



Trust Board Private Meeting July 2026

Boardroom, Trust Headquarters

Wednesday 8th July - 09:00h - 11:20h



Notice of Trust Board Meeting in Public on Wednesday, 8 July 2026

The next meeting of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday, 8 July 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



AGENDA

TRUST BOARD PUBLIC

Venue Boardroom, Trust Headquarters

Date 8 July 2026: 09:00h – 11:20h

Members attending

Mr Simon Page	Chair	(SP)	
Ms Simone Jordan	Vice Chair & Senior Independent Director	(SJ)	
Mrs Gianjeet Hunjan	Non Executive Director	(GH)	
Ms Ayodele Ajose	Non Executive Director	(AA)	
Mrs Jenny Belza	Non Executive Director	(JB)	
Miss Jan Teo	Non Executive Director	(JT)	
Mr Curig Johnston	Associate Non Executive Director	(CJ)	[Non Voting]
Mr Mathew Revell	Chief Medical Officer	(MR)	
Mrs Nikki Brockie	Chief Nursing Officer	(NB)	
Mrs Sharon Malhi	Chief People Officer	(SM)	
Mr Simon Grainger-Lloyd	Chief Governance Officer	(SGL)	
Mrs Rebecca Lloyd	Chief Strategy Officer	(RL)	[Non Voting]

In attendance

Ms Sharon Latham	Head of Patient Experience	(SL)	[Item 1]
Mr Nas Uddin	Acting Deputy Chief Operating Officer	(NU)	
Mrs Alexandra Gilder	Deputy Director of Finance	(AGi)	
Mrs Tammy Ferris	Corporate Services Manager	(TF)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
		IN PUBLIC SESSION		
09:00	1	Patient Lived Experience	Presentation	SL
09:20	2	Apologies: Steve Washbourne, Ian Reckless, Michelle Hubbard	Verbal	Chair
	3	Declarations of Interest	ROHTB (7/26) 001	Chair
	4	Minutes of Board Meeting held in Public on 3 rd June 2026: <i>for approval</i>	ROHTB (6/26) 019	Chair
	5	Actions from previous meetings in public: <i>for assurance</i>	ROHTB (6/26) 019 (a)	SGL
	6	Questions from members of the public	Verbal	Chair
09:30	7	Chair’s and Chief Executive’s update: <i>for information and assurance</i>	ROHTB (7/26) 002 ROHTB (7/26) 002 (a)	MR/SP
09:50	8	Officers’ report: <i>for assurance</i>	ROHTB (7/26) 003 ROHTB (7/26) 003 (a)	AGi



10:10	9	Chief Finance Officer's report: <i>for information and assurance</i>	ROHTB (7/26) 004 ROHTB (7/26) 004 (a)	Execs
10:30	10	Antisemitism – Lord Mann Report: <i>for assurance</i>	ROHTB (7/26) 005 ROHTB (7/26) 005 (a)	SM
GOVERNANCE AND COMPLIANCE				
10:45	11	Emergency Preparedness Resilience and Response (EPRR) - EPRR Annual Report: <i>for assurance</i> - EPRR Policy: <i>for approval</i> - EPRR Incident Response Plan: <i>for assurance</i> - EPRR Work Programme: <i>for assurance</i>	ROHTB (7/26) 006 ROHTB (7/26) 006 (a) ROHTB (7/26) 006 (b) ROHTB (7/26) 006 (c) ROHTB (7/26) 006 (d) ROHTB (7/26) 006 (e) ROHTB (7/26) 006 (f)	NU
UPWARD REPORTS FROM THE BOARD COMMITTEES				
11:00	12	Upward reports from the Board Committees: - Finance & Performance Committee - Staff Experience & OD Committee - Equality, Diversity & Inclusion Report: <i>for approval</i>	ROHTB (7/26) 007 ROHTB (7/26) 008 ROHTB (7/26) 008 (a)	GH SJ
MATTERS TO BE TAKEN BY EXCEPTION				
11:15	13	Performance Reports: <i>for assurance</i> a) Finance & Performance b) Quality Report c) Workforce Report	ROHTB (7/26) 009 ROHTB (7/26) 010 ROHTB (7/26) 011	
	14	Any Other Business	Verbal	All
	15	Meeting effectiveness	Verbal	All
11:20	BREAK			
	CLOSE: Date of next meeting: Wednesday, 9 September 2026 @ 09:00			
	Council of Governors commences at 2pm in Oncology Seminar Room			

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 JUNE 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	✓	✓	A								
Ayodele Ajose	✓	✓	✓								
Jenny Belza	✓	✓	✓								
Jan Teo	✓	✓	✓								
Curig Johnston	✓	✓	✓								
Matthew Hartland	✓	✓	✓								
Matthew Revell	✓	✓	✓								
Nikki Brockie	✓	✓	A								
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
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
Michelle Hubbard Acting Chief Operating Officer	• None declared	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 • Trustee, University College Birmingham, Guild of Students	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



MINUTES

Trust Board PUBLIC - DRAFT Version 0.1

Venue Boardroom. Trust Headquarters

Date 3 June 2026: 0900h - 1200h

Members attending:

Mr Simon Page	Chair	(SP)
Ms Simone Jordan	Vice Chair & Senior Independent Director	(SJ)
Dr Ian Reckless	Non Executive Director	(IR)
Mrs Jenny Belza	Non Executive Director	(JB)
Ms Ayodele Ajose	Non Executive Director	(AA)
Miss Jan Teo	Non Executive Director	(MH)
Mr Matthew Hartland	Chief Executive	(MH)
Mr Matthew Revell	Executive Medical Director	(MR)
Mrs Sharon Malhi	Executive Chief People Officer	(SM)
Mr Simon Grainger-Lloyd	Executive Director of Governance	(SGL)
Mrs Michelle Hubbard	Acting Chief Operating Officer	(MH)

In attendance:

Mr Jake Slassor	Advanced Apprentice Carpenter	(JS)
Mr Curig Johnston	Associate Non Executive Director	(CJ)
Mrs Rebecca Lloyd	Director of Strategy	(RL)
Mrs Emma Steele	Deputy Chief Nurse	(ES)
Mrs Tammy Ferris	Corporate Services Manager	(TF) [Secretariat]

IN PUBLIC SESSION

1	Staff Lived Experience (JS)	Presentation
The Board received a patient and staff story from JS, who joined the Trust in 2014 as a bank housekeeper while at college, later undertaking roles in theatres and portering over a nine-year period. JS described a positive experience within Facilities, highlighting access to training opportunities and strong team support. JS outlined his progression into a Carpentry Apprenticeship (2.5 years), noting this was a new initiative for the Trust. While nearing completion of Level 2, he has been exploring Level 3 course but reported challenges in achieving the full scope of required competencies due to limitations in available work activities but has discussed plans to undertake additional short courses to bridge gaps. JS expressed a strong commitment to remaining at the Trust and an aspiration to progress to		



level 3 and then onto higher-level qualifications (HNC). The Board noted JS's positive feedback regarding team culture, leadership support, and cross-trade collaboration. However, JS highlighted areas for improvement, including: • Workforce sustainability, citing an ageing Estates workforce and recent retirements. • The need for continued investment in apprenticeship training and development. • Opportunities to upskill staff in specialist areas (e.g. fire door testing and locksmithing) to reduce reliance on external contractors. • Concerns regarding the perceived lack of visibility and recognition of Facilities staff whose work is often undertaken out of hours. In discussion, the Board acknowledged the importance of Estates workforce planning, including the current cohort of four apprentices and plans for future recruitment. The Board welcomed JS's suggestions regarding targeted training investment, recognising the potential for both service improvement and cost efficiencies. The Board thanked JS for sharing his experience and insights, which would inform ongoing workforce and development planning.	
2 Apologies (chair)	Verbal
Apologies were received and accepted from Gianjeet Hunjan and Nikki Brockie. Emma Steele, Deputy Chief Nurse, was welcomed to the meeting and attended on behalf of Nikki Brockie.	
3 Declarations of Interest (chair)	ROHTB (6/26) 001
The Board noted one new declaration in addition to those previously published. It was agreed that this would be added to the register and an updated document presented at the next meeting of the Public Board. • JB declared her role as a Trustee, University College Birmingham, Guild of Students. • MH confirmed that she had no declarations to make.	
4 Minutes of Board Meeting held in Public on 1st April 2026: for approval (chair)	ROHTB (4/26) 019
The minutes of the meeting held in public on 1st April 2026 were approved and accepted.	
5 Actions from previous meetings in public: for assurance (SGL)	ROHTB (4/26) 019 (a)



SGL provided an update on the following action: • ROHTBACT.285 Honorary contracts – will be discussed at the end of the month at the next SE&OD as will be part of the medical workforce update.	
6 Questions from members of the public (chair)	verbal
No questions were received in advance of the meeting	
7 Feedback from the Board walkabouts in March	Verbal
The Board received feedback from recent engagement visits across a range of services, noting consistent examples of committed teams alongside opportunities for improvement and development. • Appointments: SP and MR reported an open and constructive discussion with staff, who clearly articulated both strengths and areas for improvement. The team demonstrated strong local pride and ownership, but highlighted challenges related to staff turnover and the need to enrich roles to support retention. • Medical Records: JT and NB observed a highly experienced and dedicated team managing significant workload volumes within constrained accommodation, with concerns raised regarding compliance. Limited engagement in the InterSystems programme was noted, alongside uncertainty about future roles. The Board recognised the need to accelerate inclusion of the team in digital developments and ensure they feel valued, with further consideration required regarding the interface with the EPR and future service organisation. It was noted that HR are engaged in supporting the team regarding future changes. • Clinical Audit: CJ highlighted a motivated and proud team; however, the department operates in a relatively siloed manner with limited awareness of organisational strategic priorities. The need for clearer and simpler top-down communication was identified. • Pain Management: JB and SM reported a positive and cohesive team, led by a manager demonstrating strong pride in the service. While challenges with referral rates were acknowledged, the team showed proactive efforts to address these. There was good engagement with wider transformation programmes, including MSK and neighbourhood health. • Operations: SJ and RL described a positive and enthusiastic team, noting a risk that improvement ideas are not being fully progressed. Following recent VITA sessions, it was recognised that dedicated time is required to implement changes and address underlying issues. • Discharge Lounge: IR and SW reported excellent patient feedback and	



positive volunteer input; however, it was noted the area appeared staff-heavy, with opportunities to improve productivity and patient flow. The Board discussed whether earlier discharge planning could reduce reliance on the discharge lounge. The Board discussed how themes and improvement opportunities from visits are captured and progressed. It was acknowledged that this could be strengthened, with VITA identified as a mechanism to support implementation and empower teams to act. Action: RL to provide an update on how improvement ideas arising from engagement visits and Business Plan discussions will be captured, tracked, and delivered. The Board noted that VITA sessions are being positively received, although some managers may require additional support to maximise their effectiveness.	
8 Chair's and Chief Executive's update, including quarterly update from the Guardian of Safe Working: <i>for information and assurance</i> (SP/MH)	ROHTB (6/26) 002 ROHTB (6/26) 002 (a)
<u>Chair Update</u> The Chair emphasised that a positive organisational culture is fundamental to continued success, noting that "if we get the culture right, other elements will follow." The Board acknowledged a strong first month and extended recognition to all staff for their contribution. It was noted that the Trust is held in high regard externally and is seen as a well-run organisation. The Board received an update on regional collaboration, with the Regional Chair promoting the sharing of best practice. It was highlighted that the Trust delivers a wide range of high-quality services and further work is needed to ensure these are more visible in the public domain. In response to recent media attention regarding access to patient records, the Board sought assurance on information governance arrangements within the Trust. Assurance was provided that robust leadership arrangements are in place, including the SIRO, DPO and Caldicott Guardian roles. It was noted that current reliance on paper records limits inappropriate access, and that the transition to an Electronic Patient Record (EPR) system will introduce enhanced access controls based on role, audit functionality, and mandatory information governance training. The Board noted that information governance breaches are minimal. Where incidents do occur, they are managed in line with established disciplinary processes. It was further noted that EPR systems will enable auditing of record access, including potential self-access by staff, and that clear communication regarding monitoring and potential disciplinary consequences is important.	



- SGL suggested a formal position statement providing assurance on data security and access controls will be developed through the Information Governance Group and shared with the Board. **ACTION SGL**

Chief Executive's Report

The Board received the Chief Executive's update, covering key developments since the previous meeting in Public.

The key points to highlight include:

- The appointment of a new Secretary of State was noted. Following a briefing session on 2 June, it was confirmed that there has been no change in national policy direction and organisations should continue to progress existing plans.
- Update was provided on the Integrated Care Board's (ICB) strategic commissioning approach, including development of the anchor model. The scope remains focused on urgent and emergency care and community services, with elective care currently out of scope. Early discussions are underway with UHB regarding the support the Trust can provide. The ICB has reaffirmed the important role of specialist trusts within the wider system. The Board noted assurance that detailed planning is undertaken to mitigate any wider system impacts arising from industrial action.
- The Board discussed the VITA programme, emphasising the importance of maintaining a bottom-up approach. It was noted that work is underway to categorise themes emerging from VITA to better understand underlying issues and embed improvements into business-as-usual processes. An action log has been established, with priorities identified and regularly refreshed. While not all actions will be completed within 90 days, clear timelines will be communicated. Independent evaluation by Birmingham University has been commissioned, with findings to be shared with the Board. The importance of communicating outcomes to staff, including a "you said, we did" approach, was highlighted, alongside use of pulse surveys to track impact.
- The Board noted updates on external engagement, including attendance at an event to celebrate the Nishkam Health Trust in Handsworth following their receipt of the King's Award for Volunteering, recognising opportunities to strengthen community and prevention work.
- The Board was advised that further industrial action is planned for the week commencing 15 June, with mitigation plans in place. The ongoing contribution of volunteers was recognised, particularly in the context of National Volunteer Week, with further consideration to be given to how their role can be maximised.
- The Guardian of safe working quarterly update is provided with no areas of concern to raise.
- JB sought assurance that there were no issues with regards to safer working. MH provided an update was provided on safer working, noting



improvements, although some behavioural issues remain to be addressed.	
9 Chief Finance Officer's report: <i>for information and assurance</i>	ROHTB (6/26) 003
SW presented the report from the Chief Finance Officer, noting that it had been reviewed in detail at the Finance and Performance Committee. The key points to highlight include: • Month 1 reporting is atypical within the NHS due to the impact of year-end accounting processes. • Income performance remains below plan, despite the plan being set at a conservative level; however, early indications suggest that activity levels in May are in line with plan. • The reprofiling of the Cost Improvement Programme (CIP), following external audit review, was noted. This approach has equalised delivery expectations across the year, creating a more challenging position in Month 1. Mitigating factors include the full-year effect of schemes carried forward from the previous year. • Private patient activity is being reviewed through the newly established Commercial Group. In discussion, the Board considered the timeliness of financial reporting. It was confirmed that there is an inherent lag within NHS reporting cycles, with a clearer financial position typically emerging from around working day 7 of the following month. Whilst activity data is available in real time, it requires validation against clinical coding processes. It was further noted that pay and non-pay expenditure present greater challenges in achieving earlier visibility. The Board was assured that there is increased focus on proactive monitoring, with weekly reviews of key metrics, including activity levels and bank staffing expenditure, to strengthen in-month financial oversight.	
10 Chief Operating Officer's report: <i>for assurance</i>	ROHTB (6/26) 004 ROHTB (6/26) 004 (a)
MHu presented the Chief Operating Officer's report, and the report was taken as read. The key points highlighted include: • Hub optimisation week commencing 11 May, with learning on theatre utilisation to be formally reported to the Finance and Performance Committee. • GIRFT reaccreditation is underway, with a Non-Executive Director to join the assessment panel. • Continued positive Referral to Treatment (RTT) performance, with all national orthopaedic metrics achieved. • Operational challenges experienced in April, primarily linked to the availability of Theatre 4, but a rectification plan in place.	



• It was noted that the Trust's private patient offering will be further considered at the next Quality Improvement Day (QUIDD) meeting. • The appointment of Nas Uddin as Acting Deputy Chief Operating Officer was noted. • Emergency Preparedness, Resilience and Response (EPRR) is transitioning into the Operations portfolio, and is being supported by an NHS England colleague to share learning and best practice. • It was further highlighted that the Trust continues to promote service developments, including the 'foot and ankle' model, to support activity delivery. The Board was invited to ask questions and comment. The following points were of particular note: • JB queried the recurring risks to activity delivery, noting similar challenges in January and April. Assurance was provided that work is underway to address estate-related risks, particularly in theatres, with option appraisals in development, alongside targeted recruitment and use of specialist support to maintain capacity. Actions to optimise pathways, including recovery processes, were also noted, with a trajectory to exceed activity plans in Quarter 1 and achieve a stronger position by Quarter 2. • SJ sought assurance on oversight of the Theatre Improvement Plan and was advised that this is monitored through the Trust Improvement Group, reporting to the Strategy Delivery Board, with onward assurance provided to the Board.	
11 Chief People Officer's report: <i>for assurance</i>	ROHTB (6/26) 005
SM presented the Chief People Officer's report, and the paper was taken as read. The key points to highlight include: • National changes to the apprenticeship levy, with associated risks outlined. The Trust is exploring shorter, more flexible training programmes to mitigate potential impacts. • Progress of the ROH Management Development Programme, with the most recent cohort presenting improvements achieved. • Updates were also provided on the national pay award and the development of People Services at system level, with learning to inform future delivery within the Trust; further detail will be shared with the Staff Engagement and Organisational Development Committee. • Improved performance in sickness absence was noted. The Board was invited to ask questions and comment.	



