Trust Board (Public) June

Wednesday 3 June, 09:00h - 12:00h

Boardroom, Trust Headquarters

Notice of Trust Board Meeting in Public on Wednesday, 3 June 2026

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 3 June 2026, in the Boardroom, Trust HQ commencing at **09:00.**

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

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

Simon Page
Chair

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

28 May 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 in the Boardroom, Trust HQ on Wednesday, 3 June 2026:

Meeting	**Timing**
Non-Executives pre-meet – Director of Finance's Office	08:00 – 08:45
Public Board Meeting – Boardroom, Trust HQ	09:00 – 12:00
Lunch	12:00 – 12:30
Private Board Meeting – Boardroom, Trust HQ	12:30 – 13:15
Nominations & Remuneration Committee	13:30 – 14:30

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 (IN PUBLIC)

Venue Boardroom, Trust Headquarters **Date** 3 June 2026: 09:00h – 12:00h

Members attending

Mr Simon Page	Chair	(SP)
Ms Simone Jordan	Non Executive Director & Vice Chair	(SJ)
Mrs Gianjeet Hunjan	Non Executive Director	(GH)
Dr Ian Reckless	Non Executive Director	(IR)
Ms Ayodele Ajose	Non Executive Director	(AA)
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 Michelle Hubbard	Interim Chief Operating Officer	(MHu)
Mr Steve Washbourne	Executive Chief Finance Officer	(SW)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)

In attendance

Mr Jake Slassor	Advanced Apprentice Electrician	(JS)	
Mr Curig Johnston	Associate Non Executive Director	(CJ)	
Mrs Rebecca Lloyd	Director of Strategy	(RL)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
		IN PUBLIC SESSION		
09:00	1	Staff Lived Experience	Presentation	JS
09:20	2	Apologies:	Verbal	Chair
	3	Declarations of Interest	ROHTB (6/26) 001	Chair
	4	Minutes of Board Meeting held in Public on 1st April 2026: *for approval*	ROHTB (4/26) 019	Chair
	5	Actions from previous meetings in public: *for assurance*	ROHTB (4/26) 019 (a)	SGL
	6	Questions from members of the public	Verbal	Chair
	7	Feedback from the Board walkabouts in May	Verbal	ALL

09:30	8	Chair's and Chief Executive's update, including quarterly update from the Guardian of Safe Working: *for information and assurance*	ROHTB (6/26) 002 ROHTB (6/26) 002 (a)	MH/SP
09:50	9	Chief Finance Officer's report: *for information and assurance*	ROHTB (6/26) 003	SW
10:10	10	Chief Operating Officer's report: *for assurance*	ROHTB (6/26) 004 ROHTB (6/26) 004 (a)	MHu
10:25	11	Chief People Officer's report: *for assurance*	ROHTB (6/26) 005	SM
10:40	12	Quality Officers' report: *for assurance*	ROHTB (6/26) 006	MR/NB/ SGL
10:55	**BREAK**			
	GOVERNANCE AND COMPLIANCE			
11:05	13	Strategy Delivery Update: *for assurance*	ROHTB (6/26) 007 ROHTB (6/26) 007 (a)	RL
11:20	14	National Oversight Framework Update: *for assurance*	ROHTB (6/26) 008 ROHTB (6/26) 008 (a)	SGL
	UPWARD REPORTS FROM THE BOARD COMMITTEES			

11:35	15	Upward reports from the Board Committees:
		• Finance & Performance Committee
		• Quality & Safety Committee
		  ○ Safer Staffing Report**: for assurance**
		  ○ Infection Prevention & Control Annual Report: **for approval**
		  ○ Human Tissue Authority Annual Report: **for approval**
		  ○ Medicines Safety Officer Annual Report**: for approval**
		  ○ Health & Safety Annual Report: **for approval**
		  ○ Quality & Safety Committee Annual Report**: for assurance**
		• Audit Committee
			ROHTB (6/26) 009
			ROHTB (6/26) 010
			ROHTB (6/26) 010 (a)
			ROTHB (6/26) 010 (b)
			ROHTB (6/26) 010 (c)
			ROHTB (6/26) 010 (d)
			ROHTB (6/26) 010 (e)
			ROHTB (6/26) 010 (f)
			
			ROHTB (6/26) 011
				GH
				IR
				
				GH

	MATTERS TO BE TAKEN BY EXCEPTION			
11:55	16	Performance Reports: *for assurance* a) Finance & Performance b) Quality Report	ROHTB (6/26) 012 ROHTB (6/26) 013	
	17	Any Other Business	Verbal	All

	18	Meeting effectiveness	Verbal	All
12:00	**LUNCH**			
	CLOSE: Date of next meeting in Private: Wednesday, 8 July 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 2026/27 UPDATED TO MAY 2026

MEMBER	ATTENDANCE										TOTAL
	01/04/2026	06/05/2026	03/06/2026	08/07/2026	03/09/2025	08/10/2025	05/11/2025	03/12/2025	04/02/2026	04/03/2026	
Simon Page (Ch)	✓	✓									
Ian Reckless	✓	✓									
Simone Jordan	✓	✓									
Gianjeet Hunjan	✓	✓									
Ayodele Ajose	✓	✓									
Jenny Belza	✓	✓									
Jan Teo	✓	✓									
Curig Johnston	✓	✓									
Matthew Hartland	✓	✓									
Matthew Revell	✓	✓									
Nikki Brockie	✓	✓									
Marie Peplow	✓										
Stephen Washbourne	✓	✓									
Sharon Malhi	A	✓									
Simon Grainger-Lloyd	✓	✓									
Michelle Hubbard		✓									

KEY:

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

TRUST BOARD DECLARATIONS OF INTEREST REGISTER

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

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

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board - DRAFT Version 0.1

Venue The Village Hotel, Walsall **Date** 1 April 2026: 1000h - 1200h

Members attending:

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

In attendance:

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]

IN PUBLIC SESSION	
1 Apologies (chair)	**Verbal**
Apologies were received and accepted from Sharon Malhi	
2 Declarations of Interest (chair)	**ROHTB (4/26) 001**
There were no new declarations to record to what has been published.	
3 Minutes of Board Meeting held in Public on 4th February 2026: *for approval* (chair)	**ROHTB (2/26) 026**
The minutes of the meeting held in public on 4th February 2026 were **approved** by the board subject to the following changes: • Change the word competition to completion on page 19 of the Board pack.	

4 Actions from previous meetings in public: *for assurance* (SGL)	**ROHTB (2/26) 026 (a)**
SGL provided an update on the following action: • ROHTBACT.285 Annual Report for Medical Appraisal and Validation – Honorary Contracts will be presented to SE&OD at the end of month.	
5 Questions from members of the public (chair)	**verbal**
No questions were received in advance of the meeting	
6 Feedback from the Board walkabouts in March	**Verbal**
Board members provided feedback from recent engagement visits across a range of services. • ADCU: JB reported positive feedback from patients following elbow surgery and noted an instance of extended waiting for patient transport. JB queried progress on implementing KPIs for the "sit to send" process following a recent audit. MR confirmed this is under review, with two improvement projects being considered. • Infection Prevention and Control (IPC): GH highlighted the strong impact of the small IPC team and noted staff concerns regarding feedback loops, with limited updates provided after raising issues. MH outlined that the reinstatement of the Trust Management Group, supported by an Estates Working Group, will provide a clearer structure for issue resolution and formal reporting. • Continuous Improvement Culture (CI): SJ emphasised the need to embed CI processes consistently across the organisation. MP and RL noted that while huddle boards exist, usage is inconsistent. MH confirmed Executive teams have completed huddle training, which will be mandated Trust-wide, with feedback to flow into the Trust Management Group and onward to the Board. • IT/BI, Nurses' Home and Medical Records: AA outlined several actions from visits, including laptop care, system updates, and challenges relating to EPR. AA queried server arrangements. SW clarified the Trust's use of SharePoint and OneDrive for cloud-based storage and described the hybrid server model aligned with NHSE guidance. Action: SW to provide assurance to FPC on system security checks and architecture. • HR House: IR provided feedback on working conditions, noting staff remained positive despite constraints. The Board recognised the strong performance of the HR team, particularly in recruitment. MP reiterated the effectiveness of the Business Partner model. • General Feedback on Visits: SP asked how visits were being received; Board members reported that staff appreciated the engagement and visibility.	

7 Chair's and Chief Executive's update: *for information and assurance* (SP/MH)	ROHTB (4/26) 002 ROHTB (4/26) 002 (a)

Chair Update

The Chair provided an update following recent ICB and NHS meetings. The strong performance and reputation of the ROH were recognised, with continued delivery against key outcomes essential to maintaining the organisation's NOF1 status. It was noted that the Trust could do more to promote and communicate its achievements externally.

Discussions are ongoing regarding Advanced Foundation Trust status. The ICB remains supportive of the Trust's strategic direction, with this support contingent on sustained delivery of results

Chief Executive Update

MH presented the Chief Executive's Update, and the paper was taken as read. Key points highlighted included:

- 2025/26 Year-End Performance: The Trust's strong year-end position was recognised as a significant achievement, and the Executive Team was thanked for their contribution.
- Chief Operating Officer Transition: The Board thanked MP for her service as she attended her final public Board meeting. Handover arrangements are underway.
- Current Issues – Bone Cement/Stryker and Industrial Action: MR outlined an information governance and supply chain risk relating to Bone Cement/Stryker, with no current concerns to escalate. MP confirmed industrial action plans and contingencies are in place. Wards remain safely staffed, outpatient pathways have been reviewed (with up to 27 patients potentially affected), and theatre impact is minimal due to scheduled maintenance. Business continuity arrangements are active.
- NOF1 Status: The Trust has improved its national position and remains at Level 1, now ranked 12th nationally.
- Blue Heart Awards: A total of 652 nominations were received, demonstrating strong peer recognition.
- Forward Look: Compliant plans for the new year have been submitted and accepted by NHSE.
- Voice Into Action: A full report will be considered by SE&OD and presented to the Board. A marginal decline in staff survey results was noted. Learning from theatre listening groups is being expanded Trust-wide to support transparency and to underpin the wider transformation programme.
- EPR Programme: Progress continues with no risks to escalate. Reporting will continue through FPC.
- Guardian of Safe Working: No issues were raised for escalation this month.

The Board was invited to ask questions and comment.

The following points are of particular note: • GH asked about the Hero Awards and their link to staff survey findings. MH explained that the scheme, launched 12 months ago, is currently open-nomination but will evolve to align more clearly with Trust values and adopt a more formal nomination process. Awards are considered by the CEO and Communications Team and approved by the Executive Team. • GH requested an update on the recent EPR board-to-board meeting. MH reported it was an informal introductory session, focused on understanding approach and commitment, and confirmed that the partner is clearly committed to successful delivery.	
7.1 Council of Governors Update: *for assurance*	**Verbal**
SGL provided an update following the Council of Governors meeting held on 18 March, which was well attended. Governors received updates on: • The Robert Jones & Agnes Hunt / Royal Orthopaedic Alliance • Year-End Forecasting and 2026/27 Plans (presented by SW) • Strategy Development (presented by RL) • The MSK Programme (presented by David Rogers) A significant part of the discussion focused on the Health & Safety Act and its implications for Governors. The Trust reiterated the important role Governors play within the organisation and emphasised how valued their contribution is.	
8 Chief Finance Officer's report: *for information and assurance*	**ROHTB (4/26) 003**
SW presented the Chief Finance Officer's report, and the paper was taken as read. The key points to highlight include: • The Trust delivered a £16k surplus, compared with a planned surplus of £90k, resulting in an adverse variance of £74k. • The Trust continues to forecast a break-even position for year-end. • Activity and income were higher than the previous month, though still below plan, with increased use of LLP capacity. • Private Patient income improved on Month 10 but remained below plan, and there is a recognised risk around restoring clinician confidence into the new year. • Agency spend increased, driven solely by medical staffing; all other areas have eliminated agency usage. • Bank spend was below average, though variability requires review. • The wider system is likely to achieve a break-even position. • The Trust will receive an NHSE allocation, which is not new funding. SW confirmed it will be accounted for and audited in line with compliance requirements. The Board was invited to ask questions and comment.	

The following points were of particular note: • SP emphasised the need for a strong focus on income generation next year, alongside productivity improvements, to deliver the financial plan. • SW provided an update on ongoing discussions with Deloitte regarding EPR accounting treatment. Detailed documentation has been shared with auditors, and the Trust has acted transparently and in accordance with NHS accounting standards. • In response to CJ's query about the new Commercial Group, MH confirmed the Group will review all non-NHS income streams, developing these into strategic business units to clarify profitable and loss-making areas and identify opportunities to enhance income.	
9 Chief Operating Officer's report: *for assurance*	**ROHTB (4/26) 004** **ROHTB (4/26) 004 (a)**
MP presented the Chief Operating Officer's Report, which was taken as read. Key points highlighted included: • NHSE Sprints: Continued focus on delivery of the NHSE sprint programme, with active participation in the 52-week, 18-week, and validation sprints. • GIRFT Hub Optimisation Week: The Trust will take part in the improvement week commencing 11 May 2026. • RTT Performance: RTT performance stands at 63.07%, exceeding national access targets. The Trust is progressing towards next year's target of 64.34%. • Outpatient Activity: Follow-up activity continues to over-perform, supporting reductions in waiting times. • Activity Levels: February activity was 53 cases below plan. • Operational Challenges: Ongoing workforce and estates-related challenges remain. • Theatres: Planned theatre maintenance commenced on 8 April. • Health Inequalities: Targeted work is underway to address inequalities in access and outcomes. • Diagnostics: The new CT scanner and digital X-ray room have opened, demonstrating significant state-of-the-art capability. • Strategic Business Units (SBUs): SBUs launched with Arthroplasty, supported by a new scorecard and evaluation framework. Clinician engagement has been very positive. • Pathology: Key risks continue, and the Trust is working with NHS partners to develop a networked solution. • MSK Programme: The integrated patient pathway has launched. The Trust continues to lead in orthopaedic MSK development and is progressing a proposal to act as lead provider. David Rogers recently presented at a national meeting. The Board was invited to ask questions and comment.	

The following points are of particular note: • **SBU Scorecards:** CJ queried how SBU scorecards will be used. MP explained that SBU scorecards differ from corporate scorecards, focusing on team-level contribution. Comparisons between SBUs will evolve over time as support functions mature. **Action:** MP to share the SBU paper with all Board members. • **Private Patient Income:** JT queried the decline in private patient activity and whether marketing spend is effectively targeted given current operational pressures. SP noted an update on this work has been requested from MH. MP confirmed that private patient income continues to grow overall, with current work focused on restoring clinician confidence to bring cases to the Trust. • **Activity vs Income Impact:** SP sought assurance that the income impact of increased activity is clearly understood. MP confirmed this is well-defined and will be reported to FPC. SW added that a detailed assessment is underway to differentiate chargeable and non-chargeable work, including analysis at sub-specialty level.	
10 Chief People Officer's report: *for assurance*	**ROHTB (4/26) 005**
AM presented the Chief People Officer's Report. Key points highlighted included: • Sickness Absence: Sickness levels have continued to improve, with overall absence at 5.93%, now below 6% for the first time in some time. The Trust remains focused on achieving its longer-term ambition for March 2028. • Return to Work (RTW) Compliance: RTW compliance has improved to 85%. • Financial Impact: The ongoing financial impact of sickness absence was noted. • Mandatory Training: Compliance is just over 91%, supported by the successful implementation of the new Learning Management System (LMS). • Nurse Pay Progression: Work continues in line with the national commitment, led by the Deputy Chief Nurse. National funding will be provided to support delivery. AA noted the encouraging progress on sickness absence figures and extended thanks to the teams involved.	
11 Quality Officers' report: *for assurance*	**ROHTB (4/26) 006**
MR, NB and SGL presented the Quality Officers' Report, which was taken as read. Key points highlighted included: • Research Performance: The Trust continues to demonstrate strong research output, with 180 papers published this year. Work is now underway to measure the quality and impact of these publications.	

• Hospital-Acquired Infections: Against a threshold of zero, the Trust will conclude the year with 2 C. difficile and 2 E. coli cases. PSIIs have been completed, and narrative findings will be reported to QSC.
• Human Tissue Authority Inspection: The HTA inspection has been confirmed for May 2026.
• Martha's Rule: Implementation is now live across all wards, with "Call for Concern" to launch next. The Board was encouraged to promote this work. Recent NHS standards updates align with the Trust's approach.
 	
GH queried the impact of hospital-acquired infections on the NOF rating. NB confirmed the rolling-year calculation adds complexity and cases will remain on the Trust's NOF profile until March 2027. MH noted a new NOF framework will be issued next week, including additional quality indicators; a self-assessment will be undertaken.
 	
• Never Events: A thematic review of 10 years of incidents has identified key themes and improvements, with actions incorporated into existing plans.
• PSIRF: Funding has been secured for PSIRF training, with sessions arranged for May.
• Duty of Candour: The refreshed policy is now live and published on the website.
• Freedom to Speak Up: A new platform has been launched to simplify and improve access.
• Information Governance (IG):
  ○ The Data Security and Protection (DSP) Toolkit audit concluded with significant assurance and minor improvement opportunities.
  ○ IG mandatory training compliance has improved, though further progress is required.
  ○ 28 IG incidents were reported between Nov 2025–Feb 2026, predominantly low-harm misfiling identified through SAR processing. No cases required referral to the Information Commissioners Office (ICO).
• Trustwide Governance Review: The review has concluded, with the revised framework to be implemented from 1 April 2026. Key changes include:
  ○ Reinstatement of a monthly Trust Management Group, reporting to Board Committees.
  ○ Introduction of a Performance Review Panel to strengthen accountability.
  ○ A detailed update will be presented at a future Board meeting.	

12 Flu Update: *for assurance*	**ROHTB (4/26) 007** **ROHTB (4/26) 007 (a)**
NB presented the Annual Flu Vaccination Report. Key points highlighted included: • The Trust achieved 43% vaccination uptake, exceeding both the 35% target and the stretch target. • A detailed breakdown of uptake was presented. NB noted that inpatients could not be vaccinated this year, and this will be an area of focus going	

forward. • Planning has already commenced for the forthcoming flu vaccination campaign. • The Trust continues to engage in regional flu vaccination meetings. • Lessons learned from the 2025/26 campaign were reviewed to inform future improvements. The Board was invited to ask questions and comment. The following points are of particular note: • SP queried whether, given the relatively low overall uptake despite exceeding target, staff sickness attributed to flu could be linked to vaccine status. NB confirmed that the vaccine cannot be mandated, and the Trust cannot make connections between sickness absence and vaccination status. • JB asked how the Trust plans to address uptake challenges, noting the charitable decision not to fund chocolate incentives. NB explained that staff had purchased chocolates themselves this year and acknowledged that incentives can improve engagement. Further challenges include the need for stronger system-wide communication. There will be an increased focus on supporting and expanding the peer vaccinator model for future campaigns.	
GOVERNANCE AND COMPLIANCE	
13 Modern Day Slavery Statement Annual Review: *for approval*	**ROHTB (4/26) 008** **ROHTB (4/26) 008 (a)**
NB presented the Modern Slavery Statement for approval prior to publication. The Board approved the statement for publication.	
UPWARD REPORTS FROM THE BOARD COMMITTEES	
14 Upward reports from the Board Committees: (cttee chairs) **a) Finance & Performance Committee** **b) Quality & Safety Committee** ○ **Learning Disability & Autism Strategy** ○ **Safeguarding Strategy**	**ROHTB (4/26) 009** **ROHTB (4/26) 010** **ROHTB (4/26) 010 (a)** **ROHTB (4/26) 010 (b)**
Finance and Performance Committee – GH GH presented the report of the Finance and Performance Committee, which was taken as read. Many of the items discussed had been covered earlier in the meeting. GH highlighted the presentation from Nas Uddin on British Association of Daycase Surgery (BADS) performance and the ongoing work to improve performance against the metric.	

Quality & Safety Committee – IR IR presented the report of the Quality & Safety Committee. Key points highlighted included: • Never Events: The Committee received assurance on the work taking place in Theatres, with significant assurance gained. • GOSH Contract: Ongoing challenges were discussed, along with the assurance provided around mitigation and oversight. • Opioid Usage: Although opioid usage appears high at ROH, benchmarking demonstrated the Trust is comparable to peer organisations. • CNST: CNST indicators have risen slightly, though this is not currently a cause for concern. • Strategies Approved: The Board approved the Learning Disabilities and Autism Strategy and the Safeguarding Strategy for publication.	
Performance Reports	
15 Performance Reports: *for assurance* • **Finance & Performance** • **Quality Report**	**ROHTB (4/26) 012** **ROHTB (4/26) 013**
The reports were taken as read.	
16 Any Other Business	**Verbal**
There was no further business to raise.	
17 Meeting Effectiveness	**Verbal**
Date of next meeting: Wednesday, 6 May @ 0900h	

PUBLIC SESSION

Next Meeting: 3rd June 2026, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 27th May 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 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	~~29/04/2026~~ 24/06/2026	**Update to be included as part of the Medical Workforce Update that is scheduled to be presented to SE&OD in June.**	
ROHTBACT.287	Chief Operating Officer's Report	ROHTB (4/26) 004	01/04/2026	Circulate the strategic business unit paper to the Trust Board for information.	MP	03-Jun-26	**On Board agenda in Private session. 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:	**3 June 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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT

Report to the Trust Board (in Public) on 3 June 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, Black Country and Solihull system (BBCS).

2. NATIONAL/REGIONAL UPDATE

2.1 Secretary of State for Health and Social Care

On 14 May it was announced that James Murray is the new Secretary of State for Health and Social Care following the resignation of Wes Streeting. Following the change I joined a CEO briefing with Sir Jim Mackey, CEO of the NHS, who confirmed that there is no change to the government's priorities and we are required to continue to deliver the plans we have agreed for the short and longer term. I have been invited to a briefing session with the new Secretary of State on the 2 June and I will inform Board of the outcome of the discussion when we meet.

2.2 Regional/ICB Cluster Restructuring

The management of change process continues at Regional level and is expected to conclude in the summer. At this stage there is no indication that our relationship managers will change, however there will be greater clarity on the impact for the Trust over the next few weeks.

Similarly, the restructuring of the Birmingham and Solihull and Black Country ICB's is underway ahead of the proposed merger, with a similar timeframe to the regional restructuring.

2.3 Strategic Commissioning Approach

The ICB was required to write to Jim Mackey during May confirming the ICB's approach to implementing its strategic commissioning approach in line with the 10 year plan. Strategy Delivery Board will oversee the Trust's response to the approach, but it was clarified that specialist hospitals in the system, including the ROH, will be

supported to spread their expertise across the whole Cluster geography and be a part of the new 'Anchor Institution' model in each Place.

2.4 Bone Cement/Stryker

It is pleasing to report that there are no material ongoing issues in relation to the availability of bone cement and Stryker products.

3 CHIEF EXECUTIVE ACTIVITIES

3.1 Chief Operating Officer

Welcome to Michelle Hubbard, Acting Chief Operating Officer, following the retirement of Marie Peplow at the end of May. Michelle has agreed to act-up until a substantive appointment is made. Again, a huge thank you to Marie for all of her hard work and dedication to the hospital and her commitment to our patients, colleagues and to the Trust Board. I know the whole Board gives their best wishes to Marie for her future retirement.

3.2 Birmingham Health Partners

I attended the Board of Birmingham Health Partners since the last Board, at which an excellent presentation was made regarding the launch of the Birmingham Implant Retrieval Centre, a joint initiative between the University of Birmingham and the Royal Orthopaedic Hospital. There was support from all partners and we look forward to seeing its progress. It was also agreed to hold a deep-dive into the establishment of a Secure Data Environment for all members which will be held in September.

3.3 NHS Leadership Event – London and Birmingham

The senior team of NHS England held their Executive meeting in Birmingham in May which was followed by an event for Chief Executives and Chairs where we heard from members of the NHS Team and the new Regional Chair Russell Hardy.

This was followed by an NHS Leadership event in London, where the priorities for the 2026/7 financial year were clarified. The strategic and operational plans for the Trust are aligned to the national ambition, and the need to implement at pace was reinforced.

3.4 Kings Award for Voluntary Service

It was a pleasure to attend an event to celebrate the Nishkam Health Trust in Handsworth receive the Kings Award for Voluntary Service. It was a wonderful evening and reinforced the opportunity the ROH has to provide care to patients in their local environment rather than at the Hospital. We have agreed to explore how this may come to fruition as part of our work to support neighbourhood health.

3.5 Birmingham City University

A group of ROH executives visited Birmingham City University to agree how to progress the partnership between the two organisations. There was great enthusiasm and commitment to collaborate on research, evaluation, placements of AHP's, sports medicine amongst others.

3.6 Acute Advisory Board: NHS Alliance

Following the merger of the NHS Confederation & NHS Providers to form the NHS Alliance, I am now a member of the Alliance's new Acute Advisory Board which met on the 7th May. We heard from the new CEO, Ciaran Devane on his priorities and also from an executive from the Independent Reconfiguration Panel on how to navigate service change.

3.7 Honouring Excellence at the Royal Orthopaedic (HERO) Awards

The approach to the above was refreshed in April and I look forward to awarding HERO awards in June which is 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.

One special HERO award was made in May, however, when we honoured the dedication and excellence of one of our HDU nurses for her incredible 51 years' service within the Trust. We thank Barbara Simms for her commitment and wish her well on her retirement.

3.8 NHS Long Service Awards

It was a pleasure celebrating Long Service during May when we held our ceremony to recognise 10, 20, 30 and 40 years' service. It was a lovely day, congratulations to everyone and a huge thank you to those colleagues that were recognised.

3.9 Service Accreditation Presentation

The Chief Nurse and I were pleased to present Service Accreditation certificates to the various Wards and Admissions Day Case Unit (ADCU) that participated in this review. Thank you and congratulations to all colleagues.

3.10 Commercial Group

The new commercial group met in May to review all non-NHS income received by the Trust. This is an important element of the ROH business model with all income received invested to support NHS patient care.

4. ROH UPDATE

4.1 Industrial Action

The BMA has announced that a further round of industrial action for resident doctors will be held from 15-19 June. We will activate our plans in the usual manner, however the level of disruption will not be fully understood until nearer the time.

4.2 New CT Scanner/Ultrasound Machine

In April we commenced use of a new CT Scanner and Ultrasound machine. It will make a huge difference to both patients and staff, and I wanted to thank all colleagues in the Trust, and Siemanns, who collectively refurbished the physical space and implemented the new scanners excellently. It was also a pleasure to meet representatives from the Mark Benevolent Fund who generously donated funds for the ultrasound scanner.

4.3 Strategic Alliance with Robert Jones & Agnes Hunt

The Joint Board Development session with Robert Jones & Agnes Hunt (RJAH) held on 1 April was a success. Feedback from RJAH has been that they see real benefit in collaboration with the ROH, as do we with RJAH, and are fully committed to working with us to deliver the items within the Strategic Alliance MOU for the benefit of both Trusts and patients. A workplan is being developed and external communications drafted.

4.4 Voice into Action

We are currently half-way through an organisation-wide listening exercise called 'Voice-into-Action', which is the start of an improved staff engagement cycle. It builds on the results of the staff survey and encourages staff to share issues that would improve both their working environment and working lives, both in the short and long term. I am pleased by the engagement throughout the Trust and the feedback received to date which is currently being reviewed and action plans constructed to meet the 90-day ambition to resolve issues were possible. Board will be appraised fully on the programme in a future Board meeting.

4.5 Guardian of Safe Working

Attached as an appendix to this update is the report from the Guardian of Safe Working, Mr Jamie McKenzie.

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:

- Fire Safety Policy
- Mid-Level Clinical Provider Policy
- Volunteer Policy
- Private Practicing Privileges Policy
- Building Ventilation Policy
- Management of Diagnostic Imaging Tests Policy
- Bed Rails and Trolley Side Policy

6 RECOMMENDATIONS

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

Matthew Hartland
Chief Executive
May 2026

FOR ASSURANCE

UPDATE FROM THE GUARDIAN OF SAFE WORKING

REPORT TO THE TRUST BOARD – JUNE 2026

1.0 Situation

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

1.0.2 Version 13 of the 2016 Terms and Conditions of Service comes into effect from 4th February 2026. This update to the 2016 TCS includes exception reporting reforms which have been implemented. See 5.6 below.

1.1 Wellbeing

1.1.1 Resident doctors are still campaigning to improve conditions, solve workforce problems and ensure their pay is protected. BMA member resident doctors undertook their 15th round of industrial action in April after rejecting the Government's latest offer.

1.1.2 The dispute is still unresolved. The mandate for further action in England is live until August.

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

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

1.1.5 The NHS constitution states: All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted, actively listened to and provided with meaningful feedback. They must be treated with respect at work, have the tools, training and support to deliver compassionate care, and opportunities to develop and progress.

1.1.6 Dr James Brunning is Wellbeing lead for medical staff. Brett Ellis and Laura Tilley-Hood review the workforce surveys with regards to wellbeing. Wellbeing Week was held earlier in May supporting mental health, stress and MSK problems. Wellbeing group exists and is planning wellbeing courses for staff.

2.0 Background

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

2.1.1 Clinical rotas are prepared by the Administrative Specialist Registrar (SpR). Jones and Mr Politis support the Admin SpR balancing the educational and training opportunities

with the service requirement of the organisation. Many others support the resident workforce including Vicky Eccleston (medical rota coordinator).

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

2.1.3 The current consultant staff post holders are:

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

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

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

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

2.1.7 The role of Khalid Baloch as ROH Director of Medical Education (DME) is now well established. He has taken the lead, with David Richardson, for the implementation of the NHS England 10-point plan on workplace improvement (published August 2025). Work is ongoing to ensure that compliance is properly recorded and reported to the Resident Doctor forum. There is collaboration with RJAH hospital to share values and experiences.

3.0 Resident Doctor Establishment

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

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

3.1.2 New SpR trainees started in Feb 2026. Face to face teaching is on-going on Fridays. A new cohort will arrive in August 2026.

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

3.1.4 HR team have been working to prevent payroll issues. One payroll error occurred in February 2026 but was resolved in 24hrs.

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

3.2 *GP Trainees*

3.2.1 There are a variable number of GP trainees at the ROH (1-10). There are currently four. GP trainees are encouraged to choose the ROH and it is acknowledged that they receive excellent education when here. Morgan Jones is working hard to improve their ROH experience and is trying to actively promote the ROH. There have been difficulties with GP trainees having additional requirements with regards flexible training (no nights or long days) that can be difficult for the trust to accommodate.

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

3.3 *FY2 Doctors*

3.3.1 The ROH has currently one FY2.

4.0 Resident Doctors' Forum

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

4.2 In practice the meeting has become more of an operational platform and the team are looking into a regular less formal forum for residents to raise concerns.

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

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

5.0 About the Guardian for Safe Working Role

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

5.2 The current version, 13, of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (2016 TCS) has introduced some reforms to exception reporting as described below in 5.6.

5.3 The GOSW role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the resident doctors employed by it. It should report into different management structures, including the local negotiating committee (LNC) and the trust board, but will also have a regular input into resident doctor forums.

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

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

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

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

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

5.9 Since February the ROH is using Allocate software to record exception reports. All resident doctors are given access to the software at their induction. The software reports directly to HR who can action all additional hours reports independently. The GOSW reviews the outcome of reports.

5.10 Educational reports go to the DME for review.

5.11 Doctors need to evidence their exception reports.

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

6.0 Recommendations and Ongoing Work

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

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

Jamie McKenzie, Guardian for Safe Working

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Finance Officer's Report M1**
SPONSOR (EXECUTIVE DIRECTOR):	**Steve Washbourne, Chief Finance Officer**
AUTHOR:	**Steve Washbourne, Chief Finance Officer**
DATE OF MEETING:	**3rd June 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Month 1 Financial Report

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Delivery against plan in month Fully identification of CIP target for the year	Underperformance of variable income Underperformance of Private patient income Under delivery of CIP in month

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)*:
Finance and Performance Committee May 2026

CFO's Report Month 1

1. Summary

The Trust delivered a deficit in month of £59k, which is £8k favourable to plan.

	£'000		
Statement of comprehensive income	**Plan**	**Actual**	**Variance**
Operating income from patient care activities	11,593	10,851	-742
Other operating income	497	521	24
Employee expenses	-7,011	-6,871	140
Operating expenses excluding employee expenses	-5,014	-4,509	504
OPERATING SURPLUS/(DEFICIT)	**66**	**-9**	**-74**
FINANCE COSTS			
Finance income	20	78	58
Finance expense	-21	-13	8
PDC dividend expense	-141	-124	17
NET FINANCE COSTS	**-142**	**-60**	**82**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**-76**	**-69**	**7**
Remove capital donations/grants/peppercorn lease I&E impact	9	9	0
Adjusted financial performance surplus/(deficit)	**-67**	**-59**	**8**

2. Income

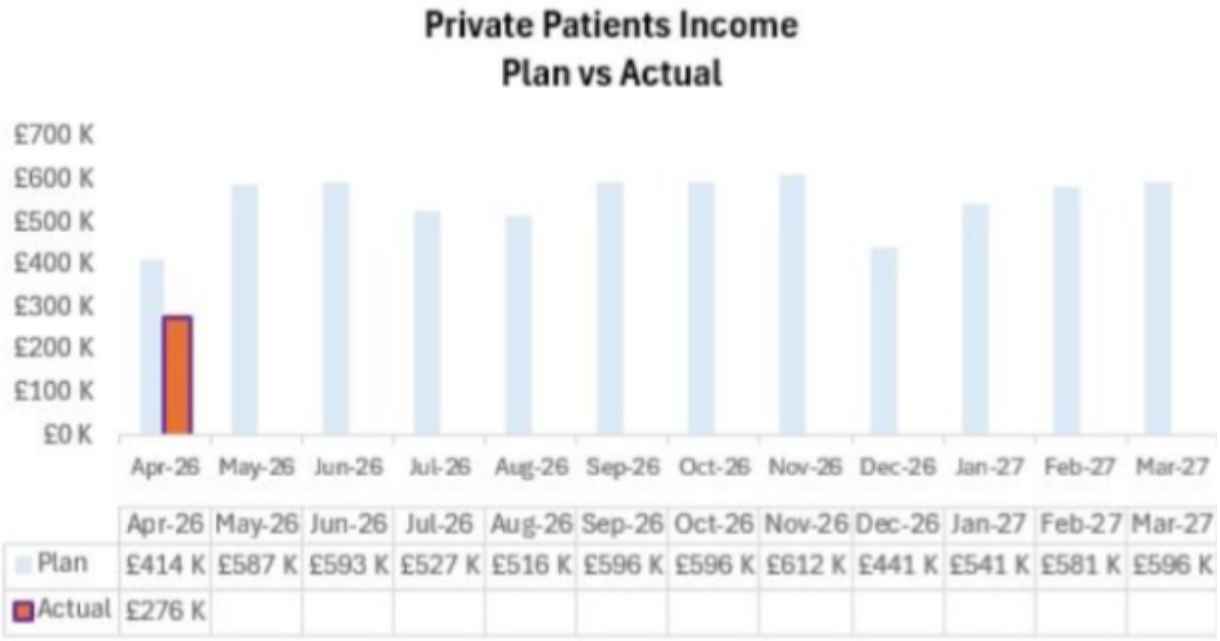
At Month 1 the Trust has delivered income from patient care activities of £11.6m against a plan of £10.8m, a net under performance of £0.7m.

Total Elective and day Case activity decreased from March, with £4.5m variable income delivered against a plan of £5.1m resultingin £665k underperformance.

Appendix A provides a split of variable income across POD and commissioner.

A more detailed deep dive into Income variation has been undertaken and discussed at Execs. This will be shared at F&P next month.

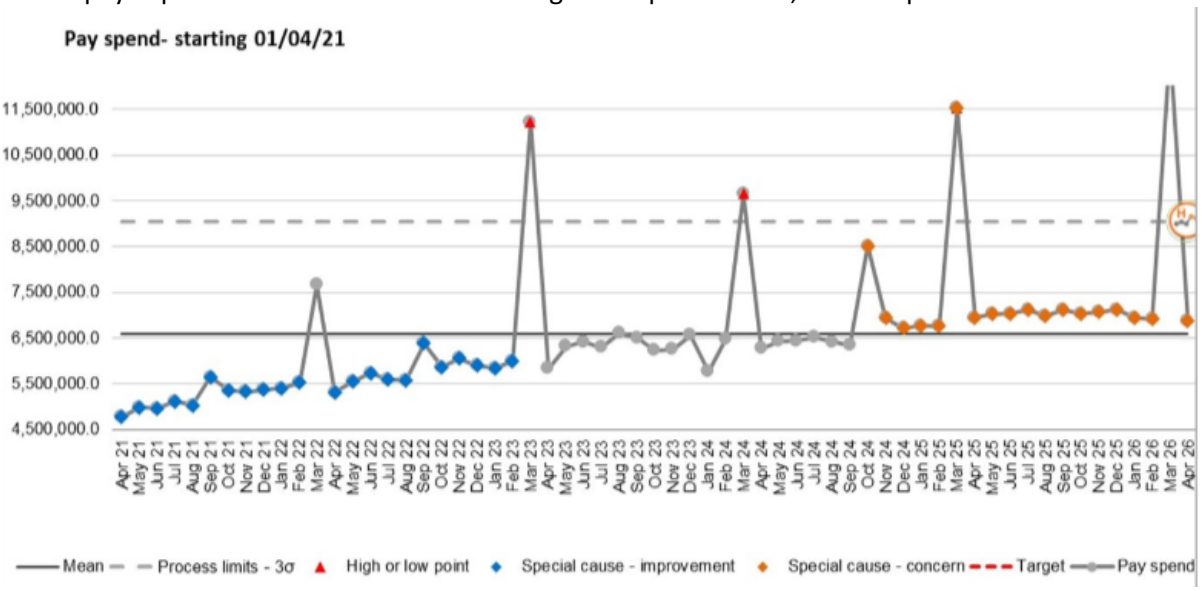
PP income delivered £0.296m against a plan of £0.551m, an underperformance of £0.25m.



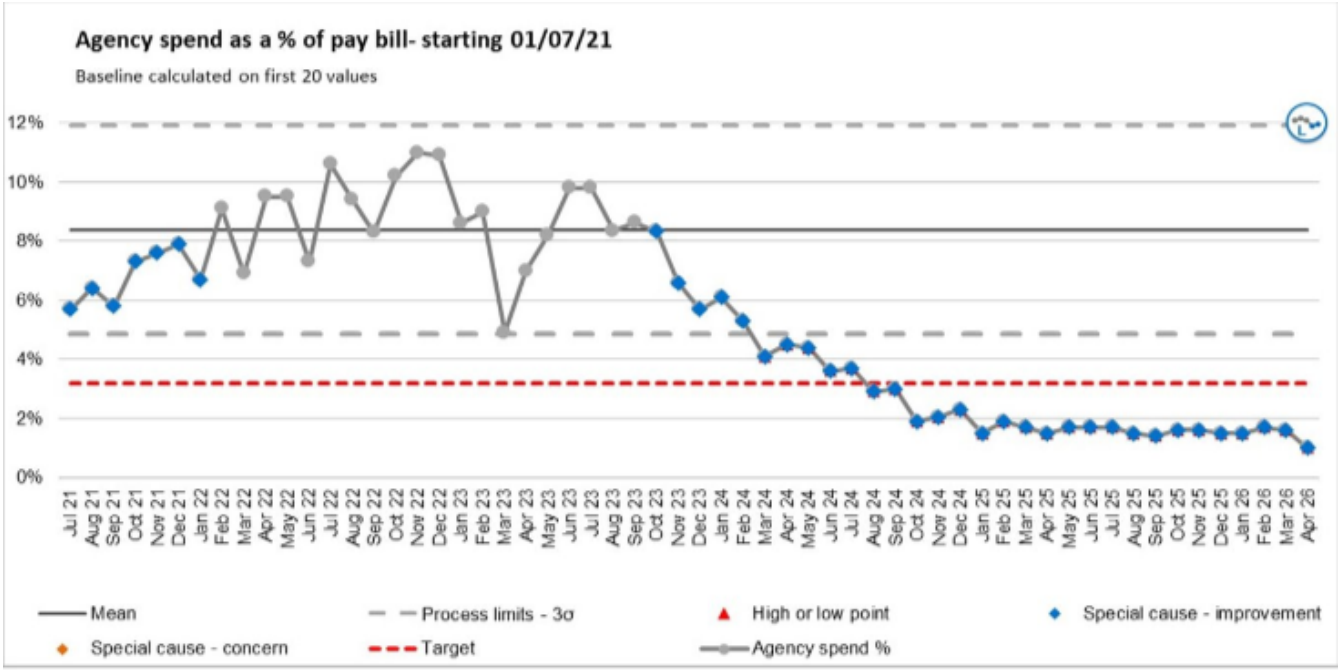
	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Plan	£414 K	£587 K	£593 K	£527 K	£516 K	£596 K	£596 K	£612 K	£441 K	£541 K	£581 K	£596 K
Actual	£276 K											

3. Pay

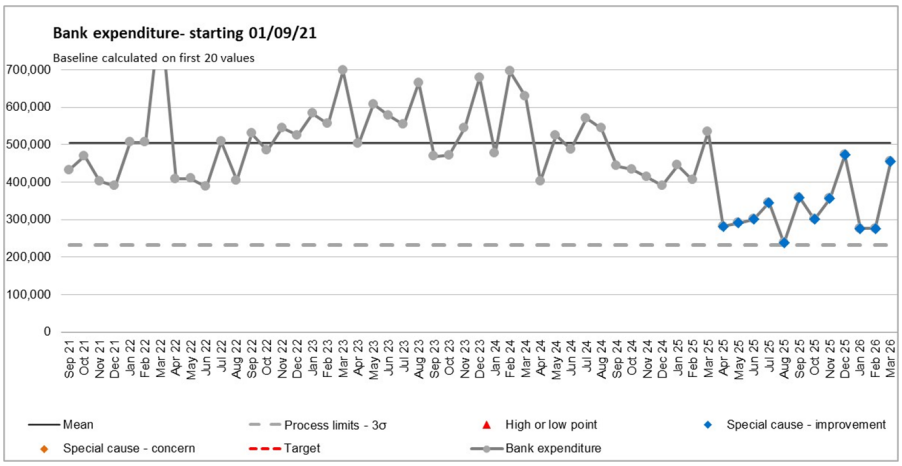
Actual pay expenditure in month was £6.8m against a plan of £7m, an overspend of £0.14m in month.



Agency spend is £4k in month or 1.4% of pay, which is an underspend of £70k in month.

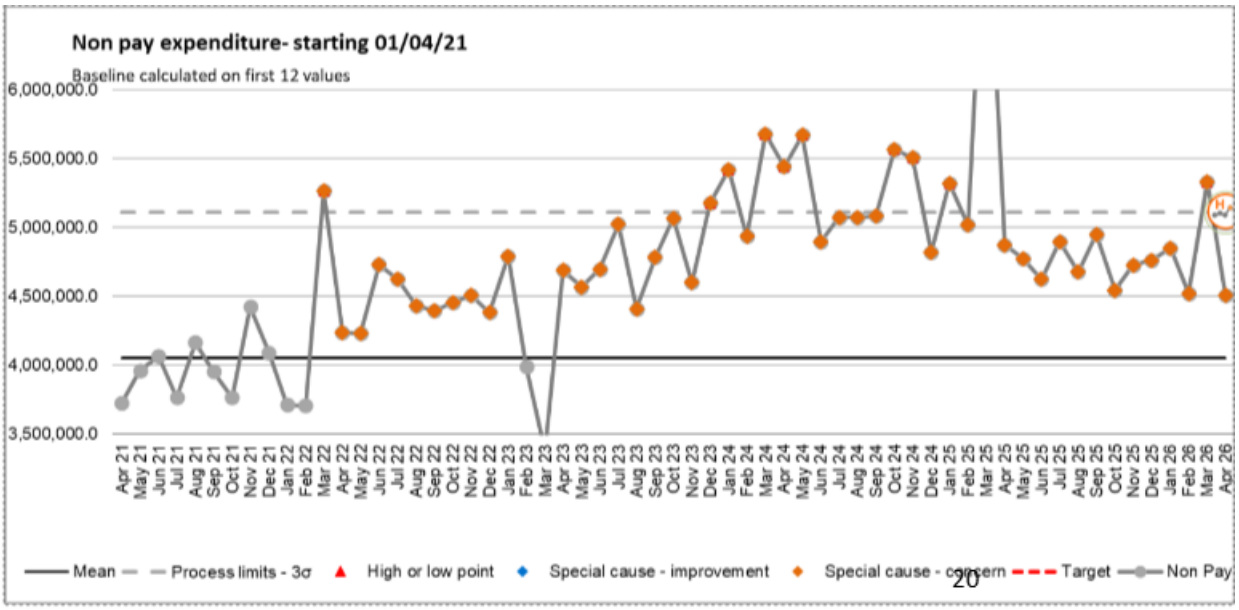


Bank expenditure decreased to £251k in April from £475k in March. Whilst this was above plan of £20k.

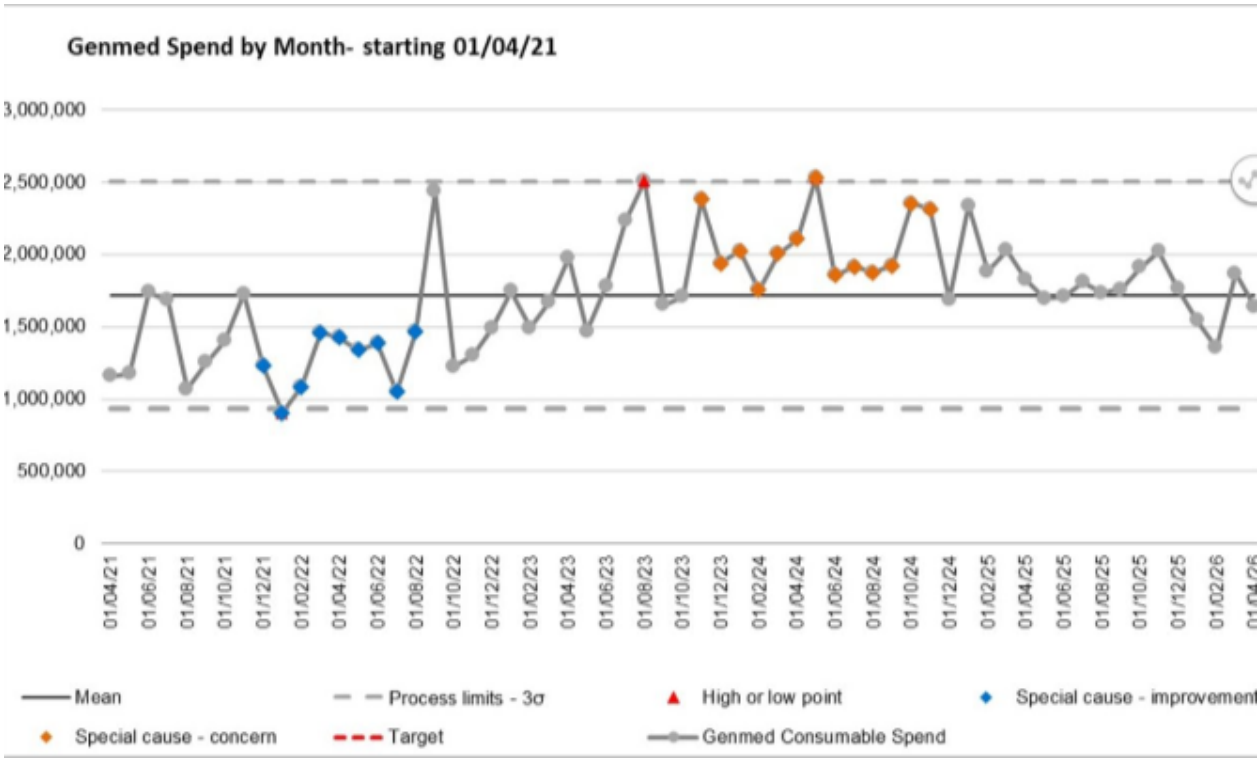


4. Non-Pay

Non pay expenditure underspent in month by £504k. This is primarily driven as a result of a reduction in clinical supplies related to activity delivery.



Genmed spend continues to be low and shows a significant reduction in spend from previous years.



5. Cash

The cash position is still relatively strong, although is highest cash position in month was lower than previous month when the DSF monies was received.

5

6. Capital

Capital schemes are being collated from the outputs of the business planning and VITA exercises, risk assessed and prioritised against the year's capital limit, and will be shared when this has been fully finalised.

7. CIP and Route to Break Even

CIP identification has progressed in month with the 5% CIP delivery target fully identified, totalling £7.7m CIP. In month efficiencies of £316k have been recorded, generating an underperformance of £331k in month.

8. System Position

The system position was not available at the time of writing this report.

Appendix A: Operating Income

Variable Income

	£'000s		
	Current Plan	Actual	Variance
NHS England	1,195	1,143	(52)
Integrated Care Boards	9,729	9,280	(449)
Non-NHS: private patients	551	296	(255)
Injury cost recovery scheme	7	20	13
Non-NHS: other	111	113	2
Total income from patient care activities	**11,593**	**10,851**	**(742)**

	Actual	Plan	Variance
Day Cases	£802,650	£977,336	-£174,686
Elective	£2,583,591	£2,636,494	-£52,903
Excess bed days EL	£96,760	£97,777	-£1,017
Outpatient FA Single Professional Consultant Led	£296,486	£436,491	-£103,023
Outpatient FA Consultant Led Non Face to Face	£36,982		
Outpatient Procedures FA	£7,413	£39,669	£14,863
Outpatient Procedures FUP	£47,119		
Diagnostics	£140,851	£160,763	-£19,912
Deconstructing block adjustment - agreement different to plan	-£42,871		-£42,871
Private patients	£296,000	£551,000	-£255,000
Passthrough income	£208,0000	£239,000	-£31,000
TOTAL	**£4,558,723**	**£5,138,529**	**-£665,548**

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:	**3rd June 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 OFFICER'S REPORT

Report to Trust Board – 3 June 2026

1 NATIONAL OPERATIONAL CONTEXT AND DEVELOPMENTS

1.1 The Trust participated in the GIRFT Hub Optimisation Week (HOW) from 11th May 2026 in conjunction with Robert Jones and Agnes Hunt, Wrightington, Wigan and Leigh and the Royal National Orthopaedic Hospital. The week was positive and a paper on findings and opportunities will be tabled at the next Finance and Performance Committee.

1.2 GIRFT have advised that the year 3 Elective Hub Accreditation is a reaccreditation rather than a review. An onboarding webinar is scheduled for Monday 8th June 2026 with an uploader webinar scheduled Monday 15th June 2026. The programme will be operationally led by the Associate Director of Operations (Division 2) with oversight from the Chief Operating Officer (COO). This is an exciting opportunity to showcase the amazing work of the Trust.

There is a new requirement for a Non-Executive Director to be available for the 4 hour on-site visit by the GIRFT Assessor team that will be in September 2026 (exact date to be confirmed). More details will follow at the next Trust Board meeting.

1.3 There is a new national incentive scheme that offers a payment for referral to treatment (RTT) follow ups for patients that have a clock stop through an intervention where the patient is not present.

1.4 Further Junior Doctor Strikes have been announced for the week commencing 15th June 2026 ending on the morning of Friday 19th June 2026.

2. OPERATIONAL PERFORMANCE

2.1 A positive referral to treatment (RTT) performance continued for April 2026 exceeding March 26 performance by 0.14% and the target for April by 0.8%. The percentage of patients waiting over 52 weeks reduced to 0.87% ahead of the Trust target of 0.91%. Excellent progress on the percentage of patients receiving an appointment within 18 weeks and a reduction in the overall waiting list that are both significantly ahead of plan.

2.2 The March 2026 cancer target was met for the 31-day standard with 100% compliance achieved. However, the Faster Diagnostic Standard (FDS) and 62 day Cancer standard

targets were not met due to continued challenges with Histology turnaround times. Interventions remain in place with support from NHS England.

2.3 Diagnostic performance exceeded National standards with a reported performance of 99.7% in April 2026.

2.4 April 2026 elective activity performance was –59 cases against the in-month plan. The activity trajectory for April 26 had been profiled to reflect the expected impact of bank holidays and scheduled maintenance activity; however, performance was further adversely affected by several operational challenges during the month.

- A rectification plan is now in place to recover the activity within quarter 1 monitored weekly at the operational Senior Leadership Team meeting chaired by the COO reporting directly to the executive meeting weekly.

2.5 Theatre capped utilisation on Model Hospital for March 26 is currently at 83.4% remaining in the top quartile.

3. PRIVATE PATIENTS

3.1 Private patient activity and income for April 26 were below the planned trajectory, with total income of £275,992 against a planned position of £414,000. Patient cancellations during the month resulted in approximately £90,420 of lost income. During April 26, the Woodland Suite was closed for 3 weeks to facilitate essential maintenance works.

Plans have been developed to recover the income position which is being implemented by the Private Patients Group, overseen by the Commercial Group.

In addition, the Private patient team held a stand at the April QIDD to promote private patients and encourage clinicians to bring their private practice to the Trust.

4. TRUST IMPROVEMENT GROUP (TIG) – KEY HIGHLIGHTS

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

- The outpatient transformation update covered a broad range of activity. During discussion, several members acknowledged that the programme has expanded over time and that the scale of activity makes it more difficult to report effectively within a single update but felt the updated provided showed the breadth of the programme.

- The POAC (POCT) update confirmed that good progress has been made and that the new nurse-led process was scheduled to go live from 5 May 2026. It was confirmed that all new clinic templates have been updated and are now live, with patients actively being booked into the new format from May onwards.

- The theatre improvement update confirmed that a consolidated master action plan is now in place, bringing together previously separate action plans into a single

document owned by the divisional triumvirate. It was confirmed that progress against this plan will be upward reported through divisional governance and then to TIG.

- Imaging accreditation submission will proceed, subject to Finance confirming the subscription funding route

5 KEY RISKS

5.1 Theatre 4 continues to have temperature issues; an options appraisal is being prepared for reallocation of activity and options for the future use of theatre 4. This is due to go to the Executive Team for consideration on Monday 8th June 2026. Temperature is monitored daily with theatre schedules forward looked and mitigation plans in place.

5.2 Delays in Pathology services are being actively managed and have been escalated with colleagues at NHSE. NHSE are continuing to support remedial actions to improve pathology turnaround times with the UHB histopathology service. Improvements to performance are expected during Quarter 2.

6 WORK PLANNED IN NEXT MONTH

6.1 On the 22nd June 2026, the COO will be part of the elective hub accreditation assessment team for Leicester to support readiness for the Trust's reaccreditation. The focus will be on preparatory work for the GIRFT Reaccreditation process.

6.2 Embedding interim operational structure with the appointment of Nasir Uddin as the Acting Deputy Chief Operating Officer.

6.3 Transitioning Emergency Planning Resilience and Response from the Chief Financial Officer to the COO. The COO has managed to source some resource from NHS England to help the Trust with the submission of the core standards by the end of July 2026. The Trust will be participating in the regional emergency preparedness exercise on Tuesday 30th June 2026.

6.4 Continue to pilot and develop the strategic business unit model.

6.5 Work with the Spinal team to revise the 52 weeks wait trajectory to eradicate 52 weeks earlier than plan. An update will be included at the next Finance and Performance Committee meeting.

6.6 Operational planning underway for the next junior doctor strike.

6.7 The COO has been invited to a Midlands COO workshop session on 9th July 2026, combining presentations, updates, and focused discussion on the COO development pipeline, divisional and leadership reporting into COOs, and the future workings of the NHSE provider interface on performance.

6.8 A focus on consultant workforce recruitment aligned to the agreed operational plan.

7. RECOMMENDATION(S)

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

Michelle Hubbard

Acting Executive Chief Operating Officer

May 2026

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

CHIEF PEOPLE OFFICER'S REPORT

Report to Trust Board (Public) – June 2026

1 LOCAL MATTERS FOR BOARD ATTENTION

1.1 Core Skills Training Framework (CSTF) Mandatory Training Compliance

Trust compliance for the CSTF is at 91.41% as of April 2026. This figure is reported from the new Learning Management System (LMS).

New Cyber Security and Information Governance modules launched on 1st April 2026. Current compliance will carry forward however current figures for Cyber at 81.54%, and IG at 81.74%. Fire training has moved to a 2 yearly renewal from 1st April 2026 and we should see the impact of this presenting as more consistent compliance.

2.2 Learning Management System Launch

The new Learning Management System continues to receive an incredibly positive response from staff, stating that it is clear, concise and user friendly.

The team are near complete of the Phase 2 launch with the Clinical Education Team and mapping the clinical competencies onto the LMS. The content is awaiting approval before launch. Phase 3 was linking our appraisal process to the LMS, and this launched on 1st April 2026. Future functionality around succession planning and talent mapping are currently in development.

2.3 Apprenticeship Activity:

The Growth and Skills Levy (nee Apprenticeship Levy):

From April 2026 the Growth & Skills Levy will replace the Apprenticeship Levy, which the government states will give employers more flexibility in how they use levy funds.

It will allow spending on short training modules ("apprenticeship units") and foundation apprenticeships, not just full apprenticeship programmes, enabling faster upskilling in national priority areas such as AI, engineering, and digital skills.

Core rules are being tightened:

- Levy funds will now expire after 12 months, increasing the risk of losing unused levy
- Co-investment increases to 25% once levy funds run out (currently 5%). (Trust does not currently use this)
- Level 7 apprenticeships lose levy funding for new starters aged 22+ from Jan 2026 and Level 3 - 6 management apprenticeships lose levy funding from Sept 2026.

- The system shifts national focus to early-career development (16–24-year-olds) and sectors with skills shortages.

The Growth & Skills Levy is a more flexible but more tightly controlled replacement for the Apprenticeship Levy, widening training options while prioritising young people and high-demand skills, but imposing stricter expiry and co-investment conditions.

Management and career-development apprenticeship qualifications have been the backbone of the Trust's apprenticeship strategy since 2017, underpinning performance against targets and supporting effective levy utilisation. Over the past 24 months, **48% of all new apprenticeship starts** have been in management or career-development pathways.

With the new Growth and Skills Levy placing a strong emphasis on **early-career pathways for 16–24-year-olds**, this shift in national policy presents a **significant strategic risk** for the Trust. It will remove the ability to fund management and development apprenticeships that have historically supported leadership capability, internal progression, and workforce stability.

The Trust will need to significantly change how it manages the new Growth and Skills Levy and manage the associated risks, particularly in relation to:

- **Financial management and effective utilisation of levy funding**
- **Leadership and management development pathways within the Trust**
- **Workforce planning, particularly in the context of national priorities for early-career opportunities and young people**

However, these changes also create several important opportunities, including:

- **Strengthening early-career pathways** by prioritising apprenticeships for young people and entry-level roles
- **Introducing short-course training options** to support workforce flexibility and targeted skills development
- **Expanding the scope of levy gifting** to maximise utilisation while supporting local partners

2.4 Me as Manager: The ROH Management Development Framework

As of April 2026, 441 individual people had accessed the Me as Manager webpage 2207 times. (Average of 5.00 visits per viewer, which continues to steadily increase).

Find out more about the framework here: Me As Manager

The Developing Leaders in the ROH programme continues strongly, with Cohort 2 delegates awaiting the outcomes of their assessments and Cohort 3 already 3 months into their courses. Cohort 4 has a waiting list already, and is due to commence in September 2026, with applications opening this month.

2.5 Post Graduate Education and the Birmingham Orthopaedic Training Programme (BOTP)

The delivery and coordination of the BOTP continues with positive feedback from the registrars and good performance during exams. In the last 6 months the following has been achieved:

- FRCS (Fellowship of the Royal College of Surgeons) Part 1: 2 passed Nov 25, 1 passed Feb 26
- FRCS Part 2: 2 passed in Nov 25, 3 passed February 2026
- CCT (Certificate of Completion of Training): 3 achieved in their January Annual Review of Competence Progression (ARCP).

2.6 Resident Doctors 10 Point action plan:

On Tuesday 17th March 2026, a second review meeting was held with Mr Manjit Obhrai (Associate Dean, PSW and Revalidation, NHS England West Midlands) to review the Trusts progress with implementing the 10-point plan and to support with any issues arising.

Mr Khalid Baloch, DME, Mr Abdus Burahee (Resident Doctor Peer Lead (RDPL)) and David Richardson, Head of Education and Training, met to review the Trusts self-assessment and action plans. Positive examples of good practice were noted, and progress in delivering the 10-point plan recognised.

Following an additional request from NHS England to appoint a Non- Executive lead, Simone Jordan has been appointed and has met with Mr Khalid Baloch during April 2026 to review progress.

2.7 NHS Education Contract Annual Self-Assessment 2025:

On 17th March 2026, we received acknowledgement of our Education Contract Self-Assessment. NHS England thanked us for our honesty and transparency in our return, and confirmed that there were no further questions, or concerns arising from our submission.

2.8 Library Services:

Library Services launched Literature Search e-learning course for all staff. Available on the LMS under “Literature Searching.” https://learning.roh.nhs.uk/login/index.php
The Royal Orthopaedic Hospital Library Impact - Health Libraries Midlands

2.9 MSK Academy

Royal Orthopaedic Hospital | MSK Academy - Home

The MSK Academy continues to gain momentum and growth. The MSK Academy website has had new content uploaded, and planned workshops have been advertised with strong engagement.

A GP Trainees regional training session was attended in February 26. This was an MSK education sessions, and with positive feedback received, our MSK academy

have been invited back later in the year. This training was provided free of charge and was used to increase awareness of the ROH and the MSKA.

A Young adult hip study day for advance practice physiotherapists was help on 25th March 26, to positive feedback. 20 delegates attended. From the advertising of this study day, Worcestershire Hospitals have requested a bespoke training day for 40 of their physiotherapists later in the year.

On the 29th April 26, the MSK Academy hosted the first Wrist and hand study day for surgical trainees.

2.10 Industrial Action

Resident doctors in England, represented by the BMA, undertook action between 7:00 AM on 7 April to 6:59 AM on 13 April 2026. Resident doctors are seeking a 26 per cent pay rise. Impact at the ROH was minimal but well managed with no impact on service delivery.

2.11 AFC Appraisals

The Appraisal window is now live from 1st April 2026 through to the end of July 2026.

The Appraisal form has been updated through consultation with colleagues and is available through the LMS system. This change will allow for more efficient and effective reporting.

Following the NSS results on the quality of appraisals, which have seen a marginal improvement, we have undertaken a review of the structure and questions. The revised questions have been themed around the three NSS quality questions, of "helping me improve how I do my job", "setting clear objectives" and "leaving me feeling valued" and are worded in an open, coaching style format to facilitate meaningful conversations.

Additional changes include the inclusion of a collective team objective, along with three manager questions supporting strategic Trust objectives around improving staff engagement, addressing sickness and continuing to support cost improvements. These changes are sought to improve the quality of appraisals while ensuring a focus and shared objectives around improving Trust performance in key areas.

2.12 The Voice into Action (VITA) staff feedback sprint has now closed. There has been positive engagement from all teams. Focus is now on reviewing the feedback received and developing plans and communications for implementation of actions which is critical to build staff trust and confidence in sharing their experiences and the things that would improve their working lives.

2 NATIONAL CONTEXT AND DEVELOPMENTS

2.1 Nursing Profiles

Following the successful conclusion of the Band 2/3 HCSW process, the task group, led by Emma Steele (Deputy Chief Nurse) has shifted its focus to the Nursing Profiles

in line with the national Commitment to Nursing programme. This requires a re-assessment of the different nursing job description; the group have identified at least 34 profiles to be updated, matched and consistency checked, which has been underway since the release of the new profiles in the summer. The project will progress over the coming months on a similar pathway to other Trusts in the system who we are working collaboratively with. We also have delegates at national meetings with NHS Employers to understand shared learning and developments.

NHS England announced that they are working with the RCN and other unions to undertake a number of measures, including: prioritising nursing graduate pay, reviewing the roles and pay bands of every band 5 nurse and establishing a single national nursing preceptorship to create a national framework to support newly qualified nursing. We are ensuring that we prioritise the Band 5 roles in the organisation.

HR and Staff Side have worked in partnership to complete the national job evaluation audit, submitted on 1st April 2026. This audit noted where our strengths and opportunities are in job evaluation; an action plan has been put in place to ensure robustness of the job evaluation service. This includes training more nursing staff in job evaluation to support the process.

2.2 National Pay Awards

With effect from 1 April 2026, a 3.3 per cent consolidated uplift has been awarded for all Agenda for Change staff on NHS terms and conditions. As a result the full-time Agenda for Change Band 3 entry point increases to £25,760 meaning that healthcare support workers will be eligible for international sponsorship, as the role appears on the Immigration Salary List and exceeds the minimum salary requirement for the health and Care Worker Visa which remains at £25,000.

What this means practically for us is that our costs associated with issuing of visas may increase at this level and robust workforce planning may be instrumental in avoiding increased costs but also creating a pipeline from Band 2 development.

The Doctors' and Dentists' Review Body (DDRB) has also awarded a 3.5 per cent uplift for consultants, Specialty and specialist (SAS) doctors, and doctors and dentists in training.

2.3 Transforming People Services

During March 2026 both the NHSE/DHSC Joint Executive Team and the DHSC Joint Investment Committee approved the Outline Business Case for the Transforming People Services Programme.

Detailed design of the operating model will now commence. 2 Regions, London and the South West, have been identified as accelerators in the programme, national funding is being explored to support other Regions make further advancements in their journey to Transforming People Services, subject to NHSE business planning and approvals.

We are yet to receive the Board pack which will be shared in due course.

3.0 KEY RISKS

3.1 There remains a risk that not acting upon staff feedback following the Voice into Action engagement sprint will further impact on staff morale. Mitigations include open communication on steps being taken to action the feedback, delivery of achievable actions in a timely manner and local accountability for acting on staff feedback.

4 WORK PLANNED IN NEXT MONTH

4.1 Continue to focus on supporting leaders with robust management of sickness absences.

4.2 Develop robust plan to adapt to changes in the Growth and Skills Levy.

4.3 Review learning from the Voice into Action staff feedback considering implications for staff engagement.

5 RECOMMENDATION(S)

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

Sharon Malhi
Chief People Officer
June 2026

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

QUALITY & GOVERNANCE OFFICERS' REPORT

Report to Trust Board on 3 June 2026

1 MEDICAL DIRECTOR'S UPDATE

1.1 Audit and Outcomes

The team is regaining ground on a temporary backlog on outcomes due to staff sickness. We awaiting data processing of newly released patient level PROMS data to restore clinical level feedback.

The Quality Improvement Day continues to broaden and mature as a high impact quality intervention day.

1.2 Research and Innovation

There is strong progress on reducing project approval times.

There is good progress with innovation and IP process with first Innovation and IP Committee due to meet soon as well as commercialisation and innovation hub starting to take shape conceptually

The Birmingham Health Partners Executive was held on 7 May 2026. Topics discussed included Secure Data Environment – a further detailed summit is planned. Research around Patient Safety was also discussed.

1.3 Clinical

The spinal unit hosted a regional spinal meeting presenting British Spinal Registry audit regionally. This was well received and is now driving internal improvements in collection and support for analysis.

Strategic Business Unit development is proving popular and motivational.

There was a constructive Clinical Service Leads meeting held on 20 May 26, which focused on follow up outpatients, theatre admission times, evolution of pre-operative process, safe surgery policy, radiology representation. An upward report will now be presented to Trust Management Group.

1.4 Medical Education

The team has engaged a non-executive director and the working group continues to progress the resident doctors' 10-point plan.

