The Royal Orthopaedic Hospital NHS Foundation Trust

Trust Board (Public) -February 2026

Wednesday 4th February 2026, 13:00h - 16:30h

Boardroom, Trust Headquarters

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Notice of Trust Board Meeting in Public on Wednesday, 4 February 2026

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 4 February 2026, in the Boardroom, Trust HQ commencing at **13:00.**

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

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

Simon Page
Chair

The Royal Orthopaedic Hospital NHS Foundation Trust

AGENDA
TRUST BOARD (IN PUBLIC)

Venue Boardroom, Trust Headquarters **Date** 4 February 2026: 13:00h – 16:30h

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

In attendance

Mr Curig Johnston	Associate Non Executive Director	(CJo)	
Mr Amos Mallard	Deputy Director of Strategy	(AM)	[Item 1]
Mrs Emma Steele	Deputy Chief Nurse	(ES)	[Item 12]
Mrs Claudette Jones	Freedom to Speak Up Guardian	(CJn)	[Item 26]
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
		IN PUBLIC SESSION		
13:00	12	Patient Lived Experience	Presentation	ES
13:20	13	Apologies: None	Verbal	Chair
	14	Declarations of Interest	ROHTB (2/26) 007	Chair
	15	Minutes of Board Meeting held in Public on 5th November 2025: *for approval*	ROHTB (11/25) 018	Chair
	16	Actions from previous meetings in public: *for assurance*	ROHTB (11/25) 018 (a)	SGL
	17	Questions from members of the public	Verbal	Chair

13:25	18	Chair's and Chief Executive's update, including the Guardian of Safe Working Quaterly Update: *for information and assurance*	ROHTB (2/26) 008 ROHTB (2/26) 008 (a) ROHTB (2/26) 008 (b)	MH/SP
13:45	19	Chief Finance Officer's report: *for information and assurance*	ROHTB (2/26) 009	SW
14:00	20	Chief Operating Officer's report: *for assurance*	ROHTB (2/26) 010 ROTHB (2/26) 010 (a)	MP
14:10	21	Chief People Officer's report: *for assurance*	ROHTB (2/26) 011	SM
14:20	22	Quality Officers' report: *for assurance*	ROHTB (2/26) 012	MR/NB/ SGL
14:30	23	ROH Strategy 2023-2027 Progress of Delivery: *for assurance*	ROHTB (2/26) 013 ROHTB (2/26) 013 (a)	RL
14:45	**BREAK**			
14:55	24	Safer Staffing Update: *for assurance*	ROHTB (2/26) 014 ROHTB (2/26) 014 (a)	NB
15:05	25	Sexual Safety Update: *for assurance*	ROHTB (2/26) 015 ROHTB (2/26) 015 (a)	NB
	GOVERNANCE AND COMPLIANCE			
15:15	26	Freedom to Speak Up update: *for assurance*	ROHTB (2/26) 016 ROHTB (2/26) 016 (a)	CJn
15:35	27	Board Assurance Framework Update: *for assurance*	ROHTB (2/26) 017 ROHTB (2/26) 017 (a-l)	SGL
15:45	28	Learning from Deaths Update: *for assurance*	ROHTB (2/26) 018 ROHTB (2/26) 018 (a)	MR
15:50	29	Application of the Trust Seal - Amended Lease Agreement for Maryland Drive: *for approval*	ROHTB (2/26) 019 ROHTB (2/26) 019 (a) ROHTB (2/26) 019 (b)	SW
	UPWARD REPORTS FROM THE BOARD COMMITTEES			

15:55	30	Upward reports from the Board Committees:
		• Staff Experience & OD Committee
		• Quality & Safety Committee
		  ○ **For Approval to Publish**
		  ▪ Controlled Drugs Annual Report
		  ▪ Radiation Safety Report
		• Finance & Performance Committee
		• Audit Committee
			ROHTB (2/26) 020
			ROHTB (2/26) 021
			ROHTB (2/26) 021 (a)
			ROTHB (2/26) 021 (b)
			ROHTB (2/26) 022
			Verbal
				SJ
				IR
				
				GH
				GH

16:10	**MATTERS TO BE TAKEN BY EXCEPTION**			
	31	Performance Reports: *for assurance* a) Finance & Performance b) Quality Report	ROHTB (2/25) 023 ROHTB (2/25) 024	
	32	Any Other Business	Verbal	All
16:15	33	Meeting effectiveness	Verbal	All
16:30	**CLOSE: Date of next meeting (in Private): Wednesday, 4th March 2026 @ 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 DECEMBER 2025

MEMBER	ATTENDANCE										TOTAL
	** 09/04/2025	07/05/2025	04/06/2025	02/07/2025	03/09/2025	08/10/2025	05/11/2025	03/12/2025	04/02/2026	04/03/2026	
Tim Pile (Ch)	✓	✓	✓								
Ian Reckless	A	✓	✓	✓	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	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.

TRUST BOARD DECLARATIONS OF INTEREST REGISTER

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

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

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board PUBLIC - DRAFT Version 0.1

Venue Boardroom, Trust Headquarters **Date** 05 November 2025: 0900h - 1230h

Members Attending:

Mr Simon Page	Chair	(SP)
Ms Simone Jordan	Vice Chair and Senior Independent Director	(SJ)
Ms Ayo Ajose	Non Executive Director	(AA)
Ms Jenny Belza	Non Executive Director	(JB)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Dr Ian Reckless	Non Executive Director	(IR)
Mrs Nikki Brockie	Executive Chief Nurse	(NB)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)
Mr Matthew Hartland	Chief Executive	(MH)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mrs Marie Peplow	Executive Chief Operating Officer	(MP)
Mr Matt Revell	Executive Medical Director	(MR)
Mr Steve Washbourne	Chief Finance Officer	(SW)

In Attendance:

Mr Pete Law	Media Studio Manager and Staff Governor	(PL)	Item 1
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Mandy Wilson	Executive PA to the Chief Operating Officer	(MW)	Secretatiat

IN PUBLIC SESSION

1 Staff Story **Presentation**

RL began this Item by introducing and welcoming PL to the meeting.

PL continued by outlining that he had commenced at the Trust in 2018 and whilst he was the Media Studio Manager he was also a Staff Governor and then continued by sharing some personal information which included that he had finished College at eighteen after which he had approached a number of Media Companies with the intention of learning more about the various roles within Media and he undertook this for a few years following which he moved into Education primarily managing the various media aspects and requirements. This was carried out for eight to nine years and ceased when he was made redundant.

PL reported that following his redundancy he decided to take a career break and went to University following which he then joined the Trust.

Upon joining the Trust PL has worked on various projects including the 'facing areas' to raise awareness of Dementia and the Beyond Stigma Campaign.

PL reported that as a Graphic Designer he's role was not to make people "look pretty" but to help provide a solution to any problems or issues and he shared an analogy for the role of a Graphic Designer which is that to show people what is meant by a statement and an example was given of a door with a "Push" sign and "flat plate" as opposed to a "Pull" sign and "handle or knob".

PL continued that one of his first roles in the Trust had been to look at the various forms used by Nursing Staff with the aim being to have them be intuitive and easy to use.

Another area of work, that is still ongoing, is in relation to Patient Information and primarily ensuring that this is delivered to patients at the right stage of their journey and is specific to the operation or procedure being undertaken.

To help achieve this a number of Working Groups have been convened to identify what is needed and whether the information should be produced electronically or in written form.

MH continued this Item by reporting that he recently had the pleasure of working with PL to record a number of videos and he appreciated the support and guidance provided.

A question was then asked to PL as to whether there was any specific technology that could be provided to help him undertake he's job better and PL responded by saying that whilst Artificial Intelligence was a good platform to be explored it was not something, at present, that was particularly viable or useful for Media work largely because a lot of the source material produced by Artificial Intelligence was American and very stereo typical.

A further question was then asked of how awareness of the Trust could be improved and it was considered the best and most suitable approach was to raise awareness via G.P.s.

PL was thanked for attending and sharing his story.

2 Apologies (Chair) **Verbal**

Apologies were received and accepted from Jan Teo.

3 Declarations of Interest (Chair) **ROHTB (11/25) 001**

SJ outlined that she needed to update her Declaration of Interest.

Action:- SJ

4 Minutes of Board Meeting held in Public on 3rd September 2025: *for approval* (SGL) **ROHTB (9/25) 030**

The minutes of the meeting held in public on 3rd September 2025 were accepted and **approved** by the Board.

5 Actions from previous meeting in public: *for assurance* (SGL) **ROHTB (9/25) 030(a)**

ROHTBACT.282

This Item can be closed as will be discussed as part of the meeting.

ROHTBACT.283

A meeting between SGL, GH and Adam Roberts, Assistant Director of Governance and Risk is to be arranged.

ROHTBACT.284

It was agreed that an update would be provided at the end of the Flu Campaign in March 2026.

6 Questions from members of the public (Chair) **Verbal**

No questions were received in advance of the meeting.

7 Feedback from the Board walkabouts in October (ALL) **Verbal**

It was outlined that this was the first time that Walkabouts had been undertaken and felt it provided an opportunity for staff to engage and talk to Directors and Non Executive Directors openly and honestly.

As part of the feedback it was highlighted that the visits had been welcomed and staff were engaging and provided the Directors and Non Executive Directors with the opportunity to provide assurance; if needed; and to assure staff that they voice was being heard. It was also reported that staff appreciated the fact that Directors and Non Executive Directors had taken the time to visit.

From a Non Executive Directors perspective it was questioned how the feedback provided is actioned and not 'ignored' and it was agreed that a process needs to be introduced to enable feedback to be shared with the appropriate Departments \ Teams and a log of these to be kept.

8 Chair's and Chief Executive's update *for information and assurance* (MH/SP) **ROHTB (11/25) 002** **ROHTB (11/25) 002 (a)**

Chief Executive

MH began by sharing information on the new ICB Cluster leadership with David Melbourne been appointed as Chief Executive and Danielle Oum as Chair although it was noted that there are still some 'changes' in relation to structures to be made with staff possibly facing redundancy.

It was then reported that whilst the new Planning Guidance document has not yet being produced work is already underway alongside other important elements of work such as EPR.

MH continued by reporting that monthly contractual meetings were being held between the Trust, ICB and NHS England.

This Item was concluded by the Committee being informed of the recent loss of two members of and it was clarified that support was being provided, if needed, to colleagues.

Chair's

SP continued by reporting on a recent visit by Danielle Oum who holds the Trust in high esteem and that the visit had been very successful.

SP also stated that he had also recently attended a meeting with Dale Bywater, Regional Director (Midlands), NHS England, who had outlined that all Trusts needed to be pay close attention to ensuring they were meeting the Key Performance Indicators.

The Committee were informed that following a recent recruitment process two new Non Executive Directors had been appointed: Sharon Thompson who will be chairing the Finance and Performance Committee and who Curig Johnston was the new Associate Non Executive Director.

The Item was continued by it being reported that the Planning Guidance would e actioned by SW and although it was due to be received on 07 November 2025 it was anticipated that it would be later and it was agreed that the submission would be shared at the next Board meeting although there was a need to be aware that it would not be the final submission.

MH concluded by stating that there would be a need to produce a new five year Strategy which would require involvement and engagement of the general public.

9 Chief Finance Officer's report: *for information and assurance* (SW) **ROHTB (11/25) 003**

SW began by stating the Trust had ended Month 6 in a positive position with a deficit of £17k against the planned surplus of £47k and whilst performance continues to be the same there are numerous discussions being undertaken to ensure that performance is maintained and continues to deliver over the next few months.

It was acknowledged that the second half of 2025 \ 2026 will be the most challenging for the Trust and that the main focus of the Financial Sustainability Group will be to look at ideas on a monthly basis rather than annually.

A question was asked in relation to the possibility of having Shared Services and It was stated that this was highly unlikely to be implemented particularly for Procurement but there was a possibility it could be introduced for HR but would need to be carried out on a collaborative basis.

10 Chief Operating Officer's report: *for assurance* (MP) **ROHTB (11/25) 004**

MP began by outlining that she had recently had the pleasure of attending two meetings the first being with Jim McKay which provided an opportunity to raise concerns and have questions answered and the second with Sarah-Jane Marsh which will continue to be held on a monthly basis.

MP then stated that in her capacity as MMEG Executive Lead she had had the pleasure of attending an annual event on 15 October 2025 to help raise cultural awareness.

It was then reported that the Trust were currently eighty cases ahead of plan and that work was currently underway to look at boosting activity towards year end.

In relation to the Private Patient Service income is £363k against a plan of £383k and it was outline that whilst delivering Year to Date it is below the stretch target. It was also reported that a new Surgeon was commencing in post in January 2026.

It was also reported that work was being undertaken in relation to raising awareness of the Private Patient service with a focus being carried out in respect of marketing although it was reported that some patients have reported that they would prefer to be treated by the NHS rather than privately.

Also a brief consultation with International patients has been carried out which shows that the majority opted for their treatment to be carried out in Oxford of London rather than Birmingham and it was clarified that this consultation does not relate solely to this Trust but also other Private Patient Organisations.

In terms of the Ambulatory Day Case Ward the pilot had now been completed and feedback was being gathered and it is hoped to be able to provide this for other Specialties.

A deep dive into PTLs is being undertaken with the aim being to help improve activity and increase income.

A question was asked as to whether 'stand by' patients are being fully "utilised" and to this MP reported that work was currently underway to improve as it was acknowledged not fully implemented across all Specialties as it should be.

The Committee were then informed that as part of the Trust Improvement Group six projects had commenced and work was being undertaken by the PMO Office to ensure these projects were aligned to the Trust Strategy.

11 Chief People Officer's report: *for assurance* (SM) **ROHTB (11/25) 005**

SM began by reporting that the "Me as Manager" training, which commenced in March 2025, was progressing well and that the intention was for a full report to be presented to the SE & OD Committee in December 2025.

Work is still being undertaken in relation to Appraisals and staff are being encouraged to complete as soon as possible.

The new Learning Management System has now been introduced and initial findings show staff prefer this System to ESR especially in relation to completing mandatory training.

In respect of the Staff Survey as of the 05 November 2025 the Trust were at 34% which is behind what should be Nationally but not overly concerned as it appears that other Trust are in the same position.

Acknowledged that some planning will be needed ahead of the Junior Doctors Industrial Action which is scheduled to take place between 14 and 19 November 2025 although it was anticipated that this would have a low impact on the Trust.

SM continued by reporting that short term sickness still remains an area of concern but is regularly being monitored and to ensure that Policies were being followed work was currently underway by the HR Team to review the Policies, in particularly the Sickness \ Absence, to make sure the information provided and action needed is clear and concise.

In respect of the Staff Survey a question was asked as to whether "You Said \ We Did" from the 2024 \ 2025 has been shared with staff and to this SM reported that all Teams \ Departments have been provided with their bespoke Action Plans for onward sharing with staff.

12 Quality Officer's report: *for assurance* (MR/NB/SGL) **ROHTB (11/25) 006**

Chief Nurse (NB)

NB began by reporting that she had recently attended a Chief Nursing Officer for England Conference and the aim of the Conference was to bring people together, not just from the NHS but also the Community and Military, to look at the future of Nursing and Midwifery through strategic collaboration and professional development.

It was also reported that the Pharmacy Team had recently undergone their annual CQC assessment and feedback received outlined there was some good practice around patient information.

The Committee were also informed that on the 29 October 2025 the first Person Designate (Human Tissues Management) event had been held.

In terms of the Flu Campaign NB reported that the Trust had now 'run' out of vaccines with 72.6% of staff being vaccinated.

NB concluded her segment by reporting that the Trust had completed its first years Veterans Accreditation review and had successfully been re-awarded the Bronze accreditation. Plans were being put in place to work towards the Silver accreditation which would involve undertaking increased training and raising awareness of the Health Inequalities is associated with Veterans and their families.

Governance (SGL)

The Committee were informed that October was the "Freedom to Speak Up" month and this was celebrated by samosas being delivered to staff to help raise awareness and provide an opportunity to 'speak up'.

SGL reported that work continued in relation to the Trust governance review and that good progress had been made with the hope that it would be concluded by 31 December 2025.

The Item was concluded by it being reported that SGL and NB would be meeting with the CQC Relationship Manager on a regular basis.

13 Supreme Court Ruling for Human Rights Update: *for assurance* (SM/NB) **ROHTB (11/25) 007**
ROHTB (11/25) 007 (a)

The Committee were informed that following the Gender Rights Supreme Court Ruling in April 2025 the Trust had undertook an initial action review to ensure compliant with the legal requirements for both staff and patients.

It was outlined that the key issue was to ensure all risks were being addressed as well as ensuring that staff were aware of this new Ruling and what it means to them as individuals.

Work was also underway by EDI Leads to identify what action is needed and by who to avoid any duplicated work.

It was also reported that work was underway with the Estates Team in respect of undertaking a review and assessment of the toilet and changing facilities provided to staff and patients \ visitors to ensure they are appropriate and have the correct signage in place.

14 ROH Strategy 2023-2028: Strategy Update: *for assurance* (RL) **ROHTB (11/25) 008**
ROHTB (11/25) 008 (a)

RL began by reporting that the Trust were currently in year three of the five year Strategy and a mid year review had been undertaken which showed there was a need to improve the collaboration between the Trust and Community.

A Trust Delivery Plan has been produced which includes eighty plans which are split across a variety of Delivery Groups all led by an Executive Lead and work is currently underway looking at how these can be delivered.

The report included with the Meeting Papers showed what had already being "achieved" and what was on "track" and it was outlined that detailed information on each plan could be provided if needed.

Following a discussion it was suggested that using a 'Driver Diagram' may be of some use to help show progress visually.

15 WDES/WRES Actions Plans: *for assurance* (SM) **ROHTB (11/25) 009**
ROHTB (11/25) 009 (a)

SM began by reporting that initial data had been provided to the Committee in October 2024 and that the data period was from 01 April 2024 to 31 March 2025 with information being provided by ESR.

The WDES data has shown a decline in seven indicators, an improvement in four and no change in one but generally not overly concerned as feel all of the indicators will be achieved.

It was clarified that the purpose of presenting these two Action Plans at today's meeting was to seek Approval for them to be published on the Trust Website which was duly granted.

A question was then asked in relation to Bully and Harassment and what action was being taken to tackle this and SM responded by saying that a lot of work was being carried out in the 'background' to help educate staff and Line Managers on the action that needs to be taken.

It was also noted that a number of staff do not appear to have a Workplace Assessment Passport and to this it was clarified that this was a shared responsibility between staff and Line Managers to identify what is needed as well as any additional support.

16 Sexual Safety Charter: *for assurance* (NB) **ROHTB (11/25) 010**
ROHTB (11/25) 010 (a)

This was published by NHS England in September 2023 and in August 2025 a Self Assessment Charter was circulated which was presented at the SE & OD Committee and it was clarified that the intention was to bring the complete data to the next meeting.

In the meantime work is being undertaken to build a relationship with the University of Worcester and raise awareness by engaging with Teams via a number of Road Shows.

It was acknowledged that whilst awareness levels have now been raised there is still more work needed.

17 Annual Report for Medical Appraisal and Validation: *for assurance* (MR) **ROHTB (11/25) 011**
ROHTB (11/25) 011 (a)

MR outlined that this is an annual report that has to be submitted to NHS England and outlined that there were no specific areas of concern to be raised.

It was queried whether Consultants from University Hospitals Birmingham NHS Foundation Trust have a MFIT Contract and to this MR reported that they did not but have a Honorary Contact which was working well. Following a discussion MR agreed to explore the option of introducing a MFIT Contract.
Action:- MR

18 Upward reports from the Board Committees: **ROHTB (11/25) 012**
ROHTB (11/25) 013
ROHTB (11/25) 014

Finance & Performance Committee (LW)

This was taken as Read and whilst Les Williams (LW) was not at today's meeting as he had left his position as Non Executive Director he was thanked for Chairing the Finance and Performance Committee.

Staff Experience and OD Committee (SJ)

SJ reported that the Report circulated covered the majority of discussions from the last meeting and did not have anything else to add.

Audit Committee (GH)

GH reported that as part of National Awareness Week in November 2025 she would be undertaking a Counter Fraud Roadshow.

19 Performance Reports: *for assurance* **ROHTB (11/25) 015**
ROHTB (11/25) 016
ROHTB (11/25) 017

a) Finance & Performance
b) Quality Report
c) Workforce Report

All three Performance Reports were taken as Read and accepted.

20 Any Other Business (All) **Verbal**

Integrated Performance Report

It was reported that data was being gathered automatically and the intention was to do an exception reporting template.

21 Meeting effectiveness (All) **Verbal**

It was agreed that the meeting had ran efficiently which provided members with the opportunity to discuss items in detail.

Date of Next meeting: Wednesday 03 December 2025 @09:00

PUBLIC SESSION

Next Meeting: 4th February 2026, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 16th January 2026

Number	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT.283	Refreshed Board Assurance Framework	ROHTB (9/25) 010 ROHTB (9/25) 010 (a-f)	03/09/2025	Update the Board Assurance Framework to ensure mitigating actions being undertaken include patient safety actions.	SGL	~~08/10/2025~~ 04/02/2026	**It was agreed a meeting would be arranged between SGL, GH and Adam Roberts, Assistant Director of Governance to discuss. Therefore completion date to be extended to February meeting for update.**	
ROHTBACT.284	Flu Vaccination Programme Plan	ROHTB (9/25) 011 ROHTB (9/25) 011 (a)	03/09/2025	Once the vaccination programme has been completed provide an update on the sickness absence rate v vaccination uptake to understand if linked.	NB	01-Apr-26	**ACTION NOT YET DUE**	
ROHTBACT.285	Annual Report for Medical Appraisal and Validation	ROHTB (11/25) 011 ROHTB (11/25) 011 (a)	05/11/2025	Explore the option of introducing a MFIT contracts instead of Honorary contacts and provide update to SE&OD Committee.	MR	29-Apr-26	**ACTION NOT YET DUE**	
ROHTBACT.282	ROH Strategy Refresh	ROHTB (9/25) 009 ROHTB (9/25) 009 (a)	03/09/2025	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	04-Feb-26	**This was discussed as part of the November meeting and it was agreed the action could be closed.**	

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

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	**Chief Executive's Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Chief Executive**
AUTHOR:	**Matthew Hartland, Chief Executive**
DATE OF MEETING:	**4 February 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

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

ASSURANCE PROVIDED BY THE REPORT:

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

REPORT RECOMMENDATION:

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

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

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

Comments:

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

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

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

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

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

N/A

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

N/A

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

N/A

CHIEF EXECUTIVE'S REPORT

Report to the Trust Board (in Public) on 4 February 2026

1. INTRODUCTION

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

1.2 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, Solihull and Black Country system.

2. NATIONAL/REGIONAL UPDATE

2.1 ICB and NHSE restructures

Recruitment of the executive and non-executive ICB leadership team is almost complete, with a few posts remaining to be appointed. Formal management of change is active in both the ICB Cluster and NHSE and will be concluded in the coming months. We are conscious of the impact on our colleagues and are supportive of those who are part of both processes.

2.2 Medium Term Planning

NHS Trusts are expected to develop medium term financial, operational and workforce plans for the next 3 years that align to the Trust's strategic intent and commissioner expectations and submit by 4 February.

As at the time of writing this paper a draft submission has been made to NHSE, however we have not yet received contract offers from all commissioners to enable us to conclude our plans. Private session will include the proposed submission and a discussion on risks and consequences of the plans to date, including the ICB's strategic commissioning approach for the next 3 years.

3 CHIEF EXECUTIVE ACTIVITIES

3.1 Trust Strategy

Strategy Delivery Board met in January to inform the paper on today's agenda. It shows that we are making good progress on the majority of initiatives, however red ratings are against indicators drawn from the planning guidance where we have met our local ambition but not national. As part of the review of organisational priorities and portfolios, for 2026 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 from April 2026.

3.2 NHSE Leadership Event

On 27 January I attended an NHS Leadership 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. The event also described the challenging environment for the medium term planning round, but clear expectation on delivery for the 3-year period. Private session includes a discussion on progress on this item.

3.3 Robert Jones and Agnes Hunt Strategic Alliance

It was a pleasure to host Harry Turner and Stacey Keegan, Chair and CEO of Robert Jones & Agnes Hunt NHS Trust on 6 November 2025 as part of our strategic alliance. We discussed excellent progress being made and agreed a joint Board meeting on 1 April where we will review progress to date and agree our workplan for 2026/7.

3.4 Visit to Birmingham City University - Life and Health Sciences Senior Team

I met Hannah Abbott, Dean of Life and Health Sciences at Birmingham City University, and a governor of ROH, and her senior team in January. I travelled to the university's new facility at Birmingham Alexander Stadium and discussed the opportunities for further joint working between our organisations which includes sports science, research, AI/innovation, joint community offers, placements and recruitment pathways. A plan is being developed for the year.

3.5 Health & Life Sciences – Al Carns MP Visit (12 December 2025)

The Trust received a visit from Al Carns, MP for Selly Oak and Minister for the Armed Forces in December. Mr Carns had a particular interest in our research, noting the specialist nature of our services, but we also discussed our support to veterans and the potential for an Osseointegration service.

3.6 National Orthopaedic Alliance / Federation of Specialist Hospitals

I attended the National Orthopaedic Alliance (NOA) Board meeting in January. We agreed our workplan for 2026/7 which includes a balance of workstreams to improve operational delivery and performance of member orthopaedic hospitals, but also items of a more strategic nature with a focus on issues relevant to specialist hospitals in the new NHS infrastructure.

3.7 Birmingham Health Partners

There has not been a meeting of BHP since the last Board meeting.

3.8 Acute Provider Collaborative (APC)

The Acute Provider Collaborative has not met since last Board. Following the Cluster of Birmingham and Solihull ICB with Black Country ICB there are on ongoing discussions about the most appropriate provider collaboration model, which needs to take account of the new neighbourhood health imperative as required by the 10-year

plan. The ROH will continue to engage and continue to lead on MSK transformation, including how this can be expanded across the Black Country.

3.9 NHS Confederation / NHS Providers

I attended the NHS Providers conference in November and their Chair & CEO Network in December. 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. We await further details of the offer from the merged NHS Confederation/NHS Providers which is due to be implemented on 1 April.

3.10 ROH Internal Visits

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

3.11 Honouring Excellence at the Royal Orthopaedic (HERO) Awards

One of the most enjoyable parts of my role is to recognise staff who have gone above and beyond to make the ROH what it is. It was a pleasure to award HERO awards to the following members of staff:

- Matthew Ford, Stores Manager, was recognised for his work ethic, his willingness to support anyone who needs help, and his ability to find solutions even when things feel impossible. Matt's knowledge, generosity and determination make a real difference to those around him.

- Brigette De La Cruz, Outpatients nurse was recognised for improving the Nurse Led Dressing Clinic through thoughtful innovation. Her aide memoire is a practical example of how kindness, professionalism and a drive to improve patient care can go hand in hand, benefiting both patients and colleagues.

- Marilou Macabante, Pre-Operative Assessment nurse, was recognised for the compassion she brings to every interaction. Her dedication, warmth, and commitment to putting patients first exemplify the values we strive to live by every day.

- Louise Cook, McMillan nurse, was recognised for her leadership and perseverance in transforming the Paediatric Oncology Service. Her resilience, innovation and patience played a vital role in rebuilding and strengthening the service.

4. ROH UPDATE

4.1 Electronic Patient Record

The procurement for an Electronic Patient Record has concluded with InterSystems our preferred supplier. The national EPR Investment Board has approved the business

case, and associated funding, and final steps are being taken prior to implementation. This is the most significant transformation programme for the Trust in many years and aligns with the development of the new operating model for the Trust.

4.2 Guardian of Safe Working

There is a requirement for an update from the Guardian of Safe Working to be received by Board quarterly. The report from the Guardian, Mr McKenzie, is attached to this report and there is currently nothing of significant concern to report.

4.3 Financial Position

It is pleasing to report that the Trust remains at a break-even position as at month 9. A huge thank you to our staff for taking the required action to achieve this. Quarter 4 is challenging, however, so focus will need to remain on both income and cost.

4.4 Performance

We continue to perform well from a performance perspective. Headline reported performance metrics for December include 61.9% Referral to Treatment Time (RTT), exceeding the target trajectory of 59.3%. The number of patients waiting over 52 weeks reduced ahead of plan to 198, 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.

4.5 Segmentation

The Trust remains in Segment 1 of the new NHS National Oversight Framework. This is excellent news for the Trust, however as the methodology of the framework, and financial override, can result in significant variability as assessments are made throughout the year, there is continued focus on improving applicable metrics. The main challenge for the Trust on such metrics is sickness, which is discussed further in the paper from Staff Engagement and Organisational Development Committee. We are awaiting confirmation from NHSE on the outcome of the Board Capability assessment.

4.6 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:

- Patient Correspondence Policy
- Overseas Visitors Access to Treatment Policy
- Radiation Safety Policy
- Transition to Adult Services Policy for Children and Young People
- Bring Your Own Device (BYOD) Policy
- Acceptable Use Policy for IT Systems and Equipment

- Intellectual Property (IP) Management Policy
- Draft ADH Policy

6 RECOMMENDATIONS

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

Matthew Hartland
Chief Executive
January 2026

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	**Update from the Guardian of Safe Working – Report for 4th February 2026**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Chief Executive**
AUTHOR:	**Jamie McKenzie, Guardian for Safe Working**
DATE OF MEETING:	**4 February 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Guardian for Safe Working has confirmed no concerns for the last quarter with respect to the safety of resident doctors.
The document describes the team overseeing resident doctors' working and the current work in progress to improve both patient and employee experience.

ASSURANCE PROVIDED BY THE REPORT:

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

REPORT RECOMMENDATION:

The BOARD is asked to: accept the report for assurance

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

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

Comments:

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

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

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

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

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PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
Trust Board May 2025

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FOR ASSURANCE

UPDATE FROM THE GUARDIAN OF SAFE WORKING

REPORT TO THE TRUST BOARD – Feb 2026

1.0 Situation

1.0.1 The Guardian for Safe Working (GOSW) is required to raise concerns about Safe Working for resident doctors by exception. Exception reports are the mechanism by which resident doctors record unscheduled episodes of work outside their normal working pattern. As of 21st Jan 2026, there have been no exception reports raised in the last quarter.

1.0.2 The guardian role at the ROH has evolved. It is broad and assists many of the other members of the education and leadership teams in their roles, promoting a safe and supportive environment for medical staff.

1.0.3 Version 13 of the 2016 Terms and Conditions of Service comes into effect from 4th February 2026. This update to the 2016 TCS includes exception reporting reforms, improving confidentiality by removing consultant supervisors from the reporting process. See 5.7 below.

1.1 Wellbeing

1.1.1 Resident doctors are still campaigning to improve conditions, solve workforce problems and ensure their pay is protected. BMA members are being balloted this month on further industrial action.

1.1.2 '**Embedding cultures which make healthcare professionals feel valued is vital, not only to doctors' wellbeing and patient care, but also to the future of the health service.**'

1.1.3 Organisations like the ROH can make a difference to resident doctors' autonomy, self-worth and value.
https://www.som.org.uk/sites/som.org.uk/files/LTF_SOM_mental_health_of_doctors.pdf

1.1.4 The NHS constitution states: All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, actively listened to and provided with meaningful feedback. They must be treated with respect

at work, have the tools, training and support to deliver compassionate care, and opportunities to develop and progress.

1.1.5 Dr James Brunning is Wellbeing lead for medical staff. He continues to innovate and encourage medical staff to improve their wellbeing. Brett Ellis and Laura Tilley-Hood review the workforce surveys with regards to wellbeing.

2.0 Background

2.1 Leadership Team

The current team supporting middle grade doctors has input and support from the clinical service managers.

2.1.1 Clinical rotas are prepared by the Administrative Specialist Registrar (SpR), currently Ranjodh Sanghera (nominated 6-monthly). Mr Jones and Mr Politis support the Admin SpR balancing the educational and training opportunities with the service requirement of the organisation. Many others support the resident workforce including Vicky Eccleston (medical rota coordinator).

2.1.2 Through regular contact and meetings with trainees and management, the leadership team ensure safe, effective and rewarding postgraduate training. This is monitored by the leadership team and a rapid and effective response is ensured when concerns, challenges and opportunities are identified. Formal feedback via anonymous surveys (including the GMC trainee-satisfaction survey and the National Education and Training Survey) are similarly monitored and responded to.

2.1.3 The current consultant staff post holders are:

Mr Morgan Jones	Post Graduate Clinical Tutor	All postgraduate medical and surgical trainees (ST1+) at the Royal Orthopaedic Hospital
Dr James Brunning	Wellbeing Lead and Tutor	Anaesthetics
Mr Angelos Politis	Clinical Lead for Mid-Level Care Providers	Locum doctors & Fellows
Mr Jamie McKenzie	Guardian for Safe Working	Safe working conditions of resident doctors
Mr Khalid Baloch	Director of Medical Education	DME
Mr Matthew Revell	Medical Director	

2.1.4 There are regular medical workforce meetings arranged as part of normal operations. In addition, there is a regular Resident doctors' forum attended by the leadership team and all resident doctors are invited.

2.1.5 The Post Graduate Clinical Tutor, Medical Director and Safeguarding lead provide input to the doctors' induction meetings. The Medical Director and Post Graduate Clinical Tutor each have 2-monthly meetings with the GP trainees and contribute to the training programme as speakers and medical educators.

2.1.6 All clinical supervisors and allocated educational supervisors are accredited as per the GMC and Academy of Medical Educators directive. Consultants are currently supported in providing evidence of accreditation to their appraisers. This process is under the guidance of the director of medical education (DME).

2.1.7 The role of Khalid Baloch as ROH Director of Medical Education (DME) is now well established. He has taken the lead for the implementation of the NHS England 10-point plan on workplace improvement (published August 2025).

3.0 Resident Doctor Establishment

3.1 *Specialist Registrars (SpRs) and Fellows Training in Orthopaedic Surgery*

3.1.1 There is presently a combination of Specialist Registrars and Fellows on the Royal Orthopaedic Hospital roster. All contribute significantly to the safe working of the Trust on a day-to-day basis, being timetabled for ward-round cover, theatres and outpatient clinics, as well as on-calls. Fellows do not normally take part in the on-call rota.

3.1.2 New SpR trainees started in Aug 2025. Face to face teaching is on-going on Fridays. A new cohort will arrive on 4th February (7 staying on, 7 new).

3.1.3 SAS doctors have a specific teaching programme for their needs, set up by the DME.

3.1.4 Matt Dingle and team have been working to prevent payroll issues.

3.1.5 On call rooms are limited. There has been a request to add an additional on call room along the old Ward 10 corridor. This has not been actioned yet.

3.2 *GP Trainees*

3.2.1 There are a variable number of GP trainees at the ROH (1-10). There is currently only one. Four are due to come in April. GP trainees are encouraged to choose the ROH and it is acknowledged that they receive excellent education when here. Morgan Jones is working hard to improve their

ROH experience and is trying to actively promote the ROH. There have been difficulties with GP trainees having additional requirements with regards flexible training (no nights or long days) that can be difficult for the trust to accommodate.

3.2.2 Remaining posts at Senior House Officer level are filled with locums or, more preferably, substantive mid-level care providers (MLCPs) where possible. The aim is to reduce the reliance on locum cover by appointing doctors into 2-year fixed appointments when possible. There is a policy on mid-level providers.

3.3 ***FY2 Doctors***

3.3.1 The ROH has currently one FY2 who has received very positive feedback.

4.0 Resident Doctors' Forum (formerly *Postgraduate* Doctors' Forum)

4.1 The resident doctors' forum meetings provide an opportunity for the leadership team, including management, to discuss and plan improvements. Encouraging trainees and other medics to attend is a priority.

4.2 Wellbeing is often raised. James Brunning and Laura Tilley-Hood (Engagement and Wellbeing Officer) are helping to raise the profile of wellbeing.

4.3 The induction process is constantly being improved, often due to direct input at the resident doctors' forum.

4.4 Theatre changing rooms have been improved with lockers now available for the resident doctors. The facilities would be further improved with a regular cleaning schedule as there is substantial footfall through the rooms which are often left in disarray.

4.5 Fellows are being encouraged to play a greater role in the forum meetings.

5.0 About the Guardian for Safe Working Role

5.1.1 During negotiations on the junior (now resident) doctor contract (2016), agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS trainee doctors to oversee the process of ensuring safe working hours for resident doctors.

5.1.2 The current version, 13, of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (2016 TCS) has introduced some reforms to exception reporting as described below in 5.7.

5.2 The GOSW role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the resident doctors employed by it. It

should report into different management structures, including the local negotiating committee (LNC) and the trust board, but will also have a regular input into resident doctor forums.

5.3 The guardian is responsible for overseeing compliance with the safeguards outlined in the 2016 TCS. The post holder is to identify and either resolve or escalate problems, and act as a champion of safe working hours for resident doctors.

5.4 The guardian provides assurance to the employer that issues of compliance with safe working hours will be addressed, as they arise.

5.5 The guardian is accountable to the board. The line management arrangements for the guardian should be independent of the medical director and other medical managers to ensure appropriate independence.

5.6 The guardian has a page on the ROH external website with contact details and a description of the role. The role is explained at resident doctors' induction and leaflets are distributed with further details. The guardian attends the resident doctors' forum meetings. The guardian is easily and frequently contacted.
https://roh.nhs.uk/about-us/corporate-information/guardian-of-safe-working

5.7 The purpose of exception reporting is to ensure prompt resolution and/or remedial action to maintain safe working hours, protect patient safety, and uphold the delivery of agreed educational opportunities. Exception reporting also serves as the mechanism by which doctors can secure compensation for all work undertaken and ensure that agreed educational opportunities are preserved.

5.8 In the past, ROH management has been remarkably responsible and has been able to resolve any resident doctor disputes or exceptions without recourse to fines etc.

5.9 The reforms to exception reporting place more trust on the resident doctors to conduct themselves professionally as HR will directly action the reports without consultant oversight. The GOSW will retain oversight of all reports. The reforms improve confidentiality by removing the need for doctors to first discuss the issue with their consultant supervisor.

5.10 The ROH is using Allocate software to record exception reports. The software will report directly to HR who will now action all additional hours reports independently. The GOSW will review the outcome of reports. Educational reports will go to the DME for review. One key change is that consultant supervisors must no longer have access to the reports without specific consent from the resident doctor. Doctors can decide to receive payment or TOIL.

5.11 Doctors will need to evidence their exception reports. The reforms describe a process which involves the GOSW if evidence is not provided.

5.12 It is noted that individual doctors can choose to undertake additional activities for personal development. In these cases, exception reporting does not apply.

6.0 Recommendations and Ongoing Work

The Trust Board is asked to:
RECEIVE and ACCEPT the assurances provided by the report
SUPPORT the following intentions:

- To provide continued support for the key individuals working to support resident doctors' working conditions, especially those involved directly in health and wellbeing.
- To support HR and IT with exception reporting reform implementation (via Allocate software).
- That improving working conditions and wellbeing for resident doctors is a priority for the trust.
- To ensure that when any changes occur in the trust, the impact on resident doctors is considered (that doctors are involved in those changes and the doctors' concerns are addressed).

Jamie McKenzie, Guardian for Safe Working
21st Jan 2026

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TRUST BOARD

DOCUMENT TITLE:	**Chief Finance Officer's Report M9**
SPONSOR (EXECUTIVE DIRECTOR):	**Steve Washbourne, Chief Finance Officer**
AUTHOR:	**Steve Washbourne, Chief Finance Officer**
DATE OF MEETING:	**4 February 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Month 9 Financial Report

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Still on plan YTD	Underperformance of variable and PP income Continued risk of CIP and income delivery over the remainder of the financial year.

REPORT RECOMMENDATION:

The Board is asked to:

NOTE the Finance Report

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

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

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

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

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

Risk register and BAF

ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:
NA
BENCHMARKING SOURCE *(Indicate data sources included in report IF APPLICABLE)*:
NA
PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
Finance & Performance Committee January 2026

CFO's Report Month 9

1. Summary

The Trust delivered a surplus in month of £41k against a planned surplus of £36k, generating an favourable variance of £5k in month. This results in a deficit of £496k YTD, a favourable variance of £9k against plan.

Income & expenditure summary	Current month				Year to date			
	Plan £000s	Actual £000s	Variance £000s	%	Plan £000s	Actual £000s	Variance £000s	%
Operating income	12,512	11,919	(593)	(4.7%)	109,799	106,643	(3,156)	(2.9%)
Agency pay	(123)	(92)	31	25.0%	(1,230)	(964)	266	21.6%
All other employee expenses	(6,781)	(7,071)	(290)	(4.3%)	(61,657)	(62,548)	(891)	(1.4%)
Operating non pay	(5,458)	(4,627)	831	15.2%	(46,379)	(42,791)	3,588	7.7%
Total operating surplus / (deficit)	150	129	(21)	(0.2%)	533	340	(193)	(0.2%)
Non operating items	(122)	(98)	24	19.3%	(1,106)	(920)	186	16.8%
Surplus/(deficit) for the period/year	28	31	3	0.0%	(573)	(580)	(7)	(0.0%)
Less I&E impairments/(reversals) & (gains)/losses on transfers by absorption	0	0	0		0	0	0	
Surplus / (deficit) before impairments and transfers	28	31	3	0.0%	(573)	(580)	(7)	(0.0%)
Technical adjustments	8	10	2	22.2%	68	84	16	22.8%
Adjusted financial performance surplus/(deficit)	36	41	5	0.0%	(505)	(496)	9	0.0%
Less Non-Recurrent Deficit Support	0	0	0		0	0	0	
Adjusted financial performance surplus/(deficit) excluding non-recurrent deficit funding	36	41	5	0.0%	(505)	(496)	9	0.0%
Underlying position								
EBITDA as a percentage of related income	5.7%	5.6%	(0.1%)		5.1%	4.9%	(0.2%)	
I&E margin	0.3%	0.3%	0.1%		(0.5%)	(0.5%)	(0.0%)	

Whilst this remains a positive position YTD for the first 9 months, 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. Whilst a surplus was also delivered in month, this was still below the planned surplus required, thus further improvement still need to be undertaken for the reminder of the year.

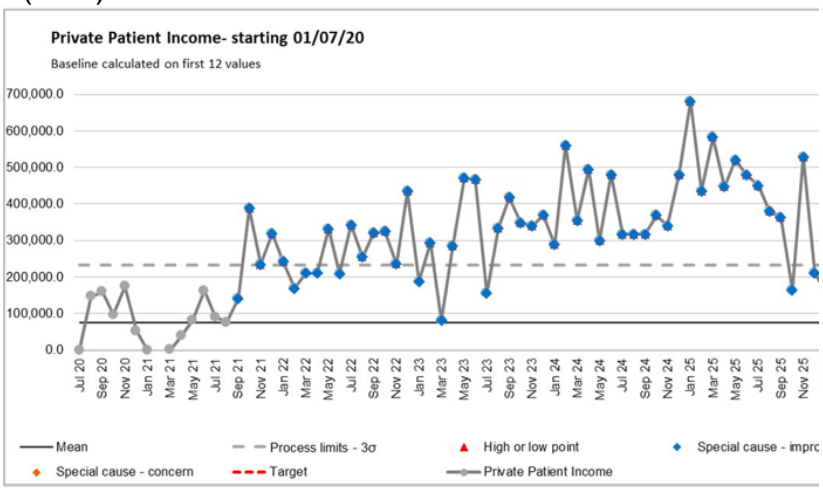
2. Income

At Month 9 the Trust has delivered actual operating income of £106m against a plan of £109m, a net under performance of £3.1m.

Appendix A provides more detail of the drivers of this. £1.7m relates to variable ERF underperformance, £0.8m relates to diagnostics and £464k relates to PP income.

Additionally, payment cap limit performance will be managed by individual commissioner. As such there is an additional risk with commissioners where we have an overperformance against the limit (the net underperformance is currently shown).

Private patients' income is below plan by £464k year to date against the original plan of £5.5m, £953k against the revised yearly plan of £6.1m and £1.2m against the £6.6m stretch plan.

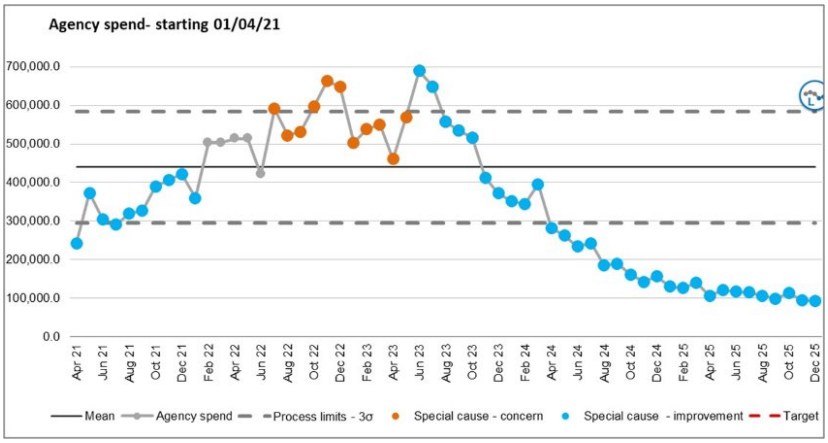


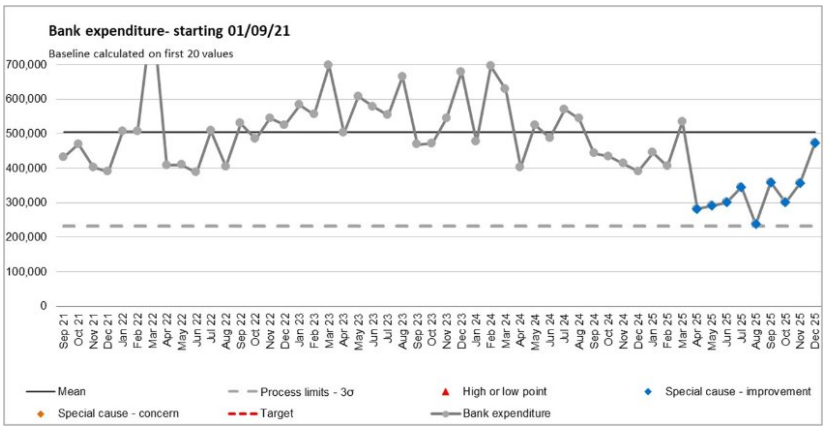
3. Pay

Pay expenditure is overspent in month by £259k contributing to an overspend of £625k YTD.

Agency spend is £92k in month or 1.5% of pay.

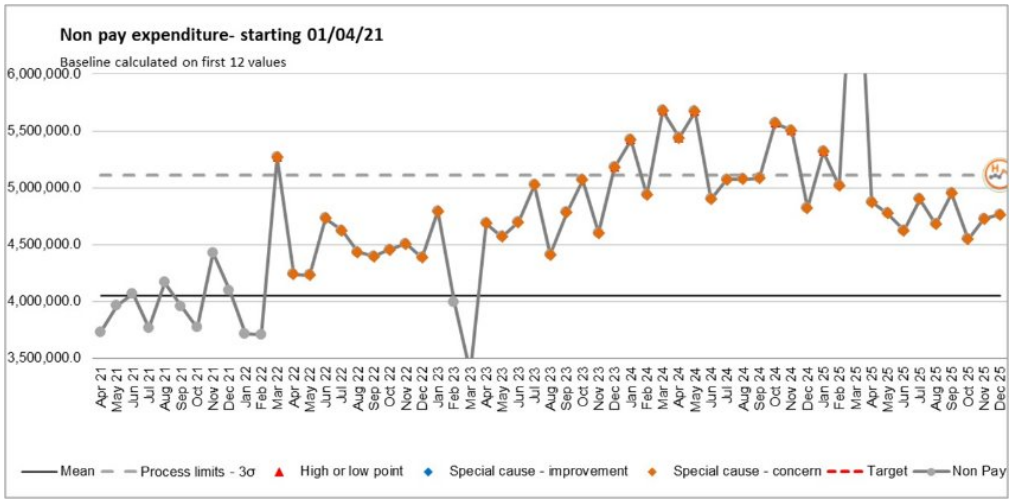
Bank expenditure has increased compared to last month with £472k spent in month, which is the highest monthly spend this year, contributing towards a YTD overspend of £329k. Nursing increased from £85k to £141k in month relating to sickness, Therapies increased from £31k to £63k and Medical spend increased from £68k to £103k (this includes ADH Spend).





4. Non-Pay

The non-pay position is favourable overall, supported by a non-recurrent £1.1m release from the bad debt provision year to date, resulting in an underspend of £831k in month and a YTD underspend of £3.6m



This aggregate position does ask continued pressure relating to LLPs, where there is a year to date overspend of £767k, offset slightly by £94k underspend on ADH spend.

5. Cash

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

6. Capital

We had spend in month of £228k which takes us to actual spend YTD of £1.4m against a plan of £2.6m. We need to be conscious of the cash impact of increased capital spend through the rest of the year.

7. CIP and Route to Break Even

In month efficiencies of £441k have been recorded. This increases the year to date achieved to £5.2m against a plan of £6.3m, generating an underperformance of £1m.

8. System Position

After nine months the system position is a YTD deficit of £44.6m, £33.4m adverse to plan and £9.9m adverse compared to the recovery plan trajectories. This represents a £1.3m decrease in deficit compared to month 8 and a £1m in-month deterioration in variance against plan.

Total Performance	YTD Current Plan £000s	YTD Actual £000s	YTD Variance £000s	FOT Annual Plan £000s	FOT FOT £000s	FOT Variance £000s	Prior Month variance £000s
BSOL ICB	-3,161	-1,142	2,019	0	0	0	1,064
BSMHT	3,141	175	-2,966	4,200	4,200	0	-2,716
BCHC	500	504	4	0	0	0	-714
BWC	0	-6,841	-6,841	0	0	0	-5,999
ROH	-505	-496	9	35	35	0	5
UHB	-11,187	-36,766	-25,579	-4,200	-4,200	0	-23,960
Total	-11,212	-44,566	-33,354	35	35	0	-32,320

Appendix A: Operating Income

Elective Variable / Diagnostic Variable Income

	Actual	Plan	Variance
Day Cases	£8,573,019	£10,348,897	(£1,775,878)
Elective	£27,428,882	£25,672,280	£1,756,603
Excess bed days EL	£681,653	£879,992	(£198,340)
Outpatient FA Consultant Led	£3,439,067	£3,618,183	(£179,116)
Outpatient FA Consultant Led Non Face to Face	£163,558	£	(£201,039)
Outpatient Procedures FA	£58,301	£104,576	(£46,275)
Outpatient Procedures FUP	£375,860	£608,891	(£233,032)
CIP		£736,836	(886,541)
Elective variable (ERF)	£40,720,339	£41,597,416	(£1,763,619)
Diagnostics variable	£1,429,370	£2,315,912	(£886,541)
Total Variable			**(£2,650,160)**

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD (PUBLIC)

DOCUMENT TITLE:	**Trust Officers' Reports**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Chief Executive**
AUTHOR:	**Executive Directors**
DATE OF MEETING:	**4 February 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

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

ASSURANCE PROVIDED BY THE REPORT:

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

REPORT RECOMMENDATION:

The BOARD is asked to receive and note the updates

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

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

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

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

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

Financial sustainability and recovery

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

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

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

None specifically

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

None apart from the Chief Finance Officer's update at Finance and Performance

CHIEF OPERATING OFFICERS REPORT

Report to Trust Board – February 2026

1 NATIONAL OPERATIONAL CONTEXT AND DEVELOPMENTS

1.1 January has been a busy month operationally with several Regional and National operational meetings to share information regarding the national sprint programme. The sprint programme is a national initiative led by NHS England (NHSE) to accelerate progress on waiting times. The sprint focusses on elective care and Referral to Treatment (RTT) performance to help achieve the waiting list performance targets set for March 2026. It is a focussed time limited outcomes driven programme to boost activity in the last quarter of 2025/26.

Trusts had the opportunity to submit expressions of interest at the beginning of January to participate in the sprint programme. ROH submitted a template bid in early January to participate and were selected to be part of the sprint. Details were confirmed on 22/1/26. The Trust are currently participating in the 'RTT validation sprint' and are performing well above the baseline target set and therefore have a track record of delivery in this type of initiative. The sprint has the following four elements:

- 18-week Outpatient sprint – There is an agreement that any outpatient new activity delivered above plan for Q4 (regardless of performance in Q1-3) will be remunerated at a fixed tariff. (Details to be confirmed).
- 52-week sprint – A bid has been submitted to NHSE to fund outpatient and inpatient activity to support a reduction in patients waiting over 52 weeks and increase regional and Trust RTT performance.
- Independent Sector Support – An agreement that outsourcing to the independent sector would be funded if Trusts utilised this option to expedite treatment for long waiting patients, supporting the nationally agreed 52 weeks wait target by 31st March 2026.
- Validation sprint – the Trust continues to participate in this sprint and is already receiving payment for every patient validated over and above the agreed baseline.

The ROH team have trajectories in place to support both the 18-week Outpatient sprint and the 52-week sprint. There is not an intention to use the independent sector due to the timeframes for delivery and specialist nature of the trust. Efforts are being concentrated on maximising internal expertise and capacity throughout February and March, with some additional activity mobilised for end of January.

1.2 The National Chief Operating Officers (COO) forum continues led by Sarah Jane Marsh and ROH are actively participating in this programme. These sessions are aimed at supporting operational leaders across the UK with key updates from NHSE and to share current challenges and best practice. There are opportunities to showcase achievements in productivity and operational excellence.

1.3 The Deputy COO has been successful in securing a place on the NHS England 100 leaders programme with the launch event planned for the 10th of March 2026.

1.4 The Deputy COO is participating in a regional Spinal Task and Finish Group chaired by NHSE. The group will be considering the following:

1. Agreeing standards for referral criteria into interface services.

2. Establishing standards for referral criteria to MRI.

3. Minimum standards for Spinal MDT membership and terms of reference

Next steps will be included in the Spinal service review upward report to the Trust Improvement Group.

2. OPERATIONAL PERFORMANCE

2.1 RTT performance reached 61.93%, exceeding the target trajectory of 59.31%, by 2.62% reflecting strong progress in improving patient access. Notably, the number of patients waiting over 52 weeks reduced ahead of plan to 198, 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. Overall, this highlights robust performance on all the required operational imperatives relating to RTT performance.

2.2 Cancer targets were met for the 62 day and 31-day standard. However, the November Faster Diagnostic Standard (FDS) Cancer target was not met due to continued challenges with Histology turnaround times. Interventions are now in place with support from NHS England and it is expected that FDS performance will return to compliance from January 2026.

2.3 Theatre capped utilisation on Model Hospital for December 25 is currently at 82.6%. The Trust remains in the top quartile and all available theatre sessions are being maximised.

2.4 Overall Outpatient activity has overperformed YTD by 1,513 with the overperformance being delivered through follow ups and outpatient procedures that have over performed by 892 up to 31.12.2025. This signifies a shift from day case to OP procedures this will be reflected in planning for 2026/27. The outpatient transformation programme continues to focus on the five key workstreams. For Q4

the focus will be on maximising new outpatient activity to support the NHSE 18-week sprint to reduce waiting times.

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

2.6 Diagnostic performance exceeded National standards with a reported performance of 99.8% in December 2025.

2.7 December 2025 activity generated a surplus of sixteen patients. This overperformance is to support the Trust's breakeven recovery target. This was particularly pleasing as the activity was delivered despite two periods of industrial action demonstrating a strong continued focus on delivery of activity. Activity YTD is showing a deficit of fifty-four cases, and the recovery trajectory plans to recover this deficit in quarter four to support the Trust financial breakeven plan.

3. PRIVATE PATIENTS

3.1 The Private Patient Service has a stretch revenue target of £6.1m for 2025–26. December activity was below the planned volume and revenue. This reflects the seasonal impact of the Christmas period, during which elective private patient demand is historically reduced, compounded by a reduction in operational days across the holiday period. Year-to-date actual income is £3.88m vs a Year-to-date plan of £4.53m. Therefore, a variance: £656k adverse to £6.1m plan.

A targeted marketing programme is focussing on:

- Print and digital advertising campaigns ongoing
- A focused three-month campaign supporting robotic arthroplasty activity Jan – March
- Search Engine Optimisation campaign increasing the service visibility in Google rankings.

4. TRUST IMPROVEMENT GROUP (TIG) – KEY HIGHLIGHTS

4.1 Key highlights from the January 2026 TIG meeting are outlined below:

- An update was provided on the key actions agreed aligned to the theatre service review. Positive progress is being made with examples included below:

    - The first of three civility training sessions were delivered on QIDD day, focusing on awareness. The second session is planned for 29th January 2026 and will cover case studies, followed by a final session to support embedding civility into practice.

- Theatre Equipment Management Oversight Committee (TEMOC) established Dec 2025 with agreed membership & terms of reference TOR.
- Loan kit approval task and finish group established Dec 2025.
- Initial discussions over rationalisation of Hip sets to commence Feb 2026.
- A new MDT team brief has been introduced to enhance communication and provide a safe space for open discussion, alongside morning safety huddles where theatre representatives report back in recovery to forward look challenges for the next day to enable early resolution.

- Theatreman/Aqua has been fully mobilised with vendor engagement with onsite demonstration sessions booked to support engagement with key stakeholders.
- An audit has been completed as part of the outpatient transformation programme to improve ethnicity data capture to strengthen health inequalities reporting. Actions from the audit are underway with progress being upward reported to TIG. Ethnicity data in the future will be included in the performance on a page data presented to the Quality and Safety committee.
- Imaging accreditation remains on track for completion by March 2026 providing an important external quality benchmark for service assurance.
- The BADS group is focussing on data quality to ensure that the intended length of stay is captured as a day cases for all relevant patients improving data accuracy. The primary hip pathway is now fully operational, and the group is now focussing on Spinal pathways. A full presentation by specialty will be delivered at the February 2026 Finance and Performance Committee meeting.

5 KEY RISKS

5.1 Focus remains on spinal services, whilst currently all operational imperatives are being delivered, the spinal service still has the highest proportion of long waiting patients. As part of the spinal service review a second workshop to accelerate progress against the GIRFT best practice was chaired by the Chief Operating Officer on the 27th of January 2026. The January meeting focussed on a standardised approach to triage across the services providing greater empowerment to advanced pain practitioners.

5.2 As documented on the Risk Register current delays in Pathology services have for the first time impacted our reported cancer performance for November 2025 on the Faster diagnosis standard. All other cancer performance standards remain compliant.

The delays in Pathology services have been escalated locally and are discussed on the weekly Strategic Oversight meeting Chaired by NHSE. Recent conversations involving NHSE have been positive and their support has enabled a current reduction in backlog and improved turnaround times.

The pathology team at UHB have drafted recommendations regarding future service provision which are currently being considered. The ROH has been successful,

(supported by NHSE) in acquiring a small amount of funding to support the design of a national network solution to ensure service resilience for this national specialised service going forward. 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 MSK programme continues to be led by the ROH team, in January the system celebrated the launch of the Integrated Patient Pathway (IPP), with the support of funding from NHSE. This has been championed nationally as a significant pathway transformation programme attracting national interest. It is pleasing to note that the proof of concept and system business case agreement was initiated by the ROH team though the MSK transformation programme. Use of the self-management 'get u better 'patient app continues to strengthen with over 27,000 users now using the app.

The workforce plan data collection is now complete, and a workforce report is being finalised. This work will culminate in an options appraisal that 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 next Acute Provider Collaborative meeting as the November 25 meeting was cancelled due to operational pressures in the system.

Phase 2 of the programme has now been scoped which will include pain management and spinal services aligned to the national spinal service review currently being led by the national spinal team. The programme will also focus on expanding capacity the community, development of the MSK academy and supporting the return-to-work initiative both at ROH and system wide.

7 WORK PLANNED IN NEXT MONTH

7.1 The Theatre triumvirate continue to prioritise the theatre service review that is scheduled to be completed by 31st January 2026.

7.2 The Spinal service review has been supported by a series of workshops to improve access to first appointment. Progress on the review will be upward reported to the Trust Improvement Group with a scheduled completion date of 31st March 2026.

7.3 The Patient tracking list validation is now complete, and meetings have been held with all subspecialties chaired by the Chief Operating officer gaining a detailed insight into the challenges at subspecialty level with actions being progressed to improve performance which is evident in improved RTT performance outlined under the operational imperative section of this report.

7.4 January 26 will focus on implementing key actions in line with the sprint initiative to continue to overperform against the RTT operational imperatives and aim to deliver performance of 0 x 52 week waits by March 2026. As part of the initiative 'super Saturday clinics' have been undertaken in January 26 and are planned for February

and March 26 to accelerate reduction of waiting times for patients across all specialties.

7.5 Planning is being finalised ahead of the February submission to NHSE that is due on 4th February 2026.

8. RECOMMENDATION(S)

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

Marie Peplow - **Executive Chief Operating Officer January 2026.**

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

CHIEF PEOPLE OFFICER'S

Report to Trust Board (Public) – February 2026

1 LOCAL MATTERS FOR BOARD ATTENTION

1.1 Work Experience Quality Standard Award

I am delighted to share that after a period of assessment and verification we have been awarded the Bronze Work Experience Quality Standard by NHS England. We have low numbers of work experience however this is a testament to the quality of the programme which is a great achievement for all colleagues across the Trust who support our widening participation agenda. Below is the extract of the feedback received. The team will work towards addressing the areas for improvement - we will go for Gold!

"Overall, the offer for work experience is a fantastic opportunity to showcase and encourage the exploration of careers in the NHS. This offer meets the standard requirements, however, could be greatly improved by building on the generic foundation you have created and expanding it to fit bespokely to each department. Well done on starting your work experience journey and good luck for the future."

1.2 Sickness Absence

The management of sickness absence remains as a key priority across the Executive Team supported by the HR and OD teams. The teams are progressing a strengthened and balanced approach to sickness absence management which has clear CEO oversight.

The focus is on improving high rates of short-term absence, consistency in application of policy and management accountability across the Trust. Targeted hotspot interventions are in place within areas of highest absence supported by enhanced performance oversight, improved compliance with return-to-work processes and timely trigger reviews in line with policy.

Early indications show improvement with rates of long-term absence with further improvements expected as the full programme of interventions embeds over the coming months.

1.3 Developing Leaders Programme

During December I had the pleasure of being invited to and attending the stretch assignment presentations for Cohort 2 of our 'Developing Leaders' programme which is delivered by our partners the Activity Group.

The Developing Leaders programme has been designed to unlock leadership potential, providing participants with the skills, confidence, and insight needed to drive meaningful improvement. By focusing on leadership through engagement, the programme equips our colleagues to lead teams more effectively, deliver outstanding results, and place continuous improvement at the heart of everything we do.

Alongside practical leadership development, the programme worked towards a Chartered Management Institute (CMI) Level 5 Management and Leadership qualification, a nationally recognised standard of excellence.

A member of the service improvement team also attended so we could capture the improvement programmes – a real joined up approach across our ROH teams!

I was particularly impressed with the practicality of some of the projects with all the delegates grasping the financial and productivity challenges and being able to relate these back to staff engagement.

1.4 Mandatory training compliance/ LMS implementation

We are seeing a continued increase in mandatory training compliance targets ranging at around 90% during January 2026 – a huge thanks to all colleagues who have helped drive these improvements.

Feedback from colleagues suggests that the ease of completing mandatory training has supported the update in completions.

The OD and Education & Training teams are currently exploring the possibility of also hosting our appraisals on the system so that we can start tracking completion of objectives in a streamlined manner.

1.5 Resident Doctors 10 Point Plan Performance

I am pleased to say that the ROH received a 81% compliance rate for the resident doctors 10 point plan submission.

During January the team met with Manjit Obhrai, Associate Dean (AD) at West Midlands Deanery who has been allocated to our Trust as a link AD to support us with any issues arising in medical doctors training along with my colleagues.

Feedback on our plan was extremely positive and below is an extract from the email which was sent to us following our plan submission

"Thank you for completing the initial assessment which shows your Trust is doing well in delivering the 10-point Plan. I have been asked to follow up on this with a meeting to discuss your return, any ongoing plans you have, and to learn from things at your Trust which have worked week and which may support other Trusts scoring less well."

81% was in the upper range of performance with Trusts nationally ranging between 40-90%.

The areas for improvement and our response is outlined below:

Beds/sleeping pods available free of charge	Yes to beds - action to streamline access to beds when on call.
Process course related expenses (currently after course attendance)	Current process is that RD are reimbursed following the course within 3 weeks after submission of expenses (or next payroll). Plan to change to reimbursement prior to course attendance from 1st January 2026, however need to confirm the process to reclaim this back if the RD does not ultimately attend the course.
A rostering systems for Resident Doctors allow for self/preferential rostering	There is self / preferential rostering for Less Than Full Time (LTFT) Resident Doctors following discussion with Director of Medical Education and Training Programme Director. LTFT Champion has been appointed and will oversee this area. Rota coordinator provides flexibility where able. Action to explore how this can be expanded with Full time Resident Doctors, with learning from LTFT doctors.

2 NATIONAL CONTEXT AND DEVELOPMENTS

2.1 Growth and Skills Levy

From April 2026, the Government plans to replace the Apprenticeship Levy with the Growth & Skills Levy (GSL), alongside the first wave of funded short courses. This isn't just a policy refresh. It's a response to a growing productivity and skills crisis, and it will place more responsibility on employers to use funding well or lose it.

The Key changes are

- More flexibility - funding beyond traditional apprenticeships

- Short, modular training - digital bootcamps, green skills, targeted upskilling
- A shorter “use it or lose it” window - levy funds may expire after 12 months, down from 24
- Greater employer accountability - planning, prioritisation, and outcomes matter more

There are some key considerations for us (which we are working through) including

- How much levy funding are we currently losing?
- Do long apprenticeships still fit all our skills needs?
- Where would short, targeted training deliver faster impact?
- Are managers equipped to make skills part of everyday performance?

2.2 Chartered Management Institute Petition

As the Government’s transition to the Growth and Skills Levy gathers pace, there is risk that vital management training could be reduced. The Chartered Management Institute has launched a campaign to ensure management and leadership training remains an integral part of the Government's skills agenda rather than being sidelined.

They are asking Ministers to protect the full suite of management apprenticeships and expand employer choice through shorter, flexible courses.

2.3 Medical Training (Prioritisation) Bill

The Medical Training (Prioritisation) Bill intends to implement the commitment set out in the 10 Year Health Plan for England to prioritise UK medical graduates for foundation training places, and to prioritise UK medical graduates and other doctors with significant NHS experience for specialty training places. The Government has decided to introduce emergency legislation so that prioritisation can be implemented during the current application process, securing the commitment for future years.

The Bill aims to secure a reliable supply of doctors for the future, ensuring those with a UK medical link are more likely to progress to consultant roles and continue their careers within the NHS. Internationally trained doctors make a huge contribution and will continue to do so. If passed, the Bill will also enable prioritisation of internationally trained doctors with significant NHS experience.

For 2026 starts, prioritisation will be applied at the offer stage because shortlisting is already underway. From the Autumn 2026 application round for 2027 starts, subject to the Bill’s passage, prioritisation will apply from shortlisting through to offers, and we will define “significant NHS experience”

more precisely through regulations. Over the coming months, the government will engage with key stakeholders across the UK to agree how NHS experience will be recognised from 2027 onwards.

2.4 NHS Workforce Plan

The publication of the new NHS workforce plan has been delayed until spring 2026, according to reports in late 2025. This delay follows ongoing concerns about staffing levels, with 80% of NHS staff surveyed in late 2025 expressing worry about capacity. We continue to await publication.

3.0 KEY RISKS

3.1 Continued short term absence/reduced workforce availability and impact on productivity.

4 WORK PLANNED IN NEXT MONTH

4.1 Begin staff survey action planning work.

4.2 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
February 2026

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY OFFICERS' REPORT

Report to Trust Board on 4 February 2025

1 MEDICAL DIRECTOR'S UPDATE

1.1 Clinical

Theatres: Ongoing work in theatres is being tracked by the Quality & Safety Committee is the priority for the triumvirate. Medical support is being offered particularly on education and culture.
There has been an escalation to Specialised Commissioners and the region around cancer service pathology with positive early progress.
The Trust hosted a visit from Rt Hon Al Carns MP in December 2025, providing a chance to showcase the Osseointegration work and veterans.

1.2 Audit and Outcomes

There are currently staffing challenges in team which is understood and is being addressed; it related to a combination of Cost Improvement Programme schemes, Service reviews and unavoidable absence.

AQILA highlights:

- Learning from deaths: Exploring mortality trends at AQILA and Q&S – themes include comorbidity coding, sensitivity to small numbers, model variations, casemix (major revisions and metastatic disease) and frailty
- Length of stay (LOS) is improving – Hip and Knee LOS now 2.88–2.9 days (down from ~3), with 20–24% of patients discharged on day 1. This is associated with the implementation of the 23-hour pathway, booking-form fixes and ward cohorting of primaries driving gains and setting the conditions for moving to genuine day case expansion.
- The post-discharge service is expanding – a Deep Vein Thrombosis (DVT) pathway pilot has been extended; work is progressing on a single point of contact and in-house 24/7 triage to cut 30-day readmissions and avoid unnecessary A&E attendances. Evidence of impact is suggested in the figures.

- National Joint Registry (NJR) performance is solid and outliers are being managed through the Clinical Service Lead for arthroplasty. Trust compliance, consent and linkability rates are excellent; overall revision and mortality rates are around the national average at high volume.
- Spinal post-operative documentation has markedly improved. A template-driven audit shows significant uplift in recording neurological observations. A SHOUT protocol (protocol **for** neck surgery) has been introduced, VTE prophylaxis and mobilisation plans are in place. A full audit cycle has been completed and praised as a model for other services.

1.3 Research

- There has been a successful launch of the Birmingham Implant Retrieval Centre – this is a collaboration with University of Birmingham, analysing reasons for implant failure in a research lab. Clinical engagement and uptake has been so good they asked us to restrict the numbers.
- Study set-up performance has improved - study start-up times are dropping substantially (for NIHR studies from about 125 to 80 days, and overall from about 110 to 70 days), reflecting more efficient parallel processes. There is more to do however.
- Grant income and pipeline are strong - multiple successful awards have been gained (e.g. PORTRAIT, BACPAKS, ALIGN, explant retrieval work) and further high profile applications are in train, indicating a healthy external funding and collaboration environment.
- Junior Research Fellows productivity: this cohort of medics is delivering multiple audits, completed datasets, manuscripts in preparation or under review, conference presentations and prizes, and projects that would not have happened without the scheme.
- Bibliometrics and publications show quality impact, with iCite RCR analysis embedded in reporting and an average Relative Citation Ration (RCR) rising to around 3.25 in 2023, suggesting influence above field norms despite a modest fall in publication volume.
- The University Hospitals Coventry & Warwick tissue bank work is nearing completion and reopening for business is expected February 2026
- A key challenge is that recruitment to studies is significantly reduced, at roughly half of the previous year's level, with national and regional recruitment also down and projections suggest only 150–180 recruits for the year, creating a risk for performance-linked funding and portfolio delivery.

2 CHIEF NURSE'S UPDATE

National / Regional updates

2.1 On 22 December 2025, the NMC and Chief Nursing Officers for England, Wales, and Northern Ireland issued a joint communication reassuring registrants that the context of care delivery will be considered in regulatory decisions during the challenging winter period. Supported by the Chief Nursing Officer for England, the message acknowledges pressures from flu, high demand, and staff absences, emphasises adherence to professional standards while adapting practice when necessary, and highlights the importance of employer support and open channels for raising concerns. It concludes with sincere appreciation for the continued commitment of health and social care professionals.

2.2 On the 21st January 2026, CQC published the Children and Young People's service report with the overall rating of *Good*, demonstrating clear progress since earlier inspections. The findings highlighted strong patient-experience results, compassionate and respectful care, effective multidisciplinary working, and well-embedded infection-prevention practices. Areas for improvement identified in the report relate to strengthening the consistency of safeguarding flags, improving mandatory training compliance (Safeguarding), and ensuring robust application of reasonable adjustments for children and young people with additional needs. These areas of improvement are being addressed through improvement work including the introduction of EPR and the Safeguarding compliance action plan.

Core work

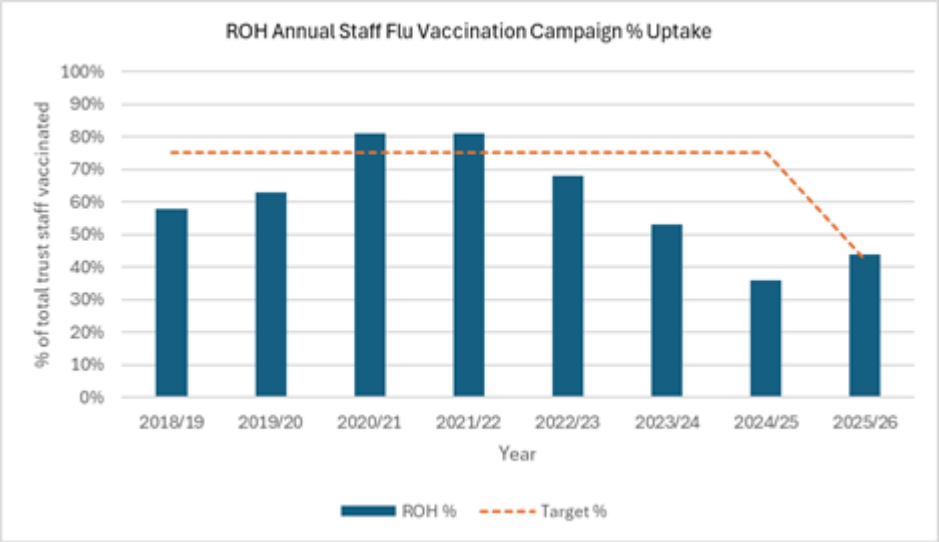
2.3 The Midlands Critical Care Network is conducting peer review visits via MS Teams to each of our Adult Critical Care units throughout the year. Following initial communications it has been confirmed that the peer review visit for Royal Orthopaedic Hospital HDU will take place on 30th April 2026. A HDU self-assessment declaration spreadsheet will be completed ahead of this.

2.4 Quality priorities quarter 3 update: All owners of the quality priorities report good progress against their plan improvement work.

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	On-track

	young people with limited engagement in health services due to existing health-related barriers.	
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

2.5 As of the date of this report, a total of 596 flu vaccines have been administered onsite at ROH. Additional uptake captured through Federated Data Platform (FDP) data reflects ROH staff who received vaccination through external providers, contributing to the overall organisational position. Taken together, this activity confirms that the Trust has met its primary objective of increasing frontline healthcare worker flu vaccination uptake by 5% compared with the previous year, as well as achieving the agreed stretch target of 42%. Graph 1. Provides oversight over the last 8 years.



Graph 1.

3 DIRECTOR OF GOVERNANCE'S UPDATE

3.1 As of 1 January, the Information Governance portfolio transferred over into the portfolio of the Director of Governance. Early benefits of this shift have been experienced as the Subject Access Requests team and IG Manager have undertaken somejointworking.

3.2 The annual internal audits of the Trust's risk management processes and Board Assurance Framework and the Trust's compliance with the Information Governance Data Security and Protection Toolkit have begun this month. Evidence gathering and fieldwork is currently underway, with final reports currently scheduled for review at Audit Committee in Q1 2026/27.

3.3 The organisational governance review is nearing its conclusion in readiness for the change in operating model from 1 April 2026. The review provides for an improved accountability framework within the organisation and an improved means of providing upward assurance to the Board and its committees.

3.4 Health & Safety:

- Work is progressing with the action plan against national Violence and Prevention Standards. A meeting has been held with Trade Union staff regarding staff perceptions on how we manage violence / abuse against staff.
- H&S Training is experiencing continued positive engagement and feedback regarding Health and Safety for Managers Course (Me as Manager). COSHH awareness training is planned for February / March to capture facilities housekeeping staff.
- Strengthened links with wider NHS H&S colleagues have been forged through the Subject Matter Experts network (as part of the Statutory and Mandatory framework review). The H&S Advisor attended a 'townhall' in January with other SMEs.

3.5 Planning is underway for the joint Board meeting with Robert Jomes & Agnes Hunt NHSFT on 1 April 2026. Further details will be provided in due course.

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

The Royal Orthopaedic Hospital NHS Foundation Trust

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:	**4 February 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The ROH is now three-quarters of the 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
• Good progress with delivery across all domains, with n significant delay in any areas	• 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.

The Royal Orthopaedic Hospital NHS Foundation Trust

ROH Strategy 2023-2028: Strategy Update

Trust Board | 4 February 2026

1. Introduction

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.

2. Delivery Plan – 2025/26

The Strategy Delivery Board met on 28 January 2026 and reviewed the 2025-26 Trust Delivery Plan, which includes a combination of national planning guidance imperatives and ROH priorities.

Progress has been positive across Q3, much of which has been explored in detail at relevant Board sub-committee meetings. Section 3 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 3 (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:** • Approved system wide clinical decision support tool for orthopaedics and MSK (now 'IPP' - Integrated Patient Pathway). IPP launch meetings completed, with clinically led pathway reviews commencing at sub speciality level. (ROH Surgeon plus Advanced Physiotherapy Practitioner representation)
	On track for delivery: • All national operational targets for Referral to Treatment (RTT) targets are on track for delivery by March 2026, and this is reviewed in FPC. • The Outpatient Transformation Programme continues to drive best practice, aligned to GIRFT and NHS Impact.
	Delay but progressing: • Reduce inequalities for patients accessing ROH services – following the Board workshop in October 2025 a refreshed action plan with fewer priorities is being developed for 2026/2027. Positive progress has been made through the Outpatients Transformation Programme improving access to the ROH services.
	Significant delay and risks to completion: • None

Digitally enabled CARE	**Completed:** • 70% elective care appointments available by NHS App
	On track for delivery: • EPR readiness Trust-wide engagement to refine pathways • EPR procurement completed and awarded to InterSystems. Awaiting Board approval of FBC. Next stage of deployment underway. • Adoption of the federated data platform is on track to deliver.
	Delay but progressing: • 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 – working towards HiMS Level 4 Digital maturity status.

	• Clinical portal not yet fully embedded, progress reviewed at DDaT Board, along with other high priority digital transformation schemes. • Expand use of technology and Artificial Intelligence – prioritisation for 2026/2027 scoping currently taking place.
	Significant delay and risks to completion: • None

High quality CARE and cutting-edge EXPERTISE	**Completed:** • Maintain GIRFT Accreditation (July 2025), a formal follow up visit is expected in July 2026.
	On track for delivery: • 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 awarded 'working towards' status for national QSI (Quality Standard for Imaging) accreditation on 5 November 2025. • 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. • 165 ROH authored research publications against target of 200 • On track to implement new PROMS system
	Delay but progressing: • 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 163 patients recruited against annual target of 350 • Increased public and patient engagement – improving patient engagement through the patient experience report. Recent recruitment drive to help increase membership of the wider population.
	Significant delay and risks to completion: • None

PEOPLE and continuous improvement	**Completed:** • Me as Manager programme implemented • Advanced Clinical Practitioner oversight in place, led by Corporate Nursing and Consultant Physiotherapist
	On track for delivery: • Agency spend continues to be below the 1.6% mandatory target.

