# Trust Board (Public) - April 2026

Wednesday 1st April 2026 - 10:00-12:00

The Village Hotel, Walsall, WS2 8TJ

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

**Notice of Trust Board Meeting in Public on Wednesday, 1 April 2026**

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 1 April 2026, at the Village Hotel, Walsall commencing at **10:00.**

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**

26 March 2026

**Notice of a meeting of the Board of Directors**

Notice is hereby given to all the members of the Board of the Royal Orthopaedic Hospital NHS Foundation Trust that the following meetings of the Trust Board will be held at the Village Hote, Walsall, WS2 8TJ on Wednesday, 1 April 2026:

| Meeting | Timing |
|---|---|
| Non-Executives pre-meet | 09:15 – 10:00 |
| Public Board Meeting | 10:00 – 12:00 |
| Private Board Meeting | 12:00 – 13:00 |
| Lunch | 13:00 – 13:30 |
| Joint Board Meeting ROH/RJAH | 13:30 – 16:00 |

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

**Simon Page**
**Chair**

The Royal Orthopaedic Hospital NHS Foundation Trust

# AGENDA
# TRUST BOARD (PUBLIC)

**Venue** The Village Hotel, Walsall **Date** 1 April 2026: 10:00h – 12:00h

**Members attending**

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

**In attendance**

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|---|---|---|---|
| Mr Curig Johnston | Associate Non Executive Director | (CJ) | |
| Mrs Rebecca Lloyd | Director of Strategy | (RL) | |
| Mrs Alison Money | Deputy Chief People Officer | (AM) | |
| Mrs Tammy Ferris | Corporate Services Manager | (TF) | [Secretariat] |

| TIME | ITEM | TITLE | PAPER | LEAD |
|---|---|---|---|---|
| | | **IN PUBLIC SESSION** | | |
| **10:00** | 1 | Apologies: Sharon Malhi | Verbal | Chair |
| | 2 | Declarations of Interest | ROHTB (4/26) 001 | Chair |
| | 3 | Minutes of Board Meeting held in Public on 4th February 2026: *for approval* | ROHTB (2/26) 026 | Chair |
| | 4 | Actions from previous meetings in public: *for assurance* | ROHTB (2/26) 026 (a) | SGL |
| | 5 | Questions from members of the public | Verbal | Chair |
| | 6 | Feedback from the Board walkabouts in March | Verbal | ALL |
| **10:10** | 7 | Chair's and Chief Executive's update: *for information and assurance* | ROHTB (4/26) 002<br>ROHTB (4/26) 002 (a) | MH/SP |
| | 7.1 | Council of Governors Update: *for assurance* | Verbal | SGL |

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| **10:30** | 8 | Chief Finance Officer's report: *for information and assurance* | ROHTB (4/26) 003 | SW |
| **10:45** | 9 | Chief Operating Officer's report: *for assurance* | ROHTB (4/26) 004<br>ROHTB (4/26) 004 (a) | MP |
| **10:50** | 10 | Chief People Officer's report: *for assurance* | ROHTB (4/26) 005 | AM |
| **11:00** | 11 | Quality Officers' report: *for assurance* | ROHTB (4/26) 006 | MR/NB/ SGL |
| **11:15** | 12 | Flu Update: *for assurance* | ROHTB (4/26) 007<br>ROHTB (4/26) 007 (a) | NB |
| | **GOVERNANCE AND COMPLIANCE** | | | |
| **11:25** | 13 | Modern Day Slavery Statement Annual Review: *for approval* | ROHTB (4/26) 008<br>ROHTB (4/26) 008 (a) | NB |
| | **UPWARD REPORTS FROM THE BOARD COMMITTEES** | | | |
| **11:35** | 14 | Upward reports from the Board Committees:<br>• Finance & Performance Committee<br>• Quality & Safety Committee<br>  ○ Learning Disability & Autism Strategy<br>  ○ Safeguarding Strategy | ROHTB (4/26) 009<br>ROHTB (4/26) 010<br>ROHTB (4/26) 010 (a)<br>ROHTB (4/26) 010 (b) | GH<br>IR |
| | **MATTERS TO BE TAKEN BY EXCEPTION** | | | |
| | 15 | Performance Reports: *for assurance*<br>a) Finance & Performance<br>b) Quality Report | ROHTB (4/26) 012<br>ROHTB (4/26) 013 | |
| | 16 | Any Other Business | Verbal | All |
| | 17 | Meeting effectiveness | Verbal | All |
| **11:50** | **Break** | | | |
| **13:00** | **CLOSE: Date of next meeting in Private: Wednesday, 8 May 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 YEAR END

| 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) | ✓ | ✓ | ✓ | | | | | | | | 3/3 |
| Ian Reckless | A | ✓ | ✓ | ✓ | A | ✓ | ✓ | ✓ | ✓ | ✓ | 8/10 |
| Simone Jordan | A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | A | 8/10 |
| Gianjeet Hunjan | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10/10 |
| Ayodele Ajose | ✓ | ✓ | ✓ | ✓ | A | ✓ | ✓ | ✓ | ✓ | ✓ | 9/10 |
| Les Williams | ✓ | ✓ | ✓ | A | ✓ | ✓ | | | | | 5/6 |
| Simon Page (Ch) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10/10 |
| Jenny Belza | A | ✓ | ✓ | A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 8/10 |
| Jan Teo | A | ✓ | ✓ | A | A | A | A | A | ✓ | ✓ | 4/10 |
| Curig Johnston | | | | | | | | | ✓ | A | 1/2 |
| Matthew Hartland | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10/10 |
| Matthew Revell | ✓ | ✓ | ✓ | ✓ | ✓ | A | ✓ | ✓ | ✓ | ✓ | 9/10 |
| Nikki Brockie | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10/10 |
| Marie Peplow | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10/10 |
| Stephen Washbourne | ✓ | ✓ | ✓ | A | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 9/10 |
| Sharon Malhi | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10/10 |
| Simon Grainger-Lloyd | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10/10 |

**KEY:**

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

| Name | • Interest | Voting Member |
|---|---|---|
| **Simone Jordan**<br>**Non Executive Director & Vice Chair** | • NHS Leicestershire, Northamptonshire & Rutland ICB Cluster - Non Executive Member (From 1 October 2025)<br>• Derbyshire Community Health Services NHS Foundation Trust - Non Executive Director (From 1 December 2025) | Yes |
| **Gianjeet Hunjan**<br>**Non Executive Director** | • Lay Member, National Clinical Impact Awards - National Main Committee and West Midlands Committee<br>• Governor, Ferndale Primary School<br>• Member of IHSCM<br>• Member of HFMA<br>• Fellow of Chartered Institute of Public Finance and Accountancy (CIPFA)<br>• Member of Nishkam Healthcare Trust at local Gurdwara<br>• Lay Panel Chair, Nursing and Midwifery Council<br>• Trustee, Birmingham Museum Trust | Yes |
| **Ayodele Ajose**<br>**Non Executive Director** | • Legal Consultant to Law Firm Addleshaw Goddard LLP – Currently Assigned Full-Time to Group Canon | Yes |
| **Ian Reckless**<br>**Non Executive Director** | • Executive Director (Medical Director and Deputy Chief Executive), Milton Keynes University Hospital NHS Foundation Trust<br>• Director, ADMK Limited (wholly owned subsidiary of Milton Keynes University Hospital NHS Foundation Trust)<br>• Director, JTER Trading Limited (company involved in property services and antiques trading)<br>• Fellow, Royal College of Physicians<br>• Fellow, Faculty of Medical Leadership and Management | Yes |
| **Jenny Belza**<br>**Non Executive Director** | • Governor, University College Birmingham | Yes |

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

# MINUTES

## Trust Board (IN PUBLIC) - DRAFT Version 0.1

**Venue** Boardroom, Trust Headquarters **Date** 4 February 2026: 1300h - 1500h

**Members attending:**

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

**In attendance:**

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

| IN PUBLIC SESSION | |
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| **12 Patient Lived Experience (ES)** | **Presentation** |
| The Board received a detailed and impactful account of Bethan's lived experience at the Trust. The Chair and Executive Chief Nurse emphasised that this item is titled 'Patient Lived Experience' to recognise the individual behind the narrative and uphold respect and dignity in all public reporting.<br><br>ES presented the case with candour and clarity, outlining key events:<br><br>• Bethan, a previously active police officer, sustained life-changing injuries in a serious road traffic incident. | |

- After initial recovery, she experienced escalating pain and was referred to Professor Snow for specialist assessment.
- Multiple operational and administrative issues resulted in significant delays to surgery, which ultimately occurred on 15 August.
- Post-operative care did not meet required standards. Incorrect wound dressings and delayed recognition of infection contributed to unnecessary distress, an avoidable A&E admission, and a prolonged recovery period.
- The patient felt a concerning disconnect between hospital and community care, highlighting systemic continuity-of-care weaknesses.
- This experience had a profound psychological and emotional impact, ultimately accelerating her retirement by 12 months.
- Although she did not wish to pursue a formal complaint, Bethan expressed a strong commitment to supporting organisational learning.
- A Learning on a Page (LOOP) review was completed, shared with all teams involved, and actions were initiated to address care delivery gaps.

The Board was invited to ask questions and comment.

The following points are of particular note:

- SP questioned the frequency of experiences of this severity; ES confirmed that such clusters of issues are rare but acknowledged the seriousness of this case.
- NB confirmed swift action had already been taken, particularly addressing gaps in pin-site wound-care competence.
- SGL emphasised the governance value of hearing cases where care falls short. The Board reaffirmed its expectation that LOOP learning must translate into Trust-wide improvements, not remain isolated.
- JB questioned pre-operative pathway assurance mechanisms. NB confirmed enhanced ward 'spotlight' reviews and increased direct engagement with patients to identify issues earlier.
- CJ highlighted the importance of understanding end-to-end patient experience and recommended broader screening questions pre-operatively.
- MP noted that theatre 'look-back' reviews and patient 'coffee catch-ups' are key sources of real-time learning.
- SJ encouraged framing LOOP outputs through a continuous-improvement lens, not just as retrospective learning.
- JT raised the importance of logging this as a complaint for governance purposes, irrespective of the patient's reluctance; NB confirmed reporting

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| processes are being strengthened following QSC challenge.<br>• SP reinforced the expectation that the Trust must demonstrate proactive, measurable improvements to patient experience arising from such learning. | |
| **13 Apologies: (Chair)** | **Verbal** |
| There were no apologies to note.<br>SP formally welcomed Curig Johnston as Associate Non Executive Director. | |
| **14 Declarations of Interest (chair)** | **ROHTB (2/26) 007** |
| There were two new declarations to record to what has been published.<br>• GH – Removal of previous ICB position; new role as Trustee at Birmingham Museums Trust.<br>• AA – Updated current work assignment from Lotus to Canon. | |
| **15 Minutes of the previous meeting in public held on 5th November 2025 : *for approval* (chair)** | **ROHTB (11/25) 018** |
| The minutes of the meeting held in private on 5th November 2025 were accepted and **approved** by the board. | |
| **16 Actions from previous meetings in public: *for assurance* (SGL)** | **ROHTB (11/25) 018 (a)** |
| SGL presented the updated action log.<br>The Board noted that work is underway to strengthen the Board Assurance Framework (BAF), particularly the care section, incorporating feedback from both the Audit Committee and Quality & Safety Committee.<br>The Board recognised that Electronic Patient Record (EPR)–related risks must be fully reflected to maintain an accurate organisational risk profile. | |
| **17 Questions from members of the public (Chair)** | **Verbal** |
| There are no questions received ahead of the meeting. | |
| **18 Chair's and Chief Executive's update, including the Guardian of Safe Working Quarterly Update: *for information and assurance* (TP/MH)** | **ROHTB (2/26) 008**<br>**ROHTB (2/26) 008 (a)**<br>**ROHTB (2/26) 008 (b)** |
| MH presented his report, which the Board received and discussed.<br>The Board noted the following key points:<br>• The medium-term financial, operational, and workforce plan for the next three years was reviewed and formally approved in the private session earlier | |

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| the same day.<br>• Progress continues on strategic collaboration with Robert Jones and Agnes Hunt (RJAH), with a joint Board meeting planned for 1 April 2026. Further Executive-level engagement is being scheduled to articulate benefits and agree shared priorities.<br>• Positive discussions have commenced with Birmingham City University on opportunities for partnership working.<br>• The Guardian of Safe Working will provide quarterly updates, with an annual attendance from Mr James McKenzie.<br>• The Trust remains in NOF1 segmentation, with NHSE expressing confidence during the initial Provider Relationship Meeting.<br>• Quarter 4 continues to present significant operational challenges. The Board noted the sustained efforts of staff and the recognition this has received from NHSE.<br><br>The Chair provided his update, highlighting constructive engagement with Birmingham Health Partners and reaffirming the Trust's strong clinical reputation, evidenced by recent consultant recruitment activity. | |
| **19 Chief Finance Officer's Report: *for assurance* (SW)** | **ROHTB (2/26) 009** |
| SW presented the Chief Finance Officer's report, and the report was taken as read.<br><br>The key points to highlight include:<br>• The Month 9 position remains broadly on plan.<br>• Ongoing income underperformance linked to diagnostic coding changes.<br>• December saw unexpected increases in bank expenditure driven by sickness levels.<br>• Non-pay budgets remain underspent, supported by a Month 9 release of bad debt provision.<br>• Cash remains stable, though reductions are expected through Quarter 4.<br>• CIP delivery is slightly behind plan but significantly ahead of previous years' performance.<br>• KPMG has completed an audit of CIP phasing, with findings to be shared with the Board.<br><br>The Board reviewed the information and sought assurance on mitigations for Quarter 4, recognising it as the most challenging quarter for delivery. | |

| **20 Chief Operating Officer's Report: *for assurance* (MP)** | **ROHTB (2/26) 010**<br>**ROHTB (2/26) 010 (a)** |
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| MP presented the Chief Operating Officer's report, and the paper was taken as read.<br><br>The key points to highlight include:<br>• Continued delivery and, in some areas, exceeding of operational targets.<br>• Outpatient sprint activity providing opportunities for additional income where plan delivery is surpassed.<br>• Work underway to introduce community-style weekend clinics.<br>• Diagnostics continue to meet required targets.<br>• Despite industrial action, December activity remained above plan.<br>• The MSK programme has launched the integrated patient pathway following the system securing the £3m for system-wide integrated pathway delivery.<br>• Review of spinal services is progressing with strong clinical engagement.<br>• January activity has been significantly impacted by staff sickness, including 18 private patient cancellations. Recovery trajectories are in place to support year-end breakeven objectives. | |
| **21 Chief People Officer's Report: *for assurance* (SM)** | **ROHTB (2/26) 011** |
| SM presented the Chief People Officer's report, and the report was taken as read.<br><br>The key points to highlight include:<br>• The Trust has received recognition through a Work Experience Award, reinforcing its commitment to developing future workforce pipelines.<br>• Sickness absence remains a significant operational and financial risk. A deep dive has been commissioned through the Staff Experience & OD Committee. Early data indicates a downward trend in January; however, the Board emphasised that sustained reduction requires targeted managerial accountability and improved local oversight.<br>• The Developing Leaders Programme continues to build capability, with assignments focused on productivity and improvement. The Board noted the importance of maintaining ambition and embedding behavioural expectations once participants complete the programme.<br>• Mandatory training compliance has increased to 91.5%, the highest since 2021. This improvement is attributed to the transition to the Learning Management System. The Board welcomed this progress but stressed the need for consistent compliance across all staff groups. | |

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| • Resident doctor workforce updates were given, alongside confirmation that a new industrial action mandate has been secured nationally. The Board requested close monitoring of operational and financial implications.<br><br>JT praised the new LMS for improving accessibility and user experience. | |
| **22 Quality Officers' Report: *for assurance* (MR/NB/SGL)** | **ROHTB (2/26) 012** |
| MR/NB/SGL presented the Quality Officers' report, and the paper was taken as read.<br><br>The key points to highlight include:<br>• 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 have been so good they asked us to restrict numbers.<br>• A joint communication on regulatory decisions in the context of care from the NMC and Chief Nursing Officers for England, Wales and Northern Island was received which acknowledged the challenging winter period.<br>• Care Quality Commission (CQC) report has been received following their visit to the Children and Young People's Service, with an overall rating of Good being awarded. The highlighted areas were expected, and one has already been addressed with regards to training compliance, the others will be resolved with EPR.<br>• Information Governance function has moved under the Director of Governance portfolio.<br>• The annual internal audits around Data Security and Protection Toolkit and Board Assurance Framework are underway.<br>• The organisational governance review is nearing is conclusion in readiness for the change in operating model from 1 April 2026.<br>• Health & Safety action plan against National Violence and Prevention Standards is being progressed and will come through Staff Experience & OD Committee.<br><br>The Board was invited to comment and ask questions.<br><br>The following points are of particular note:<br>• JB questioned the challenges within the Audit Team. MR explained this has improved and is a reflection of a team growing productivity through a number of challenges. | |

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| **23 ROH Strategy 2023-2027 Progress of Delivery: *for assurance* (RL)** | **ROHTB (2/26) 013**<br>**ROHTB (2/26) 013 (a)** |
| RL presented the ROH Strategy 2023-2027 progress and the paper was taken as read.<br><br>The key points to highlighted include:<br>• The report presented provides an update as at Quarter 3.<br>• The plan is to shift toward a balanced scorecard for future Board assurance.<br>• The document details those that are not delivering and details what is being doing to address this. | |
| **24 Safer Staffing Update: *for assurance* (NB)** | **ROHTB (2/26) 014**<br>**ROHTB (2/26) 014 (a)** |
| NB presented the safer staffing update that was previously presented to the Quality and Safety Committee. The paper was taken as read.<br><br>The key points to highlight include:<br>• This is a regulatory requirement to be presented twice per year.<br>• The Quality and Safety Committee were assured with the paper presented.<br>• Since this report was produced it was agreed that there will be a Theatre review which will be undertaken separately.<br>• The next paper will come in May.<br><br>The Board was invited to comment and ask questions.<br><br>The following points are of particular note:<br>• SP queried what is being done about absence. NB explained that this will be reflected in the next paper. Flu-related staff absences, particularly on one ward, caused temporary pressure. Masking was reinstated to mitigate infection risk and has since been stepped down. An update on flu vaccination uptake will be provided at the March Trust Board. | |
| **25 Sexual Safety Update: *for assurance* (NB)** | **ROHTB (2/26) 015**<br>**ROHTB (2/26) 015 (a)** |
| NB presented the Sexual Safety Update, and the paper was taken as read.<br><br>The key points to highlight include:<br>• Strong collaboration with FTSU colleagues continues, with improved reporting pathways.<br>• Previous national data placed the Trust as an outlier; updated data is awaited | |

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| to evaluate progress.<br>• A proposal was made for quarterly upward reporting to strengthen Board oversight.<br>• The Domestic and Sexual Abuse Advisor role has proved highly impactful, but the postholder has now returned to a previous role; the Safeguarding Team is reviewing options for continuity.<br>The Board was invited to comment and ask questions.<br><br>The following points are of particular note<br><br>• SP queried what is the level of concerns raised and questioned are we doing everything we are asked to do by the NHS. SM explained concerns raised are low in volume but high in complexity, often requiring multi-agency safeguarding and HR coordination. | |
| **GOVERNANCE AND COMPLIANCE** | |
| **26 Freedom to Speak Up Update: *for assurance* (CJ)** | **ROHTB (2/26) 016**<br>**ROHTB (2/26) 016 (a)** |
| Claudette Jones, CJ, Freedom to Speak Guardian joined the Board to provide an update on Freedom to Speak Up, the paper was taken as read.<br><br>The key points to highlight:<br>• Increased numbers of issues raised, reflecting improved confidence in speaking up mechanisms.<br>• FTSU themes remain focused on inclusion, civility, and dismantling barriers.<br>• Leadership support for FTSU was acknowledged.<br>• The range of available reporting routes has improved accessibility for colleagues who feel unable to speak up directly.<br>• The National Guardian Office will close in June 2026; NHSE will retain responsibility for data oversight.<br>• Training compliance for Guardians is fully up to date.<br>• The Trust maintains 10 well-trained FTSU Champions.<br>• A case management system is now operational.<br>• The strategic priority for 2026 is to enhance the service impact on staff wellbeing and patient safety.<br>The Board was invited to comment and ask questions.<br><br>The following points are of particular note: | |

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| • Board Members praised the clarity and maturity of the FTSU service.<br>• SGL emphasised the importance of documenting changes resulting from staff feedback.<br>• GH queried the training and questioned whether this has now been mandated. CJ explained this was not mandated at presented but focus is on awareness to encourage competition of the training. SM highlighted once the national update is shared, we will be able to make the decision as to the approach to take.<br>• JT praised the figures presented and would like to see the overlay with the staff survey results when they are published. CJ explained this is also being shared across the system too. | |
| **27 Board Assurance Framework Update: *for assurance* (SGL)** | **ROHTB (2/26) 017**<br>**ROHTB (2/26) 017 (a - l)** |
| The Board received the Board Assurance Framework (BAF) update. While the report was taken as read, the Board noted the importance of maintaining clear visibility of strategic risks, controls, and mitigating actions. The Board emphasised the need for ongoing alignment between the refreshed BAF and the revised operating model that will commence on 1 April 2026. | |
| **28 Learning from Deaths Update: *for assurance* (MR)** | **ROHTB (2/26) 018**<br>**ROHTB (2/26) 018 (a)** |
| MR presented the Learning from Deaths report, previously scrutinised at the Quality & Safety Committee. The Board noted the findings and acknowledged the importance of maintaining robust mortality governance as part of wider clinical effectiveness oversight. | |
| **29 Application of the Trust Seal – Amended Lease Agreement for Maryland Drive: *for approval* (SW)** | **ROHTB (2/26) 019**<br>**ROHTB (2/26) 019 (a)**<br>**ROHTB (2/26) 019 (b)** |
| SW presented the lease agreement for Maryland Drive and requires Board approval for renewal.<br><br>The Board received and approved the request to apply the Trust Seal to the amended lease agreement for Maryland Drive. SW confirmed that all due diligence requirements had been met. | |
| **UPWARD REPORTS FROM THE BOARD COMMITTEES** | |
| **30 Upward reports from the Board Committees:**<br>• **Staff Experience and OD Committee**<br>• **Quality & Safety Committee** | **ROHTB (2/26) 020**<br>**ROHTB (2/26) 021** |

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|---|---|
| ○ **For Approval to Publish**<br>■ **Controlled Drugs Annual Report**<br>■ **Radiation Safety Report**<br>• **Finance & Performance Committee**<br>• **Audit Committee** | **ROHTB (2/26) 021 (a)**<br>**ROHTB (2/26) 021 (b)**<br>**ROTHB (2/26) 022**<br>**Verbal** |
| **Staff Experience & OD Committee - SJ**<br><br>The paper was taken as read and the key point to highlight was the trust absence rate. SJ confirmed a deep dive will be presented at the next meeting.<br><br>- SP queried is the assurance being provided that action is being taken. SJ explained that at committee level the detail is not there yet, but this is what should be presented at the next meeting.<br><br>- MH explained that there is a link to the management of bank with sickness absence.<br><br>- Quality & Safety Committee - IR<br><br>The paper was taken as read. The key points to highlight include:<br><br>- Water safety was presented and it was queried should the visibility of this be at Board level. SGL explained that this is discussed Health & Safety Group and this is included in upward reported to QSC. IR raised this does not feel enough just in an upward report. NB highlighted it also links to IPC. MH explained as part of the Governance review this work is being covered. **ACTION: SGL to review the reporting upwards**<br><br>- Two reports for publication were presented 1. Controlled Drugs Annual Report and Radiation Safety Report; the Board approved publication.<br><br>**Finance & Performance Committee - GH**<br><br>The paper was taken as read. The key points to highlight include:<br><br>- The CIP audit highlighted the phasing needs to be reviewed as it is an ongoing risk.<br><br>**Audit Committee - GH**<br><br>- Fit and Proper Persons Test Audit complete and the recommendation is for Board members to undertake annually; currently only self-attestation is completed and instead needs to be fully completed annually.<br><br>- Reviewed the EPR funding. | |
| **MATTERS TO BE TAKEN BY EXCEPTION** | |
| **31 Performance Reports: *for assurance***<br><br>• **Finance & Performance** | **ROHTB (2/26) 023** |

| | |
|---|---|
| • **Quality Report** | **ROHTB (2/26) 024** |
| The reports were taken as read.<br>SW explained the Finance & Performance Pack includes the workforce data and is the new integrated performance pack and by the end of the year quality will be included and it will be one pack for all committees. | |
| **28 Any Other Business** | **Verbal** |
| There was no further business to discuss. | |
| **29 Meeting Effectiveness** | **Verbal** |
| The Board reflected positively on the quality of discussion and the Chair's facilitation, noting that the meeting enabled constructive scrutiny and balanced debate. | |
| Date of next meeting in Private: Wednesday, 4th March 2026 @ 0900h | |
| | |

**PUBLIC SESSION**

**Next Meeting: 1st April 2026, Boardroom, Trust HQ**

**ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD**

Last Updated: 23rd March 2026

| Number | Agenda item | Paper Ref | Date raised | Action | Owner | Completion Date | Response submitted/Progress update | Status |
|---|---|---|---|---|---|---|---|---|
| ROHTBACT.285 | Annual Report for Medical Appraisal and Validation | ROHTB (11/25) 011<br>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.284 | Flu Vaccination Programme Plan | ROHTB (9/25) 011<br>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 | **Included on agenda. Propose Closure** | |
| ROHTBACT.286 | Upward Reports from Board Committees | ROHTB (2/26) 021 | 04/02/2026 | Review the upward reporting for items discussed at Health & Safety Group in particular Water Safety. | SGL | 01-Apr-26 | **Review undertaken and to be reflected in QSC committee workplan going forward. Propose Closure** | |
| ROHTBACT.283 | Refreshed Board Assurance Framework | ROHTB (9/25) 010<br>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 | **The Board was presented with the refreshed Board Assurance Framework and it was noted this incorporated the feedback from both Audit Committee and Quality & Safety Committee. Propose Closure** | |

**KEY:**

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

The Royal Orthopaedic Hospital NHS Foundation Trust

# TRUST BOARD (IN PUBLIC)

| | |
|---|---|
| **DOCUMENT TITLE:** | **Chief Executive's Update** |
| **SPONSOR (EXECUTIVE DIRECTOR):** | **Matthew Hartland, Chief Executive** |
| **AUTHOR:** | **Matthew Hartland, Chief Executive** |
| **DATE OF MEETING:** | **1 April 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 1 April 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

The ICB leadership team is now fully recruited and consultation on the restructure of the organisation due to conclude imminently. The restructure of the NHS Regional Team is also due to commence. 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

The national planning process for 2026/7 to 2028/9 is due to conclude by 31 March with the majority of ICB's, providers and systems having 'compliant' plans. Further work continues within the Birmingham, Solihull and Black Country cluster, however the ROH has submitted compliant plans which have been accepted by NHSE.

### 2.3 Bone Cement / Stryker

Board will be aware of the national shortage of bone cement due to manufacturing process issues at Heraeus Medical, the supplier of the majority of cement in the UK. The Trust has also been impacted by the cyber attack on Stryker. The Trust adopted business continuity principles to manage both issues and there has been very limited impact on patient care to date.

### 2.4 ICB Strategic Commissioning

The ICB has published its strategic commissioning approach in the form of strategic commissioning intentions for 2026/7. It is proposed to use a future Board Development session to consider the impact on the ROH.

## 3 CHIEF EXECUTIVE ACTIVITIES

### 3.1 Chief Operating Officer

I want to start the section of my report by sharing my gratitude and best wishes to Marie Peplow, who has confirmed her intent to retire. Marie will leave the Trust at the end of May and I'm pleased to report that Michelle Hubbard, Deputy COO, has agreed to act-up until a substantive appointment is made.

**3.2 Birmingham City University**

I have been asked to join the Advisory Board of the Business School at Birmingham City University. I attended the inaugural Board meeting on 24 March and I believe there are numerous benefits and opportunities to the Trust from enhancing our relationship with BCU.

**3.3 Strategic Alliance with Robert Jones & Agnes Hunt**

On 24 March a Joint Executive Meeting was held with Robert Jones and Agnes Hunt NHS FT as part of our Strategic Alliance. It was an excellent meeting where we heard the achievements from the alliance to date and importantly work planned for the forthcoming financial year. The enthusiasm and benefits for such joint working was clear, and the outcome will be presented to the Joint Board Development session with the Board of Robert Jones & Agnes Hunt which will be held on 1 April.

**3.4 Dr Subeena Sumelan**

I met with Dr Subeena Suleman, who is the new chair of the BSOL GP Partnership Board. It was a very positive meeting which clear benefits to both the ROH and Primary Care of stronger working relationships. I will also meet with the equivalent Black Country chair in the near future.

**3.5 Consultant Careers Day**

It was a pleasure to present at the inaugural Consultant Careers Day, a new event established by the Medical Education team for resident doctors and fellows in anticipation of their first consultant post. I was asked to present on the role of the Trust Board, the role of the Chief Executive and a 'life in a day'. It was enjoyable and the event received great feedback so thank you to the team for arranging such a worthwhile day.

**3.6 NHSE Leadership Event**

On March I attended an NHS Leadership event in Leicester. The focus of the session was digital. It reaffirmed the national ambition to become a 'digital-first' health service, but it was also clear that organisations need to have some of the 'basics' in place. We will make significant progress with the implementation of our electronic patient record, but we must ensure we continue with aligned developments, such as ambient voice technology, in parallel.

**3.7 National Orthopaedic Alliance / Federation of Specialist Hospitals**

In March I met with both the NOA and FOSH to give my support to the proposed workplans for 2026/7 but also clarify the expectations of the ROH from our membership. They were both productive meetings and it is vital that we use these membership bodies to benefit operationally but also strategically, particularly with the focus on MSK and issues relevant to specialist hospitals in the new NHS infrastructure.

**3.8 Birmingham Health Partners**

There has not been a meeting of BHP since the last Board meeting, however it was a pleasure to attend the launch of the Birmingham Implant Retrieval Centre, a joint centre led by the University of Birmingham and the ROH with the aim of collecting retrieved

implants, capturing “real-world” performance of medical devices, using advanced engineering analysis to evaluate failure modes and link them to patient demographics and National Joint Registry data.

**3.9 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.

**3.10 NHS Confederation / NHS Providers**

As a member of the NHS Providers Acute Advisory Board I attended the March meeting which updated on the NHS Alliance, the new merged organisation, followed by an in-focus session on the CQC.

**3.11 ROH Internal Visits**

I have continued to take the time to meet and 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. It was a pleasure to meet the ADCU (Admissions Day Case Unit) Team, Pre-Op Assessment, Spinal Medical Secretaries, the Service Improvement area, Oncology Medical Secretaries, the Appointments Department and colleagues in the Imaging Department.

**3.12 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:

- Brigette De La Cruz, Outpatients
- Louise Cook, Oncology
- Marilou Macabante, POAC
- Jamie Cooke, Estates
- Mia Cameron, Discharge Lounge
- Felicity Smith, Theatres
- Vicky Eccleston, Operations
- Neil Clarke, Facilities
- Teresa Foley, Facilities
- Jayne Bradley, POAC

**3.13 CHAIN**

On Thursday 26 February, I took part in the CHAIN (cycling against hip pain) session, led by Hayley Jennings, one of our Physiotherapists at Cocksmoor Wood Leisure Centre. This CHAIN session was the final class of an 8 week cycling and education programme for patients with hip osteoarthritis, sponsored by the ROC Charity. The programme aims to promote self-management of osteoarthritis through lifestyle change and I can personally testify that attendees are ‘put through their paces’.

## 4. ROH UPDATE

### 4.1 NOF Segmentation

The Trust has been confirmed as retaining its Segment 1 rating in the NHS National Oversight Framework. We have also improved our position in the national league table, rising to 12th. This is excellent news for the Trust and is testament to the work done by all staff throughout the Hospital.

### 4.2 Call for Concern – 10 March

I am pleased to confirm that the Trust launched Call for Concern, part of the national 'Martha's Rule' roll-out on 16 March. This is an important safety improvement for our patients to be led by our Critical Care Outreach team.

### 4.3 Staff survey / Voice into Action

The Trust received the results of the 2025 staff survey in March. Nationally there has been a reduction in staff survey scores, however the majority of our scores have either remained stable or seen marginal deterioration. The overall Trust Engagement Score, which is the key indicator used by NHSE to assess results, saw a reduction from 7.12 to 7.00 which is deemed 'not-significant' by IQVIA, the external facilitator of the survey.

The survey is vitally important, however, and the Trust will be adopting a new approach in its response. Staff Experience and Organisational Development Committee will oversee the formal action plan as previously, but we are launching a focussed Trust-wide 'listening' programme called 'Voice into Action'. It will begin in April and give teams the opportunity to share feedback on the results of the staff survey but also inform us of short and long term actions that we can take to improve the working lives of our staff. It will also be the start of a longer-term engagement programme as we embark on our new Trust-wide transformation programme.

### 4.4 Blue Heart Awards

We have had 652 nominations for the Trust's Blue Heart Awards. This is a fantastic demonstration of the excellent work undertaken every day in the Trust the support staff have of their peers and I look forward to the ceremony in July.

### 4.5 Electronic Patient Record

Executives from the Trust met with Intersystems, our new Electronic Patient Record partner, at their offices in Windsor. In addition to the official signing of the contract, it was great to meet their executives and I had an open discussion with their UK lead on expectations and how we will build the partnership. The day was a success and the implementation programme has now commenced.

### 4.6 Guardian of Safe Working

There is nothing to escalate from the Guardian for this report.

### 4.7 Financial Position

It is pleasing to report that the Trust continues to forecast a break-even position for the year. A huge thank you to our staff for taking the required action to achieve this which has been extremely challenging. We have a similar plan for 2026/7, and the controls and mechanisms to ensure we continue to achieve our financial plans will continue.

**4.8 Performance**

We continue to perform well from a performance perspective. Headline reported performance metrics for February include 63.1 Referral to Treatment Time (RTT), exceeding the target trajectory of 59.7%. The number of patients waiting over 52 weeks reduced ahead of plan to 104, 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 which we have achieved.

## 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:

- DNACPR/ReSPECT Policy
- Mid-Level Clinical Provider Policy
- Engaging Patients and Families Following a Patient Safety Incident (Duty of Candour & Being Open Policy)
- Safe Operation and Maintenance of Water Systems Policy

## 6 RECOMMENDATIONS

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

**Matthew Hartland**
**Chief Executive**
**March 2026**

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

# TRUST BOARD (PUBLIC)

| | |
|---|---|
| **DOCUMENT TITLE:** | **Chief Finance Officer's Report M11** |
| **SPONSOR (EXECUTIVE DIRECTOR):** | **Steve Washbourne, Chief Finance Officer** |
| **AUTHOR:** | **Steve Washbourne, Chief Finance Officer** |
| **DATE OF MEETING:** | **1st April 2026** |

**PURPOSE OF THE REPORT:**

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

**EXECUTIVE SUMMARY:**

Month 11 Financial Report

ASSURANCE PROVIDED BY THE REPORT:

| POSITIVE | GAPS IN ASSURANCE/RISKS TO ESCALATE |
|---|---|
| Small surplus in month<br>Increased activity / income<br>Continued low Non-Pay spend | Increased cost of activity delivery<br>Underperformance of variable and PP income<br>Continued risk of CIP and income delivery over the remainder of the financial year. |

**REPORT RECOMMENDATION:**

The Committee/Board is asked to:

**NOTE** the Finance Report

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

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

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

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

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

Risk register and BAF

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

# CFO's Report Month 11

## 1. Summary

The Trust delivered a surplus in month of £16k against a planned surplus of £90k, generating an adverse variance of £74k in month. This in-month position was only possible due to the release of further non-recurrent resource in month. This results in a deficit of £888k YTD. This in-month position was only possible due to the release of further non-recurrent resource in month. We are still forecasting a break-even position for the year.

| Income & expenditure summary | Current month | | | | Year to date | | | |
|---|---|---|---|---|---|---|---|---|
| | Plan £000s | Actual £000s | Variance £000s | % | Plan £000s | Actual £000s | Variance £000s | % |
| Operating income | 12,202 | 11,694 | (508) | (4.2%) | 134,431 | 129,527 | (4,904) | (3.6%) |
| Agency pay | (110) | (123) | (13) | (11.7%) | (1,463) | (1,164) | 299 | 20.5% |
| All other employee expenses | (6,640) | (6,935) | (295) | (4.4%) | (74,944) | (76,348) | (1,404) | (1.9%) |
| Operating non pay | (5,248) | (4,522) | 726 | 13.8% | (57,077) | (51,871) | 5,206 | 9.1% |
| Total operating surplus / (deficit) | 204 | 114 | (90) | (0.7%) | 947 | 144 | (803) | (0.6%) |
| Non operating items | (122) | (108) | 14 | 11.8% | (1,350) | (1,135) | 215 | 16.0% |
| Surplus/(deficit) for the period/year | 82 | 7 | (75) | (0.6%) | (403) | (990) | (587) | (0.4%) |
| Less I&E impairments/(reversals) & (gains)/losses on transfers by absorption | 0 | 0 | 0 | | 0 | 0 | 0 | |
| Surplus / (deficit) before impairments and transfers | 82 | 7 | (75) | (0.6%) | (403) | (990) | (587) | (0.4%) |
| Technical adjustments | 8 | 9 | 1 | 16.0% | 84 | 102 | 18 | 22.0% |
| Adjusted financial performance surplus/(deficit) | 90 | 16 | (74) | (0.6%) | (319) | (888) | (569) | (0.4%) |
| Less Non-Recurrent Deficit Support | 0 | 0 | 0 | | 0 | 0 | 0 | |
| Adjusted financial performance surplus/(deficit) excluding non-recurrent deficit funding | 90 | 16 | (74) | (0.6%) | (319) | (888) | (569) | (0.4%) |
| Underlying position | | | | | | | | |
| EBITDA as a percentage of related income | 6.3% | 5.6% | (0.7%) | | 5.3% | 4.7% | (0.6%) | |
| I&E margin | 0.7% | 0.1% | (0.6%) | | (0.2%) | (0.7%) | (0.4%) | |

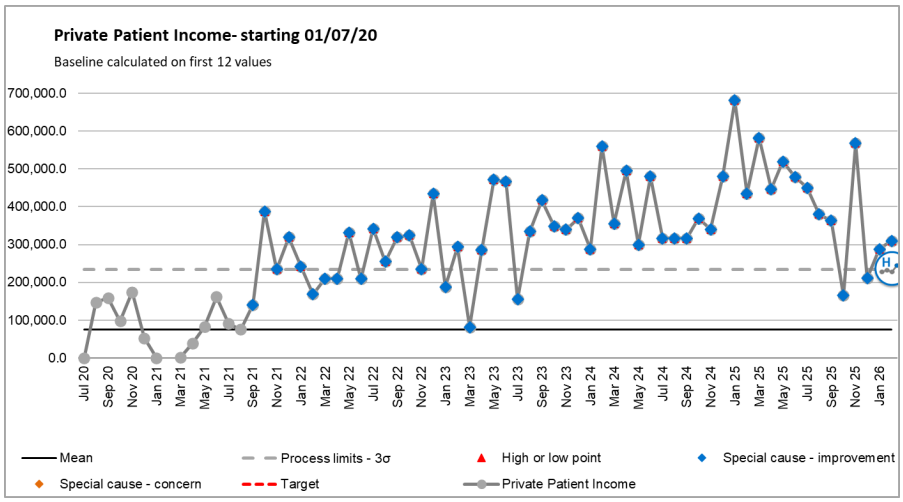
## 2. Income

At Month 11 the Trust has delivered actual operating income of £130m against a plan of £134m, a net under performance of £4.9m. Appendix A provides more detail of the drivers of this.

Total Elective and day Case activity increased from month 10, resulting in an increase of £297k in variable income (both of which are positive), but there was a related increase in cost of delivery with LLP expenditure being the highest this month at £218k. Not all the additional income can be attributed to LLP activity, and LLP costs are only an element of the additional cost of delivery.

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).

PP income was £310k in month (plan of £484k) and has also been impacted by cancelations. PP income is now £4.1m YTD against a plan of £5m, and delivery of the planned annual value of £5.5m and stretch target of £6.5m is not now going to happen.

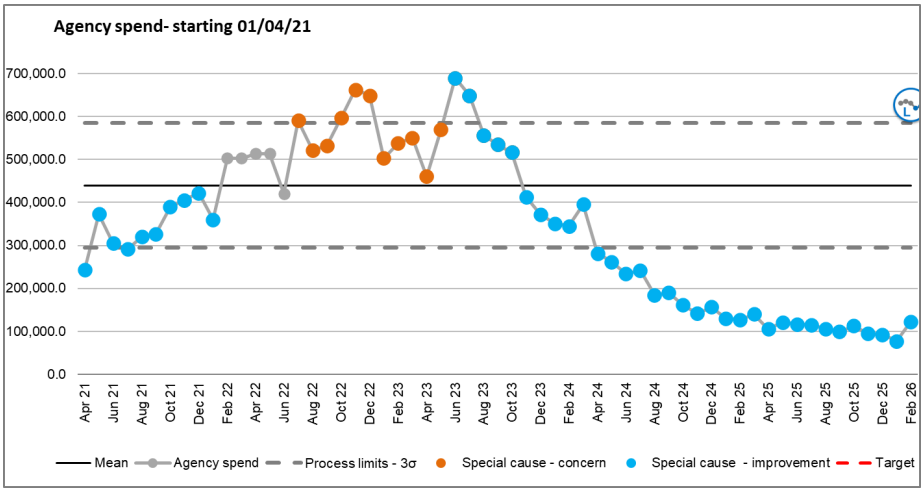


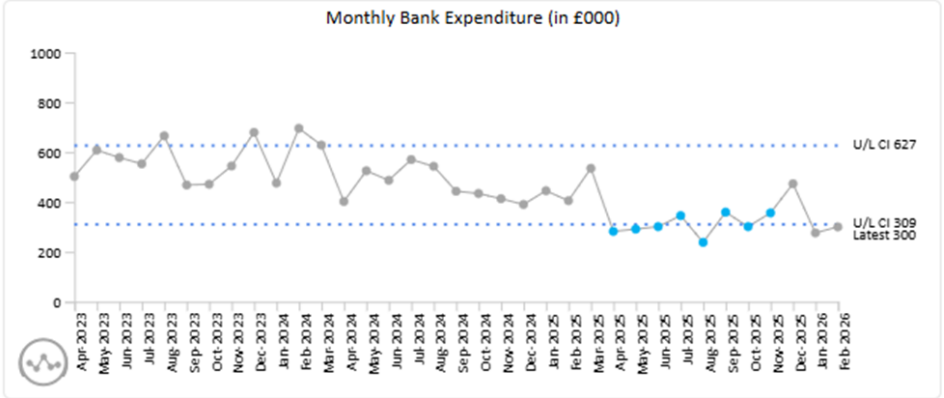

## 3. Pay

Pay expenditure is overspent in month by £308k contributing to an overspend of £1,404k YTD.

Agency spend is £123k in month or 1.7% of pay. This is the highest monthly spend this year caused by an increase in spend on medics. This account for 93% spend in month and 67% YTD.

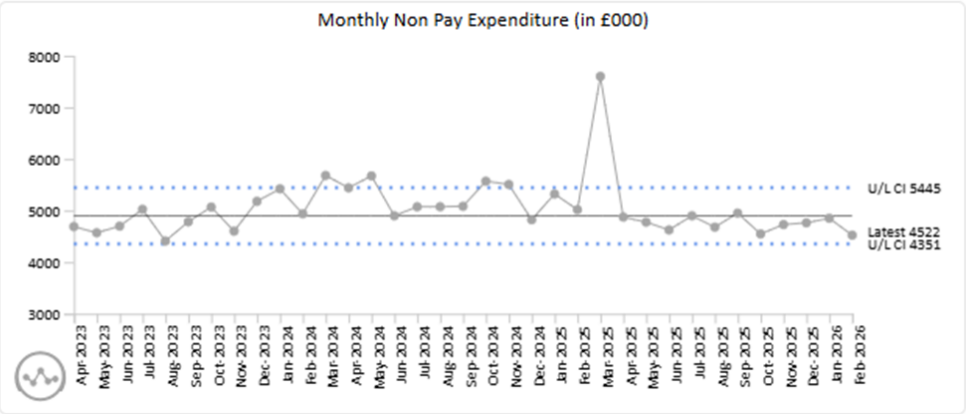
Bank expenditure (£300k) was a small increase form last month (£276k), and higher than plan of £253k.. Nursing increased to £69k from £38k last month. Therapies increased from £16k to £28k and Infrastructure remained constant at £65k. Medical spend reduced from £128k to £81k year ( this includes ADH Spend and retrospective claims).



**4. Non-Pay**

The non-pay position remains favourable overall, supported by a non-recurrent £1.7m release from the bad debt provision and other flex held year to date, resulting in an underspend of £726k in month and a YTD underspend of £5.2m




Genmed spend continues to be low.

As previously mentioned, LLP spend is the highest all year with Large Joints (£68k), Spinal (£80k) and Anaesthetics (£70k), which means total expenditure for the year is now £2.4m, nearly £1m more than planned. Anaesthetics spend is also a result of a number of consultants using up all their planned annualised hours.

**5. Cash**

The cash position has been boosted with the receipt of £13.1m of EPR funding. This will be invoiced and paid in M12.

**6. Capital**

We had spend in month of £145k which takes us to actual spend YTD of £2m against a plan of £4.1m. 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 £352k have been recorded. This increases the year to date achieved to £6.2m against a plan of £8.4m, generating an underperformance of £2.2m.

**8. System Position**

After eleven months the system position is a YTD deficit of £12.9m, £9.7m adverse to plan and £21.3m favourable compared to the recovery plan trajectories, noting that three organisations (BSOL ICB, BCHC and UHB) have agreed to a combined £26.6m improvement and so the favourable movement will reflect progress towards this agreement. This represents a £25.4m improvement in the year-to-date deficit position compared to month 10 and a £20.9m in-month improvement in variance against plan.

The system is now expecting to deliver a break-even position in year.

| Total Performance | YTD | | | FOT | | | Prior Month |
|---|---|---|---|---|---|---|---|
| | Current Plan £000s | Actual £000s | Variance £000s | Annual Plan £000s | FOT £000s | Variance £000s | variance £000s |
| BSOL ICB | -1,052 | 13,074 | 14,126 | 0 | 15,716 | 15,716 | 2,303 |
| BSMHT | 3,847 | 2,249 | -1,598 | 4,200 | 4,200 | 0 | -1,684 |
| BCHC | 166 | 2,088 | 1,922 | 0 | 2,084 | 2,084 | 4 |
| BWC | 0 | -2,253 | -2,253 | 0 | 0 | 0 | -3,797 |
| ROH | -319 | -888 | -569 | 35 | 35 | 0 | -495 |
| UHB | -5,866 | -27,189 | -21,323 | -4,200 | -22,000 | -17,800 | -26,909 |
| Total | -3,224 | -12,919 | -9,695 | 35 | 35 | 0 | -30,578 |

## Appendix A: Operating Income

## Elective Variable / Diagnostic Variable Income

| | Year to date | | |
|---|---|---|---|
| | Actual | Plan | Variance |
| Day Cases | £10,338,065 | £12,739,131 | -£2,401,067 |
| Elective | £32,693,453 | £32,432,008 | £261,445 |
| Excess bed days EL | £793,679 | £1,075,546 | -£281,867 |
| Outpatient FA Single Professional Consultant Led | £4,295,438 | £4,389,786 | -£94,348 |
| Outpatient FA Single Professional Consultant Led Non Face to Face | £303,408 | £427,074 | -£123,666 |
| Outpatient Procedures FA | £173,659 | £122,373 | £51,286 |
| Outpatient Procedures FUP | £528,572 | £713,489 | -£184,917 |
| **Elective variable** | **£49,126,274** | **£51,899,407** | **-£2,773,134** |
| **Diagnostic variable** | **£1,753,320** | **£2,573,235** | **-£819,915** |
| **Total** | **£50,879,594** | **£54,472,642** | **-£3,593,048** |

| | | | | | | | | | | | | Year to date | | | In Month | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | Actual | Plan | Variance | Actual | Cap | Variance |
| Hereford & Worc | £446,679 | £588,234 | £677,735 | £631,529 | £622,068 | £748,709 | £751,178 | £678,006 | £735,313 | £770,337 | £751,925 | 7,466,228 | 6,559,583 | 906,645 | 751,925 | 601,904 | 150,021 |
| BSOL | £2,055,993 | £2,217,469 | £2,299,298 | £2,347,850 | £2,286,330 | £2,479,847 | £2,319,949 | £2,295,505 | £2,409,740 | £2,110,220 | £2,237,540 | 25,144,786 | 27,463,610 | (2,318,824) | 2,237,540 | 2,730,705 | (493,165) |
| Staffs & Stoke | £178,007 | £168,807 | £133,587 | £132,149 | £205,059 | £119,600 | £114,819 | £205,551 | £130,065 | £169,397 | £162,541 | 1,705,538 | 1,802,191 | (96,653) | 162,541 | 165,649 | (3,108) |
| Black Country ICB | £639,972 | £590,798 | £595,625 | £724,893 | £665,294 | £838,974 | £785,942 | £739,150 | £592,292 | £678,488 | £737,172 | 7,587,248 | 7,765,027 | (177,779) | 737,172 | 712,845 | 24,326 |
| Cov & Warwick | £167,332 | £107,341 | £90,807 | £126,345 | £118,022 | £138,055 | £122,415 | £117,249 | £130,547 | £173,496 | £142,382 | 1,412,544 | 1,365,070 | 47,474 | 142,383 | 123,835 | 18,546 |
| Spec Com | £563,699 | £559,615 | £538,132 | £541,711 | £655,543 | £542,029 | £568,070 | £537,349 | £572,552 | £302,522 | £481,264 | 6,075,780 | 7,290,392 | (1,214,612) | 281,264 | 669,163 | (187,899) |
| **Actual** | **£4,060,038** | **£4,241,434** | **£4,347,274** | **£4,520,931** | **£4,566,311** | **£4,897,367** | **£4,689,375** | **£4,592,526** | **£4,580,802** | **£4,215,528** | **£4,512,822** | **49,579,527** | **52,245,873** | **(2,853,750)** | **4,538,023** | **5,004,101** | **(491,278)** |

The Royal Orthopaedic Hospital NHS Foundation Trust

# TRUST BOARD (PUBLIC)

| | |
|---|---|
| **DOCUMENT TITLE:** | **Trust Officers' Reports** |
| **SPONSOR (EXECUTIVE DIRECTOR):** | **Executive Directors** |
| **AUTHOR:** | **Executive Directors** |
| **DATE OF MEETING:** | **1st April 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 – April 2026**

## 1 NATIONAL OPERATIONAL CONTEXT AND DEVELOPMENTS

1.1 During February there has been a continued focus on the NHSE sprint commissioned until the end of March 26. 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. The Trust is actively participating in the following 3 sprints:

- 52-week sprint – An opportunity for funding focussed on reducing the number of patients waiting over 52 weeks for treatment.
- 18 – week sprint – a payment is available for all outpatient first cases above plan for Quarter 4.
- 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. More details will follow in terms of delivery and impact at the May Board Meeting.

1.2 The Trust is participating in an Anaesthetic and Perioperative review and will be hosting members of the 'Getting It Right First Time' team on 23rd April 2026.

1.3 The Trust is also participating in the GIRFT Hub Optimisation Week (HOW) commencing on the 11th of May 2026 in conjunction with Robert Jones and Agnes Hunt, Wrightington and the Royal National Orthopaedic Hospital. The aim of the week is to simulate what an optimally functioning network of hubs can achieve by applying best practice consistently for one week. The programme will be led by the COO supported by the theatre triumvirate and the wider multidisciplinary team Buddy groups have been set up to discuss progress and agree metrics/measurables for the week. A further update will be provided at the next Board meeting.