National Education and Training Survey results were discussed in detail at the Resident Doctors' forum and MPEG on 22 May 2026 – these show the Trust to be in the lower quartile for bullying and harassment (witnessed or experienced) and sexual safety. These concerns being are mirrored in other professional training groups. This was discussed in detail with a two front plan agreed (trainees and permanent staff).

The team delivered new appraisal system training for trainees on 19 May 2026.

The MSK Academy Delivery Group meeting was held on 8 May 26 which discussed first charging courses, adding a commercial lens to discussions and GP engagement sessions.

1.5 Visits

- GIRFT team in Hartlepool on 13 May 2026
- NHS Alliance Network event 14 May 2026
- BSol localities SROs on 15 May 2026

2 CHIEF NURSE'S UPDATE

National/Regional Updates

2.1 On Wednesday 27 May, the Nursing and Midwifery Council (NMC) announced a significant historical failure over a 12-year period in which the full process for assessing health and character declarations was not consistently followed. This issue was uncovered under new leadership following the introduction of a strengthened "speak up" culture and revised organisational values. The NMC and Duncan Burton, Chief Nursing Officer for England briefed the CNO network last week in readiness for the release of a statement by the NMC. The briefing asked organisations to support the process and any staff affected.

NMC explained that a comprehensive review of 18,060 cases has been undertaken. Findings indicate that 98% (17,626 cases) require no further action. However, 434 cases have been identified for further detailed assessment by an Assistant Registrar. At this stage, no Interim Orders have been deemed necessary, though ongoing risk assessments are in place. It is anticipated that only a very small number of cases (estimated up to 15 registrants, approximately 0.002% of the register) may ultimately result in referral to an independent panel, with potential removal from the register. At the time of writing this report, no ROH staff have identified that they have been affected by this situation. All senior nurses and HR have been brief and asked to support any staff who may declare they have received notification.

2.2 On 21 May 2026, the Minister for Women and Equalities laid an updated statutory Code of Practice before Parliament relating to services, public functions and associations under the Equality Act 2010. This follows the UK Supreme Court ruling of 16 April 2025 in *For Women Scotland Ltd v The Scottish Ministers*, which clarified that, for the purposes of the Act, sex is defined as biological sex recorded at birth. Parliament now has a 40-day review period before the Code may come into force.

In response, we are progressing internal work to ensure our facilities remain inclusive and accessible for all patients and staff. This includes reviewing the provision and signage of toilet facilities to ensure they are appropriate and clearly communicated. A dedicated working group is overseeing this work, and we continue to await further guidance from the Department of Health to inform our approach.

2.3 On the 7 May 26, as part of an executive team, I visited Birmingham City University. The purpose of the visit was to strengthen the relationship between the two organisations around the Allied Health Care workforce. I was then the keynote speak

at the universities International Nurses Day conference on the 18 May 26, where I had the honour of meeting BCU's international students from Pittsburgh.

Internal

2.4 On the 13 May 26, the Human Tissue Authority undertook the bi-annual routine inspection on site. The initial feedback was positive, with a couple of minor Corrective Action & Prevention Actions (CAPA) expected. Work is underway to address these ahead of the report which is due in July 26.

2.5 On the 20 November 26, we successful recruited the Chief Nursing Information Officer (CNIO) role. The new CNIO is expected to commence in post in August 26.

2.6 Barbara Simms retired after an exceptional 51 years at the Trust, reflecting a remarkable and dedicated nursing career at ROH. Her commitment and compassion left a lasting legacy, recognised with a Hero Award presented by Matt Hartland following nomination from the HDU team. She is warmly thanked for her invaluable contribution to patient care, the organisation, and the nursing profession.

2.7 On 11 May 2026, we celebrated International Nurses Day, followed by Operating Department Practitioners (ODP) Day on 14 May 2026, using these opportunities to recognise and showcase the contribution of our nursing and theatre teams. Across the organisation, teams developed and displayed posters to celebrate their services, highlight achievements, and share examples of compassionate, high-quality care. These activities created a visible sense of pride and recognition across clinical areas. The events were further strengthened by the valued support of staff side colleagues, who played an important role in championing and promoting the celebrations, ensuring staff felt acknowledged and appreciated.

2.8 Hospital Associated Infection (HACI): Below outlines the position at the end of March 26, the new thresholds have not been shared at the time of this report. At present there have been no cases reported in the new FY.

Organisms	2025/26 threshold	Total ROH cases YTD (Apr-Mar)
***C.difficile* Infection (toxin +ve)**	0	2
***E. coli* BSI**	0	2
***P. aeruginosa* BSI**	0	0
***Klebsiella Sp*. BSI**	0	0

3 DIRECTOR OF GOVERNANCE'S UPDATE

3.1 Health & Safety

The Health & Safety Adviser is building H&S annual audit template into AMaT, with a plan to trial before next H&S Group meeting in July.

Key staff groups have been identified as requiring COSHH awareness training (environmental cleaners, caterers, waste operatives and specimen drivers). COSHH e-learning awareness has now been uploaded onto the Learning Management System and assigned to these staff groups, including bank staff. H&S Advisor continues to hold drop in face-to-face training sessions on COSHH awareness over June / July for those staff who find e-learning less accessible.

The last Health & Safety Group was held on 20 May 2026 and was well attended.

3.2 Freedom to Speak Up

A new Freedom to Speak Up Champion has been nominated, Dr Narendra Siddaiah (Dr 'Sid'), one of the Anaesthetist team. Dr Sid will bring a much needed focus on speaking up and signposting to avenues to raise concerns within the theatres environment. His formal induction as a champion is planned within the next few weeks.

Work is underway to plan for the FTSU Awareness day in July. Ideas are currently being gathered to support this event and promote the benefits of speaking up about matters that concern staff.

Claudette Jones continues to support the Robert Jones & Agnes Hunt Hospital NHSFT as their interim FTSUG. She has received some positive feedback from RJAH around her work while their new Guardian is onboarded.

It is with pride that the FTSU team have been nominated for a Blue Heart Award for the second consecutive year, which reflects the value of this team and their work to ensure all staff feel safe and supported to speak up about concerns.

3.3 Corporate Services

The embedding of the new governance & accountability framework continues, with the second Trust Management Group meeting held and the plans for the first Performance Review Panel for Division 1 in June being developed.

The first draft of the Annual Report has been submitted, with comments now received from auditors, which will be built into the final version due for approval at the special meeting of the Trust Board in June 2026.

3.4 Clinical Governance

Patient Safety Incident Investigation (PSII) Training

PSII training was held on 12 May 2026, with over 20 staff attending from a wide range of teams across the Trust (anaesthetists, pharmacy, theatres, resus, patient safety, FTSU, medical directorate).

The training was facilitated by Morgan Human Systems, who are nationally renowned experts on PSIRF, and focused on the investigation methodology and formulation of actions when undertaking a PSII and was very well received.

Following the training, it is intended that the cohort of attendees will form a pool of trained investigators who, with further planned support from the governance team, will undertake future PSII investigations. Further details on the planned improvements and changes in relation to PSIIs and PSIRF will follow in due course.

Change to NHS England guidance on Never Events and PSIRF Investigations

There has been an update to NHS England PSIRF guidance on responding proportionately to patient safety incidents that relate to Never Events.

Following the recent Never Events framework consultation, the Never Events framework is currently under review, and we are still awaiting the final outcomes and recommendations.

During this time healthcare organisations must continue to respond to Never Events to support learning and improvement; however, as a result of the new guidance it is no longer mandatory that the learning response to a Never Event is a Patient Safety Incident Investigation (PSII). In line with PSIRF's principle of proportionality, organisations should now consider the most proportionate and appropriate learning response for the event in question.

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

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Strategy Delivery Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland – Chief Executive Officer**
AUTHOR:	**Rebecca Lloyd – Director of Strategy**
DATE OF MEETING:	**3 June 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This paper provides an update on delivery against the Trust's five-year strategy in 2025-26 (year 3). It includes key achievements against each of the strategic objectives, as well as a summary of the key challenges faced as the organisation moves into year 4 of delivery.

Progress against the Trust strategy is monitored via the bi-monthly Strategy Delivery Board, chaired by the Chief Executive Officer.

The critical success metrics included in the Trust's five-year strategy are as follows:

- **Care**: By 2028, we will maintain outstanding, high-quality care across all services and improve access, experience and outcomes for our patients.
- **Expertise:** By 2028, we will have increased our influence as the leading centre for orthopaedic surgery and MSK care through our cutting-edge research and MSK Academy.
- **People:** By 2028, we will be rated in the top 5% of Trusts to work for by our people in the NHS Staff Survey, recognising our commitment towards inclusivity and wellbeing for all.
- **Community**: By 2028, we will be leaders in MSK Prevention across our communities, improving access to our services and increasing the provision of MSK expertise at locality level
- **Sustainability:** By 2028, the ROH will be financially sustainable, having increased the number of people we treat through continuously improving our processes, standardising pathways and improving productivity.
- **Collaboration:** By 2028, we will have transformed MSK and orthopaedic services for our patient population through our strategic partnerships across healthcare, third sector, industry, research and academia.

A combined delivery & transformation plan for year 4 of the strategy has been reviewed by Trust Management Group in May 2026 and, following final amends, will be used as a key tool for staff engagement. It is intended to:

- Reflect priorities within the NHSE Medium Term Planning Framework
- Support priority/objective setting for teams and individuals
- Act as a clear overview for all services to recognise their role in both delivery and transformation
- Inform continuous quality improvement across the organisation
- Form part of the newly introduced Performance Review Panels
- Demonstrate the organisation's commitment to maintaining its NOF segmentation rating
- Articulate the vision for a new Care Model, Operating Model and Business Model

This will be shared with Trust Board at its next meeting in July 2026.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Key achievements for 2025-26 are listed against each of the six strategic objectives	• Key challenges identified in 2025-26 are listed against each of the six strategic objectives, and priority actions included

REPORT RECOMMENDATION:

The BOARD is asked to RECEIVE the Strategy update for 2025-26 for ASSURANCE

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

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

Comments:

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

Care	X	**Community**	X
Expertise	X	**Sustainability**	X
People	X	**Collaboration**	X

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

Aligned to BAF

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

Trust Strategy aligned to ICS Strategy

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

N/A

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

Trust Board (September 2025) and Board Development workshop (March 2026)

Summary of Year 3 (2025-26) progress against Trust Strategy (2023-2028)

KEY ACHIEVEMENTS

Strategic objective	Key achievement	Impact	Priority action for 2026-27
CARE	CQC Inspection Rating (Children & Young People's Department – May 2025)	'Good' across all CQC domains	Continue with self-assessment process and CQC preparedness programme ahead of future/full inspection
	CQC Inpatient Survey Result: 'Much better than expected'	Validated quality of care. Enhances reputation and staff morale. Provides a platform for sustained improvement.	Focus on becoming 'best in class' and achieving higher overall score (when compared with specialist trusts)
	Performance against 18-week referral to treatment target (RTT) above plan	Improved access to ROH services. Robust plan for 26-27 RTT delivery.	Continue to exceed RTT trajectory (target = 65.62%), with the ambition to deliver 92% RTT compliance by March 2028 (Federation of Specialist Hospital target)
	Maintained accreditation as a GIRFT Elective Hub	Maintaining reputation as leader in MSK & Orthopaedics. Demonstrating improved productivity and performance.	Shared learning from Hub Optimisation week. Continue to improve on GIRFT performance metrics. Maintain accreditation in July 2026.
EXPERTISE	180+ ROH authored publications (target = 200)	Relative citation ratio (RCR) from ROH publications has materially increased demonstrating knowledge leadership and 'reach' of ROH research	Continue to improve the impact of ROH research to demonstrate its impact on the national/internal research community
	Exceeded research income: £803k above plan	Exceeded CIP target, maintained a stable workforce and moved towards Strategic Business Unit model	Transition to SBU model and explore match-funded posts as income generation increases
	MSK Academy delivery programme with positive engagement and feedback	Example: Young Adult Hip Study Day – 87% recommendation rate across 24 delegates. Scope for repeat delivery. Overall social media activity around MSK Academy generated 391 engagements and a total reach of 19,118.	Build on existing course programme, and scope commercial viability
PEOPLE	Me As Manager programme delivery	4.46/5 rating for Me As Manager Development Framework. Good level of engagement. 6-month evaluation demonstrates increased manager confidence.	Consolidate course offering, and mandate modules based on service/team performance. Strengthen use of self-development guide and personal development plans.
	Reduction in long-term sickness absence	Days lost to LTS: 3.90% (March 2025) v 3.39% (March 2026)	Sickness Workstream Group will continue to drive priority actions aimed at reducing sickness absence and aligning performance with the forecasted glide path to 2028 (4% target).
COMMUNITY	30,000+ users of 'getUBetter' – digital self management tool for MSK (including NHS staff) across BSOL	£90,181 savings (across system) due to reduction in Physiotherapy waiting list	Full procurement of self-management tool for MSK and rollout across 40+ GP practices (as a pre-requisite for self-referral)
	First Community Appointment Day held	27% patients discharged onto PIFU (patient initiated follow up) pathway, and 17% patients discharged	Full evaluation of BSOL Community Appointment Day model to be completed by June 2026 to inform future programme of events
SUSTAINABILITY	Financial break-even	Maintained National Oversight Framework (NOF) segmentation (1)	Deliver recurrent cost improvement savings (including bank & agency spend) and grow commercial income
	Strong delivery against activity plan	All Inpatient Activity YTD 14,822 v Target 15,089 Outpatient Activity YTD 74,457 v Target 71,919	Alignment of activity and income at sub-specialty level.
COLLABORATION	Completed demand & capacity planning for all MSK workforce across Birmingham and Solihull	Locality data now available to quantify gap between MSK capacity and MSK demand	Building a proposition for 'delivering therapies differently' across each locality in response to population health need
	Secured funding for MSK Occupational Health pilot	Anticipated impact: reduction in MSK related absence	Rollout MSK case management service and line manager toolkit across Birmingham & Solihull, reporting progress to NHS Charities Together
	Strategic partnership with Robert Jones & Agnes Hunt	Opportunities for shared learning and improvement identified across each Directorate portfolio	Bi-annual Board to Board meeting in addition to planned Executive to Executive sessions. Collaborative programme delivery as per Memorandum of Understanding.
	Collaboration on FOSH policy document ('The power of specialism in the future NHS')	Influencing national policy around the role of specialist hospitals	Articulate ROH leadership role for MSK & Orthopaedics across the system

KEY CHALLENGES

Strategic objective	Key challenges	Current position	Priority action for 2026-27
CARE	Maximising benefit of JointCare pathway to ensure it is fit for 2026 and beyond (i.e. aligns to day case model)	Elements of JointCare pathway embedded. Day Case Project Group driving increase in day case delivery, including rollout to additional services such as Spinal.	Rejuvenate JointCare pathway via Arthroplasty Strategic Business Unit. Increase day case rates.
	Improving digital pathways ahead of EPR	Process mapping workshops across all services planned across May & June 2026	Optimised digital processes agreed ahead of EPR implementation from July 2026 onwards.
	Optimising referral management through new Integrated Patient Pathway (IPP)	ROH representatives across all pathway design groups to sign off clinical pathways for MSK & Orthopaedic sub-specialties.	Key focus is to ensure referrals are received appropriately into ROH referral management system from IPP.
EXPERTISE	Challenges recruiting patients to research studies	Challenge nationally. ROH study set up time has reduced by 50% (using QSIR methodology) in 2025-26 which improves opportunities to recruit patients.	Actively participate with patient engagement programme through Birmingham Health Partners, and build on academic partnership with University of Birmingham ALIGN programme to increase patient participation from under-represented groups & those from disadvantaged communities
	Expanding specialised service offer e.g. Osseointegration	Clinical Service Reviews will include transformation of service offer including specialised services.	Strategic Business Unit model will build on clinical service reviews and present strong case for specialised services (as leaders in MSK & Orthopaedics)
	Access to training and development for all professional staff groups	New Apprenticeship Levy will impact access to professional development (removal of Level 7 for individuals aged 22+). Awaiting NHS Management & Leadership Framework.	Map access to training & development for all workforce groups, including demographic data. Reporting through to Staff Experience OD Committee.
PEOPLE	Gender Pay gap has increased	Negative increase in the ROH Gender Pay gap from 31.69 % in 2024 to 33.01% in 2025	Review starters and leavers as part of the inclusion recruitment project. Enhance development opportunities including coaching. Support women's health (including MSK issues).
	MSK & mental health related sickness continues to be above trajectory	MSK related absence (April 2025 v April 2026) = 729 days lost in month v 503 days lost in month Mental health related absence (April 2025 v April 2026) = 380 days lost in month v 465 days lost in month	MSK occupational health service 'Workfit' to expand. Similar service being scoped for mental health.
	Decline in WDES and WRES indicators	Decline in WRES & WDES indicators from 2024 to 2025 (WRES: 4 indicators have declines / WDES: 7 indicators have declined)	Further WRES and WDES reports will follow in June 2026 with full information, additional data from above sources, analysis of results and priority actions.
COMMUNITY	MSK remains low priority in neighbourhood health agenda	ROH active members of Locality Delivery Partnerships and Community Care Collaborative, and leading MSK transformation across the system	Deliver early priorities for Phase 2 MSK Transformation Programme and establish ROH Neighbourhood Health model.
	Use of Health Inequalities data to improve access, experience and outcomes	Actively using IMD data to support patients accessing outpatient appointments (IMD 1 & IMD 2).	Priority agreed as part of Health Inequalities action plan (2026-27) to implement a structured data quality and insight framework to routinely monitor waiting list demographic data, analyse variation by protected characteristics, use population health data within and beyond ICB boundaries, and translate quantitative and qualitative findings into targeted service improvements.
	Co-production and public engagement	Public engagement currently delivered via Trust membership approach.	Review in line with national guidance and planned changes to Health and Social Care Act.
SUSTAINABILITY	Achieving Private Patient Unit growth plan	2025-26 year end position: £1.205m variance to plan	Private Patient Oversight Group now reporting into Commercial Group. Clear delivery plan for 26-27.
	Transition to 6/7 day working	Consultation concluded.	Timing for go-live to be agreed via Executive Team.
	Challenge to maintain CIP delivery	CIP target for 26-27: total amount identified	QIA completion for all CIPs. Support and challenge through Financial Sustainability Improvement Group.
COLLABORATION	Strategic partnership with industry	Innovation Hub being scoped, including opportunities with industry and MedTech.	Learning outside of the NHS/UK. Innovation Hub options appraisal complete & implementation of virtual/physical space.
	System governance for MSK	Acute Provider Collaborative not currently meeting. No direct system oversight of MSK Transformation programme.	Proposal to report MSK Transformation Programme directly through ICB governance & strategic commissioning function.

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NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**National Oversight Framework metrics**
SPONSOR (EXECUTIVE DIRECTOR):	**Matthew Hartland, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**3 June 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Following the implementation of the National oversight framework by NHSE last year, the guidance for the coming year has been released, which includes a revise set of metrics which will inform the delivery score element of the segmentation process.

The list of metrics which has now been validated by NHSE for the ROH are attached in the attached document, which will subsequently be populated when the technical guidance has been released later this month, with a self-assessment to understand how our performance sits.

Confirmation has been gained from NHSE that cancer performance remains excluded from consideration.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
The Trust remains within Segment 1 at present, pending the outcome of the latest, Q4 ratings from NHS	Performance against the additional metric, Relative cost difference (NCC Index) may create challenge

REPORT RECOMMENDATION:

The Board is asked to: note the changes from the previous year and consider any potential pressures or areas of challenge based on the new set of metrics to be used.

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		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:

No specific entries on the risk registers

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

N/A

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

Model Hospital data

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

Executive Team and Trust Management Group in May 2026

Oversight Metrics – National Oversight Framework

A revised set of metrics has been published which will be used to underpin the segmentation scores within the National Oversight Framework (NOF) for 2026/27. These scores taken together, translate to a provisional oversight segment, which is used to generate discussions between NHS England and organisations to reach a final segmentation judgement. These metrics relate to the national objectives set out in priorities and operational planning guidance for 2026/27 and other commitments related to the NHS Constitution.

For the ROH, 21 metrics will be used to inform the delivery score, with a further 5 being contextual.

From this year, the National Oversight Framework segmentation will also apply to ICBs.

Technical guidance is yet to be published providing more detail around the scoring mechanisms and reporting periods, which will be used to underpin the self-assessment required to establish the Trust's likely scores and rating.

May 2026

DOMAIN 1: POPULATION HEALTH, PREVENTION AND REDUCING INEQUALITY

DOMAIN 2A: ALLOCATING RESOURCES DOMAIN 2B: ACCESS TO SERVICES		
Metric	**ROH Position Statement/Performance**	**Reporting period**
ELECTIVE		
Percentage of patients waiting less than 18 weeks for care		
Percentage of patients waiting less than 18 weeks for care vs target		
Percentage of patients waiting over 52 weeks for care		
DIAGNOSTICS		
Percentage of diagnostic referrals waiting over 6 weeks		

DOMAIN 3: EXPERIENCE OF CARE		
Metric	**ROH Position Statement/Performance**	**Reporting period**
EXPERIENCE		
CQC inpatient survey satisfaction rate		Annual
NHS Staff Survey advocacy rate		Annual

DOMAIN 4: EFFECTIVENESS OF CARE		
Metric	**ROH Position Statement/Performance**	**Reporting period**
EFFECTIVE DISCHARGE		
30 day readmission rate band		

DOMAIN 5: PATIENT SAFETY		
Metric	**ROH Position Statement/Performance**	**Reporting period**
SAFE OUTCOMES		
Number of cases of MRSA in the last 12 months		
Rate of *E.coli*		
Rate of *C.difficile*		
Rate of inpatient falls that cause harm		
% of inpatients to acquire a new grade 3 or 4 pressure ulcer		
% of safety incidents causing harm		
SAFE CULTURE		
NHS staff survey raising concerns sub-score		

DOMAIN 6: FINANCE, PRODUCTIVITY AND INNOVATION		
Metric	**ROH Position Statement/Performance**	**Reporting period**
FINANCE		
Planned surplus or deficit		
Variance to plan to date		
PRODUCTIVITY		
Implied Productivity Index		
Relative cost difference (NCC Index)		
INNOVATION		
% clinical trials set up within 90 days		
Data Quality maturity index		

DOMAIN 7: PEOPLE		
Metric	**ROH Position Statement/Performance**	**Reporting period**
PEOPLE & CULTURE		
Sickness absence rate		
NHS staff survey engagement theme score		
National Education and Training Survey Satisfaction Score		
National Staff Standards score		
Healthcare Worker Flu Vaccination Rate		
WORKFORCE		
Temporary staffing costs as % total pay bill		

KEY

- Indicators in dark red are contextual (non scoring)
- Indicators in purple are those that were previously contextual but are now scoring
- Indicators in green are those that were previously scoring but are now contextual

The Royal Orthopaedic Hospital NHS Foundation Trust

1.UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 26th May 2026

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Month 1 performance fell below plan across several areas (notably elective activity, private patients, and outpatients), with a corresponding adverse financial impact. • Private patient income below plan, driven by cancellations and reduced consultant activity flow. • Ongoing constraints with Theatre 4 affecting operational resilience. • Workforce gaps impacting outpatient delivery and activity levels. • UHB pathology services performance has stabilised but remains at risk • CIP delivery behind profile, increasing financial risk if not recovered quickly.	• Targeted recovery plans for activity and financial performance across Q1. • Private patient strategy reset, including consultant engagement, capacity allocation and commercial opportunities. • Productivity and optimisation work (including hub optimisation) to drive efficiency. • Development of mitigation options for Theatre 4 and estate utilisation. • Workforce recruitment and cost control measures, including reduced reliance on premium staffing. • Continued escalation and monitoring of pathology services with NHS England.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**

• Strong RTT performance, ahead of plan, with continued reduction in long waits.
• Cash position remains favourable.
• Effective cost control, particularly in agency spend.
• Clear evidence of active performance management and recovery focus across the organisation.
• Confidence that Month 1 underperformance is recoverable in the short term.
	• Reinforced expectation for timely delivery of actions and improved governance reporting.
	• Agreed continued close monitoring, with a key performance review at end of Quarter 1.
	• Requested further updates on:
	  ○ Private patient recovery plan
	  ○ Productivity initiatives
	  ○ Capital programme detail
	  ○ Updated risk register

Chair's comments on the effectiveness of the meeting: A challenging start to the year, but with robust recovery actions in place and strong underlying operational performance, the Committee retains cautious confidence subject to delivery through Q1.

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM QUALITY AND SAFETY COMMITTEE

Date Group or Board met: 27 May 2026

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Patient Experience Quarterly Report – It was noted that there had been a decrease in compliance with the key performance indicator for complaint responses in Quarter 4 due to workforce challenges in the Patient Experience Team and issues related to the implementation of a new telephone system. A targeted recovery plan has been agreed to improve the timeliness of formal complaint responses.	• Further work to be undertaken to update the Corporate Risk Register related to measurable actions and detailed timescales. • The new single integrated dashboard, which will be an amalgamation of metrics for workforce, quality, operations and finance, will be presented to the Quality and Safety Committee in July 2026. • There has been a reduction in incident reporting due to improvements in medicines safety issues and a reduction in long waits. The Governance Team will undertake incident reporting training for ancillary, estates and theatre staff to increase awareness of incident reporting on the Ulysses system. • A deep dive review was undertaken following an increase in in-patient falls in April, however it was noted that no themes/issues had been identified. • The committee received a paper analysing the theatre wait times for elective admissions for January to March 2026 and noted the proposed phased improvement project regarding staggered admission times. • The committee received a verbal update regarding the recent Critical Care Peer Review and it was agreed that the formal report and action plan would be presented at the next meeting.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Two safeguarding risks on the Corporate Risk Register have had their risk scoring downgraded following a safeguarding risk summit. • The committee received an update regarding a recent coroner's case which demonstrated effective organisational learning, with improvements implemented in cancer pathway tracking.	• It was agreed that a brief high-level summary and narrative conclusion would be included in the Quality Report for any future coroner's inquests. • The Quality Priorities for 2026/2027 were agreed subject to consideration around incorporating a patient experience improvement as a priority.

• The committee received an update on the completion of the Quality Priorities for 2025/2026 and reviewed the proposed priorities for 2026/2027. • The Infection Prevention and Control Annual Report 2025/26 provided assurance regarding the Trust's overall IPC performance and highlighted key achievements including strengthened governance arrangements, reimplementation of the IPC audit programme and a Trust wide decontamination improvement programme. • The committee received the Annual Safer Staffing Report for nursing and allied health professions which outlined the Trust's positive compliance with national workforce standards. Key achievements include no use of agency nursing or ODP staff in the last 12 months, no increase in harm and graduation of two degree nurse apprenticeships. • The committee received a Service Accreditation update highlighting the establishment of a Service Accreditation Steering Group, the development of a suite of accreditation standards in partnership with subject matter experts, the successful pilot assessment of two services in September 2024 and completion of Phase 1 and Phase 2 of the Service Accreditation programme. • The HTA Inspection has provided positive assurance regarding the Trust's compliance with Human Tissue Authority regulatory requirements with only minor corrective and preventative actions identified. • The committee received a report from KPMG regarding an audit of the management of controlled drugs which provided significant assurance with minor improvements and actions are underway to strengthen the Omnicell process and destruction of controlled drugs. • The Health and Safety Annual Report highlighted key improvements for the year and there will be focused education with line mangers regarding workplace risk assessments and work to improve assurance regarding the Trust's compliance with legal and statutory duties of health and safety legislation.	• It was agreed that the following reports would be presented at the next Trust Board meeting: - Fire Safety Annual Report - Quality Priorities for 2026/2027 - Safer Staffing Report - Infection Prevention and Control Annual Report - Human Tissue Authority Annual Report 2025/2026. - Medicines Safety Officer Annual Report January – December 2025 - Health and Safety Annual Report - Quality and Safety Committee Annual Report

• The committee received an annual update from the Medicines Safety Officer which provided positive assurance regarding the handling of medicines related incidents, national patient safety alerts and MHRA medicine recalls for 2025. • The committee received the Fire Safety Annual Report which identified the Trust's high-level compliance with relevant fire safety legislation and training. It was noted that fire safety is a standard agenda item at the Health and Safety Group meeting and fire safety training is currently in excess of 91% compliance due to inclusion on the LMS system. • The committee received an update regarding the establishment of the Advanced Practice Oversight Group. The group have reviewed the NHS England Multi-Professional Framework for Advanced Clinical Practice identifying risks and gaps and an action plan has been developed. • The Committee received and accepted an annual report on its work during 2025/26.	

Chair's comments on the effectiveness of the meeting: A positive meeting with good attendance. It was suggested that where reports could be summarised or more concise then that would be a welcome development for the Committee in future.

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Safer Staffing Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Nikki Brockie, Chief Nurse**
AUTHOR:	**Jennifer Bryan, Workforce & Education Lead** **Emma Steele, Deputy Chief Nurse**
DATE OF MEETING:	**3 June 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY: The purpose of this paper is to provide the Board of Directors with a bi-annual, comprehensive safer staffing report for Nursing and Allied Health Professions (AHP), which outlines staffing capacity and compliance. The report details the Trust position against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards (2016)[1], and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance[2], published in October 2019.
Progress against the actions arising from the October 2025 Safer Staffing review demonstrates that the majority of planned improvements have been delivered, with six of the eight actions completed, and three actions remaining in progress or paused.

Below outlines the action achieved:

- Safer Nursing Care Tool (SNCT) census undertaken to inform establishment changes
- Band 2/3 job description review completed in partnership with staff side
- Review of headroom for 2025/26 in line with mandatory training requirements
- Review of Healthroster templates to align with agreed establishments
- Benchmarking against Model Hospital completed
- Review of Association for Perioperative Practice (AfPP) guidance completed

Outstanding actions:

- The Outpatients establishment review, which continues to be progressed alongside current job planning activity
- The rollout of 7-day working in theatres, which is currently paused
- Clinical training plans for 2025/26 has been delayed and will be progressed in the next reporting period.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Establishment review agreed and signed off by DOF & MD.	• CYP OPD & ROCS not included in the review process, as they are currently

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

• All wards / departments and theatre 's areas establishments review carried out. Including all Healthroster template reconciled back to funded establishments. • Nursing workforce (vacancies) has remained reduced in reporting period. • Signed off by system as completing compliance with Developing Workforce Safeguards (DWS) framework and NICE safe staffing guidance (SG1) • No agency for nursing and ODP in over 12 months. • Apprenticeships Degree nurse apprentices and OPD's graduated • Nurse & OPD's agency stopped in the last six months. Bank usage reduced. • Complete band 2 to band 3 Health care support worker job evaluation and implemented. • Harm free metric reflects a stable workforce, with no concerns highlighted in triangulation.	undergoing a wider review in relation to demand and capacity. • Nurse sickness high, actions in place to monitor and work with manager to address. • Red flag usage requires re-enforcing. • PNA's remain below recommend target- work in progress to address gap and ensure consistent provision.

REPORT RECOMMENDATION:

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

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

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

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

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

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

BAF – Care, safer staffing policy.

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

N/A

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

Model hospital data

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

Dec 25 Safer staffing papers, monthly safer staffing reports.

FOR ASSURANCE

The Royal Orthopaedic Hospital NHS Foundation Trust

Annual Safer Staffing Report

Quality & Safety Committee May 26

1.0 EXECUTIVE SUMMARY

1.1 The purpose of this paper is to provide the Board of Directors with an annual assurance report on safe staffing for Nursing and Operating Department Practitioners (ODPs) at The Royal Orthopaedic Hospital (ROH). The report outlines staffing capacity, workforce stability, and compliance with national safer staffing requirements. The report sets out the Trust's position against the National Quality Board (NQB) Safer Staffing Guidance for adult inpatient wards (2016)[1] and the Developing Workforce Safeguards (DWS) framework (2018)[2]. It provides assurance through triangulated analysis of workforce data, patient acuity and dependency, professional judgement, and nurse-sensitive quality indicators.

1.2 The paper will cover the 13-month period from February 2025 to February 2026. It should be noted that the data presented in the October 25 paper will be included in this timeframe. The intention is to realign the reporting cycle with annual planning, with the annual report presented in May and a mid-year safer staffing report presented in December each subsequent year.

1.3 A key workforce achievement during the reporting period is the Trust's delivery of over 12 consecutive months of zero agency usage for both Nursing and ODP staffing. This reflects a stable and sustainable workforce and demonstrates strengthened recruitment, retention, and roster oversight across all clinical areas.

1.4 Perio-operative staffing (skill-mix) has been reviewed against the Association for Perioperative Practice (AfPP) "Staffing for Patients in the Perioperative Setting" (2022). This ensures alignment with recognised best practice, ensuring appropriate skill mix, defined minimum staffing levels, and the effective deployment of roles across perioperative services.

1.5 Progress against the actions arising from the October 2025 Safer Staffing review demonstrates that the majority of planned improvements have been delivered, with six of the eight actions completed, and three actions remaining in progress or paused.

Below outlines the action achieved:

- Safer Nursing Care Tool (SNCT) census undertaken to inform establishment changes
- Band 2/3 job description review completed in partnership with staff side

[1] NHS England (2016) National Quality Board guidance on safer staffing

[2] [2] NHS England (2018) Developing Workforce Safeguards

- Review of headroom for 2025/26 in line with mandatory training requirements
- Review of Healthroster templates to align with agreed establishments
- Benchmarking against Model Hospital completed
- Review of Association for Perioperative Practice (AfPP) guidance completed

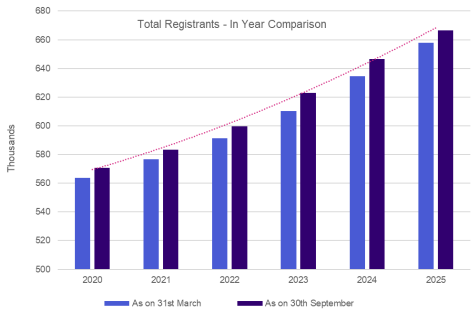
Outstanding actions:

- The Outpatients establishment review, which continues to be progressed alongside current job planning activity
- The rollout of 7-day working in theatres, which is currently paused
- Clinical training plans for 2025/26 has been delayed and will be progressed in the next reporting period.

2.0 NATIONAL CONTEXT

2.1 National workforce data outline an overall strengthening position for the nursing workforce, providing assurance of increased capacity and improved stability. This is demonstrated in the recent NHS England workforce statistics date (Feb 2026)[3] where vacancy rates have reduced overall from 7.4% to 6.7%[4]. Collectively, these trends demonstrate the positive impact of national recruitment and retention initiatives and provide assurance that the NHS workforce is becoming more stable, supporting the delivery of safe and effective care while maintaining a focus on long-term sustainability.

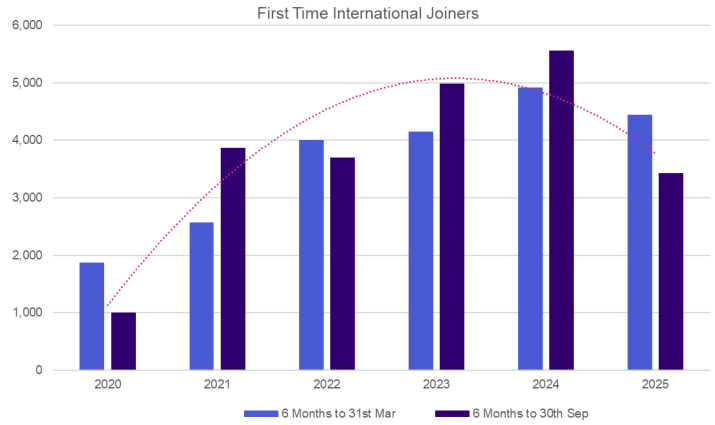
2.2 The Nursing and Midwifery Council (NMC)[5] Register also shows continued growth across both England and the wider UK. As of 30 September 2025, there were 666,652 professionals on the register in England, representing growth of 1.3% over the preceding six months. This growth is higher than the overall UK increase of 0.8% over the same period, indicating a relatively stronger workforce expansion within England compared to the wider UK position.



Graph 1. Total registrants by year on the NMC register

2.3 However, in line with national trends, the rate of growth has slowed compared to the same period in the previous year. This is evident across both England and the UK register and is primarily driven by a reduction in internationally educated joiners. In England, joiners reduced by 12.6% overall, with international recruitment falling significantly, reflecting wider global workforce pressures. Despite this, retention remains stable, with the proportion of leavers consistent with previous periods.

[3] NHS Workforce Statistics - February 2026 - NHS England Digital
[4] NHS workforce: Size, characteristics and staffing levels - House of Commons Library
[5] data-report-england-web-2025.pdf



Graph 2. International joiner to the NHS register

2.4 Overall, the register continues to expand, with the workforce becoming increasingly diverse, with over one-third of registrants in England from Black, Asian and minority ethnic backgrounds. The Trust's commitment to the anti-racism pledge aligns with national expectations set by the NMC, reinforcing a zero-tolerance approach to racism and discrimination, and supports ongoing engagement with a diverse workforce.

2.5 Overall, the national position provides assurance that the nursing workforce has strengthened significantly in recent years, with reduced vacancy rates and continued growth in registered professionals. The comparison between England and the wider UK position highlights relative resilience in England; however, the slowing rate of growth and reduction in international inflow reinforce the need for sustained focus on domestic workforce supply, retention, and long-term workforce planning to maintain this progress.

3.0 REGIONAL & SYSTEM CONTEXT

3.1 BSOL ICS continues to demonstrate improvement in the nursing and midwifery workforce, with substantive staffing increasing from 34,142 WTE in April 2022 to 40,904 WTE in December 2025, representing growth of 19.8%. At Month 9, most providers are reporting staffing at or above plan, with ROH aligned to this position and reporting a small positive variance of 0.54% (7 WTE) above trajectory. Vacancy rates across the ICS now range between approximately 4% and 11%, reflecting continued improvement and reduced reliance on temporary staffing. This is further supported by a significant reduction in temporary workforce utilisation between March 2024 and December 2025, with bank usage decreasing by 21.7% (1,064 WTE) and agency usage reducing by 75.2% (666 WTE), demonstrating strong progress against system workforce and financial recovery objectives.

3.2 As previously set outline the October 25 report and in line with BSOL ICS requirements and the NHS Long Term Workforce Plan, the Trust has maintained a focus on controlling workforce growth and reducing reliance on temporary staffing. ROH has made strong progress against these objectives, achieving zero nursing agency usage for the last 12 consecutive months, with substantive staffing levels remaining stable and aligned to system expectations.

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

3.3 National data indicates ongoing pressure within the nursing education pipeline, with 26,315 students accepted onto undergraduate nursing programmes for the October 2025 intake, representing a slight 0.7% decrease compared to the previous year. While England saw a modest increase in acceptances, this was offset by declines in other UK nations. Applications to pre-registration nursing programmes also remain below pre-pandemic levels, with 41,890 applications in 2025, only a marginal increase on 2024 and significantly lower than the peak seen in 2021.

3.4 Despite this national picture, local universities within Birmingham continue to report successfully recruitment to nursing and Operating Department Practitioner (ODP) programmes through bi-annual intakes. This is supporting the stabilisation of the systems nursing and OPD workforce.

Graduate Guarantee for Newly Qualified Nurses and Midwives

3.5 In August 2025, national guidance was issued by the Chief Nursing Officer for England and the NHS Chief Financial Officer outlining the Secretary of State's graduate guarantee for newly qualified nurses and midwives. The guarantee supports qualifying nursing students to join the nursing workforce across health and social care.

3.6 Supporting this national initiative, the Trust recruited seven newly qualified nurses during the reporting period (five registered nurses and two Registered Nursing Associates). A range of activities were undertaken to support this initiative, including a review of all job descriptions and adverts to encourage applications from student nurses, attendance at local university careers events, and advertising all posts on social media and national NHS Jobs platforms.

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

3.8 The National Education and Training Survey (NETS)[6] is a national, multi-professional tool that provides insight into the experience of healthcare learners, supporting organisations to assess the quality of education and training environments and inform continuous improvement. Within the Trust, 2025 results indicate a generally positive experience for nursing and ODP students, with engagement improving to 22 respondents compared to very low participation in previous years. While this remains a small proportion of the overall student cohort, findings are triangulated with other sources of feedback, including end-of-placement evaluations, which have been consistently positive, with some areas, particularly theatres highlighted as providing excellent learning environments.

3.9 No widespread concerns were identified through local review, one quality of care concern was appropriately escalated and managed. A small number of responses referenced bullying and undermining; however, these were not raised through local reporting routes to enable further investigation. Actions are focused on strengthening student support and increasing awareness of reporting mechanisms, including continued promotion of the Sexual Safety Charter, dedicated drop-in sessions with the Practice Placement Manager, and

[6] The National Education and Training Survey (NETS) | NHS England | Workforce, training and education

ongoing engagement with university partners, alongside reinforcing induction, Freedom to Speak Up, and placement support arrangements.

Apprenticeship Pathways and Workforce Supply

3.10 The Trust continues to invest in nursing and ODP apprenticeship pathways to support the career development and to recruitment. Current programmes include the Registered Nurse Degree Apprenticeship (RNDA top-up), Student Nursing Associate (SNA) programme, and ODP apprenticeship. Table 1. Outlines the current position of all apprentices.

Programme	Numbers of Learners	Completion date
Registered Nurse Degree Apprentice - top-up	2	2 in April 2026 – Both graduate in June 26 and have posts in the Trust
Student Nursing Associates	3	1 in May 2026 1 in May 2027 1 in on a Break in Learning
Operating Department Practitioner apprentices	6	4 in April 2026 2 in April 2028

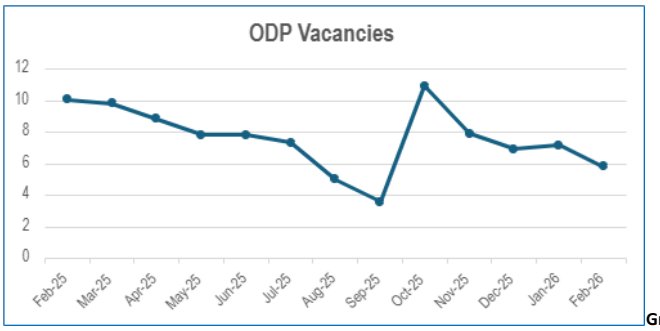
Table 1. Apprenticeship programme

3.11 While there remains a trust wider commitment to supporting apprenticeship in non-medical clinical posts, there are currently no approved business cases. However, the Matron for theatre, is currently developing a business for the coming year.

Operating Department Practitioner Workforce

3.12 The Operating Department Practitioner (ODP) workforce at ROH has continued to strengthen during the reporting period, supported by a well-established apprenticeship pathway and improved internal supply. Of the four apprentices due to complete in April 2026, three have secured substantive roles within the Trust, with one taking up a position in another NHS organisation due to relocation, demonstrating strong retention while contributing to the wider system.

3.10 As illustrated in the vacancy trend data (Graph 3.), ODP vacancies have reduced overall from approximately 10wte in early 2025 to 6wte by February 2026, despite a temporary increase in October 2025, indicating improving workforce stability over time. This reflects the positive impact of internal apprenticeship programmes and retention initiatives.

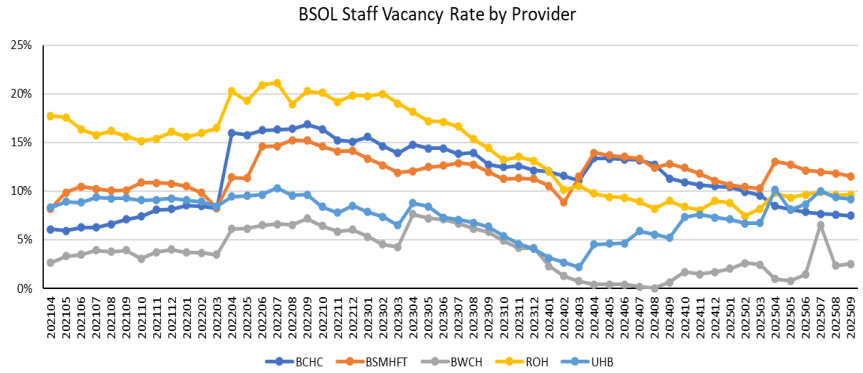


Graph 3. ODP Vacancies

4.0 ROH Workforce Overview (Nursing & ODP'S)

System Vacancy Context

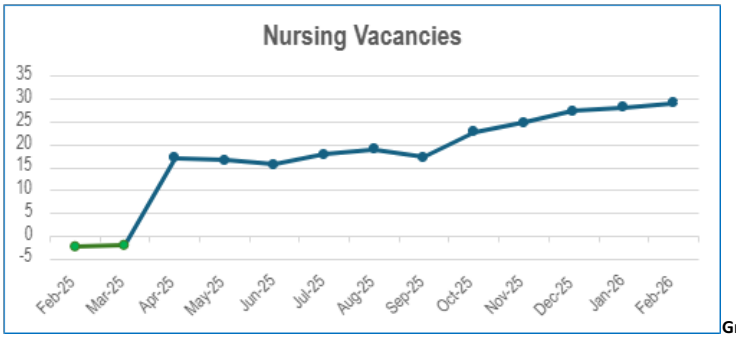
4.1 Graph 5. demonstrates a sustained improvement in nursing and midwifery vacancies across BSOL ICS; vacancies have reduced from 1,673 WTE in April 2022 to 781 WTE in September 2025, representing the lowest vacancy position over the three-year period. This reflects the impact of coordinated system-wide recruitment and workforce initiatives.



Graph 5. BSOL nursing and midwifery vacancies

ROH Nursing Vacancy Position

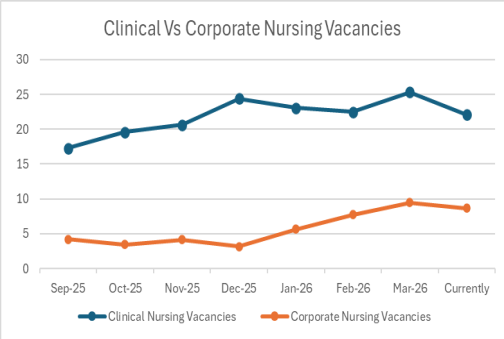
4.2 Graph 6. demonstrates variation in registered nurse vacancy levels across the reporting period. Vacancy levels were low in early 2025, followed by an increase in April 2025 to approximately 17 vacancies. From April to September 2025, the position remained relatively stable, fluctuating between approximately 15 and 19 vacancies. From October 2025 onwards, a gradual upward trend is observed, rising to approximately 29 by February 2026.



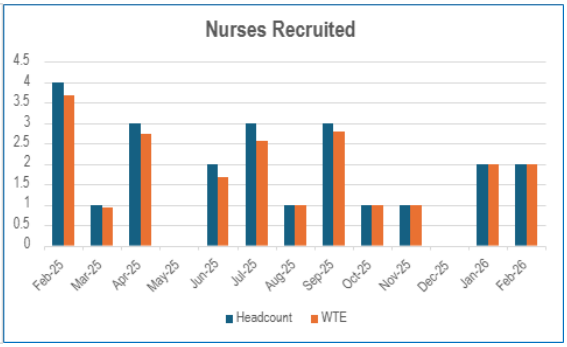
Graph 6. Rolling 13-month nurse vacancy

4.3 This increase does not reflect establishment growth but is attributable to a temporary hold on recruitment to several posts to allow service review to be undertaken. The temporary hold did not affect patient safety or impact activity but was designed to allow review and transformation.

4.4 Graph 7. Illustrates that the trust reported a total of 30.74 WTE registered nurse vacancies at the end of the reporting period. This comprising of 22.06 WTE in clinical roles (patient-facing) and 8.68 WTE in corporate positions. Patient-facing roles represent the biggest workforce gap.



Graph 7, Clinical Vs Corporate Nursing Vacancies



Graph 8. Illustrates recruitment activity across reporting period

Unregistered workforce

4.5 At the end of February 2026, the Band 2 workforce had slight decrease in posts, with a noted increase vacancies from the previous reporting period. As outlined below the Band 2 workforce has 31.18wte vacancies, this was across two clinical areas: Outpatient Department and Theatres. Local reviews of services provision were undertaken and has resulted in a change to establishments which will be reflected in the April 26 Start points.

Job Title	Budget	Actual	Vacancy
Healthcare Assistant	96.38	80.47	15.91
Theatre Assistant	56.58	41.31	15.26
Grand Total	152.96	121.78	31.18

Table 2. Band 2 posts

National Review of Support Worker Roles

4.6 The national review of the Band 2 to Band 3 support worker roles concluded in January 2026. Updated role titles and job descriptions will therefore be reflected in the next reporting cycle. It must be noted that Theatre Assistants and HDU band 2 staff were out of scope, with plans to undertake separate reviews for theatre assistance in Quarter 1 of 26/27.

5.0 National Safe Staffing Framework and Assurance

5.1 During the reporting period, the Trust has undertaken a comprehensive review against the national Developing Workforce Safeguards (DWS) framework and NICE safe staffing guidance (SG1). Two DWS submissions (June 2025 and February 2026) demonstrate continued progress, with identified gaps either addressed or supported by clear, time-bound action plans ahead of formal NHS England review. In parallel, a NICE baseline assessment has been completed to evaluate current practice against national standards. This confirms that core safer staffing principles are in place, including use of SNCT, SafeCare acuity tools, professional judgement, and robust governance. The assessment has been updated to reflect the Trust's current position, with targeted actions identified to strengthen consistency, documentation, and alignment with NICE guidance, which will be progressed during quarter 2/4 of 26.

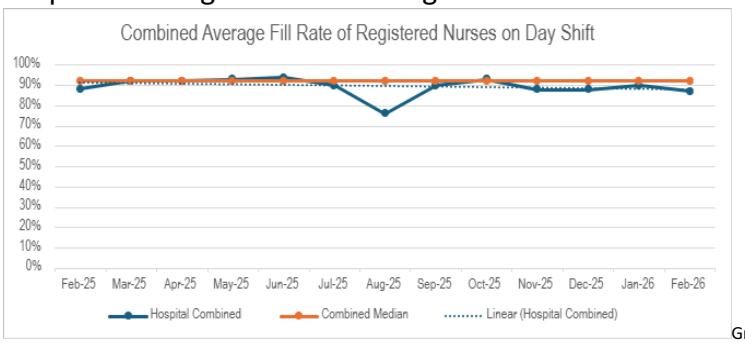
5.2 BSOL ICS have led the oversight of this update and have noted and commended the work undertaken by the ROH, and specifically the WEL.

Safe Staffing Data and Triangulation

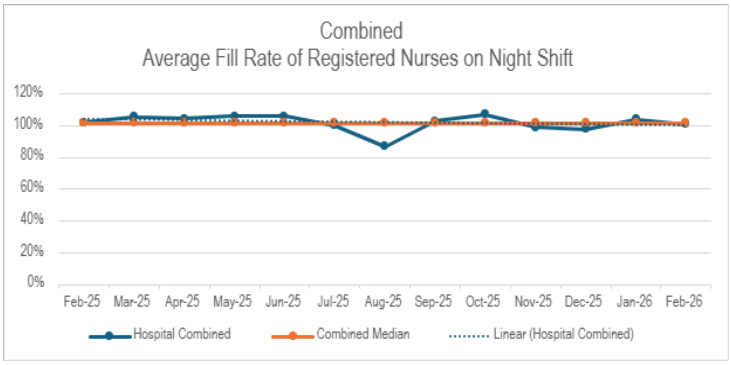
5.3 The Trust is required to submit a monthly Safe Staffing Unify Report[7] to NHSI detailing actual registered nurse staffing levels as a percentage against those that were planned. The average fill rate against planned shifts in October 2025 was 91% for registered nurses and 92% for unregistered staff. These fill rates are based on the commissioned bed base, therefore it important to note that due to reduced activity over holiday periods, the management of bed use has been agile around activity, and wards have been closed intermittently.

5.4 Nursing Associate hours are recorded as "unregistered" in UNIFY and are not included in RN fill-rates, meaning these figures understate the true registered workforce. When considered, overall clinical cover is higher than RN metrics suggest. There is no evidence of a correlation between fill-rate variation and nurse-sensitive harms, providing assurance that safe and effective care has been maintained.

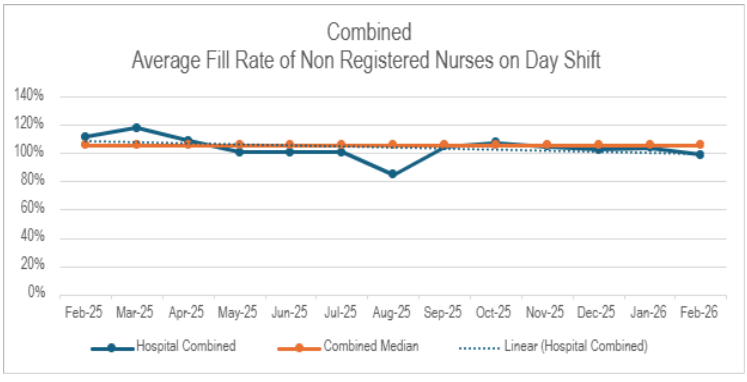
Graph 9. average fill rates for registered nurses



Graph 9. average fill rates for RN's (Days)

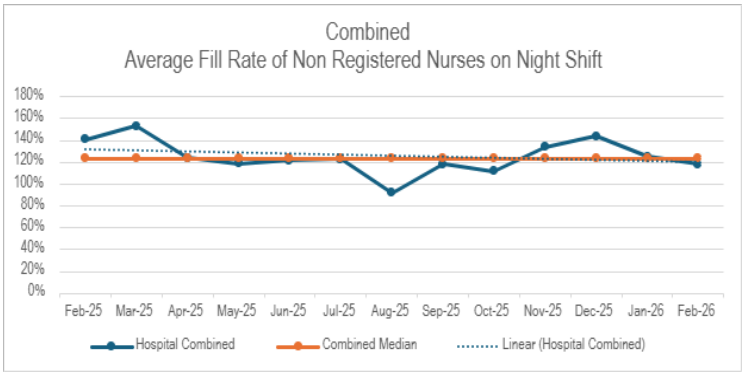


Graph 10. average fill rates for RN's (night shift)



Graph 11. average fill rates for un-registered (Day)

[7] NHS England » Freedom of Information: UNIFY return



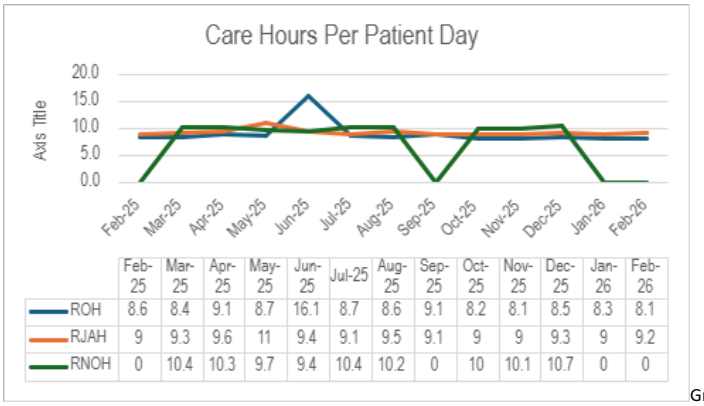
Graph 12. average fill rates for unregistered(night shift)

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

Care Hours Per Patient Day (CHPPD) and Benchmarking

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

5.7 There is no national target for CHPPD, however NHSI publish the data on the NHSI Model Hospital. Graph 11. Illustrates the recent Trust CHPPD data against the median for specialist hospitals. The ROH average CHPPD level is 9.11 hours per patient against an average of 9.5 hours against the three specialist trusts, suggesting that the Trust staffing levels result in a CHPPD level aligned with the other two trusts.



	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
ROH	8.6	8.4	9.1	8.7	16.1	8.7	8.6	9.1	8.2	8.1	8.5	8.3	8.1
RJAH	9	9.3	9.6	11	9.4	9.1	9.5	9.1	9	9	9.3	9	9.2
RNOH	0	10.4	10.3	9.7	9.4	10.4	10.2	0	10	10.1	10.7	0	0

Graph 13. CHHPD benchmarking against specialist hospitals

Daily Staffing Oversight, Rostering Controls and Public Reporting

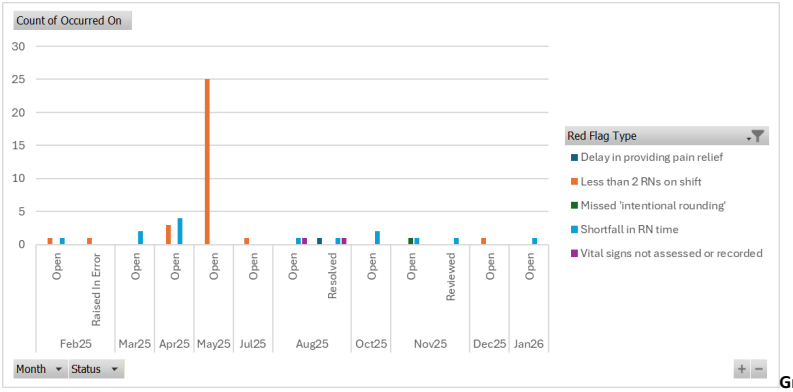
5.7 All wards and departments use Allocate Healthroster and the rosters are aligned with agreed establishments that are reviewed every six months. Ward/Department managers are responsible and accountable for the provision of safe staffing levels to meet patient needs by preparing and managing the roster.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

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

5.9 In line with Developing Workforce Safeguards and National Quality Board expectations, the Trust maintains transparent public reporting of safer staffing information. Staffing data is publicly displayed within inpatient ward areas and HDU, and published on the Trust website, including planned versus actual staffing, fill rates and CHPPD. The Trust's Safe Staffing webpage has also been updated to enhance transparency and provide clear public assurance regarding staffing deployment and compliance with national safer staffing requirements.

Red Flags, Acuity and Professional Judgement

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

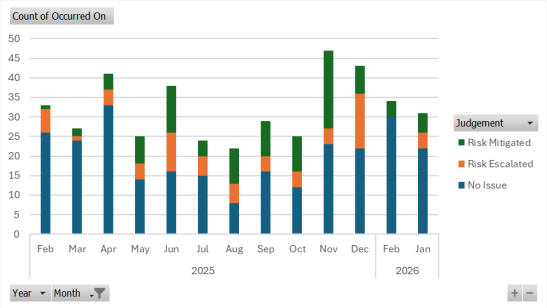


Graph 14. Red Flag data

5.12 Across the reporting period, there was no observed correlation between periods of lower fill-rates and increases in nurse sensitive harms, including falls, pressure damage or

medication incidents. This provides assurance that risks identified through acuity assessment, red-flag escalation and professional judgement were effectively mitigated through active staffing management and escalation processes.

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

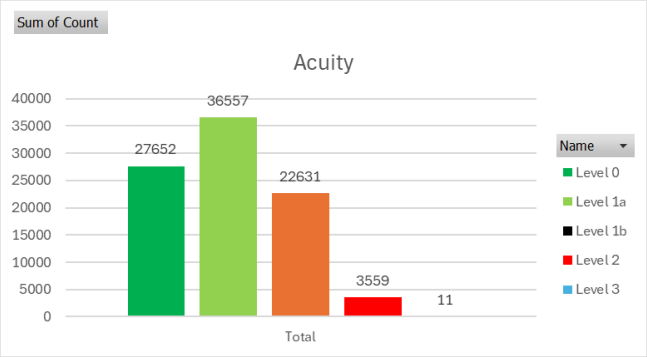


Graph 15. Overview of Professional judgement

Acuity data

5.14 Data entered into SafeCare twice daily provides an overview of patient acuity (Appendix A outlines the criteria) as demonstrated in graph 16. The current dataset shows that the largest proportion of patients are within Level 1a and Level 1b, indicating a cohort requiring ongoing nursing input, with Level 1b activity remaining significant and reflective of patients needing higher levels of nursing time and support (post-operative care). Compared to the previous reporting period, there has been a reduction in the proportion of Level 0 patients, indicating a shift towards a more dependent and higher acuity inpatient population in line with services changes such as bone infection, revision services and more complex learning disability patients.

5.15 Levels 2 and 3 activities remain very low, in line with service configuration, with Level 3 patients appropriately transferred within the Critical Care Network (they maybe held at level 3 until ACCOT services arrive, if in the bed at census time this would trigger Level 3). Overall, this trend suggests increasing patient complexity and dependency; however, this is recognised within workforce planning, and the triangulation of acuity, staffing, and quality indicators continues to provide assurance that staffing levels are aligned to patient need.



Graph 16. Accuity scores (average reporting period)

SafeCare and SNCT Assurance

5.15 As part of the Trust's safer staffing assurance framework, an independent SafeCare and Safer Nursing Care Tool (SNCT) census audit was undertaken across selected inpatient wards and the High Dependency Unit (HDU). The audit confirmed that staffing levels were safe and appropriate at the census point. Nursing workload across inpatient wards was predominantly driven by patient dependency rather than acute physiological instability, and no unsafe staffing scenarios were identified (see appendix A.)

5.16 The audit did identify variation in the application of SafeCare scoring, particularly in differentiating between SNCT Levels 0, 1a and 1b. These findings relate to consistency of scoring and interpretation, and plans are in place for additional training. HDU acuity classification and staffing alignment were assessed as accurate and appropriate. Improvement actions arising from the audit are included in the recommendations section of this report, with detailed findings provided separately as supporting evidence.

6.0 Workforce Establishment Review

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

6.2 As part of the annual review process, the Director of Finance (DoF) and the Medical Director (MD) have been asked to review both the current and proposed establishment models. Triangulation between the DoF, Chief Nursing Officer (CNO) and MD is undertaken to ensure an appropriate balance between patient safety and financial accountability. Due to the timing of this review, alongside the outcomes of previous reviews, only a limited number of changes have been proposed, as most areas have only recently implemented previously agreed changes. The proposals agreed are outlined below.

Division 1.

Area	Proposal – agreed	Sign off
Ward 1	Uplift of Band 4 to Band 5 following completion of top-up apprenticeship	Agreed
Ward 2	Uplift of Band 4 to Band 5 following completion of top-up apprenticeship	Agreed
Ward 3	No change (previous changes are just being introduced)	Agreed
Ward 4	Removal from budget of a post (Band 2), role has never introduced. – No change to nurses establishment.	Agreed
Ward 12	Proposed skill mix change within budget: moving band 5 (1.03wte plus Band 6 (0.6wte) to create 1wte Band 6 to strengthen leadership in the team.	Agreed
OPD	Reduction in Band 6 establishment (3.87 wte) to 2.66 wte. Previously an uplifted had been agreed to support proposed job plan changes, but these have not been introduced. Recruitment has not occurred to this additional 1.21 wte, therefore the posts will be reduced.	Agreed

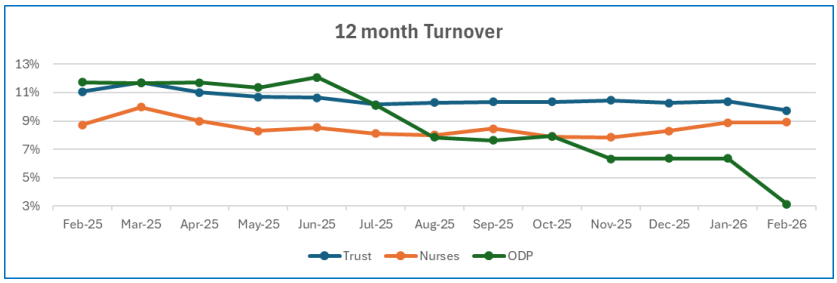
	Reduction of 1wte to Band 4 1itwe to support the introduction of Nursing Associates to the team.	
ROCS	Change 2 band 6 posts to 2 band 5, to support early careers recruitment.	Agreed
D/L	No change	Agreed
Topography	No change, vacant posts held until services review continues	Agreed
CYP OPD	No change, vacant posts held until services review continues	Agreed

Division 2.

Area	Proposed – agreed	Sign off
CCOT	No change	
POAC	No change	
Theatre	No change	
HDU	Review of working pattern (weekend) over the next 6 months, report to be shared at next review.	
Recovery	No change	
ADCU	Nurse-led was delayed, therefore a review will be undertaken before the next report.	

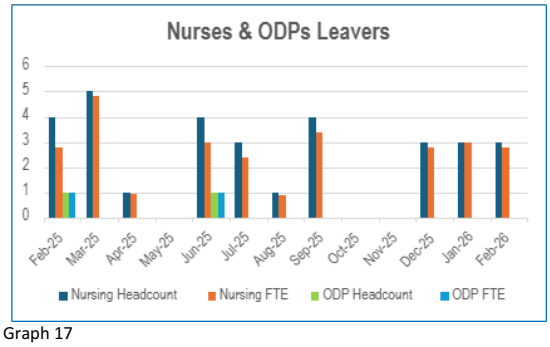
7.0 WORKFORCE DATA

7.1 Nursing turnover has shown sustained improvement over the reporting period, reducing from 11% in September 2024 to 8.5% in September 2025 and remaining relatively stable between approximately 7.5% and 9% thereafter, consistently below the overall Trust rate and reflecting the positive impact of retention initiatives. In contrast, ODP turnover has been more variable, peaking at around 12% in mid-2025 before demonstrating a steady and sustained reduction to approximately 3% by February 2026; while this reflects a clear overall improvement, the variation observed is consistent with the smaller size of the workforce, where a limited number of leavers can have a disproportionate impact on reported turnover rates.

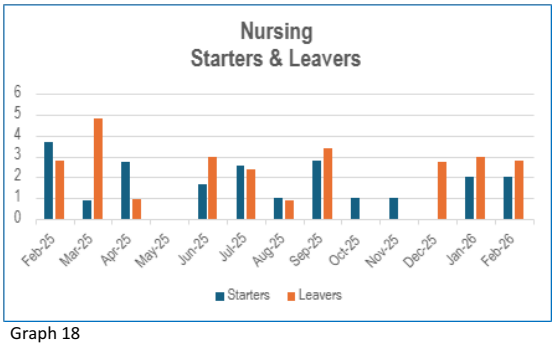


Graph. 16 Turnover

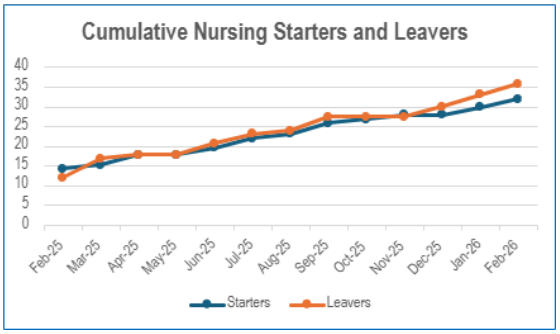
7.2 Over the past 12 months, nursing leavers have predominantly exited through voluntary resignation, with a smaller proportion retiring, reflecting national workforce trends. Starter and leaver activity has been broadly aligned overall; however, in the latter part of the reporting period, leavers have slightly exceeded starters, resulting in a small net reduction in the registered nursing workforce. ODP leaver numbers remain low but variable, consistent with the small size of the workforce (as demonstrated in the below graphs).