	• Positive National Education & Training Survey Satisfaction Rate (85.59%) • A number of key priorities featured within the Trust's Inclusion Plan are on track for delivery, including embedding the RACE Equality Code, which was launched during Black History Month, 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 has been recruited and commenced in post.
	Delay but progressing: • Implement high performing team framework – this will take place through emerging operating model (small business units). • Reduction in corporate function spend to 2022 levels – NHSE target has been achieved, internal CIP partially achieved through service reviews.
	Significant delay and risks to completion: • Reducing sickness absence rate trajectory on the increase (6.75%) – following internal audit report action plan in place and updates provided at Staff Experience & OD Committee. • Achieving close to 100% core consultant capacity before accessing premium capacity is behind plan. This was a NHSE planning guidance expectation and is being discussed in detail at Executive level. • Bank spend saw a significant increase in Month 9 generating a YTD overspend of £329k. This has been monitored closely through Financial Delivery Board.

Organisational SUSTAINABILITY and productivity	**Completed:** • Application of 5% cost improvement target in place for all services
	On track for delivery: • Major CIP schemes showing positive performance to date include, increasing commercial income, optimising medicine value and optimising energy value. • Financial plan achieved for Month 9 (and Q3) but there is a risk of not delivering the CIP programme which could impact delivery of the financial plan. • Progress continues to be made with rationalising theatre trays
	Delay but progressing: • Behind plan for delivering NHS commissioned income (detailed review at Financial Delivery Board) • 90% Consultants job-planned (against 95% target) • Nurse led preoperative pathway agreed and anticipated implementation from April 2026.

	• Early finishes in Theatres have improved however sustained improvement at risk. • Future proofing of Theatres 1,2 and 4 remains on the Corporate Risk Register with maintenance scheduled for April. • 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. Average LOS reducing and data quality audit underway to capture all day case activity.
	Significant delay and risks to completion: • Private patient income target is off track. • CIP programme is behind plan which could impact the full year delivery of the financial plan. Financial Delivery Board is reviewing all CIPs.

Supporting our COMMUNITY through COLLABORATION	**Completed:** • None
	On track for delivery: • Chief Operating Officer leading review of demand and capacity requirements for Orthopaedics and Spinal services across BSOL, reported through Acute Provider Collaborative and will continue through phase 2 MSK transformation. • 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 March 2026.
	Delay but progressing: • MSK/Orthopaedics through Community Care Collaborative neighbourhood health service model. Detailed Demand and Capacity modelling has been completed across all MSK and physio providers to assess opportunity for improved access to services at locality level.
	Significant delay and risks to completion: • None

4. Planning for 2026/27 and beyond

The Trust is currently developing its 2026/27 operational, workforce and financial plans in line with the NHS England Medium Term Planning Framework. This planning process is intended to ensure alignment with national priorities, system-wide objectives and the

medium-term expectations for providers. In parallel, the Trust Strategy will be reviewed to ensure it remains fit for purpose and continues to provide a clear strategic direction that supports the delivery of the emerging plans. This integrated approach will support sustainable service delivery, improved productivity and access, and financial recovery, while maintaining quality and safety. The plans and refreshed strategic priorities will be refined through engagement with system partners and brought forward for Board consideration in line with the national planning timetable.

Rebecca Lloyd – Director of Strategy

28 January 2026

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Safer staffing Bi-annual report**
SPONSOR (EXECUTIVE DIRECTOR):	**Nikki Brockie, Chief Nurse**
AUTHOR:	**Nikki Brockie, Chief Nurse**
DATE OF MEETING:	**4 February 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY: The purpose of this paper is to provide the Board of Directors with a bi-annual, comprehensive safer staffing report for Nursing and Allied Health Professions (AHP), which outlines staffing capacity and compliance. The report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016)[1], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance[2], published in October 2019.

The process involved a full establishment review of all wards and department (except CYP OPD and the ROC service). The bi-annual review involved an appraisal of funded establishments, roster template, taking into account current activity. The following action have been agreed ahead of the next bi-annual review paper in April 26:

- Review apprenticeship requirements for the coming year.
- Refresh and roll out clinical supervision (review policy and provision)
- Complete the actions identified in the census audit – moving audit to AMAT and ensure a regular audit cycle is implemented, following an update period of training for nursing staff.
- Nurse-led POAC to be implemented and the workforce to be reviewed post implementation in March 26.
- Review senior nurse cover (Matrons'), exploring having a senior of the day until 18:00hrs to support flow.
- Review the current ward model, specifically the private ward model and explore if staffing can be managed in a more agile way.
- Review theatre staffing – Band 7 review, re-introducing the specialist model and extend the working day in recovery to 22:00hrs to support activity.
- Full review of enhanced observation and additional staffing needs require to support this.
- HDU – review bed model
- Job planning to feed into the OPD model, review to inform future model and requirements.
- ROCS to complete review and to provide overview of activity.

[1] NHS England (2016) National Quality Board guidance on safer staffing
[2] NHS England (2018) Developing Workforce Safeguards

- Working with Training and education following the national review of mandatory training review and headroom required.
- Ensure red flags and professional judgment is consistently informing safer staffing
- Monitor sickness (LTS & STS) and ensure robust management in place, with an aim to reduce.
- Complete all Healthroster adjustments.

As part of the review process in ensuring safer sta

ASSURANCE PROVIDED BY THE REPORT:	
POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
• Establishment review agreed and signed off by DOF & MD. • All wards / departments and theatre 's areas establishments review carried out. Including all Healthroster template reconciled back to funded establishments. • Nursing workforce (vacancies) has remained stable over the year with 1.15% vacancies factor. • Apprenticeships DNA, due to graduate early 26, OPD's – 2 due to graduate. • Fill rates consistent over the year at 91%. • OPD's vacancies have reduced and stabilised, as has LTS. • average CHPPD level is 9.25 hours per patient against an average of 9.2 hours against the three specialist trusts • Starter and leaver numbers were broadly balanced during the same period, with 26 WTE starters compared to 27.44 WTE. Nurse turnover has stabilised. • Nurse & OPD's agency stopped in the last six months. Bank usage reduced. • Monitoring and control in place to ensure safer staffing. • Quality indicators demonstrate low levels of harm (Falls 5-12 per month, medication errors 8-15 incidents per month, pressure ulcers 1 – 7 per month across all clinical areas. • PNA embed and restorative session being delivered. Themes identified.	• CYP OPD & ROCS not included in the review process, as they are currently undergoing a wider review in relation to demand and capacity. • Nurse sickness high, actions in place to monitor and work with manager to address. • HCSW vacancy high overall at 32wte. Recruitment has commended in key areas. • Red flag usage requires re-enforcing. • PNA target only 54% achieved. • Census audit identified the need to ensure consistent application of the acuity tool. • Two key consultation identified within theatre and recovery to improve services.

• Changes to establishments identified to improve patient contact.	

REPORT RECOMMENDATION:

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

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

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

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

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

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

BAF – Care, safer staffing policy.

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)***:**

Model hospital data

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

Quality & Safety Committee November 2025

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

Biannual Safe Staffing Report (Nursing)

Quality & Safety Committee October 25

1.0 EXECUTIVE SUMMARY

1.1 The purpose of this paper is to provide the Board of Directors with a bi-annual, comprehensive safer staffing report for Nursing and Allied Health Professions (AHP), which outlines staffing capacity and compliance. The report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016)[1], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance[2], published in October 2019.

1.2 This report provides analysis of the Trust's Nursing and AHP workforce position at the end of September 2025. For the purpose of this report AHP'S workforce will only refer to Operating Department Practitioners (OPD). The paper will cover the last 12-months from October 2024 until September 2025. The paper leads on from the bi-annual nursing paper presented to the Board of Directors in January 2025. The Nursing Workforce and Education Group present their workforce positions via the Safer Staffing report to Quality Safety Committee on a two monthly basis, and monthly to Trust Board as part of the Quality Report.

1.3 The safer staffing report in January 2025 made the recommendations for the preceding 6-month period as detailed below. All areas have been completed and feed into the report, except the training plans, which remains on-going and will be reported in the March 26 paper.

- Undertake the Safer Nursing Care Tool (SNCT) Census of clinical areas before implementing changes to establishments/budgets.
- Complete the OPD establishment review
- Continue to work with staff side to complete the Band 2/3 job description review
- Roll out of the 7-day working in Theatres
- Review headroom for 25/26 in view of current mandatory training requirements.
- Review all training plans for 25/26 (clinical)
- Review Healthroster templates to ensure they are in line with agreed establishments
- Review Association for Perioperative Practice (AFPP) recommendations against current working model in theatre.

[1] NHS England (2016) National Quality Board guidance on safer staffing
[2] NHS England (2018) Developing Workforce Safeguards

- Benchmark against model hospital current baseline

2.0 NATIONAL CONTEXT – NURSING

2.1 Data from NHS England[3] demonstrates a continued improvement in registered nursing vacancy rates. As of 31 March 2025, the vacancy rate stood at 6.0%, representing 25,632 vacancies within the registered nursing staff group (including midwives and health visitors). This marks a significant reduction compared to the same period in the previous year, when the rate was 7.5% (31,294 vacancies). The downward trend reflects progress in recruitment and retention strategies, building on earlier improvements seen in June 2024, when the vacancy rate was 7.8% (32,738 vacancies), down from 10.7% (43,628 vacancies) the year before. These figures indicate that while challenges remain, targeted workforce initiatives have had a positive impact on reducing vacancies and stabilising the nursing workforce nationally.

2.2 Birmingham and Solihull ICS have seen a strong improvement over the past year, with nursing and midwifery vacancies now between 4% and 11%, a significant reduction from the previous year. Substantive staffing has grown from 34,142 WTE in April 2022 to 40,784 WTE in September 2025, an increase of 16.3% (6,642 WTE) across the system.

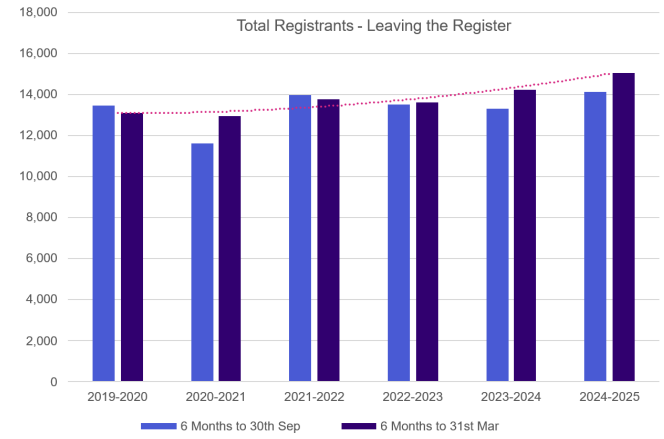
2.3 In line with the NHS Long Term Plan and national efficiency targets, Trusts have been asked to review and reduce workforce costs to ensure sustainability. As part of this process, ROH has submitted a workforce reduction plan, focusing on aligning staffing levels with service demand while maintaining safe, high-quality patient care. This approach supports the broader aim of improving productivity and financial resilience across the NHS. BSOL remain 1.28% above plan, with ROH reporting in July 25, a slight over plan position of 3.6%.

2.3 The NMC Register reported that on 31st March 2025, there were 853,707 nurses, midwives, and nursing associates registered in England. This reflects an increase of 27,289 (3.3%) over the preceding 12 months from March 2024. However, this marks a decline in overall growth, down from 4.8% the previous year, and appears to be linked to a significant drop in internationally educated nurses joining the register. While UK-educated joiners continued to grow, the rate of increase has slowed and is not sufficient to offset the fall in international recruitment. Graph 1 illustrates a 15% growth in registrants over the past five years, rising from approximately 741,000 in 2020 to 853,707 in 2025.

[3] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/april-2015---march-2025-experimental-statistics (March 25)

Graph 1. Five-year comparison in registrants (Graph supplied by NMC)

2.4 Graph 2. highlights a steady rise in registrants leaving the NMC register, which has increased from around 13,500 in 2019–2020 to over 15,000 in 2024–2025, with the highest attrition occurring in the most recent period, signifying an upward trend in potential future workforce instability.



Graph 2. Total number of registrants leaving the register (Graph supplied by NMC)

2.5 The latest NMC data shows a sharp rise in international trained nurses leaving the register with leavers around 2,000 in 2023–2024, now over 2,600 in 2024–2025 over the five-year trend. Graph 3. outlines the growing trend in internationally educated nurses leaving the register with a 5 year high noted in the data. This trend is being closely monitored by providers in order to understand future staffing models and impacts.

Graph 3. Rate of internationally trained nurses leaving the register

3.0 REGIONAL & SYSTEM CONTEXT

Undergraduate Nursing and AHP (OPD) Pre-Registration Education Pipeline

3.1 Overall, the number of applications to nursing programmes nationally remains at historically low levels, as highlighted in the UCAS end-of-cycle 2025 data. In 2025, there were 41,890 applications to UK nursing courses, a marginal 0.9% increase from 2024 (41,520) but still 26% lower than 2021, when applications peaked during the pandemic surge. England saw a slight decline of 0.3%, while Wales and Northern Ireland reported increases of 13% and 2%, respectively. Despite this national challenge, Birmingham universities continue to report strong candidate interest and have successfully recruited to bi-annual programmes.

3.2 **Graduate Guarantee for Newly Qualified Nurses and Midwives**

In August 2025, the CNO Duncan Burton and the Chief Financial Officer Elizabeth O'Mahony for England, wrote to all CNO outlining the Secretary of State Graduate Guarantee scheme for newly qualified nurses and midwifes in England. The scheme ensured that every graduate had an opportunity to apply to join the health and social care workforce. The scheme focus was on supporting workforce stability and reduce reliance on temporary staffing. During this time ROH recruited three newly qualified nurses, with focused work undertaken to ensure newly qualified nurses and nursing associates could apply for all band 4 & 5 posts.

Nursing / OPD apprenticeship

3.2 ROH has a long history of supporting apprenticeship programme to grow the clinical workforce. This has continued over the last year. Table 1. outlines the current clinical apprenticeships currently in train with expected graduation dates.

Programme	Numbers	Completion date
RNDA Degree nurse apprentice top-up	2	• April 2026 – two graduates

Student Nursing Associates	4	• May 26 – 2 graduates (theatres) • March 26 – one graduate • One on break in studies
Operating Department Practitioner apprentices	6	• Feb 26 – three graduates • July 25 – one graduate • Feb 28 – two graduates

Table 1. Apprenticeship programme underway

There are currently no business cases approved for additional apprenticeships past the above programmes of study. This will be reviewed in the coming year, with the release of the workforce plan.

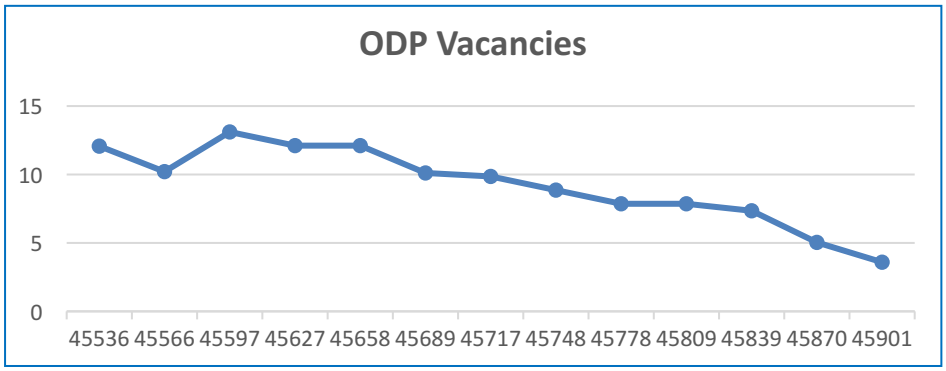
3.3 The trust continues to support student nurses and ODP students on placement with support from the Practice Placement Manager (PPM). The PPM and the Workforce & Education Lead (WEL) attend the BSOL Education Collaborative, which is a community of practice forum to share learning and raise concerns about student needs.

Allied Health Professionals

3.4 The national context for AHPs has continued to improve, with NHS England reporting steady growth in the workforce under the Long-Term Workforce Plan. As of July 2025, NHS Hospital and Community Health Services employ around 1.4 million FTE staff, including a significant number of AHPs. According to the HCPC register snapshot (November 2025), there are 17,797 Operating Department Practitioners (ODPs) registered in the UK, reflecting a slight increase compared to previous months but still highlighting ongoing recruitment challenges for this profession.

3.5 Graph 4. Demonstrates ODP Vacancies have dropped consistently over the last 12 months reducing by circa 70% from a high in Jan-25 of 12.1 WTE to 3.6 WTE in Sep-25.

However, table 1. Outlines the expected OPD apprentices expected to graduate in the coming months which will enter the workforce, thereby reducing that vacancies gap.

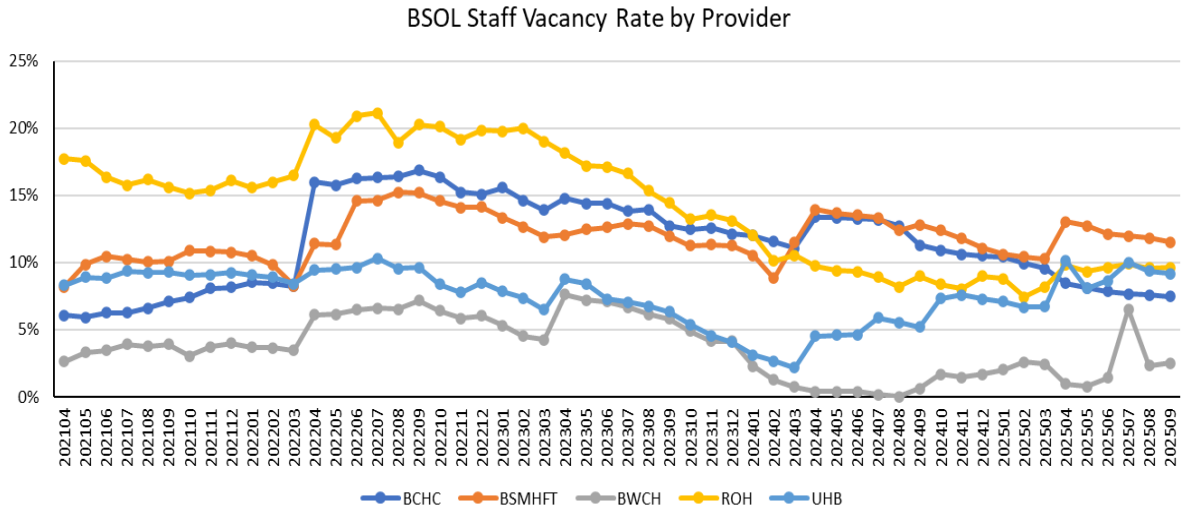


3.6 The ROH OPD apprenticeship programme has been established for over 4 years and has successfully supported several apprentices to registration. Table 1. Outlines the current numbers and expected completion dates.

3.7 There is no equivalent to the Safer Nursing Care Tool for AHPs to determine optimal staffing levels, however there is guidance for ensuring 'Staffing for Patients in the Perioperative Setting' by AFPP[4] last updated 2022. ROH currently works within the AFPP recommendations thereby meeting best practice and ensuring patient safety.

4.0 ROH WORKFROCE (NURSING & OPD'S)

4.1 Graph 4. illustrates a 12-monthly staff turnover rates across BSOL ICS from April 2022 to September 2025. All providers are reporting an improved positions with the overall vacancy dropping from (1,673) nursing vacancies in April 22, to a current low position off (781) nursing vacancies in September 25. This improvement in retention coincides with a positive shift in nursing vacancy rates across BSOL, which have steadily declined over the past two years. The introduction of the System International Nursing Bureau and a targeted recruitment programme, supported by NHSE funding, played a critical role in addressing workforce gaps. These initiatives strengthened both international and domestic pipelines, reducing reliance on agency staff and stabilising the nursing workforce. However, the NHSE funding scheme has now ceased, and the International Bureau was stood down in March 2025.

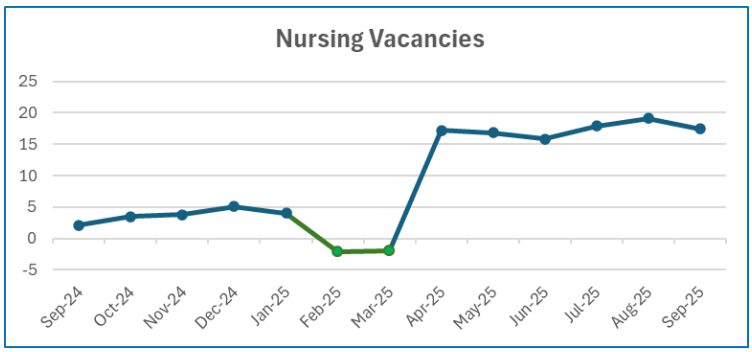


Graph 4. BSOL nursing and midwifery vacancies

4.2 The ROH nursing establishment is 329.98 WTE, with 326.17 WTE in post at the end of September 2025 giving the Trust an overall nursing vacancy rate of 1.15%, significantly lower than the national rate of 7.8% and the Midlands rate of 6.4%. Vacancies remained steady through Quarter 4 of 2024/25 and reached full establishment by March 2025. However, an increase in the nursing establishment for 2025/26 resulted in a sharp rise in vacancies to over 15 WTE in April 2025 as demonstrated in Graph 5 below, as recruitment slowed during an establishment review. This review is now complete, and a significant recruitment drive is underway to fill these vacancies, which have remained at this elevated level through the summer months. As of September 2025, the nursing vacancy rate stands

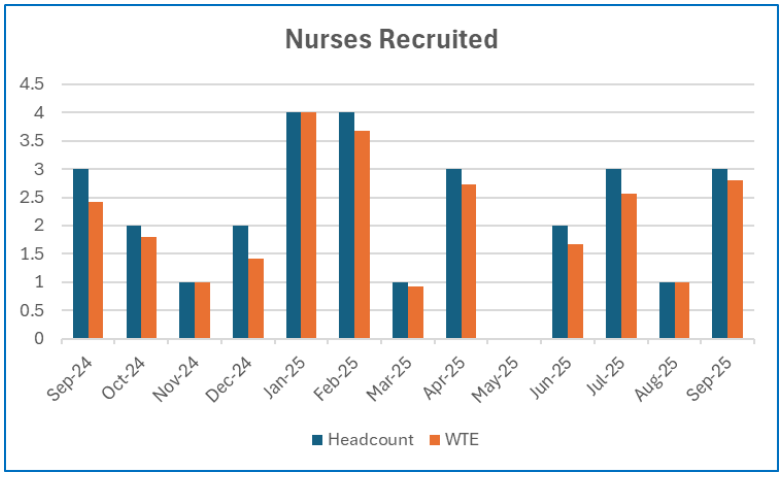
[4] Home - The Association for Perioperative Practice

at 5.28%. The trust has implemented a vacancy control panel requiring all posts clinical and non-clinical to present a QIA and to be reviewed prior to approval.



Graph 5. Nurse vacancy

4.3 Graph 6. Outlines that despite a hold on recruitment during the establishment review recruitment has been steady over the year.



Graph 6. Demonstrates the recruitment of nurses over 12 months

Unregistered workforce

4.4 At the end of September 25, the Band 2 workforce was a stable with 13.98 wte vacancies this is an improved on the previous years vacancies position of 19.21wte vacancies across the Trust. The establishment is set at 158.58wte and currently we have 125.78 wtc in posts, this figure also includes theatre assistants which are the group with the biggest vacancy at preset. Currently, the theatre leadership team are recruiting to 5 wte posts and following the service reviews planned for early in 2026, the remaining posts will be considered. Table 2. Provides an overview of current posts. However, as part of the national job role review for band 2 – 3 Healthcare support workers a consultation is underway.

Job Title	Budget	Actual	Vacancy
Healthcare Assistant	95.17	81.19	13.98

Theatre Assistant	56.58	38.59	17.99
ODP Apprentice	7	6	1
Grand Total	**158.75**	**125.78**	**32.97**

Table 2. Band 2 posts

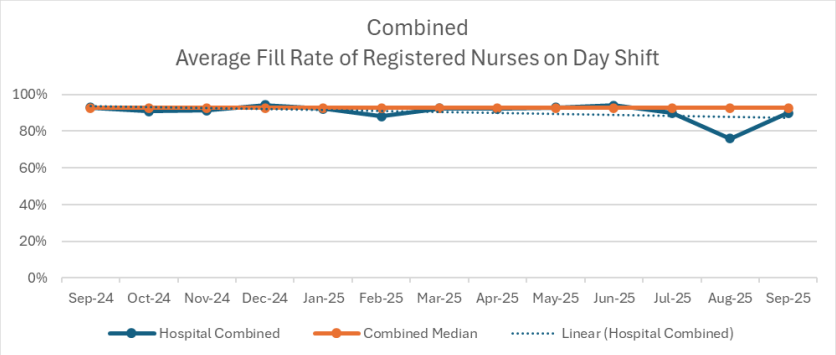
4.5 ROH has been working through the Band 2/ 3 re-banding process, working with staff side. At the time of writing the report the trust is waiting on confirmation of the offer from staff side and consultation with relevant staff has commenced.

5.0 SAFE STAFFING NATIONAL GUIDANCE

5.1 Recommendations set out in the Developing Workforce Safeguards Report 2018 focus on accountability and monitoring of nursing establishments and responding to unplanned changes in daily staffing. The guidance states organisations must demonstrate compliance with the key principles of safe staffing, supporting a triangulated approach to decide staffing requirements combining evidence-based tools such as Safer Nursing Care Tool (SNCT)[5] data to measure patient acuity and dependency, professional judgement, patient quality outcomes, accreditation, and harm.

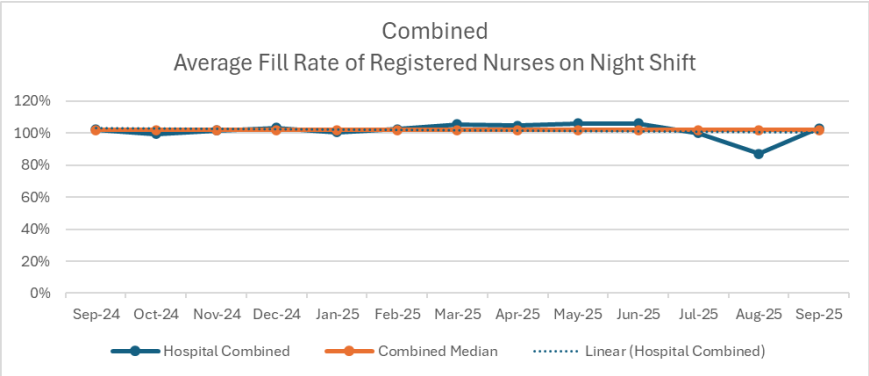
Registered Nurse & un-registered nursing fill rates

5.2 The Trust is required to submit a monthly Safe Staffing Unify Report[6] to NHSI detailing actual registered nurse staffing levels as a percentage against those that were planned. The average fill rate against planned shifts in October 205 was 91% for registered nurses and 92% for unregistered staff. These fill rates are based on the commissioned bed base, therefore it important to note that due to reduced activity over holiday periods, the management of bed use has been agile around activity and a ward has been closed.

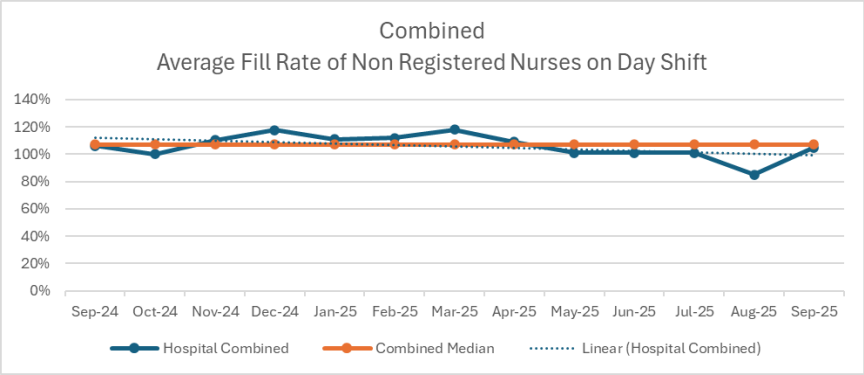


Graph 7. Of average fill rates for registered nurses on day shift

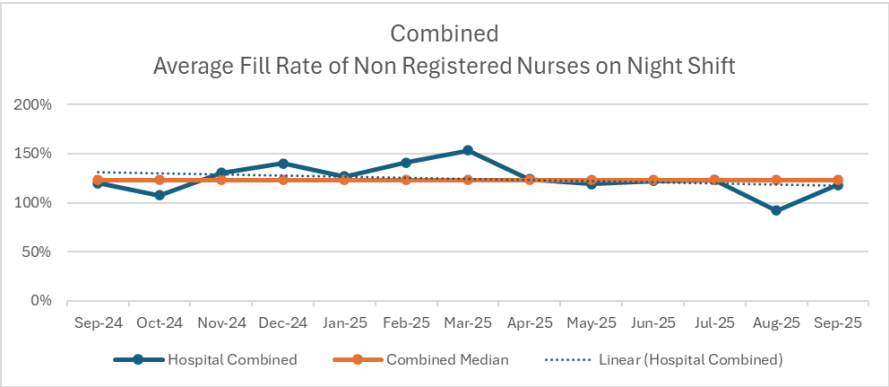
[5] NHS England » Safer nursing care tool
[6] NHS England » Freedom of Information: UNIFY return



Graph 8. Of average fill rates for registered nurses on night shift



Graph 9. Of average fill rates for un-registered nurse on day shift



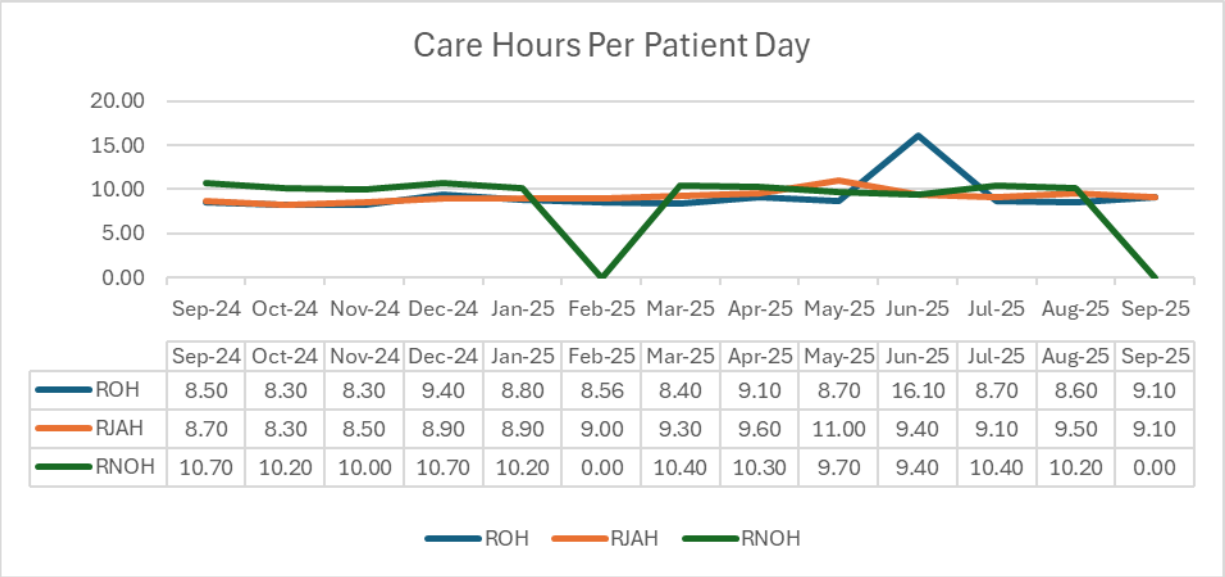
Graph 10. Of average fill rates for unregistered nurses on night shift

5.3 Fill rates for un-registered nurse on night shifts averages at 123%, which is higher than the planned rates. Themes identified as to explain the high fill rates are enhanced observations: patients on Deprivation of Liberty requiring enhanced supervision. Nationally, it has been noted that there has been an increase in the requirement for enhanced observation. Therefore, NHSE have established a working group to review and explore enhanced hours. ROH are engaging with this work and exploring alternative approaches to ensuring patient safety.

Care Hours Per Patient Bed Days (CHPPD)

5.4 Care hours per patient day (CHPPD) is the principal measure of workforce deployment in ward-based settings since April 2016. CHPPD is a metric to reflect care hours per patient bed day and is calculated by taking all the shift hours worked over the 24 hours period by registered nurses and nursing assistants and dividing this by the number of patients occupying a bed at midnight. CHPPD is not indicative of the total amount of care provided on a ward nor does it directly show whether care is safe, effective or responsive, therefore must be considered in conjunction with measures of safety and quality and using professional judgement. CHPPD relates to hospital inpatient wards only where patients stay overnight.

5.5 There is no national target for CHPPD, however NHSI publish the data on the NHSI Model Hospital. Graph 11. Illustrates the recent Trust CHPPD data against the median for specialist hospitals. The ROH average CHPPD level is 9.25 hours per patient against an average of 9.2 hours against the three specialist trusts, suggesting that the Trust staffing levels result in a CHPPD level aligned with the other two trusts.



	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
ROH	8.50	8.30	8.30	9.40	8.80	8.56	8.40	9.10	8.70	16.10	8.70	8.60	9.10
RJAH	8.70	8.30	8.50	8.90	8.90	9.00	9.30	9.60	11.00	9.40	9.10	9.50	9.10
RNOH	10.70	10.20	10.00	10.70	10.20	0.00	10.40	10.30	9.70	9.40	10.40	10.20	0.00

Graph 11. CHHPD benchmarking against specialist hospitals

5.6 The lack of national CHPPD targets limits the validity and use of this data to inform safer staffing decisions although it is recommended that benchmarking against other organisations is considered when undertaking a workforce review.

Controls

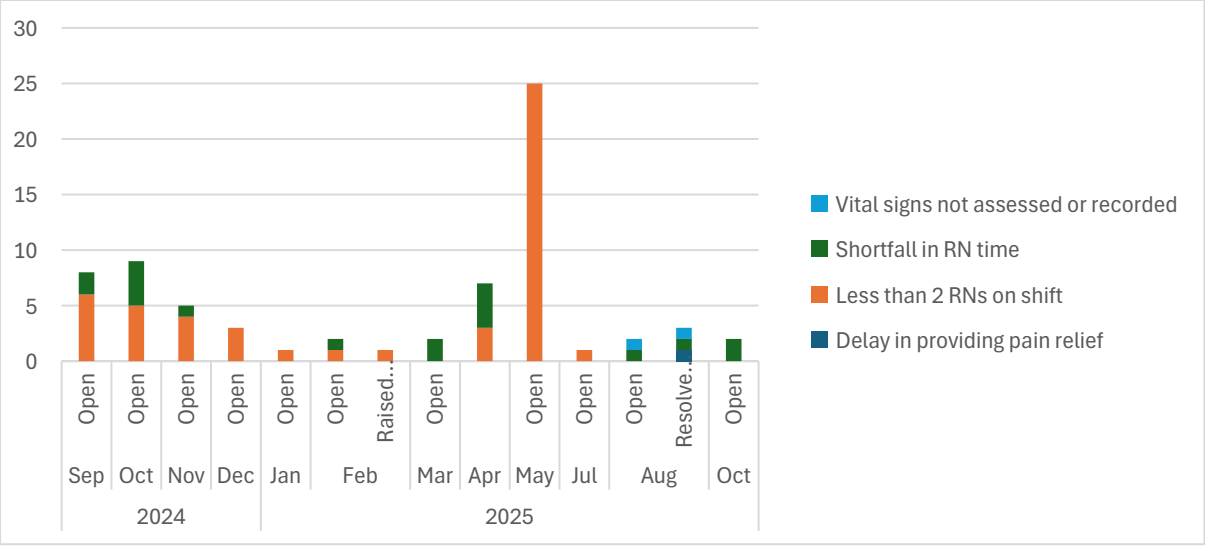
5.7 All wards and departments use Allocate Healthroster and the rosters are aligned with agreed establishments that are reviewed every 6 months. Ward/Department managers are responsible and accountable for the provision of safe staffing levels to meet patient needs by preparing and managing the roster. Matrons are responsible and accountable for reviewing, overseeing and approving the roster. This is completed following a 'Confirm and

Challenge' meeting where checks are made regarding appropriate annual leave, study leave etc.

5.8 Nurse staffing levels are reviewed daily and then weekly in real time and monitored through the 'staffing meeting' to ensure they are adequate to meet patient acuity and nursing needs on each ward and department. The review includes level of staffing requirements including bed occupancy, planned v's actual staffing. Planned v's actual staffing numbers are displayed visually outside each in-patient ward and on the Trust website. The daily staffing levels are viewed along with reported outcome measures to provide safe and effective patient care. Professional judgment in managing unplanned absences or increased demand, alongside the skill mix and competences is paramount to provide the safest care possible across the trust. The process informs identification of the staffing escalation position and the identification of any red flag staffing events.

Red Flags

5.9 Red flags, as identified by NICE (2014; 2018a; 2018b), are raised when planned, required, and available nursing hours are insufficient and pose a clinical risk to patient care. They require immediate action by the nurse in charge and the Matron and are embedded within SafeCare and Ulysses as part of daily staffing oversight. Red flags must be reviewed daily, and any resolution should not create staffing risks in other wards or areas. Red flags opened relating to

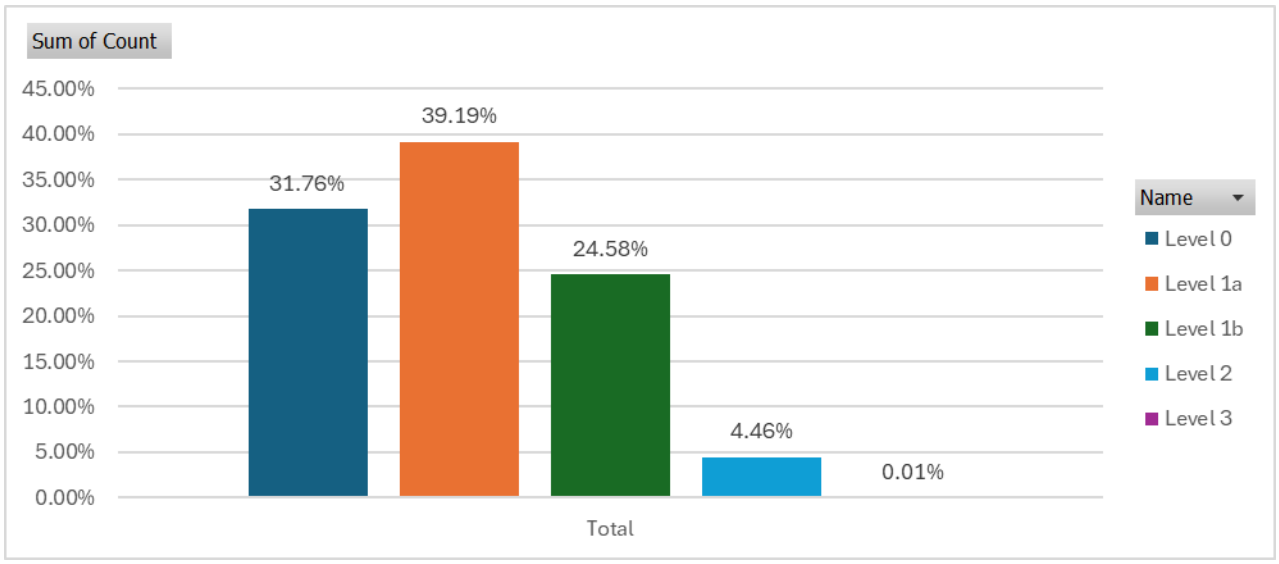


Graph 12. Red Flag data

5.10 The monthly Safer Staffing reports provide a comparison of Nursing & OPD workforce and safe staffing data against quality outcomes. On review of the planned staffing fill rate, there is no direct correlation found between wards with a lower fill rate and nurse sensitive indicators including patient falls, pressure damage and medication errors.

Acuity

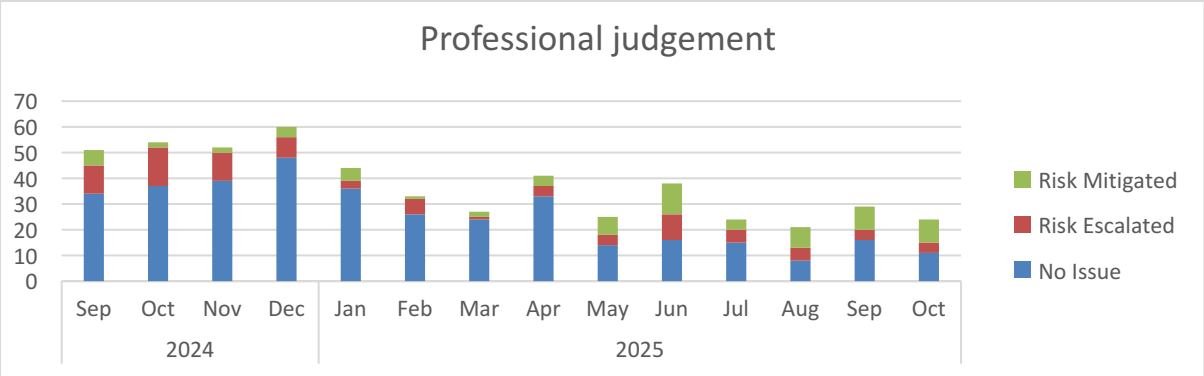
5.11 Data is entered into Safecare twice a day by the nurse in charge of the ward/dept which reflects the patient acuity (Appendix A describes the criteria) . The overall average percentage of data for adult ward acuity demonstrates that the highest proportion of patients are stable, and dependent on nursing care with (24.58%) of level 1b patients. This level indicates a patient is requiring a high level of nursing time and support. The data in Graph 13. Highlighted a reduction in the number of level 0 patient form the previous report of (41.27%) to (31.76%). As expected, there are a low number of level 3 patients (0.01%). All level 3 patients are transferred to critical care units within the Critical Care Network.



Graph 13. Accuity scores (average reporting period)

5.12 As part of the triangulation of safer staffing the nurse in charge of the ward / department raise a red flag. This is supported by the professional judgement that speaks to the dynamic risk assessment that is undertake taken by the senior nurses and matrons. During the analysis of the professional judgment the following themes have been identified: lower staffing than acuity, skill mix and increased acuity.

Professional judgment



Graph 14. Overview of Professional judgement

5.13 The SafeCare audit undertaken in this reporting period highlights notable inconsistencies between area scores and audit scores across wards, particularly in Levels 0, 1a, and 1b. Higher audit scores at Level 0 suggest that baseline care needs may be underestimated during routine assessments, while lower audit scores at Level 1a indicate potential overestimation of acuity or gaps in documentation. Conversely, Level 1b shows frequent under-recognition of patient dependency, with audit scores exceeding area scores. These findings emphasize the need for improved accuracy and consistency in recording patient acuity and dependency, ensuring that staffing decisions align with actual care requirements. Strengthening documentation practices and reinforcing professional judgment will support the aim of having the right staff, with the right skills, in the right place, at the right time to deliver safe, high-quality care. Appendix A. provides a full breakdown of the census.

6.0 WORKFROCE ESTBLISHMENT REVIEW

6.1 The annual safer staffing establishment review aligns with the National Quality Board (NQB) standards and Developing Workforce Safeguards by ensuring workforce models are responsive to patient acuity, service demand, and financial sustainability. Key actions include reviewing the ward establishments and ensuring that activity data supports existing templates and that roster reflect the establishment and consider staffing data and harm free historical data.

6.2 As part of the annual review process the Director of Finance (DOF) and the Medical Director (MD) have been asked to review the current establishment models and the processed models. The triangulation between the DOF, CNO and the MD is to ensure patient safety and financial accountability is balanced. The Executive Directors have both supported the proposed plans and changes to establishment that support patient safety and ensure delivery of the activity. (Appendix B. outlines the plan is detail).

6.3 Overview of proposed changes:

Division 1.

<table>
<tr><td>Ward 1</td><td>No change</td></tr>
<tr><td>Ward 2</td><td>No change</td></tr>
<tr><td>Ward 3</td><td>Proposed change to template uplift the band 5 to include a 4th on a Sunday due to activity and acuity.
Keep ring in budget to support flexibility</td></tr>
<tr><td>Ward 4</td><td>No change</td></tr>
<tr><td>Ward 12</td><td>Agreed to continue at current model until after the proof of concept around the ambulatory pathway.</td></tr>
<tr><td>OPD</td><td>Proposed plan of rostering a band 6 on Saturday supported.
Change to establishment:
Band 2 -
<table>
<tr><td></td><td>Current</td><td>Change</td></tr>
<tr><td>Band 2</td><td>18.05</td><td>18.18</td></tr>
<tr><td>Band 3</td><td>2.18</td><td>2.18</td></tr>
</table>
</td></tr>
</table>

	<table><tr><td>Band 5</td><td>13.79</td><td>12.84</td></tr><tr><td>Band 6</td><td>3.63</td><td>3.87</td></tr></table> Discussed the staff being able to work 12 hours in the injection suite. However, job plans don't support activity.
ROCS	No changes
D/L	No changes proposed
Topography	Service review underway. No recruitment at present.
CYP OPD	Review underway but not included in this process.

Division 2

Area	Proposed to templated / establishment / workforce
HDU	The proposal to reduce the beds to 4 at a weekend This would require a change in commissioning and would yield a small staffing return due to the staffing model required to maintain safety.
CCOT	No change proposed
POAC	No change proposed until after nurse led is fully implemented
Theatre	Band 7's establishment will be reviewed as part of a wider piece of work related to moving theatre teams back to specialities. The establishment is budgeted to provider staffing for 14 theatres, however currently this included support roles such as clinical educators and co-Ordinator, HTA lead and support posts. Therefore, the current budgeted establishment would struggle to support 14 theatres running concurrently. Changes requested: • Band 7's to deliver 2 clinical shifts (in the numbers every month). Five at present. • Establishment changes: <table><tr><td></td><td>Current est</td><td>Current run rate</td><td>Proposed est</td></tr><tr><td>Band 2</td><td>61.02</td><td>44.92</td><td>61.02</td></tr><tr><td>Band 4</td><td>2.53</td><td>0.51</td><td>2.53</td></tr><tr><td>Nurse Band 5</td><td>28.03</td><td>26.24</td><td>39.38</td></tr><tr><td>& ODP Band 5</td><td>11.21 **Total 39.24**</td><td>14.14</td><td></td></tr><tr><td>Nurse Band 6</td><td>22.08</td><td>25.21</td><td>43.46</td></tr><tr><td>OPD Band 6</td><td>21.92 **Total 44**</td><td>14.66</td><td></td></tr></table> Within this current establishment are the following training posts:

<table>
<tr><td></td><td>
<table>
<tr><th></th><th>Numbers on course</th><th>On-going</th></tr>
<tr><td>ODP</td><td>6 on course</td><td>2 completing April 26.
4 remain on programme</td></tr>
<tr><td>SNA</td><td>3 on course</td><td>1 on break, 1 commend training April 25, 1 completing training May 26</td></tr>
</table>
</td></tr>
<tr><td>Recovery</td><td>Support the change in working pattern to support activity:
Less staff will start at 8am, and more staff will shift to working later to support later finishes.
Band 7 – to work clinically twice a week and in the team roster template</td></tr>
<tr><td>ADCU</td><td>Changes to establishment
<table>
<tr><th></th><th>Current</th><th>Proposed</th></tr>
<tr><td>Band 2</td><td>12.83</td><td>11.29</td></tr>
<tr><td>Band 4</td><td>2.42</td><td>7.5</td></tr>
<tr><td>Band 5</td><td>17.34</td><td>12.99</td></tr>
<tr><td>Band 6</td><td>3.95</td><td>2.02</td></tr>
<tr><td>Band 7</td><td>1</td><td>1</td></tr>
</table>
Reduce the band 6 line with 2.02wte. Currently 4 wte in post, therefore we would freezer posts and not recruit as the post holders left)
Saturday – removal of late shift (due to the impact of the ambulatory work)
Band 2 – we would reduce from substantive establishment but keep 2.02wte within the ring in budget. This would support flexible working and being responsive to changes of the service.
The team would reduce the band 5 establishment but increase the band 4 establishment as staff became available to recruit. This would prompt band 4 recruitment.
Continue to hold 2 wte band 2 in bank and ring fence to support flexibility</td></tr>
</table>

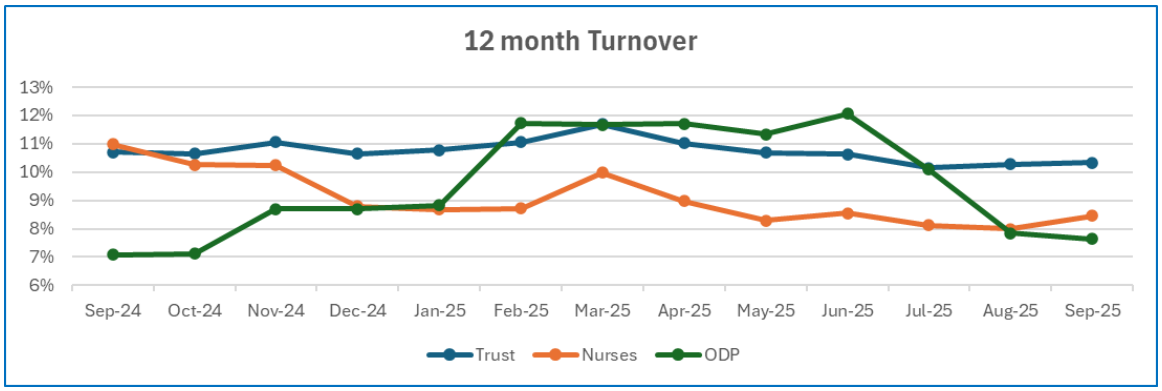
6.4 The proposed changes ensure that safer staffing continues to be delivered to all wards and department. However, the review has highlighted areas that is currently undergoing transformation, with dates for review outlined in Appendix B.

6.5 As part of the establishment reviews, all rostered template within Healthroster have been reviewed and where template adjustment were required this is underway or complete. The area identified that required the most focus has been theatre and as part of the speciality review process theses will be updated.

7.0 WORKFORCE DATA

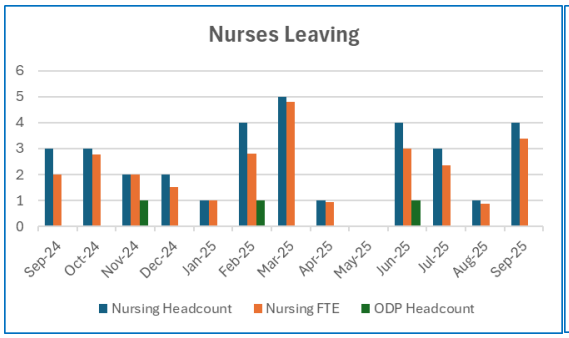
7.1 Nursing turnover has improved significantly over the past year, reducing from 11% in September 2024 to 8.5% in September 2025, representing an almost 25% reduction. The nursing turnover rate now sits comfortably below the overall Trust turnover rate. In

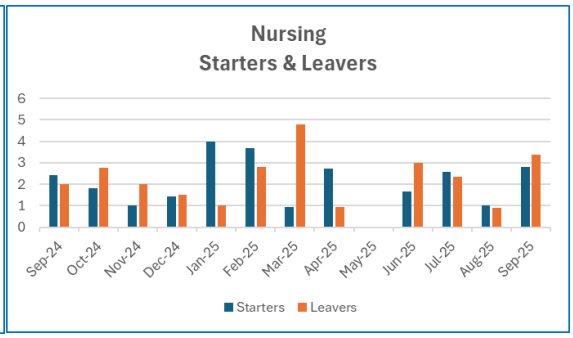
contrast, Operating Department Practitioner (ODP) turnover has been more variable. A sharp increase occurred in February 2025, which persisted for five months before returning to levels similar to those seen 12 months ago. This volatility is largely due to the small size of the ODP workforce, where just a few leavers can have a significant impact on turnover percentages.

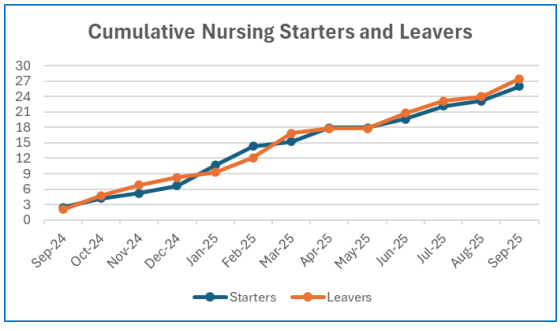


Graph 15 Turnover

7.2 Over the past 12 months, the Trust recorded 27.44 WTE leavers, with the majority leaving due to resignation (72%), while almost 20% retired. Starter and leaver numbers were broadly balanced during the same period, with 26 WTE starters compared to 27.44 WTE leavers, indicating overall workforce stability.



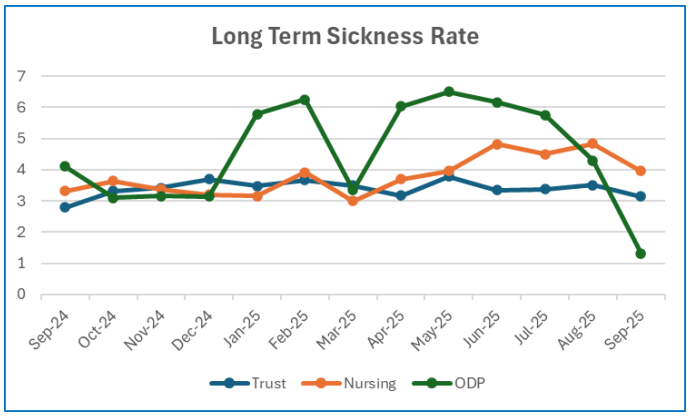




Graphs 16, 17 & 18

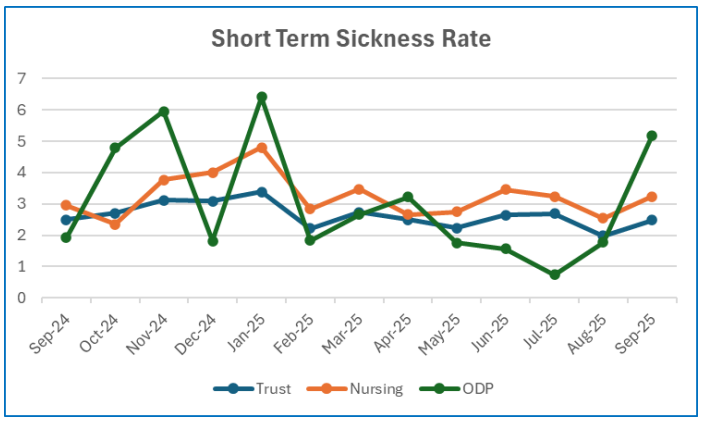
Nurse and AHP sickness

7.3 Long-term sickness among nursing staff tracked slightly below the overall Trust rate during the early part of the period but has increased since March 2025. In contrast, Operating Department Practitioner (ODP) long-term sickness has fallen sharply over the past four months, dropping from 4.1% at the start of the period to 1.3%, now sitting significantly below the Trust average.



Graph 19. Long term sickness

7.4 Short-term sickness among nurses has consistently remained above the overall Trust rate over the past 12 months. For Operating Department Practitioners (ODPs), short-term sickness has been more variable due to the small workforce size, where a few cases can significantly affect percentages.



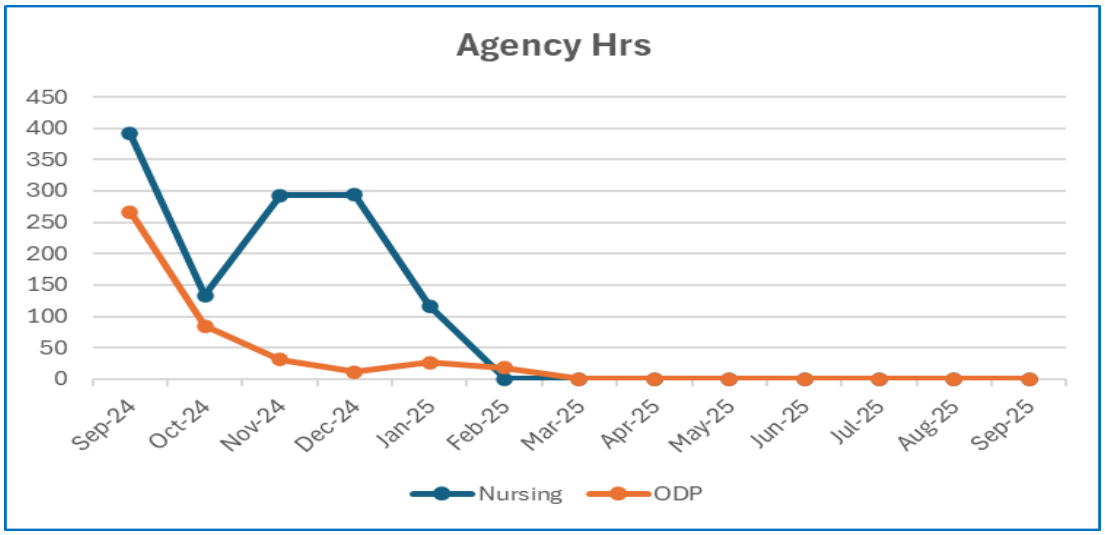
Graph 20. Short term sickness

7.5 Targeted initiatives to reduce sickness have been introduced to key area with high sickness levels across the trusts, as described in the HR operational plan. It is recognised that sickness is high across the nursing, with a reduction in year of long-term sickness in the OPD group. Specific work is underway to try and reduce the sickness levels as we move into winter, such as the flu campaign, managers supporting, flexible working initiative being prompted and prompting well-being.

Temporary workforce

7.6 Nationally, NHS reliance on agency staff remains a key efficiency challenge, with spending falling in the last five years from £3.5 billion in 2022/23 to £3.0 billion in 2023/24 and recently reported by a further £1 billion for 2024/25. NHS England has set expectations for trusts to reduce agency costs by 30% and bank staffing costs by 10% in 2025/26, supported by stricter controls on off-framework and inappropriate staffing.

7.7 Graph 21. demonstrated that over the last 6 months, nursing and OPD Agency usage has stopped.

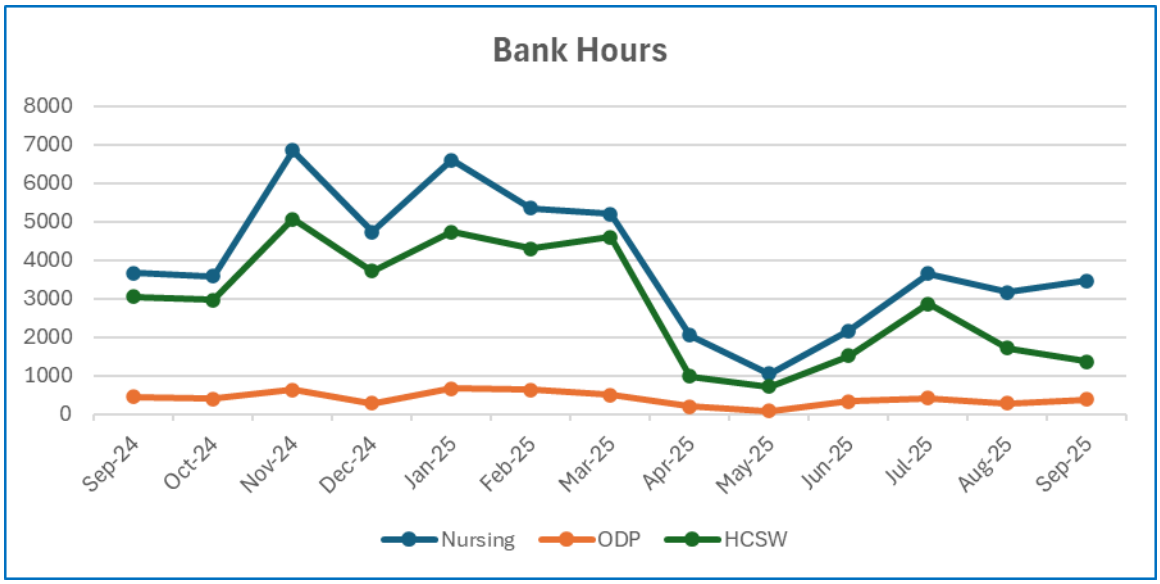


Graph 21. Agency activity

Temporary staffing Controls

7.8 Temporary staffing is utilised to support short term staffing gaps, created by short notice unavailability. There has been no block booked bank staff in the reporting period. ROH has continued to focus on removal of nursing agency for the wards and departments and as demonstrated in Graph 21. this has been achieved to date.

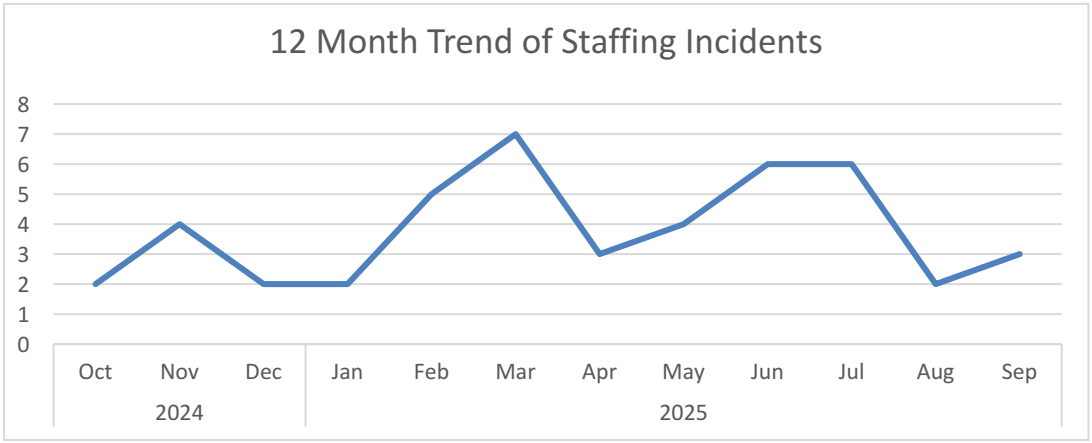
7.9 The Heads of Nursing and Matrons are committed to reducing the use of temporary staffing within their areas and are responsible for reviewing and authorising requests. A Confirm and challenge process is followed before rosters are signed off which supports reduced reliance on temporary staffing.



Graph 22. Bank shifts

8.0 Quality Metrics (support safe staffing triangulation)

8.1 Safer staffing recommends that organisations triangulate safer staffing data with staffing incidents; there is an expectation that these incidents are reviewed, and action taken at divisional quality groups level prior to review at corporate nursing level and report to Board



Graph 23. Staffing incidents by month

8.2 Staffing themes identified

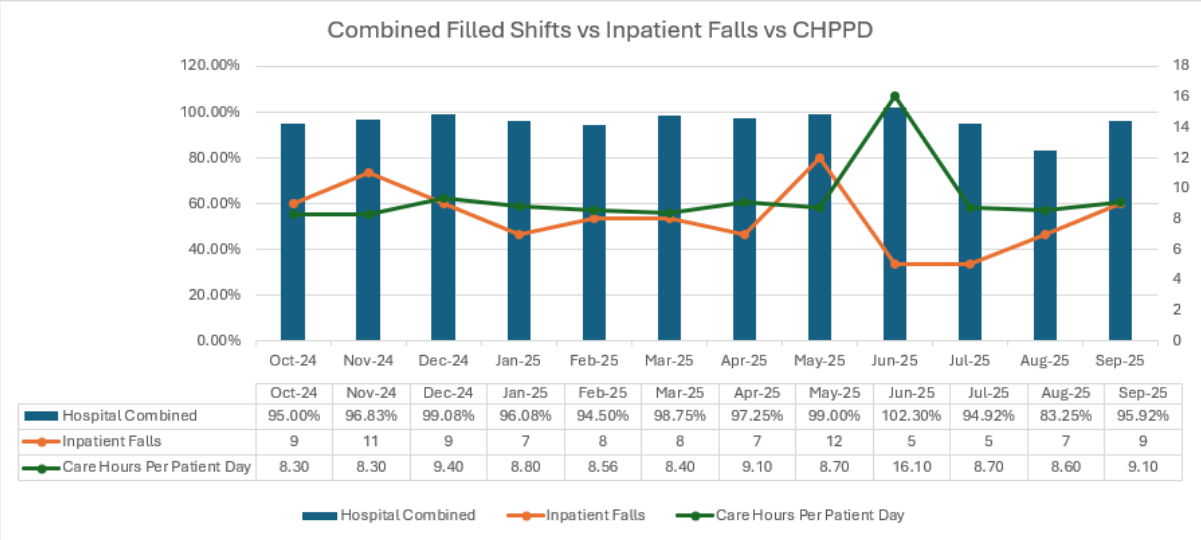
- **Lack of suitably trained staff due to staff illness/absence & Pressures in Theatre to manage lists with appropriate staff** – there were 19 incidents reported, specifically affecting theatres and Imaging. Actions that have been taken include:
  - Increased numbers of trained members in theatre
  - Improvement on 'challenge and confirm' process when covering known staff shortages due to leave and sickness
  - Demand and capacity modelling underway to support business case to request additional funding for staff

- New processes in place to ensure senior in charge and coordinator in charge are easily identifiable

- **Shortages on in-patient wards resulting in inability to provide escort for patients -** there were 10 incidents reported. Actions that have been taken include:
  - Improved communication between departments to ensure enough staff to support requests
  - Improved escalation pathways

Patient harm free data

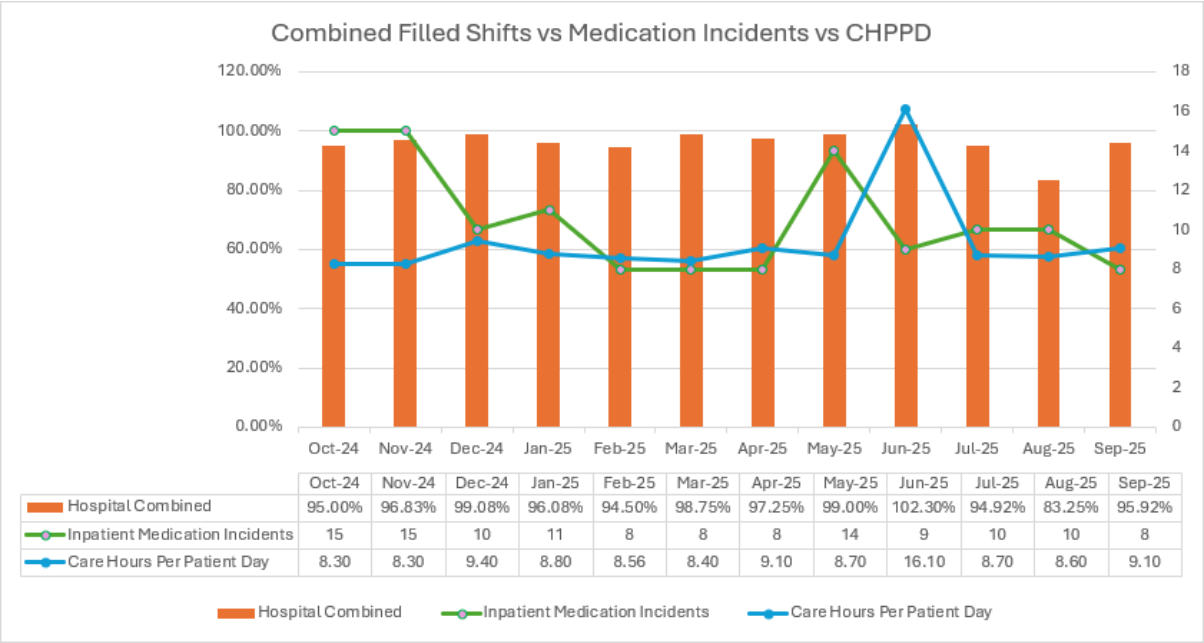
8.3 Patient Falls - Graph 16. shows that Hospital Combined fill rates remained high throughout the year, generally between 94% and 98%, except for August 2025, where the rate dropped to 83.25%. Inpatient falls ranged from 5 to 12 per month across all areas, with the highest count in May 2025 (12 falls) and the lowest in June and July 2025 (5 falls each). Care Hours Per Patient Day (CHPPD) stayed mostly between 8.3 and 9.4, except for June 2025, which recorded a peak of 16.10. These figures indicate that staffing levels were largely stable, with notable variations in CHPPD and inpatient falls across the reporting period. This data indicates that when the fill rates are consistently hight there falls levels are low. The data does not highlight an area that indicate staffing is a contributing factor to the fall.



	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Hospital Combined	95.00%	96.83%	99.08%	96.08%	94.50%	98.75%	97.25%	99.00%	102.30%	94.92%	83.25%	95.92%
Inpatient Falls	9	11	9	7	8	8	7	12	5	5	7	9
Care Hours Per Patient Day	8.30	8.30	9.40	8.80	8.56	8.40	9.10	8.70	16.10	8.70	8.60	9.10

Table 24. outlines the number of fall (total across the wards)

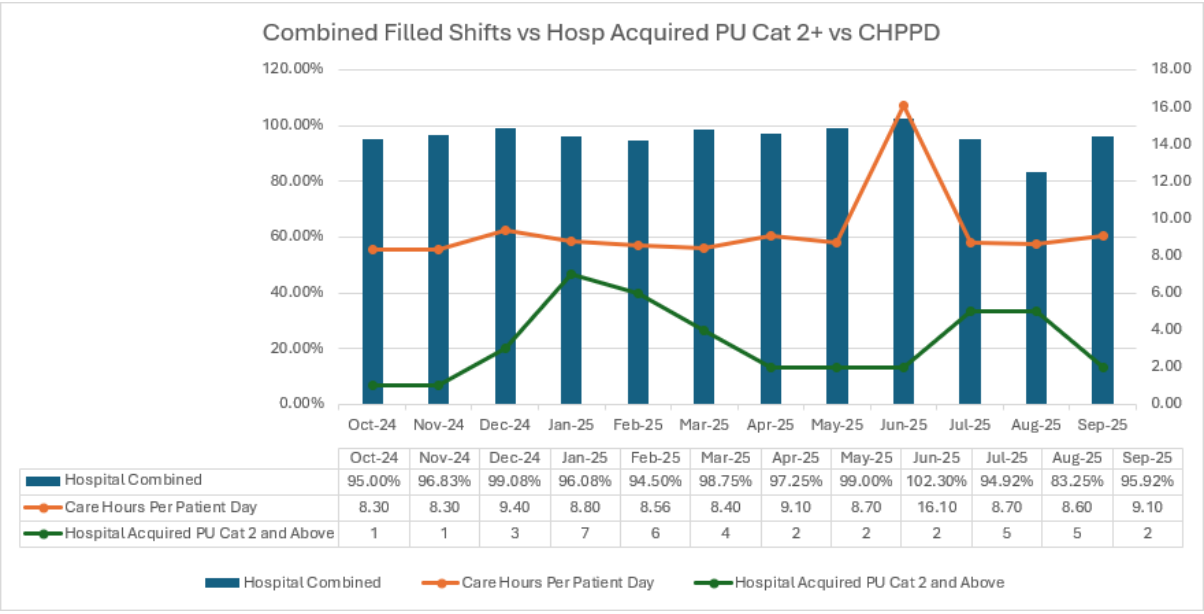
8.4 Medication Incidents - The graph shows that Hospital Combined fill rates remained consistently high across most of the year, ranging from 94.50% to 102.30%, with the lowest point in August 2025 at 83.25%. Inpatient medication incidents varied between 8 and 15 per month, with the highest counts in October and November 2024 (15 incidents each) and the lowest in February and March 2025 (8 incidents each). Care Hours Per Patient Day (CHPPD) stayed relatively stable between 8.30 and 9.40, except for a significant increase in June 2025 to 16.10. Overall, the data indicates that while fill rates were generally maintained, medication incidents and CHPPD showed fluctuations throughout the reporting period.



	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Hospital Combined	95.00%	96.83%	99.08%	96.08%	94.50%	98.75%	97.25%	99.00%	102.30%	94.92%	83.25%	95.92%
Inpatient Medication Incidents	15	15	10	11	8	8	8	14	9	10	10	8
Care Hours Per Patient Day	8.30	8.30	9.40	8.80	8.56	8.40	9.10	8.70	16.10	8.70	8.60	9.10

Table 25. outlines the number of medication errors across the wards / departments

8.5 Pressure ulcer -Staffing levels remain relatively high throughout the period, mostly above 90%, except for Jul-25 (94.92%) and Aug-25 (83.25%), where there is a noticeable dip. Care hours per patient day are fairly stable between 8.3–9.4 hours, except for a sharp spike in Jun-25 (16.10), which coincides with the highest recorded pressure ulcer incidence of 7 cases. This graph does not expand of pressure ulcers classified as unavoidable or avoidable or pressure damage on admission. However, the staffing does not appear to be a fa



	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Hospital Combined	95.00%	96.83%	99.08%	96.08%	94.50%	98.75%	97.25%	99.00%	102.30%	94.92%	83.25%	95.92%
Care Hours Per Patient Day	8.30	8.30	9.40	8.80	8.56	8.40	9.10	8.70	16.10	8.70	8.60	9.10
Hospital Acquired PU Cat 2 and Above	1	1	3	7	6	4	2	2	2	5	5	2

Table 26. Outlines the number of hospital acquired Pressure ulcers (above cat 2)

8.6 All incidents are reviewed as part of the divisional governance process, with the following themes / trends identified relation to medication errors: wrong Drug administered (15), wrong dose administration (11) and medication omitted (17). Reflecting on the previous 12-month, no mediation errors have been identified as directly related to staffing

shortages. However, one serious medication error was identified as being impacted due to a temporary location move (HDU was relocated to allow infrastructure repairs). A PSII was carried out and an action plan developed to address gaps.

9.0 STAFF WELL-BEING

7 day working consultation

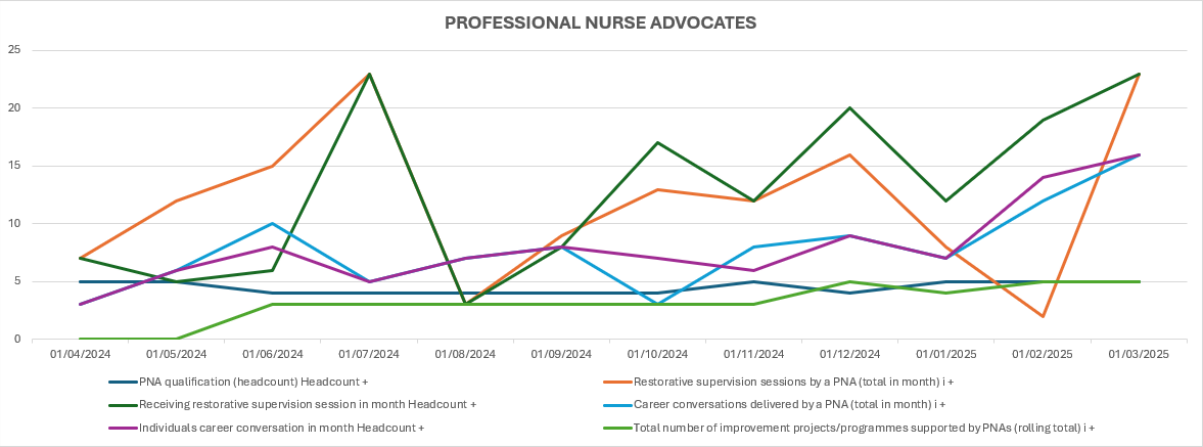
9.1 In August 2024, employees on agenda for change (AfC) terms and conditions within the Theatre team were consulted to support 7 days operating. The consultation was concluded following a 6-week process, and it was agreed that a change to contracts would be implemented in March 2025. However, due to changes in the planning for 2024 – 25, the decision was made not to go forward with the change.

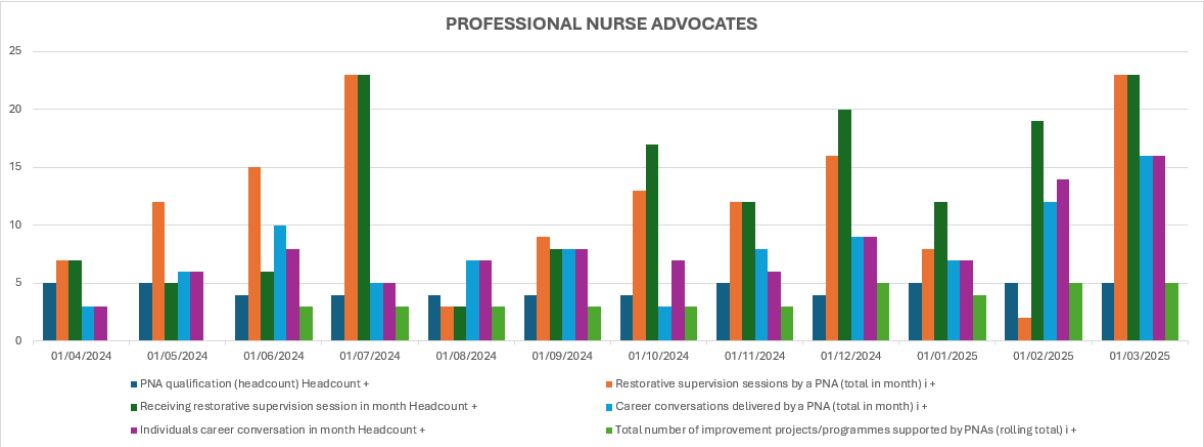
Health and Wellbeing of Nursing and AHP Workforce

9.2 The health and wellbeing of the Nursing and AHP workforce remains a key priority with initiatives across each Division to ensure staff are supported whilst at work and links with the trust's retention strategy.

Professional Nurse Advocate

9.3 The Professional Nurse Advocate (PNA) programme was launched by England's Chief Nursing Officer (CNO) in 2021 in response to the pandemic recovery to support the wellbeing of our nursing workforce. The PNA supports staff through restorative clinical supervision (RCS) with a recommended target of 1:20 PNA to registered nurse ratio by 2025.





9.4 To meet this ratio, and to ensure all registered nurses have access to a PNA, a minimum of 13 PNAs are required across the organisation. Currently there are five registered nurses have completed the PNA programme, with a further 3 undertaking training taking us to 53% of the target.