Lessons learnt during the HOW will inform preparation for the formal Elective Hub re accreditation in July 2026.

## 2. OPERATIONAL PERFORMANCE

2.1 RTT performance for February was 63.07%, exceeding the target trajectory of 59.64%, by 3.43% reflecting strong progress in improving patient access. Notably, the number of patients waiting over 52 weeks reduced ahead of plan by 71 patients ending the month with 104 Patients over 52 weeks. This performance puts the Trust in a strong position to strive towards 65% for 31.03.26 and to further reduce patients waiting over 52 weeks to remain ahead of KPIS. Performance is being monitored weekly via SITREPS to NHSE due to the national focus on reducing patient waiting times aligned to the 'go faster further sprint.'

2.2 Cancer targets were met for the 62 day and 31-day standard. However, the January 26 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 (detailed later in the report) and it is expected that FDS performance will return to compliance from January 2026.

2.3 Theatre capped utilisation on Model Hospital for January 26 is currently at 84.9%. The Trust remains in the top quartile and all available theatre sessions are being maximised.

2.4 Overall Outpatient activity has overperformed YTD by 2,134 with the overperformance being delivered through a mixture of follow ups and outpatient procedures. In addition, during Q4 the Trust has exceeded the 1st outpatient activity targets in line with the sprint. This signifies a shift from day case to OP procedures which has been 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 February 2026, 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 98.7% in February 2026.

2.7 February 2026 activity performance was –53 cases against in month plan. The performance improved from January 26, however, there was a continuation of reduction in available theatre capacity due to staff availability and environmental issues within theatre 4. To improve the March position additional activity has been agreed to help maximise activity in March and in line with sprint ambitions. The maintenance and repair of theatre 1, 2 and 4 commences in April for three weeks alongside maintenance and upgrading of ward 4 facilities. The activity plan has been profiled to support this reduced capacity whilst essential maintenance is carried out.

## 3. PRIVATE PATIENTS

3.1 February activity was below the planned volume and revenue. This reflects the challenges relating to staff availability and the ability to provide additional weekend lists.

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.
- Targeted discussions with surgeons to promote private working.

A new Trust commercial group will support the expansion of private services in 2026/27

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

4.1 Key highlights from the TIG meeting are outlined below:

- The theatre improvement programme shows strong momentum with active civility work, skills analysis, scheduling improvements, tray rationalisation and IPC/capital actions progressing well. The draft theatre service review is being reviewed by the deputy executive triumvirate and will be shared with the executive team week commencing 31st March.
- Ethnicity capture has improved significantly, with a 38% response rate to post‑appointment surveys and patients actively declaring ethnicity, strengthening data quality and future health inequalities reporting.
- Targeted health inequalities work, including admin calling support and discussions being undertaken to look at transport solutions with National Express and parking options, is showing early benefit for patients in IMD 1–2 cohorts.
- Theatre Man Aqua has been fully re‑mobilised with vendor engagement re‑established, on‑site sessions booked and clinical safety (DCB0129/0160) incorporated into governance and assurance. The completion of the new functionality is on track for delivery in April 2026.
- Imaging accreditation remains on track for submission by the end of March, providing an important external quality benchmark for service assurance.
- The new CT scanner and digital x-ray room will open on the 31st March, and an informal opening ceremony is planned by the department to celebrate. There will be a formal opening ceremony later in the year to mark this important milestone for improved imaging facilities. It should be acknowledged that working with our estates team and the equipment providers the impact on service provision has been minimised, thanks to great teamworking.
- The development of the pilot Strategic Business Units is in place to commence with Arthroplasty and Imaging in April 2026. Balance score cards have been developed, with active clinical engagement to support maximising benefits of this model of

working promoting greater autonomy and accountability. An interim evaluation of the trial will be reported to board at the end of Q1.

## 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 third workshop is planned in April 2026 to continue progress against the GIRFT best practice chaired by the Chief Operating Officer. Work is also underway with Robert Jones and Agnes Hunt to collaborate on in this area and the MSK agenda. This presents an exciting opportunity to share best practice as specialist providers.

5.2 As documented on the Risk Register current delays in Pathology services relating to availability of specialist histopathology skills have impacted our achievement of the Faster Diagnosis cancer Standard for January 2026.

The delays in Pathology services are being actively managed and have been escalated with colleagues at NHSE. NHSE are supporting remedial actions to improve pathology turnaround times with the UHB histopathology service. This involves supporting mutual aid and developing service resilience through development of national network arrangements.

The impact will continue to be monitored at the weekly Patient tracking meetings, the Trust Cancer board and a series of Task and finish meetings supported by the COO and Medical Director working with the ROH Oncology services and the UHB Histopathology service.

## 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. MSK / Orthopaedic clinical pathways within the IPP are currently being reviewed and updated by ROH clinicians prior to the gradual roll out of the project across primary care in 26/27.

The digital therapeutic self-management ‘get u better ‘patient app continues to strengthen with over 30,000 users now using the app. This digital therapeutic creates personalised treatment plans for users and helps to adapt beliefs and behaviours that can often delay recovery from MSK pain. Funding for a further 12 months has been secured, extending the contract to April 2027. This gives the group an opportunity to scope development of a system wide tool reviewing current market options and the possibility of a locally developed solution.

The workforce project has identified a number of priorities to optimise our MSK workforce, to enable capacity to be optimised and demand to be mitigated. This includes RAG rating to ensure providers are all adhering to GIRFT Further Faster principles, standardising clinic templates, DNA policy and using the BSol system access policy as reference for change. We are also looking at optimising 'just in time recruitment' across providers to reduce the gap in capacity when an employee leaves an organisation. This work will all be underpinned by a data dashboard to measure effectiveness on demand and capacity. This work will also seek to address health inequalities using the approach recommended by ARMA.

Phase 2 of the programme has now been scoped which will include pain management elective orthopaedics 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 in the community, development of the MSK academy and supporting the return-to-work initiative both at ROH and system wide. Our new MSK occupational case manager is now in post, with the launch of the service planned for April 2026.

The digital outputs of the programme were presented as an exemplar at the regional Midlands MSK conference on Friday 20th March, with particular focus on digital self-management – this received warm praise from representatives of NHS England, showcasing the achievements of phase1 of the MSK programme.

## 7 WORK PLANNED IN NEXT MONTH

7.1 Focus will be on the Anaesthetic and Perioperative Medicine (APOM) GIRFT Review meeting and preparation for the Hub optimisation week preparation.

7.2 The team are striving to achieve the best RTT position possible for the 31st of March 2026 working towards 65% and eliminating 52 week waits.

7.3 Members of the operational team will be attending the Learning & Improvement Network (LINS) event at Leicester Tigers on Friday 27th March 2026. The purpose of the event is to bring Clinical, Ops and Improvement colleagues together from Elective and UEC to understand how we can use the LINs to promote a Learning and Improvement focus and an Improvement methodology, to support the delivery of 2026/27 priorities, as opposed to the traditional performance management approach.

## 8. RECOMMENDATION(S)

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

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

**FOR ASSURANCE**

The Royal Orthopaedic Hospital NHS Foundation Trust

# CHIEF PEOPLE OFFICER'S REPORT

## Report to Trust Board (Public) – April 2026

## 1 LOCAL MATTERS FOR BOARD ATTENTION

### 1.1 Sickness Absence

The management of sickness absence remains a key priority across the Executive Team supported by the HR and OD teams.

We are seeing positive assurances around interventions with a decrease in the 12-month rolling figure of 5.93% for February. This is the first time for a long time that the rolling figure has been below 6%.

We have seen a marked improvement in return-to-work compliance which is now reporting at 85%.

Targeted hotspot interventions continue to be in place within areas of highest absence supported by enhanced performance oversight.

The impact of absence financially is high with over £3m per annum attributed towards costs on staff and high temporary staff allocation on replacements.

### 1.2 Mandatory training compliance/ LMS implementation

Introduction of the LMS system continues to show positive impact in the improvement in compliance rate at 91.45% in February against a 93% KPI target.

We have agreed that annual fire safety requirements will align to national recommendations and move to 2 yearly renewals.

AFC appraisal forms will be accessed via LMS from April 2026.

### 1.3 Staff Survey

The staff survey embargo was lifted on the 12th March 2026. We had 797 colleagues share their views, representing 55% of our workforce which was a decline from 60% the previous year. Overall, the Trust Engagement score has declined from 7.12 in 2024 to 7.00 in 2025. Trust level results have been shared with Executive Directors including breakdowns for each Executive Director portfolio.

Themes from the staff feedback include:

- Improving staff engagement
- Improving team working and performance
- Enhancing recognition
- Supporting learning and development opportunities
- Reducing Discrimination

We recognise that things feel challenging which is the message across the broader NHS. We know that action is needed and this year we are implementing a Voice into Action programme which will be rolled out in April 2026. Voice into Action is about trying to make positive change happen quickly.

We will be asking Line Managers to have team conversations which focusses on 3 quick wins and two areas that will take more time. Voice Into action is about solving some of the basics and simple issues to improve staff experience at work. Line Managers will be invited to a briefing to understand how the process will work and understand how to have the right conversation, how to capture feedback and support Voice into Action. A focussed approach will take place over 90 days with support from OD and Inclusion.

The 10-year Workforce plan is due to set targets for the NHS to become the Country's best Employer, not just the biggest. Therefore, it is important that we demonstrate our commitment and accountability.

## 2 NATIONAL CONTEXT AND DEVELOPMENTS

### 2.1 Nursing Pay & Progression

NHS nurses are set to receive a career boost, as the government and the Royal College of Nursing (RCN) have agreed a package to properly recognise the vital work they do.
Following engagement with all nursing unions including UNISON, Unite and GMB, and a dedicated period of intensive engagement with RCN - the biggest nursing union - it has agreed a series of measures which aim to transform the nursing profession and make sure that nurses get the appropriate pay and support.

This includes:

- prioritising increasing graduate pay
- reviewing the roles and pay bands of every band 5 nurse
- establishing a single national nursing preceptorship to create a national framework to support newly qualified nurses

This announcement comes ahead of discussions with health unions on improving the Agenda for Change pay structure, which the government has committed to fund following NHS Pay Review Body recommendations in both 2024 and 2025.

Backed by a funded mandate from the government, unions and employers will agree changes to the Agenda for Change pay structure to benefit employees. One of the conditions will be that pay for all graduates should be increased, with the NHS Staff Council deciding the level of uplift. This will not only benefit graduate nurses, but also

other vital NHS professions such as occupational therapists, pharmacists and speech and language therapists.

Additional funding will be made available to support the band 5 review process and any resulting salary uplifts - separate to the funding for the 2026 to 2027 cost of living pay award and pay structure reform discussions. The government will also review evidence to determine whether further action is needed to make sure all nurses are being paid fairly.

**2.2 NHS Future Workforce Solution Update**

The Department of Health and Social Care has commissioned The NHS Business Services Authority (NHSBSA) to identify and deliver the Future NHS Workforce Solution. The NHSBSA has led a procurement exercise to identify the supplier of the future solution.

Infosys has been awarded the £1.2bn contract to deliver a new enhanced workforce management solution for the NHS. The future solution will build upon the Electronic Staff Record (ESR)

NHSBSA and Infosys will be preparing and planning for the implementation phases.

**2.3 NHS Workforce Plan**

The NHS 10-year Workforce plan is expected in Spring 2026. This is a key component of the UK Labour government's 10-year health plan aimed at reforming the NHS into a more preventative, community focussed and digitally enabled service. We will await the publication.

**3.0 KEY RISKS**

**3.1** Continued focus on absence/reduced workforce availability and impact on productivity.

**4 WORK PLANNED IN NEXT MONTH**

**4.1** Roll out Voice into Action (VITA) programme.

**4.2** Support Managers with the VITA programme and developing local plans.

**4.3** Continue to focus on supporting leaders with robust management of absences.

**5 RECOMMENDATION(S)**

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

Sharon Malhi/Alison Money
Chief People Officer/Deputy Chief People Officer
April 2026

**FOR ASSURANCE**

The Royal Orthopaedic Hospital NHS Foundation Trust

# QUALITY OFFICERS' REPORT

## Report to Trust Board on 1st April 2026

## 1 MEDICAL DIRECTOR'S UPDATE

### 1.1 Formal Launch of the Birmingham Implant Retrieval Centre

1.1.1 The Trust formally launched the Birmingham Implant Retrieval Centre on 23 March 2026, marking a significant development in our national contribution to implant safety, research and device performance monitoring.

### 1.2 Visit to InterSystems

1.2.1 On 12 March 2026, the full Executive Team, supported by the DCMO (CCIO) and CSO, attended the first formal Board-to-Board meeting with InterSystems, our EPR provider, at their UK headquarters in Windsor. The session focused on strengthening the strategic partnership, reviewing progress on the EPR implementation, and ensuring alignment across the programme's clinical, operational and digital priorities.

### 1.3 Health Innovation West Midlands

1.3.1 On 5 March 2026, the Trust supported the Health Innovation West Midlands CEO interview process. The outcome of the appointment has not yet been confirmed.

### 1.4 Research

1.4.1 The Trust continues to demonstrate strong research performance, with publication numbers remaining high and, notably, a significant increase in the external impact of our work. This year has seen greater citation and referencing of ROH research by external organisations and academic partners, providing clear evidence of growing influence and the national reach of our research outputs.

### 1.5 Audit

1.5.1 The Annual Clinical Audit Report has now been published, confirming continued strong performance across the Trust. NJR and PROMS compliance remain at excellent levels, reflecting consistent engagement with national quality requirements. The Trust has also made a meaningful contribution to national clinical audits, demonstrating a robust approach to assurance, learning and continuous improvement.

## 2 CHIEF NURSE'S UPDATE

### National / Regional / ICB updates

### 2.1 CNO Conference – Deputy Chief Nurse Update

2.1.1 Emma Steele, Deputy Chief Nurse, attended the Chief Nursing Officers' Leadership Event in London on 4 March, representing the Chief Nurse. The event, chaired by Duncan Barton (Chief Nursing Officer for England), brought together senior national nursing leaders, including Sam Jones, Permanent Secretary for the Department of Health and Social Care, and the Deputy Chief Nursing Officers for England.

2.1.2 The programme covered several national priority areas:

- Workforce, including future capacity, supply, and leadership pipelines.
- The National Quality Strategy, with a focus on consistency, improvement, and reducing unwarranted variation.
- Professional standards, including expectations for clinical leadership and professional accountability.
- The NHS 10-Year Plan, outlining long-term ambitions for care delivery, digital transformation, and integrated working.

2.1.3 A dedicated session explored Palliative and End of Life Care, featuring specialist speakers and structured discussion on emerging priorities and quality measures.

2.1.4 The event generated strong engagement, shared learning, and practical insights relevant to Trust priorities. Emma has subsequently provided a detailed feedback summary to the ROH Nursing Council, supporting continued professional development and ensuring alignment with national policy direction and professional standards.

### 2.2 Care Quality Commission (CQC) engagement session

2.2.1 On the 19 March, the Director of Governance and the Chief Nursing Officer held their monthly engagement session with the CQC Inspector, providing updates on key quality, safety and workforce priorities. The discussion supported ongoing transparency and strengthened relationships with the regulator. Planning is underway for the next session, which will include the Chief People Officer and focus on the Trust's approach to the Staff Survey results and the planned '*voice into action'* initiative.

### 2.3 CNO forum (Birmingham & Solihull (BSol) & Black Country)

2.3.1 The first joint CNO Forum for BSoL and the Black Country took place this month, led by Sally Roberts, bringing Chief Nurses together to strengthen collaboration across the two systems. The forum aims to enhance shared learning, alignment of priorities, and collective leadership on cross-system quality and workforce issues. It was agreed that the group will meet monthly, providing a regular platform for Chief Nurses to drive coordinated improvement and support consistent standards of care across both ICS areas.

## 2.4 Quality & Safety walkabout

2.4.1 Two members of the ICB Quality Team, attended the Quality and Safety Walkabout at ROH in February, visiting the POAC department. Both colleagues expressed their thanks for the time taken to show them around and for the opportunity to observe the walkabout in practice. They shared how valuable it was to see patient and staff experience firsthand, as it brings the subsequent reporting to life for them. They were assured and impressed by the robustness of the process, the strong staff engagement, and the enthusiasm shown during discussions. They are keen to consider how any elements of this approach could be adopted system-wide and will discuss at future patient safety and system improvement meetings.

**Organisational report**

## 2.5 Infection Prevention & Control update

| **Mandatory Reportable Infections** | **NHSE set Threshold** | **ROH Year to Date** April 25 – Mar 26 |
|---|---|---|
| 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 | 2 |
| *Klebsiella spp*. bloodstream infection | 0 | 0 |
| *Pseudomonas aeruginosa* bloodstream infection | 0 | 0 |

2.5.1 In February 2026, a Hospital-Onset Healthcare-Associated (HOHA) E. coli bloodstream infection was reported. The infection was linked to a wound source, with matching E. coli identified from samples taken during wound re-exploration and debridement. There are no immediate concerns regarding IPC practice or care delivery; however, a full IPC review is underway and will be presented at the Division 1 Governance Meeting to identify any further actions required.

## 2.6 Safeguarding

2.6.1 Over the last quarter, the Safeguarding Team has experienced an increase in requests to attend Social Care strategy meetings involving significant harm to children and young people, often with only 24 hours' notice to prepare the required information and reports. There has also been a rise in scoping requests for Safeguarding Adult Reviews, requiring timely retrieval of records and coordinated responses to local partnership boards.

The Head of Safeguarding has completed the Trust's annual review of the safeguarding strategy and the Modern-Day Slavery Statement. The updated strategy reinforces the Trust's commitment to protecting vulnerable patients and families and ensuring robust compliance with statutory safeguarding responsibilities.

## 2.7 Learning Disability

2.7.1 The Learning Disability Clinical Nurse Specialist has completed and submitted the Trust's LD NHS Benchmarking return. Staff response rates to the accompanying benchmarking survey have been low; therefore, a two-week engagement campaign is underway to encourage wider participation.

## 2.8 Mental Health and Dementia

2.8.1 In addition, the Mental Health and Dementia Practitioner was invited to present at the Alzheimer's Society Conference in London, in recognition of her dementia care work at the Trust. This represents positive external acknowledgement of the quality and impact of our dementia support services.

## 2.9 NMC pre-registration standards

2.9.1 I, attended a session led by Mark Radford ahead of his departure from the organisation, which focused on the proposed changes to the NMC pre-registration standards and the future model for student nurse training. The session provided an opportunity to hear the emerging national direction, discuss implications for workforce supply and clinical education, and contribute views on how the revised standards may support a more flexible and practice-aligned approach to student nurse development.

## 2.10 Chief Nurse Information Officer (CINO)

2.10.1 Interviews for the newly established Chief Information Nursing Officer (CINO) post will take place at the end of March, with a strong focus on patient safety given the post's critical role in supporting the safe implementation of the Trust's EPR programme. In parallel, on 12 March 2026 the full Executive Team, including the CNO, attended the first formal Board-to-Board meeting with InterSystems at their UK headquarters in Windsor to review progress and strengthen strategic alignment. As part of ongoing engagement, InterSystems will also attend the Nursing Council meeting in May to work directly with nursing and AHP colleagues to ensure frontline perspectives inform the next phase of EPR design, readiness and deployment.

## 2.11 Sexual Safety Charter

2.11.1 The Trust continues to implement its Sexual Safety Charter action plan, with steady progress across the ten commitments. A refreshed awareness campaign is planned for April, with an increased focus on wellbeing. Following my attendance at the Sexual Safety in Medicine study day in January, the working group has focused on strengthening engagement with female doctors and registrars and ensuring the programme reflects their lived experience and concerns. The Sexual Safety Policy is due to be published shortly, providing strengthened guidance and expectations for all staff. This work remains central to our commitment to ensuring a safe, respectful, and supportive environment for patients and colleagues.

## 2.12 Associates of Peri-Operative Practitioners (AfPP)

2.12.1 In March, the AFPP undertook a peer review within theatres, following the patient journey through the perioperative pathway. The review involved engagement with the wider

multidisciplinary team and the collection of evidence across key aspects of patient safety. The final report is awaited and will be reviewed through the appropriate governance routes once received.

### 2.13 Human Tissue Authority inspection

2.13.1 The annual Human Tissue Authority (HTA) audit was submitted by the deadline of 31 March, providing assurance of ongoing compliance with Human Tissue legislation and licensable activity standards. This is followed by the bi-annual HTA inspection, which has been formally notified and is scheduled for May 2025. Preparations for the inspection are underway to ensure the Trust is fully compliant and well-positioned for the forthcoming review.

### 2.14 Band 5 / Preceptorship

2.14.1 The Deputy Chief Nurse is leading work to support the national commitments announced by the Government and NHS Staff Council regarding the nursing workforce. This includes commencing a structured review of all Band 5 nursing posts to ensure job descriptions, roles and banding reflect national expectations and professional value. Early scoping work is underway, with engagement planned across clinical areas to ensure consistency, transparency and alignment with the national direction of travel.

2.14.2 In parallel, work is progressing to refresh the Trust's preceptorship programme in line with the new national nursing preceptorship framework. This will ensure newly registered nurses receive a high-quality, standardised start to their careers, fully aligned with national guidance and best practice. The refreshed model will strengthen support, supervision and professional development for our early-career nurses, ensuring the Trust is well placed to deliver the new national requirements.

### 2.15 Nursing & OPD Well-being (Theatre / recovery)

2.15.1 Work is being led by the Workforce & Education Lead to launch the RCN's *Rest, Rehydrate, Refuel* campaign within the peri-operative environment, following recent staff engagement sessions. The campaign, developed by the RCN promotes safe working conditions and ensure nursing staff take adequate breaks, hydration and nutrition, highlights the impact of fatigue on safety and wellbeing and the importance of protected rest periods during shifts. Initial actions will focus on prompting staff to access breaks consistently, supported by strengthened facilities within the theatre coffee room to improve access to hydration and healthy refreshments.

### 2.16 Marath's rule / Call 4 Concern

2.16.1 Implementation continues to progress well across the Trust. All wards have now adopted the PWQ, and the patient-level communication resources have been launched. Video materials are being shared across social media and internal channels, supported by a Trust-wide poster campaign. This work aligns with the recent NHS standards notification on the national rollout of Martha's Rule, and the Trust is making strong progress in meeting these requirements.

Royal Orthopaedic Hospital - Call for Concern (Martha's Rule)

https://roh.nhs.uk/supporting-services/call-for-concern-marthas-rule


## 2.17 Facilities

2.17.1 Sandra Crook retired from the Facilities team earlier this month after more than 40 years of dedicated service. As the Deputy Manager, she was a highly respected and valued member of the department, known for her professionalism, commitment and deep organisational knowledge. Sandra will be greatly missed by colleagues across the Trust, and her longstanding contribution to patient and staff experience is sincerely acknowledged and appreciated.

2.17.2 A structured review of the Facilities operating model is underway to determine the future configuration of the service following her retirement. This work is assessing leadership capacity, functional alignment and opportunities to strengthen resilience, efficiency and service quality. Recommendations will be developed in the coming months to ensure the directorate is positioned to meet both current and future organisational needs.

## 3 DIRECTOR OF GOVERNANCE'S UPDATE

### Clinical Governance

### 3.1 Never Event Thematic Review

3.1.1 The review of the previous Never Events is now complete. The report identified areas of good practice in terms of the reporting culture and the engagement of patients and staff in investigation processes and provides assurance that the patients involved came to no harm as a result of the Never Events.

3.1.2 The report also highlights a positive level of assurance regarding the benchmarking of the number of never events over the last 10 years, compared to our peer specialist orthopaedic trusts.

3.1.3 Themes have been identified in relation to the adverse impact of list changes, standard of documentation, communication, supervision and support as well as the theatre environment and storage of implants.

3.1.4 The report evidences the existence of systems and processes that create safeguards against the occurrence of Never Events but highlights areas for improvement in terms of adherence and compliance with these processes.

3.1.5 The recommended actions from the report align with wider improvement work identified as part of the theatre service and safety review.

### 3.2 Patient Safety Incident Investigation (PSII) Training

3.2.1 Funding has been agreed to facilitate training to staff who are tasked with conducting Patient Safety Incident Investigations (PSIIs). The training will be provided by an external organisation with considerable expertise on PSIRF and PSIIs.

3.2.2 Training is to occur in May and will be aimed at a select group of senior and experienced staff, with the aiming being to have a smaller more specialised cohort of PSII investigators that have access to detailed training and ongoing support and mentoring from the governance team going forward.

### 3.3 Engaging Patients and Families in Patient Safety Incidents (Duty of Candour Policy)

3.3.1 The updated and amended policy has been re-ratified and implements the core PSIRF principle of compassionate engagement into our existing duty of candour process.

3.3.2 The policy strengthens and clarifies the process, places a stronger and clearly defined responsibility on to the governance teams in regard to compliance with the duty of candour regulations and increases the level of involvement in, communication with and compassionate engagement of patients and their families in the investigation of patient safety incidents.

### 3.4 Freedom to Speak Up

3.4.1 Improved Reporting**:** Keep an eye out for upcoming communications regarding our new “Speaking Up” platform, designed to make raising concerns simpler and more accessible.

3.4.2 Cultural Review: Freedom to Speak Up (FTSU) leads across BSOL are currently reviewing the definition of bullying and harassment to ensure consistency and clarity in our standards.

### 3.5 Information Governance

3.5.1 The 2025/26 Data Security and Protection Toolkit internal audit has concluded with a positive outcome of “Significant Assurance with Minor Improvement Opportunities”. Information Governance recommendations primarily relate to strengthening the Trust’s Information Asset Register and Data Flow Map, which is a substantial piece of work that has now commenced. This has a target completion date of 30 June 2026 which aligns with the DSPT submission deadline. The overall audit position demonstrates a strong IG control environment within ROH.

3.5.2 Mandatory training compliance for Information Governance is at 81%, this is following targeted messaging to non-compliant staff during December and January. There is more work to be done on this as we endeavour to reach the 93% compliance target. The Trust is ending its current external contract as of 31 March 2026, and a new mandatory training package is being developed in-house by the Information Governance Manager and Digital Training Team. This will be bespoke to the Trust and align with the requirements of the DSPT and is due to go live on 1 April 2026.

3.5.3 In addition to mandatory training, two new modules are now available on the LMS platform: National Data Opt-Out (NDOO) and Information Assets. These modules are designed for one-time completion, though staff are welcome to revisit them whenever needed. All Trust staff involved in NDOO data flows have successfully completed the new training. The Information Asset module is intended for all Information Asset Owners and Administrators, and promotion of this requirement is currently underway to ensure all relevant colleagues are aware of and complete the training.

3.5.4 A module on IG with a focus on Data Protection Impact Assessments will also be developed as part of the “Me as Manager” programme and will be delivered alongside the Governance Risk and Incident training.

3.5.5 A total of 28 IG incidents were reported between November 2025 and February 2026, mostly low-harm and primarily due to misfiling identified through SAR processing. All incidents remain manageable in-house with no referrals required to the Information Commissioner’s Office.

3.5.6 IG continues to support the EPR programme, with Data Protection Impact Assessments under way for the PAS extraction, data migration, and subsequent stages. Given the scale of the programme, Caldicott Guardian, Data Protection Officer, and Senior Information Risk Owner oversight is being sought for each phase.

### 3.6 Corporate Governance

3.6.1 The Trustwide Governance Review has concluded and the revised framework and recommendations will be implemented from 1 April 2026. This includes the reinstatement of the monthly Trust Management Group which will report upwards to the Board Committees and the introduction of a Performance Review Panel to improve the accountability framework of the Trust. A more detailed update will be provided at a future meeting of the Trust Board.

3.6.2 The Corporate Services Manager is planning to lead a piece of work to implement an enhanced CoPilot solution into the Trust which will support meeting administration across the Trust. The work will be led in conjunction with the Digital Team.

## 4 RECOMMENDATION(S)

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

Matthew Revell, Medical Director
Nikki Brockie, Chief Nurse
Simon Grainger-Lloyd, Director of Governance

April 26

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# TRUST BOARD (PUBLIC)

| | |
|---|---|
| **DOCUMENT TITLE:** | **2025/26 Healthcare Worker Influenza Vaccination Campaign Report** |
| **SPONSOR (EXECUTIVE DIRECTOR):** | **Nicola Brockie, Executive Chief Nursing Officer & DIPC** |
| **AUTHOR:** | **Victoria Clewer, Head of IPC & Deputy DIPC** |
| **DATE OF MEETING:** | **1st April 2026** |

**PURPOSE OF THE REPORT:**

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

**EXECUTIVE SUMMARY:**

The annual healthcare worker influenza vaccination campaign aims to enhance patient safety, protect staff, and reduce the overall burden on healthcare services during the flu season. As frontline caregivers, healthcare workers are at higher risk of both contracting and transmitting influenza, which can lead to severe illness in vulnerable patients. This campaign encourages all healthcare staff to receive the annual flu vaccine to safeguard both their health and that of the patients in their care.

This paper provides a summary of the 2025/26 healthcare worker influenza vaccination campaign.
The 2025/26 campaign was launched on the 6th of October 2025 and concluded on the 28th of February 2026.

To date (13/03/2025), 625 (42.2%) of all ROH staff have received the flu vaccine between. This includes 404 (43.2%) of all frontline healthcare workers (with patient contact) have received the vaccine.

ASSURANCE PROVIDED BY THE REPORT:

| POSITIVE | GAPS IN ASSURANCE/RISKS TO ESCALATE |
|---|---|
| • Ongoing leadership of the vaccination campaign, ensuring timely planning and roll out, overseen by the campaigning planning group. | • Whole Trust approach to campaign promotion and delivery is required.<br>• Ownership and engagement from all managers is required. |

**REPORT RECOMMENDATION:**

The BOARD is asked to: review the report and provide comment for discussion.

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

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

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

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

| **ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:** |
| --- |
| The contents of this report align to the:<br>• Health and Adult Social Care Act; code of practice on the prevention and control of infections and related guidance (DH 2012).<br>• National Infection Prevention and Control Board Assurance Framework. |
| **ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:** |
| This report identifies how ROH contributes to the BSOL ICB shared objective 'Protect people from harm '. The contents of this report are shared at ICB IPC committee meetings and operational groups. |
| **BENCHMARKING SOURCE** *(Indicate data sources included in report IF APPLICABLE)***:** |
| N/A |
| **PREVIOUS CONSIDERATION** *(Indicate board/committee/group & date)***:** |
| N/A |

# HEALTHCARE WORKER INFLUENZA VACCINATION CAMPAIGN REPORT

**Reporting Period:** 6th of October 2025 to 28th of February 2026
**Prepared by:** Victoria Clewer, Head of Infection Prevention and Control
**Prepared for:** Executive Quality and Safety Committee & Trust Board

## 1. Executive Summary

This paper provides a summary of the 2025/26 healthcare worker influenza vaccination campaign which ran between Monday 6th of October 2025 and Friday 27th of February 2026.

All frontline healthcare workers are eligible to receive a free flu vaccine as part of the 2025/26 seasonal influenza vaccination campaign.

At ROH, this offer is extended to all Trust staff – clinical and non-clinical.

New for 2025/26, NHS England introduced the requirement for all Trusts to offer influenza vaccination to eligible patients who had been admitted for 21 days or more (long stay), or who were due to be discharged to a care home, as these patients may otherwise miss the opportunity to receive vaccination during a hospital admission.

NHS England set a 5% increase in frontline HCW uptake target for all Trusts, based on 2024/25 final uptake figures.

**Uptake summary (accurate as of 13/03/2026):**

- 42.2% of all Trust staff were vaccinated. (625 out of 1474).
- 43.2% of all frontline HCW were vaccinated. (404 out of 936).
- ROH achieved the 5% uptake increase on final numbers from the 2024/25 campaign (≥ 38.9%) as instructed by NHS England.
- 596 vaccines were delivered onsite by the trained staff vaccinators, the rest were delivered else where such as pharmacies, other Trusts or GP practices.
- 43 inpatients were identified as ‘long-stay’ (≥ 21 days), of these 33 were eligible to be vaccinated. However, no vaccines were administered.

## 2. Campaign Objectives

The primary objectives of the campaign are to:

- Minimise patient risk by preventing the spread of influenza to vulnerable individuals, including the elderly, immunocompromised, and those with chronic conditions.
- Protect healthcare workers by reducing illness-related absenteeism, ensuring sufficient staffing, and maintaining operational efficiency during high-demand periods.
- Promote public health by contributing to herd immunity and reducing the community-wide transmission of the flu virus.
- Fulfil ethical and legal obligations to provide a safe and effective healthcare environment.

## 3. Campaign Overview

The planning group met from May 2025 and meetings were held monthly, chaired by the Deputy Chief Nurse and Head of IPC.

The national communications resources package was utilised locally to raise awareness of the vaccination offer and direct staff on when and how to access vaccination. This included internal posters, screensavers, internal comms bulletins and regular messaging via weekly updates and social media messages.

During September, the Head of IPC held four lunchtime drop-in sessions in the wellbeing room for staff who had questions or concerns about the vaccine. These sessions provided an opportunity for staff to have their concerns heard and their questions answered. Only two members of staff attended, both of whom subsequently chose to be vaccinated.

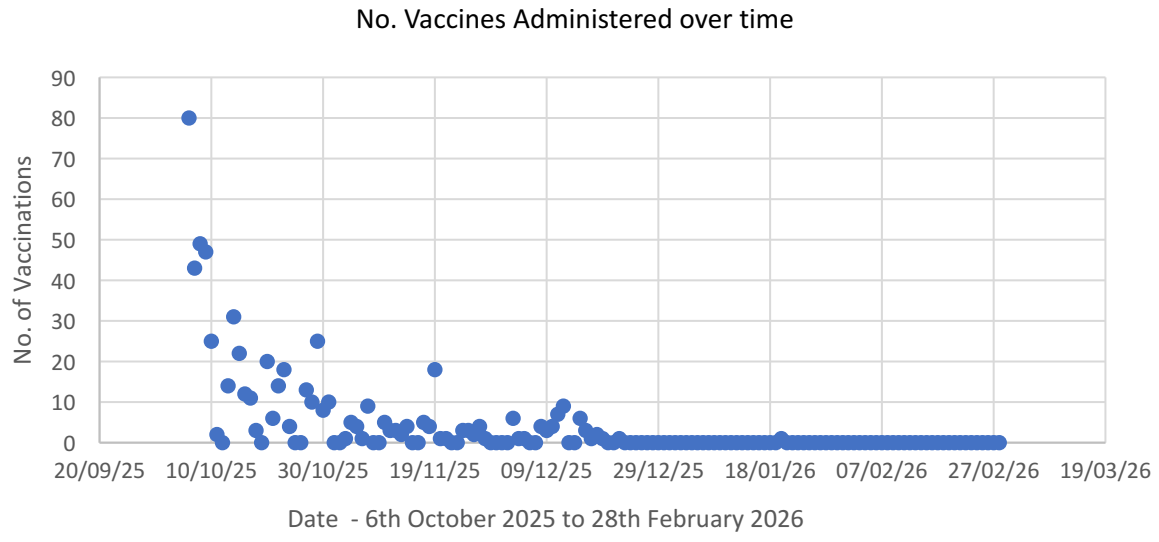
The use of the 'record a vaccination service' (RAVS) was mandated for capturing vaccination events. This enabled a record of the vaccination to be visible to the individuals GP and linked to their NHS app.

As with previous years, efforts were made to create a group of 'peer' vaccinators within clinical areas, however, of the 10 clinical staff vaccinators trained by the Head of IPC, only 1, an RN from POAC, fully supported the campaign and took ownership of offering vaccinations to colleagues within their clinical area.

The majority of vaccines were administered by 6 vaccinators within IPC and Corporate Nursing.

Support was provided during the first two months of the campaign by the Critical Care Outreach Team, who delivered out-of-hours and roaming vaccination sessions, administering 16 vaccines.

A vaccination hub was set up for the first two week of the campaign in the wellbeing room, that was open between specified hours Monday to Friday. Footfall through the hub was highest during the first week of the campaign, and this then dropped off dramatically.



Department managers were provided with simple tools to monitor vaccine uptake at a local level, with the expectation that this information would be shared with vaccination leads to support targeted interventions and optimise vaccinator time. However, these tools were not utilised by department managers, and there was limited evidence of local ownership or leadership in ensuring staff were offered and supported to access flu vaccination.

A decision was made by Trust Executives not to offer incentives for this campaign, in part due to the cost of this approach. An application was made to the Royal Orthopaedic Charity to provide a £3.50 drink voucher for each vaccination however this was declined. Tubs of chocolate were brought using personal funds by the Head of IPC, Chief Nurse and Deputy Chief Nurse.

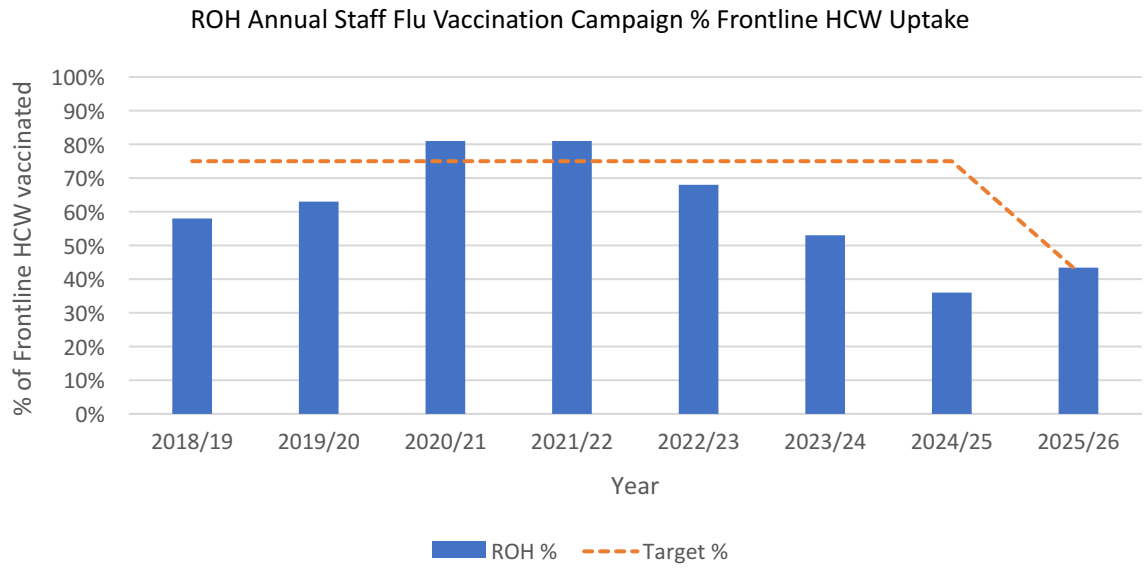
After the staff vaccination campaign began, NHS England instructed Trusts to vaccinate eligible long-stay patients (admitted ≥21 days) and those being discharged to care homes. The IPC Team rapidly set up a process despite limited preparation time; however, implementation was challenging due to a lack of trained ward-based vaccinators and variable engagement from medical teams.

The IPC team cannot administer vaccines as they do not hold medicines-administration competencies, nor is this part of their role. Once eligible patients were identified, further delays occurred in obtaining timely medical review to confirm clinical suitability, particularly around proximity to surgery, and in securing the necessary prescribing. As a result, although 33 eligible patients were identified, none were ultimately able to receive vaccination.

If this requirement continues in future campaigns, a more sustainable and operationally viable model will be needed, such as dedicated vaccinators, guaranteed medical support for review and prescribing, or a clearly defined Trust-wide pathway.

There were no serious adverse events reported during this campaign.

**4. Vaccination Uptake (as of 10/03/2026)**



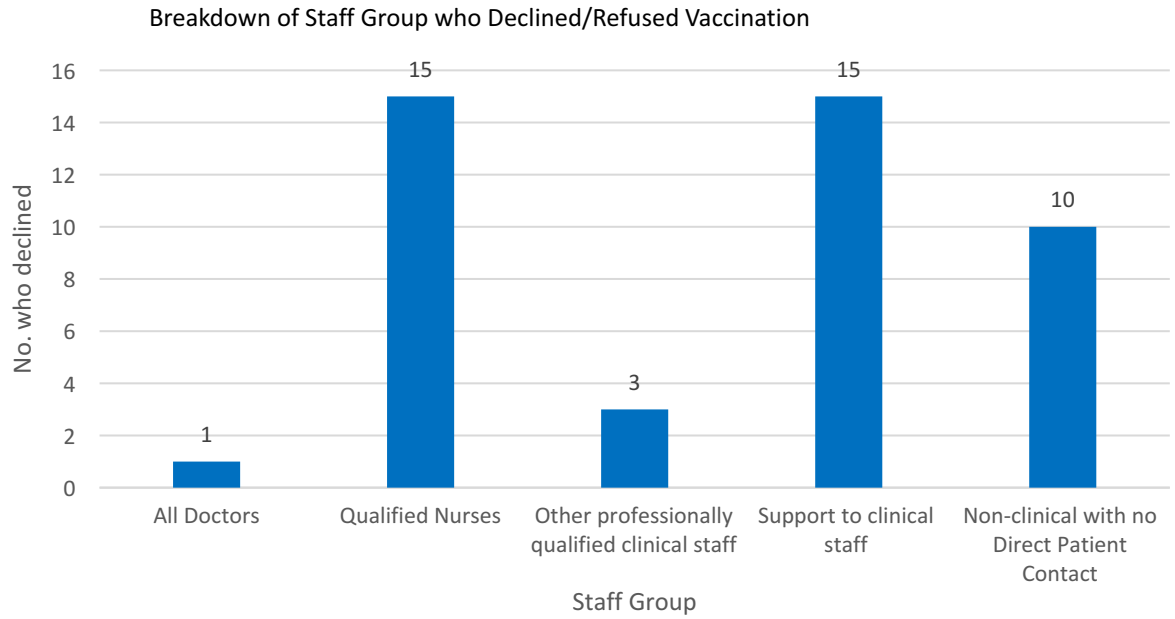
- Of the 1474 members of staff within the Trust, 625 **(42.2%)** received the flu vaccine between the 6th of October 2025 and the 28th of February 2026.

- **43.2%** (404) of all eligible frontline HCW with patient contact (936) received the flu vaccine between the 6th of October 2025 and the 28th of February 2026, which is an Improvement on uptake from 2024/25 by more than 5%.

- Of the 625 staff vaccinated across the Trust, 596 of these were vaccinated onsite by the trained staff vaccinators, the rest were delivered else where such as pharmacies, other Trusts or GP practices.

- 43 inpatients were identified as 'long-stay' (≥ 21 days), of these 33 were eligible to be vaccinated. However, no vaccines were administered.

Staff were asked to document their reasons for declining the vaccine; however, uptake of this request was limited, with many choosing not to provide a response. As flu vaccination is not mandatory, there is also no requirement for staff to give a justification for declining. Among the responses received, the breakdown is as follows. Please note that this includes both staff who declined the vaccine and those who were unable to receive it for medical reasons, such as a history of anaphylaxis:




Data from BSOL is not yet available for comparison. Reports will be shared once available.

**Flu vaccines administered onsite at ROH:**

Note, data as captured from ESR and RAVS - this data does not include staff who were vaccinated elsewhere.

| Staff Group | Total Staff | No. Vaccinated | Uptake % |
|---|---|---|---|
| Doctors | 155 | 65 | 41.9% |
| Qualified Nurses | 374 | 154 | 41.2% |
| Other professionally qualified staff | 183 | 92 | 50.3% |
| Support to clinical staff | 219 | 126 | 57.5% |
| Non-clinical staff | 532 | 159 | 29.9% |

**5. Impact**

Despite an improvement in staff uptake compared to previous years, not meeting the expected target still limits the overall impact of the campaign. While increased uptake offers some additional protection against staff illness, reduces potential transmission to vulnerable patients, and supports winter resilience, the shortfall means the Trust may continue to face higher sickness absence, reduced workforce capacity, and increased risk of flu outbreaks. This highlights ongoing challenges in engagement and the need for strengthened strategies to further improve uptake in future campaigns.

It is important to recognise the small but committed group of staff who consistently support the campaign each year, despite competing priorities. Their engagement plays a valuable role in maintaining organisational resilience and setting a positive example for others.

**7. Recommendations / Next Steps**

- The planning group will reconvene to debrief and develop a structured approach to gathering staff feedback, including a survey to identify opportunities for improvement ahead of the 2026/27 campaign. Planning meetings for the 2026/27 programme will begin in May 2026.

- Vaccines for the 2026/27 campaign have already been selected, and the procurement process is underway to ensure timely availability.

- Delivery of the flu vaccination programme must be taken seriously and supported through clear senior management accountability, with regular oversight from the Trust Board. Improved investment and dedicated resourcing are essential; staff cannot continue to deliver or improve the programme solely alongside existing duties. Additionally, the current situation, where staff use personal funds to support the campaign, is unacceptable and must not continue.

- Champions should be identified from staff groups with historically lower uptake, particularly medical staff and AHPs. These individuals should sit on the planning group and actively promote the campaign within their professional networks to support culture change and improved engagement.

- The internal communications strategy needs to be more visible and impactful. Current messaging is overly subtle. Future campaigns should adopt a more prominent, confident approach that clearly communicates the importance of flu

vaccination, addresses misconceptions directly, and ensures messages cannot be easily overlooked.

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# TRUST BOARD (PUBLIC)

| | |
|---|---|
| **DOCUMENT TITLE:** | **Modern day slavery Trust statement (Annual review)** |
| **SPONSOR (EXECUTIVE DIRECTOR):** | **Nikki Brockie, Executive Chief Nurse** |
| **AUTHOR:** | **Rebecca Furnival, Head of Safeguarding** |
| **DATE OF MEETING:** | **1st April 2026** |

**PURPOSE OF THE REPORT:**

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

**EXECUTIVE SUMMARY:**

This Modern Slavery Annual Review Statement outlines the actions taken by the organisation during the reporting period to identify, prevent, and mitigate risks related to Modern Slavery and Human Trafficking of the Modern Slavery Act 2015. Our approach focuses on transparency, accountability, and continuous improvement across all areas of our business.

**ASSURANCE PROVIDED BY THE REPORT:**

| POSITIVE | GAPS IN ASSURANCE/RISKS TO ESCALATE |
|---|---|
| • Confirms the organisation's commitment to a zero-tolerance approach to exploitation and forced labour.<br>• Demonstrates compliance with the requirements of the Modern Slavery Act 2015.<br>• Evidence shows that relevant policies, procedures, and governance structures are in place and regularly reviewed.<br>• Supplier due diligence and monitoring processes are used to identify and manage potential risks within the supply chain.<br>• Staff training and awareness programmes help employees recognise and report potential signs of exploitation.<br>• Reporting and whistleblowing mechanisms are available to allow concerns to be raised safely and confidentially. The report considers contextual safeguarding, recognising that risks may arise from wider social, environmental, or organisational contexts. | • Limited visibility over lower-tier suppliers in the supply chain, which may increase the risk of Modern Slavery occurring beyond direct supplier relationships.<br>• Potential under-reporting of concerns due to lack of confidence in external whistleblowing mechanisms or limited awareness of reporting channels. |

**REPORT RECOMMENDATION:**

The BOARD is asked to: review and approve

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

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

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

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

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

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

Relevant risks have been considered in relation to the organisation's Board Assurance Framework (BAF) to ensure senior leadership oversight and strategic monitoring.

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

Contributes to the ICS priority of protecting vulnerable populations, particularly individuals who may be at risk of Modern Slavery or Human Trafficking.
Strengthens safeguarding frameworks across health and care services, ensuring risks of exploitation are recognised and addressed in healthcare settings.

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

n/a

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

n/a

FOR APPROVAL

The Royal Orthopaedic Hospital NHS Foundation Trust

**Modern Day Slavery Annual Statement**

**April 2026**

1.0 Trust revised modern day slavery declaration annual review:

### 1.1 Modern Slavery and Human Trafficking Statement

This statement is made in accordance with Section 54(1) of the Modern Slavery Act 2015 and outlines the actions taken by The Royal Orthopaedic Hospital NHS Foundation Trust to prevent modern slavery and human trafficking within our organisation and supply chains.

### 1.2 Our Commitment

The Trust maintains a zero-tolerance approach to modern slavery and human trafficking. We are dedicated to promoting human rights and safeguarding vulnerable people across our services and procurement activities. We expect all staff, partners, and suppliers to uphold this commitment in line with national legislation and NHS standards.

Our safeguarding approach is informed by the Care Act 2014, Children Act 1989, Children Act 2004, and NHS safeguarding frameworks, recognising modern slavery as a form of exploitation and abuse.

### 1.3 Contextual Safeguarding and Duty of Care

The Trust adopts a contextual safeguarding approach, acknowledging that exploitation of children and adults can occur beyond family settings, in schools, communities, workplaces, and online environments. This holistic approach enables us to identify and respond to risks arising in these broader contexts.

We have a duty of care to protect both children and adults from all forms of exploitation, including trafficking and modern slavery. This includes proactive identification of risks, effective multi-agency collaboration, and supporting victims to ensure their safety and wellbeing.

### 1.4 Organisational Context

The Royal Orthopaedic Hospital NHS Foundation Trust provides specialist orthopaedic services within the NHS. We procure a wide range of goods and services and acknowledge that supply chains may present risks. We are committed to mitigating these risks through robust governance, procurement controls and policy frameworks.

**1.5 Monitoring, Assurance and Policies**

- Procurement Processes: Exclusion criteria are applied when awarding contracts to address modern slavery risks.
- NHS Supply Chain Review: A review has been undertaken with NHSE, our primary supplier of consumables, assessing approximately 1,300 suppliers and 600,000 products. An improvement action plan is in progress.
- Contractual Controls: All new contracts incorporate standard NHS Terms and Conditions, including clauses addressing modern slavery compliance.

**1.6 Supporting policies include:**

- Trust Safeguarding Policy: Outlines the Trust's commitment to protecting adults and children from harm, including exploitation and trafficking, aligned with national safeguarding legislation.
- Modern Slavery Policy: Details our approach to identifying, reporting, and managing modern slavery risks, applicable to all staff, volunteers, and third parties.

**1.7 Training**

We provide safeguarding and modern slavery awareness training to staff, focusing on recognising signs of exploitation and understanding reporting procedures to protect potential victims effectively.

**2.0 Looking Forward**

**2.1 Over the coming year, the Trust will:**

- Review and update policies to reflect legislative changes and best practice.
- Enhance supplier monitoring and assurance processes to uphold anti-slavery commitments.
- Expand targeted training for staff in high-risk roles to improve awareness and reporting of exploitation and modern slavery risks.

The Trust remains firmly committed to continuous improvement in preventing modern slavery and exploitation, ensuring compliance with national legislation, safeguarding standards, and delivering on our duty of care to vulnerable children and adults.