Graph 17



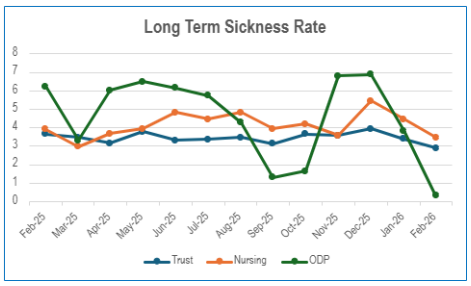
Graph 18



Graphs 19

Nurse and OPD sickness

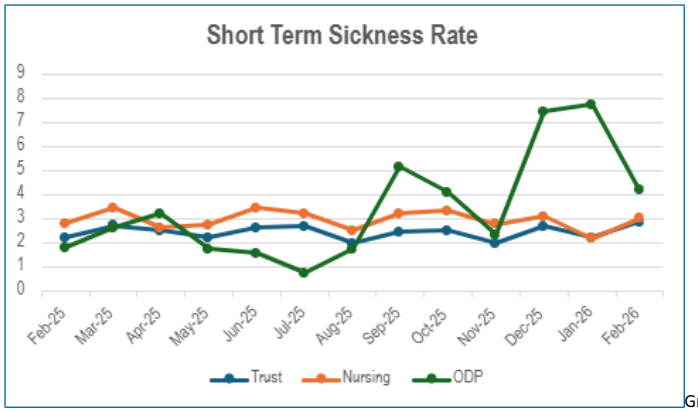
7.3 Long-term sickness absence among nursing staff was initially slightly below the Trust average but increased from March 2025 onwards, with rates peaking at approximately 5.5% in December before showing a gradual reduction to around 3.5% by February 2026. In contrast, ODP long-term sickness demonstrates greater volatility, ranging from a low of approximately 1.2% in September 2025 to peaks of around 6.5–6.8% in November and December 2025, before falling sharply to below 1% by February 2026. In line with the wider Trust's programme to address high sickness management, there has been oversight by matrons and HON.



Graph 20. Long term sickness

7.4 Short-term sickness among nursing staff has consistently remained above the overall Trust rate throughout the reporting period, generally ranging between approximately 2.5% and 3.5%, with some reduction noted in the latter months. In contrast, ODP short-term sickness demonstrates greater variability, fluctuating from below 1% in July 2025 to peaks of around 7–8% in December 2025 and January 2026, before reducing again by February 2026.

Overall, the data reflects the relatively stable but higher position for nursing, while variation within ODP rates is consistent with the smaller workforce size, where a limited number of absences can have a disproportionate impact on reported figures.



Graph 21. Short term sickness

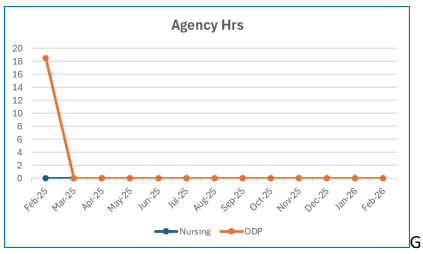
7.5 Sickness absence trends over the past year present a mixed but gradually improving position. While nursing sickness remains higher, with relative stability and some increase in long-term absence, early signs of improvement have been observed in recent months. In contrast, the ODP workforce has demonstrated a reduction in long-term sickness, although short-term absence continues to show expected variability due to the small workforce size.

7.6 Building on the previous year's plan, targeted initiatives continue to be implemented in areas of higher absence as outlined in the HR operational plan. This includes strengthened management oversight of attendance, promotion of flexible working, and a range of wellbeing initiatives to support staff. Seasonal measures, including the flu vaccination campaign, are also being actively promoted to support workforce health and reduce sickness levels as the organisation moves into winter.

Temporary workforce

7.6 Nationally, NHS reliance on agency staffing remains a key efficiency challenge. Agency expenditure has reduced in recent years, supported by national controls and strengthened governance arrangements. NHS England has set clear expectations for Trusts to reduce agency usage by 30% and bank usage by 10% in 2025/26, reinforced through stricter controls on off-framework and inappropriate temporary staffing.

7.7 There has been no agency usage of Nursing or ODP workforce February 2025 as outlined in Graph 22. This signifies a significant change in the trusts workforce behaviour and support patient safety while representing a more stable recruitment pipelines, improved retention, and robust roster oversight.

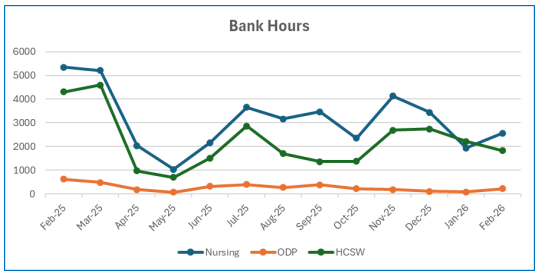


Graph 22. Agency activity

Temporary staffing Controls

7.8 Graph 23. outlines the use of bank staff over the reporting period. In line with national initiatives to reduce bank usage, additional approval measures have been

introduced to strengthen oversight of any bank utilisation, including Head of Nursing (HoN) approval in hours and out-of-hours executive-level approval processes.



Graph 23. Bank shifts

8.0 Quality Metrics (support safe staffing triangulation)

Staffing Incidents

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

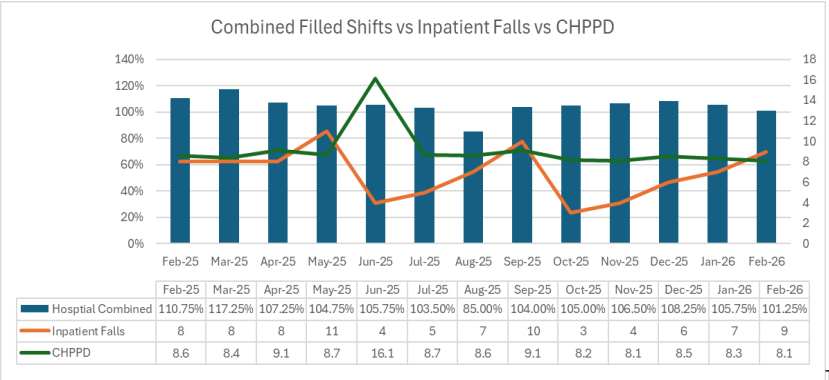
Graph 24. Staffing incidents by month

8.2 **Staffing Themes Identified:**

Review of staffing incidents has identified a number of recurring themes, aligned with known service pressures, primarily within theatres, HDU and inpatient wards. These include challenges relating to maintaining safe staffing levels, availability of suitably trained staff, and the impact of fluctuating demand on patient care. Such issues are most evident during periods of short-notice absence, increased activity, or where specialist skills are required.

Patient harm free data

8.3 Graph 16. shows that hospital combined fill rates remained consistently high throughout the reporting period, generally exceeding 100% and peaking at 117.25%, with the exception of August 2025 where this reduced to 85%. CHPPD were largely stable, ranging between 8.1 and 9.1, aside from a notable outlier in June 2025 (16.1). Inpatient falls fluctuated between 3 and 11 per month, with the highest level recorded in May 2025 (11 falls) and the lowest in October 2025 (3 falls). These figures indicate that staffing levels were largely stable, with notable variations in CHPPD and inpatient falls across the reporting period. This data indicates that when the fill rates are consistently high there falls levels are low. The data does not highlight an area that indicate staffing is a contributing factor to the fall.

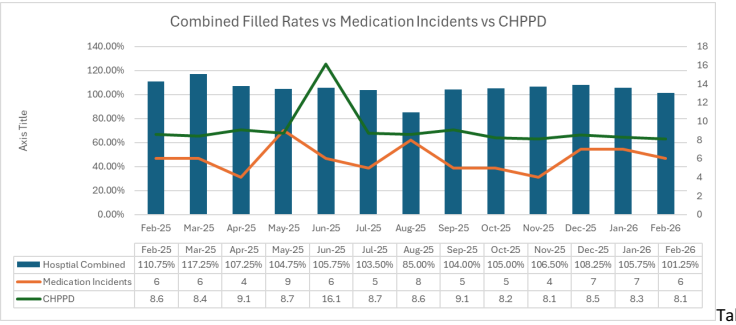


	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Hosptial Combined	110.75%	117.25%	107.25%	104.75%	105.75%	103.50%	85.00%	104.00%	105.00%	106.50%	108.25%	105.75%	101.25%
Inpatient Falls	8	8	8	11	4	5	7	10	3	4	6	7	9
CHPPD	8.6	8.4	9.1	8.7	16.1	8.7	8.6	9.1	8.2	8.1	8.5	8.3	8.1

Table 25. number of falls (total across the wards)

Medication Incidents

8.4 Medication incidents fluctuated across the reporting period, ranging from 4 to 9 incidents per month, while fill rates remained consistently high (predominantly at or above 100%), with a single notable dip in August 2025 (85.00%). CHPPD was stable between 8.1 and 9.1 for most of the year, with an isolated increase in June 2025 (16.1). Variations in medication incidents do not align with changes in staffing levels or care hours, indicating no consistent correlation between workforce capacity and medication safety. One identified increase in incidents relating to the HDU was associated with a change in the care environment rather than staffing levels. This was fully investigated through the Patient Safety Incident Response Framework (PSIRF), with learning identified and actions implemented.



	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
Hosptial Combined	110.75%	117.25%	107.25%	104.75%	105.75%	103.50%	85.00%	104.00%	105.00%	106.50%	108.25%	105.75%	101.25%
Medication Incidents	6	6	4	9	6	5	8	5	5	4	7	7	6
CHPPD	8.6	8.4	9.1	8.7	16.1	8.7	8.6	9.1	8.2	8.1	8.5	8.3	8.1

Table 25. outlines the number of medication errors

8.5 Hospital-acquired pressure ulcer incidence varied across the period, with no consistent relationship to staffing levels. Fill-rates remained consistently high, generally at or above 100%, with a single notable dip in August 2025 (85.00%), before recovering in subsequent months. Care hours per patient day (CHPPD) were stable, ranging between 8.1 and 9.1 for most of the period, with an isolated increase in June 2025 (16.1). However, this increase did not correspond to the highest level of pressure ulcer incidence, which was observed in March 2025 and November 2025 (4 cases).

8.6 Overall, fluctuations in pressure ulcer incidence do not align with periods of reduced staffing or changes in CHPPD, providing assurance that staffing levels are not a primary driver. This analysis does not differentiate between avoidable and unavoidable harm or pressure damage present on admission.

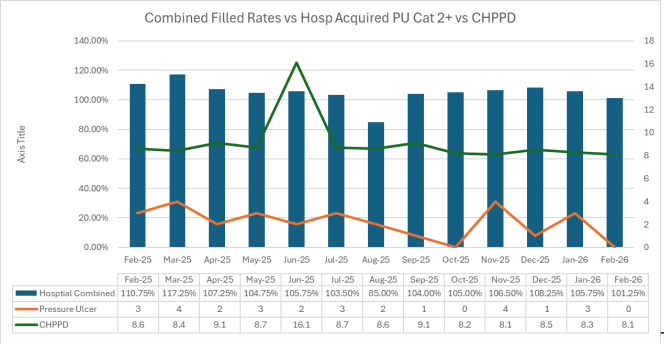


Table 26. Outlines the number of hospital acquired Pressure ulcers (above cat 2)

9.0 STAFF WELL-BEING

Health and Wellbeing of Nursing and AHP Workforce

9.1 The health and wellbeing of the Nursing and AHP workforce remains a key priority for the Trust and is recognised as a core enabler of safe staffing, workforce sustainability and retention. During the reporting period, staff wellbeing was supported through a variety of initiative: well-being weeks, celebrating international nurses and OPD day, local lead team meetings, supervision and the below specific mechanisms.

Professional Nurse Advocate (PNA) and Restorative Clinical Supervision

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

9.4 To meet this ratio, and to ensure all registered nurses have access to a PNA, a minimum of 13 PNAs are required across the organisation. Currently, eight registered nurses have completed the PNA programme, achieving approximately 62% of the target. However, due to the lead being unavailable over the last several months, this has had an impact on provision, the team are working to address this and ensure the services is available.

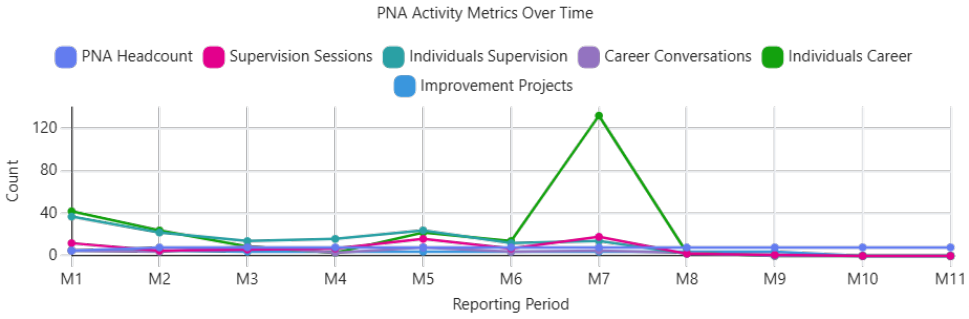


Table 27. PNA activity

Preceptorship and Accreditation

9.4 The Clinical Education Team continues deliver the established 12-month rolling preceptorship programme, designed to allow staff to 'step on' and 'step off' as described in

the October 26 paper. This programme was awarded the interim Quality Award[8] in 2024, and work is underway to renew the accreditation in line with NHSE requirements.

9.5 The trust has supported 79 preceptees since the programme commenced with overall positive feedback.

Continuing Professional Development (CPD)

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

9.7 CPD has funded externally academic programmes such as the Orthopaedic Course delivered by Robert Jones and Agnes Hunt and a number of Master's programmes designed to develop experts within teams. In addition, there has been focused programme to support staff understand mental health need to the population and a focus on upskilling nurses to take on additional rolls to support activity.

10.0 Recommendations

10.1 The following outlined below are the intended actions to be undertaken over the next six months, with a view to presenting the findings to the board in the mid-year report:

- Work with NHSE to review the preceptorship programme in line with national recommendation and work toward renewed accreditation.
- Establish a clear census audit programme, embedding the programme in AMAT.
- The WEL will lead a quality priority in FY 26/27 designed to support clinical staff to remain health at work: Rest, Rehydrate and Refuel Project, this is an RCN initiative and will be embeded over the year.
- Bank usage will be reviewed in the coming reporting period to support national reduction initiatives.
- Review Nurse Led POAC model following implementation
- Review of ongoing service review in CYP OPD
- Outcome of the service review in Topography
- Realignment of establishment to weekend activity on HDU
- AfPP new safer staffing manual has been released. It is planned that the peri-operative team will review and consist of this for the next establishment review.
- Strengthen recording and reporting of professional judgement, red flag escalation and Nursing Associate contribution within safer staffing returns
- Review level 3 activity as highlighted in acuity, to understand if this matches transfer outs over a 12-month period.

11.0 Conclusion

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

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

11.2 This Annual Safer Staffing Report provides assurance that Nursing and Operating Department Practitioner staffing arrangements during the reporting period February 2025 to February 2026 supported safe and effective patient care.

11.3 The report demonstrates compliance with National Quality Board guidance, Developing Workforce Safeguards and NICE safer staffing principles, supported by triangulated analysis of workforce data, patient acuity, professional judgement and nurse sensitive quality indicators.

11.4 Ongoing safer staffing assurance will continue to be maintained through established governance arrangements, bi-annual establishment reviews and quality oversight, with the next safer staffing update scheduled for quarter 3 of 26.

Jennifer Bryan
Workforce & Education Lead

Emma Steele
Deputy Chief Nurse
April 26

Appendix A: SafeCare and SNCT Audit – March 2026

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

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

Audit Scope and Census Methodology

An independent SafeCare and SNCT census audit was undertaken at 08:00 on 31 March 2026, aligned to standard clinical handover time.

The audit reviewed the following clinical areas: Wards 1, 2, 3, 4, Ward 12, and the High Dependency Unit (HDU). Patient acuity and dependency were assessed using standard SNCT definitions and compared with ward entered SafeCare scores.

Table A2.1: Audit Coverage

Clinical Area	Census Date / Time	Patients Reviewed
Ward 1	31 March 2026 – 08:00	22
Ward 2	31 March 2026 – 08:00	15
Ward 3	31 March 2026 – 08:00	21
Ward 4	31 March 2026 – 08:00	5
Ward 12	31 March 2026 – 08:00	14
HDU	31 March 2026 – 08:00	1

A3. Summary of Audit Findings

Across all inpatient wards, nursing workload at the census point was predominantly driven by patient dependency (SNCT Level 1b) rather than acute physiological instability. A number of patients were appropriately classified as Level 0, particularly where care needs were met through routine ward care. True Level 1a cases were uncommon.

No unsafe staffing was identified at the time of census. Differences between ward entered SafeCare scores and audit findings related to scoring interpretation and consistency rather than staffing risk.

Table A3.1: SafeCare Area Score vs Audit Outcome Summary

Clinical Area	Area Score Pattern	Audit Outcome	Assurance Conclusion

Ward 1	Mixed Level 0 / 1a	Predominantly Level 1b	Staffing safe; scoring variance identified
Ward 2	Higher Level 1a	Primarily Level 0 / 1b	Staffing safe; over acuity noted
Ward 3	Mixed scoring	Predominantly Level 1b	Staffing safe; dependency under recognised
Ward 4	Variable	Mainly Level 1b	Staffing safe; scoring variation
Ward 12	Higher acuity applied	Majority Level 0	Staffing safe; over classification
HDU	Level 2	Level 2	No variance identified

A4. Audit Outcome Summary and Agreed Actions

The audit confirmed that staffing at the time of census was safe across all areas reviewed. Variations identified related to interpretation and application of SNCT scoring rather than staffing adequacy.

The following actions have been agreed to strengthen scoring consistency and ongoing assurance:

- Implement SafeCare SOP: Introduce a standard operating procedure to ensure consistent census-time scoring, with clear definitions of SNCT Levels 0, 1a and 1b.
- Deliver targeted refresher training: Provide focused training for ward leaders and nurses in charge to support consistent recognition of acuity versus dependency and application of professional judgement.
- Embed ongoing assurance: Establish a rolling programme of independent SafeCare and SNCT audits to monitor scoring consistency and support continuous Board-level assurance.
- Strengthen governance and reporting: Enhance recording and reporting of professional judgement, red-flag escalation and Nursing Associate contribution to better reflect clinical decision-making and skill mix.

Appendix B : SNCT Acuity and Dependency Levels (Reference)

- **Level 0 – Normal Ward Care**
  Patients whose care needs are met through routine ward care without additional nursing dependency or increased monitoring requirements.
- **Level 1a – Acutely Ill**
  Patients who are clinically unstable or experiencing acute physiological deterioration and who require increased monitoring, clinical intervention, or escalation of care.
- **Level 1b – Dependency**
  Patients who are clinically stable but require a high level of nursing input to support activities of daily living, including mobility, personal care, wound management, medication support, or frequent nursing interventions.
- **Level 2 – High Dependency Care (HDU)**
  Patients requiring Level 2 care, including continuous monitoring or single organ support, delivered within a high dependency or critical care environment.

(Adapted from the Safer Nursing Care Tool – SNCT)

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TRUST BOARD

DOCUMENT TITLE:	**IPC Annual Report 2025/26**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Chief Nurse & DIPC**
AUTHOR:	**Victoria Clewer, Head of IPC, TV & Deputy DIPC**
DATE OF MEETING:	**3 June 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This report provides assurance on the effectiveness of IPC arrangements for 2025/26 and outlines priorities for 2026/27.

The Trust maintained strong IPC performance overall, including zero bloodstream infections (BSIs) attributable to MRSA, sustaining a 14-year position. Performance was in line with NHS England thresholds for *Klebsiella* spp. and *Pseudomonas aeruginosa* BSIs. However, thresholds were exceeded for *Clostridioides difficile* and *Escherichia coli* BSIs, with improvement actions identified and incorporated into forward plans.

Key achievements include strengthening governance and assurance arrangements, reimplementation of the IPC audit programme via AMaT, and a Trust-wide decontamination improvement programme following multidisciplinary review. Environmental cleanliness remained a priority through planned maintenance and deep cleaning programmes.

The redesign of the surgical site infection (SSI) surveillance process improved efficiency and reduced duplication, while a review of the IPC team structure enhanced clarity, sustainability, and alignment with organisational priorities.

The IPC team continued to support vaccination delivery and led key awareness campaigns to promote a culture of infection prevention. The team was also recognised as finalists in the Trust's Blue Heart Awards.

The report includes the IPC Annual Service Plan for 2026/27, focused on addressing performance gaps and sustaining improvements in patient safety.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	**GAPS IN ASSURANCE/RISKS TO ESCALATE**
As described above.	None.

REPORT RECOMMENDATION:

The Committee is asked to review and approve the annual report for publication.

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

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

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

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

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

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

The contents of this report align to the:
- Health and Adult Social Care Act; code of practice on the prevention and control of infections and related guidance (DH 2012).
- National Infection Prevention and Control Manual.
- KPIs for; MRSA, *Clostridioides difficile* and Gram-negative blood stream infections.

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

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

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

ROH IPC surveillance and UKHSA date capture system.

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

2024/25 IPC Annual Report Submitted during 2025.

INFECTION PREVENTION AND CONTROL

Annual Report 2025/26

LESS PAIN
MORE INDEPENDENCE
LIFE-CHANGING CARE

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

LEAVE BLANK

Foreword

I am pleased to introduce the annual Infection Prevention and Control (IPC) Report for The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) for the financial year 2025/26.

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

Throughout 2025/26, we have built upon our strong foundations, ensuring that IPC is embedded into every aspect of patient care and Trust operations. Key highlights this year include continued low rates of healthcare-associated infections, successful delivery of key national IPC targets, and further development of our IPC surveillance and audit programmes. We have responded proactively to emerging challenges, such as the evolving antimicrobial resistance agenda and seasonal infection pressures, by strengthening our stewardship initiatives and enhancing our staff education programmes.

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

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

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

Nicola Brockie

Executive Chief Nursing Officer

Director of Infection Prevention and Control (DIPC)

Contents **Page**

Lead Author: Victoria Clewer, Head of Infection Prevention and Control & Deputy DIPC
Contact: Victoria.clewer@nhs.net

Acknowledgements for their input and support:

Nicola Brockie – Executive Chief Nursing Officer and DIPC
Rachel Powell – Senior IPC Nurse
Wendy Jones – IPC Administrator
Nickisha Patel – Advanced Clinical Pharmacist – AMS & Perioperative Medicine
Steve Harnett – Head of Facilities
Tracy Price – Logistics and Sterile Services Manager
Stuart Lovack – Deputy Director of Estates

Abbreviations

AMS	Antimicrobial stewardship
BAF	Board Assurance Framework
BIS	Bone Infection Service
BSI	Bloodstream infection
BSOL	Birmingham and Solihull
COHA	Community onset – healthcare associated
CPE	Carbapenemase-producing Enterobacterales
CQUIN	Commissioning for Quality and Innovation
CVAD	Central venous access device
DIPC	Director of Infection Prevention and Control
HCAI	Healthcare associated infection
HCAI DCS	Healthcare associated infections Data Capture System
HDU	High Dependency Unit
HOHA	Hospital onset – healthcare associated
ICB	Integrated Care Board
IPC	Infection prevention and control
MDR	Multidrug-resistant
MDT	Multidisciplinary team
MRSA	Methicillin-resistant *Staphylococcus aureus*
MSSA	Methicillin-susceptible *Staphylococcus aureus*
NHSE	National Health Service England
NIPCM	National Infection Prevention & Control Manual
PIVC	Peripherally inserted venous catheter
PPE	Personal protective equipment
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
RCN	Royal College of Nursing
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital
RNOH	Royal National Orthopaedic Hospital NHS Trust
ROH	Royal Orthopaedic Hospital NHS Foundation Trust
RSV	Respiratory Syncytial Virus
SSI	Surgical site infection
SSIS	Surgical site infection surveillance
UC	Urinary catheter
UHB	University Hospitals Birmingham
UKHSA	UK Health Security Agency
UTI	Urinary tract infection
VAD	Vascular access device
VRE	Vancomycin-resistant Enterococci

Executive Summary

- ROH ended 2025/26 above the NHS England threshold for *Clostridioides difficile* (*C. difficile*) and bloodstream infections (BSI) attributable to *Escherichia coli* (*E. coli*). However, equal to the NHS England threshold for healthcare associated BSI attributable to *Klebsiella species* and *Pseudomonas aeruginosa (P. aeruginosa)*.
- The Trust reported zero bloodstream infections attributable to Methicillin-resistant *Staphylococcus aureus* (MRSA). No MRSA BSI have been reported by ROH for the last 14 years.
- The annual closure, decanting, planned preventative maintenance and deep cleaning of clinical areas continues to be prioritised, significantly supporting efforts to keep HCAIs a low as possible.
- Organised and celebrated several key events in the IPC calendar across ROH, this included World Hand Hygiene Day, World Antimicrobial Awareness Week, and International Infection Prevention Week 2025.
- Refreshed and reimplemented the IPC audit programme, utilising the Audit Management and Tracking (AMaT) system.
- Supported and delivered the annual healthcare worker vaccination programme.
- A multidisciplinary review has led to a prioritised improvement programme for decontamination across ROH, including strengthening governance through separate decontamination policies. Initial focus is on improving and standardising environmental and non-invasive device decontamination, with progress on track and ongoing oversight to ensure sustainable improvement.
- The SSI surveillance process was redesigned, eliminating the need for both paper and separate digital data collection. By embedding surveillance requirements into existing workflows, the Trust reduced duplication, improved efficiency, and released staff time while continuing to meet national reporting requirements.
- A review of the IPC team structure, prompted by a vacancy, led to clearer and more streamlined roles, improving efficiency, workforce sustainability, and alignment with organisational priorities while maintaining high-quality delivery of surveillance and assurance requirements.
- Continued to deliver and innovate services in relation to decontamination, water, and ventilation safety.
- Strengthened governance and assurance arrangements to ensure compliance with contractual requirements.
- IPC team was shortlisted as finalists for the Clinical Team of the Year award at the ROH Blue Heart Awards.
- This report includes a summary of the IPC annual service plan and programme of work for 2026/27.

About The Royal Orthopaedic Hospital NHS Foundation Trust

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

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

The Trust has 14 operating theatres, 6 wards and 115 beds, including 8 beds for private treatment and 6 being on a High Dependency Unit. Of these, 56 are single occupancy rooms with en-suite and 3 are single occupancy rooms without en-suite. The Trust employs in excess of 1,200 staff. Only a small amount of emergency and urgent activity is undertaken, generally in the field of spinal disorders; the core business of the ROH is elective surgery. The main elective surgery activities are joint replacement surgery (arthroplasty), joint arthroscopy and reconstruction (keyhole surgery and ligament repairs), plus hand and foot surgery.

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

ROH IPC Vision:

Preventing harm from infection by delivering clean, safe care.

ROH IPC Mission:

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

Healthcare-associated Infection (HCAI) Surveillance

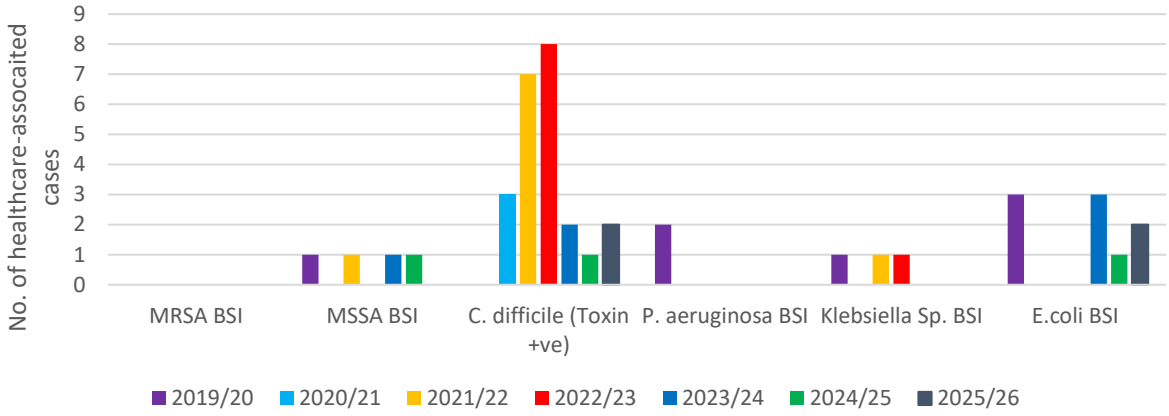
The Trust participates in the mandatory HCAI surveillance programme facilitated by the UK Health Security Agency (UKHSA) including:

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

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

The NHS Standard Contract includes quality requirements for NHS trusts to minimise rates of both *C. difficile* and Gram-negative bloodstream infections to threshold levels set by NHS England. Objectives have been set for 5 of the 6 HCAI included in mandatory surveillance. MSSA is the only HCAI without a national objective.

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

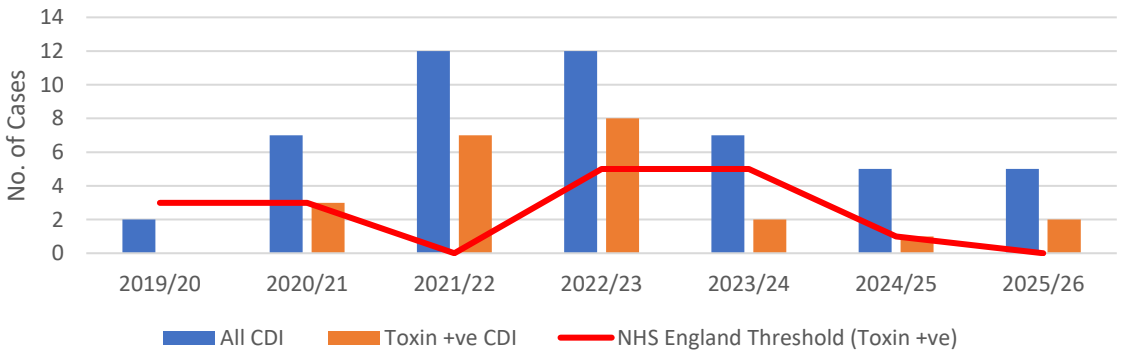


ROH contributes relatively few cases of HCAIs to the overall Birmingham and Solihull (BSOL) system totals – monthly data for ROH and other Trusts within BSOL are available here: MRSA, MSSA, Gram-negative bacteraemia and CDI: monthly data, 2025 to 2026 - GOV.UK

Clostridioides difficile infection

- During 2025/26 there was 2 healthcare-associated *C. difficile* toxin-positive (reportable), against the NHS England threshold of 0.
- There has been a 100% increase in toxin-positive cases reported during 2025/26 (2 cases) compared with 2024/25 (1 case). The total number of all cases reported during 2025/26 has remained unchanged compared with 2024/25 (5 cases).
- An IPC review using the Patient Safety Incident Response Framework (PSIRF) approach was undertaken for each healthcare-associated reportable infection; no themes or issues related to cross-transmission were identified.

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



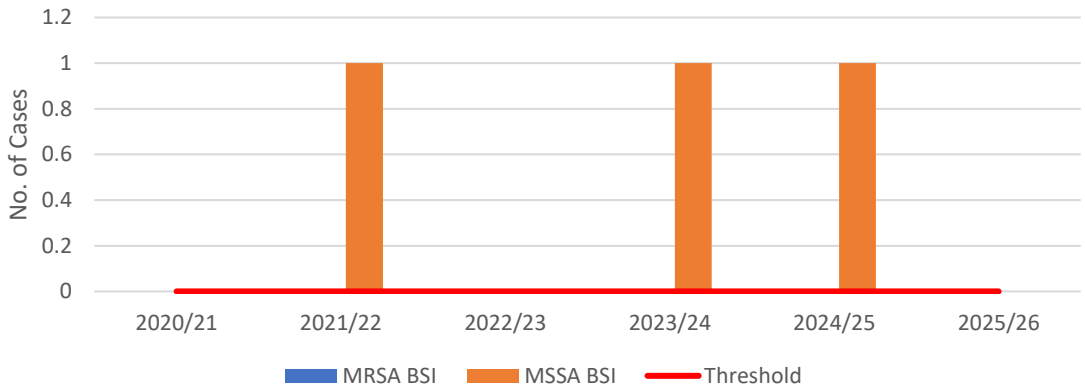
Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections

- During 2025/26 there was 0 healthcare-associated MRSA BSI. There remains a zero-tolerance approach for MRSA BSIs nationally.
- ROH have not reported an MRSA BSI for the last 14 years (last case reported during 2011/12).

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

- During 2025/26 there was 0 healthcare associated MSSA BSI. There is currently no national threshold provided by NHS England.
- There has been a complete reduction in the number of cases reported since 2024/25.

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



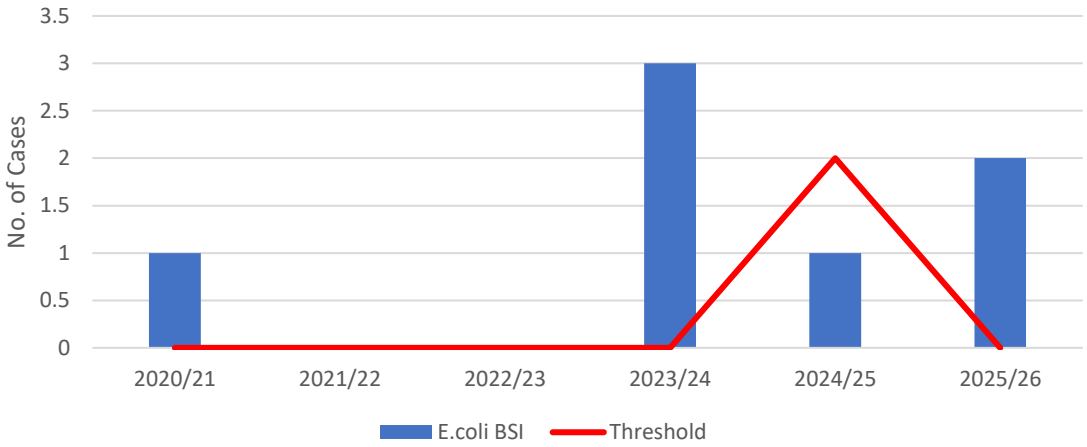
Gram-negative bloodstream infections

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

***Escherichia coli* bloodstream infections**

- During 2025/26 there was 2 healthcare-associated *E.coli* BSI, against the NHS England threshold of 0.
- There has been a 100% increase in cases reported during 2025/26 (2 cases), compared to 2024/25 (1 case).
- IPC review highlighted no care or management concerns that are believed to have contributed to this blood stream infection. Infections were largely non-preventable or associated with complex clinical factors.

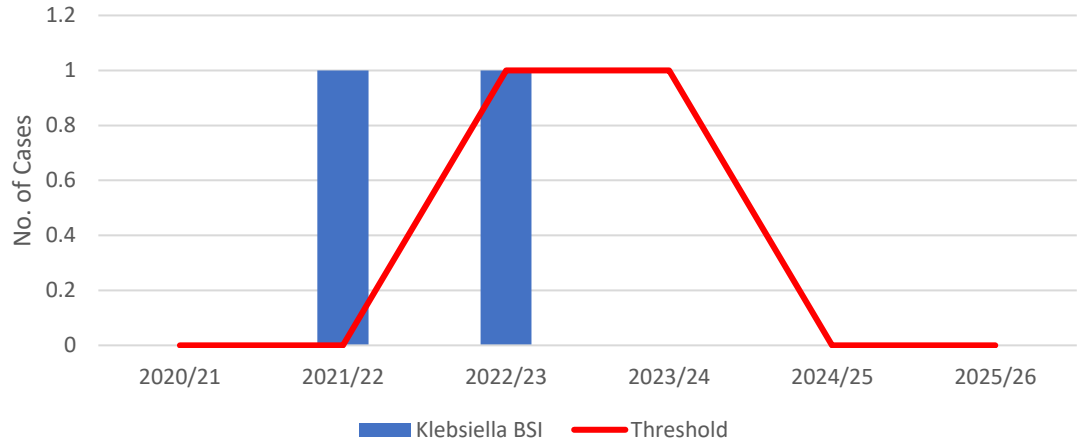
Total number of *E. coli* BSI cases reported by ROH annually:



Klebsiella species blood stream infections

- During 2025/26 there was 0 healthcare-associated *Klebsiella sp.* BSI, against the NHS England threshold of 0.
- This is equal to the number of cases reported during 2024/25 (0 cases).

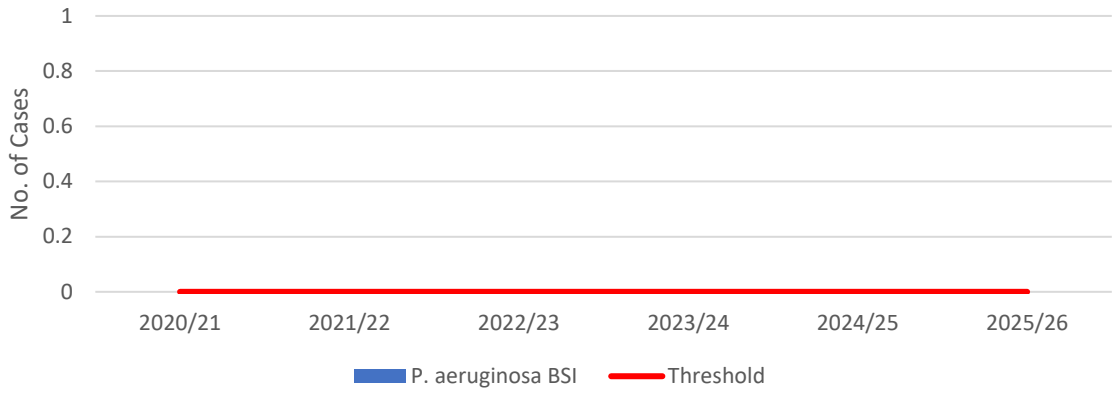
Total number of *Klebsiella sp.* BSI cases reported by ROH annually:



Pseudomonas aeruginosa bloodstream infections

- During 2025/26 there were 0 healthcare-associated *P. aeruginosa* BSI, against the NHS England threshold of 0.
- This is equal to the number of cases reported during 2024/25 (0 cases).

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

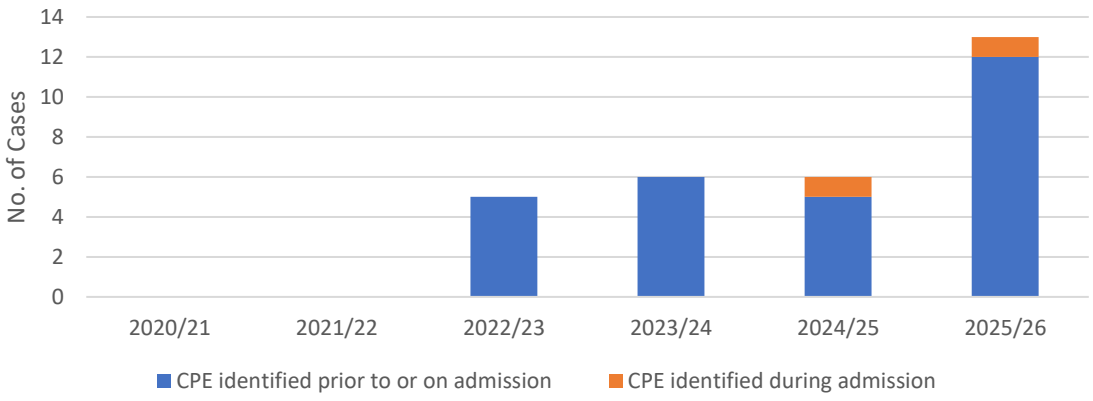


Carbapenemase-producing Enterobacterales (CPE)

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

- During 2025/26, A total of 13 positive CPE cases were identified compared to 7 in 2024/25.
- 6 cases were identified prior to admission through pre-admission screening. A further 6 cases were identified on admission following transfer from another acute NHS Trust. 1 case was identified on the third sample taken as part of the admission screening process; however, this was not classified as an acquisition, as the patient had been transferred from another acute NHS Trust.

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

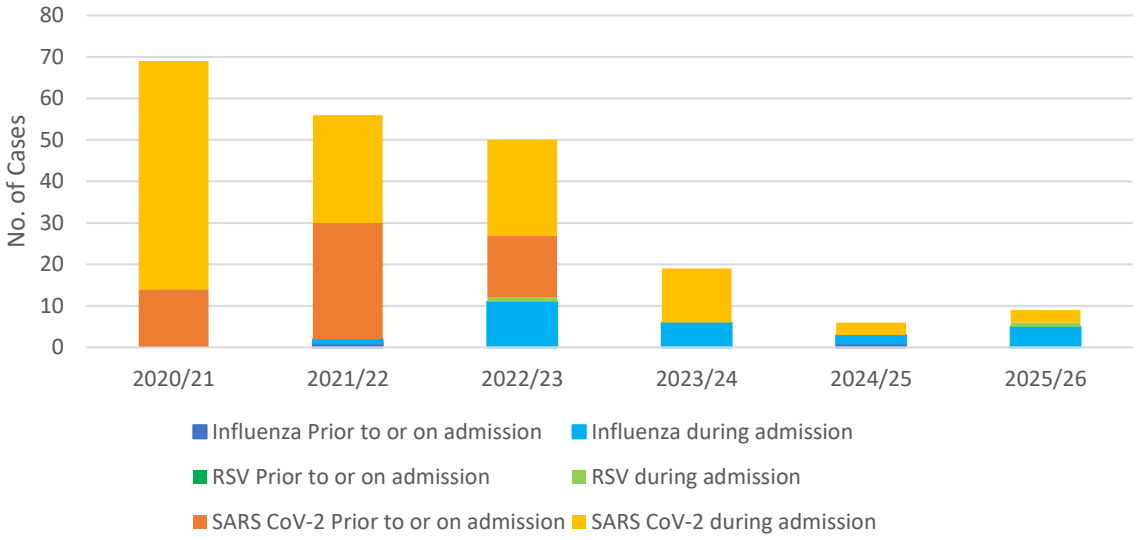


Respiratory virus infections

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

- During 2025/26, a total of 5 Influenza A, 1 RSV and 3 SARS CoV-2 cases were identified, compared to 3 Influenza A, 0 RSV and 3 SARS CoV-2 cases identified in 2024/25.

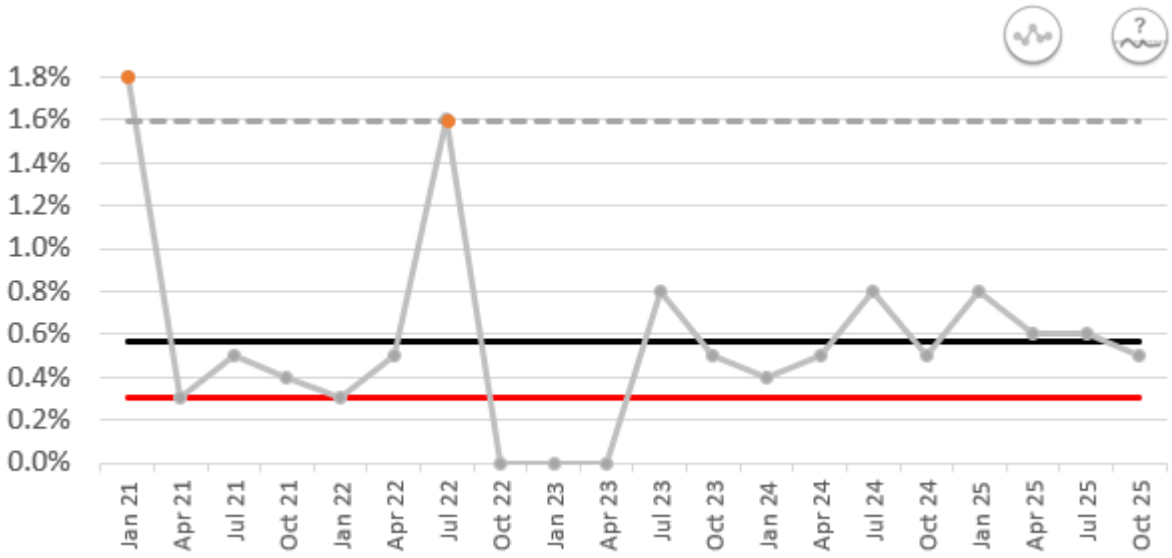
Total number of respiratory viral infections identified prior to, on and during admission to ROH annually:



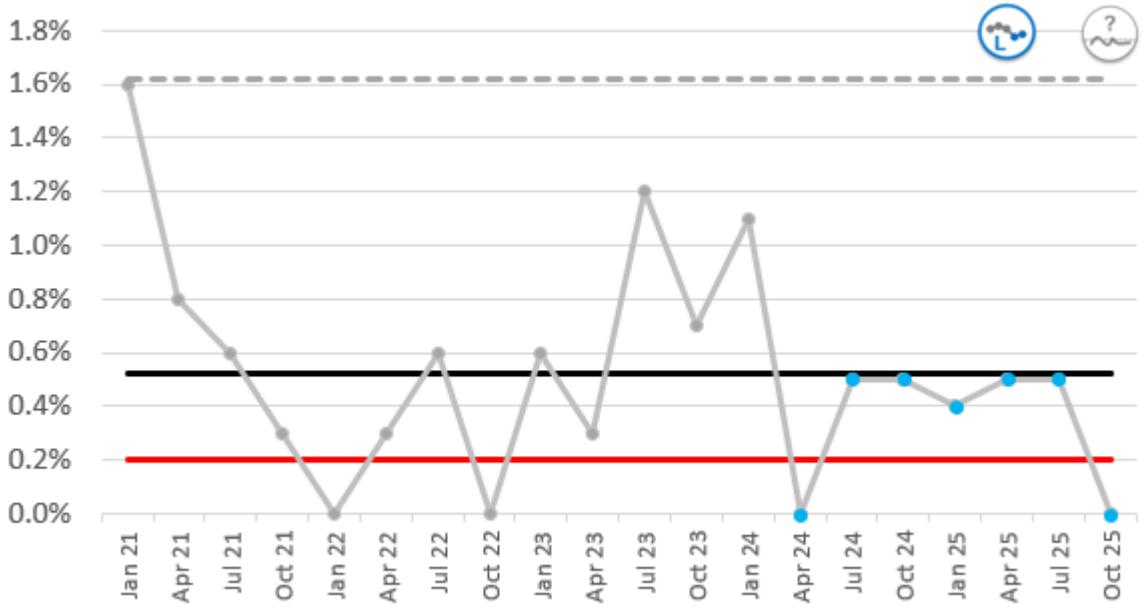
Surgical Site Infection Surveillance (SSIS)

- Rates of SSI are monitored by the IPC team for arthroplasty surgery (total hip and knee replacement – mandatory) and spinal surgery (voluntary).
- SSI Surveillance is undertaken by 1 WTE band 3 SSI Coordinator, supported by IPC Nurses.
- The main risk factors for SSI continue to be raised BMI and length of surgery. Work continues to pre-optimise patients for surgery with a focus on education and support pre-operatively whilst awaiting a surgery date.
- The reduction of SSI risk rate for total knee replacement and spinal surgery was made a Trust quality priority for a second year, rolled on to 2025/26.
- As part of the quality priority, the SSI Prevention Group (SSIPG) has continued work on developing a Royal Orthopaedic Hospital (ROH) bespoke SSI prevention standard operating procedure (SOP) and care bundle, supported by a monitoring programme aligned with the IPC audit programme.

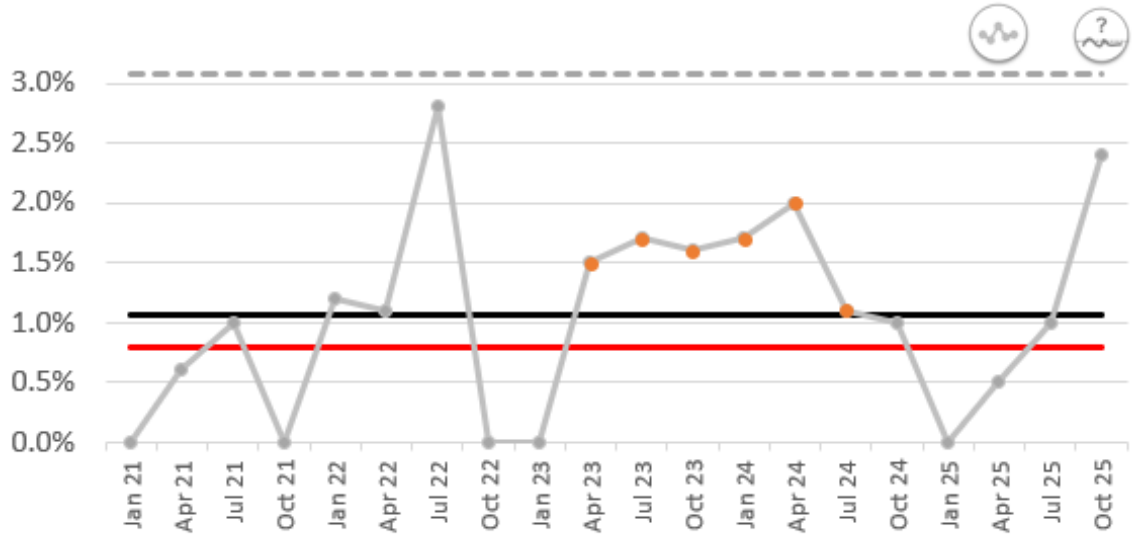
Total hip replacement surgery SSI risk rate per quarter, identified from inpatients or on readmission - January 2021 to December 2025:



Total knee replacement surgery SSI risk rate per quarter, identified from inpatients or on readmission - January 2021 to December 2025:



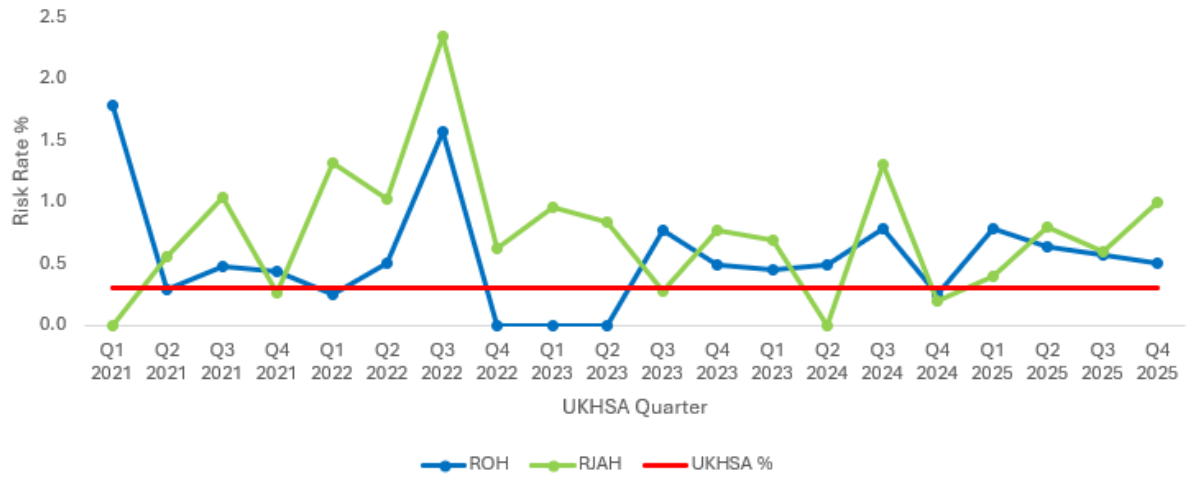
Spinal surgery SSI risk rate per quarter, identified from inpatients or on readmission – January 2021 to December 2025:



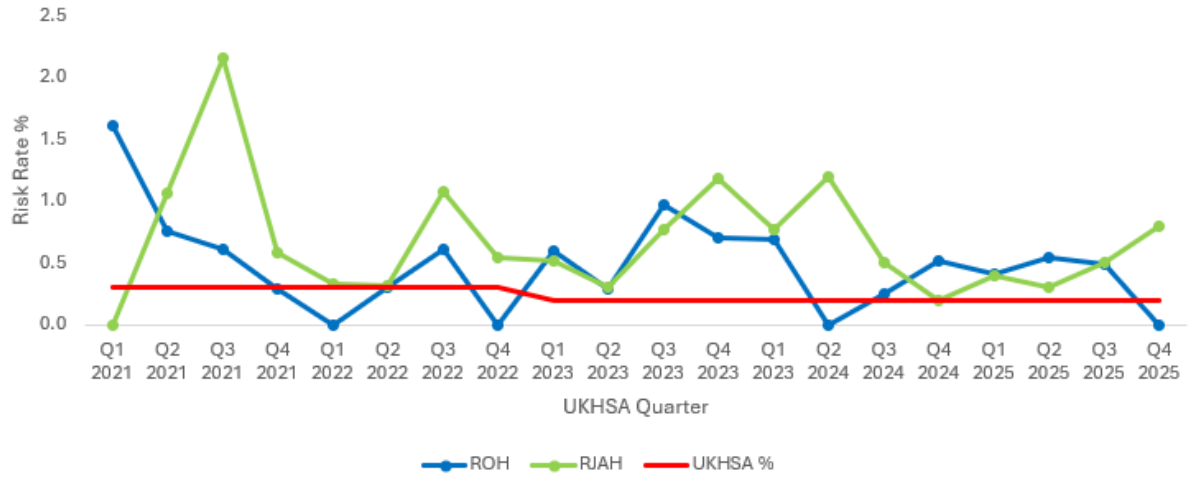
Note: ROH withdrew from SSI surveillance for Q4 2022 due to lack of surveillance team personnel due to sickness.

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

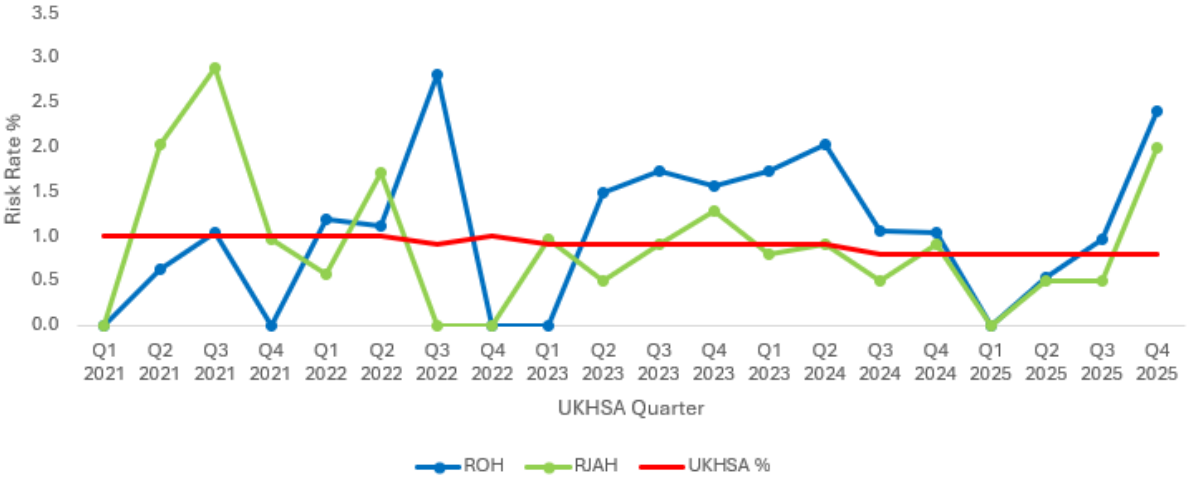
Total hip replacement:



Total knee replacement:



Spinal surgery:



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

Clinical Activity and Incidents

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

Incidents:

- During December 2025, an Influenza outbreak was declared on Ward 1 involving 4 patients. The outbreak was recognised and responded to efficiently, minimising the impact and duration of the outbreak. Peer reviews of the Trust response by UKHSA and ICB IPC team reported that the response to the outbreak was comprehensive.

- Routine six-monthly Legionella and *Pseudomonas aeruginosa* testing identified several outlets that were positive for *Pseudomonas aeruginosa*. Remedial actions

and retesting were undertaken in line with HTM 04-01 Safe Water in Healthcare Premises, including the use of point-of-use filters while negative results were awaited. All but 2 outlets were successfully cleared and returned to use. Ongoing positivity remains in 2 wash-hand basins; these have been risk assessed, and further remedial actions are being overseen by the Water Safety Group.

Clinical activity:

- All inpatient wards (expect Ward 4 due to operational pressures) and Theatres were deep cleaned as part of the annual shut down and planned preventative maintenance schedule.

- Organised and celebrated several key events in the IPC calendar across ROH, this included World Hand Hygiene Day, World Antimicrobial Awareness Week, and International Infection Prevention Week 2025.

- Supported the annual Patient Led Assessment of the Care Environment (PLACE) assessment.

- Continued support was provided to the Theatre department through auditing activities and direct engagement with theatre staff. Several spinal surgery lists were observed, during which aspects of clinical practice were identified that require improvement.

- The IPC audit programme underwent a major overhaul and has been re-implemented. Audits are now captured using the Audit Management and Tracking (AMaT) system. Audit completion and associated actions are monitored at multiple levels, including by department managers, matrons, and heads of service, with assurance and progress reported through the IPC Committee.

Quality Improvement:

- A multidisciplinary review has led to a prioritised improvement programme for decontamination across ROH, including strengthening governance through separate decontamination policies. Initial focus is on improving and standardising environmental and non-invasive device decontamination, with progress on track and ongoing oversight to ensure sustainable improvement.

- The SSI surveillance process was redesigned, eliminating the need for both paper and separate digital data collection. By embedding surveillance requirements into existing workflows, the Trust reduced duplication, improved efficiency, and released staff time while continuing to meet national reporting requirements.

- A review of the IPC team structure, prompted by a vacancy, led to clearer and more streamlined roles, improving efficiency, workforce sustainability, and alignment with

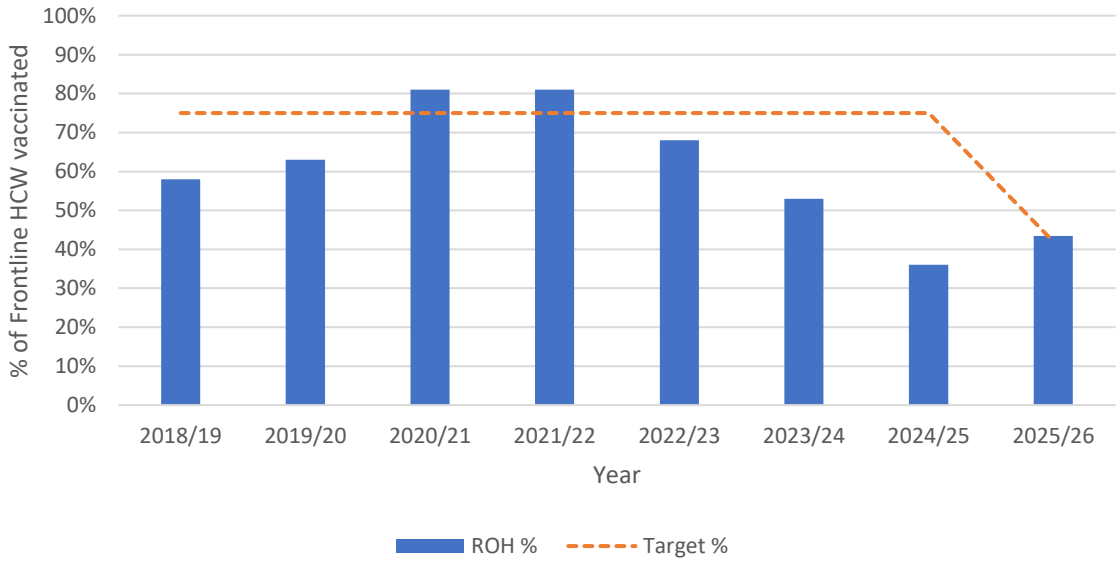
organisational priorities while maintaining high-quality delivery of surveillance and assurance requirements.

Seasonal Influenza Vaccination Programme for Healthcare Workers

The seasonal influenza staff vaccination campaign is well established at ROH. The 2025/26 campaign officially commenced on the 6th of October 2025 with a wealth of information available to staff on the Trust intranet, information boards across the site and locally based influenza champions.

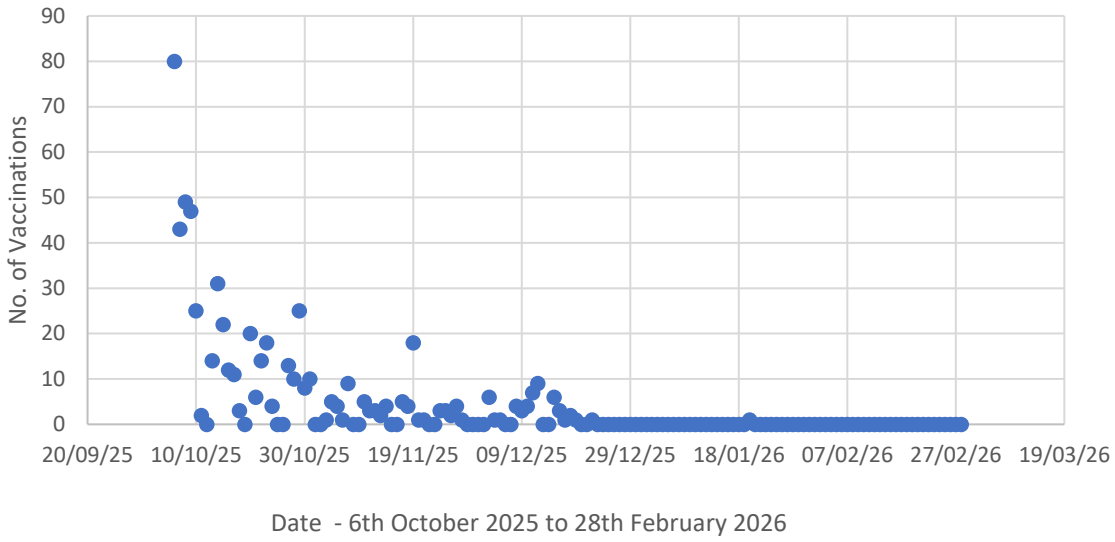
- 42.2% of all Trust staff were vaccinated. (625 out of 1474).
- 43.2% of all frontline HCW were vaccinated. (404 out of 936).
- ROH achieved the 5% uptake increase on final numbers from the 2024/25 campaign (≥ 38.9%) as instructed by NHS England.
- 596 vaccines were delivered onsite by the trained staff vaccinators, the rest were delivered elsewhere such as pharmacies, other Trusts or GP practices.
- 43 inpatients were identified as long-stay (≥21 days), of whom 33 were eligible for vaccination. However, no vaccines were administered due to challenges with medical staff prescribing via the Patient Information and Communication System (PICS).

Annual ROH frontline healthcare worker influenza vaccine uptake percentage



Red dotted line shows the minimum threshold as set by NHSE.

Number of Influenza vaccines delivered over time – Oct 25 to Feb 26



Antimicrobial Stewardship Programme 2025/26

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

Antimicrobial Consumption Report 2025/26

Consumption of antibiotics is monitored by the Chief Pharmacist and analysed for trends by the Antimicrobial Pharmacist.

The National Action Plan (NAP) 2024-2029 sets out targets for antimicrobial consumption across the human population, not isolated to secondary or tertiary care facilities.

1. Reduce total human antibiotic consumption by 5% by 2029
2. Increase the proportion of the WHO 'Access' category antibiotics to more than 70% by 2029.

The UK 5-year action plan for Antimicrobial Resistance 2024-2029, outlines that by 2029, we should aim to reduce total antibiotic use in human populations by 5% from the 2019 baseline. To achieve this ROH has set targets to reduce overall consumption by 1% year-on-year reductions in their rate of total antibiotic usage per 1000 admissions.

ROH antimicrobial baseline data for the year 2018/19:

2018/19 Baseline Data	Total DDD	42008
	DDD / 1000 patients	3239
NHSE target (2022/23)	Target DDD / 1000 patients	3174

DDD = Defined daily doses

All antibiotics

Total Antibiotic consumption data in defined daily doses (DDDs) and DDD per 1000 admissions compared to the 2018 /19 reference year. At the time of this report, total consumption for quarter 1 to 3 has been reported within this annual report.

All antibiotics including BIS Abx

Year	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26 (Q1-3)
Total Antimicrobial consumption (DDD)	48607	39194	50179	54639	53814	61351	46998
Target Total DDD	41587.9	41587.9	41587.9	40117	37807.2	41732	41167
Antimicrobial consumption Per 1000 admission	3719	5518	3947	4114	3892	4292	4461
Target DDD/ 1000	3206	3206	3206	3093	2915	2888	3174

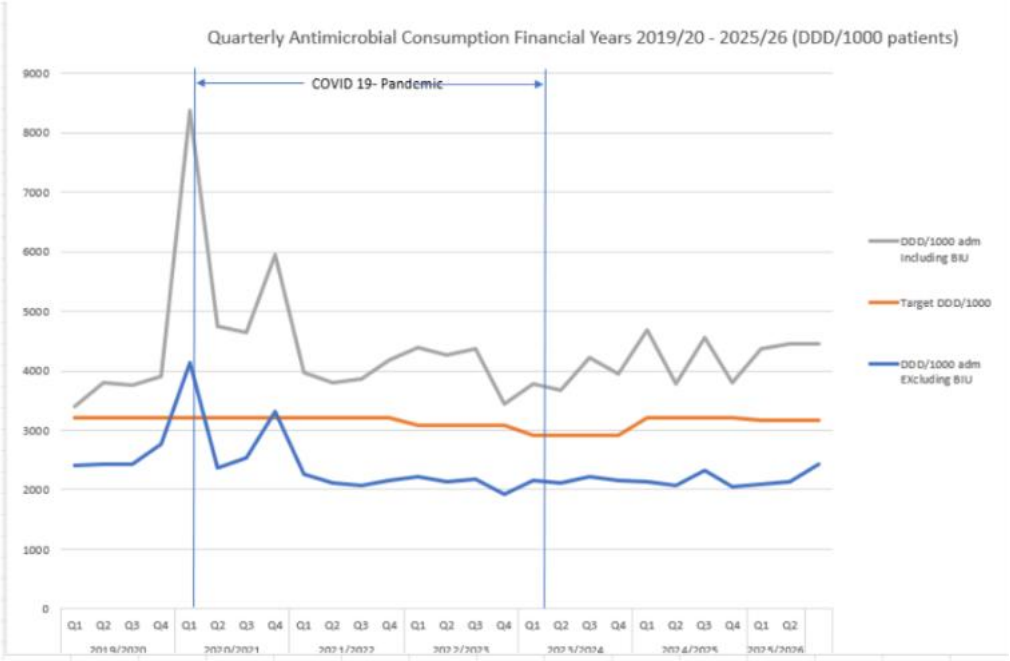
All antibiotics excluding BIS Abx

Year	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26 (Q1-3)
Total Antimicrobial consumption (DDD) (Excluding BIS)	27647	20549	27400	27984	29813	31410	23197
Target Total DDD	41587.9	41587.9	41587.9	40117	37807.2	41732	41167
Antimicrobial consumption Per 1000 admission (Excluding BIS)	2115	2894	2159	2107	2156	2197	2202
Target DDD/ 1000	3206	3206	3206	3093	2915	2888	3174

The table above provide a breakdown of overall antimicrobial consumption for each financial year since 2019. Both graphs show we have reached back to pre-pandemic levels, however with an overall incline can be seen in total consumption but aligns with an increased in bone infection service patients, as excluding BIS the

consumption remains consistent over the past 3 years. As part of the upcoming year plan, understanding the growth will allow for fairer assessment of data against an expanded service compared to the 2019 baseline.