9.5 Data in relation to the number of restorative supervision sessions, career conversations and improvement projects supported by PNAs is reported monthly to NHSE. Themes raised from restorative clinical supervision are:

- Workload and Staff Shortages
- Emotional Resilience and Well-being
- Career Development and Recognition
- Interpersonal Challenges
- Need for Psychological Safety
- Transition Support for New Staff and International Recruits
- Reflective Practices and Patient-Centred Care

Preceptorship Accreditation

9.6 The Clinical Education Team developed a 12-month rolling preceptorship programme, designed to allow staff to 'step on' and 'step off' as they require. This programme was awarded the interim Quality Award[7] in 2024. The trust is now supporting the 3rd cohort, with positive feedback from staff, having supported 48 staff to attend the protected programme.

Continuing Professional Development (CPD)

9.7 Annually, the continuing professional development (CPD) funding is provided by NHS England to support nursing, nursing associate and AHPs, training and development to meet the needs of patients and service users.

[7] National Preceptorship Interim Quality Mark - National Workforce Skills Development Unit

9.8 CPD has funded externally academic programmes such as the Orthopaedic Course delivered by Rober Jones and Agnes Hunt and a number of Master's programmes designed to develop experts within teams, such as the Infection Prevention Control (IPC) Lead undertaking a IPC masters.

10.0 RECOMMENDATION(S)

10.1 The following outlined below are the intended actions to be undertaken over the next six months, with a view to presenting the findings to the board in April 26, as part of the bi-annual report/review:

- Review apprenticeship requirements for the coming year.
- Refresh and roll out clinical supervision (review policy and provision)
- Complete the actions identified in the census audit – moving this on to AMAT and ensure a regular audit cycle is implemented, following an update period of training for nursing staff.
- Nurse led POAC to be implemented and a workforce review to be reviewed in March 26.
- Review senior nurse cover (Matrons'), exploring having a senior of the day until 18:00hrs to support flow.
- Review the current ward model, specifically the private ward model and explore if staffing can be managed in a more agile way.
- Review theatre staffing – Band 7 review, re-introducing the specialist model and extend the working day in recovery to 22:00hrs to support activity.
- Full review of enhanced observation and additional staffing needs require to support this.
- HDU – review bed model
- Job planning to feed into the OPD model, review to inform future model and requirements.
- ROCS to complete review and to provide overview of activity.
- Working with Training and education following the national review of mandatory training review and headroom required.
- Ensure red flags and professional judgment is consistently informing safer staffing
- Monitor sickness (LTS & STS) and ensure robust management in place, with an aim to reduce.
- Complete all Healthroster adjustments.

11. CONCLUSION

11.1 The Board of Directors are asked to receive this paper and note the current position and planned work to be undertaken in the preceding 6 months and the following recommendations.

11.2 Safer Staffing reports for Nursing and AHP, will be presented on a bi-annual basis.

11.3 Conduct a further SNCT Census of clinical areas before implementing changes to establishments/budgets in quarter 4.

Nicola Brockie
Chief Nurse
October 2025

APPENDICES:

Appendix A. Census data

Our aim is to have the right staff, with the right skills, in the right place, at the right time to deliver safe, high-quality care. This report summarises the Royal Orthopaedic Hospital's SafeCare annual audit against National Quality Board standards, Developing Workforce Safeguards, and NICE guidelines, forming part of the annual Safe Staffing Report.

SafeCare, within Allocate, uses patient acuity data and health roster information to calculate care hours per patient day (CHPPD), ensuring wards are safely staffed with the correct skill mix. The Shelford Group Nursing Care Tool (SNCT) supports this process by recording patient dependency and acuity, enabling a triangulated approach that combines evidence-based tools, professional judgement, and patient outcomes.

Census periods—08:00 (early), 12:30 (late), and 20:00 (night)—are aligned with handover times. During each census, patient acuity, tasks, and professional judgement are recorded, and dashboards indicate whether wards are under or over required hours. This enables real-time, informed decisions to maintain safe staffing.

Table x. Outlines the outcomes for each ward / department following a snapshot audit of SafeCare:

Ward 1	**Area score (Number of patients)**	**Audit score (Number of patients)**	**Difference (Number of patients)**
Level 0	6	12	6
Level 1a	11	2	9
Level 1b	2	5	3
Level 2	0	0	
Level 3	0	0	
Ward 2	**Area score**	**Audit score**	
Level 0	5	9	4
Level 1a	7	0	7
Level 1b	0	3	3
Level 2	0	0	
Level 3	0	0	
Ward 3	**Area score**	**Audit score**	
Level 0	10	7	3
Level 1a	5	1	4
Level 1b	5	12	7
Level 2	0	0	
Level 3	0	0	
Ward 4	**Area score**	**Audit score**	
Level 0	5	9	4

Level 0
Patient requires Hospitalisation. Needs met by provision of normal ward care.

Level 1a
Acutely ill patients requiring intervention or those who are Unstable with a greater potential to deteriorate.

Level 1b
Patients who are in a stable condition but are dependent on nursing care to meet most or all the activities of daily living

Level 2
Requiring level 2 facility ie HDU

Level 3
Requiring advanced respiratory support and or therapeutic support of multiple organs.

Level 1a	5	4	1
Level 1b	5	2	3
Level 2	0	0	
Level 3	0	0	
Ward 12	**Area score**	**Audit score**	
Level 0	5	8	3
Level 1a	8	0	8
Level 1b	0	5	5
Level 2	0	0	
Level 3	0	0	
HDU	**Area score**	**Audit score**	
Level 0	0	0	
Level 1a	0	0	
Level 1b	0	0	
Level 2	4	4	0
Level 3	0	0	

Findings:

Audit data shows consistent discrepancies between area scores and audit scores across Levels 0, 1a, and 1b. At Level 0, audit scores were higher than area scores, suggesting an underestimation of basic care needs. At Level 1a, audit scores were lower than area scores, indicating possible overestimation of acuity or inconsistent documentation. At Level 1b, audit scores often exceeded area scores, pointing to missed dependency recognition during routine assessments. These variations highlight the need for improved consistency in scoring and documentation, particularly within ward areas.

Actions planned:

- Revise safecare documentation to reflect current system functionality and guidelines.

- Clearly state that SafeCare is a guidance document, not a policy, and ensure this is communicated to staff.
- Resolve the issue where RNAs are not recognised by the system, as this impacts patient ratios and related metrics (e.g., fill rates).
- Address gaps in nursing entries, particularly during extended stays or overnight periods.

- Implement spot checks and escalation for wards with minimal entries to ensure accurate acuity recording.
- Continue refresher training on SafeCare for all staff, focusing on accurate census completion and documentation standards.
- Include dependency recognition and correct scoring in competency assessments.

- Monitor discrepancies between area scores and audit scores (Levels 0, 1a, 1b) monthly.

- Share findings with ward managers and incorporate into Safe Staffing Committee reports.
- Use audit feedback to reinforce correct scoring practices and reduce variation.

Appendix B. Staffing overview

Safer staffing workforce review 25-26 (6 monthly review)

Division 1.

<table>
<tr><th>Area</th><th>Proposed to templated / establishment / workforce</th><th>MD & DOF outcome</th><th>Ask</th></tr>
<tr><td>Ward 1</td><td>No change</td><td>Agreed</td><td></td></tr>
<tr><td>Ward 2</td><td>No change</td><td>Agreed</td><td></td></tr>
<tr><td>Ward 3</td><td>Proposed change to template uplift the band 5 to include a 4th on a Sunday due to activity and acuity. Keep ring in budget to support flexibility</td><td>Agreed</td><td>Increase of 1.43 wte band 5 and band 2 1.43wtc for a long day Sunday. This will reduce bank on Sunday and support increased acuity.</td></tr>
<tr><td>Ward 4</td><td>No change</td><td>Agreed</td><td></td></tr>
<tr><td>Ward 12</td><td>Agreed to continue at current model until after the proof of concept around the ambulatory pathway.</td><td>Agreed</td><td>Review to be undertaken in December of the ambulatory pathway impact on establishment</td></tr>
<tr><td>OPD</td><td>Proposed plan of rostering a band 6 on Saturday supported.
Change to establishment:
Band 2 -
<table><tr><td></td><td>Current</td><td>Change</td></tr><tr><td>Band 2</td><td>18.05</td><td>18.18</td></tr><tr><td>Band 3</td><td>2.18</td><td>2.18</td></tr><tr><td>Band 5</td><td>13.79</td><td>12.84</td></tr><tr><td>Band 6</td><td>3.63</td><td>3.87</td></tr></table>
Discussed the staff being able to work 12 hours in the injection suite. However, job plans don’t support activity.</td><td>Agreed</td><td>Change proposed
Band 5 – reduction in Band 5 establishment and slight increase in Band 6 to support Saturday working.
Band 2 – slight change.</td></tr>
<tr><td>ROCS</td><td>No changes</td><td>Agreed</td><td>Review of activity / plan underway by Matron and finance</td></tr>
<tr><td>D/L</td><td>No changes proposed</td><td>Agreed</td><td></td></tr>
</table>

Topography	Service review underway. No recruitment at present.	Agreed	On part time post holder remains. This service is being review and part of the CIP plan
CYP OPD	Review underway but not included in this process.		

Division 2.

<table>
<tr><th>Area</th><th>Proposed to templated / establishment / workforce</th><th>MD & DOF outcome</th><th>Ask</th></tr>
<tr><td>HDU</td><td>The proposal to reduce the beds to 4 at a weekend This would require a change in commissioning and would yield a small staffing return due to the staffing model required to maintain safety.</td><td>Not agreed – No change to establishment</td><td></td></tr>
<tr><td>CCOT</td><td>No change proposed</td><td>No change</td><td></td></tr>
<tr><td>POAC</td><td>No change proposed until after nurse led is fully implemented</td><td>No change</td><td></td></tr>
<tr><td>Theatre</td><td>Band 7’s establishment will be reviewed as part of a wider piece of work related to moving theatre teams back to specialities.

The establishment is budgeted to provider staffing for 14 theatres, however currently this included support roles such as clinical educators and co-Ordinator, HTA lead and support posts.
Therefore, the current budgeted establishment would struggle to support 14 theatre running concurrently.
Changes requested:
Band 7’s to deliver 2 clinical shifts (in the numbers every month). Five at present.
Establishment changes:
<table>
<tr><th></th><th>Current est</th><th>Current run rate</th><th>Proposed est</th></tr>
<tr><td>Band 2</td><td>61.02</td><td>44.92</td><td>61.02</td></tr>
<tr><td>Band 4</td><td>2.53</td><td>0.51</td><td>2.53</td></tr>
<tr><td>Nurse Band 5</td><td>28.03</td><td>26.24</td><td>39.38</td></tr>
<tr><td>& ODP Band 5</td><td>11.21
Total 39.24</td><td>14.14</td><td></td></tr>
<tr><td>Nurse Band 6</td><td>22.08</td><td>25.21</td><td>43.46</td></tr>
<tr><td>OPD Band 6</td><td>21.92
Total 44</td><td>14.66</td><td></td></tr>
</table></td><td>TBC</td><td>Hold 7 day working – agreed
(New posts) Band 5 roster co-ordinator post developed (1WTE)
Clinical educator & HTA posts to be moved out of theatre establishment.
No ask to increase establishment at this time with above moves, to be reviewed in the new year following planning guidance.
Current in posts holds:
Propose we hold 5 OPD band 6 posts as these posts can</td></tr>
</table>

<table>
<tr>
<td></td>
<td>Within this current establishment are the following training posts:

<table>
<tr><th></th><th>Numbers on course</th><th>On-going</th></tr>
<tr><td>ODP</td><td>6 on course</td><td>2 completing April 26.
4 remain on programme</td></tr>
<tr><td>SNA</td><td>3 on course</td><td>1 on break, 1 commend training April 25, 1 completing training May 26</td></tr>
</table>
</td>
<td></td>
<td>be covered by nursing band 6.
• Band 2 have 15 vacancies – recruit to 5 has been agreed. Proposed to hold 10 wte at present to allow for training. Review in New year following planning guidance.</td>
</tr>
<tr>
<td>Recovery</td>
<td>Support the change in working pattern to support activity:
Less staff will start at 8am, and more staff will shift to working later to support later finishes.
Band 7 – to work clinically twice a week and in the team roster template</td>
<td>Agreed (how potential consultation will be required to implement the changes)</td>
<td>Support changing the working time of the team to extend until 10pm (supporting later finished)
Support recovery on-call (one band 5 per night)
Increase in band 5 by .4</td>
</tr>
<tr>
<td>ADCU</td>
<td>Changes to establishment
<table>
<tr><th></th><th>Current</th><th>Proposed</th></tr>
<tr><td>Band 2</td><td>12.83</td><td>11.29</td></tr>
<tr><td>Band 4</td><td>2.42</td><td>7.5</td></tr>
<tr><td>Band 5</td><td>17.34</td><td>12.99</td></tr>
<tr><td>Band 6</td><td>3.95</td><td>2.02</td></tr>
<tr><td>Band 7</td><td>1</td><td>1</td></tr>
</table>
Reduce the band 6 line with 2.02wte. Currently 4 wte in post, therefore we would freezer posts and not recruit as the post holders left)
Saturday – removal of late shift (due to the impact of the ambulatory work)
Band 2 – we would reduce from substantive establishment but keep 2.02wte within the ring in budget. This would support flexible working and being responsive to changes of the service.
The team would reduce the band 5 establishment but increase the band 4 establishment as staff became available to recruit. This would prompt band 4 recruitment.
Continue to hold 2 wte band 2 in bank and ring fence to support flexibility</td>
<td>Agreed</td>
<td>Support band 6 reduction
Support Band 2wte within the ring in budget
Support change in establishment to support band 5 budget moving to band 4 and recruitment
Support band 2 establishment reduction</td>
</tr>
</table>

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Sexual Safety Action plan update**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Executive Chief Nurse**
AUTHOR:	**Nicola Brockie, Executive Chief Nurse**
DATE OF MEETING:	**4 February 26**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The NHS England Sexual Safety Charter, published in September 2023, set a national expectation for a zero-tolerance approach to sexual misconduct across all NHS organisations. All Trusts and ICBs, including ROH, signed the Charter and committed to delivering its ten principles. In August 2025, NHS England reaffirmed this commitment and required all providers to complete a self-assessment against the Sexual Safety Charter Assurance Framework, ensuring Trust Boards maintain clear oversight of the work required to create a sexually safe environment for staff and patients.

In December 2025, a further national letter outlined additional actions to strengthen the prevention, reporting and investigation of sexual misconduct. This included requirements for specialist national training for investigators, nomination of staff for the March 2026 training cohort, and ensuring responsible officers are appropriately trained. By early 2026, providers must update chaperoning policies in line with new national principles, establish review groups to oversee sexual-misconduct cases, and ensure appropriate management of concerns involving resident doctors. The letter also restated statutory duties on DBS referrals and clarified expectations for information-sharing during active police investigations. These requirements have been incorporated into the Trust's action plan to ensure full compliance and robust Board oversight.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Named Executive Lead in place, supported by an established multidisciplinary working group. • Strong Freedom to Speak Up structures embedded, including champions and anonymous feedback routes. • Repeated reviews of sexual misconduct incidents undertaken, triangulated with staff survey data. • Sustained awareness campaign delivered, including leadership visibility, stand up events, walkabouts, induction sessions and communications.	• Finalise and launch the sexual safety policy. • Complete and implement updates to the chaperoning policy and associated training. • Complete the Equality Impact Assessment (EIA) for sexual safety work. • Develop and share case study materials to support learning. • Embed sexual misconduct e learning within the LMS for all staff. • • Strengthen monitoring processes to identify inappropriate access to electronic patient records.

• Bystander training rolled out and accessible to all staff. • Clear support pathways in place through HR, safeguarding, Occupational Health, FSUG and DA/SVA leads. • Reporting mechanisms strengthened with flowcharts and dedicated intranet pages. • Data triangulation embedded across safeguarding, HR and FTSU processes.	

REPORT RECOMMENDATION:

The Board is asked to : note the work underway to achieve the key requirements within the sexual safety NHSE action plan.

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

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

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

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

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

Workforce risk

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

Workforce

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

N/A

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

Update to Staff Experience & OD Committee December 2025

Sexual Safety Charter Assurance Framework

Self-Assessment & Action Plan (Updated January 26)

1. Executive Summary:

1.1 In September 2023, the Sexual Safety Charter[1] 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[2].

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 (action incorporated into the action plan).

1.3 In December 2025, the Trust received a further letter from Glen setting out additional national actions to strengthen sexual-misconduct prevention and investigation processes. The letter introduced national specialist-training requirements for investigators, with chief people officers asked to nominate staff for the March 2026 training cohort and reinforced the need for appropriately trained responsible officers. By 2 February 2026, organisations are required to update chaperoning policies in line with new national principles, establish review groups to oversee sexual-misconduct reports, and ensure appropriate handling of cases involving resident doctors. The letter also reiterated statutory duties relating to DBS referrals, information-sharing during active police investigations.

[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: January 26
Owner: Nicola Brockie, Chief Nurse

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 the workplace. 2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or	• 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 all staff and specialist training for those who need it • 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	• sexual misconduct, its prevalence, impact and how to eradicate it, is discussed openly and appropriately within the organisation • 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	• 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 meet quarterly. The working group is support by the HON of SG/ FSG/ HR and other key members. • 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 review has been repeated and incorporated into the work underway in Dec 25. This has been triangulated with the staff survey	On track

Updated: January 26

Owner: Nicola Brockie, Chief Nurse

inappropriate sexual behaviours.	• 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	misconduct and improving safety for all staff	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: ○ 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 ○ 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.	

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			• Bystander training rolled out and available to all on the internet. Recorded locally as ESR doesn't support. **Actions planned:** • Sexual safety policy to be launched by HR (Going to TCC in March 26) • Develop and share case studies (Planned for Dec 25)	
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.	• complete equality impact assessment of sexual safety and misconduct work (including policies) • 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	• a clear understanding of the prevalence of sexual misconduct within different workforce groups • support is tailored, appropriate and effective in tackling intersectional experience of sexual misconduct	• 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. • 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.	Complete

	misconduct at a disproportionate rate		**Actions planned:** • 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. Compete and included in work.	
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.	• 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 and pathways to specialist support • 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	• 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 organisational staff support structures	Support is currently offered via the following avenues: • Website – flow chart that outlines how staff can get support. Appendix A. • line managers • Human resources • Safeguarding team • Occupational Health • 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.	On track

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5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.	• 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	• 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	• 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. **Actions planned:** • Sexual safety policy to be launched by HR (Going to TCC in March 26)	On track
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.	• 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	• 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	• 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. **Actions planned:** • Review the Chaperoning policy / training is underway. (NHSE released update in Dec 25, work through key action) • Civility policy is planned for early 26.	On track

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	• 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 • 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	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		

	chaperones in relation to sensitive examinations			
7. We will ensure appropriate, specific, and clear training is in place.	• 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	• 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	• 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. **Planned actions:** • Explore elearning now LMS is embedded	Complete
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.	• policy outlines sexual misconduct reporting mechanisms, including anonymous reporting • reporting mechanisms are widely communicated to ensure awareness • Freedom to Speak Up infrastructure and	• 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	• 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. **Actions planned:**	Complete

	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)	• disproportionate and inappropriate access of patient records is picked up earlier	• Policy remains outstanding • Ensuring FSGU training includes sexual safety training. • Explore monitoring mechanisms for monitoring staff accessing patient record inappropriately with HR.	
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.	• 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 serious and complex sexual misconduct cases,	• 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 • concerns that are initially identified as relating to clinical capability are effectively recognised and dealt with as potential sexual misconduct	The following process are in place to raise concerns: • Safeguarding & risk assessment process • Position of Trust process • Human Resources • Freedom to speak-up guardians. • Line managers • Reporting chains • FSG **Planned actions:** • Policy – ensure timeframes are incorporated. • Reporting to Board.	On track

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	with defined escalation thresholds for executive and Board review • 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			
10. We will capture and share data on prevalence and staff experience transparently.	• 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	• 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	• 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	Complete

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Status key:	5	Complete	4	On track	3	Some delay– expect to completed as planned	2	Significant delay– unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Current status (January 26)

4 actions are complete and cover the following areas of work:

- Named Executive Lead in place, supported by an established multidisciplinary working group.
- Strong Freedom to Speak Up structures embedded, including champions and anonymous feedback routes.
- Repeated reviews of sexual-misconduct incidents undertaken, triangulated with staff-survey data.
- Sustained awareness campaign delivered, including leadership visibility, stand-up events, walkabouts, induction sessions and communications.
- Bystander training rolled out and accessible to all staff.
- Clear support pathways in place through HR, safeguarding, Occupational Health, FSUG and DA/SVA leads.
- Reporting mechanisms strengthened with flowcharts and dedicated intranet pages.
- Data triangulation embedded across safeguarding, HR and FTSU processes.

6 Actions are on track and cover the following areas:

- Finalise and launch the sexual-safety policy.
- Complete and implement updates to the chaperoning policy and associated training.
- Complete the Equality Impact Assessment (EIA) for sexual-safety work.
- Develop and share case-study materials to support learning.
- Embed sexual-misconduct e-learning within the LMS for all staff.
- Strengthen monitoring processes to identify inappropriate access to electronic patient records.

Timeframe	Total Actions	Complete	On track	Minor Delay	Recovery Plan

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Sexual safety action plan (Q4 FY 25/26)	10	4	6	0	0

3.0 Additional areas in the August 2025 NHS letter

Area	Action	Work underway	Time line / Progress
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. New NHSE standards released in Dec 25. Training on LMS being uploaded and to be reviewed.	Approval of new policy by April 26 and comm's plan to be developed along side, with training package.
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	On track
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	On track
Board level assurance & complete self-assessment /	Trust Boards to assess compliance with the Sexual safety actions	Self-assessment completed. Action plan in place. SE&OD in Oct 25, Trust Board Feb 26	Complete

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Sexual safety audit	Trust to ensure the audit is completed by 1 Sept by HR teams.	Complete	Complete – closed
HR staff to undertake investigation training in Mach 26	Staff to be identified and nominated	Staff nominated.	March 26 complete

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.

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.

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Appendix A. Trust internet

Updated: January 26
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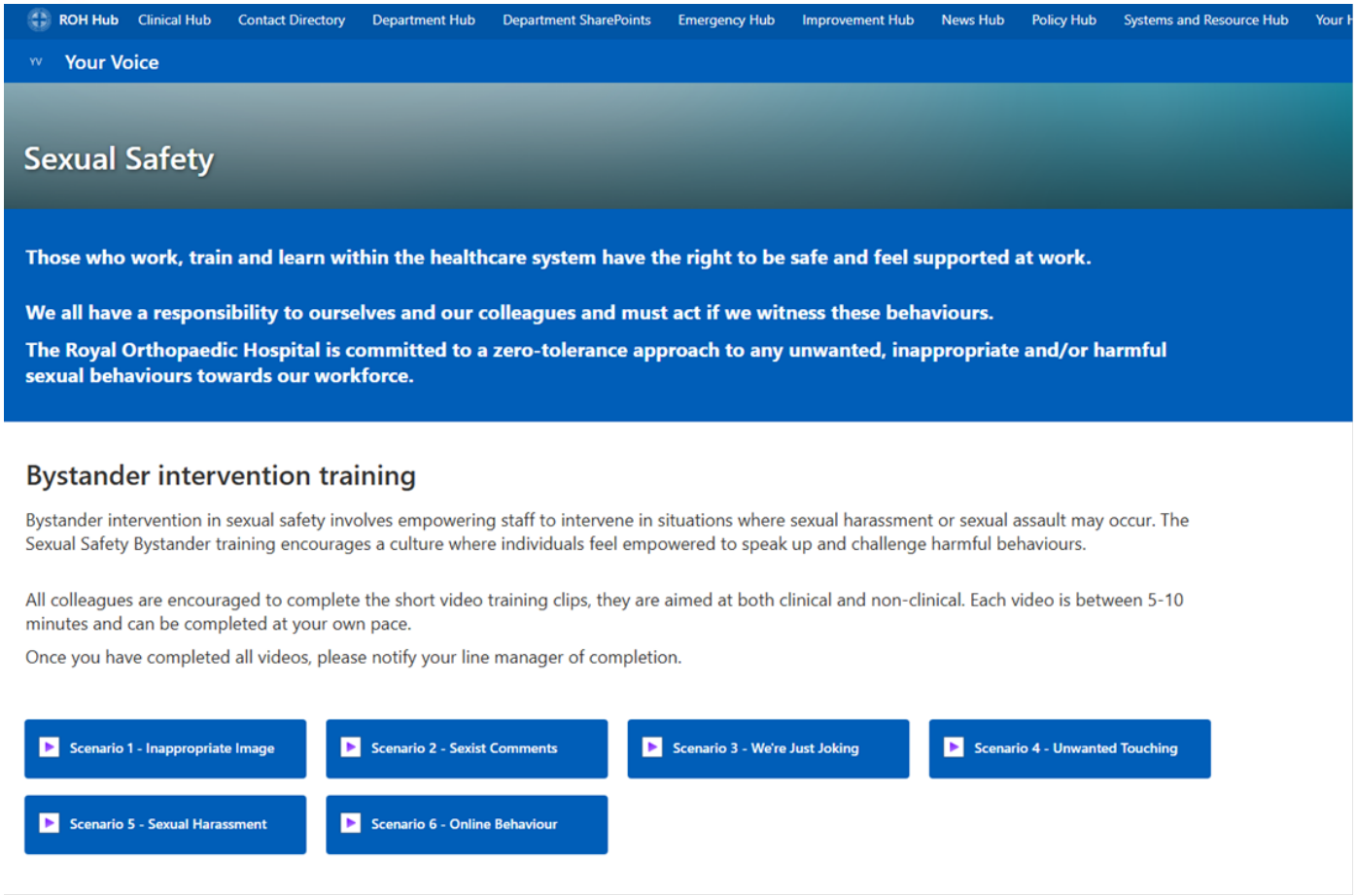

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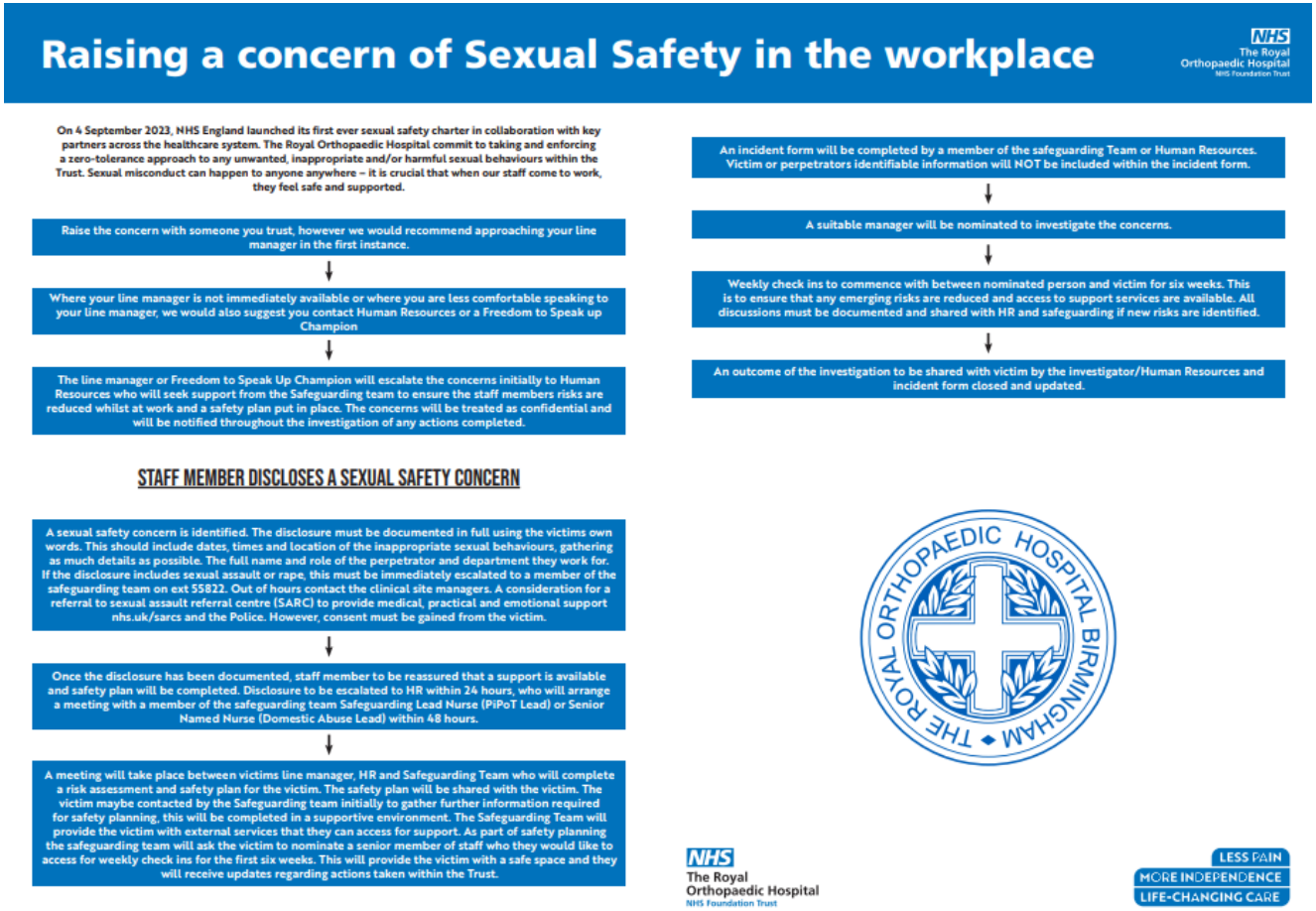
Appendix B. How to safely raise concern



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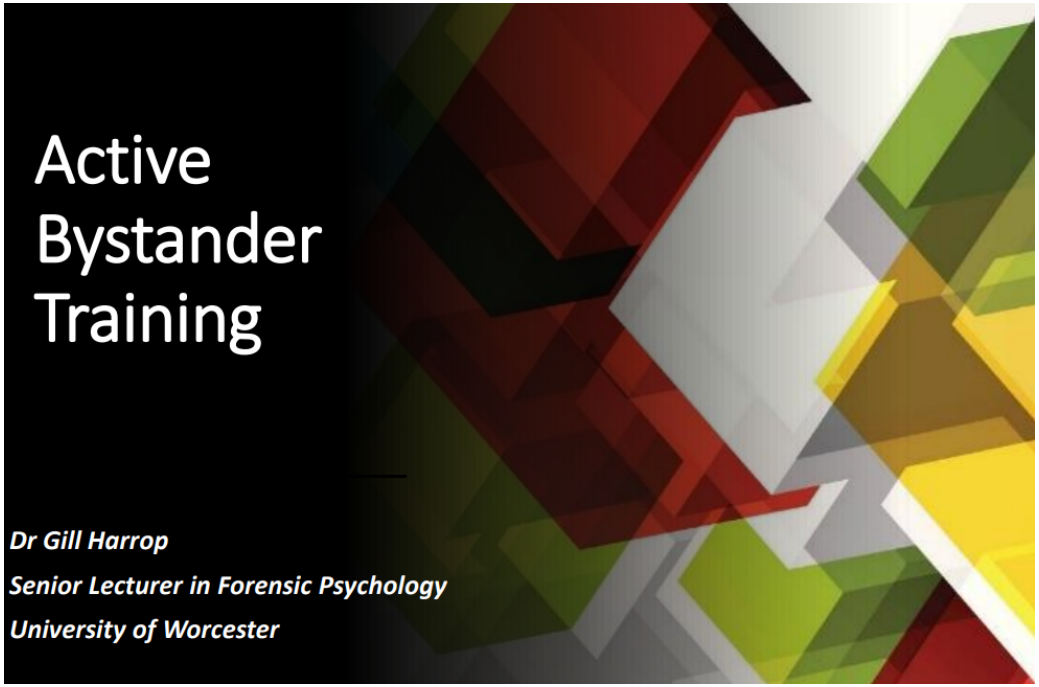
Appendix C. Bystander training



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Owner: Nicola Brockie, Chief Nurse

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Freedom To Speak Up update**
SPONSOR (EXECUTIVE DIRECTOR):	**Gianjeet Hunjan, Non-Executive Lead for FTSU** **Simon Grainger-Lloyd, Director of Governance**
AUTHOR:	**Claudette Jones, Freedom to Speak Up Guardian** **Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**4 February 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Freedom to Speak Up (FTSU) team continues to embed a culture where raising concerns is considered "business as usual'' at the Royal Orthopaedic Hospital NHSF (ROH).

75 FTSU cases have been handled by the Trust in 2025, with the predominant theme being worker safety/wellbeing.

Cases are triaged by the Guardian, with more complex issues managed as a formal caseload. This structure has improved communication, empowered staff to partner with senior leaders, and slightly increased completion rate for FTSU training modules. Furthermore, soft intelligence is shared via quarterly safety and quality reports, HR, OD and Inclusion Team, Deputy Chief People Officer, Governance, Medical Director and Deputy Chief Nurse to ensure workers feedback directly informs patient safety and service improvement.

The Trust has seen consistent improvements in its speaking-up processes, supported by initiatives such as listening sessions, teaching sessions, roadshows, and accessible resources like dedicated FTSU boxes, emails, a dedicated phone line, and the establishment of a FTSU office. These activities are strongly championed by both Executive and Non-Executive Directors for FTSU.

The visible presence of the team in their green branded attire has fostered a sense of unity, giving staff the confidence that their voices will be heard. Consequently, the Trust has seen increased engagement from a diverse range of staff, including overseas workers and minority groups across various pay bands speaking up.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• The FTSU policy has been updated in line with national guidance dated policy • A detriment document has been developed providing reassurance to staff that no-one should experience recriminations should a concern be raised and to articulate the process if this is unfortunately the case	• Part-time role restricts some activities to dedicated days of the week

• A Case Management System has been implemented in line with the recommendations of an Internal Audit into Speaking Up	

REPORT RECOMMENDATION:

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

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

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

FTSU is fully integrated into the Board Assurance Framework ensuring that cultural insights are triangulated against the Risk Register and performance metric to provide holistic view of organisational health.

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

In alignment with Birmingham and Solihull strategic objectives, the Guardian is in collaboration across the system to address bullying and harassment, also utilising resources such as our Equality & Diversity Network-led religious guidance booklet to promote an inclusive culture that mirrors the diverse population we serve.

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

The local Freedom to Speak Up data is systematically triangulated with the Model Health System to provide our organisation culture alongside national performance benchmarking.

PREVIOUS CONSIDERATION:

February 2025.

1.0 Purpose of the Report

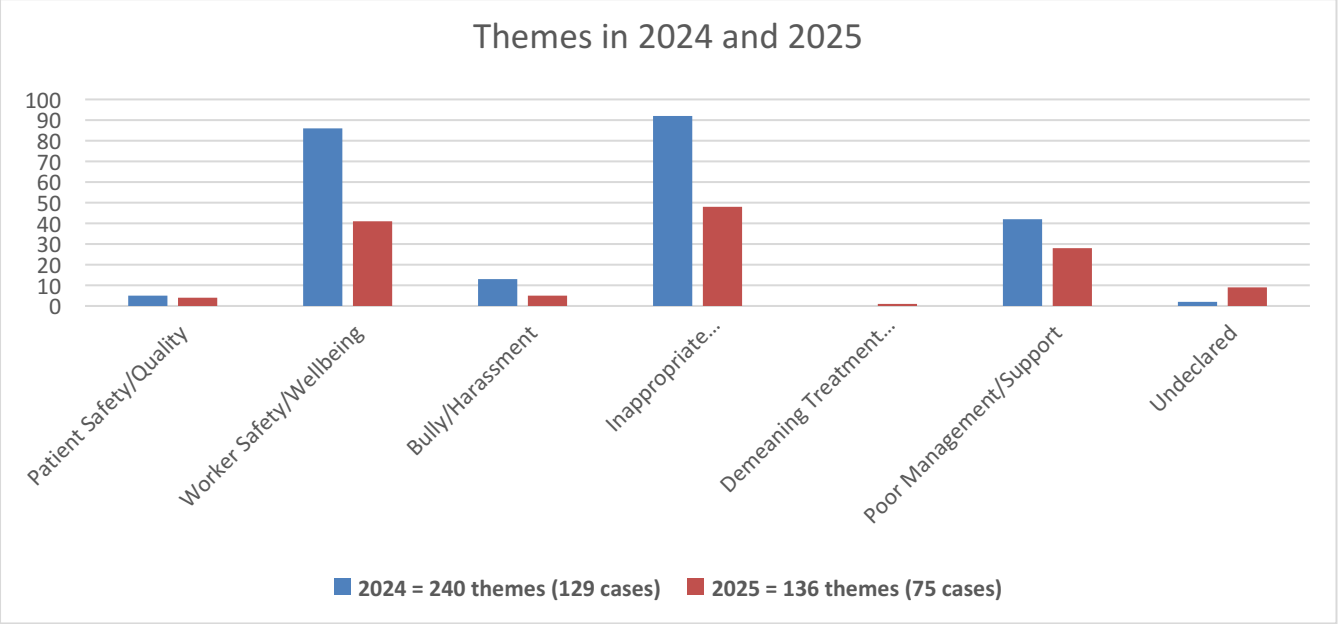
The purpose of this report is to provide the Trust Board of Directors with an overview of the cases and themes identified between January 2025 to December 2025. This report serves as a vital tool for triangulating data with other safety reports to drive organisational learning and improvement. It outlines trends captured via face-to-face contact, telephone, email and FTSU boxes, while providing an update on the implementation of the new Case Management System. Additionally, the report includes relevant internal and national updates to provide wider context for the Trust's speaking up culture.

2.0 Overview

Activity levels

The Guardian handled 75 cases in 2025. Although, this is a decrease there has been a notable increase in reporting from overseas worker and minority staff groups, reflecting the success of recent and ongoing engagement with these cohorts of staff. Unexpectedly the cases from the overseas and minority staff groups have been a lot more time consuming, which has limited the time available for the FTSUG to complete extensive walkabouts which have previously generated a number of concerns from other staff groups.

3.0 All Cases Related to (2024 – 2025)



NOTE: One case may be categorised into more than one theme if there are different components to the concern

	Patient Safety / Quality	Worker Safety / Wellbeing	Bullying / Harassment	Inappropriate Behaviours / Attitudes	Demeaning Treatment due to Speaking Up	Poor Management / Support	Undeclared
2024	5	86	13	92	0	42	2
2025	4	41	5	48	1	28	9

4.0 Key Themes

The prevailing themes during this period related to Inappropriate Attitude & Behaviour and Workers' Safety & Wellbeing. While there are currently no directly reported patient safety incidents, staff wellbeing remains a critical lead indicator of risk. Some employees have disclosed that high stress levels prevent them from performing at their full capacity, which poses a threat to patient safety. These themes are cross-referenced with HR, and Governance data to ensure a joined-up approach to organisational learning.

5.0 Case Demographic and Anonymity

During the 2025 period, the Trust received 4 anonymous concerns in 2025. These were received via the FTSU Box and from an external email. While the FTSU team encourages open dialogue, the ability to process anonymous reports ensures that all staff have a voice, regardless of their current level of confidence. Concerns have also been received from across the organisation, spanning a wide variety of banding levels. This broad engagement demonstrates that the "speaking up" message is reaching both frontline staff and management. These trends reinforce the Trust's ongoing commitment to operating an open, honest, and transparent culture where the focus remains on learning and improvement rather than blame.

6.0 National update

The National FTSU Conference in 2025 was focused on "Breaking Down Barriers and Incivility within Teams." The Trust has proactively translated these national themes into local action through several targeted initiatives with the FTSU team delivering the following:

- Addressing Incivility and Enhancing Culture - clinical outreach: targeted visit to Ward 2 to listen to staff concerns and provide high-level support within their clinical environment.
- Allyship and Bystander Awareness - facilitating pledges and awareness sessions to empower staff to act as active allies and challenge inappropriate behaviours.
- Sexual Safety – jointly with the nursing team, providing critical information and awareness regarding sexual safety to ensure a secure environment for all.
- Belonging and Networks - promoting staff networks and hosting "safe to speak" listening sessions to ensure every worker feels a sense of belonging.

The overarching improvement of this outcome is designed to create a shift to cultural accountability and the full meaning of belonging, where staff are not only protected by policy but are also active participants in maintaining a safe, respectful and supportive workplace. The significant majority of staff pledges represent commitment to cultural improvement. By committing to speak up and support one another, our team is actively dismantling barriers.

6.1 Key Points from the FTSU National Update

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

recommendations and currently maintains a part-time Band 7 Freedom to Speak Up Guardian.

- NGO have implemented a new reporting system and advised organisations to download any save data from the previous system. Following NGO guidelines, the Trust has downloaded the reports from the previous reporting platform.
- Guardians are expected to join, and attend, their regional guardian network group on a regular basis. Network meetings provide a safe space for guardians to meet their peers regularly to discuss guardian related matters such as changes to policies, procedures or recommendations on how to go about their role and receive peer support. The Guardian attends network events when possible, although due to ringfenced time, attendance at all events is not possible.
- FTSUG Training - All Freedom to Speak Up Guardians must complete the following relevant training provided by the National Guardian's Office: The Guardian is up to date with National training.
    - Foundation training - part one and part two. Part one is undertaken before registration with part two a requirement within three months of registration.
    - Annual refresher training.

7.0 Internal Update

In addition to our routine engagement activities, several key administrative and team development activities have occurred.

- Team Changes: in December, one of our valued FTSU champions stepped down from their role to enjoy retirement. We would like to express our gratitude to Jane Bevan for her valuable service. Concurrently, we have successfully recruited a new champion to maintain our support capacity across the Trust. We welcome Nattassia Graham-O'Connor.
- Policy Update: The three yearly review has been completed and is currently awaiting final review and approval. The Trust Freedom to Speak Up policy has been fully aligned with the National Guardian's Office guidance since January 2022. It is important to note that this alignment has been achieved without compromising the bespoke, high-level standards established by the Trust, ensuring our local policy remains robust and tailored to the needs of our workforce.

7.1 Champion Training and Development

The Trust currently benefits from a dedicated network of 10 FTSU Champions who provide vital signposting and peer support. The structure of this network is designed to provide adequate support. They represent various staff groups across the Trust, ensuring that the "Speaking Up" message is culturally inclusive and reaches all staff groups.

To ensure our Champions are equipped to handle complex workplace dynamics, they have completed specialised training:

- Conflict Resolution - Utilising the "Drama Triangle" framework to move from reactive to proactive problem-solving.
- Psychological Safety – Deeping the understanding of how to create safe space for dialogue.

- Sexual Safey Charter – Awareness regarding the latest update to the national sexual safety charter.

The Guardian facilitates regular team meetings to provide Champions with peer support and to coordinate the planning of awareness events and roadshows. To ensure that every worker including those on frontline clinical shifts has a voice, the FTSU service is designed for 24-hours accessibility. This includes physical and digital access to dedicated emails, telephone service and FTSU boxes. As mentioned previously, work is underway to encourage staff to also use the Case Management System.

Some champions work rotational shifts, including nights and weekends, providing out of hours visibility and immediate support for the night duty workforce.

7.2 Access and Innovation

While traditional methods: face-to-face, email and telephone contact remain the most popular, the Trust has successfully launched a new digital Case Management System for FTSU concerns. Work is ongoing to encourage staff awareness and usage of this platform.

FTSU Feedback Form: We are currently piloting a new feedback form to capture feedback from staff regarding speaking up culture. Data capture will be presented in future reports to provide deeper insight into the "speaking up" culture and staff experience once they have registered a concern.

7.3 Freedom to Speak Up National Awareness Month in October 2025:

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

7.4 Barriers to Effectiveness Resource and Capacity

Despite the successes noted above, there remains some challenge regarding the allocated time for the FTSU Guardian role. Currently, the time available presents a challenge to meet the rising demand and complexity of cases. In 2025 there has been a significant drop in the number of reported cases as there has been less time available for the Guardian to provide walkabout sessions to provide visibility and listening opportunities. Lack of time produces the following risks:

- Response delays: impacting the overall wellbeing of workers awaiting resolution.
- Perception of Care: there is a risk that staff may feel their concerns are not being taken seriously due to slower response times.

- Feedback loops: delays in consistently capturing outcome and closing the feedback loop with staff.

To address these challenges and improve the timeliness of our responses, the following measures have been introduced:

- A new structured approach with defined timelines has been implemented to ensure staff receive timely update and response – Key Performance Indicators have been included within the policy
- Champion Empowerment – we have proactively developed FTSU Champions to support and signpost staff. Direct signposting from Champions to Guardian is now being captured within the recording system.

7.5 Bullying and Harassment, Detriment due to Speaking Up and Worker Safety & Wellbeing

The Trust maintains a zero-tolerance approach to inappropriate attitudes and behaviours. Themes relating to workers safety and wellbeing, bullying and harassment, and inappropriate attitude are treated with highest priority. To ensure these issues are addressed systemically rather that in isolation, the FTSU Guardian works in close partnership with the Equality, Diversity and Inclusion (EDI) Team to ensure concerns from minority groups are handled with cultural sensitivity, and drive inclusion. Discussions are held with the HR People Partner to identify specific departments or teams requiring targeted management support or cultural interventions. The FTSU Guardian is an active member of the Trusts' relevant working groups such as, civility and respect and Schwartz working group. Serving as the Chair of the Equality and Diversity Network, the Guardian collaborates closely with the Chief Nurse in their capacity as Executive Sponsor for EDI Network. The Guardian maintains an active presence across the Trust by participating is the Minority, ABLE, Menopause, and Women's Network. Furthermore, the Guardian lead the national annual 'inclusion Week' initiative, a key event designed to foster unity and celebrate diversity across the organisation. This helps to ensure that the "staff voice" directly informs policy and behavioural standards. In addition, the FTSU service is clearly advertised across the Trust as a safe, additional channel for staff who may feel uncomfortable using traditional routes to report anything that prevents doing a good job.

A key metric of a healthy "Speak Up" culture is the absence of retaliation against those who raise concerns. For the reporting period of 2024-2025, there was just one case reported of detriment. This was reported anonymously, via the FTSU Box, so could not be followed up in the same way as usual. However, to address this on a general level, the FTSU team re-circulated the detriment information document to remind workers of the Trust commitment to as safe, professional and respectful workplace. To maintain this high standard and provide further assurance to the workforce, the FTSU Guardian would like to recommend the following:

- Management Training - completion of the national FTSU training modules, highly recommended for all managers. This ensures that they have the necessary skills and equitable approach to support workers who raise concerns.
- Cultural Assurance – through existing forums and routes to educate staff and particularly managers, on the "Listen Up" and "Follow Up" principles, so that the Trust proactively prevents negative behaviour and reinforces a supportive environment.

7.6 FTSU Staff Feedback and Impact

The effectiveness of the FTSU service is best demonstrated through the direct feedback of the staff who have used it. Recent testimonials confirm that the service provides a vital psychological safety net, directly impacting staff retention and patient safety. Workers reported that the FTSU service provides a high level of value, offering a safe space to discuss their concerns. Crucially, staff having reported feeling empowered to escalate concerns to their line manager after a consultation with the FTSU Guardian. The Guardian has started to capture this data on the reporting spread sheet and it will and, in the future, will form part of FTSU reporting update. This demonstrates that the FTSU route does not replace management structure but rather strengthens the process by giving staff the confidence to engage in difficult conversations. The Guardian often meets with staff who are in a state of significant distress, frustration, or fear. Feedback indicates a profound shift after these sessions. Staff reported a "sense of relief" and a clearer mindset, allowing them to return to their clinical duties and focus effectively on safer patient care.

Case Study 1

Two members of staff from different departments stated they had been, "fighting against a brick wall due to inappropriate attitude and behaviour from colleagues and unsatisfactory outcome" as a result they were planning to leave the Trust. Following support from the FTSU Guardian, both decided to stay and work through their challenges, directly preventing the loss of experienced clinical leaderships.

Case Study 2

The FTSU service has proven to be a lifeline for our international colleagues. One overseas worker reported experiencing severe stress and lack of support since joining the Trust, leaving them feeling isolated, without family or friends in a new country. They described the impact of the Guardian as "helped hold on to their sanity" by listening in a non-judgmental manner. After "giving up hope" and "expecting the worst", the worker stated that they felt heard and was provided with regular updates about their case outcome. This intervention helped restore their trust in the organisational support structure and their sense of belonging.

To prevent similar issues and ensure a supportive onboarding experience, the following" soft intelligence" has been identified:

- There is a need for a more joined up approach as a staff member joins the Trust.
- Line managers require clearer guidance on how to escalate and support physical safety for staff to ensure they do not feel "unsupported".

- The FTSU service provides vital psychological support to the workforce.

7.7 Equality, Diversity and Inclusion (EDI) Insights

The FTSU service plays a vital role in identifying cultural disparities that may not always be visible through formal data. During 2024-2025 the Guardian identified a perception amongst some staff that policies and concern-management processes are applied inconsistently between white and black staff members in some instances. While most concerns continue to be raised by white British female workers, there has been a significant and increase in reports from overseas staff during 2025. In 2024 51% of cases were brought from white British staff, with 49% from minority groups, but in 2025 the white British proportion dropped to 35%, with 65% of the caseload being from minority groups. It is particularly positive to note an emerging trend of allyship, where staff members have advocated for, or raised concerns on behalf of their minority ethnic colleagues. This demonstrates a growing collective responsibility for fairness across the Trust. To address these perceptions and support international workforce, the FTSU Team implemented the following:

- Increased Visibility - specific areas were targeted where disparities were perceived, providing direct support and a safe channel for staff to voice experience.
- Network Integration – overseas staff were encouraged to join the Trusts staff networks to address cultural issues and access moral support from peers with shared lived experiences.
- National Inclusion Month – as leader of the Equality and Diversity Network the Guardian organised and facilitated a Trust-wide inclusion event in September 2025, (yearly event). This was highly successful, with strong attendance from managers, senior leaders and frontline staff, who reported that the sessions were both impactful and practically useful. Staff stated that the visible outcome from this was psychological safety, reduced anxiety and a deeper sense of belonging which will positively impact staff retention.

8.0 Strategic Priorities for 2026

To build upon the progress made during 2024-2025 period and ensure the FTSU service remains sustainable, the following priorities have been identified for the upcoming year:

1. Build on the sustainable resources model to ensure the FTSU team can meet the increased demand and strengthen the follow up processes.
2. Streamline the transition to the new Case Management System to automate data collection and free up more time for face-to-face support.
3. Building on the success of National Inclusion Month and the increased engagement from overseas staff - launch a “Cultural Allyship linked in with Sexual Awareness Campaign” to strengthen staff voice, advocate for minority colleagues and address any perceived disparities in policy application.
4. Enhance the triangulation of Patient Safety reporting to identify departmental hotspots before they impact patient care.
5. Through the alliance with Robert Jones and Agnes Hunt NHSFT, aim to understand and share best practice and where possible, methods of creating resilience between the two organisations.

9.0 Conclusion

The Freedom to Speak up (FTSU) function at the Royal Orthopaedic Hospital NHS FT has evolved into a vital cultural safety asset. The service successfully transitioned from a simple reporting route to a proactive support system that directly impacts staff retention, mental wellbeing, and patient safety.

The evidence presented in this report highlights three key elements:

1. Cultural Maturity and Inclusion – the rise in concerns from overseas workers and the emerging "allyship" amongst staff, demonstrate that the Trust is successfully breaking down barriers. The high visibility of the Champion Network and the leadership of Equality and Diversity have created a safer environment for minority staff.
2. Operational Impact - the FTSU service is a proven tool for workforce retention. By providing a "safe space" for distressed staff to be supportive, the Guardian has prevented the loss of experienced senior clinical leaders and supported the mental wellbeing of international recruits who felt isolated.
3. Strategic risk – despite these successes, the current time allocation for the Guardian role is a challenge. The risks to this position have been clearly articulated in this report.

In summary, the ROH is operating an increasingly open and honest culture with few reported cases of detriment. To sustain this trajectory, the Trust must now focus on providing the necessary resources to meet the growing demand and continue the vital work of triangulating staff voices with organisational safety goals.

10.0 Recommendation to Board

The Board is asked to:

- RECEIVE and ACCEPT this report, noting the assurances within
- REVIEW and SUPPORT the proposed 2026 priorities as outlined above

Claudette Jones
Freedom to Speak Up Guardian

January 2026

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Executive Director of Governance**
AUTHOR:	**Helen Genders, Corporate Governance Lead and Executive Team**
DATE OF MEETING:	**4 February 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

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

The BAF was refreshed in 2025 to reflect the mid-term review of the Trust's strategy, including the reframed priorities.

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

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

Following consideration at the last meeting of the Audit Committee and the Quality & Safety Committee, the mitigations to address the risks associated with the 'Our Care' domain have also been strengthened, however following recent committee meetings further changes have been suggested in readiness for the next refresh.

The annual Internal Audit on the BAF and risk register process is due to start shortly, where it is anticipated that following the positive outcome in 2025, improvements made during the year will also be recognised.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Refresh aligns to the reframed strategy • Controls and mitigations and planned actions (and timescales for delivery) aligned to strategic delivery plan	• Theatre staffing risk, risk number 1694 has been aligned to SR1, SR3 and SR5 to reflect the impact this risk has on the delivery plan.

REPORT RECOMMENDATION:

The BOARD is asked to:

- RECEIVE and ACCEPT the assurances provided that the risks to the delivery of the Trust strategy have been identified, mitigated and updated where relevant.

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

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

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

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

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

Board Assurance Framework – all domains

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

Takes into account the duty to collaborate, including through System processes

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

None

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

Relevant extracts at each Committee meeting.

Board Assurance Framework (BAF): SR1 CARE - January 2026

Risk Reference: SR1 - Our Care	Strategic Risk: There is a risk that the Trust will fail to meet its objective of maintaining outstanding, high-quality care across all services and meeting the needs of our patients through continuously improving our services.	**Causes**	As a result of the Trust:- Not being able to maintain current standards of service and patient care; Not being able to optimise pathways to ensure they are seamless and patient centred; Not enabling patient-led booking via implementation of innovative digital technologies; Not having enough staff and resources; Not having a suitable physical estate or environment	**Consequence**	With the consequence of detriment to:- Patient safety, The quality of service we provide; and Our reputation and rating as a Trust.	**Improvement Targets**	• Achieve a CQC rating of Outstanding • Achieve a CQC Inpatient Survey Score of over 85% (should be broader than Inpatient only?) • Achieve the RTT target by 2027 (two years ahead of the national Elective Recovery Plan) • Reduce our hospital acquired infections to zero. • Maintain GIRFT Accreditation as a Surgical Hub	**Strategic objective:**	**CARE - By 2028, we will maintain outstanding, high-quality care across all services and improve access, experience and outcomes for our patients.**
Lead Committees	Quality & Safety Committee, SE & OD Committee, Finance & Performance Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	4		4			**October 2024**	12 (3lX4c)
Executive Lead:	Chief Nurse & Chief Operating Officer	**Likelihood**	4		1			**January 2025**	12 (3lX4c)
Initial Date of Assessment	January 2024	**Risk Rating**	16		4	TBC		**April 2025**	12 (3lX4c)
Risk appetite Statement	The Trust has a low/no tolerance to risks that have the potential to negatively impact the quality of care we provide and the safety of our patients							**August 2025**	12 (3lX4c)
								November 2025	16 (4lX4c)

KEY PRIORITY IMPROVEMENT PROGRAMMES

Continuously improve our inpatient experience through our Service Accreditation Programme
Embed seamless, connected, efficient processes and pathways in readiness for a fully integrated Electronic Patient Record
Evolve our JointCare pathway to meet the needs of our joint replacement patients, increasing the number of day case patients we treat
Mobilise a suite of meaningful outcome targets that are actively used to improve the quality of care we delivery (including PROMS, National Joint Registry - Support and Embedd clinical outcome metrics as core reporting PROMS and Patient Progress Dashboard
Optimise referral management to improve waiting times and access to our services
Digital transformation programmes to facilitate new, innovative models of care

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS for 2025-26

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

Key Action/Metric	Date for completion	Executive Lead
Deliver Phase 2 of the Service Accreditation Programme	Mar-26	Chief Nurse
Deliver high priority digital transformation schemes to support national imperitives	Mar-26	Chief Operating Officer & Chief Financial Officer
Clinical Portal fully imbeded across all services	Jul-25	Chief Financial Officer
Expand use of technology and AI (to include implementation EPR)	Mar-26	Chief Financial Officer
Align all outpatient clinic templates to GIRFT Further Faster	Mar-26	Chief Operating Officer
Approval of system wide clinical decision support tool for orthopaedics and MSK	Apr-25	Chief Operating Officer
Reduce no of missed appointments	Mar-26	Chief Operating Officer
Implement digital PIFU as standard in all appropriate pathways	Mar-26	Chief Operating Officer
Reduce inequalities for patients accessing ROH services	Mar-26	Chief Nurse

Align outpatient scheduling process to NHS Impact best practice	Jun-25	Chief Operating Officer
70% elective care appointments available by NHS App	Mar-26	Chief Operating Officer
Full adoption of Federated Data Platform	Mar-26	Chief Financial Officer
Complete EPR procurement	Dec-25	Chief Financial Officer
Deploy Electronic Prescription Service	Mar-26	Chief Financial Officer
Full integration with eRS to include Oncology	Mar-26	Chief Operating Officer
Maintain compliance with NHS Multi-Factor Authentication Policy	Mar-26	Chief Financial Officer
Implement framework for NHS action on digital inclusion	Mar-26	Chief Financial Officer
Trust-wide engagement to refine pathways ahead of EPR (EPR Readiness)	Dec-25	Chief Financial Officer
Implement new PROMS system	Dec-25	Medical Director
Delivery of 2025-26 Quality Priorities	Mar-26	Chief Nurse
Reduce to zero hospital acquired infections	Mar-26	Chief Nurse
Increased engagement and representation with patients, young people, children, transition patients and carers	Mar-26	Chief Nurse
Improved dissemination and reauditing of lessons learned and improvement, harnessing the outputs from investigations into patient safety incidents and Never Events	Mar-26	Director of Governance
Introduction of Swarm huddles into PSIRF Response Plan and introduction of Exec Level swarm discussions regarding declaration of Never Events	Mar-26	Director of Governance
Improved practices and processes regarding scanning, labelling and identification of surgical implants	Mar-26	Chief Nurse & Director of Governance
Improved oversight and escalation of patients triaged as urgent & revised clincal guidance for the triaging of urgent referrals	Mar-26	Chief Nurse & Director of Governance
Strengthening of WHO checklist process and auditing to ensure appropriate levles of communication & check and challenge	Mar-26	Chief Nurse & Director of Governance
Introduce more proactive self-assessment into the Trust's position in regards to compliance with regulatory standards (CQC, HSE, HTA)	Mar-26	Director of Governance
Strengthen processes for and education of staff to improve the reporting and investigation of non-clinical and occupational health incidents	Mar-26	Director of Governance
Delivery of National initiative to reduce waiting times - "RTT Validation Sprint - GIRFT	Mar-26	Chief Operating Officer
Theatre review in line with Trust strategic service review	Mar-26	Director

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

Aligned Clinical Risks	Target Score	Current Score
Risk 2093 - There is a risk of harm as a result of patients receiving care on an isolated single specialty site. This may be from patients developing a clinical condition outside the expertise of the clinicians on site or requiring organ support at a level above that provided on the ROH site.	5 (1Lx5C)	10 (2Lx5C)
Risk 1694 - There is a risk to service delivery due to reduced substantive staffing within Theatre department which will impact service delivery for both NHS patients and private patients.	4 (1Lx4C)	16 (4Lx4C)
Risk 2094 - There is a risk that patient care may be compromised as a result of large numbers of long waiting patients. This may manifest in reduced ability to treat within usual clinical timeframes, reduced ability to mitigate health inequalities. This may result in clinical harm, or have legal, reputational or financial impact for the Trust.	6 (2Lx3C)	12 (4Lx3C)
Risk 1918 - Risk relating to patients no longer having access to specialist speech and language assessment and support	4 (1Lx4C)	12 (3Lx4C)
Risk 1759 - risk relating to abilty to meet the national standard of having access to a senior children's nurse for advice at all times throughout the 24 hour period.	4 (1Lx4C)	4 (1Lx4C)
Risk 1467 - Risk relating to non-compliance with blood transfusion standards as a result of no Transfusion Practitioner dedicated to ROH.	5 (1Lx5C)	10 (2Lx5C)
Risk 1573 - risk relating to patient outcomes and consequent risk of harm due to ongoing backlog and increased waiting times for physiotherapy.	3 (1Lx3C)	9 (3Lx3C)
Risk 1938 (MD4) - risk of patient harm when novel techniques and devices are used in care provision, as happens in research and in service evaluation of a new technology. The cause is that all procedures and devices carry a risk of harm; in the case of new technology the level of uncertainty about the outcome is higher and there is a possibility of a cohort of patients experiencing harm before a pattern is identified. The consequences of patient harm would be clinical, reputational, and financial.	8 (2Lx4C)	12 (3Lx4C)

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

Aligned Operational Risks	Target Score	Current Score
Risk 1893 - Risk of patient harm due to delays in receiving histology results which may impact patients treatment and/or outcomes Turnaround times as described in the Service Level Agreement with UHB are not being met and result in Cancer target breaches and poor patient experience	8 (2Lx4C)	16 (4Lx4C)

Aligned Workforce Risks	Target Score	Current Score
Risk 2059 - People Priority 5: Planning	4 (1Lx4C)	8 (2Lx4C)
Risk 2057 - People Priority 3: Improving	4 (1Lx4C)	12 (3Lx4C)
Risk 2058 - People Priority 4: Engaging	6 (2Lx3C)	12 (4Lx3C)
Risk 2060 risk relating to Healthcare Support Workers job profile review	6 (2Lx3C)	9 (3Lx3C)

Aligned Estates Risks	Target Score	Current Score
Risk 770 - risk relating to aged theatre plant	4 (1Lx4C)	12 (3Lx4C)

Aligned Digital/IT Risks	Target Score	Current Score
Risk 1648 - Risk of non-delivery of Quality Improvement Projects due to problems with clinical informatics projects	3 (1Lx3C)	12 (4Lx3C)
Risk 1181 - risk relating to lack of abilty for IT systems to flag safeguarding alerts	6 (2Lx3C)	12 (4Lx3C)
Risk 1902 - There is a risk that ROH will not have EPR in place as per national requirements. There are 7 trusts which will not have an EPR in place as per the deadline of March 2026.	3 (1Lx3C)	9 3Lx3C)

Aligned Governance Risks	Target Score	Current Score
791 - risk relating to number of Trust policies overdue for review	4 (1Lx4C)	8 (2Lx4C)

Aligned Finance Risks	Target Score	Current Score
Risk No 2130 - There is a risk that the trusts financial sustainability will be adversely impacted due to the new financial payment framework and failure to deliver identified efficiencies and activity	6 (2Lx3C)	12 (4Lx3C)

Aligned risk
Estates: [1]
Digital [3]
Operational: [1]
Clinical [10]
Workforce: [4]

Finance [1]

Board Assurance Framework (BAF): SR2 EXPERTISE - January 2026

Risk Reference: SR2 - Our Expertise	Strategic Risk: OUR EXPERTISE - There is a risk that the Trust will fail to increase our influence as the leading centre for orthopaedic surgery and MSK care through our cutting-edge research and MSK Academy	**Causes**	Shortfalls in the ability to: Research and innovate, teach and train, continuously improve May have underlying cause in:- Insufficient capital and/or resource, insufficient infrastructure or resillience, insufficient agility and dynamic capability to adapt to rapid change rapidly enough to keep up with changes in the Trust's external environment	**Consequence**	Consequences include: Failure to keep pace or ahead of technological gains which would benefit patients Failure to teach and train our staff Failure to continuously improve the quality of our work or maintain and monitor standards	**Improvement Targets**	>700 participants recruited to NIHR funded studies • 200 ROH authored publications • Increased R&D income: - NIHR grants with ROH applicants = £9m - NIHR grants with ROH lead = £5m - Commercial income = £1m • Minimum of 3 Post Graduate qualifications (level 6/7) developed in partnership with Birmingham higher education institutions	**Strategic objective:**	**OUR EXPERTISE - Innovate, improve, research and teach - By 2028, we will have increased our influence as the leading centre for orthopaedic surgery and MSK care through our cutting-edge research and MSK Academy**
Lead Committees	SE & OD Committee, Finance & Performance Committee, Quality & Safety Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	3		3			**October 2024**	9 (3Lx3C)
Executive Lead:	Medical Director	**Likelihood**	3		2			**January 2025**	9 (3Lx3C)
Initial Date of Assessment	Jan-24	**Risk Rating**	9		6	TBC		**April 2025**	9 (3Lx3C)
Risk appetite Statement	The Trust has a higher level of tolerance to risks that involve innovation and service improvement which would enable us to grow and expand our expertise and our reputation as a specialist provider of orthopaedic care. The Trust needs to be brave and at the forefront of change. This has to be balanced with a no/low tolerance of risk to patient harm.							**August 2025**	9 (3Lx3C)
								November 2025	9 (3Lx3C)

PRIORITY IMPROVEMENT PROGRAMMES

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

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS for 2025-26

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

Key Action/Metric	Date for completion	Executive Lead
Maintain GIRFT accreditation (complete and maintained for 2025)	Jul-25	Chief Operating Officer
Obtain Imaging national service accreditation (QSI)	Mar-26	Chief Operating Officer
Deliver year 1 objectives for MSK Academy	Mar-26	Medical Director
Increased patient participation in research	Mar-26	Medical Director
Increased ROH authored publications	Mar-26	Medical Director

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

Aligned Clinical Risks	Target Score	Current Score
Risk 1938 - risk of patient harm when novel techniques and devices are used in care provision, as happens in research and in service evaluation of a new technology. The cause is that all procedures and devices carry a risk of harm; in the case of new technology the level of uncertainty about the outcome is higher and there is a possibility of a cohort of patients experiencing harm before a pattern is identified. The consequences of patient harm would be clinical, reputational, and financial.	8 (2LX4C)	12 (3LX4C)
Risk 2094 - There is a risk that patients may come to harm as a result of their long wait if there is insuficient capacity to deliver the work required in the context of mutual aid. The wait may be due to intrinsic factors within the Trust or the Trust may inherit a risk transferred from other providers as part of mutual aid arrangements. This could result in a reputational and legal impact for the Trust and negatively impact our major revision centre and surgical elective hub accrediations.	6 (2LX3C)	12 (4LX3C)

Aligned Operational Risks	Target Score	Current Score
Risk 2146 There is a ris that the Trust will not meet its speciality targets in Spinal services due to the size of the local, regional and national backlog. This is due to growth in demand and gaps in the workforce.	8 (2LX4C)	12 (3LX4C)

Aligned Workforce Risks	Target Score	Current Score
Risk 2057 - People Priority 3: Improving	4 (1LX4C)	12 (3LX4C)

Aligned Finance Risks	Target Score	Current Score
Risk 2130 - financial sustainability	6 (2LX3C)	12 (4LX3C)

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

Board Assurance Framework (BAF): SR3 - PEOPLE - January 2026

Risk Reference: SR3 - Our People	Strategic Risk: OUR PEOPLE - There is a risk that the Trust will fail to meet its objective of being rated 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	**Causes**	As a result of the Trust:- Having difficulties in recruiting and retaining staff at both a trust/local level and is also impacted upon by the difficulties the NHS is experiencing with recruitment and retention at a national level.	**Consequence**	With the consequence of detriment of:- The culture within the Trust and also potential impact on our abilty to deliver large aspects of the Trust's Strategy (for example our ability to provide outstanding care, our ability to continue to provide our current level of service, our abilty to expand and innovate, our inability to addres health inequalities within our region and our ability to collaborate and contribute to wider system work.	**Improvement Targets**	• Reduce MSK and mental health related sickness absence by below 4% • Turnover rate <10.5% • Establishment >90% • Improve WRES/WDES scores on annual basis • Reduce the gender pay gap	**Strategic objective:**	**OUR PEOPLE - Rated as among the best NHS hospitals to work for by our team - By 2028, we will be rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey, recognising our commitment towards inclusivity and wellbeing for all**
Lead Committees	SE & OD Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	5		5			**October 2024**	20 (4Lx5C)
Executive Lead:	Chief People Officer	**Likelihood**	4		2			**January 2025**	20 (4Lx5C)
Initial Date of Assessment	Jan-24	**Risk Rating**	20		10	TBC		**April 2025**	20 (4Lx5C)
Risk appetite Statement	The Trust has a low tolerance for risks relating to our people and the recruitment and retention of staff, as being able to attract and retain staff is absolutely essential to not only our abilty to achieve our stategic objectives but also to our continued day to day delivery of services and care.							**August 2025**	20 (4Lx5C)
								November 2025	20 (4Lx5C)

Priority Improvement Programmes

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

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS for 2025-26

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

Key Action/Metric	Date for completion	Executive Lead
Implement Me as Manager programme	Mar-26	Chief People Officer
Embed Race Equality Code	Mar-26	Chief People Officer
Reduce Gender Pay Gap	Jan-26	Chief People Officer
Implement all domains of the People Promise Programme by April 2026	Mar-26	Chief People Officer
Refresh inclusive workforce approach	Mar-26	Chief People Officer
Implement high performing teams framework	Mar-26	Chief People Officer
Advanced Clinical Practitioner oversight	Mar-26	Chief Nurse
Enhanced occupational physiotherapy provision for staff	Dec-26	Chief People Officer
Achieve close to 100% planned core capacity before accessing premium capacity	Mar-26	All
Reduction in agency spend	Mar-26	All
Reduction in bank spend	Mar-26	All
Reduce corporate function spend to April 2022 levels	Sep-25	Chief People Officer

Reduce voluntary turnover with a key focus on first year leavers. Percentage of NHS Trust staff to leave in the last 12 months	Mar-26	Chief People Officer
Reduce sickness absence rate	Mar-26	Chief People Officer
Increase staff engagement score in Staff Survey	Mar-26	Chief People Officer
National Education and Training Survey Satisfaction rate	Mar-26	Chief People Officer
Improvement Huddles running in 100% of teams	Dec-26	Strategy Director

Corporate Risk Register Risks aligned to BAF Risk SR3 - Our People

Aligned Workforce Risks	Target Score	Current Score
Risk 2059 - People Priority 5: Planning	4 (1Lx4C)	8 (2Lx4C)
Risk 2057 - People Priority 3: Improving	4 (2Lx2C)	12 (3Lx4C)
Risk 27 - Additional unplanned expenditure due to inability to control the use of unfunded medical temporary/agency staffing.	4 (1Lx4C)	8 (2Lx4C)
Risk 2058 - People Priority 4: Engaging	6 (2Lx3C)	12 (4Lx3C)
Risk 2060 - Healthcare Support Worker job profile review	6 (2LX3C)	9 (3Lx3C)

Aligned Finance Risks	Target Score	Current Score
Risk 2130 - financial sustainability	6 (2Lx3C)	12 (3Lx4C)

Aligned Clinical Risks	Target Score	Current Score
Risk 1694 There is a risk to service delivery due to reduced substantive staffing within Theatre department which will impact service delivery for both NHS patients and private patients.	4 (1Lx4C)	16 (4Lx4C)

Aligned risk
Estates: [0]
Digital [0]
Operational: [0]
Clinical [1]
Workforce: [5]
Finance [1]
Governance [0]

Board Assurance Framework (BAF): SR4 - COMMUNITY - January 2026

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

Priority Improvement Programmes

Support the development of neighbourhood health models and community care collaboratives
Deliver our Health Inequalities action plan, including greater visibility of data
Deliver our three-year Health Promotion and Prevention Plan, using our orthopaedic and MSK expertise to build tools and develop services for our partners and communities
Deliver a rolling programme of Community Appointment Days and Community Roadshows to provide condition and community specific MSK advice & signposting
Embed engagement and co-production into our services to ensure people help design and deliver the services they need
Utilise digital technology to optimise how patients access ROH services (Clinical Decision Support, Self-Management, AI, Triage)

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS for 2025-26

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

Key Action/Metric	Delivery Date	Executive Lead
Expand ROH services available in BSOL localities through neighbourhood health service model, through an agreed workforce model for BSOL MSK and orthopaedics	Mar-26	Chief Operating Officer & Strategy Director
Deliver Year 1 of the new health promotion and prevention plan (including MSK roadshow, Health Hacks)	Mar-26	Chief Operating Officer & Strategy Director
Delivery of Phase 1 MSK programme with options shared at system acute provider collaborative for consideration	Dec-25	Chief Operating Officer

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

Aligned Clinical Risks	Target Score	Current Score
Risk 2095 - There is a risk that patients may come to harm within the Trusts referral and treatment pathways as a result of inequities of access based on protected characteristics. Patients failing to access or having reduced access to the care they need due to patient, cultural, social, politcal, structural, process or bias factors.	6 (2Lx3C)	9 (3Lx3C)

Aligned Workforce Risks	Target Score	Current Score
Risk 2059 People Priority 5: Planning	4 (1Lx4C)	8 (2Lx4C)

Aligned Finance Risks	Target Score	Current Score
Risk 2130 - Financial sustainability	6 (2Lx3C)	12 (3Lx4C)

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

Board Assurance Framework (BAF): SR5 - SUSTAINABILITY - January 2026

Risk Reference: SR5 - Our Sustainability	Strategic Risk: There is a risk that the Trust will fail to meet its objective to: By 2028, the ROH will be financially sustainable, having increased the number of people we treat through continuously improving our processes, standardising pathways and improving productivity	**Causes**	As a result of the Trust:- current financial sustanability and productivity levels; breakdown of aged theatre plant/estates; increased costs associated with staffing and retention levels; mutual aid and collaborative work within the BSOL system to ease waiting list pressure; increased demand for services via health inequality work plans; the risk of breaches of our cyber security defences; further financial controls imposed by NHS E and/or BSOL ICB due to current national and system financial positions.	**Consequence**	With the consequence of detriment to:- increased restrictions on ability to make strategic and operational management decisions independantly; further financial controls; detrimental impact on the achievement of the 6 strategic priorities, reputational damage; and enhanced internal and external reporting and governance requirements; an increase in patient safety incidents; as well as financial and reputational loss and poor compliance with national targets.	**Improvement Targets**	• Achieve financial break-even position on recurrent basis • Achieve annual activity plan (aspiring to 18k patients treated each year by 2028) • Achieve Private Patient annual growth target	**Strategic objective:**	**OUR SUSTAINABILITY - Efficient, effective and sustainable- By 2028, the ROH will be financially sustainable, having increased the number of people we treat through continuously improving our processes, standardising pathways and improving productivity**
Lead Committees	Finance & Performance Committee, Quality & Safety Committee & Trust Board	**Risk Rating**	**Current Risk Score**		**Target Risk Score**	**RISK ASSURANCE RATING**		**RISK HISTORY**	
		Consequence	5		5			**October 2024**	N/A
Executive Lead:	Chief Operating Officer	**Likelihood**	3		1			**January 2025**	N/A
Initial Date of Assessment	Jan-24	**Risk Rating**	15		5	TBC		**April 2025**	15(3L x 5C)
Risk appetite Statement	The Trust has a low tolernance for this risk due to the potential negative impact on our activity levels, the quality of our patient care and the potential impact on the autonomy to make operational and strategic decisions in regards to the current and future management of the Trust.							**August 2025**	15(3L x 5C)
								November 2025	15(3L x 5C)

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

SUMMARY OF KEY PLANNED MITIGATIONS & ACTIONS for 2025-26

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

Key Action/Metric	Delivery Date	Executive Lead
Implementation of nurse led pre-operative pathway	Mar-26	Chief Nurse, Chief Operating Officer, Medical Director
Optimise medicine and prescribing value	Mar-26	Chief Nurse
Optimise energy value	Mar-26	Chief Finance Officer
Variance year to date to financial plan	Mar-26	Chief Finance Officer
5% cost improvement target across all budgets	Mar-26	All
Deliver total efficiencies of 6.5% (£9.453m)	Mar-26	All
Deliver NHS commissioned income levels in line with 2025/2026 agreed funding gap	Mar-26	Chief Operating Officer
Implementation of new pre-operative pathway	Mar-26	Chief Nurse, Chief Operating Officer, Medical Director
Reduce number of early finishes in Theatres	Mar-26	Chief Operating Officer
Commission dedicated day case pathway and bed modelling to deliver overall day case performance, including joint replacements.	Mar-26	Chief Operating Officer, Chief Nurse
Commission dedicated day case pathway and bed modelling to deliver overall day case performance, including joint replacements.	Mar-26	Chief Nurse, Chief Operating Officer, Medical Director

95% of individuals job planned - NHS IMPACT action plan	Apr-25	Chief Operating Officer, Medical Director
Reduction in LLP spend	Mar-26	Chief Operating Officer
Theatre tray rationalisation	Feb-25	Chief Operating Officer
Commercialisation of Private patients aligned to ring-fenced theatre capacity - complete August 2025	Mar-26	Chief Operating Officer
Repatriation of orthopaedic activity from the Independent Sector	Mar-26	Chief Operating Officer
Generate new commercial income opportunities	Mar-26	Chief Operating Officer, Medical Director, Strategy Director
Transition of BCH services (initial scoping underway)	Mar-26	Chief Operating Officer
Future proofing theatre estate (1,2,4)	Mar-26	Chief Finance Officer

Corporate Risk Register Risks aligned to BAF Risk SR5 - Sustainability

Aligned Clinical Risks	Target Score	Current Score
Risk 2093- If a patient develops a clinical condition that is outside the scope or level of organ system support they need, there may be harm as a result of delay or a ceiling on the care offered at the ROH site. The impact will be clinical and may be financial, reputational, and legal.	5 (1Lx5C)	10 (2Lx5C)
Risk 1694 There is a risk to service delivery due to reduced substantive staffing within Theatre department which will impact service delivery for both NHS patients and private patients.	4 (1Lx4C)	16 (4Lx4C)
Risk 27 - Additional unplanned expenditure due to inability to control the use of unfunded medical temporary/agency staffing.	4 (1Lx4C)	8 (2Lx4C)
Risk 1759 - risk relating to abilty to meet the national standard of having access to a senior children's nurse for advice at all times throughout the 24 hour period.	4 (1Lx4C)	4 (1Lx4C)
Risk 1938 - risk of patient harm when novel techniques and devices are used in care provision, as happens in research and in service evaluation of a new technology. The cause is that all procedures and devices carry a risk of harm; in the case of new technology the level of uncertainty about the outcome is higher and there is a possibility of a cohort of patients experiencing harm before a pattern is identified. The consequences of patient harm would be clinical, reputational, and financial.	8 (2Lx4C)	12 (3Lx4C)
Risk 2094- There is a risk that patient care may be compromised as a result of large numbers of long waiting patients (eg via system mutual aid). This may manifest in reduced ability to treat within usual clinical timeframes, reduced ability to mitigate health inequalities. This may result in clinical harm, or have legal, reputational or financial impact for the Trust.	6 (2Lx3C)	12 (4Lx3C)

Aligned Operational Risks	Target Score	Current Score
Risk 1573 - risk relating to patient outcomes and consequent risk of harm due to ongoing backlog and increased waiting times for physiotherapy.	3 (1Lx3C)	9 (3Lx3C)
Risk 1893 - Risk of patient harm due to delays in receiving histology results which may impact patients treatment and/or outcomes Turnaround times as described in the Service Level Agreement with UHB are not being met and result in Cancer target breaches and poor patient experience	8 (2Lx4C)	16 (4Lx4C)

Aligned Workforce Risks	Target Score	Current Score
Risk 2059 - People Priority 5: Planning	4 (1Lx4C)	8 (2Lx4C)
Risk 2057 - People Priority 3: Improving	4 (2Lx2C)	12 (3Lx4C)
Risk 2058 - People Priority 4: Engaging	6 (2Lx3C)	12 (4Lx3C)

Aligned Estates Risks	Target Score	Current Score
Risk 770 - risk relating to aged theatre plant	4 (1Lx4C)	12 (4Lx3C)

Aligned Digital/IT Risks	Target Score	Current Score
1298 - cyber security risk	4 (1Lx4C)	12 (3Lx4C)
Risk 1181 - risk realting to lack of abilty for IT systems to flag safeguarding alerts	6 (2Lx3C)	12 (4Lx3C)
Risk 1902 - There is a risk that ROH will not have EPR in place as per national requirements. There are 7 trusts which will not have an EPR in place as per the deadline of March 2026.	3 (1Lx3C)	9 (3Lx3C)

Aligned Governance Risks	Target Score	Current Score
791 - risk relating to number of Trust policies overdue for review	4 (1Lx4C)	8 (2Lx4C)

Aligned Finance Risks	Target Score	Current Score
Risk 2130 - financial sustainability.	6 (2Lx3C)	12 (4Lx3C)

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

Board Assurance Framework (BAF): SR6 - COLLABORATION - January 2026

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

Priority Improvement Programmes

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

SUMMARY OF PLANNED MITIGATIONS & ACTIONS for 2025-26

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

Key Action/Metric	Delivery Date	Executive Lead
Expand ROH services available in BSOL localities through Neighbourhood Health Service Model through an agreed workforce model for BSOL MSK & Orthopaedics	Mar-26	Chief Operating Officer, Strategy Director
Review of demand and capacity requirements for orthopaedics and spinal services across BSOL	Mar-26	Chief Operating Officer
Deliver year 1 of the new Health Promotion & Prevention Plan (including MSK Roadshow, Health Hacks)	Mar-26	Chief Operating Officer, Strategy Director
Secure minimum 3 formal Strategic Partnerships (Healthcare, Industry, Academia)	Mar-26	Chief Executive, Strategy Director
Develop and implement a Mutual Aid Strategy	Mar-26	Chief Operating Officer

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

Aligned Clinical Risks	Target Score	Current Score
Risk 2093 - There is a risk of harm as a result of patients receiving care on an isolated single specialty site. This may be from patients developing a clinical condition outside the expertise of the clinicians on site or requiring organ support at a level above that provided on the ROH site. This may result in delays in treatment or a ceiling of care. The impact would be clinical, financial, reputational and legal.	5 (1Lx5C)	10 (2Lx5C)
Risk 2094 - There is a risk that patient care may be compromised as a result of large numbers of long waiting patients. This may manifest in reduced ability to treat within usual clinical timeframes, reduced ability to mitigate health inequalities. This may result in clinical harm, or have legal, reputational or financial impact for the Trust.	6 (2Lx3C)	12 (4Lx3C)

Aligned Estates Risks	Target Score	Current Score
Risk 770 - Theatres' engineering plant is beyond its normal life expectancy.	4 (1Lx4C)	12 (4Lx3C)

Aligned Finance Risks	Target Score	Current Score
Risk 2130 - financial sustainability	6 (2Lx3C)	12 (3Lx4C)

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

ROHTB (2/26) 018 / 018 (a)

TRUST BOARD

DOCUMENT TITLE:	**Learning From Deaths Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Revell – Executive Medical Director**
AUTHOR:	**Author:** **John Va Faye – Associate Medical Director** **Contributors:** **Adam Roberts – Assistant Director of Governance & Risk** **Hayley Phillips – Information Manager** **Sally Breecher – Clinical Governance Lead**
DATE OF MEETING:	**4 February 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This report provides assurance to AQILA and the Quality & Safety Committee on mortality management at The Royal Orthopaedic Hospital NHS Trust over the rolling 12-month period October 2024 to September 2025, and demonstrates active alignment with national NHS safety, frailty and system-integration priorities.

