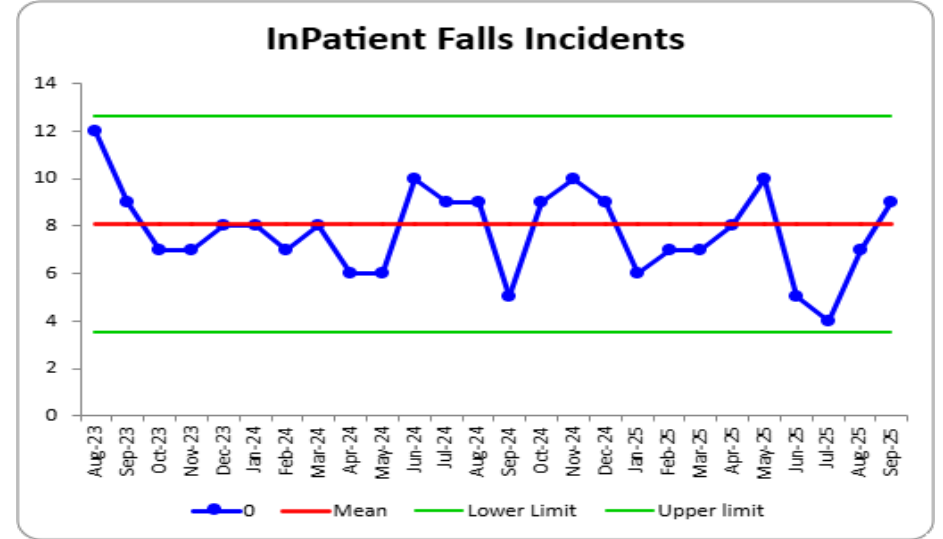
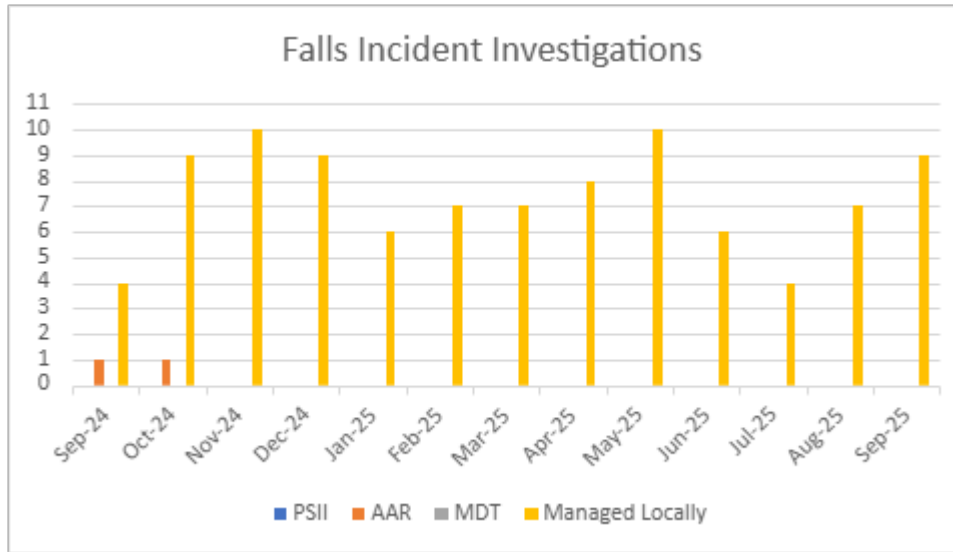
Quality Improvement & Learning

There was 1 hospital acquired category 2 pressure ulcer incident reported in September 2025. This incident is being managed locally.

Summary of on-going Quality Improvement work

- PURPOSE-T fully implemented
- Tissue Viability Assurance audits – Clinical areas – 100% compliance
- ROH Registered Nurses Education Review
- Data collection in progress
- Pressure Ulcer Policy
- Amendments regarding PURPOSE – T in progress
- Awaiting European Pressure Ulcer Advisory Panel (EPUAP) & National Pressure Ulcer Advisory Panel (NPUAP) guidelines - due for release Oct 25

Falls



Quality Improvement & Learning

There were 9 inpatient falls reported in September 2025. All incidents were reported as no or low harm and are all being managed locally. There is an increase in the number of inpatient falls this month, compared to the last 3 months. However, the number of falls in the last 3 months has been exceptionally low compared to the monthly average. All incidents are rated as no or low harm and are being managed locally.

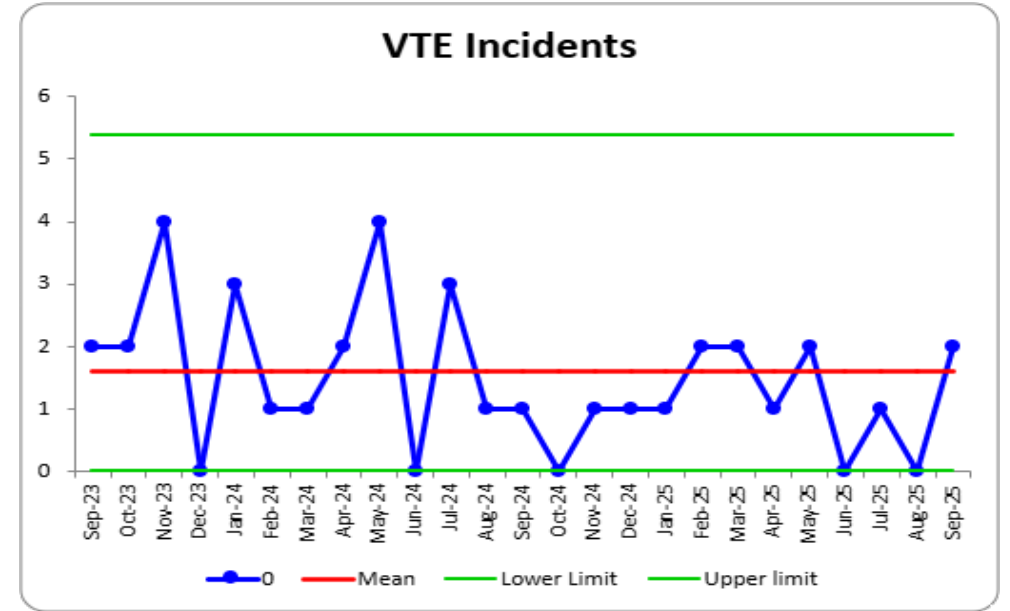
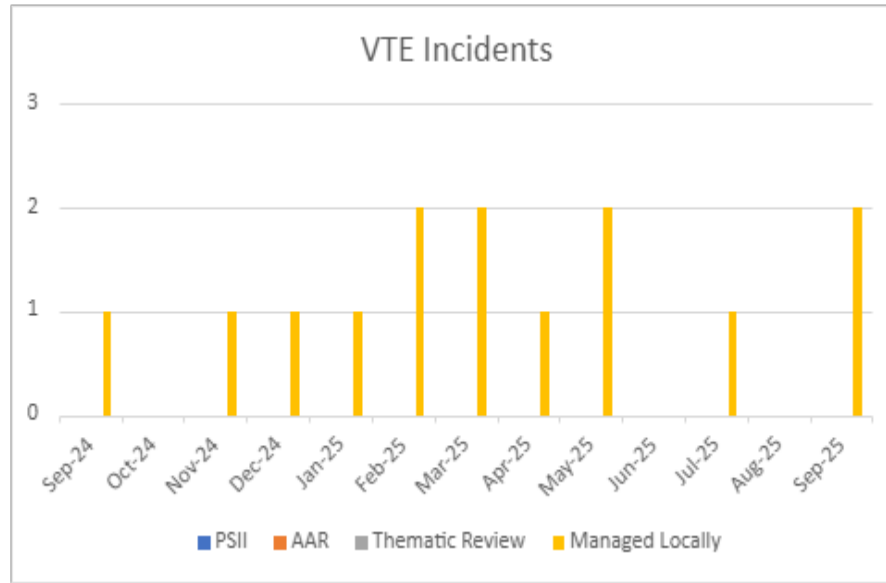
Themes

- 4 of the reported falls involved patients mobilising against advice and not wearing suitable footwear - an increase in the number of patients falling after mobilising against advice, particularly when either wearing AES, not wearing slippers or not using a walking aid. Action: dissemination of message through ward managers - to reinforce to patients the risks of mobilising against advice, particularly to wear appropriate footwear and use prescribed walking aid.
- 3 of the falls involved spinal patients.

Quality and Improvement Work

- Successful promotion of National Falls Prevention Awareness Week 15th to 19th September 2025, stand held outside Café Royal to raise awareness, multiple staff made pledges of how they could personally take action to reduce falls in their area.
- New bed rails risk assessment for In-patients due to be launched at next leader's forum meeting.
- New toilet roll holders for Ward 4 have been commissioned, will be fitted following walk round of Ward 4 to ensure correct positioning.

VTEs



Quality Improvement & Learning

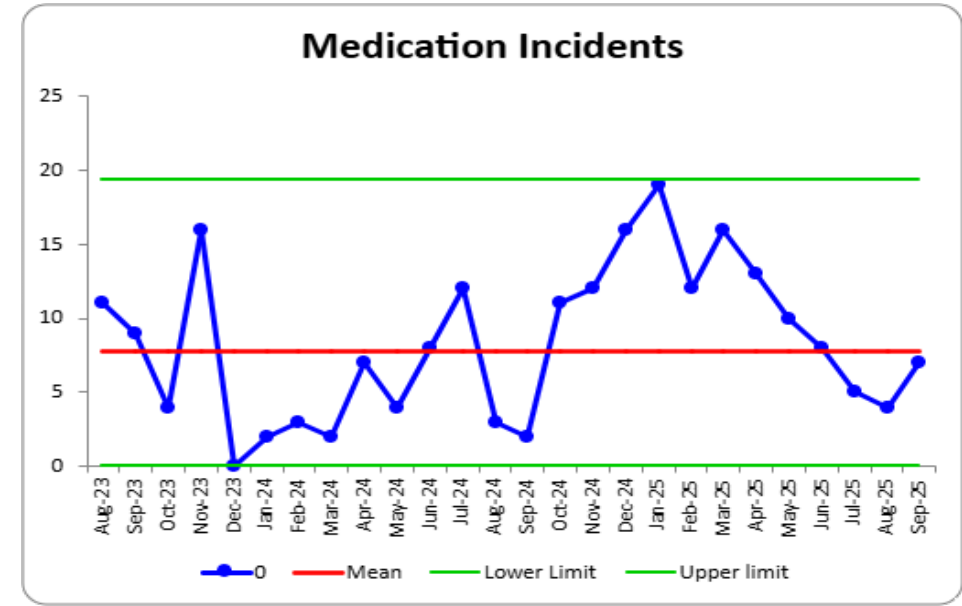
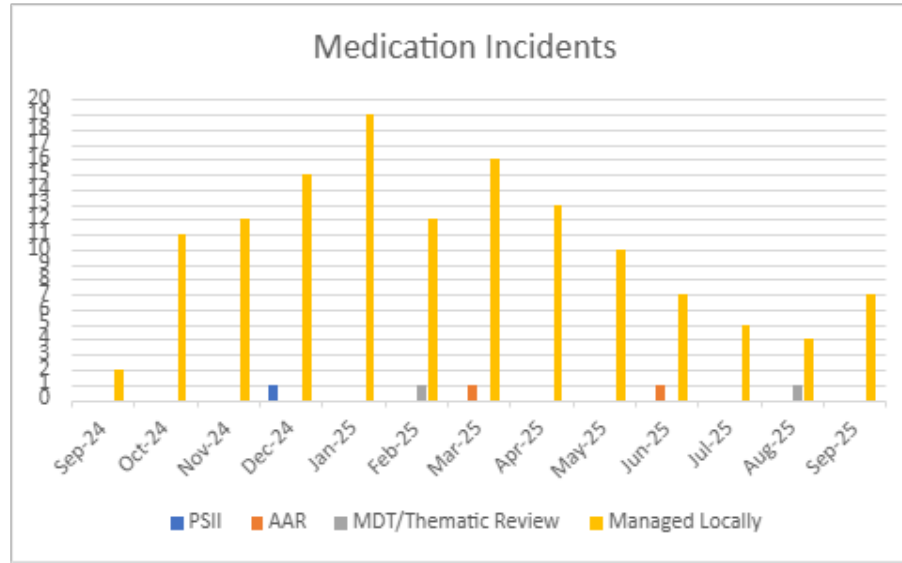
There were 2 confirmed VTE incidents reported in September 2025.

All recent VTE incidents have been deemed unavoidable after triage review.

VTE On Admission Assessment Compliance

Compliance figure for September 2025: 99.11%

Medication Errors

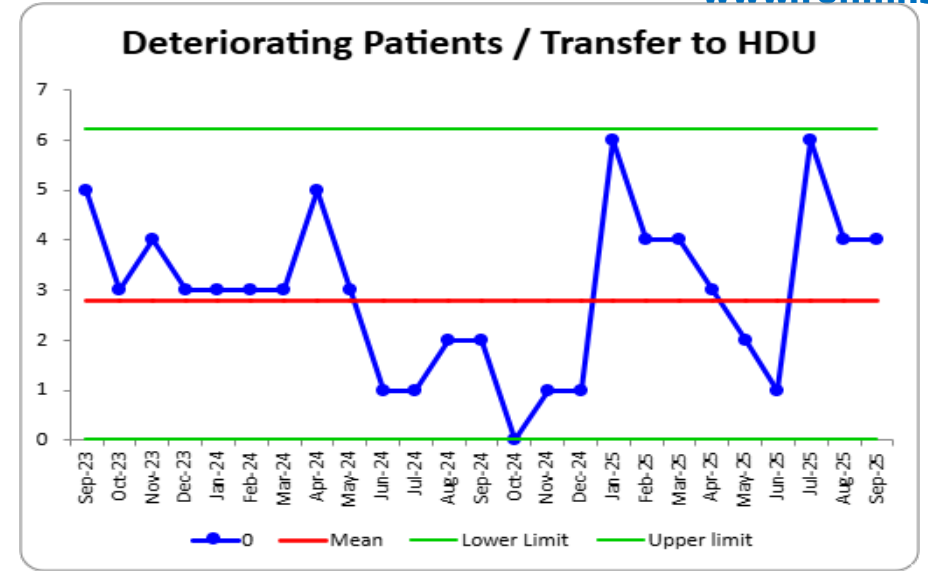
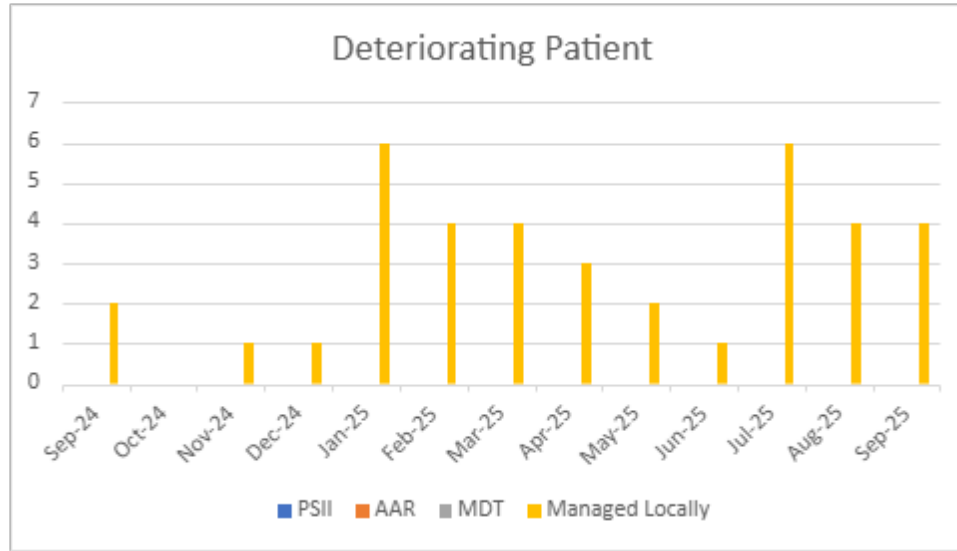


Quality Improvement & Learning

There were 7 Medication incidents reported in September 2025. All are being managed locally

Planned learning and actions around the variable rate intravenous insulin infusion (VRII) process by way of a coordinated approach with Consultant Physician to offer diabetes education for all staff. Pharmacy are piloting additional support for the discharge lounge and piloting a new way of counselling patients on their discharge medication using new resources, including links to in house recorded medicines information videos. The work of the acute pain short life working group is ongoing, and a revised trust wide pain management leaflet will be ready for approval at the October acute pain meeting.

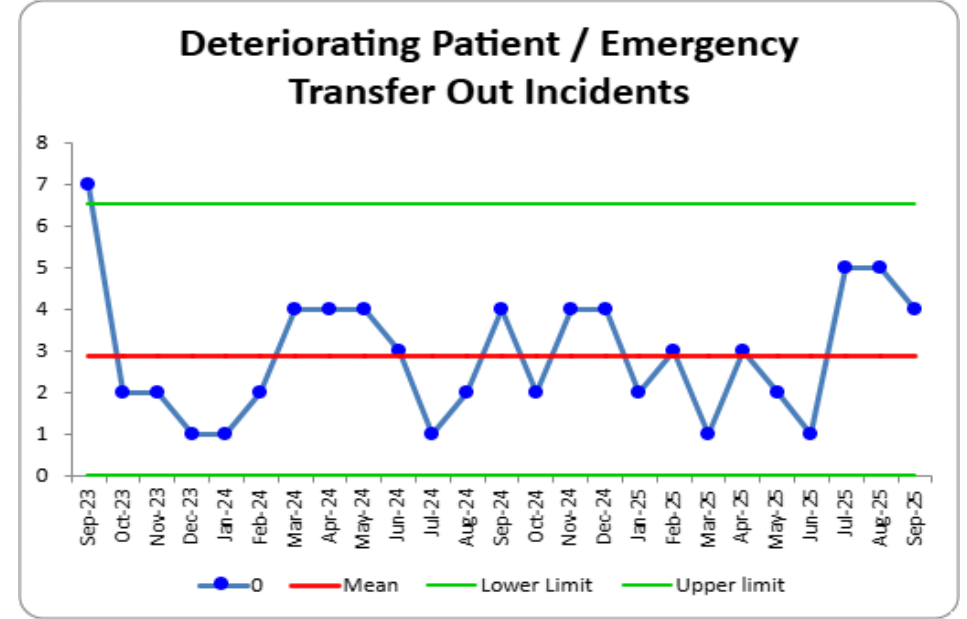
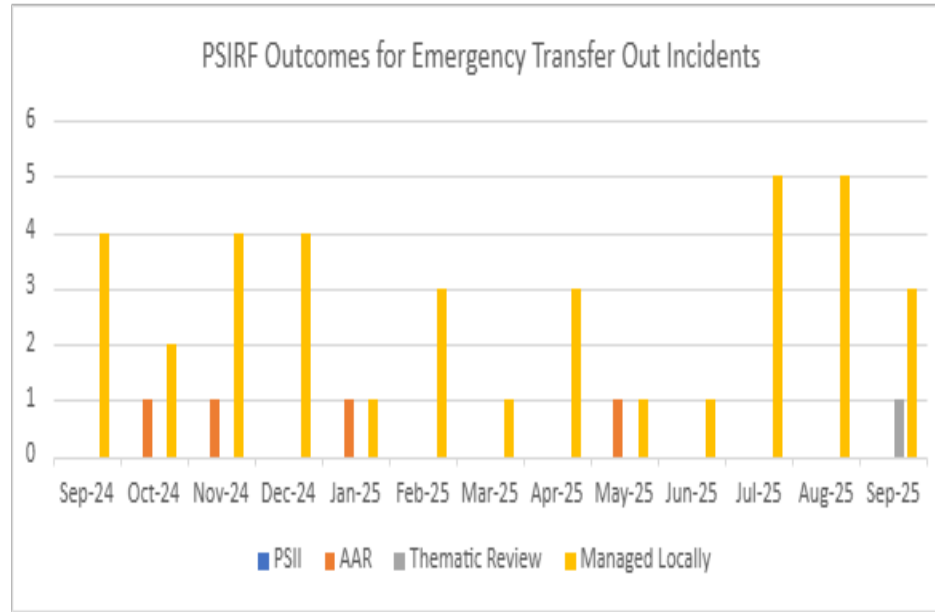
Deteriorating Patients



Quality Improvement & Learning

There were 4 deteriorating patient incidents reported in September 2025. All incidents were reported as no harm or low harm and are being managed locally.