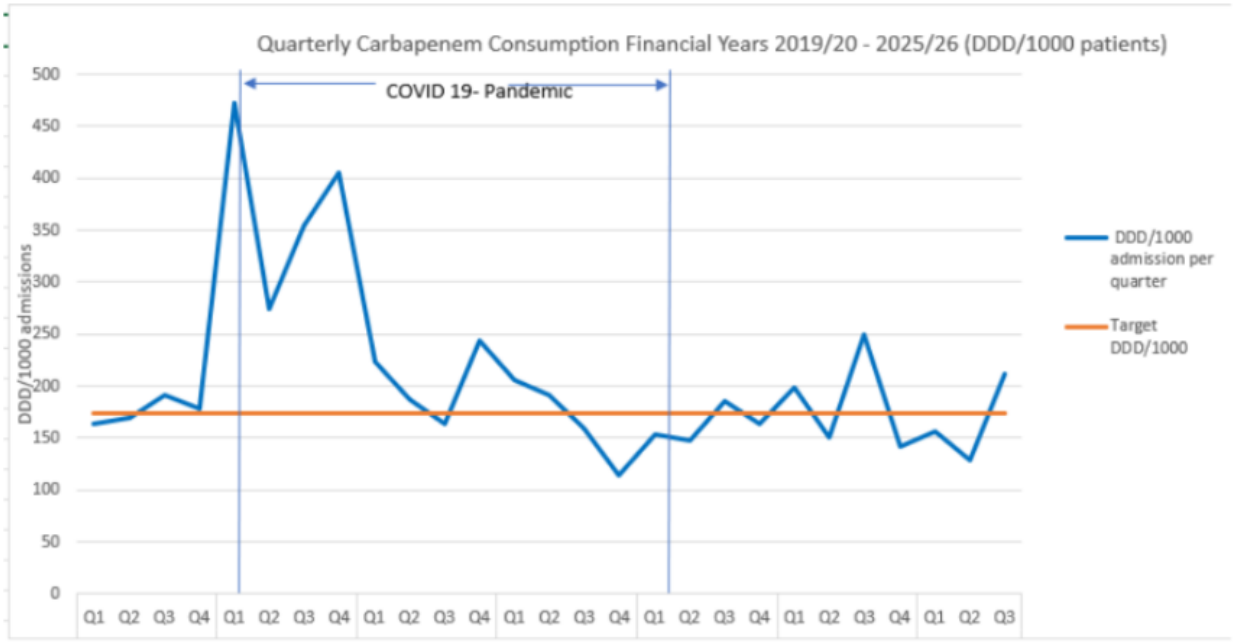
Total antimicrobial consumption (DDD) 2019/20 to 2025/26:



Carbapenem Usage

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

Year	2018	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26 (Q1-3)
Carbapenem consumption (DDD)	2420.8	2300.5	2548.8	2586	2202	2258	2677	1714
Carbapenem consumption (DDD Per 1000 admission)	177.5	176.01	358.9	204	166	163	187	163
Target DDD/ 1000		173.9	173.9	173.9	173.9	173.9	173.9	173.9

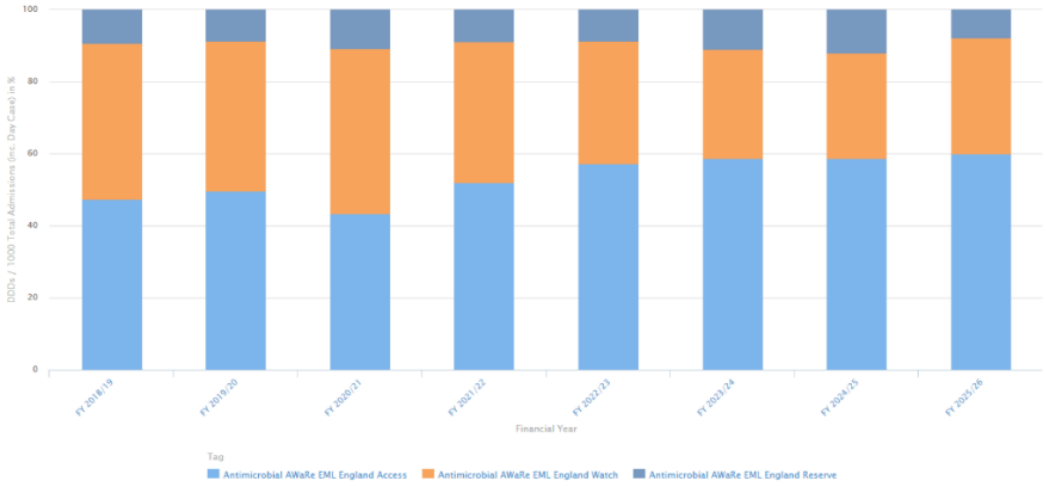


Quarterly data indicates a marked increase in carbapenem usage in the most recent quarter. An exception review identified that five patients received high dose meropenem for a cumulative total of 105 treatment days over the three-month period, with all courses recommended by microbiology and reviewed regularly. This was considered the primary driver of the observed rise in carbapenem consumption.

For the remaining cases, whilst the choice of carbapenem was clinically appropriate, continuation of therapy was largely guided by wound healing progress. This highlighted opportunities for earlier de-escalation to narrower spectrum agents. Additionally, limited documentation of antimicrobial plans for complex surgical cases may have contributed to meropenem being used as the default option.

Carbapenem reviews form a crucial part of the Antimicrobial Stewardship round work commenced in March 2025. Sustained energy and inquisitiveness are required to challenge prescribing and scope the opportunities for optimising prevention and treatment regimes.

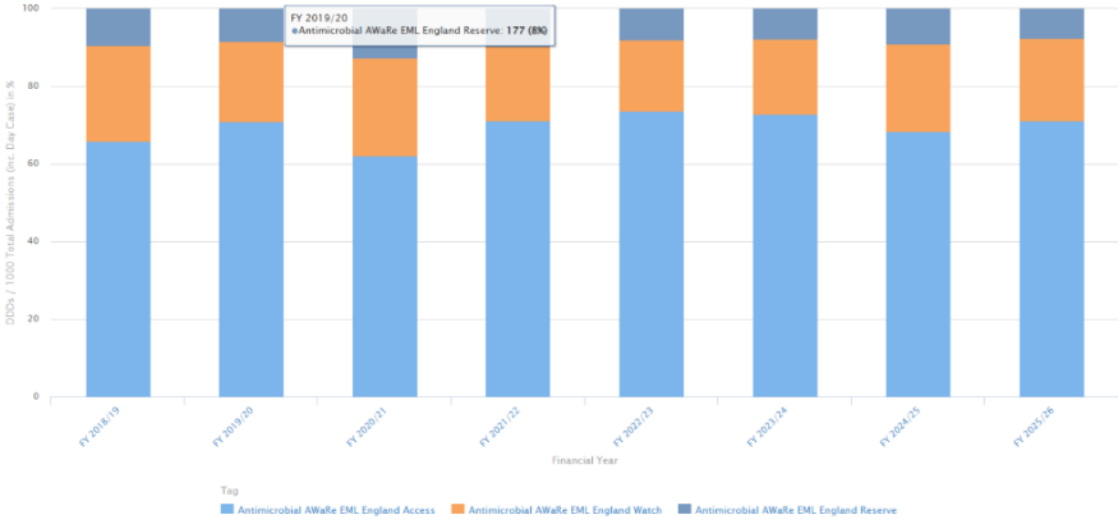
Yearly usage of antimicrobials within the WHO “Access” category of the AWaRe list financial years 2019/20 – 2025/26:



The percentage of antibiotics within the Access group category has been steady over the past 5 years. An overall decrease has been in the reserve category has been seen.

The NAP target for 2024-2029, states we should aim to achieve 70% of total use of antibiotics from the Access category (new UK category) across the human healthcare system- this is not isolated to the hospital settings. We sit below this target when excluding the bone infection service for 2025/26 YTD.

It is important to note antibiotics routinely used for BIS MDT are mostly found within either the Reserve or Watch categories; therefore, as activity remains high for BIS Outpatient then this impacts on the percentage consumption of Access antibiotics. Excluding BIS antibiotics causes the Trust to comfortably achieve the CQUIN targets as evidenced below:



Antimicrobial Stewardship Governance and Evidence of Compliance

A robust antimicrobial stewardship structure is in place, with clear evidence of compliance with the local prescribing formulary. Oversight is provided through the AMSSG, which meets quarterly and is chaired by the Lead Antimicrobial Pharmacist. This multidisciplinary forum enables detailed review of antimicrobial use, prescribing trends, and opportunities for optimisation.

Attendance and engagement have remained consistently strong, with representation from pharmacy, IPC, microbiology, infectious diseases, surgery, anaesthetics, bone infection services, and patient safety. This breadth of expertise supports informed decision making and ensures stewardship principles are embedded across clinical pathways.

The AMSSG has maintained a rolling action log, updated at each meeting to track progress and ensure accountability. Meetings took place on the following dates:

- 8 April 2025
- 31 July 2025
- 6 November 2025
- 5 March 2026

This programme of work demonstrates an active and collaborative approach to antimicrobial stewardship, supporting safe, effective, and evidence based antimicrobial use across the organisation.

Audit and Surveillance Activity Supporting Antimicrobial Stewardship

Regular auditing continues to provide valuable insight into prescribing behaviours and highlights areas requiring improvement. A programme of structured audits is in place to support antimicrobial stewardship and ensure compliance with local and national standards.

An annual Point Prevalence Survey (PPS) is undertaken, offering a snapshot of antimicrobial prescribing and compliance across the Trust during a designated week. This survey enables benchmarking, identification of variation, and targeted quality improvement actions.

An annual audit of antimicrobial prophylaxis is also completed, with a specific focus on preoperative induction agents. This ensures that surgical prophylaxis remains aligned with current guidelines and reflects best practice.

In addition, post implementation audits are carried out following changes to antimicrobial guidelines. Recent examples include assessing compliance after the revision of gentamicin dosing from 1.5 mg/kg to 3 mg/kg at induction and evaluating adherence to updated vancomycin prescribing practices. These audits help confirm that changes in practice are embedded effectively and safely across clinical teams.

Dedicated Antimicrobial Stewardship Ward Rounds

In March 2025, a six-month antimicrobial stewardship (AMS) initiative was undertaken within the elective orthopaedic inpatient setting to better understand prescribing practices and identify opportunities for improvement. Although elective orthopaedics is often viewed as low acuity with protocol driven antimicrobial use, the project demonstrated that stewardship challenges remain comparable to those seen in wider secondary care.

Weekly multidisciplinary AMS ward rounds were introduced across five wards and a high dependency unit between March and August 2025. Pharmacist led screening identified all inpatients receiving antimicrobials, who were then categorised according to indication and guideline alignment. Cases requiring review were escalated to a multidisciplinary AMS team comprising an Infectious Diseases Consultant, Antimicrobial Pharmacist and Bone Infection Service nurse.

Across 14 ward rounds, 40% of inpatients were receiving antimicrobials. Of these, 22% required AMS review due to complex or nonprophylactic antimicrobial use. Fifty-three patients were discussed during rounds, resulting in 43 stewardship interventions, including de-escalation, optimisation of therapy and referral to specialist MDTs. Recurrent themes included inconsistent documentation of postoperative plans, off-guideline prescribing and treatment of clinically insignificant microbiology results.

The project demonstrated that structured AMS rounds are feasible, valuable and effective within an elective orthopaedic environment. The approach supported improved prescribing culture, highlighted variation in practice and identified areas where guidelines and education require strengthening. Future priorities include monitoring outcomes, refining prophylaxis guidance, enhancing education (including sepsis related prescribing) and further exploring antimicrobial use within Watch and Reserve categories.

This work was accepted for a poster presentation at the British Society for Antimicrobial Chemotherapy and subsequently published in the 2025 JAC–Antimicrobial Resistance journal on the Oxford Academic platform.

These rounds are now a sustained practice within ROH and continue to support ongoing quality improvement opportunities.

Care and Management of the Healthcare Environmental and Equipment

Decontamination

No decontamination of critical medical devices is undertaken onsite at ROH. This is contracted out to Steris who deliver an accredited decontamination service and oversee the process and management of all decontamination of surgical instruments. No other equipment used onsite or offsite as part of ROH services requires sterile decontamination.

Transportation of instrument trays is undertaken by Steris using UN 3291-compliant transport trolleys and containers, ensuring safe and secure handling throughout transit.

Tracking and traceability are managed via the bespoke SynergyTrak system, which provides full visibility of instruments across the entire decontamination and reprocessing cycle. The system enables real-time communication, allowing incidents to be identified and managed promptly. The defect management process has improved, with most issues now resolved efficiently through the service review system.

A Pan-Birmingham Trust working group has been established and has convened to review issues relating to missing instruments. This collaborative forum brings together all Trusts and Steris to examine processes, identify common themes, and develop a coordinated action plan to address identified gaps and improve system reliability.

ROH have an appointed Sterile Services Manager (SSM) who takes responsibility for coordinating activity between the theatre, decontamination, and supply/purchase teams. They ensure that the inventory of surgical instruments is proactively reviewed and managed in accordance with Health Technical Memorandum (HTM) 01-01, which offers best practice guidance on the whole decontamination cycle including the management and decontamination of surgical instruments used in acute care as well as local guidance, clinical requirements, and industry best practice.

The SSM reports to the Trust's Decontamination lead. In the absence of a formal Decontamination Lead, this responsibility is held by the DIPC. The SSM provides an upward report on decontamination at the IPC committee.

Water

The Water Safety Group (WSG) continues to meet bi-monthly and reports upwardly to the IPC Committee. The group is chaired by the Deputy Director of Delivery (Estates). The Trust continues to monitor and review work and actions undertaken towards maintaining a robust water safety plan (WSP). The plan was developed based on the peer review and reflects the status and identified risks of the Trust's water systems. This is monitored at the WSG.

The Estates Department carried out planned preventive maintenance in accordance with the relevant water safety guidance documentation. Every two years the Trust commissions an independent Legionella risk assessment to be completed across the site, the outcome/actions from the assessment are discussed at the WSG.

Six monthly Legionella water sampling to several fixed and random points was undertaken. Following an in-depth *Pseudomonas aeruginosa* risk assessment, from January 2024, this also included testing for *P. aeruginosa* in 'higher risk' areas which include Ward 1, Ward 3 and HDU. The results are reported through the WSG. As noted in the clinical activity section, routine 6-monthly water testing identified several *Pseudomonas aeruginosa* positive outlets.

Water quality in the hydrotherapy pool is tested on a weekly basis, tests are undertaken and monitored by hydrotherapy staff and exceptions are reported to the WSG.

Ventilation

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

As per the requirements set out in HTM 03:01 specialised ventilation for healthcare premises, the VSG is a multidisciplinary group whose remit is to assess all aspects of ventilation safety and resilience required for the safe development and operation of the ROH healthcare premises.

The Trust have 14 operating theatres, 13 of which are ultra clean ventilated (UCV). Canopies are serviced/validated twice yearly by a specialist external provider.

Annual theatre ventilation verification was completed during 2025/26. The resulting report and any associated recommendations were reviewed by the Ventilation Safety Group (VSG), with completion of related works subject to formal risk assessment.

Estate

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

During 2025/26 the IPCT have advised on:

- Routine programme of ward and theatre closures to allow maintenance and deep cleaning to take place.
- Replacement of CT Scanner.
- Replacement of X-ray machine.
- New energy efficient boilers in Knowledge Hub.
- Demolition of Rabone Hall and creation of car park.
- Estate challenges are ongoing throughout the theatre complex and orthotics department. These areas are historic buildings that require investment to ensure prolonged use.

Environmental Hygiene (Cleanliness)

Cleaning and environmental decontamination services provided at ROH are undertaken by an in-house team within the Facilities department. These services are provided by a dedicated team of environmental cleaners and an enhanced cleaning team. Environmental cleaners provide cover in all patient areas from 06:00 to 22:00hrs Monday to Friday and 08:30 to 19:00hrs Saturday & Sunday. The enhanced cleaning team undertake all enhanced cleaning and terminal cleaning requests which includes

ultraviolet light cleaning (UV-C) and Bioquell (hydrogen peroxide vapour misting) between the hours 08:30 to 05:30hrs (split over two long shifts) Monday to Sunday.

Training for domestic staff continues to be provided by the housekeeping coordinators which includes the completion of a training manual.

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

Facilities audit programme:

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

Star ratings

Star ratings are displayed to give patients, staff, and the public an easily understood visual score of the standard of cleanliness being met. It reflects the cleanliness of a functional area regardless of which staff group is responsible for cleaning each element. Our star ratings are derived from the original audit score at the time of audit. Scores can only be updated following the next full re-audit. The monthly star ratings are displayed within all patient facing locations displays. This system enables easier administration and allows monitoring to take place. All areas achieved 5 stars at each audit during 2025/26.

Efficacy audits

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

Location	**Date performed**	**Scoring %**
Ward 1	July 25	97
Ward 2	May 25	96
Ward 3	Jan 25	96
Ward 4	Jun 25	98
Ward 12	Aug 25	97
Community Hub	April 25	97
X-Ray & MRI	Feb 25	98

Patient led assessment of the care environment (PLACE)

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

Discipline	National Average	ROH 2025/26	Compared to 2024/25	Comment
Cleanliness	98%	98%	↓	In line with National Average
Food	92%	98%	↑	Above National Average
Organisational Food	92%	98%	↑	Below National Average
Ward Food	92%	91%	↓	Above National Average
Privacy, Dignity	89%	92%	←→	Above National Average
Condition/Appearance	97%	99%	←→	Above National Average
Dementia	85%	91%	←→	Above National Average
Disability	87%	95%	↑	Above National Average

Successes:

- *Introduced revised and much improved digital cleanliness audit system*
- *Successfully training additional staff on Bioquell system (HPV misting)*

Waste management

The Trust has an appropriate waste management process in place following HTM 07-01 Safe and Sustainable Management of Healthcare Waste. This includes appropriate streaming of clinical/non-clinical waste/sharps, disposal and recycling where appropriate.

Clinical waste is categorised within the following core waste streams.

- Infectious waste contaminated with Category A pathogen – Yellow stream
- Infectious Waste – Orange Stream
- Offensive Waste – Tiger stream
- Pharmaceutical/Waste medicines – Blue stream
- Cytotoxic/Cytostatic waste - Purple stream
- Anatomical Waste- Red stream

Clinical waste is segregated according to its waste type. To provide assurance that correct segregation is in place waste management audits are performed by the waste and linen services coordinator in-line with the functional risk category of the location.

Auditing Principles and Frequencies		
Functional Risk Category	**Frequency of Audit**	**Outcome Required %**
FR 1 – Theatres & supporting areas	Monthly	98% or above
FR 2 – General Wards & Clinics	Bi -Monthly	95 % or above
FR 3 – Outpatients & public access areas	6 Monthly	90% or above
FR 4 – Offices	Every 12 Months	85% or above

Location	Date performed	Scoring %
Theatres	Feb 26	98
Ward 1	Jan 26	99
Ward 2	Dec 25	97
Ward 3	Mar 26	98
Pharmacy	Oct 25	97
Discharge Suite	Nov 25	98

Results and findings are shared, if any issues are identified these are communicated to the ward/departmental leads to action, location is then re-audited within one month to provide assurance improved segregation is observed.

Successes:

In line with the NHS Clinical Waste Strategy the NHS set out its intent to become a Net Zero health system for direct emissions by 2040 and indirect emissions by 2045. To achieve this ambitious target Trusts have been asked to look into ways on how to improve clinical waste segregation by the flowing targets.

- 20% of waste segregated to be sent for incineration
- 20% of waste segregated to be sent for alternative treatment; orange bagged waste.
- 60% of waste segregated to be classified and disposed of as offensive waste, tiger stripe waste.

2025/26 Waste segregation generation data evidence the trust has achieved the following:

- 9% - Incineration
- 4% - Alternative Treatment
- 86% - Offensive

This was achieved by the introduction of improved clinical waste segregation with theatres, improved clinical waste bin labelling and positioning, implementation of local waste segregation tool box talks with wards & departments, improved Waste generation and handling observation performed by the waste collection team and their lead supervisor, and the introduction of a much improved trial waste management audit tool, which is hoped to be rolled out once financial approval has been granted.

Future plans:

- Roll out of "office and staff room food waste caddies"
- Roll out of "single source plastics recycling"

IPC Training and Education

- The IPC team deliver training sessions year-round according to a training needs analysis.
- Mandatory IPC training continues to be delivered in-person (level 1 – all staff) and online (level 2 – staff providing direct patient care). Trust compliance is monitored at the IPC Committee.
- Ad-hoc, turbo tutorials are delivered by the IPC team in clinical settings to share updates, important messages, and target education on specific subjects.
- The IPC team has a dedicated full time FFP3 respirator fit tester that delivers the fit testing programme for the Trust. Much work has gone into ensuring clinical staff are tested on at least one UK manufactured respirator as well as providing training on the use of the Trusts respirator hoods.
- A Link Champion programme remains in operation; however, participation across clinical areas is inconsistent, primarily due to operational demands and staffing constraints. The IPC team holds quarterly face-to-face Link Champion meetings, with attendance declining in the latter part of the year in the context of these pressures.

Engagement and training undertaken by the IPCT during 2025/26:

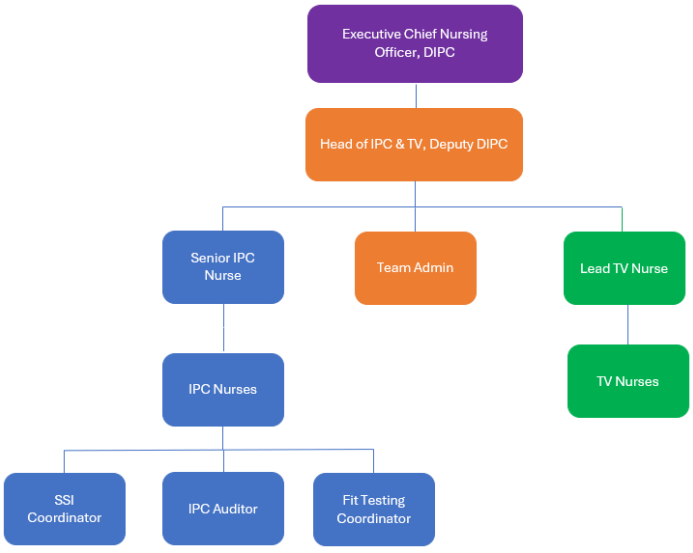
- Facilitated quarterly meetings for IPC link champions (from each ward and department).
- Continued to work collaboratively with suppliers, estates, and facilities teams to ensure that infection risk is considered and managed when commissioning works, new equipment, or processes.
- Continued to facilitate communication of key messages via several media methodologies including social network, newsletters, and emails.
- Facilitated the national antibiotic awareness and hand hygiene days across ROH.
- Supported new and updated policy roll out and dissemination utilising external industry partners.

Governance and Assurance Arrangements

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

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

ROH Infection Prevention and Control Service Structure 2025/26:



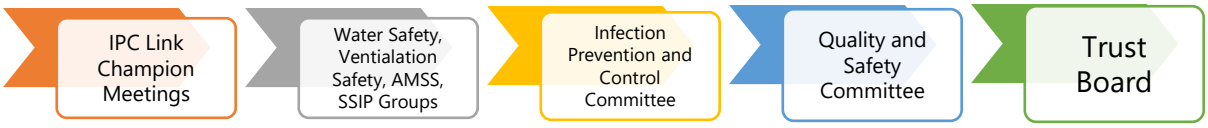
During 2025/26, the IPC team took part in the following development opportunities:

- During June 2025, the Lead IPC Nurse expanded their remit to include the roles of Head of IPC and Deputy DIPC, alongside additional service responsibility for the Tissue Viability Team.
- Head of IPC continued to pursue a master's degree in IPC at Dundee University (due to finish in January 2027).
- Head of IPC continued to undertake a DIPC development course.
- During September 2025, an IPCN started their master's degree in IPC at Dundee University.
- An away day to review previous year's performance and plan for the year ahead.
- Several Infection Prevention Society study days attended focusing on key topics that benefit service provision at ROH.

Governance

- A bi-monthly Trust Infection Prevention and Control Committee (IPCC) is chaired by the Chief Nursing Officer and reports to the Trust Board. It receives regular reports and updates from each Clinical Group and the following sub-committees:
  - Water Safety Group
  - Ventilation Safety Group
  - Antimicrobial Stewardship Steering Group
  - Surgical Site Infection Prevention Group
- The IPCC also receives updates from our regional UKHSA Advanced Health Protection Nurse, Integrated Care Board IPC lead, estates, facilities, and UHB Occupational Health team.
- Assurances associated to Trust IPC matters is provided three times a year by the DIPC to the Quality and Safety Committee, which reports directly to Trust Board. Any interim exceptional reporting to the Trust board is undertaken via existing reports from the Chief Nurse's Office.
- As part of the Trusts PSIRF approach, the IPCT supports timely reviews of reportable HCAI and IPC incidents which are presented and discussed at divisional governance meetings.
- To keep IPC high on the agenda the IPCT regularly attend and champion IPC at relevant groups, committees, and forums.
- Improved communication and patient flow lead to positive outcomes for patients and their families when the system works together. The IPCT have been actively engaged in maintaining and expanding networks locally, regionally, and nationally. This has included:
  - Regional and national meetings with NHS England.
  - Birmingham and Solihull system IPC Meetings.
- In June 2025, a joint ICB and NHS England assurance visit was undertaken. This visit provided full assurance that ROH has appropriate processes and policies in place to meet the requirements of the Health and Social Care Act and to effectively assess and manage all IPC-related risks.

- Also in June 2025, a Health and Safety Executive (HSE) inspection was carried out, focusing on safe sharps management and occupational dermatitis. The key recommendations arising from this inspection included the need for improved assurance around safe sharps management within the Theatre department, as well as enhanced access to hand moisturisers and improved monitoring of their use within clinical areas.



Assurance

The IPC audit programme provides assurance of compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections. Under the revised audit programme, audits are categorised as either technical or managerial.

Technical audits are undertaken by clinical departments to assess day-to-day practice, while managerial audits are completed by the IPC team to provide independent assurance of compliance and oversight of infection prevention and control standards. Where additional risks are identified, or where a period of increased incidence or outbreak is declared, the IPC team undertakes targeted audits outside of the routine programme, in line with the identified level of risk.

Actions arising from audits are assigned to the relevant departments, with progress and completion monitored within the responsible division and reported through fortnightly divisional governance meetings. Findings and actions from clinical area audits are escalated to the IPCC by the Divisional Head of Nursing, either by exception or to highlight good practice. Outcomes of audits undertaken by the IPC team are summarised within the IPC audit report presented to the IPCC by the Senior IPC Nurse.

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

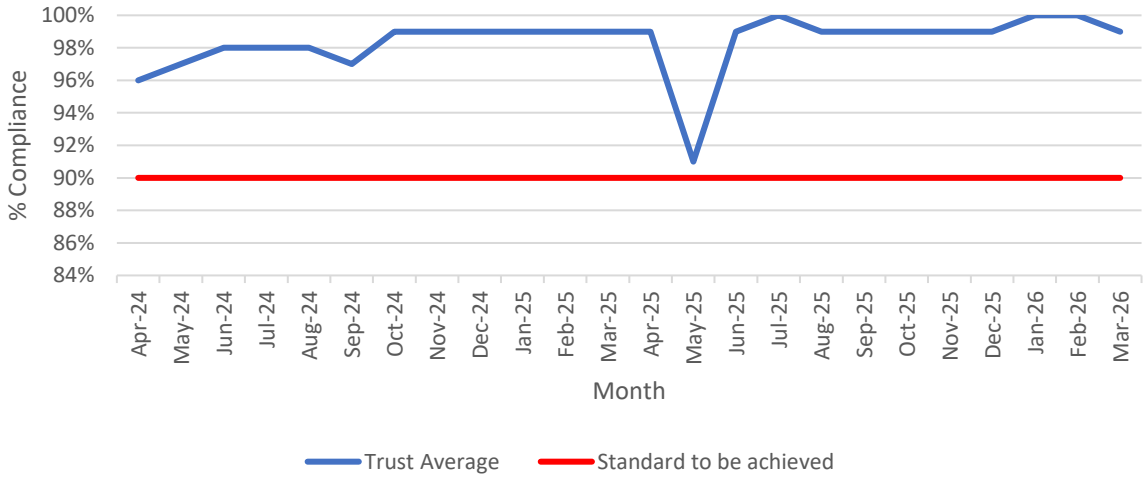
Overall hand hygiene compliance for 2025/26 was 99%, consistent with performance in 2023/24. Overall compliance with PPE auditing for 2025/26 was also 99%.

Following the transfer of responsibility for PPE auditing to clinical departments, challenges were identified in achieving consistent audit completion and meeting minimum observation thresholds. In response, the IPC team worked closely with clinical areas to provide education and support on audit methodology and accurate data entry within the AMaT system. This targeted support resulted in improved audit completion rates and enhanced quality of observations towards the latter part of the year.

During 2024/25, an application was submitted to the Training and Development Committee to make hand hygiene and PPE training mandatory. Approval was not granted due to concurrent national changes to mandatory training requirements. The absence of mandated hand hygiene and PPE training has therefore been added to the

IPC risk register and continues to be monitored. Audit findings relating to non-compliance with hand hygiene and PPE consistently indicate themes associated with knowledge and practical application, which can only be fully addressed through appropriate training and competency assessment.

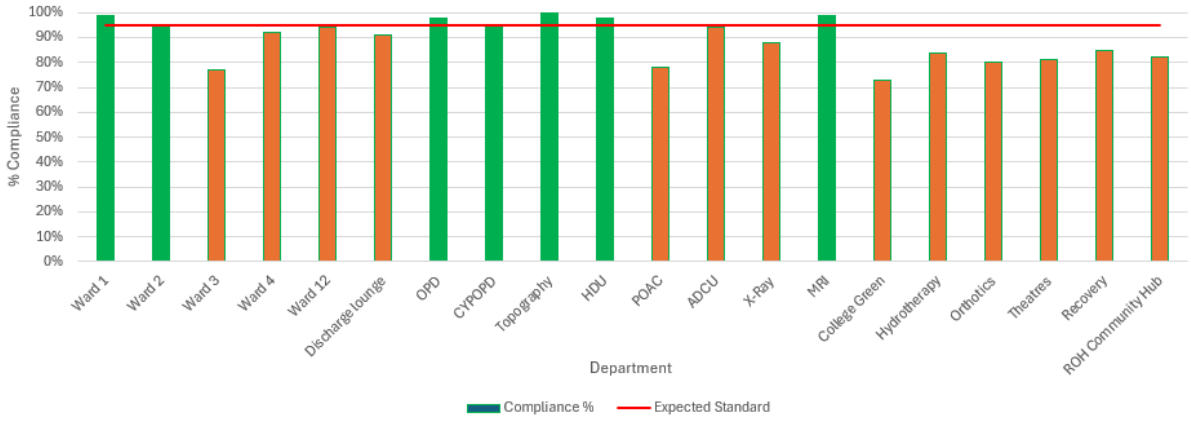
Trust Hand Hygiene Audits - % Monthly Average:



IPC Practice Audit:

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

Annual IPC Audits Scores:



Policy

All IPC policies and guidelines are available for staff to view via the Trust intranet. There is a formal governance structure in place for reviewing and ratifying such documents

within the Trust and the corporate governance team produce a directory of documents alerting lead authors when policies are due for review. Policies are also updated prior to review date if national guidance or evidence base is updated/changed. All polices are agreed and approved for use at the IPCC (if minor or no change) or Quality and Safety Committee (if the changes are major or introduction of new policy).

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

During 2025/26 the IPCT wrote and implemented the following polices and documents:

- Mouth Care for Adults (Aged 16 and Over) SOP
- Inpatient Seasonal Influenza Vaccination SOP
- Infection Prevention and Control Policy

During 2025/26 the IPCT reviewed and/or updated the following polices and documents:

- Hand Hygiene SOP
- Transmissible Spongiform Encephalopathies including Creutzfeldt-Jakob Disease SOP
- Tuberculosis SOP
- Management of Infectious Diarrhoea and Vomiting SOP
- Use of Portable Fans in Clinical and Non-Clinical Settings SOP
- Respirator Hood (Respiratory Protective Equipment) SOP
- High Consequence Infectious Diseases Procedure SOP
- Carbapenemase-producing Enterobacterales Policy
- Communicable Diseases and Notification Policy
- Patient Safety Incident Response Plan for Infection Prevention and Control Related Incidents

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

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

Risk

The IPC Board Assurance Framework has been updated throughout 2025/26. Actions arising from the framework are monitored via the IPC Committee.

IPC risks are included on a risk register which is reviewed bi-monthly at the IPC Committee.

No risks were closed during 2025/26:

4 new risks were added to the IPC risk register:

- April 2025: risk relating to the condition of the healthcare estate – specifically deteriorating floors, walls and doors.
- September 2025: risk that the annual ward/theatre shut down, and deep cleaning programme will not be able to take place due to operational pressures.
- September 2025: risk relating to the lack of mandatory practical PPE and hand hygiene training. This increases the risk of infectious agent transmission, potentially leading to higher rates of HCAIs, particularly in high-risk clinical areas.
- January 2026: risk relating to the Trust's continued use of non-medicinally licensed Clinell HEXI HUB wipes for pre-procedural skin antisepsis is not aligned with national guidance or MHRA expectations, creating a risk of regulatory non-compliance, avoidable patient harm, and potential legal liability.

Service Plan

Below is a snapshot of the IPC service plan priority objectives and programme of work for 2026/27, mapped against our Trust strategic objectives (1=Care, 2=Expertise, 3=People, 4=Community, 5=Services, 6=Collaboration).

Quality and Continuous Improvement:

- Variation and inefficiencies in environmental decontamination processes continue to present a risk to patient/staff safety and infection prevention outcomes, requiring further optimisation through the ongoing environmental decontamination project. (2,5,6)

- The Link Champion programme currently has limited trust-wide impact, operating largely at departmental level rather than embedding an "IPC and Me" culture. We propose developing a manager support package for those accountable for IPC assurance across clinical and non-clinical areas, to be incorporated into the "Me as a Manager" training offer. (3,5,6)

- Address the funding and delivery gap for the 2026/27 seasonal vaccination programme for healthcare staff and eligible inpatients, with key challenges including senior buy-in and protected time for vaccinators rather than reliance on "free time". (2,3,5,6)

- Develop a digital assurance dashboard to support continuous improvement by enabling department-level input, visibility, and monitoring of compliance and evidence in relation to the Health and Social Care Act (2008) Code of Practice for infection prevention and control. (2,5)

Productivity:

- Digitise SSI surveillance processes to improve efficiency and workforce productivity by reducing manual data collection and input. This will include exploring automated

data extraction and CSV file transfers and assessing system capability to support surveillance data capture with minimal manual intervention. (2,5)

Financial improvement

- Review the scope of the UHBFT SLA for IPC and bone infection consultant services, ensuring alignment with current service structures and confirming the appropriate funding source, given that bone infection is no longer part of the IPC service. (5,6)

Conclusion

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

Throughout 2025/26, the IPC team has continued to lead with innovation and professionalism, successfully delivering the IPC programme with measurable progress in minimising healthcare-associated infections.

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

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

Related Documents

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

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

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

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

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

The Royal Orthopaedic Hospital NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Human Tissue Annual Report 25/26**
SPONSOR (EXECUTIVE DIRECTOR):	**Mathew Hartland, Chief Executive Officer & Licence Holder**
AUTHOR:	**Nikki Brockie, Chief Nursing Officer & Designated Individual**
DATE OF MEETING:	**3rd June 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This report provides assurance that the Trust remains compliant with Human Tissue Authority (HTA) regulatory requirements across procurement, storage and distribution of human tissue. Robust governance arrangements, clear accountability through the Designated Individual and supporting roles, and effective oversight via the Human Tissue Application Group (HTAG) underpin continued compliance. The Trust has demonstrated strong performance in maintaining traceability, meeting training requirements, and closing all identified regulatory actions within required timeframes. While overall assurance is positive, continued focus is required to further strengthen training compliance consistency, audit systems, and upstream supply chain processes to minimise incidents.

Human Tissue Inspection – 13 May 26

The bi-annual HTA inspection took place on 13 May 2026, with initial feedback being positive. It is expected (but not confirmed until the final report) that the Trust will receive 2–3 minor CAPA's and 2 advisory CAPA.

These relate to recent changes (implemented the day before the inspection), the need to update an SOP in relation to the change, and to strengthen governance in relation to incidents. It was recognised that changes and improvements had been made to address incidents; however, it was felt that the feedback within reports would benefit from further improvement.

The final report is not expected until early July.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Full regulatory compliance maintained with HTA requirements during the reporting period • All Corrective and Preventative Actions (CAPAs) from the 2024 inspection successfully closed within agreed timescales	• Further embedding consistent training compliance, particularly sustaining improvements across all staff groups. Review planned. • Transition of audit processes to AMaT system to strengthen assurance and efficiency • Continued strengthening of supply chain and distribution processes following reported incidents

• Strong governance framework in place, with clear accountability (Licence Holder, Designated Individual, Person(s) Designated) • Effective oversight through HTAG, including independent clinical challenge • All Serious Adverse Events (SAEs) appropriately reported, investigated, and formally closed by the HTA • No Serious Adverse Reactions (SARs) reported in the last five years • Robust traceability processes with no sustained loss of tissue traceability • Annual HTA return submitted on time with no concerns raised • Improved training compliance achieved across theatres during 2025 • Independent audit completed (2025) providing additional assurance with only low-level findings	• Monitoring emerging national regulatory changes (SoHO framework) to ensure future readiness

REPORT RECOMMENDATION:

The Board is asked to : note and accept report.

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

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

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

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

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

BAF

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)***:**

Annual report 24-25

PREVIOUS CONSIDERATION *(Indicate board/committee/group & date)*:
Quality & Safety Committee May 2026

The Royal Orthopaedic Hospital NHS Foundation Trust

Human Tissue Annual Report

License Number: ***12379***

Report to Quality & Safety Committee on May 2026

1 EXECUTIVE SUMMARY

1.1 The purpose of this paper is to provide the Board with an overview of the Trust's annual compliance with Human Tissue Authority (HTA) regulations[1]. The report provides assurance regarding the Trust's adherence to statutory requirements and the effectiveness of governance arrangements relating to regulated human tissue activities. The reporting period covered by this paper is 1 January 2025 to 31 December 2026 which is in line with HTA audit cycle.

1.2 The Human Tissue Authority (HTA) is the statutory body responsible for regulating activities involving human tissue in the United Kingdom, ensuring compliance with the Human Tissue Act 2004 and associated Codes of Practice.

1.3 The Care Quality Commission (CQC)[2] and the Human Tissue Authority operate under a Memorandum of Understanding which sets out how the two regulators work together, share information, and coordinate regulatory activity where providers are subject to both CQC registration and HTA licensing requirements.

1.4 The Memorandum of Understanding was most recently updated and formally agreed in April 2025, reinforcing a clearer framework for joint working, information sharing, and regulatory boundaries. The updated agreement supports proportionate regulation, reduces duplication, and strengthens assurance in relation to patient safety, quality of care, and public confidence.

1.5 This report covers the Trust's licensable HTA activities, which include:

- Procurement of human tissue
- Storage of human tissue
- Distribution of human tissue

1.6 In addition, the paper provides assurance in relation to governance processes and oversight, as well as training and competency requirements for staff undertaking HTA-regulated activities.

1.7 Activities related to research, including associated HTA research requirements, are out of scope for this report.

2 Governance / Structure

2.1 The Trust is required by the Human Tissue Authority to establish and maintain defined key roles to ensure effective oversight, accountability, and compliance with the Human Tissue Act 2004. These roles are set out by the HTA and are:

[1] Legislation | Human Tissue Authority

[2] Memorandum of understanding - Human Tissue Authority - Care Quality Commission

- Licence Holder
- Designated Individual (DI)
- Person(s) Designated

2.2 The appointment and operation of these roles underpin the Trust's governance framework for HTA-regulated activities and provide assurance that licensable activities are undertaken safely, legally, and in accordance with HTA Codes of Practice.

2.3 The quality management approach (outlined below) has been adopted to ensure all activities conform to the specified requirements and all processes are continually monitored and evaluated. This results in the Trust meeting the requirements of the end users and the Human Tissue Authority (HTA) and being able to provide assurance to the Trust Board that activities comply with the HTA licence.

2.4 The Licence Holder holds overall organisational responsibility for compliance with the conditions of the HTA licence. This role ensures that appropriate governance arrangements, resources, and systems of oversight are in place to support compliance across all licensed activities.

2.5 The Designated Individual is accountable to the HTA for the supervision of licensable activities and for ensuring that these activities are carried out in accordance with the licence conditions and statutory requirements. The DI provides operational leadership, oversight of compliance, and assurance that any risks to compliance are identified and managed appropriately.

2.6 Person(s) Designated support the Designated Individual by undertaking delegated responsibilities relating to specific areas of licensed activity. They act on behalf of the DI to ensure day-to-day compliance, adherence to procedures, and timely escalation of issues or incidents that may impact HTA compliance.

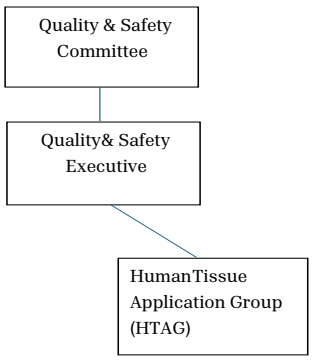
2.7 Collectively, these roles provide a clear line of accountability and assurance to the Board that HTA-regulated activities are appropriately governed, with defined responsibilities and effective oversight arrangements in place.

Corporate Licence Holder Matthew Hartland **Designated Individual** Nicola Brockie		
Head of Nursing – Div 2 Jennifer Pearson	**Person Designate** Matthew Coombe - HTA Lead Talitha Neville – Matron Kristian Duce – Matron Lucy Young – Theatre Sister	**Clinical Services Manager** William Overfield
HTA Co-ordinator Joanne Booth		

Reporting structure

2.8 The Trust has an established Trust Human Tissue Application Group (HTAG), as outlined within the governance structure below. The group provides formal oversight and assurance in relation to compliance with Human Tissue Authority requirements.

HTAG Reporting structure



2.9 The Designated Individual chairs the HTAG and is responsible for providing leadership and accountability for HTA-regulated activities. The Person(s) Designated report directly into the group. The

HTAG meets on a bi-monthly basis, ensuring regular review and oversight of compliance, risk, and assurance matters.

2.10 An Orthopaedic Consultant, Professor Snow, attends the group to provide independent professional challenge, scrutiny, and clinical insight. This arrangement strengthens governance by enabling robust independent oversight, promoting constructive challenge, and ensuring that HTA compliance arrangements are effective and well‑assured.

2.11 The HTAG is responsible for overseeing compliance with HTA statutory and regulatory requirements across all licensed activities. This includes assurance in relation to traceability arrangements and the maintenance of systems that ensure full trace and traceability of human tissue at all times.

2.12 The group receives, reviews, and formally signs off all HTA-related incidents, ensuring that incidents are appropriately investigated, learning is identified, and notifications and escalations to the HTA are completed as required. The HTAG also approves HTA standard operating procedures to ensure alignment with current Codes of Practice and operational requirements.

3 Regulatory requirements

3.1 The Human Tissue Authority regulates the removal, storage, and use of human tissue for medical, scientific, and educational purposes. This includes assessing compliance with regulatory requirements, ensuring the safe and ethical use of human tissue, and providing assurance in relation to transparency and traceability systems across NHS organisations. The HTA undertakes bi-annual inspections, supported by an annual activity submission, which is submitted in March each year.

3.2 ROH's most recent bi-annual inspection was undertaken by the HTA in May 2024. During this inspection, three minor Corrective and Preventative Actions were identified against regulatory requirements. All CAPAs were formally closed by the HTA at the end of February 2025.

3.3 All three CAPAs related to the Trust's Autologous Chondrocyte Implantation activity. To address these findings, the Trust worked closely with Joint Operations and University Hospital Birmingham to implement the required improvements. These actions included strengthening contractual arrangements with UHB, updating licensing arrangements, improving patient communication, and amending the Trust's consent process to specifically identify autologous blood sampling.

3.4 The Trust's next HTA inspection is scheduled for the 13th May 2026.

3.5 In addition to formal HTA inspections, the HTA advises organisations to undertake an independent inspection by an expert practitioner. This was completed in May 2025 and identified a small number of low-level CAPAs. Such reviews are intended to provide local assurance and support compliance in the preceding year. The outcomes are shared with the HTA at the point of the next formal inspection.

3.6 The HTA requires all Trusts to submit an annual activity report to demonstrate full traceability of all human tissue procured, stored, and used. The Trust submitted its annual activity report by the required deadline, and no areas of concern were identified.

3.7 Internal monthly audits are undertaken to provide ongoing assurance of traceability for all human tissue held within the Trust and to identify any gaps in compliance. Work is currently underway to transition these audits to the AMaT system.

3.8 All HTA documentation is stored in line with the Trust Records Management Policy and retained for a minimum of 30 years, in accordance with HTA expectations. During the reporting period, the Trust refreshed its archiving facilities to support long-term record retention.

3.9 The Trust also maintains a Human Tissue Quality Manual, setting out its HTA-related requirements and activities. This was last updated in April 2026 to reflect a change in Licence Holder.

4. Traceability and Compliance

4.1 Traceability is fundamental to ensuring that human tissue is used ethically, legally, and in accordance with the consent provided. The HTA requires all human tissue used within the NHS to be fully traceable from the point of collection through to final use, providing transparency and accountability throughout the process.

4.2 The HTA requires all losses of traceability and compliance concerns to be reported within 24 hours of identification. These events are classified as Serious Adverse Event/Incidents (SAEs). Following notification, the Trust is required to undertake a full investigation. The outcome of the investigation is reported to the HTA, and only the HTA can formally close or stand down an SAE.

4.3 A Serious Adverse Event/Incident is defined as any untoward occurrence associated with the procurement, processing, storage, or distribution of tissue or cells intended for human application.

4.4 During the reporting period, three SAEs were reported. All investigations have been completed, and the SAEs have been formally closed by the HTA with satisfactory outcomes.

Date reported	SAE	Outcome
17.2.25	Loss of traceability of Matrix HD	Reported within timescale. Extensive work carried out to track missing items. Item located. SAE closed by HTA
18.3.25	ACI transplant box unsealed upon arrival at ROH	HTA confirmed not a SAE. May be reportable under MRHA but Pharmacy to deal
25.9.25	Receipt of damaged box of DBX Putty from supplier (J&J) and issues with arranging return of damaged box to them.	Item returned to supplier. As this issue came under "distribution", the supplier to liaise with the HTA

4.5 Table 1. Outlines that since 2021, only ten SEA have been reported to HTA (including the aforementioned), all have been closed and learning implemented to drive regulatory improvements.

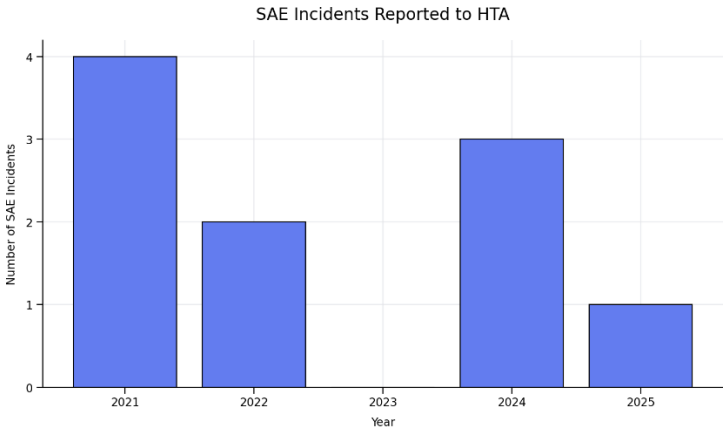


Table 1. SAE reported to HTA.

4.6 There have been no SER reported by ROH in this reporting period, nor have there been any reported in the last 5 years.

5 Training requirements

5.1 All staff involved in the management of human tissue are required to meet defined training requirements to ensure compliance with the Human Tissue Act 2004 and associated HTA Codes of Practice. The Trust ensures that staff are appropriately trained in the following areas.

5.2 All staff working with human tissue, whether under a Human Tissue Authority licence or approval from a recognised Research Ethics Committee, are required to complete training relating to the Human Tissue Act and relevant Codes of Practice.

5.3 Clinicians who are responsible for obtaining consent for any human tissue application must complete appropriate consent training to ensure that consent is lawful, informed, and documented in line with regulatory requirements.

5.4 Some specialist activities, such as Autologous Chondrocyte Implantation transplants, require additional company-specific training to support safe and compliant practice.

5.5 HTA-related training is delivered by the Person(s) Designated, supported by clinical educators within theatres. Training specific to Autologous Chondrocyte Implantation is delivered by the Joint Operations clinical support team. During 2025, focused work was undertaken to improve training compliance across the theatre department, achieving sustained improvement during the year, as illustrated in Graph 2.

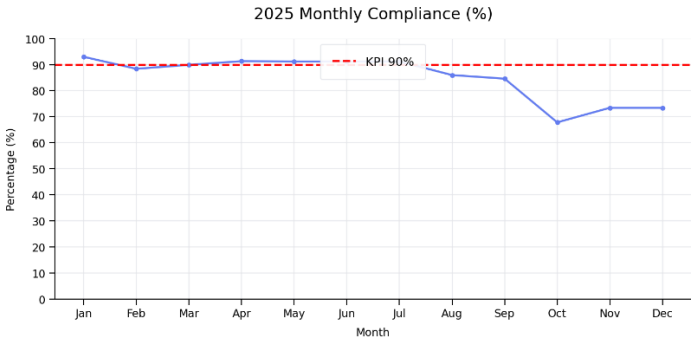


Table 2. Training compliance across the 2025

6. National developments

6.1 Since December 2025, there have been no amendments to primary Human Tissue Authority legislation or to the core regulatory framework governing procurement, storage, and use of human tissue under the Human Tissue Act 2004 and associated regulations. The statutory duties on NHS Trusts therefore remain unchanged.

6.2 On 25 March 2026, the Department of Health and Social Care published a call for evidence on the future regulatory landscape for substances of human origin used in medical treatment. The call seeks views on whether the current UK legislative framework remains appropriate in light of scientific and technological advances and the forthcoming implementation of the EU SoHO Regulation, which will apply in Northern Ireland under the Windsor Framework from August 2027. The call for evidence is open for 12 weeks and closes on 17 June 2026. The Royal Orthopaedic Hospital is monitoring the outcome of this process and related national guidance, including updates from the Human Tissue Authority, to ensure awareness of any future regulatory changes that may impact Trust activity.[3]

6 Conclusion

6.1 The Accountable Officer confirms that the Trust meets its legislative and Human Tissue Authority requirements through the appointment of a named Designated Individual and Person(s) Designated.

6.2 The Accountable Officer provides assurance on the safe and compliant management of human tissue by ensuring the following arrangements are in place:

- Maintenance of appropriate professional knowledge of HTA requirements through receipt of HTA updates and active engagement with the HTA on any Corrective and Preventative Actions.
- Assurance that standard operating procedures and risk assessments are in place, subject to regular review, and updated in response to changes in regulation, guidance, or practice.
- Oversight of staff training arrangements to ensure that required training is delivered and compliance is maintained in line with agreed key performance indicators.
- Assurance that any Serious Adverse Events or Serious Adverse Reactions are reported to the HTA within the required 24-hour timeframe and that full investigations are undertaken.
- Oversight of the identification, management, and closure of all CAPAs, ensuring that risks relating to human tissue activities are appropriately identified and mitigated.

[3] Regulation on standards of quality and safety for substances of human origin intended for human application (SoHO) | Human Tissue Authority

6.3 Through these arrangements, the Accountable Officer provides assurance to the Board that effective leadership, governance, and oversight are in place to support ongoing compliance with HTA requirements.

Nicola Brockie
Chief Nurse / Designated Individual
April 26

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Yearly Update from the Medicines Safety Officer 2025**
SPONSOR (EXECUTIVE DIRECTOR):	**Nicola Brockie, Chief Nursing Officer**
AUTHOR:	**Ruth Roadley-Battin, Medicines Safety Officer**
DATE OF MEETING:	**3rd June 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

This Report Summarises the activity of the Medicines Safety Group (MSG) under the direction of the MSO during 2025.
It provides positive reassurance for the handling of medicines related incidents, national patient safety alerts relating to medicines and MHRA medicines recalls throughout 2025.

Key points to note include:

- The successful collaboration with the acute pain short life working group (ACSLWP) to reduce modified release opiate use by 85-90% after the MHRA alert in March 2025.
- Improved Patient information on discharge through the creation of a suite of counselling resources (flashcards, videos) and patient information leaflets.
- Production of materials, and training for staff, to support the safe introduction of DOACs as part of the VTE prophylaxis protocol for primary arthroplasty patients.
- Ongoing Management of the Penicillamine patient safety alert through regional ICB collaboration.

The MSG have increased frequency of meetings to bimonthly to support timely response and learning from incidents.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
Excellent engagement and support from the Medicines Safety Group members to ensure learning from medicines related incidents and address national priorities.	Nil

REPORT RECOMMENDATION:

The Committee 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	x
Clinical	x	Equality and Diversity		Workforce	
Inequalities		Integrated Care		Continuous Improvement	x

Comments:

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

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

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

n/a

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

n/a

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

n/a

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

Quality & Safety Committee May 2026

Yearly Update from the Medicines Safety Officer

Report to Quality & Safety Committee: Jan 2025 - Dec 2025

1. Purpose of this Paper

The purpose of this paper is to give assurance that the Medicines Safety Officer at the Trust is fulfilling the role and provide that assurance to the Quality & Safety Committee. The paper is not designed to provide detailed analysis of Medicine Incidents in the Trust. This is provided to the Drugs & Therapeutic Committee via the Medicines Safety Group at each quarterly meeting and through Divisional Governance committees to Exec Governance committee.

2. Requirement for a Medicines Safety Officer (MSO)

The Medication Safety Officer role was created on 20th March 2014 following the publication of an NHS England Patient Safety Alert "Improving Medication Incidents and Reporting" - *https://www.england.nhs.uk/wp-content/uploads/2014/03/psa-med-error.pdf*

This aimed to help healthcare providers increase the quality and frequency of incident reporting for medication errors and medical devices. The alert called on large healthcare provider organisations across a range of healthcare sectors and the independent sector, along with healthcare commissioners, to identify named responsible persons in both medication and medical device safety roles.

The MSO at the Royal Orthopaedic Hospital is Ruth Roadley-Battin (Deputy Chief Pharmacist). Dr Raj Gowni (Consultant Anaesthetist and Vice Chair of the Drug and Therapeutics Committee) provides support to the role as the Medicines Management Consultant for the Royal Orthopaedic hospital.

3. Role of the MSO

A key role of the MSO continues to be the promotion of safe use of medicines across their organisation and provide expertise in this area. This is done at the Trust by:

- Being an active member of the National Medication Safety Network;
- Linking with the Governance Teams/Heads of Nursing for the Divisions in managing; and promoting medication incident reporting in the organisation, and improving the reporting and learning from incidents;
- Being a resource for staff for advice regarding medicines incidents;
- Vice Chair for Medication Safety Group (MSG) – which is a multi-professional committee to support the safe use of medicines in the Trust; The meeting is chaired by the Medicines Management link consultant for the Trust.

- Supporting the dissemination of medication safety communications from NHS England and the MHRA throughout the organisation;
- Ensuring that the Trust has presence at the West Midlands Regional Medicines Safety Officer Meetings and feeding back wider learning from the Region.

4. The Medicines Safety Group/Medicines Incidents

The Medicines Safety Group, chaired by Dr Gowni, is a multi -professional group that meets to review any trends in medicine related incidents in the Trust, ensure the learning from incidents is effective and discuss the Trust response to MHRA drug alerts.

All incidents with medicines are logged on ULYSSES and the system sends an automatic notification to the MSO in the Trust, along with other key individuals relevant to the incident. The MSO is sent monthly data from ULYSSES and in conjunction with the Division 1 Lead Pharmacist an incident tracker is used to identify any trends, any open incidents that require clarification and any near miss or no harm incidents that require action to avoid more serious harm occurring.

The MSO and/or a pharmacy representative joins the bi-weekly Divisional Governance Meetings where incidents of concern or those with attributable harm are discussed. A pharmacy representative comments within the incident managers form with any pharmacy specific actions that have been or need to be taken. If any concerns are identified, then these are fed back to the senior member of staff who is investigating the incident to review.

Incidents with no harm, near misses or trends in incident data are reviewed in detail at the Medicines Safety Group (MSG). This includes commissioning of thematic reviews where further investigation is required, ensuring incidents have been closed with appropriate actions and, wider learning has occurred.

Any exceptions identified are reported to the Drugs and Therapeutics Committee.

In addition, the MSO contributes to a general summary of incidents (of which medicines is one of the classes) that is presented within the Quality report to the Quality and Safety Committee by the Governance Manager.

Controlled Drug (CD) Incidents are reviewed at the Medicines Safety Group to ensure they are both closed and lessons are learnt within the Trust. Any trends or incidents of concern relating to CDs are discussed in detail at the Controlled Drug Accountable Officer (CDAO) assurance meeting.

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

There is also a yearly CDAO report submitted to the Quality and Safety Committee which has a detailed breakdown of the CD incidents in the year.

5. Regional Reporting and Learning from Medicines Related Patient Safety Events.

The ROH Chief Pharmacist (CP) chairs the ICS (Bsol) Medicines Safety Group. This group has representatives interested in medicines safety from primary and secondary care representatives. Attendees are invited according to topics presented at National MSO Network webinars to national webinars. The group attendance had been sporadic but since November 2024 the CP and MSO have been working to encourage reporting of incidents from across the system. The meeting attendance has been variable during 2025.

This year's meetings have covered topics aligned with national MSATS (Medication Safety Across the System) presentations, therefore reviewing insulin incidents and Incidents relating to palliative care across BSol.

The west midlands regional MSO group meets bimonthly to share learning from local incidents, discuss national webinars in relation to local practice and to agree regional workplan. The workplan for 2025 included reviewing clozapine safety across the system and a review of self-administration policies to support a reduction in missed or delayed doses of time critical medicines. The work is reported upwards to the regional Chief Pharmacists group.

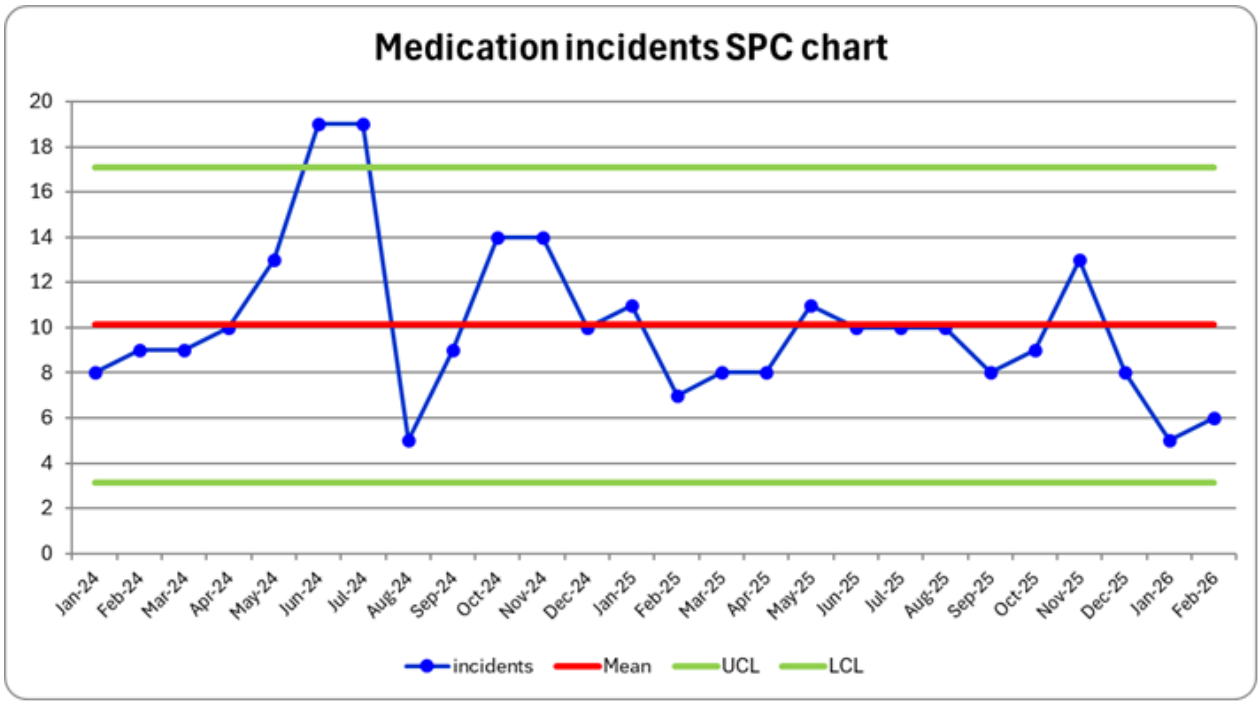
6. Analysis of ROH Medicines Incidents – Jan 25-Dec 25

The tables below show that 97% of medication incidents (not including controlled drugs) and 98% of controlled drug related incidents within the organisation are low or no harm. During 2025 the MSG reviewed the local incident tracker labelled with key words (for example insulin, pain, expired medicines) to allow the identification of trends in low or no harm incidents. In line with PSIRF methodology this allows the earlier identification of trends which may need a thematic review to avoid future incidents with attributable harm.

Medication CD incidents	2025												Total
Row Labels	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
1 - No Harm	7	3	7	5	9	3	7	7	6	6	11	4	75
2 - Low Harm	1	1	1	0	0	1	0	0	1	0	1	2	8
3 - Moderate Harm	0	0	0	0	0	0	0	0	0	0	0	0	0
4 - Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0
5 - Death	0	0	0	0	0	0	0	0	0	0	0	0	0
6 - Near Miss	0	0	0	0	1	0	0	0	0	0	0	0	1
Total	**8**	**4**	**8**	**5**	**10**	**4**	**7**	**7**	**7**	**6**	**12**	**6**	**84**

Medication incidents	2025												Total
Row Labels	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
1 - No Harm	7	6	5	8	9	7	9	8	5	8	10	5	87
2 - Low Harm	3	1	3	0	2	2	1	2	3	0	3	3	23
3 - Moderate Harm	0	0	0	0	0	0	0	0	0	0	0	0	0
4 - Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0	0
5 - Death	0	0	0	0	0	0	0	0	0	0	0	0	0
6 - Near Miss	1	0	0	0	0	1	0	0	0	1	0	0	3
Total	**11**	**7**	**8**	**8**	**11**	**10**	**10**	**10**	**8**	**9**	**13**	**8**	**113**

The number and type of incidents (shown below) reported throughout 2025 has been consistent with previous years.


Medication incidents SPC chart
20
18
16
14
12
10
8
6
4
2
0
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
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incidents
Mean
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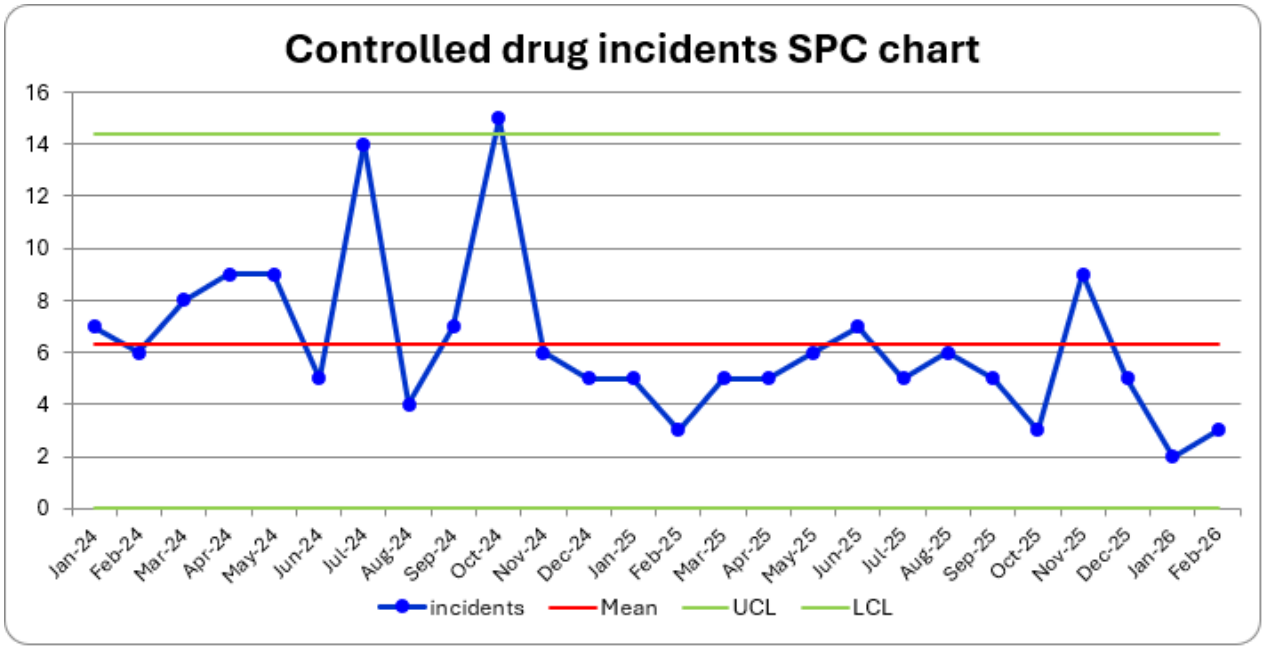
Controlled drug incidents SPC chart
16
14
12
10
8
6
4
2
0
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
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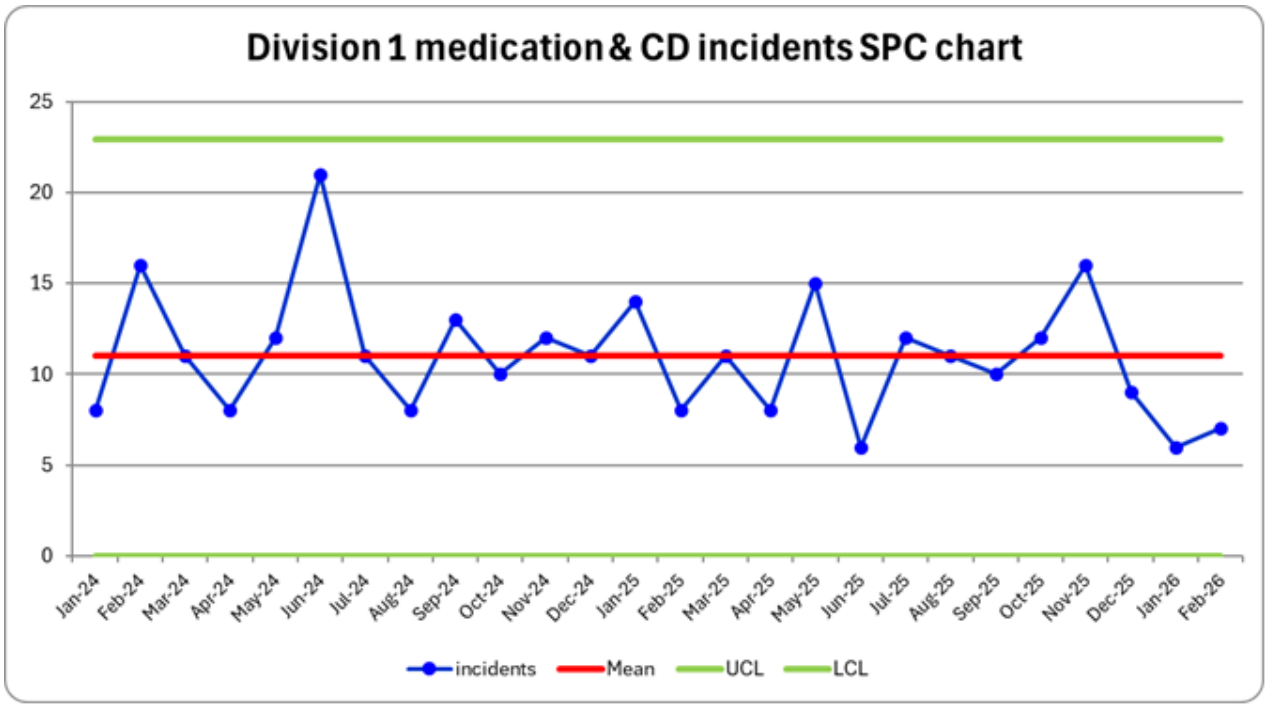
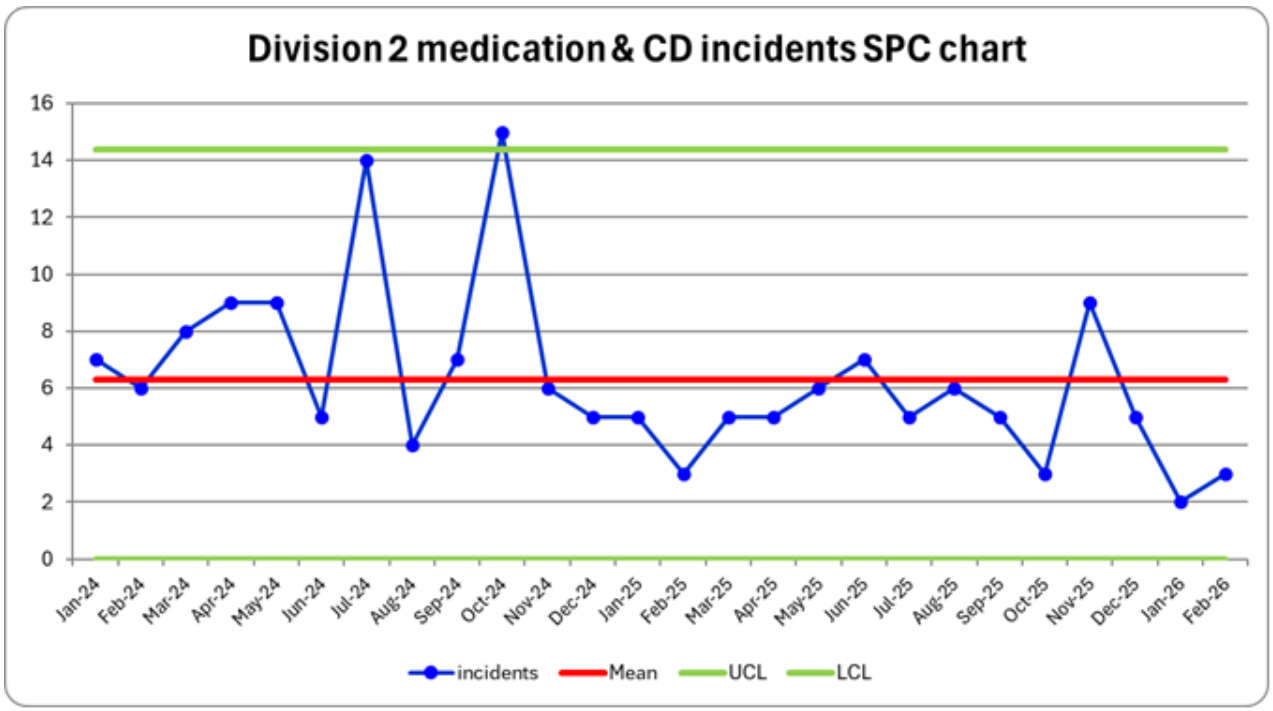




The incident reports for each division (shown above) have also remained consistent with previous years. There was an emerging trend towards a reduction in incidents in division 2

but normal variation resumed mid year. Incident reports have fallen for both divisions since December 2025 and this is being closely monitored through MSG with Matron review.