The Trust continues to operate with low absolute mortality, with a 12-month rolling total of 26 deaths within 30 days of surgery compared with 25 in the preceding period and 22–23 earlier in the year; Health Evaluation Data indicators remain within expected limits, though with an upward trend that is being monitored and explored in line with national patient-safety expectations.

The report comprises quantitative analysis, qualitative case-based review, a thematic Learning from Deaths analysis and a coronial summary, providing a rounded view of both outcomes and learning.

Taken together, these sections confirm that deaths predominantly reflect increasing age, co-morbidity and frailty within the case-mix, rather than lapses in clinical care, and that the Trust's governance processes are functioning as intended under PSIRF and Just Culture.

In line with NHS and Integrated Care System priorities on ageing well, prevention of harm and high-reliability urgent and elective care, the Trust is focusing improvement on three areas: optimising frail and multi-morbid patients before surgery, strengthening peri-operative risk management (including anticoagulation and sepsis documentation) and improving interface working at discharge and across regional pathways.

A new pre-operative / complex-patient MDT, integrated with the HDU team on a daily basis, will support consistent thresholds for operative selection, pre-optimisation and escalation decisions, directly supporting ICS ambitions to "deliver integration for people", "be there across the life course" and "protect people from harm".

The work described in this report also contributes to national NHS priorities on patient experience and workforce culture by reinforcing transparent mortality review, strong family communication around end-of-life care, and learning-focused, non-blaming governance.

Overall, the picture is of a specialist Trust delivering safe, skilled and compassionate care to a high-risk population, with targeted actions in place to strengthen system reliability in step with wider NHS and ICS strategies and surveillance of a potential numerical rise in deaths.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
LfDRP provides multidisciplinary check-and-challenge, supporting consistent judgement and avoidability scoring. Cause-of-death coding remains broadly stable with no single novel category dominating.	Rolling 12-month total has increased to 26; suggestion of an upward trend has prompted fuller qualitative analysis. Increase appears driven largely by T&O volume in this interval; ensure triangulation with case-mix, frailty, discharge interface and peri-operative risk themes. Small numbers can mask themes highlighting the need for detailed reviews with our small numbers. Similarly, a small number of months at 4 deaths can cumulatively drive an apparent rolling increase but does not assist greatly identifying special cause (e.g., frailty pathway).

REPORT RECOMMENDATION:

The Committee is asked to: check and challenge -accept for assurance

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

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

Comments:

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

Care	x	Community	
Expertise	x	Services	x
People	x	Collaboration	

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

Our expertise

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

Deliver integration for people
Be there across the life course

Protect people from harm Build, develop and retain a great, inclusive workforce Contribute to the wider determinants of health
BENCHMARKING SOURCE (Indicate data sources included in report IF APPLICABLE):
Other stand-alone orthopaedic Trusts. Though noted that there is little data available from RNOH on the HED system
PREVIOUS CONSIDERATION (Indicate board/committee/group & date):
Regular report to AQILA and Board through Q&S

Introduction

The Learning from Deaths Review Panel (LfDRP) provides multidisciplinary check-and-challenge of Structured Judgement Reviews (SJRs) and related PSIRF investigations, supporting consistency of avoidability scoring and ensuring learning is surfaced and actioned. It reports to the Audit Quality Improvement Learning and Analysis (AQILA) group.

AQILA receives reports and supports by triangulating mortality learning with broader divisional governance themes (e.g., frailty, peri-operative risk, discharge interface, escalation practice).

A Thematic Review of LfDRP output has been undertaken and summary included later in this report to supplement the regular Quantitative and Qualitative analysis from the group. A summary of coronial cases is also included.

Quantitative Analysis

Rolling 12-month mortality by treatment function (Oct 2024 – Sep 2025)

The Trust continues to operate with a low absolute mortality, and we appear to be operating around our recent historical base of approximately 25 annual deaths within 30 days of surgery, based on a 12 monthly rolling average. However, the rolling 12-month total has increased to 26 deaths, compared with 25 in the immediately preceding rolling period and 22–23 earlier in the year. Health Evaluation Data indicators currently are all within expected limits but with the suggestion of an upward trend.

Table 1 Deaths over the period by Treatment Function

Treatment Function	Deaths	Commentary
Trauma & Orthopaedics	16	Higher contribution in this rolling interval; warrants focused review of case mix and themes.
Clinical Oncology	7	Lower than earlier periods; consistent with expected variation in advanced disease cohorts.
Spinal Surgery	2	Small-number fluctuation but notable change from 1 to 2 in the latest window.
General Medicine	0	Unchanged.
Physiotherapy Service	1	Stable; rare event in context of complex comorbidity.
TOTAL	**26**	Very slight increased compared with earlier rolling totals.

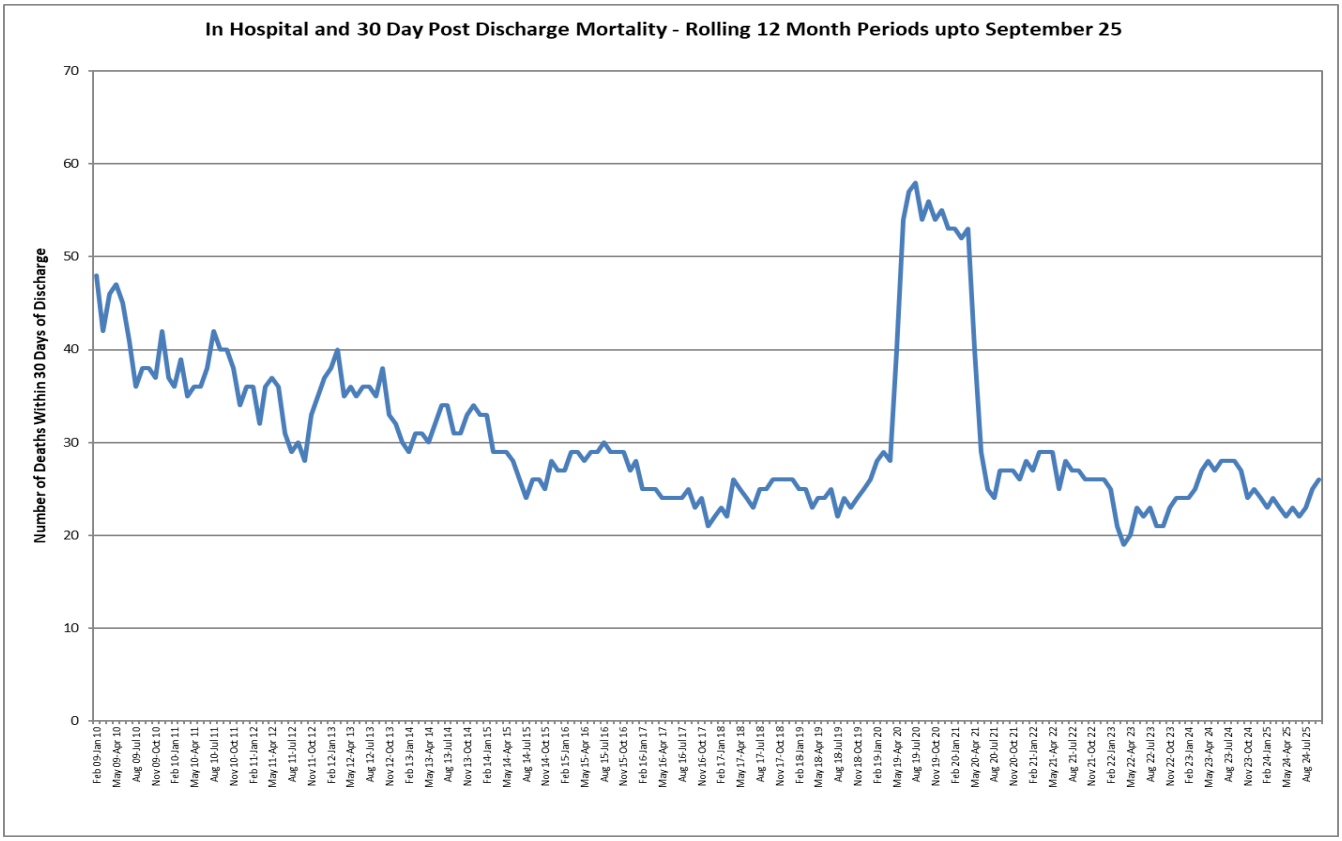


Figure 1 12 month rolling avergage of deaths within 30 days

Cause of death profile (ONS-coded)

Broadly stable distribution, including:

- **Malignancy** (lung, bone/connective tissue, unknown primary, prostate)
- **Cardiac disease** (AMI, chronic ischaemic disease, atherosclerotic heart disease)
- **Respiratory/systemic** (pneumonia; bronchiectasis)
- **Neurological/frailty contexts** (cerebral infarction; cerebral palsy)
- **COVID-19** (single coded case)
- A small number coded under procedural/device complications (still low volume; requires case-level triangulation rather than inference from coding alone)

Further detail

The full report to AQILA is included as an appendix.

Qualitative (Case) Analysis

Learning From Deaths Reviews

Case 1

Overview

This patient underwent an elective primary uncemented total hip replacement following appropriate pre-operative assessment. The procedure and immediate post-operative course were uncomplicated, with early mobilisation and discharge on post-operative day one supported by ROCS follow-up.

Quality of care

Observations and post-operative investigations were stable, pain was well controlled, and community reviews documented good functional recovery, an intact wound and no cardiorespiratory symptoms. Safety-netting advice regarding infection, venous thromboembolism and deterioration was clearly provided and reinforced.

Outcome and avoidability

The patient died a short interval after discharge; review found no evidence of omissions in peri-operative, inpatient or early post-discharge care that would reasonably be considered contributory to the death. The death was therefore judged unlikely to have been prevented by different care at ROH.

Learning

Learning from this case lies in reinforcing existing good practice around robust pre-assessment, structured community follow-up and explicit safety-netting, rather than in specific system changes.

Case 2

Overview

An 88-year-old man, functionally independent and cognitively intact with low frailty, underwent an elective complex uncemented total hip replacement. Surgery was technically successful and initially uncomplicated.

Quality of care

Pre-operative assessment appropriately identified comorbidities, functional status and operative risk, with documented informed consent. Post-operatively, hypercapnic (type 2) respiratory failure was recognised early, escalation to HDU and MET/CCOT occurred without delay, and decision-making was senior-led, proportionate and clearly documented, including treatment-escalation planning and family involvement. When the patient's ongoing needs exceeded the remit of an elective orthopaedic centre, timely transfer to an acute medical trust was arranged.

Outcome and avoidability

The patient died several weeks later at the receiving trust from hospital-acquired pneumonia on a background of cardiac disease. Review concluded there was no evidence of delay, omission or inappropriate decision-making during the ROH admission, and that the death was not avoidable through changes to care delivered at ROH.

Learning

Key learning relates to the value of early recognition and escalation of post-operative medical deterioration in older patients, and to clear inter-trust pathways when needs exceed ROH's scope. The case supports continued emphasis on senior-led multidisciplinary decision-making, capacity assessment and family communication in complex deteriorations.

Case 3

Overview

An 85-year-old woman underwent an elective right total knee replacement, with care delivered in line with national standards. Surgery and immediate recovery were uncomplicated, with stable observations, good wound healing and early mobilisation.

Quality of care

The patient completed guideline-recommended apixaban prophylaxis and was reviewed after discharge with documented good functional progress. No signs of infection or venous thromboembolism were identified during the recognised post-arthroplasty risk period.

Outcome and avoidability

She died from a pulmonary embolism five months after surgery. There were no identified care problems or omissions at ROH, and no evidence that the orthopaedic episode contributed to her death; it was therefore judged unlikely that different care at ROH would have altered the outcome.

Learning

The case reinforces the importance of clear documentation of VTE risk assessment, prophylaxis and follow-up, particularly when deaths occur outside typical risk windows.

Case 4

Overview

This patient underwent revision total hip replacement for recurrent dislocation, followed by rehabilitation in a care-home setting. Initial post-operative progress was satisfactory, with appropriate MDT review and community wound assessment.

Quality of care

When wound deterioration was identified by the care home, escalation back to ROH was timely, with urgent review, readmission, senior assessment and operative washout alongside HDU-level support. Coroner's review later confirmed that Trust care was appropriate and responsive, and commended the quality of the Trust's investigation and evidence.

Outcome and avoidability

Despite appropriate intervention, the patient deteriorated due to infection on a background of significant frailty and physiological vulnerability and subsequently died. The inquest concluded that earlier intervention would not have altered the outcome and that the death resulted from recognised complications, so the death was not considered avoidable through changes to ROH care.

Learning

Learning focuses on strengthening cross-boundary communication and wound-surveillance pathways between ROH and external care providers, building on already robust internal escalation processes.

Case 5

Overview

An 81-year-old woman with significant frailty and multiple long-term conditions underwent a complex elective revision knee replacement. Early post-operative recovery appeared stable, with clear documentation, appropriate monitoring and effective pain control.

Quality of care

When acute pneumonitic respiratory failure developed around one week post-operatively, escalation was timely with Sepsis Six actions, CCOT involvement and senior medical review.

ROHTB (2/26) 018 (a)
Goals-of-care discussions with the family led to a well-documented DNACPR and comfort-focused plan when it became clear that deterioration was not reversible.

Outcome and avoidability
Despite maximal supportive treatment, respiratory failure progressed and the patient died; the process was clinically consistent with an inflammatory pneumonitis rather than aspiration, pulmonary embolism, cardiac failure or anaesthetic complication. No shortcomings in care were identified that were felt likely to have contributed to her deterioration, and the death was judged unlikely to have been prevented by different care at ROH.

Learning
Learning points include considering earlier respiratory input in complex cases and further sharpening documentation of anticoagulation rationale and fluid decisions, which are being reinforced via QIDD and Resident Doctors' Forum.

Case 6

Overview
A 52-year-old man with disseminated metastatic renal cell carcinoma was admitted with structural failure of a femoral endoprosthesis requiring specialist revision for palliative stability. The decision to operate was clearly aligned with his goals of care and fully documented.

Quality of care
The technically demanding revision proximal femoral replacement was completed safely with adherence to infection-prevention and VTE protocols. As his systemic disease progressed, deterioration was recognised promptly, escalation actions were appropriate, and care was smoothly redirected towards comfort in partnership with his family, with good symptom control and dignified end-of-life care.

Outcome and avoidability
Death resulted from predictable progression of advanced malignancy rather than from the surgical intervention itself. There were no care delivery problems or system failures judged likely to have altered this outcome.

Learning
The case illustrates the Trust's role in providing high-quality palliative surgical care, highlighting the importance of clear documentation of operative intent and early planning for transition to end-of-life care where appropriate.

Case 7

Overview
This case concerns a patient who underwent elective lower-limb arthroplasty at ROH and initially experienced an uncomplicated peri-operative course in line with national standards. Surgery, immediate recovery and early follow-up showed stable observations, good wound healing, early mobilisation and no clinical features of venous thromboembolism within the recognised post-operative risk window.

Quality of care
Pre-operative assessment, anaesthetic and surgical management were appropriate, and VTE prophylaxis was prescribed in accordance with guideline recommendations. Post-discharge, the patient was reviewed with documented good functional progress and no signs of infection or cardiorespiratory compromise during routine follow-up.

ROHTB (2/26) 018 (a)

Outcome and avoidability

The patient died from a pulmonary embolism several months after surgery, outside the usual timeframe in which arthroplasty-related VTE is typically observed. The review identified no care-delivery problems or omissions at ROH and found no evidence that the orthopaedic episode contributed to the events leading to death; different care at ROH was therefore unlikely to have altered the outcome.

Learning

The case highlights the importance of clear documentation of peri-operative VTE risk assessment, prophylaxis decisions and post-arthroplasty follow-up when deaths occur at a distance from surgery. It also reinforces the need to maintain robust safety-netting advice for patients and primary care regarding new thrombotic symptoms after the immediate post-operative period.

Case 8

Overview

This 75-year-old woman underwent an elective right total knee replacement with an entirely uneventful peri-operative course. She had stable observations, early mobilisation and no post-operative complications during her inpatient stay.

Quality of care

Discharge planning was safe and well structured, including appropriate medicines reconciliation, correct VTE prophylaxis and clear written and verbal safety-netting advice. Both ROCS and outpatient follow-up documented normal recovery, with no symptoms suggestive of thrombosis or other surgical sequelae during the recognised post-arthroplasty risk period.

Outcome and avoidability

Her subsequent death from a pulmonary embolism occurred almost five months after surgery, well beyond the timeframe typically associated with arthroplasty-related VTE. The review found no care-delivery problems, no contributory factors and no evidence that the ROH admission played any role in the events leading to her death, so different care at ROH was considered unlikely to have prevented this outcome.

Learning

Learning from this case centres on reinforcing comprehensive documentation of VTE risk, duration of prophylaxis and advice given at discharge, particularly in older patients. It also supports continued emphasis on clear communication with patients and primary care about when to seek urgent assessment for new cardiorespiratory or thrombotic symptoms after joint replacement.

Thematic Review

Overview

The thematic review draws together findings from completed Structured Judgement Reviews, coronial outcomes and Learning from Deaths Panel discussions, with a focus on system-level learning rather than individual attribution. The panel was satisfied that care in the cases reviewed generally met expected standards, that deaths were best explained by underlying frailty, multimorbidity or advanced malignancy, and that appropriate actions have been identified where system issues were detected; no new significant risks requiring immediate escalation were identified.

Across the cohort, patients typically had advanced cancer, extreme frailty or complex long-term conditions, and mortality patterns aligned with this inherent risk profile and the Trust's role in delivering major surgery, including palliative or symptom-directed procedures. Technical surgical and anaesthetic care was consistently rated Good–Excellent, and deaths were not judged attributable to poor clinical practice at ROH.

The Learning from Deaths process itself is functioning well, with a mature, transparent governance culture that routinely revisits avoidability ratings, triangulates with PSIRF investigations, coroners and complaints, and commissions further review where needed. Learning has been deliberately framed around improving system reliability and support for staff, in line with PSIRF and Just Culture principles.

Key themes

1. Frailty and comorbidity as primary mortality drivers

Across cases, age-related frailty, advanced malignancy, immunosuppression, anaemia and cardiovascular and respiratory disease overwhelmingly dictated outcomes. This reinforces the need for continued emphasis on robust frailty assessment, optimisation of long-term conditions and realistic shared decision-making at the point of referral and consent.

2. Strong technical care; system reliability to refine

Operative and peri-operative care were appropriate across the reviewed cohort, but several opportunities to strengthen system reliability were identified. These included ensuring consistent access to key equipment (e.g. pressure-relieving surfaces, ABG analysers), improving clarity and completeness of documentation, and further refining interface working with partner organisations.

3. Anticoagulation and GI-bleed risk as an emerging coronial theme

A small but recurrent coronial theme relates to use of apixaban for VTE prophylaxis in frail arthroplasty patients, subsequent upper GI bleeding in external hospitals and inconsistent gastroprotection. This has been escalated to Pharmacy and the Trust VTE Committee, who are reviewing the role of routine PPI co-prescription and developing a GI-bleed risk decision aid to support more consistent practice.

4. Sepsis management clinically sound; documentation to sharpen

Clinical management of sepsis was timely and appropriate, with escalation and treatment generally in line with expectations. However, documentation did not always clearly record when a fluid bolus was not indicated and why, or make explicit the reasoning behind antibiotic timing; critical care outreach, QIDD and the Resident Doctors' Forum are continuing to address this through education and feedback.

5. High-quality palliative surgical care

Several deaths followed operations undertaken for symptom relief, bleeding control or stabilisation in metastatic disease, where the primary goal was quality of life rather than cure. In

these cases, communication with patients and families, clarity of surgical intent and timely transition to end-of-life care were repeatedly of a high standard, demonstrating strong practice in palliative surgical care.

6. Interfaces with regional pathways

Some issues arose at the interfaces with regional oncology and metastatic spinal cord compression pathways, external respiratory services, safeguarding in rare adolescent deaths and hospice capacity. These largely reflect wider system pressures rather than ROH-specific failings, but they underline the importance of continued engagement with ICS partners to improve timeliness and coordination across organisational boundaries.

7. Documentation standards and framing of intent

Reviews identified variable recording of frailty scores, operative intent (curative vs palliative), anticoagulation rationale, expected trajectory at discharge and safety-netting advice. Standardising these elements will support coronial defensibility, internal learning and staff confidence, and is being reinforced through QIDD, specialty governance and the Resident Doctors' Forum.

8. Governance culture and use of the LfD process

The panel felt it had demonstrated robust challenge and re-evaluation of avoidability, proactive commissioning of SJRs beyond regulatory minimums, and alignment with PSIRF and Just Culture. Multidisciplinary discussion and learning capture were cohesive, indicating a developing high-reliability culture around mortality review.

Summary

Overall, the thematic review supports assurance that clinical care at ROH is safe, skilled and compassionate, with deaths reflecting complex case-mix rather than systemic lapses in care. The main opportunities are in strengthening anticoagulation strategy, sepsis documentation, frailty and intent framing, and pathway interfaces, with targeted actions already underway through Pharmacy/VTE governance, critical care outreach and wider ICS engagement.

Coronial Review

Case 1 – Inquest 18 November 2025

Background

The deceased underwent revision surgery on 8 January 2025 to repair recurrent dislocations of a historic left hip replacement and was discharged to a nursing home for rehabilitation. Wound oozing was documented by 28 January and a gaping wound identified on 3 February, prompting readmission to ROH and a limited washout procedure on 5 February, during which she deteriorated, likely due to a "septic shower", and died on 7 February 2025.

Medical cause of death and conclusion

The coroner delivered a narrative conclusion that death was the consequence of complications from the washout procedure on 5 February 2025 against a background of prosthetic joint infection. The coroner was satisfied that wound deterioration had been escalated in a timely manner, that admission and washout were appropriate, and commended the Trust's investigation and expert evidence.

Learning

Key learning relates to strengthening expectations and documentation around wound surveillance and escalation in external care settings, and to the value of robust internal investigation reports in supporting coronial scrutiny.

Case 2 – Inquest 28 October 2025

Background

The deceased had chronically infected hip and knee joints managed conservatively for more than five years, with no plan to replace metalwork because of frailty, comorbidities and her wishes. She was being worked up for minor surgery to remove an eroding patella resurfacing prosthesis, but this was delayed for echocardiography and later cancelled at her request; she was then admitted to Heartlands Hospital with suspected chest infection/sepsis and died on 10 June 2024.

Medical cause of death and conclusion

The provisional medical examiner's cause of death had placed joint infection directly in the causal chain. After hearing evidence from the ROH and UHB clinicians, the coroner accepted the following formal medical cause of death:

- 1a Sepsis
- 1b Pneumonia
- 2 Chronic infected prosthetic hip and knee joints, heart failure, atrial fibrillation

This reflected joint infection and cardiac disease as contributory factors rather than direct causes, and the coroner recorded a short-form conclusion of natural causes.

Learning

The case underlines the need for early dialogue between clinicians and medical examiners in complex cases and for clear documentation of treatment intent and comorbidity burden when managing chronic prosthetic infection in frail patients.

Case 3 – Inquest 24 November 2025

Background

Following a right neck of femur fracture in October 2023 and failed healing after surgery at Heartlands, the deceased experienced persistent pain and further complications. After extensive consultation and consent, she underwent elective surgery at ROH on 19 June 2025 to repair the

non-union and relieve pain but suffered a severe reaction during insertion of a cemented femoral component consistent with bone cement implantation syndrome and died the same day.

Medical cause of death and conclusion

The coroner confirmed the medical cause of death as:

- 1a Multisystem failure
- 1b Bone Cement Implantation Syndrome
- 2 Frailty of old age, neck of femur fracture non-union (operated)

A narrative conclusion was returned that the deceased died from recognised complications of elective surgery.

Learning

Learning focuses on clear pre-operative explanation and documentation of the rare but serious risk of bone cement implantation syndrome in frail patients, and on maintaining robust intra-operative monitoring and rapid response protocols.

Case 4 – Inquest in writing

Background

The patient, with severe frailty and multiple comorbidities, was admitted on 20 August 2025 for total hip replacement to improve chronic pain from severe arthritis. Surgery at ROH was technically successful, but she deteriorated post-operatively and was transferred to Queen Elizabeth Hospital ITU on 23 August, where she died later that day.

Medical cause of death and conclusion

The written Record of Inquest documented the medical cause of death as:

- 1a Ischaemic bowel
- 1b Aortic arch thrombus
- II Interstitial lung disease, type 2 diabetes, chronic kidney disease, total hip replacement (operated)

The coroner concluded that the patient died of natural causes.

Learning

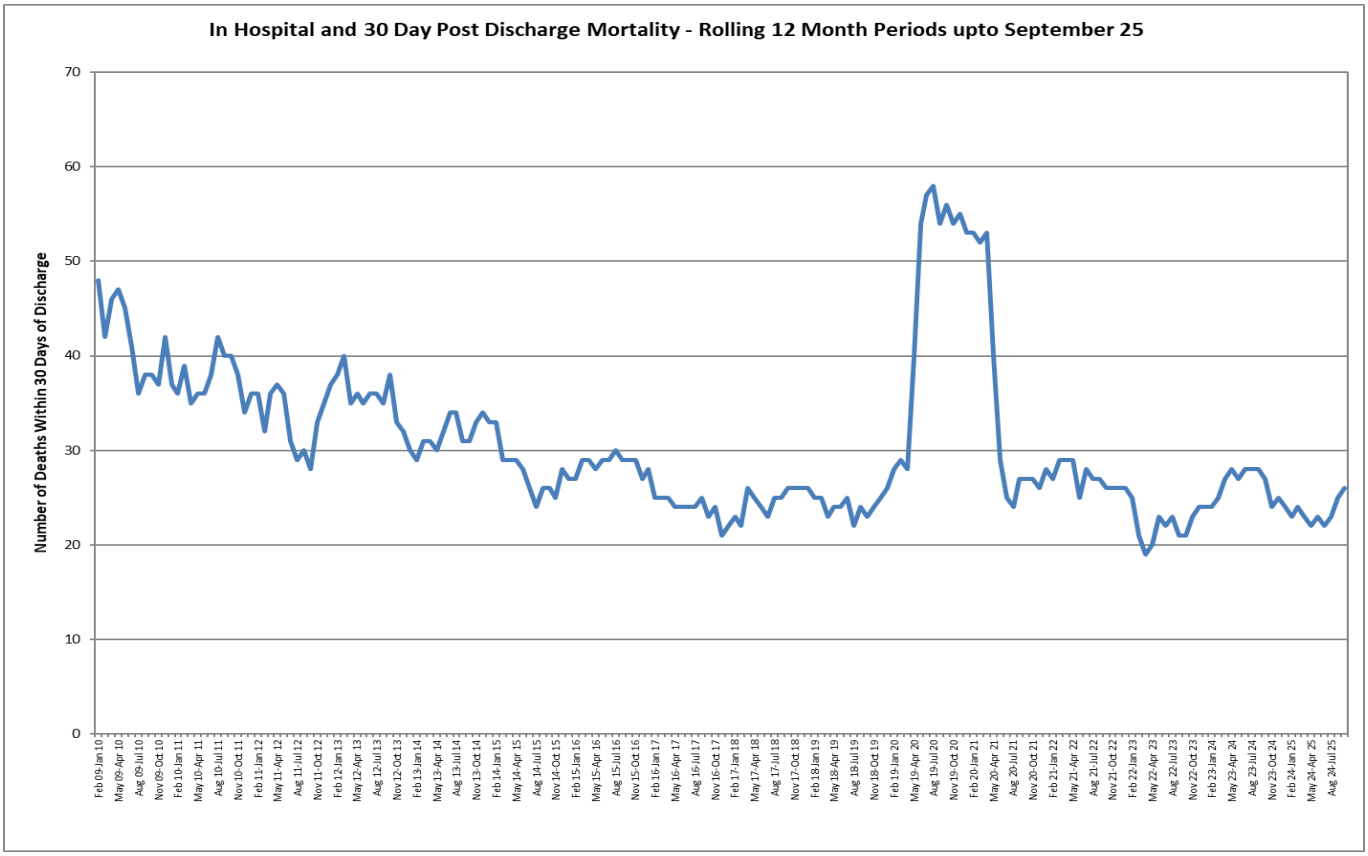
This case reinforces the importance of comprehensive pre-operative risk assessment and communication in severely frail, multi-morbid patients and of precise documentation of comorbidities and peri-operative risk to support both internal learning and coronial review.

Appendix- Data Detail Received by AQILA to sept 2025

Mortality

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

Treatment Function	Nov 23-Oct 24	Dec 23-Nov 24	Jan 24-Dec 24	Feb 24-Jan 25	Mar 24-Feb 25	Apr 24-Mar 25	May 24-Apr 25	Jun 24-May 25	Jul 24-Jun 25	Aug 24-Jul 25	Sep 24-Aug 25	Oct 24-Sep 25
T&O	11	14	14	13	14	12	12	13	13	14	15	16
Spinal Surgery	2	1	1	1	1	1	1	0	0	0	1	2
General Medicine	0	0	0	0	0	0	0	0	0	0	0	0
Clinical Oncology	11	10	9	9	9	10	9	9	8	8	8	7
Physiotherapy Service	0	0	0	0	0	0	0	1	1	1	1	1
TOTAL	**24**	**25**	**24**	**23**	**24**	**23**	**22**	**23**	**22**	**23**	**25**	**26**



30 Day Mortality by Month Oct 24 – Sep 25

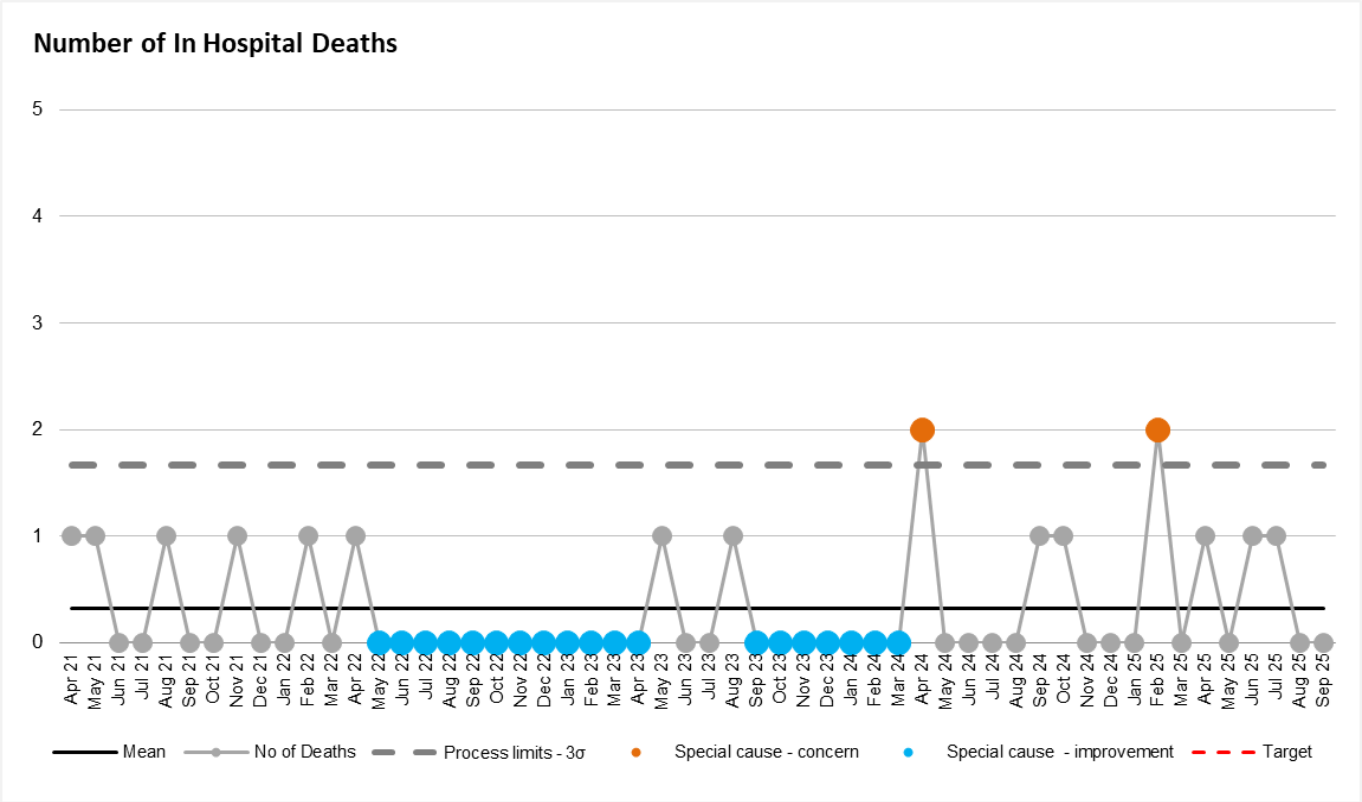
	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Deaths In Hospital	1				2		1		1	1		
1-7 Days from discharge		1				1		1			3	1
8-30 Days from discharge		3	1	1		1	1	2	1	1	1	1
Total	**1**	**4**	**1**	**1**	**2**	**2**	**2**	**3**	**2**	**2**	**4**	**2**

ROHTB (2/26) 018 (a)

Cause of Death (ICD10 Diagnosis Code – Oct 24 – Sept 25

Cause of death is taken from the death certificate in the ONS data, additional information relating to the table can be provided if required.

Mortality Outcome	CCS Code	Cause of Death Description	Total
DEATHS IN HOSPITAL	**237 - Complication of device; implant or graft**	Bronchiectasis	1
		Exposure to unspecified factor	1
		N/A	1
	42 - Secondary malignancies	Malignant neoplasm of kidney, except renal pelvis	1
		Malignant neoplasm: Bronchus or lung, unspecified	1
	21 - Cancer of bone and connective tissue	Malignant neoplasm: Connective and soft tissue, unspecified	1
1-7 DAYS	**203 - Osteoarthritis**	Acute myocardial infarction, unspecified	1
		N/A	1
	238 - Complications of surgical procedures or medical care	Pneumonia, unspecified	1
	205 - Spondylosis; intervertebral disc disorders; other back problems	Chronic ischaemic heart disease, unspecified	1
	237 - Complication of device; implant or graft	Acute myocardial infarction, unspecified	1
	42 - Secondary malignancies	Malignant neoplasm of prostate	1
	95 - Other nervous system disorders	Multiple myeloma	1
8-30 DAYS	**203 - Osteoarthritis**	Atherosclerotic heart disease	1
		Coxarthrosis, unspecified	1
	238 - Complications of surgical procedures or medical care	Malignant neoplasm of prostate	1
		N/A	1
	237 - Complication of device; implant or graft	Vascular disorder of intestine, unspecified	1
	42 - Secondary malignancies	Malignant neoplasm: Bronchus or lung, unspecified	1
	44 - Neoplasms of unspecified nature or uncertain behavior	Cerebral infarction, unspecified	1
		Covid	1
		Malignant neoplasm, primary site unknown, so stated	1
	21 - Cancer of bone and connective tissue	Malignant neoplasm, unspecified	1
		Malignant neoplasm: Long bones of lower limb	1
		Malignant neoplasm: Pelvic bones, sacrum and coccyx	1
	82 - Paralysis	Cerebral palsy, unspecified	1
Grand Total			**26**


Number of In Hospital Deaths
5
4
3
2
1
0
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
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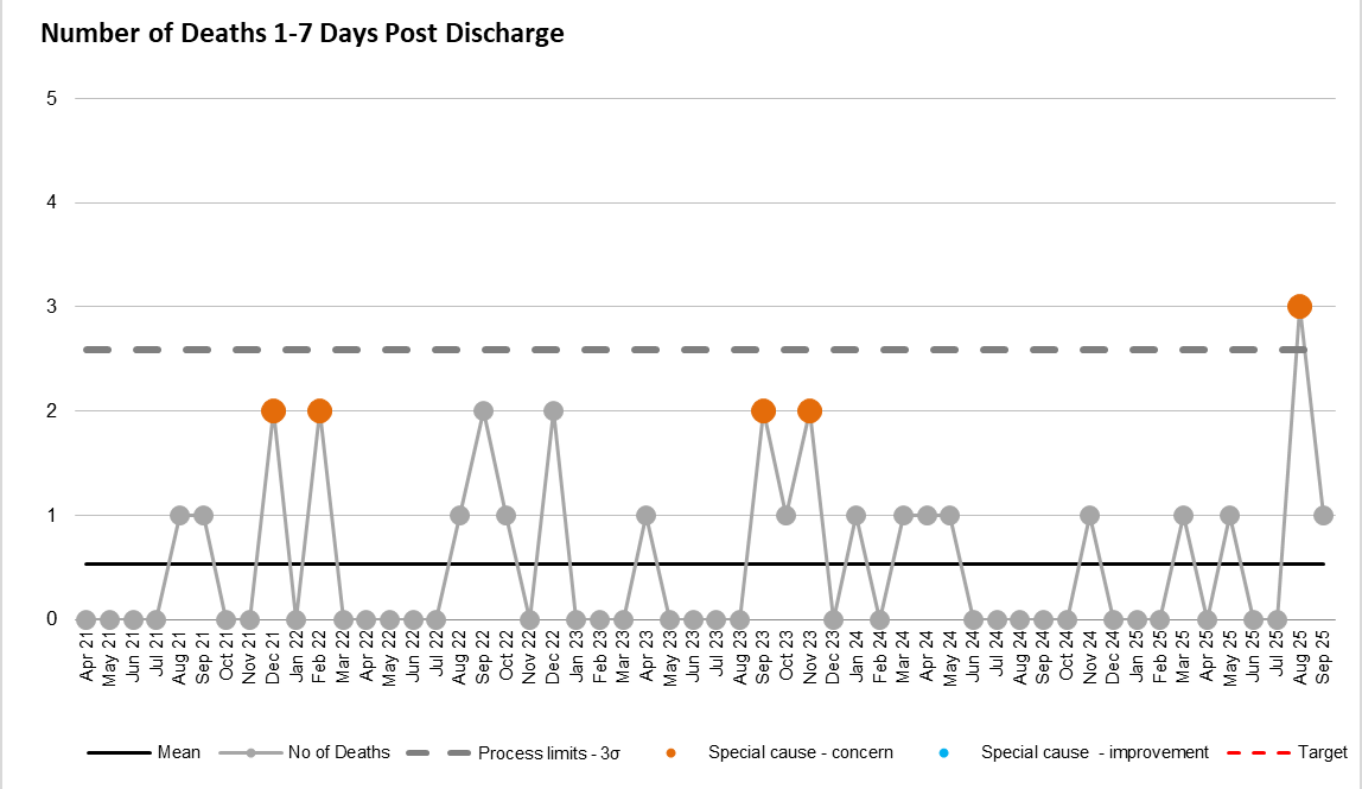
Jul 24
Aug 24
Sep 24
Oct 24
Nov 24
Dec 24
Jan 25
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Mean
No of Deaths
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


Number of Deaths 1-7 Days Post Discharge
5
4
3
2
1
0
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
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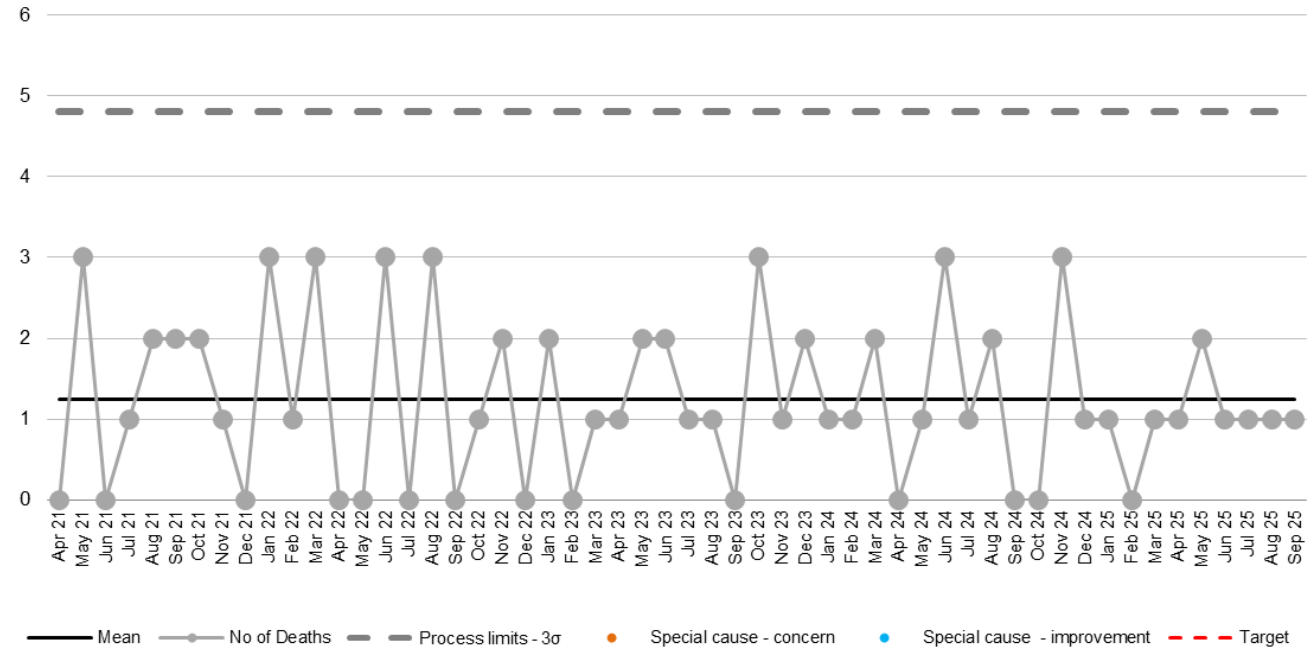
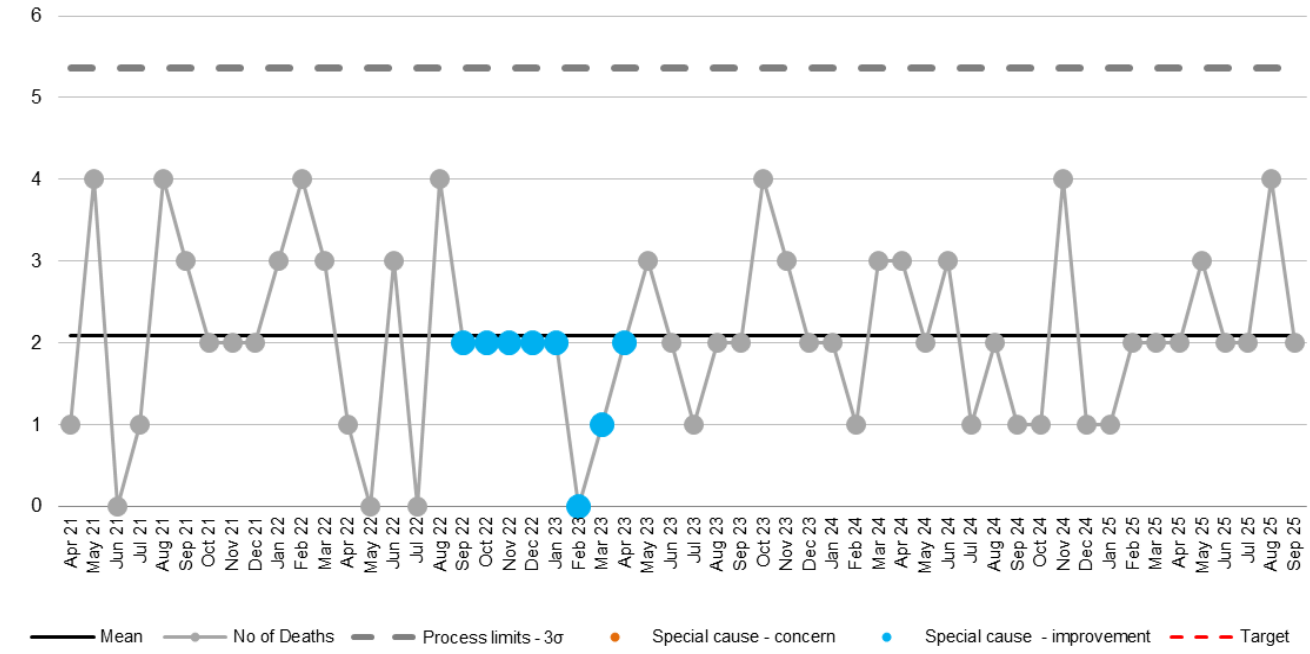
Feb 25
Mar 25
Apr 25
May 25
Jun 25
Jul 25
Aug 25
Sep 25
Mean
No of Deaths
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Number of Deaths 8-30 Days Post Discharge

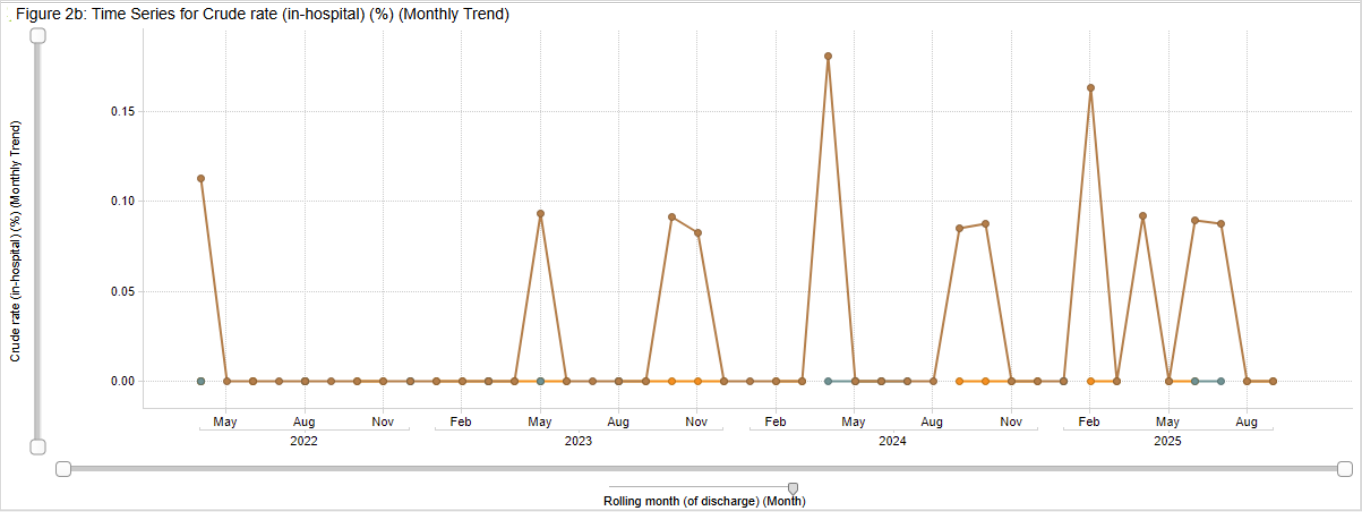


Number of Deaths Within 30 Days Discharge (Including In Hospital Deaths)



Comparison of Mortality Data between Royal Orthopaedic Hospital, Royal National Orthopaedic Hospital and Robert Jones and Agnes Hunt Orthopaedic Hospital

April 22 – September 25
Crude In-Hospital Death Rate (number of in hospital deaths in period/number of discharges in period) by month

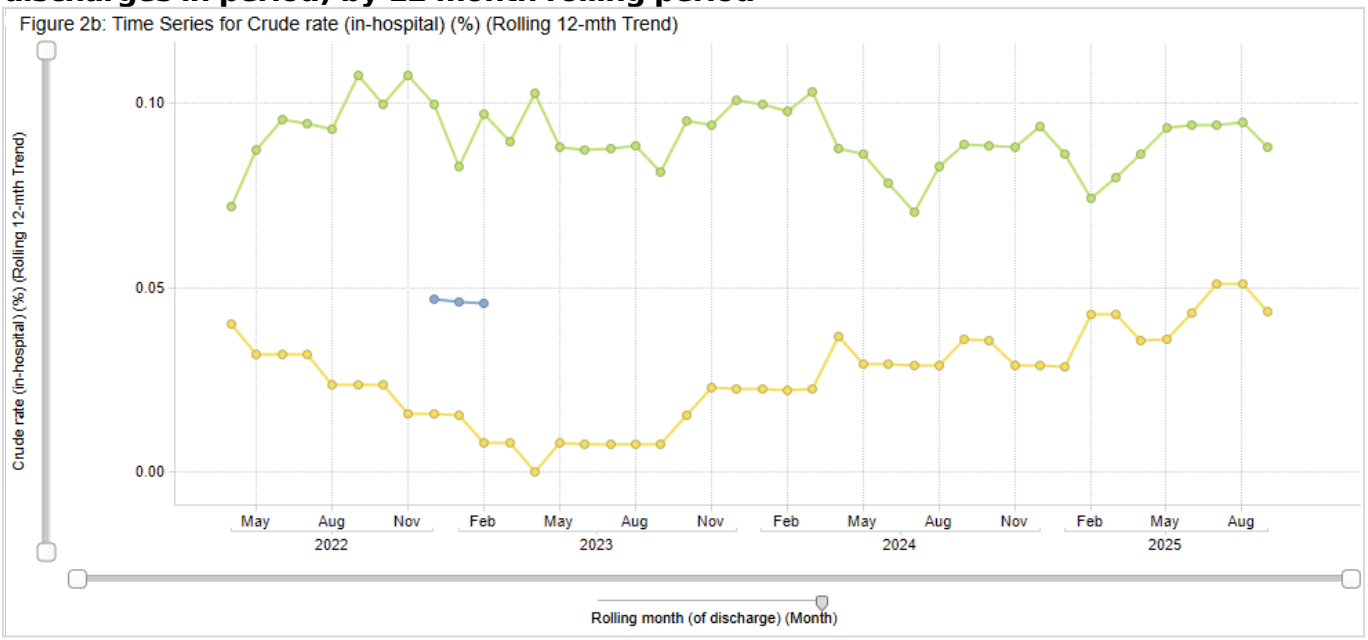


Data table:
Time Series

Color by:
(Column Names) » Organisation (provider)

- Crude rate (in-hospital) (%) (Monthly Trend) » RAN - ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST
- Crude rate (in-hospital) (%) (Monthly Trend) » RL1 - THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
- Crude rate (in-hospital) (%) (Monthly Trend) » RRJ - THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

Crude In-Hospital Death Rate (number of in hospital deaths in period/number of discharges in period) by 12 month rolling period

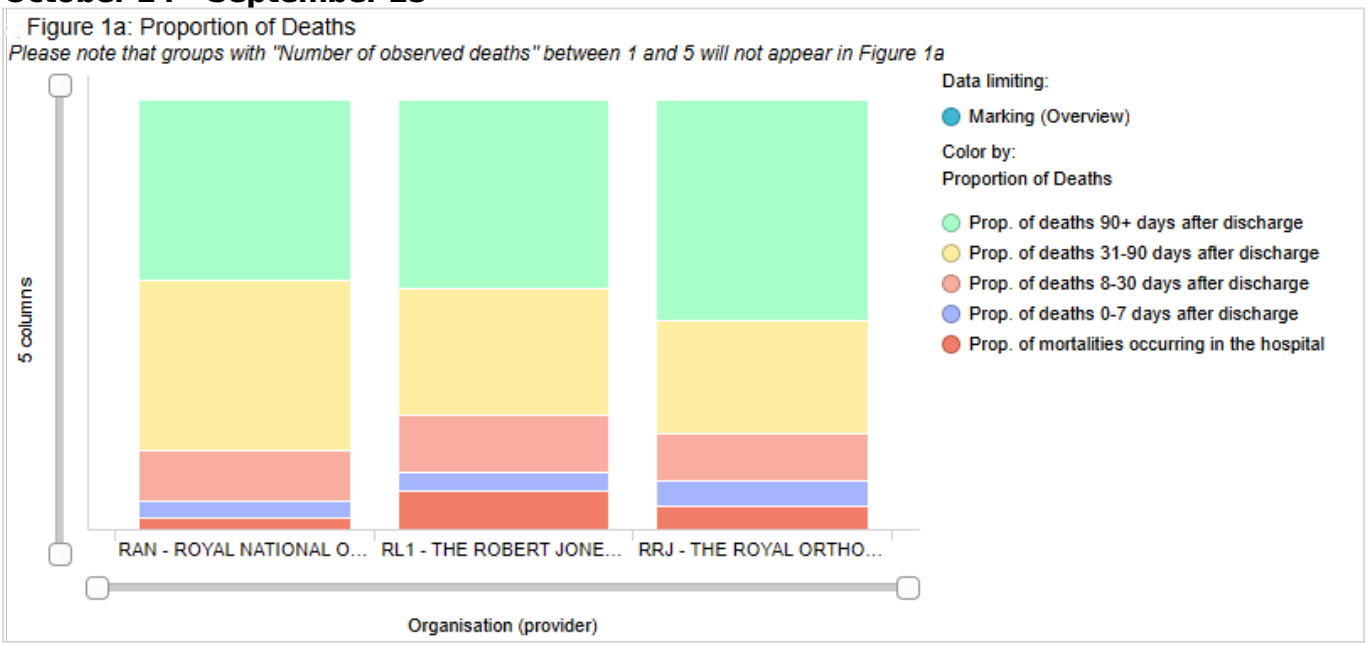


Data table:
Time Series

Color by:
(Column Names) » Organisation (provider)

- Crude rate (in-hospital) (%) (Rolling 12-mth Trend) » RAN - ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST
- Crude rate (in-hospital) (%) (Rolling 12-mth Trend) » RL1 - THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST
- Crude rate (in-hospital) (%) (Rolling 12-mth Trend) » RRJ - THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

October 24 – September 25



NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Maryland Drive Car Park Lease Agreement**
SPONSOR (EXECUTIVE DIRECTOR):	**Steve Washbourne, Chief Finance Officer**
AUTHOR:	**Steve Washbourne, Chief Finance Officer**
DATE OF MEETING:	**4 February 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

The Trust is seeking application of the Board Seal on the lease renewal for the car park on Maryland Drive. The term is for a further 5 years.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• NA	• BA

REPORT RECOMMENDATION:

The BOARD is asked to:
APPROVE application of the Trust Seal

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

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

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

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

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

NA

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

NA

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

NA

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

NA

DATED **2025**

CAR PARKING LEASE

between

THE TRUSTEES OF THE CHARITY OF BOURNVILLE VILLAGE TRUST

and

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

THIS LEASE is dated 2025

Parties

(1) **THE TRUSTEES OF THE CHARITY OF BOURNVILLE VILLAGE TRUST** of 350 Bournville Lane, Bournville, Birmingham B30 1QY **(Landlord)**

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

Agreed terms

1. Interpretation

The following definitions and rules of interpretation apply in this lease.

1.1 Definitions:

Act of Insolvency:

a) the taking of any step in connection with any voluntary arrangement or any other compromise or arrangement for the benefit of any creditors of the Tenant or any guarantor;

b) the making of an application for an administration order or the making of an administration order in relation to the Tenant or any guarantor;

c) the giving of any notice of intention to appoint an administrator, or the filing at court of the prescribed documents in connection with the appointment of an administrator, or the appointment of an administrator, in any case in relation to the Tenant or any guarantor;

d) the appointment of a receiver or manager or an administrative receiver in relation to any property or income of the Tenant or any guarantor;

e) the commencement of a voluntary winding-up in respect of the Tenant or any guarantor, except a winding-up for the purpose of amalgamation or reconstruction of a solvent company in respect of which a statutory declaration of solvency has been filed with the Registrar of Companies;

f) the making of a petition for a winding-up order or a winding-up order in respect of the Tenant or any guarantor;

g) the striking-off of the Tenant or any guarantor from the Register of Companies or the making of an application for the Tenant or any guarantor to be struck-off;

h) the Tenant or any guarantor otherwise ceasing to exist (but excluding where the Tenant or any guarantor dies);

i) the making of an application for a bankruptcy order, the presentation of a petition for a bankruptcy order or the making of a bankruptcy order against the Tenant or any guarantor.

The paragraphs above shall apply in relation to a partnership or limited partnership (as defined in the Partnership Act 1890 and the Limited Partnerships Act 1907 respectively) subject to the modifications referred to in the Insolvent Partnerships Order 1994 (*SI 1994/2421*) (as amended), and a limited liability partnership (as defined in the Limited Liability Partnerships Act 2000) subject to the modifications referred to in the Limited Liability Partnerships Regulations 2001 (*SI 2001/1090*) (as amended).

Act of Insolvency includes any analogous proceedings or events that may be taken pursuant to the legislation of another jurisdiction in relation to a tenant or guarantor incorporated or domiciled in such relevant jurisdiction.

Adjoining Land: the adjoining land owned by the Landlord and registered under title number WM63803.

Competent Authority: any statutory undertaker or any statutory public local or other authority or regulatory body or any court of law or government department or any of them or any of their duly authorised officers.

Easement Area: the land coloured green on the Plan.

Interest Rate: four per centum (4%) above the base rate from time to time of Barclays Bank plc with a minimum of ten per centum (10%) or, if that base rate stops being used or published, then a comparable commercial rate reasonably determined by the Landlord.

LPA 1925: Law of Property Act 1925.

LTA 1927: Landlord and Tenant Act 1927.

LTA 1954: Landlord and Tenant Act 1954.

LTCA 1995: Landlord and Tenant (Covenants) Act 1995.

Permitted Use: a car park for the parking of private motorcars and motorcycles.

Plan: the plan annexed to this Lease.

Property: the land at Maryland Drive, Northfield, Birmingham shown edged red on the Plan.

Rent: rent at the rate of £5,657.00 per annum (exclusive of VAT).

Rent Commencement Date: [ ].

Rent Payment Dates: 1 January, 1 April, 1 July and 1 October on each year

Reservations: the rights and reservations granted to the Landlord, its agents, contractors and workmen in **clause 3**.

Scheme of Management: the Bournville Scheme of Management and Design Guide Rules and Regulations in force from time to time

Service Media: all media for the supply or removal of Utilities and all structures, machinery and equipment ancillary to those media.

Term: a term of five years commencing on, and including, the date of this lease.

Utilities: electricity, water, sewage, telecommunications, data and all other services and utilities.

VAT: value added tax chargeable in the UK.

1.2 A reference to this **lease**, except a reference to the date of this lease, is a reference to this deed and any deed, licence, consent, approval or other instrument supplemental to it.

1.3 A reference to the **Landlord** includes a reference to the person entitled to the immediate reversion to this lease. A reference to the **Tenant** includes a reference to its successors in title and assigns. A reference to a **guarantor** includes a reference to the **Guarantor** and to any other guarantor of the tenant covenants of this lease including a guarantor who has entered into an authorised guarantee agreement.

1.4 Unless the context otherwise requires, references to the **Property** are to the whole and any part of it.

1.5 A reference to the **end of the Term** is to the end of the Term however it ends.

1.6 A **working day** is any day which is not a Saturday, a Sunday, a bank holiday or a public holiday in England.

1.7 A reference to laws in general is a reference to all local, national and directly applicable supra-national laws as amended, extended or re-enacted from time to time and shall include all subordinate laws made from time to time under them and all orders, notices, codes of practice and guidance made under them.

1.8 Unless otherwise specified, a reference to legislation or a legislative provision is a reference to it as amended, extended or re-enacted from time to time and shall

include all subordinate legislation made from time to time under that legislation or legislative provision and all orders, notices, codes of practice and guidance made under it.

1.9 Any obligation on the Tenant not to do something includes an obligation not to allow that thing to be done and an obligation to use best endeavours to prevent that thing being done by another person.

1.10 Any obligation on a person to do something includes an obligation to ensure that any person under its control complies with that obligation.

1.11 A **person** includes a natural person, corporate or unincorporated body (whether or not having separate legal personality).

1.12 Unless the context otherwise requires, references to clauses are to the clauses of this lease.

1.13 Clause headings shall not affect the interpretation of this lease.

1.14 Unless the context otherwise requires, any words following the terms **including**, **include**, **in particular**, **for example** or any similar expression shall be construed as illustrative and shall not limit the sense of the words, description, definition, phrase or term preceding those terms.

1.15 Unless the context otherwise requires, a reference to one gender shall include a reference to the other genders.

1.16 Unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular.

1.17 If any provision or part-provision of this lease is or becomes invalid, illegal or unenforceable, it shall be deemed deleted, but that shall not affect the validity and enforceability of the rest of this lease.

2. Grant

2.1 The Landlord lets the Property to the Tenant for the Term.

2.2 The grant is made excepting and reserving to the Landlord the Reservations, and subject to all rights, restrictions and covenants affecting the Property under title number WM63803.

2.3 The grant is made with the Tenant paying to the Landlord as rent, the Rent and all VAT in respect of it, and all other sums due under this lease.

3. Rights excepted and reserved

3.1 The following rights are excepted and reserved from this lease to the Landlord for the benefit of the Adjoining Land:

(a) rights of light, air and support as those rights are capable of being enjoyed at any time during the Term;

(b) at any time during the Term, the full and free right to develop any part of the Adjoining Property as the Landlord may think fit; and

(c) a right of way with or without vehicles at any time and for all purposes over and along the Easement Area together with a right to enter the Property with or without workmen plant and machinery to inspect, maintain, repair and renew the Easement Area .

3.2 The Landlord reserves the right to enter the Property for any purpose mentioned in this lease or connected with it at any reasonable time and, except in the case of an emergency, after having given reasonable notice to the Tenant.

3.3 The Reservations may be exercised by the Landlord and by anyone else who is or becomes entitled to exercise them and by anyone authorised by the Landlord.

4. Payment of the Rent

4.1 Subject to **clause 4.2**, the Tenant shall pay the Rent and any VAT in respect of it by four equal instalments in advance on or before the Rent Payment Dates.

4.2 The first instalment of the Rent and any VAT in respect of it shall be made on the Rent Commencement Date and shall be the proportion, calculated on a daily basis, in respect of the period beginning on the Rent Commencement Date and ending on the day before the next rent payment date.

4.3 All sums payable by the Tenant are exclusive of any VAT that may be chargeable and the Tenant shall pay VAT in respect of all taxable supplies made to it in connection with this lease. Every obligation on the Tenant under or in connection with this lease to pay, refund or to indemnify the Landlord or any other person any money or against any liability includes an obligation to pay, refund or indemnify against any VAT, or an amount equal to any VAT, chargeable in respect of it.

4.4 If any Rent or any other money payable under this lease has not been paid by the date it is due, whether it has been formally demanded or not, the Tenant shall pay

the Landlord interest on that amount at the Interest Rate (both before and after any judgment). Such interest shall accrue on a daily basis for the period from (and including) the due date to and including the date of payment.

4.5 The Rent and all other money due under this lease are to be paid by the Tenant or any guarantor (as the case may be) without deduction, counterclaim or set-off.

5. Rates and outgoings

5.1 The Tenant must pay all present and future rates, taxes utility costs and other impositions and outgoings payable in respect of the Property, its use and any works carried out there (or a fair proportion of the total cost of those rates, taxes, impositions and outgoings if any are payable in respect of the Property together with any other property.

5.2 The Tenant must not make any proposal to alter the rateable value of the Property (or that value as it appears on any draft rating list) without the approval of the Landlord.

5.3 If, at or after the end or sooner determination of the Term, the Landlord loses rating relief (or any similar relief or exemption) because it has been allowed to the Tenant, the Tenant must pay the Landlord an amount equal to the relief or exemption that the Landlord has lost.

6. Insurance

The Tenant shall at its own expense procure and maintain insurance in respect of all third-party liability risks in relation to the Permitted Use. The Tenant shall, at the request of the Landlord, provide a letter from the Tenant's insurers confirming the policy number, period of cover and limit of indemnity.

7. Prohibition on Dealings

Except as expressly permitted by this lease, the Tenant shall not

(a) assign, underlet, charge, part with or share possession or share occupation of this lease or the whole or part of the Property;

(b) hold the lease on trust for any person (except by reason only of joint legal ownership);

7.2 The Tenant shall not without the consent of the Landlord grant any right or licence over the Property in favour of any third party or allow any other person to use the

Property except persons parking vehicles on the Property in accordance with the Permitted Use, such consent not to be unreasonably withheld.

8. Assignments

8.1 The Tenant shall not assign the whole of this lease without the consent of the Landlord, such consent not to be unreasonably withheld.

8.2 The Landlord and the Tenant agree that for the purposes of section 19(1A) of the LTA 1927 the Landlord may give its consent to an assignment subject to all or any of the following conditions:

(a) a condition that the assignor enters into an authorised guarantee agreement which:

(i) is in respect of all the tenant covenants of this lease;

(ii) is in respect of the period beginning with the date the assignee becomes bound by those covenants and ending on the date when the assignee is released from those covenants by virtue of section 5 of the LTCA 1995;

(iii) imposes principal debtor liability on the assignor;

(iv) requires (in the event of a disclaimer of this lease) the assignor to enter into a new tenancy for a term equal to the unexpired residue of the Term; and

(v) is otherwise in a form reasonably required by the Landlord;

(b) a condition that a person of standing acceptable to the Landlord acting reasonably enters into a guarantee and indemnity of the tenant covenants of this lease in such form as the Landlord may reasonably require.

8.3 The Landlord and the Tenant agree that for the purposes of section 19(1A) of the LTA 1927 the Landlord may refuse its consent to an assignment if any of the following circumstances exist:

(a) the Rent or any other money due under this lease is outstanding or there is a material breach of covenant by the Tenant that has not been remedied; or

(b) in the Landlord's reasonable opinion the assignee is not of sufficient financial standing to enable it to comply with the Tenant's covenants and conditions contained in this lease; or

(c) the assignee and the Tenant are group companies within the meaning of section 42 of the LTA 1954.

8.4 Nothing in this clause shall prevent the Landlord from giving consent subject to any other reasonable condition, nor from refusing consent to an assignment in any other circumstance where it is reasonable to do so.

9. Repair

9.1 The Tenant shall keep the Property clean, tidy and clear of rubbish and shall not cause any damage to it and shall make good any damage caused to the Property by any act or omission of the Tenant or any person under the control of the Tenant.

9.2 The Tenant shall maintain, repair and (where necessary) renew any boundary structures, gates, barriers and lighting at the Property.

9.3 The Tenant shall be responsible for carrying out any necessary tree surveys and shall maintain all trees at the Property in accordance with the principles of good husbandry.

10. Signs

10.1 The Tenant shall not erect any signs fascia, placards, boards, posters or advertisements at the Property save with the Landlord's prior written consent and approval to the size, design and location (such consent and approval not to be unreasonably withheld or delayed).

11. Alterations

11.1 The Tenant may install, alter, remove, relocate, maintain, renew or replace any equipment required in connection with the Permitted Use from time to time including (without limitation) signage, advertisements, parking equipment, entry/exit barriers, security barriers (including but not limited to those which are collapsible or retractable bollards and/or parking posts) or similar, tariff machines, ticket machines and an automatic number plate recognition system provided that the Tenant obtains any necessary consents under the Scheme of Management..

11.2 Subject to **clause 11.1** the Tenant shall not make any alterations or additions to, or build any structure on, the Property, without the prior approval of the Landlord, such approval not to be unreasonably withheld or delayed (and provided that the Tenant obtains any necessary consents under the Scheme of Management)..

12. Use

12.1 The Tenant shall not use the Property for any purpose except the Permitted Use.

12.2 The Tenant shall not use the Property (or permit the Property to be used):

(a) for any illegal purpose; or

(b) for the carrying out or permitting the carrying out of any trade profession or employment on the Property; or

(c) for the manufacture, storage, sale, supply or other distribution of beer, wine, spirits or other alcoholic liquor; or

(d) for the carrying out or permitting the carrying out of any repairs or mobile valeting on the Property; or

(e) for any purpose or in a manner that would cause any loss, nuisance or inconvenience to the Landlord or any owner or occupier of any other property; or

(f) in a manner that interferes with any right, restriction or covenant subject to which this lease is granted.

12.3 The Tenant shall not and shall not permit the fuel tanks to be filled of any vehicle on the Property.

12.4 The Tenant shall not and shall not permit any persons to take onto or keep on the Property any motor fuel or any other inflammable liquid or substance except that already within the fuel tank or engine of a vehicle parked at the Property.

12.5 The Tenant shall not obstruct any of the entrances to or exits from the Property.

12.6 The Tenant shall at all times comply with the terms of the Scheme of Management.

13. Compliance with laws

13.1 The Tenant must comply with all laws relating to:

(a) the Property and the use of the Property by the Tenant;

(b) the use or operation of all Service Media and any other machinery and equipment at or serving the Property whether or not used or operated;

(c) any works carried out at the Property; and

(d) all materials kept at or disposed of from the Property.

13.2 Within five working days of receipt of any notice or other communication affecting the Property or the Estate (and whether or not served pursuant to any law) the Tenant must:

(a) send a copy of the relevant document to the Landlord; and

(b) to the extent that it relates to the Property, take all steps necessary to comply with the notice or other communication and take any other action in connection with it as the Landlord may require.

13.3 The Tenant must not:

(a) apply for any planning permission for the Property without the Landlord's consent (such consent not to be unreasonably withheld where the application relates to works or a change of use permitted under this lease); or

(b) implement any planning permission for the Property without the Landlord's consent (such consent not to be unreasonably withheld).

13.4 Unless the Landlord otherwise notifies the Tenant, before the Termination Date the Tenant must carry out and complete any works stipulated to be carried out to the Property (whether before or after the Termination Date) as a condition of any planning permission for the Property that is implemented before the Termination Date by the Tenant, any undertenant or any other occupier of the Property.

13.5 The Tenant must:

(a) comply with its obligations under the CDM Regulations;

(b) maintain the health and safety file for the Property in accordance with the CDM Regulations;

(c) give that health and safety file to the Landlord at the Termination Date;

(d) procure, and give to the Landlord at the Termination Date, irrevocable, non-exclusive, non-terminable, royalty-free licence(s) for the Landlord to copy and make full use of that health and safety file for any purpose relating to the Estate. Those licence(s) must carry the right to grant sub-licences and be transferable to third parties without the consent of the grantor; and

(e) supply all information to the Landlord that the Landlord reasonably requires from time to time to comply with the Landlord's obligations under the CDM Regulations.

13.6 As soon as the Tenant becomes aware of any defect in the Property, the Tenant must give the Landlord notice of it.

13.7 The Tenant must indemnify the Landlord against any liability under the Defective Premises Act 1972 in relation to the Property by reason of any failure of the Tenant to comply with any of the tenant covenants in this lease.

13.8 Without prejudice to the generality of the remainder of this clause 13 the Tenant will:

(a) execute all works to the Property required in order to comply with this clause 13;

(b) not do in or near the Property any act or thing by reason of which the Landlord may under any statute incur any losses;

(c) comply with the provisions of the CDM Regulations including all requirements in relation to the provision and maintenance of a health and safety file;

(d) take all steps necessary to comply with the Equality Act 2010 (save where valid legal exemptions apply);

14. Encroachments, notices and communications

14.1 Within five working days after receipt of any notice or other communication affecting the Property the Tenant shall send a copy of the relevant document to the Landlord.

14.2 If a third party makes or attempts to make any encroachment over the Property or takes any action by which a right may be acquired over the Property, the Tenant shall:

(a) immediately inform the Landlord and shall give the Landlord notice of that encroachment or action; and

(b) take all steps (including any proceedings) the Landlord reasonably requires to prevent that encroachment or action.

15. Indemnity

The Tenant shall keep the Landlord indemnified against all liabilities, expenses, costs (including but not limited to any solicitors' or other professionals' costs and expenses), claims, damages and losses suffered or incurred by the Landlord arising out of or in connection with any breach of any tenant covenants in this lease, or any act or omission of the Tenant, any undertenant or any person on the Property with its actual or implied authority.

16. Returning the Property to the Landlord

16.1 At the end or sooner determination of the Term, the Tenant shall return the Property to the Landlord in a clean and tidy condition and shall remove any alterations made by the Tenant and any signs, collapsible or retractable bollard and any other property or equipment from the Property and make good any damage caused to

the Property to the Landlord's reasonable satisfaction but shall not be obliged under this **clause 15** to put the Property into any better state of repair than it is in at the date of this lease as evidenced by the schedule of condition annexed to this lease..

16.2 The Tenant irrevocably appoints the Landlord to be the Tenant's agent to store or dispose of any items which have been left by the Tenant on the Property for more than ten working days after the end or sooner termination of the Term. The Landlord shall not be liable to the Tenant by reason of that storage or disposal. The Tenant shall indemnify the Landlord in respect of any claim made by a third party in relation to that storage or disposal.

16.3 The Tenant shall return to the Landlord any keys or control cards to any security barriers, bollards or gates to the Property at the end of the Term.

16.4 Within one month after the end or sooner determination of the Term (and notwithstanding that the Term has ended), the Tenant shall make an application to remove any entries on the Landlord's title relating to the easements granted by this lease and shall ensure that any requisitions raised by HM Land Registry in connection with that application are dealt with promptly and properly. The Tenant shall keep the Landlord informed of the progress and completion of its application.

17. Reinstatement following damage

17.1 If the Property is damaged or destroyed so as to make the Property unfit for use, the rent or a fair proportion of it according to the nature extent of the damage sustained and any other sums payable under this Lease shall be suspended until the earliest of:

(a) The date the Property has been reinstated and is fit for occupation and use

(b) The end of the Term.

18. Landlord's covenant

18.1 The Landlord covenants with the Tenant that, so long as the Tenant pays the rents reserved by and complies with its obligations in this lease, the Tenant shall have quiet enjoyment of the Property without any interruption by the Landlord or any person claiming under the Landlord except as otherwise permitted by this lease.

19. Re-entry and forfeiture

19.1 The Landlord may re-enter the Property (or any part of the Property in the name of the whole) at any time after any of the following occurs:

(a) any rent is unpaid 21 days after becoming payable whether it has been formally demanded or not;

(b) any breach of any condition or tenant covenant of this lease;

(c) failure of the Tenant to provide the requested documentation specified in clause 13 within 28 days following the Landlord's request;

(d) an Act of Insolvency.

19.2 If the Landlord re-enters the Property (or any part of the Property in the name of the whole) pursuant to this clause, this lease shall immediately end, but without prejudice to any right or remedy of the Landlord in respect of any antecedent breach of the covenants of this lease by the Tenant or any guarantor.