The Royal Orthopaedic Hospital NHS Foundation Trust

# 1.UPWARD REPORT FROM FINANCE AND PERFORMANCE COMMITTEE

**Date Group or Board met: 24TH MARCH 2026**

| MATTERS OF CONCERN OR KEY RISKS TO ESCALATE | MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY |
|---|---|
| • **BADS Day-Case Performance:** Current rate ~60% remains significantly below national target (85%). Structural case-mix challenges and July 2024 basket changes have increased difficulty in achieving compliance. Data quality issues—including pathway misclassification and clinical noting omissions.<br>• **Theatre Workforce Fragility:** February activity remained affected by reduced bank workforce availability, consultant sickness and gaps within theatre teams, although more sessions, and more activity delivered than M10 (M11 also having fewer operational days)<br>• **Private Patient Income:** Notable decline due to earlier operational challenges; requires active restoration of clinician confidence.<br>• **Risk Register Accuracy:** Several entries require updating; clearer linkage needed between risks, responsible committees, and planned mitigations. | • **Clinically-Led BADS Transformation:** Updated PAS options for day-case hips/knees, improved booking form use (85%), revised patient communications, and re-launch of spinal day-case pathways. Consultant-level trajectories and SBU accountability being embedded.<br>• **Theatre Workforce Recovery:** Recruitment campaign progressing (300 applications, 20 shortlisted), targeted competency development, revised bank arrangements, and direct senior support to maintain activity.<br>• **Private Patient Recovery Plan:** Focused clinician engagement, cancellation audit, and establishment of a formal Commercial Group to strengthen governance and income oversight.<br>• **Risk Framework Improvement:** Full review commissioned to realign risks, mitigations, and committee responsibilities. |
| **POSITIVE ASSURANCES TO PROVIDE** | **DECISIONS MADE** |
| • **Operational Performance Strong:** RTT at 63% (ahead of plan), 52-week waiters down to 104, strong performance across cancer and diagnostics, and theatre list utilisation at 90%. Model Hospital Capped Utilisation for M11 is 83.1% (top quartile).<br>• **Quality Indicators:** All cancer standards met except 28-day FDS (pathology-related). DNAs at 7.14% and PFO at 11.29%.<br>• **Capital & Infrastructure:** New CT scanner installed; service to go live in April.<br>• **Financial Delivery:** Month shows small surplus; YTD deficit reduced to <£900k. CIP delivery stands at £6.2m—best ever performance but still short of target.<br>• **Forecast:** Increased confidence in hitting break-even position but only through use of non-recurrent resource. | 1. Six-Month BADS Programme Update to be scheduled to measure impact of pathway improvements.<br>2. Risk Register & BAF will be reviewed to update risks and strengthen alignment with committee structures.<br>3. Commercial Group Formalised to oversee private patient and wider non-NHS income.<br>4. Theatre Workforce Plan Endorsed, including recruitment, upskilling and reduced reliance on bank staffing.<br>5. SBU Roll-Out Supported, beginning with Arthroplasty, with evaluation framework to measure operational and clinical impact.<br>6. Approval of Starpoint budgets for ratification at Board |

**Chair's comments on the effectiveness of the meeting: The Committee meeting was highly effective, demonstrating strong engagement, constructive challenge and clear forward momentum. Members explored complex issues—particularly around BADS performance, theatre workforce resilience and private patient recovery—with a high degree of openness and analytical rigour. Overall, the meeting provided the Committee with good assurance on operational and financial performance while reinforcing the Trust's commitment to continuous improvement and patient-centred care.**

# UPWARD REPORT FROM QUALITY & SAFETY COMMITTEE REPORT TO TRUST BOARD

**Date Group or Board met: 25 March 26**

| MATTERS OF CONCERN OR KEY RISKS TO ESCALATE | MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY |
|---|---|
| • **Bone cement shortage:** A verbal update was provided on the national shortage. The Trust has completed a risk assessment and stratified patients, with high-risk cases prioritised. An alternative supply is in use, supported by consultant involvement and an evidence-based approach. Stock levels are being closely monitored, with the aim of maintaining a 2-week supply buffer.<br>• **Cyber-attack (Stryker):** The company has experienced a cyber incident affecting three areas of its service (shared data, hospital-facing systems, and the supply chain). Initial findings indicate low impact for the Trust, as the data involved is anonymised and suitable alternative implants have been identified. This remains an ongoing risk and continues to be closely monitored. | • **Quality report:** The committee discussed the observed decrease in Trust-wide incident reporting. Governance provided assurance that a recent deep dive identified that Division 2 reporting remains stable, while the reduction is primarily within Division 1. This follows recent education on the use of Omnicell management systems and focused work within the Outpatient Department to address reporting delays is attributed to this decline.<br>• **E. coli and C. difficile Update**: The committee received an update on the recent E. coli case and a reportable C. difficile incident. The IPC team will provide a full overview and assurance report at the next committee meeting.<br>• **Theatres – Never Events Thematic Review and Improvement Plan:** The committee reviewed the thematic analysis of the six previous Never Events and noted that the findings have directly informed the Theatre Improvement Plan. Assurance was provided that actions arising from the review are actively being implemented, with good progress reported against the improvement plan and ongoing oversight in place.<br>• **GOSH / Cambridge Paediatric Orthopaedic Incidents:** The committee received a paper summarising learning from the recent scandals and took assurance that ROH has a robust five-layer assurance model in place. The thematic review has directly informed the Theatre Improvement Plan, with good progress noted and actions underway to strengthen safety, oversight, and early detection of concerns. |
| **POSITIVE ASSURANCES TO PROVIDE** | **DECISIONS MADE** |
| • **Opioid Use:** The committee received a paper on opioid use within the Trust. Assurance was provided that, following detailed analysis and benchmarking, the Trust is not an outlier and is positioned mid-range compared with peers. Ongoing work continues to focus on reviewing prescribing and reducing unnecessary usage, with the Pain Team leading the improvement actions.<br>• **PSIRF Process:** The committee noted the ongoing work to strengthen the PSIRF process, including the rollout of PSIRF education and updates to the Duty of Candour policy to ensure meaningful patient involvement throughout the process.<br>• **Clinical Audit:** The committee received an update on the AQILA report, outlining the Trust's clinical effectiveness activity, audit performance and key areas requiring further focus. Assurance was provided that strong progress continues across national audits, NICE compliance and ward accreditation. The committee | • It was agreed the following reports would be presented at the next Trust Board meeting:<br>  ○ Learning & Disabilities Strategy<br>  ○ Safeguarding Strategy<br>  ○ Quality & Safety Committee Terms of Reference (for approval)<br>• The committee approved the following Term of Reference following annual update:<br>  ○ Infection Prevention & Control |

| | |
|---|---|
| noted the priorities for 2026–27 and the actions underway to strengthen audit ownership, sepsis pathway compliance and team capacity.<br>• **Litigation:** The committee received an update on open litigation, noting the rise in the Trust's CNST premium for 2026–27, which has increased by £71,181 to £2.30m. Assurance was provided that a structured review of previous claims is planned to strengthen organisational learning and reduce future risk exposure. | |

**Chair's comments on the effectiveness of the meeting: It was agreed that the meeting focused on the right areas for focus and assurance was provided.**

# Learning Disability and Autism Strategy 2026 - 2029

## Our Vision

At the Royal Orthopaedic Hospital NHS Foundation Trust (ROH) putting patients at the centre of their care is fundamental to our commitment to delivering safe, high quality, effective and compassionate care.

In line with the wider Trust Strategy and Trust Values, the Learning Disability and Autism Strategy embodies the ethos of compassionate, patient-centred care, empowering patients and people with a learning disability and/ or autism to access the healthcare they need in order to improve their quality of life.

We are committed to ensuring all patients with a learning disability and/ or autism have equal access to healthcare without facing barriers or exclusion. The ROH will work proactively to ensure patients and their families/ carers feel safe, listened to and respected. We are passionate that all staff have the awareness and understanding to identify and implement appropriate reasonable adjustments to achieve this.

## Alignment with our Trust Vision

Our Learning Disability and Autism Strategy supports the Trust's vision to deliver excellent specialist orthopaedic care, underpinned by safety, dignity and respect.

We recognise the health inequalities that a patient may experience and are committed to mitigating these and providing inclusive, effective and timely care. Implementing reasonable adjustments through individually tailored care plans to support patients with a learning disability and/ or autism is an integral part of providing care in all areas across the Trust.

## Our commitments

The Royal Orthopaedic Hospital NHS Foundation Trust commits to:

- **Person-Centred Care**
  Providing person-centred care to all patients with learning disability and/ or autism diagnosis, ensuring the person is at the centre of all decisions and outstanding care is delivered.
- **Skills and Awareness**
  Ensuring staff have the skills and awareness to implement reasonable adjustments and provide appropriate patient care.
- **Listening**
  We will promote a culture of listening, ensuring that the people we care for and their parent/ carers are heard by everyone with feedback effectively addressed with meaningful change.
- **Co-production and collaborative working**
  We will ensure that people with a learning disability and/ or autism are included in the

development and evaluation of services. We will work collaboratively across the system to ensure partnership working and sharing of best practice.

## Learning Disability and Autism Core Values

### Person-Centred Care

The patient's voice is integral to all care and services provided by the ROH. We place the individual at the centre of all discussions and decisions made about them, and for them. It is imperative that we empower patients by listening to their views and wishes, and those of their parent/ carers where applicable and promoting informed choice.
We advocate for people with a learning disability and/ or autism diagnosis to ensure their voice is heard throughout the Trust to enable an inclusive culture.

### Compassion and Respect

We approach all patients with compassion and respect, ensuring communication is adapted sensitively and appropriately.
We reduce barriers and strive for equal access to all services and the reduction of health inequalities.

### Excellence and Safety

We are committed to high standards of learning disability and autism practice whereby a culture of continuous learning is encouraged where incidents and near misses are learnt from and best practice is shared and celebrated. This is supported by ongoing review, clear accountability and the use of annual audits, governance procedures, benchmarking projects and findings from national reports and LeDeR (learning from lives and deaths) reviews assist the evaluation and improvement of our services.

### Learning and Improvement

The Trust fosters a culture of openness, learning and reflection supporting a continual cycle of improvement in response to feedback, concerns and incidents.
Training in Learning Disability and Autism Awareness is mandatory, so all staff have the right knowledge and the right skills to work with and support a patient with a learning disability and/ or autism diagnosis and respond to their needs effectively.
We acknowledge the importance of the patient voice within learning and improvement and is an area we identify requires an increased focus.

## Strategic Framework and Assurance

The Trust's Learning Disability and Autism Strategy is aligned with national legislation, regulatory standards, professional guidance and system expectations, and provides assurance to the Board that the Trust can provide effective care to patients with learning disability and/ or autism diagnoses subject to ongoing oversight.

- Relevant legislation, including the Down Syndrome Act 2022, the Health and Social Care Act 2022, the LeDeR Policy 2021, the Care Act 2014, the Equality Act 2010, the United Nations Convention on the Rights of Persons with Disabilities 2010, the Autism Act 2009, the Mental Capacity Act 2005, the Children's Act 2004, the Human Rights Act 1998.
- National strategy and standards such as the NHS Ten Year Health Plan for England 2025, NHS Long Term Workforce plan 2023, National strategy for autistic children, young people, and adults: 2021-2026, the Learning Disability Improvement Standards for NHS Trusts 2018, the Accessible Information Standards 2018.
- Care Quality Commission (CQC) Fundamental Standards and Right Support, Right Care, Right Culture (2026) guidelines ensuring reasonable adjustments and equitable care are embedded within Safe, Effective, Caring, Responsive and Well-Led services, with robust governance, clear lines of accountability and a culture that promotes openness, learning and improvement.
- Local arrangements, including effective partnership working with Integrated Care Boards, local authorities, community teams and cross-service working to ensure timely information sharing, coordinated responses and shared learning.
- Strategic visions as set out by the Birmingham and Solihull Integrated Care Board such as local LeDeR (learning from lives and deaths) arrangements, with attendance on oversight and governance panels.
- Feedback sought from patient experience team, local NHS Trusts, patients, families and experts by experiences ensuring patient voice is heard throughout.

**Governance of the Learning Disability and Autism Strategy**

The Learning Disability and Autism Strategy is included within the safeguarding and vulnerabilities workplan with actions and progress being reported annually to the Safeguarding and Vulnerabilities Committee. It will also go through Quality and Safety Committee before implementation and be overseen by this group and the executive board.

Specific actions will be set out for each year of delivery with oversight through the Safeguarding and Vulnerabilities workplan via the Head of Safeguarding and Vulnerabilities with assurance provided to the Chief Nurse.

**Three-Year Delivery Framework (2026–2029)**

This Delivery Framework translates the Trust's commitments, priorities, and core values into actionable annual plans with measurable outcomes over three years.

**Year 1 – 2026/27: Foundations and Workforce Strengthening**

- Strengthen and maintain resilience within the learning disability and autism service.
- Support the launch of the updated safeguarding and vulnerabilities workplan for Board assurance.
- Identify key areas of development in line with annual audit and NHS Benchmarking ensuring actions clearly reflected in an action plan.
- Continue to embed robust learning disability and autism pathways ensuring staff are aware of expectations and resources available.
- Strengthen reporting and escalation mechanisms.
- Increase visibility across all departments through regular presence, walkarounds, bespoke sessions, and liaison with clinical and corporate teams.

**Year 2 – 2027/28: Bespoke Training and Implementation**

- Implement bespoke learning disability and autism training programmes across the Trust using the Learning Management System, ensuring staff have awareness and understanding of Trust specific pathways.
- Continue to support the system wide roll out and implementation of the Oliver McGowan Mandatory Training (government preferred awareness package) encouraging compliance across the Trust.
- Evaluate staff confidence and competence via supervision, audits and feedback surveys.
- Strengthen cross-service working and external networking.

**Year 3 – 2028/29: Evaluation and Governance**

- Conduct in depth evaluation of the learning disability and autism strategy against commitments, priorities, values and outcomes.
- Review lessons learned from audits, complaints, incidents, learning from death reviews (including LeDeR), and serious case reviews.
- Update the strategy and contribute to the safeguarding and vulnerabilities workplan for the next three years.
- Support continuous learning and staff engagement to enable positive health outcomes and experiences for patients with learning disability and/ or autism.

Through alignment with this strategic framework, the Trust ensures that the learning disability and autism core values are embedded across governance, workforce development, clinical practice and partnership working, and that the Trust is providing care in line with expectations laid out in national policy and strategy.

# Learning Disability and Autism Strategy 2026-2029 development: patient and parent/carer input

## What is one positive of your experience at ROH?

- Not as noisy as other hospitals
- I was seen quickly
- The nurses are amazing
- I was given a hospital passport
- Improvement in physical condition
- We were listened to
- We couldn't have asked for more
- LD team input and pre-planning
- Consultant goes above and beyond
- Treated better than any other hospital
- Support in place was brilliant
- Patient is at the centre
- We knew what to expect
- We couldn't have asked for more

## What is one thing you'd like to improve at the ROH?

- Staff awareness and understanding of autism
- Staff reading plans
- Communication
- More face to face contact with LD team
- Staff knowing diagnoses
- Felt in the dark
- Communication with waiting list times
- No virtual appointments
- Parking
- Staff attitudes
- Realistic expectations
- Clear information
- To be given the right form of medication
- Not having to explam over and over
- Staff to read notes
- Clear guidance
- Waiting list communication

**Commitments: person-centred care, skills and awareness, listening, co-production and collaboration**

# The Royal Orthopaedic Hospital Safeguarding Strategy 2026 – 2029

## Safeguarding Vision

At the Royal Orthopaedic Hospital NHS Foundation Trust, safeguarding is fundamental to our commitment to delivering safe, high-quality, compassionate and inclusive care.
We are committed to ensuring that children, young people and adults at risk are protected from harm, abuse and neglect, and that safeguarding is embedded in everything we do.

Safeguarding is everyone's responsibility, and we will work proactively to create an environment where people feel safe, listened to, respected and supported, in line with our Trust values and vision.

## Alignment with our Trust Vision

Our safeguarding approach supports the Trust's vision to deliver excellent specialist orthopaedic care, underpinned by safety, dignity and respect.
We recognise that people who use our services may be vulnerable due to health needs, disability, age, or personal circumstances, and we are committed to early identification of risk and timely, effective intervention.

Safeguarding at ROH is not separate from clinical care — it is an integral part of quality, patient-centred care.

## Our safeguarding commitments

The Royal Orthopaedic Hospital NHS Foundation Trust commits to:

- Promoting a safe, open and inclusive culture where safeguarding is everyone's business
- Listening to patients, families and carers and responding to concerns effectively
- Providing appropriate training and supervision in line with national guidance, ensuring all staff understand and fulfil their roles and responsibilities in safeguarding.
- Ensuring our staff feel safe, respected and supported in the workplace, through a safeguarding culture that promotes sexual safety, dignity and zero tolerance of sexual misconduct, harassment or abuse.
- Working in partnership to safeguard children, young people and adults at risk

## Safeguarding and Core Values

### Patient-Centred Care

We place the individual at the heart of safeguarding practice, listening to their views, wishes and lived experience.
We promote empowerment, informed decision-making and advocacy, ensuring that safeguarding responses are proportionate, respectful and person-centred.

### Compassion and Respect

We approach safeguarding concerns with compassion, sensitivity and professionalism, recognising the impact that abuse, neglect or trauma can have on individuals and families.
We treat everyone with dignity, fairness and respect, and challenge discrimination and inequality in all its forms.

### Excellence and Safety

We are committed to high standards of safeguarding practice, supported by robust governance, clear accountability and continuous improvement.
Safeguarding risks are identified, reported and escalated appropriately, and learning from safeguarding incidents, audits and reviews is used to improve practice and outcomes.

### Working Together

We recognise that effective safeguarding requires strong partnership working.
The Trust works collaboratively with Integrated Care Boards, local authorities, police, and other partner agencies to ensure a coordinated and timely safeguarding response.

### Learning and Improvement

We foster a culture of openness, learning and reflection, where staff feel confident to raise concerns and are supported to do so.
Safeguarding training, supervision and development are prioritised to ensure staff have the knowledge, skills and confidence to recognise and respond to safeguarding concerns.

### Strategic Framework and Board Assurance

The Trust's safeguarding strategy is aligned with national legislation, statutory duties, professional guidance, regulatory standards and system expectations, and provides assurance to the Board that safeguarding arrangements are effective, embedded and subject to ongoing oversight.

- The NHS Safeguarding Accountability and Assurance Framework (SAAF), which defines clear roles, responsibilities and accountability for safeguarding children, young people and adults at risk across NHS organisations.
- Relevant legislation, including the Children Act 1989, Children Act 2004 (including Section 11 duties), the Domestic Abuse Act 2021, the Care Act 2014, and the Mental Capacity Act 2005.

- National statutory and professional guidance, including *Working Together to Safeguard Children* (2023), guidance relating to looked after children and care leavers, and other relevant safeguarding documents, ensuring staff are trained, supervised and competent to fulfil their safeguarding responsibilities.
- The NHS Sexual Safety Charter, supporting a culture of zero tolerance to sexual misconduct, harassment and abuse, and providing assurance that staff feel safe, respected and supported to raise concerns, in line with Freedom to Speak Up principles.
- Care Quality Commission (CQC) Fundamental Standards, ensuring safeguarding is embedded within Safe, Effective, Caring, Responsive and Well-Led services, with robust governance, clear lines of accountability and a culture that promotes openness, learning and improvement.
- Local multi-agency safeguarding arrangements, including effective partnership working with Integrated Care Boards, local authorities, police and other safeguarding partners, to ensure timely information sharing, coordinated responses and shared learning.

**Governance of the safeguarding strategy**

A safeguarding workplan has been developed to support delivery of this strategy and to measure impact against agreed priorities, objectives and outcomes. Oversight of the workplan will be provided by the Head of Safeguarding and Vulnerabilities, with assurance provided to the Chief Nurse as the Safeguarding Executive Lead. Regular progress reports will be presented to the Safeguarding Committee and the Quality and Safety Committee, with the Quality and Safety Committee receiving bi-annual assurance on the effectiveness and responsiveness of the Trust's safeguarding arrangements.

**Three-Year Delivery Framework (2026–2029)**

This Delivery Framework translates the Trust's commitments, priorities, and core values into actionable annual plans with measurable outcomes over three years.

**Year 1 – 2026/27: Foundations and Workforce Strengthening**

- Strengthen safeguarding team, workforce capacity, retention, and statutory roles.
- Embed statutory and regulatory safeguarding requirements across all services.
- Launch updated safeguarding annual workplan for Board assurance.

- Strengthen reporting and escalation mechanisms.
- Increase safeguarding team visibility across all departments through regular presence, bespoke sessions, and liaison with clinical and corporate teams

**Year 2 – 2027/28: Bespoke Training and System-Wide Implementation**

- Implement bespoke safeguarding training programmes across the Trust, ensuring content is available to external professionals to promote system-wide safeguarding competence and partnership working.
- Targeted training for clinical and corporate staff, including role-specific modules.
- Evaluate staff confidence and competence via supervision and audits.
- Strengthen supervision and mentoring for the safeguarding team.
- Embed sexual safety principles in safeguarding practice.

**Year 3 – 2028/29: Evaluation, Governance and Sustainability**

- Implement enhanced safeguarding governance and reporting systems with dashboards for KPIs and outcomes.
- Deepen multi-agency working with local authorities, ICBs, police, and voluntary sector.
- Conduct comprehensive evaluation of the safeguarding strategy against objectives, priorities, and outcomes.
- Review lessons learned from audits, incidents, and serious case reviews.
- Update the strategy and workplan for the next three years.
- Ensure sustainability of safeguarding culture, continuous learning, and staff engagement.

Through alignment with this strategic framework, the Trust ensures that safeguarding is embedded across governance, workforce development, clinical practice and partnership working, and that all statutory and regulatory safeguarding responsibilities are met.

NHS

The Royal Orthopaedic Hospital
NHS Foundation Trust

# Safeguarding Strategy 2026–2029

## Safeguarding Vision

Safeguarding is everyone's responsibility, and we will work proactively to create an environment where people ***feel safe***, listened to, ***respected*** and ***supported***, in line with our *Trust* values and vision.

## Safeguarding Commitments

**Promote a culture of safety and transparency**
Foster openness and accountability.

**Strengthen staff knowledge, skills & confidence**
Provide training and support.

**Improve early identification and response**
Recognise risk and act swiftly.

**Work with partners & communities**
Collaborate to protect those at risk.

**Ensure continuous learning & improvement**
Learn and evolve our practices.

## Three Year Delivery Plan

| 2026 | 2027 | 2028 |
|---|---|---|
| Building Strong Foundations | Embedding Best Practice | Sustaining Excellence & Innovation |

# Integrated Performance Report

## Month 11

## February 2026

The Intergated 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, workforce and quality 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.

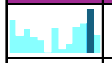
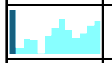
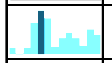
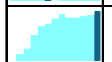
# Assurance Reports: Operational Performance Summary

| Metric | In Month | Previous Month | Target | Variation | Assurance |
|---|---|---|---|---|---|
| RTT Combined (against trajectory constitutional target remains 92%) | 63.07% | 62.18% | 59.64% | H | P |
| 65 Week waits (65-77 weeks) | 0 | 0 | 0 | L | P |
| 52 week waits (52-64 weeks) | 104 | 171 | 175 | L | P |
| RTT Proportion of Patients Waiting 52 weeks | 0.81% | 1.32% | 1.33% | L | P |
| RTT First Appointment Waiting List | 69.25% | 69.19% | 66.73% | H | P |
| RTT Waiting List Size | 12,800 | 12,987 | 13,138 | L | P |
| Diagnostics volume YTD (compared to plan) - CT, MRI and Ultrasound | 24,721 | 22,502 Cumulative | 23,297 YTD Target | H | P |
| Diagnostic 6 week target | 98.7% | 96.9% | 95% | H | P |
| Theatre Session Utilisation | 90.9% | 80.9% | 85% | | ? |
| Theatre Insession Utilisation (Capped) | 79.5% | 80.7% | 85% | | ? |
| Bed Occupancy (excluding CYP and HDU) | 75.3% | 74.1% | 82-85% | | F |
| LOS - Excluding Oncology, Paeds,YAH, Spinal | 3.32 | 3.59 | n/a | | - |

| Metric | In Month | Previous Month | Target | Variation | Assurance |
|---|---|---|---|---|---|
| All Activity YTD (compared to plan) | 13,487 | 12,291 | 13,725 | | F |
| Outpatient activity YTD (compared to plan) | 67,799 | 61,701 102.9% | 65,665 | H | P |
| Outpatient Did Not Attend (YTD) | 7.14% | 8.73% | 8.00% | | P |
| PIFU | 646 11.29% | 608 11.07% | 512 5% | H | P |
| Virtual Consultations (target is to plan, operational planning guidance is 25%) | 10.33% | 11.39% | 19% | L | F |
| Cancer - 31 day first treatment | 100.0% | 100.0% | 96% | H | P |
| Cancer - 62 day (traditional) | 81.8% | 75.0% | 75% National 85% Trust | H | P |
| 28 days FDS | 73.8% | 72.8% | 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) | 21,236 | 19,417 | 21,184 YTD Target | H | P |
| LOS - elective primary hip | 3.04 | 3.10 | 2.70 | | F |
| LOS - elective primary knee | 3.48 | 3.45 | 2.70 | | F |

| Metric Grouping | Metric Name | Reporting Period | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | YTD | Trend | Direction of Travel | Latest Variation Monthly | Latest Assurance Target | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Inpatients | IP Activity Monthly Performance % | Monthly | 109.9% | 95.4% | 109.4% | 103.0% | 101.5% | 96.3% | 98.3% | 99.7% | 94.3% | 94.6% | 101.3% | 89.8% | 95.8% | 98.27% | | high is good | L | F | 100% |
| Inpatients | IP Activity Electives Monthly Performance % | Monthly | 102.0% | 90.9% | 111.8% | 108.6% | 98.9% | 102.8% | 100.7% | 102.1% | 101.5% | 104.2% | 114.2% | 93.9% | 104.3% | 103.70% | | high is good | H | P | 100% |
| Inpatients | IP Activity Daycases Monthly Performance % | Monthly | 116.7% | 97.1% | 109.2% | 98.5% | 103.9% | 91.6% | 96.4% | 99.3% | 88.6% | 88.0% | 92.4% | 84.9% | 89.5% | 97.83% | | high is good | L | F | 100% |
| Inpatients | IP Activity Non-Electives Monthly Performance % | Monthly | 118.2% | 215.4% | 57.75% | 113.43% | 86.21% | 99.11% | 99.82% | 56.18% | 113.12% | 73.84% | 83.42% | 156.87% | 94.11% | 94.2% | - | - | - | - | - |
| Inpatients | IP Activity Monthly Discharges | Monthly | 1,340 | 1,252 | 1,168 | 1,204 | 1,208 | 1,231 | 1,205 | 1,304 | 1,280 | 1,269 | 1,254 | 1,168 | 1,196 | 13,487 | | high is good | - | - | - |
| Inpatients | IP Activity Elective Discharges | Monthly | 571 | 547 | 485 | 530 | 487 | 539 | 527 | 565 | 565 | 586 | 586 | 507 | 542 | 5,919 | | high is good | - | - | - |
| Inpatients | IP Activity Daycase Discharges | Monthly | 756 | 677 | 672 | 649 | 702 | 670 | 656 | 726 | 689 | 667 | 649 | 627 | 634 | 7,341 | | high is good | - | - | - |
| Inpatients | IP Activity Non-Elective Discharges | Monthly | 13 | 28 | 11 | 25 | 19 | 22 | 22 | 13 | 26 | 16 | 19 | 34 | 20 | 227 | | - | - | - | - |
| Outpatients | OP Activity Monthly Performance % | Monthly | 110.4% | 98.0% | 106.8% | 104.3% | 106.1% | 100.1% | 99.4% | 109.6% | 100.8% | 105.9% | 95.8% | 100.7% | 107.8% | 103.3% | | high is good | H | P | 100% |
| Outpatients | OP Activity First Monthly Performance % | Monthly | 114.3% | 96.4% | 84.4% | 89.3% | 93.8% | 93.1% | 93.0% | 104.9% | 93.1% | 100.7% | 85.9% | 99.2% | 105.3% | 94.8% | | high is good | L | F | 100% |
| Outpatients | OP Activity Follow Up Monthly Performance % | Monthly | 110.9% | 101.7% | 117.5% | 111.0% | 111.4% | 103.5% | 101.2% | 109.9% | 101.2% | 103.8% | 96.5% | 97.3% | 104.9% | 105.2% | | high is good | H | P | 100% |
| Outpatients | OP Activity Procedures Monthly Performance % | Monthly | 83.7% | 66.4% | 138.1% | 130.4% | 131.3% | 108.8% | 125.9% | 143.8% | 157.4% | 176.1% | 166.4% | 159.8% | 167.6% | 145.7% | | high is good | H | P | 100% |
| Outpatients | OP Activity Monthly Attendances | Monthly | 6,035 | 6,248 | 6,072 | 5,927 | 6,334 | 6,543 | 5,651 | 6,855 | 6,589 | 6,025 | 5,724 | 6,018 | 6,061 | 67,799 | | high is good | - | - | - |
| Outpatients | OP Activity First Monthly Attendances | Monthly | 1,997 | 1,964 | 1,682 | 1,779 | 1,964 | 2,133 | 1,852 | 2,300 | 2,133 | 2,007 | 1,798 | 2,077 | 2,098 | 21,823 | | high is good | - | - | - |
| Outpatients | OP Activity Follow Up Monthly Attendances | Monthly | 3,772 | 4,038 | 4,049 | 3,826 | 4,029 | 4,101 | 3,488 | 4,164 | 4,009 | 3,578 | 3,493 | 3,522 | 3,616 | 41,875 | | high is good | - | - | - |
| Outpatients | OP Activity Procedures Monthly Attendances | Monthly | 266 | 246 | 341 | 322 | 341 | 309 | 311 | 391 | 447 | 440 | 433 | 419 | 347 | 4,101 | | high is good | - | - | - |

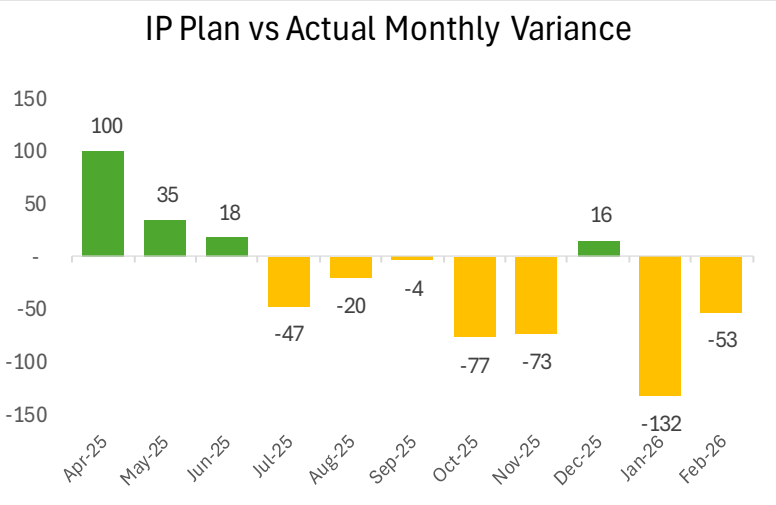
# Integrated Performance Dashboard: Operational

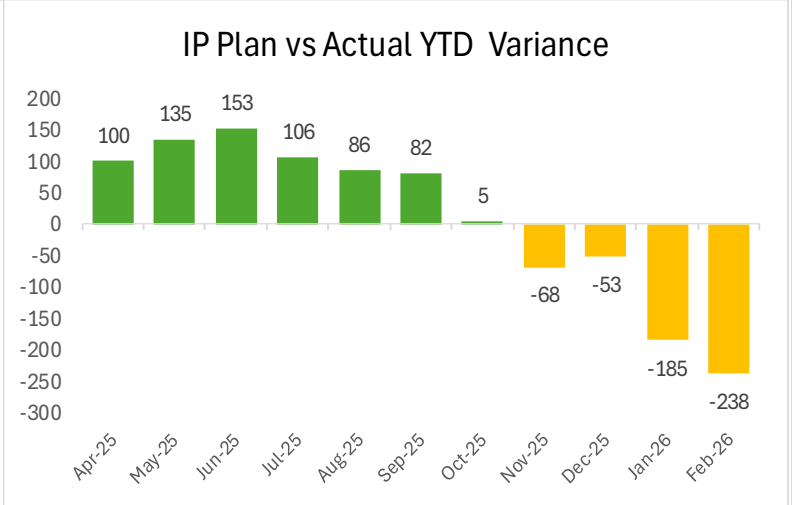
| Metric Grouping | Metric Name | Reporting Period | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | YTD | Trend | Direction of Travel | Latest Variation Monthly | Latest Assurance Target | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Outpatients | Outpatient Did Not Attend | Monthly | 8.0% | 7.1% | 7.45% | 7.0% | 6.8% | 6.0% | 7.5% | 6.3% | 6.6% | 7.6% | 7.8% | 8.7% | 7.1% | 7.2% |  | low is good |  |  | 8% |
| Outpatients | PIFU | Monthly | 11.8% | 10.1% | 10.5% | 10.4% | 9.8% | 10.6% | 11.0% | 11.4% | 10.9% | 10.5% | 10.7% | 11.1% | 11.3% | 10.7% |  | high is good |  |  | 5% |
| Outpatients | Virtual Attendances | Monthly | 9.3% | 9.8% | 10.08% | 9.79% | 10.45% | 10.30% | 10.88% | 10.30% | 10.09% | 10.34% | 12.18% | 12.66% | 10.33% | NA |  | high is good | | | |
| Outpatients | OP Attendances Patients Who Waited 31 to 60 Mins to be Seen | Monthly | 7.5% | 6.1% | 7.44% | 12.78% | 15.51% | 13.82% | 7.67% | 9.65% | 10.80% | 9.50% | 7.97% | 11.53% | 10.38% | 10.64% |  | low is good | | | |
| Outpatients | OP Attendances Patients Waited Over 60 Mins to be Seen | Monthly | 1.9% | 1.6% | 2.15% | 4.16% | 5.11% | 5.60% | 1.47% | 3.26% | 3.52% | 3.92% | 1.93% | 3.65% | 4.02% | 3.53% |  | low is good | | | |
| referral to treatment | RTT Total Waiting List Under 18 weeks | Month Ending | 53.14% | 54.66% | 55.63% | 58.33% | 60.07% | 60.35% | 61.48% | 62.32% | 61.77% | 61.83% | 61.93% | 62.18% | 63.07% | NA |  | high is good |  |  | 59.64% |
| referral to treatment | RTT First Appointment Waiting List Under 18 weeks | Month Ending | 53.06% | 54.06% | 54.61% | 57.78% | 61.78% | 62.03% | 64.55% | 66.54% | 66.82% | 66.49% | 66.09% | 69.19% | 69.25% | NA |  | high is good |  |  | 66.73% |
| referral to treatment | RTT Total Waiting List Size | Month Ending | 13,291 | 12,738 | 12,736 | 12,795 | 12,952 | 13,343 | 13,446 | 13,350 | 13452 | 13,195 | 13,175 | 12,987 | 12,800 | NA |  | low is good |  |  | 13,138 |
| referral to treatment | RTT Patients Waiting 65 Week waits | Month Ending | 6 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | NA |  | low is good |  |  | 0 |
| referral to treatment | RTT Patients Waiting 52 week waits (52-64 weeks) | Month Ending | 672 | 487 | 486 | 507 | 465 | 445 | 427 | 375 | 318 | 227 | 198 | 171 | 104 | NA |  | low is good |  |  | 175 |
| referral to treatment | RTT Proportion of Patients Waiting 52 weeks and over | Month Ending | 5.10% | 3.83% | 3.82% | 3.96% | 3.59% | 3.34% | 3.18% | 2.81% | 2.37% | 1.72% | 1.50% | 1.32% | 0.81% | NA |  | low is good |  |  | 1.33% |

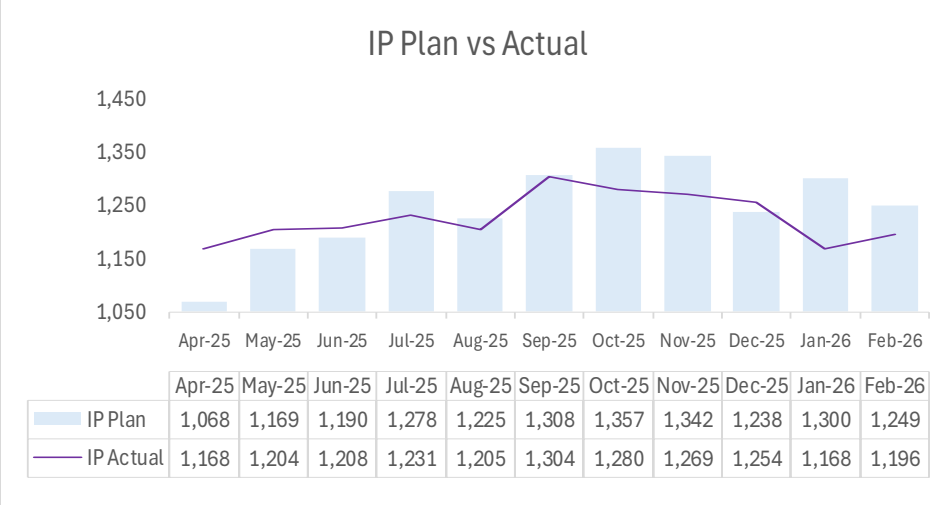
# Integrated Performance Dashboard: Operational Productivity

| Metric Grouping | Metric Name | Reporting Period | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | YTD | Trend | Direction of Travel | Latest Variation Monthly | Latest Assurance Target | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Operational Productivity | Theatre Number of Sessions Planned | Monthly | 520 | 558 | 533 | 530 | 535 | 590 | 515 | 572 | 600 | 534 | 553 | 583 | 524 | 6,069 | | | - | - | |
| Operational Productivity | Theatre Session Utilisation | Monthly | 89.23% | 84.64% | 90.40% | 84.60% | 83.10% | 85.00% | 84.20% | 87.90% | 88.70% | 94.50% | 87.23% | 80.89% | 90.91% | | | high is good | | P | 85% |
| Operational Productivity | Theatre In-Session Utilisation Upcapped | Monthly | 83.64% | 84.04% | 84.38% | 84.53% | 82.37% | 81.68% | 85.39% | 83.61% | 82.72% | 84.63% | 83.58% | 82.24% | 81.14% | | | high is good | L | F | 85% |
| Operational Productivity | Theatre Touchtime Utilisation Upcapped | Monthly | 80.29% | 81.12% | 82.80% | 81.70% | 80.80% | 80.30% | 82.80% | 82.30% | 81.10% | 80.90% | 80.53% | 80.67% | 79.53% | | | high is good | L | F | 85% |
| Operational Productivity | Average Number Of Operations Per List | Monthly | 3.08 | 2.96 | 3.18 | 3.19 | 3.12 | 3.00 | 3.16 | 3.07 | 2.91 | 3.01 | 3.07 | 2.99 | 3.06 | 3.07 | | high is good | - | - | - |
| Operational Productivity | Average Mins Late Starts(minutes) *Based on 9pm Start Time | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 5 | 11 | 1 | 2 | | low is good | - | - | - |
| Operational Productivity | Average Early Finishes (minutes) | Monthly | 85 | 83 | 82 | 84 | 85 | 92 | 81 | 83 | 86 | 78 | 84 | 73 | 91 | 84 | | low is good | - | - | - |
| Operational Productivity | Average Patient Turnaround (minutes) | Monthly | 13 | 11 | 13 | 17 | 13 | 16 | 14 | 16 | 15 | 16 | 16 | 15 | 15 | 15 | | low is good | - | - | - |
| Operational Productivity | Admitted Treatment Deferred | Monthly | 36 | 24 | 28 | 34 | 24 | 38 | 24 | 34 | 43 | 52 | 33 | 49 | 45 | 277 | | low is good | - | - | - |
| Operational Productivity | Cancelled By Hospital On Day of Admission | Monthly | 2 | 3 | 2 | 2 | 2 | 5 | 0 | 4 | 2 | 6 | 3 | 27 | 13 | 23 | | low is good | - | - | - |
| Operational Productivity | Cancelled By Hospital Day Before Day of Admission | Monthly | 22 | 26 | 35 | 19 | 28 | 27 | 24 | 24 | 42 | 41 | 35 | 42 | 41 | 240 | | low is good | - | - | - |
| Operational Productivity | LOS - Trust Wide All Services | Monthly | 3.4 | 3.7 | 4.0 | 3.7 | 3.8 | 3.5 | 4.2 | 3.4 | 3.5 | 3.5 | 4.2 | 4.0 | 3.6 | 3.8 | | low is good | - | - | - |
| Operational Productivity | LOS - Excluding Oncology, Paeds,YAH, Spinal | Monthly | 3.03 | 3.15 | 3.31 | 3.37 | 3.41 | 2.96 | 3.69 | 2.94 | 2.96 | 2.64 | 3.54 | 3.49 | 3.32 | 3.2 | | low is good | - | - | - |
| Operational Productivity | LOS - Elective Primary Hip | Monthly | 2.4 | 2.7 | 3.2 | 3.1 | 3.5 | 3.6 | 3.4 | 3.3 | 2.6 | 2.9 | 3.4 | 3.1 | 3.0 | 3.2 | | low is good | | F | 2.7 |
| Operational Productivity | LOS - Elective Primary Knee | Monthly | 2.6 | 2.7 | 3.3 | 3.6 | 3.6 | 3.1 | 3.4 | 2.9 | 3.4 | 2.7 | 3.3 | 3.4 | 3.5 | 3.3 | | low is good | | F | 2.7 |
| Operational Productivity | BADS Daycase rate | Monthly | 51.10% | 53.40% | 54.60% | 53.50% | 53.00% | 52.40% | 53.60% | 56.30% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 29.40% | | high is good | - | - | |
| Operational Productivity | OP for first or follow-up Attendances attracting a procedure tariff | Monthly | 37.35% | 37.50% | 33.32% | 35.45% | 36.39% | 37.32% | 38.28% | 39.26% | 39.16% | 40.61% | 38.98% | 41.48% | 0.00% | 34.57% | | high is good | | | |

# Assurance Reports: Inpatients



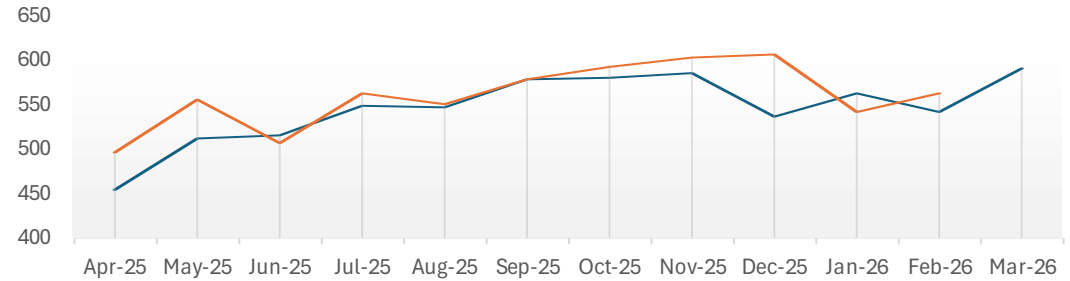




| | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IP Plan | 1,068 | 1,169 | 1,190 | 1,278 | 1,225 | 1,308 | 1,357 | 1,342 | 1,238 | 1,300 | 1,249 |
| IP Actual | 1,168 | 1,204 | 1,208 | 1,231 | 1,205 | 1,304 | 1,280 | 1,269 | 1,254 | 1,168 | 1,196 |

| 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 |
|---|---|---|---|---|
| February 2026 performance was –53 cases increasing the YTD deficit to –238 cases. The performance improved from January 26, however, there was a continuation of cancellations due to:<br><br>• A change in theatre Bank Rates aligning the Trust to rates across the system led to reluctance for theatre staff to pick up additional shifts Impacting on private patient lists ) or to stay late if a theatre was overrunning. This highlighted a vacancy factor that had previously been mitigated by the use of bank.<br>• Theatre Estate issues (Theatre 4 temperature issues). | Weekend capacity agreed for end of Feb / March 26 to help mitigate further deterioration in activity due to a continuation of staffing and theatre estate pressures into February 26.<br><br>Theatre bank rate issues resolved as of week beginning 16th February 26. | Weekly senior review of activity by executive team and COO to monitor risk and agree actions .<br><br>Daily oversight by Director of operations to support management of lists with escalation to Deputy COO.<br><br>Weely theatre business continuity meeting held by CEO with executive team to monitor progress and agree remedial actions. | Corporate Risk Register Ref 269 | High |

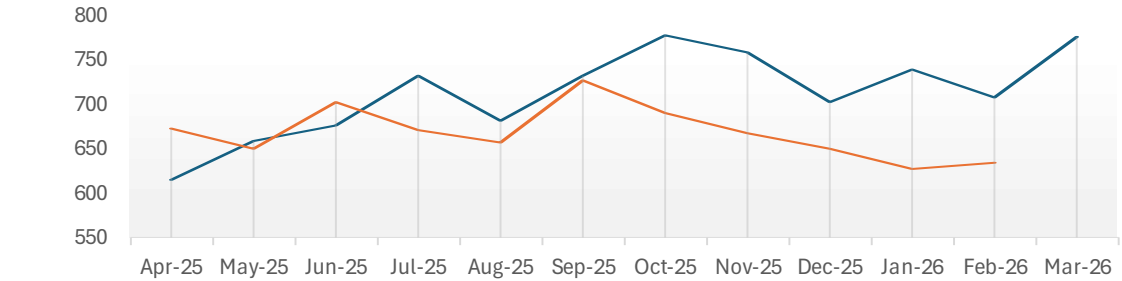
# Assurance Reports: Inpatients continued

## IP Electives (Including Non-Electives)




| | 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 | 541 | 562 | |

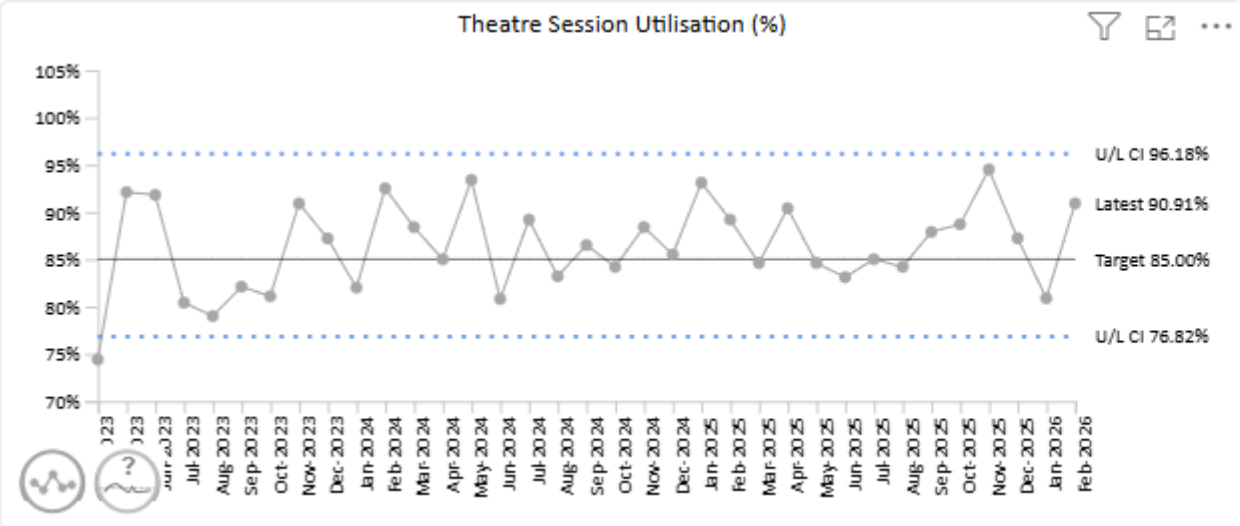
## IP Daycases

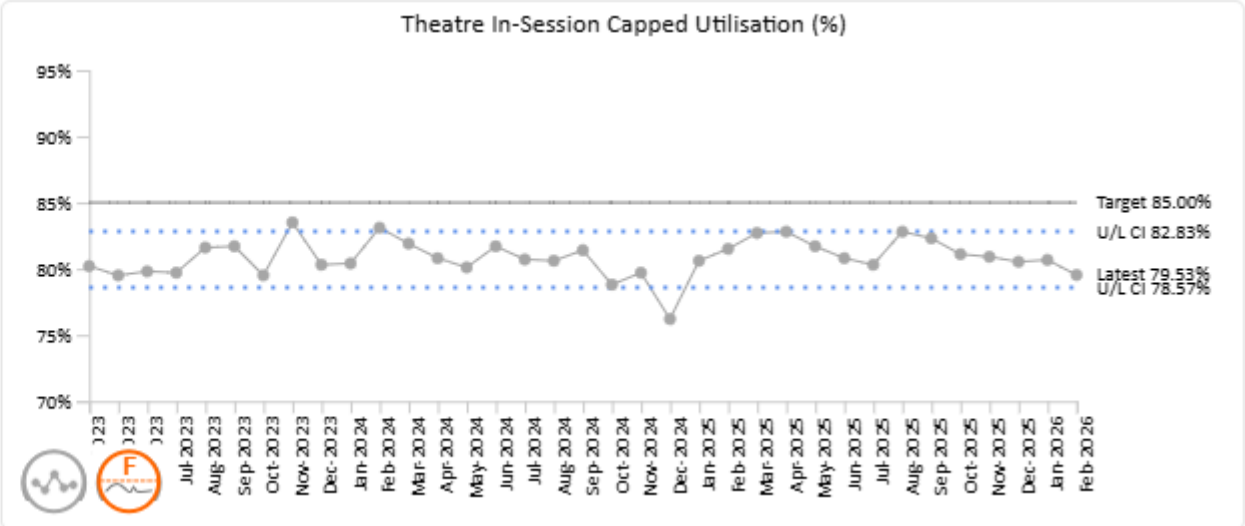



| | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Plan | 615 | 659 | 676 | 731 | 680 | 731 | 777 | 758 | 702 | 739 | 708 | 775 |
| Actual | 672 | 649 | 702 | 670 | 656 | 726 | 689 | 667 | 649 | 627 | 634 | |

| 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 by 21 cases in month and the overall elective income YTD is ahead of plan by circa £260k.<br><br>Day case activity in month is 74 cases behind plan. There is a natural shift in day case procedures to outpatient settings and outpatient procedures continue to overperform YTD by Circa 1,200 cases. | Additional elective activity agreed to support recovery of lost activity YTD.<br><br>Daily review of activity with specialities. | 31.03.2026 | Corporate Risk Register Ref 269 | High |

# Assurance Reports: Theatres



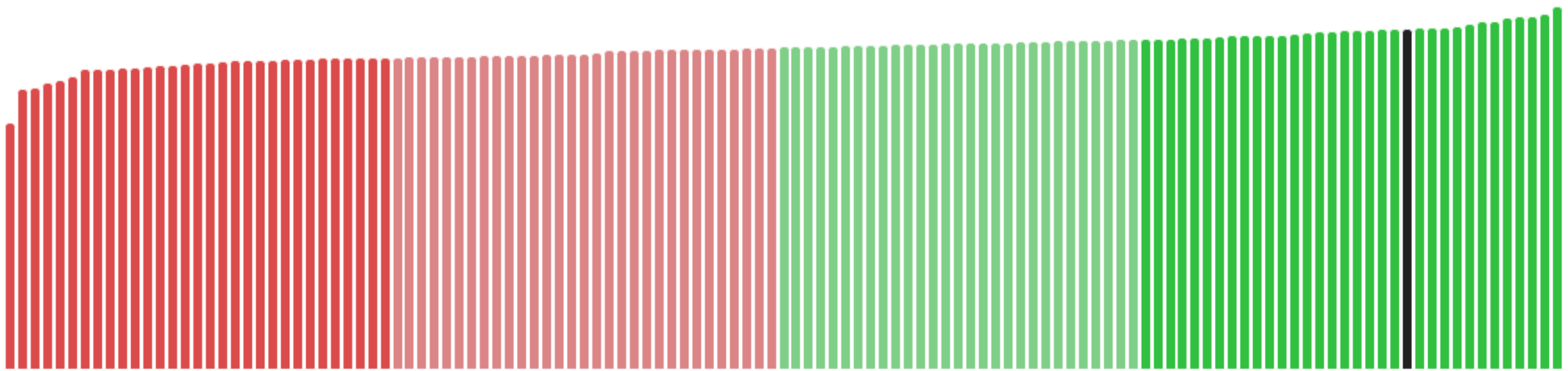

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| February session utilisation was 90.91% with capped theatre utilisation at 79.53% below the 85% cap. However, model hospital data for January 2026 shows performance remains in the top quartile at 84.9%.<br><br>Challenges with theatre staffing continued in February – please refer to slide 7. In addition, the Trust had activity cancelled due to surgeons being unavailable at short notice for instance sickness.<br><br>Theatre 1, 2 and 4 continue to have challenges with temperature and the plant is being monitored regularly. Essential maintenance has been planned for April 2026. | Revised bank rates have been introduced which has seen improvements in staffing rota fill rates in recent weeks. Recruitment of theatre staff ongoing with high numbers of applicants being reviewed for shortlisting. Recruitment programme underway to include Saturday working as per the annual plan agreed at February 2026 Trust Board.<br><br>Theatres 1 2 & 4 are planned to 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. | Planned maintenance in April 2026 | Corporate risk ref:770 | High |