Incident Themes and actions undertaken 2025

Opioids, acute Pain Management and patient counselling

Following on from the incidents reported at the end of 2024 (49745, 49850, 49836 and 49692) and further incidents in January and February 2025 a thematic review was commissioned. The review highlighted the need for more effective patient communication and updated acute pain guidelines.

In March 2025 an MHRA alert was published, removing the license for use of prolonged release opiates in acute post-operative pain management. An acute pain short life working group was convened to oversee the actions from the earlier thematic review including Trustwide acute pain guideline update. This was overseen directly by the Trust Drugs and Therapeutics Committee . Actions taken included

- Producing an updated pain counselling leaflet (available on the Trust intranet),
- An interim update to the acute pain guideline was launched 4th June 2025
- Overview training offered to all clinical areas between May-October 2025.

The use of modified release morphine 10mg capsules and modified release oxycodone 10mg (a common starting dose) fell drastically by 90% and 85% respectively from March to May 2025- in line with the changes made to guidelines and sustained reduction has been seen. In addition oral oxycodone use has reduced by 40% since the position as second line strong opiate was reinforced with the interim guideline launch.

Ongoing actions will be reviewed and monitored through the acute pain group in 2026.

Patient Experience

Following feedback from the 2023 CQC inpatient survey the pharmacy team reviewed ways to improve patients understanding of their medication on discharge. Counselling flashcards and videos with QR codes were developed. These were trialled in arthroplasty patients over 2 weeks in February 2025. Patients received discharge counselling supported by custom-designed information cards and educational videos created by pharmacy staff. Pre- and post-intervention questionnaires were used to assess patient understanding and experience.

Pre-intervention, 53% of patients recalled discussing medications with pharmacy staff, and 16% reported not fully understanding their medications. The average experience rating was

3/5. Post-intervention, 94% found the counselling helpful, 76% found the information cards useful, and 24% preferred the combination of cards and videos. No patients preferred videos alone. Patient experience ratings improved to 4/5, with 16 out of 17 patients reporting the intervention as beneficial. Those aged 45-65 reported the most benefit from the intervention. Limitations included time constraint for pharmacy staff, lack of post-discharge follow-up and varying patient preferences. It was agreed to repeat the trial alongside pharmacy support to standardise counselling in the discharge lounge in November 2025. The follow up report is in progress.

The CQC inspection of children and young people services published in January 2026 noted access to this suite of resources as a positive contribution to helping patients understand there medication.

Allergy Recording and AMS Updates

Joint working with the antimicrobial stewardship team led to some communications with clinical teams in October 2025. The learning was shared with clinical teams:

- How to identify MRSA status prior to prescribing induction antibiotics (52418),
- Information to support the management of the rifampicin national shortage and
- An update on the importance of accurate allergy recording following a prevention of future deaths report at another Trust in the midlands.

Omnicell Update training

Incidents 51471, 51194, and 51741 related to CD's and management of discrepancies via the Omnicell. Update training on Omnicell use was offered to all areas.

Safe use of Direct oral anticoagulant agents

To support the introduction of apixaban as VTE prophylaxis in primary arthroplasty patients (guideline update in July 2025) an FAQ document was released in September 2025 and the change was publicised through QIDD and Clinical News articles.

The key concern was difference in timing of first dose post operatively. Pharmacy teams were briefed to ensure that the first dose was not prescribed for 12- 24 hours postoperatively (versus 6 hours for enoxaparin).

Broken Ampoules in Theatres

Incident 51840 highlighted 2 further broken ampoules for alfentanil. Investigation was limited as the vials had already been discarded however the narrative suggested an impact

had occurred on one side of the box. The report was added to our local broken ampoule tracker and will be kept under review.

In September 2025 following incident 52181 some additional packaging was procured for transporting ketamine vials to avoid breakages in transit.

Penicillamine Alert

Incident 53586 identified a patient incorrectly labelled as penicillamine allergic instead of penicillin. This was reported 1 day after the penicillamine patient safety alert. In conjunction with the alert response the MSO reviewed all digital systems where allergies to medications are recorded. Synopsis and PICS have updated the allergy recording sections to avoid input errors in line with the alert. Medication allergies should not be recorded in any other digital systems. 18 patients were identified as penicillin allergy but incorrectly reported as penicillamine in PICS. These were corrected. 33/46 patients identified with a record of penicillamine allergy were incorrect in some way and the allergy status not reflective of the primary care record. 12 patients were contacted where the information was missing or confusing. These records were updated but await a regional digital team response before the patients are rechecked and the alert is marked completed. Regional meeting planned for April 2026. Deadline for alert completion 20th November 2026.

7. The National Patient Safety Alerts (drug related) and Drug Safety Updates (MHRA)

National patient safety alerts are issued where it has been identified that systemic actions can be taken to prevent or reduce errors by healthcare staff. These alerts may come from different national bodies including DHSC and MHRA. The reports are issued via the Central Alerting System to all Trusts in the NHS and need to be acted on in the prescribed time. During 2025 there were 7 National Patient Safety Alert relevant to medicines. Of these 3 could apply to patients treated within the services of ROH or admitted with a co-existing condition affected by the alert (see Appendix 1).

In addition, the MHRA monthly Drug Safety Update is reviewed together with MHRA recalls of drugs at the MSG to assess if any issues are relevant to Royal Orthopaedic and if/what level of actions are appropriate. Updates and any actions taken can be found in Appendix 2.

From January to December 2025, the MHRA has issued 72 Medicines Notifications and class 2, 3, or 4 medicines recalls. The Royal Orthopaedic Hospital (ROH) pharmacy stocked drugs affected by 40 drug recalls. The pharmacy master spreadsheet for recalls is updated for assurance for each recall. The ROH pharmacy held affected stock relating to 2 alerts only. Sodium fusidate tablets 250mg, affected batches were found in the dispensary stock. These

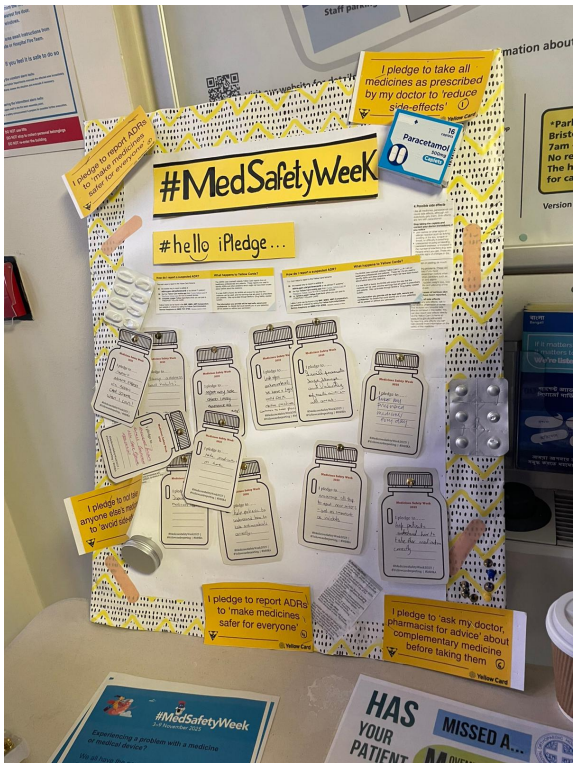
were quarantined and returned to the supplier, no stock had been issued to patients since December 2023. Secondly incorrect patient information in packages of hydroxychloroquine 200mg tablets was replaced with the correct Patient Information Leaflet (PIL).

8. Medicines Safety Week November 2025

The ninth annual Medicines Safety Week took place between the 3rd-9th November 2025.

This year's theme was a call to action to 'all help make medicines safer'. The pharmacy team ran an 'ask your pharmacist: you'll be getting good advice' stand alongside wellbeing week. Staff and patients were encouraged to ask questions about their medicines, prescribed or over the counter. The aim was to broaden the understanding of what the pharmacy team can offer for patients and staff alike.

Some enriching conversations were had and pledges made to use medicines safely. Due to the success of this initiative the team will be continuing to support wellbeing weeks in 2026, providing medicines advice to staff and patients.



9. Audits and Policy Updates

Assurance of medicines storage to MSG/MSO is provided though the Safe and Secure Handling of Medicines as well as CD audits that are carried out regularly throughout the calendar year across wards, theatres and all other clinical areas where medicines are stocked. The quarterly CD audits are discussed in the Controlled Drugs Accountable Officer (CDAO) group as well as the MSG. Despite the introduction of automation and electronic CD registers across most of the Trust there remain incidents involving controlled drug discrepancies within ward areas. These are largely due to user error rather than unaccounted for CDS. The implementation of a collaborative approach of bi-monthly pharmacist and matron ward visits in 2026 will support tackling medicines related issues at ward level and improve medicines culture on the ward.

- **Intervention audit**

The intervention audit was conducted between 15th-19th December 2025. There were a total number of 192 interventions by pharmacists and pharmacy technicians recorded during the intervention week. The highest recorded category for interventions was optimisation which included prescription related queries, dose queries and omissions of prescriptions. There were limited interventions on medication and TTO counselling. Medicines counselling ensures patients adhere to the regimen prescribed and therefore achieve the best health outcomes through safe/appropriate medicines use. The pharmacy team will be focusing on counselling with particular focus on pain before the next audit in 6 months time.

- **Fridge temperature monitoring audit**

The fridge audit was repeated to determine if the governance processes for acknowledging and actioning fridge alarms were adequate, and actions had been implemented to highlight an improvement in monitoring fridge temperature. This repeat audit demonstrates significant improvements in all three areas, though there is still room for further progress**.** The audit highlighted overall responsiveness to temperature alarms has significantly improved. The median time to act on alarms reduced sharply from 233 minutes to 22.5 minutes—a nearly 90% improvement. Theatres reached a median of 15 minutes, while non-theatre areas achieved 30 minutes. The percentage of alarms acknowledged within 15 minutes out-of-hours rose from 20.9% in 2023/2024 to 62% in 2025/2026. This improvement suggests more robust escalation protocols and greater after-hours coverage or alert responsiveness. A risk, number 2000 remains on the Divisional risk register to monitor compliance of the system. The audit is due to be repeated 6 monthly.

- **Medicines policies & Patient Group Directions**

Working together with the Drugs and Therapeutics committee (DTC) and MSG, several guidelines and policies related to medicines have been updated such as, The peri-operative anticoagulant guidelines, Acute Pain Interim Guidelines, and the guidelines for the perioperative management of medicines in surgical patients. In addition, several PGDs have been reviewed and approved as they had expired or were due to expire. Minor amendments were made to the medicines management policy and this is undergoing a review, to be updated in full during 2026/2027. The restrictive intervention policy was updated following multiple incidents. An easy-to-read quick reference guide was added for chemical interventions. The trustwide delirium guidance is currently being reviewed.

10. Examples of some Themes/Actions/Areas of Work for 2026 Identified by the Medicine Safety Group Following Review of Incidents

Themes identified from recent diabetes incidents relate to VRII management and patients on continuous infusion pumps. Dr Chamberlain, Consultant Physician, will be organising some ward teaching with pharmacy support.

Following a series of no harm administration errors, a 4 week programme of pharmacy support to ward areas is planned to commence with ward 3 in January 2026 and be rolled out to other areas throughout the year.

After discussion at MSG combined Matron and pharmacist medicines management ward visits are planned to commence in 2026 and feedback to MSG.

Incident trend data was reviewed in the June 2025 meeting. This highlighted that 73% of CD incidents remain open at 31 days. It was acknowledged that the *correct* investigation may take additional time, but it was agreed that stock discrepancy must be established within the first 48 hours. Data to be repeated in 2026.

Incident learning and feedback to be shared by the MSO with the ward doctors through their teaching forum commencing in 2026.

In addition, with the support of the MSG the MSO will ensure:

- Continuation of the Medicines Link role within each ward area as a focal point for nursing staff to raise medicines safety issues and ideas to prevent risk of harm.
- Continued awareness and publication of Medicines Safety Group Newsletter.

10. Key Areas of Development 2026

MSG meeting format – As the divisional governance meetings discuss all incidents with associated harm the MSG meeting frequency reduced to quarterly from November 2024 and

in order to focus on emerging themes in low or no harm incidents, any incidents that have remained open or have been closed without sufficient learning. Throughout 2025 the reduced meeting frequency was found to reduce the timeliness of response to any trends or themes in low/no harm incidents. Therefore, meeting frequency has reverted to bimonthly for 2026.

MSG will continue to provide effective oversight and offer constructive challenge where appropriate. MSG will continue to be responsible for actions relating to drug safety updates and national patient safety alerts (for medicines) and additional meetings or virtual consensus will be used where a more urgent Trust decision is required.

MSG remains a subgroup of the Drug and Therapeutics committee and as such a bimonthly MSO Upward report will be generated.

EPR system – The trust electronic patient record (EPR) system implementation will go live in 2027. The MSO and MSG will play an integral part of any implementation strategy throughout 2026. Their function will be to ensure robust governance for decisions relating to medicine use and the impact of changes in the system.

11. Summary

This paper illustrates the work undertaken by Medicines Safety Officer and the Medicines Safety Group in 2025. It provides assurance that all medicine related incidents are reviewed, and that themes are identified early with appropriate investigation and learning for all individuals and the organisation.

It is important that colleagues continue to be encouraged to report medication incidents in the Trust to ensure there is a positive safety culture in the organisation.

In 2026, the MSO and MSG will be focusing on targeted support to areas based on emerging incident themes, supporting the EPR project in relation to medicines safety and supporting continued improvement in acute pain management including education and training tailored to improving patient counselling.

As part of the West midlands MSO network, the MSO's will continue to work together in 2026 to ensure the Medicines Safety Improvement Programme ambitions are implemented across the new ICB footprint. This will specifically include 'improving care for patients on anticoagulant's and 'care for people with persistent pain by reducing opioid analgesic use'.

Concurrently, ongoing effective oversight through regular auditing will help achieve the CQC regulatory requirements for the safe and secure handling of medicines and improve outcomes for patients at ROH.

Report written by:

Ruth Roadley-Battin - Deputy Chief Pharmacist

Approved by: Sulthana Begum Chief Pharmacist

Appendix 1. National Patient Safety Alerts relating to Medicines

Alert Name	Date issued	Alert Reference Number	ROH NHS FT Comment
Discontinuation of Promixin (colistimethate) 1-million unit powder for nebuliser solution unit dose vials	17/03/2025	NatPSA/2025/001/DHSC	ROH does not initiate or manage patients with chronic pulmonary infections. Patients advised to liaise with their secondary care respiratory specialist if supplies are a concern.
Potential contamination of non-sterile alcohol-free skin cleansing wipes with Burkholderia spp: measures to reduce patient risk	26/06/2025	NatPSA/2025/002/UKHSA	
Shortage of bumetanide 1mg tablets	03/07/2025 *To be completed by 11/07/2025*	NatPSA/2025/003/DHSC	Minimal use at ROH. Individual patients managed without incident during the shortage

Shortage of Antimicrobial Agents Used in Tuberculosis (TB) Treatment	29/07/2025 *To be completed by 15/08/2025*	NatPSA/2025/004/MVA	A local consensus was agreed with our infectious disease colleagues across the region. Agreed to issue no new prescriptions of rifampicin for PJI and to review all patients currently receiving rifampicin. These short-term actions are intended to support national stewardship of rifampicin, prioritising its use for active tuberculosis infections. Still restricting to microbiology/Infectious disease approval only.
Harm from delayed administration of rasburicase for tumour lysis syndrome	09/09/2025 *To be completed by 09/03/2026*	NatPSA/2025/005/NHSPS	ROH do not initiate or manage patients for prophylaxis of acute hyperuricaemia in haematological Malignancies.
Harm from incorrect recording of a penicillin allergy as a penicillamine allergy	20/11/2025 *To be completed by 20/11/2026*	NatPSA/2025/006/NHSPS	Local Actions taken to update PICS and Synopsis in November 2025. PICS and Synopsis updated early December 2025 to avoid allergy mis selection. Awaiting system wide response to ensure all digital systems are accurate and up to date.
Supply of Licensed and Unlicensed Epidural Infusion Bags	02/12/2025 *To be completed by 20/11/2026*	NatPSA/2025/007/DHSC	The Trust procures an alternative brand and type of epidural bags and was therefore unaffected by the shortage.

Appendix 2 . MHRA Drug Safety Updates for 2025

Update Title	Date	MHRA ADVICE SUMMARY	ROH Comment/Actions

GLP-1 and dual GIP/GLP-1 receptor agonists: potential risk of pulmonary aspiration during general anaesthesia or deep sedation	28/01/2025	Healthcare professionals should be aware of the potential risk of pulmonary aspiration in patients using GLP-1 or dual GIP/GLP-1 receptor agonists who undergo surgery or procedures with general anaesthesia or deep sedation	Local discussion with Anaesthetic colleagues. Joint position re pre-operative planning agreed at DTC. Local pre-operative guidance updated.
Valproate (Belvo, Convulex, Depakote, Dyzantil, Epilim, Epilim Chrono or Chronosphere, Episenta, Epival, and Syonell▼): review by two specialists is required for initiating valproate but not for male patients already taking valproate	13/02/2025	Review by two specialists remains in place for patients initiating valproate under 55 years of age but the Commission on Human Medicines (CHM) has advised that it will not be required for men (or males) currently taking valproate. Three infographics have been developed to provide clarity regarding valproate prescribing.	Valproate is not initiated by clinicians at ROH.
Prolonged-release opioids: Removal of indication for relief of post-operative pain	12/03/2025	The indication for the treatment of post-operative pain has been removed from the licences of all prolonged release opioids due to the increased risk of persistent post-operative opioid use (PPOU) and opioid-induced ventilatory impairment (OIVI).	A short life working group was set up under the auspices of the DTC to plan the removal of prolonged release preparations from acute pain protocols post operatively. See update in main body.
Fezolinetant▼(Veoza): risk of liver injury; new recommendations to minimise risk	10/04/2025	Fezolinetant treatment is associated with a risk of drug induced liver injury. New recommendations have been introduced to minimise this risk. Liver function should be monitored before and during treatment in all patients taking fezolinetant. Fezolinetant should be avoided in patients with known liver disease or at a higher risk of liver disease.	This treatment is not initiated at ROH. Information shared with pharmacist colleagues in case of inpatient prescribing of pre-admission medication.
Short-acting beta 2 agonists (SABA) (salbutamol and terbutaline): reminder of the risks from overuse in asthma and to be aware of changes in the SABA prescribing guidelines	24/04/2025	Healthcare professionals and patients are reminded of the risk of severe asthma attacks and increased mortality associated with overuse of SABA with or without anti-inflammatory maintenance therapy in patients with asthma. Healthcare professionals should be aware of the change in guidance that no longer recommends prescribing SABA without an inhaled corticosteroid.	Discussion with ROH physicians and POAC prescribers. Patients admitted with salbutamol inhalers to be continued on treatment. Patients advised to discuss ongoing management with their primary care or respiratory secondary care provider. Local guideline update training provided to all pharmacy staff.
Kaftrio▼ (Ivacaftor, tezacaftor, elexacaftor): risk of psychological side effects	07/05/2025	Psychological side effects such as anxiety, low mood, sleep disturbance, poor concentration, and forgetfulness have been infrequently reported in people with cystic fibrosis treated with Kaftrio. Healthcare professionals should advise patients and their caregivers	This treatment is not initiated at ROH

		that, while the risk is small, they should be alert to changes in mood and behaviour and, if they occur, to seek medical advice as soon as possible.	
Thiopurines and intrahepatic cholestasis of pregnancy	15/05/2025	Intrahepatic cholestasis of pregnancy (ICP) has been rarely reported in patients treated with azathioprine products and is believed to be a risk applicable to all drugs in the thiopurine class (azathioprine, mercaptopurine and tioguanine). Cholestasis of pregnancy associated with thiopurines tends to occur earlier in pregnancy than non drug-induced cholestasis of pregnancy, and elevated bile acid levels may not reduce with ursodeoxycholic acid.	This cohort of patients are not managed by ROH. Noted at Medicines safety Group for information only.
Valproate (Belvo, Convulex, Depakote, Dyzantil, Epilim, Epilim Chrono or Chronosphere, Episenta, Epival, and Syonell▼): updated safety and educational materials to support patient discussion on reproductive risks	10/06/2025	Updated safety and educational materials are now available to support the implementation of the regulatory measures announced in the November 2023 National Patient Safety Alert and the September 2024 Drug Safety Update. They also include previous updates to product information on the risk of low birth weight in children exposed to valproate during pregnancy.	This cohort of patients are not managed by ROH. Updated information shared via medicines safety newsletter
Abrysvo▼ (Pfizer RSV vaccine) and Arexvy▼ (GSK RSV vaccine): be alert to a small risk of Guillain-Barré syndrome following vaccination in older adults	07/07/2025	There is a small increase in the risk of Guillain-Barré syndrome following vaccination with Abrysvo (Pfizer respiratory syncytial virus (RSV) vaccine) and Arexvy (GSK RSV vaccine) in adults aged 60 years and older. Healthcare professionals should advise all recipients of Abrysvo and Arexvy that they should be alert to signs and symptoms of Guillain-Barré syndrome and, if they occur, to seek immediate medical attention as it requires urgent treatment in hospital.	Vaccine not offered through this organisation
Paracetamol and pregnancy - reminder that taking paracetamol during pregnancy remains safe	23/09/2025	Patients should be reminded and reassured that there is no evidence that taking paracetamol during pregnancy causes autism in children. Paracetamol is recommended as the first-choice pain reliever for pregnant women, used at the lowest dose and for the shortest duration. It also acts as an antipyretic and is therefore used to treat fever.	Information shared with physicians, pharmacy teams and ward colleagues through medicines safety meetings to ensure accurate information dissemination through the organisation.
Isotretinoin – updates to prescribing guidance and survey of services	27/10/2025	The Commission on Human Medicines (CHM) has endorsed changes to isotretinoin prescribing guidance. In addition, CHM is	Noted at Medicines Safety Group for information only

		seeking further information from dermatology services who prescribe isotretinoin to inform any future changes to current risk minimisation measures.	
Mesalazine and idiopathic intracranial hypertension	04/12/2025	Idiopathic intracranial hypertension (IIH) has been very rarely reported in patients treated with mesalazine. Following a recent review, warnings for IIH are being added to the product information for all mesalazine products.	Noted at Medicines Safety Group for information only
Rybelsus ® (semaglutide tablets): transition to new formulation and risk of medication error	17/12/2025	There is a risk of patient harm arising through medication error during a transition period where the original and new formulation of Rybelsus ® tablets, which have different stated mg doses but are bioequivalent, will both be available on the market.	There is a risk of dosing error during the transition period. Pharmacy teams made aware of dosing and bioavailability changes. PICS request made to ensure updated entry for prescribing available within EPMA- still awaited.
IXCHIQ Chikungunya vaccine: temporary suspension in people aged 65 years or older	18/06/2025 Updated 11/02/2026	The Commission on Human Medicines (CHM) has temporarily restricted use of the IXCHIQ Chikungunya vaccine in people aged 65 years and over following very rare fatal reactions reported globally. This is a precautionary measure while the MHRA conducts a safety review. The IXCHIQ vaccine will be available on the UK market from 18 June 2025.	Vaccine not offered through this organisation

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Health & Safety Annual Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Simon Grainger-Lloyd, Director of Governance**
AUTHOR:	**Sophie Goddard, Health and Safety Advisor (Non-Clinical Risk)**
PRESENTED BY:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**3rd June 2026**

PURPOSE OF THE REPORT:

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

EXECUTIVE SUMMARY:

Please find enclosed the Annual Report on Health & Safety for 2025/26.

The report covers the key matters of note from a Health & Safety perspective during the year and also details work of the Health & Safety Group, the key body overseeing compliance with H&S guidance.

The content will be included within the overall Trust Annual Report for 2025/26.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Improvements in (non-mandatory) health and safety training provision. • Continued improvements to oversight by H&SG. • Compliance with HSE Enforcement Notice following inspection. • Improvements to RIDDOR reporting process.	• Work to do to complete develop and implement proactive health and safety audits • Gaps to be addressed in respect of 'suitable and sufficient' risk assessments – legal requirement of Management of Health and Safety at Work Regs 1999, and would form basis of safe systems of work, method statements or procedures. Require ownership at departmental level.

REPORT RECOMMENDATION:

The Committee is asked to RECEIVE and ACCEPT the report for assurance

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

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

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

Care	X	Community	
Expertise	X	Services	
People	X	Collaboration	

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

National Workplace Health & Safety Standards

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

ICB Objectives: • Protect people from harm

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

Not applicable

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

Quality & Safety Committee May 2026

ANNUAL REPORT ON HEALTH & SAFETY FOR 2025/26

1.0 Occupational Health and Health and Safety Performance

In June 2025 Inspectors from the HSE (Health and Safety Executive) visited ROH for a planned two topic inspection; 'Safer Sharps and Dermatitis'. The inspection took place over two days; inspectors met with colleagues from various departments at the Trust and observed practices across facilities, logistics, theatres, and inpatient wards. They also met with the Trusts' Occupational Health provider at University Hospitals Birmingham, and the procurement team as part of the scope of the inspection.

As a result of the inspection, The Trust was issued with written advice, outlining improvement recommendations in several areas across management of safer sharps, and work-related dermatitis. One improvement notice was also issued, which identified a *'failure to ensure that management had carried out a suitable investigation following an injury from a sharp medical device'.*

Work was undertaken to meet the improvement recommendations both in the written advice note and the improvement notice, with an action plan developed for longer term improvement initiatives. The outcome was that ROH successfully complied with the improvement notice, as per confirmation received from the lead inspector on 4th September 2025.

2.0 Health and Safety Audit and Assurance

The planned re-launch of an annual Health and Safety Audit programme over 2025/2026 was delayed due to other priorities (including immediate actions from the HSE Inspection). However, an audit template has been developed and is planned to be rolled out across FY 2026/2027.

The audit will aim to provide enhanced assurance around compliance with the health and safety policies and procedures across departments. Actions will be locally owned and managed by department leads and their teams, with advice and guidance from the Trust's health and safety advisor and other specialists, where appropriate. The results of the audits will be presented and discussed at quarterly health and safety group meetings.

3.0 Policies and Procedures

A suite of Trust policies and procedures are in place and meet the guidance published in the NHS Staff Council (Health, Safety and Wellbeing Group's) Workplace Standards.

The Trust's Health and Safety Policy is under review, due for consideration at the Health and Safety Group in May 2026.

Reviews and updates have been undertaken for the following policies, through the Health and Safety Group:

- Sharps and Splash Injury
- Contractors (Control and Management)
- Fire Safety Policy
- Smoke Free Policy

To enhance the assurances around policy compliance in 2026/27 a rolling programme of reports will be scheduled into the workplan of the Group, including, but limited to: fire safety, ventilation, water safety, gas safety, lone working, asbestos management and working at heights/confined spaces. From these reports, upward assurance will be reported to the relevant Board committees around the ROH's compliance with its legal and statutory duties in respect of Health & Safety legislation, particularly those associated with estates matters. Any gaps in compliance identified will require the creation of a remedial action plan that will be monitored through the Health & Safety Group and Trust Management Group.

4.0 Central Alerting System (CAS) Alerts

The ROH is a recipient of patient safety alerts issued via the Central Alerting System (CAS). The Trust has a robust governance structure for the management of patient safety alerts. The Trust's Health and Safety Adviser acts as the Central Alerting System Liaison Officer (CASLO). The CASLO is responsible for monitoring the CAS system and the dissemination of CAS alerts to the Medical Device Safety Officer for review. The MDSO will nominate a subject matter expert for each alert who is responsible for undertaking any 'actions required'.

The CAS system is continuously updated evidencing the progress for each alert until all actions required have been completed. Only then will the MDSO give authority to close each alert. Patient Safety Alerts are overseen by the Executive team. During the 2025/26 reporting period, the Trust received a total of 12 no. patient safety alerts; all of these met the timeframe for completion, with exception of one (NatPSA/2025/003/DHSC) which was completed 2 days past the deadline – note this alert had a short response deadline.

One alert previously received in 2023 was closed after the deadline - NatPSA/2023/010/MHRA (Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls). This alert was closed out on 24 Sept 2025.

5.0 CAS Alerts 2025/26

Reference	Alert Title	Issued	Response	Deadline
NatPSA/2026/002/MHRA	Recall of Quetiapine Oral Suspension (unlicensed medicine), manufactured by Eaststone Limited due to a potential for overdosing	29 Jan 26	Assessed – not relevant to organisations services	05 Feb 26
NatPSA/2026/001/DHSC	Steriflex No. 109 (1L) and No. 171 (2L): Potassium Chloride 0.15%, Sodium Chloride 0.45%, Glucose 2.5% Bags	14 Jan 26	Assessed – not relevant to organisations services	06 Feb 26
NatPSA/2025/008/NHSPS	Risk associated with adult breathing circuits lacking a patient exhalation route	11 Dec 25	Assessed – relevant to organisations services ***(Alert open)***	12 Jun 26
NatPSA/2025/007/DHSC	Supply of Licensed and Unlicensed Epidural Infusion Bags	02 Dec 25	Actions complete	12 Dec 25

Reference	Alert Title	Issued	Response	Deadline
NatPSA/2025/006/NHSPS	Harm from incorrect recording of a penicillin allergy as a penicillamine allergy	20 Nov 25	Assessed – relevant to organisations services ***(Alert open)***	20 Nov 26
CEM/CMO/2025/002	Influenza season 2025/26: early season activity and implications for clinical practice	05 Nov 25	(No response required)	N/A
NatPSA/2025/005/NHSPS	Harm from delayed administration of rasburicase for tumour lysis syndrome	09 Sept 25	Assessed – not relevant to organisations services	09 Mar 26
NatPSA/2025/004/MVA	Shortage of Antimicrobial Agents Used in Tuberculosis (TB) Treatment	29 Jul 25	Actions complete	15 Aug 25
NatPSA/2025/003/DHSC	Shortage of bumetanide 1mg tablets	03 Jul 25	Actions complete	11 Jul 25
NatPSA/2025/002/UKHSA	Potential contamination of non-sterile alcohol-free skin cleansing wipes with Burkholderia spp: measures to reduce patient risk	26 Jun 26	Assessed – not relevant to organisations services	29 Aug 25
CEM/CMO/2025/001	Influenza season 2024/25: ending the prescribing and supply of antiviral medicines in primary care	15 May 25	(No response required)	N/A
NatPSA/2025/001/DHSC	Discontinuation of Promixin (colistimethate) 1-million unit powder for nebuliser solution unit dose vials	17 Mar 25	Assessed – not relevant to organisations services	30 Apr 25

6.0 Number of Accidents by Category. 1 Apr 2025 - 31 Mar 2026 (Employees/Visitors/Contractors)

Accident data is reported via the Trusts' online incident reporting system, Ulysses. Trends are monitored to assess health and safety performance and to advise on any specific risk patterns. Accident figures (by total numbers reported, and by category type) are broadly comparable with previous years.

From April 2025 incident numbers relating to violence, aggression (including verbal abuse or harassment) have been reported and reviewed in more detail in the quarterly Health and Safety Group meetings. These have also been included below.

This category typically accounts for the largest volume of incidents reported (and can relate to incidents against either staff, visitors or patients – however the majority relate to 'verbal abuse' against ROH staff). Although incidents of this nature reported at ROH very rarely result in physical violence or injury, it is acknowledged that they can have a profound impact on staff wellbeing and psychological safety. As part of the Trusts' Violence Prevention and Reduction Strategy, a board level Action Plan has been developed to help further reduce the risks associated with workplace aggression and abuse.

Accident Category	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
Manual Handling Injuries	1	1	3	2	0	0	1	0	0	1	1	0
Burns / Scalds	1	0	0	0	1	0	0	1	0	0	0	0
Contact with hazardous substances (COSHH)	0	0	0	1	0	0	0	0	0	0	0	1
Road traffic accident/ incident	0	0	0	0	0	0	0	0	0	0	0	0
Sharps injuries	0	1	1	1	3	2	1	4	3	1	1	1
Slips, trips, and falls (staff, visitors & contractors)*	1	2	0	0	1	0	3	1	2	3	1	0
Impact Injury (with static or moving object)	3	3	0	1	2	3	3	4	1	3	1	2
Electric shock	0	0	0	0	0	0	0	0	0	1	0	0
Violence and aggression (incl. verbal	5	4	9	5	3	6	8	4	7	9	3	5
Total figure for each month	= 11	= 11	= 13	= 10	= 10	= 11	= 16	= 14	= 13	= 18	= 7	= 9

*****Excluding falls directly related to medical conditions, limited or poor mobility because of clinical factors, where other causes such as defects in premises have not been a contributing factor.*

7.0 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

It is a statutory legal requirement to report specified injuries, diseases, deaths, and dangerous occurrences to the HSE. During the reporting period eight (8 no.) RIDDOR reportable incidents were submitted:

8.0 RIDDOR Reporting 2025/26

Date of Incident	Summary of incident	Date RIDDOR Report submitted to HSE / Ref
13 April 2024	A shoulder gallows (prop frame) that is attached to the operating table for the surgical procedure detached from the table and hit the head of a member of staff. GP sign off received. Total of 15 days off work *(Head injury - 'Injury preventing the injured person from working for more than 7 days')*	12 May 2025 / 154CCC6B61 (delayed submission – internal system gaps linking days lost to accidents)
6 May 2025	Staff sorting clean linen for distribution, in the linen room. As they turned, hit their head against the side of a metal cage. Referred to hospital for assessment and signed off work by GP. *(Head injury - 'Injury preventing the injured person from working for more than 7 days')*	21 May 2025 / 8A14A17013
13 May 2025	Staff member was tucking a bed sheet under a mattress (EPB), and a second staff member used the bed controls to raise the bed. This resulted in the first staff members hand being trapped between the bed rail and the bed frame. Injured staff member off work due to swelling and bruising /pain in hand (no fracture). GP sign off received. *(Hand injury - 'Injury preventing the injured person from working for more than 7 days')*	28 May 2025 / DE151F714B
9 April 2025	Clinician removing a chest drain from a patient, drain was leaking fluid slightly. Noted a history of positive testing for a BBV. Clinician contacted OH service for self-referral, in case potential exposure had occurred. All post inoculation assessments have been completed by OH and no concerns (no contraction of BBV). *(Release or escape of biological agents – Dangerous Occurrence)*	2 Sept 2025 / 148140DFF1 (delayed submission –Flagged up by HSE inspector)
7 Oct 2025	As walking through one of the Theatre storerooms to retrieve equipment, the staff member caught their foot on the wheel of a portable x ray machine which was stored in the room. Sustained a fracture injury in the fall. *(Injury: Specified Injury fracture, lower limb)*	15 Oct 2025 / F2C5F81711
22 Oct 2025	The lead aprons were stored in storeroom corner, behind a door adjoining Theatre 1. An employee entered to retrieve a gown and was putting this on behind the door. Another employee pushed the door open, the door handle struck the 1st employee on the right side of the head and shoulder. GP sign off received. *(Injury: >7 day incapacitation)*	05 Nov 2025 / 16E15F92BE
3 Jan 2026	Staff member was cleaning in hydrotherapy (pool) department. They fell on the small flight of steps (could not recall if stumble, slip or trip). Landed on their back on the steps, resulting in bruising and pain (soft tissue injury). GP sign off received. *(Back injury – injury preventing the injured person from working for more than 7 days')*	14 Jan 2026 / AA16A9C161
17 Jan 2026	The Ward staff member went to pull a side table out from over a bed, to lower the bed rail. The rail had not been properly locked in place, and fell on her hand which was resting on the side of the bed to steady it. Resulted in a trapping injury to thumb / hand. GP sign off received. *(Hand Injury - injury preventing the injured person from working for more than 7 days')*	28 Jan 2026 / 10F9610F11

9.0 Staff Training

9.1 Core Mandatory Training Compliance (H&S/Fire)

Staff attendance figures for Health, Safety and Welfare at Work mandatory training have remained consistently high above 90% across the year, with the end of year completion rate at 94.66%. Staff may either attend a face-to-face session, or complete E-learning for this training.

Compliance figures for fire training have improved since the previous year – where they were around 80% on average. Overall compliance for ’25 – ’26 reached 90.63%. E-learning is also available for this module to help with accessibility for staff. Learning and Development team have worked with Estates team (who oversee fire management) to help achieve the target of at least 90% compliance. Fire safety compliance has now reduced from annual to once every 2 years, in line with the ongoing NHS Statutory and Mandatory training review.

9.2 Additional Training

For the reporting period 1 Apr 2025 -31 Mar 2026, the following in-house H&S training sessions were delivered by the H&S Advisor:

- 11 no. Mandatory training sessions: Apr, May, Jun, July, Aug, Sept, Oct, Nov, Dec (2025) and Jan, Feb (2026.)
- 2 no. HCA (Care Certificate) training sessions: 13 Jan ’26 and 10 Mar ‘26.
- 4 no. COSHH training sessions: 13 Nov ’25 (COSHH awareness and assessor courses – Estates). 25 Feb ’26 (COSHH awareness – Facilities).

One of the key objectives for 2025 / 2026 was to review and enhance the in-house training offering to staff. The first step in this process has been development of a one day ‘*Health and Safety for Managers*’ module (in person, classroom delivery) as part of the new ‘Me as a Manager’ training programme launched at the Trust.

In total, 4 no. Health and Safety for Managers sessions have been held – 23 Apr ’25, 1 July ’25, 29 Sept ’25 and 12 Jan ’26, with delegates from across the Trust including clinical, facilities and central functions.

10 Recommendation

The Trust Management Group is asked to receive the report for assurance, noting particularly the plans to strengthen the processes around Health & Safety policies compliance

Simon Grainger-Lloyd
Executive Director of Governance

May 2026

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Quality & Safety Committee annual report 2025/26**
SPONSOR:	**Dr Ian Reckless, Chair of Quality & Safety Committee**
AUTHOR:	**Simon Grainger-Lloyd, Director of Governance**
DATE OF MEETING:	**3 June 2026**

EXECUTIVE SUMMARY:

Attached is the annual report from the Quality & Safety Committee.

The report outlines the Committee's key areas of focus during the year, the coverage of its workplan and the plans for future developing the operation of the Committee over the next period.

REPORT RECOMMENDATION:

The Trust Board is asked to receive and note the contents of this report and assurances within that the Committee is operating in line with its terms of reference and workplan.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
x		

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	**x**	Equality and Diversity		Workforce	

Comments: [*elaborate on the impact suggested above*]

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

Good governance

PREVIOUS CONSIDERATION:

Quality & Safety Committee on 27 May 2026,

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ANNUAL REPORT 2025/26

1.0 Introduction

1.1 The purpose of the report is to formally report to the Board of Directors on the work of the Quality & Safety Committee during 2025/26 and update the Board on the plans for its work in 2026/27.

1.2 The Quality & Safety Committee reviewed its Terms of Reference in during the year and will revisit them again in summer 2026. These will be presented for approval by the Board of Directors subsequent to this. The changes are largely cosmetic but reflect some changes in titles and names of national bodies. The changes also reflect some amendment to the list of groups reporting up to the Quality & Safety Committee.

1.3 During the year, the Chair of the Quality & Safety Committee was undertaken by Dr Ian Reckless. Gianjeet Hunjan is also a member of the Committee creating a close link with the work of the Audit Committee. Jenny Belza, a Non Executive with a clinical background, who started with the Trust from 1 February 2024, is also part of the membership of the Quality & Safety Committee.

2.0 Meetings

2.1 During 2025/26 the Quality & Safety Committee met on six occasions, alternating between virtual and face to face meetings.

2.2 The attendance at these meetings is shown overleaf.

MEMBER	MEETING DATE						TOTAL
	21/05/2025	30/07/2025	24/09/202	26/11/2025	28/01/2026	25/03/2026	
Ian Reckless (Ch)	✓	✓	✓	✓	✓	✓	**6/6**
Gianjeet Hunjan	✓	✓	✓	✓	✓	✓	**6/6**
Jenny Belza	✓	✓	✓	✓	✓	✓	**6/6**
Matthew Hartland	A	A	A	✓	✓	A	**2/6**
Nikki Brockie	✓	✓	✓	✓	✓	✓	**6/6**
Matthew Revell	✓	✓	✓	✓	✓	✓	**6/6**

MEMBER	MEETING DATE						TOTAL
	21/05/2025	30/07/2025	24/09/202	26/11/2025	28/01/2026	25/03/2026	
Marie Peplow	A	✓	✓	A	✓	✓	**4/6**
Simon Grainger-Lloyd	A	✓	✓	✓	✓	A	**4/6**

KEY:

✓	Attended	A	Apologies tendered
	Not in post/not required		

2.3 The Secretariat to the Committee alternates between members of the Executive Assistant Secretariat.

2.4 The Quality & Safety Committee's minutes are submitted to the Board of Directors for consideration as part of the private Board sessions, supported by a full assurance report in public, detailing the key points of discussions, risks noted & matters to escalate and decisions taken by the Committee.

3.0 Work undertaken 2025/26

The Committee dealt with the following key matters:

Routine Work

The Committee received upward reports from the Trust's Clinical and Corporate Governance groups, namely:

- Quality & Safety Executive
- The Audit, Quality Improvement, Learning & Assurance panel (AQILA)
- Cancer Board
- Infection Control Committee
- Safeguarding Committee
- Patient Experience & Engagement Group
- Health & Safety Group
- Human Tissue Authority Advisory Group
- Research & Development Group

In year, the Committee continued to receive the upwards reports using the standard assurance template used by the Board Committees who report upwardly to the Trust Board.

The Committee during the year, has also received routine reports on:

- Quality & Patient Safety performance
- Litigation and claims
- Progress with Quality Priorities
- Patient Reported Outcome Measures (PROMS) and the National Joint Register (NJR)
- Medicines management, including antimicrobial stewardship and controlled drugs
- Learning from Deaths
- Nurse staffing
- 'Flu vaccination
- Compliance with the IPC Board Assurance Framework
- Patient Experience
- Quality & Safety risks on the corporate risk register
- Health & safety performance and statutory compliance updates

The following annual reports were received, in accordance with the Committee's routine cycle of business:

- Medicines Safety Officer
- Complaints
- Safeguarding
- Vulnerabilities
- Accountable Officer for Controlled Drugs
- Infection Prevention & Control
- Fire safety
- Radiation Safety
- Human Tissue Authority annual report
- Patient Safety Incident Response Framework (PSIRF)

Single issue or non-routine reports

During the year, the Committee requested additional assurance on a number of matters and received some specific reports on key issues or single-issue updates, these being:

- Declared Never Events and associated Patient Safety Incident Investigations (PSIIs), including a thematic review into Never Events
- Spinal Services and Endoscopic Spinal Surgery reviews and assurance updates

- Learning Disability and Autism Action Plan & Learning Disability Standards
- Health and Safety Executive (HSE) inspection findings and action plans
- Coroners' inquest outcomes and learning
- Martha's Rule implementation update
- WHO surgical safety auditing project updates
- Theatre Safety Improvement Plan
- Patient Information Group Improvement project

4.0 2026/27 Work Plan

4.1 For 2026/27, the Quality & Safety Committee will continue with its routine work as well dealing with ad hoc requirements that will emerge from time to time or remitted from the Board and/or Audit Committee.

4.2 The revised workplan was presented to the Quality & Safety Committee for its approval in November 2025 which is not likely to change significantly for the coming year.

4.3 There will remain a focus on improving the effectiveness of the Committee during 2026/27, with particular focus on seeking appropriate assurance on matters within its remit and understanding how lessons learned from incidents, complaints, litigation and clinical audit are disseminated & acted upon and the linkages to the Trust's Quality Improvement work.

5.0 Quality & Safety Committee Effectiveness

5.1 An item is included on the agenda of each meeting to review the effectiveness of the meeting and of the Committee in general.

5.2 Following the effectiveness review that was undertaken by the committee in 2023, the Committee has received regular updates on progress with these actions during the year with the final action completed with the reshaped Quality & Patient Safety report that is now presented at each meeting. An evolution of this for 2026/27 will be development and acceptance of the Integrated Performance Report (IPR) which will contain performance against the key domains of finance, operations, workforce, as well as quality metrics.

6.0 Conclusion

6.1 The Quality & Safety Committee has functioned well during 2025/26 and is operating effectively, providing clear and adequate assurance upwards to the Trust Board across a comprehensive range of matters of a quality & patient safety nature.

Ian Reckless
Chair of the Quality & Safety Committee

June 2026

The Royal Orthopaedic Hospital NHS Foundation Trust

UPWARD REPORT FROM AUDIT COMMITTEE

Date Group or Board met: 1st May 2026

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- **EPR accounting treatment**: £13m classified as an intangible asset under construction continues to be an area of external audit focus pending final national guidance and audit conclusion.
- **UHB service level agreements**: Ongoing work to improve clarity and timelines across several SLAs (notably pathology and plastics) create financial, operational and governance risk.
- **Cyber / information governance**: Further work is underway to strengthen third party risk management and formalise recovery testing processes.
- **Controlled drugs governance**: Localised opportunities for strengthening controls identified in witnessing and documentation of drug destruction and Omnicell approval controls, particularly in theatres.
- **Corporate risk register maturity**: Some legacy corporate risks lack clear ownership, review cycles and articulation compared to stronger clinical risk management.
- **Counter-fraud case timescales**: A live counter fraud case is progressing through the legal process. Timescales are extended, and organisational learning will be captured at the appropriate stage.

MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY

- **EPR assurance**: Continued close working between Finance, External Audit and Audit Committee Chair to conclude treatment early and escalate immediately if assumptions change.
- **UHB contracting review**: Commissioned a consolidated schedule of all UHB SLAs, including status, risk exposure and escalation routes.
- **Cyber improvements**: Introduction of structured, documented backup restoration testing and continued monitoring through the Information Governance Group.
- **Controlled drugs actions**: Strengthening Omnicell approval processes, embedding drug destruction checks in routine audits and analysing witnessing compliance.
- **Risk register refresh**: Support is being provided to corporate teams to refresh legacy risks and strengthen ownership and review processes.
- **Data quality**: BI-led reconciliation of PAS and theatre data; enhanced reporting of cancellations including financial impact.
- **Internal audit planning**: Risk prioritisation exercise underway for 2026/27, with explicit Non-Executive input ahead of finalisation.

POSITIVE ASSURANCES TO PROVIDE

- **Financial position**: Draft accounts submitted on time; year-end surplus delivered and liquidity strengthened.
- **Audit outcomes**: Internal audit programme for 2025/26 complete with an anticipated strong overall assurance level.
- **Controlled drugs**: Core systems and controls remain robust, with issues identified being localised and addressable.
- **Cyber and DSP Toolkit**: Continued year-on-year improvement, with the majority of standards met.
- **Data quality**: Board receives complete and reliable activity and cancellation data; additional reconciliations represent enhancement rather than correction.

DECISIONS MADE

- **EPR accounting basis**: Proceed on intangible asset under construction treatment, subject to final external audit agreement.
- **Information governance**: Approval of revised Information Governance Group terms of reference with strengthened senior oversight.
- **Risk appetite**: Board-approved cyber risk appetite confirmed; wider organisational risk appetite workshop to be scheduled.
- **Internal audit plan**: Agreement to circulate draft 2026/27 audit themes for Non-Executive comment prior to executive sign-off.
- **Controlled drugs oversight**: Expansion of routine audit scope to include destruction and theatre-specific controls.

• **Governance and culture**: Provider capability assessment rated green; evidence of constructive challenge and improving risk maturity.	• **Counter-fraud approach**: Maintain low-profile handling of live cases; organisational learning to be considered post-conclusion.

Chair's comments on the effectiveness of the meeting: The Chair reflected that the meeting was effective and well-managed, with a strong level of constructive challenge and engagement from both Executive and Non-Executive members.

Integrated Performance Report

Month 1

April 2026

The Integrated 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.

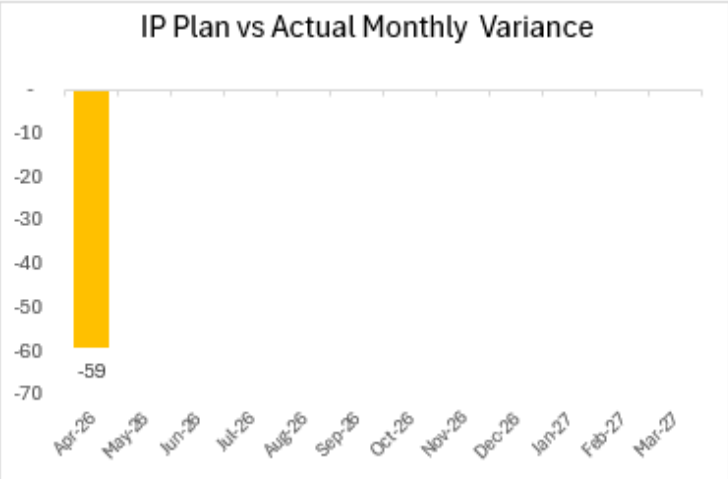
Assurance icons are also tied in with SPC rules; if the control range sits above or below the target then F or P will show depending on whether or not that is meeting the target, since we can expect 99% of our points to fall within that range. For KPIs not applicable to SPC we look at the last 3 months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

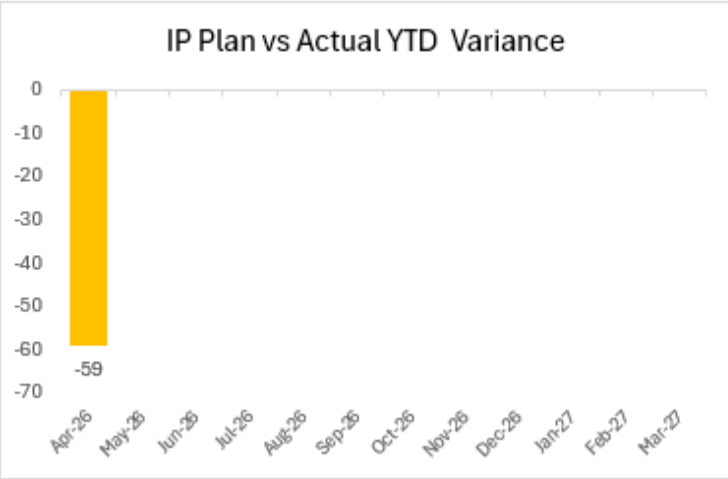
Assurance Reports: Operational Performance Summary

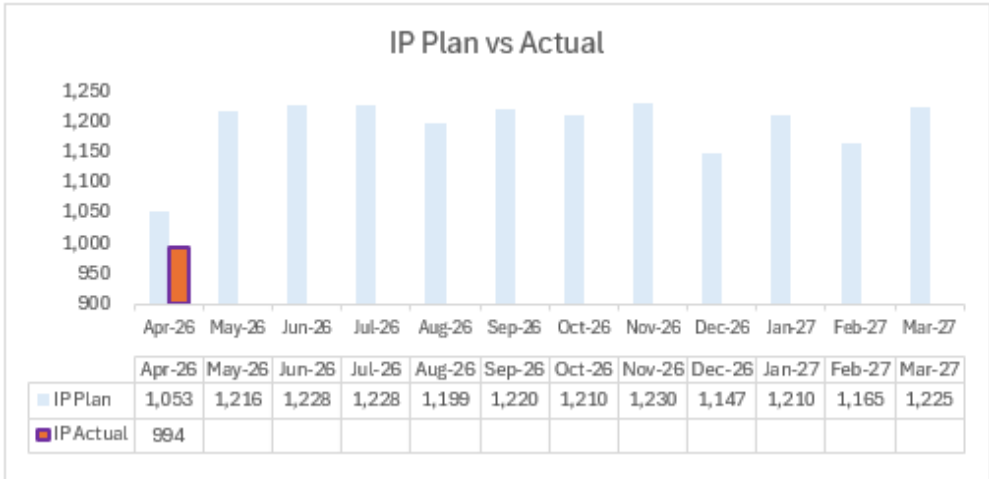
Metric	In Month	Previous Month	Target	Variation	Assurance
RTT Combined (against trajectory constitutional target remains 92%)	65.64%	65.50%	64.84%	H	P
RTT Waiting 65 Weeks and over	0	0	0	L	P
RTT Waiting 52 Weeks and over	110	96	119	L	P
RTT Proportion of Patients Waiting 52 weeks and over	0.87%	0.77%	0.91%	L	P
RTT First Appointment Waiting List	76.25%	74.75%	69.47%	H	P
RTT Waiting List Size	12,608	12,517	13,096	L	P
Diagnostics volume YTD (compared to plan) - CT, MRI and Ultrasound	2,111	NA	2,153		F
Diagnostic 6 week target	99.7%	99.3%	95%	H	P
Theatre Session Utilisation	94.24%	92.34%	85%	H	P
Theatre Insession Utilisation (Capped)	81.21%	80.94%	85%	L	F
Bed Occupancy (excluding CYP and HDU)	75.77%	77.00%	82-85%	L	F
LOS - Excluding Oncology, Paeds,YAH, Spinal	3.71	3.53	n/a		-

Metric	In Month	Previous Month	Target	Variation	Assurance
All Activity YTD (compared to plan)	994	NA	1,053		F
Outpatient activity YTD (compared to plan)	5,420	NA	6,022		F
Outpatient Did Not Attend (YTD)	7.63%	7.01%	8.00%	H	P
PIFU	642 12.47%	618 9.98%	655 10.88%	H	P
Virtual Consultations (target is to plan, operational planning guidance is 25%)	13.42%	10.09%	n/a	-	-
Cancer - 31 day first treatment	100.0%	100.0%	96%	H	P
Cancer - 62 day (traditional)	70.0%	71.4%	75% National 85% Trust		F
28 days FDS	72.8%	76.3%	77%		F
Patients over 104 days (62 day standard)	0	0	0	L	P
POAC activity volumne (YTD) (target set is average monthly 19/20 activity)	1,740	NA	1,765 YTD Target		F
LOS - elective primary hip	3.32	2.82	2.70		F
LOS - elective primary knee	3.37	3.29	2.70		F

Assurance Reports: Inpatients

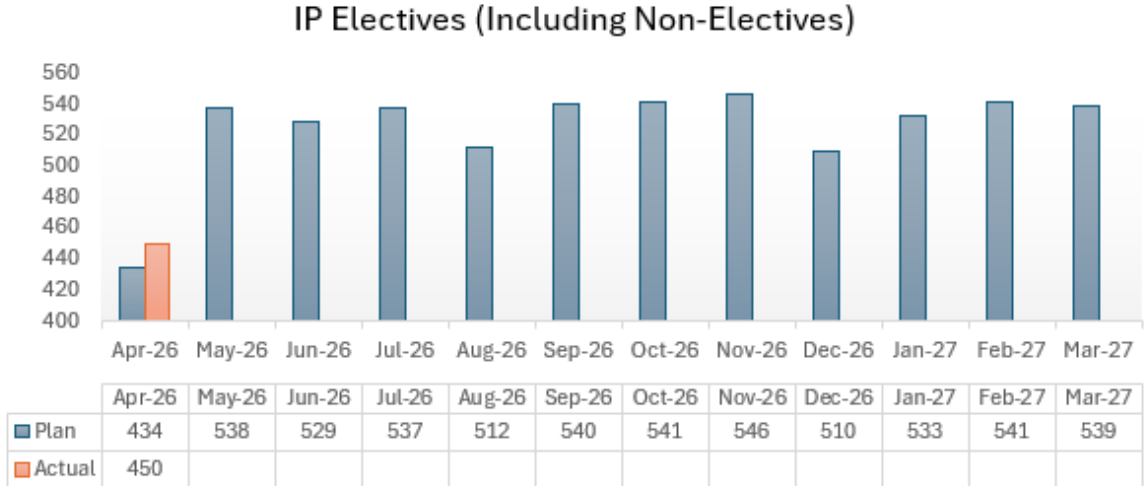




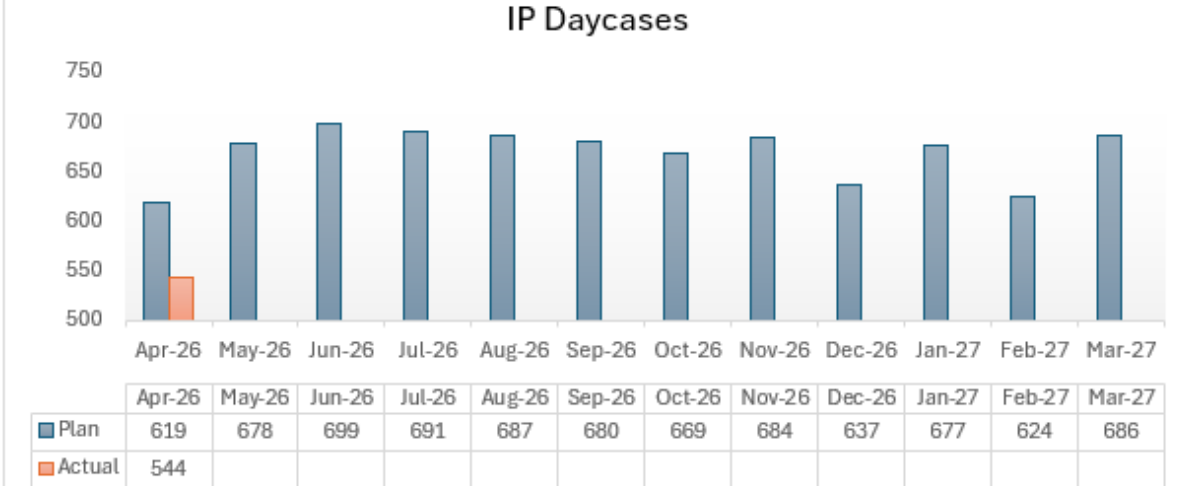


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Total activity delivered in April 2026 was 994 cases against a planned target of 1,053 cases. The activity trajectory for April had been profiled to reflect the expected impact of bank holidays and scheduled maintenance activity; however, performance was further adversely affected by several operational challenges during the month. These included unplanned surgical workforce absence, continued unavailability of Theatre 4 due to theatre temperature compliance, and the departure of a locum consultant, which created gaps that services were unable to fully backfill within the reporting period. Activity delivery was further affected by the Trust-wide QUIDD clinical audit day, which fell on a Monday historically one of the highest activity days within the weekly operating profile thereby compounding the overall impact on elective throughput for the month.	Daily operational performance meetings were established throughout April 2026, chaired by the Deputy COO and Associate Directors of Operations, with a specific focus on maximising theatre utilisation for May 2026 and minimising avoidable theatre cancellations. In addition, the forthcoming 'Hub Optimisation Week' (HOW) will be utilised as a key initiative to further improve in-session utilisation, strengthen productivity, and maximise available elective capacity across theatre services. A rectification plan is now in place to recover activity (-64 cases) within quarter 1 monitored weekly at the operational SMT chaired by the COO reporting directly to the executive meeting weekly. Future QUIDD clinical audit day, have been reviewed and will be agreed with the Deputy COO to ensure minimal impact to delivery of activity trajectory.	Weekly senior review of activity by executive team and COO to monitor risk and agree actions . Daily oversight by Director of operations to support management of lists with escalation to Deputy COO.	Corporate Risk Register Ref 269	High

Assurance Reports: Inpatients continued



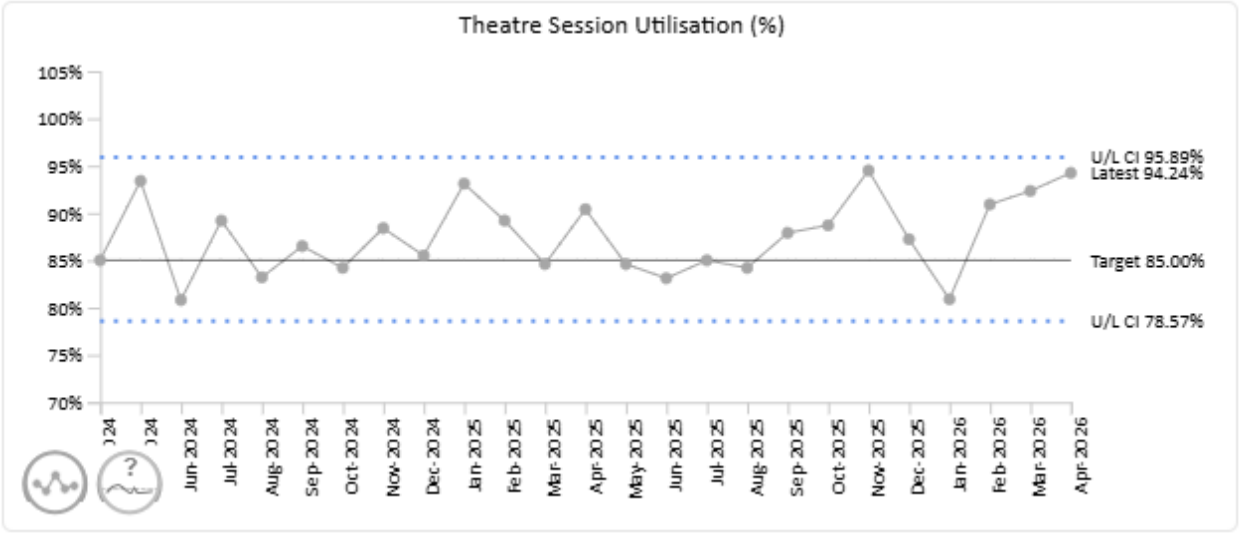
	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Plan	434	538	529	537	512	540	541	546	510	533	541	539
Actual	450											

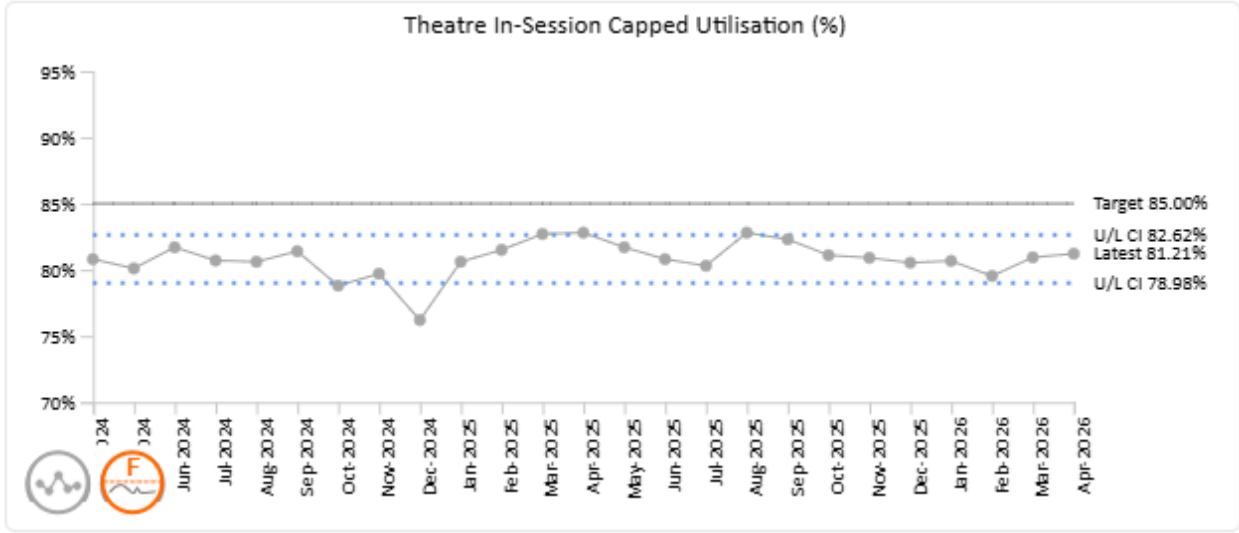


	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Plan	619	678	699	691	687	680	669	684	637	677	624	686
Actual	544											