20. Section 62 of the LPA 1925, implied rights and existing appurtenant rights

The grant of this lease does not create by implication any easements or other rights for the benefit of the Property or the Tenant and the operation of section 62 of the LPA 1925 is excluded.

21. Joint and several liability

21.1 Where the Tenant comprises more than one person, those persons shall be jointly and severally liable for the obligations and liabilities of the Tenant arising under this lease. The Landlord may take action against, or release or compromise the liability of, or grant time or other indulgence to, any one of those persons without affecting the liability of any other of them.

21.2 Where a guarantor comprises more than one person, those persons shall be jointly and severally liable for the obligations and liabilities of a guarantor arising under this lease. The Landlord may take action against, or release or compromise the liability of, or grant time or other indulgence to, any one of those persons without affecting the liability of any other of them.

21.3 The obligations of the Tenant and any guarantor arising by virtue of this lease are owed to the Landlord and the obligations of the Landlord are owed to the Tenant.

21.4 The Landlord shall not be liable to the Tenant for any failure of the Landlord to perform any landlord covenant in this lease unless and until the Tenant has given the Landlord notice of the failure and the Landlord has not remedied the failure within a reasonable time of service of that notice.

22. Notices, consents and approvals

22.1 Except where this lease specifically states that a notice need not be in writing, any notice given under or in connection with this lease shall be:

(a) in writing and for the purposes of this clause an email is not in writing; and

(b) given by hand or by pre-paid first-class post or other next working day delivery service at the party's registered office address (if the party is a company) or (in any other case) at the party's principal place of business.

22.2 If a notice complies with the criteria in **clause 22.1**, whether or not this lease requires that notice to be in writing, it shall be deemed to have been received:

(a) if delivered by hand, at the time the notice is left at the proper address;

(b) if sent by pre-paid first-class post or other next working day delivery service, on the second working day after posting.

22.3 This clause does not apply to the service of any proceedings or other documents in any legal action or, where applicable, any arbitration or other method of dispute resolution.

22.4 Where the consent of the Landlord is required under this lease, a consent shall only be valid if it is given by deed, unless:

(a) it is given in writing and signed by the Landlord or a person duly authorised on its behalf; and

(b) it expressly states that the Landlord waives the requirement for a deed in that particular case.

If a waiver is given, it shall not affect the requirement for a deed for any other consent.

22.5 Where the approval of the Landlord is required under this lease, an approval shall only be valid if it is in writing and signed by or on behalf of the Landlord, unless:

(a) the approval is being given in a case of emergency; or

(b) this lease expressly states that the approval need not be in writing.

22.6 If the Landlord gives a consent or approval under this lease, the giving of that consent or approval shall not imply that any consent or approval required from a third party has been obtained, nor shall it obviate the need to obtain any consent or approval from a third party.

23. Entire agreement

23.1 This lease constitutes the whole agreement between the parties and supersedes all previous discussions, correspondence, negotiations, arrangements, understandings and agreements between them relating to its subject matter.

23.2 Nothing in this lease constitutes or shall constitute a representation or warranty that the Space may lawfully be used for any purpose allowed by this lease.

24. Exclusion of sections 24-28 of the LTA 1954

24.1 The parties confirm that:

(a) the Landlord served a notice on the Tenant, as required by section 38A(3)(a) of the LTA 1954, applying to the tenancy created by this lease, not less than 14 days before this lease was entered into;

(b) [ ] who was duly authorised by the Tenant to do so made a declaration dated [ ] 2025 in accordance with the requirements of section 38A(3)(b) of the LTA 1954; and

(c) there is no agreement for lease to which this lease gives effect.

24.2 The parties agree that the provisions of sections 24 to 28 of the LTA 1954 are excluded in relation to the tenancy created by this lease.

25. Charity Provisions and Trustee Liabilities

25.1 The Property which is subject to this Lease is granted and is held by the Landlord in trust for charity known as Bournville Village Trust which is a non-exempt charity and the grant of this Lease is not a disposition falling within paragraph (a), (b), (c), or (d) (as the case may be) of section 117(3) Charities Act 2011, so that the restriction on disposition imposed by sections 117 to 121 Charities Act 2011 applies to the land.

25.2 The trustees of Bournville Village Trust as charity trustees certify that they have power under its trusts to affect this disposition and that they have complied with the provisions of sections 117 to 121 Charities Act 2011 so far as applicable to this disposition.

25.3 The Lease is executed by (or on behalf of) the incorporated trustees of Bournville Village Trust acting by two of its charity trustees and on behalf of all the charity trustees of Bournville Village Trust under an authority conferred under section 260(3)(b) of the Charities Act 2011.

25.4 The parties agree that notwithstanding any provision to the contrary and as long as the reversion in the Property is vested in the Trustees of the Charity known as the Bournville Village Trust any liability of the Landlord arising out of this lease or any matter connected with it shall be limited to the assets of the Bournville Village Trust in its possession from time to time.

26. Contracts (Rights of Third Parties) Act 1999

This lease does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999.

27. Governing law

This lease and any dispute or claim (including non-contractual disputes or claims) arising out of it or in connection with it or its subject matter or formation shall be governed by and construed in accordance with the law of England and Wales.

28. Jurisdiction

Each party irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim (including non-contractual disputes or claims) arising out of or in connection with this lease or its subject matter or formation.

This document has been executed as a deed and is delivered and takes effect on the date stated at the beginning of it.

Signed as a Deed by

and

for and on behalf of
The Trustees of the Charity of Bournville Village Trust
under a power of attorney dated 12 June 2025

……..
Attorney

witness signature:

witness name:

witness address:

……..
Attorney

witness signature:

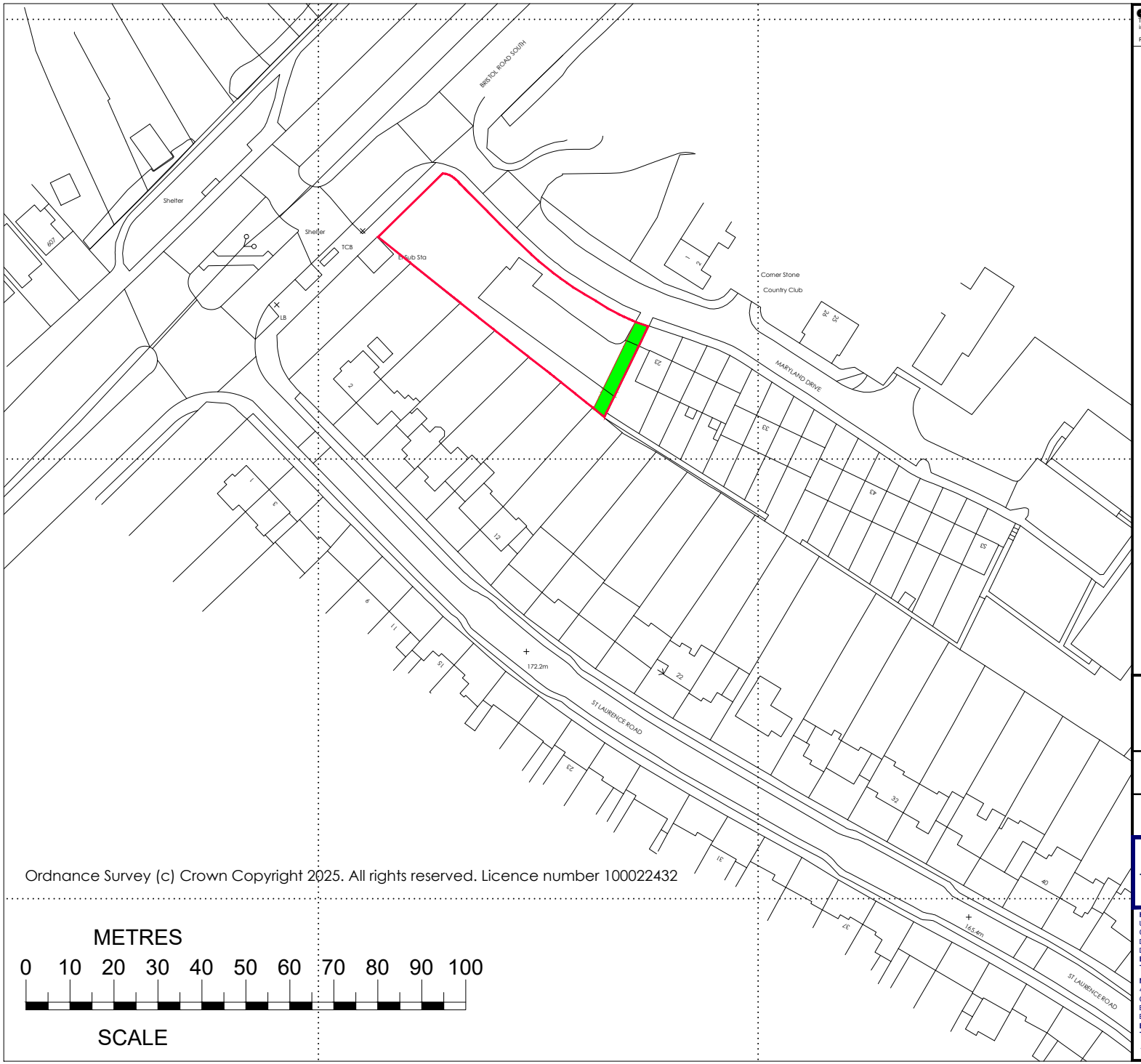
witness name:

witness address:

Executed as a Deed by affixing the Common Seal of
The Royal Orthopaedic Hospital NHS Foundation Trust
in the presence of:

……

……



Indicative

Transfer Line

Easement Area

Project :

Carpark at Maryland Drive,
Birmingham B31 2AT

Dwg No. :
S24/10327/01

Scale :
1:1250

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ASSOCIATION

PAPER REFERENCE:

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM THE STAFF EXPERIENCE & OD COMMITTEE

Date Group or Board met: 17 December 2025

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Sickness Absence remains above Trust KPI, and we are reporting at 128 / 134 Trusts within the NHS Oversight Framework, which poses a serious risk. • Mandatory Training remains below Trust KPI with 2 areas requiring significant improvement (Cyber and IG). LMS system has been rolled out and both Cyber and IG training can now be accessed vis this platform which should improve compliance moving forward. Executive Directors and Deputies receive non-compliance reports for their areas.	• Fieldwork for the National Staff Survey has now concluded and we achieved a 55% response for substantive staff and 15% for bank staff. Whilst the response rate is lower than previous years this was expected, given the current NHS climate. The initial results are due in December. • There are some changes to the Growth and Skills Levy for Apprenticeships. The ask is how we exploit the levy funds; there is more work to do from workforce planning perspective to see how we can make the most of the levy. • Given the risk and impact of sickness absence across the Trust, a report will be presented to Trust Board in February 26. • A review of the Special Leave Policy and Sickness policy is underway to support workforce productivity.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The Committee welcomed the Appointments Manager to the meeting who provided an insightful account of the work she has been doing within the Appointments Team, including cross team working with the Outpatients Department. • Sickness Absence Rate has decreased, which is 1% lower than this time last year. Real improvements come from a reduction in long term absence. This month is the lowest month we have recorded since 2019 other than one month in 2022 however risks about our current absence rate remain. • The Developing Leaders Programme has been successful with a clear link back to Trust improvement initiatives. • Evaluation of Me as Manager Development framework since launched in April 2026 provides an average rating of 4.46% out of 5% as well as a positive increase in self-reported levels of confidence and competence in key areas. • We continue to see an increase in appraisal compliance to 93.5%. Work continues to support managers in ensuring that appraisals are of reported levels of high quality.	• The Committee reviewed the Terms of Reference and the workplan for this Committee. These were agreed in principle and will be considered as part of the wider governance review. • Each Executive will present their individual staff survey results and actions plans. SE and OD Work plan will be updated to reflect the dates of the presentations. • The committee supported a pilot application to NHS Charities Together Workforce wellbeing local grant fund which would be an initial 18-month pilot. This will support MSK related sickness absence rates and presents an opportunity for ROH to demonstrate its role as a knowledge leader in MSK alongside the work across BSOL for MSK occupational health support.

Chair's comments on the effectiveness of the meeting: The tone of the meetings this year has been good and demonstrates that we are asking ourselves the questions around, what are we doing, why are we doing it and what can we do better. This is important because it is what we need to do if we want to be an outstanding Trust.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY AND SAFETY COMMITTEE

Date Group or Board met: 28 January 2026

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• It was noted that an additional risk had been added to the corporate risk register regarding controlled drug storage in the mobile CT scanner. • There has been a breach of the 28-day faster diagnosis cancer target in November which is the first breach of the target in 12 months and is a result of ongoing pathology performance issues.	• Further work to be undertaken to update the CRR/BAF related to measurable actions and detailed timescales. • A verbal update was provided regarding the planned restart of the Spinal Endoscopy Service and it was agreed that an update would be presented to the Quality and Safety Committee in May 2026. • It was agreed that an update on the theatres safety work would be presented to the Quality and Safety Committee in May 2026. • Update on the proposed digitalisation of modules of safeguarding training to be presented at the next meeting. • A deep dive exercise of BADS compliance data has been undertaken and a specialty level report will be presented at the next Finance and Performance Committee. • Audit of ethnicity data to be presented at the next meeting and added as an operational KPI to the Patient Safety and Quality Report. • A review of opioid use to be undertaken and presented to the meeting in May 2026. • The flow chart regarding booking and triaging spinal patients discussed at the last Trust Board meeting to be shared with the committee via email for enhanced assurance and to close the action.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• The committee was advised that the process for booking urgent triage appointments has been changed and there is weekly oversight via the Senior Leadership Team meeting. • The Never Event update provided assurance on specific pieces of work taking place to improve the safety culture in Theatres. It was noted that further work was underway and a further update would be provided at a future meeting.	• It was agreed that the following reports would be presented at the next Trust Board meeting: - Never Event Update - Controlled Drug Annual Report - Radiation Safety Report

• The committee received the Water Safety Report which provided assurance related to the Trust's systems and processes for water management safety. • There was a positive uptake of the flu vaccination in the Trust. The committee noted the impact of flu on safer staffing in December. • The committee received an update on work being undertaken with the wards related to patient experience following the CQC In-patient and internal surveys and individual action plans are to be developed for each area. The report acknowledged the work of the volunteers in relation to patient experience data collection. There is continued improvement of the complaint response key performance indicator target. • The committee were informed of work underway regarding quality priorities for the coming year with the focus on theatre safety. • A learning from deaths update provided assurance that Trust mortality figures remain stable and within expected limits. Deaths reflect frailty and co-morbidity in case mix from increases in metastatic and revisions cases and this will be monitored. • The committee received a comprehensive update regarding antimicrobial consumption for 2025/26. • The Committee received an update from the Head of Imaging on the Radiation Safety in the Trust, with confirmation that all policies have been reviewed in line with IE(ME)R procedures and have been approved by RRPPS. There has been successful recruitment to consultant and senior clinical fellow posts. • The Controlled Drugs Accountable Officer report shows good compliance with governance requirements for controlled drugs. Prescribing practices for post-operative pain have been changed following the MHRA alert regarding moderate release opioids. • The committee noted the CQC inspection of the Children and Young People's service which was rated as 'Good' following the review in May 2025.	

Chair's comments on the effectiveness of the meeting: It was agreed that the meeting had focussed on the areas of importance and that the pace of the meeting had been good.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Update from the Accountable Officer for Controlled Drugs

Report to Quality & Safety Committee –Jan 2025- Dec 2025

1. Purpose of this Paper

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

2. Legislative Requirement for Controlled Drug Accountable Officer

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

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

Within the Trust the CDAO is the Chief Nurse

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

Care Quality Commission (CQC) Regulation

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

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

3. Role of the CDAO

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

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

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

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

4. Controlled Drug Local Intelligence Networks (CDLIN).

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

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

5. CD Incidents

Table 1 - Number of Incidents reported to CD Lin over last 4 years

Jan 22-Dec 22	Jan 23-Dec 23	Jan 24-Dec24	Jan 25-Dec 25
177	**106**	**89**	**89**

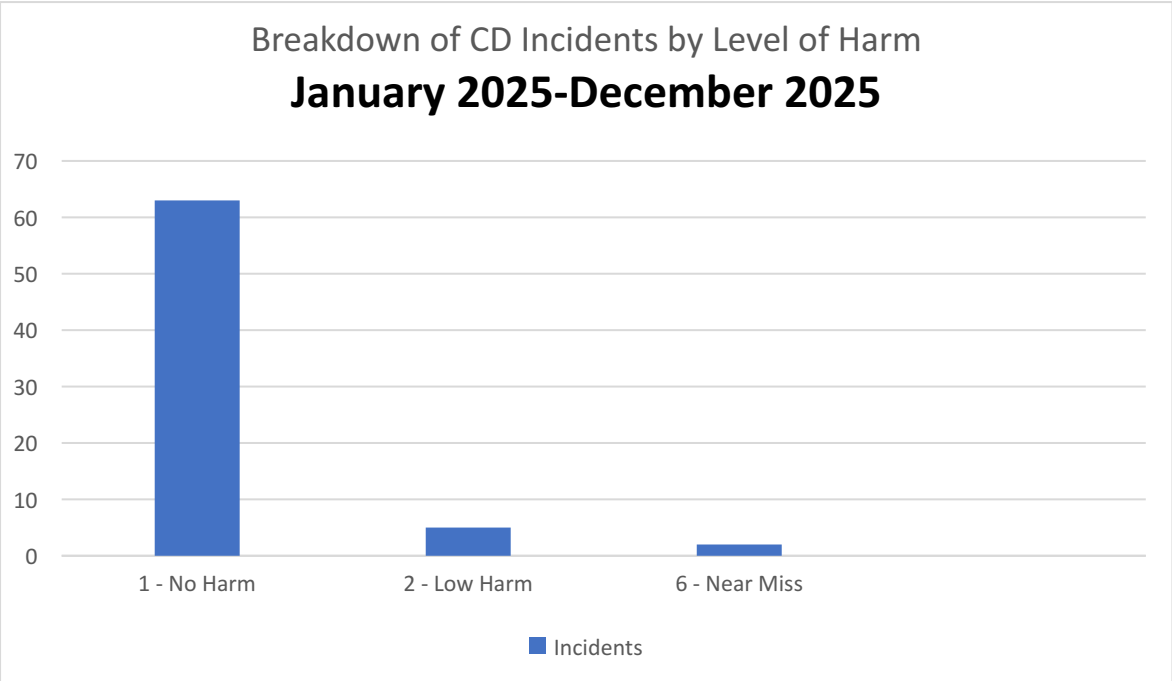
A more detailed analysis on the reported incidents is in section 8 (CD Incidents) below.

There has been a steady number of CD related incidents reported in the past 12 months compared to 2024. Controlled drugs still make up for the majority of medicines incidents however, this decline has been partially attributed to fewer liquid CD losses as more tablet forms are used, greater use of electronic registers and fewer incidents reported by pharmacy after conducting CD audits as actions place are in place.

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

No serious incidents of diversion/ harm have been reported externally via the CDLIN in 2025.

There were a cluster of incidents related Omnicell use and user errors which has an ongoing program of training.



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

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

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

Q4 24/25 Jan – March

There were 23 CD-related incidents, consistent with the previous quarter. Key examples include Incident 50546 (MR opioid given instead of short-acting, no harm), Glass ampoule breakages reduced significantly, though Incident 50902 (midazolam ampoule broke in theatre) and 50950 (two packs of midazolam fell, one smashed) were reported. Incident 51121 involved a patient difficult to rouse post-op after receiving 30mg oromucosal midazolam; sedation policy reviewed and shared. 50614 (ROCS patient self-administered three opioids post-discharge despite counselling), Four incidents (50501, 50686, 50912, 52018) related to co-administration of opioids post-discharge, prompting a thematic review by the Medicines Safety Group to improve opioid prescribing and reduce adverse events. Learning was implemented and coincided with an MHRA alert to reduce post op opiate use- explained further in section 11.

Q1 (Apr–Jun 2025)

There were 17 CD-related incidents, below the average of 23 per quarter. Key issues included gabapentin and pregabalin administration errors (3 incidents) and liquid losses (Oramorph spillage of 23ml and 7ml unaccounted). Notable prescribing/administration errors occurred on 02/04/2025 (Dihydrocodeine and Morphine MR co-administered), 05/05/2025 (oral Morphine given while on PCA), and 08/05/2025 (Dihydrocodeine instead of Codeine Phosphate). A near miss on 19/05/2025 involved incorrect booking out of Oramorph intended for an adjacent patient. Two alfentanil ampoules broke on 02/06/2025. No diversion incidents were reported this quarter. There was a wider acute pain program launched to share learning and address some of these incidents.

Q 2 (Jul–Sep 2025)

There were 22 CD incidents in this quarter. Significant cases included Incident 52329, where an LD patient required self-administration of CDs, prompting use of a secure POD locker with an Abloy key as an exception Learning was shared regarding correct use of self -administration processes. Incident 52191 involved a lost fentanyl ampoule during a theatre list, which remained unaccounted despite extensive searches. It is thought this had been administered to the patient. This was reported to the CDLIN. Incident 52181 reported ketamine loss due to breakage, leading to packaging changes by Pharmacy. Incident 53010 highlighted an unaccounted 29ml loss of oral Morphine Sulphate on HDU. Additionally, 8 Omnicell balance discrepancy incidents were recorded, all resolved after investigation but indicating ongoing training needs.

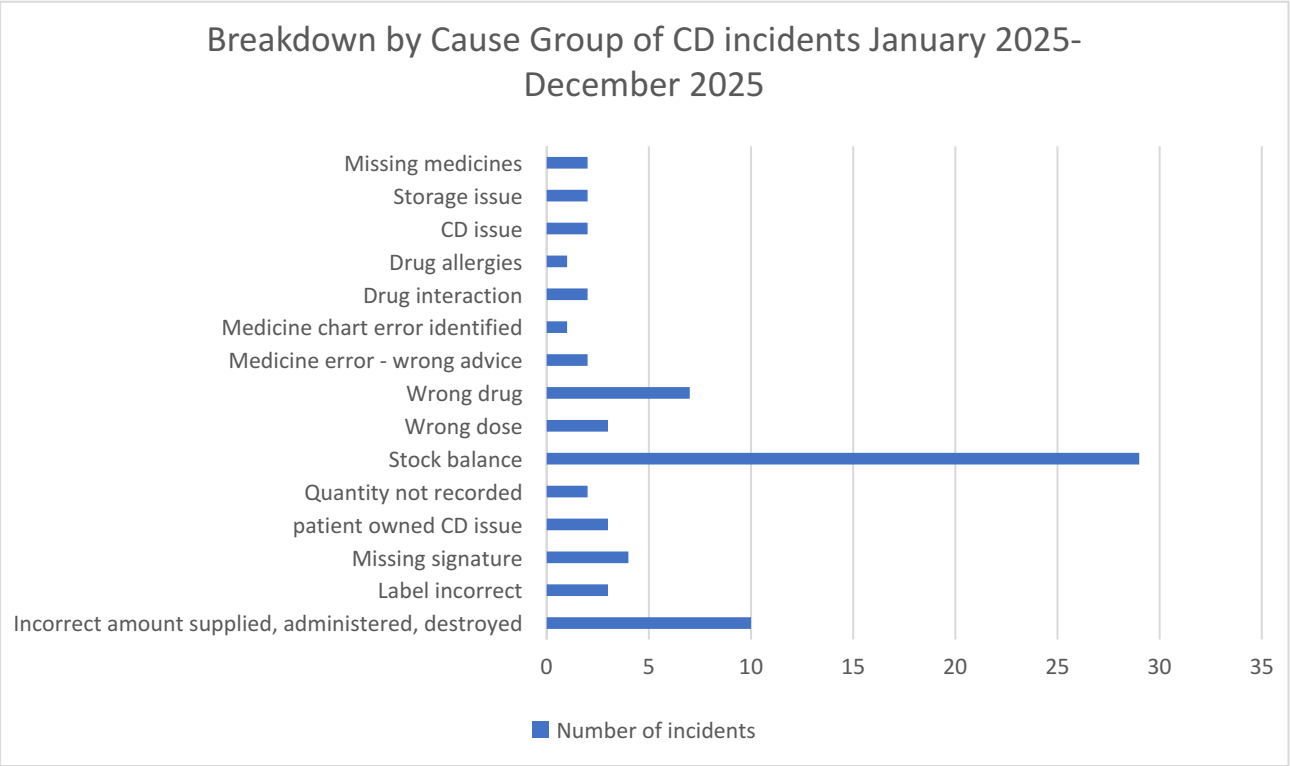
Q3 (Oct–Dec 2025)

Up to December, 27 CD incidents were logged, with a cluster on Ward 3. Examples include Incident 53603 (saline flush administered instead of Oramorph), Incident 53812 (patient discharged with CDs not signed out), and Incident 53226 (incorrect strength of oxycodone ordered and restocked into Omnicell). Other issues included significant Oramorph spillage (Incident 53618: 63ml lost; Incident 53374: 70ml spilled) and two smashed Oramorph bottles on 01/11/2025. A broken fentanyl ampoule was also reported on 07/11/2025. No patient harm occurred, but these highlight gaps in ordering, custody, and handling processes. Incident 53696 involved a discrepancy in Recovery involving morphine PCA which was not prescribed. The prescriber was asked to undertake a written reflection. There were no unaccounted for CDS.

5.2 Incidents by cause

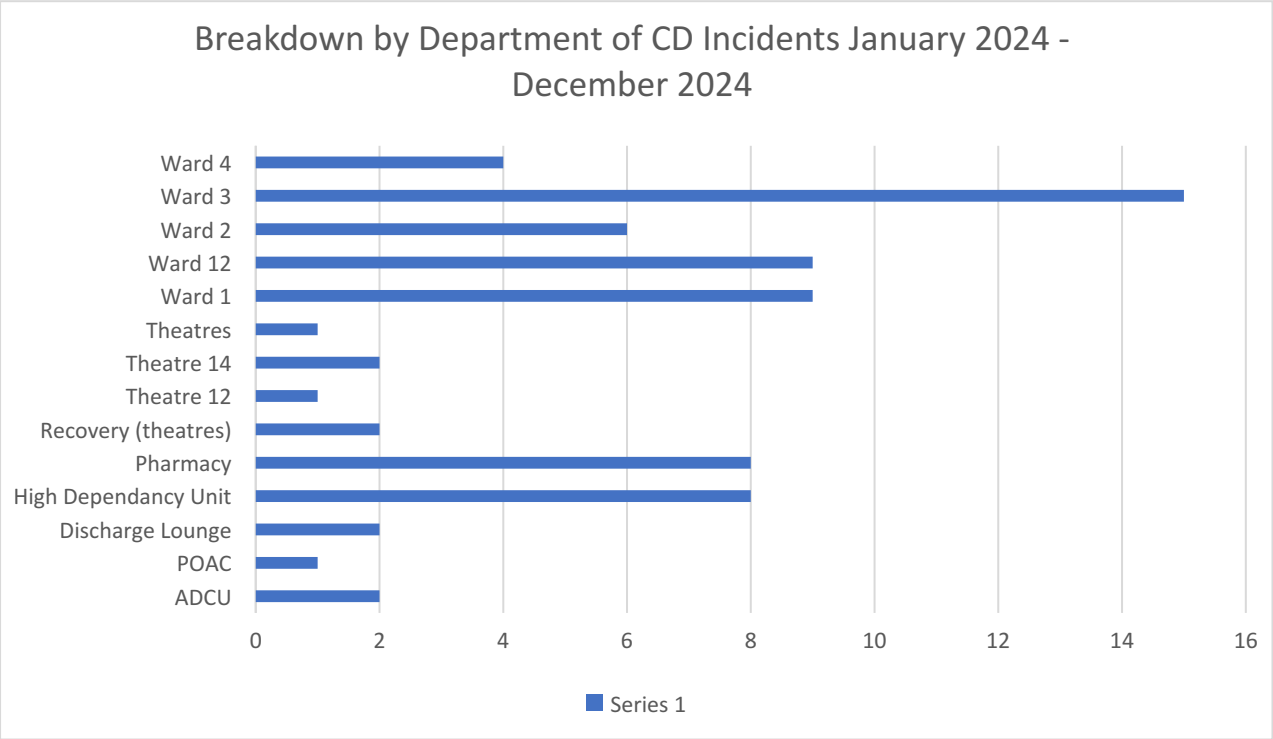
The vast majority of incidents relate to Omnicell stock balance issues due to incorrect booking out / user error. These are recurrent themes and actions are in place to continue education

for healthcare staff involved in CD administration. There were no incidents of diversion / unaccounted for CDS.



7. Where the Incidents Occurred.

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



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

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

Across theatres, departments, and wards, overall compliance in 2025 remained strong, with many areas consistently achieving results in the mid-90s to 100%. Several theatres—such as Th 1, Th 4, and Imaging—maintained excellent performance throughout the year, while a few others, including Th 6, Th 10, and the ADCU, experienced occasional dips. Ward performance showed similar fluctuations: most remained steady within the high-80s to mid-90s range, though Wards 2 and 12 saw more variation. Despite these variations, both theatres and wards generally trended back toward higher compliance by October, indicating good overall performance with only a handful of areas needing focused support.

9. CDLIN key learnings from Annual summary 2025

- Governance & Compliance: Reinforced CD policies via formal communication; updated SOPs for handling, disposal, and out-of-hours supply; introduced 5% discrepancy threshold.
- Audit & Monitoring: Weekly and monthly CD audits, self-auditing by nursing teams, and new incident reporting module for accurate harm capture.
- Training & Culture: RN/RNA medicines management training days (opioid calculations, human factors); competency assessments completed; reflective practice embedded.
- Process Improvements: Enhanced handover checks, sealed CD verification on delivery, streamlined storage and destruction planning; emergency drug "Grab Bags" introduced.
- Technology & Communication: Mobile-enabled tablet for CD processes; communications book implemented; governance meetings share lessons learned.
- Safety Actions: Independent double-checks, clearer titration directions, improved disposal governance in theatres, and proactive review of patient-owned CD use.

10.CQC annual report updates 2024

Each year the CQC publish an annual summary of learning and actions linked to Controlled Drugs for Organisations to consider. Below is a summary of the report with associated actions for ROH.

National Findings & Risks

- Legislation updates: Naloxone supply expanded beyond drug/alcohol services; ROH only uses for inpatient emergencies.
- Key risks from Regulation 28 reports: Poor communication across care settings, assumptions of drug-seeking behaviour, inadequate pain management plans, lack of fail-safes in prescribing/dispensing, and polypharmacy risks.
- Governance gaps nationally: Deviations from policy, insufficient medicines reviews for vulnerable patients, and failure to share critical medicines information.
- Emerging threats: Nitazenes and xylazine in counterfeit medicines; diversion risks via tampering, impersonation, and electronic system fraud. Limited impact for ROH.
- CQC emphasis: Board-level oversight, robust SOPs, accurate record-keeping, and statutory notifications for serious CD-related incidents.

ROH Position & Actions

- Current compliance: All CD incidents reported to CDLIN; destruction witnessed by authorised staff; FP10 use minimal; Omnicell security in place.
- Identified gaps: Discharge letters lack tapering details; limited resource for proactive polypharmacy reviews; need for improved patient counselling post-discharge.
- Actions taken: Acute pain group reviewing tapering info; SOP updates for reconciliation and CD handling; enhanced audits and governance via Medicines Safety Group.
- Training & culture: Bite-size CD training at safety huddles; RN/RNA medicines management training days; reflective practice embedded.
- Future priorities: Improve discharge communication, expand pain management planning, strengthen diversion controls through closed loop digital systems, and maintain robust auditing and reporting systems

11. CD usage trend analysis – Define

CD usage is monitored using Define which is a benchmarking tool and allows reporting of usage to be compared to that of similar Trusts. In the graphs below ROH usage has been compared to Robert Jones & Agnes Hunt (RJAH) and The Royal National Orthopaedic Hospital (RNOH) as comparable peers.

MHRA Alert Summary 2025

In March 2025, the MHRA issued a Drug Safety Update removing the indication for modified-release (MR) opioids for post-operative pain. This decision was based on evidence of increased risk of harm, including respiratory depression and overdose, when MR opioids were used for acute pain management. The alert emphasised that immediate-release opioids should be used instead, with clear tapering plans and patient counselling to prevent misuse and accidental overdose.

This had a significant impact at ROH and several actions which led a significant decline in the use of modified release opiates.

Policy & Practice Changes:

- MR opioid prescribing for post-op pain was stopped within weeks following the alert.
- Acute pain guidelines were updated to prioritise immediate-release morphine as first-line therapy.
- A working group (Surgical, Pharmacy, Nursing, Acute Pain Team, Anaesthetics) was established to review opioid pathways and implement safer prescribing practices.

Usage Trends:

- Significant reduction in oxycodone MR use observed after March 2025.
- Initial decline in morphine use followed by a gradual increase in immediate-release morphine over the last three months, likely due to activity levels and guideline changes.

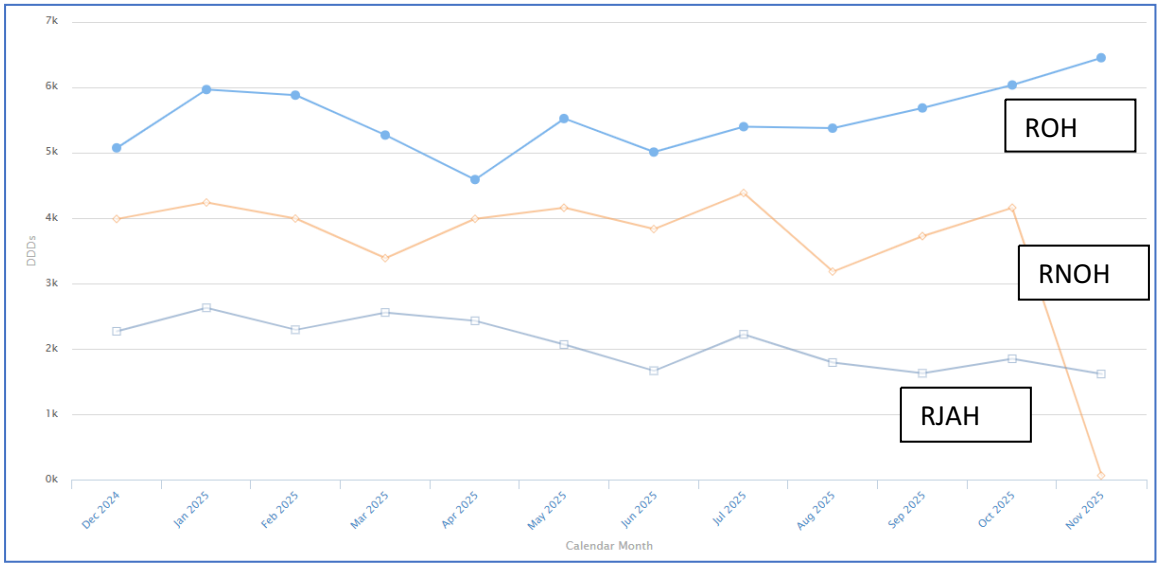
- ROH remains the highest opioid user compared to peer orthopaedic trusts, reflecting complexity of surgical cases and pain protocols.

Safety Actions:

- QI methodology used to track actions and progress produced and shared at governance meetings.
- Enhanced patient counselling on opioid tapering and risks post-discharge.
- Thematic review initiated for incidents involving opioid co-administration and patient misunderstanding of pain regimens

The graphs below indicate a significant drop in the use of MR opiates in line with the MHRA alert. There is small rise in immediate release morphine in the last quarter which is being analysed further by the acute pain group.

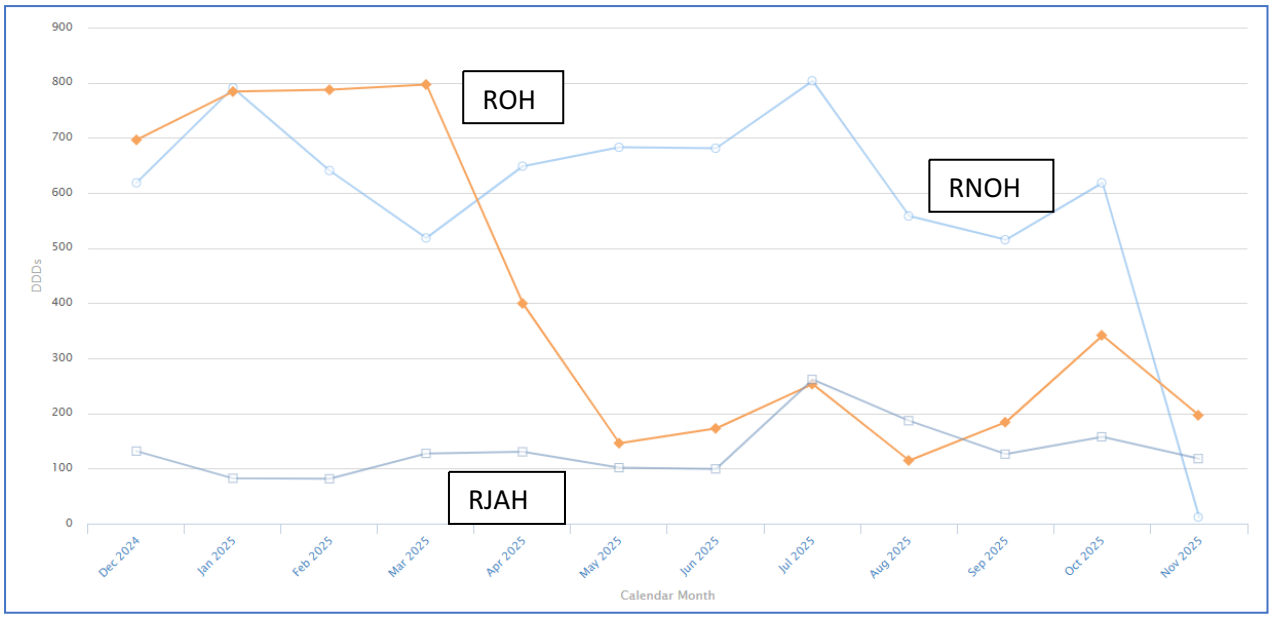
Total opioid consumption ROH vs other specialist Orthopaedic Trusts in DDDs in 2025.



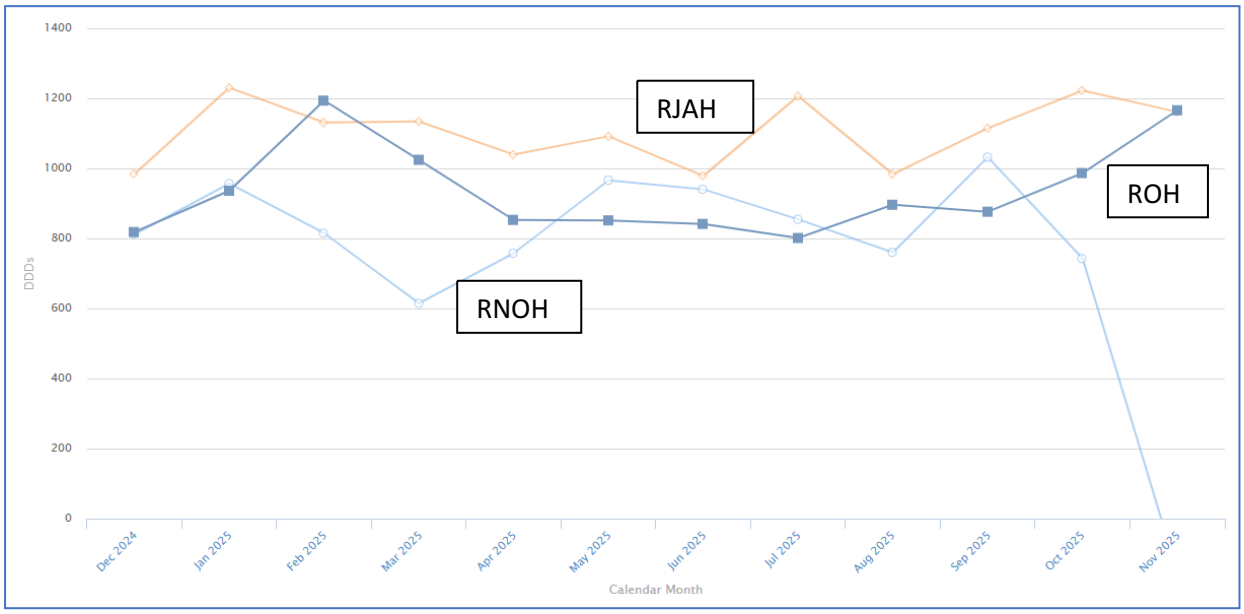
ROH has the highest total opiate consumption compared to the other Orthopaedic hospitals. This may be due to differences in pain guidelines and types of procedures. Note RNOH switched to a new EPR supplier in October 2025 hence there may be data quality issues.

Oxycodone issued in the last 12 months at ROH in DDDs vs RJAH & RNOH

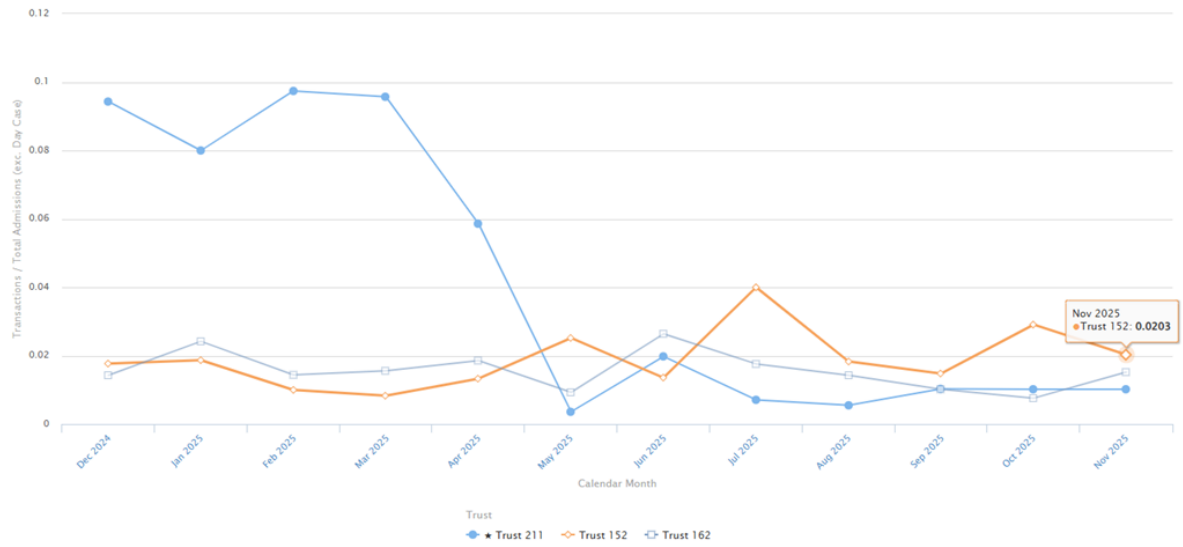
ROHQS(01-26) 09 (a)



Morphine – DDD's last 12 months ROH v RJAH & RN



Morphine MR usage – decline following MHRA alert



These graphs indicate a large reduction in the use of oxycodone following the MHRA's decision to remove the licence for modified release preparations for post op pain earlier in 2025. Use of morphine reduced initially following the changes but has gradually increased in the last 3 months, this may be down to activity as well as an increase in the use of immediate release morphine following the removal of modified release preparations. Morphine remains the first choice strong opioid ahead of oxycodone. ROH appears to use more opiates overall compared to peers RNOH and RJAH which is being explored by the acute pain group.

12. Standard Operating Procedures & Policies

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

13. Destruction and Disposal Arrangements for CDs

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

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

14. ADIOS

A decision was made to decommission the sue of ADIOS as a source of detection of anomalies. The cost had risen to 7k per annum and it was felt after review that the benefits of this software was limited and surveillance could be completed though current systems such as Pharmacy stock control and Omnicell usage reports as well as cross referencing with PICS the EPMA system.

15. A detailed KPMG audit was commissioned by the CDAO in November 2025. The results will be shared at Board in January 2026.

15. Conclusion

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

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

- Maintenance of professional knowledge of the CDAO by attendance at professional updates;
- Attendance at the CDLIN and sharing through the CDLIN occurrence report issues around CD within the Trust;
- A Governance framework which allows the Trust Board to be aware of the use and management of CD within the Trust by audits of management and usage of CD; on discharge.
- An incident reporting mechanism that allows the CDAO to be aware of all CD incidents and unaccounted for CDs within the Trust and evidence escalation to the Local Area Team CDAO;
- Mechanisms for destruction and disposal of CD take place in pharmacy in a risk assessed environment;
- A detailed audit programme exists within the Trust with frequent reviews of action plans for all clinical areas
- The roll out of automated CD cabinets and e-cd registers has improved documentation standards and security of CDS and reduced liquid discrepancies.
- Continued engagement with pharmacy and various departments and escalation via MSG CDAO group to DTC to QSE.
- Incident numbers have significantly reduced year-on-year (89 incidents to December 2025 vs 89 in 2024 and 106 in 2023), with most incidents being low harm or no harm, reflecting a strong reporting culture.
- Key themes include Omnicell booking errors, opioid co-administration post-discharge, and occasional ampoule breakages. No serious harm or diversion cases were reported externally. Pharmacy audits show >95% compliance across all areas, and automation (Omnicell cabinets and e-registers) has improved security and reduced liquid discrepancies.

Action	Owner	Timescale	Monitoring / Reporting	RAG Status
6-monthly audit of CD prescribing activity and feedback to CDAO group	Acute Pain Group / Chief Pharmacist	Every 6 months	Report to CDAO Assurance Group and QSE	Green
Strengthen discharge communication (tapering advice, polypharmacy risk)	Clinical Leads for Acute Pain/ lead pharmacist Acute pain	Q1–Q2 2026	Audit discharge letters; feedback to MSG	Amber
Enhance patient counselling post-discharge	Pharmacy Team	Q1–Q2 2026	Patient feedback; review at Medicines Safety	Amber
Ongoing education for prescribers and nursing staff (induction & updates)	Education Team / Pharmacy leads	Induction + Mid-year	Training compliance reports to MSG	Green
Embed opioid safety in induction and refresher training	Education Team / Acute Pain Group	Q1 2026 onward	Training records; governance review	Green
Maintain robust diversion controls via closed-loop digital systems	Chief Pharmacist / EPR lead/ CDAO	Q2–Q3 2026	System audit; report to CDAO group	Amber
Monitor opioid usage trends and address variance with peers	Acute Pain Group / Pharmacy	Quarterly	Benchmarking report to MSG, DTC and QSE	Amber

Sulthana Begum Chief Pharmacist for Nicola Brockie CDAO and Chief Nurse

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

Theatre	Overall Compliance (%) January 2025	Overall Compliance (%) April 2025	Overall Compliance (%) July 2025	Overall Compliance (%) October 2025
Th 1	100	100	100	100
Th 2	100	100	100	97
Th 3	97	100	100	97
Th 4	100	100	100	100
Th 5	97	100	100	97
Th 6	97	100	95	94
Th 7	97	100	100	97
Th 8	100	100	97	100
Th 9	97	92	97	100
Th 10	92	95	86	94
Th 11	94	95	89	94
Th 12	94	92	100	97
Th 14	94	100	92	97
Th 15	92	97	100	100
Main Rec	97	97	95	92
Block Area	Closed	92	100	100
ADCU	100	95	100	86
Imaging	100	100	100	100
HDU	94	92	100	94

Ward	**January 2025**	**April 2025**	**July 2025**	**October 2025**
1	95%	92%	92%	94%
2	86%	100%	95%	88%
3	92%	97%	92%	97%

4	89%	90%	87%	94%
12	96%	90%	85%	92%

LESS PAIN
MORE INDEPENDENCE
LIFE-CHANGING CARE

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

NHS
The Royal
Orthopaedic Hospital
NHS Foundation Trust

IMAGING AND RADIATION REPORT

Quality & Safety Committee: January 2026
Data Jul 2025 - Dec 2025

Author: Liz Loach
Head of Imaging
Executive Sponsor: Marie Peplow
Chief Operating officer

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Introduction

The purpose of this paper is to give assurance that Radiation safety is a priority within the Trust and that the Imaging Department it is committed to keeping exposure to ionising radiation as low as reasonably practicable. The paper will also update the Committee on the service status in Imaging and includes matters relating to patient and staff safety and experience in Imaging.

The guiding principle of radiation safety is "ALARA," which stands for "as low as reasonably achievable". This means that if there is no direct benefit from receiving radiation, even a small dose should be avoided.

1.0 Radiation safety, Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and Ionising Radiations Regulations 2017 (IRR17)

1.1 Radiation Protection Adviser (RPA)

It is essential that the Trust consults an RPA on matters relating to IRR17. X-Ray Local rules have been prepared to satisfy the IRR17 regulations. The Regional Radiation Protection and Prevention Services (RRPPS) provides this service, and our RPA is currently Mrs E Larkin.

1.2 Radiation Protection Supervisor (RPS)

As service lead, Liz Loach has been appointed as a Radiation Protection Supervisor, alongside the X-ray/CT Team Leader after completing training in October 2024. As the Lead RPS they will monitor compliance with IRR17.

1.3 Radiation Safety Advisory Group

Meetings are held bi-annually with the Radiation Physics and Protection Service. The last Radiation Safety Advisory Group (RSAG) meeting was in June 2025. Next meeting is planned for 3rd February 2026, this will provide assurance that all equipment has being checked, and any identified issues are actioned in accordance with ionising and non-ionising regulations.

1.4 Staff monitoring

All appropriate clinical staff working in x-ray, theatres and the injections suite are monitored. During this reporting period (Jul -Dec 2025) no members of staff have received an unintentional dose reading outside of national guidance. A report has been implemented internally for the ease of Dose Monitoring results sent from RRPPS which allows the RPS to keep track of any doses for each member of imaging and appropriate non-imaging staff working with radiation.

1.5 Environmental Monitoring

All x-ray rooms and the CT scanner room are monitored intermittently for dose assessment. The latest rooms to be monitored were X-Ray room 4, which covered the period 09/06/25 to 31/10/25. This showed a projected Annual Dose of <0.1 mSv (recommended is <0.3 mSv), therefore no concerns have been identified and demonstrates compliance against national standards (Appendix A).

1.6 IR(ME)R 2017

IR(ME)R procedures have been fully reviewed and transferred onto the RRPPS new template. They have been approved by RRPPS and the IRMER Lead Radiologist.

1.7 Policies

Local Rules: Updated and approved by RRPPS
Radiation Safety Policy: Reviewed, updated and approved by RRPPS, awaiting Trust approval.

1.8 Audit

RRPPS Radiation Audit, October 2024 - IRR17 and IR(ME)R 2017 documentation meet the required standards following completed actions.

2.0 MRI

2.1 MRI Safety

MRI safety is a priority therefore understanding risks is essential. All MRI Staff have completed the eLearning for Health (eLFH) MRI Safety Training and receive refresher training annually. There are 2 Magnetic Resonance Safety Officers (MRSO) on site. This enhances the understanding of scanning implants and interpreting the MRI conditions. Feedback and learning is shared with staff at QIDD bi-monthly.

RRPPS also support MRI with a Medical Physics Expert (MPE) as required. The MPE made recommendations on the annual audit report regarding additional signage, these actions are in progress and will be completed by 31.3.2026.

2.2 Policies

Local Rules: reviewed and updated in September 2024, next review date September 2026.
MRI Safety Policy: Review due February 2026 - Currently being reviewed by the MRI Team Leader and converted to a Trust Policy as opposed to a departmental policy. This will then be shared with RRPPS prior to trust approval.

2.3 Field Safety Notice

Notice received in August 2025 advising of a potential safety issue associated with the magnet venting paths of the 3 Tesla MRI system.
Potential error: an ice blockage may exist within the magnet venting system and in the event of a quench, helium gas may be unable to escape through the designed vent paths, leading to a pressure build-up within the helium containment system. This pressure build-up could ultimately rupture the helium containment system, potentially resulting in a helium leak into the scanning room.

Appropriate inspection was completed by Siemens in November 2025, within the timescale advised on the FSN. It was found that the MRI scanner had been affected by this issue and scanning should stop immediately.

Advice was followed and system was out of action for 5 days while correction works were undertaken and all advice to rectify the issue was completed.

3.0 Incidents/Patient Experience

3.1 Incidents

All incidents are logged on Ulysses. Incidents of concern and any associated with potential harm are also discussed at the Divisional Governance Meetings.

The most common categories of incident for Imaging are:

Equipment Failure - These incidents relate to three of the X-Ray rooms and the CT scanner where equipment failure occurs due to the age of the equipment which are all outside of Royal College of Radiologist recommended replacement guidance. The CT scanner and 1 x X-ray room

are on 25/26 Business Plan for replacement. Building works are currently underway, expected to finish in March 2026. The remaining 2 x X-ray rooms are included in the 26/27 Business Plan for replacement and on the Risk Register as supplier has notified that they will be unable to provide full-service and replacement support from December 2025, meaning that they may not be able to provide replacement parts, should anything break.

Clinical Assessment – The majority of these incidents relate to minor admin errors. For assurance robust training and competency documents have been devised for administration staff to support processes and avoid administrative errors. 1 x incident relates to an x-ray that was auto-reported in error, the auto-report was removed and the x-ray reported immediately to avoid delay. For assurance, this is monitored and there have been no further incidents which is positive. 1 x incident as querying the outcome of an outsourced Radiologist report, there is a robust governance procedure in place with the outsourced company to investigate any discrepancies.

Cancellation on the Day of Surgery – These relate to cancellations of interventional procedures being cancelled due to breakdowns of the CT scanner.

Radiation incidents / **Near misses** - All radiation incidents are submitted to RRPPS for a Dose Assessment and, where advised, the CQC are notified either voluntarily or as a Clinically Significant Accidental or Unintended Exposure (CSAUE).

Since the last report there have been 3 x radiation incidents submitted to RRPPS, all are recorded on Ulysses:

29/09/25	53038	CT	Patient had unnecessary SPECT CT scan (performed by Nuclear Medicine at UHB)	Referrer error – referral submitted against incorrect hospital number
05/11/25	53479	X-ray	Incorrect inpatient brought to department to have a post-op x-ray, resulting in incorrect patient receiving dose. AAR is currently in progress.	Radiographer error – correct ID checks not performed.
13/11/25	53535	X-ray	Referral for in-brace whole spine x-ray. X-rays in and out of brace were performed	Referring Consultant confirmed that out of brace x-ray was also needed, therefore not a radiation incident on investigation.

On completion of dose assessments, RRPPS advised the 2 x-ray incidents were not reportable to the CQC, in regard to dose. Upon review with the referrer these were deemed to have not caused harm and therefore were not reportable as CSAUE. The CT incident is being led by UHB as they provide the nuclear medicine service, who will advise the outcome once investigated.

Row Labels	Count of Actual Impact
1 - No Harm	41
2 - Low Harm	23
Grand Total	**64**

Of the 64 incidents reported in the time period, the vast majority of the incidents were categorised as "no harm."

Low Harm:

- 8 x related to medical equipment faults
- 7 x recategorised as "no harm" following review.
- 5 x procedures cancelled on day (due to equipment failure)
- 1 x staff fall (not reportable, no resulting sickness episodes)
- 1 x needlestick injury
- 1 x extravasation of contrast injection

1 x incident that is currently categorised as low harm remains open and is awaiting a Harm Review by an Oncology Consultant. The incident relates to a missed diagnosis on a Radiologist report. This was discussed at a Radiological Events and Learning (REAL) Meeting, where the error was noted, and area previously identified as clear, upon review, shows signs of metastatic disease. Duty of Candour has been performed on patient's clinic attendance with the Oncology Consultant.

3.2 Radiological Events and Learning (REAL) Meetings

The last REALM took place on 14th July 2025. 10 cases were reviewed including one significant discrepancy (as discussed in section 3.1)

3.3 Patient Experience

Friends and Family Test (FFT) forms are issued to patients to be completed; and the department routinely receive positive responses with overall positivity rating always exceeding 95% and patients rating their experience as 5 out of 5.

PALS – There have been 7 x PALS raised since the last report. All cases have been closed. Themes have been identified in the table below.

Theme	Modality	Quantity
Patient experience / Staff values	US	3
Appointment delays	US	2
	MRI	1
Query Radiologist report	MRI	1

COMPLAINTS - There have been 3 formal complaints since the last report was submitted.

Theme	Modality	Quantity
Communication/Patient Handling	X-RAY	1

Consent process/Pain	CT INTERVENTIONAL	1
Patient experience / Staff values	US	1

4.0 Equipment

Current guidance from the European Society of Radiology recommends that x-ray assets should be replaced at an interval of 10 years. Guidelines for Ultrasound machines are 5 years. Equipment downtime and maintenance costs escalate for assets over 10 years old. The National Imaging Data Collection found that significant numbers of CT and MRI scanners in use in the NHS are over 10 years old (>30% of MRI, >15% of CT).

4.1 Current Equipment

Modality	Manufacturer	Model	Manufacturer Date
Digital Radiography (DR)	Philips	Digital Diagnost	12/2015
	Philips	Digital Diagnost	01/2016
	Siemens	Ysio	02/2014
	Philips	Digital Diagnost	05/2023
Image Intensifiers	Siemens	Cios Fusion	04/2021
	Siemens	Cios Spin	04/2022
	Siemens	Cios Flow x6	10/2024
Mobile DR	Philips	Mobile Diagnost	03/2025
	Philips	Mobile Diagnost	03/2025
CT	Siemens	Somatom Definition AS	02/2014
MRI	Siemens	Sola 1.5T	08/2021
	Siemens	VidaFit 3.0T	01/2024
Ultrasound	Siemens	ACUSON S2000	12/2021
	Siemens	ACUSON S2000	04/2022
	Siemens	S2000	03/2019

4.2 Maintenance

- All Imaging equipment is under OEM maintenance contracts through NHSSC and RRPPS review all equipment to ensure it remains within acceptable limits.
- QA is conducted as per manufacturer guidelines and in line with IRMER Legislation by the radiographer led QA team and any variance is actioned.

4.3 Equipment Concerns

As narrated in the table above, the Digital Radiography (DR) equipment and CT Scanner are 10-11 years old. An end of full support notice has been issued for 1 x Philips and 1 x Siemens DR

room from December 2025 as a result of the age of the equipment, this could mean that parts are not as readily available and downtime could increase. The Ultrasound machines have also seen a drop in image quality which is being monitored. This is all included on the department's risk register.

This reliance on older equipment has inherent risks associated with it. While there are inevitably exceptions, newer equipment is more dependable and less likely to break down – meaning there are fewer unplanned pauses in the imaging schedule. Image quality is also significantly improved with newer equipment. As previously mentioned in section 3.1, both rooms are breaking frequently due to age. There has been a constant issue with 'image stitching' resulting in escalation to Philips on several occasions. This has caused delays to patients with at times, limited resources available.

GIRFT Feedback recommended to seek to establish a formal rolling equipment replacement plan for all imaging equipment and suggested a staggered approach when items have previously been purchased as a set. Such a plan can help reduce the effort required in each bidding cycle; it means that as well as seeking to secure the timely replacement of ageing systems, trusts can also make a stronger case for expansion – acquiring additional equipment to reflect changing demand. See Appendix B for provisional plan.

4.4 Equipment Replacement

Siemens Somatom CT Scanner: Currently undergoing replacement to a Siemens X. cite with completion planned for end March 2026. Interim solution on site.

X-ray Room 4: Currently undergoing replacement to a Siemens YSIO X. pree Gen2 with completion planned for end March 2026.

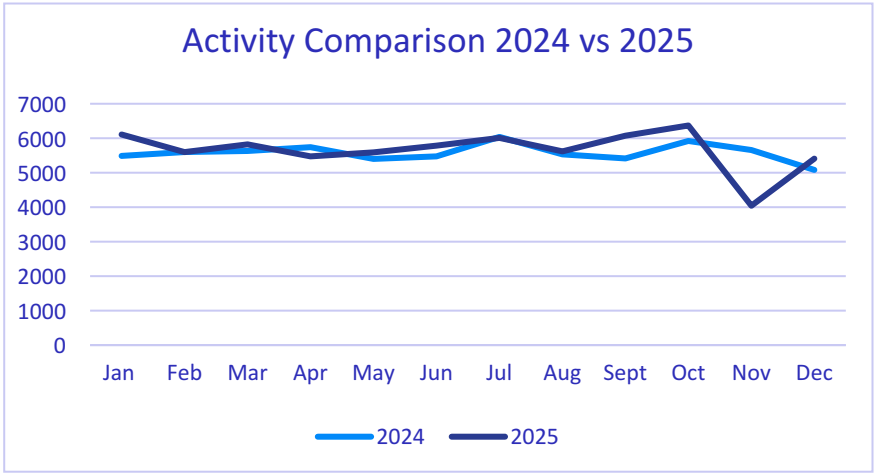
Siemens S2000 Interventional Ultrasound – GE Logic Totus Funded by the Eveson Trust charity to be delivered by end of March 2026.

The remaining 2 DR Rooms and Ultrasound machines are included in the Imaging Business Plan for Capital funding in 2026-27.

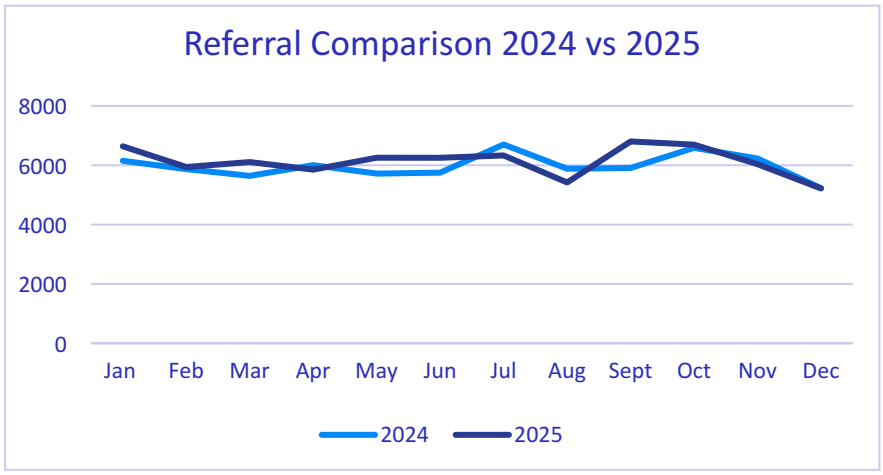
5.0 Performance

5.1 Activity Levels

Activity levels have been on the rise consistently; the graphs below show the comparison from 2024/25 to 2025/26 to date:

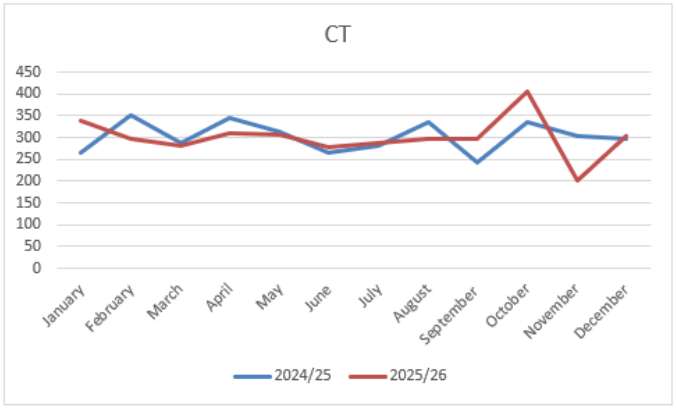


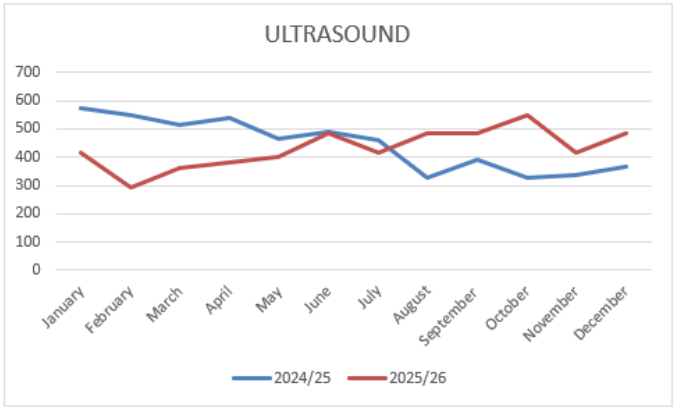
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2024	5487	5600	5631	5740	5400	5473	6039	5531	5414	5920	5657	5082
2025	6108	5597	5823	5474	5589	5786	6009	5619	6073	6369	4042	5409

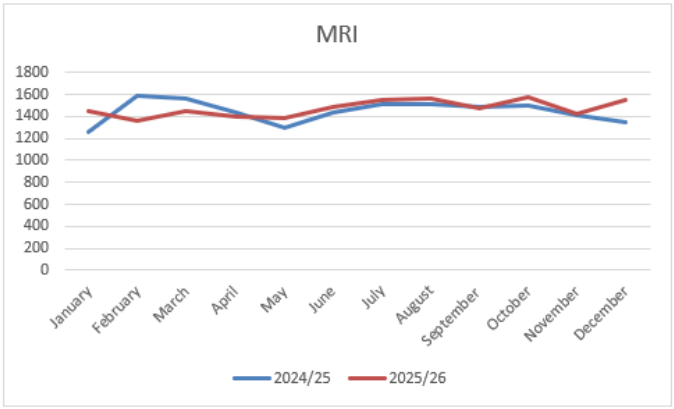


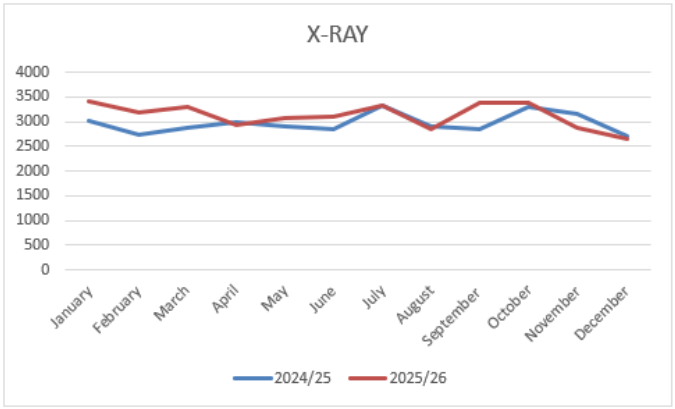
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2024	6151	5870	5642	6001	5719	5751	6698	5883	5908	6585	6227	5227
2025	6637	5940	6108	5851	6254	6252	6329	5419	6801	6695	6036	5217

Breaking this down further per modality, it shows an increase in activity across all modalities:









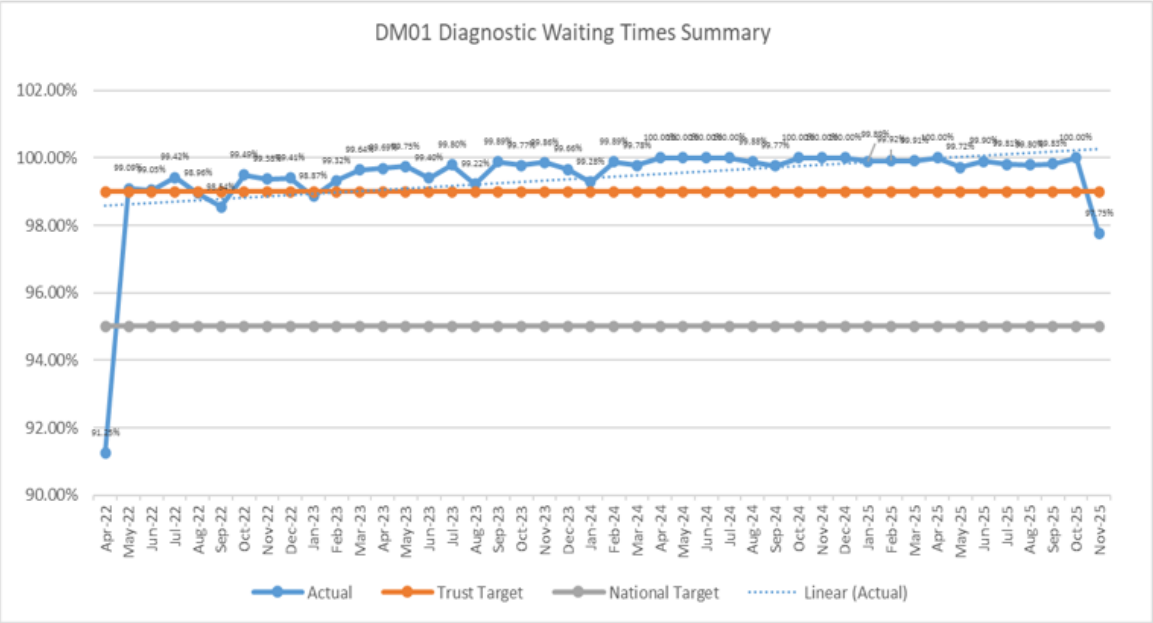
5.2 Diagnostic Waits

Current Waiting Times are as follows:

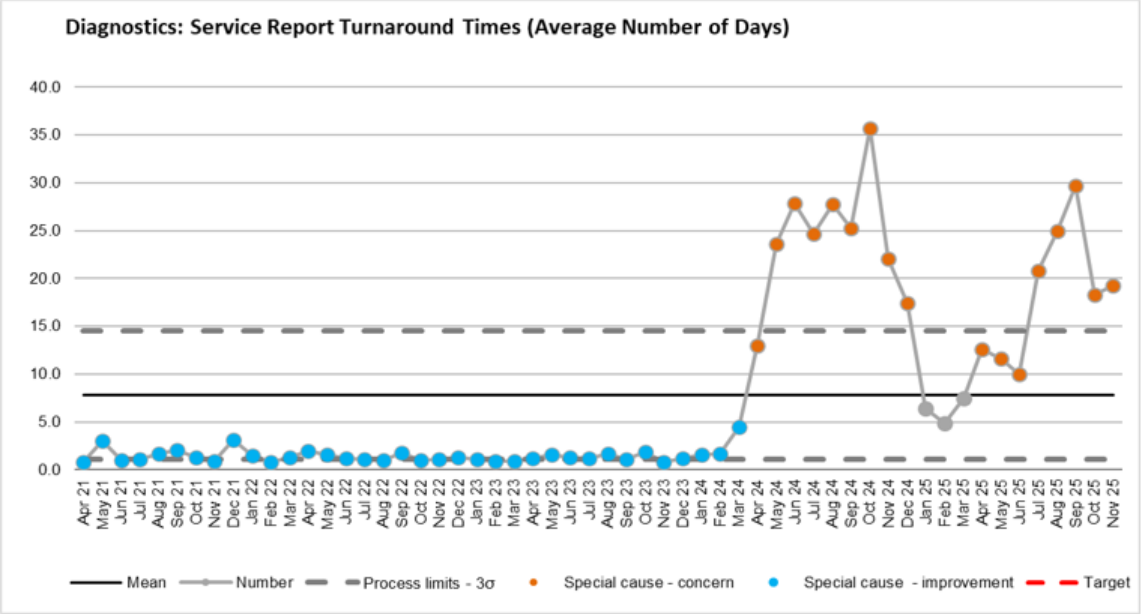
MRI	46 Days
CT	18 Days
Ultrasound	26 Days

The monthly diagnostics waiting times (DM01) and activity return collects data on waiting times and activity for key diagnostic tests and procedures. It is used to measure performance against the operational standard, that less than 1% of patients should wait 6 weeks or more for a diagnostics test.

The National 25/26 operational target is 95% is achieved consistently. ROH have maintained an internal stretch target of 99% which ROH continues to achieve consistently with the exception of November 2025 when 97% was achieved. This was due to the unexpected field safety notice served on the 3T MRI scanner, resulting in 5 days of downtime.



5.3 Reporting Times



Average reporting turnaround times have increased since the last report in June 2025 and decreased since September 2025 however remain within 6 weeks. Reporting of urgent and cancer patients is prioritised.

The main reasons for this are as follows:

- Radiologist Vacancies (See 5.4) / Maternity leave (national skill shortage)
- Increased Activity (See 5.2)
- Addition of an acceleration software package on both MRI scanners allowing more patients to be scanned per day therefore increasing total reporting capacity required.

To support the turnaround times a proportion of the Radiology reporting has been outsourced to an external company. This has enabled the service to maintain reporting times. The turnaround time for outsourced reports is 72 hours for MRI/CT and 7 days for x-ray.

With the limited reporting sessions of the Radiologists, internal reporting prioritises Oncology and urgent referrals.

The main area of concern is Young Adult Hip MRI reports. When the outsourcing began, concerns were raised by the Young Adult Hip (YAH) team regarding the quality of the reports. Due to the complexity and high quality of the MRI scans, the outsourced reports were sub-par to the ROH standard and did not provide enough information to the YAH team to assist with diagnosis. Therefore, it was agreed for all MRI Young Adult Hips to be reported internally. However, due to the limited amount of reporting sessions available, this has extended waiting times for this specialty.
The current number of Hip MRI scans to be reported is 134 . The oldest report is at the end of October as these are classified as non-urgent scans. The Radiologists are reporting these in any remaining available reporting time they have but this is limited. Therefore additional sessions have been offered outside of job plan to support this area until new recruits arrive in April 2026.The service is also exploring fellow capacity to support this reporting . Other mitigations in parallel to additional reporting sessions include ensuring that patients who have a follow up OPA are escalated to imaging by the referrer's secretary so they can be added to the urgent daily reporting list, to ensure the report is available in time for clinic. The trajectory for recovery back to 6 weeks is mid February 2026 ahead of the expanded capacity in April 2026 where full capacity will be restored.

In addition, the outsourcing company have been approached to supply a small selection of experienced MSK Radiologists that could assist with YAH reporting. These Radiologists will be selected and supplied a template from our Radiologists as to what is expected and content that needs to be included on the MRI report.

For reassurance, the following are in place for outsourced reports:

- a discrepancy process should any queries arrive regarding the content of an outsourced report.
- Urgent findings escalation process.

The auto-reporting of medically requested x-rays commenced on 06/10/2025, with the exception of Chest and Abdominal X-rays and Oncology Limb Surveillance. It is the responsibility of the medical referrer to view the x-ray and document the outcome in the patients notes in line with IRMER. Medical referrers can request an official report from the Radiologists if required. The first audit for compliance will take place in Jan 2026 followed by audit at 6 monthly intervals. Results will be shared with CSL's with an action plan for compliance as required. Audit results will be reported in this report going forward and at the Trust QID forum.

5.4 Vacancies

Radiographers

The X-Ray department have undertaken a workforce review of all clinical posts.

The X-Ray department has a funded establishment of 14.12 x WTE Band 6 X-Ray Radiographers. The current workforce is 12.96 WTE, the vacancy for 1 x WTE Band 6 Radiographer has been recruited to, awaiting HR clearance.

Radiologists

The Radiology department has a funded establishment of seven consultants. The current establishment is as follows:

Rad Number	WTE	Total PA's	Total DCC PAs per week
1.	0.95	9.5	6.75
2.	0.9	9.0	6.75
3.	1.0	10.0	7.50
4.	0.6	6.0	4.50
5.	0.6	6.0	4.50
TOTAL	**4.05**	**40.50**	**30.00**

DCC consists of Interventional Imaging, Ultrasound, MDTs, and Reporting.

We have successfully recruited two new Consultant Radiologists with a start date of 01/04/2026.

Non-Clinical

We have an establishment of 7.17 Band 2 administration posts. The current establishment is as follows:

Band 2 Admin	WTE	
1.	1.0	
2.	1.0	LTS
3.	1.0	Started 05/01/2026 – undergoing training
4.	0.8	
5.	0.53	
TOTAL	**4.33**	

These positions are currently advertised for recruitment as soon as possible and details of risk and mitigation associated with vacancies has been escalated at the Trust Vacancy panel to enable recruitment.

6.0 Risks

The Imaging risk register is reviewed monthly. The principal areas of concern at present are as follows:

- **Aging equipment** – see section 4.3.
- **Shortage of Radiologists**
  - Potential delays to diagnosis from delay in reporting of images. Risk of delay to treatment if unsuspected significant findings are discovered on the report. This risk is being managed with the continuation of outsourced reporting.

- Limited cross cover available for Annual leave. Weekly meetings with Oncology and Imaging to prioritise patients and ensure available lists are booked to full capacity. WLI's have also been offered to existing Radiologists when additional capacity is required.

7.0 Quality Standards for Imaging (QSI)

The trust is currently seeking a formal recognition for the quality imaging service provided at ROH. The 'QSI Quality Mark' is a formal recognition and offers:

- Independent recognition 'badge of quality'
- Improves and assures efficiency and validity of services.
- Assurance of the service – both internally and externally
- Compliance with regulation and guidance

The imaging department was officially awarded QSI "Working Towards" accreditation on 05/11/2025. This shows the commitment of the team to continuously improve the imaging service. We are expecting to apply for full accreditation in February/March 2026.

8.0 Conclusion

The committee is asked to receive and note the assurances offered by the paper with regard to the safety and management of the imaging service.