# Assurance Reports: Theatres Benchmarking Model Hospital

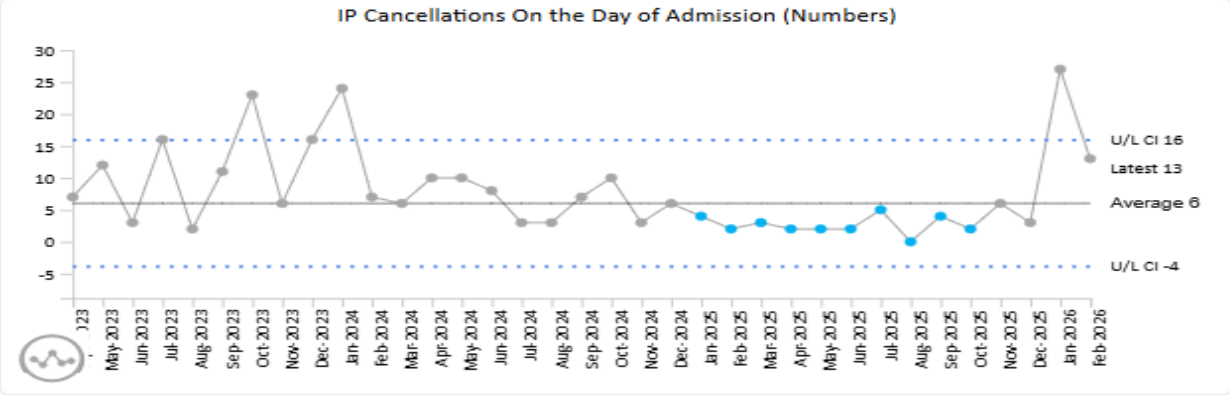
Jan 2026

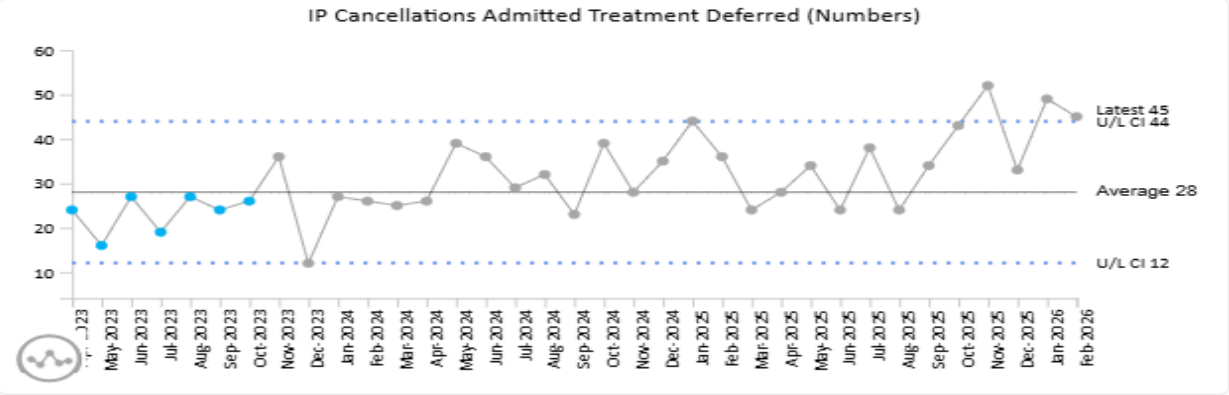
| Provider value | Peer median | Provider median |
|---|---|---|
| Provider Quartile 4 | Provider Quartile 3 | |
| 84.9% | 81.0% | 80.4% |

84.9% is in Provider quartile 4 - Highest 25% [green]



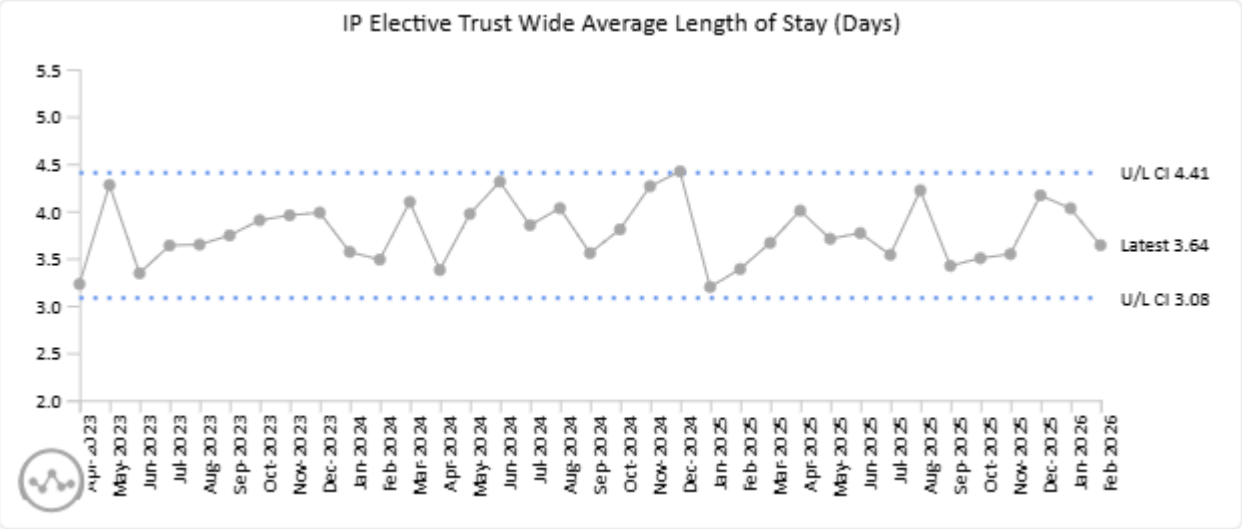
# Assurance Reports: Inpatients continued

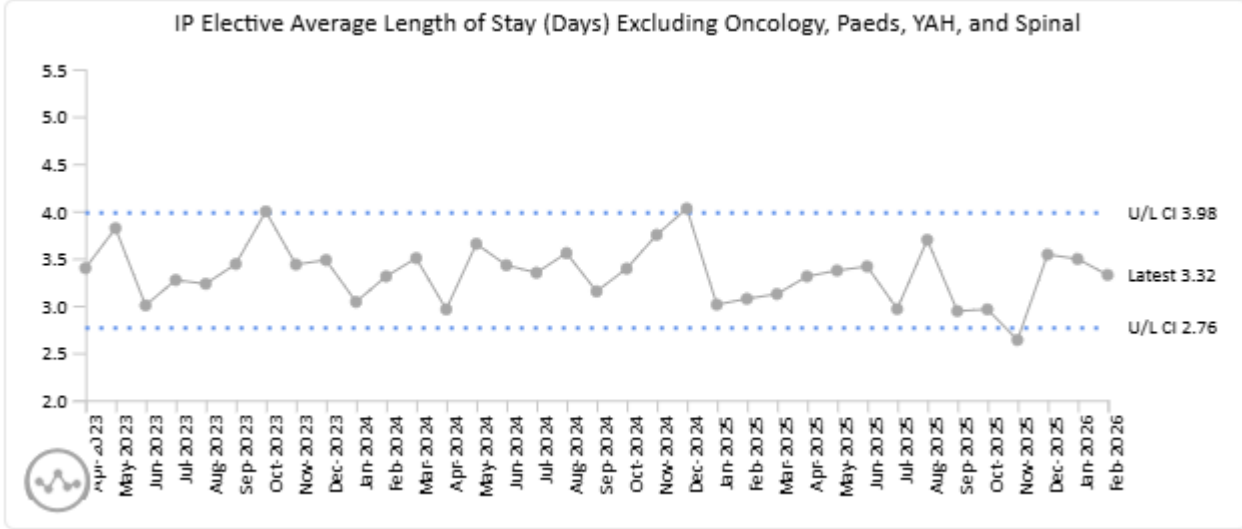



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| During February 2026, 58 patients were cancelled on the day of admission for the following reasons:<br><br>**Cancelled on the day of admission – 13 patients**<br>1 x Replaced by more urgent case<br>1 x Procedure no longer required<br>11 x Change in TCI date (10 x Botox clinic)<br><br>**Admitted on the day with treatment deferred – 45 patients**<br>1 x IT interruption<br>14 x Lack of theatre time (staffing issues) / Surgeon or theatre staff unavailable<br>19 x Medically unfit / skin integrity<br>2 x Patient declined procedure<br>2 x Procedure abandoned<br>6 x Procedure no longer required<br>1 x Replaced by more urgent case | Additional premium rate evening and weekend lists agreed to help reduce the YTD deficit.<br><br>Regular listening events with theatre staff followed by a "you said we did briefing".<br><br>Revised bank rates communicated to staff supported by executive drop-in sessions to encourage improved bank take up to bridge the gap to recruitment.<br><br>Theatre look back meetings continue with lessons learnt captured | Lists offered and booked for March 26<br><br>March 26<br><br>Completed | Corporate Risk Register 269 | High |

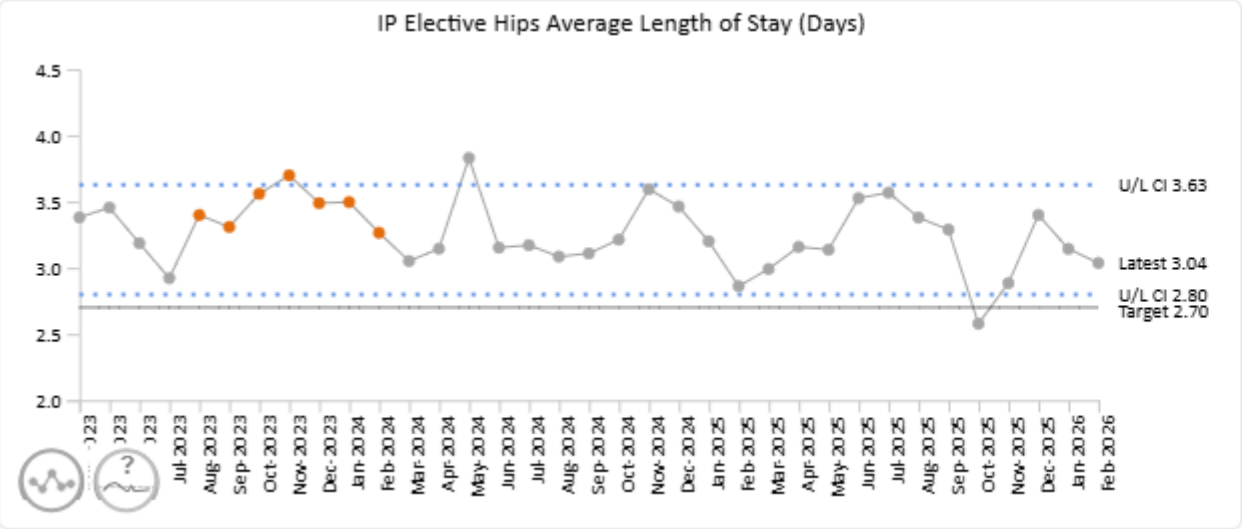
# Assurance Reports: Inpatients

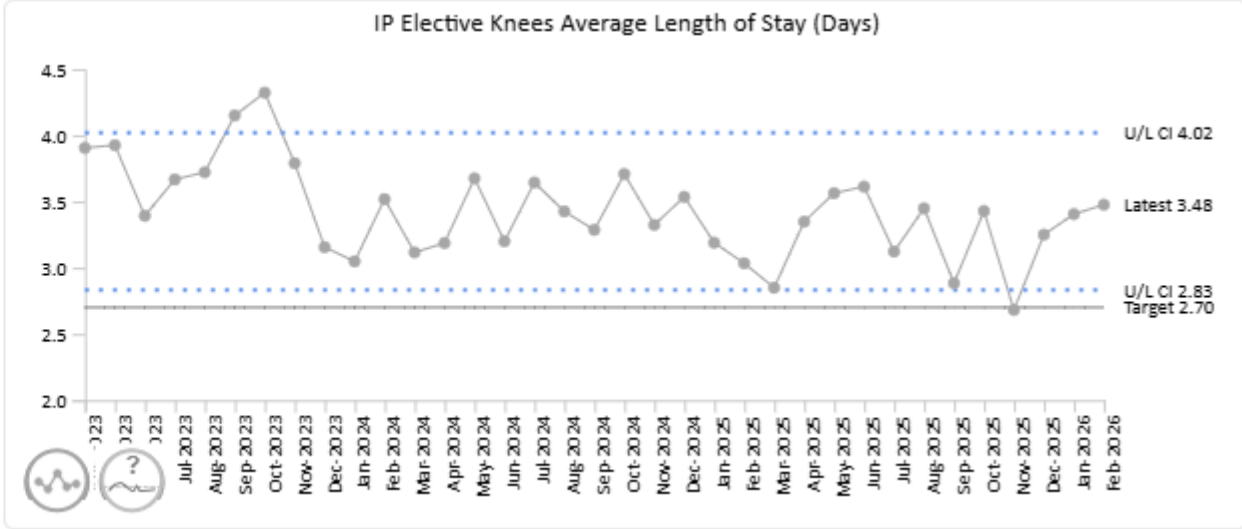



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| Average length of stay for ROH primary hips has decreased at 3.04 days (3.10 Jan 2026) and primary knees has increased to 3.48 days (3.45 Jan 2026). The average length of stay for ROH patients excluding Oncology, Young Adult Hip and Spinal has decreased to 3.32 days (3.59 data).<br>**Primary hips:** 17 (18%) patients had a LOS=> than 5 days<br>4 (4%) patients had a LOS=> than 7 days<br>**Primary Knees**:16 (25%) patients had a LOS=> 5 days<br>4 (6% ) patients had a LOS=> than 7 days<br>Data improvement noted this period- only includes procedures with OPCS descriptions for primary hips and knees.<br>All patients with LOS >7 days reviewed (longest 16 days) had on-going clinical/therapy or social care needs. ASA scores 4 grade 2, 2 Grade 3 and 1 Grade 4 | See next slide | | | |

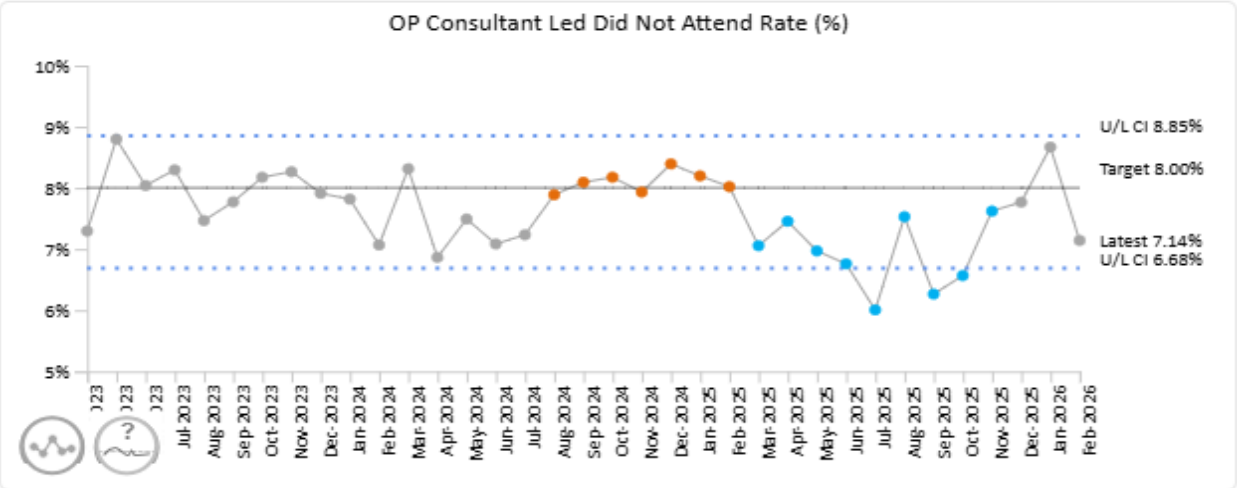
# Assurance Reports: Inpatients continued

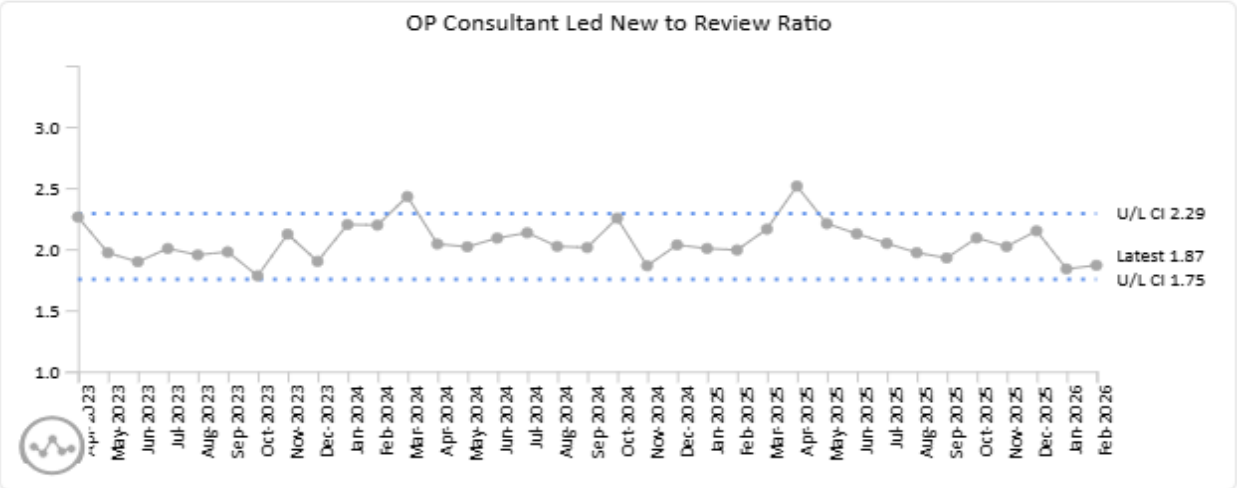



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| ROH patients excluding Oncology, Young Adult Hip and spinal: 11 (5%) had a LOS=>14 days (longest 39). These included EPRs, revisions and amputations.<br><br>2 patients ASA score 2; 7 ASA score 3 and 1 ASA score 4. | | | | |
| Daycase/23-hour pathway principles not embedded. | Progress learning and recommendations identified during the Ambulatory Unit proof of concept project.<br><br>Consider resource need- senior staff and support service availability for elective/sprint Saturday arthroplasty lists to support day case/23-hour principles. | Day case improvement group | No | |
| Consider impact of MRC/BIS on LoS data | Review referral and discharge processes for this group of patients | MRC/BIS leads discuss next MRC meeting 27/3. | No | |

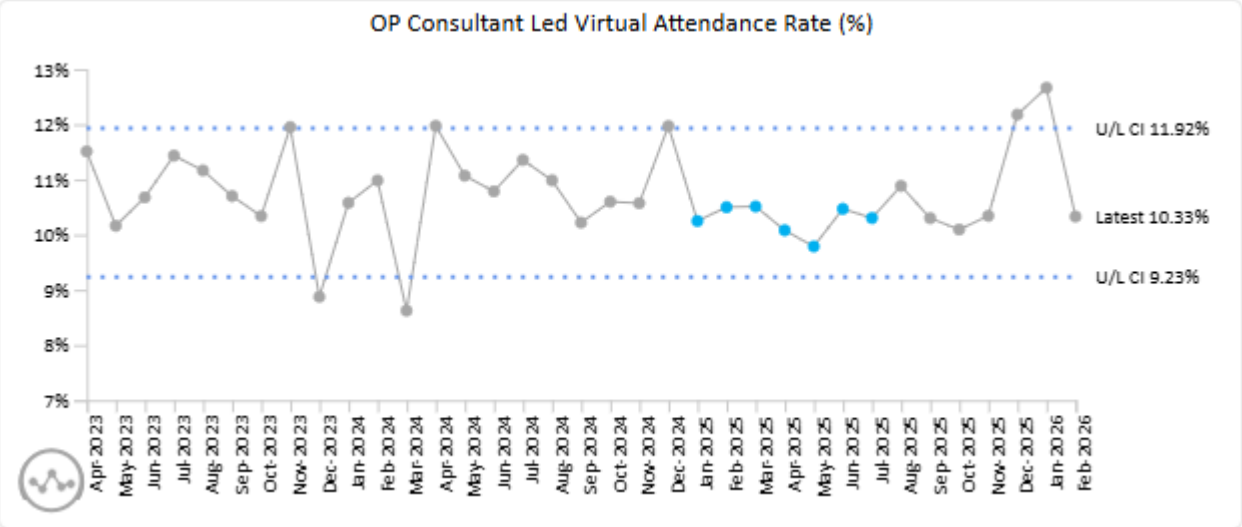
# Assurance Reports: Outpatients

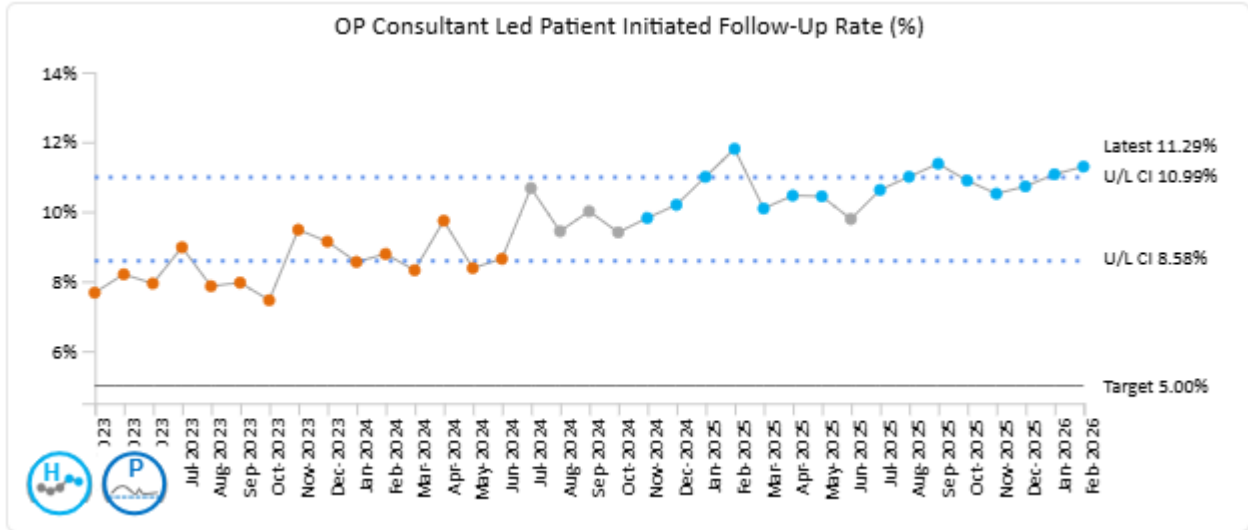



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| The DNA rate for Feb has reduced to 7.14%, following the temporary spike in Jan caused by adverse weather that disrupted patient travel and access. Reminder texts continue to be sent 7 days before face-to-face appointments and 3 days before virtual appointments.<br><br>The new-to-review ratio continues to reduce, reflecting the sustained focus on increasing first outpatient activity to improve access for new patients. This approach supports ongoing efforts to improve RTT 1st outpatient waiting times and reduce overall waiting list pressures. | Implementation of electronic clinic letters will improve patient access to clinic information via the NHS App and this is predicted to help reduce DNAs and cancellations. The letters are due to go live in April 26<br><br>Charities funding is supporting targeted interventions for patients in IMD 1–2, including targeted calls and work to secure subsidised travel. Discussions with National Express are ongoing to offer discounted travel, with a QR code planned for appointment letters. | 30.04.2026<br><br>Bid Submitted 11.03.2026 awaiting outcome | N/A<br><br>N/A | High<br><br>High |

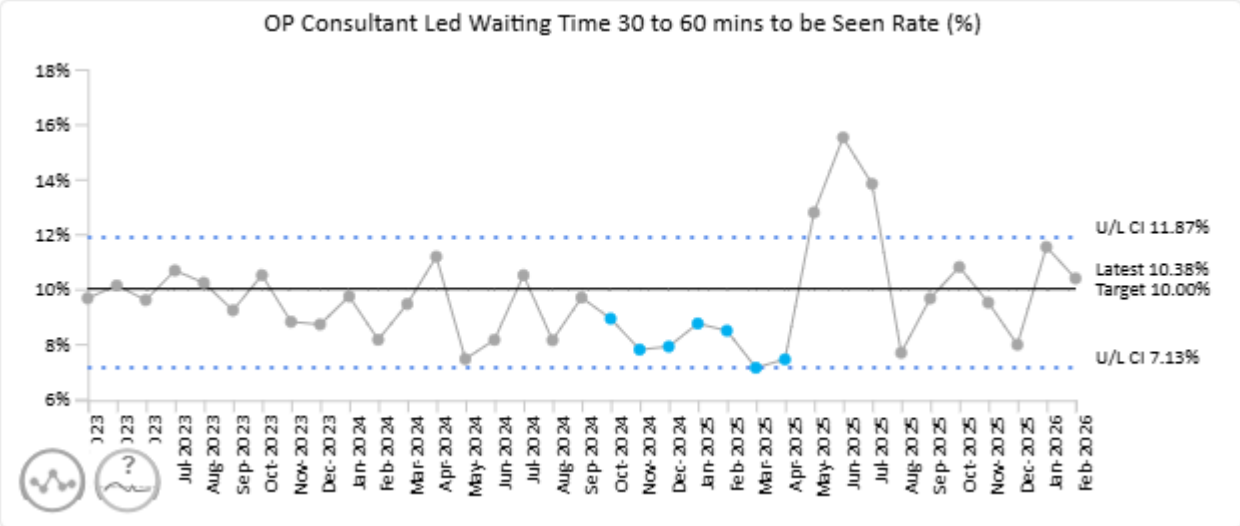
# Assurance Reports: Outpatients continued

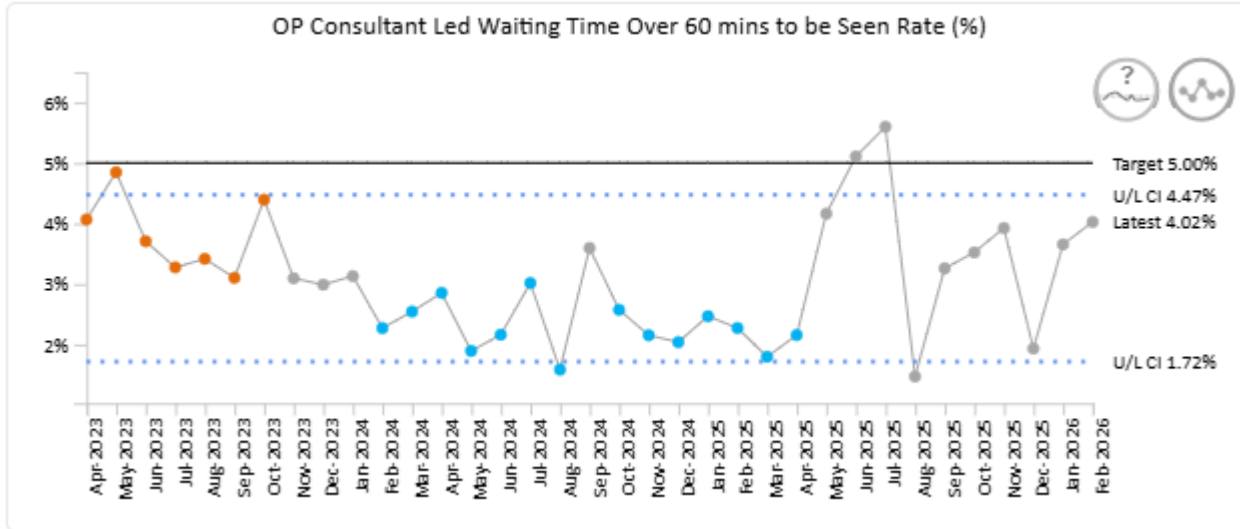



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| Virtual appointments continue to be challenging due to the need for physical examinations in orthopaedic patients, and is a recognised issue following discussions with NHSE regional Transformation colleagues. There has been recent spikes following two months of trialling virtual super-new and discharge clinics that suggests further opportunities to increase the use of virtual appointments. If a patient specifically requests a virtual appointment, the clinical team continues to accommodate patient preference.<br><br>PIFU continues to improve and is 11.29% at Feb month end. | Continued trialling virtual super-new and discharge clinics | April 2026 | N/A | High |

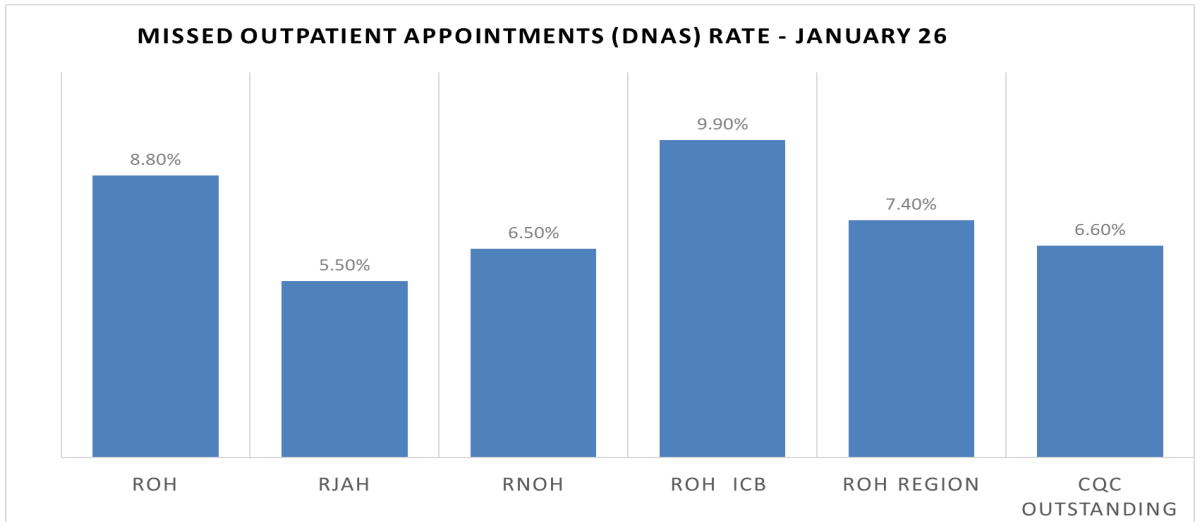
# Assurance Reports: Outpatients continued

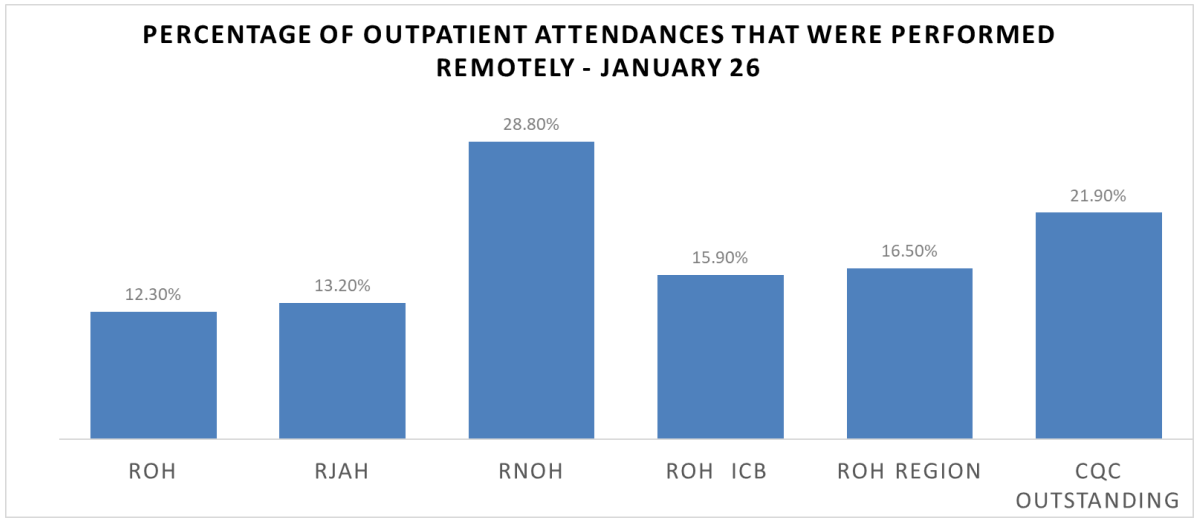


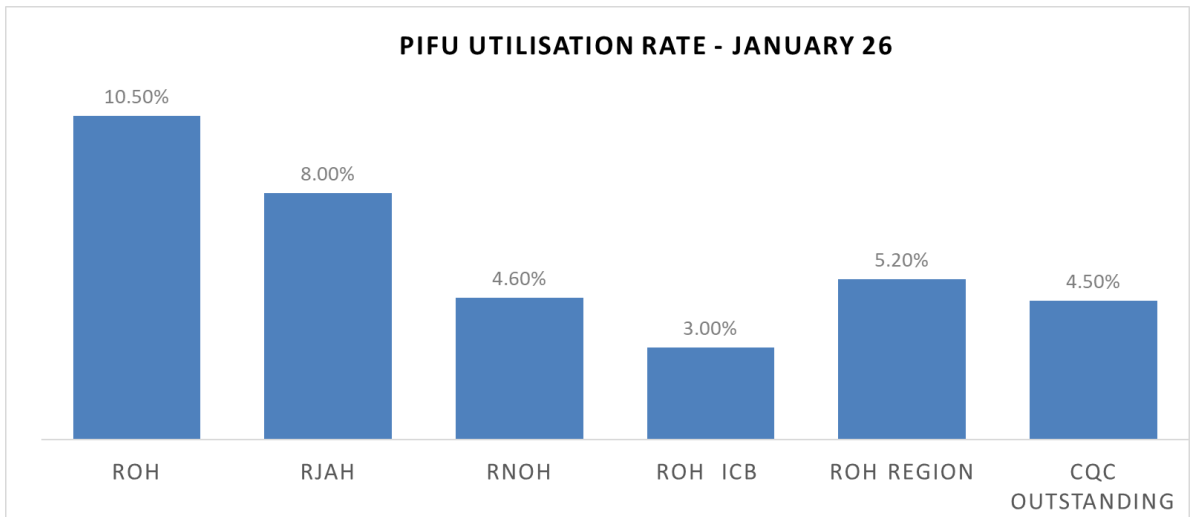



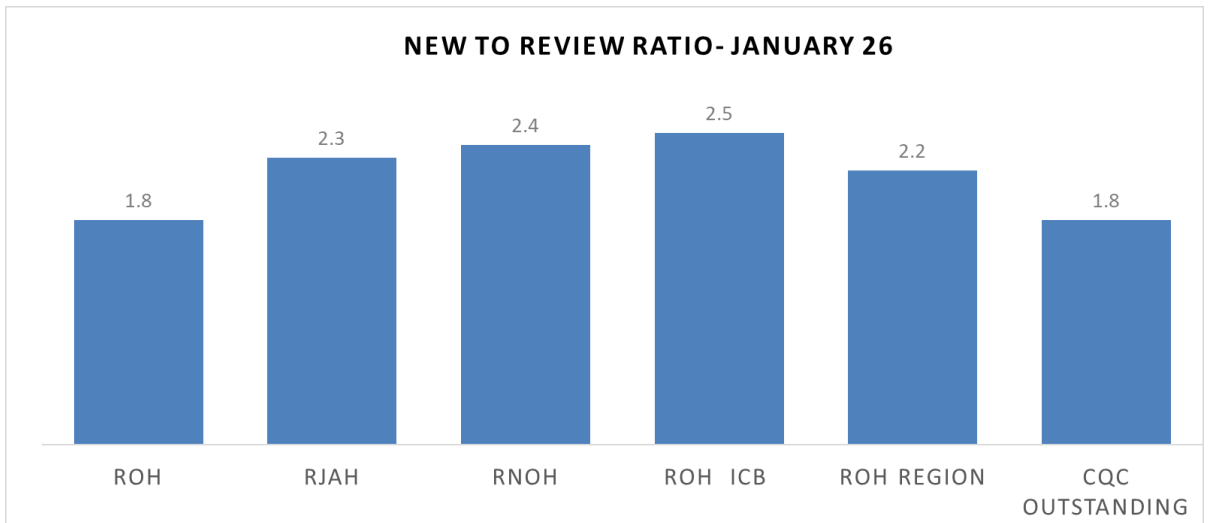

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| During February, the 30–60 minutes waiting time KPI recorded was 10.38%. This reflects an improvement on January reported figures and is slightly above the Trust KPI of 10%.<br><br>The over 60-minute waiting time KPI was 4.02%, remaining below the 5% threshold.<br><br>In February, delays were primarily linked to temporary X-ray capacity issues, with one room unavailable for part of a day due to an IT fault. This coincided with a sprint clinic with a higher reliance on Imaging. The issue was resolved within a few hours, limiting the overall impact on performance. | N/A | N/A | N/A | High |

# Assurance Reports: Outpatients Benchmarking Model Hospital

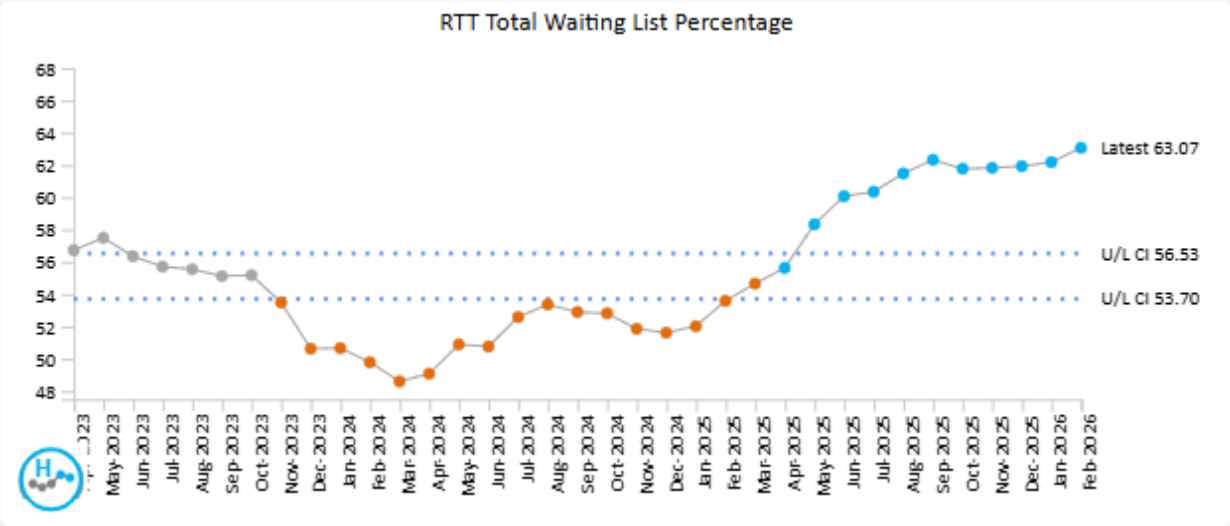


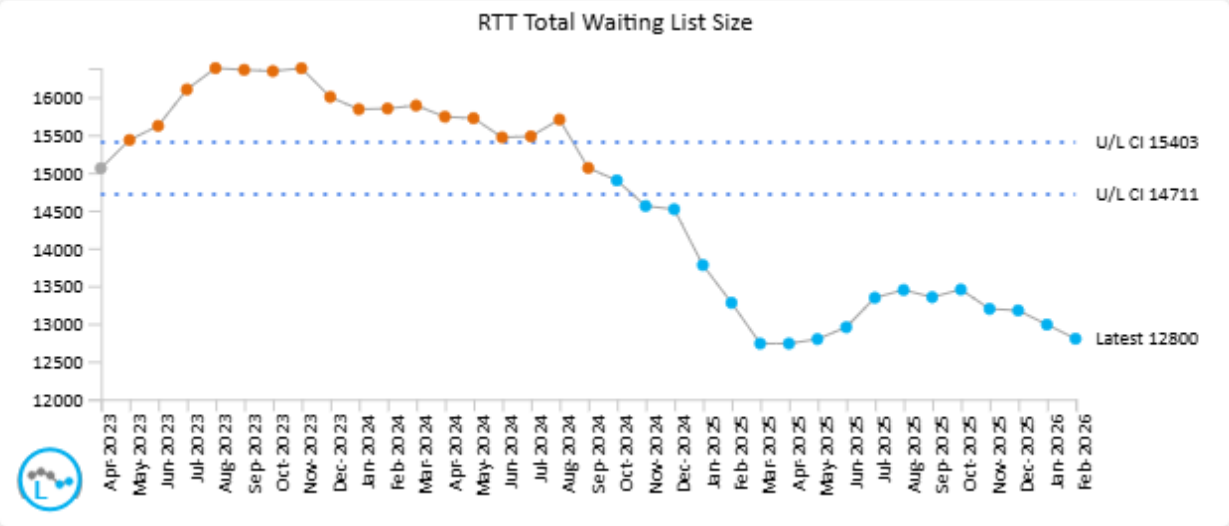



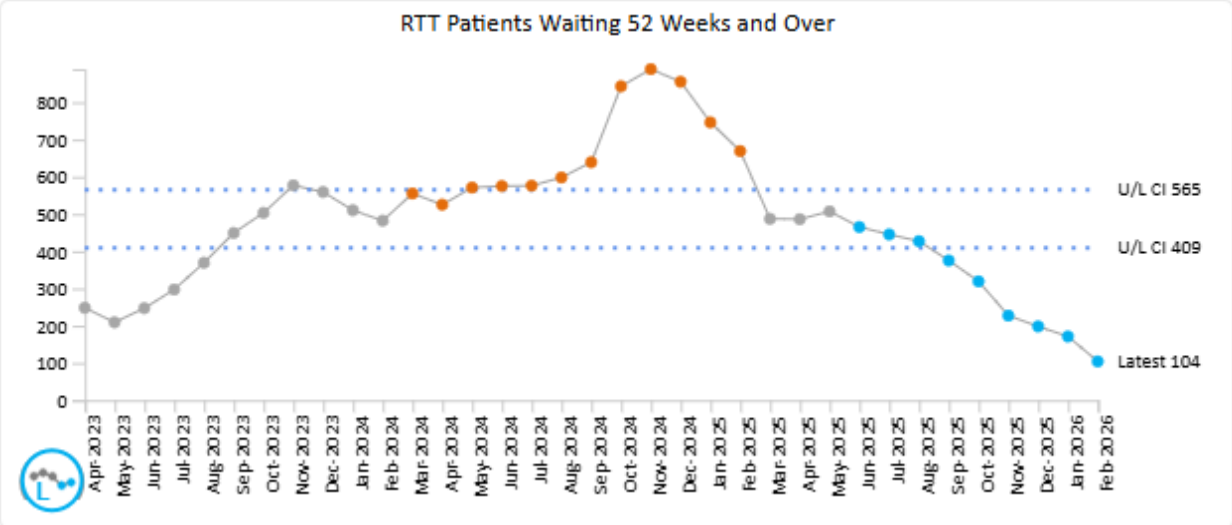
# Assurance Reports: Referral to Treatment

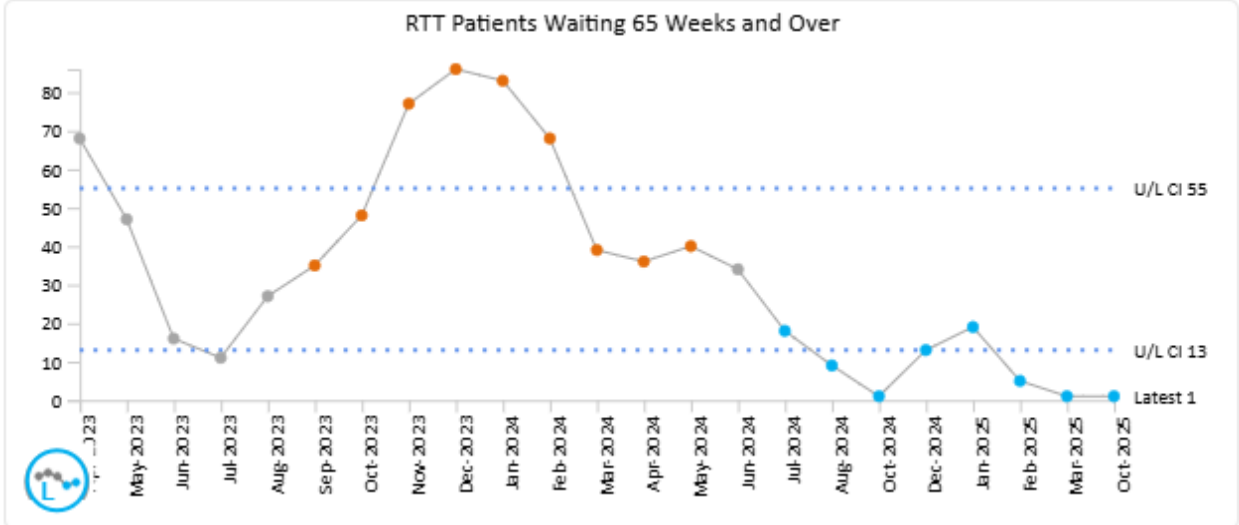



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| The total waiting list percentage position has increased to **63.07%.** The performance remains **ahead of the required trajectory** to deliver **60.32% by the end of March 2026**. The sprint target of 63% has been delivered 1 month early and the team are striving to improve on this position by 31st March 2026..<br><br>The total waiting list size position stands at **12,800** which is ahead of the monthly target of **13,138**. The Trust remains on track to deliver the required target of **13,016 by the end of March 2026**. Current performance provides assurance that the target will be delivered 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.<br><br>A daily sprint RTT meeting supported by the COO or Deputy COO is in place for March 26 to maximise performance | Weekly PTL Meetings<br><br>Weekly Divisional Operations Meeting<br><br>Monthly Divisional Management Board<br><br>Monthly Operations Management board<br><br>31.03.2026 | n/a | High |

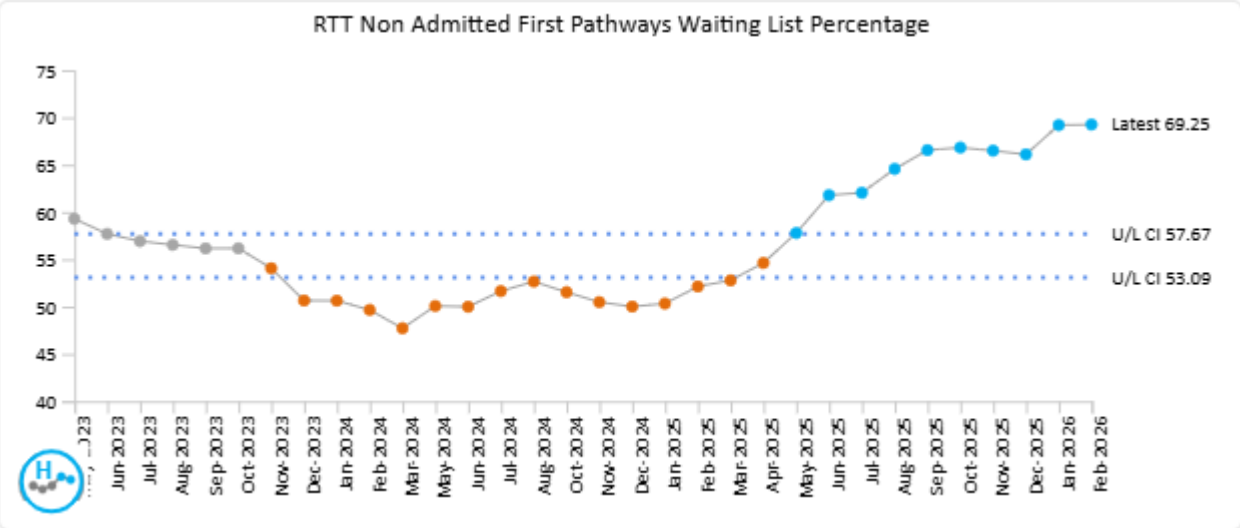
# Assurance Reports: Referral to Treatment continued

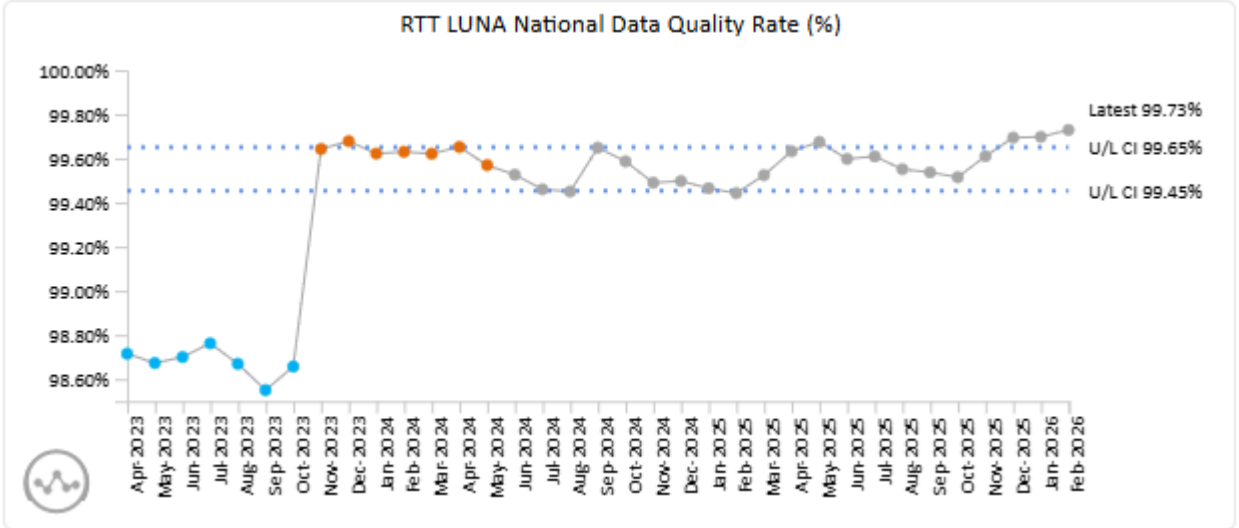



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| The number of patients waiting 52 weeks and over for treatment stands at **104**, which is significantly ahead of the monthly target of **175.** The Trust is still on track to exceed the required target of no more than **130** patients by the end of March 2026.<br><br>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.<br><br>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<br><br>Weekly Divisional Operations Meeting<br><br>Monthly Divisional Management Board<br><br>Monthly Operations Management board | Corporate Risk Register Ref 2146 | High |