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
Operational performance during April 2026 continued to be affected by several significant environmental and Consultant staff capacity challenges. Despite these challenges, overall elective activity remained marginally ahead of plan by 16 cases for the month. However, day case activity underperformed against plan by 75 cases. This variance was attributable to the ongoing unavailability of Theatre 4, which predominantly supports day case activity and therefore significantly impacted the Trust's ability to deliver planned day case throughput.	Please refer to slide 7 Recruitment plan for Consultant vacancies is in place aligned to the operational plan , with additional locum support being sourced to support capacity gaps . Any additional ADH activity required in line with current vacancies will be agreed at executive team meetings to ensure delivery of activity and to maintain operational performance targets .	N/A	Corporate Risk Register Ref 269	High

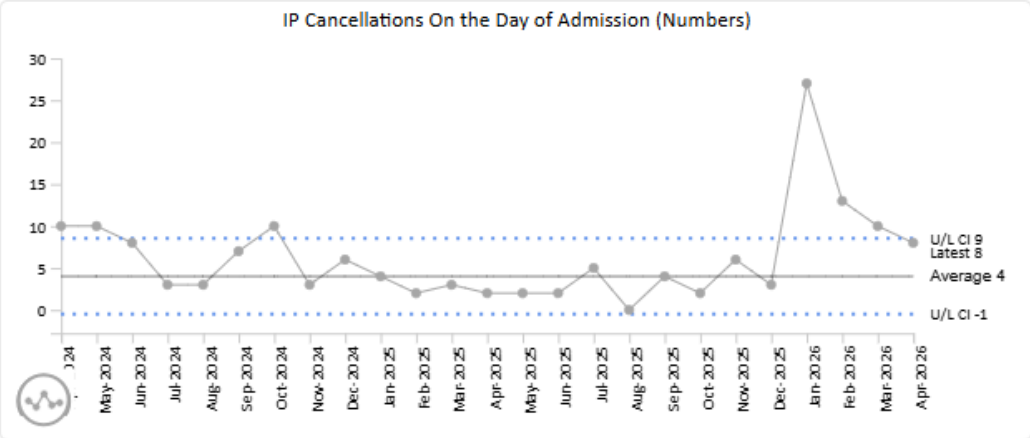
Assurance Reports: Theatres

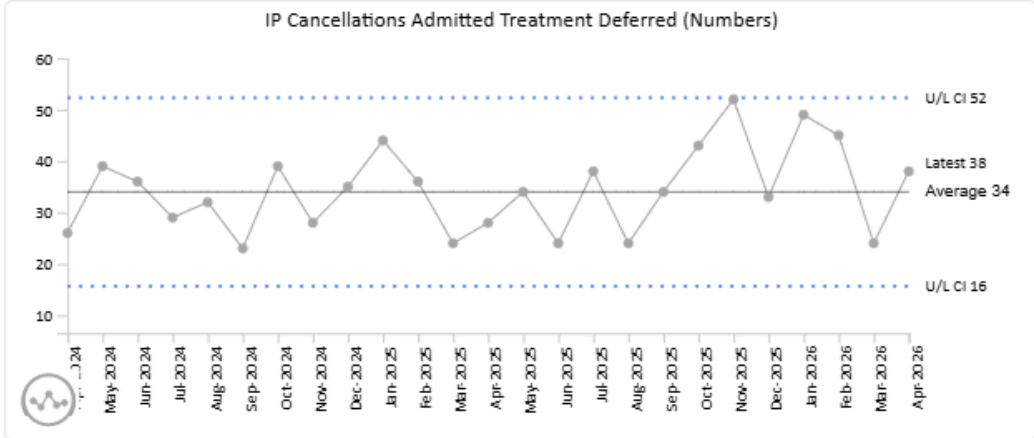




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
➢ April 2026 theatre performance delivered a session utilisation rate of **94.24%**, with capped theatre utilisation achieving **81.21**%, staying below the internal target of 85%.Benchmarking against Model Hospital data for March 2026 demonstrates that the Trust continues to perform within the top quartile nationally, with comparative performance of 83.40%. ➢ Workforce pressures within theatres continued to improve during April. A targeted recruitment event held on 25 April 2026 was successful, resulting in the recruitment of 5 additional members of staff, with start dates currently months. ➢ Planned maintenance works within Theatres were completed by the end of April 2026.Theatre 4 later experienced an unexpected further estates issue requiring more remedial works, which continued to affect operational availability. and theatre utilisation.	Theatre staff training competency framework being developed and implemented with support from internal educators as well as bespoke training sessions from external system specialists. This will add resilience and increase confidence amongst the theatre workforce . Options appraisal to be tabled at executive Committee in May 2026 to consider the continued issues in theatre 4 and agree next steps as the continued disruption to availability of this theatre despite significant maintenance work being carried out in April is impacting on patient experience and overall theatre productivity	3 – 6 months. Actions being tracked via TIG and QSG	Corporate risk ref:770	High

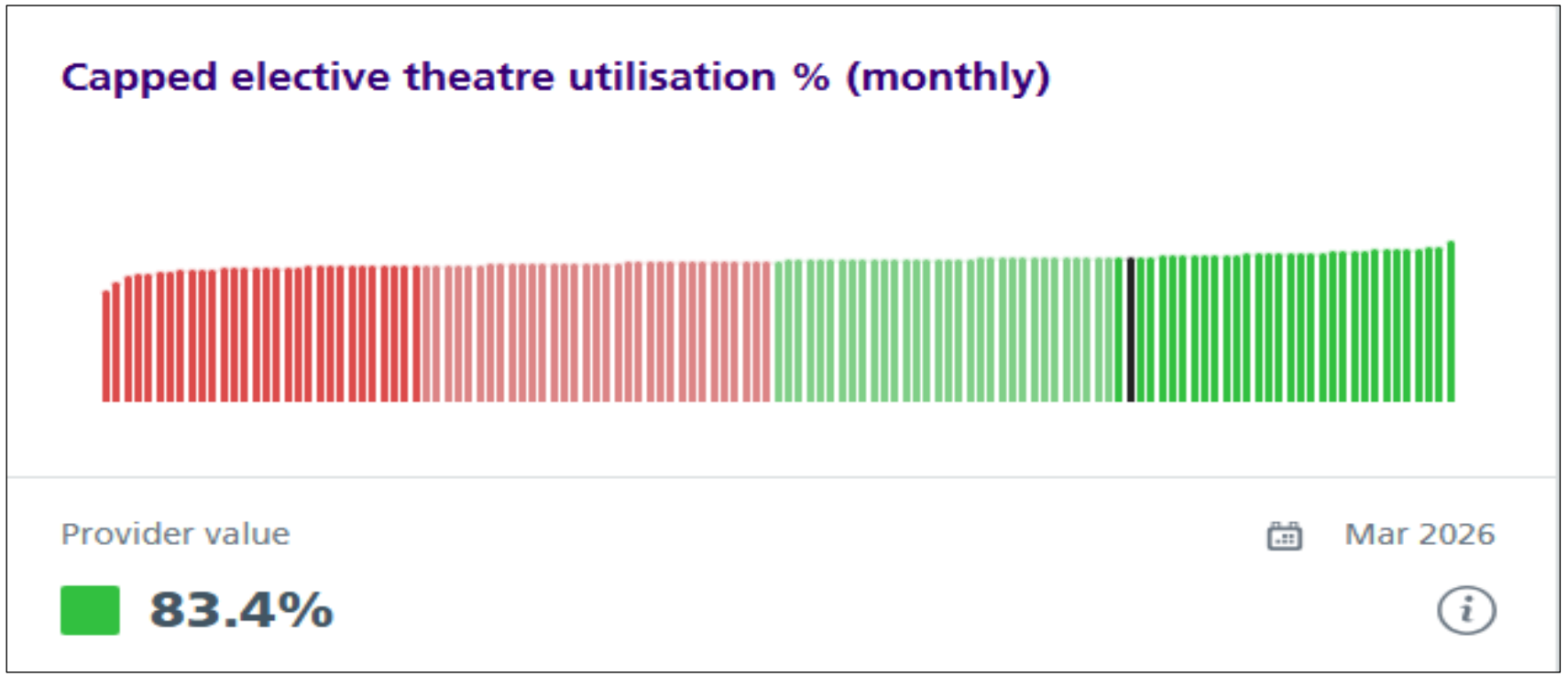
Assurance Reports: Inpatients continued



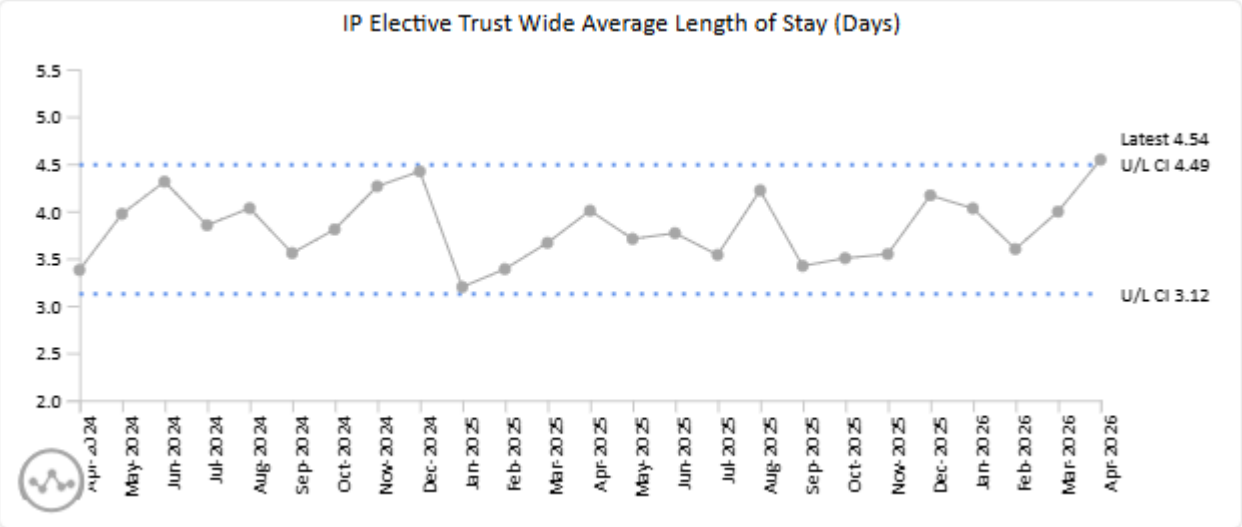


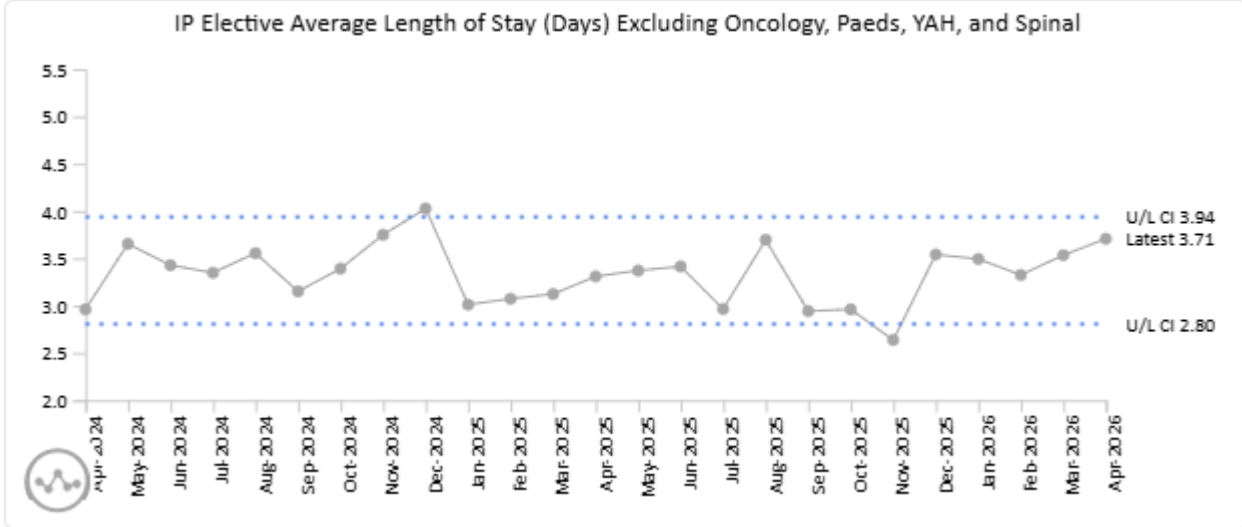
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
During April 2026, a total of 46 patients were cancelled on the day of admission/admitted and deferred under the following categories: Clinical: 21 Non-clinical: 19 Patient choice: 6	Theatre look-back meetings continue to be embedded, with lessons learned consistently captured and reviewed to support continuous improvement and performance recovery. Model Hospital reporting requirements and activity variance is now being standardised into three key categories: clinical reasons, non-clinical reasons, and patient choice. This will support greater consistency in reporting and more robust performance analysis. In parallel, work is underway to streamline theatre system reporting fields in order to reduce variation and enable clearer trend analysis against these three core categories. A dedicated workshop, led by the COO on 22 April 2026, was held to review the 6-4-2 scheduling process. This focused on alignment with best practice GIRFT principles and NHS England expectations, and included plans to relaunch the 6-4-2 process ahead of the upcoming Hub Optimisation Week (HOW) in May 2026. Adherence to best practice will be monitored as part of the HOW.	Ongoing APRIL 2026 COMPLETE APRIL 2026 Q2 Detailed review of HOW to be presented at June FPC	Corporate Risk Register 269	High

Assurance Reports: Theatres Benchmarking – Latest Model Hospital Data



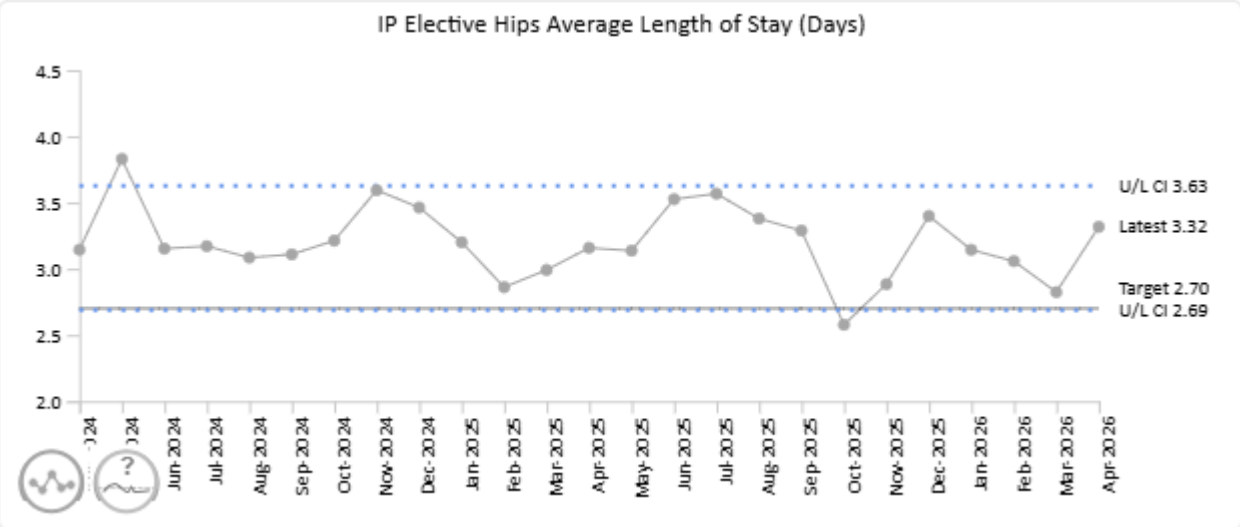
Assurance Reports: Inpatients continued

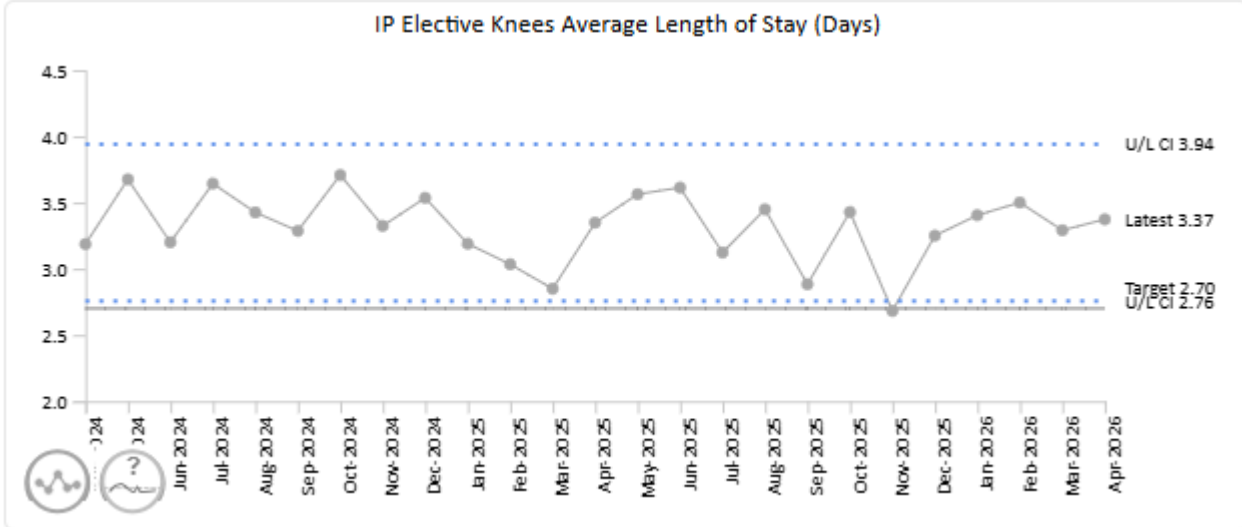




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Trust wide length of stay has increased to 4.54 (4.0 in March) this is driven by complex Oncology Arthroplasty and spinal cases. For Arthroplasty and Oncology arthroplasty excluding Oncology, Young Adult Hip and spinal: 10 patients had a LOS=>14 days (longest 52), on review they had ongoing clinical/therapy needs. These included EPRs and revisions, all 10 patients had an ASA score of 3 Daycase/23-hour pathway is being discussed within the BADS working group.	A presentation on BADs was provided at the March 26 committee. The proposal would be to provide a quarterly update. The Daycase Delivery Group has set a monthly target of 5% daycase rates to help drive improvement and are working with the Arthroplasty SBU to help achieve this. The SBU is focusing on theatre efficiency and ward configuration, both intended to facilitate improved length of stay. The admin aspects of the pathway are also being monitored, with ongoing amendments being made to patient information and the electronic booking form, helping to reduce error and reinforce expectations.	Monitored at Trust Improvement Group. Day case improvement group – update to be provided at the June 26 committee	No	High

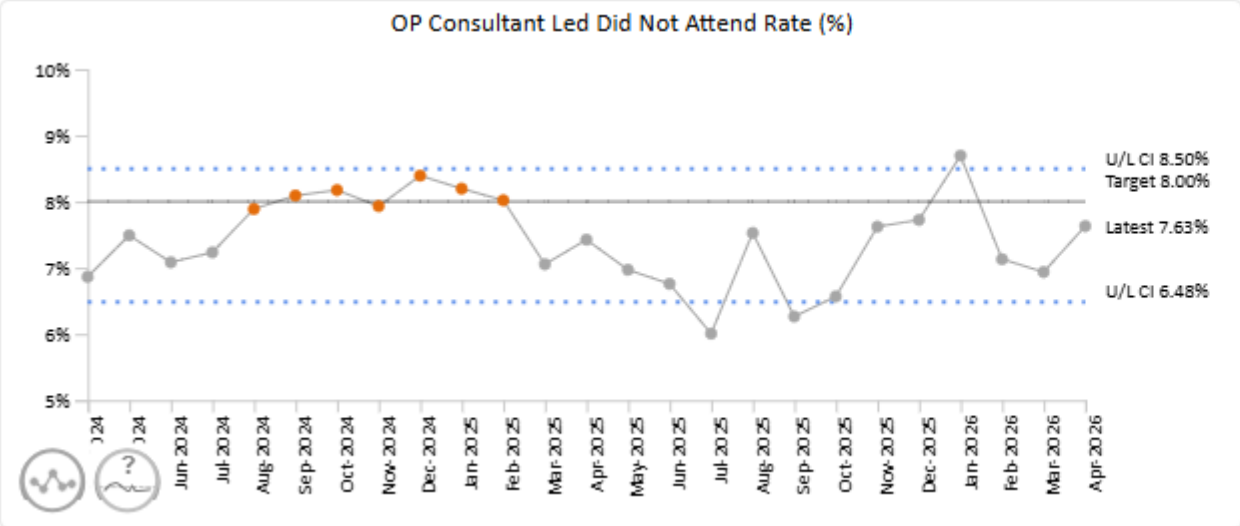
Assurance Reports: Inpatients

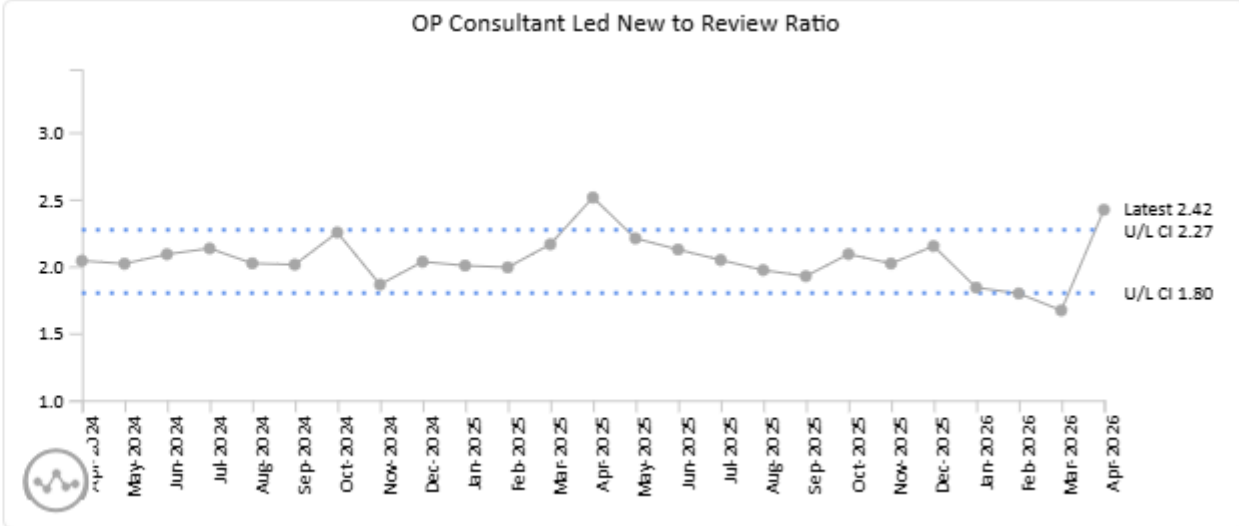




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Average length of stay for ROH primary hips has increased at 3.32 days (2.80 March 2026) and primary knees have increased slightly to 3.37 days (3.25 March 2026). The average length of stay for ROH patients excluding Oncology, Young Adult Hip and Spinal has increased to 3.71 days (3.53 March 2026). All 11 patients with LOS >7 days reviewed (longest 31 days hip, 16 days knee) had on-going clinical/therapy or social care needs. ASA score: 0 ASA 1; 7 ASA 2; 3 ASA 3	Please refer to Slide 9 for action to be supported by the BADS Delivery Group.		N/A	High

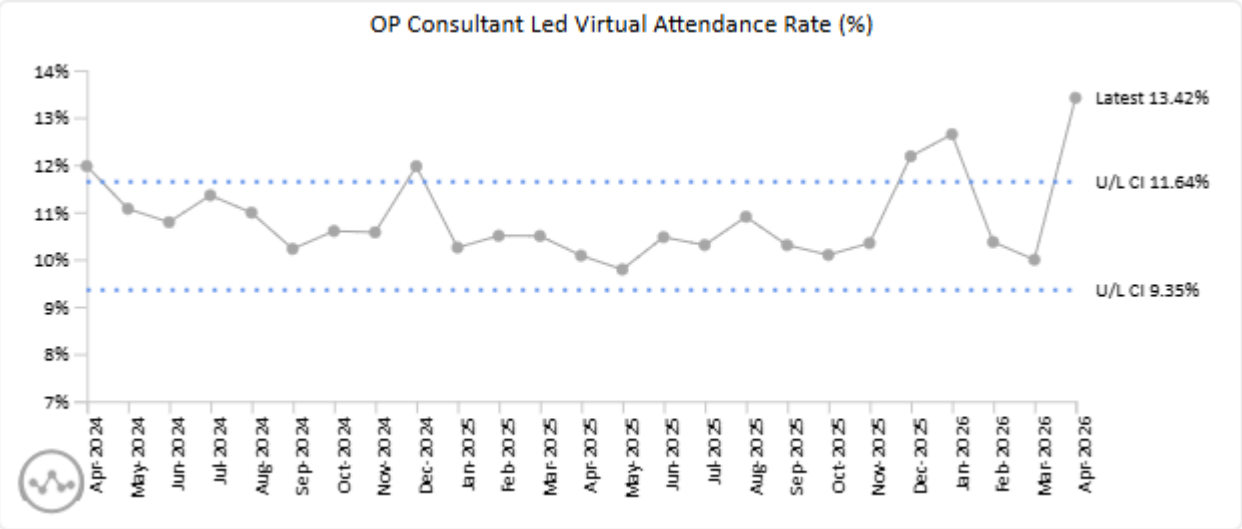
Assurance Reports: Outpatients

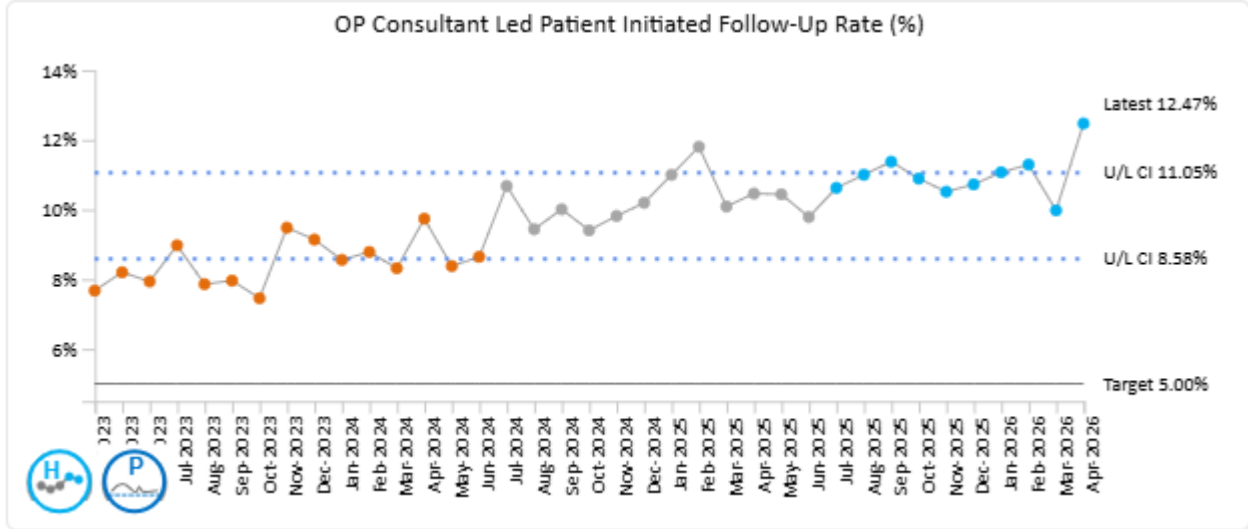




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
The DNA rate for April was 7.63%, a slight increase on the month before and remains steady with no statistically significant increase following the sustained improvement since Dec 2025/Jan 2026. Reminder texts continue to be issued 7 days prior to face-to-face appointments and 3 days prior to virtual appointments, supporting improved attendance and further focussed work is being undertaken to manage short notice cancellations to further maximise utilisation. The new-to-follow-up ratio saw an expected spike to account for outstanding follow ups following the focus on increasing first outpatient activity and RTT Position over the previous quarter.	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 went live on 27/04/2026 To improve accessibility, subsidised travel has been secured through Travel WM for all patients and additionally the Trust is involved in a pilot scheme through Travel WM to offer free 1 week travel to patients in hardship (until mid-June 2026).	30.04.2026 Update to Clinic Letters 27/04/2026 LIVE 01/05/2026	N/A N/A	High High

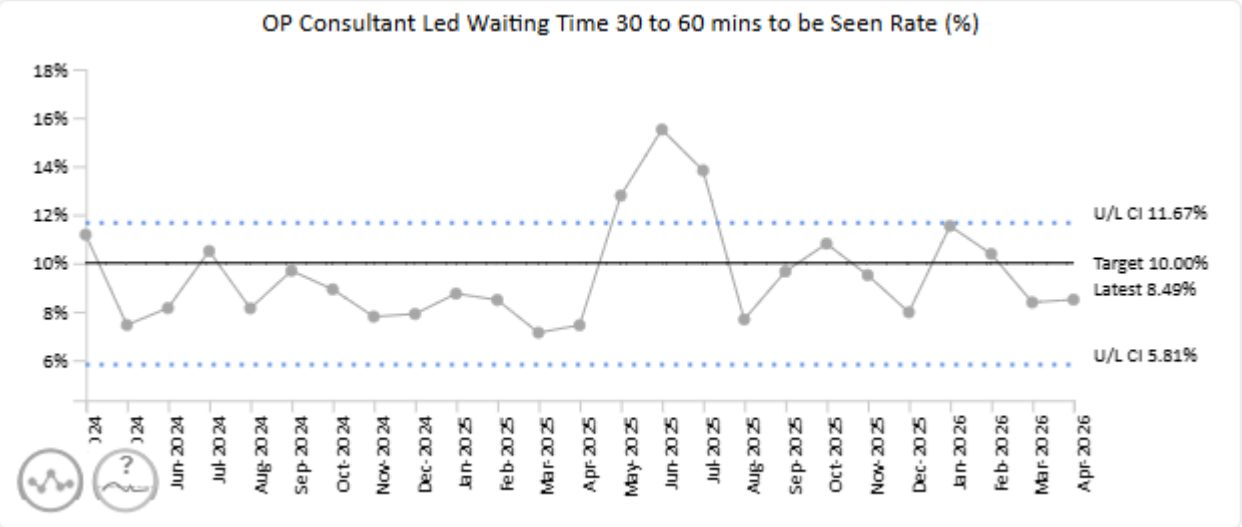
Assurance Reports: Outpatients continued

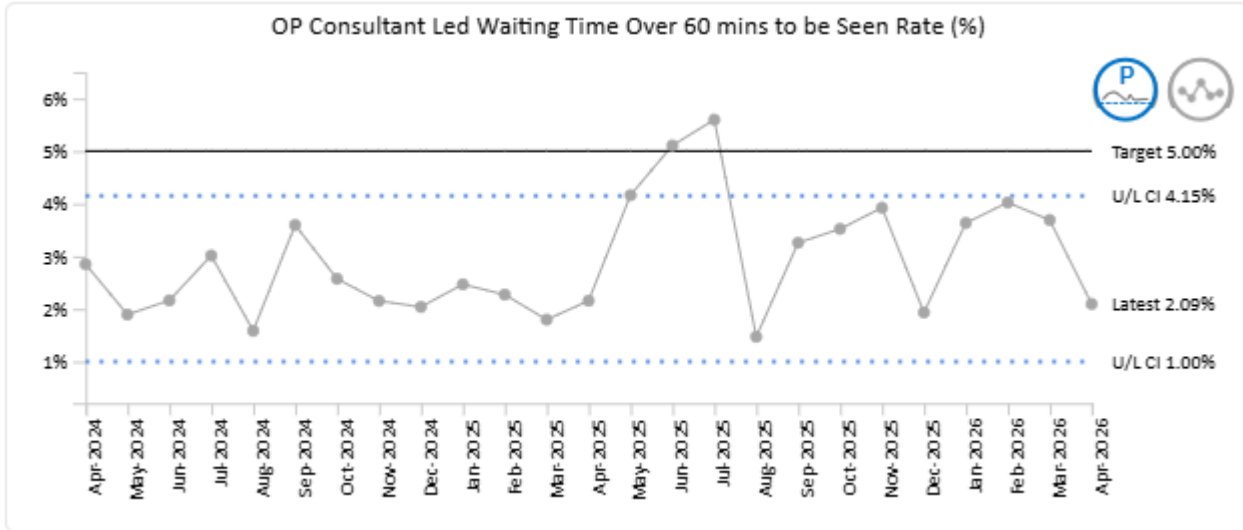




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Virtual appointments increased during the month of April with our highest levels in over 2 years. This is linked to virtual follow up clinics where we saw increased activity over April.	Continued trialling virtual super-new and discharge clinics	April 2026	N/A	High
PIFU also peaked to 12.47% as more patients were put onto a PIFU pathway following from follow up once a diagnosis and management plan were established. This increase is in line with the surge in review appointments over the month. This is being reviewed closely over May and June as further asynchronous PIFU opportunities are identified for patients (with involvement of clinicians) and a new process to safety net patients that are non-contactable is introduced.	Monitoring of PIFU conversion rates and targeted intervention in hotspots. Asynchronous PIFU rollout – trial with 1 clinician due to commence in May and conclude first of June to measure impact	June 2026	N/A	High

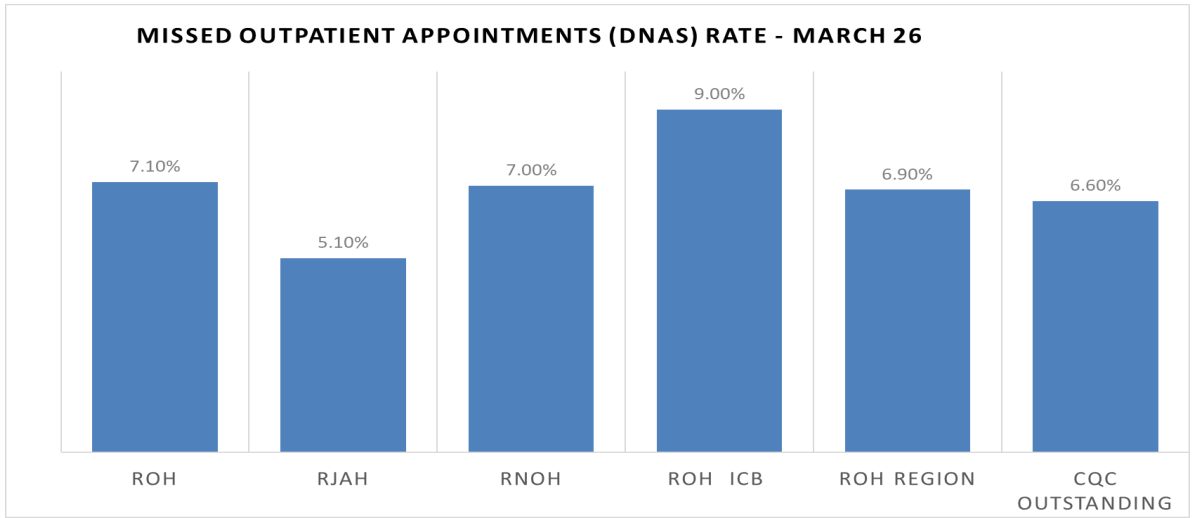
Assurance Reports: Outpatients continued

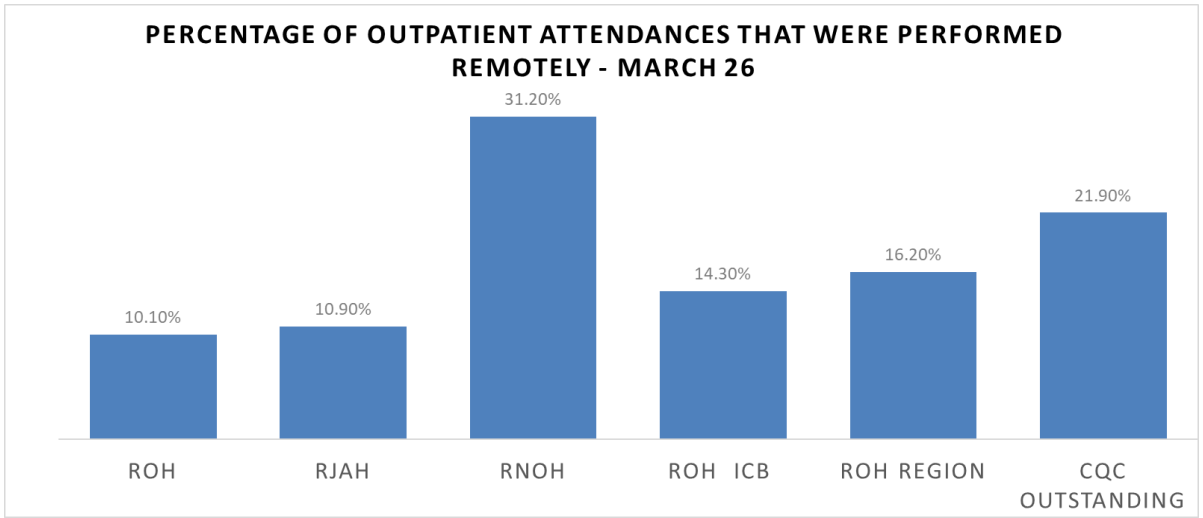


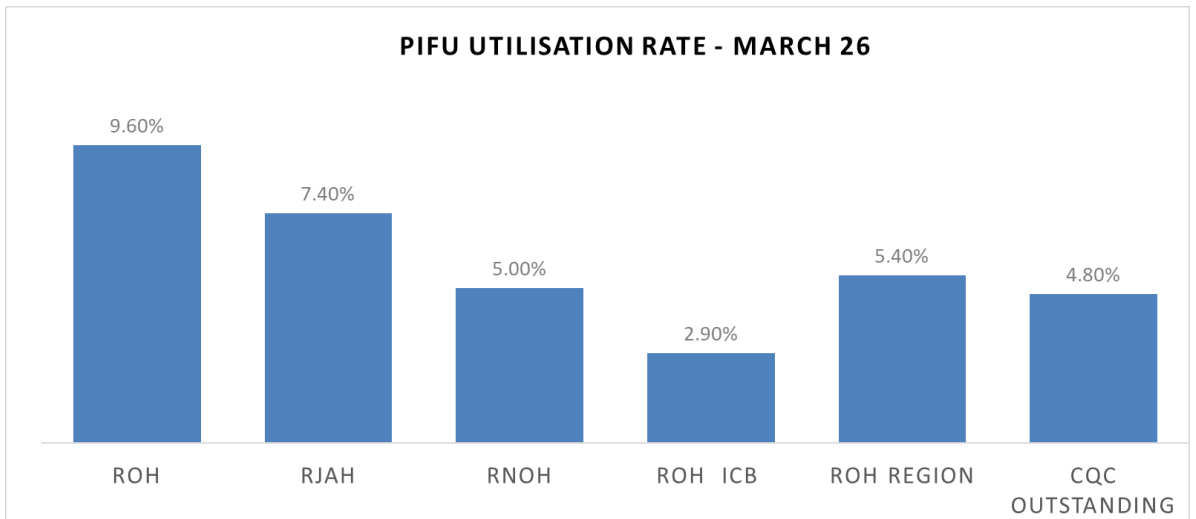


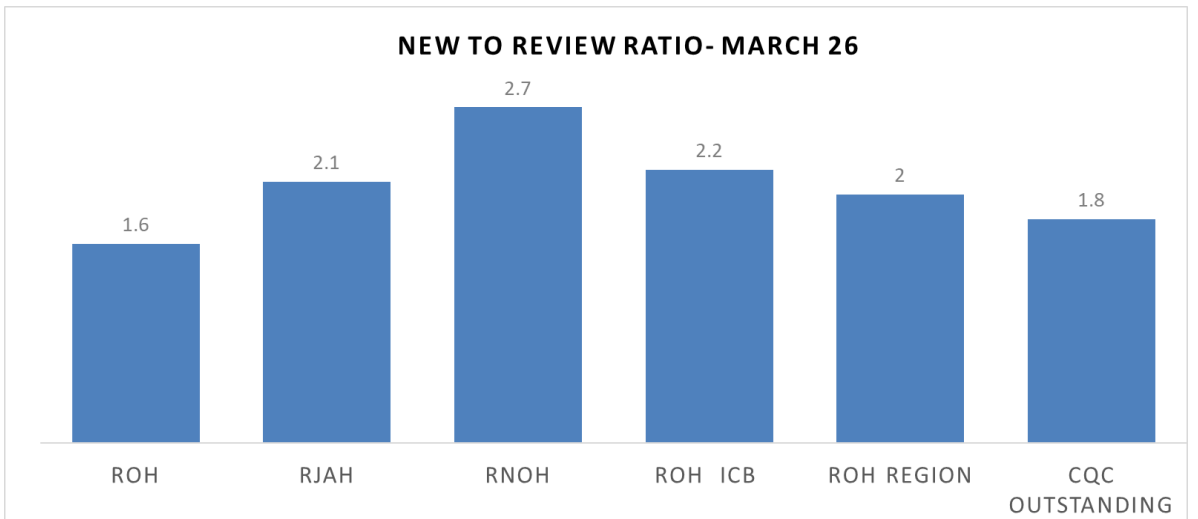
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
30-60 minute waits -Continued steady performance from the previous month remaining below the Trust KPI threshold of 10% and showing a continued recovery from earlier pressures seen at the start of 2026. The over 60-minute waiting time KPI also improved again in April to 2.09% from 3.69% in March - remaining well within the Trust threshold of 5%. The improvement over March and April reflects the resolution of the temporary Imaging capacity issues experienced in February, including a short-term X-ray room IT fault. With full capacity restored and improved flow through clinics, delays associated with imaging dependency were reduced, supporting stronger overall performance.	N/A	N/A	N/A	High

Assurance Reports: Outpatients Benchmarking Model Hospital

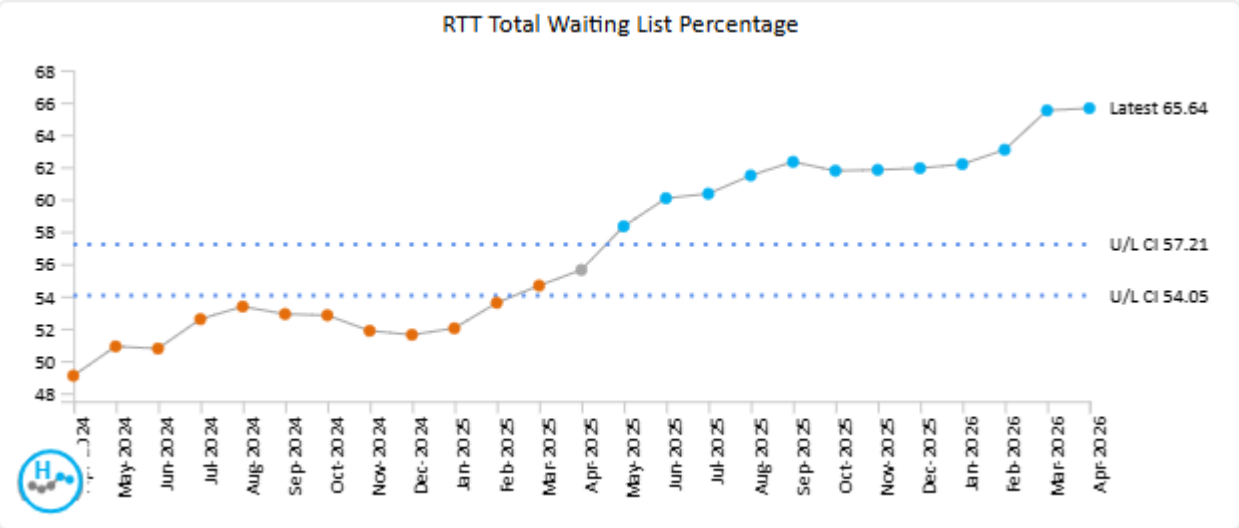


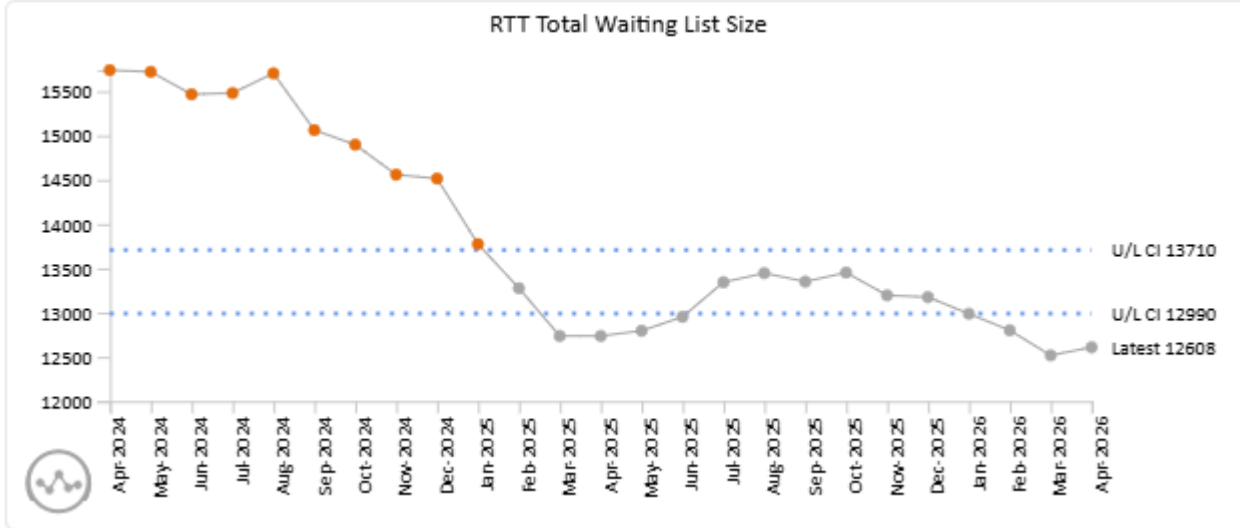






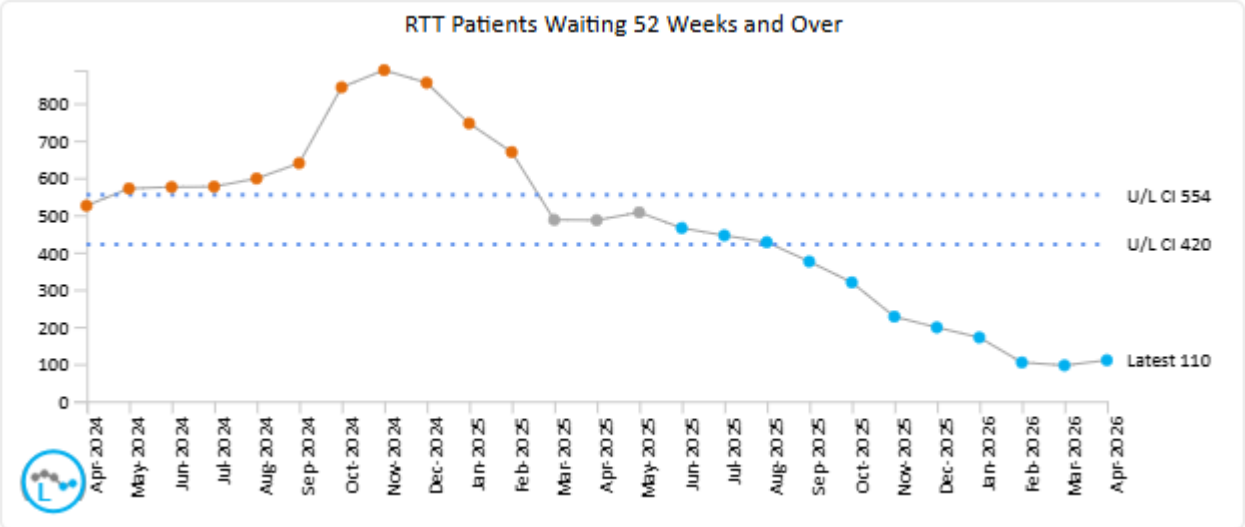
Assurance Reports: Referral to Treatment

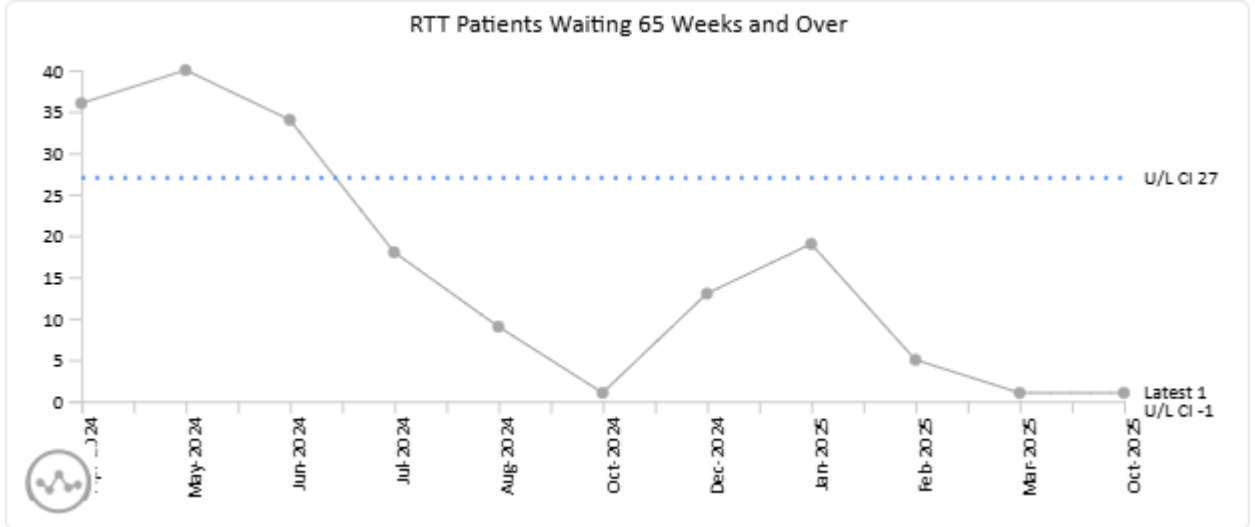




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
The team has begun the new financial year positively, achieving an April RTT performance of 65.64% against a target of 64.84%. This marks a further improvement from the previous month and highlights the team's continued focus on effective pathway management, service coordination of waiting lists and sustaining patient flow. The strong April position provides a solid platform for the year ahead and reflects the ongoing commitment to elective recovery and delivering timely patient care. In addition, although there was a slight increase in the RTT waiting list size during April, the Trust remained ahead of plan, closing the month with a waiting list below the target position of 13,096. This demonstrates continued effective management of elective demand.	To sustain this level of performance and ensure delivery of the 2026/27 targets, targeted weekly PTL meetings at sub-specialty level will continue, with a clear focus on pathway efficiency. In parallel, the validation team will continue undertaking enhanced validation. This disciplined approach will protect current gains while driving further improvement beyond the baseline plan .	Weekly PTL Meetings Weekly Divisional Operations Meeting Monthly Divisional Management Board Monthly Operations Management board	n/a	High

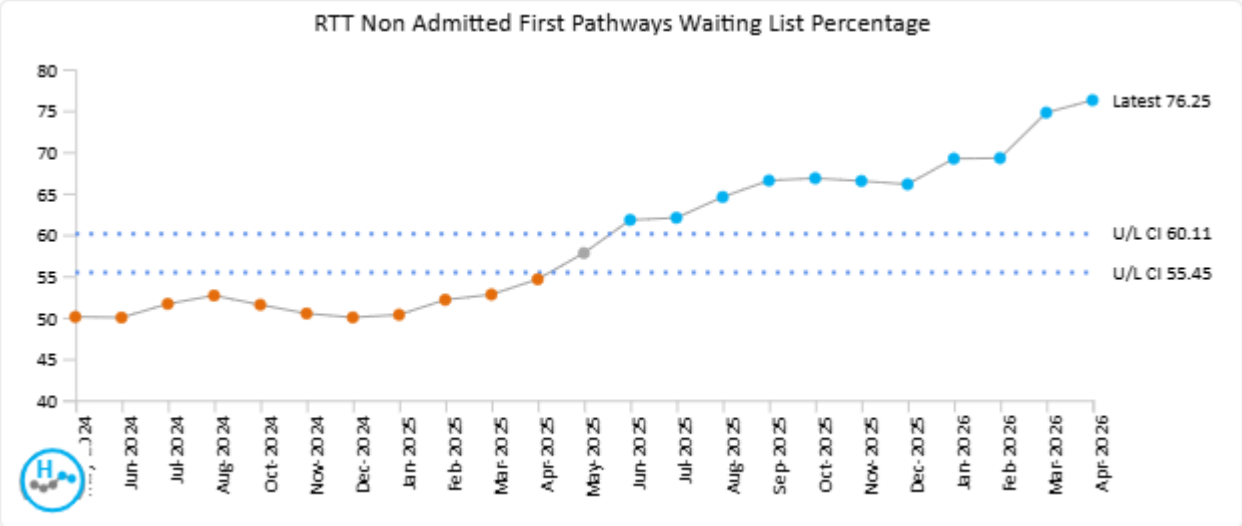
Assurance Reports: Referral to Treatment continued

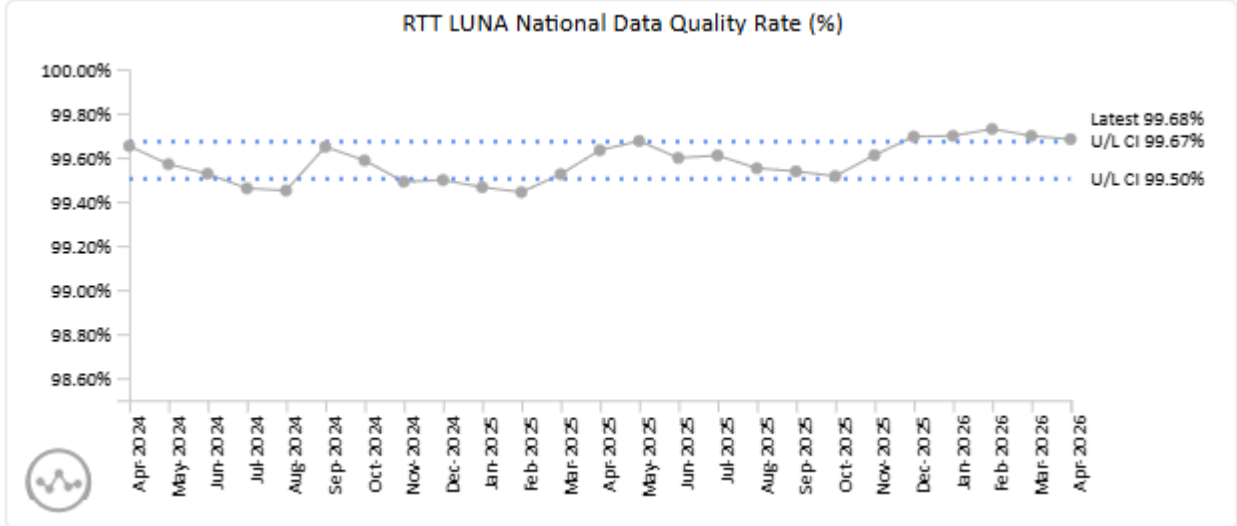




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
The number of patients waiting 52 weeks and over for treatment increased to 110 during April; however, performance remained ahead of the monthly target of 119. We continue to ensure no patients are waiting 65 weeks and over for treatment.	Patients at risk of breaching the 52- and 65-week RTT standards are still confined to the spinal and spinal deformity sub-specialties, with all other specialties performing within required targets. Spinal pathways will be 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. The clear focus for 2026/27 is to eliminate all 52-week waits by the end of March 2027	Weekly PTL Meetings Weekly Divisional Operations Meeting Monthly Divisional Management Board Monthly Operations Management board	Corporate Risk Register Ref 2146	High

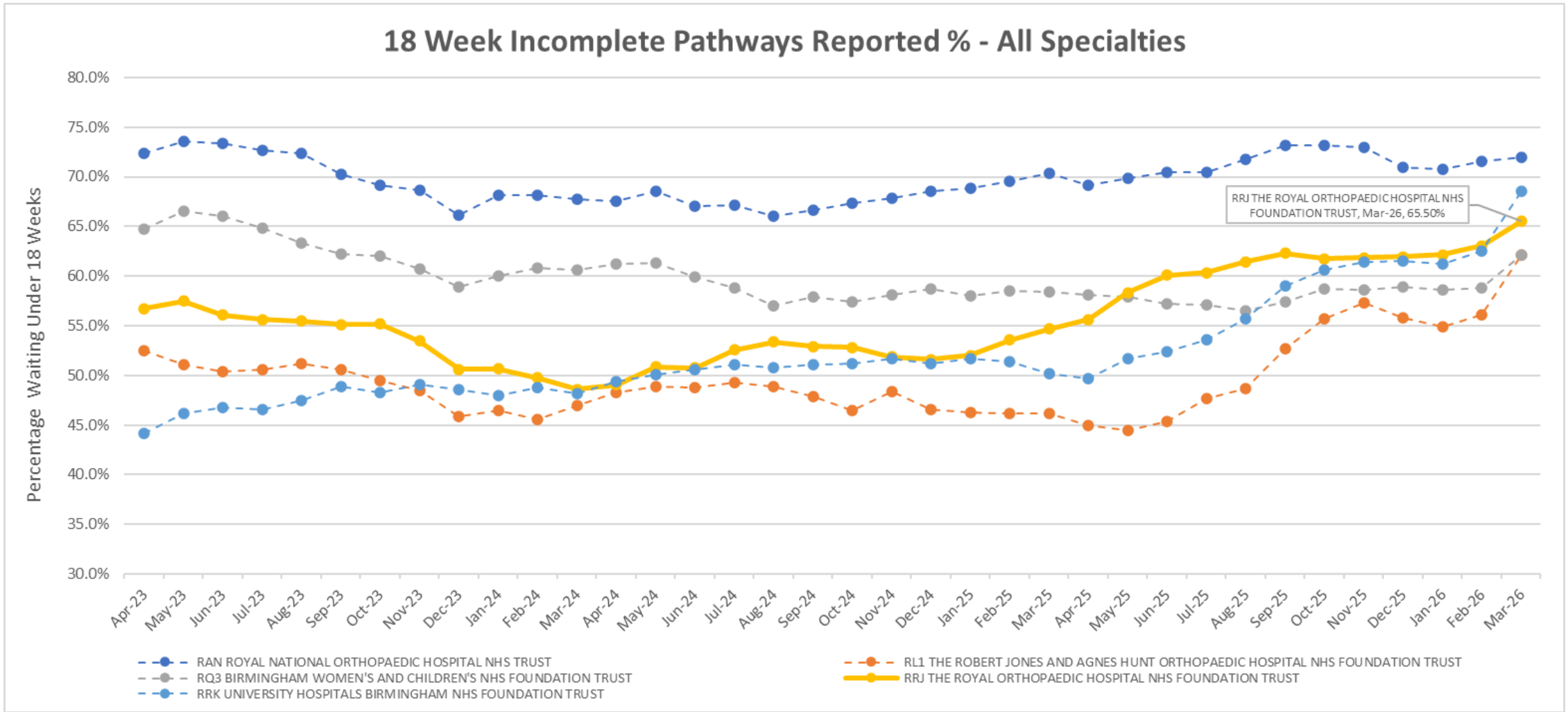
Assurance Reports: Referral to Treatment continued



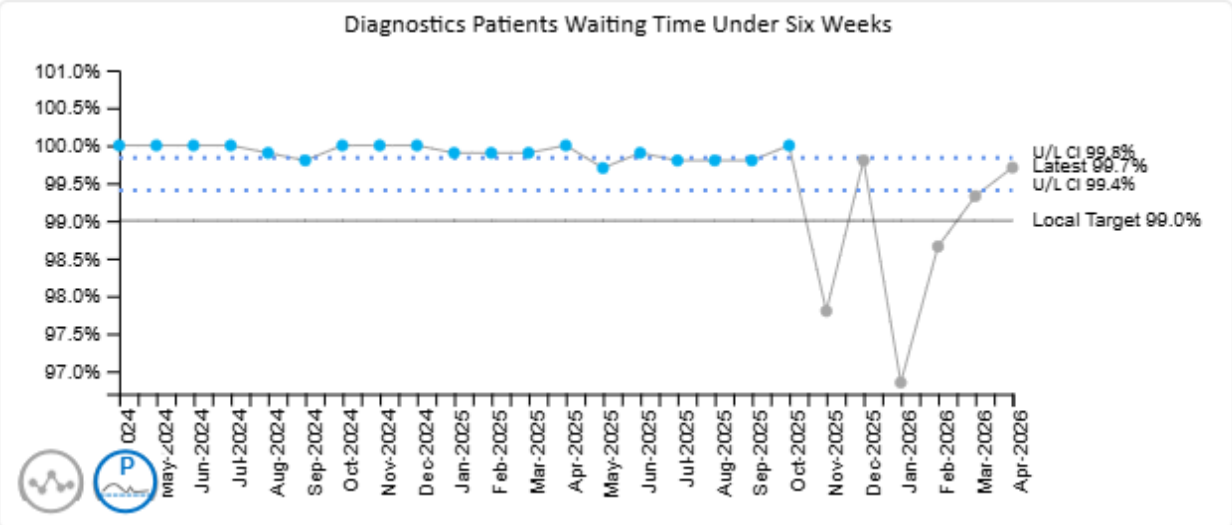


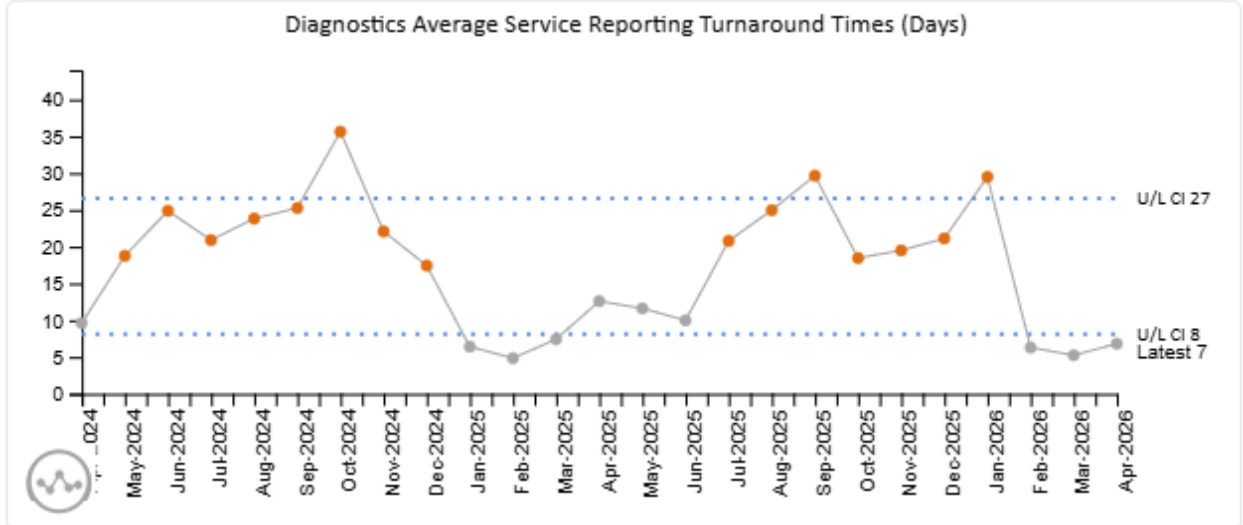
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
76.25% of patients are now waiting under 18 weeks for an RTT first new outpatient appointment, improving from 74.75% in the previous month and exceeding the planned target of 69.47%. This reflects continued progress in reducing waiting times and improving timely access to outpatient care. 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 capacity is optimised and that this level of performance is sustained into the upcoming year (26/27).	Weekly PTL Meetings Weekly Divisional Operations Meeting Monthly Divisional Management Board Monthly Operations Management board Weekly Strategic Oversite Group	N/A	High

Assurance Reports: Referral to Treatment Benchmarking Model Hospital



Assurance Reports: Diagnostics



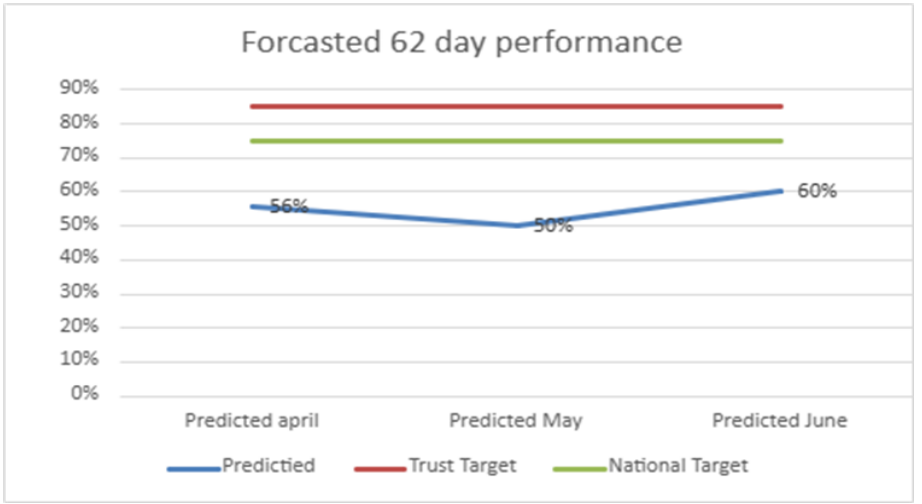


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Diagnostics achieved 99% in April meeting the trust target and exceeding the national target. Reporting turnaround times for routine images is continuing to decrease and is now within RCR Guidelines of 4 weeks for routine imaging. YAH reporting continues to have the longest turnaround due to specialist reporting requirements and inability to outsource Continuing to experience equipment errors and breakdowns across X-ray Room 1 and room 2.	Regular review of diagnostic waiting times will continue to ensure performance remains above the national standard and to maintain recovery momentum across reporting pathways. Maximum on site reporting capacity is being utilised. However, a level of outsourced reporting support will continue to be required to maintain delivery and mitigate backlog risks. Young Adult Hips (YAH) MRI reporting scans continue to be allocated weekly across the radiology workforce to support backlog reduction. This has resulted in a continued improvement in reporting turnaround times, which currently stands at approximately six weeks. Ongoing equipment breakdowns and maintenance issues continue to be escalated directly to manufacturers and actively monitored to minimise operational disruption. These risks have also been incorporated into capital business planning for future equipment replacement. Any resulting delays are monitored closely, with communication provided to Outpatients teams where required to support patient management and pathway coordination.	Diagnostic waiting list meetings Regular review of reporting times both internally and externally.	N/A 2082 Ongoing2080, 2148	High