Appendix A - X-Ray Room 4 Environmental dose survey report

NHS
University Hospitals Birmingham
NHS Foundation Trust

RRPPS
63 Melchett Road
Kings Norton
Birmingham B30 3HP

Tel: 0121 371 7000
email: rrpps@uhb.nhs.uk

Environmental Dose Survey

ENVIRONMENTAL DOSE SURVEY

Report Reference:	R2526-027
Organisation:	Royal Orthopaedic Hospital NHS Foundation Trust
Location (Department):	Royal Orthopaedic Hospital (X-Ray)
Survey Type:	Routine
Monitoring Period:	From 09/06/25 to 31/10/25
Room:	Room 4
Report sent to:	S Begum, K Walker
Copy sent to:	E Loach
Date of issue:	16 December 2025
Assessor(s):	S McKie, S Downton-Collins, P McGookin
Authorised by:	

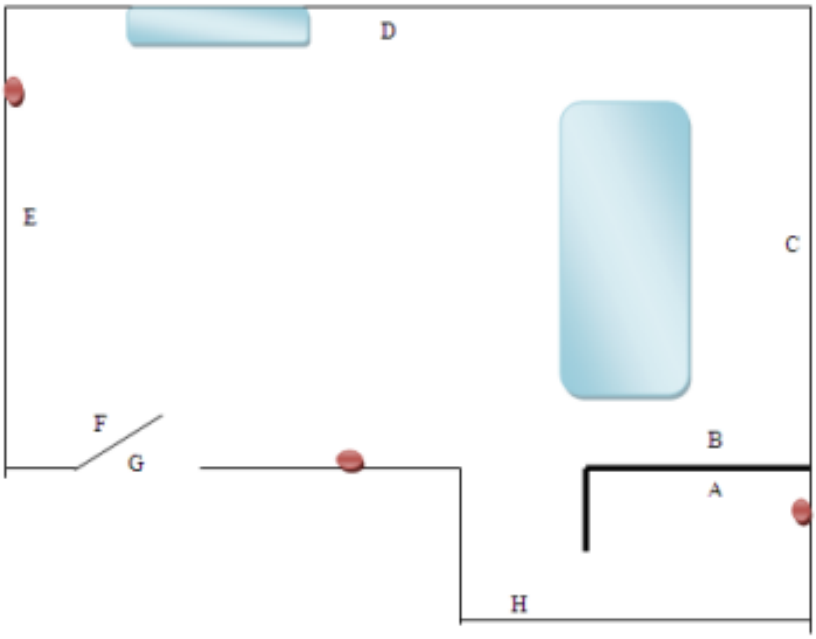
RRPPS is the Radiation Protection Service within the Imaging and Medical Physics Group of University Hospitals Birmingham NHS Foundation Trust
Director of Medical Physics: S Green PhD, FIPEM, FBIR
Head of RRPPS: Anita Jefferies MSc, MIPEM, CSci, MSRP
RRPPS operates a quality management system registered to ISO 9001:2015
XQAF901 Rev. 2.0

REPORT REF:	R2526-027	**RRPPS** 63 Melchett Road Kings Norton Birmingham B30 3HP *Tel: 0121 371 7000* *email: rrpps@uhb.nhs.uk*
ORGANISATION:	Royal Orthopaedic Hospital NHS Foundation Trust	
LOCATION (DEPT):	Royal Orthopaedic Hospital (X-Ray)	
MONITORING PERIOD:	From 09/06/25 to 31/10/25 (21 Weeks)	
ROOM:	Room 4	
Environmental Dose Survey		

Introduction

Environmental monitoring has been carried out in the X-ray department; the monitoring period is usually 12 weeks.

Room Plan



Results

TLD Position		Annual Dose at TLD Position (mSv)	Occupancy Factor (%)	Projected Annual Dose Outside Room (mSv)
A	Behind Screen	<0.1	100	<0.1
B	Inside Room	0.3	100	<0.1
C	Inside Room	2.7	100	<0.1
D	Inside Room	<0.1	100	<0.1
E	Inside Room	0.7	100	<0.1
F	Inside Room	<0.1	100	<0.1
G	Outside Room	<0.1	100	<0.1
H	Inside Room	<0.1	100	<0.1

REPORT REF:	R2526-027	**RRPPS** 63 Melchett Road Kings Norton Birmingham B30 3HP *Tel: 0121 371 7000* *email: rrpps@uhb.nhs.uk*
ORGANISATION:	Royal Orthopaedic Hospital NHS Foundation Trust	
LOCATION (DEPT):	Royal Orthopaedic Hospital (X-Ray)	
MONITORING PERIOD:	From 09/06/25 to 31/10/25 (21 Weeks)	
ROOM:	Room 4	
Environmental Dose Survey		

Conclusions

In accordance with the Ionising Radiations Regulations 2017[1], protection must be provided to ensure that doses to persons in adjacent areas are as low as reasonably practicable. The Approved Code of Practice recommends this is less than 0.3mSv per annum[2]. All projected annual doses are below this.

A complete record of all surveys and the results obtained are kept by RRPPS
In accordance with our quality system, RRPPS actively seeks customer feedback.
If you have any comments regarding the services we provide, please do not hesitate to contact us at rrpps@uhb.nhs.uk

[1] Ionising Radiations Regulations 2017, Statutory Instruments 2017, No. 1075, London, HMSO.
[2] Work with Ionising Radiation, Ionising Radiations regulations 2017, Approved Code of Practice and guidance, L121 (Second Edition), 2018, HSE.

Appendix B – Capital Replacement Pan

Modality	Equipment	Lead	Installation date	Planned replacement date	Included in Business plan?	Progress Status
CT	CT Scanner	EL	2014	2025/2026	Y	Replacement works underway
X-Ray	X-Ray Room 4	EL	2014	2025/2026	Y	Replacement works underway
X-Ray	X-Ray Room 2	SB	2014	2025/2026	Y	Quotes received - awaiting funding approval
X-Ray	X-Ray Room 1	SB	2015	2026/2027	Y	awaiting funding approval
Ultrasound	US scanner 1	CW/YN	Apr-22	2026/2027	Y	Paperwork to be sent to MDAG for approval to trial
Ultrasound	US scanner 2	CW/YN	Dec-21	2026/2027	Y	Paperwork to be sent to MDAG for approval to trial
X-Ray	Cios Fusion	SB	Apr-21	2028/2029		
X-Ray	Cios Spin	SB	Apr-22	2029/2030		
X-Ray	Cios Flow (x6)	SB	Oct-24	2031/2032		
MRI	MRI 1.5T	KD	13/09/2021	2031/2032		
MRI	MRI 3T	KD	08/01/2024	2034/2035		
X-Ray	X-Ray Room 3	SB	May-23	2033/2034		
X-Ray	Mobile X-ray (x2)	SB	Mar-25	2034/2035		

UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

Date Group or Board Met: 27 January 2026

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• There had been difficulties with meeting the December 2025 Theatre In Session Utilisation due to sickness absence which has had resulted in several cancelled procedures • It was noted that as of Month 9 the income was below plan due to variable ERF underperformance, Diagnostics and Private Patient income • There has been a decline in Private Patient income. • The continued pressure on cash was highlighted • Turnover had increased, although was anticipated to return to lower levels next month • The risks associated with the planning submission were discussed in detail	• InterSystems to be invited to a future Board workshop • Actions were reported to be underway to address sickness absence
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Performance against the RTT target was noted to be ahead of plan • There was reported to be strong performance against the Cancer and Diagnostics targets • There have been some efficiencies noted in month against the Cost Improvement Programme, although there remained under delivery against the full programme • The latest version of the Integrated Performance Dashboard was discussed and was used to highlight the exceptions from a finance perspective • Bank staffing had reduced, although was higher than desired to cover sickness absence. Agency staffing usage remained low • It was noted that management of sickness absence was much better and staff having high sickness absence were being challenged as per Policy • Mandatory Training take up was reported to have improved, this being associated with the introduction of the Learning Management System	• None specifically
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.	

Finance and Performance Report

Month 9

December 2025

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.

Assurance Reports: Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

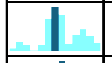
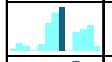
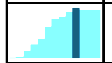
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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

Assurance Reports: Operational Performance On A Page

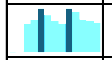
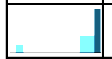
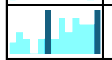
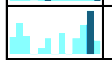
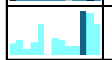
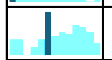
Metric	In Month	Previous Month	Target	Variation	Assurance
RTT Combined (against trajectory constitutional target remains 92%)	61.93%	61.83%	59.31%	H	P
65 Week waits (65-77 weeks)	0	0	0	L	P
52 week waits (52-64 weeks)	198	227	263	L	P
RTT Proportion of Patients Waiting 52 weeks	1.50%	1.72%	1.99%	L	P
RTT First Appointment Waiting List	66.09%	66.49%	66.20%		F
RTT Waiting List Size	13,177	13,196	13,218	L	P
Diagnostics volume YTD (compared to plan) - CT, MRI and Ultrasound	20,283 Cumulative	17,942 Cumulative	19,162 YTD Target	H	P
Diagnostic 6 week target	99.8%	97.8%	99%	H	P
Theatre Session Utilisation	87.2%	94.5%	85%		P
Theatre Insession Utilisation (Capped)	80.5%	80.9%	85%		F
Bed Occupancy (excluding CYP and HDU)	71.5%	72.7%	82-85%		F
LOS - Excluding Oncology, Paeds,YAH, Spinal	3.58	2.68	n/a		-

Metric	In Month	Previous Month	Target	Variation	Assurance
All Activity YTD (compared to plan)	11,122	9,868	11,176		F
Outpatient activity YTD (compared to plan)	55,523 102.3%	49,949 104.0%	54,010	H	P
Outpatient Did Not Attend (YTD)	7.7%	7.6%	8%	L	P
PIFU	556 10.72%	588 10.51%	537 5%	H	P
Virtual Consultations (target is to plan, operational planning guidance is 25%)	10.7%	10.3%	19%	L	F
Cancer - 31 day first treatment	100.0%	100.0%	96%	H	P
Cancer - 62 day (traditional)	80.00%	84.00%	75% National 85% Trust	H	P
28 days FDS	73.1%	86.3%	77%		F
Patients over 104 days (62 day standard)	0	0	0	L	P
POAC activity volumne (YTD) (target set is average monthly 19/20 activity)	17,674	15,880	17,282 YTD Target	H	P
LOS - elective primary hip	2.88	3.30	2.70		F
LOS - elective primary knee	2.90	2.70	2.70		F

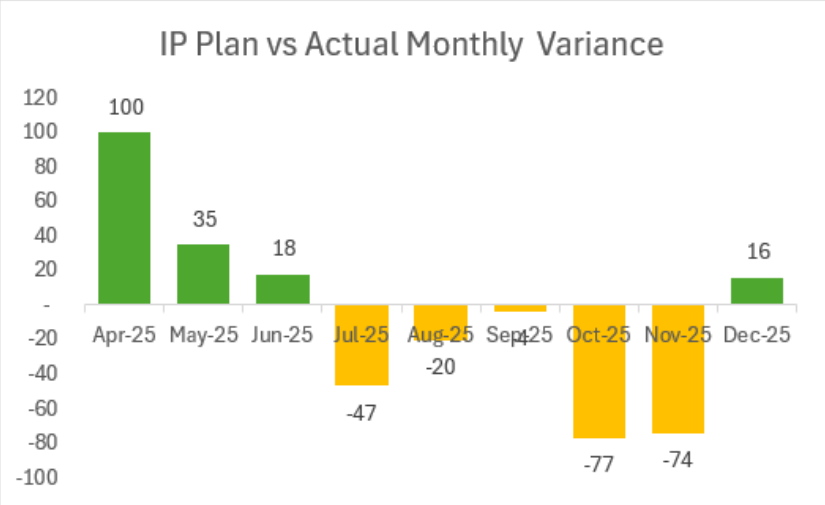
Integrated Performance Dashboard: Operational

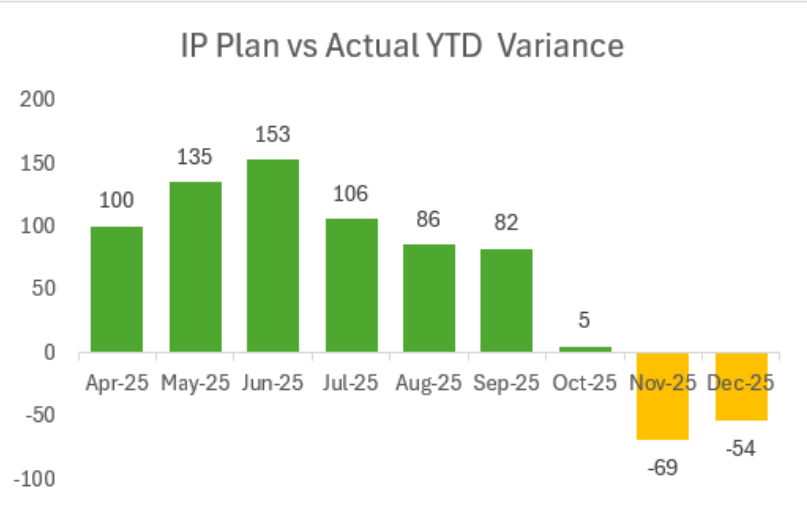
Metric Grouping	Metric Name	Reporting Period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Outpatients	Outpatient Did Not Attend	Monthly	8.4%	8.2%	8.0%	7.1%	7.5%	7.0%	6.8%	6.0%	7.5%	6.3%	6.5%	7.6%	7.7%	7.0%		low is good			8%
Outpatients	PIFU	Monthly	10.2%	11.0%	11.8%	10.1%	10.5%	10.4%	9.8%	10.6%	11.0%	11.4%	10.9%	10.5%	10.7%	10.6%		high is good			5%
Outpatients	Virtual Attendances	Monthly	11.4%	9.9%	9.3%	9.8%	10.1%	9.8%	10.5%	10.3%	10.9%	10.2%	9.9%	10.3%	10.8%	10.32%		high is good			
Outpatients	OP Attendances Patients Who Waited 31 to 60 Mins to be Seen	Monthly	6.7%	8.1%	7.5%	6.1%	7.4%	12.8%	15.5%	13.8%	7.7%	9.7%	10.8%	9.4%	8.0%	10.57%		low is good			
Outpatients	OP Attendances Patients Waited Over 60 Mins to be Seen	Monthly	1.7%	2.3%	1.9%	1.6%	2.2%	4.2%	5.1%	5.6%	1.5%	3.3%	3.5%	3.9%	1.9%	3.46%		low is good			
referral to treatment	RTT Total Waiting List Under 18 weeks	Month Ending	51.61%	52.01%	53.14%	54.66%	55.63%	58.33%	60.07%	60.34%	61.47%	62.32%	61.77%	61.83%	61.93%	NA		high is good			59.31%
referral to treatment	RTT First Appointment Waiting List Under 18 weeks	Month Ending	52.79%	53.62%	53.06%	54.06%	54.61%	57.78%	61.78%	62.03%	64.55%	66.54%	66.82%	66.49%	66.09%	NA		high is good			66.20%
referral to treatment	RTT Total Waiting List Size	Month Ending	14,517	13,777	13,291	12,738	12,739	12,798	12,952	13,345	13,447	13,351	13452	13,196	13,177	NA		low is good			13,218
referral to treatment	RTT Patients Waiting 65 Week waits	Month Ending	13	19	6	1	0	0	0	0	0	0	1	0	0	NA		low is good			0
referral to treatment	RTT Patients Waiting 52 week waits (52-64 weeks)	Month Ending	842	727	672	487	486	507	466	446	427	375	319	227	198	NA		low is good			263
referral to treatment	RTT Proportion of Patients Waiting 52 weeks and over	Month Ending	5.89%	5.41%	5.10%	3.83%	3.82%	3.96%	3.60%	3.34%	3.18%	2.81%	2.38%	1.72%	1.50%	NA		low is good			1.99%

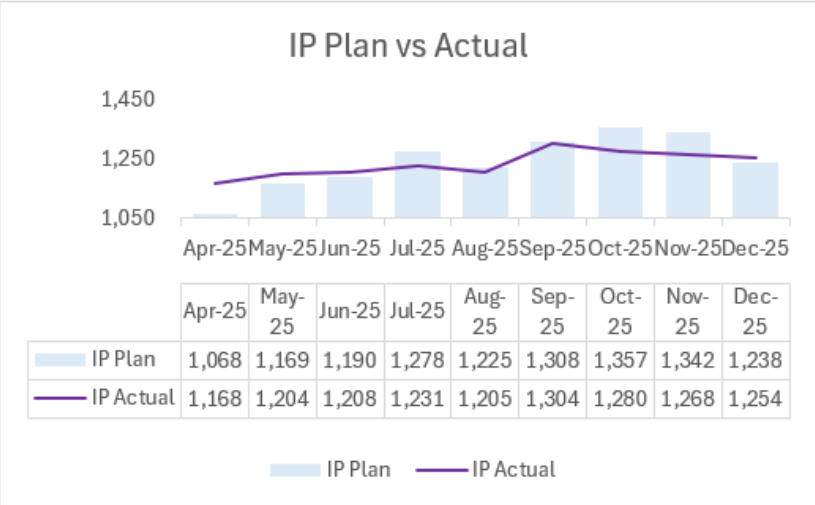
Integrated Performance Dashboard: Operational Productivity

Metric Grouping	Metric Name	Reporting Period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Operational Productivity	Theatre Number of Sessions Planned	Monthly	511	563	520	558	518	514	524	564	506	560	600	534	553	4,873			-	-	
Operational Productivity	Theatre Session Utilisation	Monthly	85.48%	93.07%	89.23%	84.64%	90.40%	84.60%	83.10%	85.00%	84.20%	87.90%	88.70%	94.50%	87.23%			high is good			85%
Operational Productivity	Theatre In-Session Utilisation Upcapped	Monthly	79.36%	82.47%	83.64%	84.04%	84.38%	84.53%	82.37%	81.68%	85.39%	83.61%	82.72%	84.63%	83.58%			high is good			85%
Operational Productivity	Theatre Touchtime Utilisation Upcapped	Monthly	75.85%	75.86%	80.29%	81.12%	82.80%	81.70%	80.80%	80.30%	82.80%	82.30%	81.10%	80.90%	80.53%			high is good			85%
Operational Productivity	Average Number Of Operations Per List	Monthly	2.78	3.05	3.08	2.96	3.18	3.19	3.12	3.00	3.16	3.07	2.91	3.01	3.07	3.08		high is good	-	-	-
Operational Productivity	Average Mins Late Starts(minutes) *Based on 9pm Start Time	Monthly	0	1	0	0	0	0	0	0	0	0	2	2	5	1		low is good	-	-	-
Operational Productivity	Average Early Finishes (minutes)	Monthly	117	94	85	83	82	84	85	92	81	83	86	78	84	84		low is good	-	-	-
Operational Productivity	Average Patient Turnaround (minutes)	Monthly	13	14	13	11	13	17	13	16	14	16	15	15	17	15		low is good	-	-	-
Operational Productivity	Admitted Treatment Deferred	Monthly	35	44	36	24	28	34	24	38	24	34	43	52	33	277		low is good	-	-	-
Operational Productivity	Cancelled By Hospital On Day of Admission	Monthly	6	4	2	3	2	2	2	5	0	4	2	6	3	23		low is good	-	-	-
Operational Productivity	Cancelled By Hospital Day Before Day of Admission	Monthly	25	27	22	26	35	19	28	27	24	24	42	41	35	240		low is good	-	-	-
Operational Productivity	LOS - Trust Wide All Services	Monthly	4.5	3.3	3.4	3.7	4.0	3.7	3.8	3.5	4.2	3.4	3.5	3.5	4.2	3.8		low is good	-	-	-
Operational Productivity	LOS - Excluding Oncology, Paeds,YAH, Spinal	Monthly	4.08	3.05	3.03	3.15	3.41	3.26	3.43	3.01	3.50	2.95	3.03	2.68	3.58	3.2		low is good	-	-	-
Operational Productivity	LOS - Elective Primary Hip	Monthly	3.0	3.0	2.4	2.7	3.0	4.1	3.1	3.3	3.2	3.6	3.5	3.3	2.9	3.3		low is good			2.7
Operational Productivity	LOS - Elective Primary Knee	Monthly	3.3	3.0	2.6	2.7	3.4	3.3	2.7	3.3	2.8	2.7	3.3	2.7	2.9	3.0		low is good			2.7
Operational Productivity	BADS Daycase rate	Monthly	51.50%	52.40%	51.10%	53.40%	54.60%	53.50%	53.00%	52.40%	53.60%	56.30%	0.00%	0.00%	0.00%	35.93%		high is good	-	-	
Operational Productivity	OP for first or follow-up Attendances attracting a procedure tariff	Monthly	37.44%	37.95%	37.35%	37.50%	32.78%	35.28%	36.24%	37.04%	38.08%	38.88%	37.23%	38.39%	36.44%	36.71%		high is good			

Assurance Reports: Inpatients



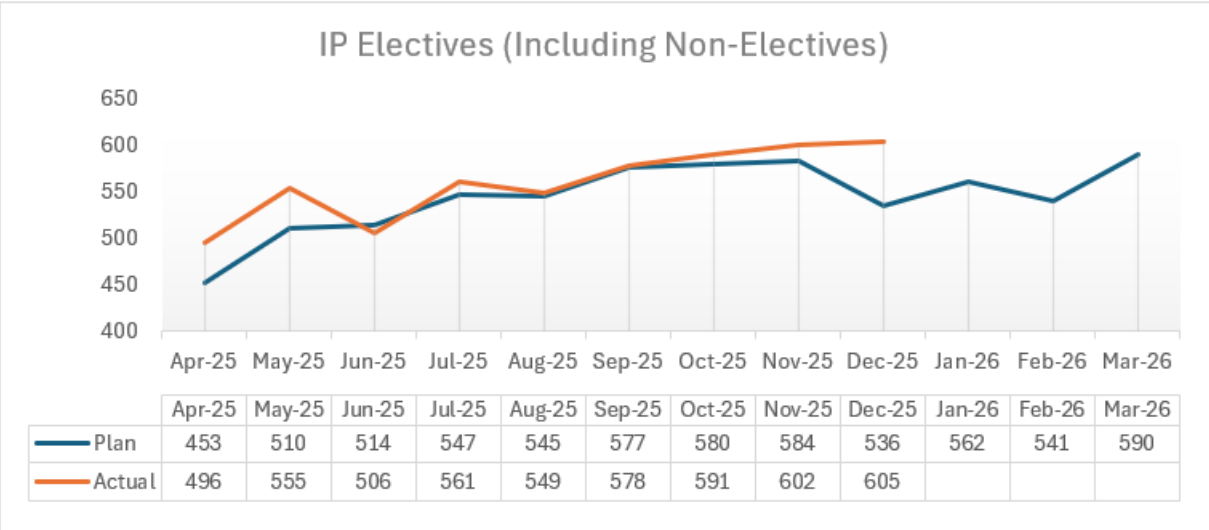




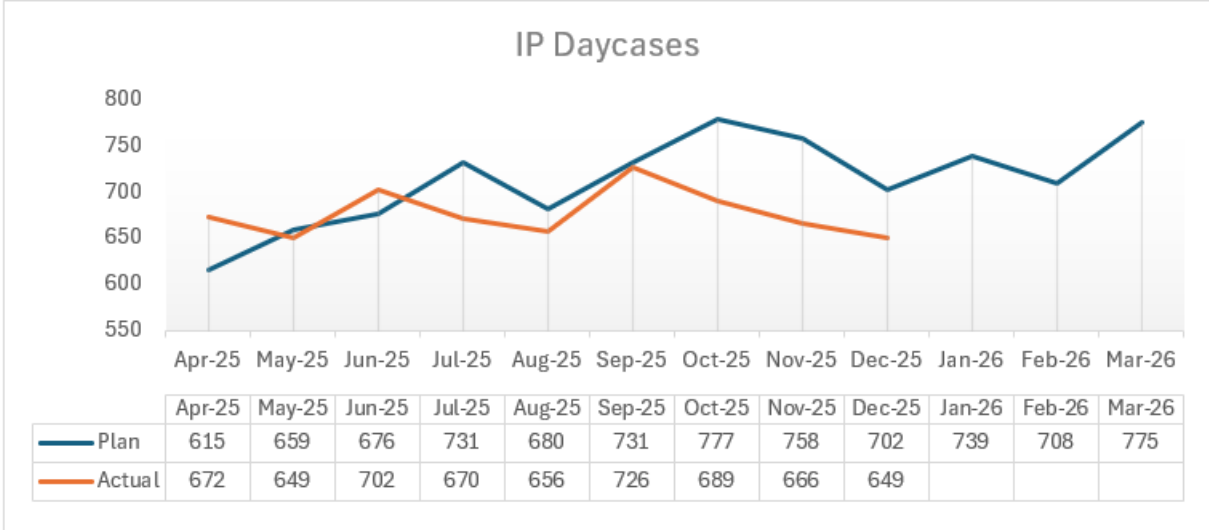
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
IP Plan	1,068	1,169	1,190	1,278	1,225	1,308	1,357	1,342	1,238
IP Actual	1,168	1,204	1,208	1,231	1,205	1,304	1,280	1,268	1,254

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Positive in month position with a surplus 16. However, YTD deficit by 54 cases. The plan as of December 25 would be to recover the YTD deficit over the rest of quarter 4, however there is now a further risk to recovery due to the forecast position for January 26 being behind plan. This relates to theatre staff availability to maximise available capacity.	Maximise existing capacity and consider opportunities for additional capacity carefully balanced against the financial position. This is contingent on theatre staff volunteering for additional sessions. Break even plan including increase in activity delivery in Q4 with associated trajectory in place.	Weekly senior review of activity by executive team and COO . Daily oversight by Director of Deputy COO/ operations	Corporate Risk Register Ref 269	High

Assurance Reports: Inpatients continued



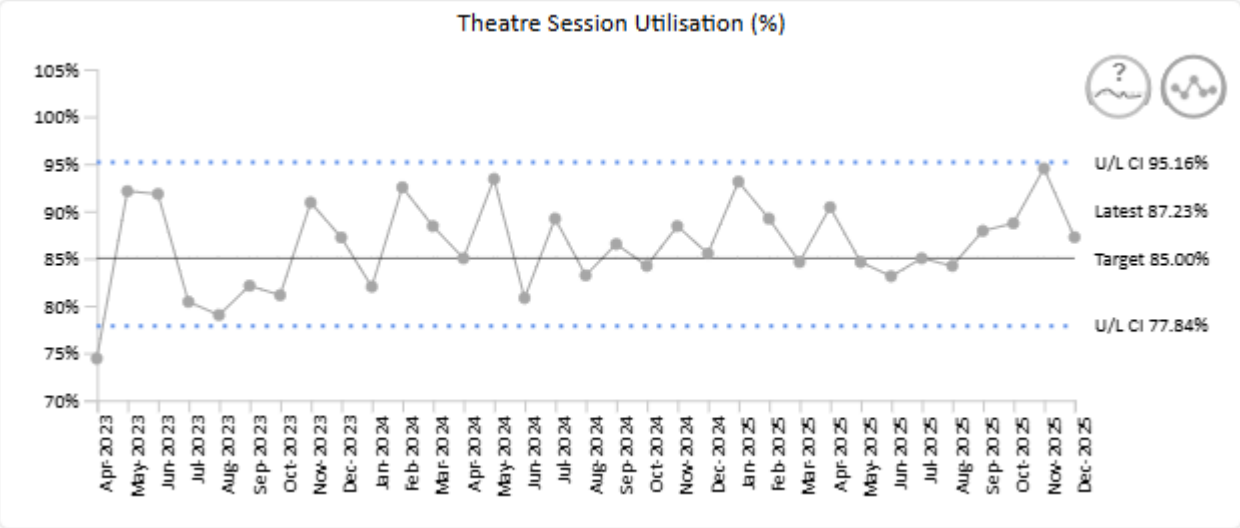
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Plan	453	510	514	547	545	577	580	584	536	562	541	590
Actual	496	555	506	561	549	578	591	602	605			

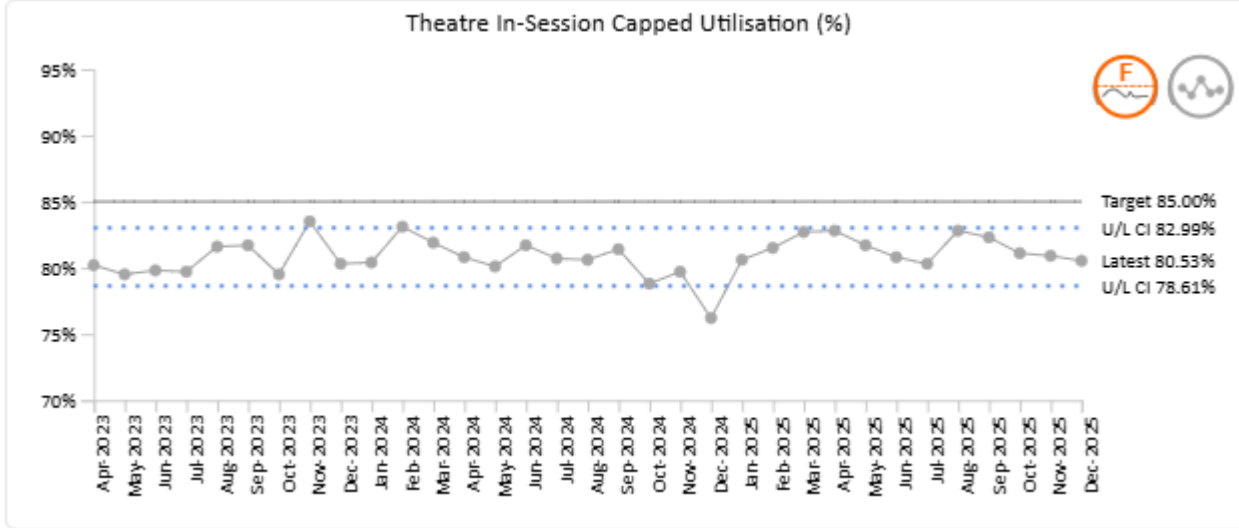


	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Plan	615	659	676	731	680	731	777	758	702	739	708	775
Actual	672	649	702	670	656	726	689	666	649			

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Elective activity was over plan for Dec 25 by 69 cases offsetting day cases being under plan by 53 cases. Electives attract a higher tariff, therefore have greater impact on financial recovery plan . There is a shift in day case procedures to outpatient settings.	BADS workforce group focussing specifically on improving day case rates for the Trust. Intended length of stay to be captured on PAS as day cases for routine joints within the outpatient setting. Focus on day case spinal underway – engagement with clinicians commenced.	31.03.2026 31.03.2026	Corporate Risk Register Ref 269	High

Assurance Reports: Theatres





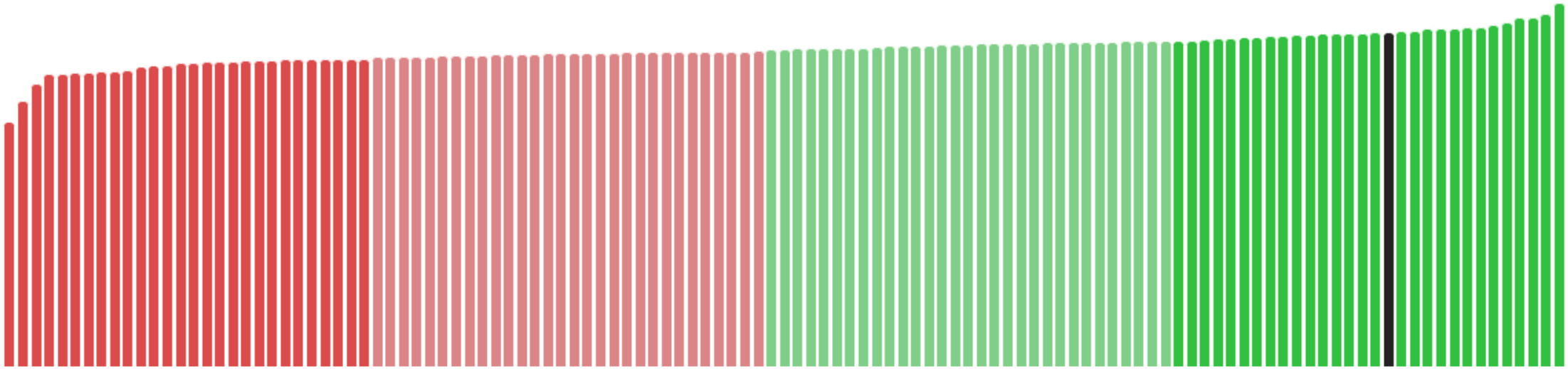
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Session utilisation is above target at 87.23% and capped theatre utilisation is currently 80.53% below the 85% cap. However, we benchmark well with peers as per the model hospital slide later in the pack. December 2025 utilisation was impacted by seasonal staff and patient illness and industrial action. Theatre 1, 2 and 4 have ongoing challenges with temperature and the plant is currently inaccessible to undertake repairs. All 3 theatres need to be closed for a minimum of 3 weeks. This has been scheduled for W/C 7th April 2026 to avoid impact on this year's activity/financial plan. There is a risk that the temperature in theatres rise over 25 degrees necessitating earlier closure.	Theatre 1 and 2 remain open and in use Theatre 4 is being used 3 days per week (Mon/Wed/Fri) supported by a SOP/QIA to include daily monitoring of the temperature anda dynamic risk assessment process supported by IPC colleagues . Reallocation of activity to other theatres where 'general offer' lists have been identified. This would be monitored via the scheduling meeting but is not guaranteed therefore potential loss of capacity if theatre temperature rises beyond control limits	Planned maintenance in April 2026	Corporate risk ref:770	High

Assurance Reports: Theatres Benchmarking Model Hospital

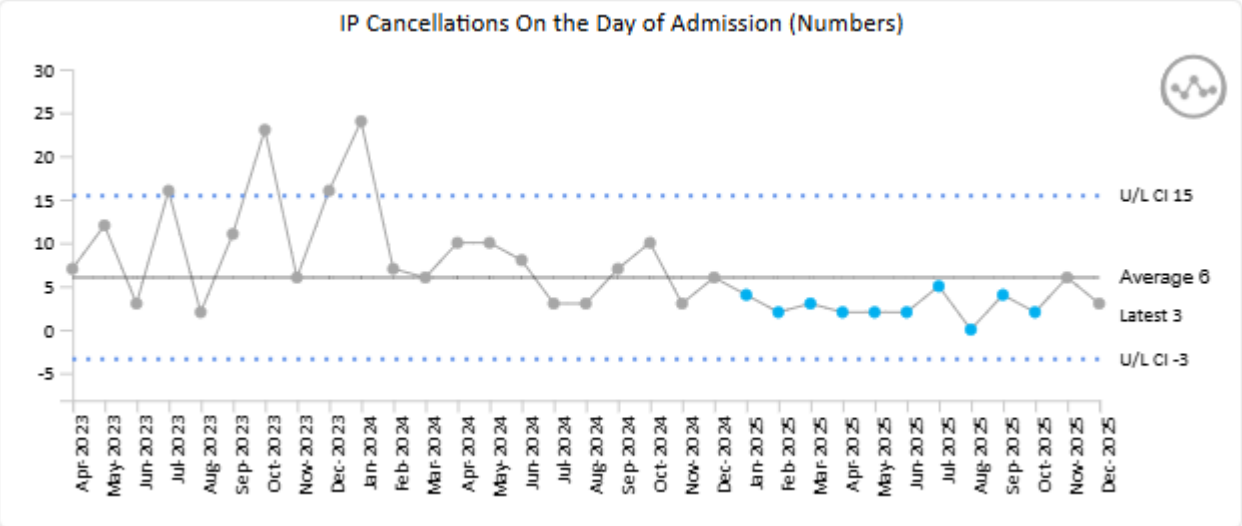
Nov 2025

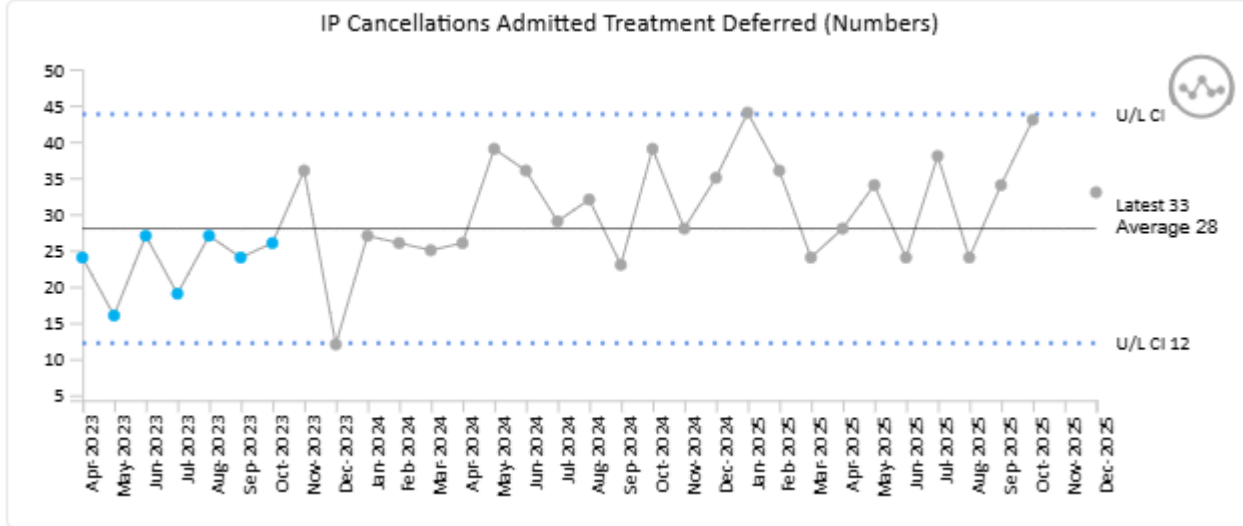
Provider value	Peer median	Provider median
Provider Quartile 4	Provider Quartile 3	
85.2%	**82.1%**	**80.7%**

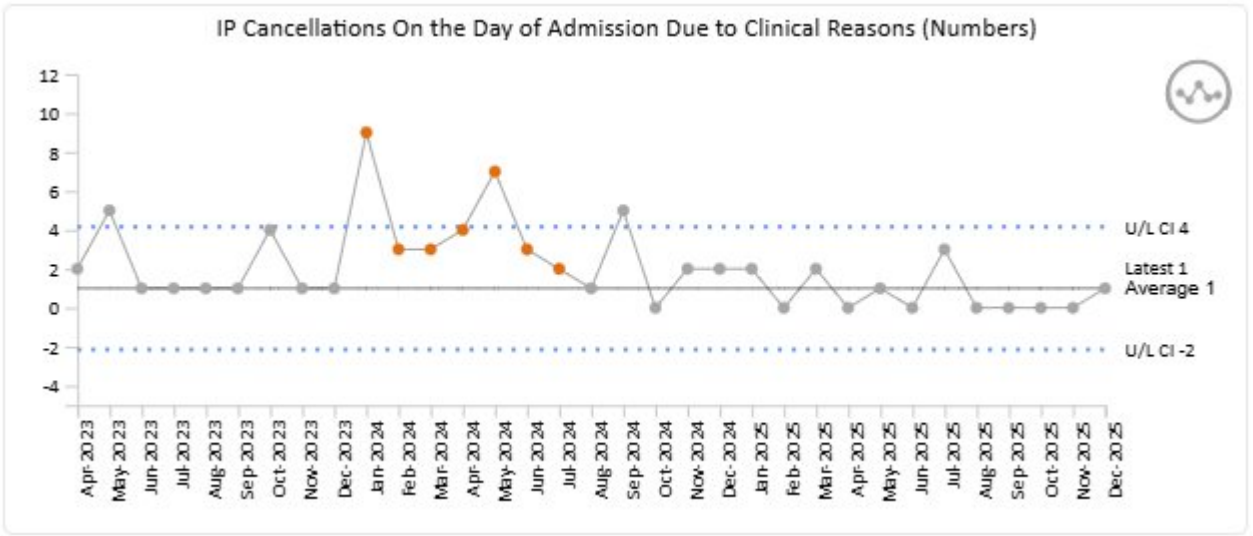
85.2% is in Provider quartile 4 - Highest 25% [green]

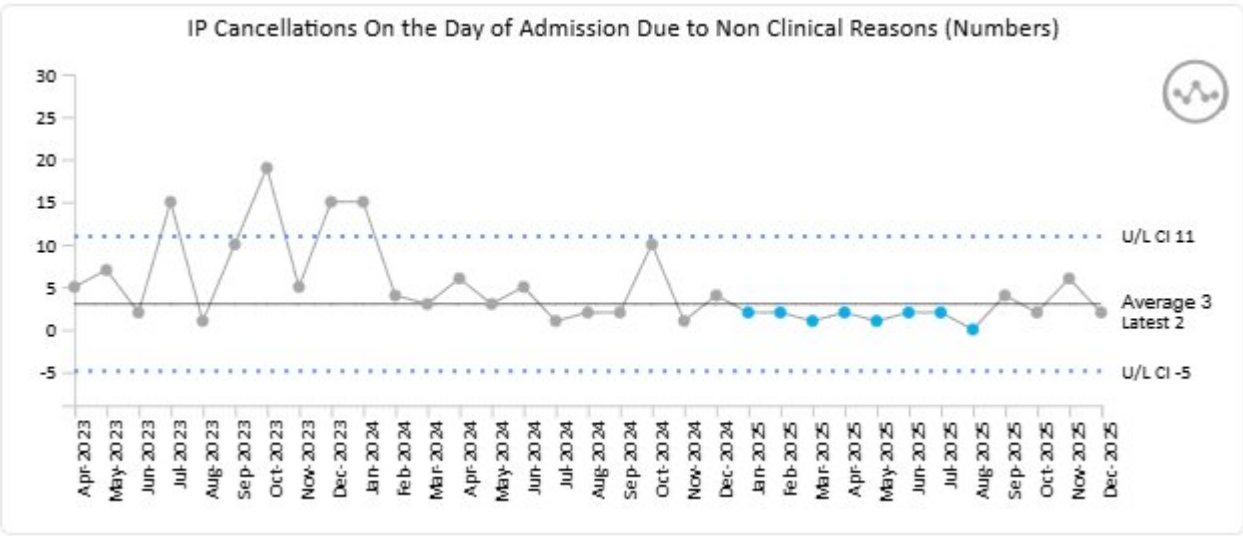


Assurance Reports: Inpatients continued – Cancellations

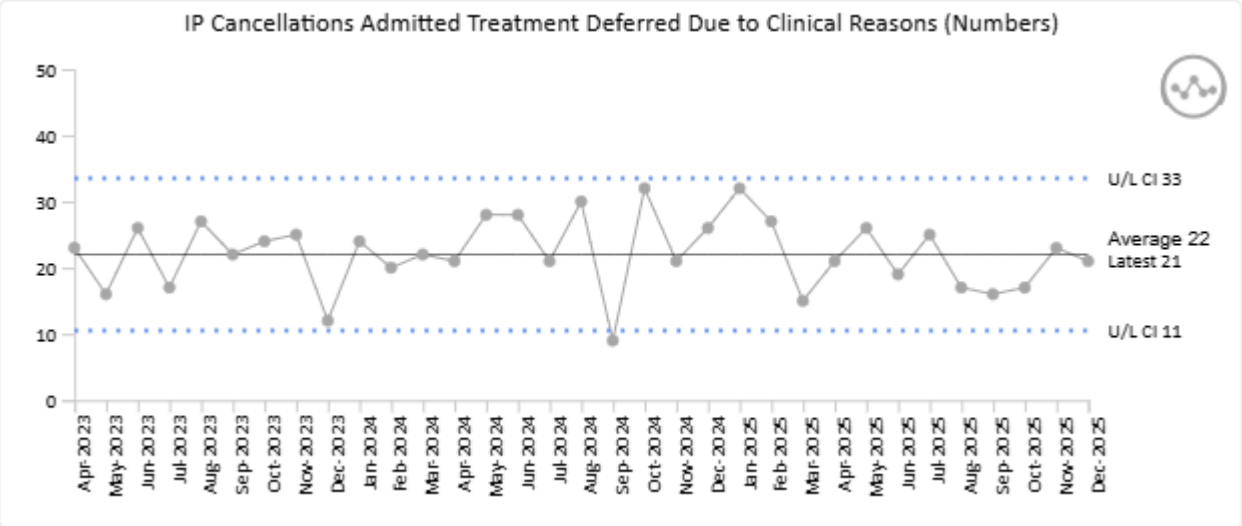


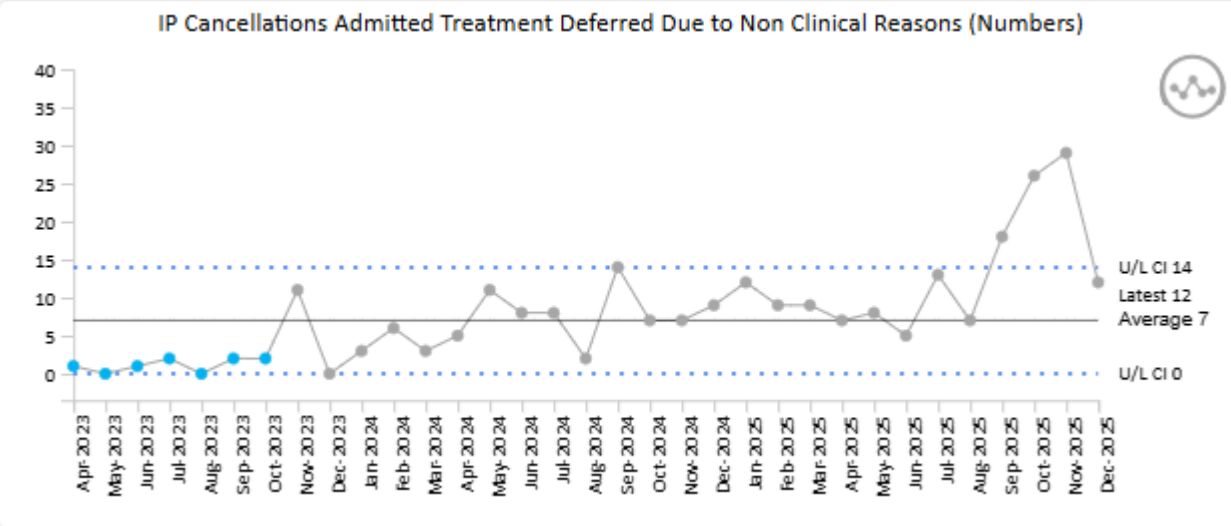






Assurance Reports: Inpatients continued - Cancellations



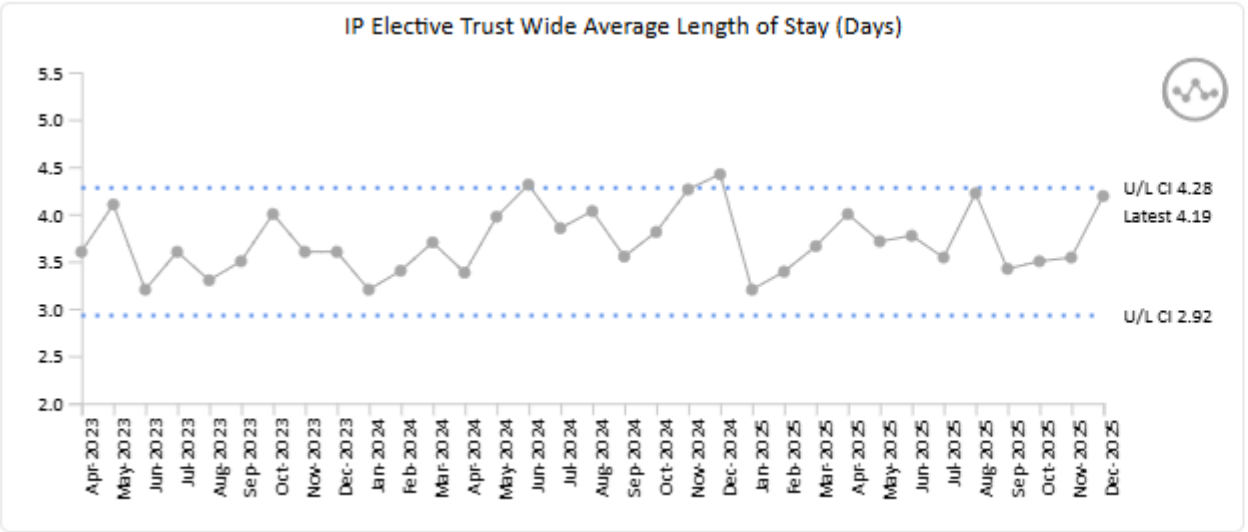


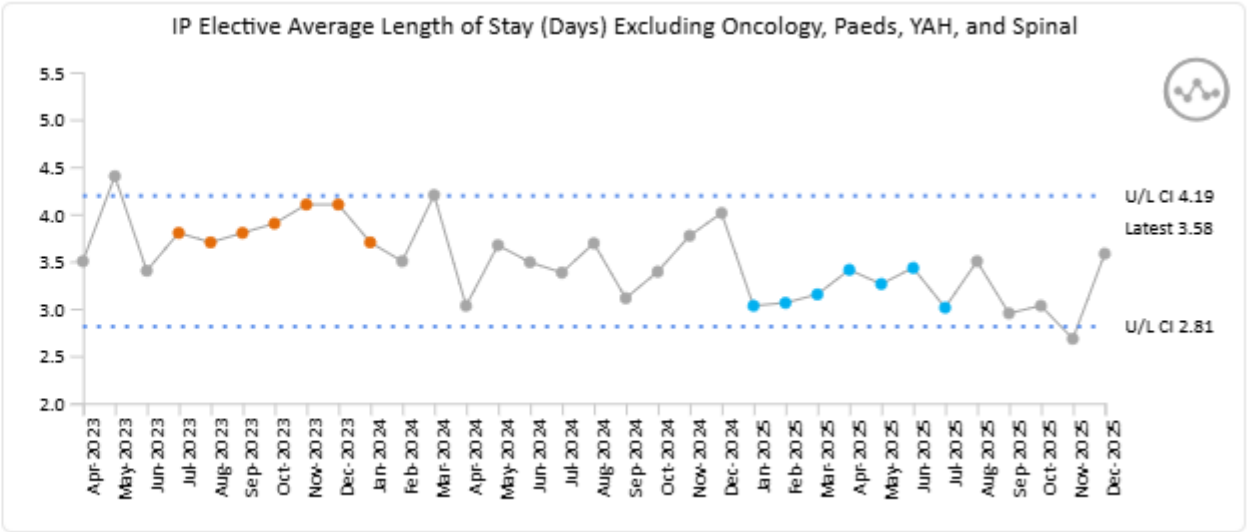
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Summary of cancellation themes with Q4 action plan in place and outlined in the action table (Column 2). December 25 cancellations on the day and admitted and deferred were lower than November 25 noting a positive improvement in performance. There has been a slight increase in clinical cancellations on the day due to seasonal illnesses. Cancellations on the day due to non-clinical reasons have reduced during December 25.	**Lack of theatre time for list completion where theatre team cannot accommodate an overrun** Planned v's actual data used to support peer challenge at theatre scheduling meetings to ensure the theatre lists accurately reflect the likely procedure times based on learnt procedure times. As a result of this, improvements have been made in early finish times, and this will improve overall utilisation. Exploring the opportunity to roster an additional late team to support unplanned overruns **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)	Weekly monitoring at Theatre Scheduling meetings Q4 Q4		high

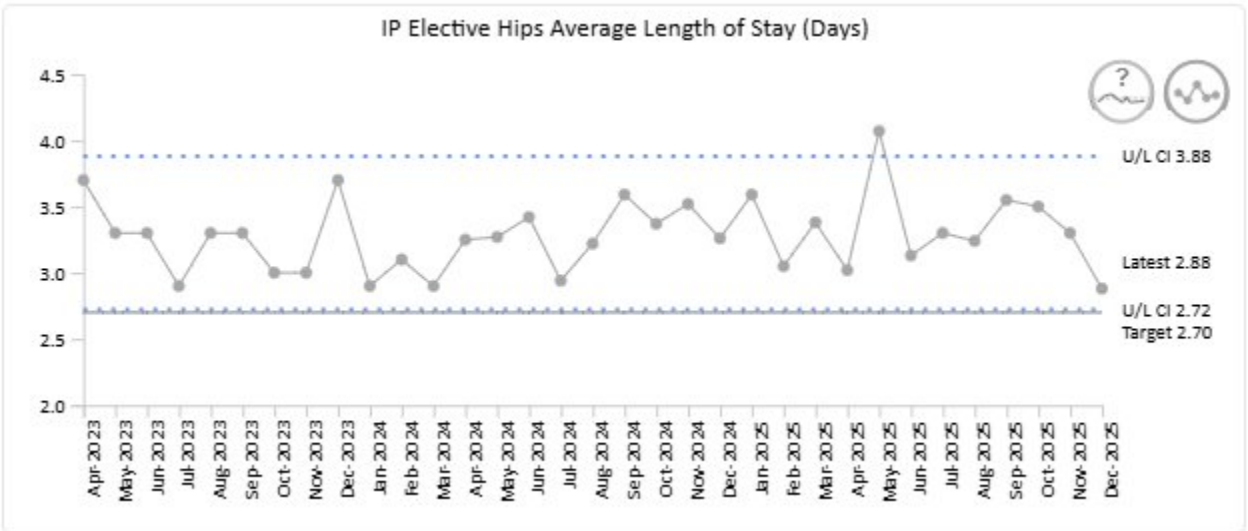
Assurance Reports: Inpatients continued - cancellations

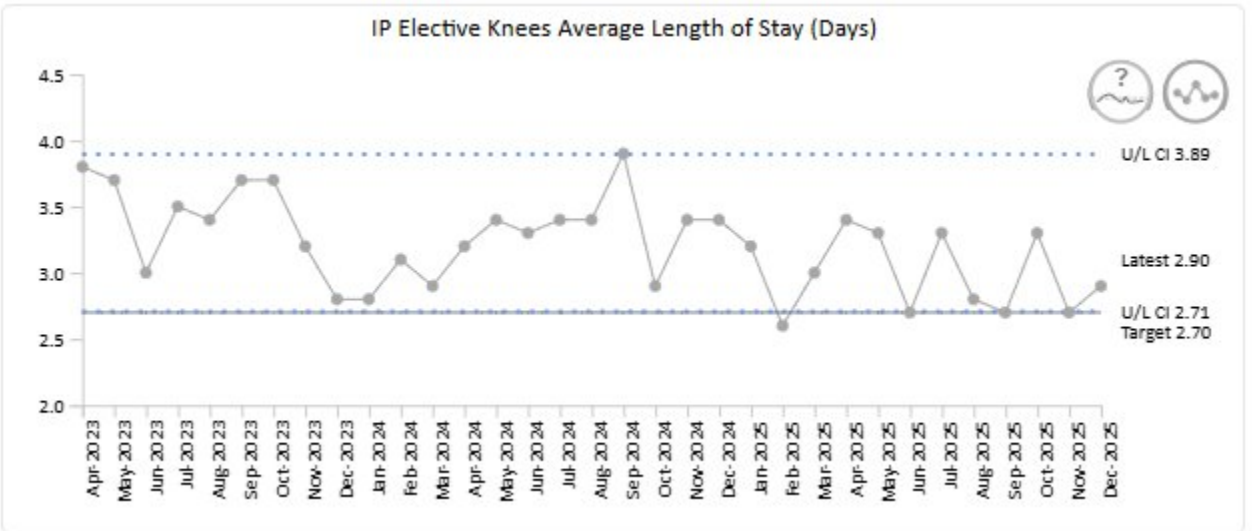
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
IP Cancellations admitted with treatment deferred due to clinical reasons and IP Cancellations Admitted and treatment deferred for non clinical reasons also reduced during December 25.	**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. **Staff availability** Regular review of staffing numbers/skill mix, led by Theatre Matron and Head of Nursing	Weekly review at theatre lookback meeting KPMG audit underway Ongoing monitoring	Ref:1386/1700/1701/1702/1784/2137 Ref:2158/2159	High

Assurance Reports: Inpatients





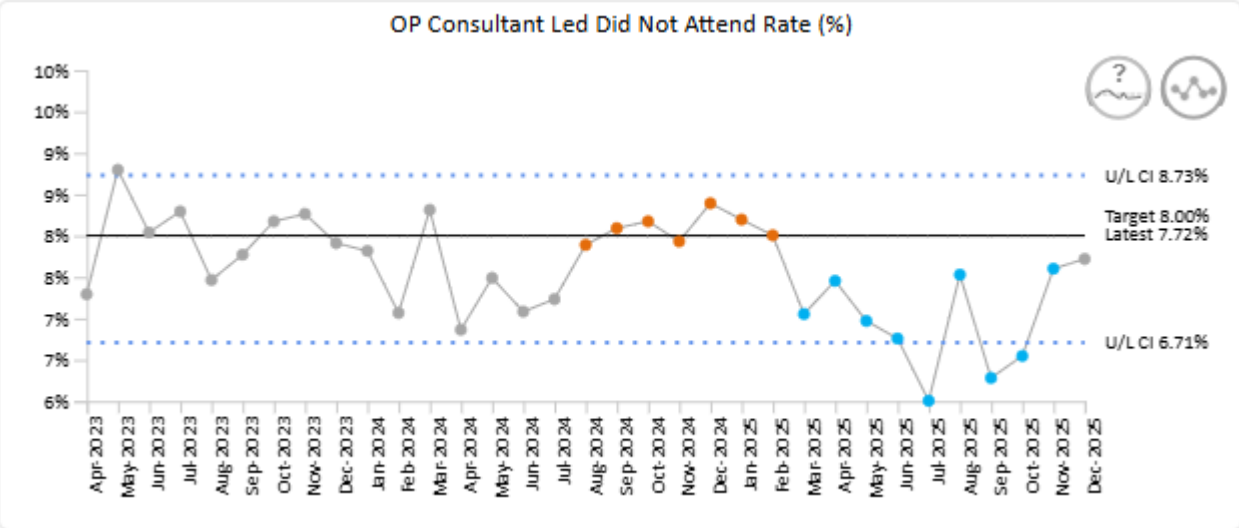


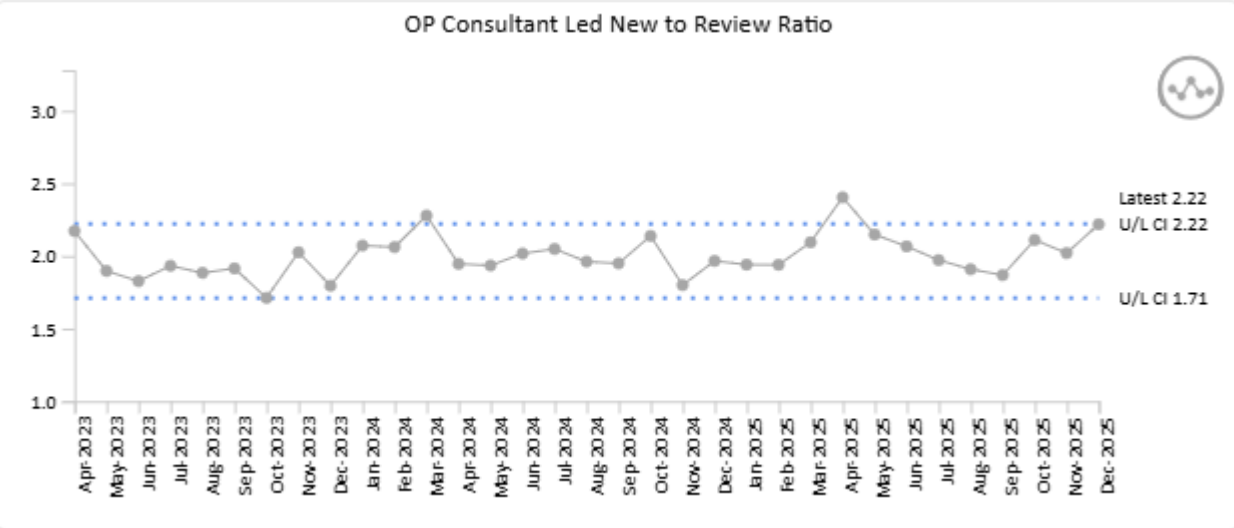


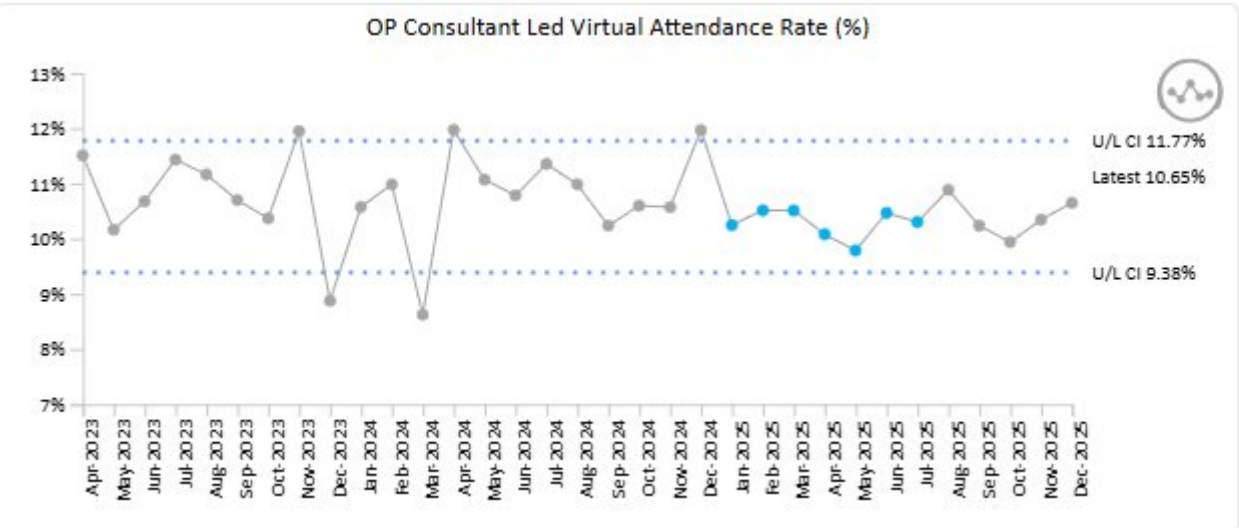
Assurance Reports: Inpatients continued – Length of stay

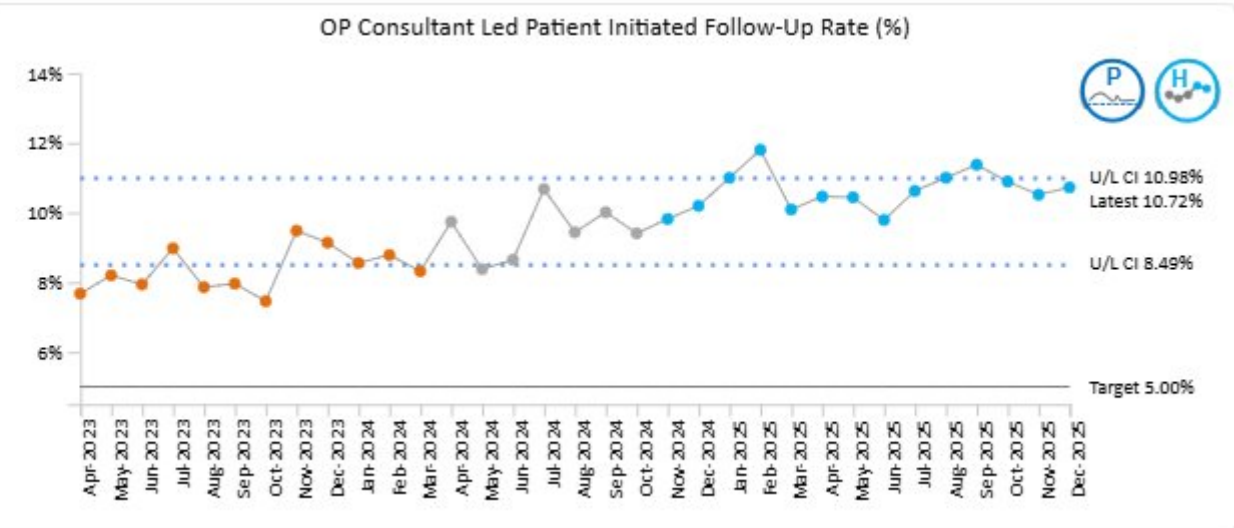
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Bone Infection, revision and MRC patients requiring extended Length of Stay (LoS)	Review of acceptance/discharge and repatriation criteria and process for Bone Infection service-operational policy under development. Delayed due to complete change of nursing team. Review of MRC demographics and funding roots. Data reviewed in MRC meeting 16/01/2026. Further analysis required. Explore whether further development of ROCS/OPAT service would support earlier discharge in this group of patients.	February 2026. February 2026 March 2026 Assurance Group MRC and DMB Div 1	N/A	High
Day case patient conversions to overnight stay- reasons include clinical, late out of theatre, social	Detailed analysis of reasons and action plan to reduce	Div 2 DMB		
BADS and GIRFT principles inconsistently applied	Renewed focus on embedding best practice. LoS data by consultant to be discussed and reviewed at a specialty level to produce an analysis of themes.	Day case improvement Group > Theatre Productivity Improvement Group > Trust Improvement Group		
Access to timely social care/repatriation beds for discharge.	Escalation process in place via Head of Nursing. Divisional escalation to Deputy COO/COO for delays requiring senior intervention for discussion with ICB colleagues.	Theatre Productivity Improvement Group		
Support services not fully aligned to 3 session and weekend working	Workforce reviews underway	Growth aligned to Trust annual plan		

Assurance Reports: Outpatients

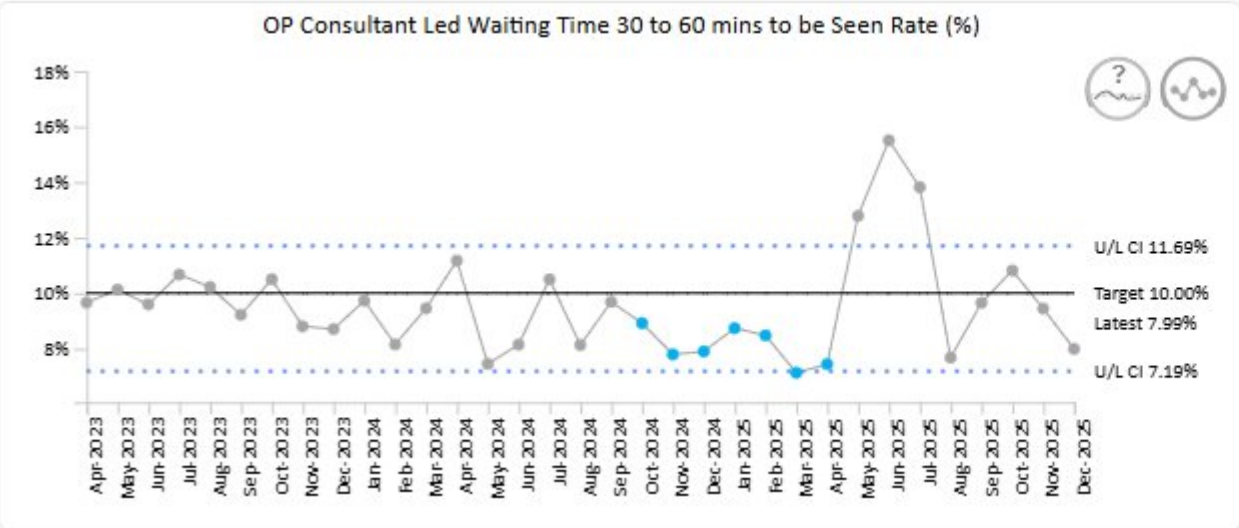


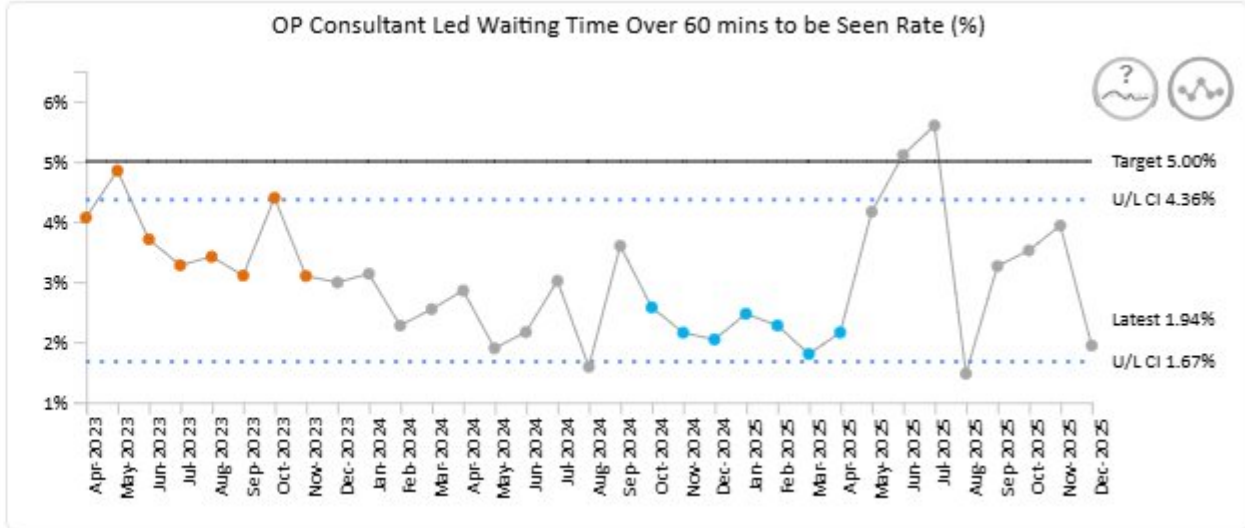






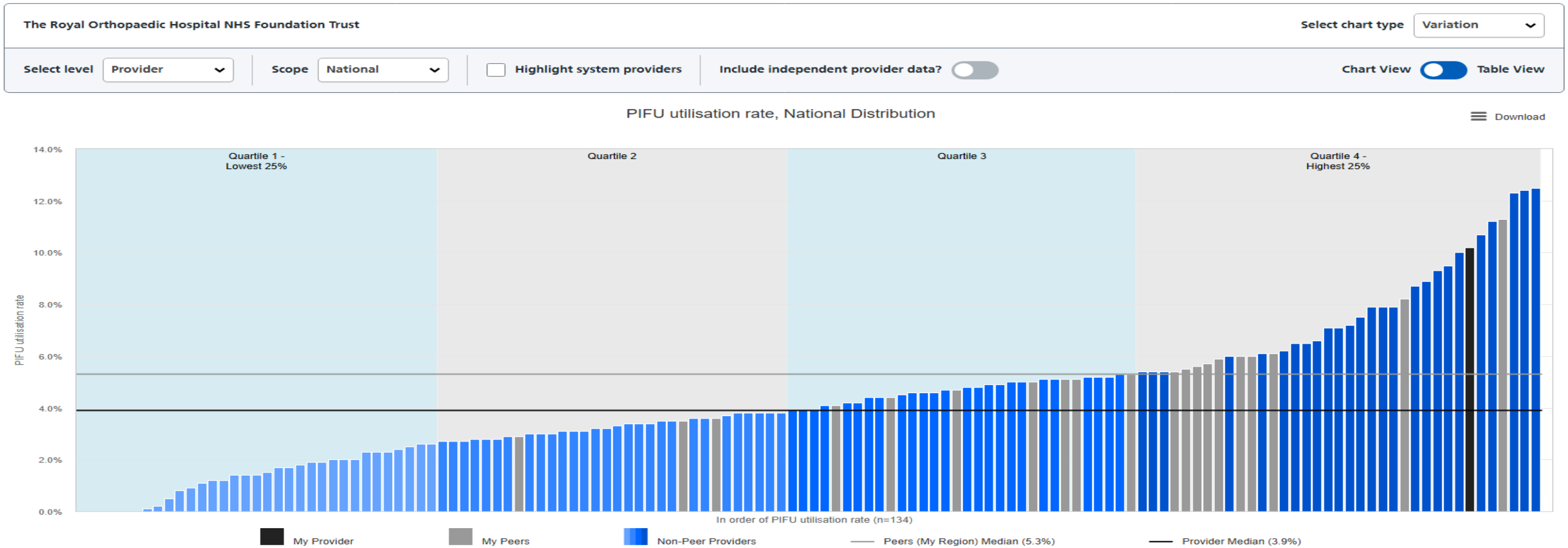
Assurance Reports: Outpatients continued



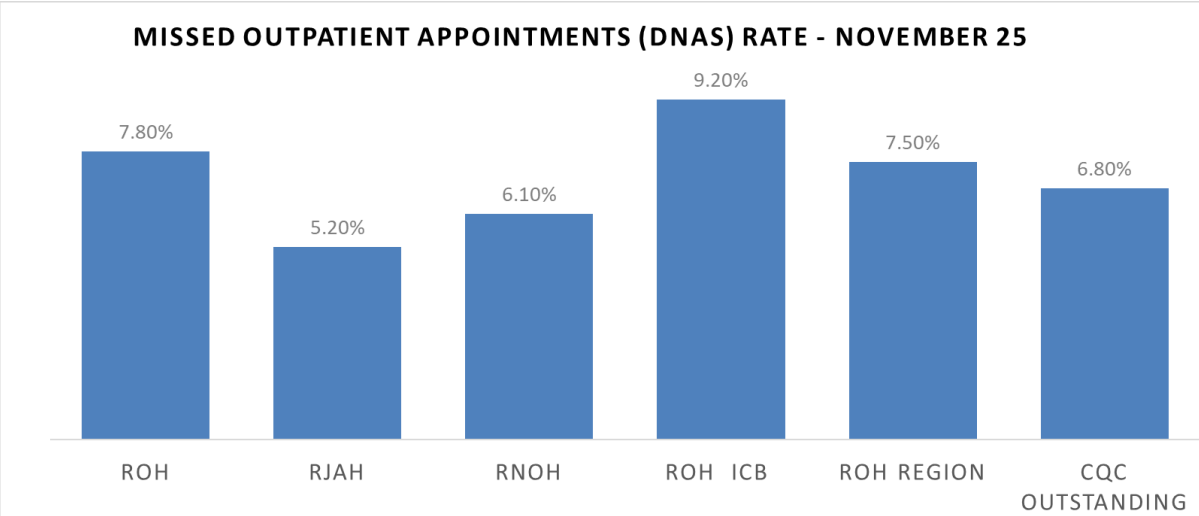


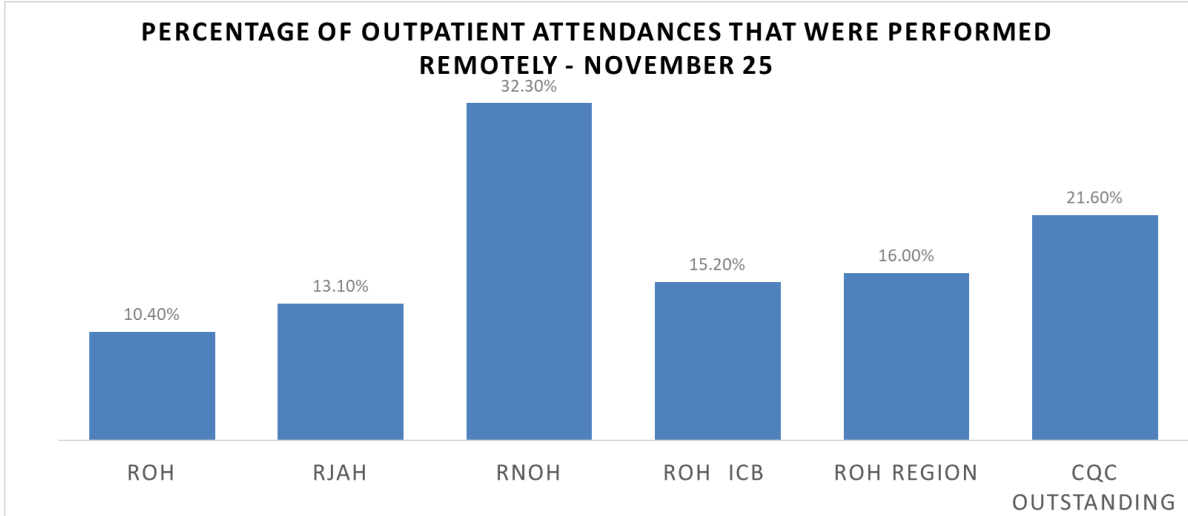
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There has been a slight increase in the number of Missed Appointments due to seasonal pressures. However, the missed appointment rate is lower than the same period last year and within the KPI threshold. Virtual attendances are challenging due to the absence of a video clinic platform. However, the volume has increased to 10.65% in December 2025. PIFU rates remain stable and the Trust is ahead of all peers for PIFU performance on Model Hospital. Please refer to Model Hospital graph on the next slide.	Exploring charities funding for targeted interventions for patients from the most deprived areas (IMD 1 and 2). Looking at targeted calls, as well as subsidised travel. The team is also looking into support directly from National Express for subsidised travel with a QR code added to appointment letters. Plans in place for super virtual Spinal and Hands Clinics during the month of January and February 26 to promote the use of remote clinics. Continue to promote PIFU through the outpatient transformation programme.	28.02.2026 31.03.2026		High

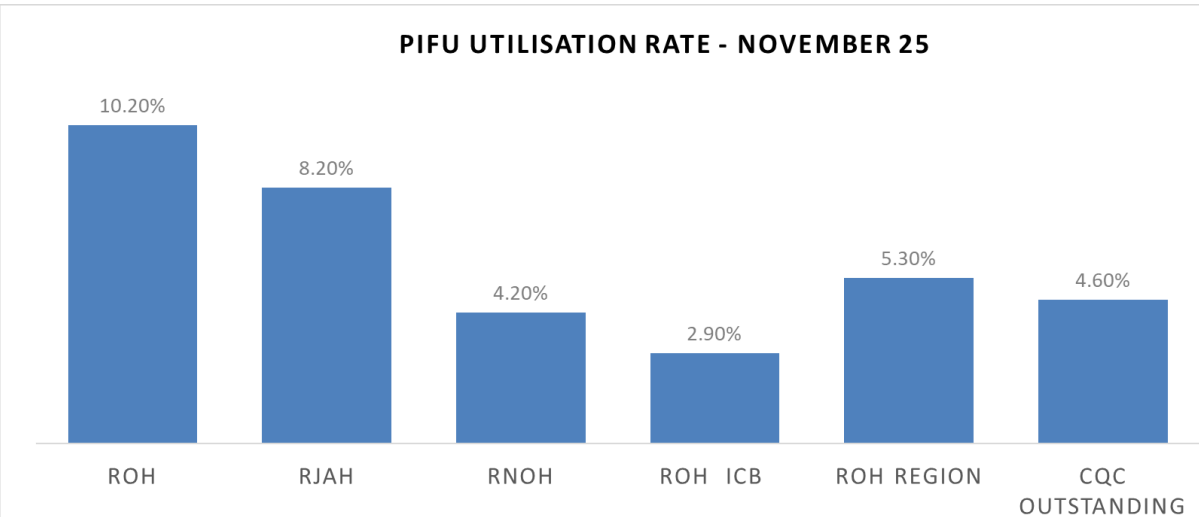
Assurance Reports: Outpatients continued – Model Hospital PIFU performance