Emergency Transfers Out



Quality Improvement & Learning

There were 4 emergency transfer out of Trust incidents reported in September 2025. All incidents were managed locally. The transfers out were all managed appropriately, with quick escalation and timely transfer for further care.

A thematic review has been commissioned to look at the emergency transfer out of Trust process and how we monitor patients after they have been transferred. The details of identified learning and improvement will be shared in a future report.

Complaints

Complaint Information

The Trust received 7 new formal complaints in September 2025. Of these, 2 were closed within the same month, while the remaining 5 were still open but within agreed timescales as of 30th September, resulting in a September KPI achievement of 100%. Additionally, 10 complaints opened in previous months were closed during September, with 6 of these breaching their originally agreed timescales. Nonetheless, the resolution of a total of 12 complaints during the month marks a positive step forward and strengthens the foundation for achieving the Trust's complaints recovery trajectory.

Below are the departments that received complaints

- Paediatrics
- Large Joints
- Pain Management
- Patient Experience
- Spinal x3

At the time of producing this report (28.10.2025) we currently have **16** formal complaints open. **6** Paused complaints – awaiting AAR investigations to be completed, NMC investigation to be completed, awaiting complainant to agree specific questions for complaint investigation, Supporting information from QEH but having to go through their complaint process.

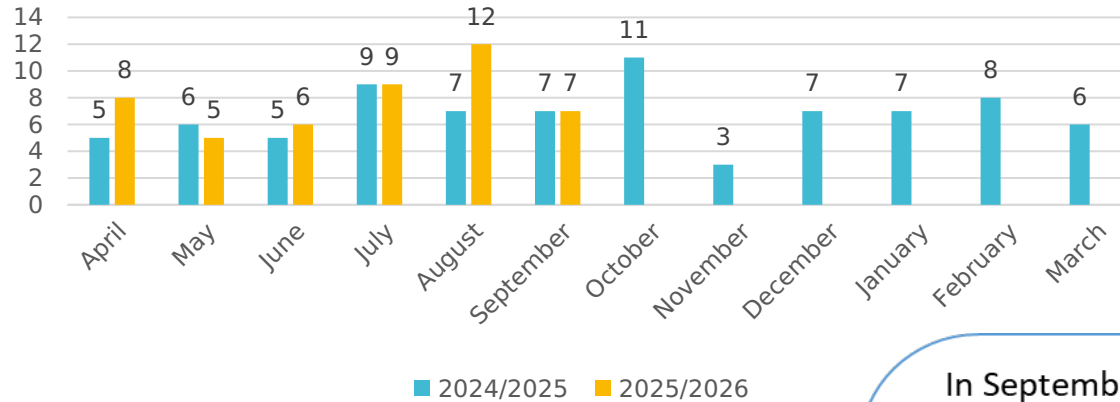
Complaint Resolution Meetings and Reopened Complaints

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 **September 2025** the Trust received 0 requests for a resolution meeting.

Complaints

Complaints received in 2025/2026 Compared to 2024/2025



Category of complaints received

- Clinical Query
- Appointments
- Communication
- Protected Characteristics
- Values & Behaviour Of Staff

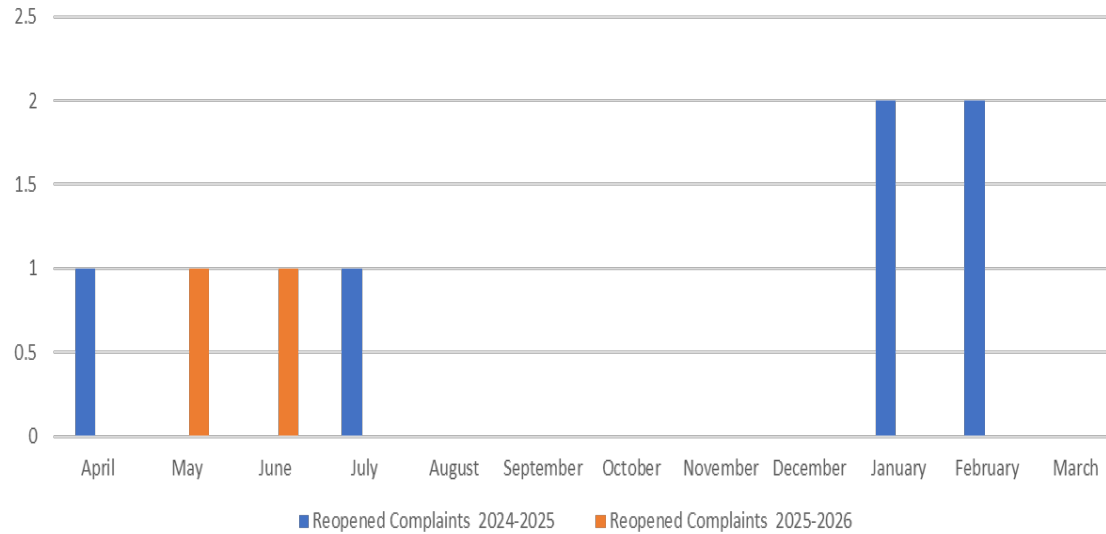
Complaint Year Totals	
April 2023 - March 2024	42
April 2024 – March 2025	92
April 2025 – September 2025	47

In September, a recurring theme emerged across patient and family complaints, highlighting concerns about not feeling heard during clinical appointments or when decisions were being made regarding care. This suggests a need to strengthen communication and further promote the shared decision-making practices to ensure patients and their families feel actively listened to and involved in their treatment journey.

Progress will be monitored through patient feedback channels such as FFT comments, complaints themes, and survey outcomes, with findings and identified actions reported through governance structures to ensure accountability and continuous improvement across the Trust.

Complaints

Reopened Complaints in 2025/2026 compared to 2024/2025



Reopened complaints

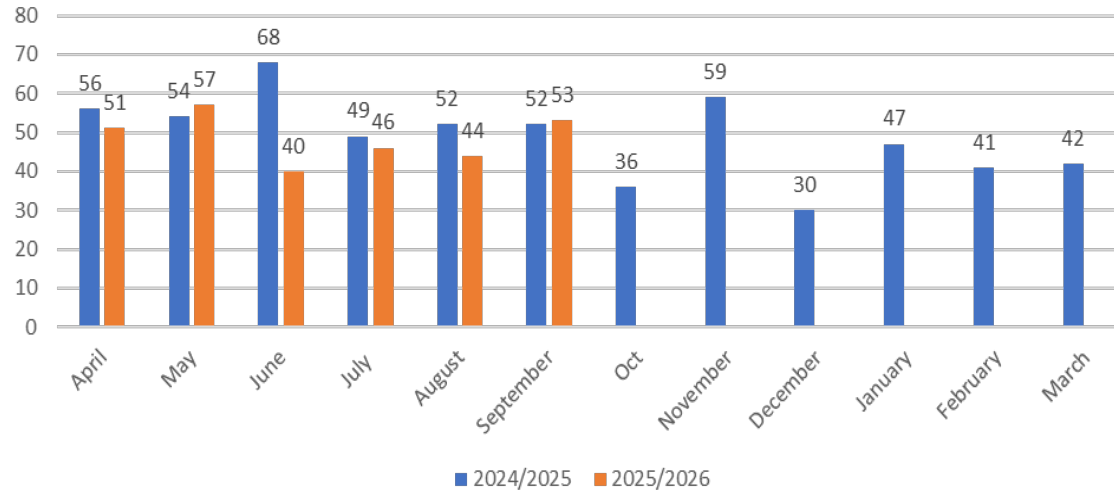
The Trust received **0** requests to reopen a complaint in **September 2025**.

What We Did / Are Doing

- Identified themes are raised and tracked through Divisional Governance Meetings
- Further tracking and oversight in Executive Governance Meetings
- Actions identified from complaints are recorded and entered into Ulysses with corresponding action plans. Where learning is identified this is shared across the Trust
- Updates on outstanding actions requested during bi-weekly governance meetings and recorded against the complaint.
- HoPE team sends weekly trackers and reminders to triumvirate, executives, and identified leads
- PALS department clarifies which cases have been resolved prior to divisional escalation
- Incident and notification reporting conducted where appropriate
- Increased cross-working with MDT teams, including Safeguarding and Learning & Development

PALS

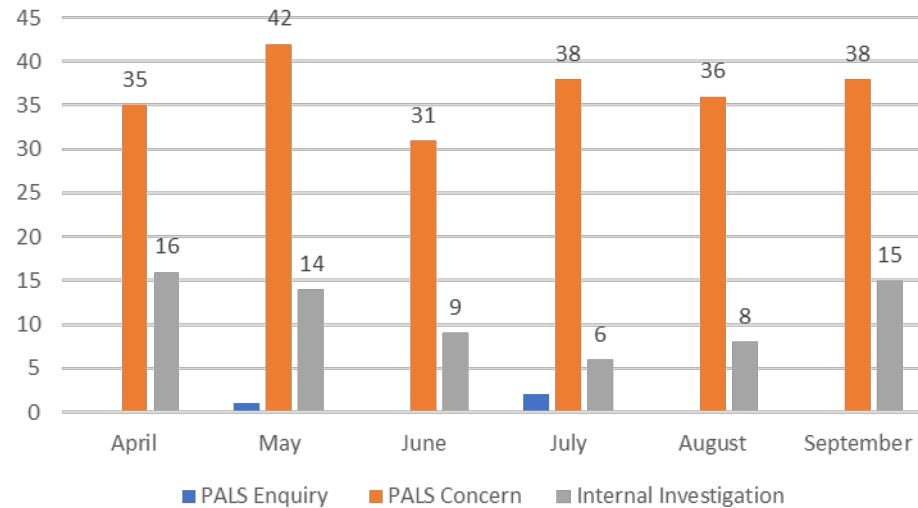
PALS Contacts received in 2025/2026 Vs 2024/2025



KPI's

KPI	Value
April 2025	83%
May 2025	74%
June 2025	81%
July 2025	70%
August 2025	70%
September 2025	67%

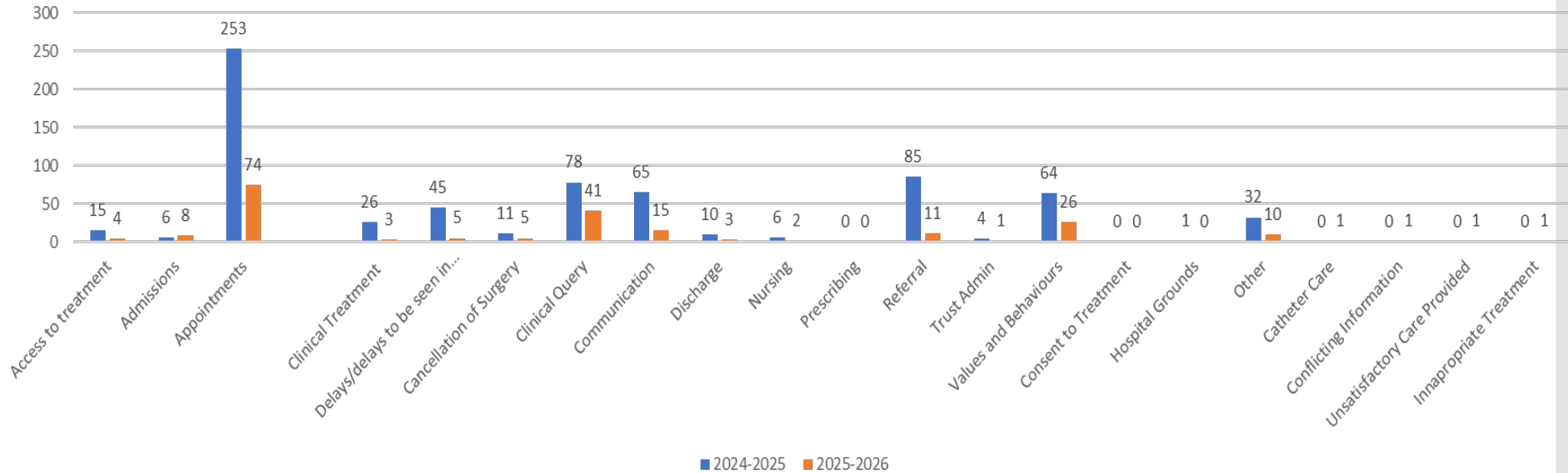
Internal Investigations VS PALS Contacts 2025



A total of 18 PALS concerns breached the agreed response timescales during September 2025. Although this can be partially attributable to seasonal annual leave being further impacted by staff absence it highlights the need for consistently improved timeliness in addressing patient concerns and ensuring that agreed standards are reliably met. Continued monitoring and escalation through governance structures is in place to support resolution and accountability.

PALS

Categories of PALS Contacts in 2025/2026 compared to 2024/2025

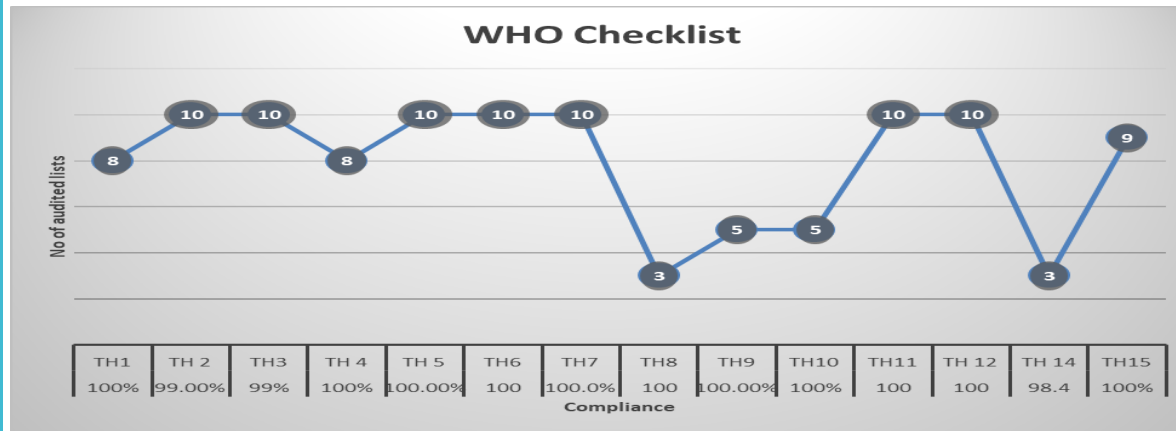
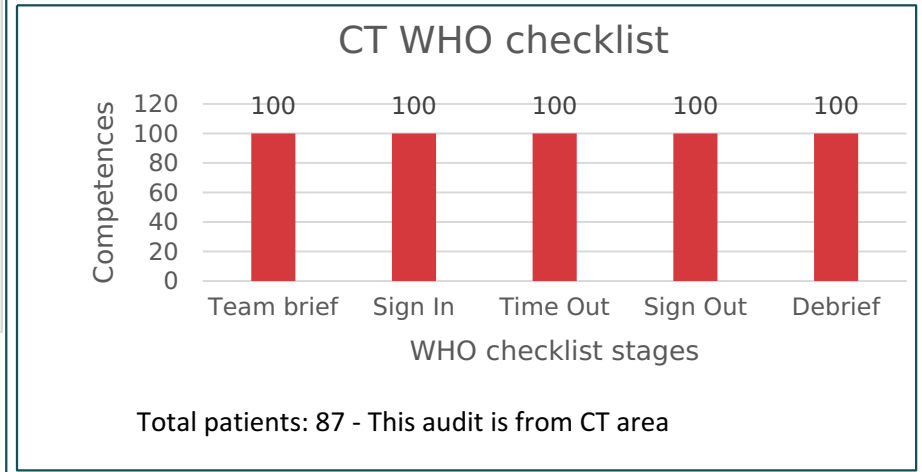
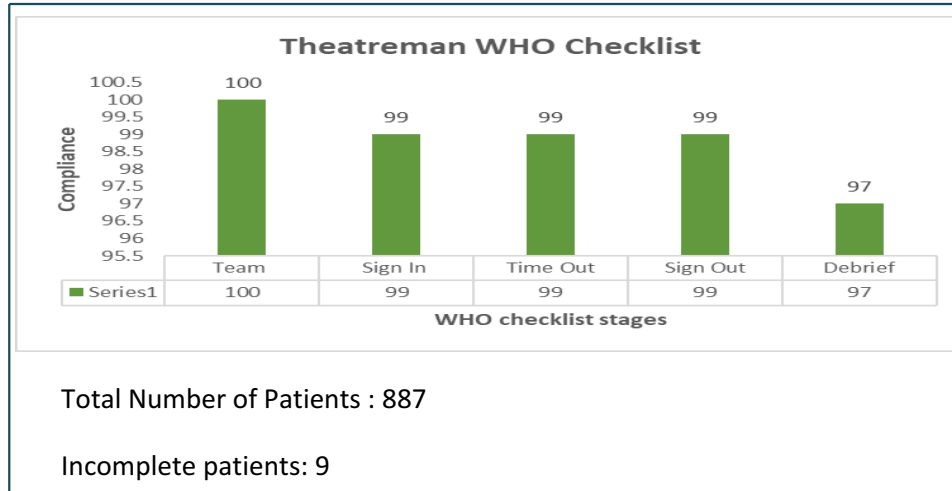


What we have done / are doing:

Tracked in Executive Governance Meetings
 Raised in Governance meetings and with departmental managers.
 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 the Triumvirates and leads to support resolution.
 PALS Team are managing and resolving PALS contacts within their remit.

In September, appointment-related issues remained the most frequently reported category of concern. These included difficulties securing appointments, repeated cancellations, and delays in referrals being actioned. Notably, there was an increase in cases where patients experienced delays in receiving test results due to an inability to access appointments with their responsible clinician. This trend highlights the ongoing impact of appointment availability on patient experience and care continuity.

WHO Audits



112 operating lists audited.

There was a positive improvement in Theatres 1, 4, and 15, with a noticeable increase in the number of completed audits.

Theatre 3 achieved the minimum required audits. However, Theatres 8, 9, 10, and 14 continued to fall below the required threshold, indicating a need for further targeted intervention.

Quality Improvement & Learning

Recommendations and Action Plan:

Theatre Leads for Theatres 8, 9, 10 and 14 to identify barriers to audit completion.

Reinforce the importance of timely and accurate WHO checklist audits during morning meetings and 1:1 s with team leaders.