The following points were of particular note: • MH advised the Board of correspondence from NHS England regarding the requirement to complete the Band 5 review by 2028, with a Trust plan to be submitted by the end of July and overseen through the Staff Engagement and Organisational Development Committee. • IR queried the apprenticeship levy utilisation. It was noted that approximately 75% of levy funding is currently utilised, with 25% gifted. Assurance was provided that, subject to robust workforce planning, there is confidence that a greater proportion of funding can be utilised going forward. It was recognised as a cost-effective approach to workforce development and retention.	
12 Quality Officers' report: <i>for assurance</i>	ROHTB (6/26) 006
MR, ES and SGL presented the Quality Officers' report, and the paper was taken as read. The key points highlighted include: • SJ will be supporting delivery of the national 10 Point Plan in her role as Non- Executive Director. • Attendance at a recent Regional Spinal Meeting was reported to have had a positive impact, supporting shared learning and collaboration. • The Board noted the successful recruitment of a Chief Nursing Information Officer, who will take up post in August. • Appreciation was formally recorded for Barbara Sims on her retirement after 51 years of service to the Trust. • The outcome of a routine Human Tissue Authority (HTA) inspection was noted as positive, with a small number of corrective actions identified and assurance provided that these will be addressed promptly. • The Board also noted good levels of engagement across the organisation in relation to International Nursing Day and International Operating Department Practitioner (ODP) Day. • Introduction of enhanced visibility of health and safety audits via AMaT. • Appointment of a new Freedom to Speak Up (FTSU) Champion who is an Anaesthetic Consultant in Theatres, with additional support being provided to Robert Jones & Agnes Hunt from our own FTSU Guardian. • Implementation of a new governance and accountability framework, with performance review panels to be introduced as the next phase. • The draft Annual Report has been submitted to auditors. • It is proposed Never Events will be reviewed in line with the Patient Safety Incident Response Framework (PSIRF). The Board was invited to comment and ask questions. The following points were of particular note:	



JB queried the progress on provision of gender-neutral facilities. Assurance was provided that the Trust is compliant with legal requirements and that further work is underway with Estates to improve signage and facilities, prioritising patient areas. It was confirmed that following the updated EHRC code of practice being published an impact assessment will be developed and presented to the Board. Action: SM	
GOVERNANCE AND COMPLIANCE	
13 Strategy Delivery Update: <i>for assurance</i>	ROHTB (6/26) 007 ROHTB (6/26) 007 (a)
RL presented the Strategy Delivery update, and the paper was taken as read. The key points highlighted include: - The purpose of the report is to provide assurance against delivery of the Trust's six strategic objectives. - It was highlighted that 2025/26 (Year 3) has focused on reset and transformation, with particular emphasis on standardising core processes. - Key achievements included a reduction in unwarranted variation and clearer definition of the Trust's role within MSK transformation across the system. Improved understanding of service utilisation across Birmingham and Solihull (BSol) was noted, with patients now benefiting from improved access to self-care and alternative services, reducing reliance on waiting lists. This approach is supporting the Trust in strengthening its position as a specialist provider. - The Board noted ongoing learning from other organisations, including initiatives such as community appointment days, sub-specialty models, and an MSK occupational health model. - Collaborative working through the Federation of Specialist Hospitals was also highlighted, with two case studies informing national policy. - Progress in workforce-related objectives, including reductions in sickness absence, and the expanding impact of the Trust's research function were noted. - The Board recognised that challenges identified within the report represent opportunities for organisational learning and improvement. - Standardisation was emphasised as a key enabler, particularly in relation to care pathways, including the joint care pathway and development of day case and digitally enabled pathways aligned to the Electronic Patient Record. - The importance of integrated system pathways was also noted. - It was confirmed that identified challenges will be aligned to the governance framework to ensure clear oversight and follow-up. The Board was invited to ask questions and comment. The following points were of particular note:	



• JB raised the inclusion of strategy delivery reporting should be across all committees. The Board considered opportunities to strengthen income generation, including the development of the private patient offer and positioning the Trust's distinctiveness and competitive advantage in delivering high-quality patient experience. • AA queried the impact of management development programmes, noting that whilst mechanisms exist (e.g. appraisal and staff survey data), there is more to be done to evaluate their effectiveness. It was agreed that this will be further explored through the Staff Engagement and Organisational Development Committee. Consideration of 360-degree feedback mechanisms will form part of wider leadership development guidance and the operating model review. • JB emphasised the importance of linking strategy delivery with patient safety outcomes, particularly in relation to improvement programmes such as theatres. Action RL: A gap analysis to be undertaken to map current strategic priorities against patient safety focus and assurance arrangements.	
14 National Oversight Framework Update: <i>for assurance</i>	ROHTB (6/26) 007 ROHTB (6/26) 007 (a)
SGL presented an update on changes to the national oversight framework (NOF) and noted that the paper had been taken as read. The key points highlighted include: • There are additional metrics to be incorporated, with technical guidance currently in development to support completion of a revised self-assessment. • It was confirmed that, once technical guidance is available, a self-assessment will be completed and presented through Trust Management Group, with onward reporting to the Board to support ongoing monitoring and oversight. The Board was invited to ask questions and comment. The following points were of particular note: • AA queried if the changes were material. SGL explained the changes are not considered significant as the Trust is already monitoring performance against most of the measures. • SW raised the potential impact of indexation within the framework and agreed that clarification through the technical guidance will be important to fully understand any associated risks. • The importance of Domain 1, including its focus on inequalities, was highlighted and it was agreed that further detail on all domains would be shared with the Board. • The Board also considered the impact of data requirements in the context of the Electronic Patient Record (EPR) implementation and was assured that data quality and reporting capability are expected to improve as EPR is	



embedded.	
UPWAR/D REPORTS FROM THE BOARD COMMITTEES	
15 Upward reports from the Board Committees: (cttee chairs) a) Finance & Performance Committee b) Quality & Safety Committee ○ Safer Staffing Report ○ Infection Prevention & Control Annual Report ○ Human Tissue Authority Annual Report ○ Medicines Safety Officer Annual Report ○ Health & Safety Annual Report ○ Quality & Safety Committee Annual Report c) Audit Committee	ROHTB (6/26) 009 ROHTB (6/26) 010 ROHTB (6/26) 010 (a) ROHTB (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
Finance and Performance Committee The Board received the update from the Finance and Performance Committee, noting that the paper had been taken as read. The Committee reported a cautious position, subject to delivery in Quarter 1, and requested a detailed review at that point. Assurance was provided that robust recovery actions are in place. The Board also noted the positive feedback regarding the forward-looking nature of the Committee's discussions. Quality & Safety Committee The Board received the update from the Quality and Safety Committee, noting that the paper had been taken as read. The Committee highlighted a reduction in the number of reported incidents. It was noted that improvements in waiting list management have contributed to a reduction in the number of long-waiting patients, and that improvements within pharmacy processes have also had a positive impact. The Board was advised that ongoing work to improve patient flow into theatres, including reducing time delays, will continue to be developed, with further updates to be provided. The Board received and approved the following annual reports: Human Tissue Authority (HTA) Annual Report, Infection Prevention and Control (IPC) Annual Report, Medical Staffing (MSO) Annual Report, Health and Safety Annual Report, and the Quality and Safety Committee Annual Report. The Safer Staffing Report was presented for assurance and noted by the Board.	



Audit Committee	
The paper was taken as read.	
Performance Reports	
16 Performance Reports: <i>for assurance</i> • Finance & Performance • Quality Report	ROHTB (6/26) 012 ROHTB (6/26) 013
The reports were taken as read.	
17 Any Other Business	Verbal
There was no further business to raise.	
18 Meeting Effectiveness	Verbal
The Board reflected positively on the effectiveness of the meeting, noting that the quality of papers supported constructive and informed debate.	
Date of next meeting: Wednesday, 8 July @ 0900h	

PUBLIC SESSION



Next Meeting: 8th July 2026, Boardroom, Trust HQ

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Updated: 19th June 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.291	Strategy Delivery Update	ROHTB (6/26) 007 ROTHB (6/26) 007 (a)	03/06/2026	Complete a gap analysis to map current strategic priorities against patient safety focus and assurance arrangements.	RL	09-Sep-26	ACTION NOT YET DUE	
ROHTBACT.290	Quality Officers' Report	ROHTB (6/26) 006	03/06/2026	Provide an update on gender neutral facilities including the implications of the EHRC Code of Practice.	SM	09-Sep-26	ACTION NOT YET DUE	
ROHTBACT.289	Chair & Chief Executive Update	ROHTB (6/26) 002 ROTHB (6/26) 002 (a)	03/06/2026	Provide a formal position statement providing assurance on data security and access controls.	SGL	09-Sep-26	ACTION NOT YET DUE	
ROHTBACT.288	Board Walkabouts	Verbal	03/06/2026	Provide an update on how improvement ideas arising from engagement visits and Business Plan discussions will be captured, tracked and delivered.	RL	09-Sep-26	ACTION NOT YET DUE	

KEY:

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



TRUST BOARD

DOCUMENT TITLE:		Chief Executive's Update			
SPONSOR (EXECUTIVE DIRECTOR):		Matthew Hartland, Chief Executive			
AUTHOR:		Matthew Revell, Chief Medical Director (In the Planned Absence of the Chief Executive)			
DATE OF MEETING:		8 July 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 <i>(Indicate with 'x' all those that apply):</i>					
Financial	X	Environmental	X	Communications & Media	X
Business and market share	X	Legal & Policy	X	Patient Experience	X
Clinical	X	Equality and Diversity		Workforce	X
Inequalities	X	Integrated Care	X	Continuous Improvement	
Comments:					
ALIGNMENT TO TRUST STRATEGY <i>(Indicate with 'x' all those that apply):</i>					
Care	X	Community	X		
Expertise		Services			X
People	X	Collaboration			
ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
The contents discuss a number of developments which have the potential to impact on the delivery of a number of the Trust's strategic ambitions.					
ALIGNMENT OR CONTRIBUTION TO BIRMINGHAM AND SOLIHULL INTEGRATED CARE SYSTEM OBJECTIVES AND STRATEGY:					
N/A					
BENCHMARKING SOURCE <i>(Indicate data sources included in report IF APPLICABLE):</i>					
N/A					
PREVIOUS CONSIDERATION <i>(Indicate board/committee/group & date):</i>					
N/A					

CHIEF EXECUTIVE'S REPORT

Report to the Trust Board (in Public) on 8 July 2026

1. INTRODUCTION

- 1.1 Welcome to the Chief Executive's report from the Royal Orthopaedic Hospital NHS Foundation Trust.
- 1.2 This paper identifies key activities and developments since the last Board meeting in June 2026, covering the national and regional NHS context, Trust updates, and Birmingham, Black Country and Solihull system developments.

2. NATIONAL UPDATE

2.1 Secretary of State for Health and Social Care

On 14 May 2026 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, the Chief Executive joined a CEO briefing with Sir James Mackey, Chief Executive of NHS England, who confirmed there is no change to the government's priorities and that the NHS is required to continue to deliver the plans agreed for the short and longer term. The Secretary of State addressed NHS ConfedExpo on 10-11 June 2026, reaffirming the direction of reform on prevention, neighbourhood health, technology, the Single Patient Record and service modernisation.

2.2 NHS Modernisation Bill (Health Bill)

The Health Bill was introduced on 14 May 2026 and reached its second reading on 1 June 2026. This is one of the most significant pieces of NHS legislation in over a decade. Key provisions include:

- Abolition of NHS England, expected to take effect from April 2027, with functions transferring directly to the Department of Health and Social Care.
- Introduction of a Single Patient Record, projected to save 500,000 clinician hours annually and reduce A&E attendances by up to 20,000.
- ICBs to take on commissioning of primary care, community pharmacy and specialised services.
- Abolition of Healthwatch England and all local Healthwatch bodies.
- Proposed removal of elected Foundation Trust governors and expanded Secretary of State powers over NHS finances and oversight.

Strategy Delivery Board will continue to oversee the Trust's response to the evolving framework. The Board should note the governance implications for Foundation Trusts as the Bill progresses through Parliament.

2.3 NHS Oversight Framework 2026/27

NHS England published the updated NHS Oversight Framework for 2026/27 on 10 June 2026. The framework sets out a revised and more transparent approach to assessing ICBs, NHS trusts and foundation trusts. It is pleasing to note that the

Royal Orthopaedic Hospital retained its Level 1 segmentation, placing it among the highest performing NHS trusts in the country. The new set of metrics against which the ROH will be assessed was presented at the last meeting of the Trust Board and a self-assessment against these is currently underway.

2.4 Resident Doctors: Dispute Resolved

On 29 June 2026, the BMA confirmed that resident doctors in England voted to accept the government's pay and jobs offer, formally ending a three-year dispute that had resulted in significant disruption to elective services. In the referendum, 52.9% voted to accept on a 57.3% turnout. The deal delivers an average 6.6% pay uplift and 4,500 additional specialty training posts over three years. This removes the immediate operational and financial risk from further strike action, though the narrow margin of acceptance warrants continuing attention to workforce sentiment. The Trust activated its plans for the 15-19 June round of action and the outcome of that period will be reported separately.

2.5 Independent Investigations into Maternity and Neonatal Services

As detailed in the Quality & Governance Officers' section of the next paper, the independent review into maternity care at Nottingham University Hospitals NHSFT was published on 24 June 2026 and the Trust is currently reviewing the findings and required immediate actions detailed within the report.

In addition to this, on 30 June 2026, Sir James Mackey wrote to all Trust and ICB chief executives, chairs, chief nursing officers and medical directors following the publication of Baroness Amos' independent investigation into maternity and neonatal services in England. The letter, issued alongside the Ockenden review, described this as a moment requiring collective leadership to act with real urgency, framing it as a turning point for maternity and neonatal services in the NHS.

An NHS 10 Point Plan for Maternity and Neonatal Services has been published, setting out urgent actions for trusts and systems to prioritise immediately:

- Commence rollout of Martha's Rule across all maternity and neonatal settings in 2026/27, covering antenatal, intrapartum, postnatal inpatient, triage, assessment units and neonatal services.
- All trusts to implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data, reported publicly through their boards, with a clear focus on patients from minority backgrounds.
- Dual board-level accountability to be established between medical directors and chief nurses for maternity and neonatal services, with directors of midwifery and clinical directors attending boards when these matters are discussed. This model applies at trust, system, regional and national board level.
- NHS England to launch an "Amos into Action" staff listening exercise to explore how recommendations are implemented across the system, covering culture, attitudes and ways of working.

- The Perinatal Equity and Anti-discrimination Programme to be available to all trusts by end of 2026. All trusts providing maternity services to fully implement the Maternal Care Bundle by March 2027.
- Boards to take direct accountability for safe 24/7 staffing arrangements and review whether non-frontline roles can be redeployed to strengthen services.
- Trusts to ensure a review of homebirth services has been completed and reported to their board, with any safety concerns actioned and improvement plans in place.
- Trust boards to review how they respond to patient safety incidents, complaints and concerns with openness, humanity, candour and a trauma-informed approach.
- All trusts to complete a board-level audit of maternity triage services within 3 months. New NHS England triage guidance is being published. Within 12 months, trusts must implement improvements in line with national standards, including dedicated midwifery staffing separate from the labour ward.
- All trusts to implement actions from the System letter on post-death care following the Fuller and NUH reviews, including responding to the board assurance statement by 31 July 2026 and reviewing incident records over the past 10 years as required by the Human Tissue Authority.

The government has also announced the creation of the UK's first Maternity and Neonatal Commissioner, providing an independent voice on safety, experience, equity and accountability. An additional £41 million has been committed to improve the maternity and neonatal estate, and £10.6 million has been made available in 2026/27 to support the recruitment of newly qualified midwives into additional Band 5 frontline roles, with £9 million becoming recurrent from 2027/28.

Although the Royal Orthopaedic Hospital does not provide maternity services, the Board should note the systemic governance and safety culture requirements arising from the Amos investigation, particularly the expectations around dual board accountability, board-level data assurance, patient safety culture and candour, which carry relevance for all NHS foundation trusts. To offer some high level assurance having reviewed the findings and actions set out within these reports, there are no immediate gaps or concerns from the ROH's perspective. A number of the findings centre on substandard Board oversight, failings in incident investigation, slow progress in rolling out Martha's Rule and improvements needed to the Speaking Up culture. A gap analysis and position statement against the findings and recommendations in the reports is currently being populated and will be offered at a future meeting of the Board.

Given the scale and severity of the findings in these reports and others recently, including the identification of NHS staff accessing medical records in an unauthorised way, the Trust is considering its approach to offering confidence to the public and patients that practices at the ROH are robust and that the Trust operates in a controlled and ethical way.

2.6 NHS ConfedExpo 2026

NHS ConfedExpo took place in Manchester on 10-11 June 2026. Key themes included financial challenge and productivity, neighbourhood health implementation, technology-enabled transformation, the Single Patient Record, and the implications of the NHS Modernisation Bill. These themes are consistent with and will continue to shape the Trust's strategic agenda.

3. REGIONAL/ICB UPDATE

3.1 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 coming weeks. The restructuring of Birmingham and Solihull and Black Country ICBs is underway ahead of the proposed merger, with a similar timeframe to the regional restructuring. Formal merger is not expected before April 2027.

3.2 Strategic Commissioning Approach

The ICB confirmed its approach to implementing strategic commissioning in line with the 10 Year Plan. Strategy Delivery Board continues to oversee the Trust's response. It has been clarified that specialist hospitals in the system, including the ROH, will be supported to spread their expertise across the whole cluster geography and be part of the new Anchor Institution model in each Place.

3.3 Regional Elective Recovery

The NHS Midlands region has reported the fastest fall in waiting lists in the country, with the waiting list for operations falling by more than 90,000 over the year to May 2026. This represents more than a quarter of the national reduction and provides a positive context for the Trust's own elective performance and recovery trajectory.

4. CHIEF EXECUTIVE ACTIVITIES

4.1 Birmingham Health Partners

The Chief Executive attended the Board of Birmingham Health Partners, 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.

5. ROH UPDATE

5.1 Voice into Action

The Trust is currently midway 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. The engagement throughout the Trust is pleasing and the feedback received is currently being

reviewed with action plans being constructed to meet the 90-day ambition to resolve issues where possible. Board will be fully appraised on the programme at a future meeting.

5.2 NOA Board Meeting

The Chief Strategy Officer attended the NOA Board meeting on behalf of the Chief Executive. The Board received positive updates from the NOA Coding Project, which has produced a near-final coding handbook to be made available to NOA members. The 2026-27 programme of monthly best practice sharing sessions was discussed, covering innovation, AI and patient outcomes. Plans are underway for the NOA Conference in London on 22 April 2027. The Board also discussed plans for a future MSK report to engage members on the role of providers in advancing MSK care and overcoming barriers within the neighbourhood health agenda.

5.3 Trust Management Group

The Trust Management Group met again in June and conversations were strengthened by the report from the first Performance Review Panel. The Panel had convened with the Division 1 management team and considered performance against a range of metrics set out in a new scorecard. The next meeting of TMG is planned for 23 July 2026.

5.4 Commercial Group

A further successful meeting of the Commercial Group took place and this group will continue to meet monthly. Non-NHS income is an important element of the ROH business model, with all income received reinvested to support NHS patient care.

5.5 Healthcare Estates and Facilities Day

On 17 June 2026 the Trust was proud to celebrate Healthcare Estates and Facilities Day, recognising the breadth and value of contribution within these areas. Every day, colleagues in Estates and Facilities play an essential role in ensuring services run safely, efficiently and effectively. A sincere thank you to our Estates and Facilities teams for their continued dedication, professionalism and commitment.

5.6 Blue Heart Awards

The Trust looks forward to the Blue Heart Awards ceremony on Friday 10 July 2026, where colleagues will be recognised for going above and beyond in their roles.