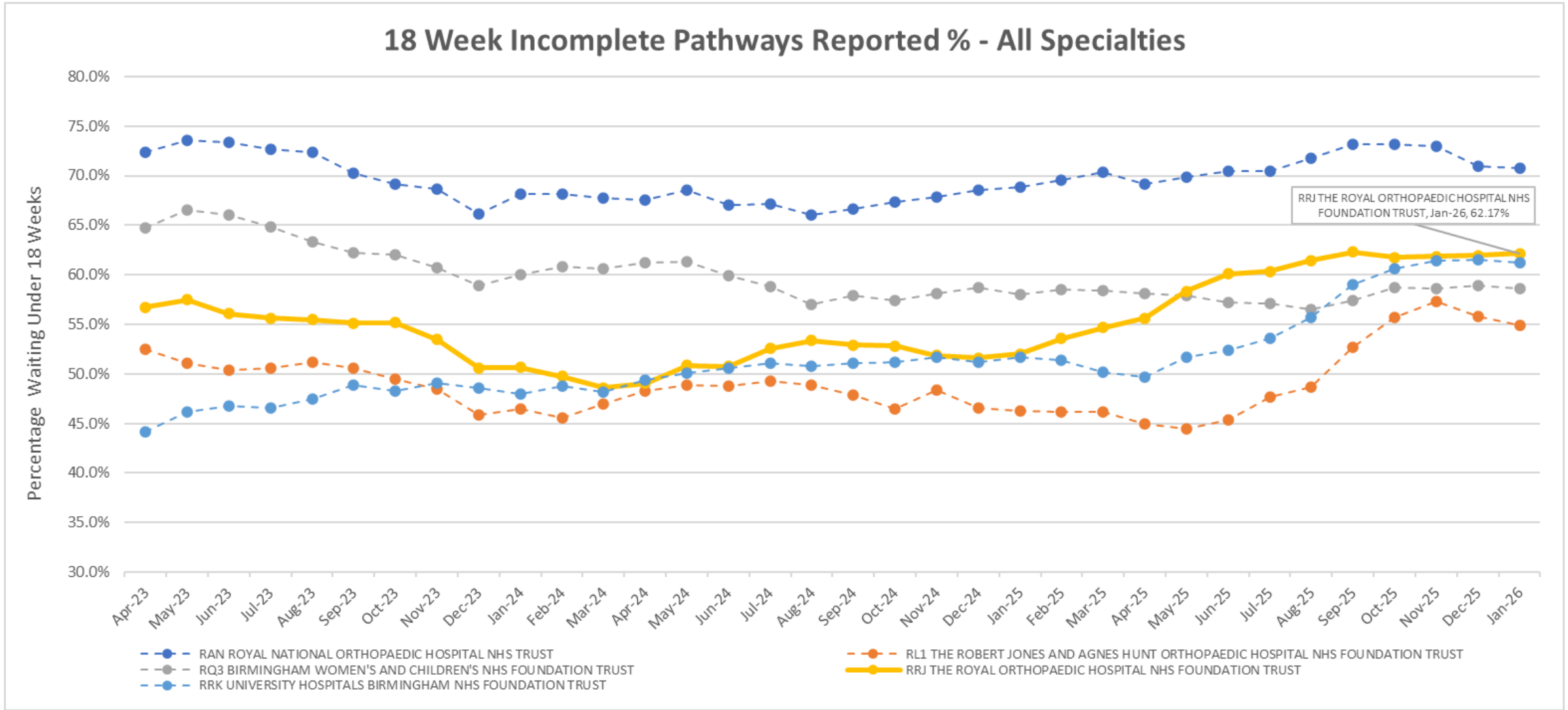
# Assurance Reports: Referral to Treatment continued



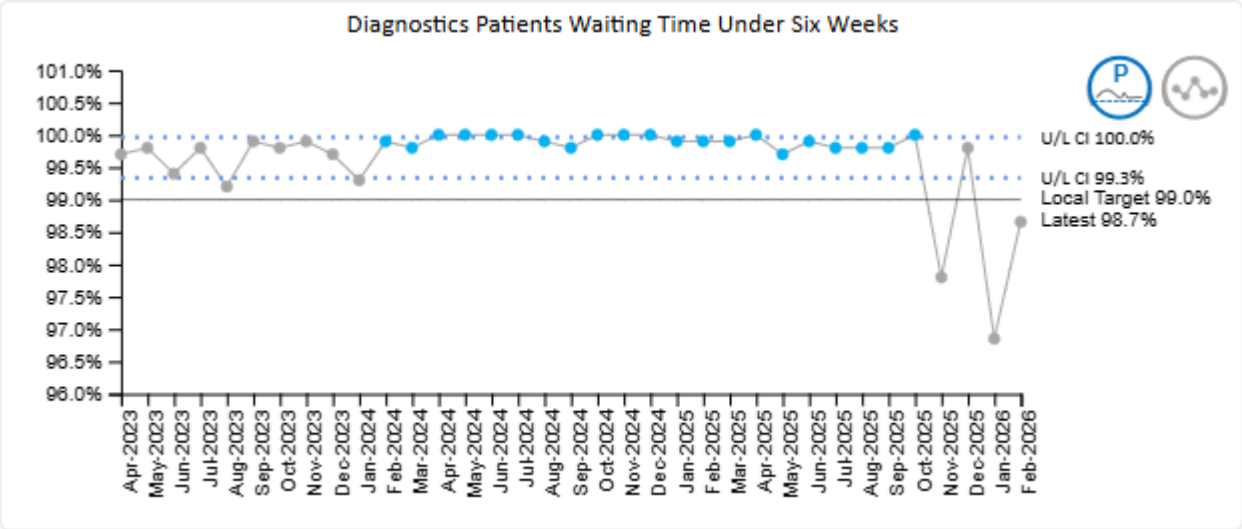



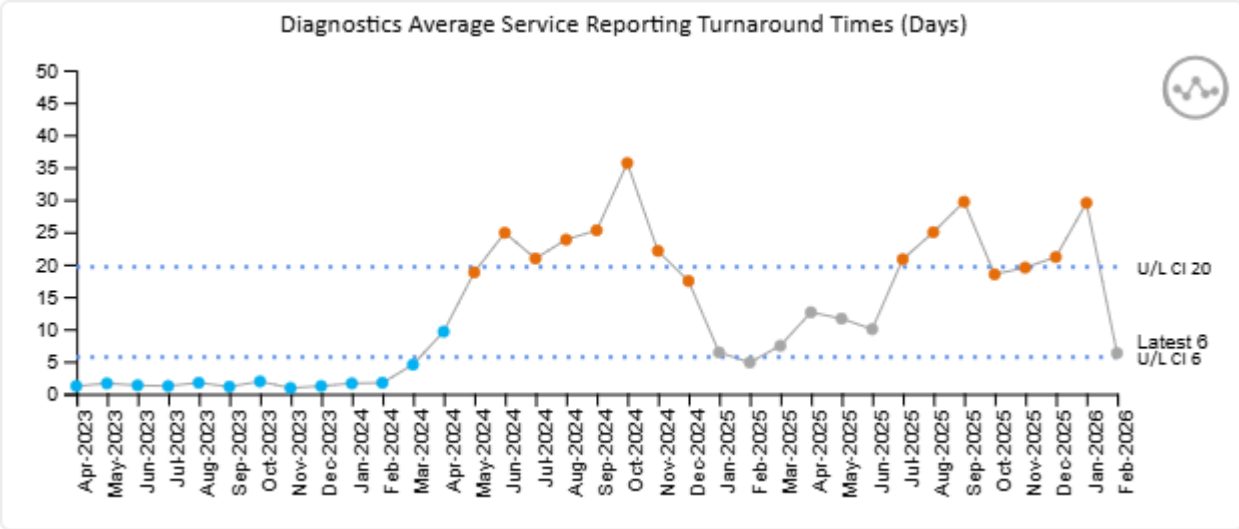

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| The actions taken last month to increase capacity with super virtual clinics has delivered a 3% improvement from the previous month. The RTT first waiting list percentage position now stands at 69.25%, performance is ahead of the monthly target of 66.73% and the national target of 67%.<br><br>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 **99%**, exceeding the **90%** target. | Working with service leads to ensure that capacity is optimised, and further planning of super virtual clinics for February and March. | Weekly PTL Meetings<br><br>Weekly Divisional Operations Meeting<br><br>Monthly Divisional Management Board<br><br>Monthly Operations Management board<br><br>Weekly Strategic Oversite Group | N/A | High |

# Assurance Reports: Referral to Treatment Benchmarking Model Hospital



# Assurance Reports: Diagnostics



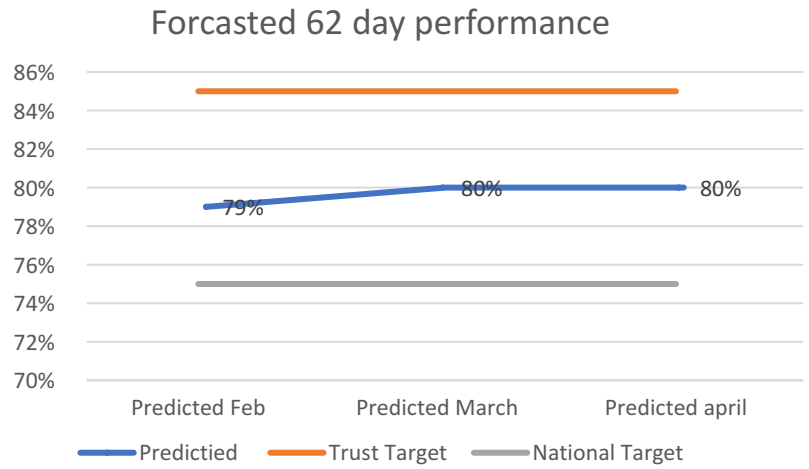




| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| Diagnostics achieved 98% in February just below the internal stretch target of 99% but still above the national target of 95%. The expectation is that this will be back to Trust target in March 2026.<br><br>Reporting turnaround times for routine images has decreased, remaining within 6 weeks for routine imaging. YAH reporting continues to have the longest turnaround due to specialist report required and inability to outsource.<br><br>Mobile CT scanner works continue and remain on track for completion end of March 2026. | Regular review of waiting times to continue to exceed national target<br><br>Regular review of reporting times while supporting RTT targets. Capacity and demand modelling being undertaken to ensure reporting time in job plans is allocated and utilised fully. 2 Consultant Radiologists have been appointed due to commence in April 2026.<br><br>Work closely with Radiologists & Anaesthetists to ensure lists run smoothly and are booked to full capacity whilst maintaining patient safety.<br><br>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<br><br>Services should resume to normal w/c 06/04/2026 on new CT scanner. | N/A<br><br>2082<br><br>2177 | High |

# Assurance Reports: Cancer

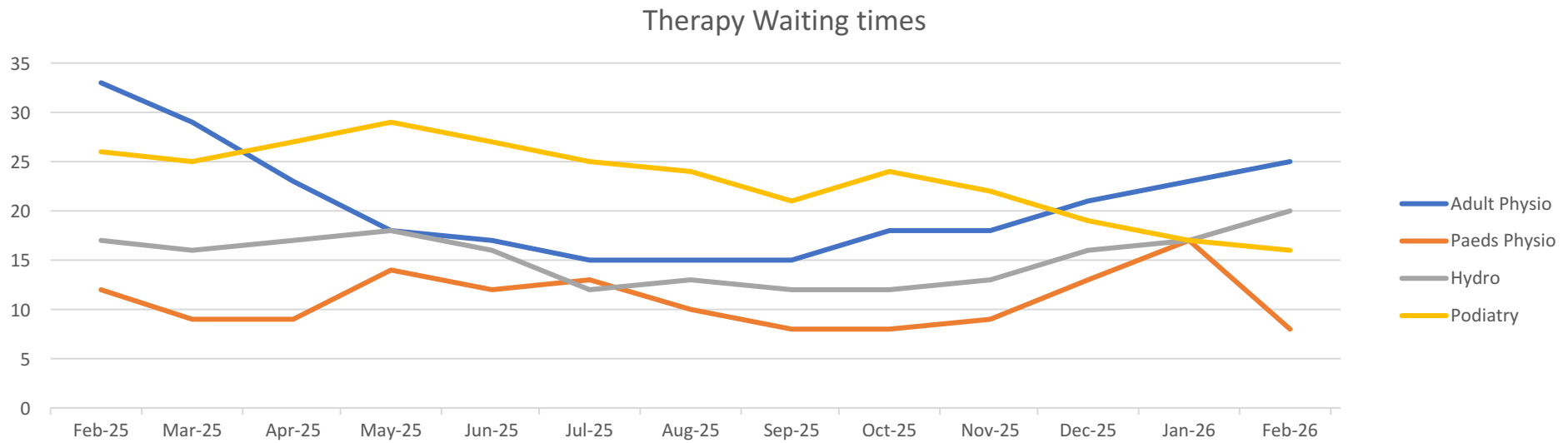
## January 26 Performance – February 26 Submission

| Target Description | Patients | Compliant | Breach | Total Accountable | % | Target |
|---|---|---|---|---|---|---|
| 31 Day | 18 | 18 | 0 | 18 | 100% | 96% |
| 62 Day | 6 | 4.5 | 1.0 | 6 | 81.8% | 75% |
| 28 Day FDS | 80 | 59 | 21 | 80 | 73.8% | 77% |
| 104 days treated at ROH | 0 | | | | | |



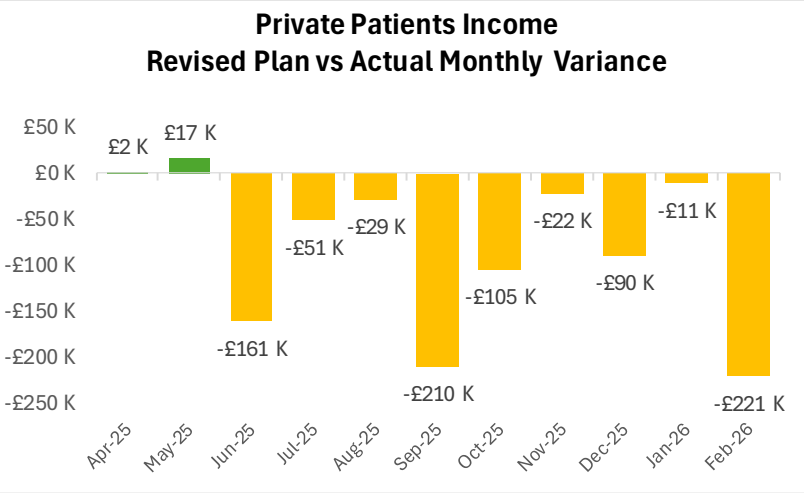

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| The Trust's Faster Diagnostic standard was not met due to continued challenges with Histopathology services provided by UHB. Improvements are 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.<br><br>Weekly escalation to regional team at the system oversight group (SOG)<br><br>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<br><br>Weekly SOG report<br><br>Cancer Board monthly<br>Division 1 Cancer PTL meeting weekly<br>Oversight at weekly senior leadership team meeting. | Corporate Risk Register Ref 1893 | High |

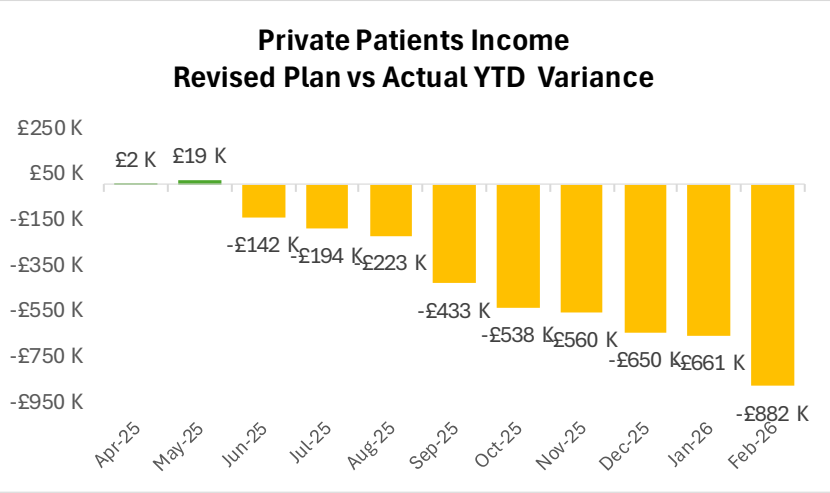
# Assurance Reports: MSK Non-Consultant led services

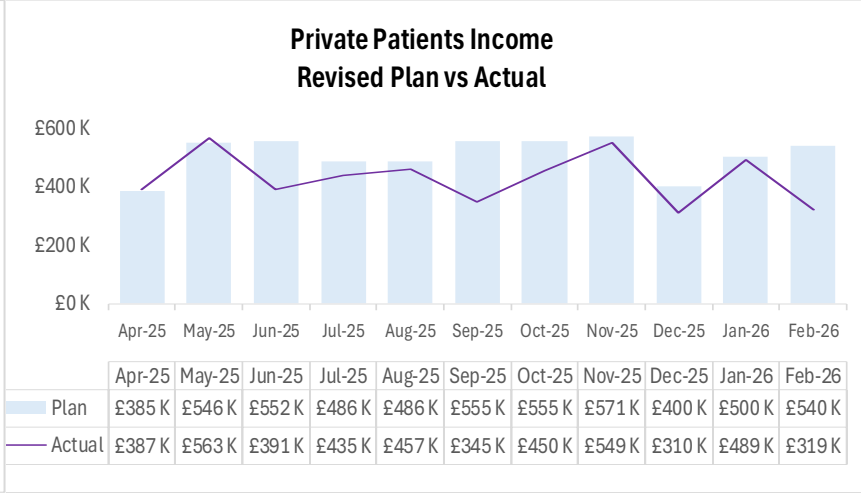



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| Adult Physio waiting times continuing to increase due to workforce challenges and increased referral numbers. Further turnover of staff due to staff progression.<br><br>Paediatric Physio and Hydro waits have increased due to current vacancies and sickness. Challenges with Hydrotherapy capacity due to sickness and A/L.<br><br>Podiatry waits continuing to gradually reduce due to the use of temporary staffing. | Ongoing temporary Assessment clinics in place to support adult demand. Digital self-referral via GetUBetter – pilot with College Green Medical Practice going well. Strength and Conditioning Practitioner and Education / Physio split posts approved through VCP.<br><br>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. Paediatric Team Leader interview due in March and bank currently in use. Further recruitment to be requested and vacancies to be put forward to VCP.<br><br>Temporary staff remains necessary in Podiatry to help reduce waiting times. | Ongoing weekly monitoring and move of resources to support demand and trust targets.<br><br>Self referral via GUB pilot due roll out to other practices in April.<br><br>Recruitment processes underway for several posts.<br><br>Reports to DMB and OMB for oversight. | No. 1573<br>Div 2 - Physio<br>Divisional risk | High |

# Assurance Reports: Private Patients



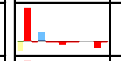
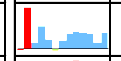
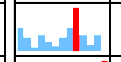
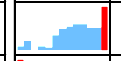
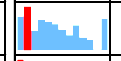
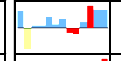
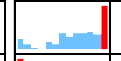
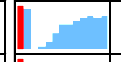
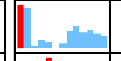
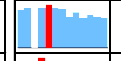
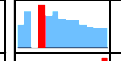
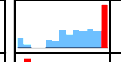
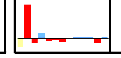




| | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Plan | £385 K | £546 K | £552 K | £486 K | £486 K | £555 K | £555 K | £571 K | £400 K | £500 K | £540 K |
| Actual | £387 K | £563 K | £391 K | £435 K | £457 K | £345 K | £450 K | £549 K | £310 K | £489 K | £319 K |

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance | Risk Register | Data Quality |
|---|---|---|---|---|
| Private patient activity and income for February was below the planned trajectory. Total income for the month was £318,971 against a planned position of £540,000.<br>A number of factors contributed to this variance. Patient cancellations accounted for £76,939 of lost income, with reasons including insurance authorisation not being approved, lack of amenity bed availability, patient choice, and patients becoming medically unfit prior to admission.<br><br>In addition, two planned weekend arthroplasty lists were not scheduled, which would have generated approximately £100,000 of additional income.<br><br>During February 26 there was no weekend theatre availability for additional private patient lists, linked to the ongoing staffing and pay arrangements affecting weekend theatre capacity at that time. | The service continues to pursue opportunities to recover activity, where possible, however the return of previously lost consultant activity and continued access to weekend theatre capacity will be important factors in improving the income trajectory.<br>• Additional weekend spinal lists have now been scheduled in March to maximise available theatre capacity and partially recover activity.<br>• The service is actively engaging with consultants to identify opportunities to bring forward or provide additional private patient lists, where capacity allows.<br>• Continued engagement with Prof Davis to explore the conditions required for the return of his private activity to the Trust.<br>• Monitoring cancellation patterns to identify whether any additional pre-operative confirmation processes could reduce late cancellations and protect theatre utilisation. | **Action Timescale:**<br>March 2026, weekend spinal lists scheduled to maximise theatre utilisation and recover activity where possible.<br><br>Engagement with consultants to identify opportunities to bring forward or provide additional private operating lists where capacity allows. | Risk 2164<br>Risk 2169 | High |

# Integrated Performance Dashboard: Finance

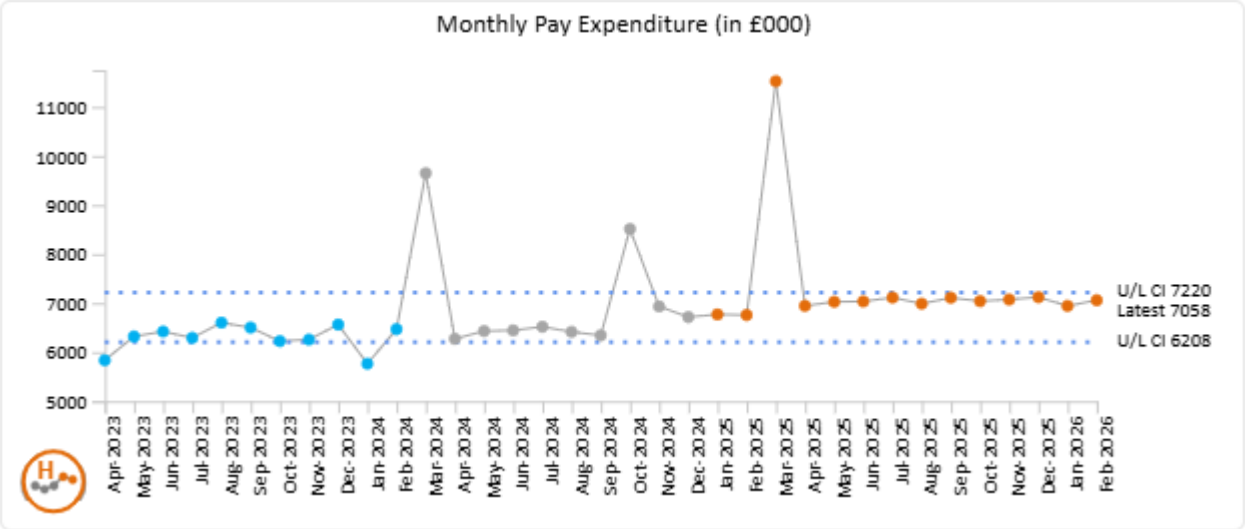
| Metric Grouping | Metric Name | Reporting Period | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | YTD | Trend | Direction of Travel | Latest Variation Monthly | Latest Assurance Target | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Finance | I&E Margin (%) | Monthly | (6.20%) | 11.40% | (3.30%) | 3.30% | (2.10%) | (0.90%) | (2.50%) | (0.10%) | 0.90% | 0.40% | 0.46% | (3.70%) | 0.10% | (0.70%) |  | high is good | - | - | -1% |
| Finance | I&E Variation from Plan | Monthly | (707) | 2,357 | (102) | 635 | (71) | (110) | (220) | (64) | (64) | 2 | 9 | (505) | (74) | (564) |  | low is good | - | - | 0 |
| Finance | EBITDA (%) | Monthly | (0.90%) | 15.10% | 2.30% | 8.40% | 3.40% | (1.10%) | 3.00% | 5.20% | 6.20% | 5.70% | 5.20% | 2.00% | 5.60% | 4.70% |  | high is good | - | - | 4% |
| Finance | CIP Value | Monthly | 691 | 553 | 409 | 575 | 484 | 418 | 549 | 683 | 961 | 581 | 441 | 582 | 352 | 6,035 |  | high is good | - | - | 3,052 |
| Finance | CIP Plan (don't show) | Monthly | 546 | 620 | 494 | 544 | 538 | 694 | 782 | 804 | 835 | 835 | 797 | 797 | 1073 | 8,193 |  | | - | - | 9,447 |
| Finance | CIP Performance | Monthly | 126.54% | 89.12% | 82.79% | 105.70% | 89.96% | 60.23% | 70.20% | 84.95% | 115.09% | 69.58% | 55.33% | 54.20% | 67.20% | (2,158) |  | high is good | - | - | 0 |
| Finance | Agency Expenditure | Monthly | 126 | 140 | 105 | 121 | 117 | 115 | 106 | 99 | 113 | 95 | 92 | 77 | 123 | 1,163 |  | low is good | - | - | 752 |
| Finance | Agency % of total pay bill | Monthly | 1.90% | 1.20% | 1.50% | 1.70% | 1.70% | 1.60% | 1.50% | 1.40% | 1.60% | 1.30% | 1.30% | 1.10% | 1.70% | 1.50% |  | low is good | - | - | 1.6% |
| Finance | Capital - Variation to Plan (including impact of IFRS 16) | Monthly | 408 | (507) | 65 | 65 | 275 | 111 | 245 | (121) | (140) | 167 | 551 | 445 | 453 | 2,185 |  | low is good | - | - | 1,128 |
| Finance | Cash Balance at end of month | Monthly | 5,570 | 3,293 | 1,578 | 835 | 4,034 | 3,258 | 8,158 | 6,696 | 8,484 | 8,528 | 8,653 | 7,701 | 21,336 | 16,802 |  | high is good | - | - | 4,976 |
| Finance | BPPC Invoices Paid < 30 days (Volume %) | Monthly | 83.70% | 82.80% | 72.20% | 73.00% | 74.10% | 76.50% | 78.70% | 78.70% | 79.60% | 80.40% | 81.20% | 80.40% | 81.00% | 81.00% |  | high is good | - | - | 100% |
| Finance | BPPC Invoices Paid < 30 days (Value %) | Monthly | 79.40% | 78.30% | 67.10% | 68.50% | 67.90% | 66.10% | 67.60% | 71.20% | 72.90% | 71.10% | 71.70% | 70.70% | 69.90% | 69.90% |  | high is good | - | - | 100% |
| Finance | Creditor Days | Monthly | 105 | 113 | 0 | 113 | 121 | 113 | 108 | 89 | 99 | 85 | 95 | 89 | 86 | 101 |  | low is good | - | - | 30 |
| Finance | Debtor Days | Monthly | 35 | 55 | 0 | 64 | 48 | 54 | 43 | 41 | 42 | 35 | 32 | 30 | 30 | 42 |  | low is good | - | - | 30 |
| Finance | Operating Expenditure Days | Monthly | 14 | 6 | 0 | 2 | 11 | 9 | 23 | 17 | 23 | 22 | 24 | 21 | 54 | 21 |  | high is good | - | - | n/a |
| Finance | I&E Surplus / (Deficit) (£k) | Monthly | (688) | 2,490 | (377) | 402 | (242) | (164) | (291) | (17) | 102 | 51 | 40 | (409) | 7 | (898) |  | high is good | - | - | (803) |

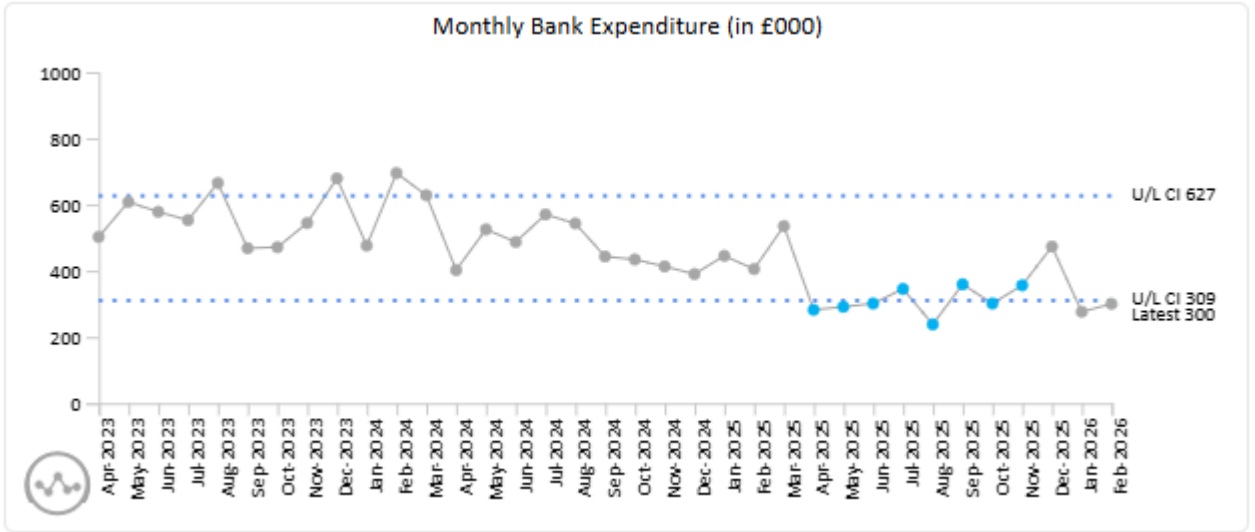
# Assurance Reports: Finance Commissioner Income

| | Actual | Plan | Variance |
|---|---|---|---|
| Day Cases | £10,338,065 | £12,739,131 | -£2,401,067 |
| Elective | £32,693,453 | £32,432,008 | £261,445 |
| Excess bed days EL | £793,679 | £1,075,546 | -£281,867 |
| Outpatient FA Single Professional Consultant Led | £4,295,438 | £4,389,786 | -£94,348 |
| Outpatient FA Single Professional Consultant Led Non Face to Face | £303,408 | £427,074 | -£123,666 |
| Outpatient Procedures FA | £173,659 | £122,373 | £51,286 |
| Outpatient Procedures FUP | £528,572 | £713,489 | -£184,917 |
| **Elective variable** | **£49,126,274** | **£51,899,407** | **-£2,773,134** |
| **Diagnostic variable** | **£1,753,320** | **£2,573,235** | **-£819,915** |
| **Total** | **£50,879,594** | **£54,472,642** | **-£3,593,048** |

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance | Risk Register | Data Quality |
|---|---|---|---|---|
| There is a net underperformance against payment cap limit of £556k in month and £3.1m year to date which has been included within the year-to-date position.<br>An improvement in the year to date position of £165k has been seen as a result of included income related to activity corrections and additions which have occurred after the income reporting cut off date. This income is at risk as this is outside of the contractual obligations of commissioners.<br>The financial risk for overperformance against cap total £954k with Hereford and Cov ICBs overperforming to date. Conversely, BSOL , Staffordshire, Black Country and Spec comm underperforming by £3.5m.<br>The position presents two principal risks:<br>• A delivery risk where underperformance against plan may not be recoverable in full in the remaining months of the financial year<br>• A contractual risk where commissioner payment caps limit income recovery despite activity delivery<br>Payment cap performance is being actively managed on a commissioner basis. Focus is being given to commissioners where overperformance against cap could result in non-payment, and where underperformance may indicate demand or pathway issues requiring corrective action | A focused recovery and assurance programme is in place, including:<br>• Detailed review of the Month12 income trajectory to assess delivery risk against forecast<br>• Scenario modelling to identify achievable recovery<br>• Review of elective and outpatient activity profiles to optimise income recognition<br>• Refinement of outpatient first attendance and procedure throughput assumptions to reflect agreed recovery<br>• Strengthened triangulation of activity, workforce capacity and income to ensure forecast robustness | - Income recovery trajectory agreed at FDB on 20/01 | n/a | High |

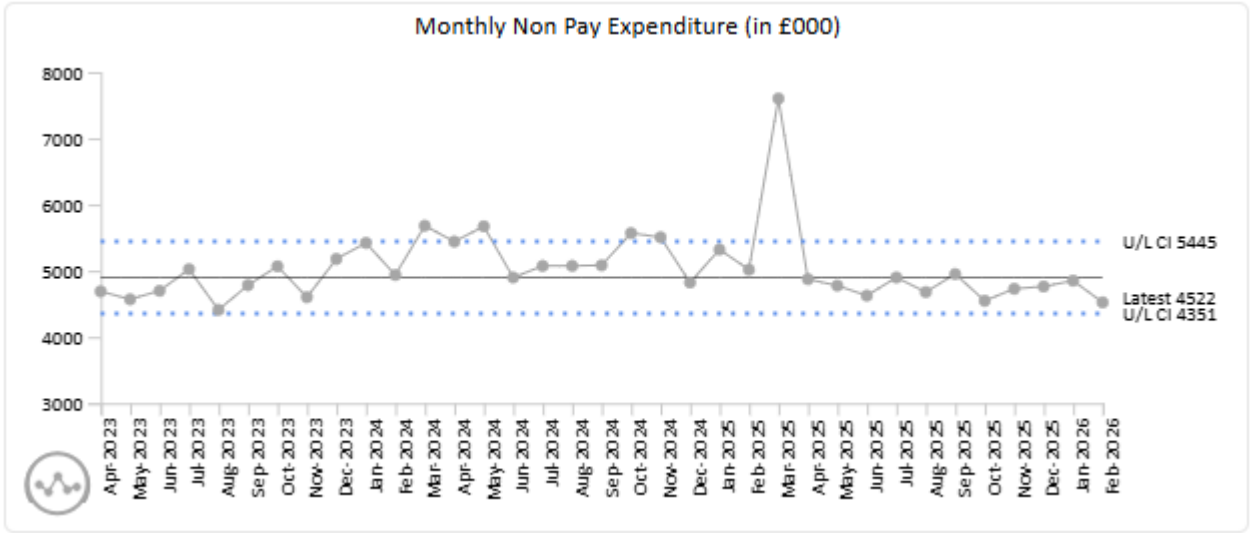
# Assurance Reports: Finance Pay Expenditure



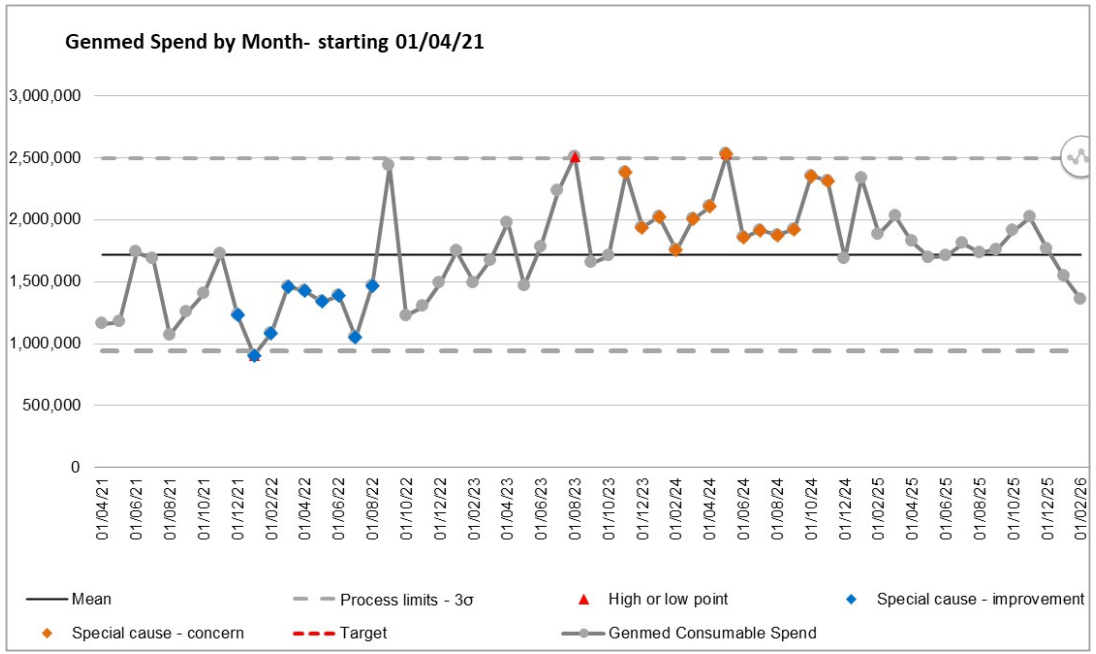

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| Pay expenditure is overspent by £1.4m YTD. Agency spend reduced in month, being 1.5% of paybill year to date, with an underspend of £299k YTD. Bank expenditure has increased compared to last month contributing towards a YTD overspend of £209k. | • Detailed review of bank expenditure against agreed reduction trajectories, with divisional accountability for delivery<br>• Implementation of additional workforce controls to support pay stabilisation, including enhanced scrutiny of shift approvals and premium usage<br>• Deep dive review of Cost Improvement Programme schemes impacting pay to confirm deliverability and timing of benefit realisation<br>• Ongoing triangulation of workforce establishment, vacancy position, and temporary staffing usage to reduce substitution risk<br>•The focus is on securing sustainable reductions rather than short term displacement between agency and bank. | • FDB route to breakeven agreed on 19/11 which included a bank reduction plan<br>• Additional pay control initiatives agreed at FDB on 17/12<br>• Further discussion on performance and mitigation plans on 21/01 | n/a | High |

# Assurance Reports: Finance Non-Pay Expenditure



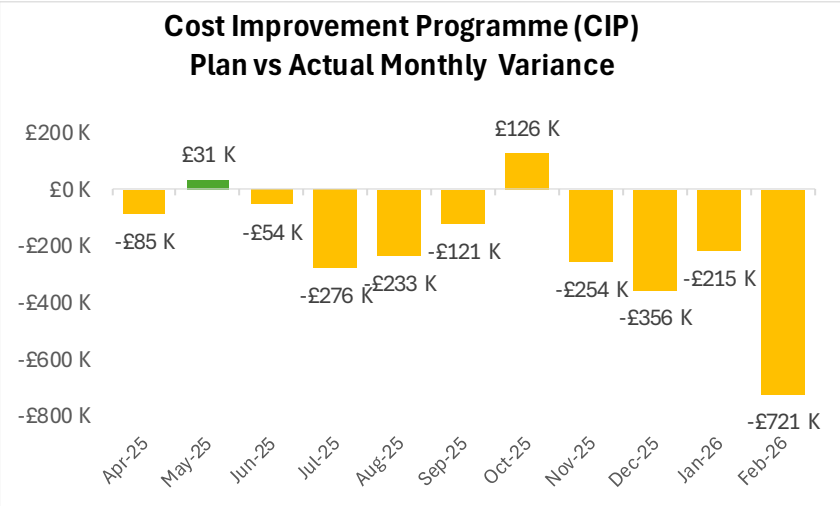

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| Non pay expenditure underspent variance YTD to £5.2m. This is primarily driven as a result of £1.9m 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 11 and 12, including resetting non-recurrent adjustments.<br>• Deep-dive into non pay CIP programme to determine expected delivery, identify high risk schemes, and confirm mitigating actions.<br>• Strengthened cost control and authorisation for non-essential non-pay | • Non pay recovery trajectory agreed at FDB on 17/12<br>• Further discussion on performance and mitigation plans at FDB on 20/01 | n/a | High |
| LLP expenditure Overspent by £193k in month taking it to over £1m overspend YTD. Spend in month is the highest all year; Large joints= £68k, Spinal £80k and Anaes = £70k against plan has overspent by £42k in month and contributing to a YTD overspend of £1,053k, additionally there is an overspend £15k on ADH spend. | • Agreement of future LLP for the remainder of the year.<br>• 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 20/01 | n/a | High |

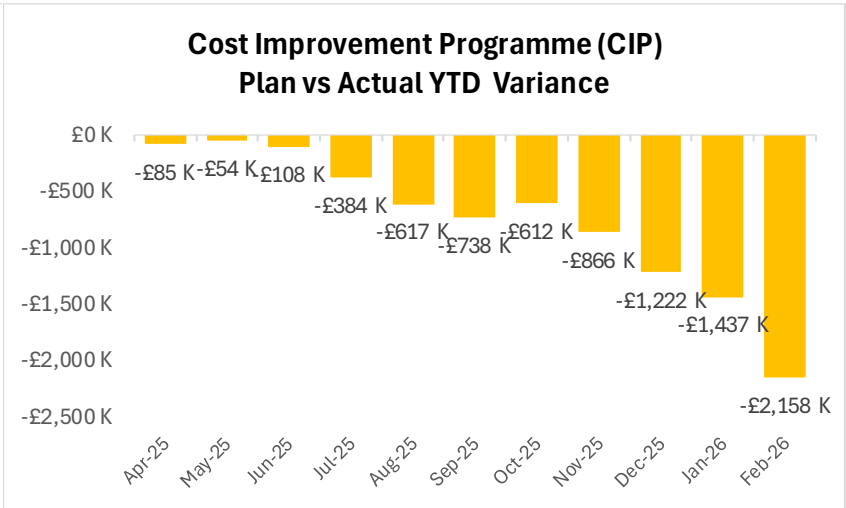
# Assurance Reports: Finance

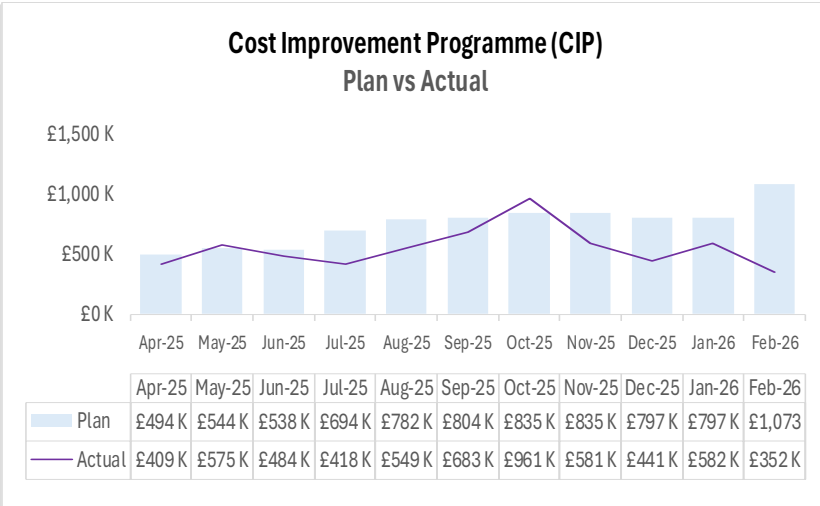



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| Genmed spend remains reduced in the current year due to the enhanced controls implemented for ad-hoc spend variance, and lower activity.<br><br>Spend in month was lower in month due to a reduction in purchasing – the difference in timing of purchasing to charging would align with the lower activity in the previous month.<br><br>Challenges remain around the ability to forecast spend, and the timing of spend compared to activity. | • Continued review of Genmed spend on a monthly basis to identify trends and areas for improvement<br>• Monthly Strategic Contract Review meetings with Genmed with attendance from CFO.<br>• BSOL procurement alliance providing pricing for Genmed review to identify further routes to savings. | • Ongoing | n/a | High |

# Assurance Reports: Finance Cost Improvement Programme (CIP)

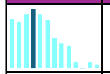
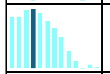
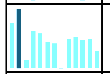
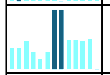
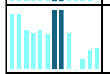
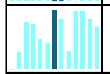
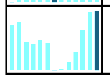
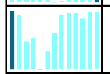
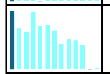
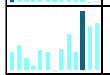
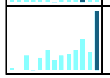


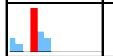
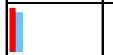
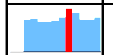
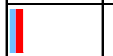
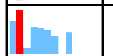
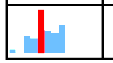




| | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Plan | £494 K | £544 K | £538 K | £694 K | £782 K | £804 K | £835 K | £835 K | £797 K | £797 K | £1,073 |
| Actual | £409 K | £575 K | £484 K | £418 K | £549 K | £683 K | £961 K | £581 K | £441 K | £582 K | £352 K |

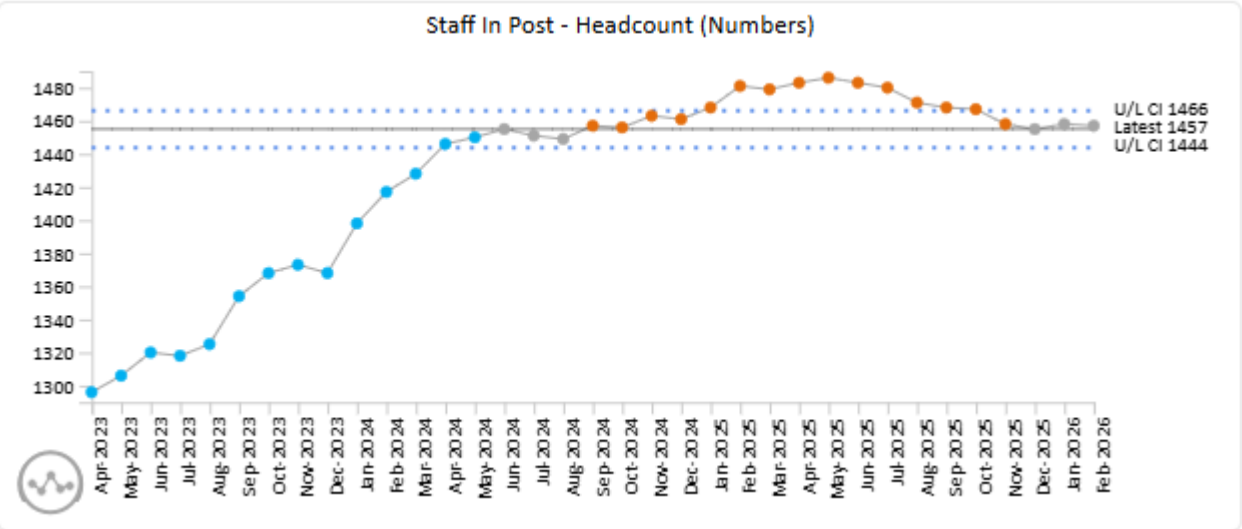
| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| In month efficiencies of £352k have been recorded. This increases the year to date achieved to £6.2m against a plan of £8.4m, generating an underperformance of £2.2m.<br>Quality Impact Assessments (QIAs) for schemes are in progress with the panel meeting weekly to review assessments.<br>The schemes in which there are concerns regarding delivery are;<br>• Additional NHS funded income - £1.1m<br>• Service review phase 1 shortfall - £286k in year and £1.1m FYE<br>• Infrastructure bank spend reduction - £1.1m<br>• LLP spend reduction - £1m | • Income underperformance recovery trajectory to be agreed<br>• Additional grip and control measures applied to all areas of spend<br>• Workforce control initiatives fully considered, and estimation of impact expected from these for the remaining months<br>• Revised bank expenditure reduction targets to be set for the remaining months<br>• Review difficult decisions log to assess which proposals could progress to QIA | • FDB discussion on 20/01<br>• Non pay recovery trajectory agreed at FDB on 17/12<br>• -FDB discussion on 17/12<br>• Additional pay control initiatives agreed at FDB on 17/12<br>• Further discussion on CIP performance and mitigation plans on 21/01 | n/a | High |

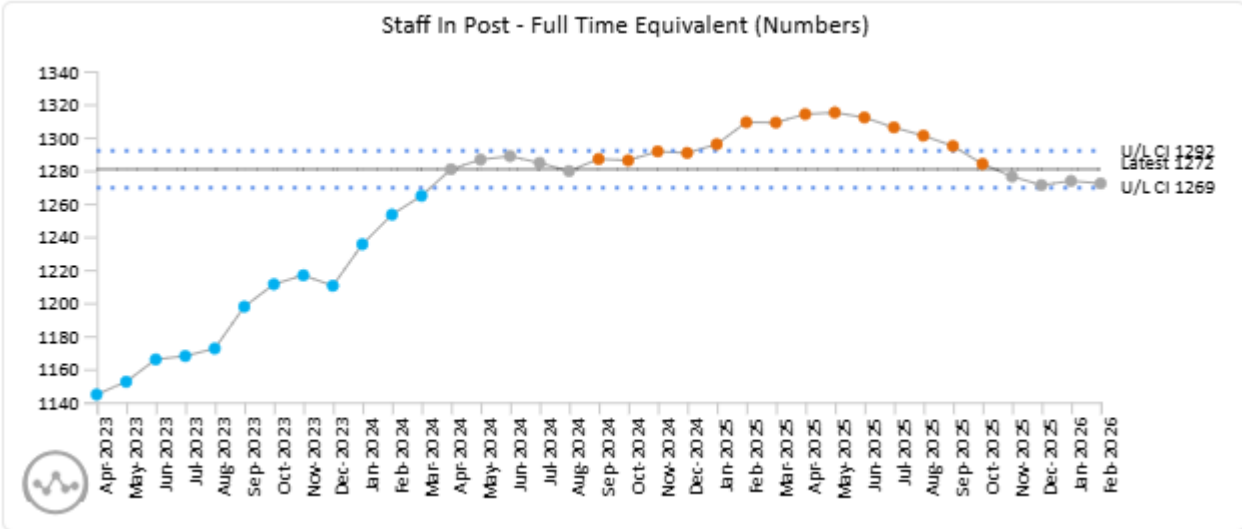
| Metric Grouping | Metric Name | Reporting Period | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | YTD | Trend | Direction of Travel | Latest Variation Monthly | Latest Assurance Target | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Workforce | Staff In Post - Headcount | Monthly | 1,481 | 1,479 | 1,483 | 1,486 | 1,483 | 1,480 | 1,471 | 1,468 | 1,467 | 1,458 | 1,455 | 1,458 | 1,457 | 1,470 |  | | - | - | - |
| Workforce | Staff In Post - Full Time Equivalent | Monthly | 1,309 | 1,309 | 1,314 | 1,315 | 1,312 | 1,306 | 1,301 | 1,295 | 1,284 | 1,276 | 1,271 | 1,274 | 1,272 | 1,293 |  | | - | - | - |
| Workforce | Staff Turnover Percentage - Adjusted | Monthly | 11.11% | 11.83% | 9.28% | 10.73% | 10.64% | 10.15% | 10.10% | 8.88% | 10.34% | 10.43% | 10.27% | 10.33% | 9.73% | 10.08% |  | low is good |  |  | 10.5% |
| Workforce | Total Whole Time Equivalent Employed as a Percentage of Establishment - Clinical | Monthly | 88.74% | 88.74% | 89.14% | 88.43% | 87.97% | 88.40% | 91.17% | 91.17% | 89.23% | 89.20% | 89.12% | 89.26% | 87.31% | 89.13% |  | high is good |  |  | 92% |
| Workforce | Total Whole Time Equivalent Employed as a Percentage of Establishment - Non-Clinical | Monthly | 91.34% | 91.34% | 90.40% | 90.25% | 90.44% | 90.20% | 91.62% | 91.62% | 90.23% | 88.09% | 88.69% | 89.26% | 89.37% | 90.02% |  | high is good |  |  | 96% |
| Workforce | Percentage of Attendance | Monthly | 93.47% | 93.78% | 94.32% | 94.27% | 94.01% | 93.93% | 94.53% | 94.38% | 93.79% | 94.52% | 94.52% | 94.38% | 94.23% | 94.26% |  | high is good |  |  | 96.3% |
| Workforce | Percentage of Staff Received Mandatory Training last 12 months | Monthly | 89.56% | 89.92% | 86.99% | 86.63% | 87.43% | 86.82% | 82.85% | 83.13% | 84.14% | 85.47% | 88.79% | 91.45% | 91.61% | 86.85% |  | high is good |  |  | 93% |
| Workforce | Percentage of Staff Received Formal PDR/Appraisal last 12 months | Monthly | 90.96% | 90.17% | 84.92% | 85.58% | 79.52% | 83.10% | 86.61% | 90.00% | 90.56% | 90.59% | 89.50% | 90.85% | 90.67% | 87.45% |  | high is good |  |  | 95% |
| Workforce | Percentage of Sickness Trust Wide Long Term | Monthly | 4.47% | 3.98% | 3.90% | 4.45% | 4.04% | 4.08% | 3.93% | 3.57% | 3.70% | 3.65% | 3.55% | 2.87% | 2.90% | 3.69% |  | low is good | - | - | - |
| Workforce | Percentage of Sickness Trust Wide Short Term | Monthly | 2.01% | 2.21% | 1.84% | 1.61% | 2.08% | 1.99% | 1.46% | 2.09% | 2.52% | 2.00% | 3.21% | 2.75% | 2.86% | 2.22% |  | low is good | - | - | - |
| Workforce | Return to Work Completion % | Monthly | 62.33% | 61.32% | 67.44% | 61.22% | 66.24% | 69.33% | 65.37% | 67.01% | 67.50% | 69.27% | 73.96% | 68.35% | 85.06% | 69.16% |  | high is good |  |  | 80% |