Work in Progress – The WHO team brief proforma has been successfully trialled within the Oncology speciality. Feedback from the trial is currently awaited and will be evaluated to inform any necessary adjustments prior to a phased rollout across all theatre specialities

CAS Alerts – New Alert

CAS Alerts Received 1- 30 SEPT 2025

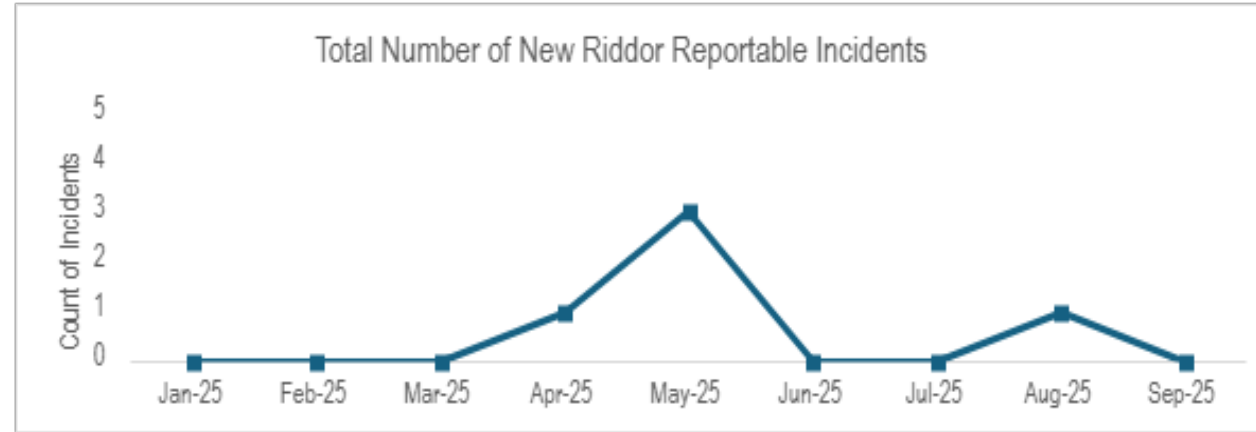
Reference	Alert Title	Originated By	Issue date	Response	Deadline
NatPSA/2025/005/NHSPS	<p>Harm from delayed administration of rasburicase for tumour lysis syndrome</p> <p>(Content): This National Patient Safety Alert requires action to prevent delays in the administration of rasburicase for tumour lysis syndrome (TLS). TLS is a life-threatening emergency that can develop when cancer cells break down rapidly, releasing harmful substances into the bloodstream. It requires urgent treatment with rasburicase in high-risk cases.</p> <p>The alert requires NHS organisations providing emergency departments and cancer services to complete specific actions within 6 months, including updating risk assessment protocols, ensuring medication availability, and addressing operational barriers to timely treatment.</p>	NHS England Patient Safety	09 Sept 2025	<p>Assessed – not relevant to organisations' services</p> <p>Confirmation from Deputy Chief Pharmacist 'The use of rasburicase in this patient cohort for haem malignancies would not be seen at ROH therefore...comfortable to recommend this alert is not applicable to ROH'. Confirmed by MacMillan Oncology Nurse Consultant.</p>	09 Mar 2026

CAS Alerts From Previous Months (Actioned)

Alerts from Previous Months (Actioned)

Reference	Alert Title	Originated By	Issue date	Response	Deadline
NatPSA/2023/010/MHRA	<p>Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.</p> <p>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.</p> <p>This National Patient Safety Alert provides further background and clinical information and actions for providers.</p>	MHRA	31 Aug 23	<p>Alert now closed (24 Sept 2025) as per confirmation from Patient Safety Team:</p> <ol style="list-style-type: none"> 1. Policy updated and reviewed, awaiting final sign off. 2. Training plan in place for all relevant staff. 3. Medical device inventory insitu - currently being updated to ensure accuracy. 4. PPM schedule has been created and implemented. 5. All patients reviewed, and entrapment risks mitigated - risk assessments to be sent to patients GP on discharge so monitoring can be continued in the community. 6. Risk assessments completed daily or more frequently if patient's condition changes. 7. Risk assessments updated daily - new more comprehensive risk assessment document created and roll out commenced. <p>(Rebecca Higwood, Patient Safety Specialist).</p>	<p>1 Mar 2024.</p> <p>On-going...</p>

RIDDOR reportable staff incidents



Quality Improvement & Learning

There were no RIDDOR reportable incident reported in September 2025.

On-going QI Work

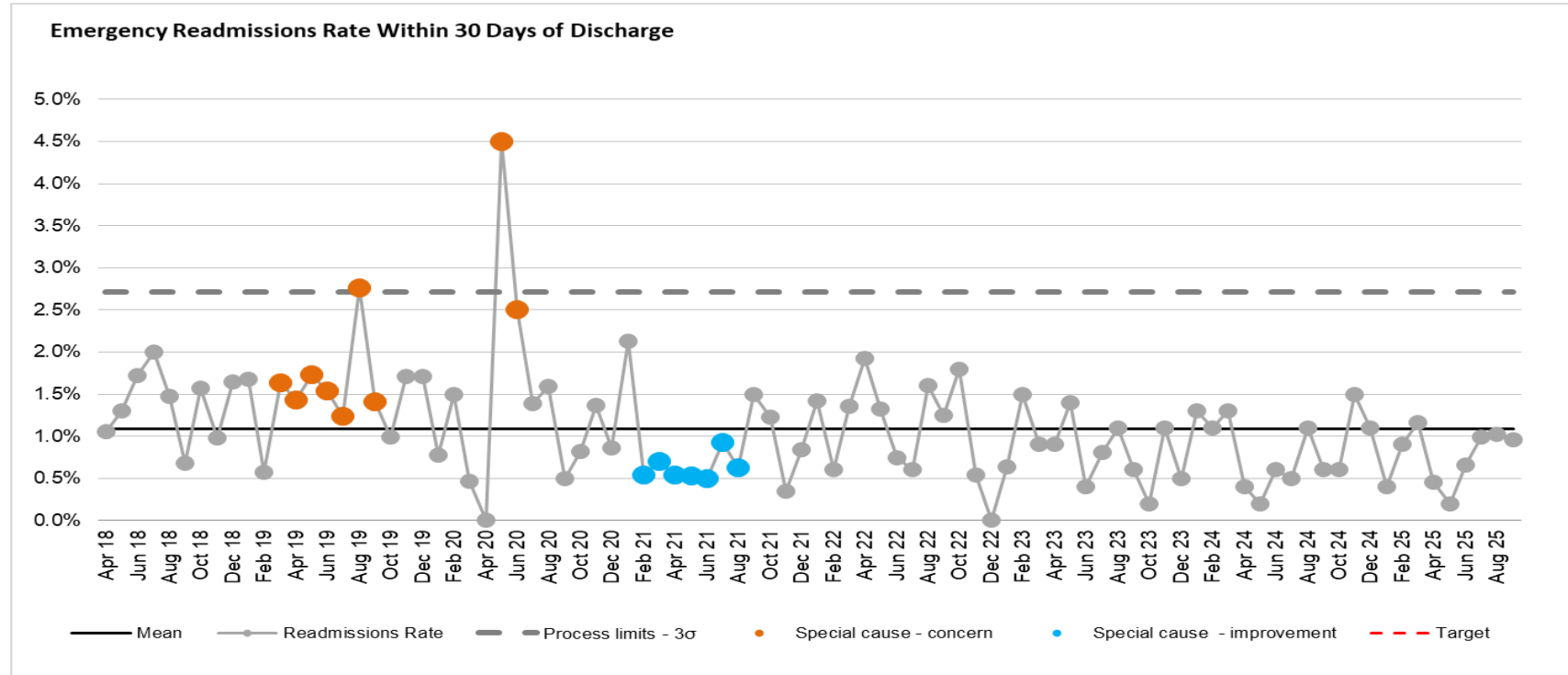
- Improvements to training / awareness with Managers; cover RIDDORs in detail in Me as a Manager training.
- Making adaptations to CMT (H&S) training to sign post Managers for more detail on RIDDOR requirements.
- HR to provide sickness absence data on a monthly basis flagging up anything under 'MSK' 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.

Safeguarding Training Compliance

KPI	September 2025
Safeguarding Adult Notifications	66
Safeguarding Children and Young People Notifications	41
Adults Level 1- Target 90%	92.52%
Adult Level 2 -Target 85%	92.59%
Adult Level 3- Target 85%	81.47%
Adult Level 4- Target 90%	80.0%
Child Level 1 -Target 90%	92.14%
Child Level 2- Target 85%	92.37%
Child Level 3- Target 85%	80.91%
Mental Capacity Act MCA- Target 85%	93.93%
Deprivation of Liberty Safeguards DoLS	94.00%
Prevent Awareness- Target 95%	91.31%
WRAP (prevent level 3)- Target 90%	79.89%
Domestic Abuse	20
FGM	5
DOLS	3
MCA	12
PIPOT cases	1
PREVENT Notifications	0

Training data for substantive staff only. Data received re training from L+D on 13.10.2025

Readmissions



Number of Emergency Readmissions to ROH within 30 Days of Discharge												
	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
No of Readmissions	3	8	5	2	5	6	2	1	3	5	5	5
Denominator	535	544	476	552	531	516	445	508	455	507	488	521
% Readmissions	0.6%	1.5%	1.1%	0.4%	0.9%	1.2%	0.4%	0.2%	0.7%	1.0%	1.0%	1.0%

Concerns Raised: There were three concerns raised to FTSUG in September 2025. The low number could reflect the planning of events and awareness activities that took place in September.

The themes from concerns raised were in relation to

- Overseas workers perceived that their challenging journey and experiences are negatively impacting their confidence, wellbeing, and mental health. They feel that the organisation's stated value of compassion is not being consistently reflected in actions.
Case raised to relevant manager
- There is a perception that some staff members do not feel listened to or adequately involved in decision-making processes. They feel that decisions are often dictated to them rather than arrived at in a collaboratively way. Advised to discuss with line manager, staff are happy to speak to line manager.
Closed from FTSU

Quality Improvements & Learning

The Freedom to Speak Up Guardian is currently contributing to a BSOL ICB bullying and harassment work stream and working group.

Freedom to
Speak Up

Safe Staffing

1. AREAS OF NON-COMPLIANCE/RISK; MATTERS TO BE ADDRESSED URGENTLY; OR MATTERS REQUIRING ESCALATION TO PROGRESS

ALERT

The team wishes to bring the following issues to the Committee attention as they:

- Represent non-compliance with required standards or pose a significant risk to the Trust’s ability to deliver its responsibilities or objectives and therefore require action to address; OR
- Require the approval of the Committee for work to progress.

Nil to report

AREAS OF ON-GOING MONITORING WITH NEW DEVELOPMENTS

ADVISE

The team wishes to bring the following issues to the committees attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust’s ability to deliver its responsibilities or objectives:

- The workforce team are continuing to work on improving the data provided with this report
- As Workforce reviews are agreed and signed off team will focus on filling vacancies and if required altering Healthroster template
- Ward 2 team are experiencing difficulties due to their prolonged ward closure, open meeting held to hear concerns and plans made to support by Head of Nursing, Director of Ops and Matron.
- No red flags or professional judgement applied in reporting period
- Delays in recruitment to vacancies due to Establishment and service reviews
- Fill rate for CYP OPD is not reflective of service provided, all clinics supported appropriately

Safe Staffing

ASSURE

The team considered the following items and did not identify any issues that required escalation to the Committee.

- The ward and department teams continue to meet and review staffing levels, red flags and implement mitigations and staff redeployment where required.
- The teams continue to monitor Bank use and follow the policy for requesting and authorising additional shifts. Bank use remains low.
- The team are reviewing the data that is published on the Trust website to ensure it complies with guidance from Developing Workforce Standards (NHSI 2021)
- Enhanced Care – note increased hours used to provide enhanced care this month,
- Harms – 9 Falls reported in month, all reviewed and discussed at Divisional Governance
- Decreased in PALS and complaints received in month
- Continued focus on sickness management

Recommendation

The Committee is asked to:
CONSIDER the content of section 1 and agree the next steps;
NOTE the content of section 2
 Review use of red flags particularly in view of number of Enhanced Observation hours and staff redeployment
 Review Falls
NOTE the content of section 3.

Safe Staffing

September Data for October Report	Fill Rate (KPI >90%=Green, 80-90%=Amber, <79%=Red)					
	Wards / HDU Ward Name	Fill Rate Day Nurses	Fill Rate Day Non reg	Fill Rate Night Nurse	Fill Rate Night Non Reg	RNA Day Hours
Ward 1	86%	104%	108%	100%	207.5	11
Ward 2	80%	102%	103%	175%	87	0
Ward 3	83%	103%	103%	117%	221.5	55
Ward 4	100%	108%	101%	121%	0	0
Ward 12	84%	106%	103%	105%	178.5	11
HDU	99%	89%	93%	100%	0	0
Total / Combined / Average	88.40%	102.05%	101.96%	119.68%	115.75	12.83

September Data for October Report	Workforce				Care Hours Per Patient Day	
	Ward Name	Total WTE as % Establishment (%)	Turnover (%)	Sickness (%)	Maternity (%)	Average Cumulative Count of Patients at 23.59 per day
Ward 1	94.66%	12.34%	6.01%	2.70%	13.35	6.6
Ward 2	84.37%	9.97%	6.49%	0.00%	14.29	7.6
Ward 3	102.53%	17.22%	8.07%	8.33%	19.32	7.3
Ward 4	92.94%	5.73%	2.64%	0.00%	14.38	8.3
Ward 12	92.62%	14.37%	5.80%	6.25%	8.45	9.1
HDU	89.81%	17.12%	5.74%	3.23%	3.16	25.9
Total / Combined / Average			5.8%	3.4%	73	64.63

Safe Staffing

September Data for October Report	Roster Safe Care Indicators			Nurse Sensitive Indicators		
Ward Name	Red Flags Opened	Red Flags Closed	Enhanced Care Hours	Medication Administration Error or Concern	ROH Acquired Pressure Ulcers Category 2,3 & 4	All Reported Falls
Ward 1	0	0	0	2	0	3
Ward 2	0	0	256.5	1	0	1
Ward 3	0	0	534.5	0	0	1
Ward 4	0	0	175.5	1	0	2
Ward 12	0	0	134.5	1	1	2
HDU	0	0	22	0	0	0
Total / Combined / Average	0	0	1123	5	1	9

September Data for October Report	Patient Satisfaction		
Ward Name	No. of PALs Contacts	No. of New Complaints	No. of FFT
Ward 1	0	0	37%
Ward 2	1	1	26%
Ward 3	0	0	47%
Ward 4	0	0	76%
Ward 12	0	0	73%
HDU	0	0	65%
Total / Combined / Average	1	1	54%

Safe Staffing

September Data for October Report	Fill Rate (KPI >90%=Green, 80-90%=Amber, <79%=Red)					
	Fill Rate Day Nurses	Fill Rate Day Non reg	Fill Rate Night Nurse	Fill Rate Night Non Reg	RNA Day Hours	RNA Night Hours
Outpatients	62%	79%	N/A	N/A	0	0
CYP OPD	61%	28%	N/A	N/A	0	0
ADCU	52%	65%	N/A	N/A	189.25	0
POAC	82%	90%	N/A	N/A	0	0
Theatres	85%	69%	N/A	N/A	31.5	0
Theatres Recovery	86%	80%	N/A	N/A	0	0
Discharge Lounge	107%	101%	N/A	N/A	0	0
Total / Combined	76.33%	73.07%	N/A	N/A	220.75	0.00

September Data for October Report	Workforce				Roster Safe Care Indicators		
	Total WTE as % Establishment (%)	Turnover (%)	Sickness (%)	Maternity (%)	Red Flags Opened	Red Flags Closed	Enhanced Care Hours
Outpatients	86.78%	12.01%	5.89%	7.69%	0	0	-
CYP OPD	64.07%	33.95%	-	-	-	-	-
ADCU	86.29%	7.07%	13.83%	2.63%	0	0	-
POAC	90.27%	0%	10.06%	2.17%	0	0	-
Theatres	88.44%	11%	9.06%	2.21%	0	0	-
Theatres Recovery	93.90%	6.68%	-	-	0	0	-
Discharge Lounge	85.84%	0%	-	-	0	0	-
Total / Combined			9.71%	3.68%	0	0	-

Safe Staffing

September Data for October Report	Nurse Sensitive Indicators			Patient Satisfaction		
Ward Name	Medication Administration Error or Concern	ROH Acquired Pressure Ulcers Category 2,3 & 4	All Reported Falls	No. of PALs Contacts	No. of New Complaints	No. of FFT
Outpatients	0	0	0	0	0	3%
CYP OPD	0	0	0	0	0	68%
ADCU	0	0	1	0	0	26%
POAC	0	0	0	1	0	14%
Theatres	0	0	0	0	0	n/a
Theatres Recovery	0	0	0	0	0	n/a
Discharge Lounge	0	0	0	0	0	25%
Total / Combined	0	0	1	0	0	27%



Operational Performance Summary

Performance to end September 25	In month	Previous month	Target	Variation	Assurance
RTT – combined (against trajectory, constitutional target remains 92%)	62.32%	61.47%	58.37%		
65 Week waits (65-77 weeks)	0	0	0		
52 week waits (52 – 64 Weeks)	375	427	397		
RTT Proportion of Patients Waiting 52 weeks	2.81%	3.18%	2.98%		
RTT First Appointment Waiting List	66.54%	64.55%	64.80%		
RTT Waiting List Size	13,351	13,447	13,304		
All activity YTD (compared to plan)	7,318	6,017	7,238		
Outpatient activity YTD (compared to plan)	36,871 102.9% Cumulative	30,213 102.2% Cumulative	35,817 YTD Target		
Outpatient Did Not Attend (YTD)	6.2%	7.1%	8%		
PIFU (trajectory to 5% target)	720 11.37%	584 11%	563 5%		
Virtual Consultations (target is plan, operational planning guidance is 25%)	8.8%	10.4%	19%		
Diagnostics volume YTD (compared to plan)	13,293 Cumulative	11,042 Cumulative	12,707 YTD Target		
Diagnostics 6 week target	99.8%	99.8%	95%		

Operational Performance Summary

Performance to end September 25	In month	Previous month	Target	Variation	Assurance
Theatre Session Utilisation	87.9%	84.2%	85%		
Theatre In Session Utilisation	83.6%	85.4%	85%		
Cancer - 31 day first treatment	100%	100%	96%		
Cancer - 62 day (traditional)	77.6%	84.2%	70% Nat 85% Trust		
28 day FDS	77.4%	80.3%	75%		
Patients over 104 days (62 day standard)	0	0	0		
POAC activity volume (YTD)	11,904 Cumulative	9,859 Cumulative	11,335 Cumulative		
Bed Occupancy (excluding CYP and HDU)	69.01%	76.9%	82-85%		
LOS - excluding Oncology, Paeds, YAH, Spinal	3.03	3.74	n/a		
LOS - elective primary hip	2.9	2.7	2.7		
LOS - elective primary knee	2.6	2.7	2.7		
BADS Orthopaedic: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period) June 25	56.3%	53.60%	85%		
Outpatient attendances for first or follow-up appointments attracting a procedure tariff (Mar 25)	35.6%	37.5%	-N/A		



Workforce Performance Report

Prepared by:

Matt Dingle, Head of Human Resources

Clare Mair, Head of OD & Inclusion

David Richardson, Head of Education and Training

Date: October 2025



Scorecard	Topic	KPI	August 2025	TREND
	Occupied Establishment - Clinical	93%	91.17%	↑
	Occupied Establishment – Non-clinical	93%	91.62%	↑
	Turnover (adjusted)	10.5%	10.10%	↓
	Staff in post - FTE	N/A	1301.32	↓
	Sickness absence	4%	5.61%*	↑
	Appraisals	95%	88.5%	↑
	Mandatory Training	93%	82.85%	↓
	Time to hire	56 days	40.6 days	↑

*September data



Section One: HR, OD and Inclusion

Prepared by: Matt Dingle & Clare Mair

Presented by: Alison Money, Deputy CPO

Ref: October 2025/HR&OPS

HR, OD and Inclusion

Summary:

The National staff survey (NSS) completion period is running between 6th October and 28th November. This contains questions on the staff engagement score and new socio-economic questions. Turnover has remained steady at 10.10% and the Trust are reporting bank and agency utilisation better than plan. Time to Hire performance is better than national targets.