6. POLICY APPROVAL

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

- Emergency Preparedness, Resilience and Response (EPRR) Policy
- DNACPR/ReSPECT Policy
- Shared Decision Making and Consent to Examination or Treatment Policy

- Data Quality Policy

7. RECOMMENDATIONS

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

Matthew Revell

(In the Planned Absence of Matthew Hartland, Chief Executive)

July 2026



TRUST BOARD

DOCUMENT TITLE:	Trust Officers' Reports						
SPONSOR (EXECUTIVE DIRECTOR):	Executive Directors						
AUTHOR:	Executive Directors						
DATE OF MEETING:	8 July 2026						
PURPOSE OF THE REPORT:							
TO PROVIDE ASSURANCE	X	FOR INFORMATION ONLY		TO CREATE DISCUSSION		TO SEEK APPROVAL	
EXECUTIVE SUMMARY:							
A summary of the Officers' reports are being presented 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 <i>(Indicate with 'x' all those that apply):</i>							
Financial	x	Environmental	x	Communications & Media	x		
Business and market share	x	Legal & Policy	x	Patient Experience	x		
Clinical	x	Equality and Diversity	x	Workforce	x		
Inequalities	x	Integrated Care	x	Continuous Improvement	x		
Comments:							
ALIGNMENT TO TRUST STRATEGY <i>(Indicate with 'x' all those that apply):</i>							
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 <i>(Indicate data sources included in report IF APPLICABLE):</i>							
None specifically							
PREVIOUS CONSIDERATION <i>(Indicate board/committee/group & date):</i>							
May 2026, with separate Officer's reports being considered at the June 2026 meeting.							



CHIEF OFFICERS' REPORT – July 2026

QUALITY & GOVERNANCE

Chief Medical Officer Report:

Research and Development

- Innovation work is progressing with planned first formal oversight meeting July 2026
- A new live dashboard of performance is enhancing real time intelligence
- Financial and patient recruitment trackers look ahead of target
- Study approval times all less than (better than) the national standard during 2026 marking a significant improvement in performance from last year
- A concern is the likely move the Birmingham Implant Retrieval Centre grant holder to Manchester later in the year. UoB is intending to retain the service and the Trust continues to support all involved.
- Trust and trainees supported a successful Birmingham Orthopaedic Research Day 12/6/26

Audit and Outcomes

- The Trust chaired an NOA online workshop on PROMs as the national programme comes back on line 2/7/2026

Clinical

- Consultant anaesthetist interviews were held on 7 June 2026
- There is an improved position of the fragile bone tumour histopathology service – with a period of sustained stability for two months and statutory target improvement hoped for from June

Meetings

- NHS Confederation meeting was attended on 11 June 2026
- I attended the Aston University Charter Dinner on 27 June 2026 which provided an opportunity to network with HIWM and meet the new Aston Dean of Life Sciences
- NHS Leadership event was attended on 30 June 2026, where the main focus was on the Ockenden / Amos reviews

Chief Nursing Officer report:

Monthly Hospital Acquired Infections (HACI) DATA:

- The NHS Standard Contract requires all trusts to minimise rates of both C. difficile and Gram-negative bloodstream infections (GNBSIs) against thresholds set annually by NHS England. To date the 26/27 threshold has not be set for ROH.

	Infections Recorded in month and Year to Date (YTD)	MAY 2026	YTD*
	Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA) bloodstream infection	0	0
	HOHA/COHA toxin positive <i>Clostridioides difficile</i> infection (CDI)	0	0
	Methicillin-Sensitive <i>Staphylococcus aureus</i> (MSSA) bloodstream infection	0	0
	<i>E. coli</i> bloodstream infection	0	0
	<i>Klebsiella spp.</i> bloodstream infection	0	0
	<i>Pseudomonas aeruginosa</i> bloodstream infection	0	0
	National: - On the 18 June 26, Professor Michelle Bateman, Deputy Chief Nursing Officer (Quality), wrote to the Trust requesting improved recording of FFP3 fit testing data within ESR in line with national preparedness requirements. Compliance is currently at 78%; however, work is underway to scope and enable consistent ESR recording, which has not previously been possible. This will support improved data completeness ahead of the November 2026 deadline. Deprivation of Liberty (DoLS) Case Law Change: Following the Supreme Court judgment on the 2 June 2026, which revises the definition of deprivation of liberty, the Department of Health has issued updated guidance with immediate effect across the UK. This has significant implications for identifying and managing DoLS cases in practice. UK Supreme Court 2026 judgment on what constitutes a deprivation of liberty - GOV.UK The Trust has commenced a programme of implementation, including targeted communications, ward-based engagement by the Safeguarding Team, and incorporation of guidance into supervision and QIDD forums. Ongoing case monitoring and staff support are in place, with further updates to policies and training to follow in line with forthcoming NHS England guidance. - On the 2 June 2026, Duncan Burton, Chief Nursing Officer for England, and Danny Mortimer, Director General for People, wrote to the Trust setting out the requirement to undertake a comprehensive review of all Band 5 nursing roles to ensure fair and consistent pay in line with Agenda for Change job evaluation principles, following identified national variability in implementation. The organisation is required to submit a Board-approved Band 5 nursing job evaluation delivery plan by 31 July 2026, with all reviews to be completed by October 2028. The Chief Nursing Officer (CNO) and Chief People Officer (CPO) will jointly oversee this programme of work, supported by strong partnership		

working with trade unions. Key actions include confirming a Board-level Senior Responsible Officer, addressing job evaluation capacity and capability gaps, and delivering a phased and credible plan with meaningful staff engagement and appropriate governance oversight. A more detailed paper outlining actions underway has been presented to the Staff Engagement and Organisational Development (SE&OD) Committee for assurance.

- The NMC is undertaking a public consultation, open until 23 July 2026, as part of its review of practice learning requirements for nursing, midwifery and nursing associate programmes. Proposed changes include potential reductions in nursing practice hours and extensions to midwifery training, aimed at ensuring safe and inclusive learning environments. This consultation has been shared with nurses across the Trust for awareness and engagement. [Practice learning review consultation - The Nursing and Midwifery Council](#)
- On 24 June 2026, the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust was published. The report is deeply distressing, and my thoughts are with the women, babies and families who were harmed, bereaved and let down. While the Trust does not provide maternity services, the review identifies significant systemic learning relevant to all care settings, particularly in relation to culture, leadership, safety and governance. The findings highlight the importance of organisational reflection, and it is planned that the Executive Team undertake a detailed review of the report and return with an assessment of implications for the Trust, including any actions required. [Final Report of the Independent Review - Ockenden Review](#). In addition, it has been outlined that, the Public Office (Accountability) (Hillsborough) Bill will extend the duty of candour and cooperation, reinforcing expectations for openness, honesty and full disclosure in investigations and reviews across the NHS.

Trust wide:

- The Learning Disabilities team marked Learning Disability Week (2026) on 17 June, welcoming 'Communicate 2U', funded by ROC, to deliver activities for staff. Feedback on the sessions has been very positive.
- In my role as **Controlled Drugs Accountable Officer**, I undertook several key activities this month. We welcomed a Controlled Drugs Midlands Police Officer for a site walkabout, during which they engaged with nursing staff and a resident doctor to address concerns and raise awareness of cannabis-based medicines. Following a patient-related concern on site, a feedback loop was developed and has been shared regionally to support wider learning and awareness of the challenges faced.
- I, also attended the Controlled Drugs Local Intelligence Network (CD LIN), where a report from the CQC highlighted ongoing work regarding the prescribing of cannabis-based medicines. Draft regional guidelines are currently in development, which ROH will review and consider as part of ongoing governance and practice improvement.
- Human Tissue Authority inspected our services on the 13 May 26, the trust has now received the final report. Three minor administration Corrective Action &

Preventive Action (CAPAs) against the standard have been identified. Work has already been undertaken to address the gaps and a response to HTA will be issued shortly. Full report will be shared with QSC.

- Emma Steele, Deputy Chief Nurse and Jennifer Pearson Head of Nursing for Division 2, attended a community event in Perry Barr lead by the Community partners in association with BLACHIR. Prompting services at ROH including the Woodlad suite.
- On the 17June 26, we celebrated Estate and Faculties Day, recognising the services they deliver and their contributions to the patient journey.

Chief Governance Officer's report:

Health & Safety

- COSHH awareness training now uploaded as e-learning module on LMS and applied as mandatory for relevant facilities staff – environmental cleaners, specimen drivers, catering staff and waste portering team. This in addition to continuing to offer some face-to-face sessions for those staff who may prefer this form of training.
- Focused support has been provided to staff (both clinical and non-clinical) with long term health conditions and returning to work after surgery, to undertake individual workplace risk assessments and support their managers.
- Our current Health & Safety Adviser leaves the Trust for a new opportunity on 29 July. We wish Sophie well for the future and thank her for her contributions over the last two years. The recruitment process for a new Health & Safety Adviser is underway and we are hopeful of an appointment by the end of July.

Clinical Governance

- The Trust receives on average 30 Freedom of Information requests each month, and there is a strict deadline to respond to these submissions. We would like to pass on our thanks to everyone who has taken the time to provide information for our responses. We currently have only 16 open requests, which is the lowest level it has been since Freedom of Information joined the governance portfolio.
- Following a recent wrong implant never event, we used a new type of investigation tool. A swarm was undertaken instead of a Patient Safety Incident Investigation (PSII) or after action review (AAR). The pilot was successful, with the team being open and supportive throughout. Actions are now underway and learning from the incident is being embedded.

Corporate Services

- The annual Fit and Proper Persons Test process has concluded for all Board members and the required submission confirming its achievement has been made to NHS England and to advise that there were no concerns identified. The process has been strengthened this year by the adoption of recommendations from the in year internal audit by KPMG.

	- The Council of Governors meeting is taking place on the afternoon of 8th July. A key focus for the session will be on the public and patient engagement framework and how this may be developed should the primary legislation change to rescind the mandate for Foundation Trusts to establish a Council of Governors. Freedom to Speak Up - The Freedom to Speak Up day was held on 7 July. The FTSU team will wear their signature green T Shirts and raise awareness about the importance of speaking up about concerns. Other key messages around the event will be the Sexual Safety Charter and Civility and Respect. - The FTSU team has been nominated for a Blue Hear Award for the second year running. - Work will be undertaken this year to understand how to improve the speaking up culture in key areas of the Trust where take up is noted to be lower. It is important that all staff feel safe to speak up without fear of reprisal.
OPERATIONS	Below is a summary of the operational performance for May 26: - Elective Activity - Total activity delivered in May 2026 was 1,174 cases against a plan of 1,196, resulting in a variance of -22 cases. YTD activity is -88 below plan. - The shortfall continues to be driven primarily by a combination temporary Estate capacity constraints and unplanned absence in the medical workforce. A ward also remained closed due to heating system issues reducing available inpatient capacity. The projected position for June 26 is that the elective plan will be achieved. - Theatre Utilisation – Session utilisation was 93.85% and in session utilisation was 81.13%. The latest model hospital data reports a capped elective theatre utilisation of 83.6% - Outpatient Activity – YTD the deficit from plan is 1,750. A deep dive has been undertaken by the operation team to understand the deficit that is primarily driven by changes since plan submission such as, vacancies, clinic template changes – the RTT sprint has led to a greater requirement for RTT follow up capacity, job plan changes and unplanned absence. A rectification plan has been discussed and agreed that will involve working towards plan for the rest of the year. The projection for June 26 outpatient activity is an improvement on April and May 26 deficits. - Referral to Treatment Targets – despite a reduction in outpatient activity, the Trust continues to be ahead of the trajectory for RTT. May 26 the team achieved a performance of 67.35% against a target of 65.62%. This month-on-month improvement demonstrates the team’s continued focus on effective

pathway management, service coordination of waiting lists and sustaining patient flow. The number of patients waiting over 52 weeks also continues to remain aligned to the trajectory

- Diagnostics – The team achieved 99% in May 26 meeting the trust target and exceeding the national target.
- Cancer – Unfortunately the Trust did not meet the Faster Diagnostic Standard or the 62-day cancer standard, primarily due to challenges with Histopathology services provided by UHB. Improvements in the 62-day performance are forecast from early Q2, supported by additional mitigations including increased reporting capacity.
- Private Patients - Income performance improved compared to month 1, reflecting an increase in activity and a higher average value per procedure. May remains below plan, with total income of £390,595 against a planned position of £587,000.

National Updates

- Getting It Right First Time (GIRFT) elective hub reaccreditation. Working groups and documentations reviews underway. Submission will be 2 weeks before the visit in September 26 – (Exact date still TBC)

Local Updates

- Acting COO and Head of Private Patient Services provided a presentation and had a discussion at QIDD based on opportunities to grow Private Patients and the importance private patients have on the financial sustainability of the Trust.

Opportunities include:

- Greater flexibility between NHS and Private
- Scheduling further in advance
- Capacity aligned to surgeon availability
- Opportunities to invest back into the NHS
- Options for mixed economy lists with the network patients to maximise list utilisation and income – consideration for the Spinal network tender
- A regular specialty day – hybrid of surgeons' cases
- Private Patients Internal Promotion Stand in the Café Royale Foyer – to support wider staff engagement
- Promotional Christmas Bags (Gift from the Private Patient service)
- Future QIDD sponsorship
- Options for outpatient rooms (in week) – potentially consider future options for a consultation room on the Woodlands Suite or alternative location for outpatients
- Pursue International Market

	○ Scope opportunities for osseointegration ○ Arthrosomid – an injectable hydrogel for the symptomatic treatment of knee arthritis ○ Short-medium-and long-term workforce model ○ Consultant engaged in helping us pursue options for Foot and Ankle shockwave therapy. ○ Ongoing engagement with clinicians to build surgeon confidence • A comprehensive action plan is being produced to include timescales, and a paper is being presented to the July 26 commercial group.
WORKFORCE	• This month the BMA announced that resident doctors have accepted the governments latest offer which ends the ongoing dispute over pay and jobs. A briefing pack detailing the deal is included in the papers for reference. • Executives have been supporting the Cluster wide High Potential Scheme with placement panels taking place during the months of July and August 2026. We have two individuals from the Trust who have joined the programme. Feedback on their experience and outcomes from the scheme will be fed through the Staff Experience and OD Committee. • I have supported the recruitment to the National People Future Leaders Programme – an aspirant Chief People Officers development programme aimed at equipping future talent with the skills and experience to move into Board and Sub Board People related roles in the future. • Matthew Hartland and I had the pleasure of attending the Graduation event for the delegates from the ROH Developing Leaders Programme. We were highly encouraged by the calibre of the graduates and the continuous improvement projects they had undertaken during their time of the programme. A really positive afternoon! • During June I also attended the Midlands Sickness Absence Summit hosted by NHSE. This was a really informative event where NHS organisations from across the Midlands were showcasing the work they had undertaken to support workforce productivity with a particular focus on supporting attendance and wellbeing of the workforce. • Sickness absence decreased in month to 5.07% and is below trajectory. We are the only Trust in Birmingham making rolling absence decreases in 2026. • AFC appraisal rate decreased however this was anticipated due to being in the April to July window. • Mandatory training increased to 92.12% edging closer to the target of 93% • Employee relations casework is steady however grievance and sickness final stage hearings are high. • Bank expenditure increased in month and agency expenditure remained above target The Temporary Working Taskforce is looking at ways in which to improve temporary booking governance and current managerial practice including effective workforce planning.

STRATEGY, PARTNERSHIPS & IMPROVEMENT	• Primary care engagement plans are progressing well, with a new Primary Care Hub due to launch next month, along with targeted GP marketing and partnership meetings planned in Q2. • The MSK Occupational Health pilot is progressing at pace. Recruitment of two Band 6 Physiotherapy Occupational Case Managers will conclude by the end of July and the 12 month pilot will commence in September 2026, aiming to reduce MSK related sickness absence across BSOL NHS providers. • The ROH's annual staff awards event, the Blue Heart Awards, will take place on Friday 10th July 2026. The shortlisting panel was made up of Staff Governor and Staff Network representatives, and the process was fully anonymised, focusing on achievements and impact of all shortlisted individuals. • Trust Management Group and Trust Improvement Group have endorsed the 2026-27 Delivery & Transformation 'Plan on a Page' which will be communicated across the organisation to frame the strategic priorities for the Trust throughout this financial year • David Rogers has been successfully appointed as GIRFT System Clinical Lead for the MSK Community Delivery Programme (1st July 2026 – 31st March 2027). This role is 1 day per week, focusing on reducing community MSK waiting times across the system, establishing First Contact Physiotherapy pathways into local work and health support and advocating for the standards set out in the Adult Community MSK service specification. This role is strongly aligned to the BSOL MSK Transformation Programme, that ROH continues to lead and which is moving into Phase 2 of its delivery.
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TRUST BOARD

DOCUMENT TITLE:		Chief Finance Officer's Report M2	
SPONSOR (EXECUTIVE DIRECTOR):		Steve Washbourne, Chief Finance Officer	
AUTHOR:		Steve Washbourne, Chief Finance Officer	
DATE OF MEETING:		8 July 2026	
PURPOSE OF THE REPORT:			
TO PROVIDE ASSURANCE	x	FOR INFORMATION ONLY	
		TO CREATE DISCUSSION	
		TO SEEK APPROVAL	
EXECUTIVE SUMMARY:			
Month 2 Financial Report			
ASSURANCE PROVIDED BY THE REPORT:			
POSITIVE		GAPS IN ASSURANCE/RISKS TO ESCALATE	
Delivery against plan in month		Underperformance of variable and PP income Under delivery of CIP	
REPORT RECOMMENDATION:			
The Committee/Board is asked to:			
NOTE the Finance Report			
KEY AREAS OF IMPACT (Indicate with 'x' all those that apply):			
Financial	x	Environmental	
Business and market share		Legal & Policy	
Clinical		Equality and Diversity	
Inequalities		Integrated Care	
		Communications & Media	
		Patient Experience	
		Workforce	
		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:			
N \ A			

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

N \ A

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

N \ A

CFO's Report Month 2

1. Summary

The Trust delivered a deficit in month of £18k, which is £9k favourable to plan. From a YTD perspective the ROH is now at a deficit of £78k against a plan deficit of £94k.