# Integrated Performance Dashboard Headline/Workforce Productivity

| Metric Grouping | Metric Name | Reporting Period | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | YTD | Trend | Direction of Travel | Latest Variation Monthly | Latest Assurance Target | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Headline Producitivity | Implied Productivity Growth (v 19/20) | Monthly | -13.60% | -11.10% | -14.70% | -12.90% | -14.30% | -14.40% | | | | | | | | |  | | - | - | |
| Headline Producitivity | Implied Productivity Growth (V previous year) | Monthly | 1.50% | 0.90% | 8.7%% | 4.60% | 2.20% | 1.50% | | | | | | | | |  | | - | - | |
| Workforce Productivity | Implied Workforce Productivity Growth (v19/20) | Monthly | -10.30% | -9.00% | -14% | -12.70% | -10.30% | -10.70% | | | | | | | | |  | | - | - | |
| Workforce Productivity | Elective Admissions per clinical WTE | Monthly | 3.15 | 2.89 | 0.44 | 0.45 | 0.45 | 0.46 | 0.46 | 0.49 | 0.48 | 0.48 | 0.47 | 0.44 | 0.46 | |  | | | | |
| Workforce Productivity | Elective Admissions per WTE | Monthly | 1.04 | 0.95 | 366.38 | 375.91 | 337.28 | 338.91 | 350.11 | 392.64 | 486.55 | 434.48 | 363.41 | 360.82 | 386.84 | |  | | - | - | |
| Workforce Productivity | Outpatient Attendances per consultant wte | Monthly | 77.52 | 77.87 | 4.48 | 4.42 | 4.64 | 4.83 | 4.27 | 5.04 | 4.92 | 4.52 | 4.19 | 4.63 | 4.57 | |  | | - | - | |
| Workforce Drivers | Total Temporary Staff Spend as % of Total pay Spend | Monthly | 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 | 8.60% | 6.90% | 6.36% | 7.71% | 7.10% | | | | | | | | | |  | | - | - | |
| Workforce Drivers | Medical Sickness Absence Rate | Monthly | 0.50% | 1.10% | 0.75% | 0.12% | 0.30% | | | | | | | | | |  | | - | - | |
| Workforce Drivers | Turnover (Adjusted) | Monthly | 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 | 4.77 | 4.59 | 5.26 | 5.19 | 6.34 | 5.50 | 5.40 | 5.70 | | | | | | |  | | - | - | |

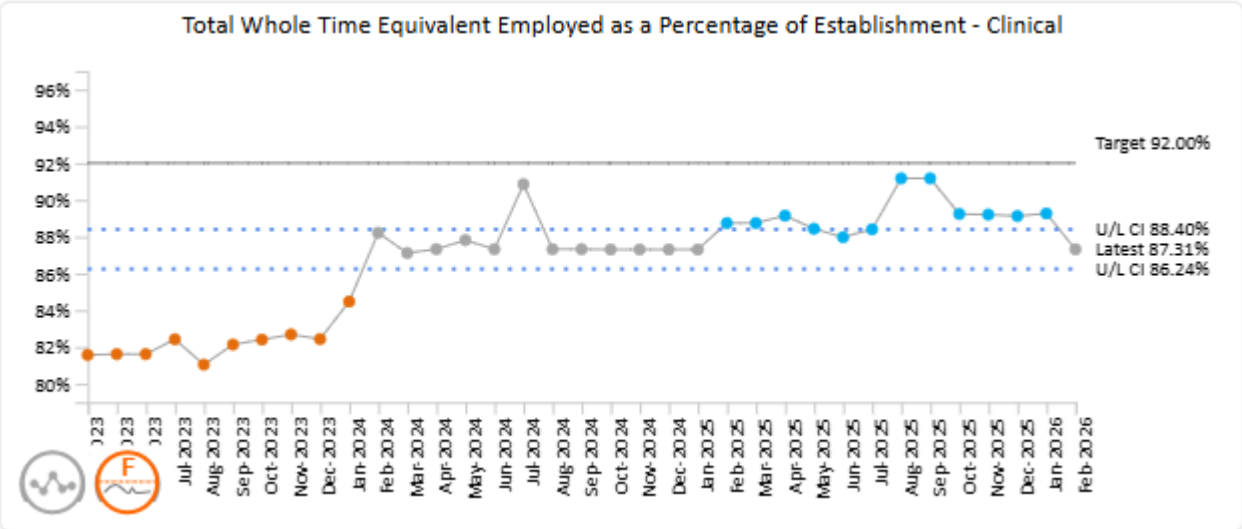
# Assurance Reports: Workforce

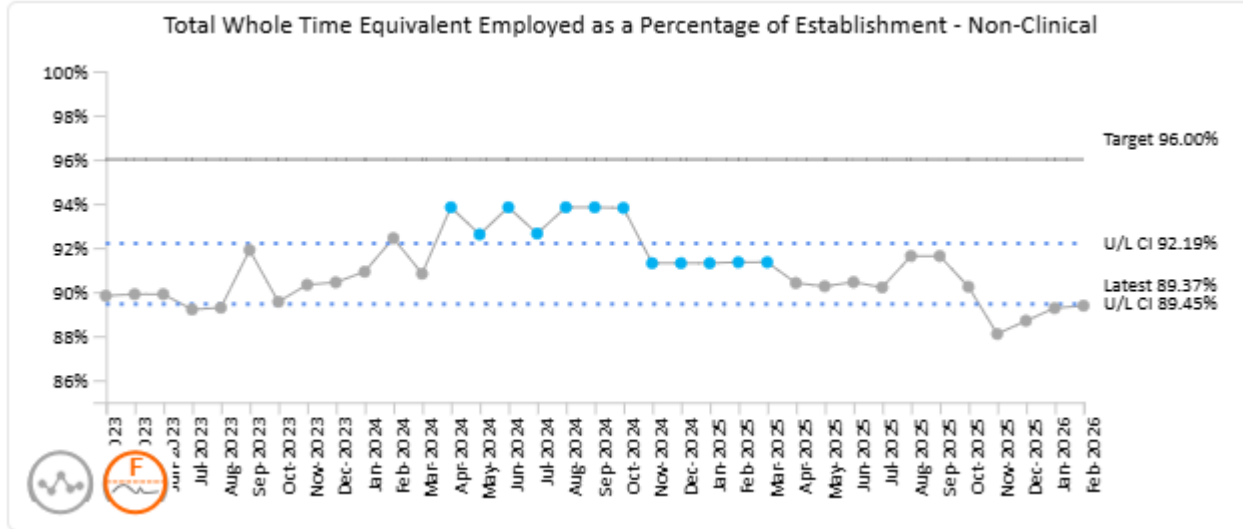



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| • There is a risk that we have the wrong number of staff in the 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.<br>• Workforce planning is becoming more embedded in the Trust, with several core services receiving workforce planning support.<br>• 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<br><br>Assurance committee: Staff Experience and Organisational Development (SE&OD) | Risk 2059 | High |

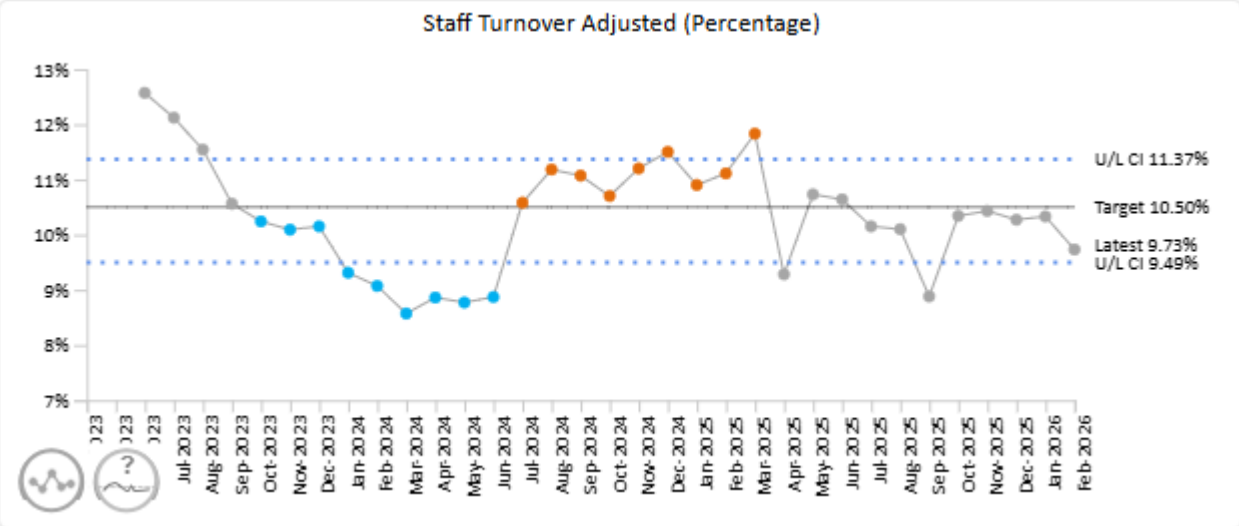
# Assurance Reports: Workforce continued

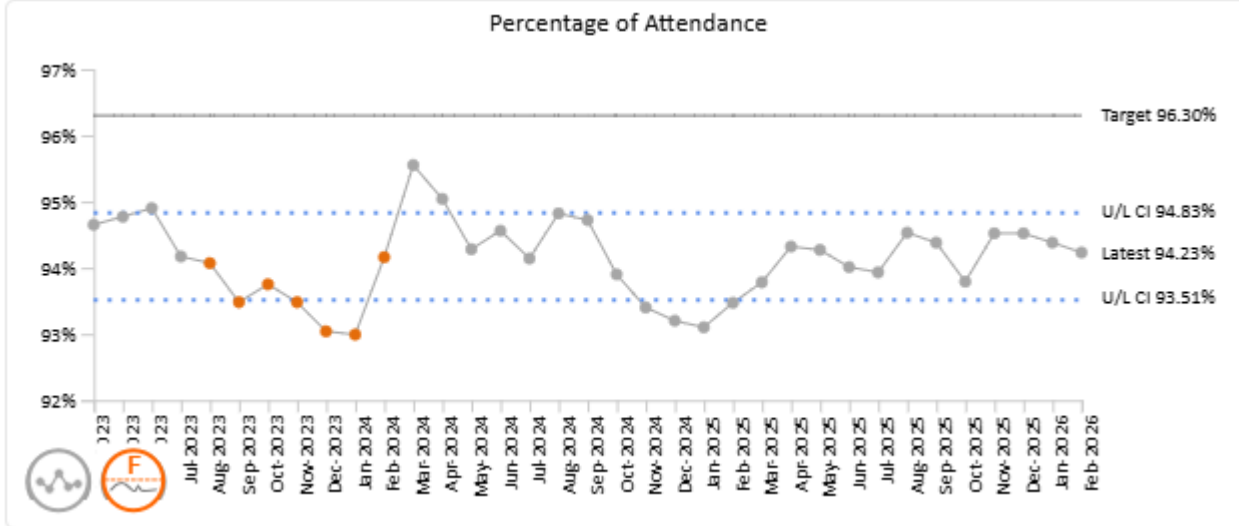



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| • There is a risk that if we don't fulfil our establishments, we will have higher temporary spend leading to poor workforce resilient.<br>• A key challenge is truly understanding our vacancies whilst also having robust vacancy controls. | • Recruitment time to hire is the lowest it has been between 35-41 days, supporting vacancies to be filled without delay. | Regular work takes place to align ledger with ESR data.<br><br>Assurance committee: Staff Experience and Organisational Development (SE&OD) | Risk 2060 | Medium – requires ongoing manual alteration |

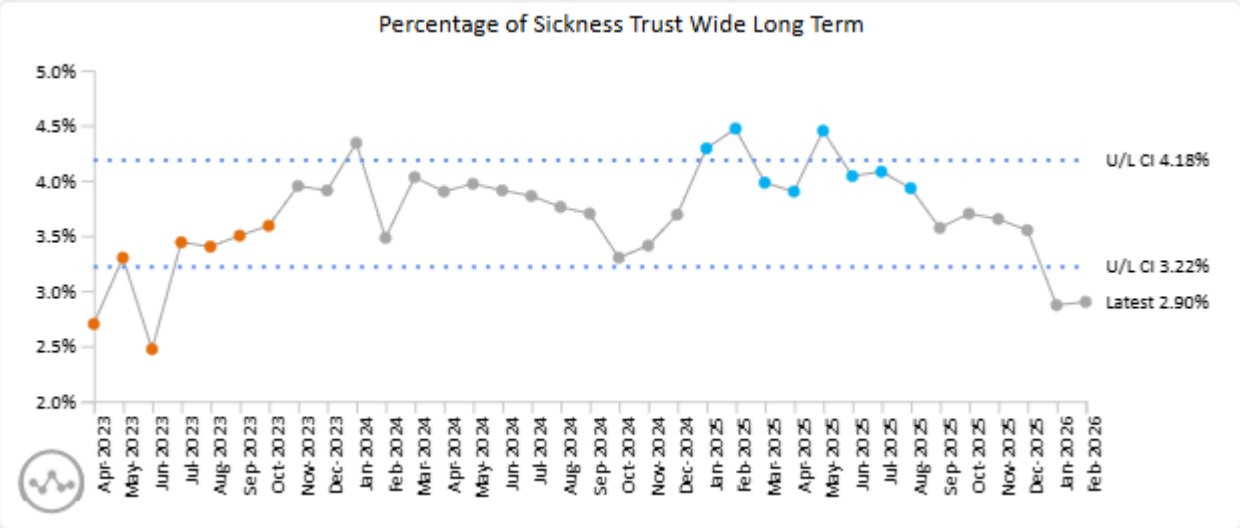
# Assurance Reports: Workforce continued

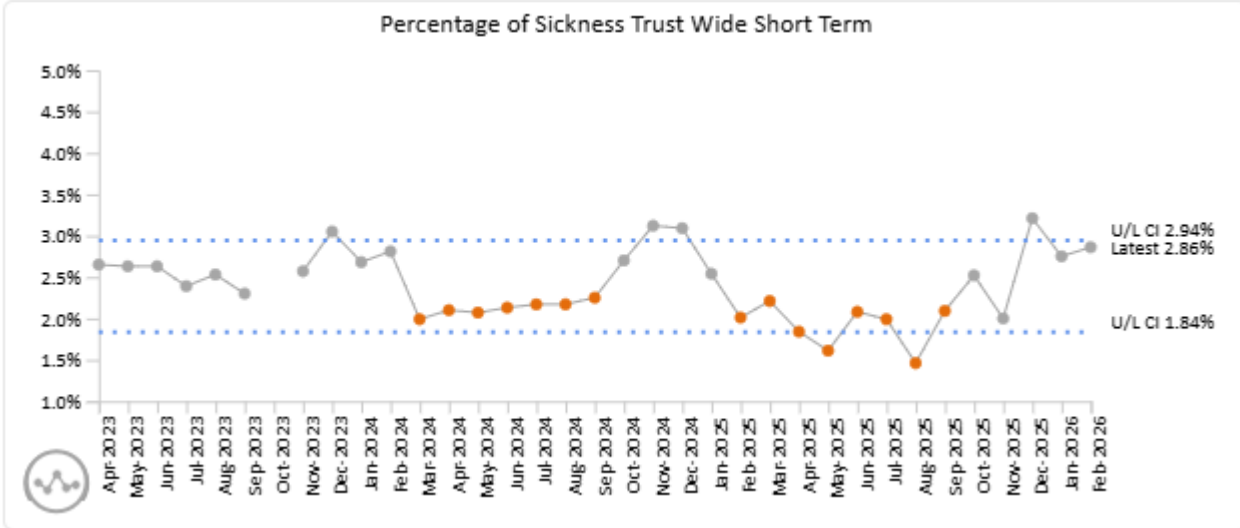



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| • There is a risk that we don't retain key staff through poor engagement and/or better reward packages at other organisations<br>• 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.<br><br>• Regular review of leavers data | February 2026<br><br>Ongoing<br><br>Assurance committee: Staff Experience and Organisational Development (SE&OD) | Risk 2058 | High assurance |

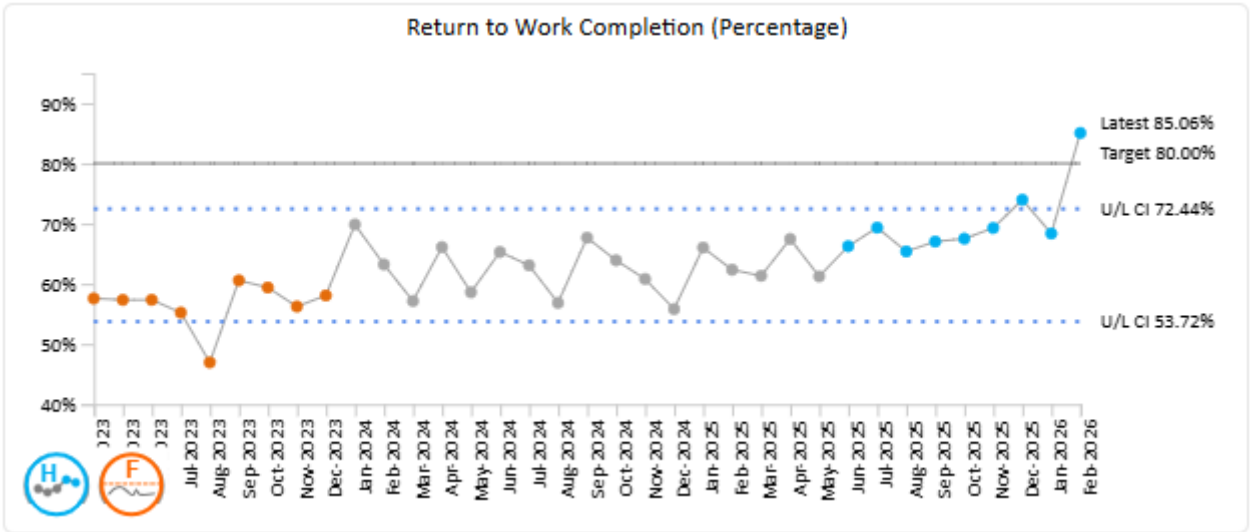
# Assurance Reports: Workforce continued



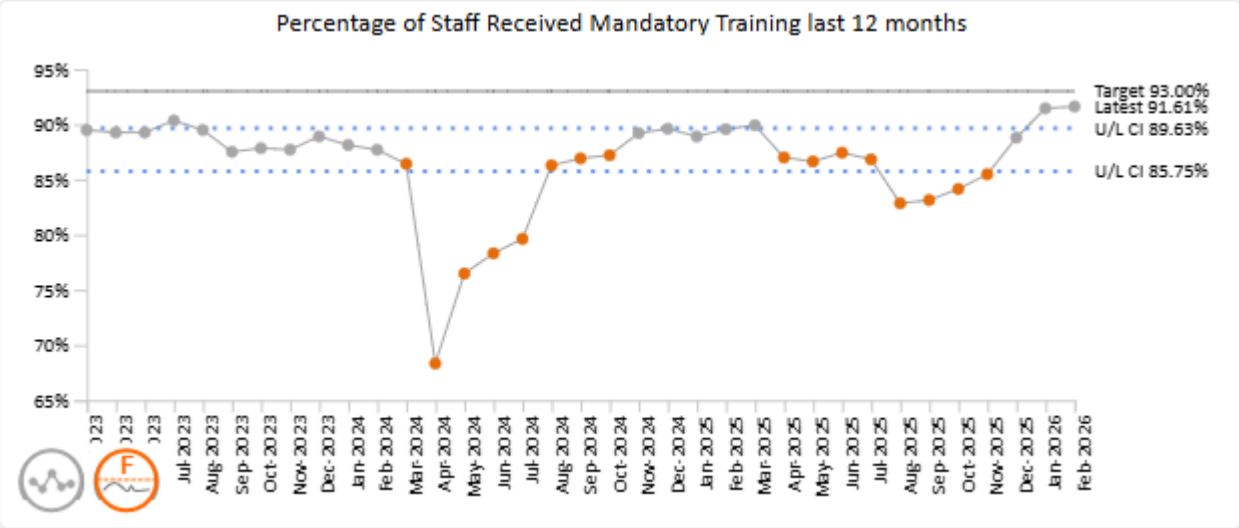

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| • There is a risk that we have excessive staff unavailability. 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:<br>• Training programme for managers<br>• MSK OH role to reduce MSK related absences (charity funded)<br>• The number of dismissals and hearings increased dramatically in 2025 and are expected to continue during 2026.<br>• Audits are in place to measure managerial compliance<br>• Enhanced support in place for high sickness areas. | Assurance committee: Staff Experience and Organisational Development (SE&OD)<br>In place (attempting to increase attendance)<br>Started Jan 26<br>Ongoing<br>Ongoing<br>Ongoing | Risk 2156 | High assurance |

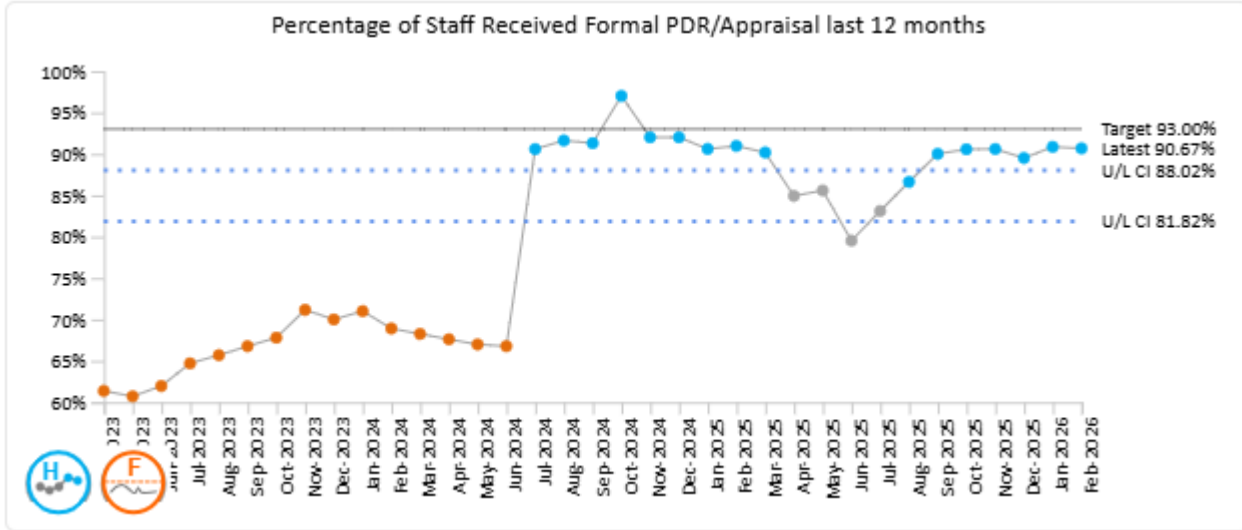
# Assurance Reports: Workforce continued




| 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 a low return to work rating demonstrates a lax approach to policy compliance, potentially leading to higher episodes of sickness absence. | • We have seen a positive increase in the return-to-work audits – now reporting at 85% which is the highest it has been for some time.<br>• We regularly audit departments with lower rates of completion<br>• The Trust rollout to Health Roster will continue to support compliance as it's an easier system to log return to work.<br>• High support/workshops in place for areas with lower compliance | On-going<br>Audits continue on an ongoing basis<br>Healthroster rollout nearing completion<br>Assurance committee: Staff Experience and Organisational Development (SE&OD) | Risk 2156 | High assurance |

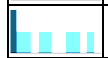
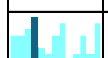
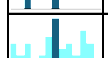
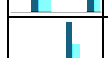
# Assurance Reports: Workforce continued




| 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 it can have a direct impact on patient care, and a financial implication from our commissioners.<br>• 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.<br>• There is a risk that the quality of objectives at individual and team level are not fully aligned to Trust strategy and therefore may impact levels of performance | - Introduction of LMS continues to show positive impact in the improvement of compliance – reporting at 91.45% in January.<br><br>- T&D team working closely with the NHSE StatandMand review project to align activity, with the potential to reduce "time" completing training.<br><br>- Agreed that annual fire safety training requirement will align to national recommendations and move to two yearly renewal from April 2026.<br><br>- A comprehensive training programme is in place to upskill managers and individuals in achieving high quality appraisal conversations and objective setting aligned to Trust strategy, one to one and wellbeing conversations<br><br>- Outcomes will be measured through post appraisal survey to all staff, staff survey results and targeted work in department. Completion compliance will be measured through the LMS systems with the new online form | - Upward report is reviewed at MPET Group.<br><br>Assurance committee: Staff Experience and Organisational Development (SE&OD) | R1436 | High assurance |

# Integrated Performance Dashboard: Governance

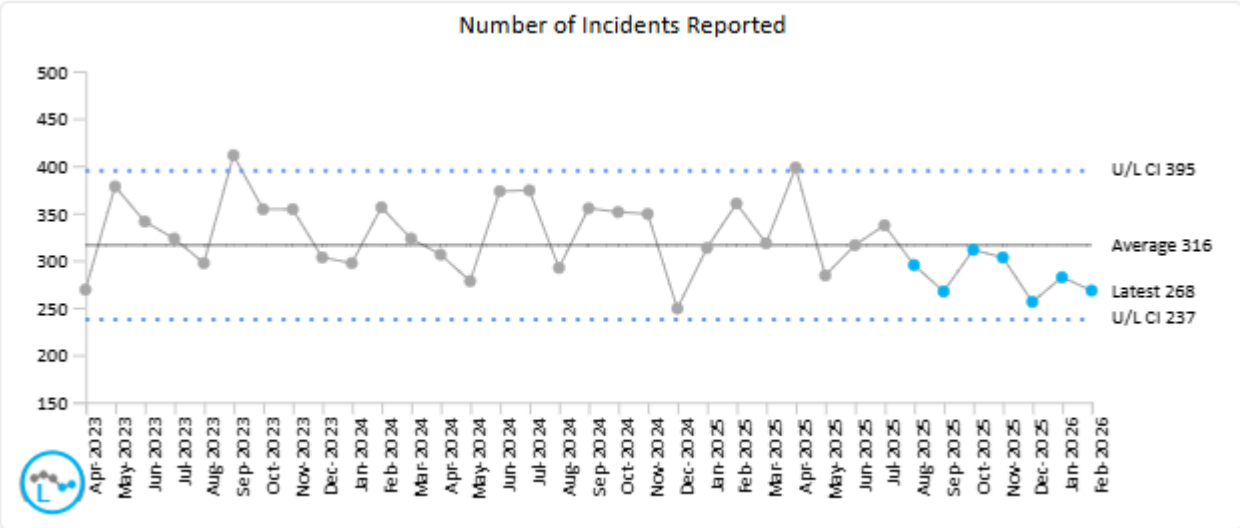
| Metric Grouping | Metric Name | Reporting Period | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | YTD | Trend | Direction of Travel | Latest Variation Monthly | Latest Assurance Target | Target |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Governance | Number of Incidents Reported | Monthly | 360 | 318 | 398 | 284 | 316 | 337 | 295 | 267 | 311 | 303 | 256 | 282 | 268 | 3,317 |  | high is good | - | - | |
| Governance | Number of PSII (Patient Safety Incident Investigations) | Monthly | 0 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 5 |  | low is good |  |  | 0 |
| Governance | Number of Inpatient Deaths | Monthly | 2 | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 1 | 0 | 6 |  | low is good |  |  | 0 |
| Governance | Number of Inpatient Deaths within 30 days of discharge | Monthly | 0 | 0 | 0 | 0 | 4 | 1 | 1 | 1 | 3 | 0 | 0 | 0 | 3 | 13 |  | low is good |  |  | 0 |
| Governance | Number of Never Events | Monthly | | | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 3 |  | low is good |  |  | 0 |
| Governance | Number of VTE | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |  | low is good |  |  | 0 |
| Governance | Number of Category 3 Pressure Ulcer Incidents ROH acquired | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |  | low is good |  |  | 0 |
| Governance | Number of Category 4 Pressure Ulcer Incidents | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |  | low is good | - | - | - |
| Governance | Number of Inpatient Falls | Monthly | 7 | 7 | 8 | 10 | 5 | 4 | 7 | 9 | 3 | 4 | 7 | 4 | 9 | 70 |  | low is good |  |  | 0 |
| Governance | Number of Infection Incidents (Reportable) | Monthly | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |  | low is good | - | - | - |
| Governance | Number of Complaints | Monthly | 8 | 6 | 8 | 5 | 6 | 9 | 12 | 7 | 8 | 6 | 10 | 8 | 5 | 84 |  | low is good | - | - | - |
| Governance | Number of PAL contacts | Monthly | 60 | 54 | 51 | 57 | 40 | 46 | 44 | 53 | 45 | 52 | 37 | 41 | 27 | 493 |  | low is good |  |  | 0 |
| Governance | Number of Claims | Monthly | 0 | 0 | 0 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 7 |  | low is good |  |  | 0 |
| Governance | Number of Inquests | Monthly | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 3 |  | low is good | | | |
| Governance | Number of Medication Incidents | Monthly | 12 | 16 | 13 | 10 | 8 | 5 | 4 | 7 | 6 | 5 | 7 | 4 | 5 | 74 |  | low is good | | | |
| Governance | Number of Deteriorating Patients Transfers to HDU | Monthly | 4 | 4 | 3 | 2 | 1 | 5 | 4 | 4 | 3 | 3 | 1 | 2 | 3 | 31 |  | low is good | | | |
| Governance | Number of Deteriorating Patients Emergency Transer OUT | Monthly | 3 | 1 | 3 | 1 | 1 | 5 | 5 | 3 | 3 | 6 | 1 | 0 | 4 | 32 |  | low is good | | | |
| Governance | Number of RIDDOR- Reportable Staff Incidents | Monthly | | | 1 | 3 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 2 | 0 | 9 |  | low is good | | | |

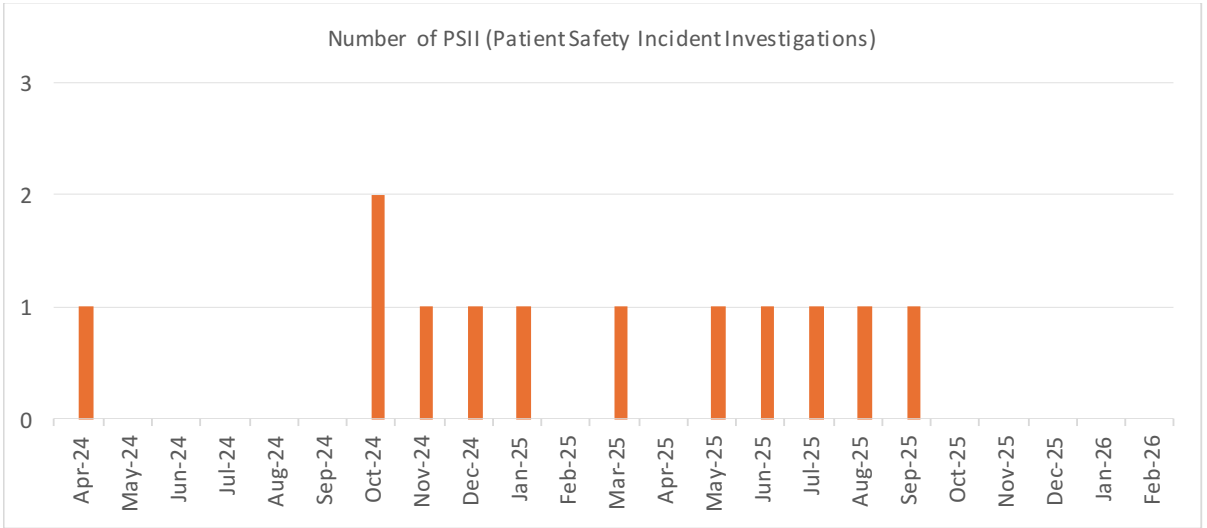
# Integrated Performance Dashboard: Infection Control

| Metric Grouping | Metric Name | Reporting Period | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | 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 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | | 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 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | low is good | | | 0 |
| Infection Control | All C. difficile cases identified on or during admission | Monthly | 0 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 0 | 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 | 3 | 0 | 0 | 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 | 1 | 0 | 0 | 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 | 3 | 0 | 2 | 1 | 2 | 3 | 1 | 2 | 1 | 5 | 1 | 1 | 1 | 20 | | low is good | | | 0 |
| Infection Control | Hand Hygiene Audit - Trust total % | Monthly | 99.00% | 99.00% | 99% | 91% | 99% | 100% | 99% | 99% | 99% | 99% | 99% | 100% | 100% | 98% | | high is good | | | 90% |

# Please note that quality slides are still work in progress

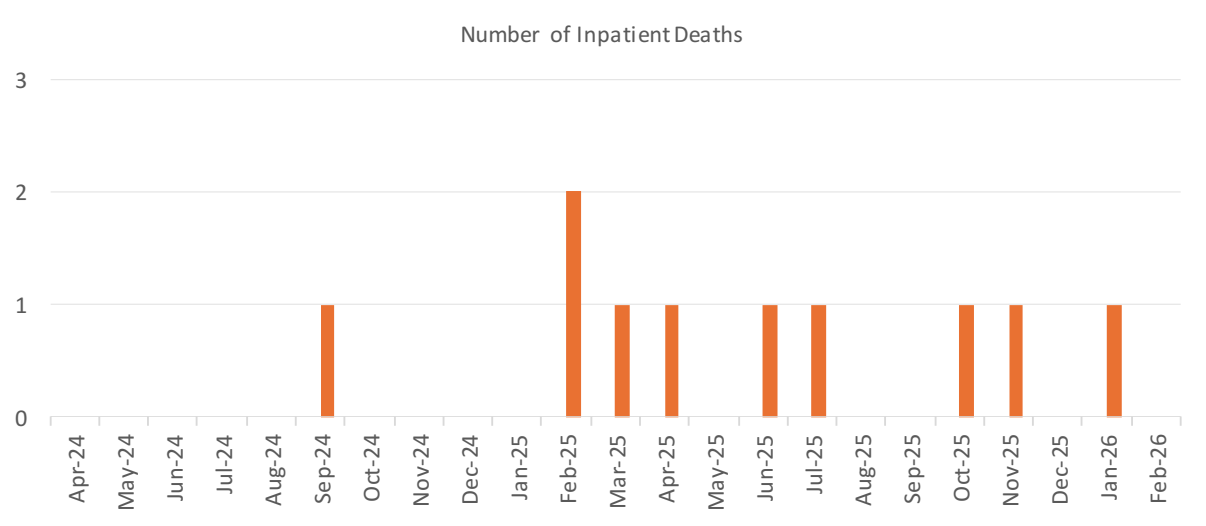
# Assurance Reports: Incidents

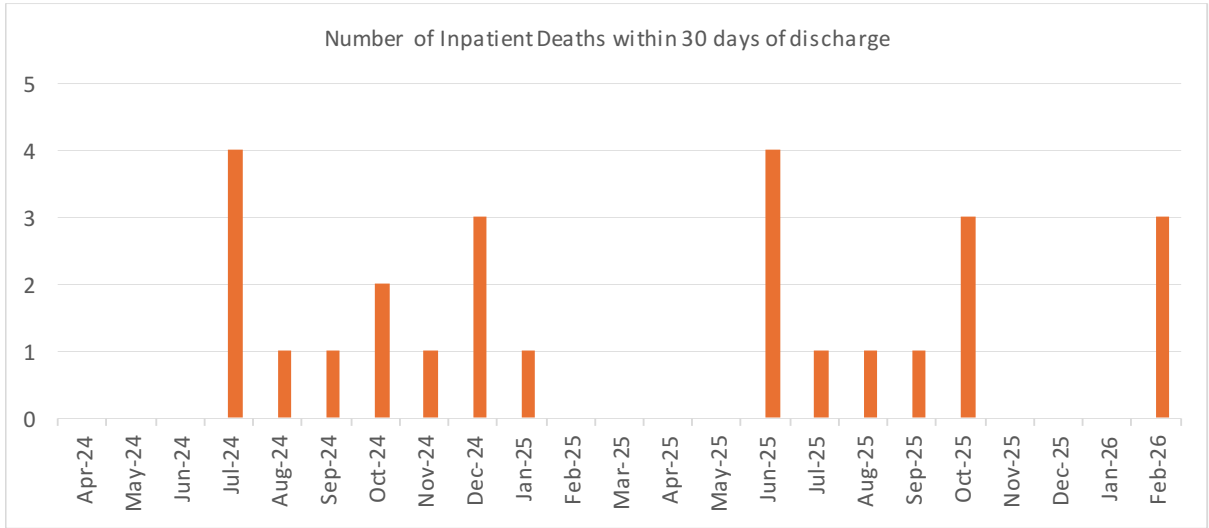



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| There were 268 incidents reported within the Trust during February 2026.<br>There continues to be a downward trend in incident reporting. | An in-depth analysis will be developed and taken to DMB in March 2026. | DMB to review in March 2026 | NA | High |

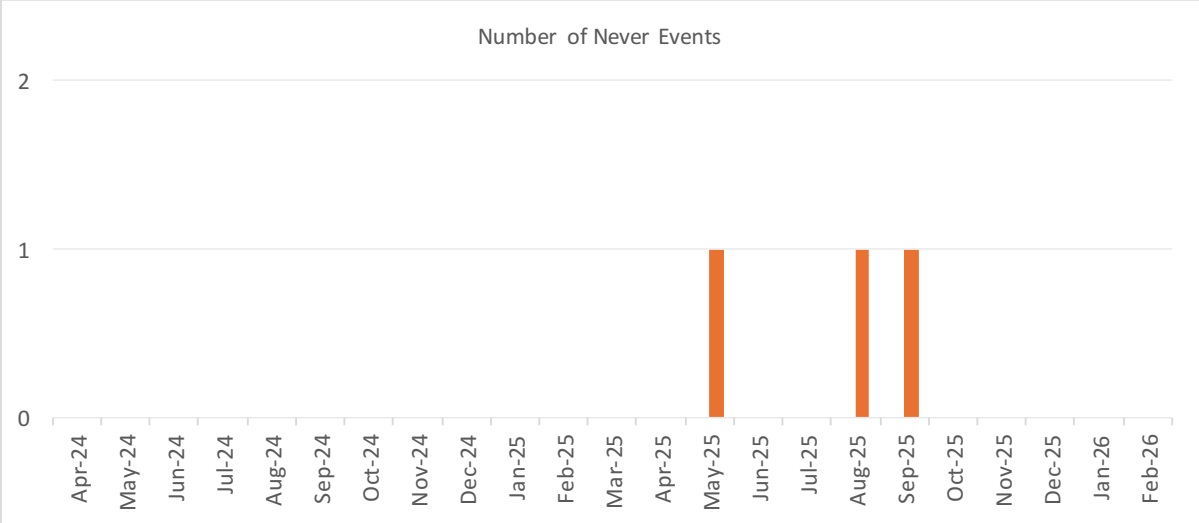
# Assurance Reports: Learning from Deaths

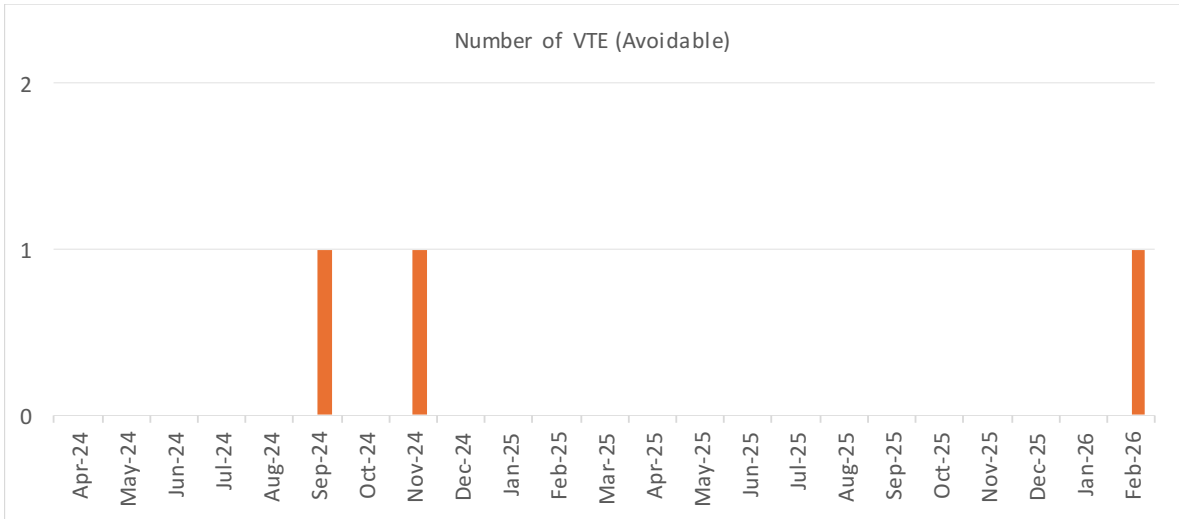



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| There were no inpatient deaths reported in February 2026.<br><br>New HED data received and figures updated to reflect new information received. All deaths to be reviewed through the LfD process. | Recent death of a patient transferred to Heartlands Hospital has been referred to coroner, concerns raised were reviewed in LfDRP and clinical governance. Very comprehensive SJR completed and clear evidence provided to support the decisions made by medical teams.<br><br>After discussion, concerns were raised over documentation around mechanical prophylaxis, these concerns will be taken back through division governance and discussed further with a view of sharing learning via an AAR and/or LOOP. | Learning From Deaths Review Panel<br><br>Learning From Deaths Review Panel | N/A<br><br>N/A | High<br><br>High |

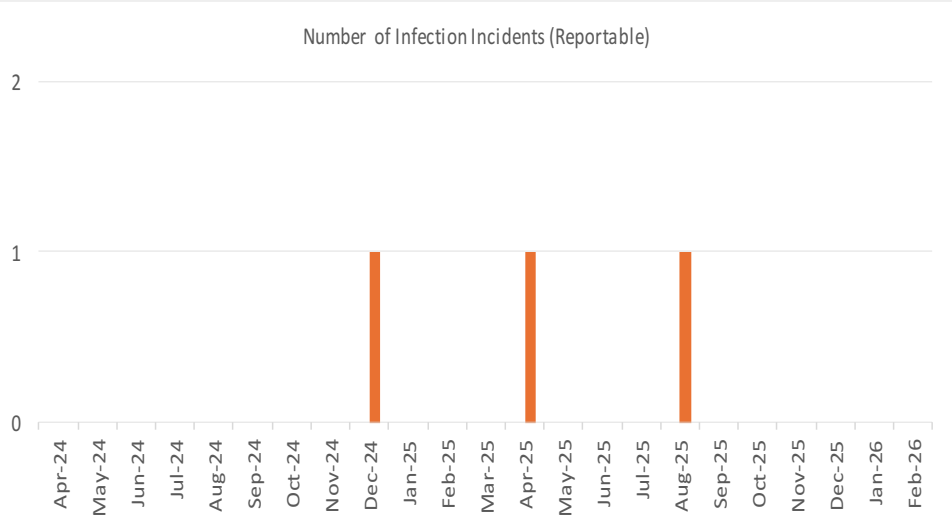
# Assurance Reports: Never Events & VTE




| 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 was 1 confirmed VTE incident reported in February 2026.<br><br>All recent VTE incidents have been deemed unavoidable after PSIRF VTE triage review<br><br>Compliance figure for February 2026: 95.52% (Provisional) | VTE Lead connects with VTE Exemplar Network regarding national improvement work or shared learning.<br><br>VTE Group currently reviewing evidence relating to Anti embolic stockings use and the standardisation of Hospital acquired Thrombosis definition and reporting. | | N/A | High |

# Assurance Reports: Infection Incidents




| Infections Recorded in month and Year to Date (YTD) | FEBRUARY 2026 | 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 |

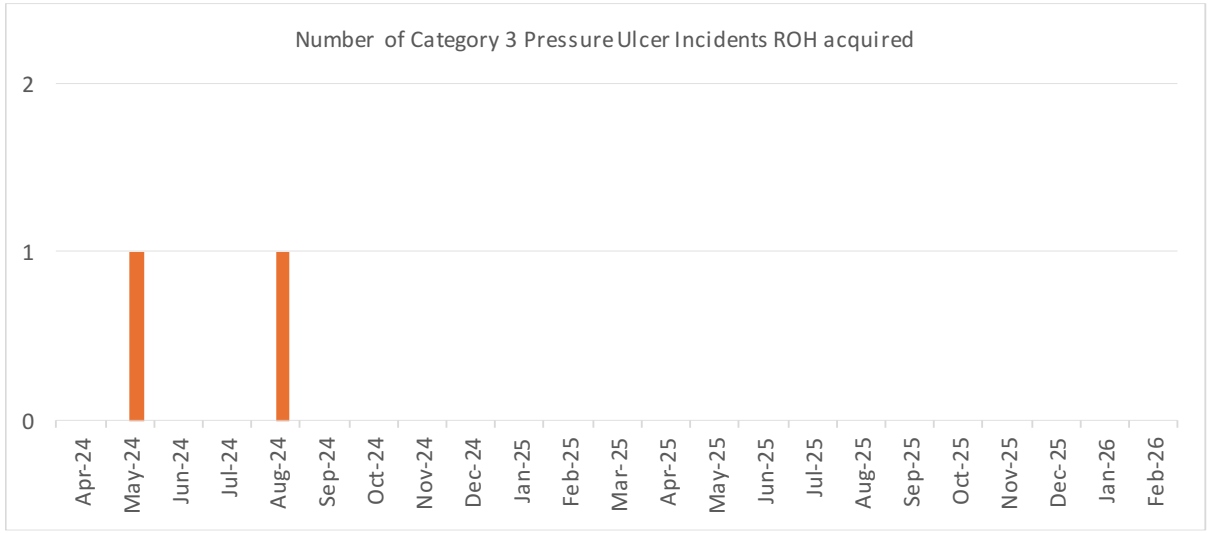
Note: Toxin positive cases of CDI are reportable, and all healthcare associated (HOHA and COHA) toxin positive cases count towards the ROH threshold

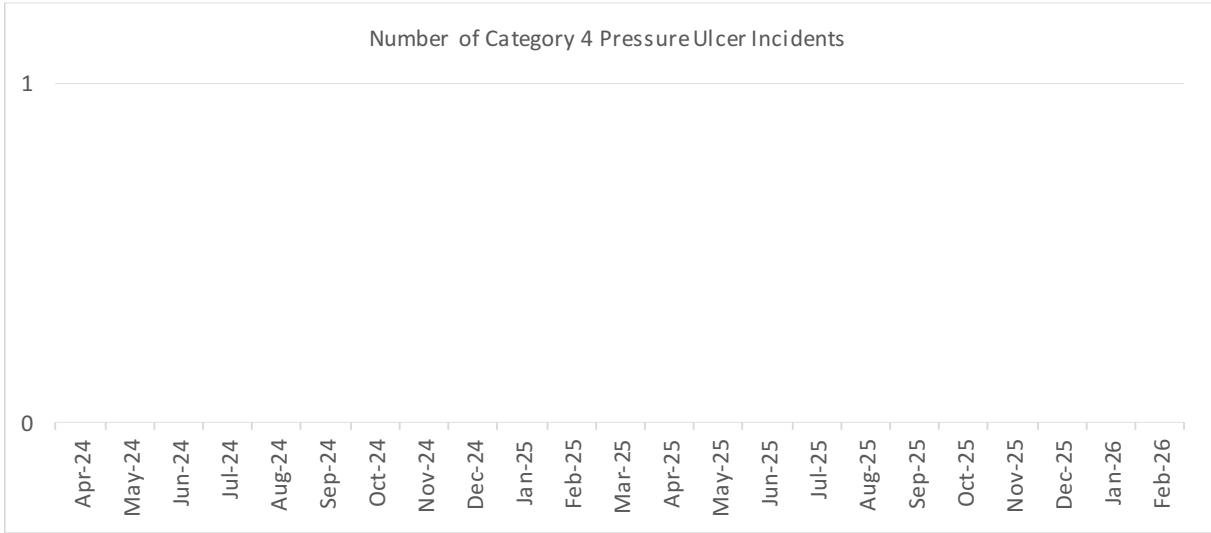
| | CDI (Toxin +ve) | E.*coli* BSI | P. *aeruginosa* BSI | *Klebsiella* Sp. BSI | MRSA BSI |
|---|---|---|---|---|---|
| 2023/24 | 5 | 0 | 0 | 1 | 0 |
| 2024/25 | 1 | 2 | 0 | 0 | 0 |
| 2025/26 | 0 | 0 | 0 | 0 | 0 |

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

| 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 |
|---|---|---|---|---|
| Delays in the development of an SSI prevention bundle 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). | SSI prevention group continues work to create and implement a bespoke ROH orthopaedic SSI prevention bundle. | SSI prevention | N/A | High |