Areas for Improvement:

Sickness absence rate remains a concern at 5.61% and an action plan has been included in this pack. There has been an increase in the appraisal completion rate to 88.5% however the compliance target of 95% is still to be achieved and the team is working with key departments to support.

Risks / Issues:

A decline is expected in the completion rate as predicted by the National NHS picture. Pulse survey results from July 2025 show a decline in some of the questions but a significant increase in completion rates. Casework levels remain high and there are 3 suspensions.

Action Plan:

Communication plan in place with Executive support to ensure staff have the opportunity to complete the staff survey.
Departments identified to provide additional support to achieve appraisal compliance
Sickness action plan included in pack

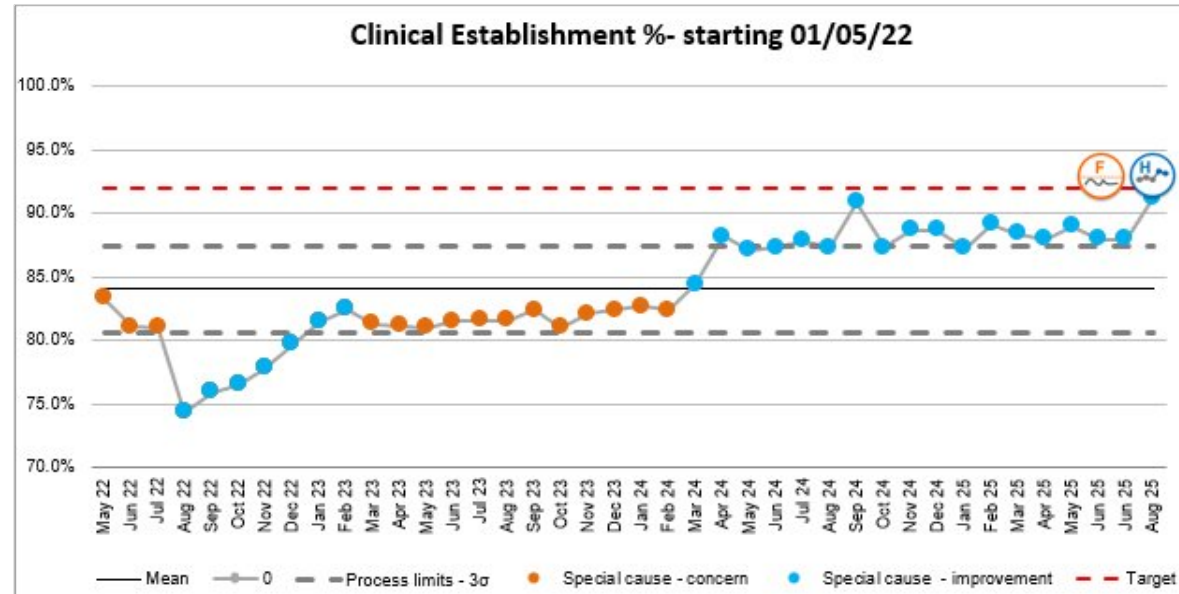
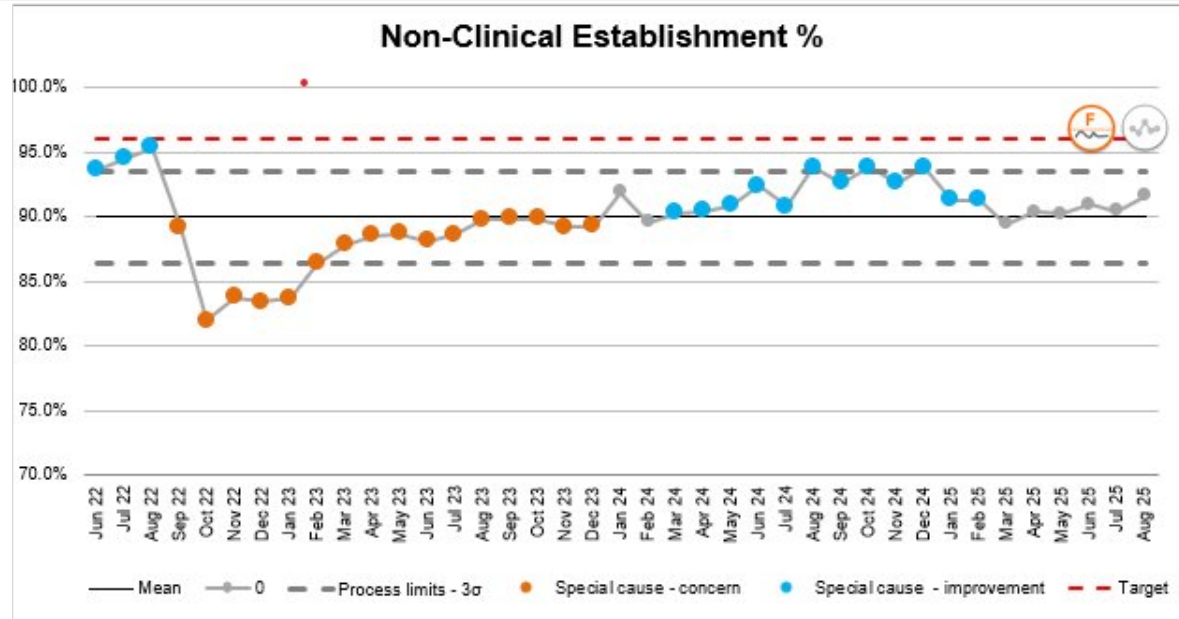
Occupied Establishment

KPI 93%

Clinical Aug 2025 91.17%

Non-clinical Aug 2025 91.62%

Trend



Turnover (adjusted)

KPI 10.5%

Aug 2025 10.10%

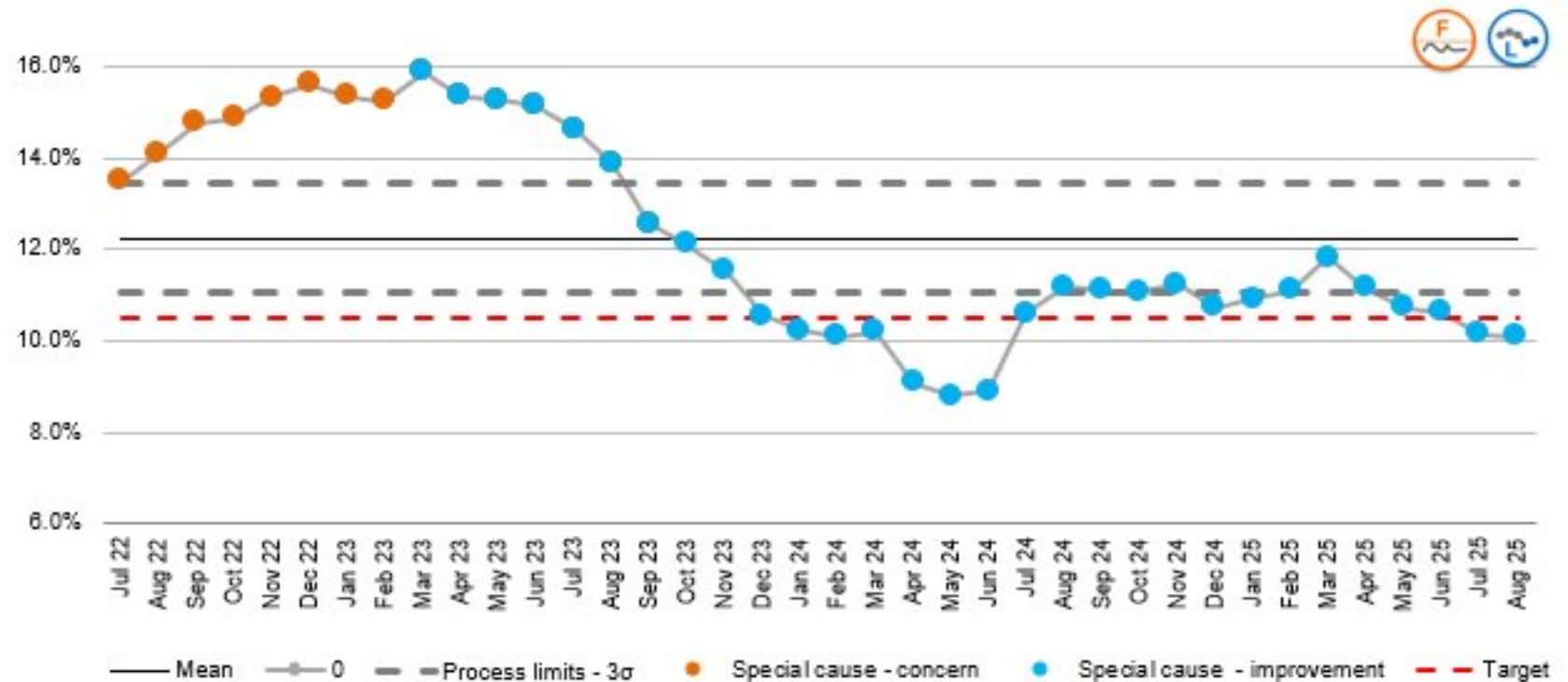
Trend

Adjusted turnover is all turnover minus:

- Junior doctor rotation
- Flexible retirement
- End of FTC

Adjusting turnover provides more meaningful data around Trust performance

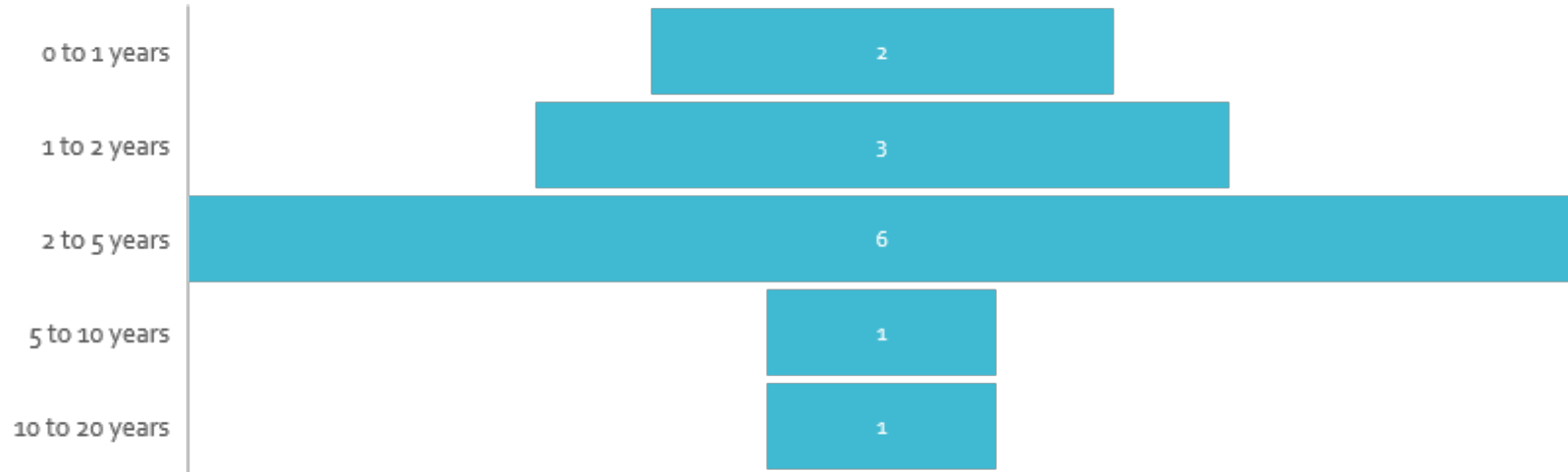
Staff turnover - Adjusted - starting 01/07/22



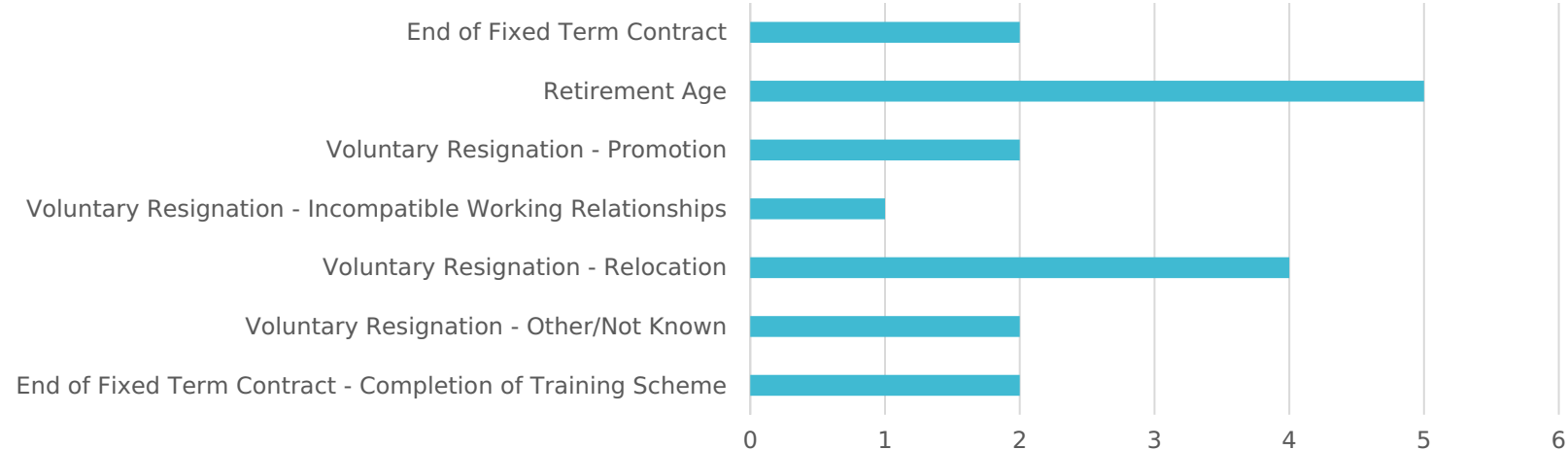
Leavers August 2025

13 leavers in month, predominantly retirees. Of the 5 staff that retired in month, 3 returned on a substantive basis.

August 25 leavers - length of service



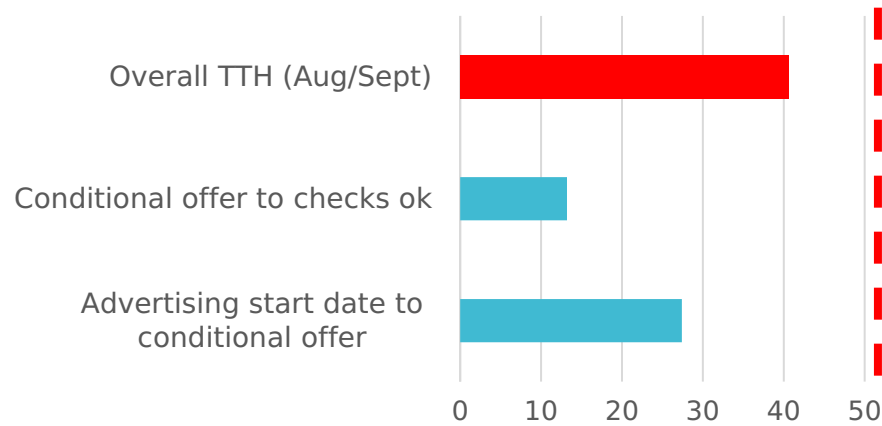
Leavers by reason



Starters - Aug 2025

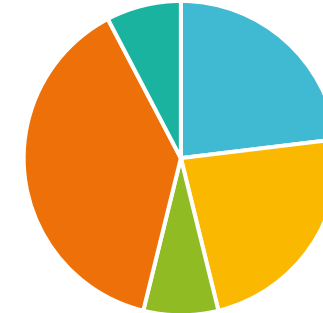
Recruitment activity in August led to 13 new substantive starters. This excludes bank and new resident doctors who also started in month.

Time to Hire (Aug/Sept)



National target - 8 weeks

August Starters



- Medical and Dental
- Nursing and Midwifery Registered
- Allied Health Professionals
- Estates and Ancillary
- Administrative and Clerical

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

68.5% of ER case work has been closed since the last workforce report in August but levels remain high with new cases commencing.

Final stage sickness cases in Q4 and Q1 had been largely LTS cases, we are continuing to see 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 November

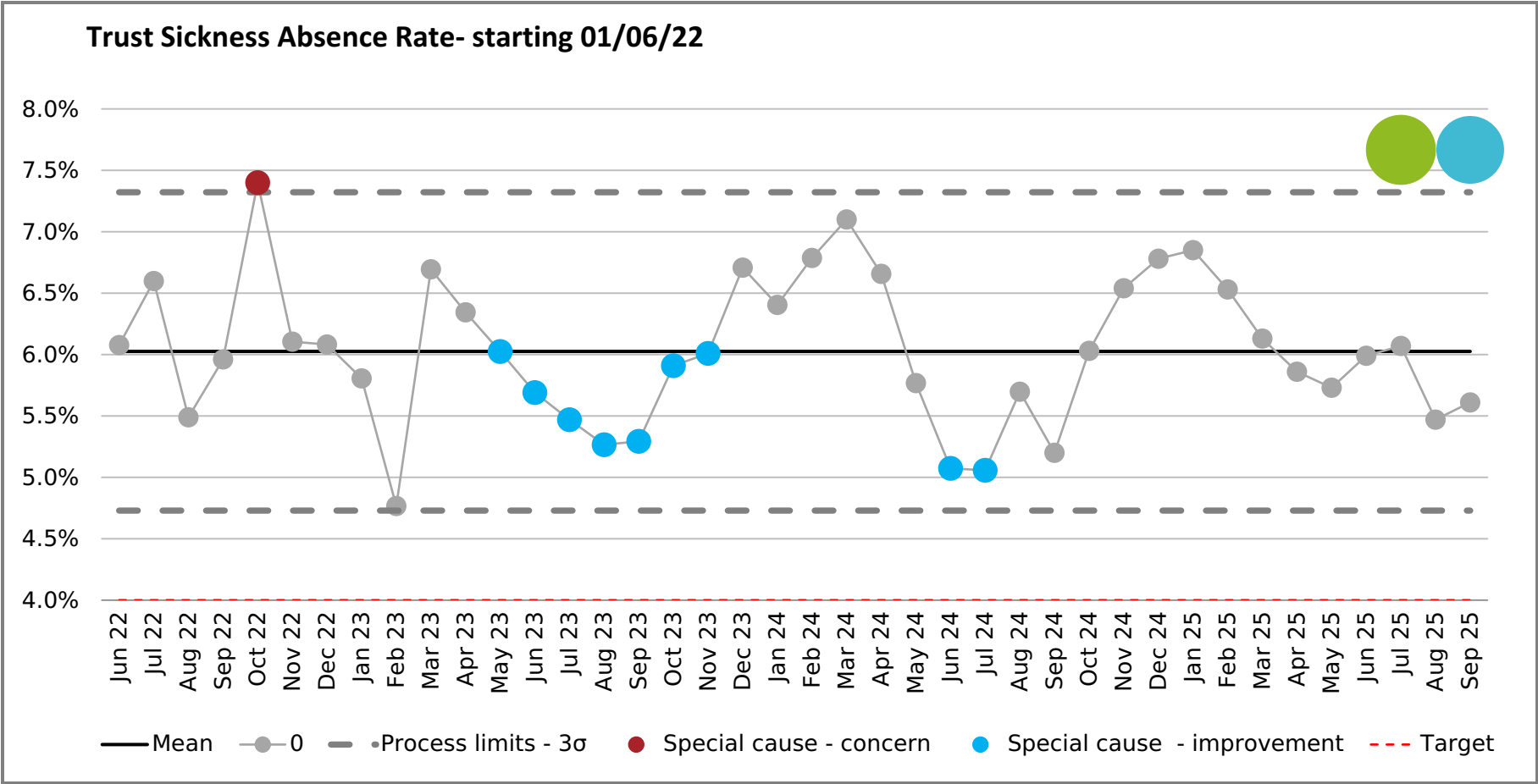
Case Type	Cases open			Total	Suspended/ Excluded	Cases Closed in Aug/Sep/Oct to date
	<8 Weeks	8- 12 Weeks	>12 Weeks			
				17		-
Disciplinary	2	2	2	6	2	1
Grievance			1	1		1
Formal Capability	1		1	2		1
MHPS			1	1	1	1
Final Stage Sickness	5	2		7		6
Appeals				0		3