	Plan £000s	Actual £000s	Variance £000s	%	Plan £000s	Actual £000s	Variance £000s	%
Operating income	12,090	12,406	316	2.6%	24,180	23,778	(403)	(1.7%)
Agency pay	(75)	(88)	(13)	(16.9%)	(149)	(92)	57	38.2%
All other employee expenses	(6,936)	(7,044)	(108)	(1.6%)	(13,873)	(13,911)	(38)	(0.3%)
Operating non pay	(4,974)	(5,203)	(229)	(4.6%)	(9,987)	(9,712)	275	2.8%
Total operating surplus / (deficit)	106	71	(34)	(0.3%)	171	62	(109)	(0.5%)
Non operating items	(142)	(99)	43	30.2%	(283)	(159)	125	44.0%
Surplus/(deficit) for the period/year	(36)	(28)	8	0.1%	(112)	(96)	16	0.1%
Less I&E impairments/(reversals) & (gains)/losses on transfers by absorption	0	0	0		0	0	0	
Surplus / (deficit) before impairments and transfers	(36)	(28)	8	0.1%	(112)	(96)	16	0.1%
Technical adjustments	9	9	0	4.8%	18	18	0	1.7%
Adjusted financial performance surplus/(deficit)	(27)	(18)	9	0.1%	(94)	(78)	16	0.1%
Less Non-Recurrent Deficit Support	0	0	0		0	0	0	
Adjusted financial performance surplus/(deficit) excluding non-recurrent deficit funding	(27)	(18)	9	0.1%	(94)	(78)	16	0.1%
Underlying position								
EBITDA as a percentage of related income	5.4%	4.5%	(1.0%)		5.3%	4.5%	(0.8%)	
I&E margin	(0.2%)	(0.1%)	0.1%		(0.4%)	(0.3%)	0.1%	

Average monthly values	Current month £000s	Current YTD £000s	To maintain YTD Var £000s	Required to hit plan £000s	Required to hit FOT £000s
Adjusted financial performance surplus/(deficit)	(18)	(39)	9	8	8

2. Income

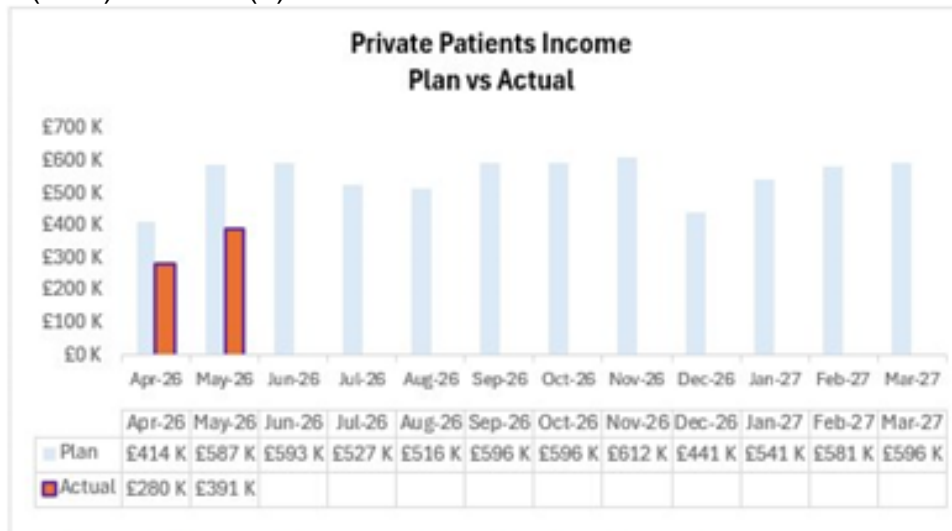
Whilst Income performance improved in month compared to Month 1 this was mainly due to an understatement of uncoded activity in m1 which has now been charged. The YTD underperformance has therefore also reduced to £403k year to date. This includes a deconstructing 'block adjustment of £86k Commissioner income improved to £14k favourable variance year to date, and private patient income by £413k against plan year to date.

Whilst Inpatient and Day case elective combined income is broadly in plan, the underperformance of outpatient activity and income is concerning. A further review of outpatients has been undertaken and a rectification plan has ben circulated.

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

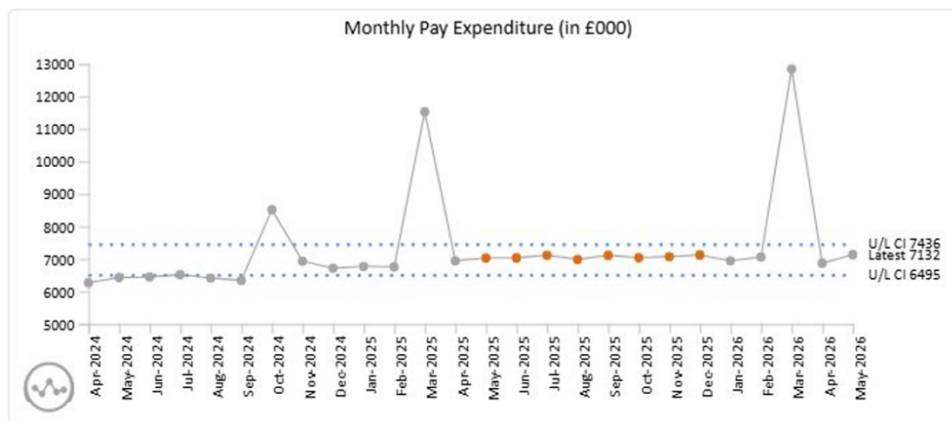
A more detailed deep dive into Income variation has been undertaken and discussed at Execs. This will be shared at F&P next month.

Further work is being undertaken around PP income to understand what a revised forecast outturn may look like.

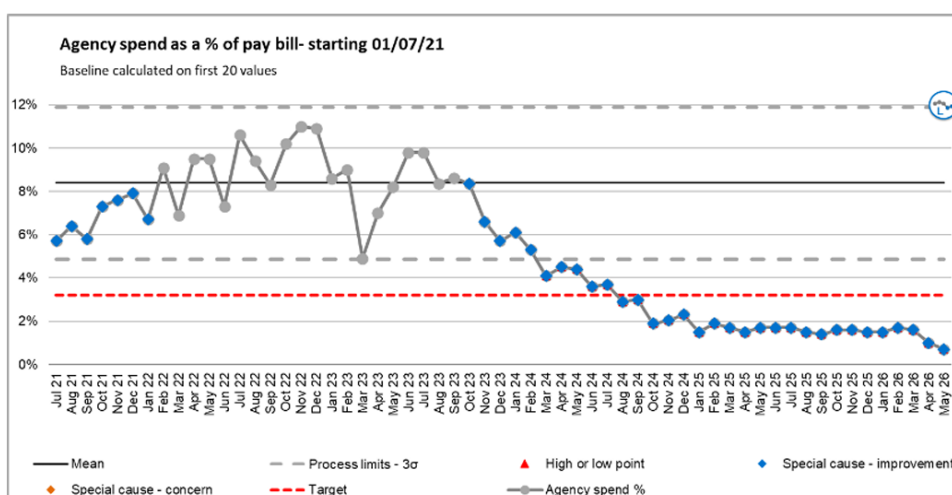


3. Pay

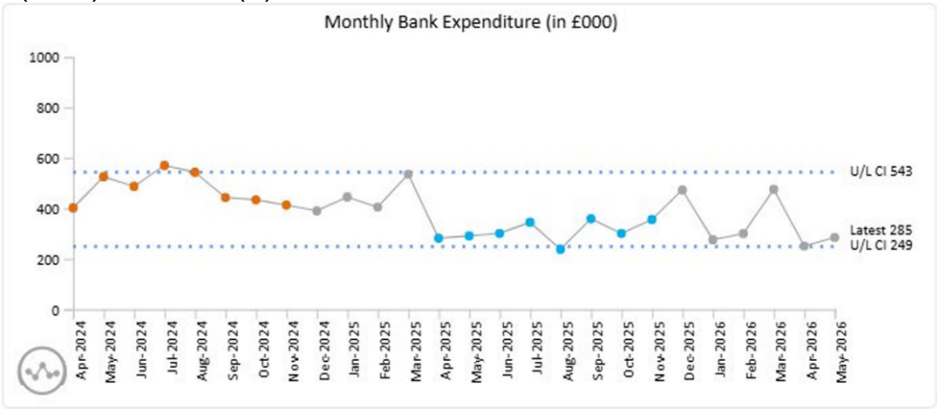
Pay expenditure is overspent in month by £121k, totalling £19k favourable variance year to date



Agency spend is £88k in month or 1.2% of pay,.

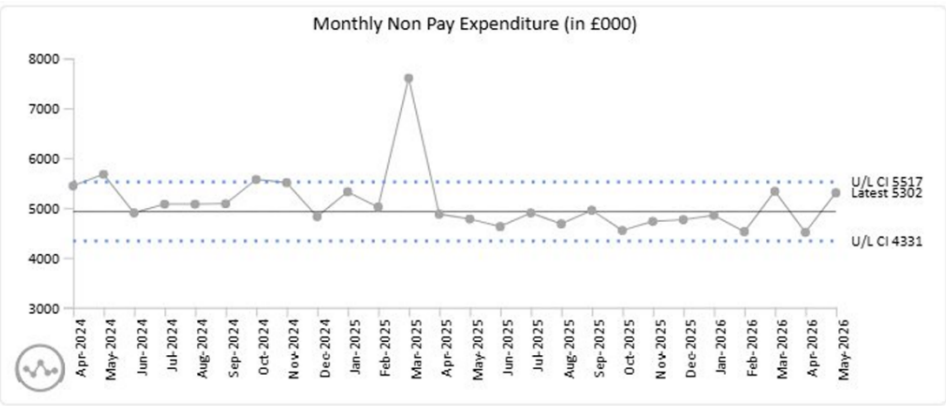


Bank expenditure increased to £285k in April from £251k in March. This lower than the 25/26 ave spend of £333k but still £38k over 26/27 plan.

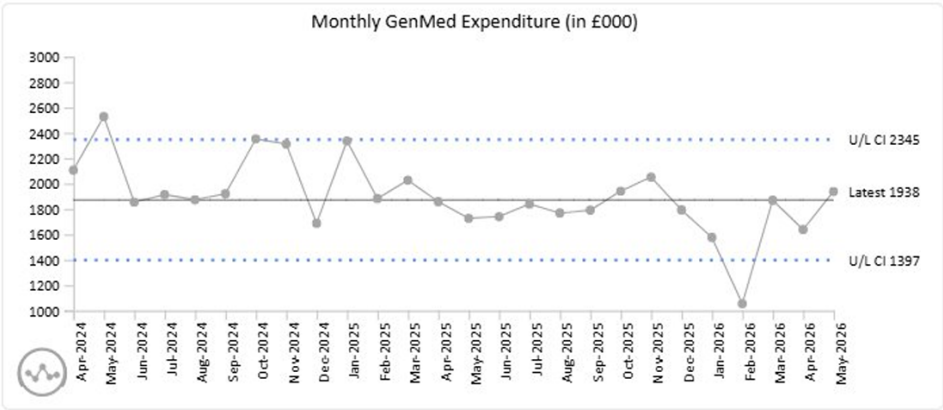


4. Non-Pay

Non pay expenditure overspent in month by £229k reducing the year to date favourable variance to £275k.



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. The high point in M11 was the receipt of FD funding which was expended in M12.



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

8.

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.

CIP Scheme	In month £'000s			Year to date £'000s			Full year £'000s
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
Bank Reduction	85	33	-52	170	100	70	£1,024.21
Agency Reduction	45	41	-4	91	178	87	£546.76
LLP	102	45	-58	205	79	-126	£1293.43
Service review phase 2	61	0	-61	123	0	-123	£740
Budget management level schemes	352	179	-167	699	276	-502	£4,160.60
Total CIP schemes 25/26	642	299	-343		335	(612)	£7,765.00

Appendix A: Operating Income

Variable Income

	1	2	Grand Total	Plan	Variance
Day Cases	£901,827	£946,299	£1,848,125	£1,994,812	-£146,687
Elective	£2,648,854	£3,017,510	£5,666,364	£5,528,513	£137,851
Excess bed days EL	£78,118	£178,348	£256,466	£195,554	£60,912
Outpatient First Consultant Led	£343,427	£314,047	£657,474	£872,983	-£215,509
Outpatient First consultant Non Face to Face	£21,819	£30,462	£52,281		£52,281
Outpatient Procedures FA	£26,851	£5,222	£32,072	£79,337	-£47,265
Outpatient Procedures FUP	£36,969	£40,239	£77,208		£77,208
Grand Total	£4,057,863	£4,532,127	£8,589,990	£8,671,198	-£81,208
Deconstructing block adjustment					-£85,742
Diagnostics	£147,643	£157,060	£304,702	£321,526	-£16,824
Private patients	£296,000	£393,000	£689,000	£1,102,000	-£413,000
Passthrough income	£208,000	£274,000	£482,000	£478,000	£4,000
	£8,767,369	£9,888,314	£10,065,692	£10,572,724	-£507,032

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	£8,767,369	£9,888,314	£10,065,692	£10,572,724	-£507,032



TRUST BOARD

DOCUMENT TITLE:	Response to the Lord Mann Review and NHS England Correspondence on Anti Semitism, Racism and Discrimination
SPONSOR (EXECUTIVE DIRECTOR):	Matthew Hartland (CEO)
AUTHOR:	Sharon Malhi (Chief People Officer)
DATE OF MEETING:	8 th July 2026

PURPOSE OF THE REPORT:							
TO PROVIDE ASSURANCE	x	FOR INFORMATION ONLY	x	TO CREATE DISCUSSION		TO SEEK APPROVAL	

EXECUTIVE SUMMARY:

The Government published the Lord Mann Review into antisemitism and other forms of racism in the NHS on 4 June 2026 and has accepted all recommendations.

NHS England subsequently wrote to NHS organisations outlining expectations for local review and implementation and highlighting forthcoming national work, including the development of NHS Staff Standards.

This report provides the Board with:

- Background to the Lord Mann Review and NHS England correspondence
- An overview of the Trusts current position
- Relevant workforce and staff survey findings
- Assurance regarding existing programmes of work already addressing the recommendations
- An update on review activity currently underway to assess any additional actions required

Significant work is already in place through the RACE Code work, WRES (Workforce Race Equality Standards) Action Plan, Equality Diversity and Inclusion Improvement Plan, Civility and Respect programmes, Bullying and Harassment Task Force and Anti Racist commitments.

The table below offers assurance to the Board on the alignment of ROH activity to the Lord Mann review themes:

Lord Mann Theme	Existing ROH Activity
Leadership & Accountability	RACE Code, EDI Improvement Plan, Trust Board/SE&OD/EXEC team oversight
Workforce Data	WREs, Staff Survey reporting; qualitative feedback, themes from investigations
Reporting & Investigations	HR processes, Bullying & Harassment Taskforce, FTSU
Staff Support	Staff Networks, Wellbeing support, FTSU, Unions
Training and Capability	Me As A Manager, Civility and Respect, Mandatory training

The Trust continues to make progress in workforce diversity and representation. However, recent workforce equality and staff survey data highlight several disparities in staff experience which require ongoing focus and support from all colleagues.

Positive Indicators

- Ethnic minority representation within the workforce increased from 31.8% to 35.0%
- Ethnic minority representation at Board level increased from 20% to 25%, exceeding the NHS average reported through WRES benchmarking
- The relative likelihood of ethnic minority staff entering formal disciplinary processes improved significantly
- Access to non-mandatory training and development opportunities for ethnic minority staff remains positive

Areas Requiring Continued Focus

- 29.98% of ethnic minority staff reported experiencing bullying, harassment or abuse from colleagues, compared to 22.04% of White colleagues. This represents an increase from the previous reporting period.
- 15.08% of ethnic minority staff reported experiencing bullying, harassment or abuse from patients, relatives or members of the public, an increase from the previous year
- 17.86% of ethnic minority staff reported experiencing discrimination from managers, team leaders or colleagues, compared to 7.88% of White colleagues
- Only 45.88% of ethnic minority staff believed the Trust provides equal opportunities for career progression, compared to 57.88% of White staff.
- Recent reporting also highlights continued differences in experience for disabled colleagues, particularly in relation to bullying, harassment and perceptions of career progression

These findings are consistent with themes highlighted through the Lord Mann Review and reinforce the importance of continuing the Trust's existing work on anti-racism, inclusion, civility and respect, bullying and harassment, psychological safety and speaking up.

A further update including the outcome of the Trust's review against the Lord Mann recommendations and emerging Staff Standards will be presented through the Staff Experience & OD Committee in August 2026 and Trust Board in September 2026.

Correspondence relating to this paper can be found in the attached documents.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Lord Mann recommendations have been reviewed. • Executives have considered adoption of the definitions. • Established governance arrangements are in place though the Staff Experience & OD Committee and Trust Board • Staff experience data is routinely monitored. • Actions are being implemented through the various programmes of work already established. • An Anti-Racist statement has been launched and communicated. • Further review is underway and will also assess alignment with emerging NHS Staff Standards.	• Workforce data continues to show disparities in bullying, harassment and discrimination experienced by ethnic minority colleagues. • National guidance regarding NHS Staff Standards is still pending and may require further local action. • Sustained improvement is required to improve staff experience and perceptions of inclusion, fairness and psychological safety.

REPORT RECOMMENDATION:

V1.0 (May 2024)

The BOARD is asked to:

- Note the publication of the Lord Mann review and subsequent NHS England correspondence
- Take assurance regarding the significant work already underway across the Trust
- Note the findings from the recent WRES and staff survey data
- Note the review activity currently underway to assess alignment with the Lord Mann recommendations and emerging NHS Staff Standards
- Note that a further update will be provided through existing governance routes during August and September 2026

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

Financial	x	Environmental		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:

Affects workforce culture, staff experience, equality, diversity and inclusion, organisational reputation, leadership, wellbeing, speaking up arrangements and compliance with future NHS Staff Standards.

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:

National Staff Standards

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

Equality and Diversity
Cluster Workforce Programme Board objectives

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

Lord Mann Review (June 2026)
NHS Employers guidance and recommendations
WRES data
NHS Staff Survey and Pulse Data
NHS England National Education and Training Survey
RACE Code
NOF Indicators

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

Executive Team – June 2026
Staff Experience & OD Committee June 2026

To: • NHS chief executives

cc. • Chief people officers
• Chief nursing officers
• Medical directors
• Communications directors
• NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 June 2026

Dear colleagues,

Lord Mann Review

Today [Lord Mann has published his review into tackling racism and antisemitism](#) within the NHS with recommendations to support our shared goal of making our services safe for all patients, communities and colleagues.

Some of the events we see at home and abroad – not least of all the distressing events surrounding the death of Henry Nowak – can polarise opinions and harden division, going against the values that make the NHS what it is.

As the NHS, we can – and often do – create an environment where every person, patient or colleague feels treated with dignity, compassion and respect.

Today's review demonstrates that we are not achieving that consistently and as effectively as we should be. Just like wider society, the NHS is not immune to the persistent and systemic challenges of all forms of racism (including antisemitism and Islamophobia), discrimination and inequality, and we all have much more to do.

These recommendations will help us strengthen the way we drive change, and our focus should be ensuring that we are a place of compassion, care and unity – not conflict or discrimination, every day, on every site, in every home we visit, in every shift. Achieving this requires us all to be honest about the challenges we face and take strong action to address them.

Lord Mann's review set out a range of recommendations for NHS England, NHS organisations and leaders, the Department of Health and Social Care, as well as arm's-length-bodies (ALBs) and regulators. Collectively, these measures aim to:

- strengthen leadership and accountability,
- improve understanding and capability through training and development,
- set clear expectations regarding political identifiers and inclusive practice,
- improve and standardise support and protection for staff who experience racism,
- improve the consistency, quality and application of data relating to racism.