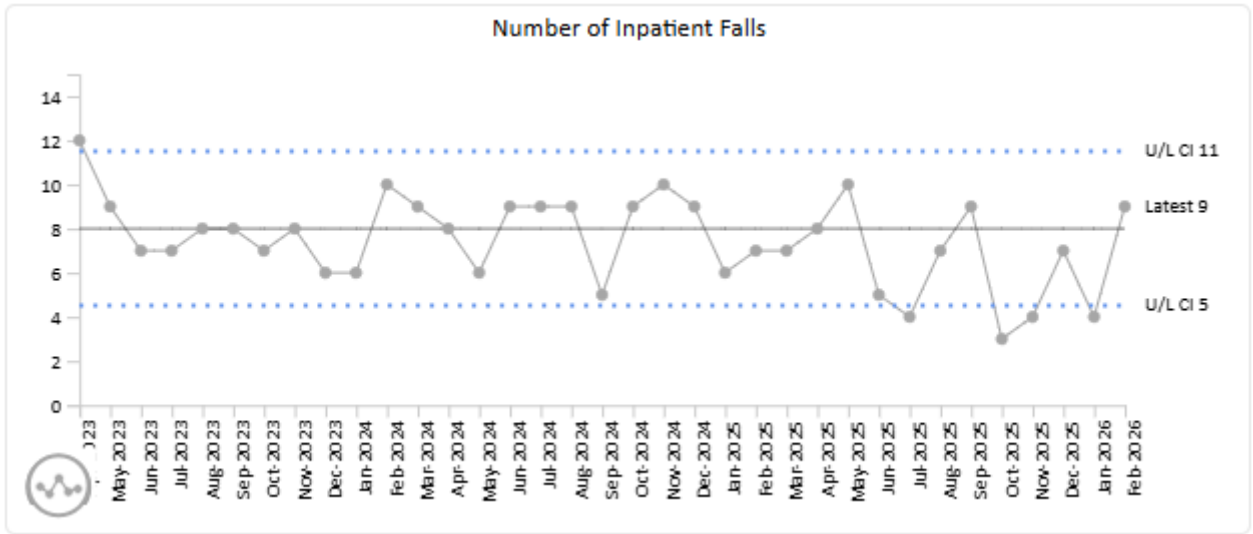
# Assurance Reports: Pressure Ulcers



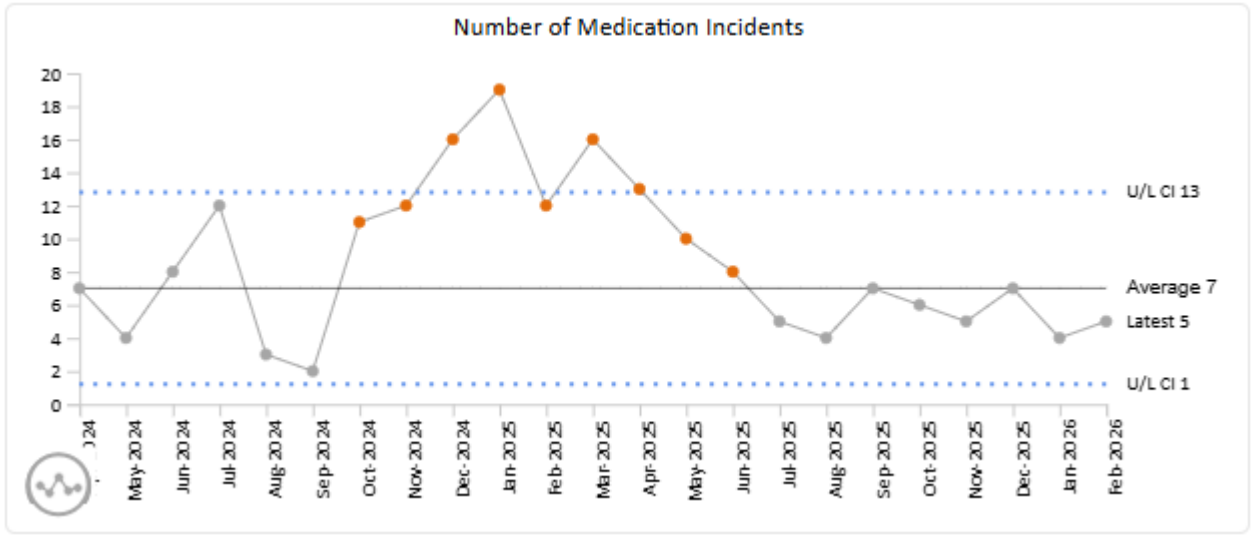

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| There were 3 ROH acquired pressure ulcer incidents reported in February 2026. After review by TV team there were no incidents that have caused concern, all incidents have been graded as no or low harm and will be managed locally via TV or ward teams. | | 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 – Awaiting feedback. | 2126 | High |

# Assurance Reports: Falls



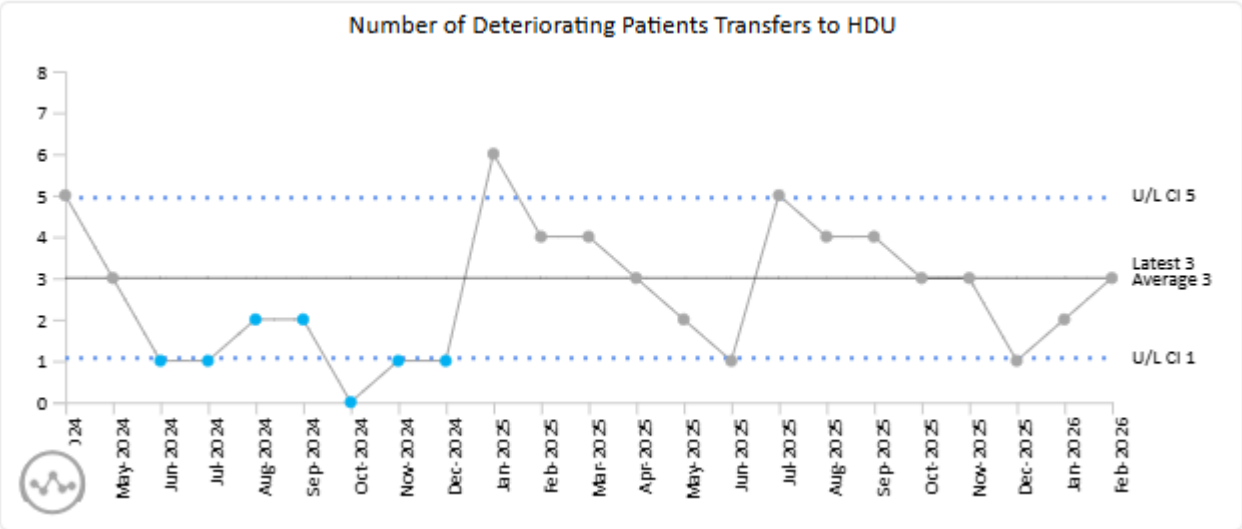

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| There were 9 inpatient falls reported in February 2026. All incidents were reported as no or low harm and after review have been as appropriate for local management.<br><br>Themes identified from falls incidents:-<br>• Mobilising against advice, particularly advice regarding walking aids<br>• Ward 2 recorded 3 falls<br>• Ward 4 recorded 3 falls | • Bedrails policy redrafted – further discussion/agreement around service & maintenance of beds & trollies ongoing with Director of Nursing & Estates.<br>• New PICS falls risk assessment now available in test system, with aim of go live within next 2 months | | | |

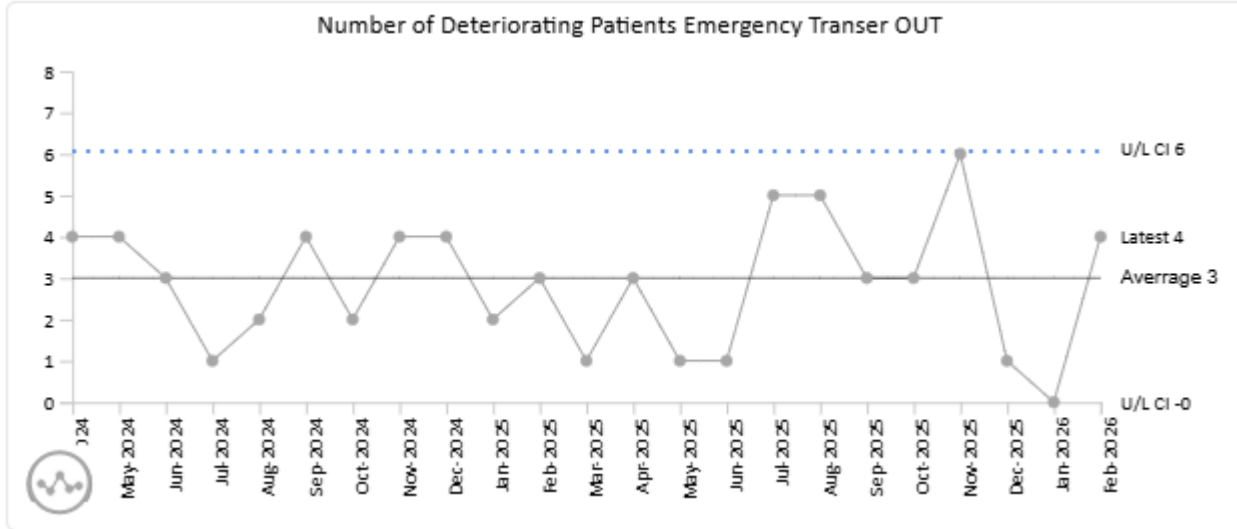
# Assurance Reports: Medication Incidents




| 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 were 5 Medication incidents reported in February 2026. All incidents have been reported as no or low harm and are being managed locally. | Pharmacy have been supporting a programme of 4 weeks of targeted medicines teaching on wards based on recent incident trends, February was ward 4 (Jan ward 3 and March is ward 2)<br><br>The reduction in incident reports has been discussed at DMB, divisional governance and medicines safety group. | DTC | N/A | High |

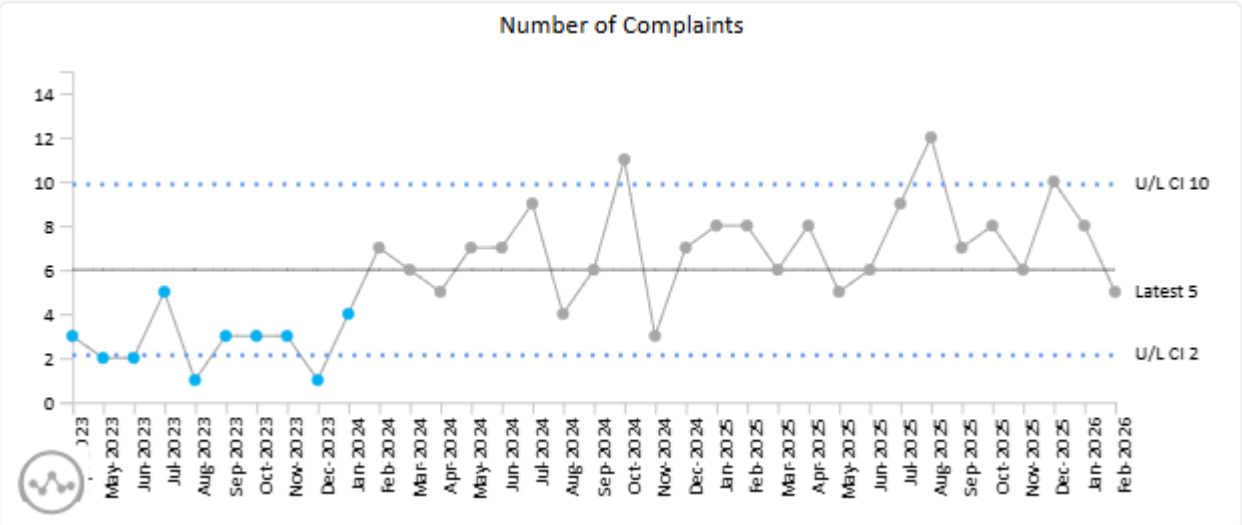
# Assurance Reports: Deteriorating Patients

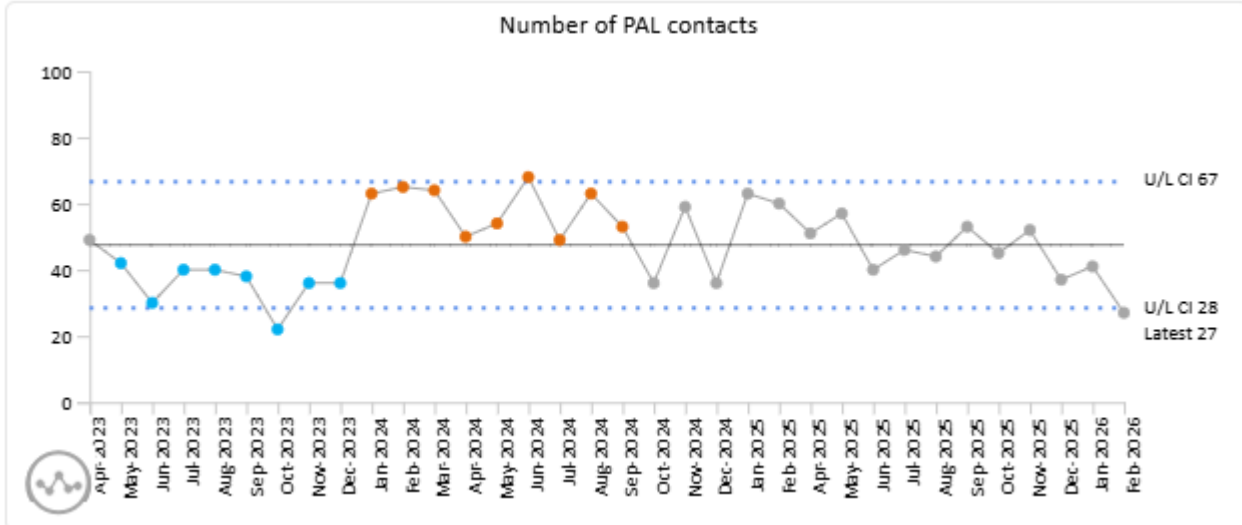



| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| There were 3 deteriorating patient incidents reported in February 2026. One incident was linked to patient death.<br><br>There were 6 emergency transfer out of Trust incidents reported in February 2026. From the 6 reported incidents there was 1 graded as Moderate harm – linked to patient death. All other incidents managed locally. | After discussion at divisional governance and the LfDRP, SJR confirms timely and well managed escalation and transfer to HDU and level 3 transfer out.<br><br>Marath's rule (Call 4 Concern): the Patient Well-being Questioner (PWQ) is being rolled out across all wards. This work is being led by the Critical Care Outreach lead and supported by the CNO. Communication and patient / staff level information has been developed to prompt the national initiative. Call 4 Concern is due to been implemented by April 26. AIM training and communication training are also being delivered by the CCOT team to support implementation. | | NA | High |

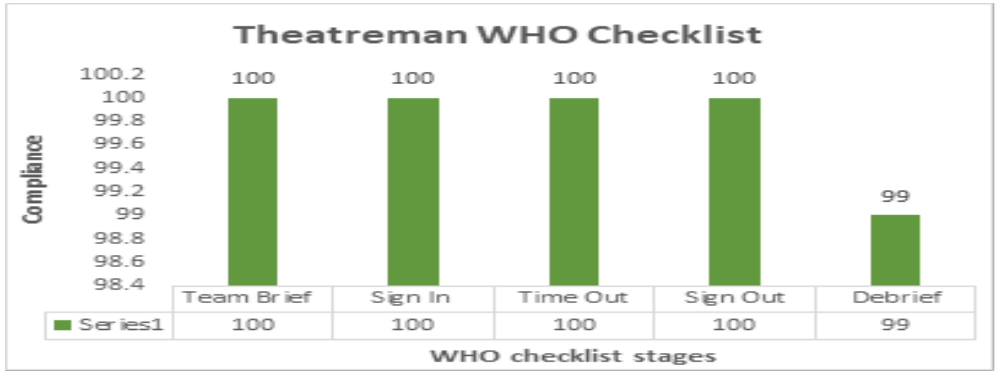
# Assurance Reports: Complaints and Pals



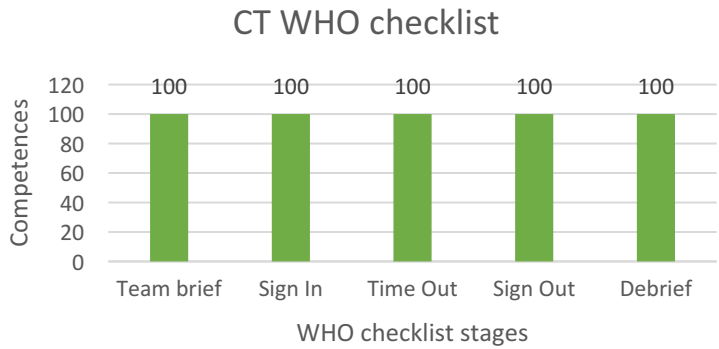

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| The Trust received 5 new formal complaints in February 2026. Of these, all remain open but within agreed timescales as of 28th February 2026 resulting in a February KPI achievement of 100%.<br><br>On 28/02/2026 The trust had 18 formal Complaints open, of which 4 had breached the agreed timescales. This provides a February closure KPI of 77%<br><br>In **February 2026** the Trust received no new requests for a resolution meeting and facilitated one Resolution Meeting successfully | • Themes identified through complaints, are raised and tracked at Divisional Governance Meetings.<br>• Tracking and oversight is provided at Executive Governance Meetings.<br>• Where learning is identified, it is shared across the Trust to support wider improvement.<br>• Increased cross-working with MDT teams, including Safeguarding and Learning & Development, has been implemented to strengthen oversight and collaboration | | N/A | High |

# Assurance Reports: WHO Audits




Total Number of Patients : 805

Incomplete patients: 7




Total patients: 95

| 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 |
|---|---|---|---|---|
| 120 operating lists audited.<br>Audit compliance across the majority of theatres was achieved in February reflecting continued engagement and monitoring.<br>However, Theatre 3 recorded 2/10 submissions. Theatre 11 recorded no audits in February. These areas will require follow-up to understand the contributing factors and to support improvement in audit engagement moving forward.<br>Overall, while compliance remains strong across most theatres, targeted support and review will be required for Theatres 3 and 11, with continued monitoring to ensure audit completion improves in the coming months. | Team brief booklet is now in place. | | N/A | High |

# Assurance Reports: CAS Alerts

CAS Alerts Received 1- 28 FEB 2026

| Reference | Alert Title | Originated By | Issue date | Response | Deadline |
|---|---|---|---|---|---|
| None received | | | | | |

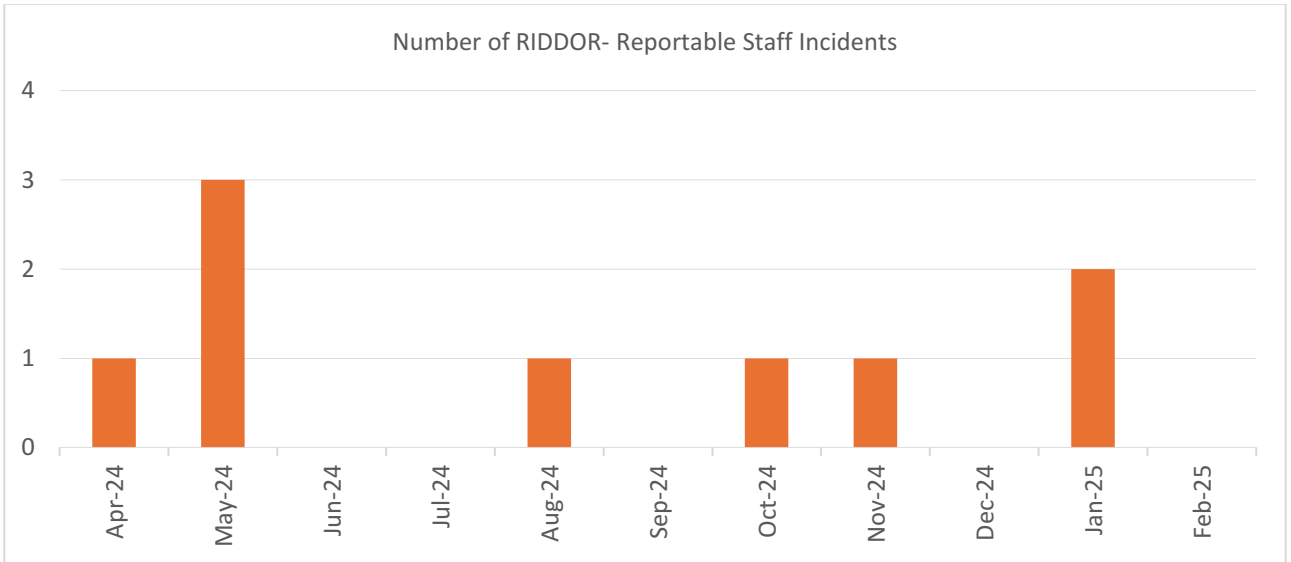
| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| There were no new CAS alerts received in February 2026 | | | N/A | High |

# Assurance Reports: Outstanding CAS Alerts

| Reference | Alert Title | Originated By | Issue date | Response | Deadline |
|---|---|---|---|---|---|
| NatPSA/2025/008/NHSPS | Risks associated with adult breathing circuits lacking a patient exhalation route.<br><br>"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.<br><br>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<br><br>Update: In progress; Patient Safety Team and Clinical Teams actioning. Developing guidance for Trust use. | 12 Jun 2026 |
| NatPSA/2025/006/NHSPS | Harm from incorrect recording of a penicillin allergy as a penicillamine allergy.<br><br>This joint National Patient Safety Alert has been issued by the NHS England National Patient Safety team, in collaboration with the Royal Pharmaceutical Society, Royal College of Physicians and Royal College of General Practitioners, on the risk of harm from healthcare staff incorrectly recording patients' penicillin allergies as penicillamine allergies in electronic prescribing systems.<br><br>This error can result in patients with known penicillin allergies being prescribed penicillin-based antibiotics, increasing the risk of a potentially fatal anaphylactic reaction. Primary and secondary care organisations must form working groups to identify and review affected patients' records and act appropriately to correct any inaccuracies, implement additional safeguards in training and processes, and work with digital system suppliers to develop technical mitigations. | National Patient Safety Alert – NHS England Patient Safety | 20 Nov 2025 | Assessed – relevant to organisations' services<br><br>Update: Actions underway.<br>PICS Support Team (Email 24.11.25): "Pharmacy are...reviewing all patients with Penicillamine listed as an allergy in PICS... will update the patient records to reflect the accurate allergy status of the patient..." | 20 Nov 2026 |

| 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 |
|---|---|---|---|---|
| | | | | |

# Assurance Reports: RIDDOR- Reportable Staff Incidents



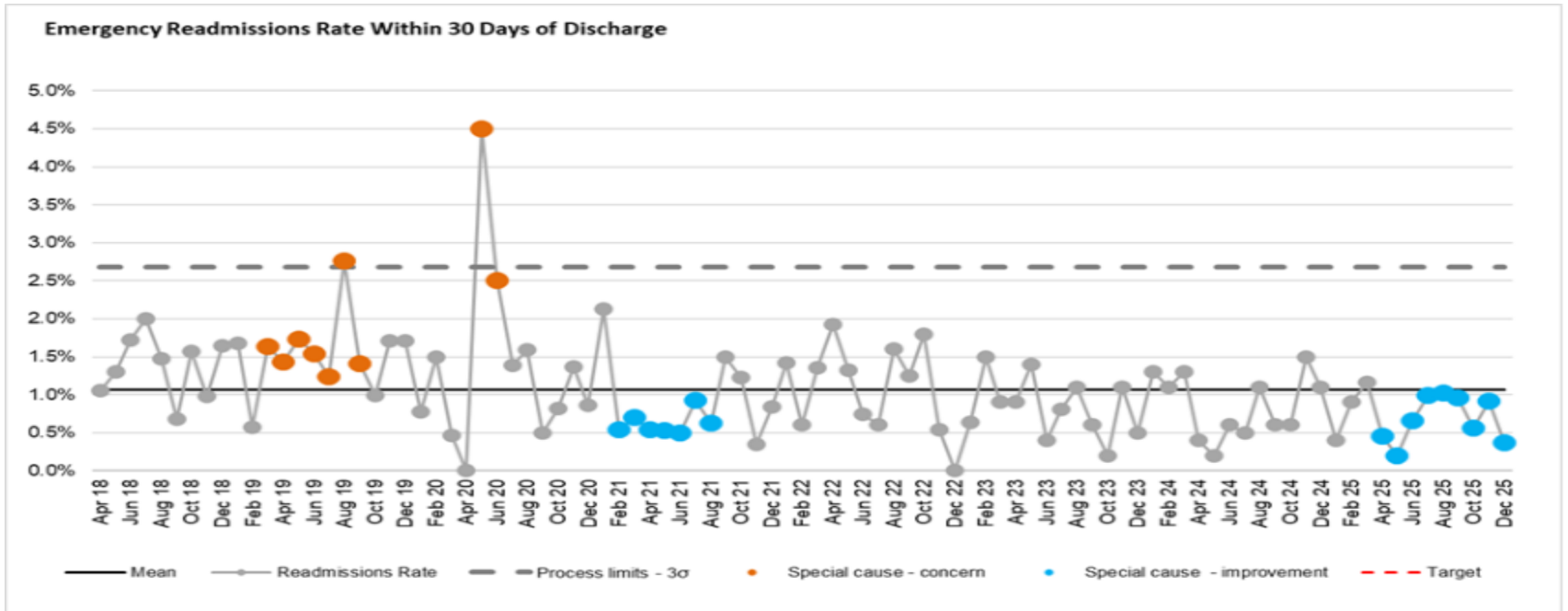

| Summary of challenges and risks | Actions to address risks, issues and emerging concerns relating to performance and forecast | Action timescales and assurance group or committee | Risk Register | Data Quality |
|---|---|---|---|---|
| There were 0 RIDDOR reportable incidents in February 2026. | •Improvements to training / awareness with Managers; cover RIDDORs in detail in Me as a Manager training.<br>•Making adaptations to CMT (H&S) training to sign post Managers for more detail on RIDDOR requirements.<br>•Updating SOP for CAS alerts - Updated version should be ready in time for February CQG. | | N/A | High |

# Assurance Reports: Safeguarding Training

| KPI | February 2026 |
|---|---|
| Safeguarding Adult Notifications | 38 |
| Safeguarding Children Notifications | 48 |
| Adults Level 1- Target 90% | 96.81% |
| Adult Level 2 -Target 85% | 94.45% |
| Adult/Children Level 3 and MCA&Dols- Target 85% | 86.13% |
| Level 4- Target 90% | 80.0% |
| Child Level 1 -Target 90% | 96.81% |
| Child Level 2- Target 85% | 94.37% |
| Prevent Awareness- Target 95% | 94.22% |
| WRAP (prevent level 3)- Target 90% | 90.87% |
| Domestic Abuse | 12 |
| FGM | 1 |
| DOLS | 4 |
| MCA | 7 |
| PIPOT cases | 1 |
| PREVENT Notifications | 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 |
|---|---|---|---|---|
| Above training data for substantive staff only. | Action plan developed to address the gap in Level 3.<br>Raised by Named Doctor at QIDD, exploring linking compliance to Medical appraisal process.<br>Increase availability of session<br>Line manager reviewing local records and ensuring staff are booking onto day.<br>Prompting online version of Prevent and Wrap training. | | | High |

# Assurance Reports: Readmissions

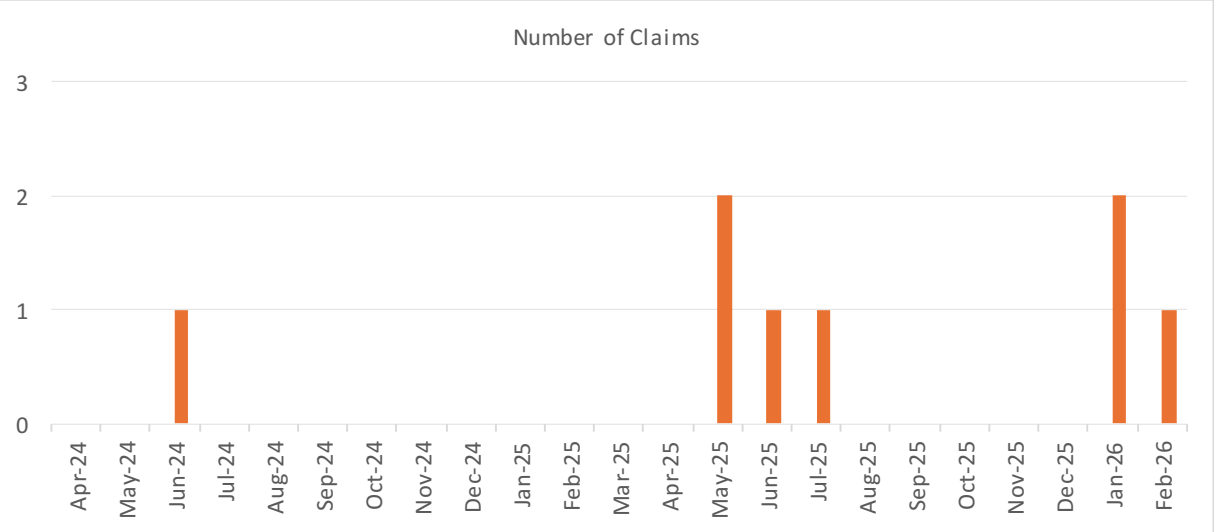


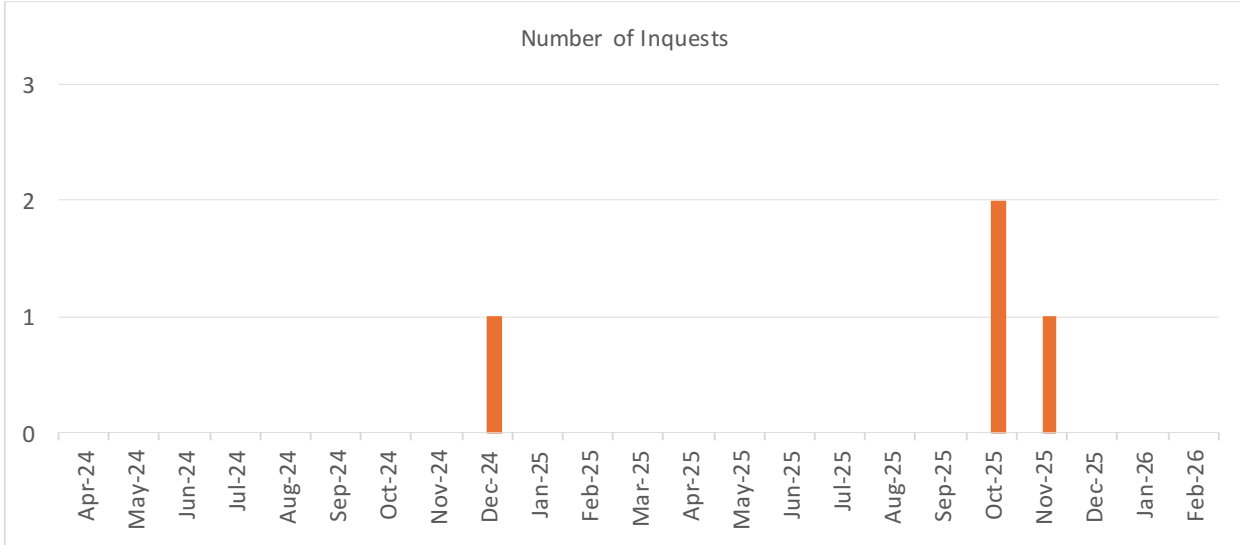

| | Number of Emergency Readmissions to ROH within 30 Days of Discharge | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 |
| No of Readmissions | 2 | 5 | 6 | 2 | 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% |

# Assurance Reports: Freedom to Speak Up

| 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 |
|---|---|---|---|---|
| **Concerns Raised:** There were Six concerns raised to FTSUG in January 2026.<br><br>**Concerns reported were related to the following themes:**<br><br>•Poor support from manager and inappropriate attitude and behaviour between manager and staff as well as staff and staff, impacting on workers safety and wellbeing.<br>•Shifts not going onto the loop system causing unfair distribution of shifts rota.<br>•Inappropriate storage of patients notes.<br>•Lack of adherence to job recruitment policy.<br><br>All cases have been escalated to the appropriate person, line managers and/or HR | **Learning and improvement:**<br><br>Themes highlight a potential need to for improved compassionate engagement and management from people in leadership/management roles | | N/A | High |

# Assurance Reports: Legal Updates




| 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 |
|---|---|---|---|---|
| | | | | |

# Quality Report

March 2026

(February 2026 Data)

# Introduction

- This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to the quality of care, patient safety, and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham and Solihull Integrated Care System for routine engagement and assurance meetings.
- The data being used has been validated by the relevant Trust Leads, and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

# Icons reading guide

## Summary Icons Reading Guide

With the redesign of the IPR you will now see 2 summary icons against each KPI, which have been designed by NHSI to give an overview of how each measure is performing at a glance. The first icon is used to show whether the latest month is of concerning or improving nature by using SPC rules, and the second icon shows whether or not we can reliably hit the target.

### Exception Reporting

Instead of showing a narrative page for every measure in the IPR, we are now only including these for those we are classing as an 'exception'. Any measure that has an orange variation or assurance icon is automatically identified as an exception, but each KPI has also been individually checked and manually set as an execption if deemed necessary. Summary icons will still be included on the summary page to give sight of how measures without narrative pages are performing.

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

### Variation Icons

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


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


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


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

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

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

### Assurance Icons

Can we expect to reliably hit the target?


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


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


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


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

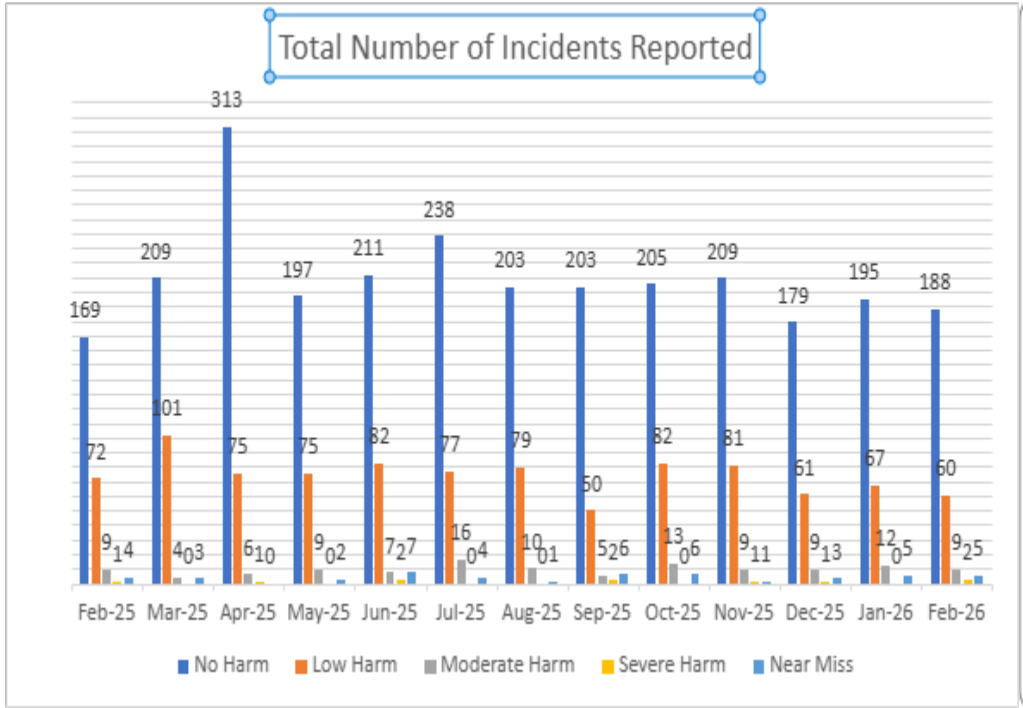

Currently shown for any KPIs with moving targets as assurance cannot be provided using existing calculations.

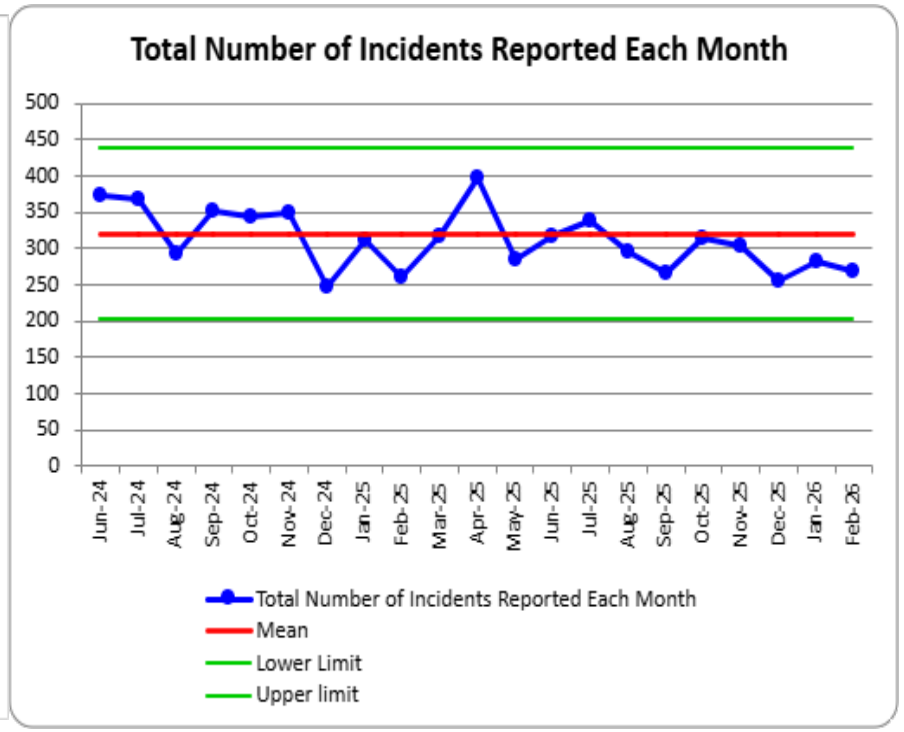
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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

# Governance Performance Summary Dashboard

| Performance to end February 2026 | In month | Previous month | Variation | Assurance |
|---|---|---|---|---|
| Total No of Incidents Reported | 268 | 282 | | |
| 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 | 0 | 1 | | |
| Category 3 Pressure Ulcer Incidents | 0 | 0 | | |
| Falls (Total No of Inpatient Falls) | 9 | 10 | | |
| Infection Incidents (Reportable) | 0 | 0 | | |
| Complaints | 5 | 8 | | |
| Claims | 1 | 2 | | |
| Inquest | 0 | 0 | | |
| RIDDOR Reportable Incidents | 0 | 2 | | |

# Incidents Reported




## Quality Improvement & Learning

There were 268 incidents reported within the Trust during February 2026.
There continues to be a downward trend in incident reporting. Initial review indicates that:

- Reduction began in approx. August 2025
- Minimal to no change in reporting within Division 2
- Reduction in number of incidents reported in Division 1
- Reduction may be due to improvements around medicine safety incidents on the wards, reduction in clinic delay incidents and also improved position in terms of 65 and 52 week wait RTT incidents

Further in-depth analysis of department incidents will be undertaken, with further update to be included in the May 2026 Quality Report

# Incidents Reported... (continued)

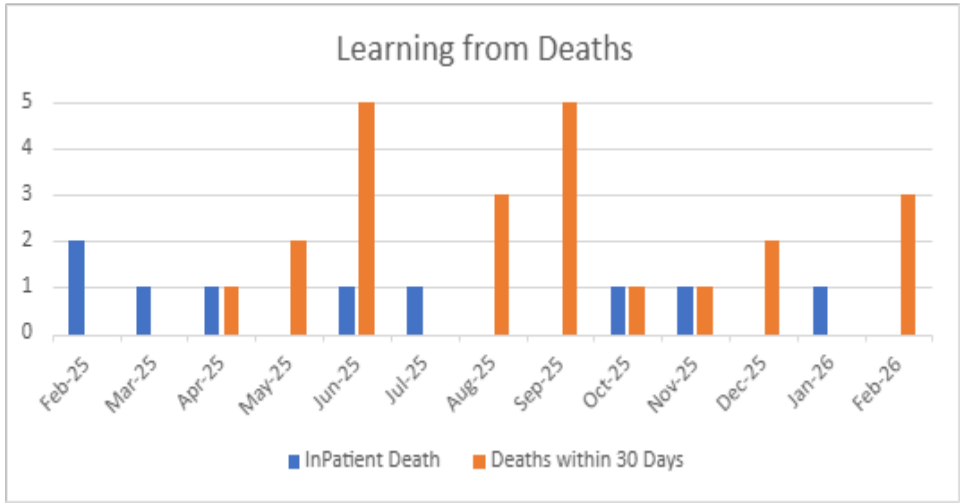
## Financial Year 2025-2026

| PSIRF Investigation Method | In Month | Last month | Year to Date |
|---|---|---|---|
| PSII | 0 | 0 | 4 |
| AAR | 0 | 2 | 15 |
| MDT | 0 | 0 | 1 |
| Thematic Review | 0 | 0 | 5 |

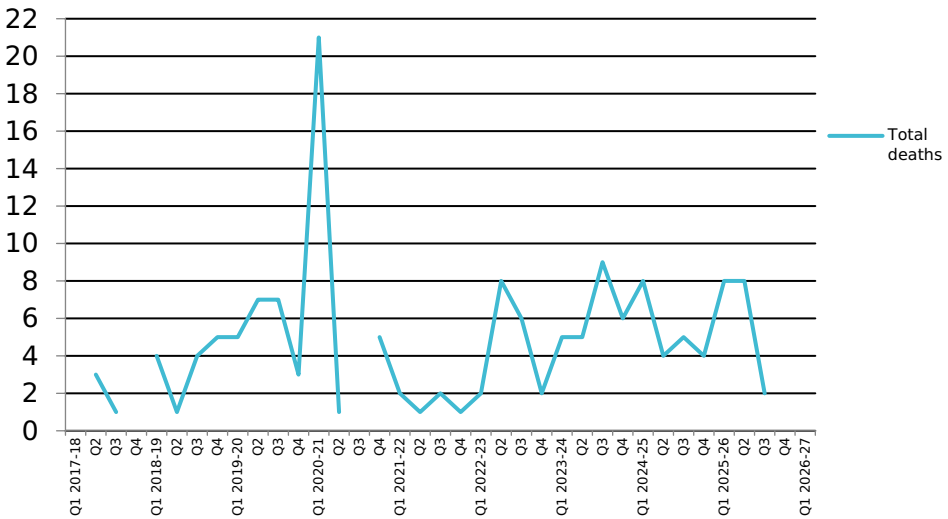
| PSIRF Investigation Method | 2024-2025 |
|---|---|
| PSII | 9* |
| AAR | 23 |
| MDT | 2 |
| Thematic Review | 4 |

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

# Learning from Deaths




**Mortality Over Time - Total Deaths Recorded**




## Quality Improvement & Learning

There were no inpatient deaths reported in February 2026.

HED & PAS data received and figures updated to reflect new information re: deaths within 30 days of discharge received. All deaths to be reviewed through the Learning from Deaths process.

Incident reported in relation to the death of a patient following emergency transfer out to Heartlands Hospital. Coroner has opened an investigation (not inquest) into the death. Separate divisional governance review and Structured Judgement Review underway. Further update to be provided in a future report.

# Infection Prevention & Control

| Infections Recorded in month and Year to Date (YTD) | FEBRUARY 2026 | 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.**

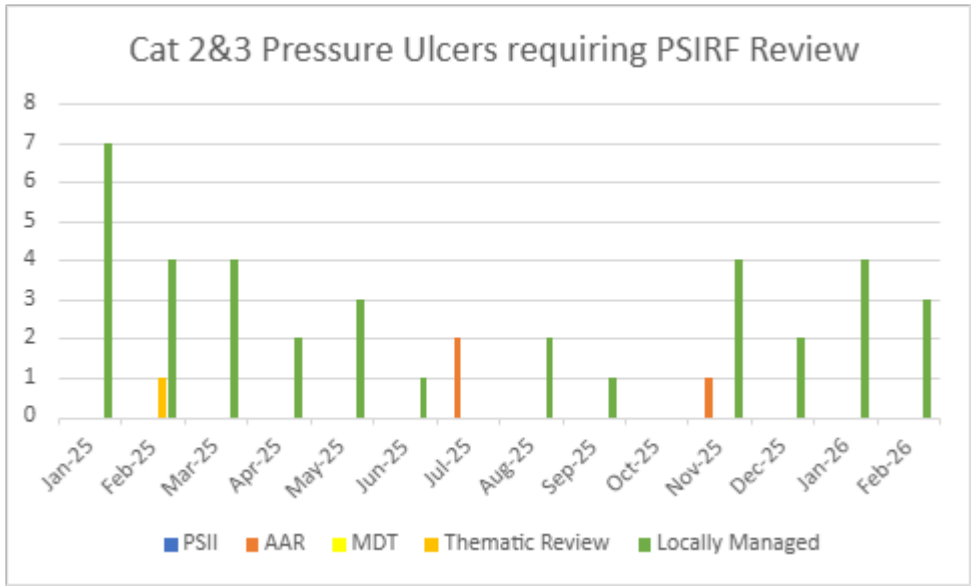
**NHS Standard Contract objectives for minimising Chloridoids difficile infection (CDI) and Gram-negative blood steam infections - ROH thresholds:**

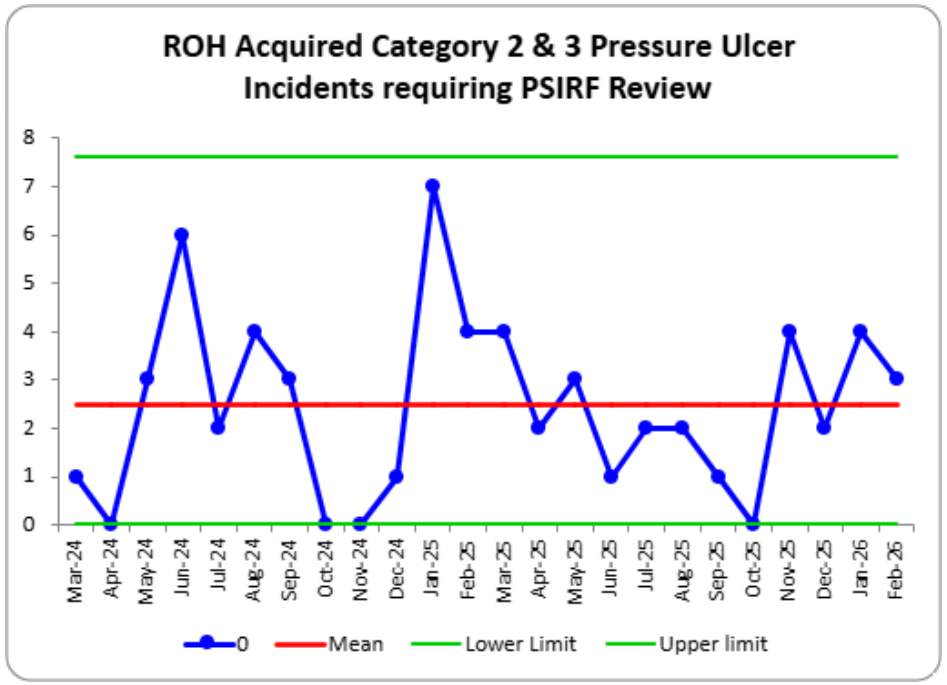
| | CDI (Toxin +ve) | *E.coli* BSI | *P. aeruginosa* BSI | *Klebsiella* Sp. BSI | MRSA BSI |
|---|---|---|---|---|---|
| 2023/24 | 5 | 0 | 0 | 1 | 0 |
| 2024/25 | 1 | 2 | 0 | 0 | 0 |
| 2025/26 | 0 | 0 | 0 | 0 | 0 |

**QUALITY IMPROVEMENT WORK**

**Themes and learning:**
Details of IPC QI work is reported to the IPC Committee and upwardly to Quality & Safety Committee via the Director of IPC (Chief Nurse).

# Tissue Viability

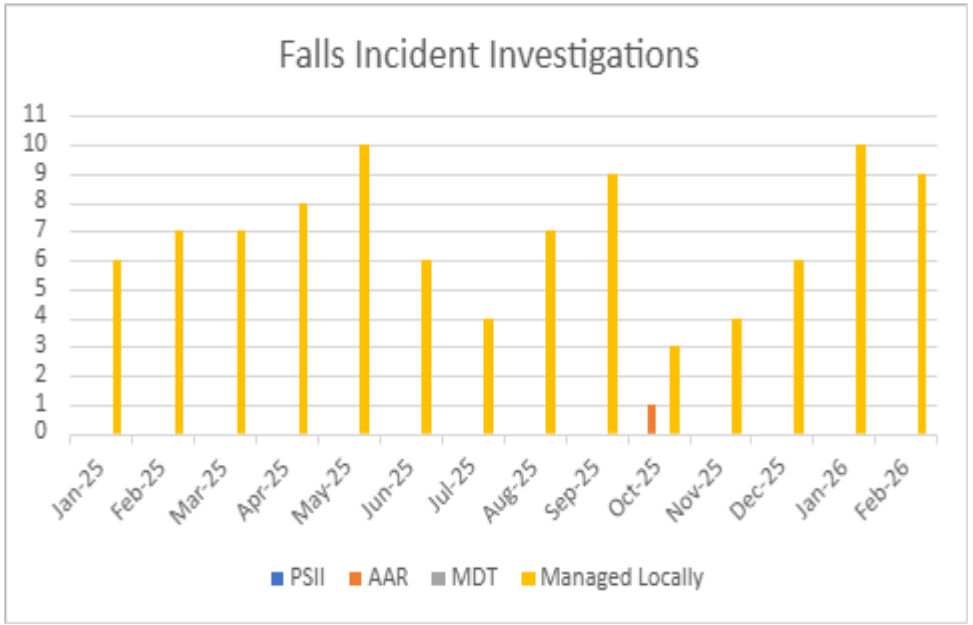


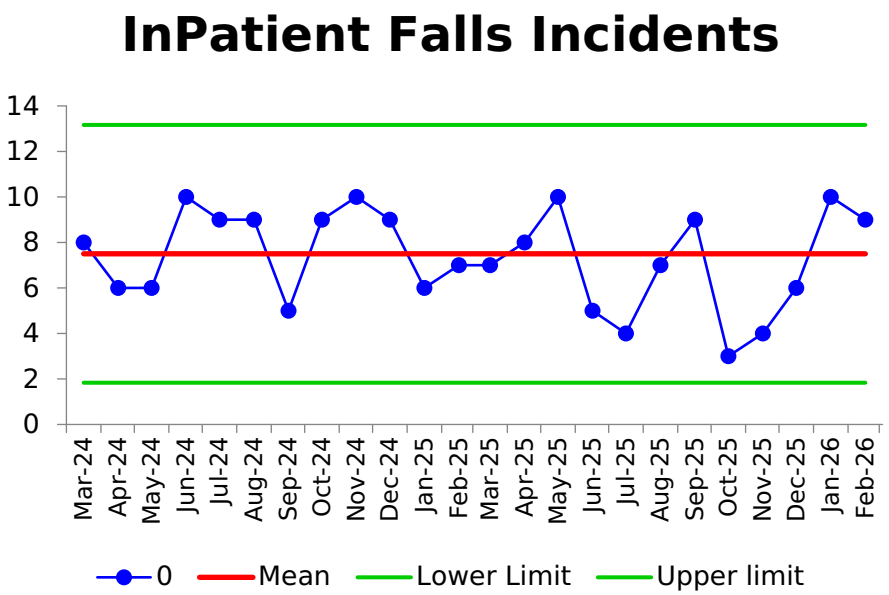




## Quality Improvement & Learning

There were 3 ROH acquired pressure ulcer incidents reported in February 2026. After review by Tissue Viability all incidents have been graded as no or low harm and will be managed locally via Tissue Viability or ward teams.

# Falls




## Quality Improvement & Learning

There were 9 inpatient falls reported in February 2026. All incidents were reported as no or low harm and are being managed locally.