Key Themes:

- The >12-week capability case will escalate to stage 3 if improvement is not demonstrated.
- The >12 week conduct cases 1x report has been submitted 1x final report in development
- The >12-week grievance case is due for closure this month, delayed as linked to an investigation in another HR process
- Ulysses bullying and harassment incident triage process will be piloted on 3 forms to see if it enables feedback loops to be closed for staff concerns
- MHPS case is paused due to health and wellbeing
- 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 to commence in October
- Sickness Template letters are under consultation; they will be uploaded for use by the end of October

Sickness

KPI	4%
Sept 2025	5.61%
Trend	↑



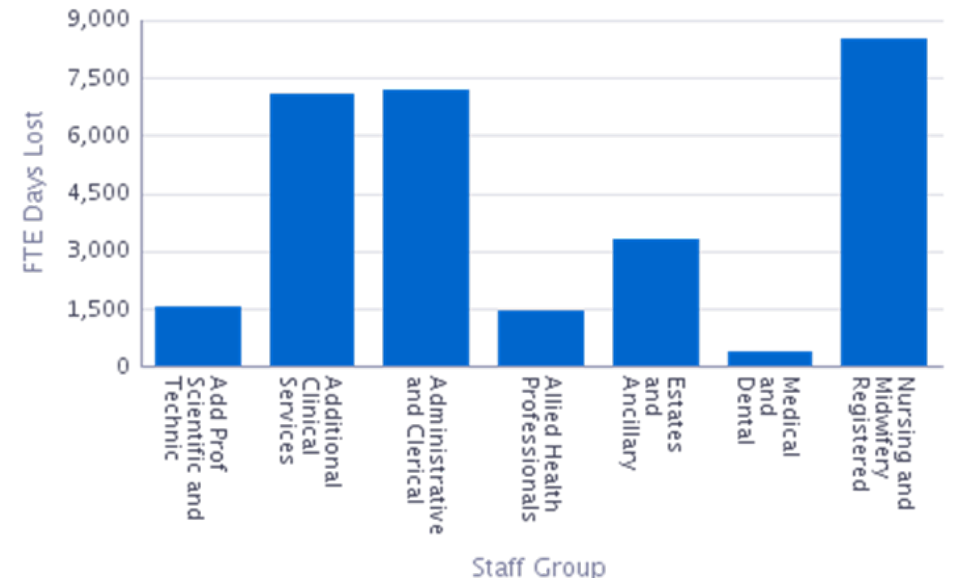
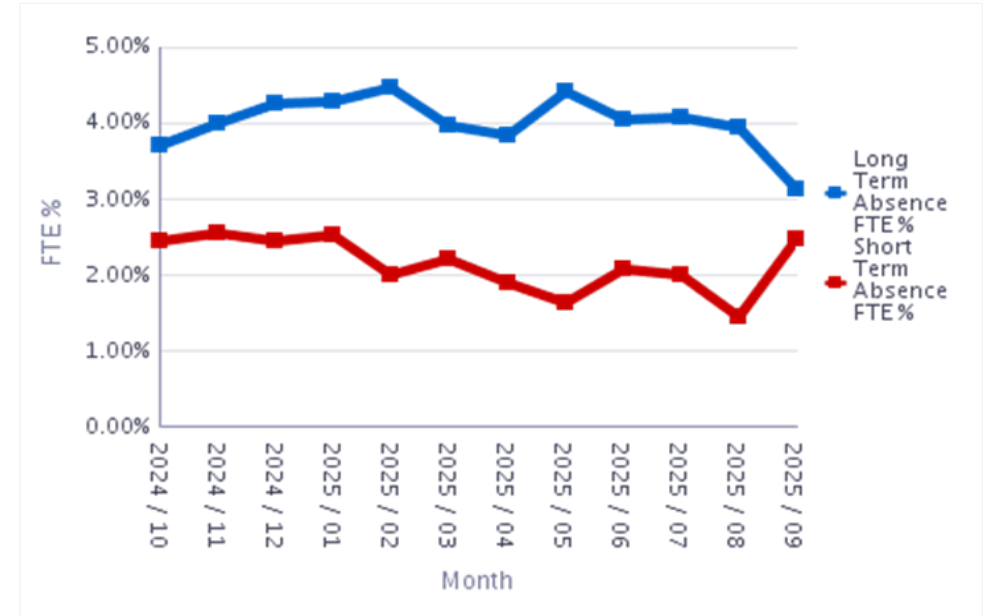
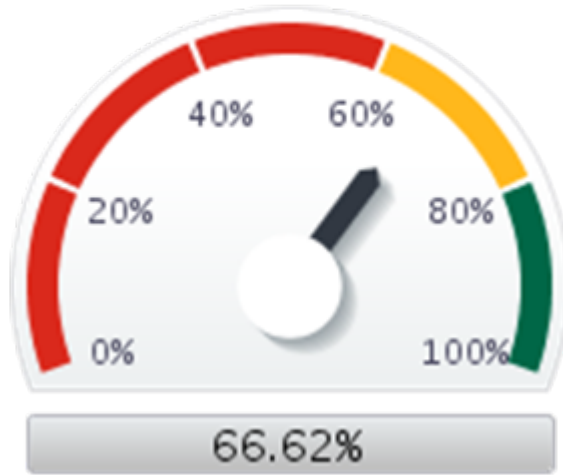
Sickness absence

Long-term absence continued to reduce which is a positive sign as our main type of absence.

However, short term increased in month, mainly due to Gasto, Cold/flu, MSK and mental health related

Return to work compliance (logged on ESR)

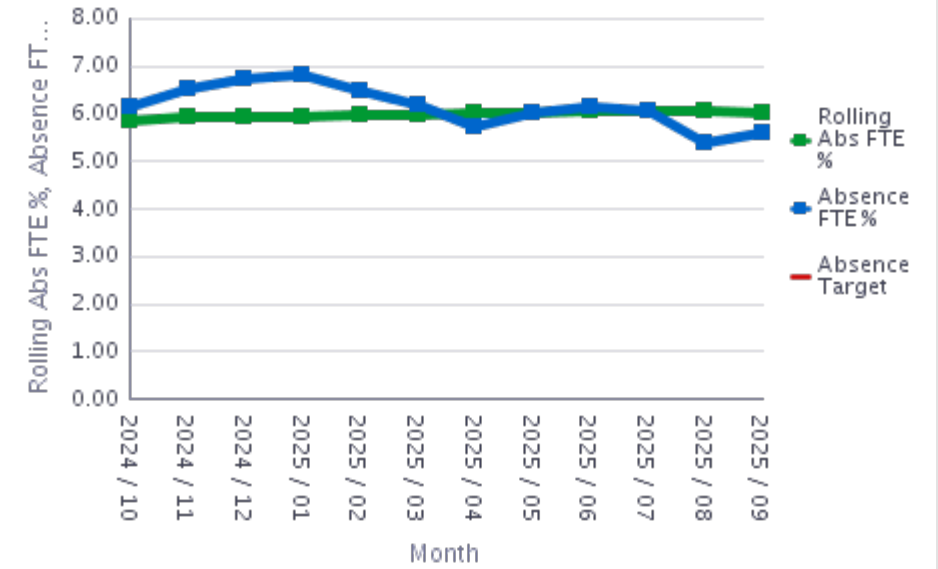
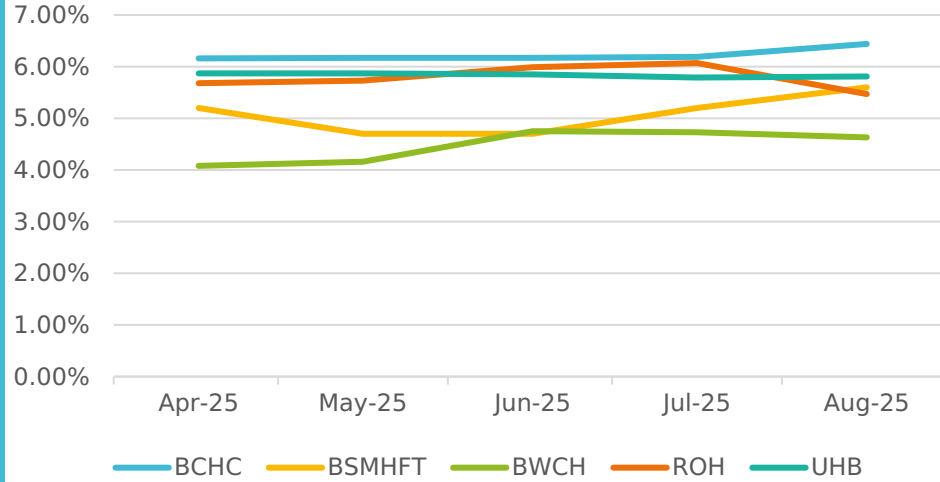
0% - 60% 60% - 80%
80% - 100%



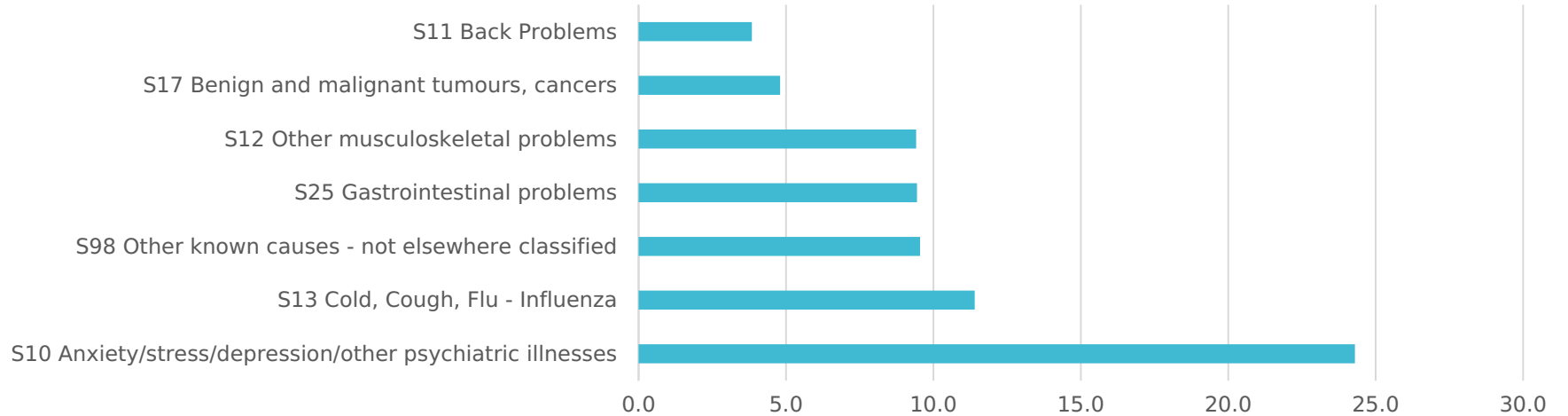
Sickness absence

Despite some positives, making sustained progress in sickness absence is proving difficult and the rolling absence FTE is not reducing as planned. This is a trend across the BSOL system.

BSOL sickness benchmark



Highest absence reasons - Sept 2025



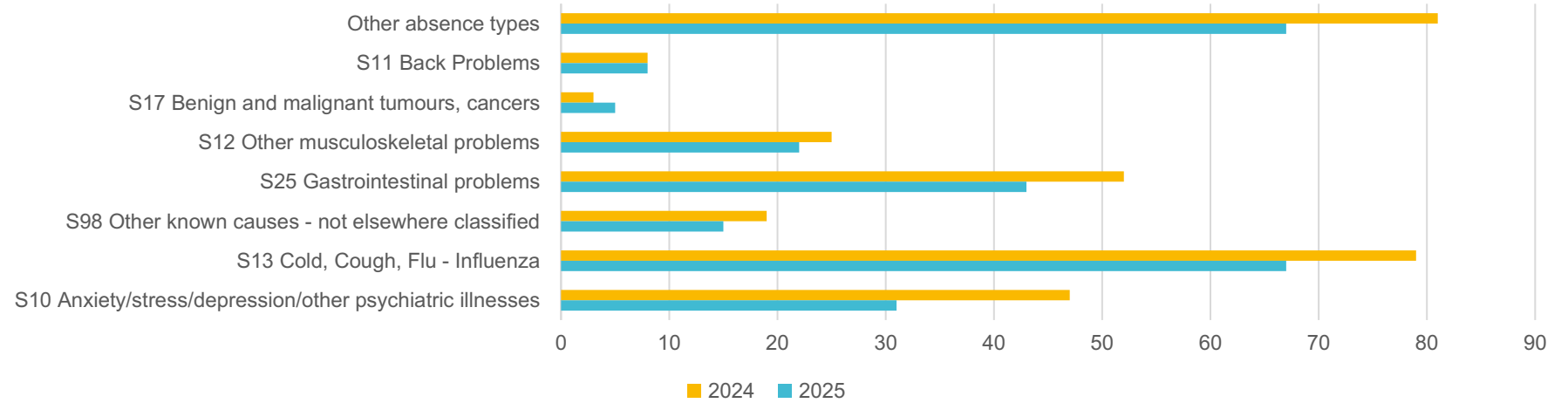
Sickness absence

Insights:

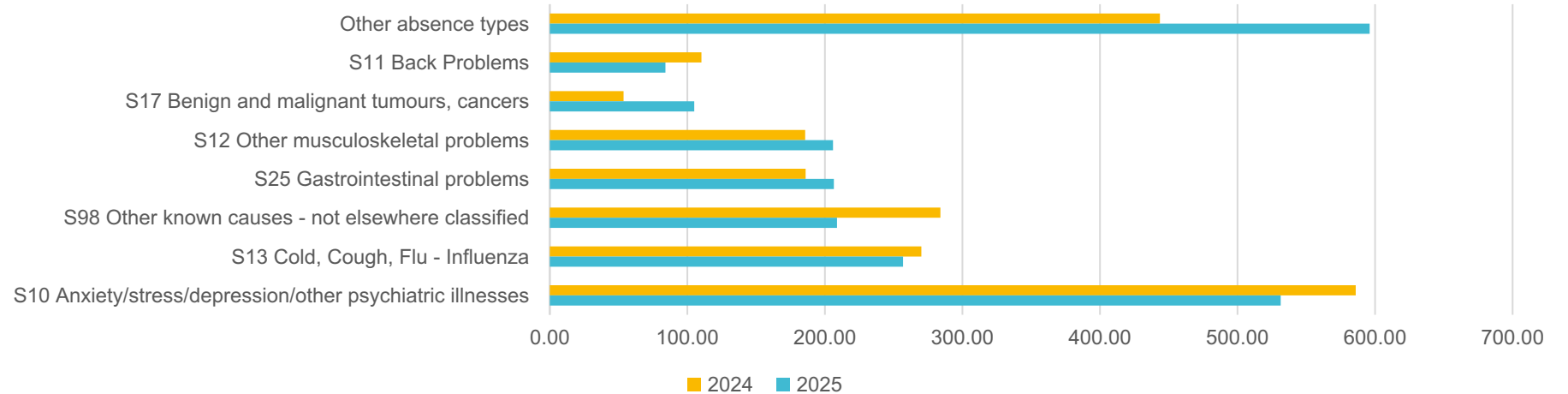
We had 42 less absences in month against Sept 24. However, we lost 75 days more per FTE, indicating staff took longer off per absence.

We experienced positive movement in mental health related absence and cold/flu related. However, we saw more time off for Gastrointestinal, other MSK and more niche absence types

Absence occurrences



FTE Lost



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 at the end of October
5. Closer links formed with Health and Safety who work to spot MSK-related patterns where an assessment may be required. Manual handling also involved in supporting specific services, Porters and Domestic.
6. Stress Policy is approved and ready for wide communication.
7. November Wellbeing week is focussed on MSK and stress and is aligned to work via managers briefings and wellbeing comms to ensure staff have access to the correct information to help reduce sickness

Aug/Sept Hearings	Outcome
Individual 1	Targets for improvement
Individual 2	Targets for improvement
Individual 3	Targets for improvement
Individual 4	Targets for improvement
Individual 5	Resigned
Individual 6	Resigned

There are 4 hearings planned in October, and we are anticipating a further 7 cases which may progress to a final stage in October/November. These are mostly related to persistent short-term absences

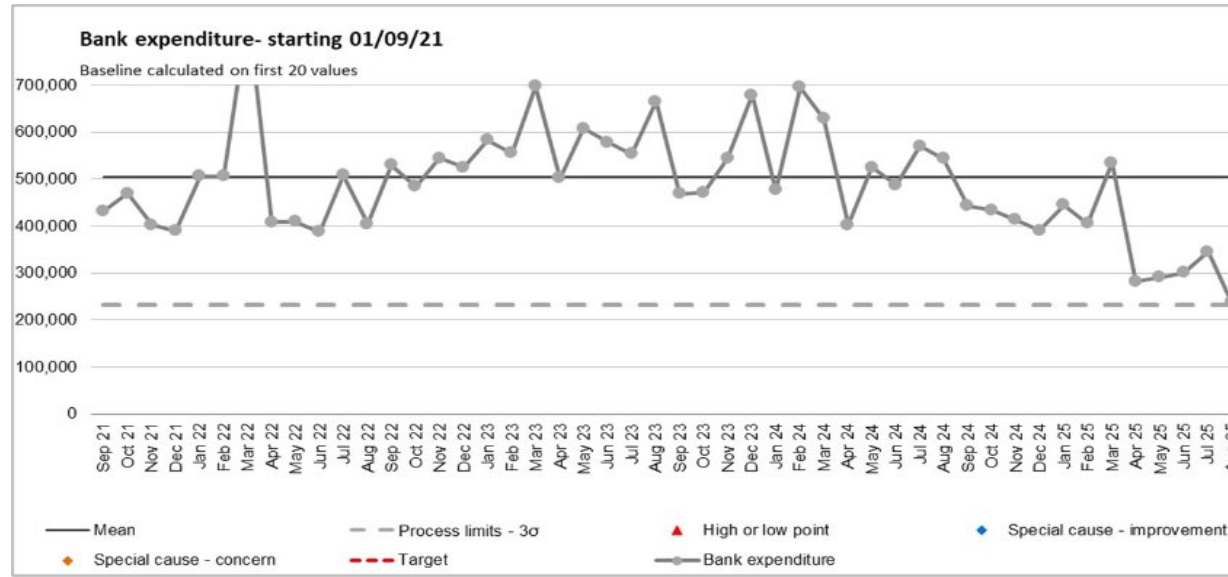
Sickness Absence – Work planned

We have the following work planned to help improve sickness absence rate:

- Special leave allocation review – December 2025
- Health Roster rollout will provide us with live data on sickness absence and we are exploring a 'real time' check-in for staff off with mental health conditions – April 2026
- Policy improvements to streamline the managerial process – January 2026
- Civility and Respect policy work to help early resolution, improving staff going off sick due to the impact of behaviours of others – February 2026
- Consideration of more active temporary redeployment across the Trust – December 2026
- Deep dive review of Additional Clinical Services – this staff group contributes disproportionately to sickness rates across Div 1 and 2 – November 2025

Temporary Workforce

Bank expenditure	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr'25	May'25	Jun'25	Jul'25	Aug'25
Registered nursing	110	136	116	101	95	112	118	92	109	108	48	41	39	48	56
Healthcare scientists and Scientific, therapeutic tech	32	47	25	33	41	38	38	34	35	38	39	38	38	40	23
Support to clinical	60	86	78	55	56	61	69	55	38	94	26	20	34	32	24
Total medical and dental staff bank	51	61	107	88	117	85	52	124	88	142	58	97	76	119	46
NHS infrastructure support	155	189	200	151	125	117	111	140	119	157	110	95	115	95	90
TOTAL	487	570	543	443	434	413	390	445	404	534	282	291	301	334	238

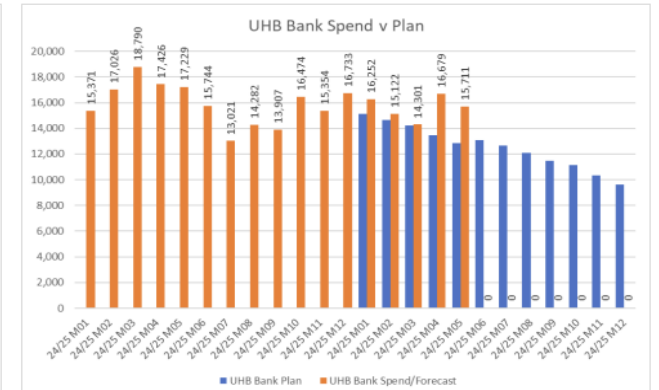
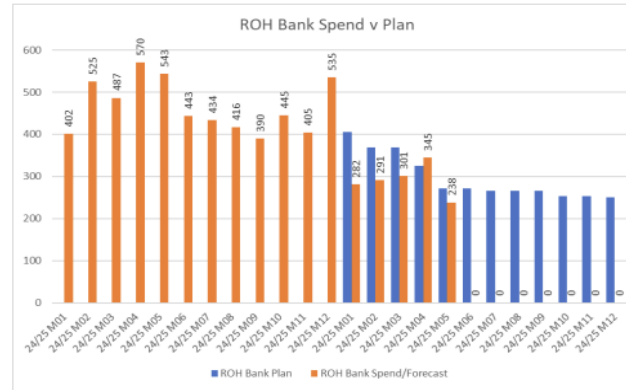
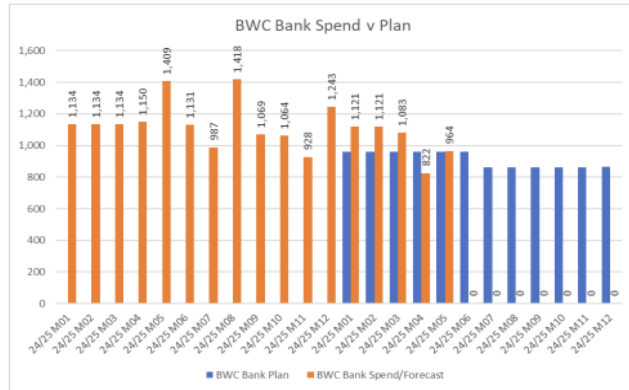
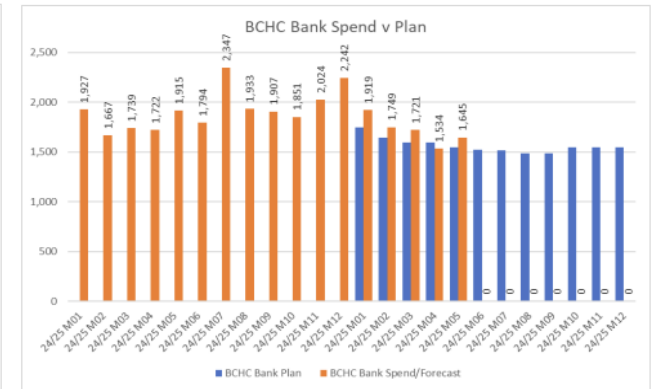
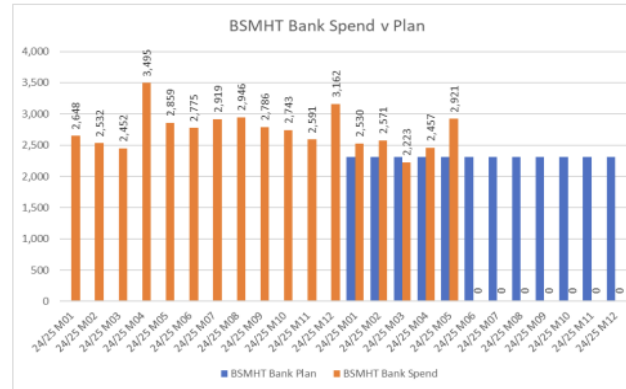
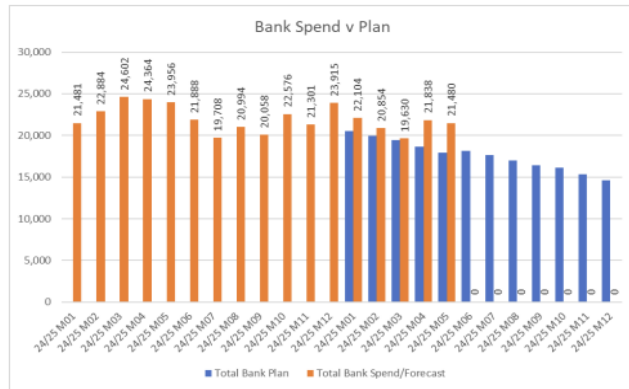


Bank - benchmark

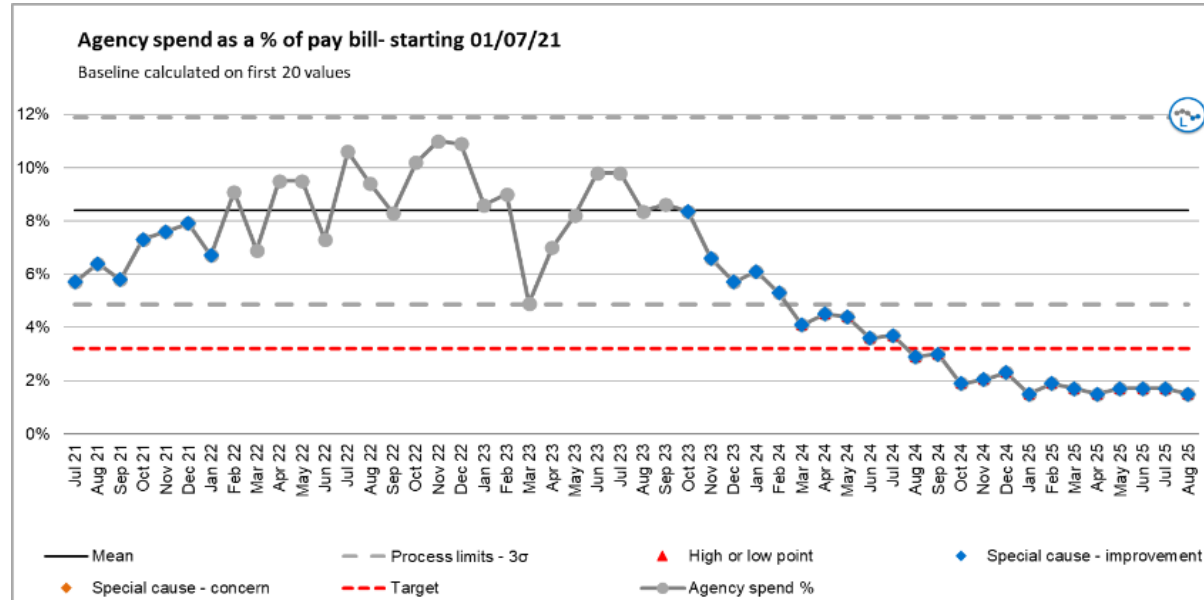
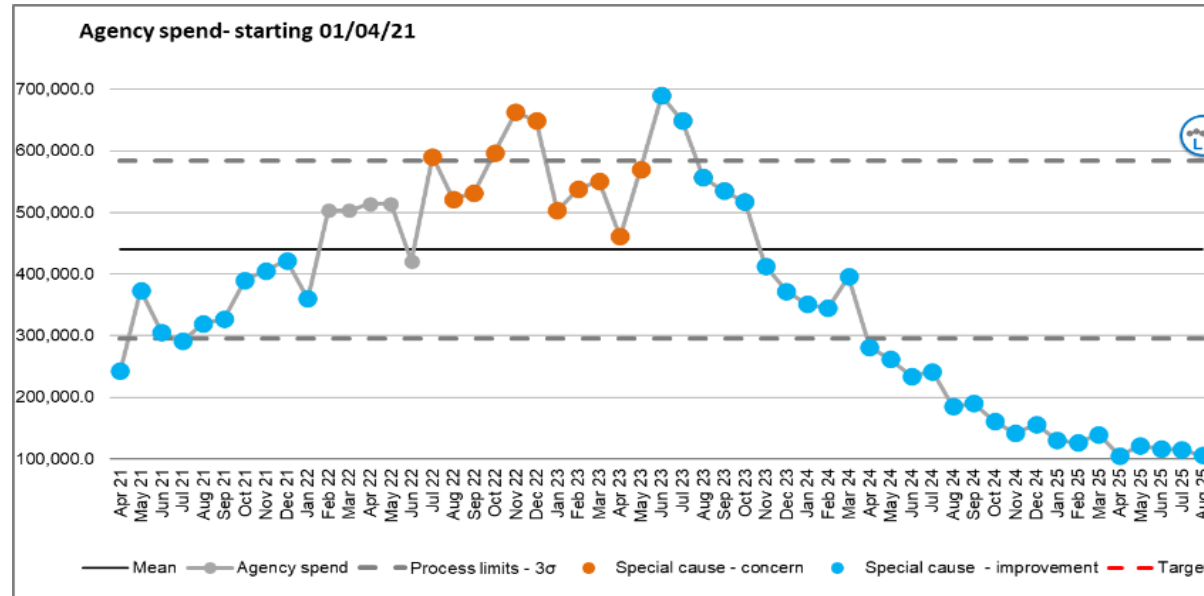
This graph shows our positive progress against plan.

We are the only Trust ahead of plan, with one other Trust (BWC) meeting plan and all other Trusts performing above plan

Bank Pay



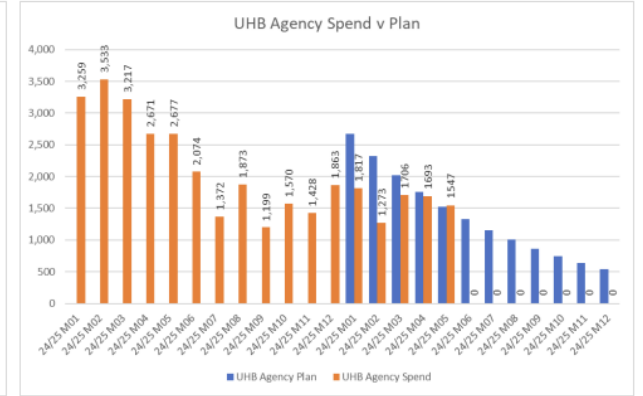
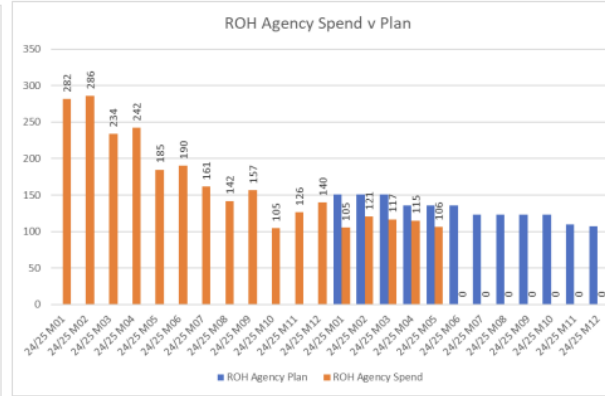
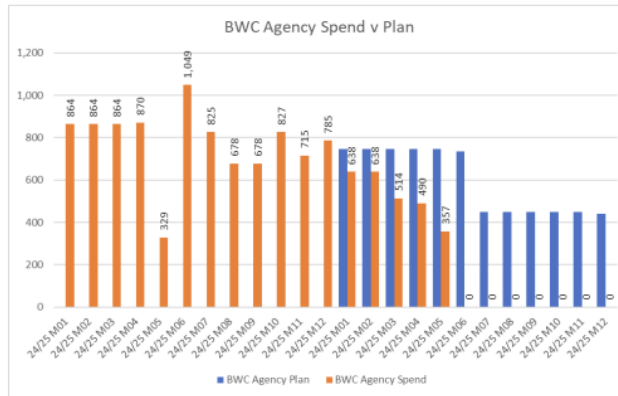
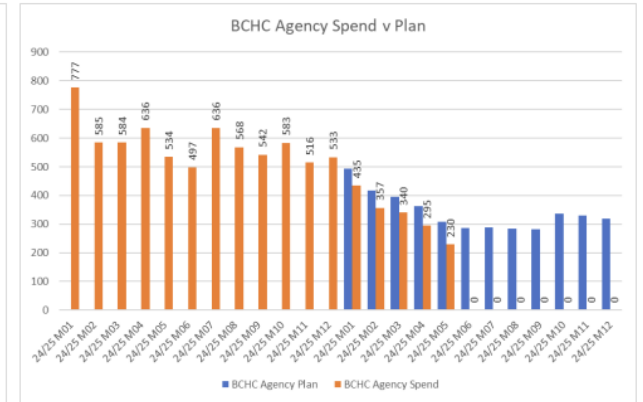
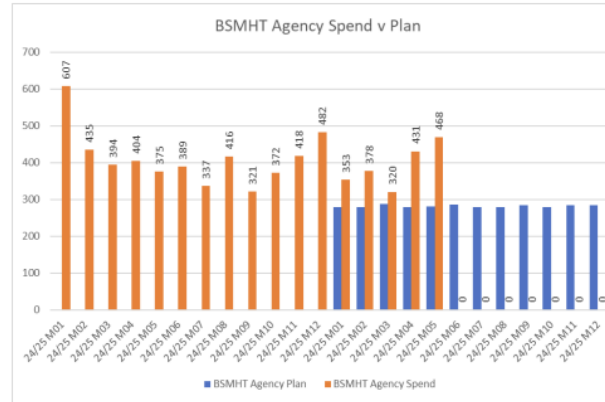
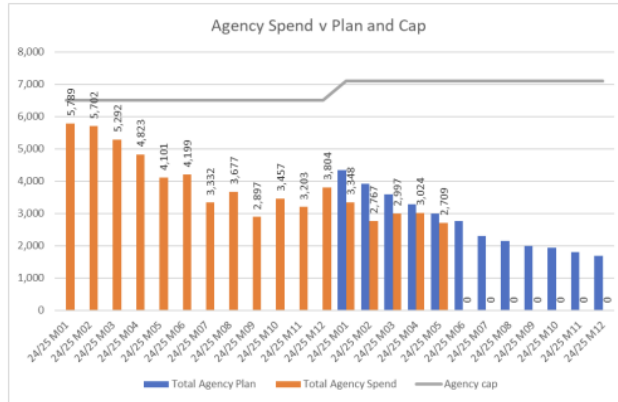
Temporary Workforce



Agency benchmark

This slide shows the Trusts positive performance against plan for agency expenditure.

Agency Pay



Nursing Job Profiles

Detail:

- National job profiles for nursing were released this summer, which provides closer clarity and distinctions for various nursing roles.
- All Trusts are required to make good progress on re-evaluating all nursing roles against the new national profiles to ensure our nursing staff are banded and paid correctly.
- Changes are thought to be moderate and substantial changes to pay are not anticipated

Progress:

- We have increased our number of trained job matchers by four, 2 x union and 2 x HR.
- Nursing managers are reviewing and updating all job descriptions

Next steps

- Our timetable for next steps are outlined below

	October	November	December	January	February	March
Collection of all updated nursing JD's	█	█	█			
Review against profiles and batching			█			
Job evaluation				█	█	
Consistency checking					█	█
Outcomes and impact review						█

Risks:

- There is a risk of increased costs resulting in pay increases. This risk can be mitigated by good workforce planning and skill mix.
- There is a risk of reduced engagement from nursing staff if we mismanage messaging and don't manage expectations well.