As NHS England, we welcome the recommendations and we accept the recommendations for us in full. As an immediate set of actions, we will:

- sign up to the NHS Race and Health Observatory Seven Anti-Racism Principles
- set clear Staff Standards relating to experience of racism
- support NHS improvement and assurance through the NHS Oversight Framework
- strengthen accountability for racial inclusion through our appraisals
- consult on adding Jewish and Sikh to NHS protected characteristic datasets
- develop bespoke eLearning for NHS PALS and complaints handlers
- ensure all NHS boards and system leaders complete regular anti-racism training

We also know the display of politicised badges and symbols has been a matter of debate and concern for staff and patients. We will complete engagement and publish the long-awaited national uniform guidance in short order.

Tackling all forms of racism within the NHS will require a joined-up, concerted effort at every level – we should all be acutely aware of the racial abuse and harassment our colleagues and patients are subject to. Our own staff surveys give clear voice to some of the unacceptable discrimination and abuse faced within our organisations. In addition, it is just as concerning when we see evidence of discrimination in our services or hear testimony from patients who have experienced unequal treatment or antisemitic or racial abuse when interacting with the NHS. We also know that we must better support staff when they experience racism in their interactions with the public.

We have set out a series of immediate actions we are asking you to take within your own organisations:

- To join NHS England in signing up to the NHS Race and Health Observatory Seven Anti-Racism Principles.

- Ensure implementation of the [Violence Prevention and Reduction Standard](#), including data capture and use to target improvement with affected groups, this will be monitored via the NHS Oversight Framework.
- Prepare to implement the forthcoming NHS Staff Standards.
- Adopt the new [government definition of anti-Muslim hostility](#).
- Ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia.
- Ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months).
 - Ensure Board agreement to undertake new anti-racism training when it becomes available.
- Ensure colleagues, staff representatives, patients and communities are aware of your actions through your internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally.
- Ensure your Board and its relevant committees fully understand your staff survey data on the experience of racism in your organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress.

In addition, following on from our communications in October 2025, please can you confirm whether your organisation has adopted the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility. [Please respond to this request, once for each organisation, by Friday 31 July 2026.](#)

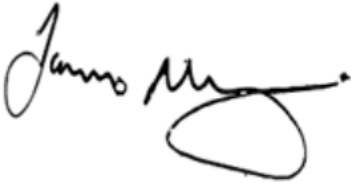
We know many organisations are already taking clear action, working in partnership with patients, community, trade unions and colleagues with lived experience – acknowledging and seeking to understand that experience is crucial to making the improvements we all want to see.

There are some fantastic examples of the work you are doing to tackle issues of racism and unequal access to services, and we'll work with you to share these widely across the system whilst encouraging you to use and support the delivery of the NHS [equality, diversity and inclusion improvement plan](#).

Antisemitism and all forms of racism have no place in the NHS. Patients should never feel anxious when receiving care and no member of staff should ever feel isolated, intimidated or unwelcome in their workplace. The Lord Mann review gives us the opportunity to raise our standards and expectations about what we will accept and put our professional values –

care, compassion and clinical excellence first. It is part of every leader's role to actively begin to dismantle the structural discrimination which exists. We are grateful for your support in delivering the actions set out.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Jim Mackey', with a large, stylized loop at the end.

Sir Jim Mackey
Chief Executive
NHS England

A handwritten signature in black ink, appearing to read 'Danny Mortimer', with a stylized, cursive script.

Danny Mortimer
Director General for People
NHS England



TRUST BOARD

DOCUMENT TITLE:	Emergency Preparedness, Resilience and Response (EPRR) Annual Board Report on the EPRR Agenda
SPONSOR (EXECUTIVE DIRECTOR):	Steve Washbourne, Chief Finance Officer (Deputy AEO)
AUTHOR:	Siobhan Carlton, EPRR Lead (interim)
DATE OF MEETING:	8th July 2026

PURPOSE OF THE REPORT:

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

1. Introduction

It is a statutory requirement set out in the Department of Health Guidelines, the NHS EPRR Framework and the NHS Core Standards for EPRR that all NHS Boards receive regular reports, at least annually on EPRR preparedness arrangements.

EPRR is a core function of the NHS and is a statutory duty of the Civil Contingencies Act (CCA) 2004. Responding to emergencies is also a key function within the NHS Act (2006) as amended by the Health and Social Care Act (2012).

It is the responsibility of the organisation's Accountable Emergency Officer (AEO) to ensure that the organisation complies with legal and policy requirements. They will provide assurance to the Board that strategies, systems, training, policies and procedures are in place to ensure their organisation responds appropriately in the event of an incident.

The following report details activities that the EPRR Team have undertaken during the year 2025/26 including the organisation's compliance against regulatory Core Standards:

- EPRR Governance Arrangements (item 2)
- Compliance with NHS England's Core Standards for EPRR (item 3)
- EPRR Policies and Plans (item 4)
- EPRR Training and Exercising (item 5)
- Incidents experienced by the organisation (item 6)

1. EPRR Governance Arrangements

1.1 Accountabilities

The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) oversees effective leadership for EPRR, addressing incidents 24/7 within the organisation and supporting Acute and other neighbouring NHS Providers with major incidents, where required. The Chief Executive Officer holds ultimate responsibility for well-established and embedded response processes. The Acting Chief Operating Officer / AEO guides strategic direction. The EPRR Team ensures that the strategic direction for the organisation and the system is accomplished.

1.2 Staffing and Resources

Currently, the EPRR Team comprises of one 0.5 WTE (whole time equivalent) Head of EPRR (Deputy Director of Delivery) and one interim “on loan” EPRR Lead from NHS England Midlands EPRR Team to support progress against this year’s Core Standards Annual Assurance process.

2. Compliance with NHS England’s Core Standards for EPRR

The NHS Core Standards for EPRR facilitates a nationwide co-ordination of EPRR activities based on the size and scope of organisations. It offers a cohesive framework for self-assessment, peer review and confirm and challenge within the assurance process.

The assurance process for 2025/26 will follow the national requirements, with initial submissions due from all organisations on 28 August 2026, the ROH will submit a self-assessed position to the ICB and NHS England Regional Team. Once evidence has been reviewed, a Confirm and Challenge process will take place between the ROH, the ICB and NHS England with collective ICB and NHS England feedback issued on the self-assessed position. A final position will be required from each organisation in November, and this will be reported to Board following agreement with the ICB and NHS England, with a confirmed Regional position reported to NHS England National in December 2026.

Further updates will be provided by the AEO to Private Board throughout this period as required, including confirmation of the ROH’s submitted self-assessed position.

There are 59 standards applicable to the ROH based on the organisation being a Specialist Provider – these standards cover the following areas:

- EPRR Governance
- Duty to Risk Assess
- Duty to Maintain Plans
- Command and Control
- Training and Exercising
- Response to Incident and Emergencies
- Warning and Informing
- External Co-Operation
- Business Continuity
- HAZMAT/CBRN (Hazardous Materials / Chemical, Biological, Radiological and Nuclear) Response.

As an organisation, over the last three years the ROH have been non-compliant (achieving on average 51%), this prompted discussions with the ROH, the ICB and NHS England to identify support that can be provided on an interim basis to support compliance.

With additional support and the continued development of plans and processes, the 2025/26 position for Core Standards is expected to reach 78% (partial compliance), this is based on the assumption that the organisation can continue to progress against the 2025/26 EPRR Work Programme in place. This leaves approximately 13 standards to progress during 2026/27 as well as maintaining the current EPRR Agenda.

The EPRR assurance rating is based on the percentage of Core Standards the organisation considers to be ‘fully compliant’ against, as described in the following table:

Outcome	Criteria
Fully compliant	The organisation is fully compliant against 100% of the relevant standards
Substantially compliant	The organisation is fully compliant against 89-99% of the relevant standards
Partially compliant	The organisation is fully compliant against 77-88% of the relevant standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant standards

A number of standards, particularly around training and exercising, have been identified to remain as partially compliant during this year's self-assessment. These areas form part of the 2025/26 EPRR Work Programme and will be prioritised once documented plans and processes are in place; this will ensure progress is made towards next year's assurance submission.

3. EPRR Policies and Plans

In accordance with legislation and guidance, all policies and plans must be current (in date), aligned with the latest National and Regional guidance and legislation and validated through Incidents and Exercises to meet the NHS Core Standards for EPRR.

NHS England mandates an annual plan review and a three-year policy review under the NHS EPRR Framework.

This year, the ROH has overhauled their EPRR approach by designing a new overarching EPRR Policy, Incident Response Plan and supporting documentation to support the delivery of incident response and EPRR throughout the organisation.

3.1 Duty to Maintain Plans

Plans are developed to allow staff to respond efficiently and effectively to any type of incident and are developed in collaboration with both internal and external stakeholders (such as internal teams, other neighbouring NHS Providers, the ICB and NHS England) to ensure that planning addresses all response areas and provides staff the knowledge to respond to all incident types.

3.2 Corporate Plans

All plan development and review schedules are within the 2025/26 EPRR Work Programme and will be reviewed, and or validated, by every July where possible to allow final, signed off documentation to be submitted as part of the annual assurance process. These plans will cover all elements of response that may be required by the organisation in different scenarios.

4. EPRR Training and Exercising

4.1 Training

In accordance with the NHS EPRR Framework and NHS Core Standards for EPRR, individuals involved in incident planning or response must undergo appropriate training at least every three years.

In light of the ROH updated EPRR Policy and Incident Response Plan, there has been one training session that has taken place; externally provided by Robert Flute for Strategic Commanders. This training provided a high-level overview of incident response arrangements across the Region which included tiers of command (strategic, tactical and operational), decision logging, inquiries and incident levels and declarations. 15 internal members of staff attended this training, 10 of which are on the On Call Rota (equating to 55% of On Call staff attendance).

Once all supporting plans and documentation have been signed off and rolled out to staff, further internal training will take place with all appropriate staff to ensure that the ROH can maintain a record of at least 90% competency across all responding staff. This Training Programme is yet to be rolled out although the planning assumptions are documented within the 2025/26 EPRR Work Programme.

4.2 Exercising

Due to the limited number of plans and policies currently in date and rolled out to staff, this is an area of work that requires more planning.

Once all documentation is in place and staff have been training, the EPRR Team will create an Exercising Programme, which will align to the planning assumptions currently within the 2025/26 EPRR Work Programme, and will meet the exercising requirements outlined in the NHS EPRR Framework – as listed below:

- Communications Exercise – minimum frequency every 6 months
- Tabletop Exercise – minimum frequency every 12 months
- Live Play Exercise – minimum frequency every 3 years
- Command Post Exercise – minimum frequency every 3 years*

*If the Incident Co-Ordination Centre (ICC) is activated in response to a live incident, this replaces the need to run a Command Post Exercise providing lessons are identified, logged and an Action Plan is developed.

5. Incidents experienced by the organisation

During 2026, there have been three incidents that led to an incident declaration directly affecting services provided by the ROH.

5.1 Major and Critical Incidents

There have been no activations of the Incident Response Plan during 2026 for Major or Critical Incident declarations however, the EPRR Team have supported three Business Continuity Incidents to minimise the impact to the organisation, as listed below.

5.2 Business Continuity Incidents

Three Business Continuity Incidents have taken place across the organisation (see below), to which, the ROH stood up arrangements using Business Continuity Plans to support the response, minimise patient impact and return to business-as-usual capabilities.

Date(s) of Incident	Incident Declaration
04/02/2026	Business Continuity Incident
13/06/2026	Business Continuity Incident
22-26/06/2026	Business Continuity Incident

The EPRR Team generates Post Incident Reports, outlining the response and experiences through Structured Debriefs to extract lessons. Reports include identified lessons and an Action Plan with nominated action owners and timescales, shared and monitored through the Executive Team Meeting and Trust Management Group, where applicable, reporting at least annually to Private Board.

These lessons are also shared externally with the Health Emergency Planners Operational Group, led by the ICB, to support other NHS Providers to update plans and training requirements based on ROH learning.

6. Summary Conclusion

The ROH continues to deliver against the requirements of the CCA and the NHS EPRR Framework. The anticipated 2025/26 self-assessment position of partially compliant reflects the significant work that has been undertaken within the organisation in the last 12 months to improve last year's position of non-compliance and there remains an opportunity for ongoing improvement, with the utilisation of the 2025/26 EPRR Work Programme and Core Standards feedback from NHS England and the ICB by November 2026.

The agreed EPRR Work Programme over the next 12 months will focus heavily on training and exercising and remaining compliant with all plans, policies and processes being in date, alongside maintaining core services with the aim to ensure an improvement on the compliance status against the Core Standards requirements.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
• Members are requested to be assured that the EPRR Work Programme is being followed and progress is being made towards achieving full compliance with the NHS Core Standards for	• Within the re-write of the EPRR Policy and the Incident Response Plan, it has been highlighted that there is a gap within the current resourcing for EPRR.

EPRR, leading to a more resilience system and better partnership working.

REPORT RECOMMENDATION:

The Board is asked to:

NOTE this Report. A streamlined version of this Report will be shared with the Public Trust Board in line with the NHS England requirements following the NHS Core Standards for EPRR self-assessment to publicly state the organisation's readiness and preparedness activities in the format of an annual 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		Equality and Diversity		Workforce	X
Inequalities		Integrated Care		Continuous Improvement	

Comments:

This Report is an annual update of the EPRR Agenda, providing assurance of the strategies, systems, training, policies and procedures in place alongside the predicated NHS Core Standards for EPRR annual assurance position.

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

Care	X	Community	X
Expertise		Services	
People	X	Collaboration	

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

N/A

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

N/A

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

N/A



TRUST BOARD

DOCUMENT TITLE:	Emergency Preparedness Resilience and Response (EPRR) Policy v5.0
SPONSOR (EXECUTIVE DIRECTOR):	Michelle Hubbard, Acting Chief Operating Officer / Accountable Emergency Officer (AEO)
AUTHOR:	Siobhan Carlton, EPRR Lead
DATE OF MEETING:	8 July 2026

PURPOSE OF THE REPORT:

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

Requirements of the Civil Contingencies Act (2004), NHS England EPRR Framework and NHS Core Standards Assurance for EPRR outline that organisations are required to have an in date EPRR Policy overarching the organisation's requirements to plan for and respond to a wide range of incidents and emergencies.

This document has been produced to meet these requirements and provide all staff with a high-level overview of how The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) assess risk, plan and prepare for emergencies that may occur internally or where support may be needed from ROH to neighbouring NHS Providers.

The policy is a re-write to meet Core Standard 1, 2, 4, 5, 6, 9 and 20 and a separate Incident Response Plan has been approved at Executives and Trust Management Group for approval, the Incident Response Plan is included on the Agenda for the Board Meeting for awareness only, alongside the EPRR Work Programme.

There is a requirement under Core Standard 5 that the EPRR Policy is signed off by the Trust Board.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
- The new policy outlines the scope of response arrangements for all responding staff to provide incident response procedures to protect the safety of patients, staff, visitors, the wider public and the infrastructure of ROH. - Clear guidance for responding staff to align their response to. - Provides a clear distinction between the Incident Response plan (internal) and the EPRR policy that captures the overall principles.	Within this Policy, it has been highlighted that there is a gap within the current resourcing for EPRR.

REPORT RECOMMENDATION:

The Board is asked to:

- Be aware of the high-level principles of incident response for the organisation and requirements set out in the Policy.
- Approval of the EPRR Policy for implementation across the ROH.

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

Financial	X	Environmental		Communications & Media	
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Business and market share		Legal & Policy	X	Patient Experience	
Clinical		Equality and Diversity		Workforce	X
Inequalities		Integrated Care		Continuous Improvement	
Comments: This Policy is a re-write of the existing policy to ensure compliance with the relevant core standards outlined above and aligns to the Civil Contingency Act legislation (2004).					
ALIGNMENT TO TRUST STRATEGY <i>(Indicate with 'x' all those that apply):</i>					
Care	X	Community	X		
Expertise		Services			
People	X	Collaboration			
ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
N/A					
BENCHMARKING SOURCE <i>(Indicate data sources included in report IF APPLICABLE):</i>					
N/A					
PREVIOUS CONSIDERATION <i>(Indicate board/committee/group & date):</i>					
Executive Team Meeting (for approval) 15/06/2026 Trust Management Group Meeting (for approval) 17/06/2026					



Emergency Preparedness Resilience and Response (EPRR) Policy

Document Author	EPRR Lead
Accountable Executive Lead	Accountable Emergency Officer
Approving Body	Please see page 2 and section 17
Document Reference	ROHET (07-25) 009

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:

All staff

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:

All staff

POLICY APPROVAL DATE:

Month and Year

POLICY IMPLEMENTATION DATE:

Month and Year

DATE POLICY TO BE REVIEWED:

June 2029

DOCUMENT APPROVAL HISTORY
(To be used for the current version only)

Document approved by (group and date):	Executive Team Meeting – 15/06/2026 Trust Management Group – 17/06/2026
To be approved by:	Private Trust Board – 08/07/2026

DOCUMENT CONTROL AND HISTORY

Version Number	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
1	February 2025	February 2025	February 2028	New Policy.
2	April 2025	April 2025	April 2028	Amended following ICB consultation.
3	May 2025	May 2025	May 2028	Amended following internal management consultation. Sent to Board for approval.
				<i>Version 4 missed</i>
5	TBC	TBC	June 2029	- Re-write to align to the requirements of the NHS Core Standards for EPRR. - Inclusion of the change in AEO and Deputy AEO. - Incorporated NHSE consultation comments.

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1. Introduction

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from severe weather to an infectious disease outbreak or a major transport accident. Please refer to [section 4](#) for the principles of planning and response.

Under the Civil Contingencies Act (CCA 2004), NHS organisations must show that they can respond to these incidents whilst maintaining services. This work is referred to in the health service as ‘Emergency Preparedness Resilience and Response’ (EPRR).

As an NHS Trust and an acting Category One Responder, The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) has a responsibility to ensure there is a duty to assess the risk of, plan and prepare for emergencies and incidents as well as undertaking Business Continuity Management.

To meet obligations within the NHS EPRR Framework (2022), CCA 2004, NHS Act 2006 and the NHS Standard Contract, the ROH is required to:

- Support Integrated Care Boards (ICBs) and NHS England in discharging their EPRR functions locally.
- Have robust and effective structures in place to adequately plan, prepare and exercise the response arrangements, both internally and with local healthcare partners and multi-agency providers.
- Ensure Business Continuity Plans mitigate the impact of any emergency, where reasonably practicable.
- Ensure robust 24/7 communication ‘cascade and escalation’ policies and procedures are in place – to inform the ICB, NHS England, healthcare and multi-agency partners, as appropriate, of any incident impacting on service delivery.
- Ensure that recovery planning is an integral part of its EPRR function.
- Provide assurance that any sub-contractors are delivering their contractual obligations with respect to EPRR.
- Ensure organisational planning and preparedness is based on current Risk Registers.
- Provide appropriate Director-level representation at Local Health Resilience Partnerships (LHRPs) and appropriate Tactical and / or Operational representation at local system planning groups in support of EPRR requirements.