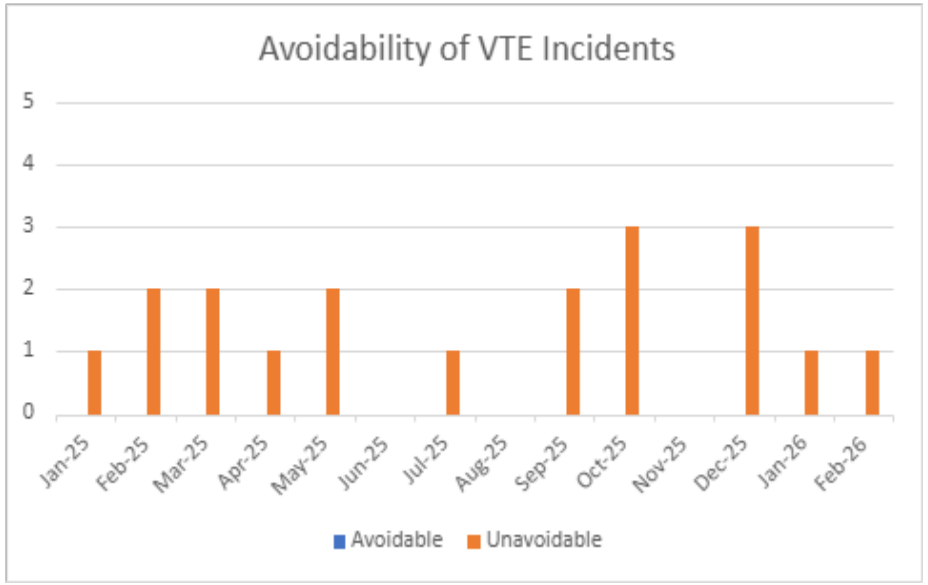
Themes identified from falls incidents:-

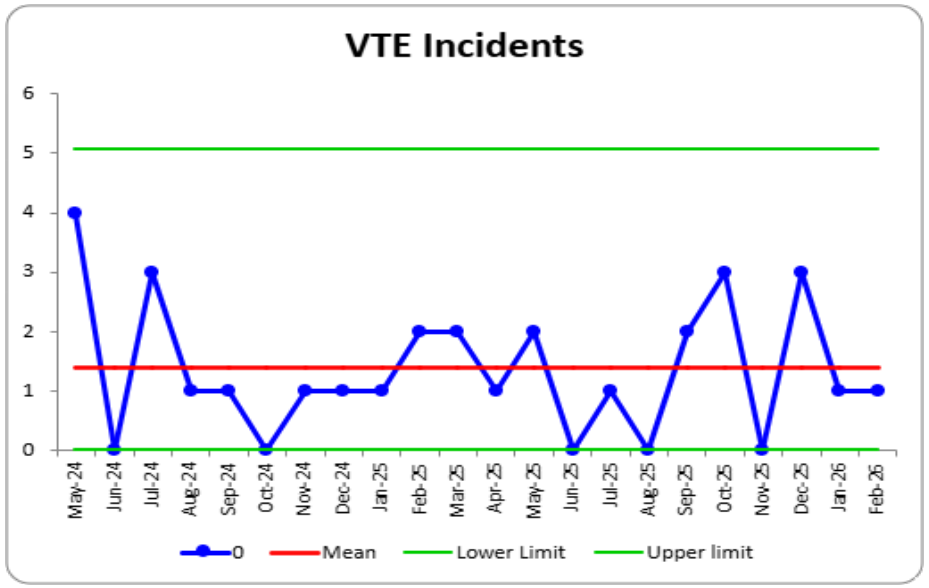
- Mobilising against advice, particularly advice regarding walking aids
- Ward 2 recorded 3 falls
- Ward 4 recorded 3 falls

Quality and Improvement Work

- Bedrails policy redrafted – further discussion/agreement around service & maintenance of beds & trollies ongoing with Chief Nurse and Head of Estates.
- New PICS falls risk assessment now available in test system, with aim of go live within next 2 months

# VTEs




## Quality Improvement & Learning

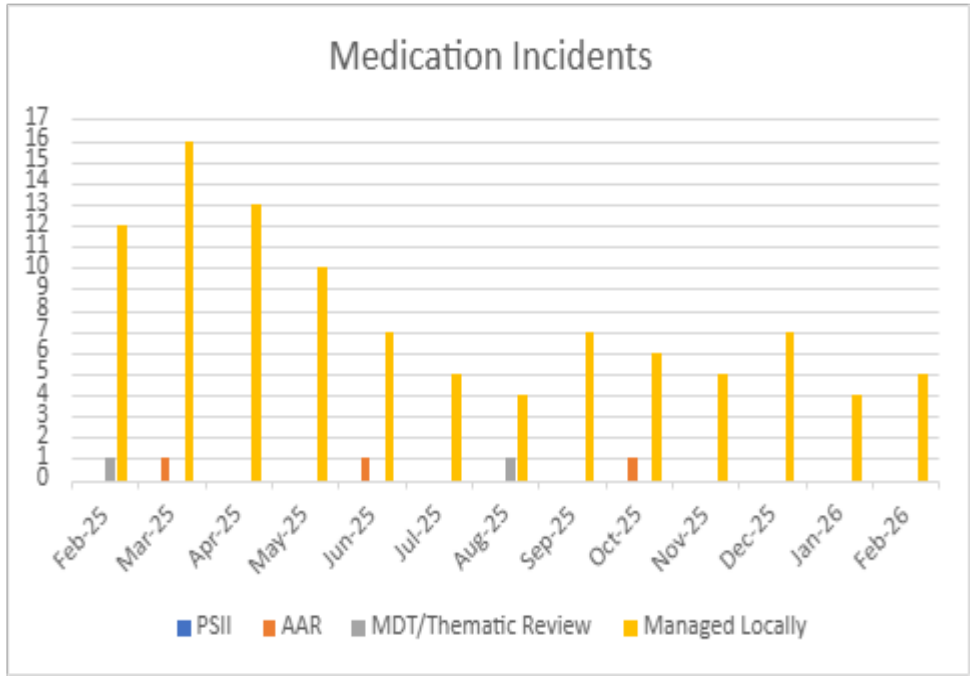
There was 1 confirmed VTE incident reported in February 2026.
All recent VTE incidents have been deemed unavoidable after PSIRF VTE triage review.

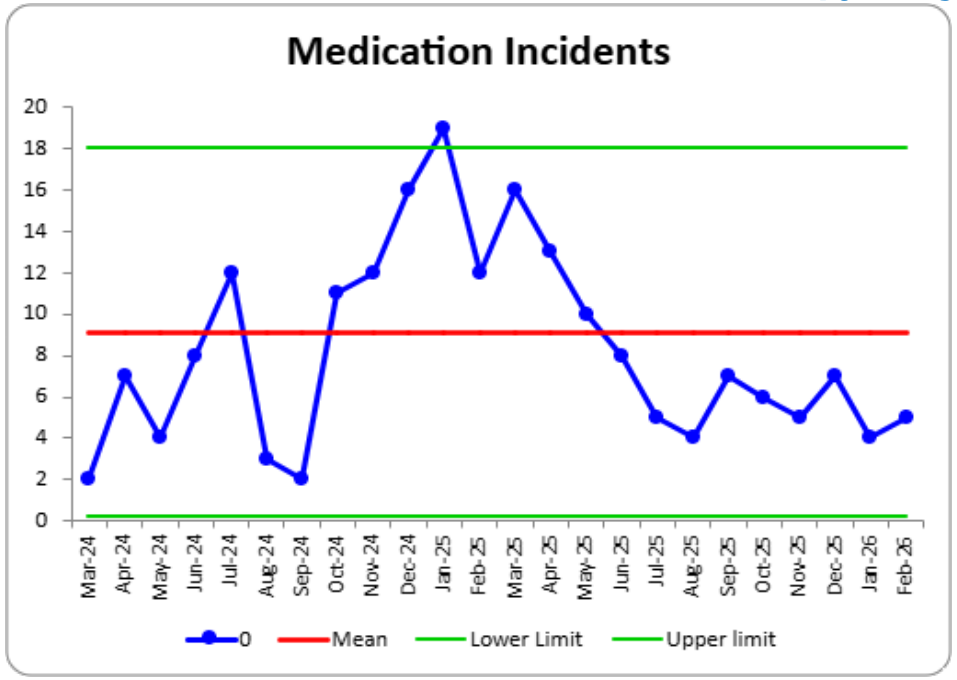
VTE Lead connects with VTE Exemplar Network regarding national improvement work or shared learning.

VTE Group currently reviewing evidence relating to Anti embolic stockings use and the standardisation of Hospital acquired Thrombosis definition and reporting.

**VTE On Admission Assessment Compliance**
Compliance figure for February 2026: 96.43%

# Medication Errors



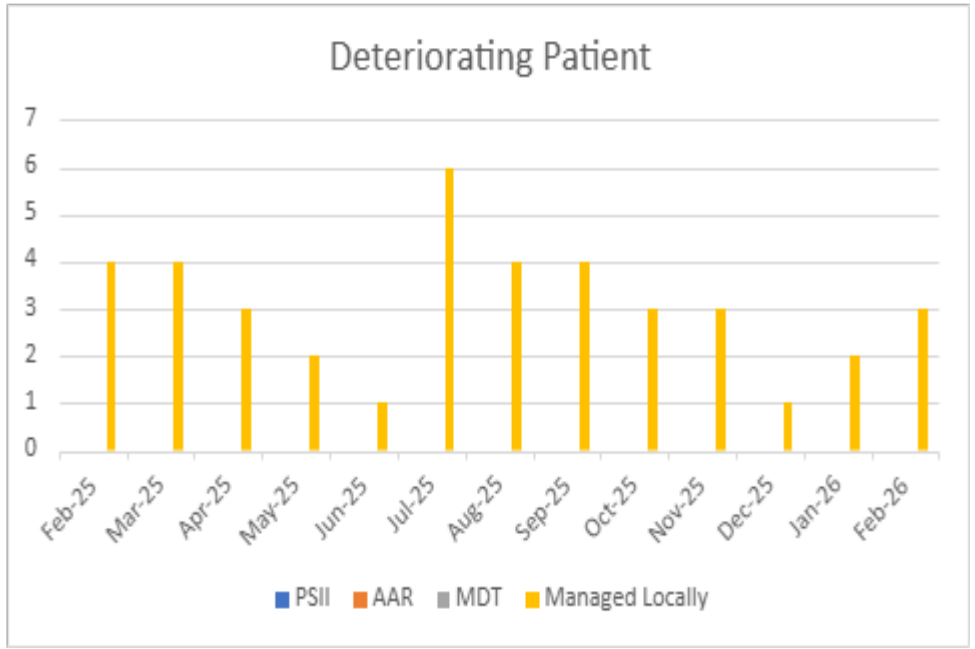



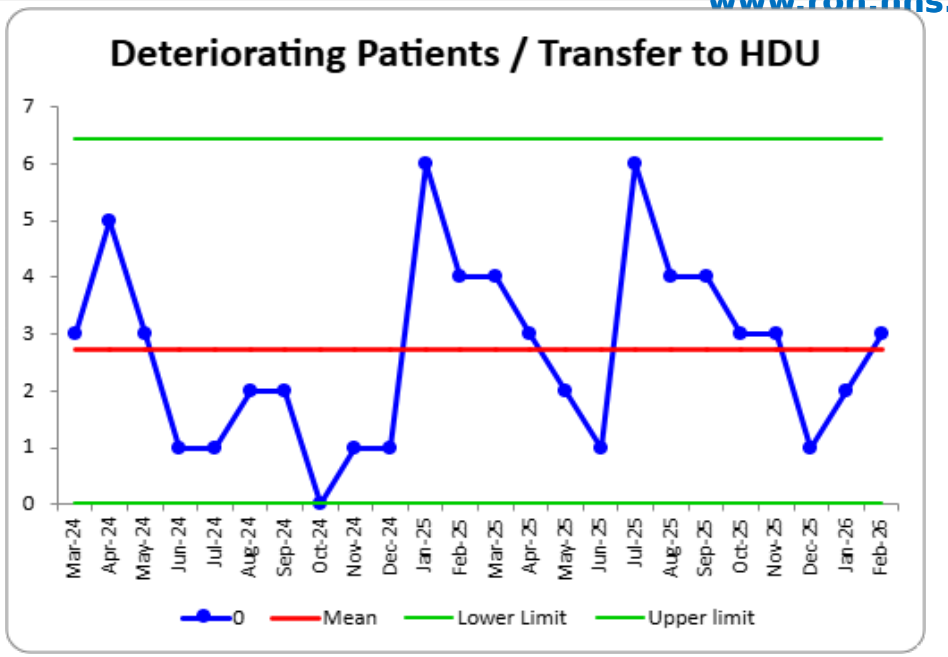

## Quality Improvement & Learning

There were 5 Medication incidents reported in February 2026.
All incidents have been reported as no or low harm and are being managed locally.

Pharmacy have been supporting a programme of 4 weeks of targeted medicines teaching on wards based on recent incident trends with a focus on ward 4 in January 2026, ward 3 in February 2026 and ward 2 to follow in March 2026.

# Deteriorating Patients




## Quality Improvement & Learning

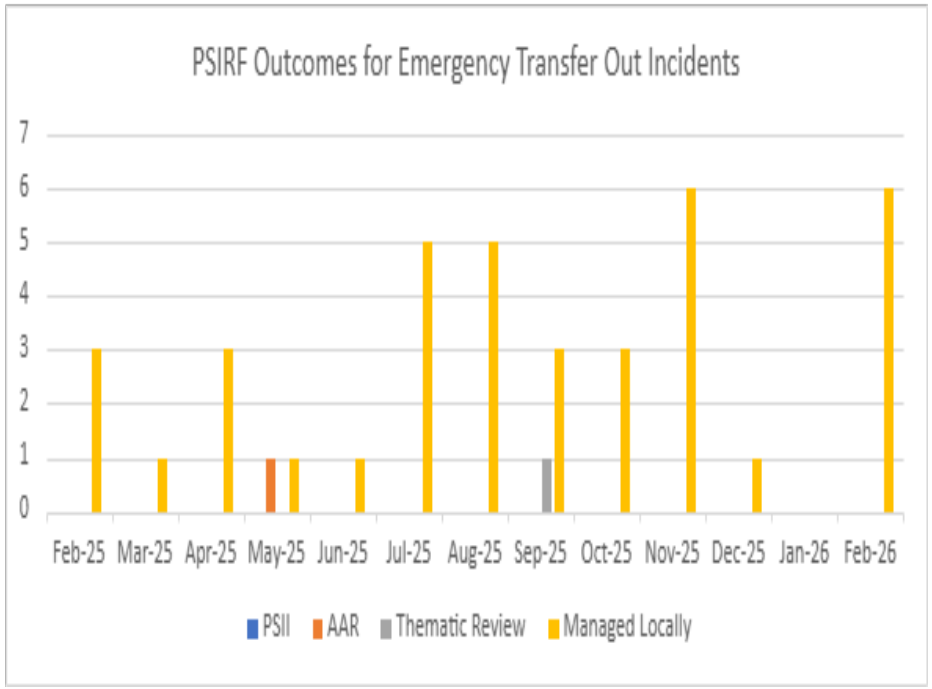
There were 3 deteriorating patient incidents reported in February 2026.

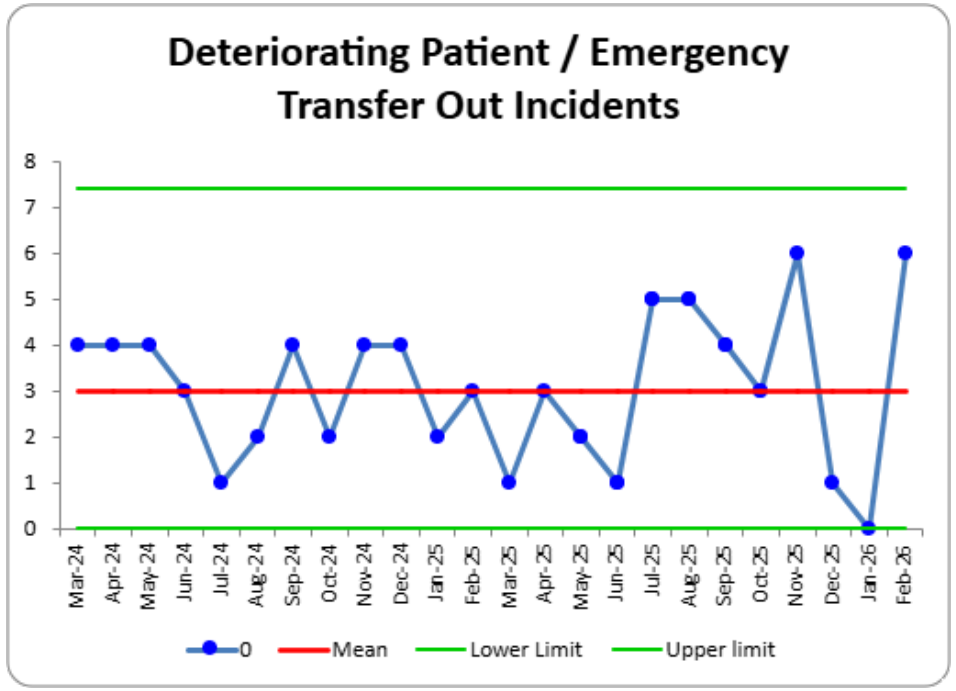
One of the incidents relates to the death following emergency transfer out to Heartlands hospital referenced in slide 7.

The 2 remaining incidents were reviewed in divisional governance and are to be managed locally.

Marath's rule (Call 4 Concern): the Patient Well-being Questionnaire (PWQ) is being rolled out across all wards. This work is being led by the Critical Care Outreach lead and supported by the CNO. Communication and patient / staff level information has been developed to prompt the national initiative. Call 4 Concern is due to been implemented by April 26. AIM training and communication training are also being delivered by the CCOT team to support implementation.

# Emergency Transfers Out




## Quality Improvement & Learning

There were 6 emergency transfer out  of Trust incidents reported in February 2026.

One of the incidents relates to the death following emergency transfer out to Heartlands hospital referenced in slide 7.

Following review at divisional governance all other incidents are being managed locally.

# Complaints

## Complaint Information

The Trust received 5 new formal complaints in February 2026. Of these, all remain open but within agreed timescales as of 28th February 2026 resulting in a February KPI achievement of 100%. Additionally, 7 complaints opened in previous months were closed during February with 5 of these breaching their originally agreed timescales.
On 28/02/2026 The trust had 18 formal Complaints open, of which 4 had breached the agreed timescales. This provides a February closure KPI of 77%

**Below are the departments that received complaints**

- Spinal x 2
- MSK x 1
- Pain Management x 1
- Large Joints x 1

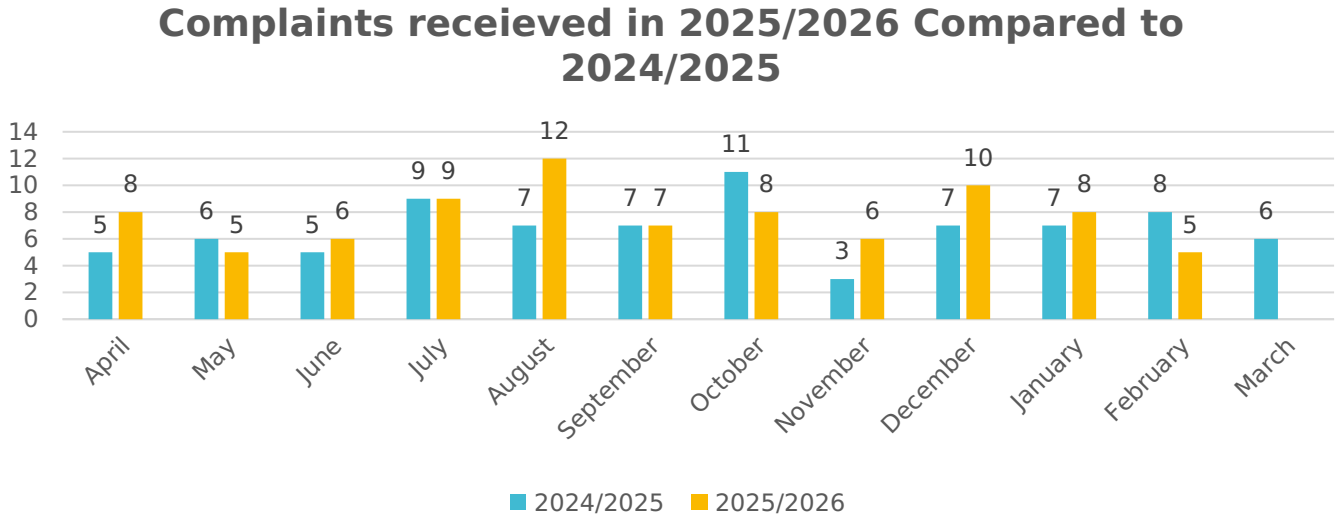
## Complaint Resolution Meetings and Reopened Complaints

The Trust offers meetings to the complainant in both the verbal and written acknowledgement letter and also within the response letter. Where the Trust did not meet the complainant's expectation in the first response or meeting, the Trust encourages complainants to write to us with any additional comments, questions or recommendations that will satisfy the complainant.

In **February 2026** the Trust received no new requests for a resolution meeting and facilitated one Resolution Meeting successfully.

There were no requests for a complaint to be re-opened

# Complaints

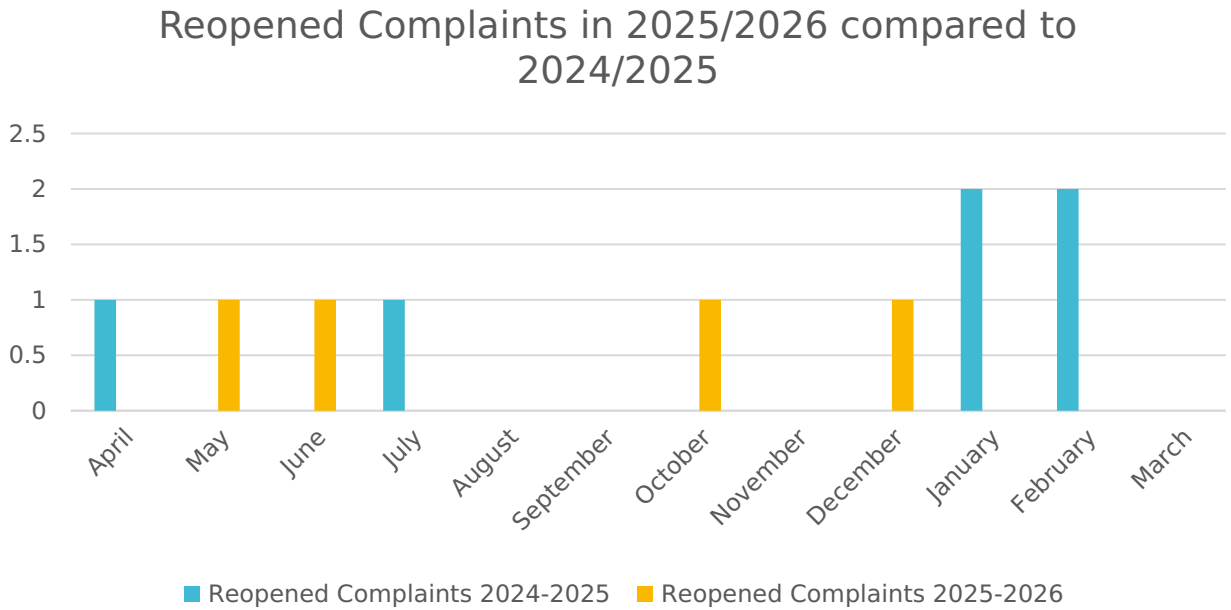



| Complaint Year Totals | |
|---|---|
| April 2023 - March 2024 | 42 |
| April 2024 – March 2025 | 92 |
| April 2025 – February 2026 | 83 |

**Category of Complaints Received**

- Clinical Query
- Unsatisfactory Care
- Appointment Delays
- Appointment Cancellations
- Failure to provide follow up

# Complaints



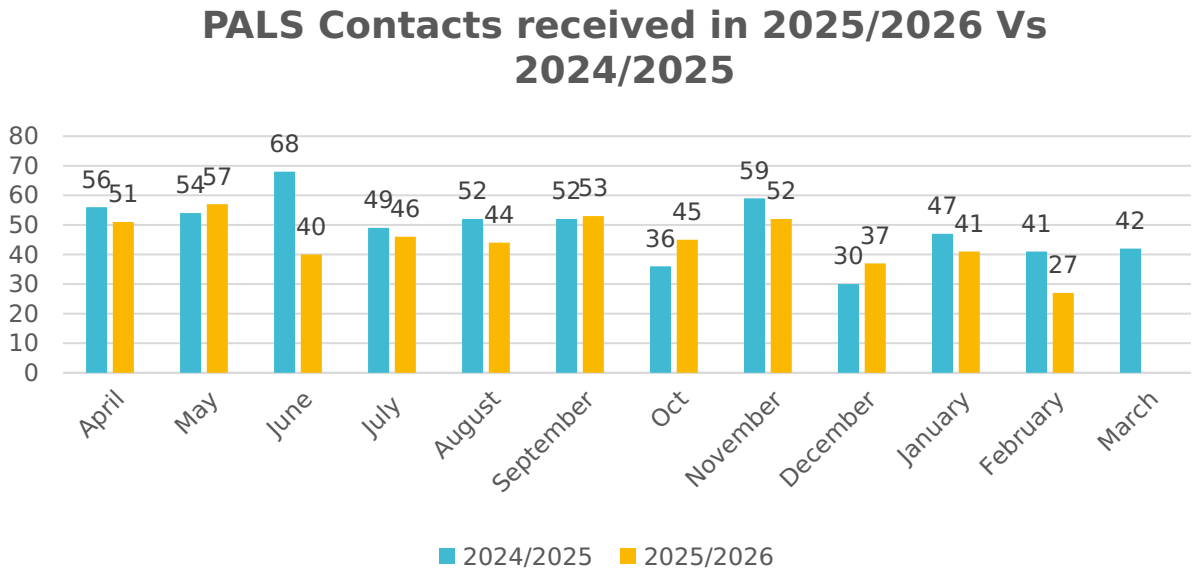

**Reopened complaints**

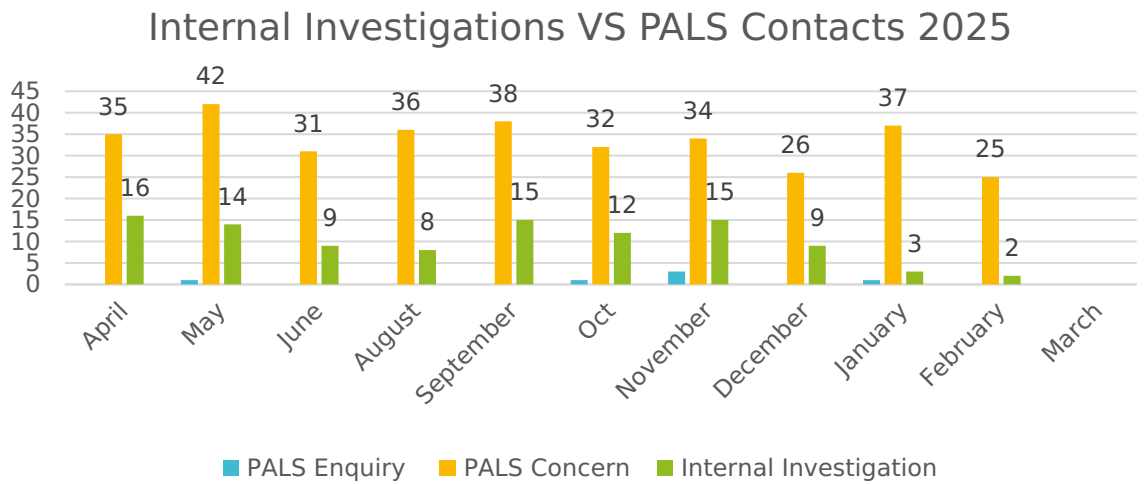
The Trust received **0** requests to reopen any complaints in **February 2026**

**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

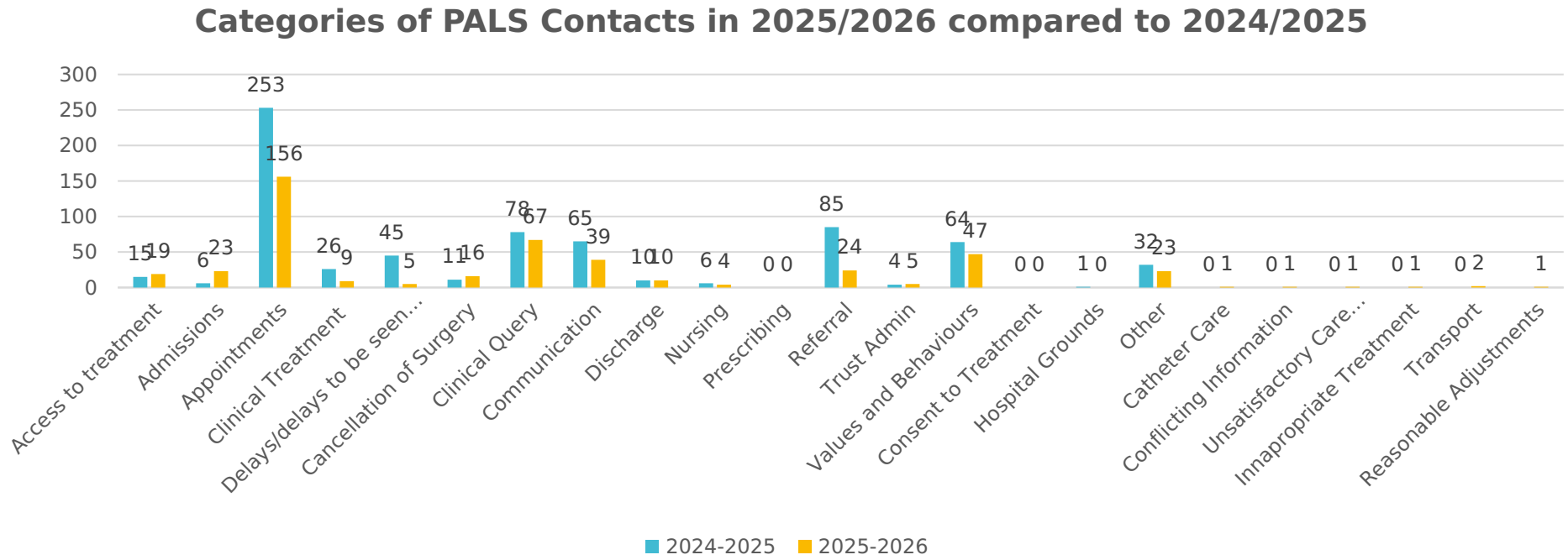



| KPI | KPI's |
|---|---|
| April 2025 | 83% |
| May 2025 | 74% |
| June 2025 | 81% |
| July 2025 | 70% |
| August 2025 | 70% |
| September 2025 | 67% |
| October 2025 | 61% |
| November 2025 | 61% |
| December 2025 | 75% |
| January 2026 | 76% |
| February 2026 | 66% |

9 PALS cases breached the agreed timeframe with the complainant / enquirer

# PALS




**What we have done / are doing:**

Tracked in Executive Governance Meetings

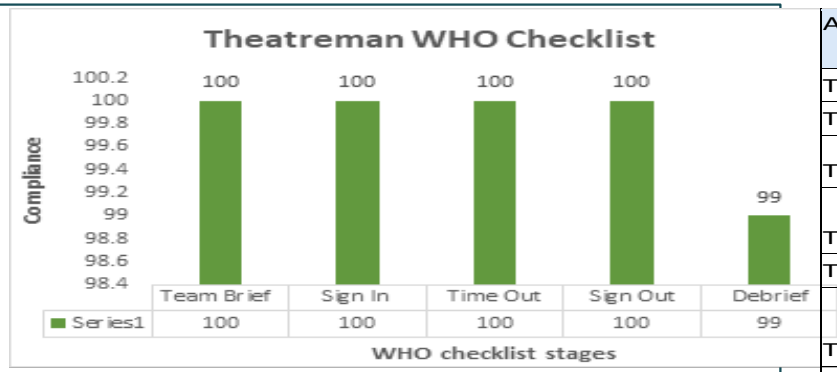
Raised in Governance meetings and with departmental managers.

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 : 805

Incomplete patients: 7

120 operating lists audited.

| Area | Dec 25 | Number of audits | Jan 26 | Number of audits | Feb 26 | Number of audits | Progress |
|---|---|---|---|---|---|---|---|
| Th1 | 100% | 10 | 100% | 10 | 100% | 10 | ↔ |
| Th2 | 100% | 10 | 99.70% | 10 | 100% | 10 | ↔ |
| Th3 | 100% | 10 | 100% | 10 | 100% | 2 | ↓ |
| Th4 | 100% | 7 | 100% | 4 | 100% | 10 | ↑ |
| Th5 | 100% | 10 | 100% | 10 | 100% | 10 | ↔ |
| Th6 | 100% | 10 | 100% | 10 | 100% | 10 | ↔ |
| Th7 | 100% | 10 | 100% | 10 | 100% | 10 | ↔ |
| Th8 | 100% | 7 | 99.70% | 10 | 100% | 8 | |
| Th9 | 99.70% | 10 | 100% | 10 | 100% | 10 | ↔ |
| Th10 | 100% | 10 | 100% | 9 | 100% | 10 | ↔ |
| Th11 | 100% | 4 | 100% | 10 | 0 | 0 | ↓ |
| Th12 | 100% | 10 | 100% | 10 | 100% | 10 | ↔ |
| Th14 | 100% | 5 | 100% | 10 | 100% | 10 | ↔ |
| Th15 | 100% | 8 | 100% | 10 | 100% | 10 | ↔ |

## Quality Improvement & Learning

The visual audit results show consistently high compliance across audited areas, with most themes achieving 100% throughout the reporting period, reflecting strong alignment with WHO guidance. Minor variances of 99.7% were observed in a few areas, indicating isolated improvement opportunities rather than systemic issues.

Performance remained stable across December, January, and February. The only exception was Theme 11 in February, where no audits were recorded, representing a coverage gap rather than a compliance failure.

Overall, compliance is strong, with only minor variations and a few coverage gaps. Continued monitoring and consistent audit completion will help maintain standards and identify emerging issues early.

Moving forward, we will ensure all audits are completed on schedule and guided by clear, standardised procedures with checklists and training. We will monitor results monthly, assign ownership, and address minor variances promptly. The condition report has been revised and separated into specialties to promote ownership of each cluster group. We will also continuously review processes and provide refresher training to maintain consistent 100% compliance, and utilise the downtime whilst Theatres 1, 2, and 4 are closed to refresh the staff.

# CAS Alerts

## CAS Alerts - February

CAS Alerts Received 1- 28 FEB 2026

| Reference | Alert Title | Originated By | Issue date | Response | Deadline |
|---|---|---|---|---|---|
| None received | | | | | |

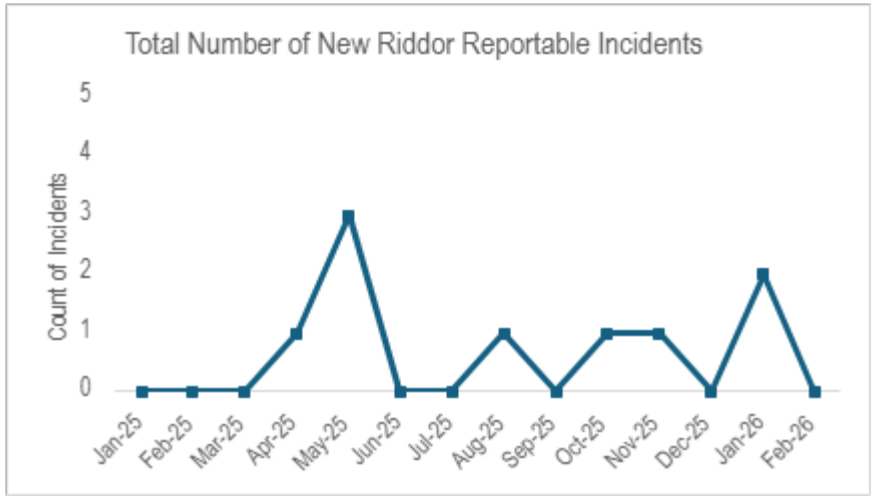
# CAS Alerts - Continued

## Outstanding CAS Alerts

| Reference | Alert Title | Originated By | Issue date | Response | Deadline |
|---|---|---|---|---|---|
| NatPSA/2025/008/NHSPS | Risks associated with adult breathing circuits lacking a patient exhalation route.<br><br>"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.<br><br>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<br><br>Update: In progress; Patient Safety Team and Clinical Teams actioning. Developing guidance for Trust use. | 12 Jun 2026 |
| NatPSA/2025/006/NHSPS | Harm from incorrect recording of a penicillin allergy as a penicillamine allergy.<br><br>This joint National Patient Safety Alert has been issued by the NHS England National Patient Safety team, in collaboration with the Royal Pharmaceutical Society, Royal College of Physicians and Royal College of General Practitioners, on the risk of harm from healthcare staff incorrectly recording patients' penicillin allergies as penicillamine allergies in electronic prescribing systems.<br><br>This error can result in patients with known penicillin allergies being prescribed penicillin-based antibiotics, increasing the risk of a potentially fatal anaphylactic reaction. Primary and secondary care organisations must form working groups to identify and review affected patients' records and act appropriately to correct any inaccuracies, implement additional safeguards in training and processes, and work with digital system suppliers to develop technical mitigations. | National Patient Safety Alert – NHS England Patient Safety | 20 Nov 2025 | Assessed – relevant to organisations' services<br><br>Update: Actions underway.<br>PICS Support Team (Email 24.11.25): "Pharmacy are…reviewing all patients with Penicillamine listed as an allergy in PICS… will update the patient records to reflect the accurate allergy status of the patient…" | 20 Nov 2026 |

# RIDDOR - Reportable Staff Incidents

## RIDDOR Reportable Incidents – February 2026




## Quality Improvement & Learning

There were 0 RIDDOR reportable incidents in February 2026.

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

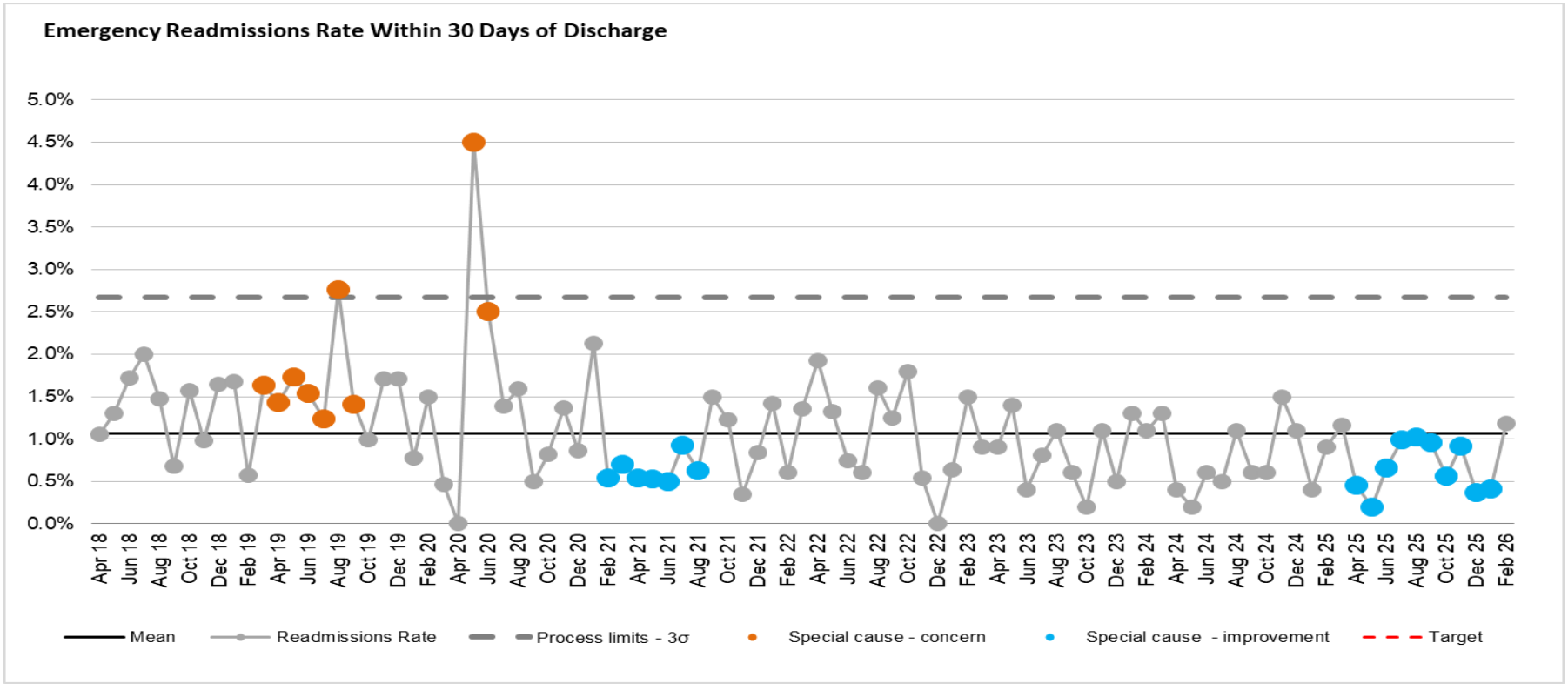
| KPI | February 2026 |
|---|---|
| Safeguarding Adult Notifications | 38 |
| Safeguarding Children Notifications | 48 |
| Adults Level 1- Target 90% | 96.81% |
| Adult Level 2 -Target 85% | 94.45% |
| Adult/Children Level 3 and MCA&Dols- Target 85% | 86.13% |
| Level 4- Target 90% | 80.0% |
| Child Level 1 -Target 90% | 96.81% |
| Child Level 2- Target 85% | 94.37% |
| Prevent Awareness- Target 95% | 94.22% |
| WRAP (prevent level 3)- Target 90% | 90.87% |
| Domestic Abuse | 12 |
| FGM | 1 |
| DOLS | 4 |
| MCA | 7 |
| PIPOT cases | 1 |
| 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.

Above training data for substantive staff only.

Report

# Readmissions




| | Number of Emergency Readmissions to ROH within 30 Days of Discharge | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
| No of Readmissions | 6 | 2 | 1 | 3 | 5 | 5 | 5 | 3 | 5 | 2 | 2 | 6 |
| Denominator | 516 | 445 | 508 | 456 | 507 | 487 | 522 | 532 | 549 | 540 | 481 | 509 |
| % Readmissions | 1.2% | 0.4% | 0.2% | 0.7% | 1.0% | 1.0% | 1.0% | 0.6% | 0.9% | 0.4% | 0.4% | 1.2% |

# Freedom to Speak Up

**Concerns Raised:** There were three concerns raised to FTSUG in February 2026.

**Concerns reported were related to the following themes:**

Workers Safety and wellbeing, inappropriate attitude, and behaviour

All cases have been escalated to the appropriate person, line managers and/or HR

The Royal Orthopaedic Hospital
NHS Foundation Trust

# Safe Staffing Summary

## Alert

1, The team wishes to bring the following issues to the committee attention:

There are no items requiring escalation for this period

## Advise

2, The team wishes to bring the following issues to the Committee's attention as they represent **areas for ongoing monitoring or emerging pressure**, taking into account the RNA reporting limitation:

Workforce – Sickness, Turnover, Establishment. And Sickness Trends shows a slight overall increase:
•Nursing Wards: 6.7%, Core Services: 8%, AHP: No sickness data supplied for this return
•Ward 4: 13.1% (highest rate across inpatient wards) , ADCU & POAC: Sickness above the Trust average

•Turnover remains low (1%), and WTE against establishment remains stable (83–97%).

•Red Flags – Interpretation and Reporting
• 0 red flags were opened or closed. While the absence of unresolved red flags is positive, the continued zero reporting position does not yet provide full assurance, as this is unlikely to reflect day to day operational activity
•The most likely cause remains variation in staff interpretation of what constitutes a red flag. This inconsistency is recognised and is being addressed through the Safer Staffing improvement work.
•Improvement actions underway include: Standardising red flag definitions across all inpatient areas, Staff refresher training on SafeCare red flag categories, System checks within SafeCare to support consistent use, Increasing confidence in raising and documenting flags, Matron level oversight to monitor compliance
• This will remain under Advise until consistent usage is embedded.

- CHPPD (Care Hours Per Patient Day)
  CHPPD across inpatient wards remains within expected ranges: Range: 6.4 – 25.0. HDU recorded a CHPPD of 25.0, which is expected for this clinical area due to the higher nurse-to-patient ratios required.
  CHPPD in HDU is also highly sensitive to changes in occupancy. With a small number of beds, even minor variations in patient numbers can significantly increase or decrease the averaged CHPPD figure. This value reflects clinical need, dependency and workload, not over-staffing or under-staffing. Matron oversight confirmed that staffing remained appropriate for the dependency and acuity of patients throughout the reporting period. Wards generally stable with no concerning variation
- Enhanced Care Hours
  324 hours of enhanced care were delivered this month. This is within the expected range for the Trust and reflects normal variation in patient dependency and the additional observation needs of individual patients. Staffing was flexed to support these needs, and no concerns were identified.
- Nurse-Sensitive Indicators
  4 total medication errors: Ward 3: 3, Ward 12: 1. All were reviewed locally with no indication of staffing-related causes
- Pressure Ulcers (Cat 2–4): 0 . Falls: 4 . PALs contacts: 7 . Complaints:1 . FFT was fully submitted this month. InpatientRange:55%–81% . Average:71%

No evidence of deterioration associated with staffing levels or safer-staffing concerns.
Future Reporting of Nurse-Sensitive Indicators
A review will be conducted, in collaboration with Nursing and Governance leads, to determine whether nurse-sensitive indicators remain appropriate for inclusion in this report. The focus will be on aligning with the Quality Report and considering whether these indicators should be reported by exception only, where there is a direct link to staffing or safer-staffing concerns.

# Safe Staffing Summary

| Assure | Recommendation |
| --- | --- |
| 3, The team considered the following items and did not identify any issues that required escalation to the Committee. | |
| Safe staffing was maintained across all areas through daily Matron oversight.<br>No staffing-related harm was identified this month.<br><br>Medication errors, while present, were low and managed appropriately.<br>FFT remains stable with positive patient feedback.<br><br>Enhanced care hours (324 hours) reflected typical patient-specific needs such as MCA/DoLS supervision, increased observation, and short periods of deterioration. This sits within the usual operational range for the Trust.<br><br>Overall, there is no evidence that staffing levels adversely affected patient safety during this period. | The Committee is asked to:<br>1. CONSIDER the content of section 1 and agree the next steps;<br>2. NOTE the content of section 2 and CONSIDER whether any further action is required; and<br>3. NOTE the content of section 3. |

# Safer Staffing - Wards / HDU

## Nursing

| Feb 26 data for March 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 Contacts | No. of New Complaints | No. of FFT |
| Ward 1 | 80.0% | 101.0% | 105.0% | 107.0% | 252.5 | 0 | 97% | 0% | 3.00% | 2.22% | 528.00 | 7.3 | 0 | 0 | 10.5 | 0 | 0 | 1 | 0 | 1 | 0.73 |
| Ward 2 | 85.0% | 106.0% | 106.0% | 154.0% | 209.5 | 55 | 83% | 3% | 7.81% | 3.79% | 585.00 | 7.6 | 0 | 0 | 313.5 | 0 | 0 | 3 | 0 | 0 | 0.81 |
| Ward 3 | 88.0% | 98.0% | 104.0% | 104.0% | 205.25 | 66 | 96% | 0% | 5.25% | 3.27% | 646.00 | 6.4 | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0.71 |
| Ward 4 | 98.0% | 98.0% | 102.0% | 109.0% | 31.5 | 0 | 92% | 0% | 13.10% | 3.38% | 426.00 | 9.0 | 0 | 0 | 0 | 0 | 0 | 3 | 0 | 1 | 0.81 |
| Ward 12 | 80.0% | 100.0% | 97.0% | 100.0% | 96 | 11 | 86% | 0% | 7.58% | 0.00% | 143.00 | 9.4 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0.55 |
| HDU | 89.0% | 75.0% | 93.0% | 0.0% | 0 | 0 | 89% | 0% | 3.58% | 2.45% | 102.00 | 25.0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.67 |
| total combined | - | - | - | - | 794.75 | 132.00 | - | - | - | - | 2430.00 | 64.7 | 0 | 0 | 324 | 4 | 0 | 7 | 1 | 2 | 4.28 |
| Total Average | 86.7% | 96.3% | 101.2% | 95.7% | 132.4583 | 22 | 90% | 1% | 6.7% | 2.5% | 405 | 10.78 | 0 | 0 | 54 | - | - | - | - | - | - |

# Safer Staffing- Core Services & Allied Health Professionals

## Core Services

| Feb 26 Data for March 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 | 78% | 78% | - | - | 0 | - | 84.14% | 0% | 5.89% | 5.35% | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.05 |
| CYP OPD | 34% | 109% | - | - | 0 | - | - | - | - | - | - | - | - | 0 | 0 | 0 | 0 | 0 | 0.5 |
| ADCU | 57% | 65% | - | - | 0 | - | 86.02% | 0% | 9.29% | 0.00% | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0.17 |
| POAC | 83% | 81% | - | - | 0 | - | 89.11% | 2% | 10.00% | 2% | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.21 |
| Theatres | 80% | 81% | - | - | 342 | - | 90.04% | 0% | 8.56% | 2.38% | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | n/a |
| Theatres recovery | 78% | 63% | - | - | 0 | - | - | - | - | - | - | - | - | 0 | 0 | 0 | 0 | 0 | n/a |
| Discharge Lounge | 100% | 99% | - | - | 0 | - | - | - | - | - | - | - | - | 0 | 0 | 0 | 0 | 0 | 0.49 |
| Total/Combined | - | - | - | - | 342.00 | - | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1.42 |
| Total Average | 73% | 82% | - | - | 48.8571 | - | 88.39% | 1% | 8% | 2% | 0 | 0 | 0 | 0% | 0% | 0% | 14% | 0% | 0.284 |

## Allied Health Professionals

| Feb 26 Data for March 26 Report | Fill Rate (KPI >90%=Green, 80-90%=Amber, <79%=Red) | | | | | | Workforce | | | | Nurse Sensitive Indicators | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 (%) | Medication Administration Error or concern | Skin Damage | All Reported Falls |
| In-patient Physio | 100% | 52% | - | - | - | - | - | - | - | - | - | - | - |
| Outpatient Physio | 100% | 53% | - | - | - | - | - | - | - | - | - | - | - |
| Radiology MRI | 69% | 53% | - | - | - | - | - | - | - | - | - | - | - |
| Radiology X-Ray/CT | 70% | 69% | - | - | - | - | - | - | - | - | - | - | - |
| Total Combined | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Total Average | 85% | 57% | - | - | - | - | - | - | - | - | - | - | - |

# Assurance Reports: Operational Performance Summary

| Metric | In Month | Previous Month | Target | Variation | Assurance |
|---|---|---|---|---|---|
| RTT Combined (against trajectory constitutional target remains 92%) | 63.07% | 62.18% | 59.64% | H | P |
| 65 Week waits (65-77 weeks) | 0 | 0 | 0 | L | P |
| 52 week waits (52-64 weeks) | 104 | 171 | 175 | L | P |
| RTT Proportion of Patients Waiting 52 weeks | 0.81% | 1.32% | 1.33% | L | P |
| RTT First Appointment Waiting List | 69.25% | 69.19% | 66.73% | H | P |
| RTT Waiting List Size | 12,800 | 12,987 | 13,138 | L | P |
| Diagnostics volume YTD (compared to plan) - CT, MRI and Ultrasound | 24,721 | 22,502 Cumulative | 23,297 YTD Target | H | P |
| Diagnostic 6 week target | 98.7% | 96.9% | 95% | H | P |
| Theatre Session Utilisation | 90.9% | 80.9% | 85% | | ? |
| Theatre Insession Utilisation (Capped) | 79.5% | 80.7% | 85% | | ? |
| Bed Occupancy (excluding CYP and HDU) | 75.3% | 74.1% | 82-85% | | F |
| LOS - Excluding Oncology, Paeds,YAH, Spinal | 3.32 | 3.59 | n/a | | - |

| Metric | In Month | Previous Month | Target | Variation | Assurance |
|---|---|---|---|---|---|
| All Activity YTD (compared to plan) | 13,487 | 12,291 | 13,725 | | F |
| Outpatient activity YTD (compared to plan) | 67,799 | 61,701 102.9% | 65,665 | H | P |
| Outpatient Did Not Attend (YTD) | 7.14% | 8.73% | 8.00% | | P |
| PIFU | 646 11.29% | 608 11.07% | 512 5% | H | P |
| Virtual Consultations (target is to plan, operational planning guidance is 25%) | 10.33% | 11.39% | 19% | L | F |
| Cancer - 31 day first treatment | 100.0% | 100.0% | 96% | H | P |
| Cancer - 62 day (traditional) | 81.8% | 75.0% | 75% National 85% Trust | H | P |
| 28 days FDS | 73.8% | 72.8% | 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) | 21,236 | 19,417 | 21,184 YTD Target | H | P |
| LOS - elective primary hip | 3.04 | 3.10 | 2.70 | | F |
| LOS - elective primary knee | 3.48 | 3.45 | 2.70 | | F |