Appraisals

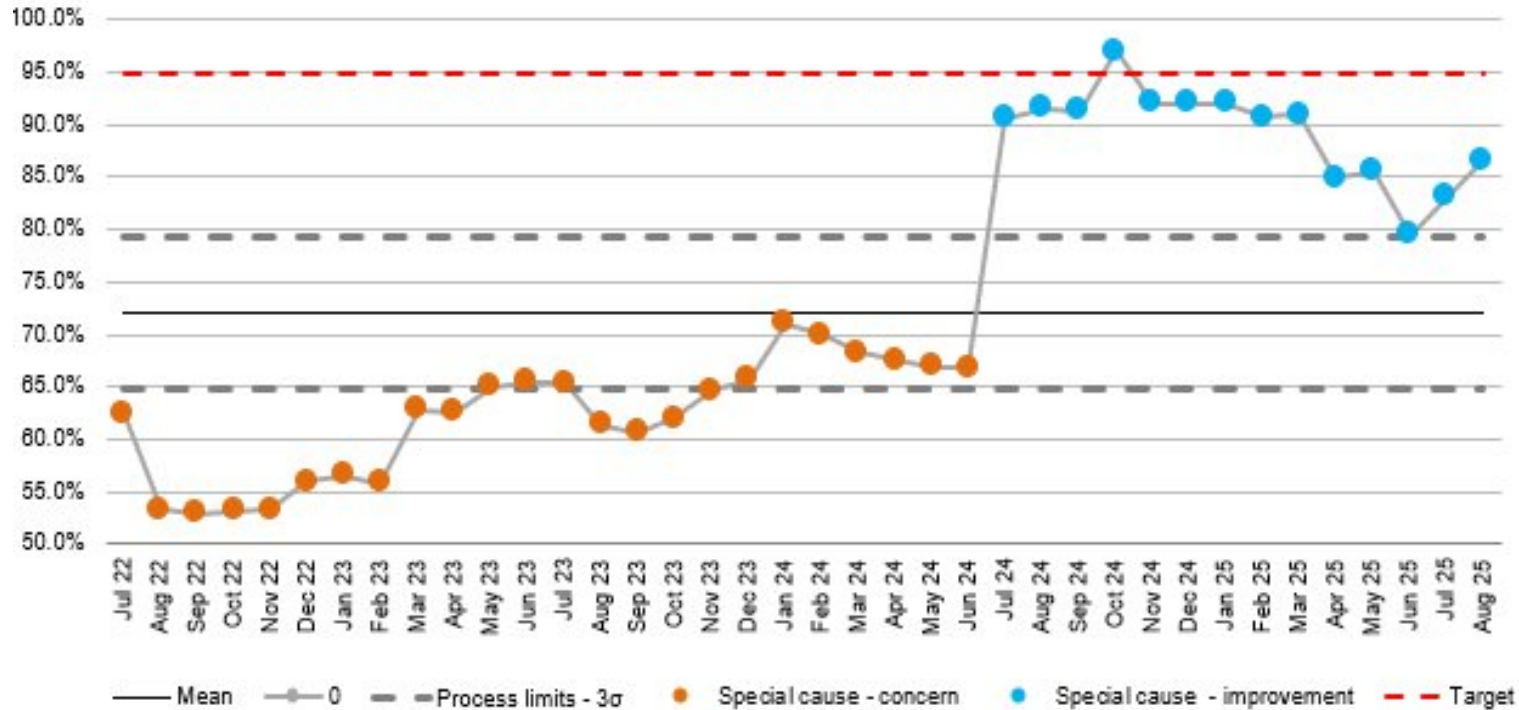
KPI 95%

Aug 2025 88.51%

Trend 

The current rate is 88.5% however excluding new starters from the date, the compliance rate rises to 90.95%. The focus will be to remind managers to conduct new starter appraisals after 100 days and not wait for 2026 window timings. Work will also continue to offer support and resources to senior managers and their teams where there are lower compliance rates. The target is to reach the 95% compliance level by the end of October

Appraisal compliance – starting 01/07/22



Work continues to ensure the appraisal compliance target of 95% is achieved by the end of October 2025. Latest information shows areas that have a lower compliance rate include IT, Estates, Facilities and new starters. The OD and Inclusion team are working with managers who may require additional support to achieve the compliance rate



Core Engagement Comparison data National Staff Survey (NSS) vs Pulse Survey (NQPS)

Staff Experience

KPI 7.4

JULY 2025 NSS 2024 7.1 6.9

Trend ↓

There has been an increase in the response rate for the Pulse (NQPS) survey in July through an enhanced communication plan. Overall, the engagement score has declined, as measured across the 9 core questions encompassing Advocacy, Motivation and Involvement

Indicates number of respondents	NSS 2023 Q3 *793*	NSS 2024 Q3 *836*		NQPS Apr 2024/25 Q1 *23*	NQPS Jul 2024/25 Q2 *47*	NQPS 2024/25 Jan Q4 *51*	NQPS 2025/26 Apr Q1 *6*	NQPS 2024/25 Jul Q2 *151*
Overall Staff Engagement Score	7.18	7.12		6.76	7.40	7.55	NA	6.93
Q1. I often/always look forward to going to work.	57%	54.8%		66.7%	54.5%	67.4%	NA	41.1%
Q2. I am often /always enthusiastic about my job.	69%	66.5%		71.4%	70.5%	81.4%	NA	57.4%
Q3. Time often/always passes quickly when I am working.	68%	68.0%		66.7%	72.7%	72.1%	NA	66.7%
Q4. There are frequent opportunities for me to show initiatives in my role.	70%	71.9%		57.1%	79.5%	81.4%	NA	69.0%
Q5. I am able to make suggestions to improve the work team/department.	71%	70.3%		57.1%	79.5%	81.4%	NA	73.6%
Q6. I am able to make improvements happen in my area of work.	57%	57%		52.4%	68.2%	62.8%	NA	63.6%
Q7. Care of patients /service users is my organisations top priority.	83%	82.9%		85.7%	86.4%	88.4%	NA	76.0%
Q8. I would recommend my organisation as a place to work.	73%	71.4%		66.7%	68.2%	83.7%	NA	62.8%
Q9. If a friend or relative needed treatment I would be	85%	84.7%		71.4%	84.1%	95.3%	NA	83.7%

National Staff Survey (NSS) Overview

Background:

- The Trust has an ambition to be in the top 5% of NHS Trusts for Staff engagement by 2028
- This is measured by the nine staff engagement questions in the staff survey under Motivation, Involvement and Advocacy

Progress 2024-25:

Four priorities were highlighted in the 2024 National Staff survey results (NSS). These priorities are shown below and an overview of the work undertaken to date:

Appraisals

- Additional training has been undertaken by 98 managers to enhance the skills of running coaching conversations

Learning focussed on Managers

- The Me as Manager programme is continuing to be rolled out with ** managers attending to date
- 32 new Apprenticeship have started this year

Fair treatment – Discrimination

- Progress has been made to implement key initiatives including anti racist statement, RACE Equality Code and Active Bystander

Wellbeing

- There has been increased wellbeing support to departments in reducing sickness levels
- Recruitment is starting for the MSK Triage role
- Staff Health Passports to support Reasonable Adjustments have been introduced

National Staff Survey (NSS) Overview

National Staff Survey 2025

As work has started for National Staff survey 2025, here are the key next steps

- Fieldwork for 2025 NSS is now underway and running from October 6th to November 28th
- The OD and Inclusion and Comms Team are leading on the communications and engagement programme for the fieldwork period to promote participation and remove any barriers
- The fieldwork is supported by the Executive Directors to engage staff in their Directorate areas
- Provisional results will be received from partners IQVIA by the end of December with full reports in February 2026
- The NHS co-ordination report will be received in February with the national embargo lifted in March 2026



Section Two: Education and Training

Prepared by: Claire Felkin, Training & Development Manager

Presented by: Claire Felkin, Training & Development Manager

Ref: Oct, 2025/HR&OPS

Education and Training

Summary:

This month has seen a slight decrease in compliance to 82.85%. Cyber and Information Governance (IG) have still not seen much of an increase and are at 61.60% and 59.39% respectively. We continue to be well below the target of 93% overall.

The new Learning Management System is scheduled to go live on 15th October following a soft launch on 1st October.

Areas for Improvement:

- Cyber and IG require improvement. Hopefully with the move to the new Learning Management System (LMS) where both modules can be completed, we hope to see a higher uptake and an overall improvement with compliance.

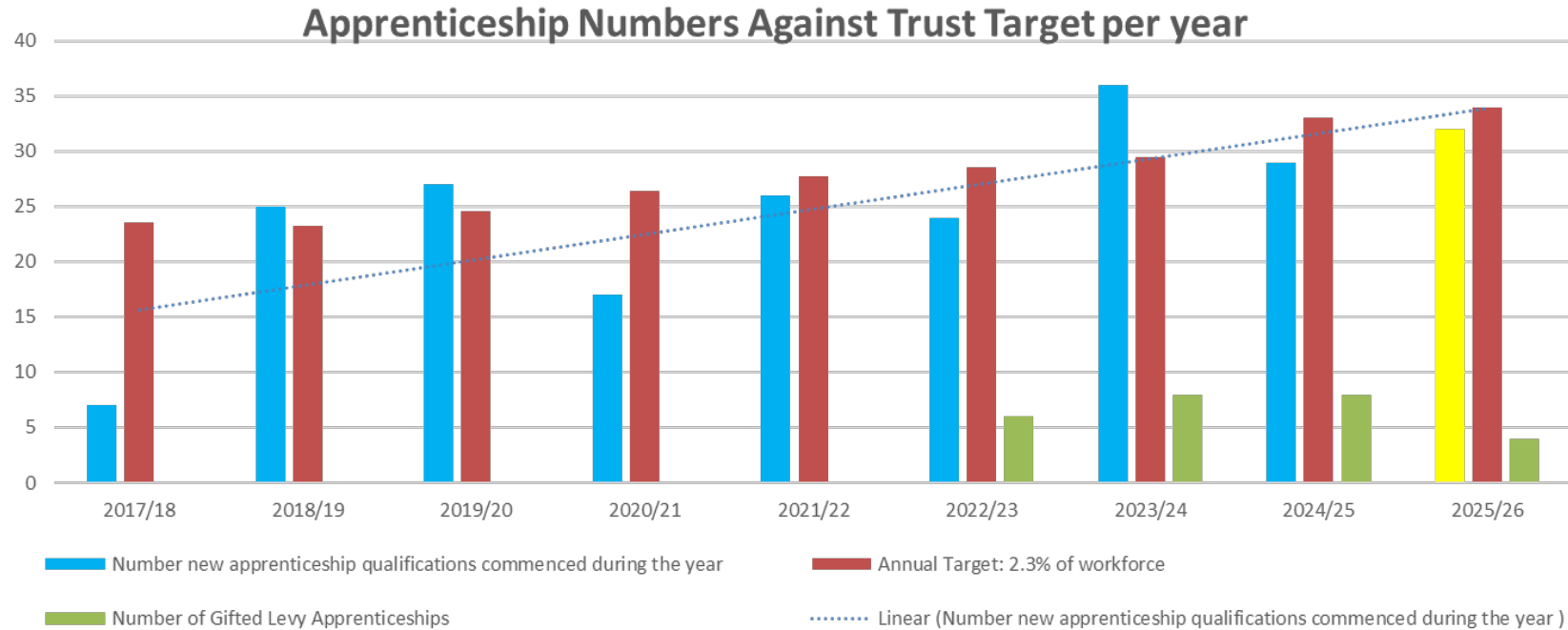
Risks / Issues:

- Changeover to the new LMS system, we are checking any data issues between ESR and the new system. (T&D/HR/WF/IT)
- Some staff do not have nhs mail which will restrict access to the LMS and single sign on. Managers will need to ensure that new staff are given access to systems and nhs mail quickly upon starting with the trust.

Action Plan:

- Launch of Learning Management System (October)
- National STATMAND training review project will outline new framework in December 2025.
- Launch National STATMAND policy (December) setting out requirements of Managers and Staff in meeting their training requirements (November T&D and MPET meetings).

Apprenticeship Activity



Achievement toward annual target:

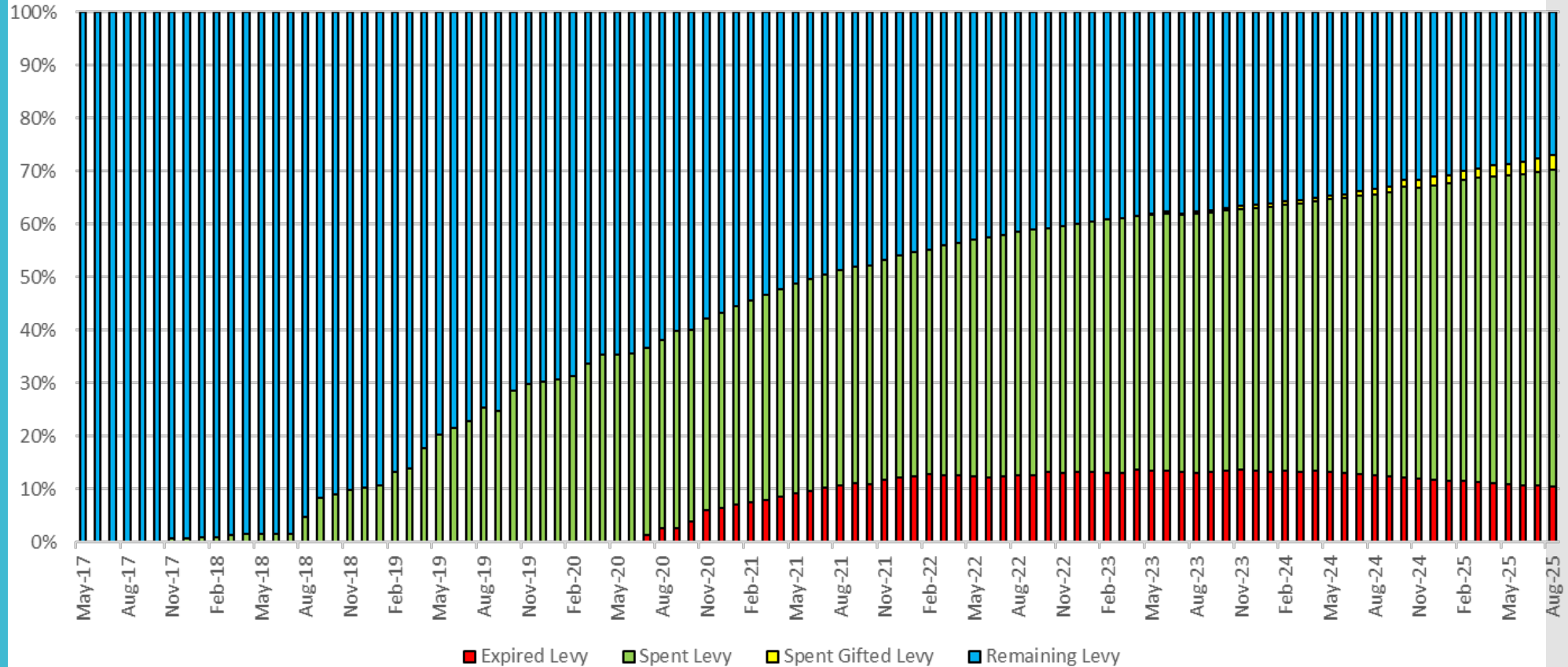
- This graph shows the number of new apprenticeship qualifications commenced in each year against the annual local trust target for that year. For 2024/25 we worked towards number of 33 apprenticeship new starts and achieved 29. The Trust also gifted levy funding to support 8 apprenticeships in 2024/25.
- For 2025/26, we are making significant progress towards our national target (34) and have gifted levy to support 7 external health and social care apprenticeships. At the end of August there have been 16 apprenticeship qualifications commence, with an additional 2 in recruitment or pre-employment stages with 5 awaiting sign up and 9 in discussion. If all commence this will be 32 against our annual target of 34 (based on target of 2.3% of workforce).

Apprenticeship Levy Funding

Total Levy	£2,052,364.58
Levy Charges	62.42%
Gifted Levy	2.75%
Levy Expired	10.54%
Remaining Levy	27.03%

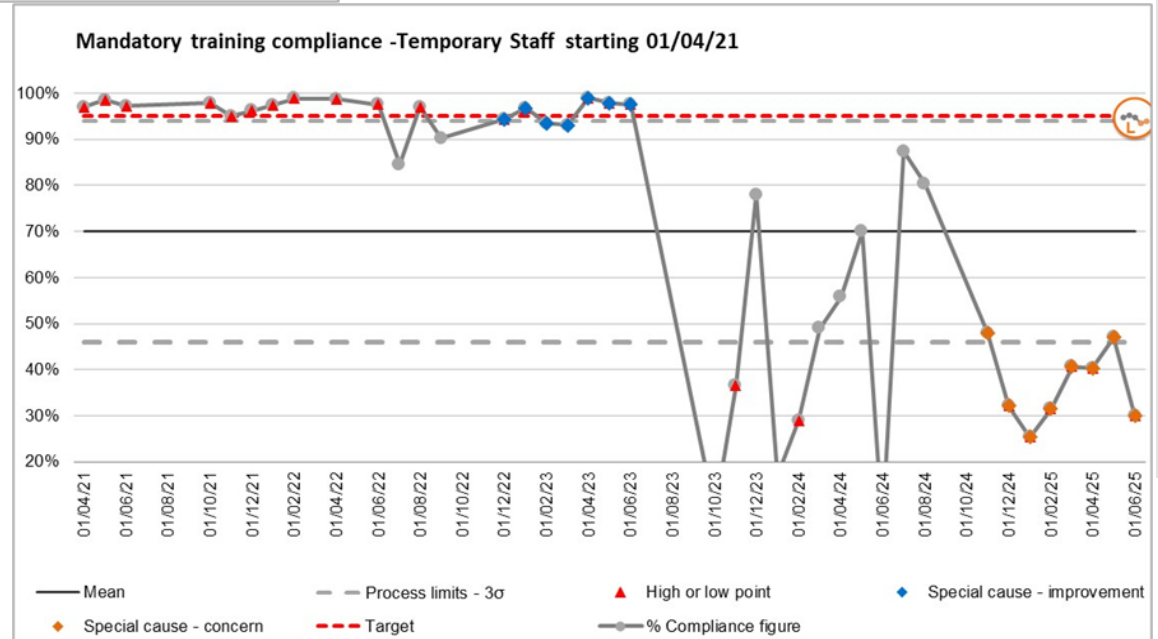
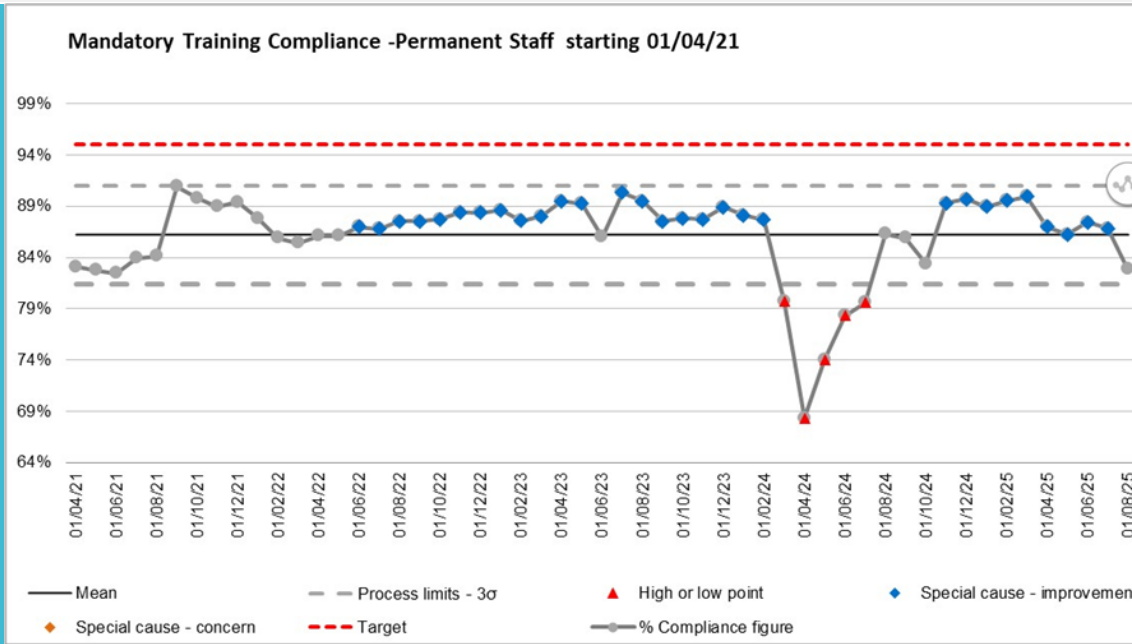


A graph to show the utilisation of the apprenticeship levy as a percentage of the Total Levy Pot per month since April 2017.



This graph shows the cumulative utilisation of the ROH Apprenticeship Levy funds. At 31st August 2025 the Trust has paid a total of £2,052,364.58 towards the Apprenticeship Levy since its introduction in April 2017. Of this total amount, 62.42% has been accessed by training providers to fund apprenticeship qualifications in the Trust, including 2.75% gifted to SME's (increase in 8.48% since August 2024), 27.03% remains available (decrease in 6.4% in August '24) and 10.54% has expired (2.08% decrease since August '24).