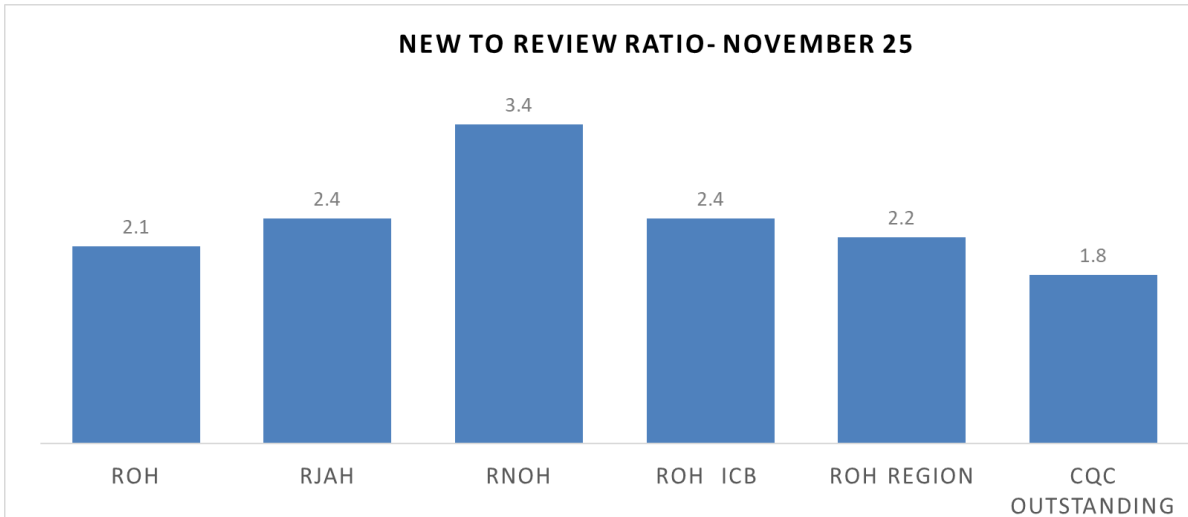


Outpatients Benchmarking Model Hospital

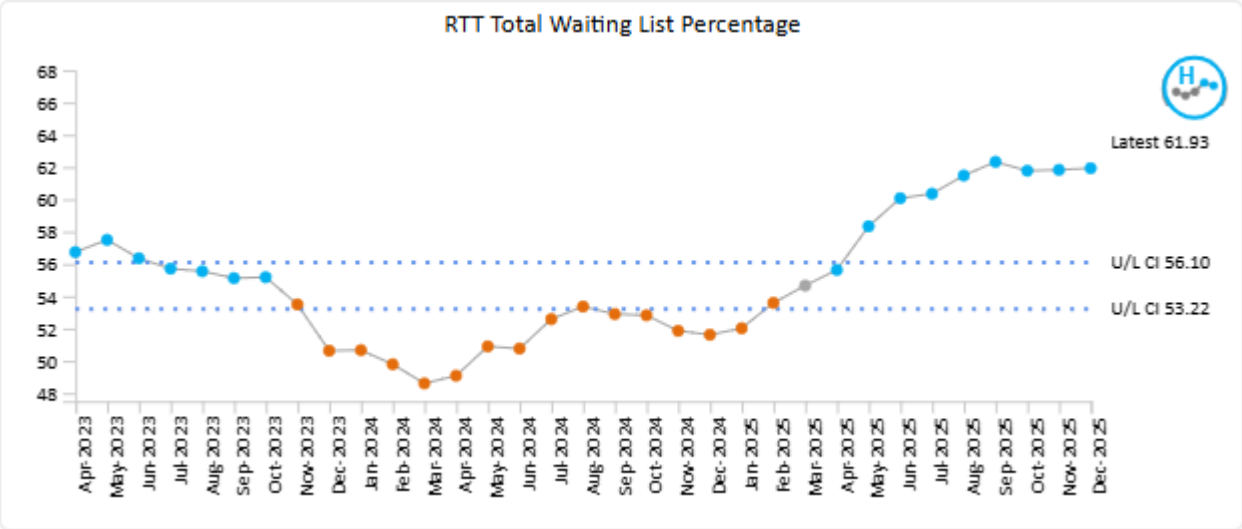


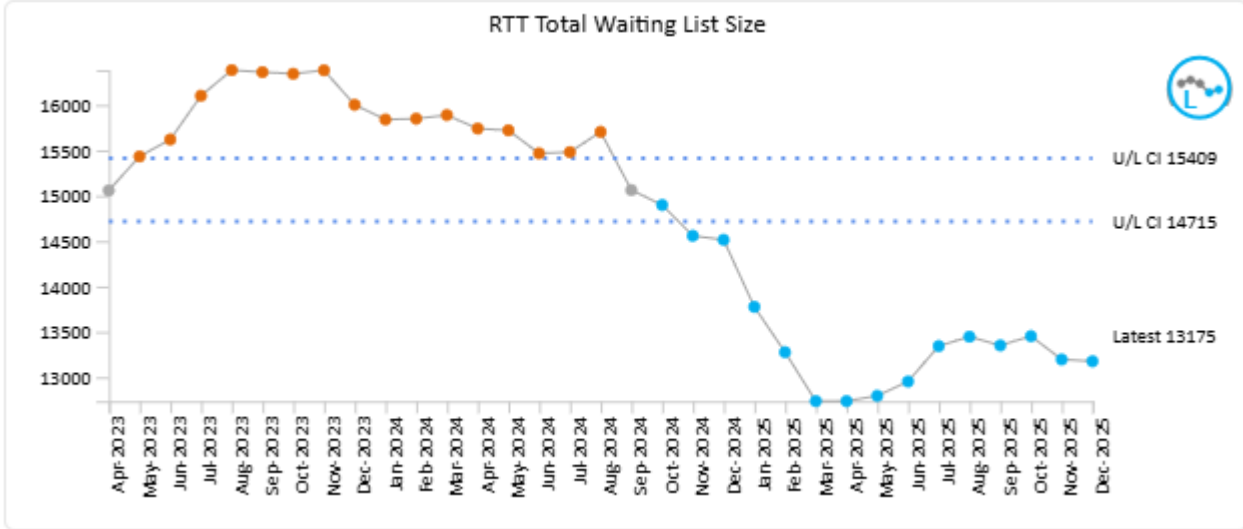






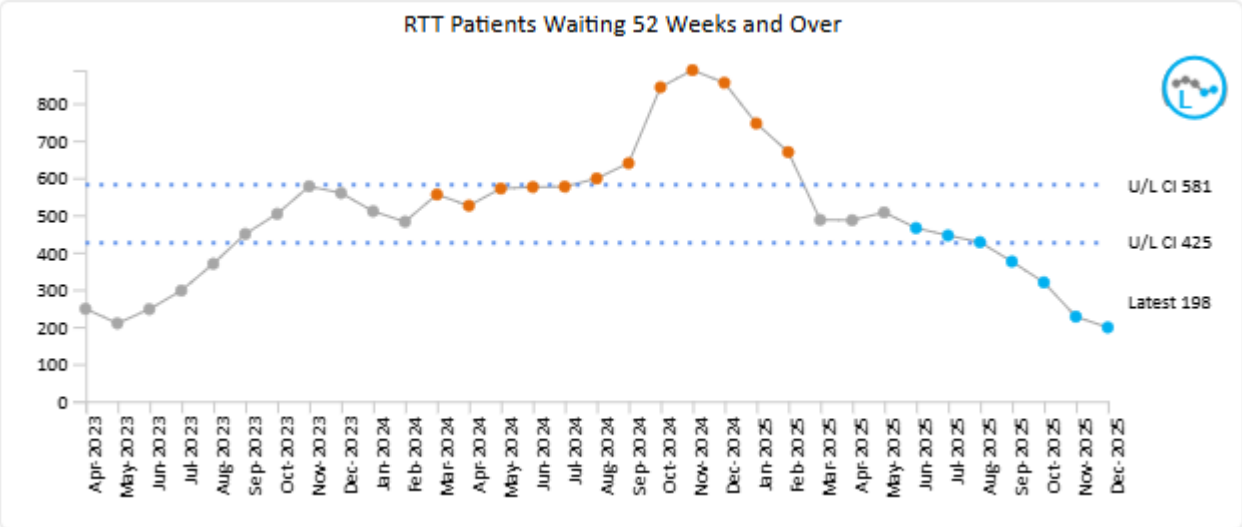
Assurance Reports: Referral to Treatment

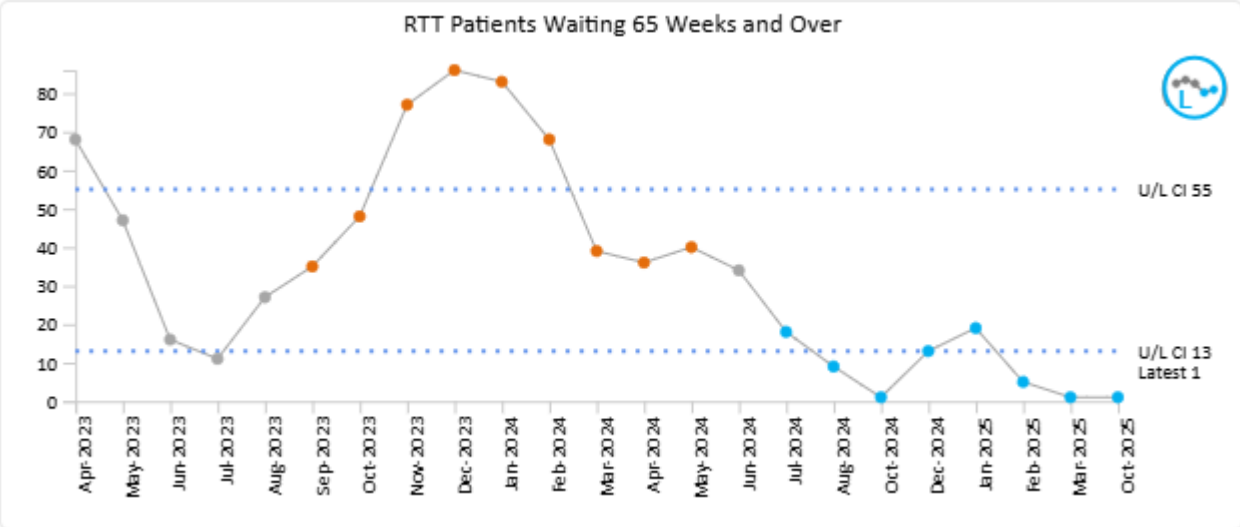




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
The total waiting list percentage position stands at **61.93%**, performance remains **ahead of the required trajectory** to deliver **60% by the end of March 2026**. Current performance provides assurance that the target remains achievable within the planned timeframe. From a benchmarking perspective, our performance exceeds that of the other two providers within the ICB and RJAH. The total waiting list size position stands at **13,175** which is ahead of the monthly target of **13,218**. We remain on course to deliver the required target of **13,016 by the end of March 2026**. Current performance provides assurance that the target remains achievable within the planned timeframe.	To sustain performance above the planned trajectory and strengthen delivery confidence, targeted weekly PTL meetings are embedded at sub-specialty level focusing on pathway efficiency. In addition, the validation team are carrying out enhanced validation to support the validation sprint. This approach ensures current gains are maintained while enabling further improvement beyond the baseline plan.	Weekly PTL Meetings Weekly Divisional Operations Meeting Monthly Divisional Management Board Monthly Operations Management board	n/a	High

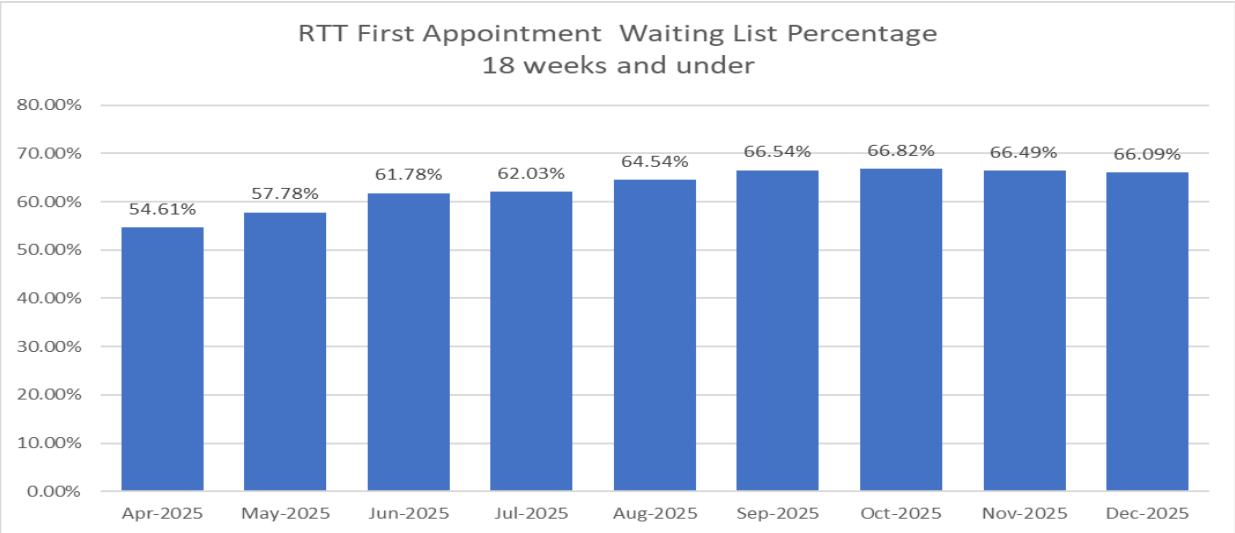
Assurance Reports: Referral to Treatment continued

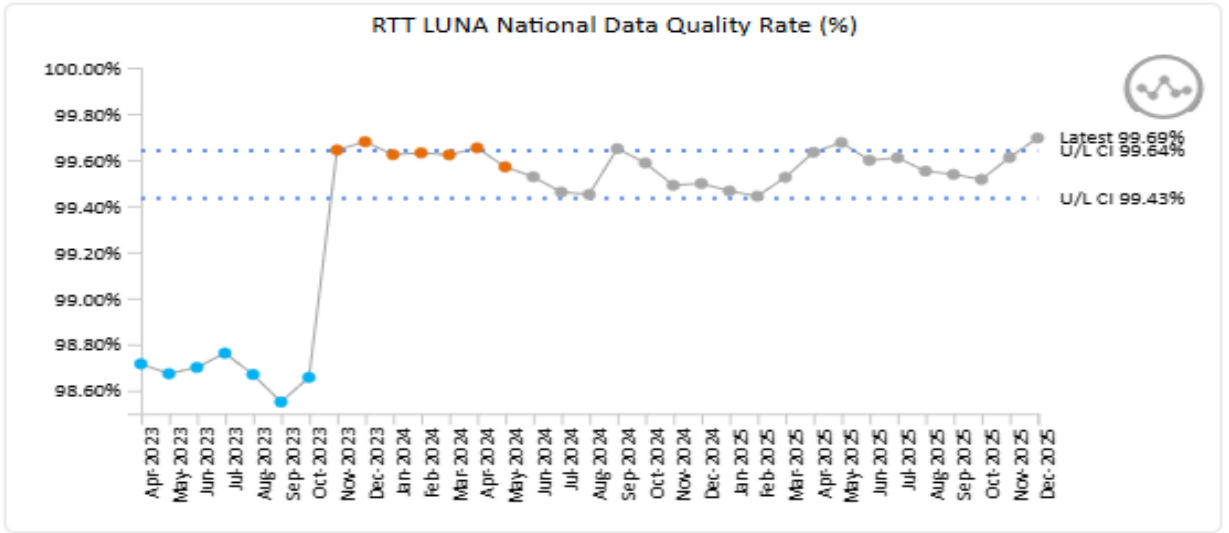




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
The number of patients waiting 52 weeks and over for treatment stands at **198**, which is ahead of the monthly target of **263.** We remain on course to deliver the required target of no more than **130** patients by then end of March 2026. We continue to ensure **no patients** are waiting 65 weeks and over for treatment.	Any patients at risk of breaching the 52 and 65 week RTT are confined to the spinal and spinal deformity sub-specialties, with all other specialties performing well within required targets. Spinal pathways are subject to enhanced oversight through weekly PTL meetings and daily operational controls, including early identification of at-risk patients, timely chronological booking, and targeted identification of additional capacity.	Weekly PTL Meetings Weekly Divisional Operations Meeting Monthly Divisional Management Board Monthly Operations Management board	Corporate Risk Register Ref 2146	High

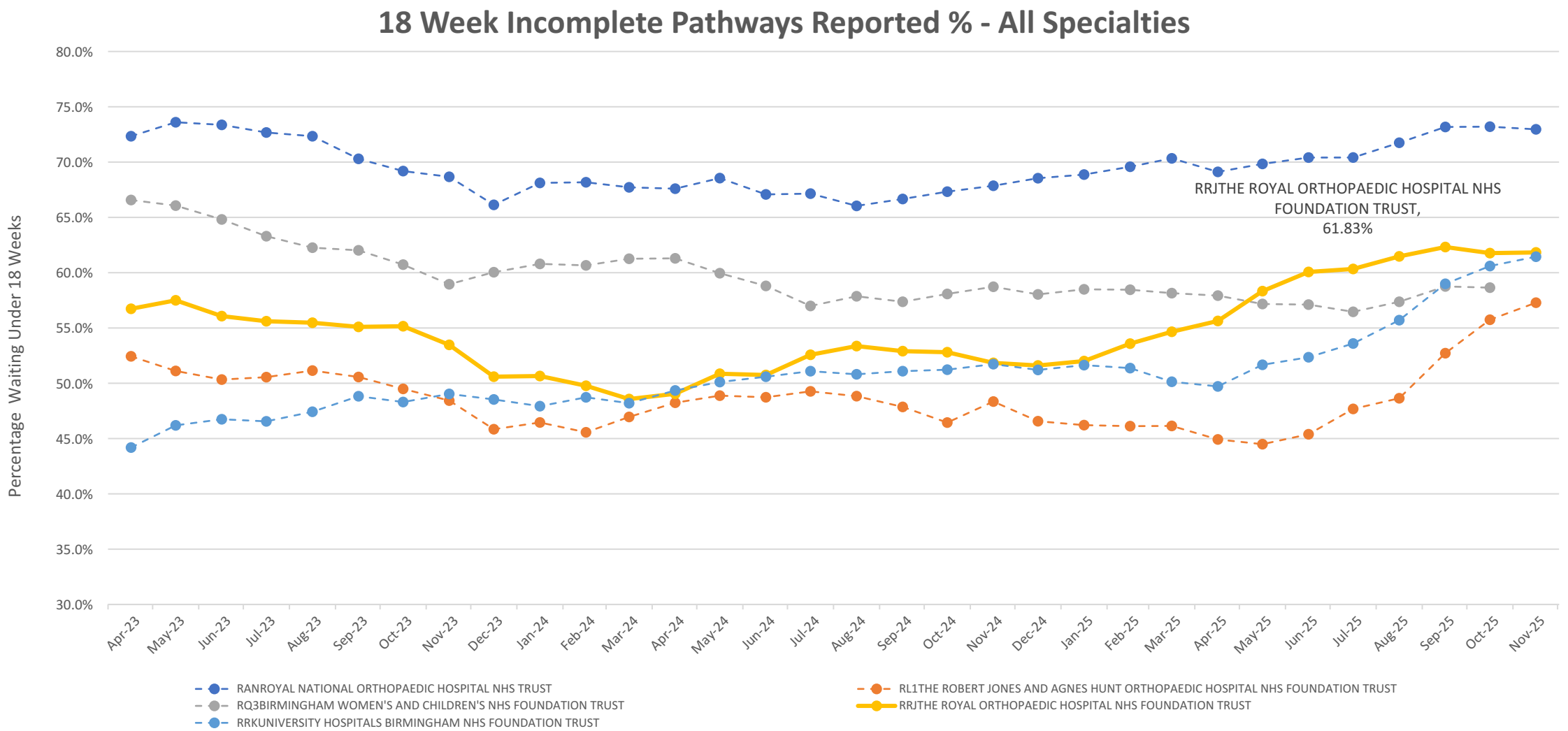
Assurance Reports: Referral to Treatment continued





Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
The RTT first waiting list percentage position stands at **66.09%**, performance is slightly behind the monthly target of **66.20%.** From a data quality perspective, performance remains strong. The LUNA National Data Quality dashboard demonstrates that confidence levels for RTT data have consistently remained above **98%**, exceeding the **90%** target.	We have identified the specialties that need extra capacity to improve this metric and are working with service leads to ensure services are optimised, including super virtual clinics to increase capacity and reduce waiting times. ROH have been agreed as part of the NHSE 18 week and 52 week sprint for Feb/March To maintain this high level of data quality, we continue to provide targeted training and focus validation efforts, demonstrating that the training has a sustained positive impact and reinforces confidence in RTT reporting.	Weekly PTL Meetings Weekly Divisional Operations Meeting Monthly Divisional Management Board Monthly Operations Management board	n/a	High

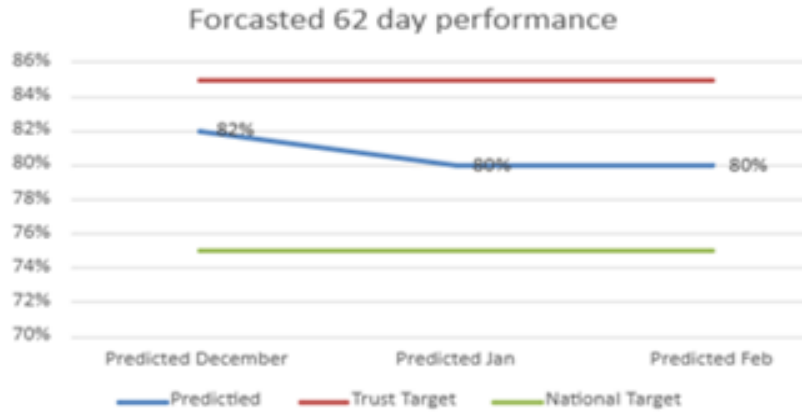
Assurance Reports: Referral to Treatment Benchmarking Model Hospital



Assurance Reports: Cancer

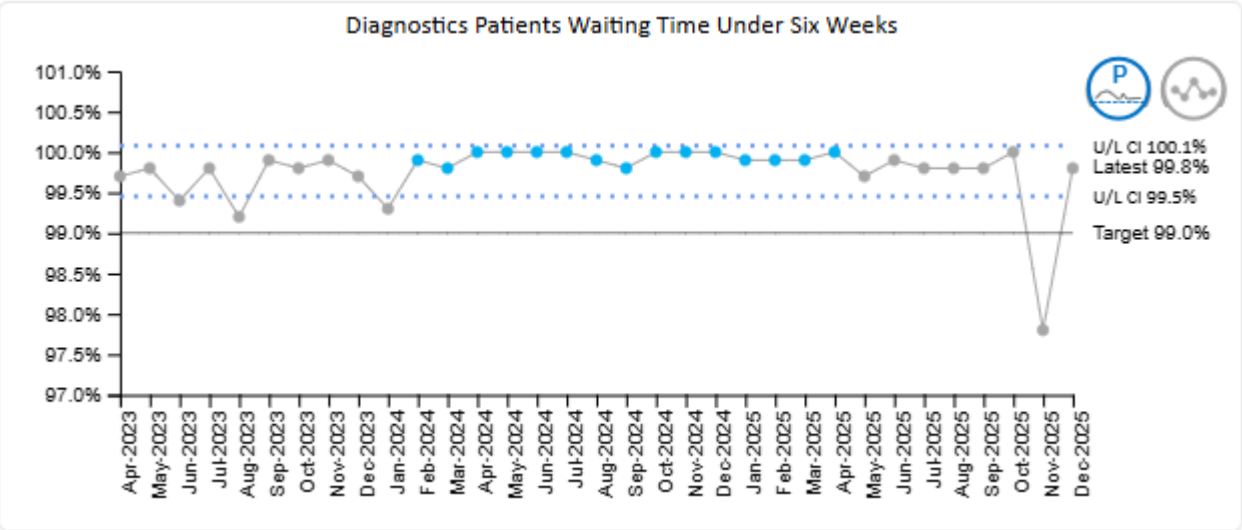
November 25 Performance – January 26 Submission

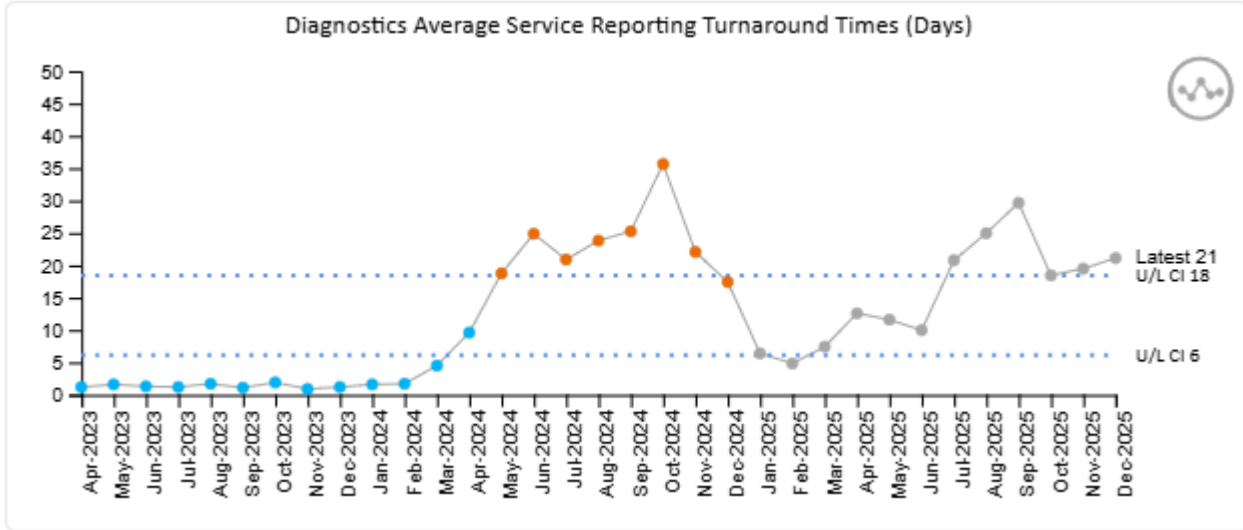
Target Description	Patients	Compliant	Breach	Total Accountable	%	Target
31 Day	32	32	0	32	100%	96%
62 Day	10	8	2	10	80%	75%
28 Day FDS	104	76	28	104	73.1%	77%
104 days treated at ROH	0					



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
The Trust's Faster Diagnostic standard was not met due to continued challenges with Histopathology services provided by UHB. Improvements expected during Q4 with further mitigation now in place supported by other NHS Trusts and NHSE.	Executive meetings with NHS England to provide regional / national support to reduce delays in the pathway. Weekly escalation to regional team at the system oversight group (SOG) Internal oversight through cancer board and PTL meetings. Regular escalations from Director of Ops COO to senior colleagues at UHB.	Meeting held 21.01.2026 Weekly SOG report Cancer Board monthly Division 1 Cancer PTL meeting weekly Oversight at weekly senior leadership team meeting.	Corporate Risk Register Ref 1893	High

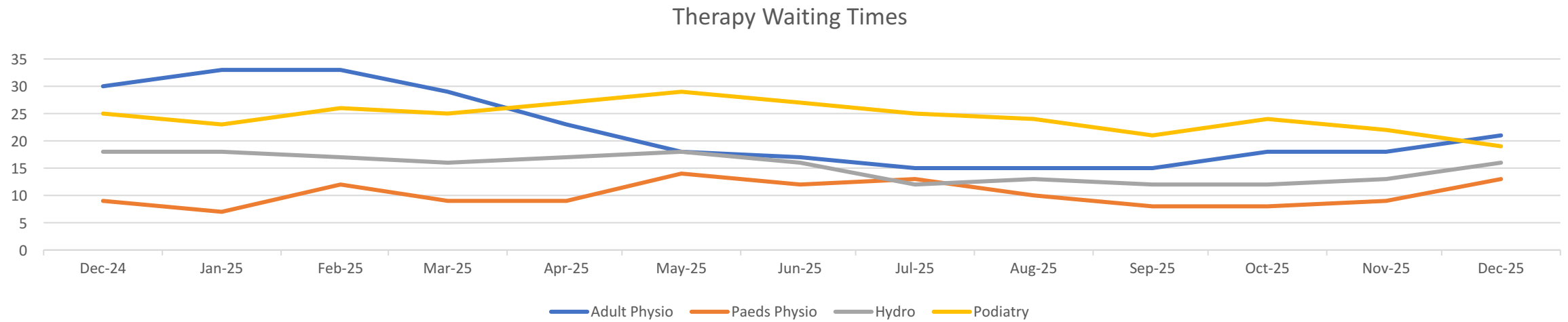
Assurance Reports: Diagnostics





Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Diagnostics continue to achieve 99% against the DM01 target, the national target is set at 95% Mobile CT scanner now operational with minimal impact on activity	Regular review of waiting times to continue to exceed national target Work closely with Radiologists & Anaesthetists to ensure lists run smoothly and booked to full capacity while maintaining patient safety. Radiology attendance at Oncology PTL to ensure targets can be met and escalate as necessary any concerns. Source additional capacity as required.	Diagnostic waiting list meetings Services should resume to normal w/c 06/04/2026 on new CT scanner.	N/A	High

Assurance Reports: MSK Non-Consultant led services



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Adult Physio waiting times reduced with GIRFT funding in the early part of the year. This is difficult to sustain due to vacancies. Paediatric Physio and Hydro waits have increased due to current vacancies. Podiatry waits are gradually reducing due to the use of temporary staffing.	Ongoing temporary Assessment clinics in place to support adult demand. Digital self-referral via GetUBetter – pilot now live with College Green Medical Practice. Adult capacity moved to support Paediatric and Hydro capacity to help prevent further deterioration in waiting times. Temporary staff ongoing to support adult physio waiting list. Approval granted to recruit to 3 of 5 vacancies and bank currently in use. Temporary staff remain necessary in Podiatry to help reduce waiting times.	Ongoing weekly monitoring and move of resources to support demand and trust targets. Pilot requires 50 referrals without issue before roll out to other practices. Reports to DMB and OMB for oversight.	No. 1573 Div 2 - Physio Divisional risk	High

Assurance Reports: Private Patients December 2025

Performance Summary

The Private Patient Service has a stretch revenue target of £6.1m for 2025–26.

December activity was below planned volume and revenue. This reflects the seasonal impact of the Christmas period, during which elective private patient demand is historically reduced, compounded by a reduction in operational days across the holiday period. Year-to-date actual income is £3.88m vs a Year-to-date plan of £4.53m Therefore, a variance: £656k adverse to £6.1m plan.

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD
Revised revenue plan 2025/26 (£6.1m)	**£385,000**	**£546,000**	**£552,000**	**£486,000**	**£486,000**	**£555,000**	**£555,000**	**£571,000**	**£400,000**	**£4,536,000**
Revenue Actual	£386,594	£563,091	£390,901	£434,522	£457,359	£344,700	£450,281	£548,628	£310,172	**£3,886,248**
Variance	-£227	-£4,251	-£144,446	-£51,478	-£28,641	-£210,300	-£104,719	-£22,372	-£89,828	**-£656,262**

Positive Assurance

Despite current operational pressures, several medium-term mitigations are progressing:

Tariff uplifts

New tariff agreements to start February with Bupa, Aviva, and AXA are nearing completion (February) equating to an approximate 6% uplift across key procedures. These uplifts will improve income per case once activity stabilises.

Self-funding pricing

Self-funding fees for robotic arthroplasty have been increased avg. 7% non-robotic and 27% robotic to align with local independent sector providers, supporting improved margins while remaining competitive.

Marketing and demand generation

A targeted marketing is performing well, including:

Print and digital advertising campaigns ongoing

A focused three-month campaign supporting robotic arthroplasty activity Jan – March

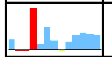
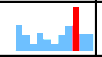
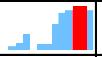
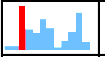
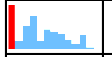
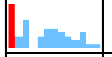
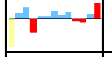
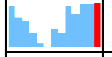
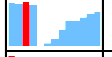
SEO campaign increasing the service visibility in Google rankings.

Financial contribution analysis

Finance continues to work with the service to assess profitability and contribution, ensuring future activity growth is financially sustainable.

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Revenue variance: The £6.1m plan is proving to be challenging YTD. The activity profile is suggesting more volume of lower to medium tariff cases and the higher tariff cases are not as frequent as previous years. The amenity bed roll out has been delayed due to prioritisation of side rooms for patients with a greater clinical need. The service is exploring options to drive this forward. Limited opportunity to promote services to overseas patients. Attracting surgeons is challenging with growing competition in the local market and surgeons remain reluctant to offer their practice at a single venue	Workforce and pay options for private patient weekend and third-session activity are under active discussion at Executive level, with consideration of affordability, equity, and sustainability. Opportunities to further optimise the Woodlands Suite for paying patients are being explored, including the use of amenity beds and protected private patient capacity.	**Action Timescale:** January–March 2026, with immediate mitigations in place and further actions subject to Executive approval. **Private Patient Oversight Group** Operational monitoring of activity, cancellations, and service delivery risks.	Risk 2164	High

Integrated Performance Dashboard: Finance

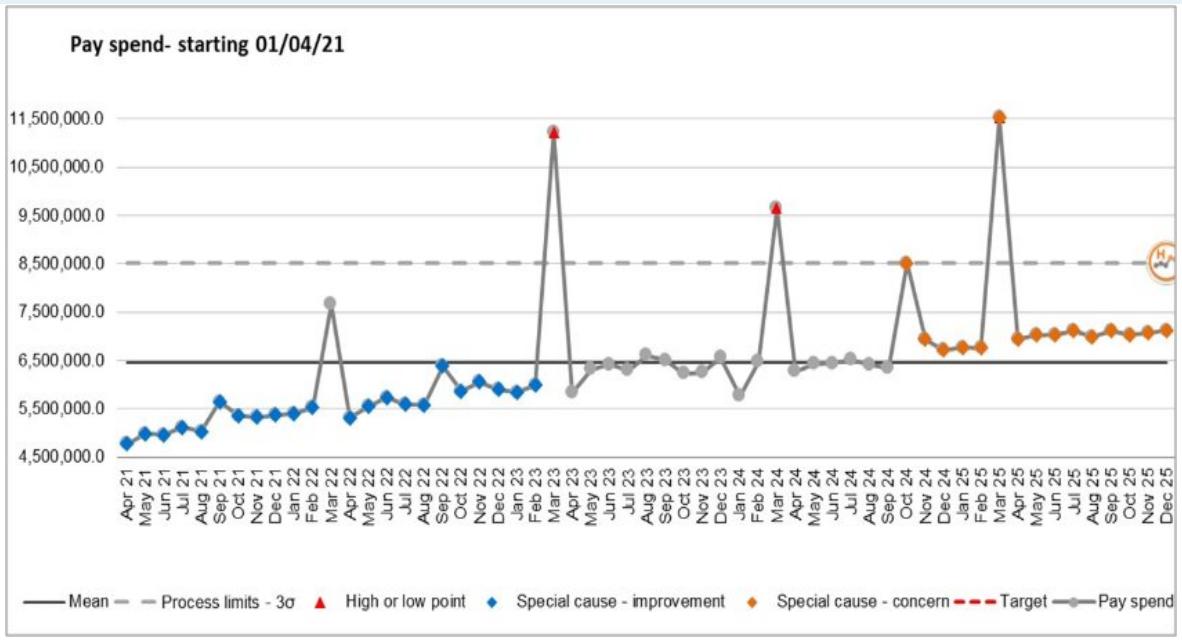
Metric Grouping	Metric Name	Reporting Period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Finance	I&E Margin (%)	Monthly	(1.60%)	(5.90%)	(6.20%)	11.40%	(3.30%)	3.30%	(2.10%)	(0.90%)	(2.50%)	(0.10%)	0.90%	0.40%	0.46%	1.10%		high is good	-	-	-1%
Finance	I&E Variation from Plan	Monthly	(271)	(541)	(707)	2,357	(102)	635	(71)	(110)	(220)	(64)	(64)	2	9	15		low is good	-	-	0
Finance	EBITDA (%)	Monthly	3.90%	(0.90%)	(0.90%)	15.10%	2.30%	8.40%	3.40%	(1.10%)	3.00%	5.20%	6.20%	5.70%	5.20%	4.30%		high is good	-	-	4%
Finance	CIP Value	Monthly	308	321	691	553	409	575	484	418	549	683	961	563	563	5,205		high is good	-	-	3,052
Finance	CIP Plan (don't show)	Monthly	492	519	546	620	494	544	538	694	782	804	835	835	797	6,323			-	-	9,447
Finance	CIP Performance	Monthly	62.60%	61.85%	126.54%	89.12%	82.79%	105.70%	89.96%	60.23%	70.20%	84.95%	115.09%	69.58%	55.33%	(1,118)		high is good	-	-	0
Finance	Agency Expenditure	Monthly	157	105	126	140	105	121	117	115	106	99	113	95	92	963		low is good	-	-	752
Finance	Agency % of total pay bill	Monthly	2.30%	1.50%	1.90%	1.20%	1.50%	1.70%	1.70%	1.60%	1.50%	1.40%	1.60%	1.30%	1.30%	1.60%		low is good	-	-	1.6%%
Finance	Capital - Variation to Plan (including impact of IFRS 16)	Monthly	(1,014)	184	408	(507)	65	65	275	111	245	(121)	(140)	167	551	841		low is good	-	-	1,128
Finance	Cash Balance at end of month	Monthly	8,139	6,173	5,570	3,293	1,578	835	4,034	3,258	8,158	6,696	8,484	8,528	8,653	8,158		high is good	-	-	4,976
Finance	BPPC Invoices Paid < 30 days (Volume %)	Monthly	83.40%	83.10%	83.70%	82.80%	72.20%	73.00%	74.10%	76.50%	78.70%	78.70%	79.60%	80.40%	81.20%	78.70%		high is good	-	-	100%
Finance	BPPC Invoices Paid < 30 days (Value %)	Monthly	82.60%	80.30%	79.40%	78.30%	67.10%	68.50%	67.90%	66.10%	67.60%	71.20%	72.90%	71.10%	71.70%	67.60%		high is good	-	-	100%
Finance	Creditor Days	Monthly	117	125	105	113	0	113	121	113	108	89	99	85	95	108		low is good	-	-	30
Finance	Debtor Days	Monthly	31	30	35	55	0	64	48	54	43	41	42	35	32	43		low is good	-	-	30
Finance	Operating Expenditure Days	Monthly	23	17	14	6	0	2	11	9	23	17	23	22	24	23		high is good	-	-	n/a
Finance	I&E Surplus / (Deficit) (£k)	Monthly	(181)	(679)	(688)	2,490	(377)	402	(242)	(164)	(291)	(17)	102	51	40	(496)		high is good	-	-	(803)

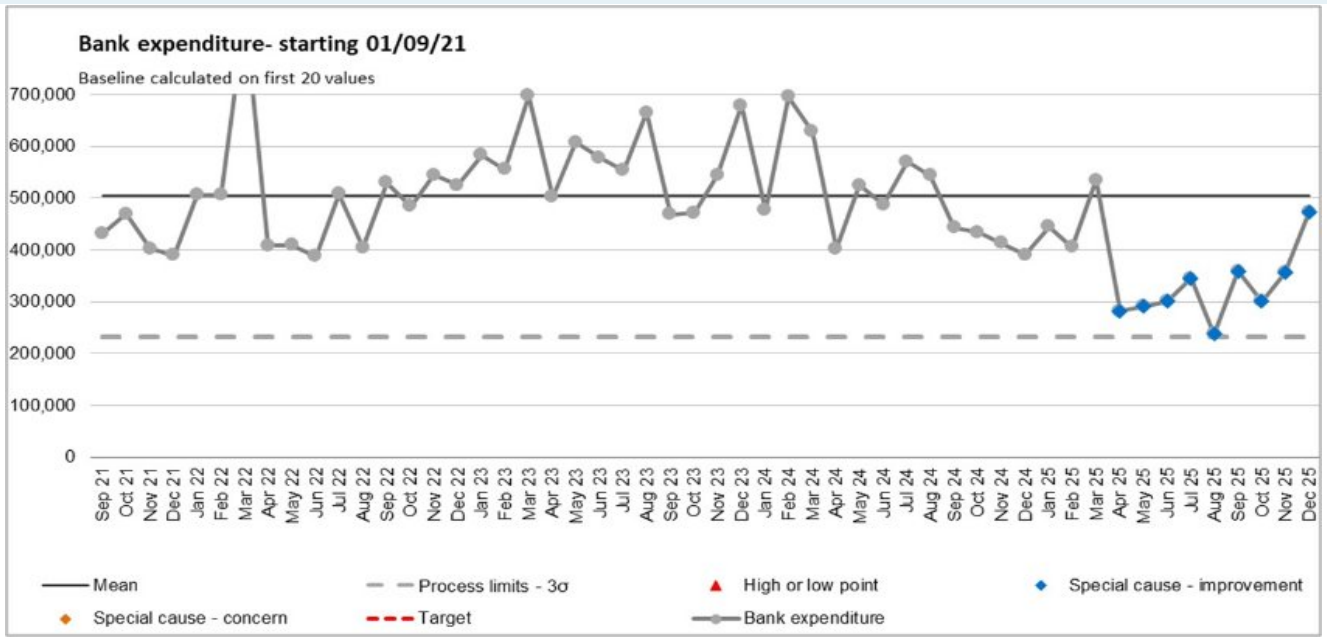
Assurance Reports: Finance Commissioner Income

	Actual	Plan	Variance
Day Cases	£8,573,019	£10,348,897	-£1,775,878
Elective	£27,428,882	£25,672,280	£1,756,603
Excess bed days EL	£681,653	£879,992	-£198,340
Outpatient FA Consultant Led	£3,439,067	£3,618,183	-£179,116
Outpatient FA Consultant Led Non-Face to Face	£163,558	£3,618,183	-£201,039
Outpatient Procedures FA	£58,301	£104,576	-£46,275
Outpatient Procedures FUP	£375,860	£608,891	-£233,032
Elective variable (ERF)	**£40,720,339**	**£41,597,416**	**-£1,763,619**
Diagnostics variable	£1,429,370	£2,315,912	-£886,541
Total Variable			**-£2,650,160**

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There is a net underperformance against payment cap limit of £265k in month and £1,763k year to date which has been included within the year-to-date position. The financial risk for overperformance against cap total £791k with Hereford and Cov ICBs overperforming to date. Conversely, BSOL , Staffordshire, Black Country and Spec comm underperforming by £2.4m. 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.	- Review of income trajectory for Months 10-12 to assess current delivery assumptions. - Scenario plan ways in which to improve income performance for Months 10-12 aligned to capacity. - Revised income profile to align to planned activity delivery e.g. Outpatient first and procedures. - Revised income profiling to reflect expected improvements in Outpatient Firsts and procedure throughput (linked to Theatre and Clinic utilisation work). - Targeted commissioner discussions for over-cap commissioners to manage risk, improve visibility of activity flows and seek clarification on Q3–Q4 expectations.	- FDB discussion on 20/01 - Income recovery trajectory to be agreed at FDB on 20/01	n/a	High

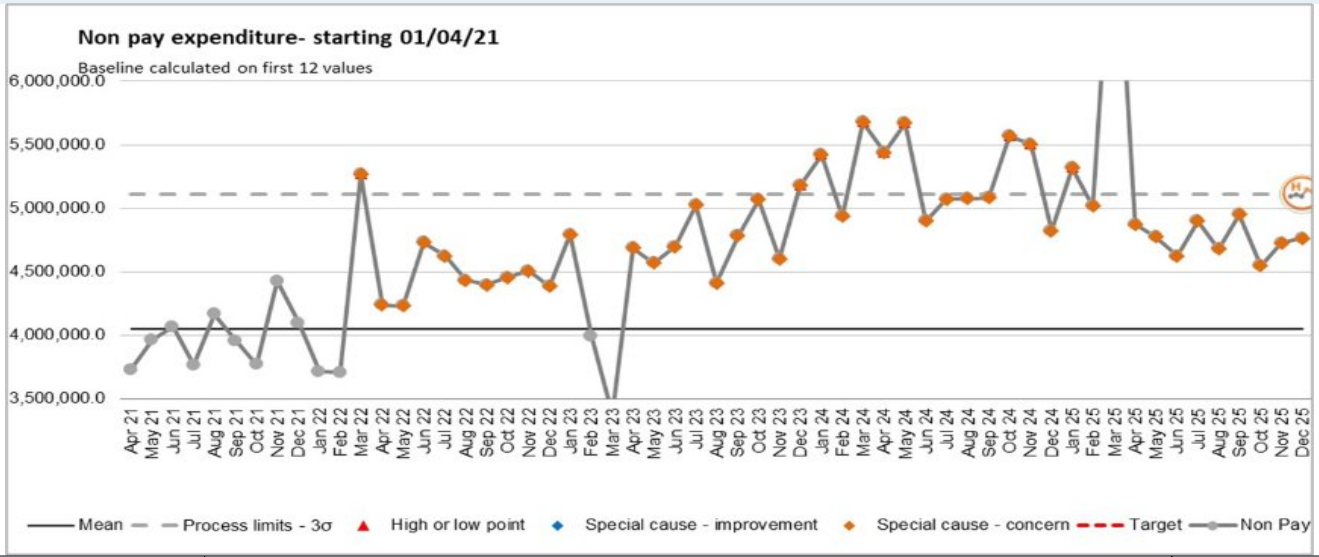
Assurance Reports: Finance Pay Expenditure





Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Pay expenditure is overspent by £625k YTD. Agency spend reduced in month, being 1.5% of paybill year to date, with an underspend of £266k YTD. Bank expenditure has increased compared to last month with £472k spent in month, which is the highest monthly spend this year, contributing towards a YTD overspend of £138k.	• Review bank expenditure against agreed reduction plans • Implement additional workforce controls to support reduced pay expenditure for the remainder of the year. • Conduct a detailed review of pay CIP schemes to confirm expected delivery, identify high-risk areas and agree mitigations.	• FDB route to breakeven agreed on 19/11 which included a bank reduction plan • Additional pay control initiatives agreed at FDB on 17/12 • Further discussion on performance and mitigation plans on 21/01	n/a	High

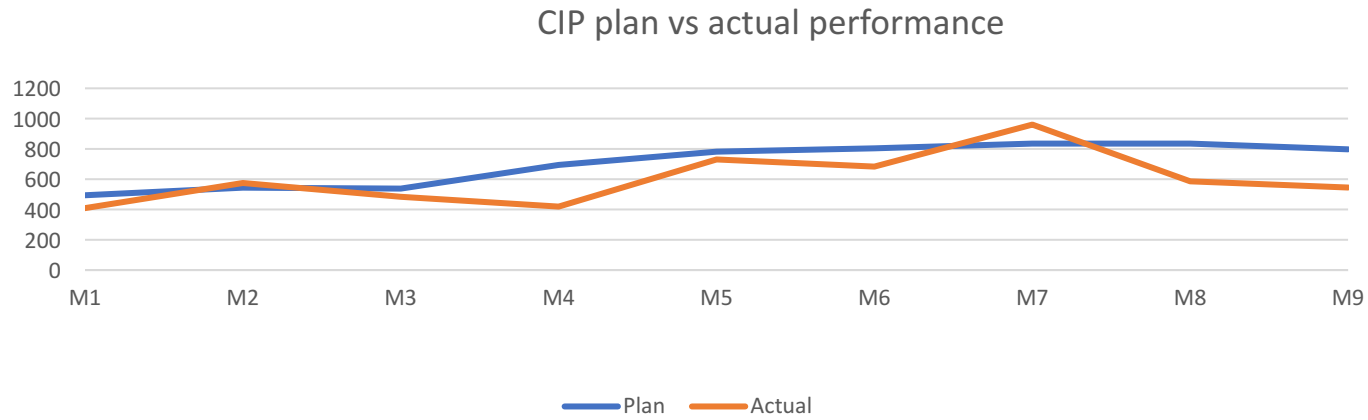
Assurance Reports: Finance Non-Pay Expenditure



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Non pay expenditure underspent variance YTD to £3.6m. This is primarily driven as a result of £1.1m provision release, better performance on non-pay CIP schemes and clinical supplies reduced spend.	• Full review of non-pay forecast outturn to establish a realistic non-pay trajectory for Months 9–12, including resetting non-recurrent adjustments. • Deep-dive into non-pay CIP programme to determine expected delivery, identify high-risk schemes, and confirm mitigating actions. • Strengthened cost control and authorisation for non-essential non-pay	• FDB discussion on 19/11 • Non pay recovery trajectory agreed at FDB on 17/12 • Further discussion on performance and mitigation plans on 21/01	n/a	High
LLP expenditure against plan has overspent by £k in month and contributing to a YTD overspend of £764k, offset by £94k underspend on ADH spend.	• Agreement of future LLP for the remainder of the year. • Consideration given to scenarios for additional capacity created by LLP session that could contribute positively to income underperformance recovery for the remainder of the year, although this would require income above the underperformance highlighted on the Commissioner Income slide to ensure sufficient contribution to the financial position	• FDB discussion on 19/11 • Scenarios discussed at FDB on 17/12	n/a	High

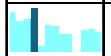
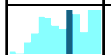
Assurance Reports: Finance Cost Improvement Programme (CIP)

	In Month £'000s			YEAR TO DATE £'000s		
	Plan	Actual	Variance	Plan	Actual	Variance
CIP	£817	£545	(£272)	£6,323	£5,266	(£1,057)

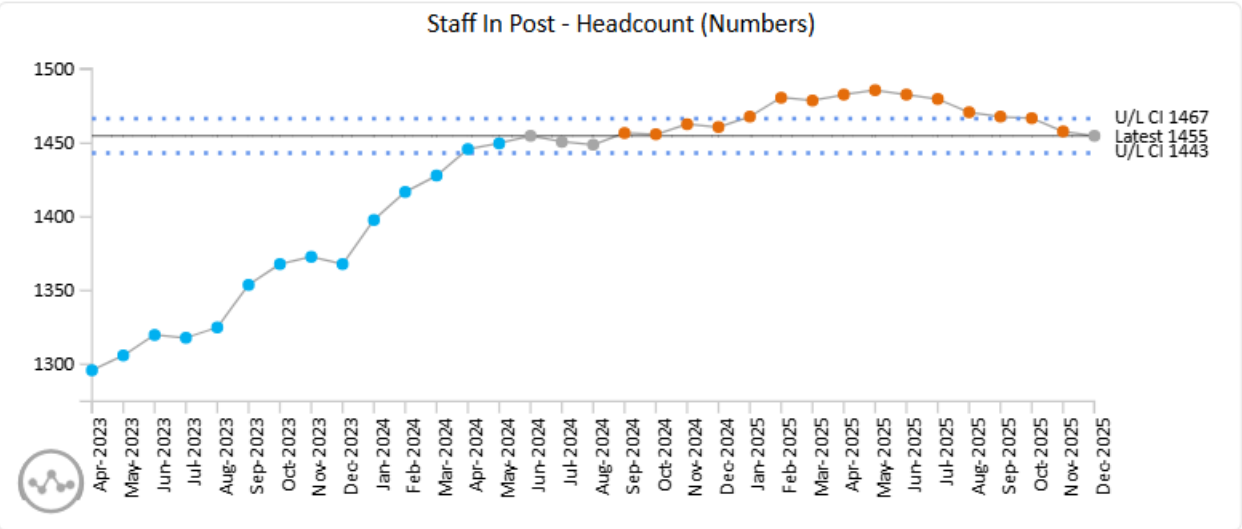


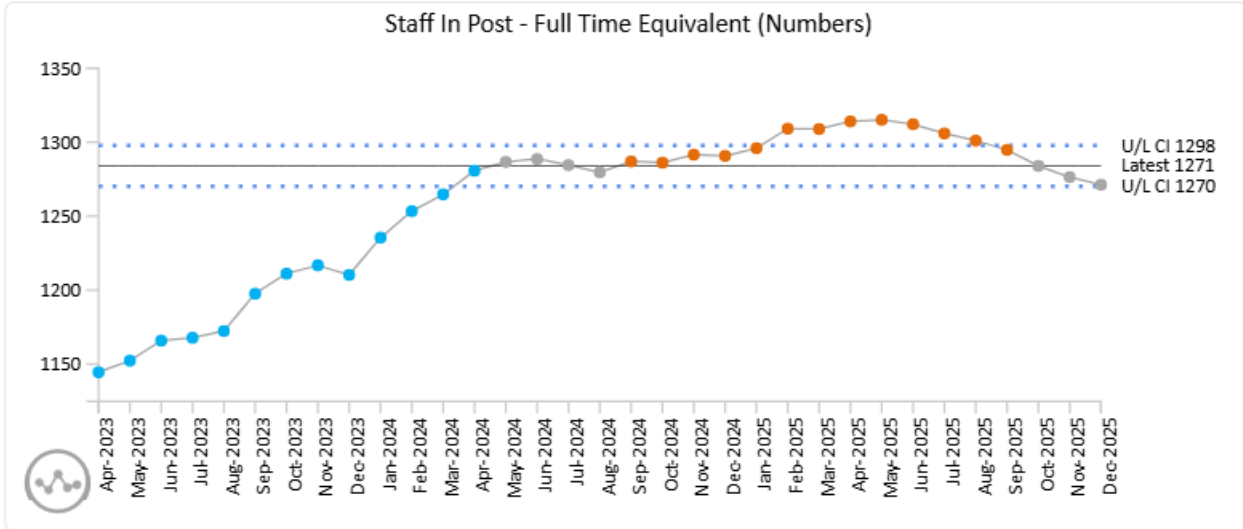
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
In month efficiencies of £454k have been recorded. This increases the year to date achieved to £5.2m against a plan of £6.3m, generating an underperformance of £1m. 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. The schemes in which there are concerns regarding delivery are; • Additional NHS funded income - £1.1m • Service review phase 1 shortfall - £286k in year and £1.1m FYE • Infrastructure bank spend reduction - £1.1m • LLP spend reduction - £1m	• Income underperformance recovery trajectory to be agreed • Additional grip and control measures applied to all areas of spend • Workforce control initiatives to be fully considered and estimation of impact expected from these for the remaining months • Revised bank expenditure reduction targets to be set for the remaining months • Review difficult decisions log to assess which proposals could progress to QIA	• FDB discussion on 19/11 • Non pay recovery trajectory agreed at FDB on 17/12 • -FDB discussion on 17/12 • Additional pay control initiatives agreed at FDB on 17/12 • Further discussion on CIP performance and mitigation plans on 21/01	n/a	High

Integrated Performance Dashboard: Workforce

Metric Grouping	Metric Name	Reporting Period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Workforce	Staff In Post - Headcount	Monthly	1,461	1,468	1,481	1,479	1,483	1,486	1,483	1,480	1,471	1,468	1,467	1,458	1,455	1,472			-	-	-
Workforce	Staff In Post - Full Time Equivalent	Monthly	1,291	1,296	1,309	1,309	1,314	1,315	1,312	1,306	1,301	1,295	1,284	1,276	1,271	1,297			-	-	-
Workforce	Staff Turnover Percentage - Adjusted	Monthly	11.50%	10.90%	11.11%	11.83%	9.28%	10.73%	10.64%	10.15%	10.10%	8.88%	10.34%	10.43%	10.27%	10.09%		low is good			10.5%
Workforce	Total Whole Time Equivalent Employed as a Percentage of Establishment - Clinical	Monthly	87.30%	87.30%	88.74%	88.74%	89.14%	88.43%	87.97%	88.40%	91.17%	91.17%	93.98%	93.98%	93.98%	90.91%		high is good			92%
Workforce	Total Whole Time Equivalent Employed as a Percentage of Establishment - Non-Clinical	Monthly	91.30%	91.30%	91.34%	91.34%	90.40%	90.25%	90.44%	90.20%	91.62%	91.62%	91.17%	91.17%	91.17%	90.89%		high is good			96%
Workforce	Percentage of Attendance	Monthly	93.20%	93.10%	93.47%	93.78%	94.32%	94.27%	94.01%	93.93%	94.53%	94.38%	93.79%	94.52%	94.52%	94.25%		high is good			96.3%
Workforce	Percentage of Staff Received Mandatory Training last 12 months	Monthly	89.60%	88.90%	89.56%	89.92%	86.99%	86.63%	87.43%	86.82%	82.85%	83.13%	84.14%	85.47%	88.79%	85.81%		high is good			93%
Workforce	Percentage of Staff Received Formal PDR/Appraisal last 12 months	Monthly	92.00%	90.60%	90.96%	90.17%	84.92%	85.58%	79.52%	83.10%	86.61%	90.00%	90.56%	90.59%	89.50%	86.71%		high is good			95%
Workforce	Percentage of Sickness Trust Wide Long Term	Monthly	3.69%	4.29%	4.47%	3.98%	3.90%	4.45%	4.04%	4.08%	3.93%	3.57%	3.70%	3.65%	3.55%	3.87%		low is good	-	-	-
Workforce	Percentage of Sickness Trust Wide Short Term	Monthly	3.09%	2.54%	2.01%	2.21%	1.84%	1.61%	2.08%	1.99%	1.46%	2.09%	2.52%	2.00%	3.21%	2.09%		low is good	-	-	-
Workforce	Return to Work Completion %	Monthly	55.80%	66.00%	62.33%	61.32%	67.44%	61.22%	66.24%	69.33%	65.37%	67.01%	67.50%	69.27%	73.96%	67.48%		high is good			80%

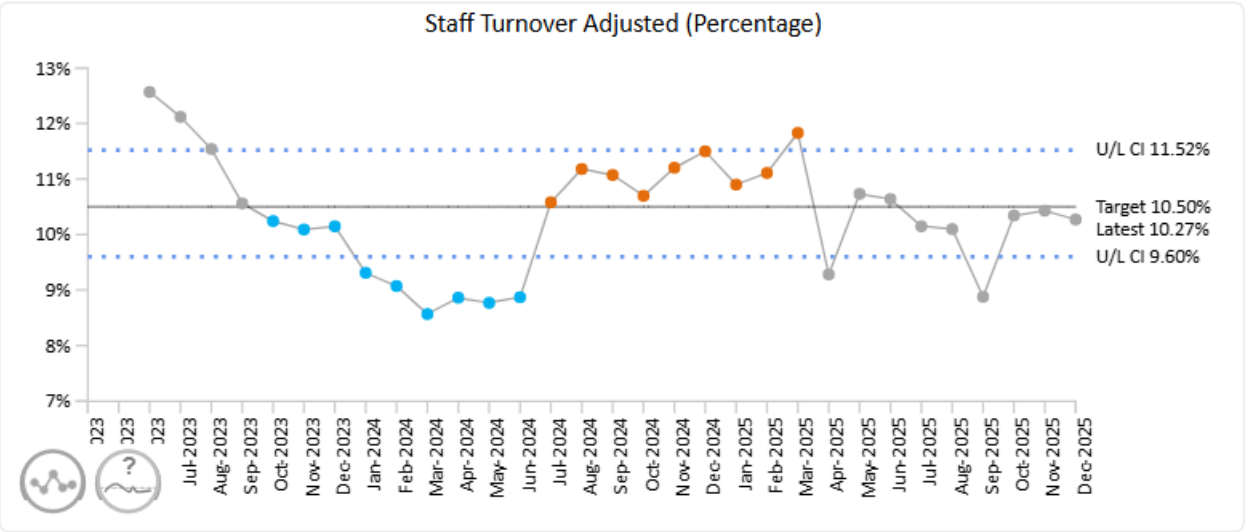
Assurance Reports: Workforce

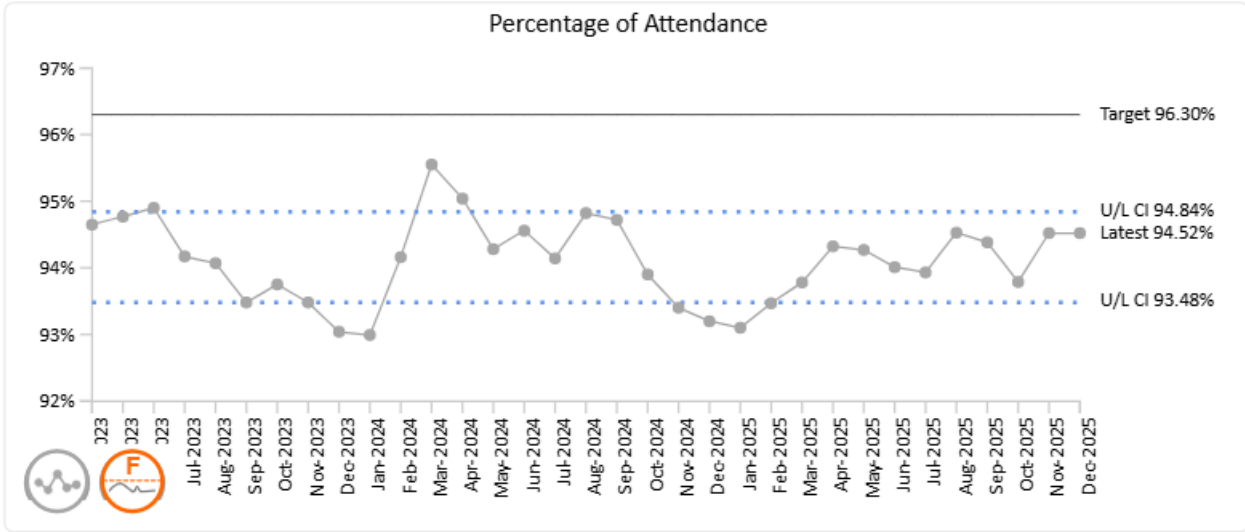




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
• There is a risk that we have the wrong number of staff in the wrong areas, balancing pay spend with workforce need.	• We have tight vacancy controls in place, requiring any recruitment to be appropriately assessed, only recruited if high need and alternative approaches are fully considered. • Workforce planning is becoming more embedded in the Trust, with several core services receiving workforce planning support. • Training on workforce planning in place as part of Me as Manager.	• Vacancy controls strengthened by new system to include all pay related changes – Jan 26 Assurance committee: Staff Experience and Organisational Development (SE&OD)	Risk 2059	High

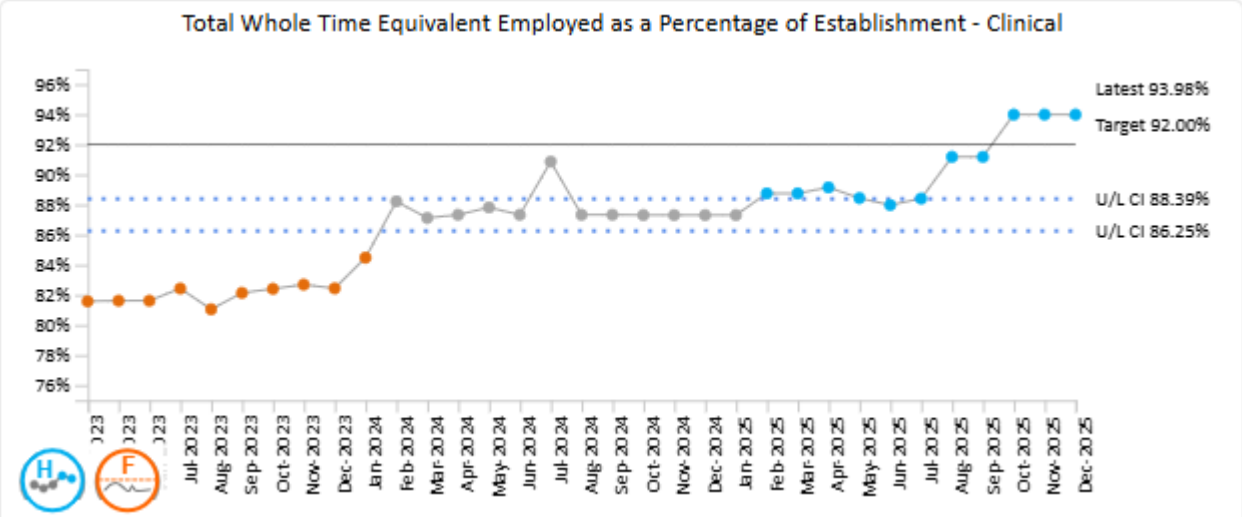
Assurance Reports: Workforce continued

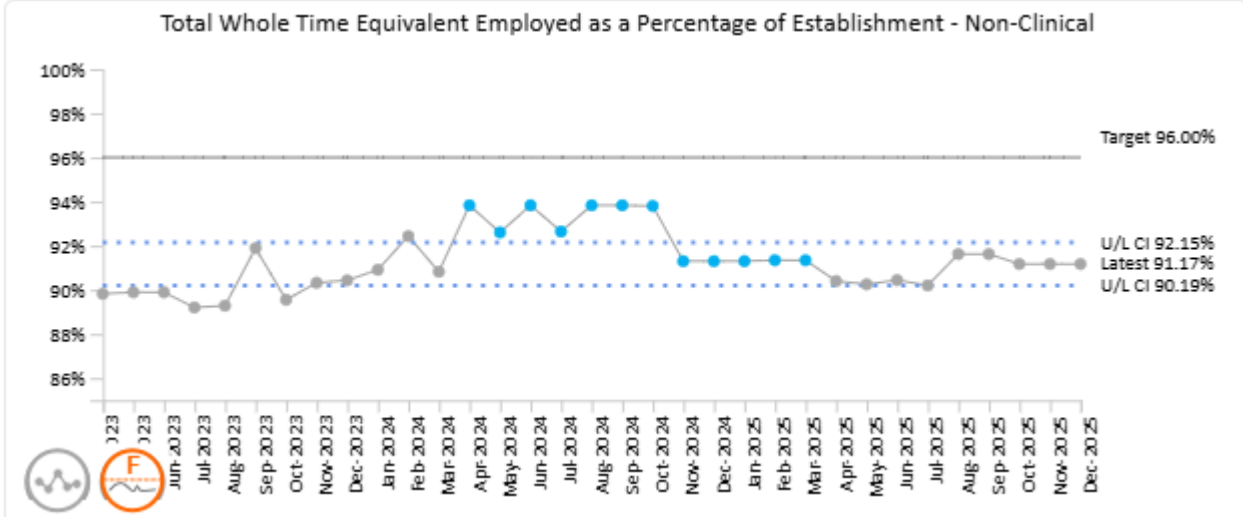




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
• There is a risk that we don't retain key staff through poor engagement and/or better reward packages at other organisations • There is also a risk that having low turnover will hinder us in reducing pay spend required for improving Trust finances.	• Staff Survey data for 2025/26 due Feb 2026. • Regular review of leavers data	February 2026 Ongoing Assurance committee: Staff Experience and Organisational Development (SE&OD)	Risk 2058	High

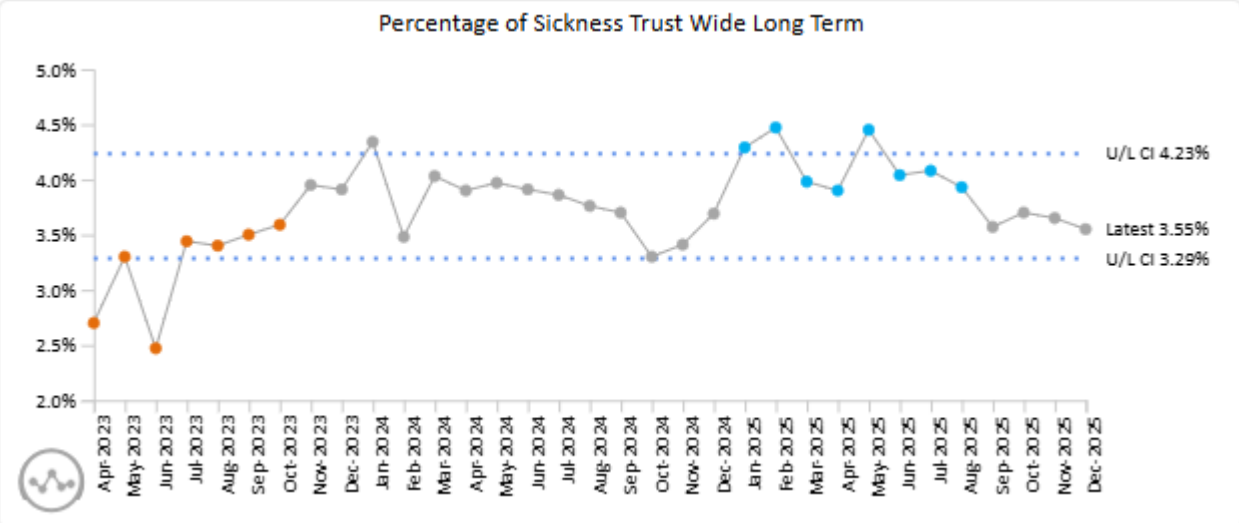
Assurance Reports: Workforce continued

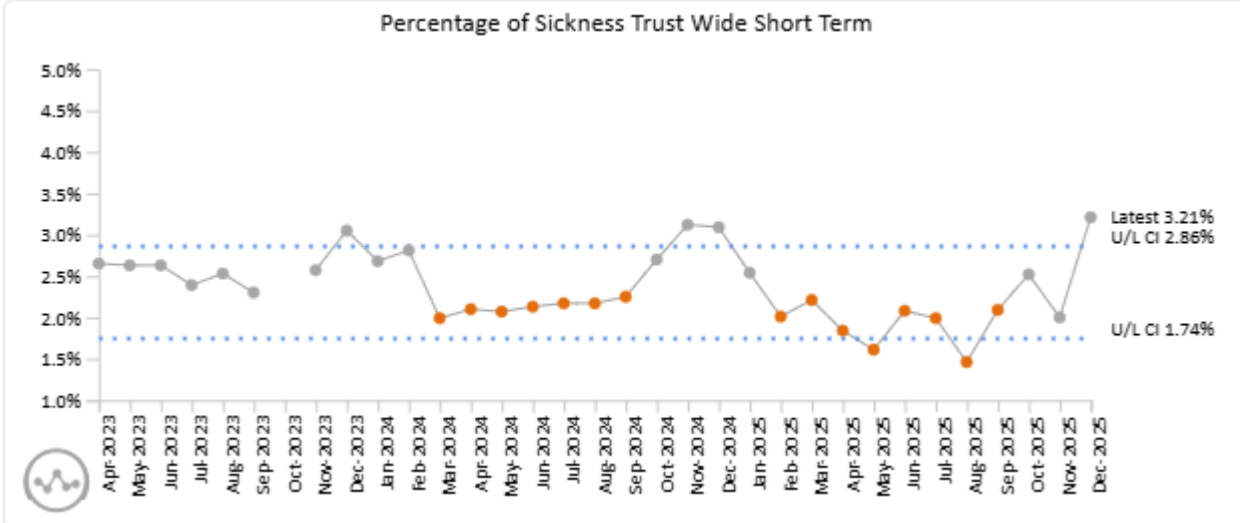




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
• There is a risk that if we don't fulfil our establishments, we will have higher temporary spend leading to poor workforce resilient. • A key challenge is truly understanding our vacancies whilst also having robust vacancy controls.	• Recruitment time to hire is the lowest it has been at 38 days, supporting vacancies to be filled without delay.	Regular work takes place to align ledger with ESR data. Assurance committee: Staff Experience and Organisational Development (SE&OD)	Risk 2060	Medium – requires ongoing manual alteration

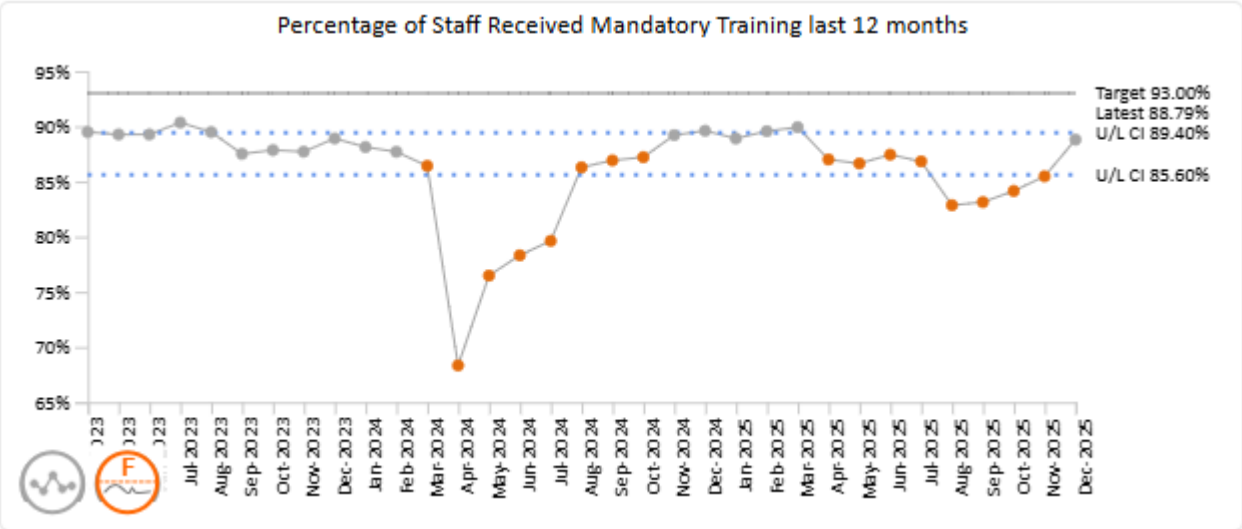
Assurance Reports: Workforce continued

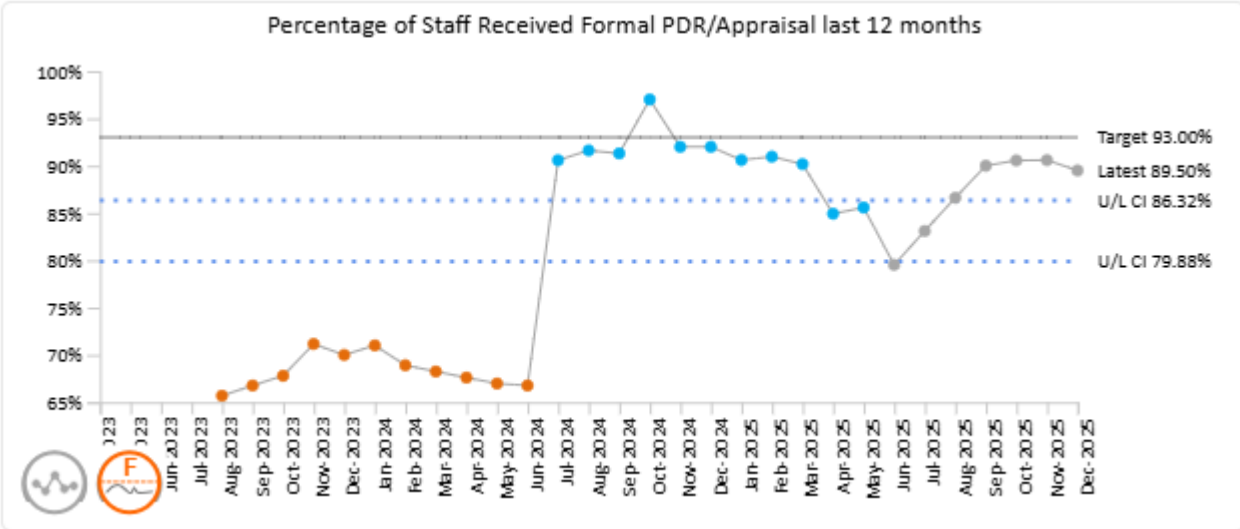




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
• There is a risk that we have excessive staff unavailability. This leads to higher temporary staffing spend and lower productivity	We have a significant and robust plan to support the Trust to support staff and ensure compliance with policy, which includes: • Training programme for managers • MSK OH role to reduce MSK related absences (charity funded) • The number of dismissals and hearings have increased dramatically in 2025 and are expected to continue in 2026. • Audits are in place to measure managerial compliance • Enhanced support in place for high sickness areas.	Assurance committee: Staff Experience and Organisational Development (SE&OD) In place (attempting to increase attendance) Started Jan 26 Ongoing Ongoing Ongoing	Risk 2156	High assurance

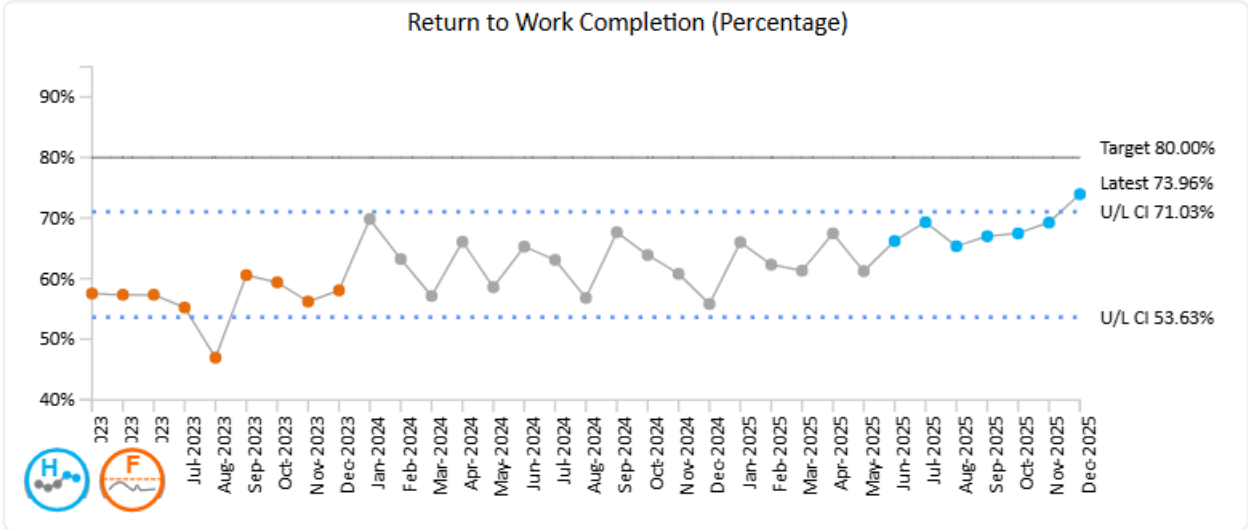
Assurance Reports: Workforce continued





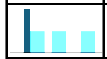
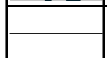
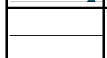
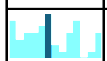
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
• There is a risk that the Trust will not achieve its mandatory training compliance target of 93%, the consequence of this is can have a direct impact on patient care, and a financial implication from our commissioners. • There are 3 core mandatory training modules that require an annual renewal (fire, IG, Cyber) . For two of these, Information Governance, and Cyber Security, this renewal requirement commenced in April 2024, and the graph shows the steady improvement during 2024, followed by a decrease from March 2025 as the annual renewals expired.	- The new Learning Management System was Launched in October 2025, with access to all elearning now in one place. Positive improvements in compliance recorded since then. - During December 2025, all non-compliant staff have been direct targeted to complete their required modules. - T&D team working closely with the NHSE StatandMand review project to align activity, with the potential to reduce "time" completing training. - Exploring the possibility of reducing the frequency of Fire training from annual to every 2 years.	- Subject Matter Leads are presenting assurance reports, and trajectory targets at the training and development group on 21st Jan 2026. Upward report is reviewed at MPET Group on 30th Jan 2026. - Assurance report provided to commissioners at meeting on 19th Jan 26. Assurance committee: Staff Experience and Organisational Development (SE&OD)	R1436	High assurance