Assurance Reports: Cancer

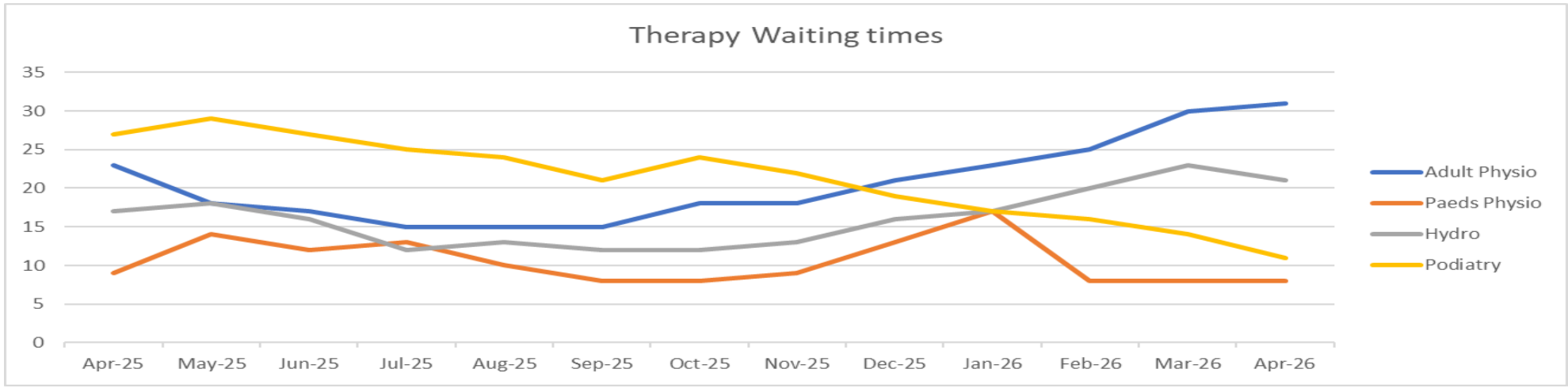
March 26 Performance

Target Description	Patients	Compliant	Breach	Total Accountable	%	Target
31 Day	17	17	0	17	100%	96%
62 Day	13	9	4	13	70%	75%
28 Day FDS	81	59	22	81	72.8%	80%
104 days treated at ROH			1			



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 and 62 Day standard target was not met due to continued challenges with Histopathology services provided by UHB. Improvements for 62 day metric are expected towards the beginning of Q2 with further mitigation now in place with additional reporting capacity. Achieving the FDS metric is still concerning due to ongoing poor TATs from UHB due to other contributing factors such as lab processing delays and further testing for more complex cases.	Twice weekly Executive meetings are in place with NHS England to provide regional / national support to reduce delays in the pathway. Internal oversight through cancer board and PTL meetings. Regular escalations from Director of Ops & COO to senior colleagues at UHB. Working group now in place to develop longer term plan for pathology support to strengthen the pathology service for both bone and soft tissue pathways. Increased touchpoint meetings with UHB pathology to monitor turnarounds	Cancer Board monthly Division 1 Cancer PTL meeting weekly Oversight at weekly senior leadership team meeting. Meeting 21.04.2026. Daily touch point with UHB/ROH Ops colleagues to monitor progress daily.	Corporate Risk Register Ref 1893	High

Assurance Reports: MSK Non-Consultant led services

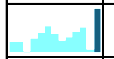
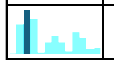
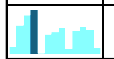
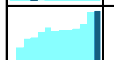


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Adult Physio waiting times continuing to increase due to workforce challenges and increased referral numbers. Further turnover of staff due to staff progression. Paediatric Physio waits remain stable at 8 weeks . 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, due roll out to top 40 referring practices. Band 6 posts due through VCP after recent recruitment / end of secondments. Trust workshop led by the COO to take place on 20th April to accelerate support for transformation . Feedback will be provided at the June FPC meeting on outcomes. 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. Further recruitment to be requested and vacancies to be put forward to VCP. Temporary staff remain necessary in Podiatry to manage demand. Demand and capacity model being rerun to determine if temporary staffing can be reduced.	Ongoing weekly monitoring and move of resources to support demand and trust targets. Self-referral via GUB pilot due roll out to other practices in April. Recruitment processes underway for several posts. Reports to DMB for oversight.	No. 1573 Div 2 - Physio Divisional risk	High

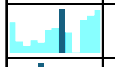
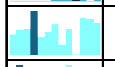
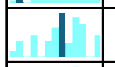
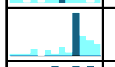
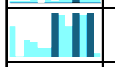
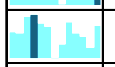
Integrated Performance Dashboard: Operational

Metric Grouping	Metric Name	Reporting Period	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Inpatients	IP Activity Monthly Performance %	Monthly	106.0%	97.7%	97.0%	92.7%	94.3%	96.1%	90.7%	89.3%	97.9%	86.0%	92.5%	96.3%	94.4%	94.4%		high is good	L	F	100%
Inpatients	IP Activity Electives Monthly Performance %	Monthly	104.7%	97.5%	90.4%	96.3%	92.1%	95.2%	94.1%	93.5%	107.9%	85.2%	97.9%	94.0%	101.7%	101.7%		high is good	L	P	100%
Inpatients	IP Activity Daycases Monthly Performance %	Monthly	108.4%	97.3%	102.3%	90.0%	95.9%	97.9%	87.6%	86.7%	91.1%	84.5%	88.4%	97.5%	87.9%	87.9%		high is good	L	F	100%
Inpatients	IP Activity Non-Electives Monthly Performance %	Monthly	57.75%	113.43%	81.67%	99.11%	99.82%	56.18%	113.12%	73.84%	83.42%	156.87%	94.11%	112.35%	145.00%	145.00%		-	-	-	-
Inpatients	IP Activity Monthly Discharges	Monthly	1,132	1,142	1,154	1,185	1,156	1,256	1,231	1,199	1,213	1,118	1,155	1,314	994	994		high is good	-	-	-
Inpatients	IP Activity Elective Discharges	Monthly	454	476	445	505	482	527	524	526	554	460	509	533	421	421		high is good	-	-	-
Inpatients	IP Activity Daycase Discharges	Monthly	667	641	691	658	652	716	681	657	640	624	626	755	544	544		high is good	-	-	-
Inpatients	IP Activity Non-Elective Discharges	Monthly	11	25	18	22	22	13	26	16	19	34	20	26	29	29		-	-	-	-
Outpatients	OP Activity Monthly Performance %	Monthly	106.8%	104.3%	106.1%	100.1%	99.4%	109.6%	100.8%	105.9%	95.8%	100.5%	107.5%	105.1%	90.0%	90.0%		high is good	H	F	100%
Outpatients	OP Activity First Monthly Performance %	Monthly	84.5%	89.3%	93.8%	93.1%	93.0%	105.0%	93.1%	100.7%	85.9%	99.1%	109.5%	112.5%	77.2%	77.2%		high is good	L	F	100%
Outpatients	OP Activity Follow Up Monthly Performance %	Monthly	117.5%	111.0%	111.4%	103.5%	101.3%	109.8%	101.2%	103.8%	96.6%	97.0%	102.1%	97.4%	96.7%	96.7%		high is good	H	F	100%
Outpatients	OP Activity Follow Up Procedures Monthly Performance %	Monthly	138.1%	130.4%	131.3%	108.8%	125.9%	143.8%	157.4%	176.1%	166.4%	159.8%	167.6%	152.2%	128.0%	128.0%		high is good	H	P	100%
Outpatients	OP Activity Monthly Attendances	Monthly	6,067	5,925	6,332	6,539	5,650	6,853	6,584	6,021	5,719	6,014	6,132	6,651	5,420	5,420		high is good	-	-	-
Outpatients	OP Activity First Monthly Attendances	Monthly	1,683	1,779	1,964	2,133	1,852	2,301	2,133	2,007	1,797	2,073	2,182	2,467	1,602	1,602		high is good	-	-	-
Outpatients	OP Activity Follow Up Monthly Attendances	Monthly	4,049	3,826	4,029	4,101	3,489	4,163	4,009	3,578	3,494	3,510	3,517	3,693	3,818	3,818		high is good	-	-	-
Outpatients	OP Activity Follow Up Procedures Monthly Attendances	Monthly	335	320	339	305	309	389	442	436	428	431	433	491	297	297		high is good	-	-	-

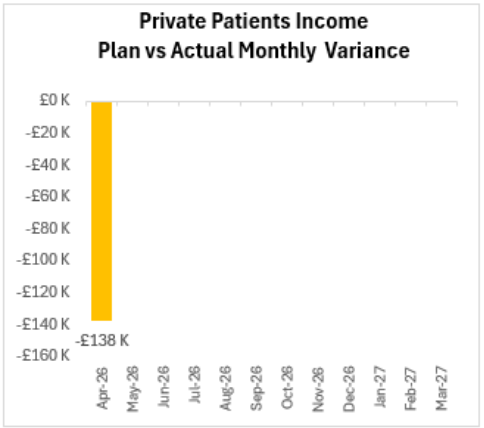
Integrated Performance Dashboard: Operational

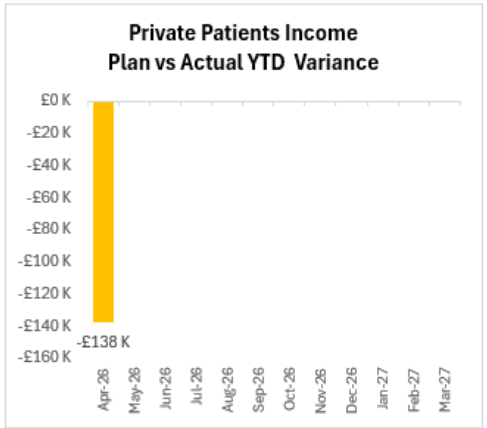
Metric Grouping	Metric Name	Reporting Period	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Outpatients	Outpatient Did Not Attend	Monthly	7.42%	6.97%	6.76%	6.00%	7.53%	6.26%	6.57%	7.62%	7.72%	8.69%	7.13%	6.94%	7.63%	7.63%		low is good			8%
Outpatients	PIFU	Monthly	10.46%	10.44%	9.78%	10.62%	11.00%	11.37%	10.89%	10.51%	10.72%	11.07%	11.29%	9.98%	12.47%	12.47%		high is good			5%
Outpatients	Virtual Attendances	Monthly	10.08%	9.79%	10.45%	10.30%	10.90%	10.30%	10.09%	10.34%	12.18%	12.64%	10.37%	9.99%	13.42%	13.42%		high is good			
Outpatients	OP Attendances Patients Who Waited 31 to 60 Mins to be Seen	Monthly	7.44%	12.78%	15.51%	13.82%	7.67%	9.65%	10.80%	9.50%	7.97%	11.53%	10.38%	8.38%	8.49%	8.49%		low is good			
Outpatients	OP Attendances Patients Waited Over 60 Mins to be Seen	Monthly	2.16%	4.16%	5.11%	5.60%	1.47%	3.26%	3.52%	3.92%	1.93%	3.63%	4.02%	3.69%	2.09%	2.09%		low is good			
referral to treatment	RTT Total Waiting List Under 18 weeks	Month Ending	55.63%	58.33%	60.07%	60.35%	61.48%	62.32%	61.77%	61.83%	61.93%	62.18%	63.07%	65.50%	65.64%	NA		high is good			64.84%
referral to treatment	RTT First Appointment Waiting List Under 18 weeks	Month Ending	54.61%	57.78%	61.78%	62.03%	64.55%	66.54%	66.82%	66.49%	66.09%	69.19%	69.25%	74.75%	76.25%	NA		high is good			69.47%
referral to treatment	RTT Total Waiting List Size	Month Ending	12,736	12,795	12,952	13,343	13,446	13,350	13,452	13,195	13,175	12,987	12,800	12,517	12,608	NA		low is good			13,096
referral to treatment	RTT Patients Waiting 65 Week waits	Month Ending	0	0	0	0	0	0	1	0	0	0	0	0	0	NA		low is good			0
referral to treatment	RTT Patients Waiting 52 week waits (52-64 weeks)	Month Ending	486	507	465	445	427	375	318	227	198	171	104	96	110	NA		low is good			119
referral to treatment	RTT Proportion of Patients Waiting 52 weeks and over	Month Ending	3.82%	3.96%	3.59%	3.34%	3.18%	2.81%	2.37%	1.72%	1.50%	1.32%	0.81%	0.77%	0.87%	NA		low is good			0.91%

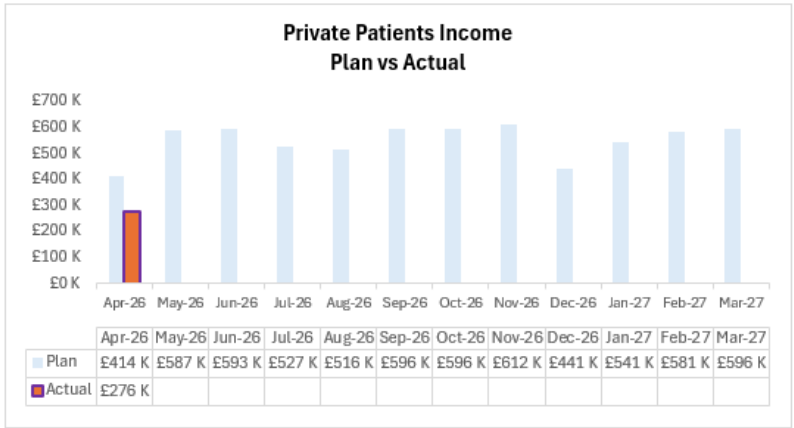
Integrated Performance Dashboard: Operational Productivity

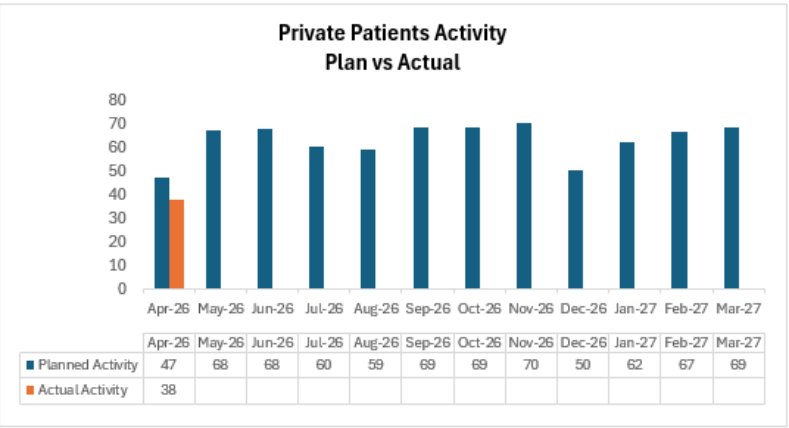
Metric Grouping	Metric Name	Reporting Period	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Operational Productivity	Theatre Number of Sessions Planned	Monthly	533	530	535	590	515	572	600	534	553	583	523	587	529	529			-	-	
Operational Productivity	Theatre Session Utilisation	Monthly	90.40%	84.60%	83.10%	85.00%	84.20%	87.90%	88.70%	94.50%	87.23%	80.89%	90.91%	92.34%	94.24%	94.24%		high is good			85%
Operational Productivity	Theatre In-Session Utilisation Upcapped	Monthly	84.38%	84.53%	82.37%	81.68%	85.39%	83.61%	82.72%	84.63%	83.58%	82.24%	82.32%	82.36%	83.24%	83.24%		high is good			85%
Operational Productivity	Theatre Touchtime Utilisation Upcapped	Monthly	82.80%	81.70%	80.80%	80.30%	82.80%	82.30%	81.10%	80.90%	80.53%	80.67%	79.53%	80.94%	81.21%	81.21%		high is good			85%
Operational Productivity	Average Number Of Operations Per List	Monthly	3.18	3.19	3.12	3.00	3.16	3.07	2.91	3.01	3.07	2.99	3.06	3.19	3.10	3.10		high is good	-	-	-
Operational Productivity	Average Mins Late Starts(minutes) *Based on 9pm Start Time	Monthly	0	0	0	0	0	0	2	2	5	11	1	0	1	1		low is good	-	-	-
Operational Productivity	Average Early Finishes (minutes)	Monthly	82	84	85	92	81	83	86	78	84	73	89	89	87	87		low is good	-	-	-
Operational Productivity	Average Patient Turnaround (minutes)	Monthly	13	17	13	16	14	16	15	16	17	15	15	14	14	14		low is good	-	-	-
Operational Productivity	Admitted Treatment Deferred	Monthly	28	34	24	38	24	34	43	52	33	49	45	24	38	38		low is good	-	-	-
Operational Productivity	Cancelled By Hospital On Day of Admission	Monthly	2	2	2	5	0	4	2	6	3	27	13	10	8	8		low is good	-	-	-
Operational Productivity	Cancelled By Hospital Day Before Day of Admission	Monthly	35	19	28	27	24	24	42	41	35	42	41	42	21	21		low is good	-	-	-
Operational Productivity	LOS - Trust Wide All Services	Monthly	4.00	3.71	3.77	3.54	4.22	3.42	3.50	3.54	4.17	4.03	3.60	3.99	4.54	4.54		low is good	-	-	-
Operational Productivity	LOS - Excluding Oncology, Paeds,YAH, Spinal	Monthly	3.31	3.37	3.41	2.96	3.69	2.94	2.96	2.64	3.54	3.49	3.32	3.53	3.71	3.71		low is good	-	-	-
Operational Productivity	LOS - Elective Primary Hip	Monthly	3.16	3.14	3.53	3.57	3.38	3.29	2.58	2.88	3.40	3.14	3.06	2.82	3.32	3.32		low is good			2.7
Operational Productivity	LOS - Elective Primary Knee	Monthly	3.35	3.56	3.61	3.12	3.45	2.88	3.43	2.68	3.25	3.40	3.50	3.29	3.37	3.37		low is good			2.7

Assurance Reports: Private Patients





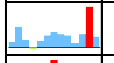
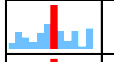
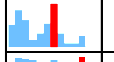
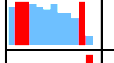
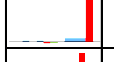
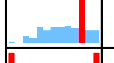
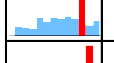
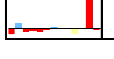




All figures shown in thousands (000s) unless otherwise stated

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 April were below the planned trajectory, with total income of £275,992 against a planned position of £414,000. Eleven patient cancellations during the month resulted in approximately £90,420 of lost income. Clinical 5 Non Clinical 2 Patient Choice 2 Funding not agreed 2 **Total** 11 Ongoing theatre staffing constraints and skill mix challenges continue to impact the ability to accommodate specific consultant requirements, with one consultant currently undertaking activity externally. This is resulting in an estimated loss of c.£100k income per month and remains a significant risk to delivery of the 2026/27 income plan. During April, the Woodland Suite was closed for 3 weeks to facilitate essential maintenance works. Private patients were cohorted onto Ward 12 and Ward 1 during this period, requiring additional operational coordination and communication to ensure patient expectations were managed and experience maintained.	A revised tariff has been agreed with Bupa for 2026/27, delivering an average uplift of approximately 7.5%, alongside the introduction of 24 new tariffs to support service development and expansion. Aviva is currently undertaking a tender process for spinal network providers, and the service has formally confirmed its intention to apply. If successful, this would support additional spinal activity within the service. The Practising Privileges Policy has been approved, with the first external surgeon progressing through the onboarding process. This will support the expansion of private hand surgery provision, addressing an existing gap in service availability. Focus remains on securing and rebuilding activity levels, with 31 bookings currently confirmed for May. The Trust Commercial group had its initial meeting in April to support the acceleration of growth in Private Patients	**Action Timescale:** Continue to utilise available weekday and weekend capacity. Further work on commercial initiatives with proposals to be brought forward through the Commercial Group in May.	Risk 2164	High

Integrated Performance Dashboard: Finance

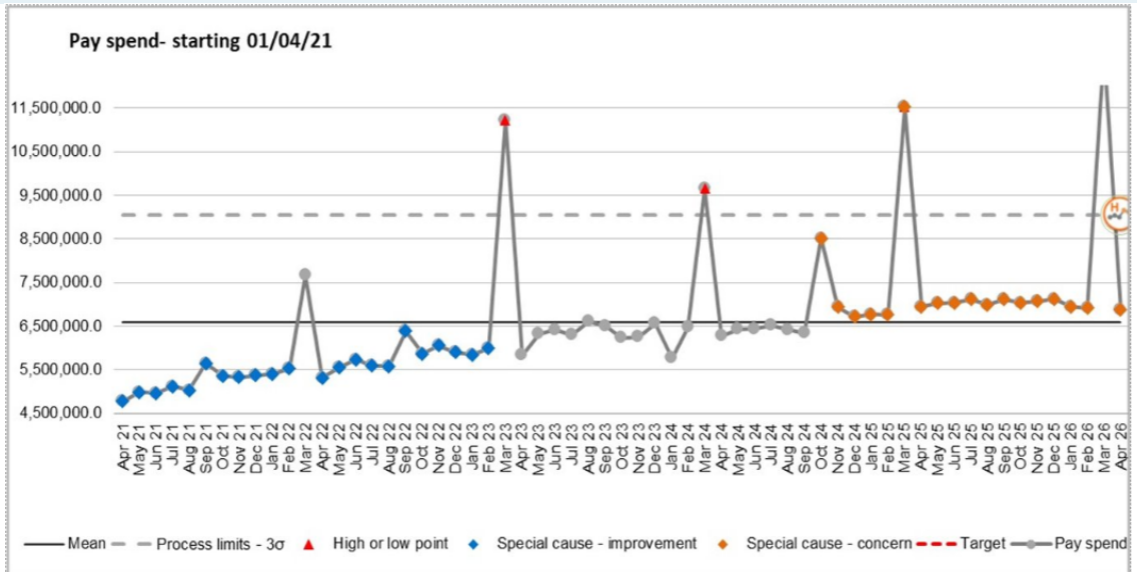
Metric Grouping	Metric Name	Reporting Period	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Finance	I&E Margin (%)	Monthly	(3.30%)	3.30%	(2.10%)	(0.90%)	(2.50%)	(0.10%)	0.90%	0.40%	0.46%	(3.70%)	0.10%	1.14%	4.50%	4.50%		high is good	-	-	1%
Finance	I&E Variation from Plan	Monthly	(102)	635	(71)	(110)	(220)	(64)	(64)	2	9	(505)	(74)	2,235	8	8		low is good	-	-	0
Finance	EBITDA (%)	Monthly	2.30%	8.40%	3.40%	(1.10%)	3.00%	5.20%	6.20%	5.70%	5.20%	2.00%	5.60%	16.49%	4.50%	4.50%		high is good	-	-	6%
Finance	CIP Value	Monthly	409	575	484	418	549	683	961	581	441	582	352	626	316	316		high is good	-	-	7,764
Finance	CIP Performance	Monthly	82.79%	105.70%	89.96%	60.23%	70.20%	84.95%	115.09%	69.58%	55.33%	54.20%	67.20%	49.92%	48.84%	0		high is good	-	-	0
Finance	Agency Expenditure	Monthly	105	121	117	115	106	99	113	95	92	77	123	56	4	4		low is good	-	-	898
Finance	Agency % of total pay bill	Monthly	1.50%	1.70%	1.70%	1.60%	1.50%	1.40%	1.60%	1.30%	1.30%	1.10%	1.70%	0.44%	0.10%	0.10%		low is good	-	-	1.5%
Finance	Capital - Variation to Plan (including impact of IFRS 16)	Monthly	65	65	275	111	245	(121)	(140)	167	551	445	453	4,903	0	0		low is good	-	-	3,857
Finance	Cash Balance at end of month	Monthly	1,578	835	4,034	3,258	8,158	6,696	8,484	8,528	8,653	7,701	21,336	6,964	6,648	6,648		high is good	-	-	11,590
Finance	BPPC Invoices Paid < 30 days (Volume %)	Monthly	86.10%	73.00%	74.10%	76.50%	78.70%	78.70%	79.60%	80.40%	81.20%	80.40%	81.00%	81.10%	86.10%	86.10%		high is good	-	-	100%
Finance	BPPC Invoices Paid < 30 days (Value %)	Monthly	86.90%	68.50%	67.90%	66.10%	67.60%	71.20%	72.90%	71.10%	71.70%	70.70%	69.90%	77.20%	86.90%	86.90%		high is good	-	-	100%
Finance	Creditor Days	Monthly	0	113	121	113	108	89	99	85	95	89	86	82	112	112		low is good	-	-	30
Finance	Debtor Days	Monthly	0	64	48	54	43	41	42	35	32	30	30	26	37	37		low is good	-	-	30
Finance	Operating Expenditure Days	Monthly	0	12	11	9	23	17	23	22	24	21	54	13	18	18		high is good	-	-	n/a
Finance	I&E Surplus / (Deficit) (£k)	Monthly	(377)	402	(242)	(164)	(291)	(17)	102	51	40	(409)	7	2,604	(59)	(59)		high is good	-	-	(803)

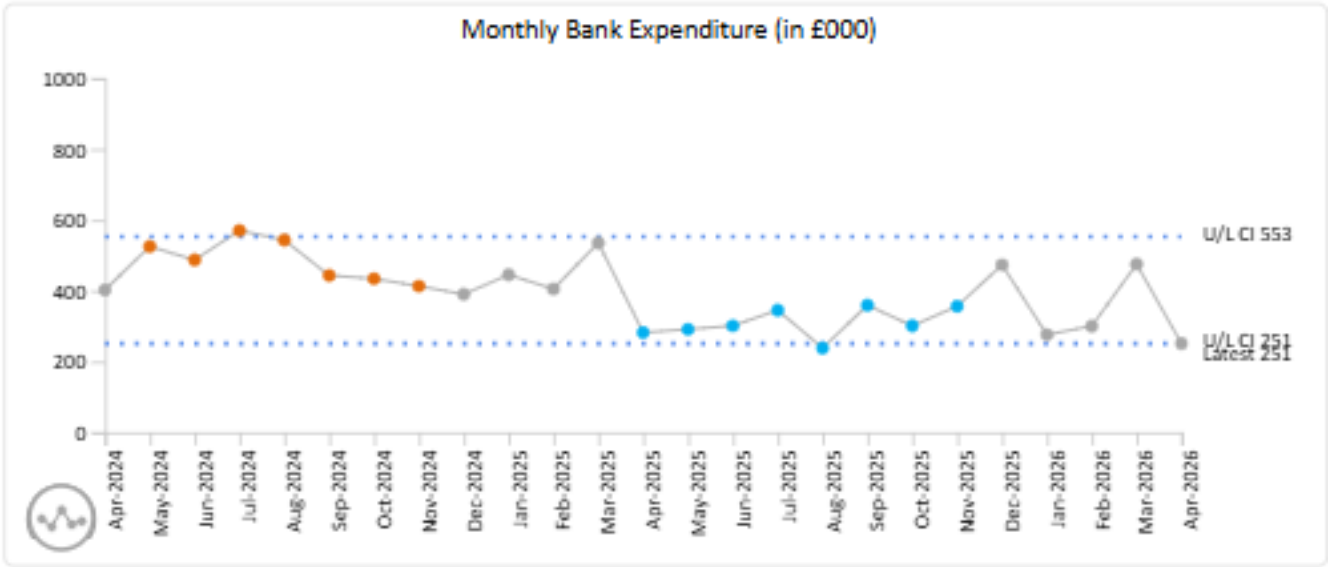
Assurance Reports: Finance Commissioner Income

	Actual	Plan	Variance
Day Cases	£802,650	£977,336	-£174,686
Elective	£2,583,591	£2,636,494	-£52,903
Excess bed days EL	£96,760	£97,777	-£1,017
Outpatient FA Single Professional Consultant Led	£296,486	£436,491	-£103,023
Outpatient FA Consultant Led Non Face to Face	£36,982		
Outpatient Procedures FA	£7,413	£39,669	£14,863
Outpatient Procedures FUP	£47,119		
Diagnostics	£140,851	£160,763	-£19,912
Deconstructing block adjustment - agreement different to plan	-£42,871		-£42,871
Private patients	£296,000	£551,000	-£255,000
Passthrough income	£208,0000	£239,000	-£31,000
TOTAL	**£4,558,723**	**£5,138,529**	**-£665,548**

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
Income performed below plan by £742k. Commissioner income underperformed in month against plan by £377k, and private patient income by £255k against plan. The position presents a delivery risk where underperformance against plan may not be recoverable in the remaining months of the financial year In addition, the detailed income variance review highlighted underlying drivers including case mix changes, tariff variances, planning assumption limitations, and differences in chargeable activity. This reinforces the need for improved alignment between operational delivery, income planning and reporting.	A focused recovery and assurance programme is in place, aligned to the action plan agreed through the Executive income variance report, including: • Implementation of enhanced income reporting at specialty and consultant level, supported by new dashboards (shadow running in Q1 with full implementation in Q2) • Strengthening reporting to clearly distinguish activity and price variance, enabling earlier identification of income risks • Scenario modelling and sensitivity analysis to quantify financial risk and identify achievable recovery actions • Review of elective and outpatient activity profiles, including validation of planning assumptions (productivity, case mix, chargeable activity) • Refinement of outpatient first attendance and procedure throughput assumptions to support income recovery • Strengthened triangulation of activity, workforce capacity and income to improve forecast robustness • Alignment of income reporting and accountability with the Strategic Business Unit framework to improve ownership and grip • Targeted focus on areas of non payment risk (e.g. overperformance against cap, prior approval requirements, non chargeable activity)	- Income recovery trajectory agreed at Financial Delivery Board. - Delivery of income reporting improvements phased through Q1–Q2. - Ongoing monitoring through FDB and Executive Team with monthly deep dives on income performance.	n/a	High

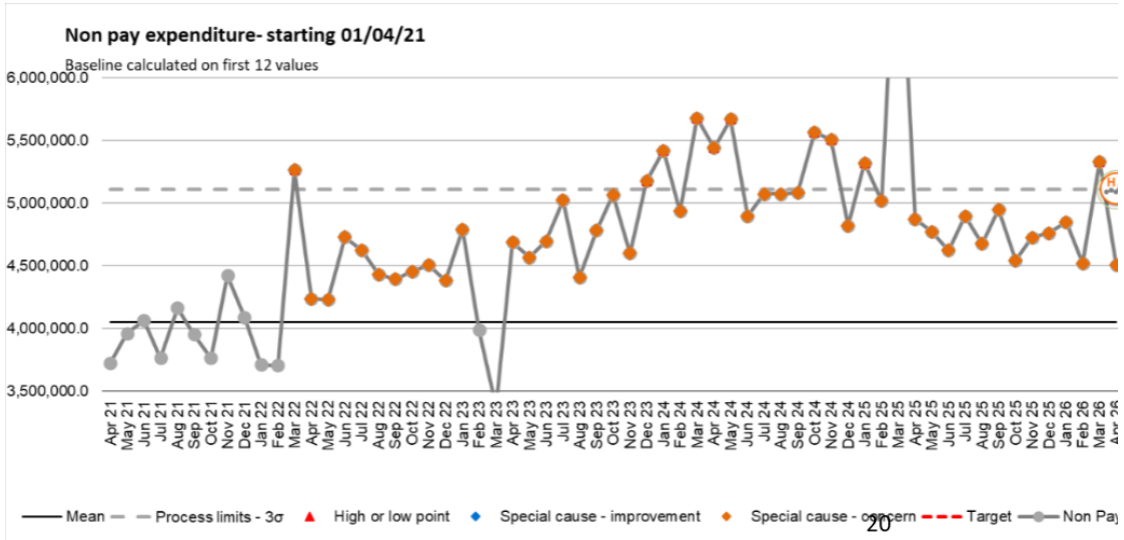
Assurance Reports: Finance Pay Expenditure





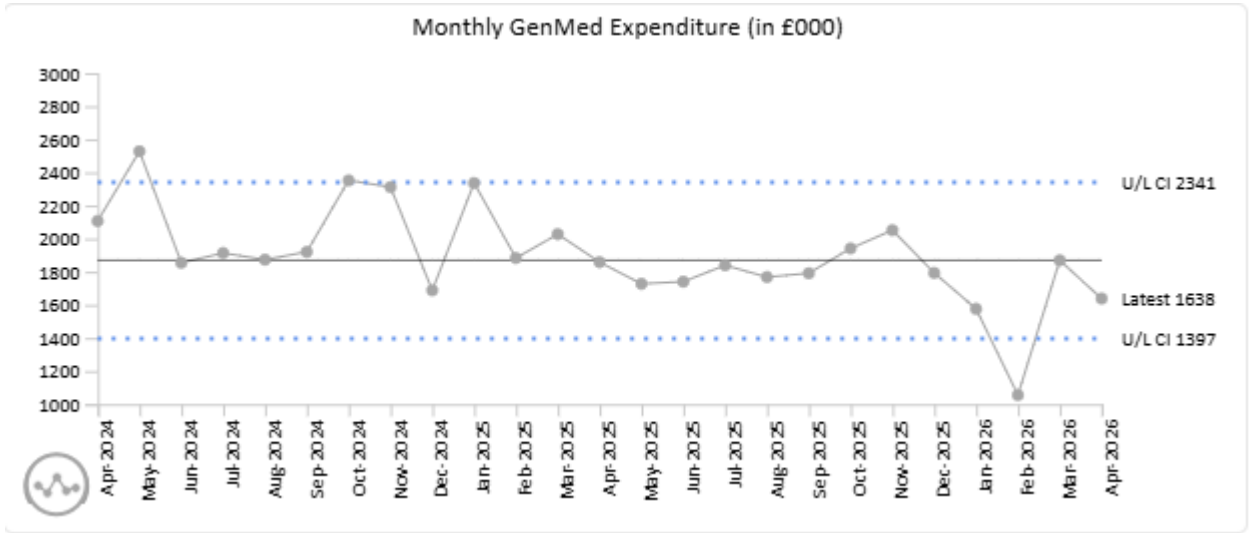
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Pay expenditure is underspent by £140k, with the largest favourable variance of £91k against substantive staffing. Agency spend reduced in month, being less than 1% of paybill, with an underspend of £70k. Bank expenditure has reduced in month compared to previous month spend but is overspent in month by £20k.	•Delivery of enhanced pay controls action plan •Targeted review of bank and agency utilisation with weekly deputy led forum •Best practice bank usage guide to be communicated •Implementation of additional workforce controls, including tighter governance over shift approvals and premium usage •Acceleration of workforce related CIP schemes, with a focus on phasing and timing of benefit realisation •Continued focus on reducing vacancy gaps and improving substantive recruitment to mitigate reliance on temporary staffing •Full roll out of electronic rostering across all staff groups and departments to optimise resource planning	• Weekly deputy led forum to monitor bank usage • New weekly Temporary staffing escalation meetings to be trailled during May • Financial sustainability improvement group (FSIG) monitoring of CIP schemes • Trust Improvement group monitoring of electronic rostering roll out	n/a	High

Assurance Reports: Finance Non-Pay Expenditure



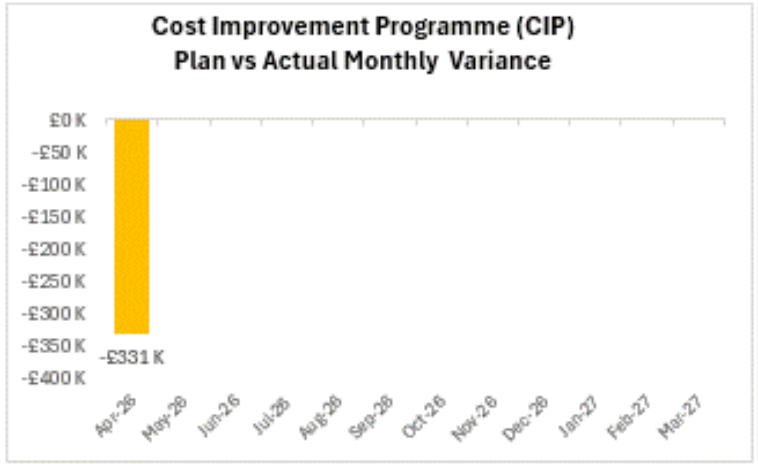
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Non pay expenditure underspent in month by £504k. This is primarily driven as a result of a reduction in clinical supplies related to activity delivery.	• Full review of non-pay forecast outturn to establish a realistic non pay trajectory for Months 11 and 12, including resetting non-recurrent adjustments. • Deep-dive into non pay CIP programme to determine expected delivery, identify high risk schemes, and confirm mitigating actions. • Strengthened cost control and authorisation for non-essential non-pay	• Non pay recovery trajectory agreed at FDB on 17/12 • Further discussion on performance and mitigation plans at FDB on 20/01	n/a	High
Premium rate additional sessions remain a key element of the cost improvement plan, with a reduction in LLP expenditure planned of £1.3m. Savings totalling £14k in month .	• Agreement of LLP spend for 26/27 aligns to activity plan • Activity, finance and workforce plan for 26/27 triangulated to ensure they reflect the available resources	• Financial plan agreed at March Trust Board	n/a	High

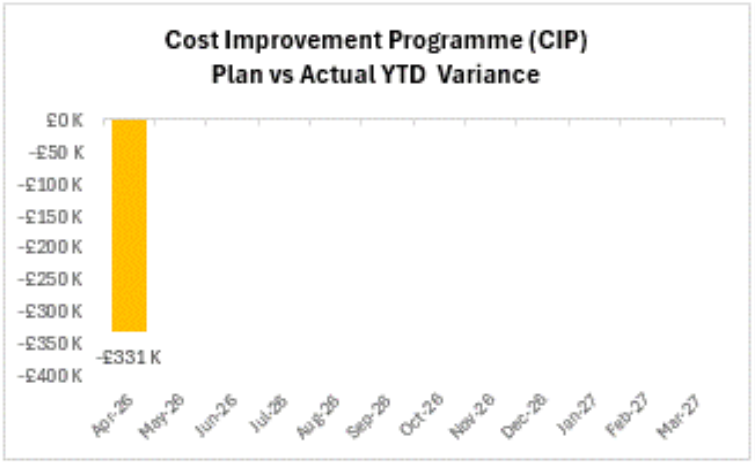
Assurance Reports: Finance

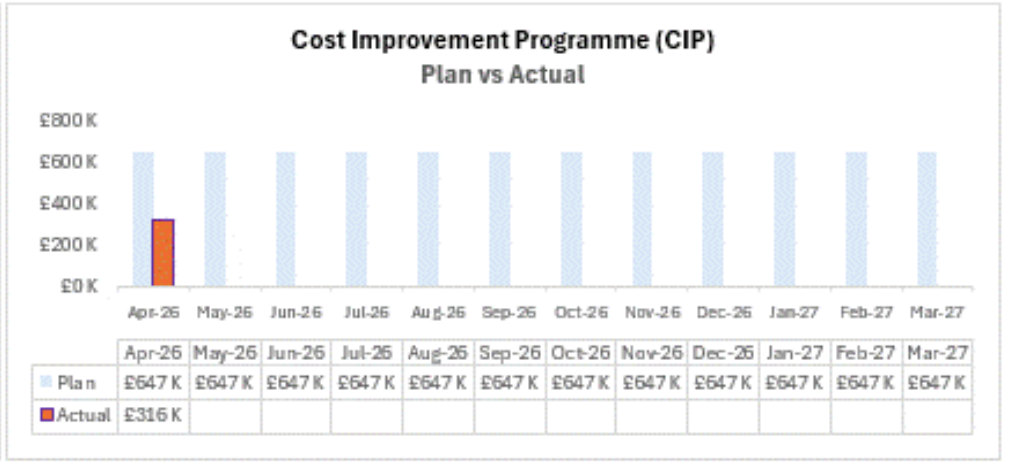


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Genmed spend remains reduced in the month due to the enhanced controls implemented for ad-hoc spend variance, and lower activity. 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. 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 • Monthly Strategic Contract Review meetings with Genmed with attendance from CFO. • 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)





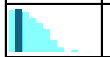
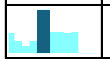
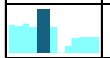
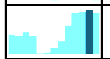
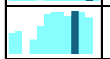
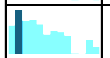
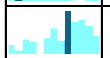


	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Plan	£647 K	£647 K	£647 K	£647 K	£647 K	£647 K	£647 K	£647 K	£647 K	£647 K	£647 K	£647 K
Actual	£316 K											

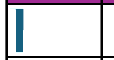
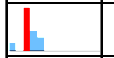
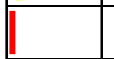
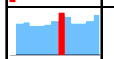
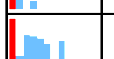
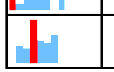
All figures shown in thousands (000s) unless otherwise stated

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
CIP identification has progressed in month with the 5% CIP delivery target fully identified, totalling £7.7m CIP. In month efficiencies of £316k have been recorded, generating an underperformance of £331k in month. Quality Impact Assessments (QIAs) for schemes are in progress with the panel meeting weekly to review assessments.	• 26/27 CIP plan phased more evenly across the year to avoid the significant increase in Q4 CIP delivery required that was seen in 25/26 • Action plan underway following Internal Audit review; ○ Revamp of Financial Sustainability improvement group meeting ○ New documentation for CIP submission	• Financial plan agreed at March Trust Board • Financial sustainability improvement group terms of reference to be updated by end May	n/a	High

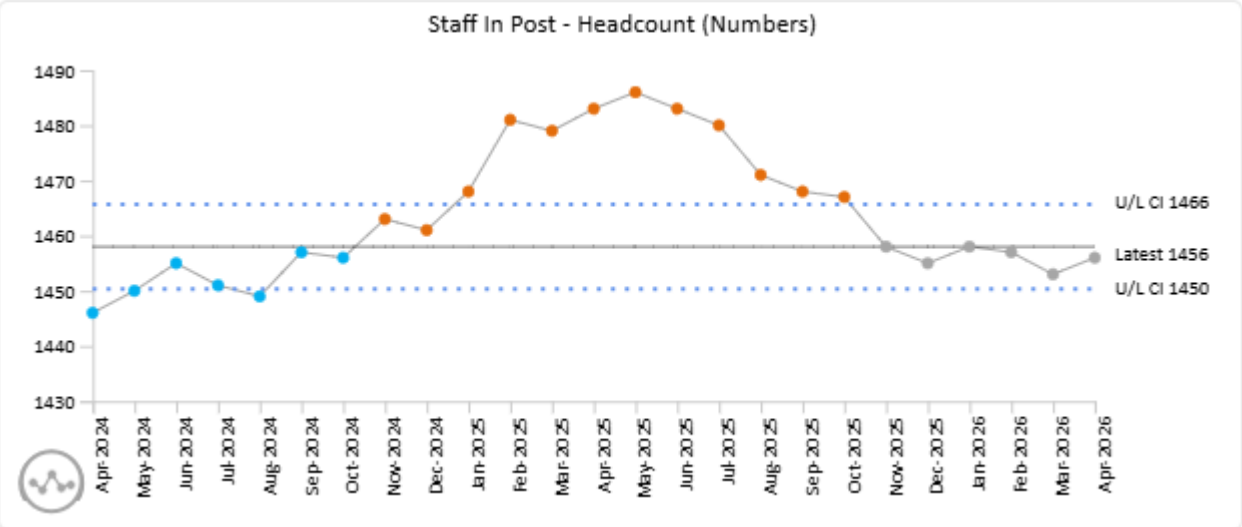
Integrated Performance Dashboard: Workforce

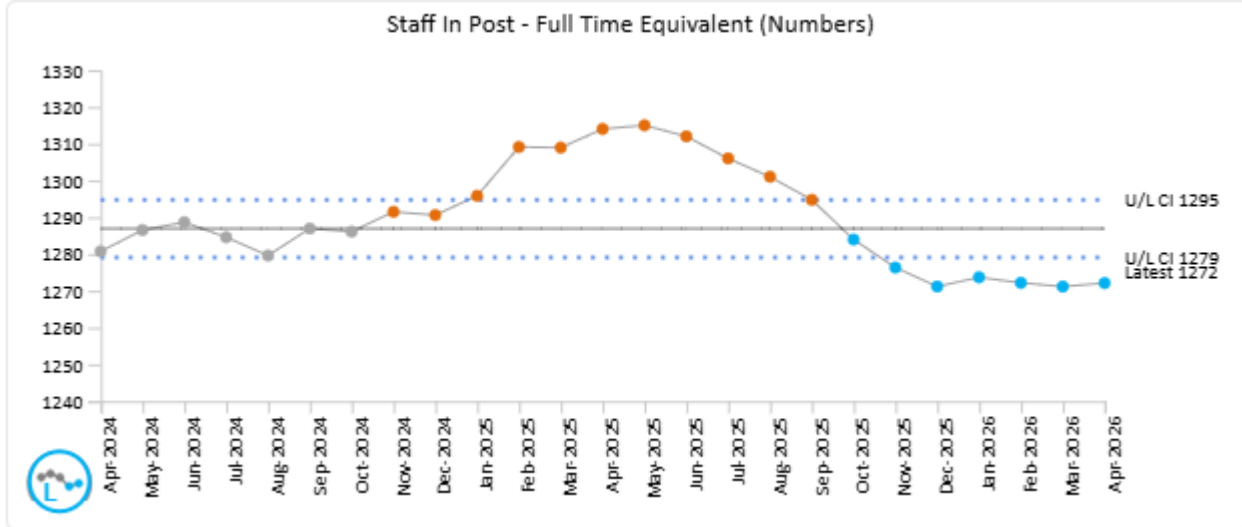
Metric Grouping	Metric Name	Reporting Period	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Workforce	Staff In Post - Headcount	Monthly	1,483	1,486	1,483	1,480	1,471	1,468	1,467	1,458	1,455	1,458	1,457	1,453	1,456	1,456			-	-	-
Workforce	Staff In Post - Full Time Equivalent	Monthly	1,314	1,315	1,312	1,306	1,301	1,295	1,284	1,276	1,271	1,274	1,272	1,271	1,272	1,272			-	-	-
Workforce	Staff Turnover Percentage - Adjusted	Monthly	9.28%	10.73%	10.64%	10.15%	10.10%	8.88%	10.34%	10.43%	10.27%	10.33%	9.73%	9.60%	9.95%	9.95%		low is good			10.5%
Workforce	Total Whole Time Equivalent Employed as a Percentage of Establishment - Clinical	Monthly	89.14%	88.43%	87.97%	88.40%	91.17%	91.17%	89.23%	89.20%	89.12%	89.26%	87.31%	87.31%	87.31%	87.31%		high is good			92%
Workforce	Total Whole Time Equivalent Employed as a Percentage of Establishment - Non-Clinical	Monthly	90.40%	90.25%	90.44%	90.20%	91.62%	91.62%	90.23%	88.09%	88.69%	89.26%	89.37%	89.37%	89.37%	89.37%		high is good			96%
Workforce	Percentage of Attendance	Monthly	94.32%	94.27%	94.01%	93.93%	94.53%	94.38%	93.79%	94.52%	94.52%	94.38%	94.23%	94.01%	94.66%	94.66%		high is good			96%
Workforce	Percentage of Staff Received Mandatory Training last 12 months	Monthly	86.99%	86.63%	87.43%	86.82%	82.85%	83.13%	84.14%	85.47%	88.79%	91.45%	91.61%	92.08%	91.41%	91.41%		high is good			93%
Workforce	Percentage of Staff Received Formal PDR/Appraisal last 12 months	Monthly	84.92%	85.58%	79.52%	83.10%	86.61%	90.00%	90.56%	90.59%	89.50%	90.85%	90.67%	89.21%	79.20%	79.20%		high is good			95%
Workforce	Percentage of Sickness Trust Wide Long Term	Monthly	3.90%	4.45%	4.04%	4.08%	3.93%	3.57%	3.70%	3.65%	3.55%	2.87%	2.90%	3.39%	3.14%	3.14%		low is good	-	-	-
Workforce	Percentage of Sickness Trust Wide Short Term	Monthly	1.84%	1.61%	2.08%	1.99%	1.46%	2.09%	2.52%	2.00%	3.21%	2.75%	2.86%	2.59%	2.21%	2.21%		low is good	-	-	-
Workforce	Return to Work Completion %	Monthly	67.44%	61.22%	66.24%	69.33%	65.37%	67.01%	67.50%	69.27%	73.96%	68.35%	85.06%	66.83%	76.35%	76.35%		high is good			80%

Integrated Performance Dashboard Headline/Workforce Productivity

Metric Grouping	Metric Name	Reporting Period	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Headline Producitivity	Implied Productivity Growth (v 19/20)	Monthly	-11.10%	-14.70%	-12.90%	-14.30%	-14.40%												-	-	
Headline Producitivity	Implied Productivity Growth (V previous year)	Monthly	0.90%	8.7%%	4.60%	2.20%	1.50%												-	-	
Workforce Productivity	Implied Workforce Productivity Growth (v19/20)	Monthly	-9.00%	-14%	-12.70%	-10.30%	-10.70%												-	-	
Workforce Productivity	Elective Admissions per clinical WTE	Monthly	2.89	0.44	0.45	0.45	0.46	0.46	0.49	0.48	0.48	0.47	0.44	0.46	0.50						
Workforce Productivity	Elective Admissions per WTE	Monthly	0.95	366.38	375.91	337.28	338.91	350.11	392.64	486.55	434.48	363.41	361.14	386.84	462.54				-	-	
Workforce Productivity	Outpatient Attendances per consultant wte	Monthly	77.87	4.48	4.42	4.64	4.83	4.27	5.04	4.92	4.52	4.19	4.64	4.63	4.84				-	-	
Workforce Drivers	Total Temporary Staff Spend as % of Total pay Spend	Monthly	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	6.90%	6.36%	7.71%	7.10%													-	-	
Workforce Drivers	Medical Sickness Absence Rate	Monthly	1.10%	0.75%	0.12%	0.30%													-	-	
Workforce Drivers	Turnover (Adjusted)	Monthly	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	4.59	5.26	5.19	6.34	5.50	5.40	5.70										-	-	

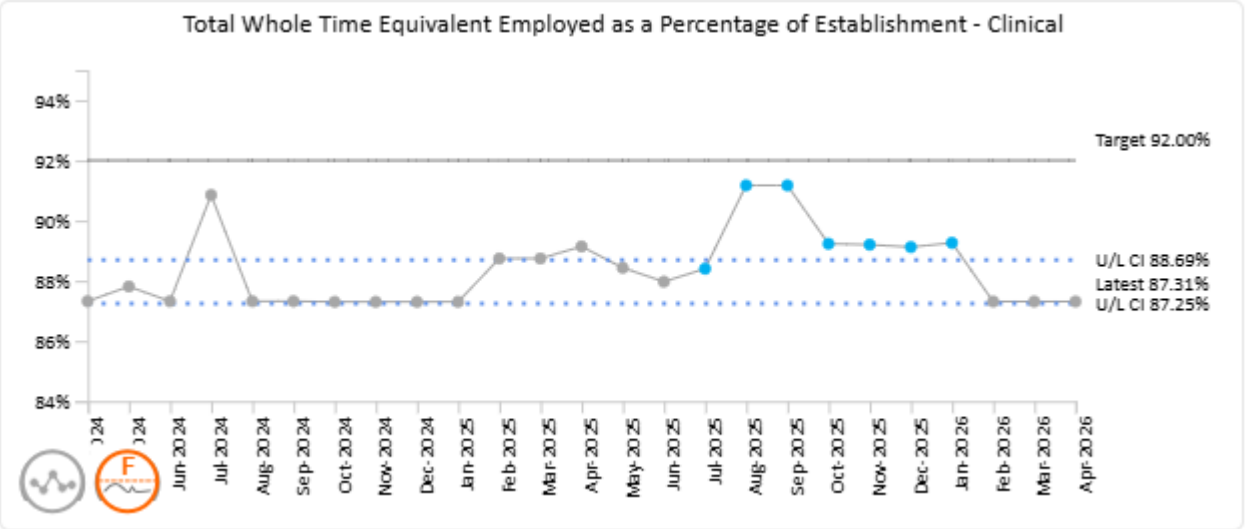
Assurance Reports: Workforce

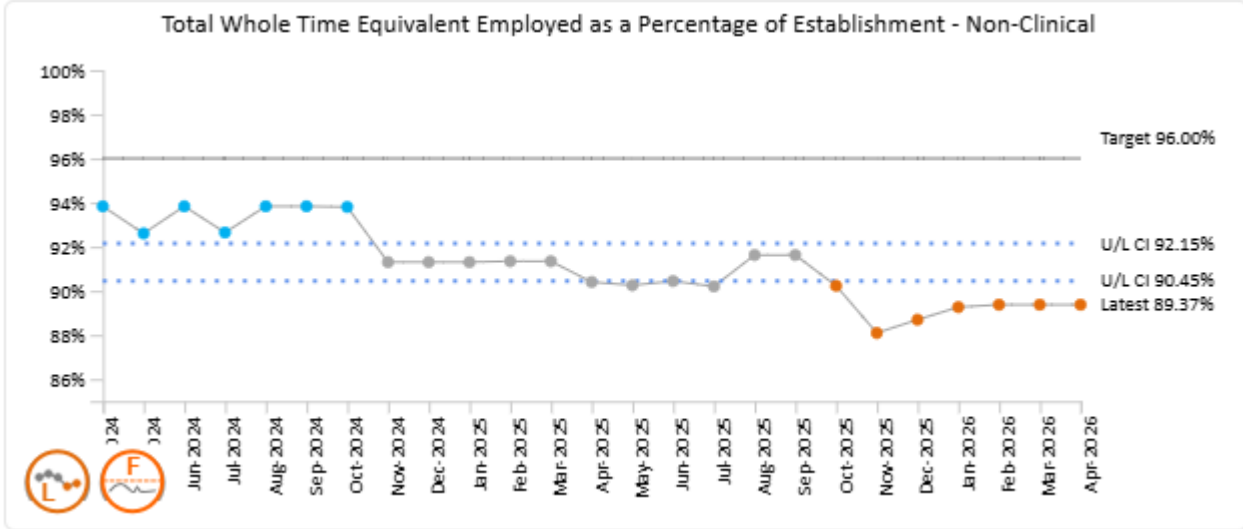




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
• There is a risk that we have the wrong number of staff in the wrong areas, balancing pay spend with 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. • Workforce planning is becoming more embedded in the Trust, with several core services receiving workforce planning support. • Training on workforce planning in place as part of Me as Manager.	• Vacancy controls strengthened by new system to include all pay related changes – Jan 26 Assurance committee: Staff Experience and Organisational Development (SE&OD)	Risk 2059	High

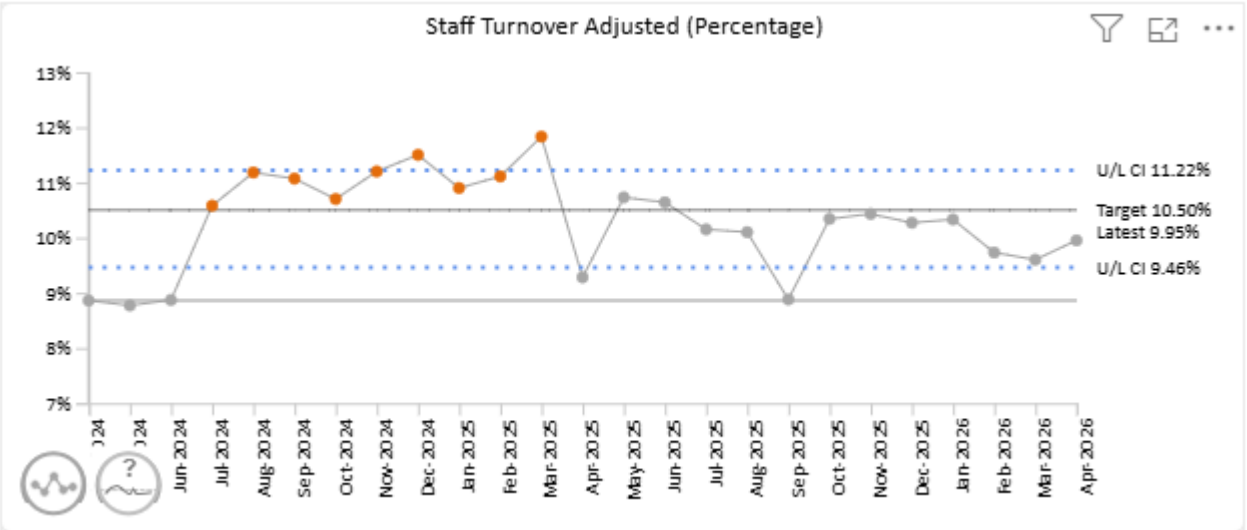
Assurance Reports: Workforce continued

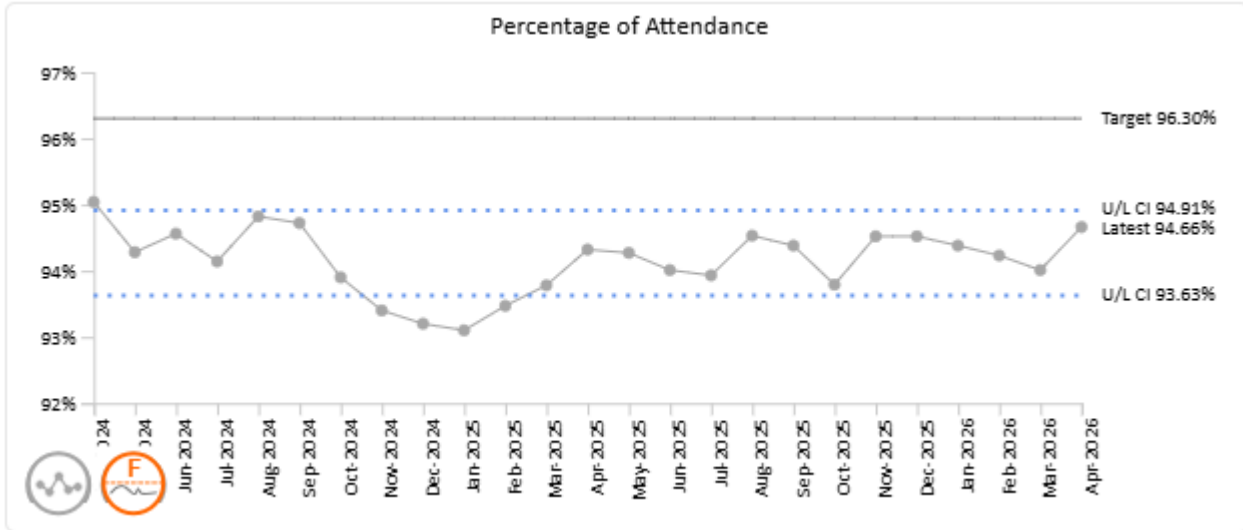




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
• There is a risk that if we don't fulfil our establishments, we will have higher temporary spend leading to poor workforce resilience. • 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. • Temporary Workforce Group has been meeting weekly from January to monitor bank requests and provide challenge where required. • Bank principles document has been distributed to all managers	Regular work takes place to align ledger with ESR data. April 26 Assurance committee: Staff Experience and Organisational Development (SE&OD)	Risk 2060	Medium – requires ongoing manual alteration

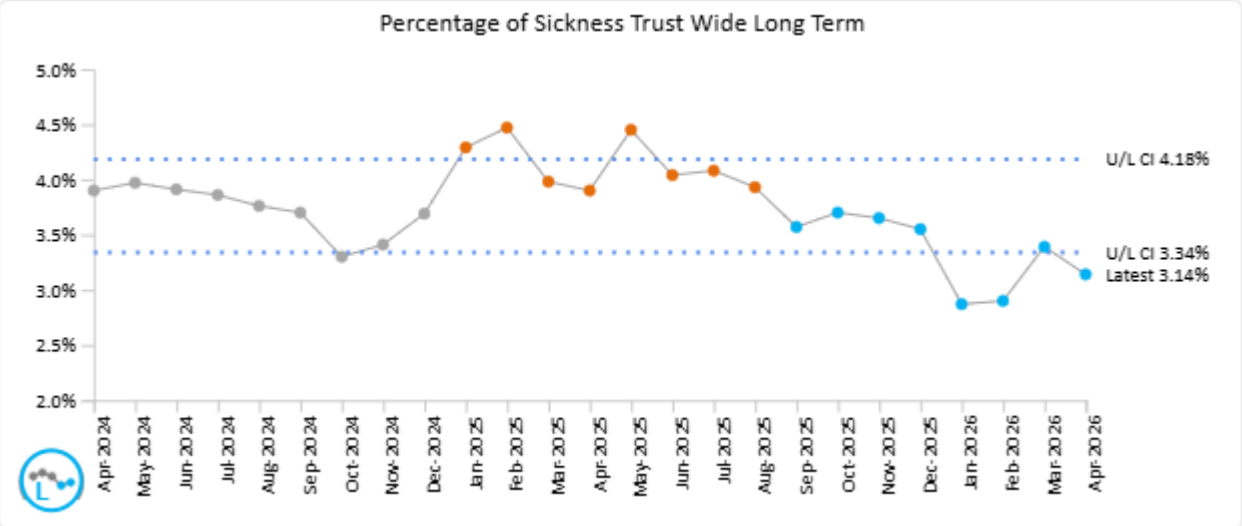
Assurance Reports: Workforce continued

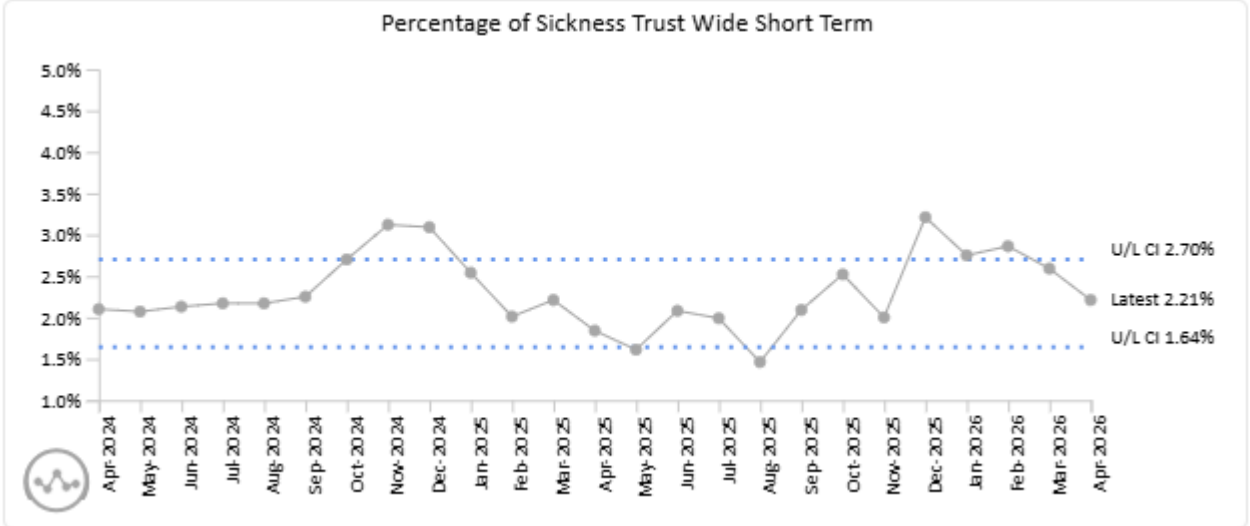




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
• There is a risk that we don't retain key staff through poor engagement and/or better reward packages at other organisations • 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 and the launch of VITA • Regular review of leavers data • Completion of national retention audit survey	April 26 Ongoing Audit Assurance committee: Staff Experience and Organisational Development (SE&OD)	Risk 2058	High assurance

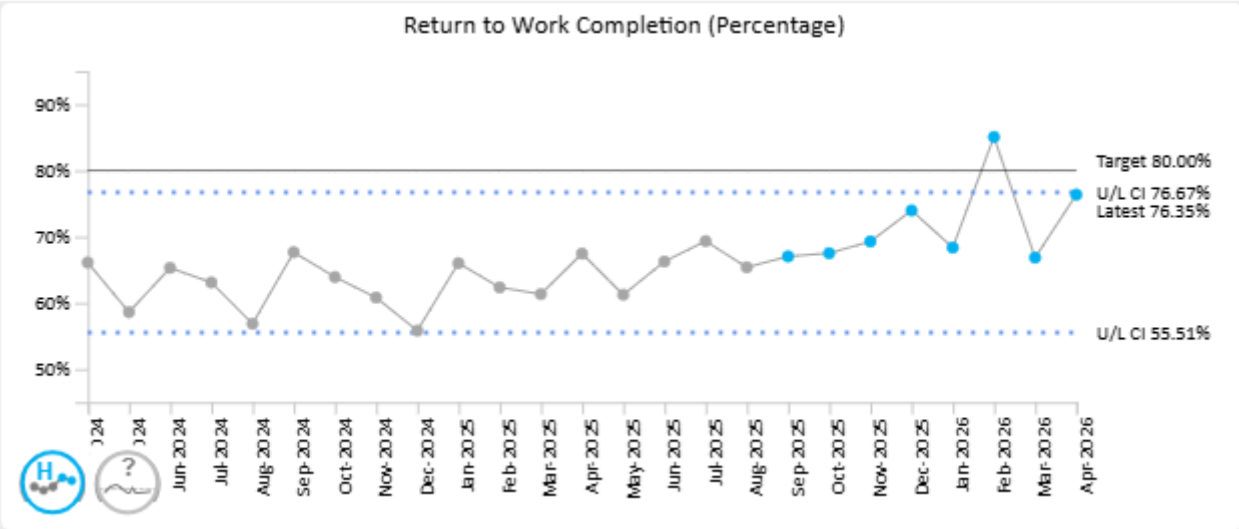
Assurance Reports: Workforce continued





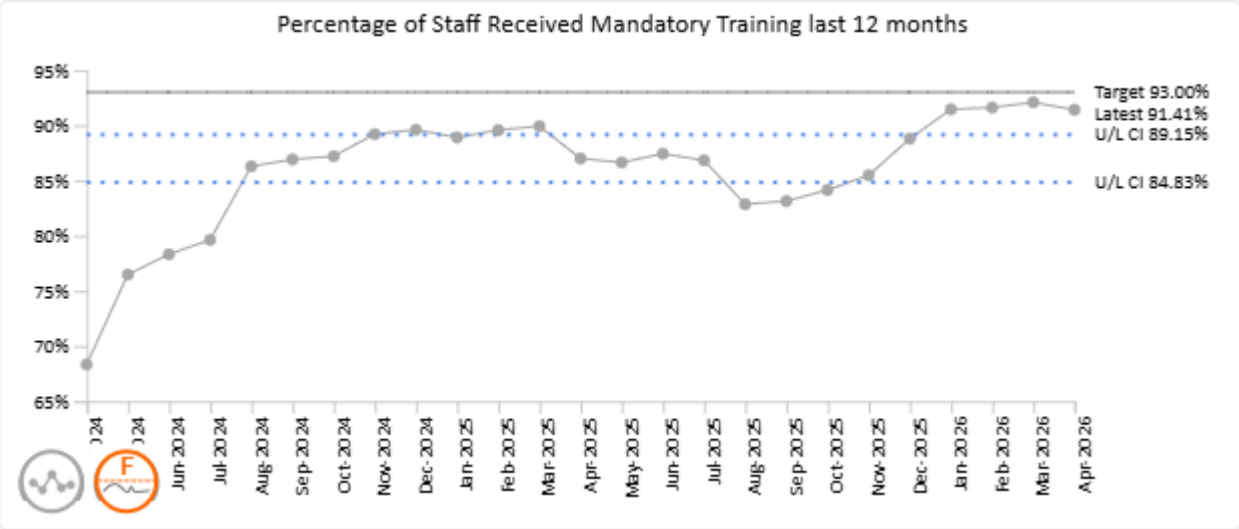
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
• There is a risk that we have excessive staff unavailability. This leads to higher temporary staffing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

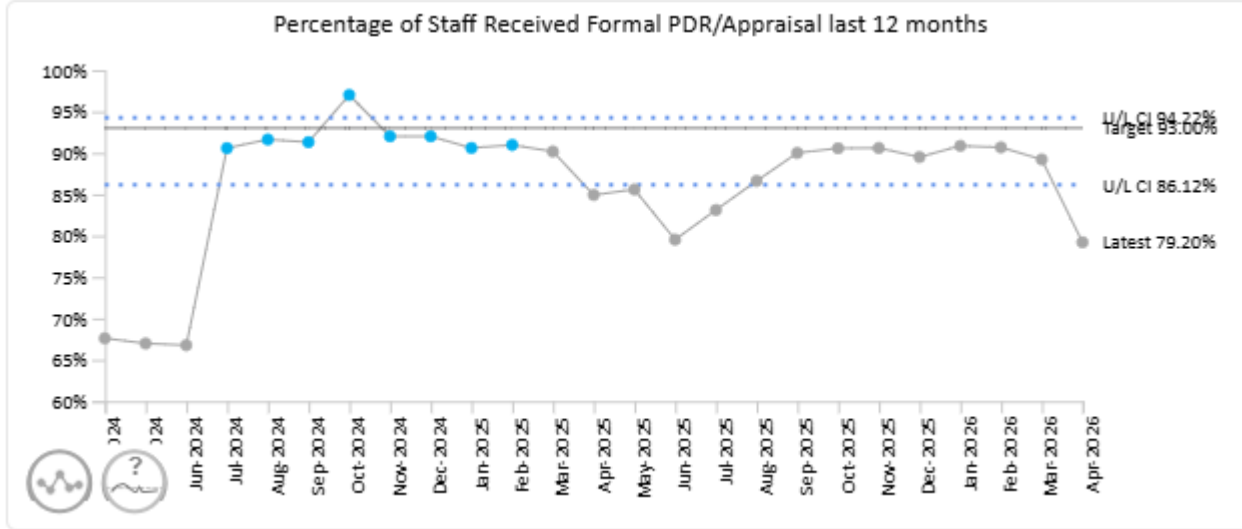
Assurance Reports: Workforce continued



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
• There is a risk that a low return to work rating demonstrates a lax approach to policy compliance, potentially leading to higher episodes of sickness absence.	• We regularly audit departments with lower rates of completion • The Trust rollout to Health Roster will continue to support compliance as it's an easier system to log return to work. • High support/workshops in place for areas with lower compliance	On-going Audits continue on an ongoing basis Healthroster rollout nearing completion Assurance committee: Staff Experience and Organisational Development (SE&OD)	Risk 2156	High assurance

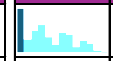
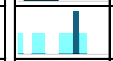
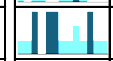
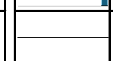
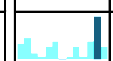
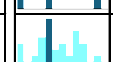
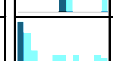
Assurance Reports: Workforce continued





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. • 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. • 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 92.08% in March - T&D team working closely with the NHSE StatandMand review project to align activity, with the potential to reduce "time" completing training. - Agreed that annual fire safety training requirement will align to national recommendations and move to two yearly renewal from April 2026. - 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 - 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. Assurance committee: Staff Experience and Organisational Development (SE&OD)	R1436	High assurance

Integrated Performance Dashboard: Governance

Metric Grouping	Metric Name	Reporting Period	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Governance	Number of Incidents Reported	Monthly	398	284	316	337	295	267	311	303	256	282	268	247	239	239		high is good	-	-	
Governance	Number of PSII (Patient Safety Incident Investigations)	Monthly	0	1	1	1	1	1	0	0	0	0	0	0	0	0		low is good			0
Governance	Number of Inpatient Deaths	Monthly	1	0	1	1	0	0	1	1	2	1	0	0	0	0		low is good			0
Governance	Number of Deaths within 30 days of discharge	Monthly	1	1	3	0	3	3	1	1	2	1	3	1	1	1		low is good			0
Governance	Number of Never Events	Monthly	0	1	0	0	1	1	0	0	0	0	0	0	0	0		low is good			0
Governance	Number of VTE	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good			0
Governance	Number of Category 3 Pressure Ulcer Incidents ROH acquired	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	1	1		low is good			0
Governance	Number of Category 4 Pressure Ulcer Incidents ROH acquired	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good	-	-	-
Governance	Number of Inpatient Falls	Monthly	8	10	5	4	7	9	3	4	7	4	9	17	7	7		low is good			0
Governance	Number of Infection Incidents (Reportable)	Monthly	1	0	0	0	1	0	0	0	0	0	0	1	0	0		low is good	-	-	-
Governance	Number of Complaints	Monthly	8	5	6	9	12	7	8	6	10	8	5	6	5	5		low is good	-	-	-
Governance	Number of PAL contacts	Monthly	51	57	40	46	44	53	45	52	37	41	27	37	37	37		low is good			0
Governance	Number of Claims	Monthly	0	2	1	1	0	0	0	0	0	2	1	0	0	0		low is good			0
Governance	Number of Inquests	Monthly	0	0	0	0	0	0	2	1	0	0	0	0	1	1		low is good	-	-	-
Governance	Number of Medication Incidents	Monthly	16	13	8	5	5	7	7	5	7	4	5	7	6	6		low is good	-	-	-
Governance	Number of Deteriorating Patients Transfers to HDU	Monthly	3	2	1	5	4	4	3	3	1	2	3	2	2	2		low is good	-	-	-
Governance	Number of Deteriorating Patients Emergency Transer OUT	Monthly	3	1	1	5	5	3	3	6	1	0	4	1	5	5		low is good	-	-	-
Governance	Number of RIDDOR- Reportable Staff Incidents	Monthly	1	3	0	0	1	0	1	1	0	2	0	0	1	1		low is good	-	-	-

Integrated Performance Dashboard: Infection Control

Metric Grouping	Metric Name	Reporting Period	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-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	L	P	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	L	P	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	L	P	0
Infection Control	Hospital-onset healthcare-associated Escherichia coli Bacteraemia	Monthly	1	0	0	0	0	0	0	0	0	0	1	0	0	0		low is good	L	P	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	L	P	0
Infection Control	Hospital-onset healthcare-associated C. difficile Toxin +ve (reportable)	Monthly	0	0	0	0	1	0	0	0	0	0	0	1	0	0		low is good	L	P	0
Infection Control	All C. difficile cases identified on or during admission	Monthly	0	0	0	1	1	0	0	1	0	0	0	2	0	0		low is good		P	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	L	P	0
Infection Control	Healthcare-associated Influenza	Monthly	0	0	0	0	0	0	0	0	3	0	0	0	0	0		low is good	L	P	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	L	P	0
Infection Control	Respiratory Infection Outbreaks	Monthly	0	0	0	0	0	0	0	0	1	0	0	0	0	0		low is good	L	P	0
Infection Control	Other Infection Outbreaks	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good	L	P	0
Infection Control	Surgical Site Infections (inpatient & readmission - month of primary surgery)	Monthly	2	1	2	3	1	2	1	5	1	2	3	2	0	0		low is good	L	P	0
Infection Control	Hand Hygiene Audit - Trust total %	Monthly	99%	91%	99%	100%	99%	99%	99%	99%	99%	100%	100%	99%	100%	100%		high is good	H	P	90%

Please note that quality slides are still work in progress

Quality Report

Month 1

May 2026 (April 2026 data)

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.