2. Aims, Objectives and Purpose

This ROH EPRR Policy establishes an integrated emergency management process across the Trust that is built on the principles of risk assessment, co-operation with partners, emergency planning, communication and information sharing.

This Policy aligns to ROH’s Strategic Objectives, of which full details can be found [here](#) – ‘Our Strategy: 2023-2028’. Although, the objectives of this Policy are to enable:

- The ROH will have in place Business Continuity Plans (BCPs) that allow services to continue to provide their core functions during an incident, where reasonably practicable and to recover from the additional pressure that an incident may place on an organisation.
- The On Call function at the ROH is led by Site Managers and Executives and Operational Leads On Call. Please see responsibilities for these roles within [section 6](#).
 - The ROH will operate a 24/7 On Call function, utilising the Switchboard at UHB (University Hospitals Birmingham NHS Foundation Trust) in hours and out of hours with calls diverted through to ROH's Site Managers.
 - All incidents will be reported to the On Call Staff (Executives and Operational Leads On Call) and the Accountable Emergency Officer (AEO) in hours and out of hours by the Site Managers upon receipt of the calls.
- The EPRR Team are responsible for maintaining appropriate staff On Call and ensuring they have received sufficient training and are provided with appropriate resources to fulfil their role – see [section 9](#).

3. Scope

This Policy applies to the organisation and all services for which it has statutory or delegated responsibility, in accordance with the NHS EPRR Core Standards Assurance process.

The scope includes:

- All Directorates, Divisions and Departments.
- All commissioned, provided, or hosted services (where EPRR accountability rests with the organisation).
- Any functions delivered on behalf of partner organisations under formal agreement.

All staff are required to understand their responsibilities under this Policy as part of Core Standard Domain 5: Training and Exercising.

This Policy applies to all hazards and threats that could disrupt the organisation's ability to deliver critical services, as required under Core Standards Domain 2: Risk Assessment and Management.

These include but are not limited to:

- Major Incidents and Civil Emergencies;
- Public Health Emergencies (e.g. Pandemics, Infectious Disease or Outbreaks);
- Severe Weather or Climate Change related events;
- Cyber Security and IT failures;
- Utilities, Estates or Infrastructure failure;
- Business Continuity Incidents;

- Industrial Action or;
- Mass Casualty Incidents.

4. Principles

This EPRR Policy will follow the principles of emergency planning as set out in the CCA. These principles surround the following:

Prevention:

The best way to address an incident is by being proactive. This means identifying potential hazards and devising mitigations for their impact.

Mitigation:

Mitigation aims to minimise the loss that identified risks pose to an organisation.

Preparedness:

Preparedness is an ongoing process in which individuals, communities, business and organisations plan and train for what they will do in the event of an incident. Preparedness is defined by ongoing training, evaluating and corrective action, and ensuring the highest level of readiness. Within the ROH, this is the responsibility of the EPRR Team and AEO.

Response:

Response is the process to manage the incident impacts. It involves both short and long-term responses. Response must set out clear roles and responsibilities of all parties involved within the incident. Within the ROH, this is primarily the responsibility of the On Call and Incident Management Team although will require all staff to be engaged with the management of patients and continuation of services, where possible.

Recovery:

Recovery is about helping individuals, communities, business and organisations return to normal, or a new normal, depending on the impact of the incident.

5. ROH EPRR Governance Structures



Figure 1

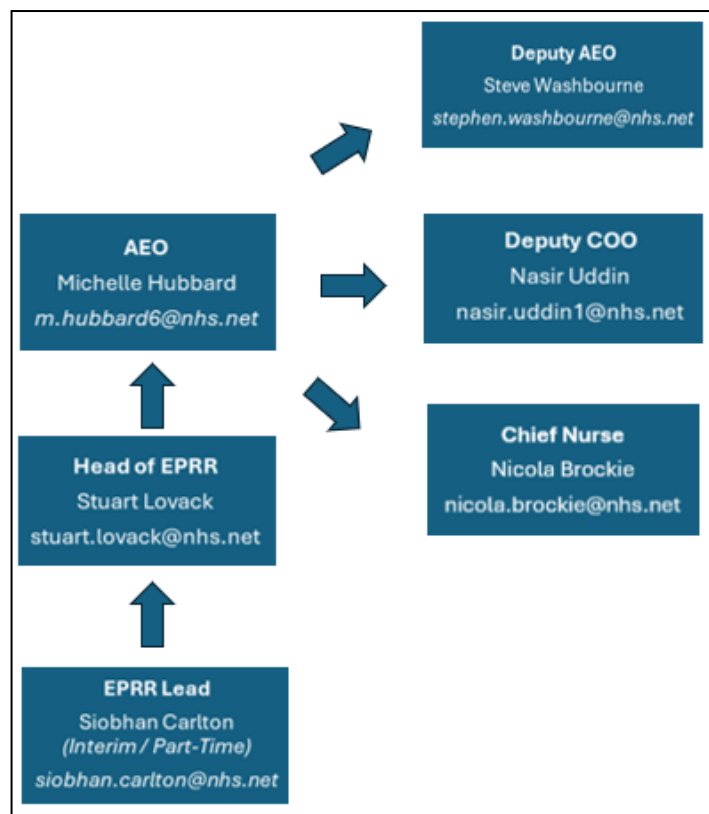


Figure 2

6. Roles and Responsibilities

Action cards for all roles are available in the Trust's Incident Response Plan.

A. Trust Board

The roles and responsibilities of the ROH Trust Board are outlined below:

- Receive Board Reports no less frequently than Annually regarding EPRR, including where appropriate reports on Training and Exercises undertaken by the Trust, significant (non-clinical) incidents, lessons learnt following Incidents or Training and compliance position for NHS Core Standards for EPRR.
- Receive and approve the declared self-assessment position of compliance with the NHS Core Standards for EPRR Annual process from the Trust's AEO.
- Formally sign off the Trust's EPRR and Business Continuity Policy.
- Ensure that adequate resources are made available to the organisation to

meet the requirements for EPRR. *This budget and resource should be proportionate to the size and scope of the organisation.*

B. Trust Management Group (TMG)

The roles and responsibilities of the Trust Management Group are outlined below:

- Ensure there is scrutiny and endorsement of the EPRR Policy and all other incident response plans and procedures.
- Monitor progress reports from the Executive Team Meeting and EPRR.
- Provide updates and recommendations to the Board on an annual basis (quarterly or more frequently, as required).

The TMG meet on a monthly basis, is chaired by the Chief Executive Officer and attended by all Executive Directors and Deputies.

C. Executive Team Meeting

The roles and responsibilities of the Executive Team Meeting are outlined below:

- Ensure there is scrutiny of the EPRR Policy and all other incident response plans and procedures for information or endorsement.

The Executive Team Meeting meet on a weekly basis, is chaired by the Chief Executive Officer and attended by all Executive Directors.

D. Chief Executive Officer (CEO)

The roles and responsibilities of the CEO are outlined below:

- Overall responsibility for EPRR and is accountable to the Board for ensuring that systems are in place to facilitate an effective incident response and recovery.
- Ensures that designated staff are nominated to perform the role of EPRR to support the Trust in preparing for potential incidents or emergencies.
- Ensures that an Executive Director of the Board is appointed as the AEO and there is a Deputy in place to deputise during AEO periods of absence – this is the Executive Chief Finance Officer. In the absence of both the AEO and Executive Chief Finance Officer, the role of AEO will be undertaken by the Chief Nurse.

E. AEO - Chief Operating Officer (COO)

The roles and responsibilities of the AEO are outlined below:

- Ensuring that the organisation and sub-contractors are compliant with the EPRR requirements set out in the:
 - CCA 2004;
 - NHS EPRR Framework;
 - NHS Core Standards for EPRR;
 - NHS Act 2006;
 - Health and Care Act 2022;
 - NHS Standard Contract;
 - And other related EPRR legislation and guidance.
- Ensuring that the ROH's EPRR Team is suitably prepared and resourced to undertake EPRR duties.
- Supporting delivery and implementation of EPRR guidance (internal plans, policies and procedures).
- Ensuring the ROH has a suitable Incident Management Team able to effectively respond to any incident.
- Attendance at LHRPs and LRF meetings, where required.
 - Or be suitably represented by a deputy who should be a Board Level Director
- Report to the Trust Board annually.
- Ensuring the ROH has a robust surge capacity plan that provides organisational response and that it has been tested with other providers and partners.
- Providing NHS England with such information as it may require for the purpose of discharging its functions.

F. EPRR Team

The roles and responsibilities of the EPRR Team are outlined below:

- Provide operational leadership with regard to EPRR and Business Continuity matters in the event of an incident.
- Support the AEO in fulfilling their duties
- Ensure plans and policies are developed, consulted on, distributed, trained, exercised and maintained against the requirements of the Trust, NHS Core Standards for EPRR and against any lessons learnt or risks identified.
- Ensure training needs are identified and appropriate training is provided for all those with responding roles.
- Record, implement and monitor lessons captured from incidents, training and exercises – with plans / policies updated where relevant.
- Liaise with staff at all levels, as appropriate, to assist with their understanding of EPRR requirements.
- Represent the Trust at external meetings including multi-agency, ICB and NHS England level meetings – where applicable.
- Adhere to the exercising requirements as set out by NHS England – as well as carrying out annual audits of the Trust's Business Continuity arrangements.
 - Participate in other provider or multi-agency Exercises across the West

Midlands.

- Develop, deliver and report on the EPRR Work Programme in accordance with NHS Core Standards for EPRR.
- Record, communicate, monitor and mitigate risks where appropriate.
- Produce an Annual Report for the Trust Board.

The EPRR Team currently consists of one Head of EPRR and one EPRR Lead (on loan from NHS England Regional Team whilst recruitment for a permanent position is underway).

G. Site Managers

The roles and responsibilities of the Site Managers during an incident are outlined below:

- Act as the point of contact for all incoming On Call alerts in hours and out of hours and would then be responsible for escalating any issues or incidents to the Executive or Operational Lead On Call.
- Escalate issues or incidents to the relevant On Call staff as well as the AEO.
- Respond as directed within the Incident Response Plan.

H. On Call Staff – Executives and Operational Leads

The roles and responsibilities of the On Call Staff are outlined below:

- Attend the relevant training, provided by the EPRR Team, to be an active member of incident response – undertaking the Strategic and Tactical Commander roles.
- Support the development and implementation of EPRR capabilities (plans and policies) in preparation for incident response.
- Ensuring divisional and corporate resilience plans, as well as Business Continuity procedures, are in place for their departments, where required.
 - Alternatively, to ensure Manager / Leads and their staff are aware of their roles and responsibilities detailed within the Trust's Incident Response Plan.
- Participate in the Trust On Call arrangements, where required.
 - On Call are responsible for handling the initial calls, responding and initiating as necessary the proportionate response for ROH both in hours and out of hours, including setting up the Incident Co-Ordination Centre (ICC) if required, holding responsibility for ROH's response and decision-making.
 - Alerting the AEO of all incident declarations.
- Maintain a Commander Personal Development Portfolio – *see the EPRR Team for a template.*



Please note, Executives and Operational Leads that are on call must ensure the following:

- That they have access to the ROH Intranet;
- That they are contactable in emergencies;
- That they have access to ROH EPRR Documents and Guidance within the Bleepholder Pack.

The ROH On Call Rota can be found on the Emergency Hub. A hard copy is also kept in Management Offices in case of an emergency / IT outage etc.

I. Providers, Suppliers and Contractors

The responsibilities of providers, suppliers and contractors are outlined below:

- The Trust expects all third parties upon which it relies on (including suppliers, contractors, partners, associated and commissioned independents) to provide and evidence all emergency preparedness and business continuity procedures that relate to services and additional support that has been agreed.

The ROH, with the assistance of the 'UHB Procurement Hub' ensures this is a part of all contracting, renewal, monitoring and other commissioning processes to include the ability to audit such arrangements. This is a system-wide collaborative Standard Operating Procedure (SOP) in place with UHB, the ICB and NHS organisations within the Birmingham and Solihull footprint. *Please see the EPRR Team for this SOP.*

For further information, please refer to the ROH Business Continuity Recovery Plan.

J. Other Responding Staff

The roles and responsibilities of other Department Leads such as IT, Communications and support functions to the IMT such as Loggists are detailed within the Incident Response Plan.

K. All Staff

The roles and responsibilities of all staff are outlined below:

- All staff are required to have awareness of the Trust's Incident Response Plan, Business Continuity Plans and know how to access EPRR advice and guidance.
- All staff are required to read and understand any EPRR information that is issued from the Communications Team and carry out any required actions.
- All staff are required to ensure they have completed any training and

awareness sessions relevant to their area of response. *(Contact the EPRR Team for confirmation if required).*

7. Incident Response

In the event of an incident, the ROH are an acting designated Category 1 Responder (under the CCA) meaning the ROH will be involved in incidents that affect the local sector.

The ROH are required to assess the risk, plan, test and exercise for emergencies and incidents, as well as undertaking Business Continuity Management (BCM).

A Critical or Major Incident could place an immense strain on the resources of the NHS and the wider community, impact on the vulnerable people in our community and could affect the ability of the ROH to work normally. When events like this happen, the ROH's resilience arrangements will be activated. It is important that all staff are familiar with any procedures and they are aware of their responsibilities. ROH's On Call staff should ensure that they are regularly updated to any changes in EPRR.

For Business Continuity Incidents, command and control arrangements should follow those detailed within the Incident Response Plan although the Trust's Business Continuity Recovery Plan should be activated for scenario-based considerations.

Tiers of Command:

The ROH follows the NHS Tiers of Command structure when an incident is being managed:

Strategic Commanders	The Strategic Commander is responsible for creating strategic aims to manage planning and co-ordination of the response phase of the incident.
Tactical Commanders	The Tactical Commander is responsible for the running of the Hospital and delivering the strategic aim with a tactical plan whilst the incident is in operation.
Operational Commanders	The Operational Commander is responsible for delivering the strategic aims using the plan created by Strategic Commanders.

Figure 3

Strategic Commanders:

At the ROH, in the event of an incident, including out of hours, an Executive Director will be nominated to provide strategic leadership and command to the Trust's response.

This role will normally be undertaken by the AEO or a nominated Deputy; however any suitably trained Executive Director may fulfil this role depending on availability.

This approach enables flexibility in response arrangements and does not require a formal additional On Call Rota for Executive Directors. Where this is enacted, the team member On Call that is not an Executive Director will fulfil the role of the Tactical Commander.

The Executive On Call will retain overall responsibility for strategic decision-making and direction of the incident, including providing support and oversight to members of the On Call Rota that are not an Executive undertaking the initial response actions.

To ensure resilience, Executive Directors will maintain appropriate co-ordination of availability to avoid gaps in strategic leadership coverage.

Tactical Commanders:

At the ROH this role would be undertaken by the Operational Lead On Call however, if at the time of the incident there is an Executive Director On Call instead, this person would undertake the role of the Strategic and Tactical Commander or alternatively, for larger scale incidents would request support from other Executive Directors On Call or the AEO to provide strategic leadership.

Operational Commanders:

At the ROH, the role of Operational Commander will likely be undertaken by the Site Manager, Clinical or Non-Clinical Managers and Clinical Staff responding to the incident.

Alerting:

Escalation or notification calls come into the ROH through to the Site Manager mobile number and these are then escalated to the Executive or Operational Lead On Call. More detail on the process and contact details are within the Incident Response Plan for calls coming internally and escalation calls alerting other external organisations.



See full details for incident response, information sharing, situation reporting etc within the ROH's Incident Response Plan along with Action Cards for all roles.

Or for Business Continuity incidents, see full details within the Trust's Business Continuity Recovery Plan.

Following any Incidents, the EPRR Team will produce a Post Incident Report, see [section 11](#) for more detail.

8. Record Retention

The ROH has appropriately trained Loggists, which are recorded within the TNA managed by the EPRR Team. Loggists support the recording of decisions made by Strategic Commanders during the management of an incident.

All those tasked with logging must log in line with best practice standards and understand the important of logs in the decision-making process, evaluation and identifying lessons. Logs will be used as evidence for any subsequent inquiries. More detail on how to access Loggists, work with Loggists and how Loggists should operate are included within the Trust's Incident Response Plan.

Following an incident, records must be retained for the above purposes – and subsequently, EPRR have a responsibility to hold all 'business as usual' records.

See figure 4 below for the retention periods for all EPRR-related records:

Category	Examples of records	Minimum Retention Period	Final Action
Incidents (declared)	- Decision Logbook - Personal On Call Logbooks - Incident-related documents - Plans - Organisational Structures - Electronic Records - Notes written on other pieces of paper	30 years	Review, archive or destroy under confidential conditions.
EPRR	- Incident Response Plans - Guidance. - SOPs. - NHS Core Standards for EPRR - LHRP and sub-group Minutes, Papers and Action Logs - Risk Registers - Electronic Records	30 years	Review, archive or destroy under conditional conditions.
Exercises	Paper and electronic records	10 years	Review, archive or destroy under confidential conditions.
On Call (Routine – non-Incident)	- Decision Logbook - Personal On Call Logbooks - Handover Records - Paper Records - Electronic Records	10 years	Review, archive or destroy under conditional conditions.
EPRR	Information Sharing	10 years	Review, archive

	Protocols • Memorandum of Understanding • Service-Level Agreements • Paper Records • Electronic Records		or destroy under conditional conditions.
--	--	--	--

Figure 4

The EPRR Team will take the lead on retaining records post incident although this is also the Strategic Commanders responsibility in ensuring all records are retained and no scrap pieces of paper are destroyed.

9. EPRR Testing, Training and Exercising

EPRR Training:

All training associated with EPRR is identified on the Training Needs Analysis (TNA), in line with the Training and Exercising Programme, both of which are completed, assessed and monitored by the EPRR Team – this includes the roles and number of staff who require training.

On Call staff, other staff responding as part of the Incident Management Team, Loggists, Communications staff and all staff general awareness training is required to meet compliance with the TNA. All training is aligned to the requirements of the Minimum Occupational Standards (MOS) for Civil Contingencies.

Attendance and attainment of training standards are recorded centrally, managed by the EPRR Team, and in the staff member's Personal Development Portfolio – which can be requested by the EPRR Team should these need to be evidenced as part of NHS Core Standards for EPRR.

Training effectiveness will be monitored by the EPRR Team with the submission of feedback forms collated post training event. These will be used to improve future training sessions.

Compliance levels are monitored and discussed where required at Trust Management Group and further with the AEO. Training delivered is also recorded as part of the Annual Governance Reports and is reported into Board.