Assurance Reports: Workforce continued



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
• There is a risk that a low return to work rating demonstrates a lax approach to policy compliance, potentially leading to higher episodes of sickness absence.	• We regularly audit departments with lower rates of completion. We are finding the rate is around 80%, and managers are at times not logging on ESR/Healthroster. • The Trust rollout to Health Roster will support compliance as it's an easier system to log return to work. • High support/workshops in place for areas with lower compliance	Audits to continue on an ongoing basis Healthroster rollout nearing completion Ongoing Assurance committee: Staff Experience and Organisational Development (SE&OD)	Risk 2156	High

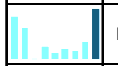
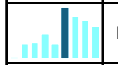
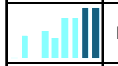
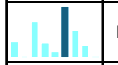
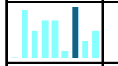
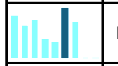
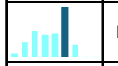
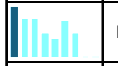
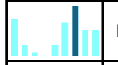
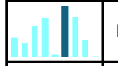
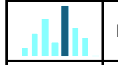
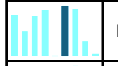
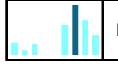
Integrated Performance Dashboard: Governance

Metric Grouping	Metric Name	Reporting Period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Governance	Number of Incidents Reported	Monthly	249	313	360	318	398	284	316	337	295	267	311	303	256	2,767		high is good	-	-	
Governance	Number of PSII (Patient Safety Incident Investigations)	Monthly	1	1	0	1	0	1	1	1	1	1	0	0	0	5		low is good			0
Governance	Number of Inpatient Deaths	Monthly	0	0	2	1	1	0	1	1	0	0	1	1	0	5		low is good			0
Governance	Number of Inpatient Deaths within 30 days of discharge	Monthly	3	1	0	0	0	0	4	1	1	1	3	0	0	10		low is good			0
Governance	Number of Never Events	Monthly					0	1	0	0	1	1	0	0	0	3		low is good			0
Governance	Number of VTE (Avoidable)	Monthly	0	0	0	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	2	0	2		low is good			0
Governance	Number of Category 3 Pressure Ulcer Incidents (Avoidable)	Monthly	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	6	7	7	8	10	5	4	7	9	3	4	7	57		low is good	-	-	-
Governance	Number of Infection Incidents (Reportable)	Monthly	1	0	0	0	0	0	0	0	1	0	0	0	0	1		low is good			0
Governance	Number of Complaints	Monthly	7	8	8	6	8	5	6	9	12	7	8	6	10	71		low is good	-	-	-
Governance	Number of PAL contacts	Monthly	36	63	60		52	56	41	41	44	45	53	52	37	421		low is good	-	-	-
Governance	Number of Claims	Monthly	0	0	0	0	0	2	1	1	0	0	0	0	0	4		low is good			0
Governance	Number of Inquests	Monthly	1	0	0	0	0	0	0	0	0	0	2	1	0	3		low is good			0

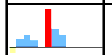
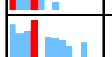
Integrated Performance Dashboard: Infection Control

Metric Grouping	Metric Name	Reporting Period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Infection Control	Hospital-onset healthcare-associated MRSA Bacteraemia	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good			0
Infection Control	Hospital-onset healthcare-associated MSSA Bacteraemia	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good			0
Infection Control	Hospital-onset healthcare-associated Pseudomonas aeruginosa Bacteraemia	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good			0
Infection Control	Hospital-onset healthcare-associated Escherichia coli Bacteraemia	Monthly	0	0	0	0	1	0	0	0	0	0	0	0	0	1		low is good			0
Infection Control	Hospital-onset healthcare-associated Klebsiella species Bacteraemia	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good			0
Infection Control	Hospital-onset healthcare-associated C. difficile Toxin +ve (reportable)	Monthly	0	0	0	1	0	0	0	0	1	0	0	0	0	1		low is good			0
Infection Control	All C. difficile cases identified on or during admission	Monthly	0	0	0	1	0	0	0	1	1	0	0	1	0	3		low is good			0
Infection Control	Healthcare-associated MRSA (acquisition)	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good			0
Infection Control	Healthcare-associated Influenza	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	3	3		low is good			0
Infection Control	Healthcare-associated SARS CoV-2	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good			0
Infection Control	Respiratory Infection Outbreaks	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	1	1		low is good			0
Infection Control	Other Infection Outbreaks	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good			0
Infection Control	Surgical Site Infections (inpatient & readmission - month of primary surgery)	Monthly	0	2	3	0	2	1	2	3	1	2	1	5	0	17		low is good			0
Infection Control	Hand Hygiene Audit - Trust total %	Monthly	99.00%	99.00%	99.00%	99.00%	99%	91%	99%	100%	99%	99%	99%	99%	99%	98%		high is good			90%

Integrated Performance Dashboard: Operational

Metric Grouping	Metric Name	Reporting Period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Inpatients	IP Activity Monthly Performance %	Monthly	92.4%	101.4%	109.9%	95.4%	109.4%	103.0%	101.5%	96.3%	98.3%	99.7%	94.3%	94.5%	101.3%	99.52%		high is good			100%
Inpatients	IP Activity Electives Monthly Performance %	Monthly	90.4%	94.3%	102.0%	90.9%	111.8%	108.6%	98.9%	102.8%	100.7%	102.1%	101.5%	104.2%	114.2%	103.59%		high is good			100%
Inpatients	IP Activity Daycases Monthly Performance %	Monthly	92.0%	106.5%	116.7%	97.1%	109.2%	98.5%	103.9%	91.6%	96.4%	99.3%	88.6%	87.9%	92.4%	97.83%		high is good			100%
Inpatients	IP Activity Non-Electives Monthly Performance %	Monthly	227.3%	157.1%	118.2%	215.4%	57.7%	113.4%	86.2%	99.1%	99.8%	56.2%	113.1%	73.8%	83.4%	87.4%	-	-	-	-	-
Inpatients	IP Activity Monthly Discharges	Monthly	1,126	1,359	1,340	1,252	1,168	1,204	1,208	1,231	1,205	1,304	1,280	1,268	1,254	11,122		high is good	-	-	-
Inpatients	IP Activity Elective Discharges	Monthly	506	579	571	547	485	530	487	539	527	565	565	586	586	4,870		high is good	-	-	-
Inpatients	IP Activity Daycase Discharges	Monthly	595	758	756	677	672	649	702	670	656	726	689	666	649	6,079		high is good	-	-	-
Inpatients	IP Activity Non-Elective Discharges	Monthly	25	22	13	28	11	25	19	22	22	13	26	16	19	173		-	-	-	-
Outpatients	OP Activity Monthly Performance %	Monthly	131.5%	106.8%	110.4%	98.0%	106.4%	103.3%	104.8%	99.5%	98.3%	108.6%	104.4%	93.7%	93.7%	102.3%		high is good			100%
Outpatients	OP Activity First Monthly Performance %	Monthly	136.6%	112.1%	114.3%	96.4%	84.4%	89.3%	93.7%	92.8%	93.0%	104.3%	88.4%	82.9%	82.9%	91.1%		high is good			100%
Outpatients	OP Activity Follow Up Monthly Performance %	Monthly	131.4%	106.3%	110.9%	101.7%	117.5%	111.0%	111.4%	103.5%	100.6%	109.8%	103.8%	91.3%	91.3%	105.9%		high is good			100%
Outpatients	OP Activity Procedures Monthly Performance %	Monthly	104.4%	84.2%	83.7%	66.4%	127.5%	108.9%	102.7%	99.6%	108.5%	125.4%	138.0%	119.7%	119.7%	116.5%		high is good			100%
Outpatients	OP Activity Monthly Attendances	Monthly	5,591	6,813	6,035	6,248	6,072	5,927	6,334	6,543	5,651	6,849	6,581	5,994	5,572	55,523		high is good	-	-	-
Outpatients	OP Activity First Monthly Attendances	Monthly	1,856	2,284	1,997	1,964	1,681	1,779	1,964	2,134	1,852	2,296	2,024	1,906	1,680	17,316		high is good	-	-	-
Outpatients	OP Activity Follow Up Monthly Attendances	Monthly	3,477	4,217	3,772	4,038	4,050	3,826	4,030	4,101	3,488	4,164	4,115	3,687	3,529	34,990		high is good	-	-	-
Outpatients	OP Activity Procedures Monthly Attendances	Monthly	258	312	266	246	341	322	340	308	311	389	442	401	363	3,217		high is good	-	-	-

Integrated Performance Dashboard Headline/Workforce Productivity

Metric Grouping	Metric Name	Reporting Period	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Headline Producitivity	Implied Productivity Growth (v 19/20)	Monthly	-14.60%	-13.50%	-13.60%	-11.10%	-14.70%	-12.90%	-14.30%	-14.40%									-	-	
Headline Producitivity	Implied Productivity Growth (V previous year)	Monthly	-0.70%	1.00%	1.50%	0.90%	8.7%%	4.60%	2.20%	1.50%									-	-	
Workforce Productivity	Implied Workforce Productivity Growth (v19/20)	Monthly	-13.10%	-10.90%	-10.30%	-9.00%	-14%	-12.70%	-10.30%	-10.70%									-	-	
Workforce Productivity	Elective Admissions per clinical WTE	Monthly	2.67	3.25	3.15	2.89	2.51	2.56	2.55	2.58	2.64	2.70	2.67	2.65	2.56						
Workforce Productivity	Elective Admissions per WTE	Monthly	0.87	1.06	1.04	0.95	0.91	0.92	0.93	0.95	0.94	1.01	0.99	1.00	0.99				-	-	
Workforce Productivity	Outpatient Attendances per consultant wte	Monthly	74.70	92.71	77.52	77.87	76.32	73.50	76.65	79.58	70.83	79.22	76.74	71.19	65.03				-	-	
Workforce Drivers	Total Temporary Staff Spend as % of Total pay Spend	Monthly	10.00%	10.00%	10.00%	10.00%	5.60%	5.90%	6.00%	6.40%	4.92%	6.44%	5.86%	6.38%	6.38%				-	-	
Workforce Drivers	Reg Nurses Sickness Absence Rate	Monthly	7.80%	8.40%	8.60%	6.90%	6.36%	7.71%	7.10%										-	-	
Workforce Drivers	Medical Sickness Absence Rate	Monthly	1.10%	0.80%	0.50%	1.10%	0.75%	0.12%	0.30%										-	-	
Workforce Drivers	Turnover (Adjusted)	Monthly	11.50%	10.90%	11.10%	11.83%	9.28%	10.73%	10.64%	10.50%	10.10%	8.88%	10.34%						-	-	
Workforce Drivers	Care Hours per Patient Day (Reg Nurses)	Monthly	5.80	5.50	4.77	4.59	5.26	5.19	6.34	5.50	5.40	5.70							-	-	

Quality Report

January 2026

(December 2025 Data)

Introduction

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

Icons reading guide

Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

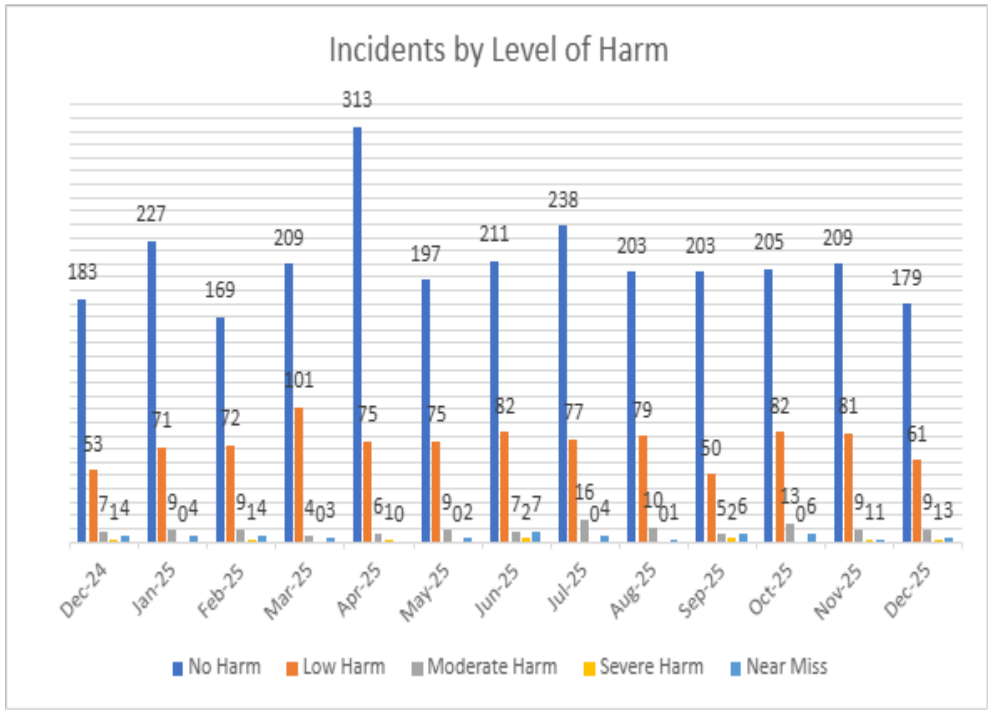
Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

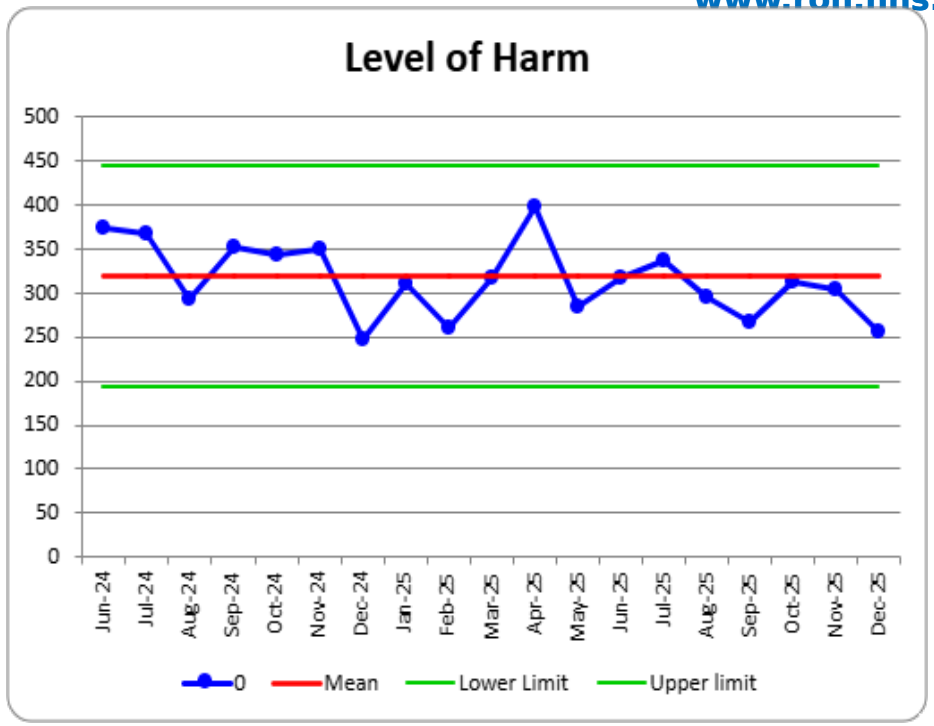
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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

Governance Performance Summary Dashboard

Performance to end December 2025	In month	Previous month	Variation	Assurance
Total No of Incidents Reported	256	303		
Inpatient Deaths	0	1		
PSII's (Patient Safety Incident Investigations)	0	0		
Never Events	0	0		
VTE Incidents (Avoidable)	0	0		
Category 2 Pressure Ulcer Incidents (Avoidable)	1	2		
Category 3 Pressure Ulcer Incidents (Avoidable)	0	0		
Falls (Total No of Inpatient Falls)	6	4		
Infection Incidents (Reportable)	0	0		
Complaints	10	6		
Claims	0	0		
Inquest	0	1		
RIDDOR Reportable Incidents	0	1		

Incidents Reported





Quality Improvement & Learning

There were 256 incidents reported within the Trust during December 2025. This is in line with the seasonal lower number of incidents around the festive period.

Incidents Reported... (continued)

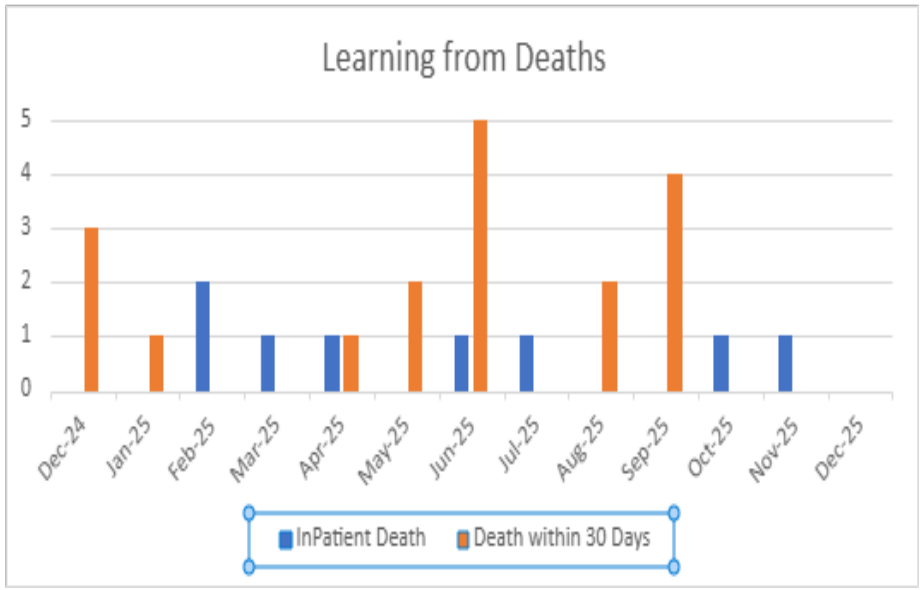
Financial Year 2025-2026

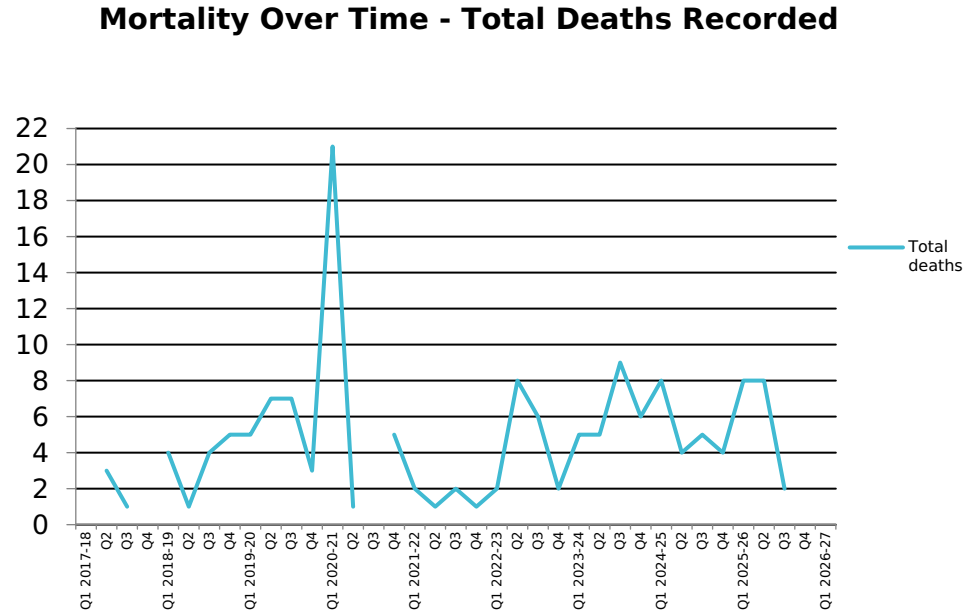
PSIRF Investigation Method	In Month	Last month	Year to Date
PSII	0	0	4
AAR	0	1	12
MDT	0	0	1
Thematic Review	0	0	5

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 or deaths within 30 days of discharge reported in December 2025.

Infection Prevention & Control

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

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:

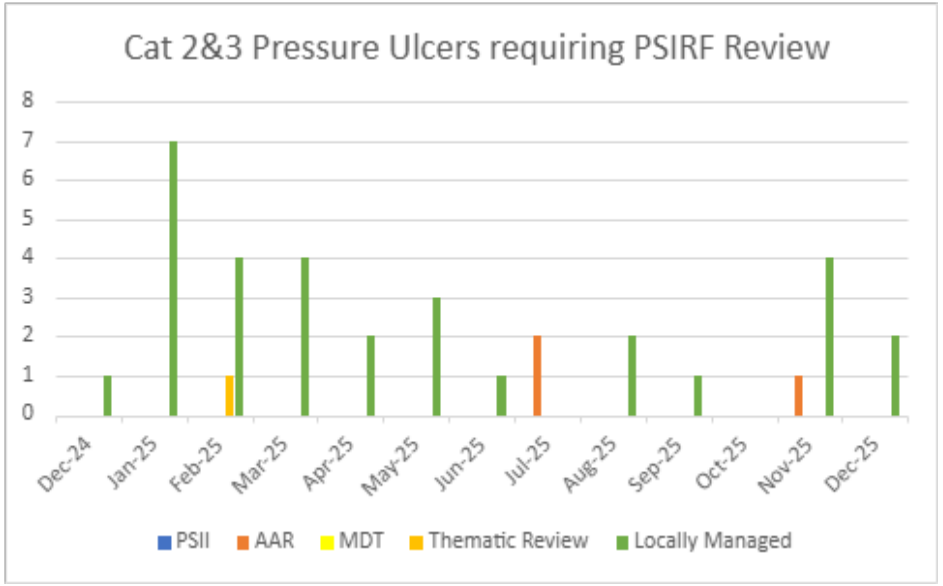
	CDI (Toxin +ve)	*E.coli* BSI	*P. aeruginosa* BSI	*Klebsiella* Sp. BSI	MRSA BSI
2023/24	5	0	0	1	0
2024/25	1	2	0	0	0
2025/26	0	0	0	0	0

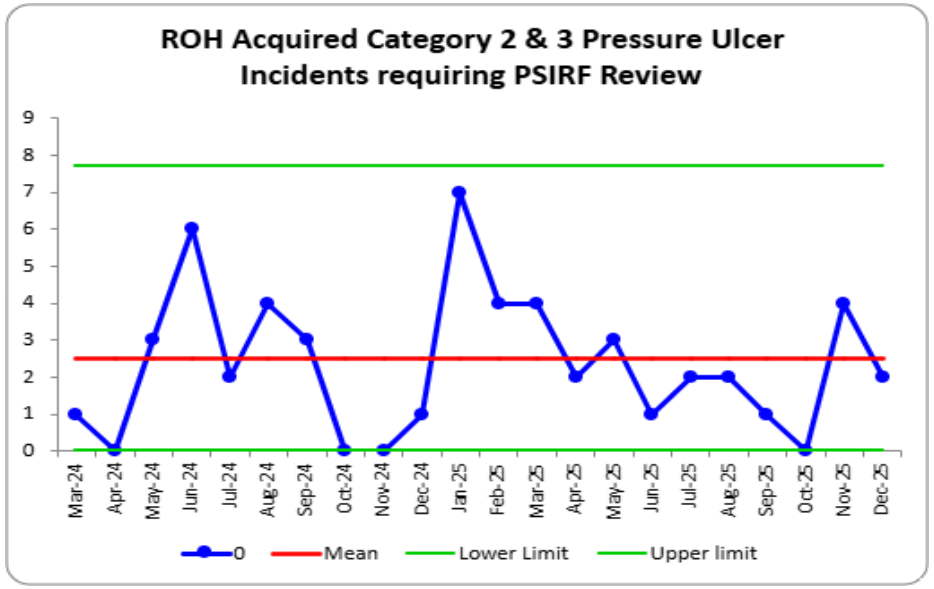
QUALITY IMPROVEMENT WORK

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 were 2 pressure ulcer incidents reported in December 2025. After completion of the PSIRF PU triage questionnaire, it was found that in 1 case there was a lapse in care therefore the category 2 PU was hospital acquired. Learning and improvement were identified in relation to the repositioning regime and the provision of an appropriate mattress.

Summary of on-going Quality Improvement work

Joint report with Theatre Matron in progress for presentation at next Quality & Safety Committee relating to issues in theatres regarding skin tears and action plan, including skin tear boxes implementation to enable best practice re wound management, following an injury.

ROH Registered Nurses Education Review - Data collection in progress

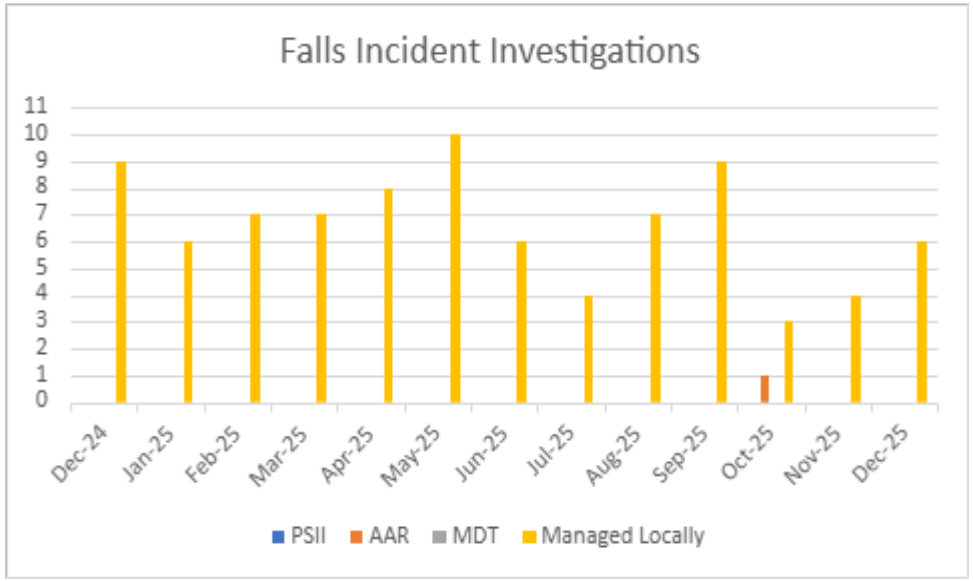
Negative Pressure Wound Therapy Guidelines – to be further amended following relevant queries, having been sent out for comments

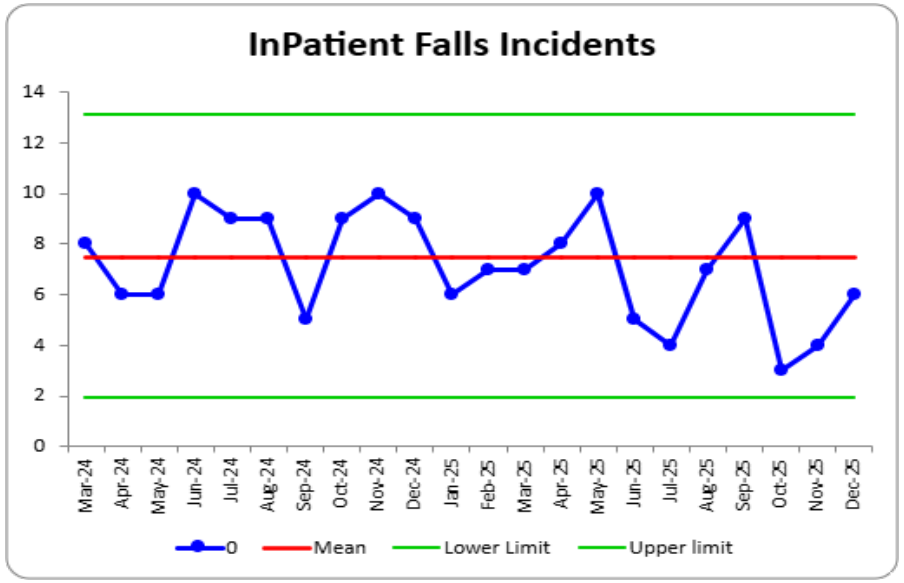
Pressure Ulcer Policy

- Amendments regarding PURPOSE – T in progress and Mattress Guidance
- Awaiting European Pressure Ulcer Advisory Panel/National Pressure Ulcer Advisory Panel guidelines due for release Oct 25 still waiting – TV Lead will update and add in when published

Positive Assurance:- During the Christmas and New Year period – ward 3 looked after 6 patients with very complex wounds that made mobilisation and moving very difficult. None of them developed pressure sores or MASD damage. Demonstrates exemplary care from Ward 3 staff.

Falls





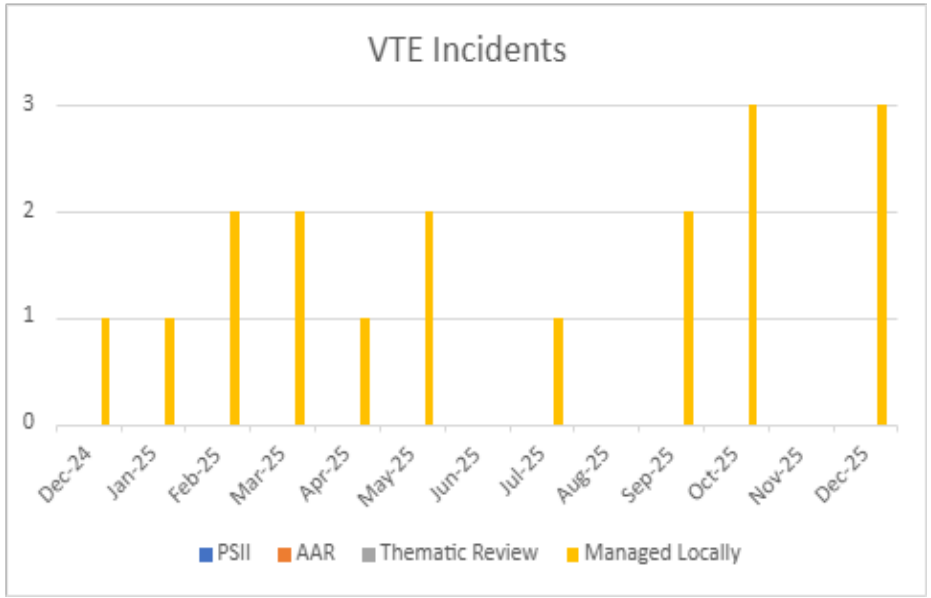
Quality Improvement & Learning

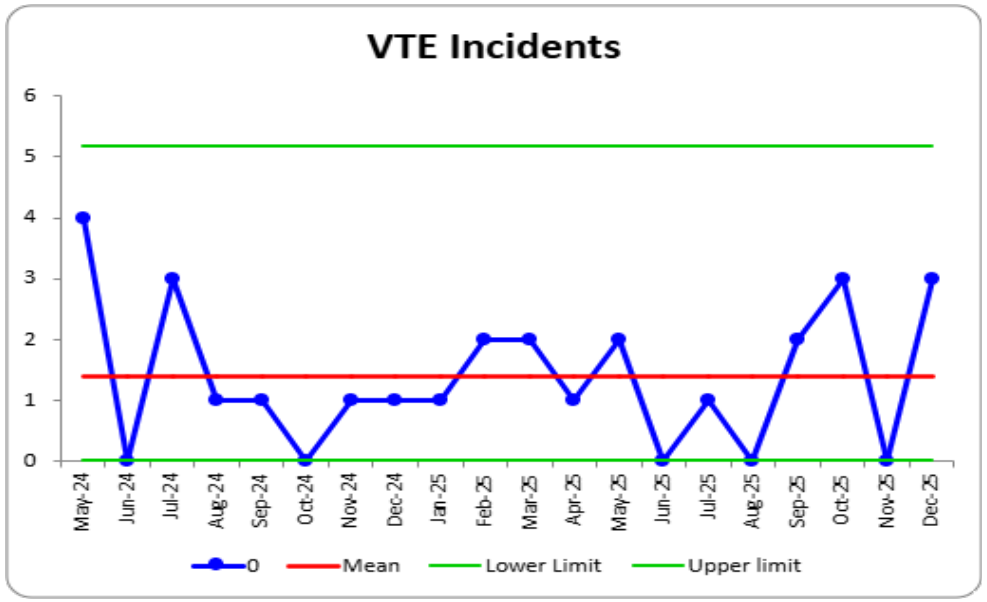
There were 6 inpatient falls reported in December 2025. All incidents were reported as no harm and were managed locally and no themes were identified.

Quality and Improvement Work

- Updated bed rail assessment for inpatients due to be launched at leader's forum meeting, awaiting formatting from Comms team.
- Bedrails policy redrafted – awaiting comments before submission for approval.
- Bsol ICS Falls Steering Group function currently being reviewed as chair has stepped down from role.

VTEs



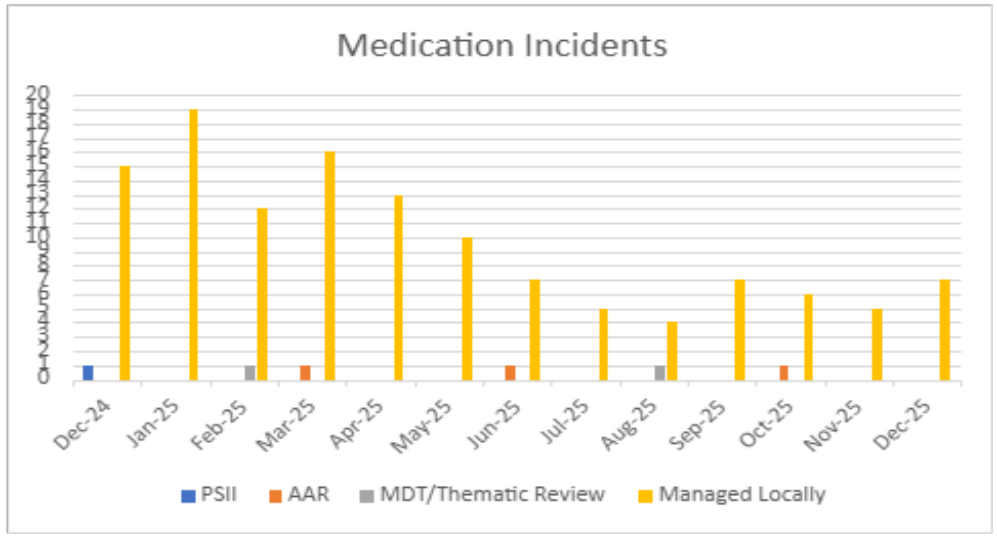


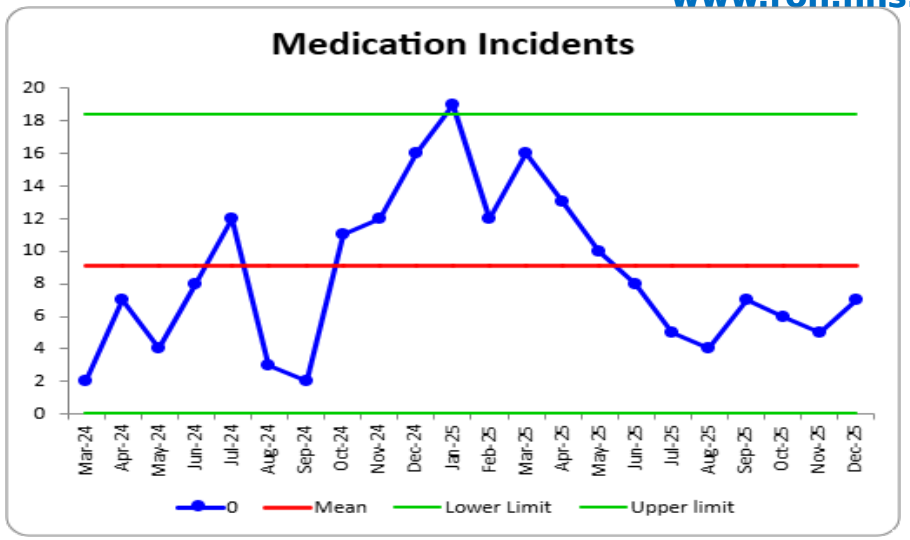
Quality Improvement & Learning

There were 3 confirmed VTE incidents reported in December 2025 review of which is underway.
VTE Lead connects with VTE Exemplar Network. Regarding any national improvement work or shared learning
All recent VTE incidents have been deemed unavoidable after PSIRF VTE triage review.

VTE On Admission Assessment Compliance
Compliance figure for December 2025: 99.22%

Medication Errors

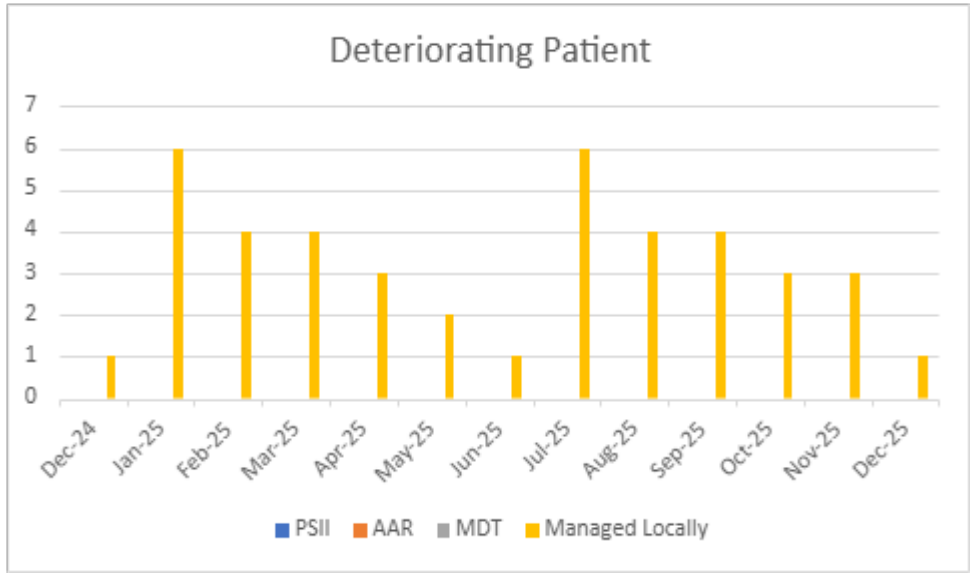


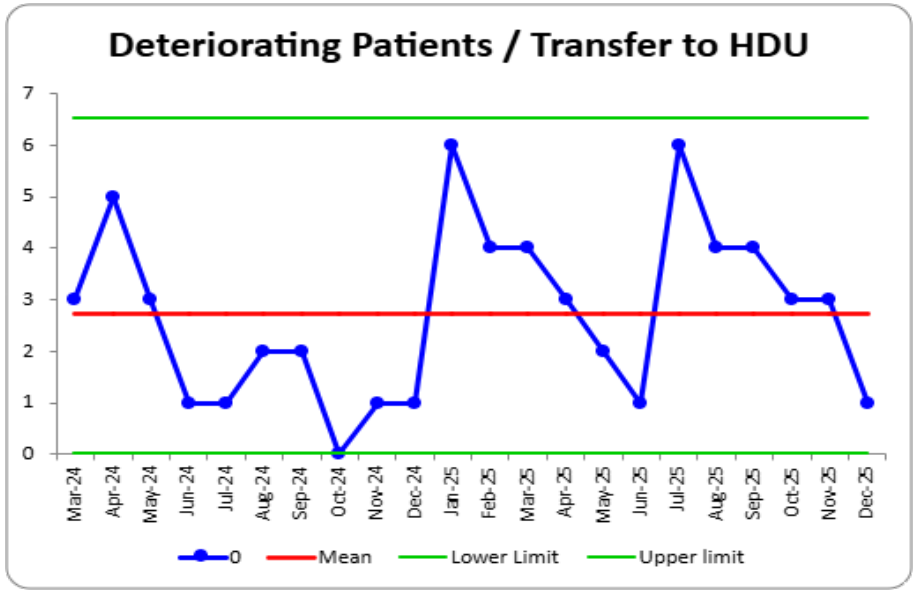


Quality Improvement & Learning

There were 7 Medication incidents reported in December 2025. All incidents have been reported as no or low harm and are being managed locally.

Deteriorating Patients

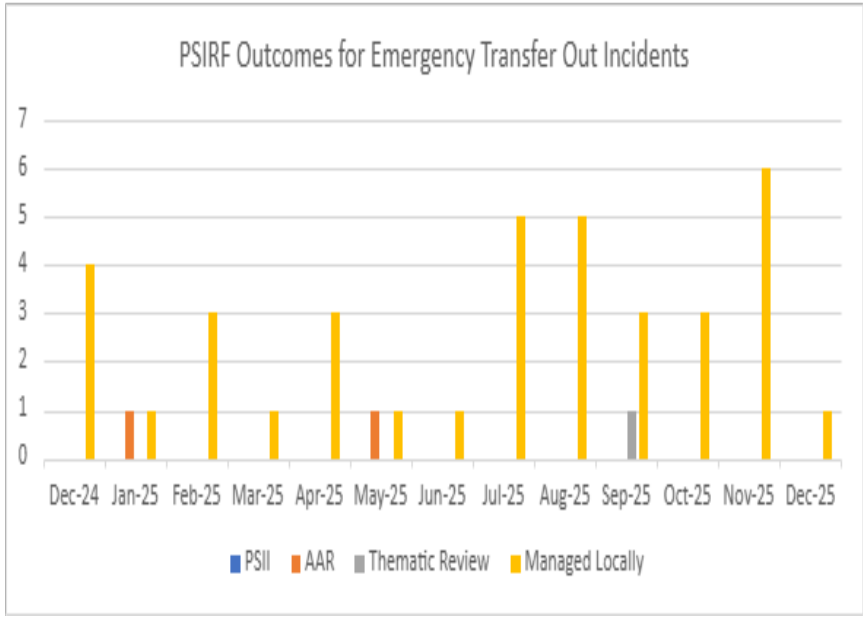


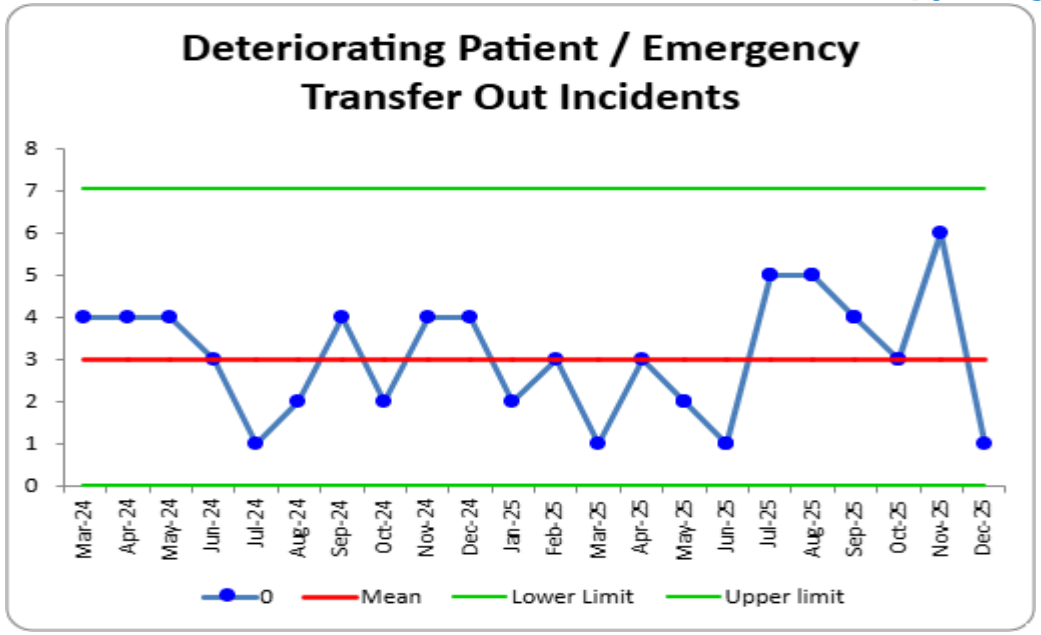


Quality Improvement & Learning

There was 1 deteriorating patient (readmission to HDU within 48 hours) incident reported in December 2025. This incident was managed locally

Emergency Transfers Out





Quality Improvement & Learning

There was 1 emergency transfer out of Trust incident reported in December 2025. Incident was reviewed within Divisional Governance and managed locally, as the appropriate escalation pathways were used and there had been appropriate acute management of the patient's deterioration.

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 – A summary of the identified learning and improvements will be included in the next report.

Complaints

Complaint Information

The Trust received 10 new formal complaints in December 2025. Of these, all remain open but are within agreed timescales as of 31st December resulting in a December KPI achievement of 100%. Additionally, 6 complaints opened in previous months were closed during November with 1 of these breaching their originally agreed timescales. This provides a closure KPI of 83%

Below are the departments that received complaints

- Spinal x 2
- Imaging x 1
- MSK x 2
- Large Joints x 2
- ADCU x 1
- Small Joints x 1
- Pain Management x 1

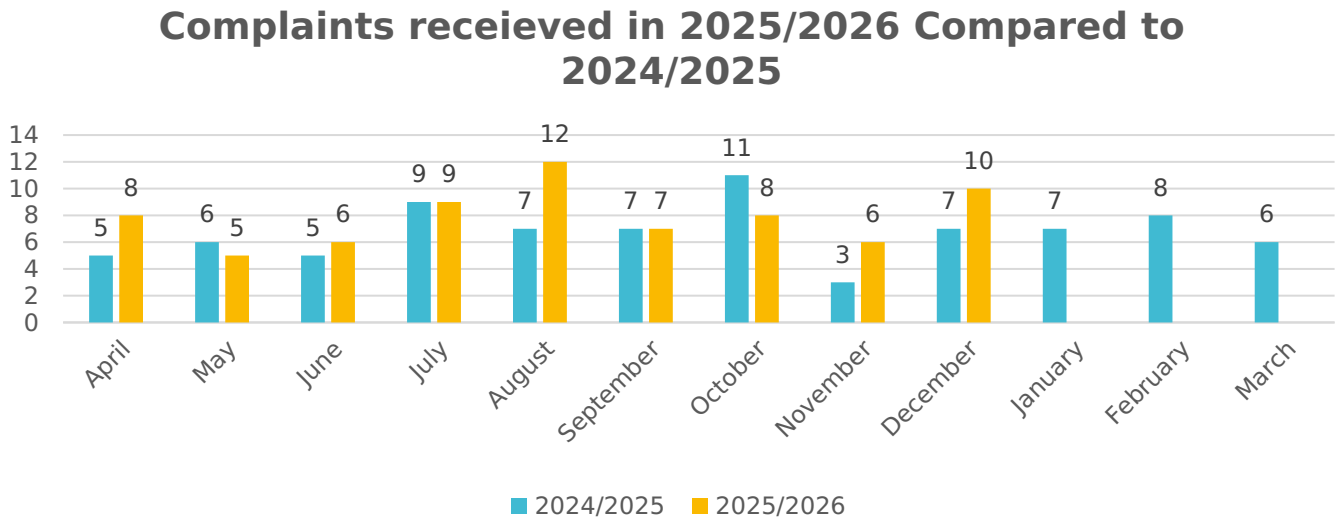
At the time of producing this report (09.01.2026) we currently have **20** formal complaints active – 3 of these have breached agreed timescales.

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 **December 2025** the Trust received one new request for a resolution meeting and this is booked for 20.01.26.

Complaints

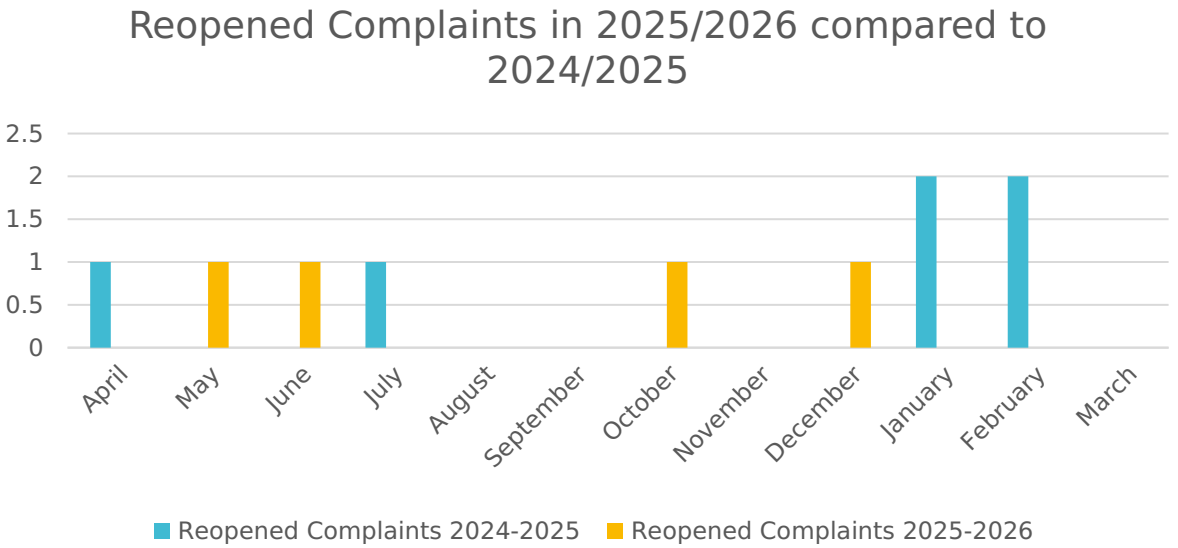


Complaint Year Totals	
April 2023 - March 2024	42
April 2024 – March 2025	92
April 2025 – December 2025	71

Category of Complaints Received

- Clinical Query
- Appointments

Complaints



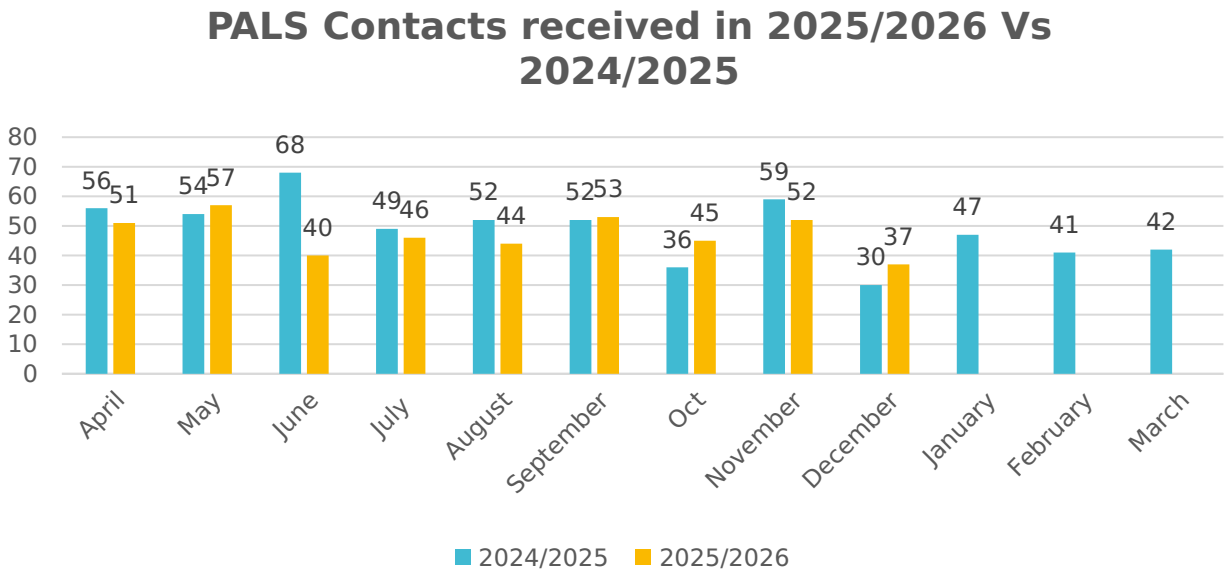
Reopened complaints

The Trust received **1** requests to reopen a complaint in **December 2025.**

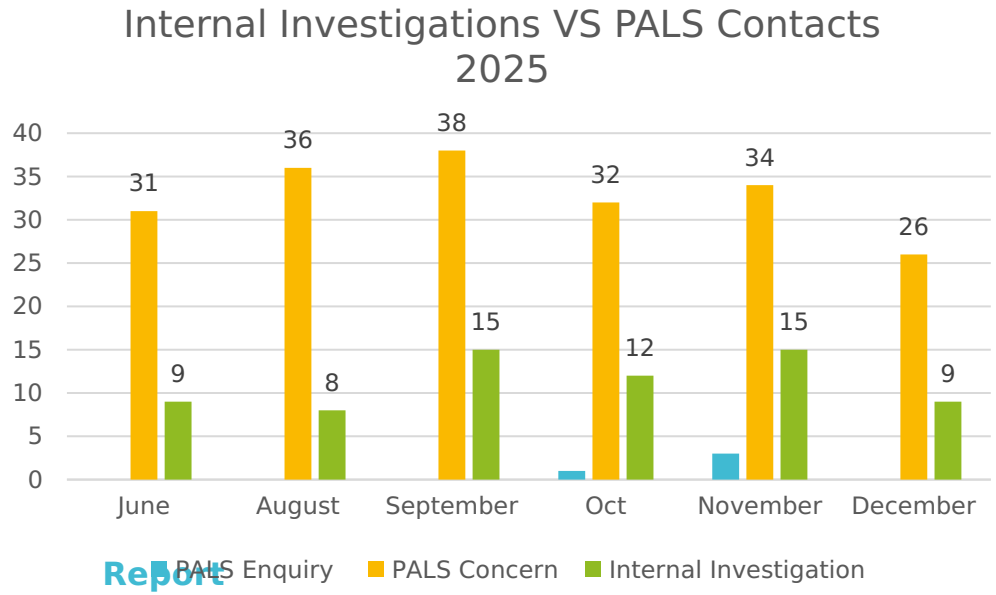
What we Did / Are Doing

- If themes are identified through complaints, these are raised and tracked at **Divisional Governance Meetings**.
- Further tracking and oversight is provided at **Executive Governance Meetings**.
- Actions arising from complaints are recorded in **Ulysses**, with corresponding action plans attached**.**
- Where learning is identified, it is shared across the Trust to support wider improvement.
- Updates on outstanding actions are requested during **bi-weekly governance meetings** and recorded against the relevant complaint.
- Increased **cross-working with MDT teams**, including Safeguarding and Learning & Development, has been implemented to strengthen oversight and collaboration

PALS



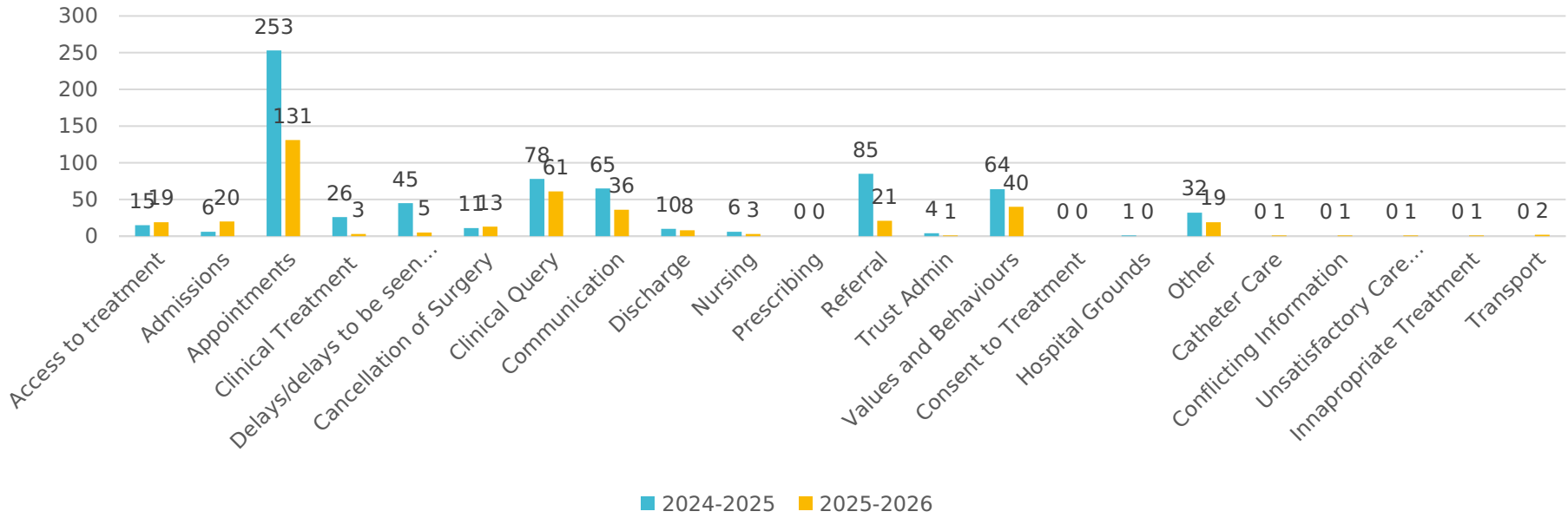
KPI	KPI's
April 2025	83%
May 2025	74%
June 2025	81%
July 2025	70%
August 2025	70%
September 2025	67%
October 2025	61%
November 2025	61%
December 2025	75%



9 PALS cases breached the agreed timeframe with the complainant / enquirer

PALS

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



What we have done / are doing:

Tracked in Executive Governance Meetings

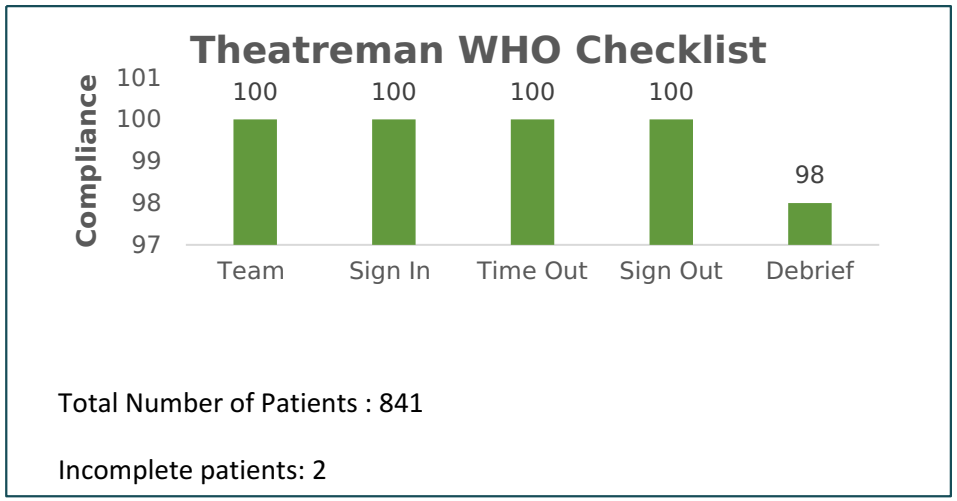
Raised in Governance meetings and with departmental managers.

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.

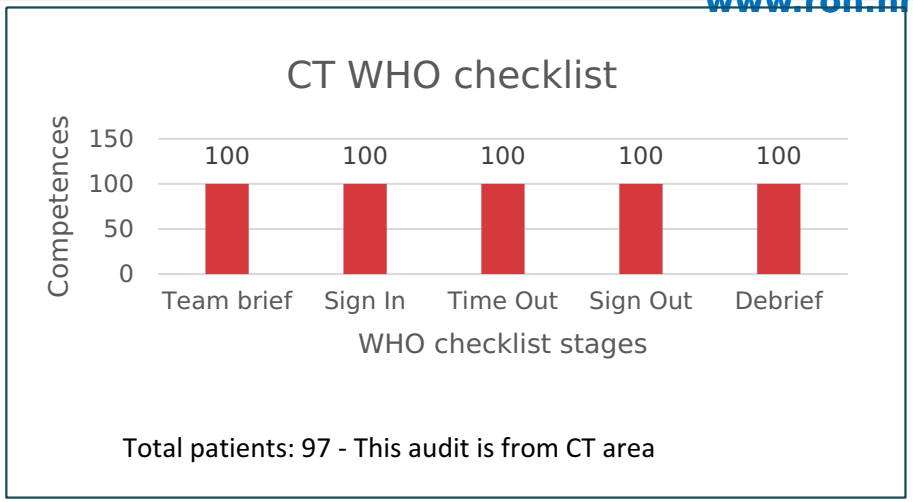
PALS Team are managing and resolving PALS contacts within their remit.

WHO Audits

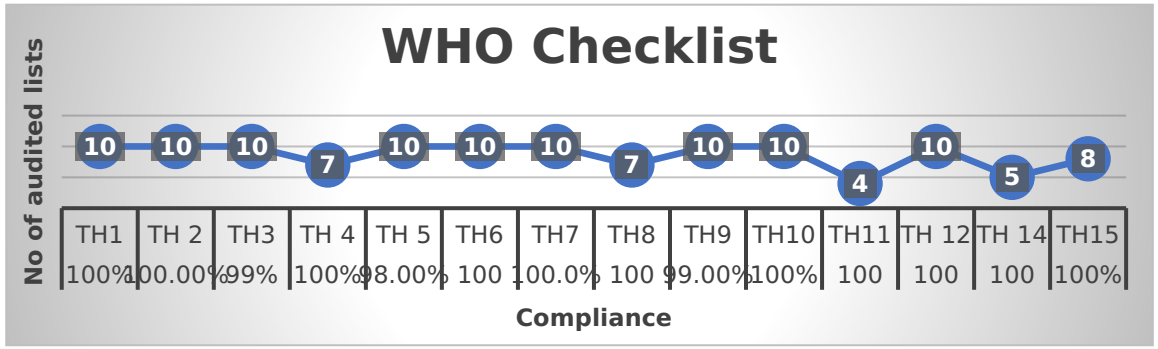


Total Number of Patients : 841

Incomplete patients: 2



Total patients: 97 - This audit is from CT area



121 operating lists audited.

Theatres 4, 8, 11, 14 and 15 did not meet the required audit threshold. Theatre 4's non-compliance was due to a reduced number of operating lists in Th4, as the theatre was not in use due to temperatures exceeding acceptable limits.

Quality Improvement & Learning

Work in Progress – To support improvement and consistency, the WHO Surgical Safety Team Brief has been rolled out across all theatre specialities. In addition, a supporting booklet is currently in development to ensure the Team Brief is completed accurately and consistently. Band 7 leads are responsible for monitoring compliance, providing support and embedding the WHO Team Brief proforma into routine practice to strengthen assurance of patient safety within the operating theatre environment.

CAS Alerts

CAS Alerts - December

2 new CAS alerts received in December 2025. 1 has been closed, with the second currently under review

Reference	Alert Title	Originated By	Issue date	Response	Deadline
NatPSA/2025/007/DHSC	Supply of licenced and unlicenced epidural infusion bags. "There are supply issues affecting epidural bags from Sandoz (licensed) and Fresenius Kabi (unlicensed) containing: · Bupivacaine only · Bupivacaine and fentanyl · levobupivacaine and fentanyl. A range of alternative licensed and unlicensed bags (including unlicensed imports) are available during the affected period expected to last until at least March 2026, but the use of these products will require a co-ordinated trust wide approach to ensure safe implementation."	National Patient Safety Alert - DHSC	02 Dec 2025	Actions complete	12 Dec 2025 (deadline met)
NatPSA/2025/008/NHSPS	Risks associated with adult breathing circuits lacking a patient exhalation route. "This joint National Patient Safety Alert has been issued by the NHS England National Patient Safety Team, in collaboration with the Faculty of Intensive Care Medicine, regarding the risk of harm from incorrectly assembled breathing circuits lacking proper exhalation routes for patients receiving invasive or non-invasive ventilatory support. Organisations caring for patients on invasive and non-invasive breathing circuits are required to develop local guidance and visual aids for circuit assembly, implement training on specific safety checks, and establish clear communication processes."	National Patient Safety Alert – NHS England Patient Safety	15 Dec 2025	Assessed – relevant to organisation's services	12 Jun 2026

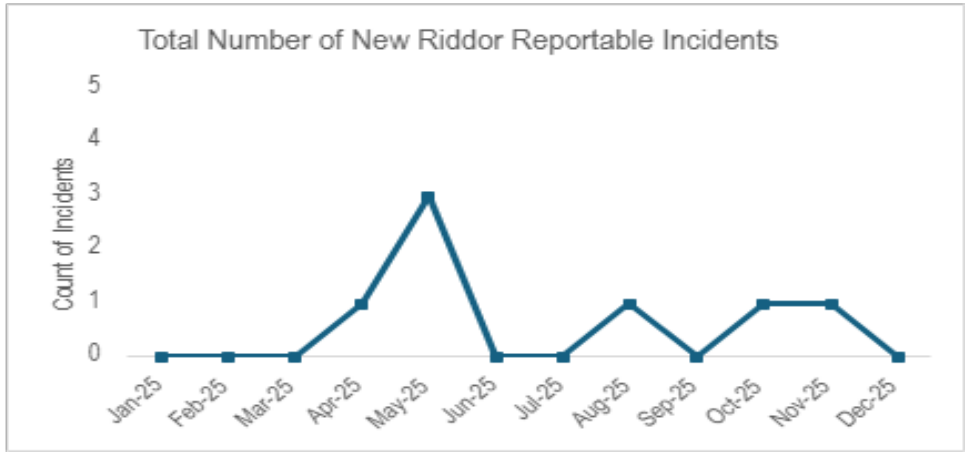
CAS Alerts - Continued

Outstanding CAS Alerts

Reference	Alert Title	Originated By	Issue date	Response	Deadline
NONE – ALL PREVIOUS ALERTS NOW ACTIONED / CLOSED					

RIDDOR - Reportable Staff Incidents

RIDDOR Reportable Incidents - December



Quality Improvement & Learning

No RIDDOR reportable incidents occurred in December 2025.

On-going QI Work

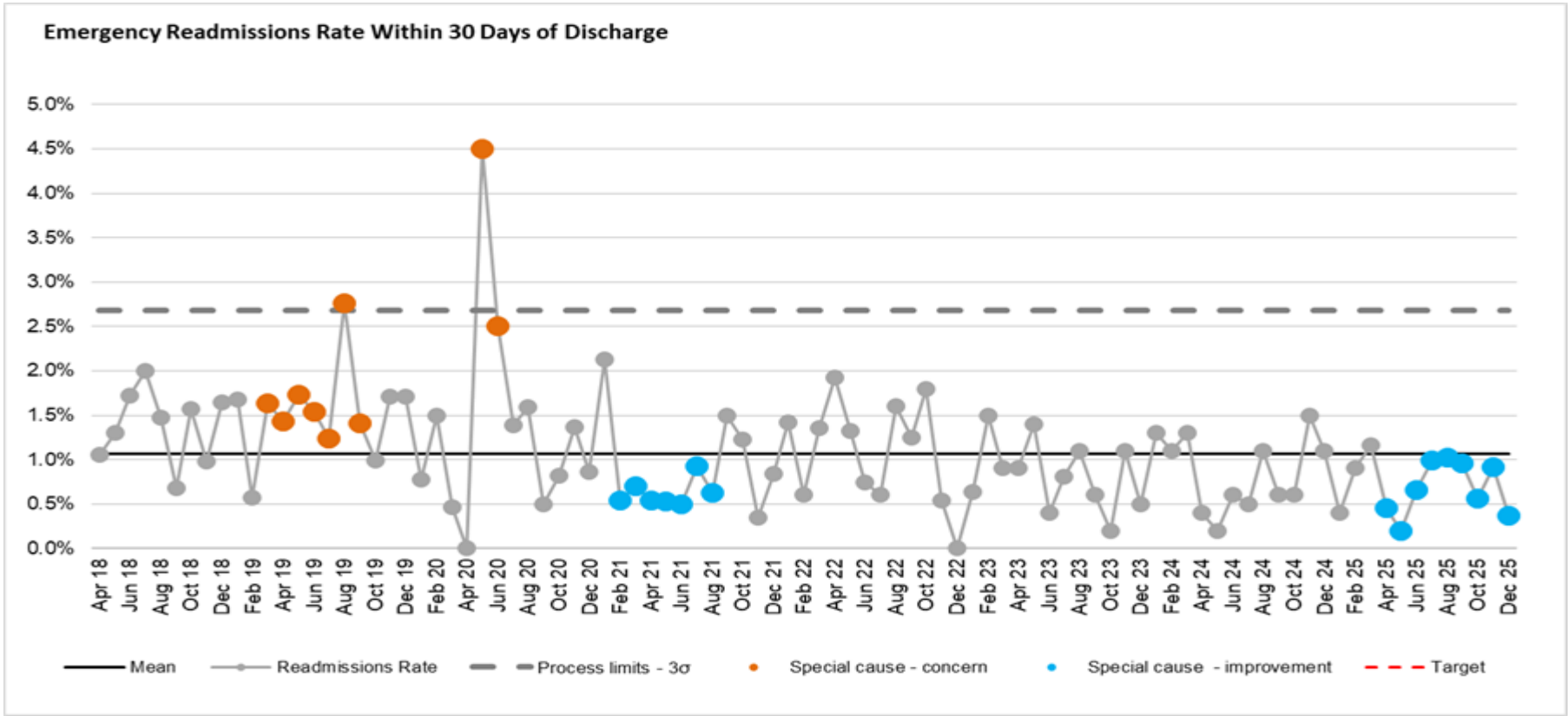
- Improvements to training / awareness with Managers; cover RIDDORs in detail in Me as a Manager training.
- Making adaptations to CMT (H&S) training to sign post Managers for more detail on RIDDOR requirements.
- Updating SOP for CAS alerts - Updated version should be ready in time for February CQG.

Safeguarding Training Compliance

KPI	December 2025
Safeguarding Adult Notifications	70
Safeguarding Children Notifications	39
Adults Level 1- Target 90%	96.63%
Adult Level 2 -Target 85%	94.18%
Adult and Children Level 3- Target 85%	84.62%
Level 4- Target 90%	80.0%
Child Level 1 -Target 90%	96.40%
Child Level 2- Target 85%	92.79%
Mental Capacity and DoLS Act MCA- Target 85%	84.62%
Prevent Awareness- Target 95%	93.10%
WRAP (prevent level 3)- Target 90%	87.46%
Domestic Abuse	25
FGM	5
DOLS	5
MCA	16
PIPOT cases	0
PREVENT Notifications	0

Above training data for substantive staff only.
Action underway:
Action plan developed to address the gap in Level 3.
Raised by Named Doctor at QIDD, exploring linking compliance to Medical appraisal process.
Increase availability of session
Line manager reviewing local records and ensuring staff are booking onto day.
Prompting online version of Prevent and Wrap training.

Readmissions



	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
No of Readmissions	2	5	6	2	1	3	5	5	5	3	5	2
Denominator	552	531	516	445	508	456	507	487	522	532	549	542
% Readmissions	0.4%	0.9%	1.2%	0.4%	0.2%	0.7%	1.0%	1.0%	1.0%	0.6%	0.9%	0.4%

Freedom to Speak Up

Concerns Raised: There were Six concerns raised to FTSUG in December 2025.

Concerns reported were related to the following Themes:

- **In**appropriate attitude and behaviour of managers
- Worker safety and wellbeing.

Quality Improvements & Learning

Learning and improvement:

Themes highlight a potential need to for improved compassionate engagement and management from people in leadership/management roles

The Royal Orthopaedic Hospital
NHS Foundation Trust

Safe Staffing Summary

Alert

The team wishes to bring the following issues to the committee attention:

- Overall nursing sickness increased, with HDU most affected.
- Red flags are not consistently utilised, representing a governance gap.

Advise

The team wishes to bring the following issues to the Committee's 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

•**Sickness:** Overall nursing sickness rose to **11%**, HDU at **16.36%** (up from 7.6%; peer benchmark 7.7%), driven by early seasonal illness and severe weather. Mitigations included flexible rostering, temporary staffing, and wellbeing support. Levels expected to reduce as pressures ease.
•**Red Flags:** Slight decrease in utilisation. Standardised reporting and staff education planned; compliance monitored.
•**Staffing & CHPPD:** Monitored to align with patient acuity and activity.
•**Enhanced Care Hours:** Increased by **333 hours**, totalling **1,189 hours**.
•**Patient Safety:** Indicators remain stable.

Assure

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

- Patient safety outcomes remain stable: one red flag opened and closed, low medication incidents (3), one pressure ulcer, six falls, no new complaints, positive FFT feedback.
- Seasonal sickness context: The increase does not reflect systemic workforce or wellbeing issues; patterns are consistent with seasonal variation and exceptional weather events.
- Governance mitigation: Actions to standardise red flag use are underway.

Recommendation

The Committee is asked to:
CONSIDER the Alert section (overall and HDU sickness, red flag utilisation) and agree next steps;
NOTE the Advise section, including seasonal trends, exceptional weather spike, month-to-month changes, and mitigation plans;
NOTE the Assure section and confirm overall assurance of safe staffing.

Safer Staffing - Wards / HDU & Core Services

Nursing

Dec 25 data for Jan 26 Report	Fill Rate (KPI >90%=Green, 80-90%=Amber, <79%=Red)						Workforce				Care Hours Per Patient Day		Roster Safe Care Indicators			Nurse Sensitive Indicators			Patient Satisfaction		
Ward Name	Fill Rate Day-Nurses	Fill Rate Day-Non reg	Fill Rate Night-Nurse	Fill Rate Night-Non reg	RNA Day Hours	RNA Night Hours	Total WTE as % establishment (%)	Turnover (%)	Sickness (%)	Maternity (%)	Cumulative count of pts at 23.59 per day	Actual CHPPD	Red Flags Opened	Red Flags Closed	Enhanced Care Hours	Medication Administration Error or concern	ROH Acquired Pressure Ulcers Category 2,3 & 4	All Reported Falls	No. of PALs Contact	No. of New Complaints	No. of FFT
Ward 1	80.0%	101.0%	101.0%	120.0%	252	0	97%	3%	10.83%	2.85%	445.00	7.9	0	0	99	0	1	2	0	0	29
Ward 2	80.0%	95.0%	97.0%	148.0%	238.5	55	86%	0%	7.08%	0.00%	589.00	7.0	0	0	337.5	0	0	1	2	0	42
Ward 3	81.0%	103.0%	91.0%	139.0%	242	77	94%	0%	6.35%	3.03%	593.00	6.8	0	0	198	3	0	0	0	0	42
Ward 4	100.0%	116.0%	102.0%	197.0%	48	0	93%	0%	12.34%	3.13%	415.00	10.3	1	0	543.7	0	0	2	1	0	63
Ward 12	93.0%	98.0%	95.0%	105.0%	75.5	33	91%	3%	12.77%	0.00%	280.00	8.4	0	0	11	0	0	1	0	0	50
HDU	100.0%	100.0%	100.0%	100.0%	0	0	89%	4%	16.36%	3.44%	92.00	25.2	0	0	0	0	0	0	0	0	38
total combined	-	-	-	-	856.00	165.00	-	-	-	-	2414.00	65.6	1	0	1189	3	1	6	3	0	264
Total Average	89.0%	102.2%	97.7%	134.8%	142.6667	27.5	92%	2%	11.0%	2.1%	402	10.93	0	0	198	1	0	1	1	0	44

Core Services

Dec 25 data for Jan 26 Report	Fill Rate (KPI >90%=Green, 80-90%=Amber, <79%=Red)						Workforce				Roster Safe Care Indicators			Nurse Sensitive Indicators			Patient Satisfaction		
Ward Name	Fill Rate Day-Nurses	Fill Rate Day-Non reg	Fill Rate Night-Nurse	Fill Rate Night-Non reg	RNA Day Hours	RNA Night Hours	Total WTE as % establishment (%)	Turnover (%)	Sickness (%)	Maternity (%)	Red Flags Opened	Red Flags Closed	Enhanced Care Hours	Medication Administration Error or concern	ROH Acquired Pressure Ulcers Category 2,3 & 4	All Reported Falls	No. of PALs Contacts	No. of New Complaints	No. of FFT
Outpatients	80%	67%	-	-	0	-	82.16%	0%	11.32%	5.13%	0	0	0	0	0	0	0	0	82
CYP OPD	52%	28%	-	-	0	-	-	-	-	-	-	-	-	0	0	0	0	0	62
ADCU	52%	67%	-	-	0	-	83.60%	3%	20.78%	2.70%	0	0	0	0	0	0	0	1	75
POAC	81%	81%	-	-	0	-	89.35%	0%	7.49%	2%	0	0	0	0	0	0	0	0	270
Theatres	82%	64%	-	-	46.75	-	87.88%	0%	9.20%	2.76%	0	0	0	0	0	0	0	0	0
Theatres recovery	78%	69%	-	-	0	-	-	-	-	-	-	-	-	0	0	0	0	0	0
Discharge Lounge	107%	96%	-	-	0	-	-	-	-	-	-	-	-	0	0	0	0	0	88
Total/Combined	-	-	-	-	46.75	-					0	0	0	0	0	0	0	1	577
Total Average	76%	67%	-	-	6.67857	-	86.94%	1%	12%	3%	0	0	0	0%	0%	0%	0%	14%	82.429

Assurance Reports: Operational Performance On A Page

Metric	In Month	Previous Month	Target	Variation	Assurance
RTT Combined (against trajectory constitutional target remains 92%)	61.93%	61.83%	59.31%	H	P
65 Week waits (65-77 weeks)	0	0	0	L	P
52 week waits (52-64 weeks)	198	227	263	L	P
RTT Proportion of Patients Waiting 52 weeks	1.50%	1.72%	1.99%	L	P
RTT First Appointment Waiting List	66.09%	66.49%	66.20%		F
RTT Waiting List Size	13,177	13,196	13,218	L	P
Diagnostics volume YTD (compared to plan) - CT, MRI and Ultrasound	20,283 Cumulative	17,942 Cumulative	19,162 YTD Target	H	P
Diagnostic 6 week target	99.8%	97.8%	99%	H	P
Theatre Session Utilisation	87.2%	94.5%	85%		P
Theatre Insession Utilisation (Capped)	80.5%	80.9%	85%		F
Bed Occupancy (excluding CYP and HDU)	71.5%	72.7%	82-85%		F
LOS - Excluding Oncology, Paeds,YAH, Spinal	3.58	2.68	n/a		-

Metric	In Month	Previous Month	Target	Variation	Assurance
All Activity YTD (compared to plan)	11,122	9,868	11,176		F
Outpatient activity YTD (compared to plan)	55,523 102.3%	49,949 104.0%	54,010	H	P
Outpatient Did Not Attend (YTD)	7.7%	7.6%	8%	L	P
PIFU	556 10.72%	588 10.51%	537 5%	H	P
Virtual Consultations (target is to plan, operational planning guidance is 25%)	10.7%	10.3%	19%	L	F
Cancer - 31 day first treatment	100.0%	100.0%	96%	H	P
Cancer - 62 day (traditional)	80.00%	84.00%	75% National 85% Trust	H	P
28 days FDS	73.1%	86.3%	77%		F
Patients over 104 days (62 day standard)	0	0	0	L	P
POAC activity volumne (YTD) (target set is average monthly 19/20 activity)	17,674	15,880	17,282 YTD Target	H	P
LOS - elective primary hip	2.88	3.30	2.70		F
LOS - elective primary knee	2.90	2.70	2.70		F