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.

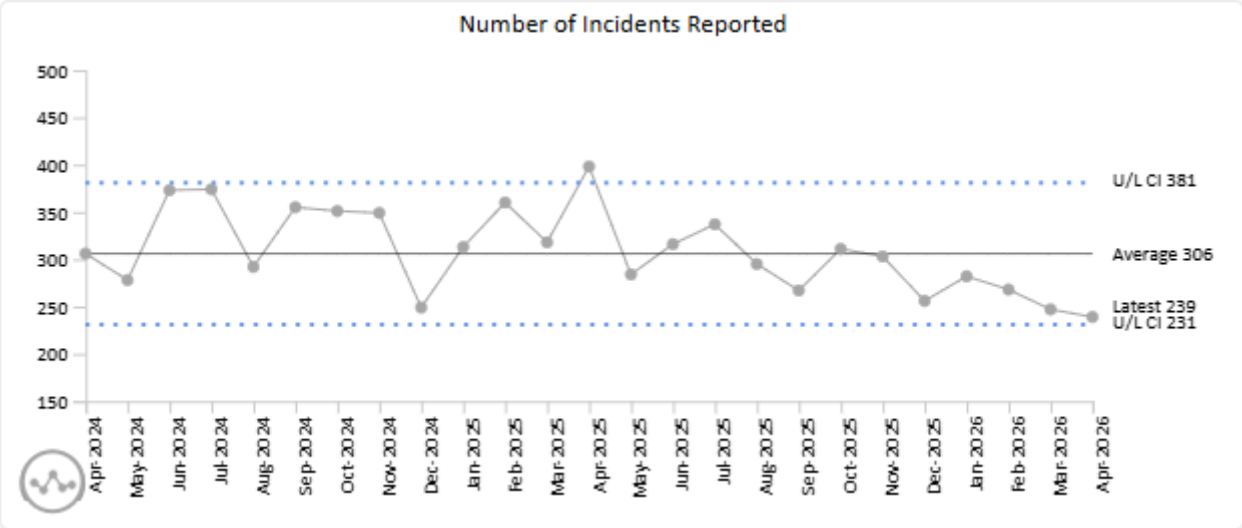
A grey assurance icon indicates inconsistently passing and falling short of the target.

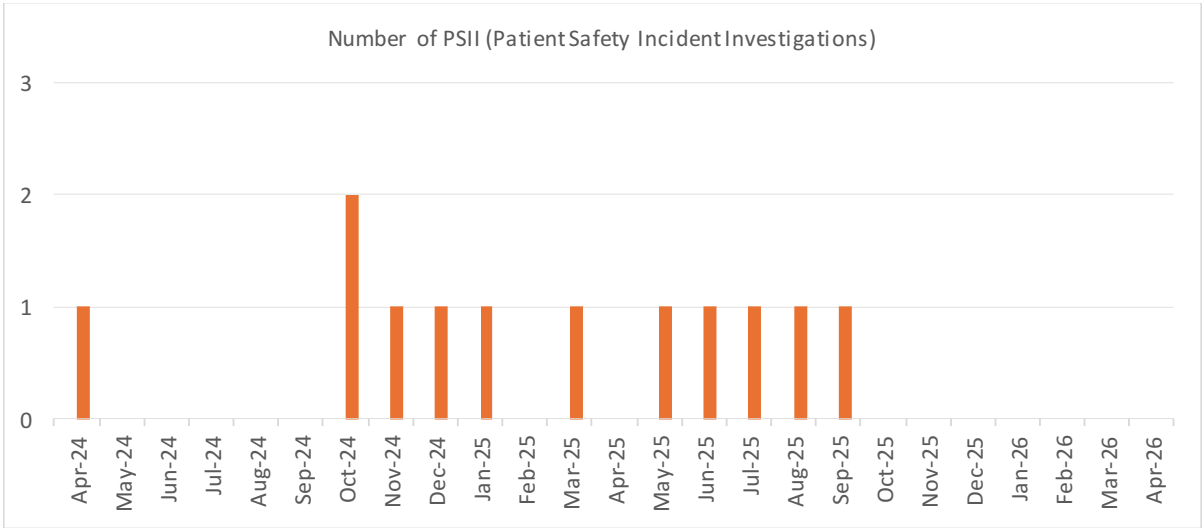
For measures without a target you will instead see the "No Target" icon.

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.

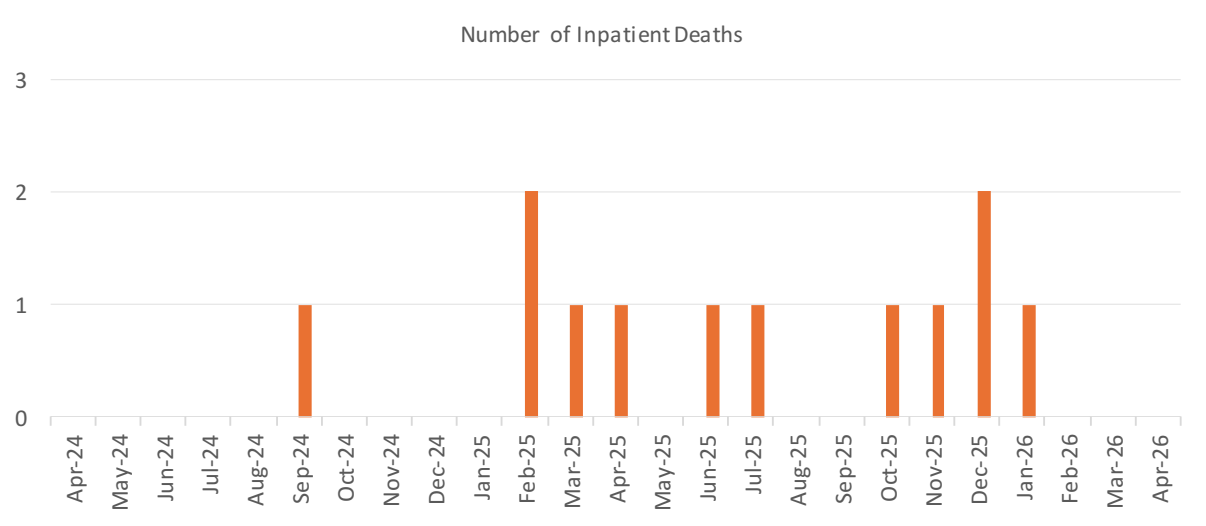
Assurance Reports: Incidents

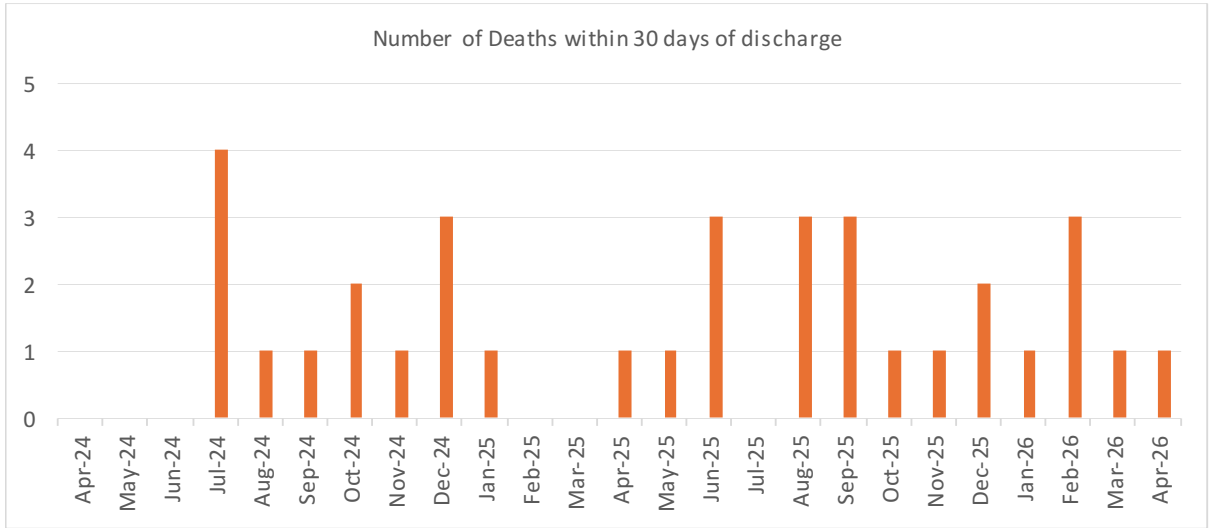




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There were 239 incidents reported within the Trust during April 2026. There continues to be a downward trend in incident reporting. A separate paper has been prepared on this for Q&S Committee review	Review of PSIRF priorities underway. Review of trends and themes causing and contributing to downward trend – see separate paper		NA	High

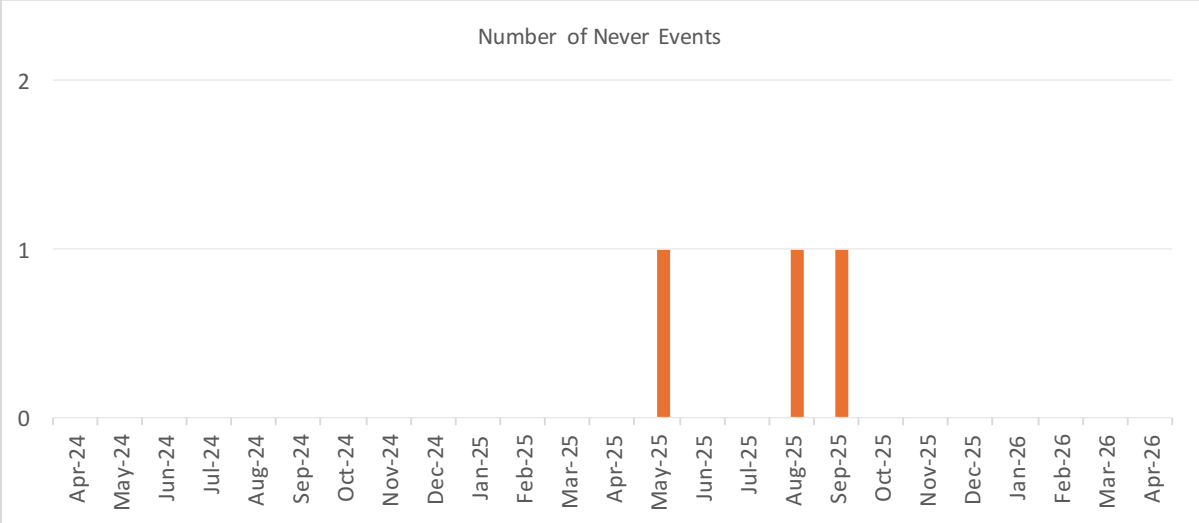
Assurance Reports: Learning from Deaths

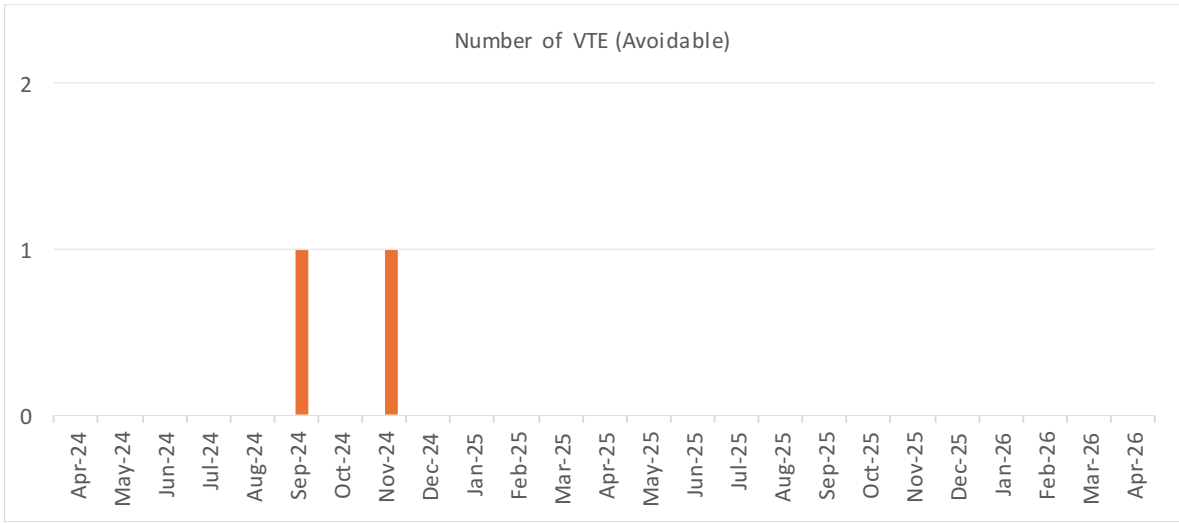




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There were no inpatient deaths reported in April 2026. HED & PAS data received and figures updated to reflect new information re: deaths within 30 days of discharge received. All deaths to be reviewed through the Learning from Deaths process.	Wider LeDeR review underway regarding the death of a patient with an LD diagnosis. To be reviewed in Divisional Governance as well as under Learning from Deaths process and Learning from Deaths Review Panel	Divisional Governance (Bi-weekly) Learning From Deaths Review Panel (monthly	N/A N/A	High High

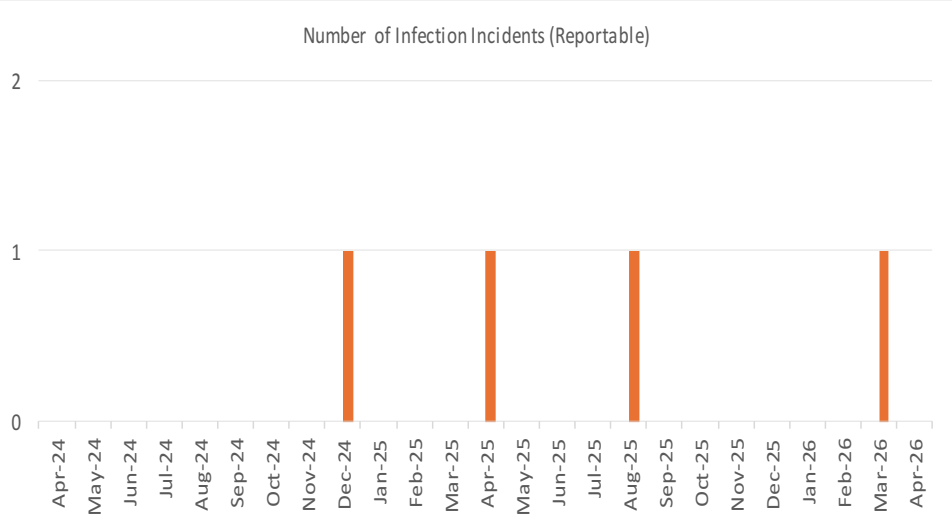
Assurance Reports: Never Events & VTE





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 were no avoidable VTE 's All recent VTE incidents have been deemed unavoidable after PSIRF VTE triage review. Compliance figure for April 2026: xx% (Confirmed) No Never Events reported in April 2026.	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. Recommendations from NE Thematic Review align with actions underway as part of the wider Theatre Safety Improvement Plan		Theatre Staffing Risk on Divisional risk register	High

Assurance Reports: Infection Incidents



Infections Recorded in month and Year to Date (YTD)	APRIL 2026	YTD*
Methicillin-Resistant *Staphylococcus aureus* (MRSA) bloodstream infection	0	0
HOHA/COHA toxin positive *Clostridioides difficile* infection (CDI)	0	0
Methicillin-Sensitive *Staphylococcus aureus* (MSSA) bloodstream infection	0	0
E. coli bloodstream infection	0	0
Klebsiella spp. bloodstream infection	0	0
Pseudomonas aeruginosa bloodstream infection	0	0

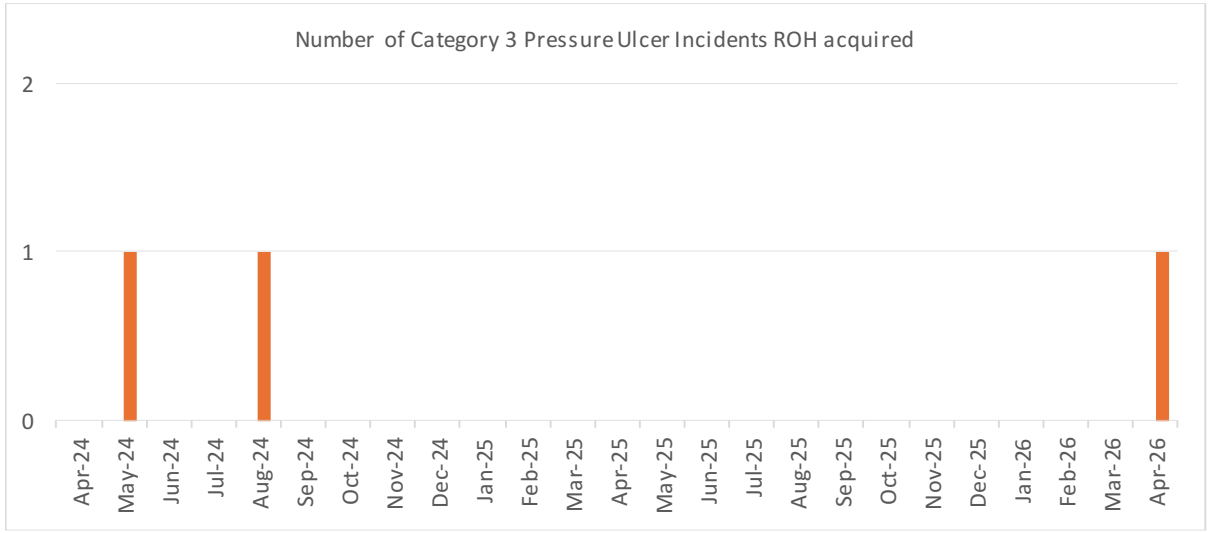
Note: Toxin positive cases of CDI are reportable, and all healthcare associated (HOHA and COHA) toxin positive cases count towards the ROH threshold

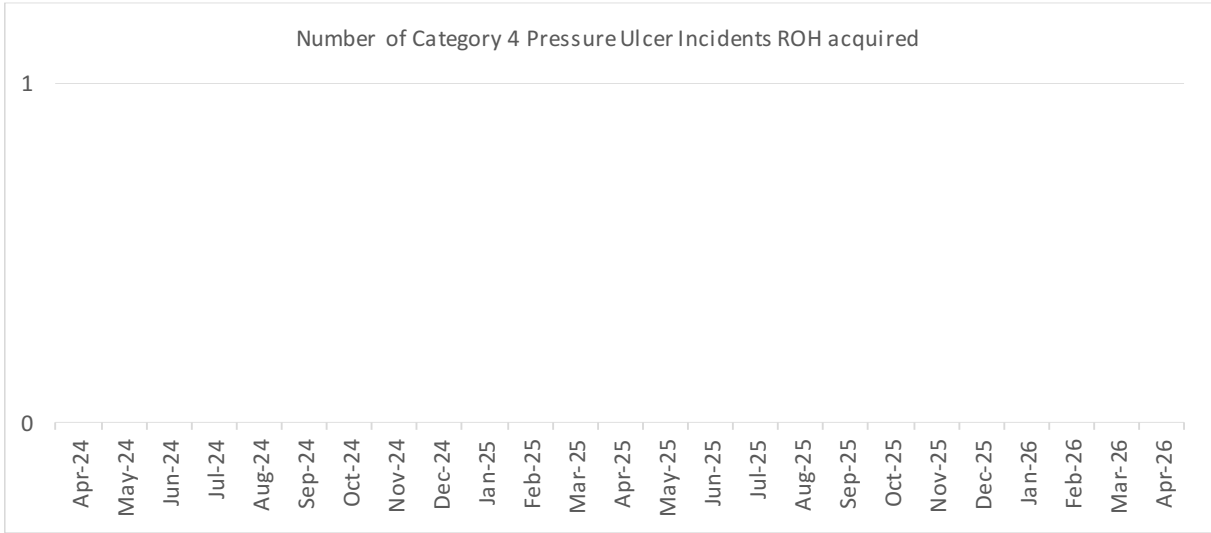
	CDI (Toxin +ve)	E. *coli* BSI	P. *aeruginosa* BSI	*Klebsiella* Sp. BSI	MRSA BSI
2023/24	5	0	0	1	0
2024/25	1	2	0	0	0
2025/26	0	0	0	0	0
2026/27	TBC	TBC	TBC	TBC	TBC

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
No reportable incidents reported in April.	Details of IPC QI work is reported to the IPC Committee and upwardly to Quality & Safety Committee via the Director of IPC (Chief Nurse). Ongoing work into Spinal SSI data due to increase in number of incidents reported. IPC to lead.	SSI prevention – IPC Committee and Q&S Committee		High

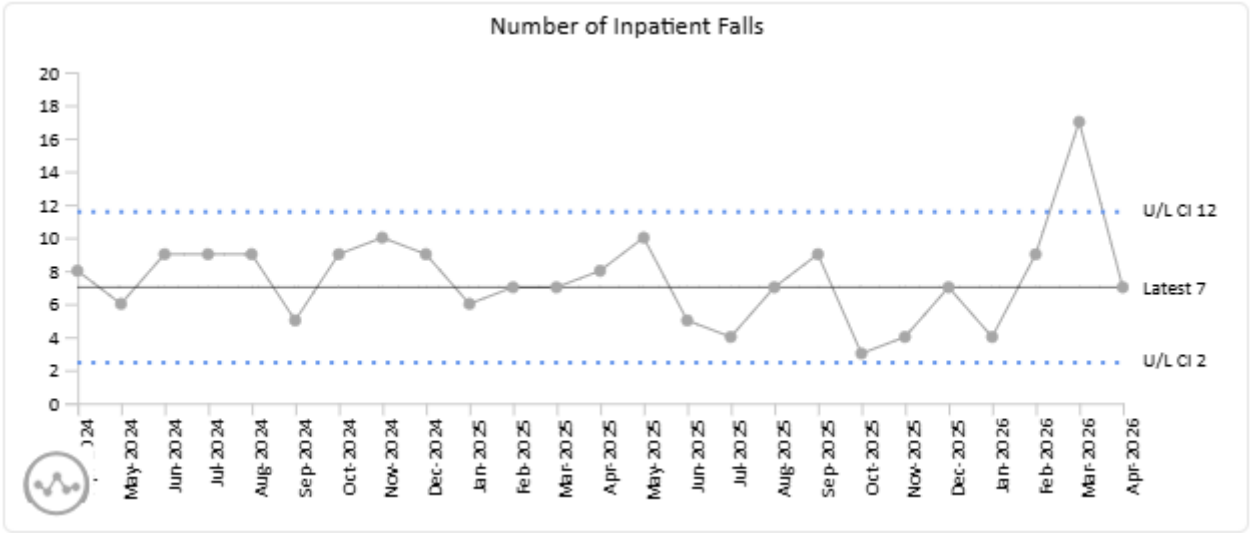
Assurance Reports: Pressure Ulcers





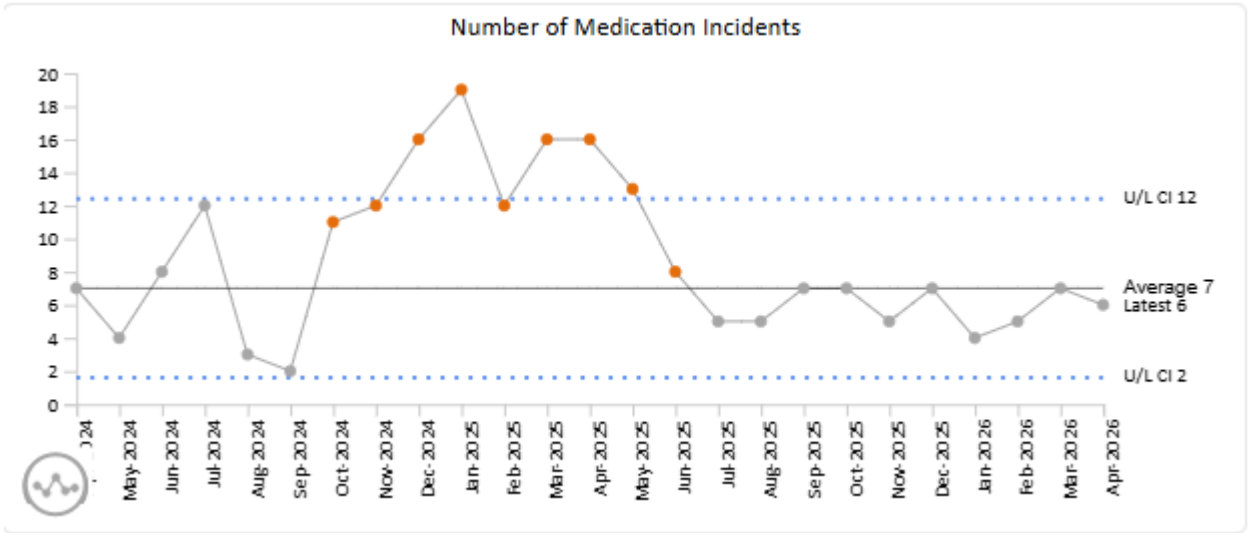
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There was 1 ROH acquired Cat 3 pressure ulcer incident reported in April 2026.	Cat 3 PU acquired as a result of identified and avoidable delays in transitioning patient from a foam mattress to an IQ mattress during period of bed rest. Feedback given to staff on importance of use of correct mattresses.	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.	Risk No 2126 – pressure relieving mattresses	High

Assurance Reports: Falls



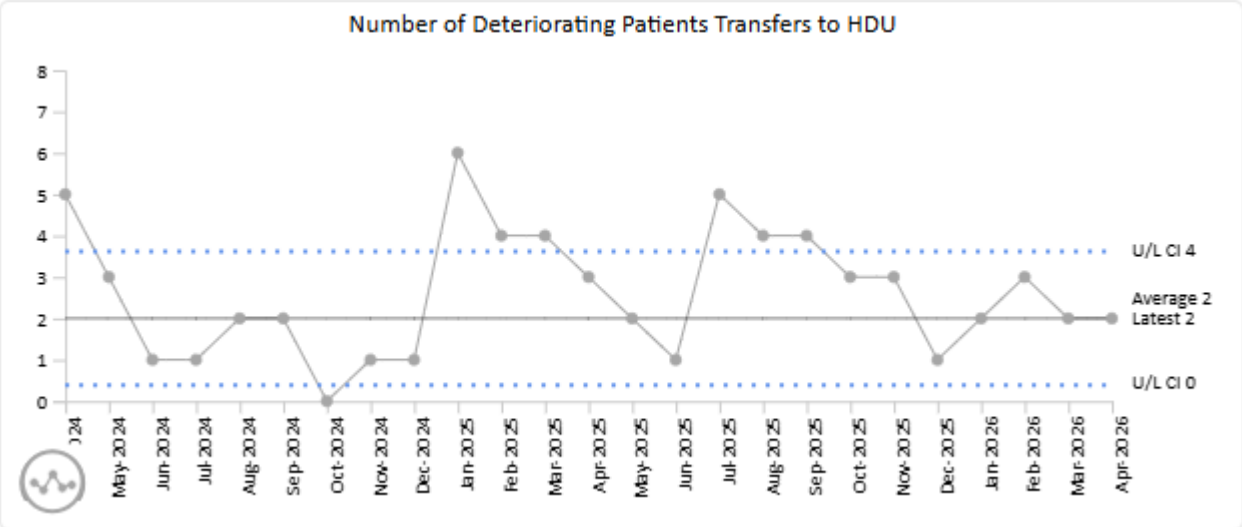
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Reported figures have returned to previous numbers, with 7 inpatient falls reported in April 2026, 6 of the incidents were reported as no or low harm. There is 1 moderate harm incident due to the fall resulting in the wound reopening, pt went back into surgery for wound closure but has since been discharged safely. Incident has been managed locally and closed. Themes identified from falls incidents:- • 3 falls were recorded on ward 1 • 6 falls were unwitnessed • 5 falls took place in the bathroom areas	• Bedrails policy submitted and approved at CQG • Work completed in bathrooms on Ward 4 to install new toilet roll holders and reduce falls risk from patients over-reaching • Task and finish Group re: beds/trollies and maintenance ongoing • Focus group set up to review previous months increase in in-patient falls			

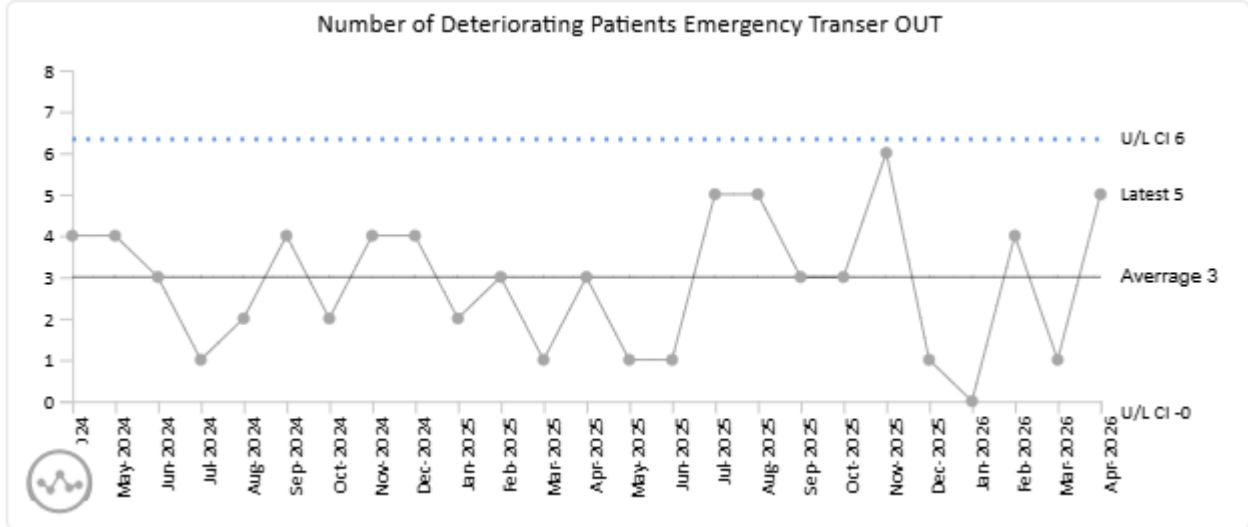
Assurance Reports: Medication Incidents



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 6 Medication incidents reported in April 2026, that currently meet the desired criteria for review. There have been 3 dispensing errors, but no system factors have been identified that contributed to these therefore local actions have been taken. One adverse reaction noted during iron infusion, which is a recognised potential complication of treatment. The remaining 2 adverse reactions were from the same batch of flucloxacillin, this has been reported appropriately to the MHRA and no further incidents have been noted with this batch within ROH or nationally.	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) There has been significant learning from an incident regarding patient owned Controlled Drugs. Pharmacy are currently developing a LOOP and updating existing guidance on illicit substances brought into the hospital, which will be shared through Divisional Governance.	DTC	N/A	High

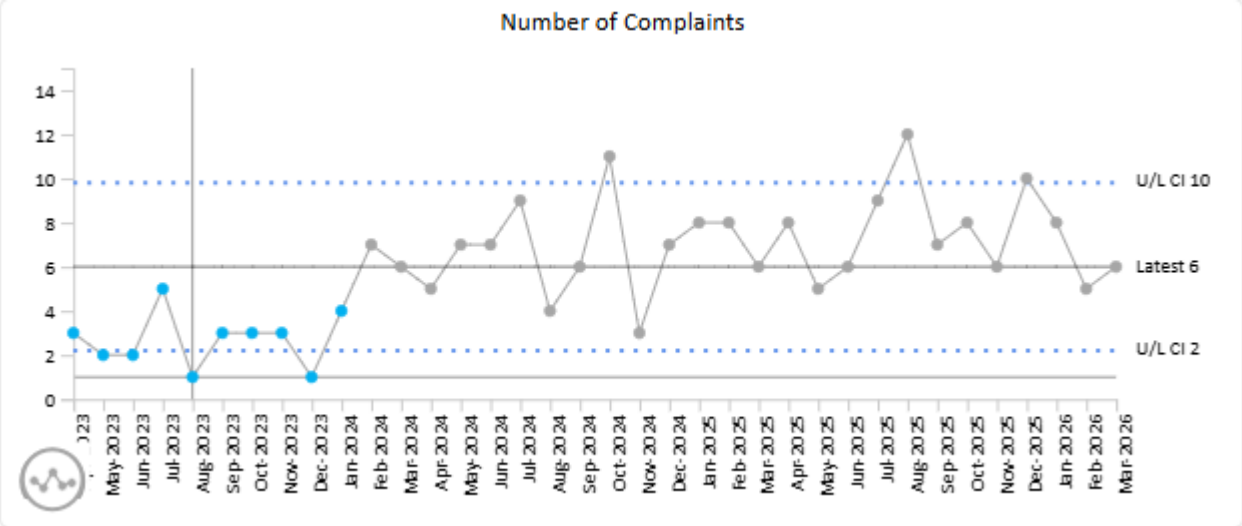
Assurance Reports: Deteriorating Patients

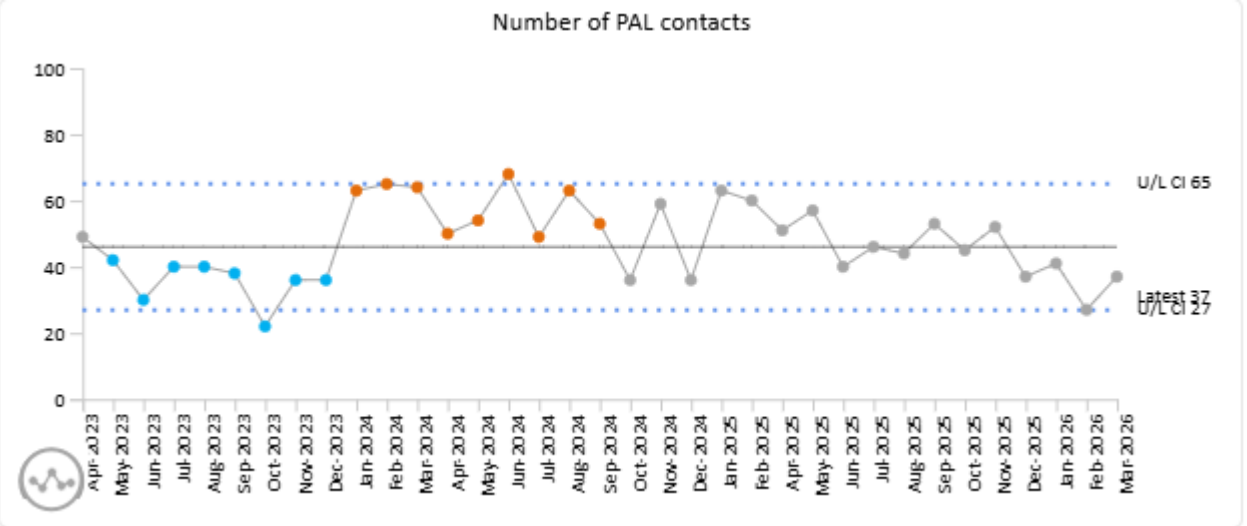




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There were 2 deteriorating patient incidents reported in April 2026. Both incidents were reviewed through Divisional Governance, 1 being graded as moderate harm and a LOOP to learn from missed opportunities to be completed. There were 5 emergency transfer out of Trust incidents reported in April 2026. All have been through divisional governance with no concerns raised. All transfers have been timely and well managed.	Areas of concern noted in moderate harm incident: • Fluid balance chart not maintained • Timeliness of medical review • Past medical history not shared • IV fluids not started		NA	High

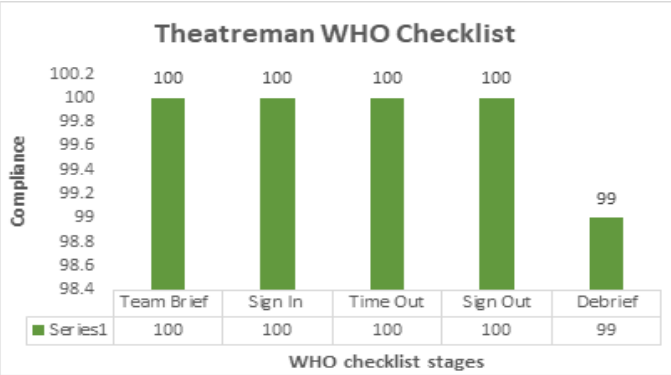
Assurance Reports: Complaints and Pals

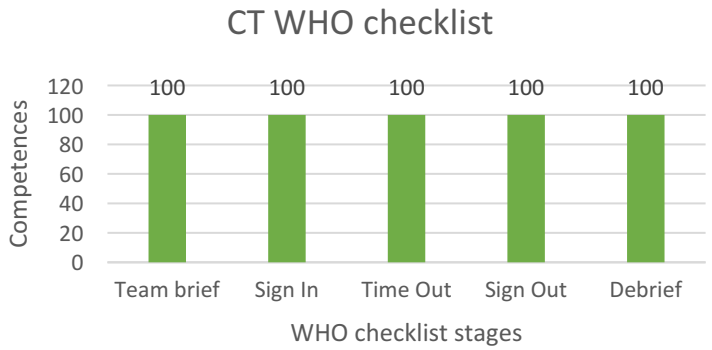




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
The Trust received 5 new formal complaints in April 2026. Of these, all remain open but within agreed timescales as of 30th April 2026 resulting in an April KPI achievement of 100%. On 30/04/2026 The trust had 17 formal Complaints open, of which 6 had breached the agreed timescales. This provides an April month end KPI of 65% In April 2026 the Trust received no new requests for a resolution meeting and facilitated one Resolution Meeting successfully. There was one request for a complaint to be re-opened	• Themes identified through complaints, are raised and tracked at Divisional Governance Meetings. • Tracking and oversight is provided at Executive Governance Meetings. • Where learning is identified, it is shared across the Trust to support wider improvement. • 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





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
Overall, performance remains robust, with teams maintaining high standards of compliance despite challenging operational conditions.	Audit compliance across all active theatres remains exceptionally strong. The variation observed in audit numbers reflects operational factors rather than any issues with performance or engagement.		N/A	High

Area	Feb 26	Number of audits	Mar-26	Number of audits	April 26	Number of audits	Progress
Th1	100%	10	100%	10	0	0	Closed
Th2	100%	10	100%	10	100%	9	Closed part month
Th3	100%	2	100%	1	100%	1	↓
Th4	100%	10	Closed	N/A	0	0	Closed
Th5	100%	10	100%	8	100%	7	↓
Th6	100%	10	100%	10	100%	10	↔
Th7	100%	10	100%	10	100%	10	↔
Th8	100%	8	99.70%	10	100%	6	↓
Th9	100%	10	100%	10	100%	10	↔
Th10	100%	10	100%	10	100%	10	↔
Th11	0	0	0	0	100%	10	↑

Assurance Reports: CAS Alerts

CAS Alerts Received 1- 30 APR 2026

Reference	Alert Title	Originated By	Issue date	Response	Deadline
None received					

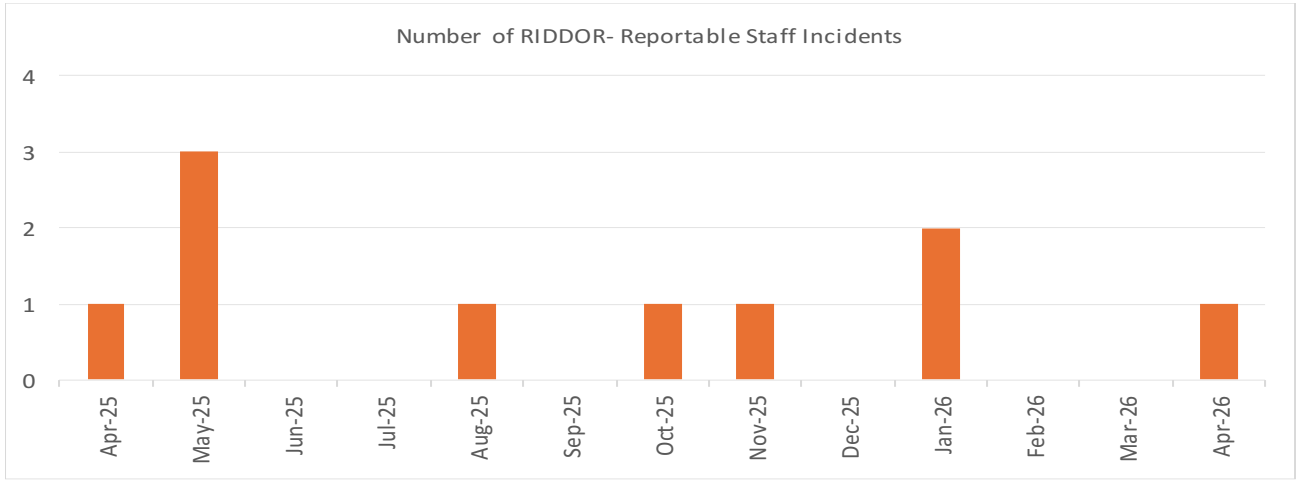
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There were no new CAS alerts received in April.			N/A	High

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. "This joint National Patient Safety Alert has been issued by the NHS England National Patient Safety Team, in collaboration with the Faculty of Intensive Care Medicine, regarding the risk of harm from incorrectly assembled breathing circuits lacking proper exhalation routes for patients receiving invasive or non-invasive ventilatory support. Organisations caring for patients on invasive and non-invasive breathing circuits are required to develop local guidance and visual aids for circuit assembly, implement training on specific safety checks, and establish clear communication processes."	National Patient Safety Alert – NHS England Patient Safety	15 Dec 2025	Assessed – relevant to organisation's services 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. 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. 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 Update: Actions underway. 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



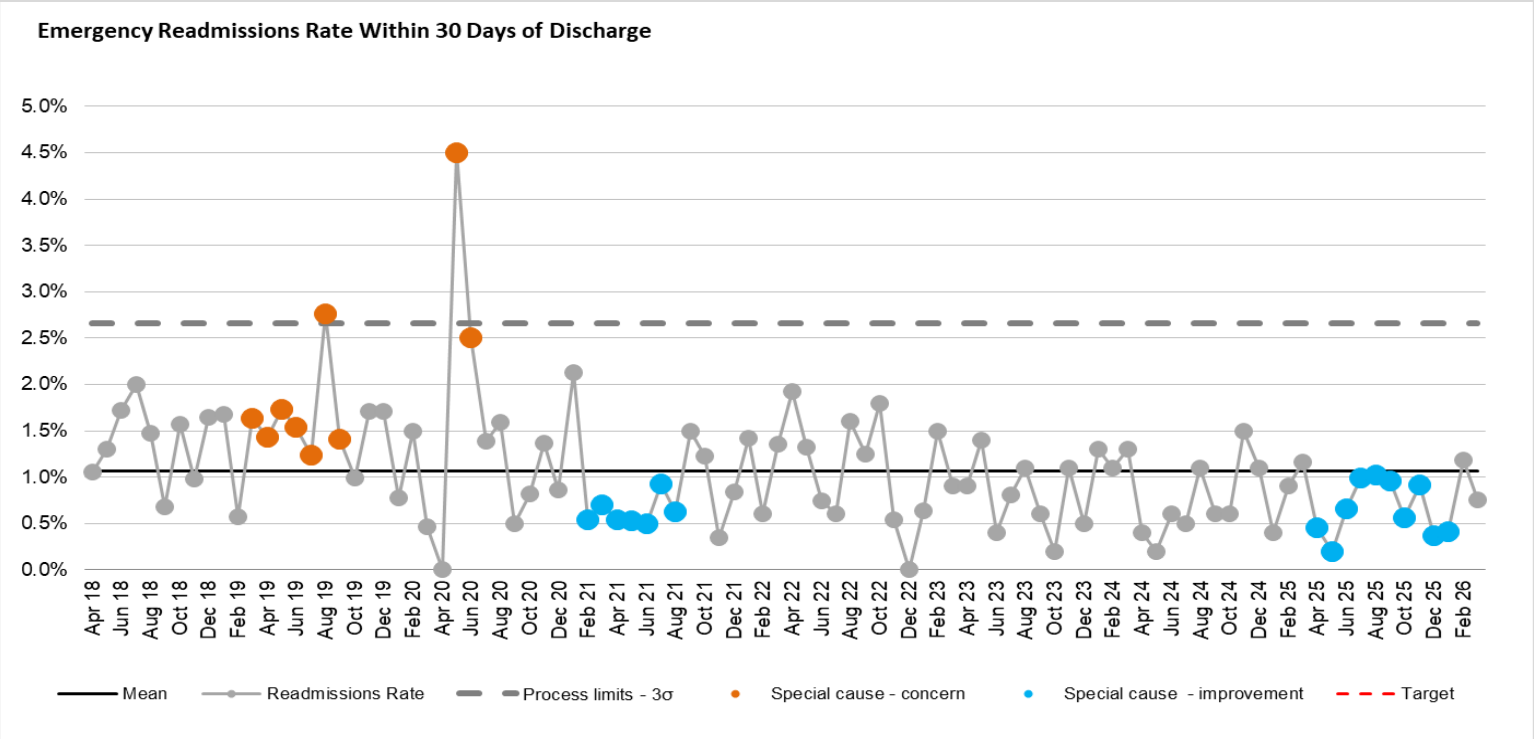
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There was 1 RIDDOR reportable incident in April 2026. This incident was entered onto Ulysses prior to being reported to RIDDOR in April. The RIDDOR report related to the risk of exposure to Asbestos.	•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. Learning from RIDDOR report relating to Asbestos:- Reinspection of Known ACM's contained in the Trust's Asbestos Register will be taking place. A detailed asbestos inspection survey has been commissioned on our older Plant Rooms namely Admin Boiler House and Hydrotherapy Boiler House. Depending on the findings, a further asbestos strip may take place subject to funding availability. The Admin Plant Room has been defined as a restricted area, notices have been displayed and Estates trade staff have been informed about its restricted access All Trades staff have attended Asbestos Awareness Training -and training completion / competence to form part of PDP review process going forward Toolbox talk and open discussion on concerns held in January 2026 by Estates management Electronic job management platform reviewed to ensure all Estates trade staff are alerted to the presence of ACM's on the ROH site before carrying out any work-related tasks Trades risk assessments are under review by Estates management and being updated Advice and referrals being sought through Occupational Health Service provider		N/A	High

Assurance Reports: Safeguarding Training

KPI	March 2026
Safeguarding Adult Notifications	50
Safeguarding Children Notifications	47
Adults Level 1- Target 90%	96.67%
Adult Level 2 -Target 85%	94.27%
Adult/Children Level 3 and MCA&Dols- Target 85%	85.86%
Level 4- Target 90%	80.0%
Child Level 1 -Target 90%	96.81%
Child Level 2- Target 85%	94.27%
Prevent Awareness- Target 95%	94.43%
WRAP (prevent level 3)- Target 90%	91.58%
Domestic Abuse	20
FGM	0
DOLS	6
MCA	9
PIPOT cases	0
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. 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.			High

Assurance Reports: Readmissions

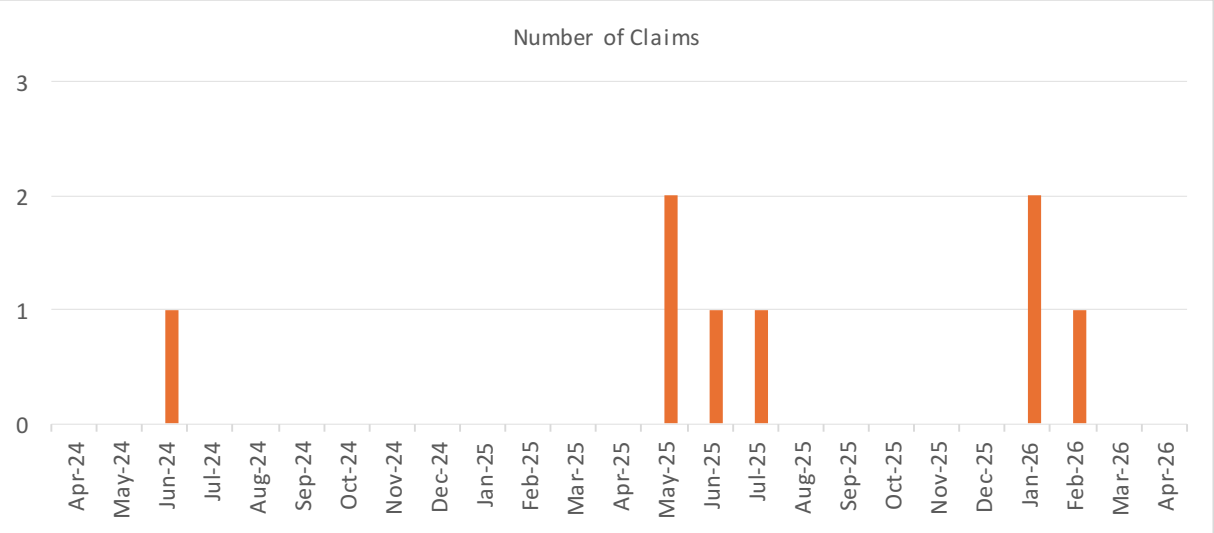


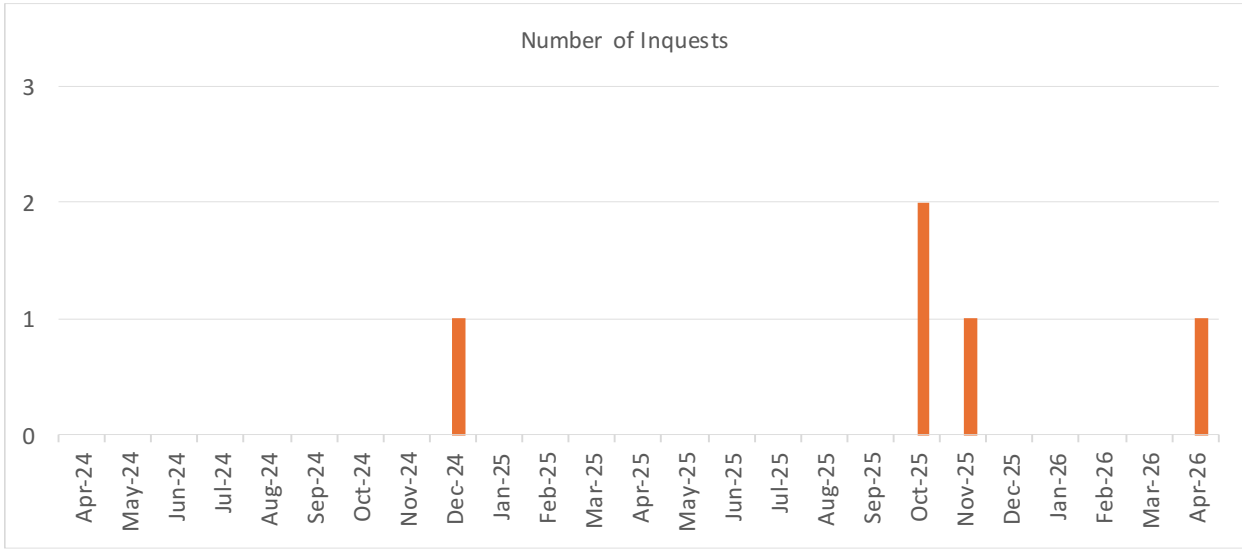
	Number of Emergency Readmissions to ROH within 30 Days of Discharge											
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
No of Readmissions	2	1	3	5	5	5	3	5	2	2	6	4
Denominator	445	508	456	507	487	522	532	549	540	481	509	530
% Readmissions	0.4%	0.2%	0.7%	1.0%	1.0%	1.0%	0.6%	0.9%	0.4%	0.4%	1.2%	0.8%

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 five concerns raised to FTSUG in April 2026. **Concerns reported were related to the following themes:** Inappropriate attitude and behaviour, workers safety and wellbeing. Incivility and respect. **Nature of concerns:** • Instances of short-notice communication regarding significant changes to employment status and processes of moving belongings from workstations without adequate prior notice. • Incivility and lack of mutual respect. Use of inappropriate language or engaging in conversations that do not align with professional standards. *These concerns were raised via the FTSU route primarily for guidance and initial advice. While currently recorded for monitoring purposes, formal escalation and further investigation will be initiated should the individuals involved seek additional support or wish to progress the matter.	The FTSU Team is currently implementing the following initiatives to strengthen the culture of transparency and continuous improvement. 1)Enhanced Visibility: FTSU Champions will be assigned to specific departments to increase visibility and provide localised peer support. The Goal is to ensure every staff member has a direct, accessible point of contact for raising concerns or seeking guidance. 2)“You Said, We Did”. Closing the Feedback Loop: To demonstrate how voices are heard and driving change, we will be displaying a dedicated FTSU information Board. The goal is to provide transparency on how we use feedback to improve workplace quality and safety. 3)FTSU Awareness and Education: Plans are in progress for the annual Trust July Awareness Day. Goal: Focused day of engagement to promote the speaking-up process, reduce barriers to reporting, and celebrate a culture of openness.		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
There was 1 coroner inquest in April. The coroner recorded a short form narrative conclusion that the deceased died from the consequence of rare high-grade spindle cell sarcoma The Trust were praised for extensive preparation carried out for inquest, the thoroughness of the PSII investigation and the thoughtful written and live evidence of the Trust witnesses	LfDPR meet monthly to discuss and review all cases going through concern review.			

Assurance Reports: Safe Staffing Summary

Alert

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

Nil

Advise

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

Sickness

Ward 4: 9.99% (↓ from 12.32%). Ward 12: 9.55% (↓ from 14.20%). Theatres: 8.88% (↓ from 10.40%)

Overall sickness has improved to 6.0% (↓ from 6.8%); however, levels remain elevated in specific areas, notably Ward 4, Ward 12, and Theatres

Red flag reporting

Red Flags 0 (→ 0). Further work continues to support consistent interpretation and application.

Falls

Falls 6 (↓ from 17). Although improved, this remains an area for continued monitoring and a Falls Prevention Group has been set up.

Pressure ulcers (Category 2–4)

5 cases reported (↑ from 3). Pressure ulcers remain an area for monitoring

Enhanced Therapeutic Observation Care (ETOC)

1198 hours delivered (↑ from 842.5). Enhanced care activity remains elevated, reflecting increased patient dependency and observation requirements

Registered Nurse Associates (RNA) data

RNA data within Theatres cannot currently be accurately identified, as both RNA and Theatre Assistant Practitioner roles are recorded as Band 4 resource. This limits role differentiation within reporting and is under review

Fill rate

Reported fill rates do not fully reflect actual staffing levels due to the exclusion of Registered Nurse Associates roles and periods of reduced activity, including closures for maintenance in Ward 4 and Theatres

Assure

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

Safe staffing was maintained across inpatient areas through Matron oversight, with all wards staffed to safe and appropriate levels when total worked hours are considered. Registered Nurse Associate roles remain embedded within the workforce model, supporting delivery of care in line with patient need, and CHPPD remained within expected ranges, with higher values in HDU reflecting patient acuity.

Patient safety indicators remain stable overall, with no evidence of staffing related harm or deterioration. Falls have reduced in month and medication errors remained stable with no link to staffing identified, and complaints were minimal across all areas with no themes indicating impact on patient experience. Patient dependency remains high, reflected in increased ETOC hours, with multiple patients requiring enhanced observation concurrently; cohorting was not always possible due to patient need, but staffing was provided to support safe care delivery.

Recommendation

The Committee is asked to:

The Committee is asked to:

- NOTE the content of section 2
- NOTE the content of section 3.

Assurance Reports: Safe Staffing Summary

Nursing

April 26 Data for May 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	81.0%	92.0%	103.0%	103.0%	259.5	11	97%	0%	6.96%	1.77%	549.00	6.7	0	0	0	1	0	3	0	0	36.00%
Ward 2	80.0%	127.0%	120.0%	203.0%	241	33	80%	0%	5.93%	1.18%	503.00	9.4	0	0	864.5	0	2	1	0	1	62.00%
Ward 3	93.0%	108.0%	107.0%	120.0%	199.5	55	96%	0%	1.96%	6.34%	605.00	6.9	0	0	221.75	3	1	1	0	0	72.00%
Ward 4	48.0%	44.0%	63.0%	50.0%	0	0	92%	0%	9.99%	1.28%	76.00	9.0	0	0	0	0	0	0	0	0	78.00%
Ward 12	85.0%	117.0%	102.0%	116.0%	169	11	88%	0%	9.55%	3.98%	281.00	9.1	0	0	112	1	1	1	0	0	97.00%
HDU	85.0%	56.0%	85.0%	0.0%	0	0	89%	0%	1.62%	2.25%	124.00	19.9	0	0	0	0	1	0	0	0	76.00%
total combined	-	-	-	-	869.00	110.00	-	-	-	-	2138.00	61.0	0	0	1198	5	5	6	0	1	-
Total Average	78.7%	90.7%	96.7%	98.7%	144.8333	18.333	90%	0%	6.0%	2.8%	356	10.17	0	0	200	-	-	-	-	-	70%

Assurance Reports: Safe Staffing Summary

Core Services

April 26 Data for May 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	87%	83%	-	-	0	-	59.78%	6%	4.82%	6.97%	0	0	0	0	0	0	0	0	2.00%
CYP OPD	28%	110%	-	-	0	-	-	-	-	-	-	-	-	0	0	0	0	0	59.00%
ADCU	55%	74%	-	-	0	-	88.16%	0%	4.20%	2.19%	0	0	0	0	0	1	0	0	9.00%
POAC	94%	88%	-	-	0	-	91.28%	0%	6.06%	2%	0	0	0	0	0	0	0	0	17.00%
Theatres	74%	75%	-	-	69	-	88.42%	1%	8.88%	1.98%	0	0	0	0	0	0	0	0	0.00%
Theatres recovery	84%	92%	-	-	0	-	-	-	-	-	-	-	-	0	0	0	0	0	0.00%
Discharge Lounge	105%	100%	-	-	0	-	-	-	-	-	-	-	-	0	0	0	0	0	36.00%
Total/Combined	-	-	-	-	69.00	-					0	0	0	0	0	1	0	0	-
Total Average	75%	89%	-	-	9.85714	-	89.29%	2%	6%	3%	0	0	0	-	-	-	-	-	17.57%

Allied Health Professionals

April 26 Data for May 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%	59%	-	-	-	-	-	-	-	-	-	-	-
Outpatient Physio	100%	25%	-	-	-	-	-	-	-	-	-	-	-
Radiology MRI	64%	75%	-	-	-	-	-	-	-	-	-	-	-
Radiology X-Ray/CT	73%	70%	-	-	-	-	-	-	-	-	-	-	-
Total Combined	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Average	84%	57%	-	-	-	-	-	-	-	-	-	-	-

Assurance Reports: Operational Performance Summary

Metric	In Month	Previous Month	Target	Variation	Assurance
RTT Combined (against trajectory constitutional target remains 92%)	65.64%	65.50%	64.84%	H	P
RTT Waiting 65 Weeks and over	0	0	0	L	P
RTT Waiting 52 Weeks and over	110	96	119	L	P
RTT Proportion of Patients Waiting 52 weeks and over	0.87%	0.77%	0.91%	L	P
RTT First Appointment Waiting List	76.25%	74.75%	69.47%	H	P
RTT Waiting List Size	12,608	12,517	13,096	L	P
Diagnostics volume YTD (compared to plan) - CT, MRI and Ultrasound	2,111	NA	2,153		F
Diagnostic 6 week target	99.7%	99.3%	95%	H	P
Theatre Session Utilisation	94.24%	92.34%	85%	H	P
Theatre Insession Utilisation (Capped)	81.21%	80.94%	85%	L	F
Bed Occupancy (excluding CYP and HDU)	75.77%	77.00%	82-85%	L	F
LOS - Excluding Oncology, Paeds,YAH, Spinal	3.71	3.53	n/a		-

Metric	In Month	Previous Month	Target	Variation	Assurance
All Activity YTD (compared to plan)	994	NA	1,053		F
Outpatient activity YTD (compared to plan)	5,420	NA	6,022		F
Outpatient Did Not Attend (YTD)	7.63%	7.01%	8.00%	H	P
PIFU	642 12.47%	618 9.98%	655 10.88%	H	P
Virtual Consultations (target is to plan, operational planning guidance is 25%)	13.42%	10.09%	n/a	-	-
Cancer - 31 day first treatment	100.0%	100.0%	96%	H	P
Cancer - 62 day (traditional)	70.0%	71.4%	75% National 85% Trust		F
28 days FDS	72.8%	76.3%	77%		F
Patients over 104 days (62 day standard)	0	0	0	L	P
POAC activity volumne (YTD) (target set is average monthly 19/20 activity)	1,740	NA	1,765 YTD Target		F
LOS - elective primary hip	3.32	2.82	2.70		F
LOS - elective primary knee	3.37	3.29	2.70		F