Core Mandatory Training 82.5%: Permanent and Temporary Staff 81.3%



Pg.	COURSE	Compliance %age	COMMENTS	TR
4	Core Mandatory Training – Permanent Staff	82.85%	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	81.33%	Based on staff working on the Bank who are compliant with training. Bank Office have been targeting staff to complete their training.	▶
6	Cyber	61.60%	Compliance has dropped this month as a <u>number of staff</u> expired this month but only 52 completed This module is not available from ESR and are not accessible until they have expired.	▶
6	IG	59.39%	Compliance has dropped this month as a <u>number of staff</u> expired this month but only 52 completed Annual renewals from April but recovering well, as per Cyber. ROH requires both modules to be completed.	▶
7	Basic Life Support – Level 1	88.07%	Regular direct chasers are keeping this requirement above target. Audience is non-clinical staff.	▶
7	Hospital Life Support – Level 2	78.85%	Continuing to see DNAs and need to push those out of date to book and attend f2f sessions.	▶
8	Immediate Life Support	80.63%	Consistently improving now over a <u>number of months</u> 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	86.67%	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	85.65%	Consistent improvement since February. New dates scheduled and available to book.	▶
10	Conflict Resolution	85.34%	Incremental improvements each month, since <u>3 year</u> renewal dip back in May 2024.	▶
11	NEWS2	98.39%	Consistently achieving over 95% compliance.	▶
11	Safe use of Insulin	89.77%	Dipped having been very near to target last month.	▶
11	VTE	93.98%	Target achieved	▶
12	CONSENT	81.93%	Static requires intervention to target those consultants out of date.	▶
12	IPC2	76.64%	Decrease due to extra staff groups being added to complete (porters and domestic staff)	▶
12	Food Hygiene	92.63%	Slight decrease on last month	▶

Mandatory Training

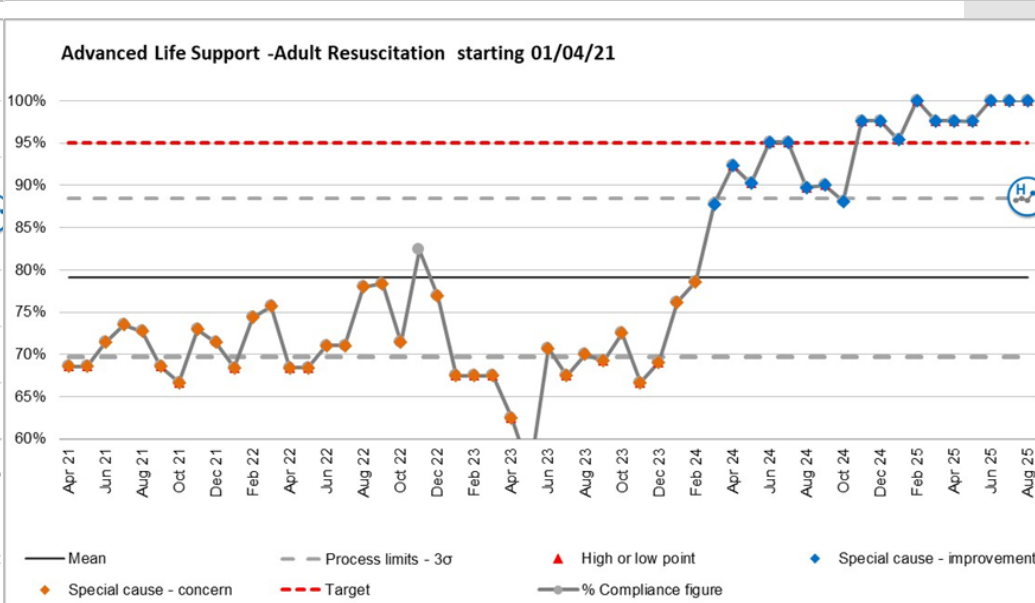
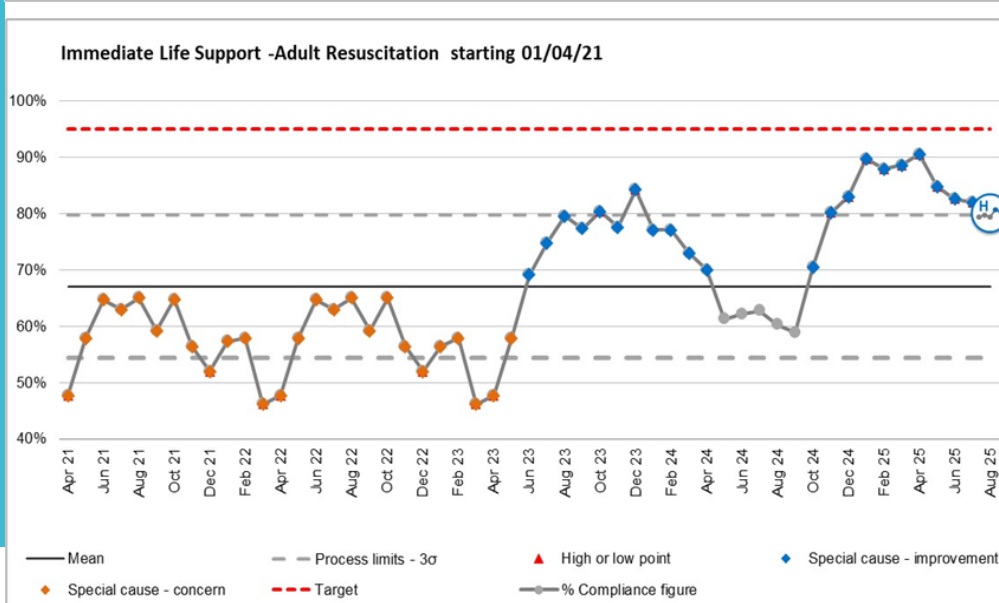
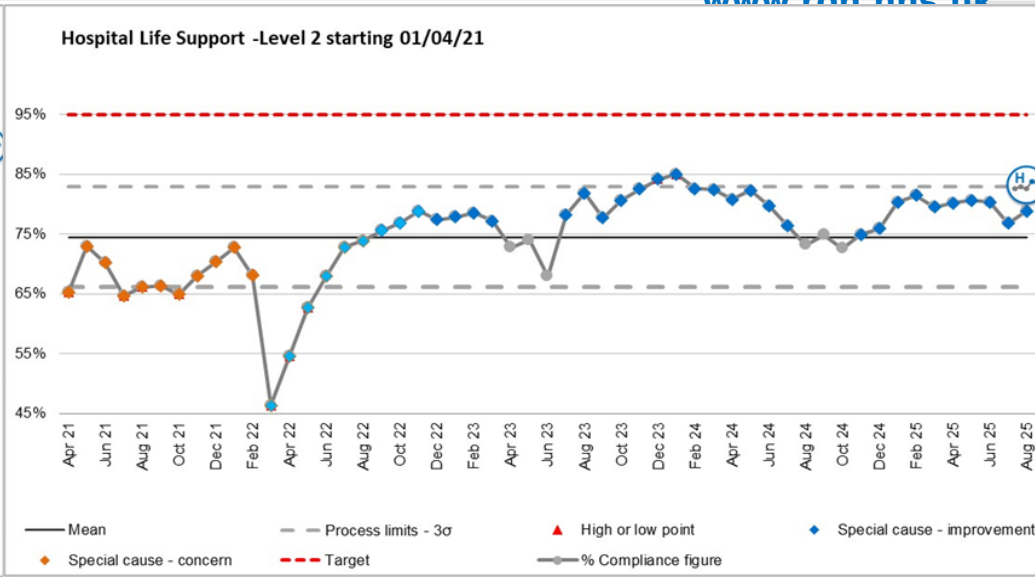
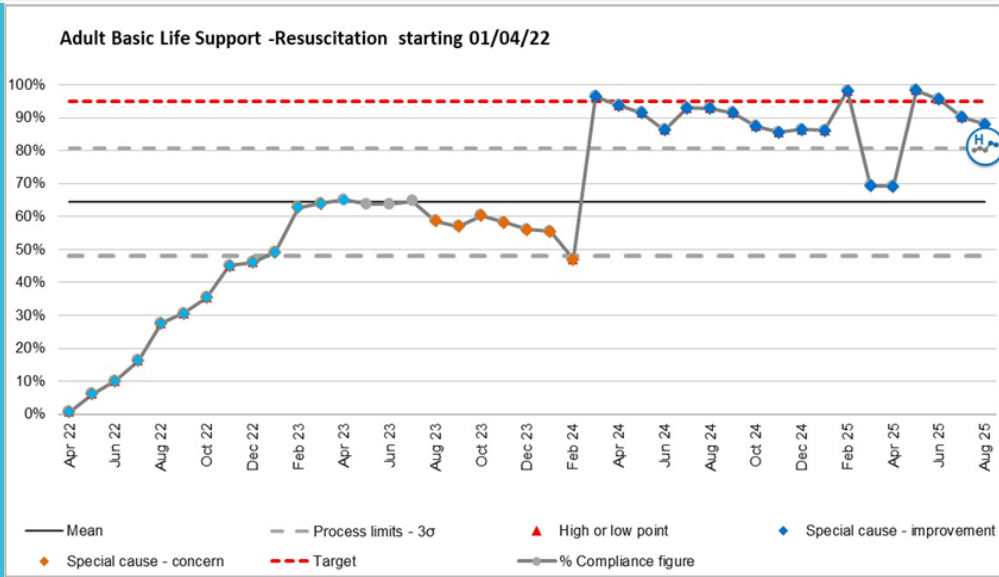
KPI 93%

Aug 25 82.85%

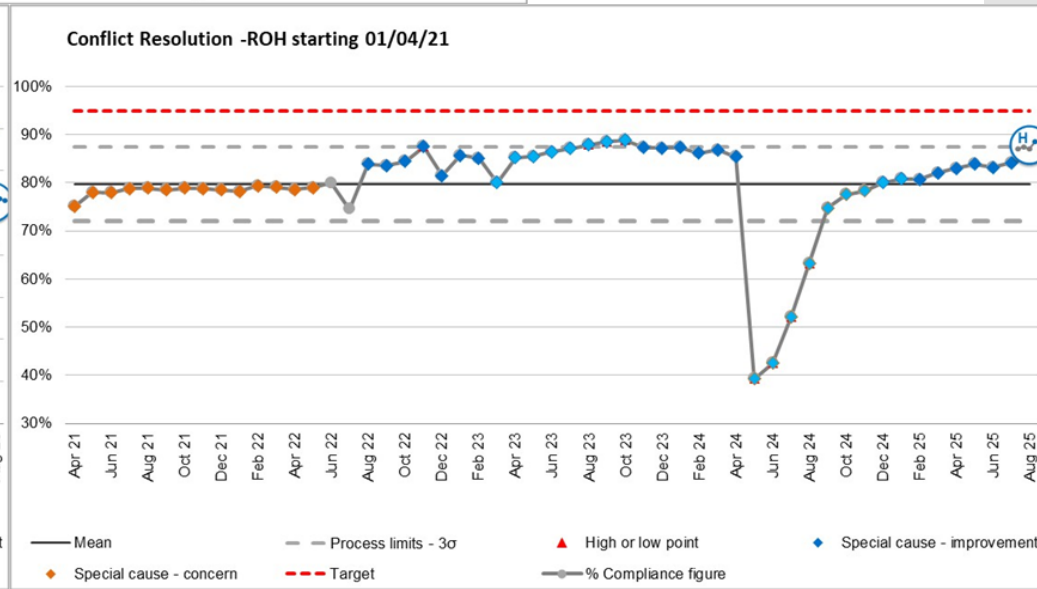
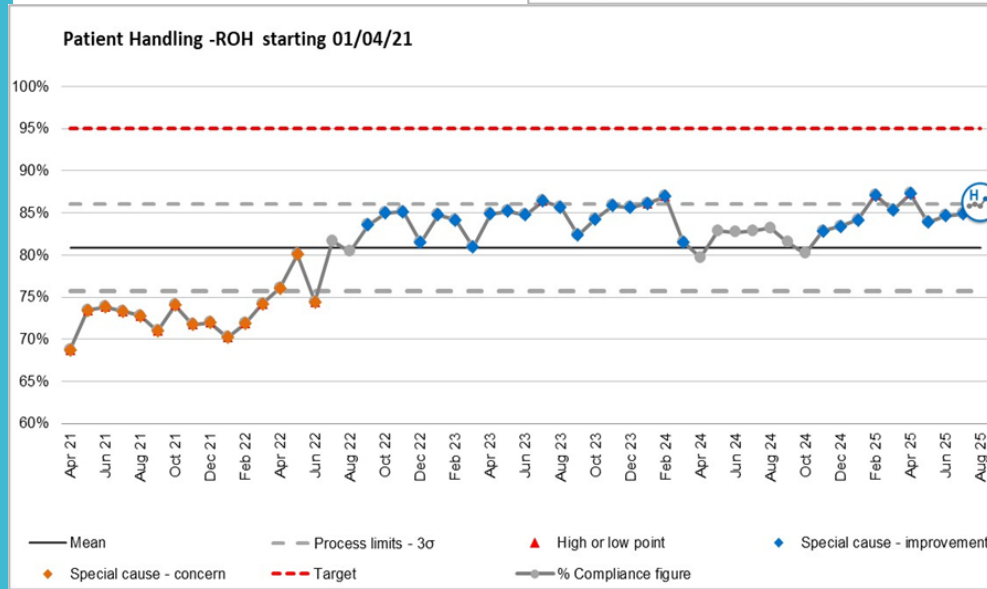
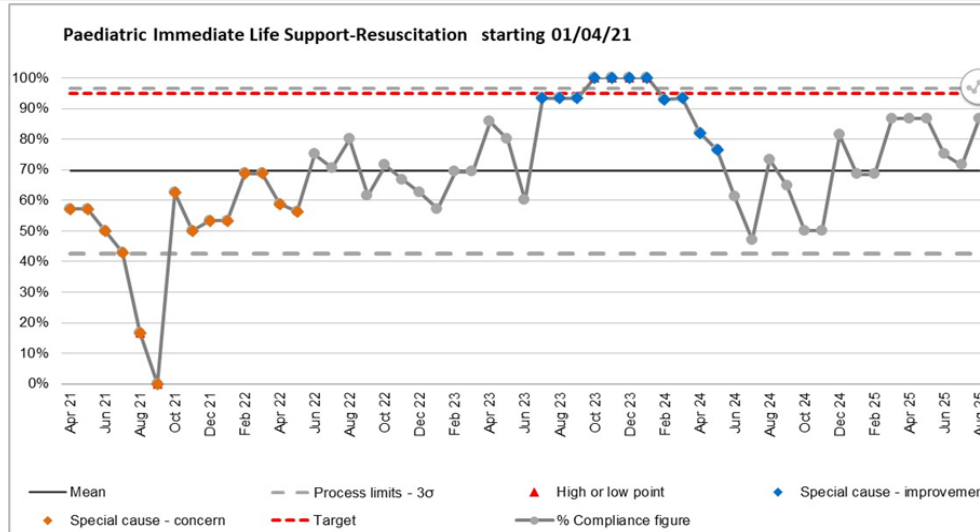


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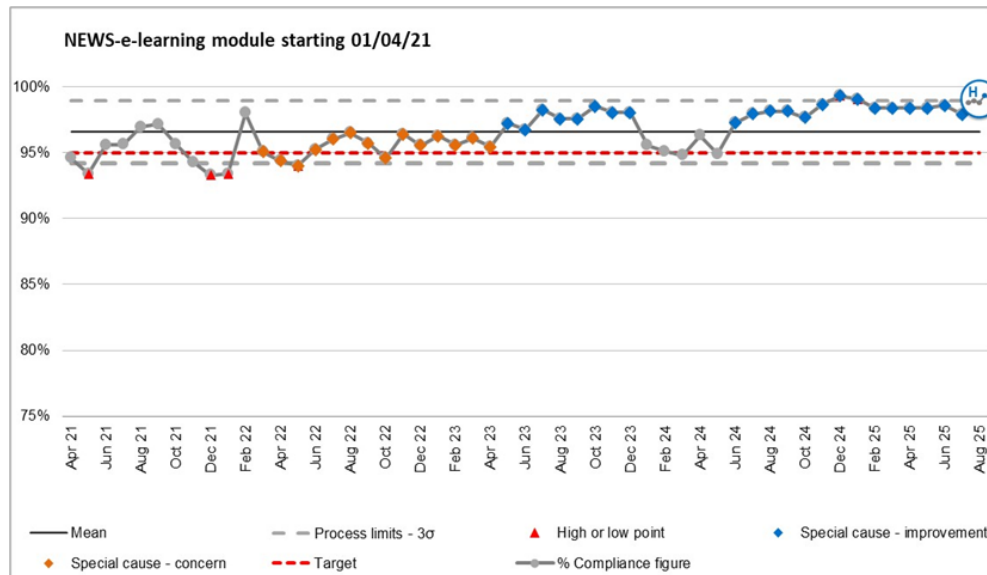
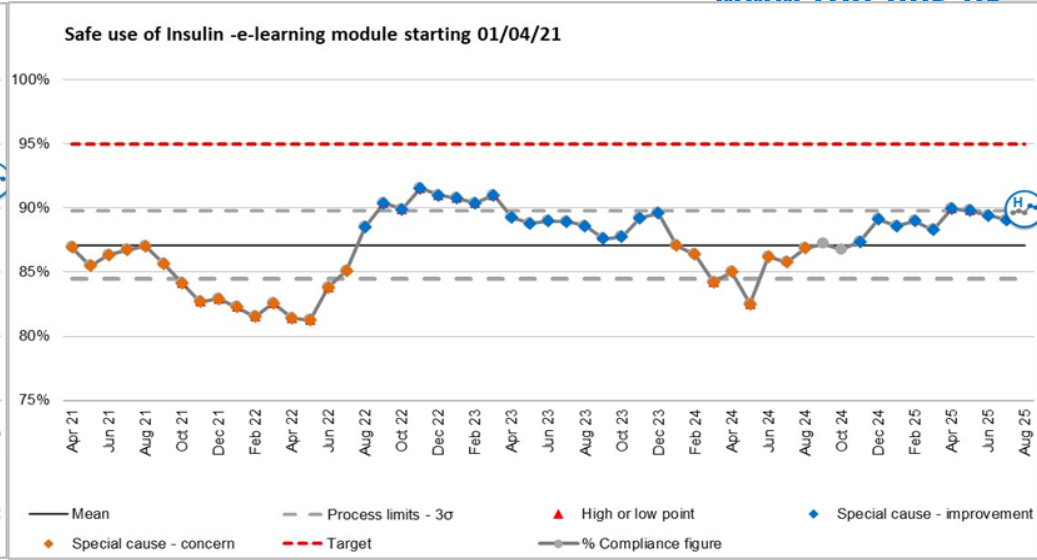
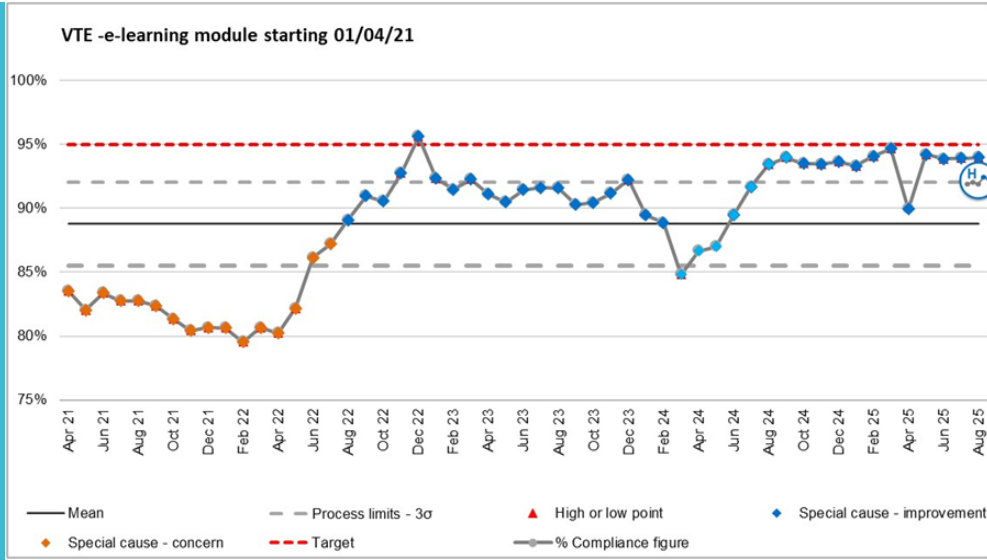
Resuscitation Training: Adult



PILS, Conflict Resolution Patient Handling



VTE, Safe use of Insulin, NEWS2



IPC Level 2, Food Hygiene, Consent