EPRR Exercises:

Exercises will be carried out by the EPRR Team in line with the requirements of NHS England and the NHS EPRR Framework. This being:

- Communications Exercises held every 6 months – including all levels of on call and Loggists.
- Annual Tabletop Exercise
- 3 yearly Live Exercise
- 3 yearly Command Post Exercise.

Staff are also requested to attend any multi-agency Exercises, when available to do so, to assist with the knowledge building of their role internally and externally and

how other organisation's plans link in with the ROH's arrangements.

Following any Exercises, the EPRR Team will produce a Post Exercise Report, see [section 11](#) for more detail.

ICC Checks:

Equipment within both the Primary and Secondary Incident Co-Ordination Centres (ICCs) is detailed in an Equipment Inventory, detailed as an Appendix to the Trust's Incident Response Plan. This equipment will be checked and tested by the EPRR Team as a minimum of every three months and equipment will be replenished post incident.

During these checks, hard copies of all plans (see full list in [section 18](#)) will be checked to ensure they are the latest version.

10. EPRR Work Programme

The ROH's EPRR Team will develop and maintain an annual Work Programme which details the review, maintenance and testing of Plans and Policies to support the delivery of the NHS Core Standards for EPRR. This will be supported, as necessary, by the Training and Exercising Programme (held by the EPRR Team).

Progress against the Work Programme will be reported by the EPRR Team to the AEO on a monthly basis, to the Executive Team Meeting and the Trust Management Group on a twice-yearly basis and annually to the Trust Board.

11. Continuous Improvement

Following any incidents, training or exercises, all lessons learnt will be tracked and monitored on the EPRR Lessons Log by the EPRR Team.

Incidents:

When an incident occurs within the ROH, the EPRR Team will use hot and cold debriefs (see the process within the Trust's Incident Response Plan) to capture strengths and weaknesses within the response and will produce a Post Incident Report.

The EPRR Team will suggest solutions to weaknesses, if these weren't identified in the debrief, and allocate tasks to staff members to complete within 8 weeks of the Post Incident Report – these will be lessons and will be captured on the Lessons Log and monitored for completion – when complete, lessons will be closed on the Lessons Log.

The same process applies to Exercises.

Post Incident and Post Exercise Reports will be shared with the Trust Board annually and through other Governance routes during routine meetings, as applicable and relevant.

In addition to this, to support continuous learning across the Midlands region, the NHS England Midlands Regional EPRR Team have developed an EPRR lessons identified process for the sharing of learning from incidents, exercises and events. This process aims to enable good practice to embed across organisations. NHS England Midlands share this information with partners on a monthly basis, this will be received by the ROH's EPRR Team and any lessons relevant to the organisation will be incorporated onto the EPRR Lessons Log and amending the organisation's response arrangements where needed.

12. Collaborative Planning

Plans, Policies and Standard Operating Procedures (SOPs) created for the ROH will be shared with NHS England, the ICB and partner organisations (part of the HEPOG and LHRP memberships, where appropriate) prior to approval. The purpose of this is to ensure that the document meets the requirements of the NHS Core Standards for EPRR as well as allowing partners to understand the ROH processes, and comment on them if they impact directly on their services as well as to share best practice and recommendations with other partners.

The ROH documentation will be shared with external partners for consultation with a minimum of 2 weeks being allowed for partners to provide comments, although where possible 4 weeks will be given.

The ROH will also undertake consultations on partner documentation as shared with the EPRR Team to support local collaboration and the sharing of best practice.

The EPRR Team will maintain a Consultation Tracker and will document any comments returned from partners on the ROH's plans along with what action has been taken to resolve or disregard the feedback and also record comments provided from the ROH EPRR Team on other partner's documentation.

13. Risk Assessment and Management

Risk management is a fundamental part of the approach to quality, corporate and clinical governance. All risk assessment and management activities within the ROH will follow the procedures and principles detailed in the Trust's Risk Management Policy.

All identified risks associated with EPRR are managed by the EPRR Team and the AEO and reported through Governance Committees and escalated to Trust Board where applicable.

The risk management assessment process will use the following principles:

- Identification of hazard / risk.
- Deciding who / what might be harmed / lost / damaged.
- Evaluation of risks / development of controls.
- Recording of findings and implementation of controls.
- Review and updating of Risk Assessments.

14. Information Sharing

Under the CCA, provision is made for Category 1 and 2 responders to share information, in order to effectively fulfil their duties during an emergency or incident. The ROH therefore, has a lawful basis to process personal data for this activity under applicable Data Protection related legislation and guidance (ie the Data Protection Act 2018, the General Data Protection Regulation 2018 and the Cabinet Office Data Sharing Guidance 2019).

In addition, the Cabinet Office Data Protection and Sharing 'Guidance for Emergency Planners and Responders' sets out the basis upon which information sharing in an emergency is permitted. This includes information sharing between private sector, public sector and voluntary sector organisations. It should be noted that the consent of the individual to share their information is not always necessary to lawful data sharing, for example in cases where information sharing is in a person's vital interests, or where there is a substantial public interest. Vital interests do not just mean 'life or death' situations but can also include situations where there is a risk of significant harm to life if information is not shared.

Further guidance and processes around information sharing during an incident can be found in the Incident Response Plan.

15. Mutual Aid

The process for requesting, accepting / declining mutual aid across NHS organisations is captured in the Incident Response Plan.

Requests for support outside of the formal embedded processes should be made via the EPRR Team (in hours) and On Call (out of hours) for consideration.

The ICB will support to obtain mutual aid from healthcare partners, either locally, regionally or nationally, depending on the requirements. Mutual aid may also be requested from wider partners through the Local Resilience Forum, via the establishment of a Tactical or Strategic Co-ordinating Group – see the Incident Response Plan for more information.

In circumstances in which the NHS does not have the capability to deliver, and all other avenues have been exhausted, military support may be sought via the Military Aid to the Civil Authority (MACA) process. The process for considering and requesting MACA support is within the Incident Response Plan.

Support is not guaranteed either via mutual aid or MACA and may incur a charge for its provision, unless it is in response to an immediate threat to life.

16. Financial Control

The budget for EPRR is managed by the AEO and is provided for:

- EPRR Training and Exercising.

- EPRR Administration and Management.
- Incident Co-Ordination Centre upkeep and maintenance.
- EPRR plans requiring resources (ie CBRN Plan for patient decontamination).

Additional funding is available for necessary spending to support the organisation's response to an incident – this can sometimes be unplanned spending. There is no specific budget for incident response, but the Trust will make financial provisions to ensure that emergency procedures and response requirements detailed in the relevant response documentations can be met.

As a Specialist Provider, ROH could be commissioned to provide a response service to support longer term incidents and as such, significant financial costs should be able to be reclaimed.

17. Document Control and Governance

Review and approval:

The owners of this document are the EPRR Team, overseen by the AEO.

This document will be reviewed three yearly, unless there are changes in guidance / legislation, incorporation of lessons learnt or changes to internal or external structures.

This document will be approved three yearly by the Trust Board with minor changes being agreed at the Executive Team Meeting and Trust Management Group.

Distribution:

This Policy will be shared widely with:

- All ROH staff on the Emergency Hub.
- NHS England Midlands EPRR Team and the BSOL ICB EPRR Team during the consultation period and during submission towards the Trust's self-assessed NHS Core Standards for EPRR position.

Old versions of documents will be identifiable by utilising the version control box on every document.

18. Associated Documentation

Externally produced guidance or legislation:

- [Cabinet Office Data Sharing Guidance](#)
- [CCA 2004](#) and associated formal Cabinet Office Guidance.
- [Data Protection Act 2018](#)
- [General Data Protection Regulation 2018](#)
- [Health and Care Act 2022.](#)
- [Health and Social Care Act 2012.](#)

- [Minimum Occupational Standards for NHS EPRR \(2022\).](#)
- [National Risk Register 2025.](#)
- [NHS Act 2006.](#)
- [NHS Core Standards for EPRR Assessment Guidance.](#)
- [NHS Constitution for England](#) – including the [NHS Standard Contract.](#)
- [NHS EPRR Framework](#) and associated Guidance.
- Other relevant NHS EPRR documentation and supporting materials, including Business Continuity.

ROH guidance documents:

- Adverse Weather Plan.
- Bleep Holder Emergency Response Information Pack.
- Business Continuity Plan, Business Continuity Policy and Business Continuity Management System.
- Bomb Warning and Suspect Package Policy.
- CBRN Plan.
- Crisis Communications Plan.
- Deceased Patient Pathway.
- EPRR Policy.
- Evacuation and Shelter and Lockdown Plan.
- Fuel Shortage Plan.
- ICC Set Up Guide.
- Loggist Handbook.
- Pandemic Plan.
- Outbreak Policy.
- Viral Haemorrhagic Fevers Quick Reference Guide.

Hard copies of all documentation is kept within the Primary ICC (Boardroom) and Secondary ICC (Oncology), these documents will be checked as part of the three monthly ICC Checks to ensure they are the latest versions – see [section 9](#) for more details.

Electronic copies of all documentation is kept on Sharepoint, accessible to all staff and will be updated by the EPRR Team when a document is amended or a new document created.

19. Acronyms and Definitions

AEO:

Accountable Emergency Officer.

Organisations must have an appointed AEO who is a Board level Director and responsible for EPRR within their organisation and ensure that this role will be maintained in the absence of the AEO by a post held at Executive level.

BCM:

Business Continuity Management.

A holistic management process that identifies potential threats to an organisation and the impacts to business operations that those threats, if identified, might cause.

A framework is put in place to build organisational resilience within the capability for an effective response that safeguards the interest in key stakeholders, the organisation's reputation and the maintenance of key critical services.

BCMS:

Business Continuity Management System.

The strategic and tactical capability of the organisation to plan for and respond to incidents and disruptions, in order to continue operations at an acceptable pre-defined level.

BCP:

Business Continuity Plan.

A documented collection of procedures and information that is developed, maintained and compiled in readiness for use in an incident to enable an organisation to continue to deliver its critical services at an acceptable pre-defined level.

CBRN:

Chemical, Biological, Radiological and Nuclear.

CCA:

Civil Contingencies Act (2004).

This is the main legislation EPRR works to and it places legal duties on Category 1 responders setting out a number of duties for organisations preparing, planning and responding to emergencies, incidents or events.

Command and Control:

Command

The direction of the members and resources of an organisation in the performance of its role and tasks. Command relates to organisations and operates vertically within its organisation to keep direction and pass information backwards and forwards.

Control

The authority to direct strategic and tactical operations to complete an assigned function using command staff at that level to ease the situation – commit resources, apply authority and define the objectives to manage the situation.

Emergency:

As defined within the CCA, an emergency means *“an event or situation which threatens serious damage to human welfare; an event or situation which threatens serious damage to the environment of a place; war, or terrorism, which threatens serious damage to the security of the United Kingdom.”*

Emergency Management:

The management of emergencies concerning all hazards, including all activities and risk management measures related to prevention and mitigation, preparedness, response and recovery.

Emergency Planning:

The development and maintenance of agreed procedures to prevent, reduce, control, mitigate and take other actions in the event of incidents or emergencies.

Emergency Preparedness:

The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of and response to emergencies.

EPRR:

Emergency Preparedness, Resilience and Response.

The function to ensure that an organisation is able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care.

Exercises:

The purpose of Exercises is to ensure that plans and procedures are tested even if they are not used within a live incident. Exercising is also a good way for people to test the processes and allow staff to understand their role internally and externally.

Command Post Exercise:

Command Post Exercises test the operational element of command and control and requires the setting up of the ICC. It provides a practical test of equipment, facilities, processes and familiarity for those undertaking roles within an incident.

Communications Exercise:

Communication Exercises test the organisation's ability to contact key staff and other partner organisations 24/7. These should include testing telephone, email, paging and other communication methods used by the organisation. These Exercises should be held both in hours and out of hours on a rotational basis and be no-notice communications.

Tabletop Exercise:

Tabletop Exercises bring together responding staff and partners, if required, to discuss the response or specific elements of a response. They work through a scenario and can help validate a new or revised plan. The purpose of these Exercises is for participants to engage with each other and gain knowledge of their own roles and responsibilities.

Live Exercise:

Live Exercises are a live test of response arrangements and include the operational and practical elements of incident response for example simulated casualties being brought into a department or an evacuation.

HEPOG:

Health Emergency Preparedness Officers Group.

To ensure alignment of EPRR activities, the Health Emergency Planners have a group that has been established as a sub group of the LHRP to carry out work on their behalf, this is HEPOG.

ICB:

Integrated Care Board.

ICBs became statutory in July 2022, replacing Clinical Commissioning Groups (CCGs). ICBs are the strategic decision-making bodies placed within systems or partnerships to bring together all organisations involved in providing NHS care services.

Incident:

An occurrence or event that disrupts normal ways of working. For the NHS, incidents are defined as:

- Business Continuity Incident;
- Critical Incident or
- Major Incident

Business Continuity Incident (BCI):

A Business Continuity Incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable pre-defined levels, where special arrangements are required to be implemented until services can return to an acceptable level.

Critical Incident (CI):

A Critical Incident is a localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services. Patients may be at harm, or the environment is not safe requiring special measures or support from other agencies, to restore normal operating functions.

Major Incident (MI):

For the NHS, a Major Incident in the NHS EPRR Framework is defined as *"any occurrence that presents serious threat to the health of the community or causes such numbers of types of casualties, as to require special arrangements to be implemented."*

Protracted Incident:

An incident lasting for an extended duration, of significant complexity and which may require enhanced measures, resources and / or mutual aid over and above those required to respond to an isolated incident.

ICC:

Incident Co-Ordination Centre.

The ICC supports the IMT to provide a level of operational support. Responses benefit from having an ICC as all members operate under a common list of objectives, everyone is accountable for a specific role and it eliminates the duplication of effort.

The functions of an ICC are to co-ordinate demands, make decisions relating to the response, manage demands of the incident, gather information and disperse information to the public.

IMT:

Incident Management Team.

The IMT are responsible for managing and delivering the incident response. Individuals that should be considered to this team vary on the type of response but a core team of Commanders, a Loggist, Comms and EPRR should be identified within planning arrangements. Optional members can be invited to support the response such as Digital Teams for a Cyber Incident etc.

LHRP:

Local Health Resilience Partnership.

This is the strategic forum for joint health planning. This sit quarterly, chaired by the ICB and have engagement from all NHS provider organisations and multi-agency organisations, where required, at Director level.

MOS:

Minimum Occupational Standards.

A set of standards applicable to all Health Commanders, Managers and staff responding to incidents as part of the IMT ensuring competencies that are relevant to their role type and are rolled out throughout all Responder Training internally and externally.

Planning:

The development and maintenance of agreed procedures to prevent, reduce, control, mitigate and take other actions in the event of incidents or emergencies.

Resilience:

The ability of the Trust to detect, prevent and if necessary, to withstand, handle and recover from disruptive challenges.

Response:

Decisions and actions taken in accordance with aims, objectives and strategies, as defined by emergency responders.

Risk:

The combination of the likelihood and the consequence of a specified hazard being realised; refers to the vulnerability, proximity or exposure to hazards, which affects the likelihood of adverse impact.

SOPs:

Standard Operating Procedures.

SOPs usually underpin planning arrangements containing written procedures with detailed instructions for operations, practices and processes within an organisation.

The ROH:

The Royal Orthopaedic Hospital NHS Foundation Trust.
Responding organisation for the purpose of this Policy.

TMG:

Trust Management Group.

See section 6 for responsibilities of this Group.

TNA:

Training Needs Analysis.

A systematic process (in the form of a document at the ROH) used to identify potential gaps in skills, knowledge and abilities amongst staff, whilst aligning to the MOS to ensure that staff are being trained appropriately.

UHB:

University Hospitals Birmingham NHS Foundation Trust.

Partner organisation for the purpose of this Policy.

20. Equality Impact Assessment (EQIA)

As part of its development, this document and its impacts on staff, patients and the public have been reviewed in line with the ROH Equality duties.

The purpose of this assessment is to identify and if possible, remove any disproportionate adverse impact on employees, patients and the public on the grounds of the protected characteristics under the Equality Act.

The Equality Impact Assessment related to this EPRR Policy can be located on the next page:



Equality Impact Assessment

Initial Assessment form

The Initial Equality Impact Assessment (EIA) is a quick and easy screening process. It should:

1. Identify those policies which require a full EIA by looking at:
 - Negative, positive or no impact on any of the protected characteristics.
 - Opportunity to promote equality for the protected characteristics.
 - Data/feedback to prioritise if and when a full EIA should be completed
2. Justify reasons why a full EIA is not going to be completed

Division or Corporate area:

Operations

Speciality/Service Area:

Emergency Planning

Executive Lead (enter name and designation):

Michelle Hubbard – Accountable Emergency Officer / Acting Chief Operating Officer

Title of Policy:

EPRR Policy

Q1) What is the aim of your Policy?

To establish an integrated emergency management process across the Trust that is built on the principles of risk assessment, co-operation with partners, emergency planning, communication and information sharing.

Q2) State to which Trust strategic objective this Policy relates:

- **Care** – this Policy ensures that high-quality patient care will remain a priority during emergencies and incident response through resilient planning.
- **People** – this Policy ensures that all staff have adequate resources to be confident members of the On Call Rota and that training and exercising is inclusive to all

learning styles and that all staff feel well supported and have welfare checks post incident response.

- **Community** – this Policy ensures that the ROH is able to properly support inpatients, visitors and the wider community during incidents internal to the ROH and wider-scale incidents.

Q3) Who benefits from your Policy?

- All staff
- Patients and the wider community (including visitors).
- Surrounding NHS Organisations and Multi-Agency Partners.

Q4) Do you have any feedback data that influences, affects or shapes this Policy?

Yes	No
☐	☒
Please complete below.	Please go to question 5

What is your source of feedback?

- ☐ Monitoring Data
- ☐ Previous EIAs
- ☐ National Reports
- ☐ Internal Audits
- ☐ Patient Surveys
- ☐ Complaints / Incidents / Claims / Litigation
- ☐ Focus Groups
- ☐ Equality & Diversity Training
- ☐ Other (please state)

What does this source of feedback reveal?

Q5) Thinking about each group below does or could the Policy have a negative impact on members of the protected characteristics below?

Protected Characteristic	Yes	No	Unclear
Age	☐	☒	☐
Disability	☐	☒	☐
Race	☐	☒	☐
Sex	☐	☒	☐

Gender Reassignment	☐	☒	☐
Sexual Orientation	☐	☒	☐
Religion or belief	☐	☒	☐
Pregnancy & Maternity	☐	☒	☐
Marriage & Civil Partnership	☐	☒	☐
Other socially excluded groups	☐	☒	☐

If the answer is “yes” or “Unclear” please complete a full EIA

Q6) Who was involved in the EIA and how?

- Siobhan Carlton – EPRR Lead – revision of existing Policy.
- Internal Consultation:
 - Stuart Lovack – Head of EPRR
 - Michelle Hubbard – Acting Chief Operating Officer / Accountable Emergency Officer.
 - Executive Team Meeting.
 - Trust Management Group.
 - Private Trust Board.
- External Consultation:
 - NHS England Regional EPRR Team.
 - Birmingham and Solihull Integrated Care Board (ICB) EPRR Team.

How were they involved?

- ☐ Surveys
☐ Team Meeting
☒ Group Review
☐ Other

Please specify:

Q7) Have you identified a negative/potential negative impact (direct /indirect discrimination)?

☐ No
 ☒ yes
 ☐

Q7a) If ‘No’ Explain why you have made this decision?

This Policy only acts as guidance to staff in the event of responding to an emergency or incident, internally or on a wider geographical scale.

Q7b) If ‘yes’ explain the negative impact – you may need to complete a full EIA

If a negative impact has been identified please continue to undertaking a full impact assessment. If no negative impact has been identified please submit your Initial EPRR Policy v5.0 FINAL

Equality Impact Assessment to roh-tr.governance@nhs.net

Justification Statement:

As member of ROH staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete this EIA by law. By stating that you have not identified a negative impact, you are agreeing that the organisation has not discriminated against any of the protected characteristics. Please ensure that you have the evidence to support this decision as the Trust will be liable for any breaches in the Equality Legislation.

Completed by:

Name:	Siobhan Carlton
Designation:	EPRR Lead
Date:	11/06/2026
Contact number:	07584 483597

This EIA has been approved:

Name:	Nasir Uddin
Designation:	Acting Deputy Chief Operating Officer
Date:	11/06/2026
Contact number:	0121 812 3342

-END OF DOCUMENT-



TRUST BOARD

DOCUMENT TITLE:	Emergency Preparedness Resilience and Response (EPRR) Work Programme v1.0
SPONSOR (EXECUTIVE DIRECTOR):	Michelle Hubbard, Acting Chief Operating Officer / Accountable Emergency Officer (AEO)
AUTHOR:	Siobhan Carlton, EPRR Lead
DATE OF MEETING:	8 July 2026

PURPOSE OF THE REPORT:

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

As part of the NHS Core Standards Assurance for EPRR, organisations are required to have in place an Annual Work Programme showing relevant areas of the standards that are applicable to the organisation type including training and exercising scheduled for the year. There is also a requirement with the NHS England EPRR Framework for organisations to have a programme of work in place.

This document has been produced to meet the national core standard requirements and provide clear structures of upcoming work and areas of priority to enable the EPRR Agenda to be met. The EPRR workplan provides a route to achieving a status of compliance against the annual assurance process for EPRR by 2027/28.

ASSURANCE PROVIDED BY THE REPORT:

POSITIVE	GAPS IN ASSURANCE/RISKS TO ESCALATE
- Outlines the programme of work for the EPRR Team. - Includes priority areas to continue to improve the Trust's compliance position for the NHS Core Standards for the EPRR annual submission.	There are areas within the Work Programme (indicated as 'not started' or 'new activity') where there is either action outstanding or no documented process in place within the organisation to build on for assurance submission on 28th August 2026.

REPORT RECOMMENDATION:

The Board is asked to:

- Be aware of the priorities within the EPRR Team.
- Be aware of the requirements on the organisation to have in place plans and processes to be compliant with the NHS Core Standards for EPRR.

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		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	X
Expertise		Services	

People	X	Collaboration	
ALIGNMENT TO RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:			
N/A			
BENCHMARKING SOURCE <i>(Indicate data sources included in report IF APPLICABLE):</i>			
N/A			
PREVIOUS CONSIDERATION <i>(Indicate board/committee/group & date):</i>			
The EPRR Work Programme was signed off by Michelle Hubbard (AEO) in June 2026. Executive Team Meeting (for information) 15/06/2026 Trust Management Group Meeting (for information) 17/06/2026			



The Royal Orthopaedic Hospital NHS Foundation Trust



Emergency Preparedness, Resilience and Response
(EPRR)

2025-26 Work Programme
Aligning to NHS Core Standards for EPRR requirements

1	Must do - urgent
2	Should do - not urgent
3	Consideration to include next year

Due this month

Red - outstanding
Orange - in progress
Green - completed

Domain (Use drop down tab to match the domain)	Activity	Priority	Core Standard	Activity Lead	Interdependencies	Timescale	Regular Activity?	Date Added	Deadline	Tasks within the Activity	Progress	Date Activity Updated
Governance	Job Description to be in place for the Accountable Emergency Officer (AEO)		1 - Senior Leadership	Accountable Emergency Officer	Chief Executive	N/A	No	28/05/2026	31/07/2026	*Job Description to be updated *Cross reference with Civil Contingencies Act and Core Standard requirements	Document / process in place	23/06/2026
Governance	Deputy Accountable Emergency Officer (Deputy AEO) to be confirmed		1 - Senior Leadership	Accountable Emergency Officer	Chief Executive	N/A	No	28/05/2026	31/07/2026	*Update the EPRR Policy	Document / process in place	04/06/2026
Governance	EPRR Policy review		2 - EPRR Policy Statement	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Board (sign-off)	Three yearly	Yes	29/05/2026	08/07/2026	*Review Policy. *Share internally for consultation. *Share with partners for consultation. *Send to Execs 15/06 for information. *Send to Trust Management Group 17/06 for information. *Send to Private Board 08/07 for approval.	Activity in progress	30/06/2026
Governance	Public Annual Board - readiness and preparedness activities		3 - Trust Board Reports	Accountable Emergency Officer	Deputy Accountable Emergency Officer	Annually	Yes	28/05/2026	2027	Last meeting 03/06/2026. 2027 date TBC	Activity in progress	03/06/2026
Governance	Private Annual Board Report - readiness and preparedness activities		3 - Trust Board Reports	Accountable Emergency Officer	Deputy Accountable Emergency Officer	Annually	Yes	28/05/2026	08/07/2026	Meeting date - 08/07/2026	Activity in progress	30/06/2026
Governance	EPRR Work Programme to be reviewed by the Accountable Emergency Officer (AEO)		4 - Work Programme	EPRR Lead	Accountable Emergency Officer	Weekly	Yes	28/05/2026	No set date		Activity in progress	18/06/2026
Governance	EPRR Work Programme to be reviewed by Governance		4 - Work Programme	EPRR Lead	Accountable Emergency Officer and Governance (awareness)	Six monthly	Yes	28/05/2026	08/07/2026	*Send to Execs 15/06 for awareness. *Send to Trust Management Group 17/06 for awareness. *Send to Private Board 08/07 for awareness.	Activity in progress	30/06/2026
Governance	EPRR Lead to be appointed		5 - EPRR Resource	Accountable Emergency Officer	HR and PA to the Accountable Emergency Officer	N/A	No	28/05/2026	No set date	*Business case to be proposed *Job Description to be created	Activity in progress	05/06/2026
Governance	Ongoing review of continuous improvement from lessons		6 - Continuous Improvement	EPRR Lead		Quarterly	Yes	28/05/2026	31/07/2026	*Inform and update planning arrangements	Not started	28/05/2026
Governance	Ongoing maintenance of Lessons Log to include Midlands regional lessons shared		6 - Continuous Improvement	EPRR Lead		Monthly	Yes	28/05/2026	16/07/2026	*Inform and update planning arrangements with learning from other Providers across the region	Not started	28/05/2026
Duty to assess risk	Review the internal Risk Assessment process		7 - Risk Assessment	EPRR Lead	Accountable Emergency Officer	N/A	Yes	28/05/2026	31/07/2026		Not started	28/05/2026
Duty to assess risk	Review the internal Risk Register and management process		8 - Risk Management	EPRR Lead	Accountable Emergency Officer	N/A	Yes	28/05/2026	31/07/2026		Not started	28/05/2026
Duty to assess risk	Ongoing maintenance and escalation of risks		8 - Risk Management	EPRR Lead	Accountable Emergency Officer	TBC	Yes	28/05/2026	31/07/2026	*Review Risk Assessments and Risk Register *Report through Governance	Not started	28/05/2026
Duty to maintain plans	Maintain record of consultations for internal and external planning arrangements and documentation		9 - Collaborative Planning	EPRR Lead	External NHS partner organisations and Governance Team	Ongoing	Yes	28/05/2026	No set date	*Continuous review of internal documentation when required and share for consultation. *Review external documentation when requested	Activity in progress	30/06/2026
Duty to maintain plans	Incident Response Plan (IRP) review		10 - Incident Response	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Annually	Yes	28/05/2026	23/07/2026	*Review Plan *Share internally for consultation *Share with partners for consultation *Send to Execs 29/06 for awareness. *Send to Trust Board 08/07 for awareness alongside the EPRR Policy	Activity in progress	30/06/2026
Duty to maintain plans	Adverse Weather Plan review		11 - Adverse Weather	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Annually	Yes	28/05/2026	27/07/2026	*Review arrangements *Share internally for consultation *Share with partners for consultation *Send to Execs 27/07 for approval	Activity in progress	04/06/2026
Duty to maintain plans	Develop an Infectious Disease / Outbreak Policy		12 - Infectious Diseases	EPRR Lead	Infection Prevention Control Lead, external partners (consultation) and Governance (sign-off)	Three yearly	Yes	28/05/2026	23/07/2026	*Review arrangements *Share internally for consultation *Share with partners for consultation *Send to Execs 20/07 for awareness. *Send to Trust Management Group 23/07 for approval.	Activity in progress	18/06/2026
Duty to maintain plans	Review Pandemic arrangements within Pandemic Plan		13 - New and Emerging Pandemics	EPRR Lead	Infection Prevention Control Lead, external partners (consultation) and Governance (sign-off)	Three yearly	Yes	28/05/2026	23/07/2026	*Review arrangements *Share internally for consultation *Share with partners for consultation *Send to Execs 20/07 for awareness. *Send to Trust Management Group 23/07 for approval.	Activity in progress	18/06/2026
Duty to maintain plans	Review Mass Countermeasures support available to the system		14 - Mass Countermeasures	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Annually	Yes	28/05/2026	27/07/2026	*Review arrangements *Share internally for consultation *Share with partners for consultation *Send to Execs 27/07 for approval	Activity in progress	04/06/2026
Duty to maintain plans	Review Mass Casualty support available to the system		15 - Mass Casualty	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Annually	Yes	28/05/2026	23/07/2026	Within the Incident Response Plan. *Review Plan *Share internally for consultation *Share with partners for consultation *Send to Execs 29/06 for approval	Document / process in place	29/06/2026
Duty to maintain plans	Evacuation and Shelter Plan review		16 - Evacuation and Shelter	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Annually	Yes	28/05/2026	27/07/2026	*Review arrangements *Share internally for consultation *Share with partners for consultation *Send to Execs 27/07 for approval	Activity in progress	04/06/2026
Duty to maintain plans	Separate the Lockdown arrangements from the Evacuation and Shelter Plan		17 - Lockdown	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Adhoc	No	28/05/2026	27/07/2026	*Review arrangements *Share internally for consultation *Share with partners for consultation *Send to Execs 27/07 for approval	Activity in progress	04/06/2026
Duty to maintain plans	Lockdown Plan review		17 - Lockdown	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Annually	Yes	28/05/2026	27/07/2026	*Review arrangements *Share internally for consultation *Share with partners for consultation *Send to Execs 27/07 for approval	Activity in progress	04/06/2026
Duty to maintain plans	Review Very Important Person (VIP) arrangements - visitors or patients		18 - VIP	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Annually	Yes	28/05/2026	27/07/2026	*Review arrangements *Share internally for consultation *Share with partners for consultation *Send to Execs 27/07 for approval	Activity in progress	04/06/2026

Duty to maintain plans	Review Excess Deaths arrangements		19 - Excess Fatalities	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Annually	Yes	28/05/2026	23/07/2026	Within the Incident Response Plan. *Review Plan *Share internally for consultation *Share with partners for consultation *Send to Execs 29/06 for approval	Document / process in place	29/06/2026
Command and Control	Develop an On Call Policy (EPRR to identify if this is already in place, if so this will need reviewing and updating)		20 - On Call Mechanism	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Three yearly	Yes	28/05/2026	27/07/2026	*Create a new Policy if not in place (or review if in place) *Share internally for consultation *Share with partners for consultation *Send to Execs 27/07 for approval.	Not started	28/05/2026
Command and Control	Review the content within the Bleepholder pack		20 - On Call Mechanism	EPRR Lead	None	Annually	Yes	28/05/2026	31/07/2026	*Review the content *Share internally for awareness	Not started	28/05/2026
Command and Control	Review of internal communication mechanisms including regular testing and exercising		20 - On Call Mechanism	EPRR Lead	None	Six monthly	Yes	28/05/2026	31/07/2026	*Review documented arrangements (Incident Response Plan) *Undertake Comms Exercises in hours and out of hours *Develop and circulate Post Exercise Report	Activity in progress	11/06/2026
Command and Control	Develop On Call Training packages for all Commanders		21 - Trained On Call Staff	EPRR Lead	Accountable Emergency Officer	N/A	No	28/05/2026	No set date	*Align to the National and Minimum Occupational Standards. *Align to incident response arrangements	New activity	28/05/2026
Command and Control	Delivery of On Call Training		21 - Trained On Call Staff	EPRR Lead	None	Ongoing	Yes	28/05/2026	No set date	*Align to the National and Minimum Occupational Standards. *Align to the Training Needs Analysis requirements *Maintain Training Records *Receive and implement feedback forms	New activity	28/05/2026
Training and Exercising	Develop a TNA for all On Call Staff, Loggists and EPRR Team		22 - EPRR Training	EPRR Lead	None	Ongoing	No	28/05/2026	No set date	*Align to National and Minimum Occupational Standards	New activity	28/05/2026
Training and Exercising	TNA review		22 - EPRR Training	EPRR Lead	None	Annually	Yes	28/05/2026	No set date	*Check alignment to National and Minimum Occupational Standards. *Check includes all relevant current staff	New activity	28/05/2026
Training and Exercising	Development of Personal Development Portfolios (PDPs) for key staff		22 - EPRR Training	EPRR Lead	On Call Executives	Ongoing	No	28/05/2026	No set date	*Align to Training Needs Analysis of who needs a PDP. *Have PDPs in place for the relevant people.	New activity	28/05/2026
Training and Exercising	Develop and deliver six monthly Communications Exercises		23 - Exercising and Testing Programme	EPRR Lead	None	Six monthly	Yes	28/05/2026	No set date	*Design and deliver - incorporating On Call and Loggists *Develop Post Exercise Reports and circulate *Capture, record, implement and monitor lessons	New activity	28/05/2026
Training and Exercising	Develop and deliver Business Continuity Exercises		23 - Exercising and Testing Programme	EPRR Lead	Department Leads	Annually	Yes	28/05/2026	No set date	*Design and deliver *Develop Post Exercise Report and circulate *Capture, record, implement and monitor lessons	New activity	28/05/2026
Training and Exercising	Develop and deliver annual Tabletop Exercise		23 - Exercising and Testing Programme	EPRR Lead	Accountable Emergency Officer	Annually	Yes	28/05/2026	No set date	*Design and deliver *Develop Post Exercise Report and circulate *Capture, record, implement and monitor lessons	New activity	28/05/2026
Training and Exercising	Develop and deliver three yearly Live Exercise		23 - Exercising and Testing Programme	EPRR Lead	Accountable Emergency Officer	Three yearly	Yes	28/05/2026	No set date	*Design and deliver *Develop Post Exercise Report and circulate *Capture, record, implement and monitor lessons	New activity	28/05/2026
Training and Exercising	Develop and deliver three yearly Command Post Exercise (if not activated the ICC for a live incident)		23 - Exercising and Testing Programme	EPRR Lead	Accountable Emergency Officer	Three yearly	Yes	28/05/2026	No set date	*Design and deliver *Develop Post Exercise Report and circulate *Capture, record, implement and monitor lessons	New activity	28/05/2026
Training and Exercising	Continue to support On Call staff encountering any issues		24 - Responder Training	EPRR Lead	None	Ongoing	Yes	28/05/2026	No set date	*Identify any processes not aligning to documented arrangements *Offer support to the person On Call - using feedback from training or issues during on call response.	Not started	28/05/2026
Training and Exercising	Check the Fire Awareness Package contains general EPRR awareness training		25 - Staff Awareness and Training	EPRR Lead	Estates and Accountable Emergency Officer	N/A	No	28/05/2026	10/07/2026	*Check and amend training content	Not started	28/05/2026
Training and Exercising	Ongoing delivery of the Fire Awareness Package for new staff		25 - Staff Awareness and Training	Estates	EPRR Lead	Ongoing	Yes	28/05/2026	No set date	*Monitor and record uptake	New activity	28/05/2026
Response	Establish and record equipment within the Primary and Secondary Incident Co-Ordination Centres (ICCs)		26 - Incident Co-Ordination Centre	EPRR Lead	None	N/A	No	28/05/2026	10/07/2026	*Identify equipment within both ICCs. *Create Equipment Inventory and include within the Incident Response Plan.	Activity in progress	11/06/2026
Response	Incident Co-Ordination Centre (ICC) Activation Plan review		26 - Incident Co-Ordination Centre	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Annually	Yes	28/05/2026	27/07/2026	*Review Plan and activation processes *Share internally for consultation *Share with partners for consultation *Send to Execs 27/07 for approval	Not started	28/05/2026
Response	Incident Co-Ordination Centre (ICC) Maintenance Checks		26 - Incident Co-Ordination Centre	EPRR Lead	None	Three monthly	Yes	28/05/2026	31/07/2026	*Check equipment in the Primary and Secondary ICC against the Equipment Inventory *Ensure hard copy plans are the latest version	Not started	28/05/2026
Response	Review the content in the Grab Bags		27 - Access to Planning Arrangements	EPRR Lead	None	Three monthly	Yes	28/05/2026	31/07/2026	*Incorporate within the ICC Maintenance Checks	Not started	28/05/2026
Response	Review Business Continuity escalation into Incident Response processes		28 - Management of BC Incidents	EPRR Lead	Department Leads and or Comms Team and Accountable Emergency Officer	Annually	Yes	28/05/2026	No set date	*Review Trust-wide Business Continuity Plan and Communication Plan	New activity	28/05/2026
Response	Incorporate personal logging requirements into the On Call Training		29 - Decision Logging	EPRR Lead	None	N/A	No	28/05/2026	No set date	*Inclusion in the Commander Training Packages	New activity	28/05/2026
Response	Review and update the online Logging Template		29 - Decision Logging	EPRR Lead	None	N/A	No	28/05/2026	31/07/2026	*Add to Incident Response Plan *Update on the Emergency Hub	Activity in progress	25/06/2026
Response	Inclusion of Loggists in Communications Exercises and the Training Needs Analysis.		29 - Decision Logging	EPRR Lead	None	N/A	No	28/05/2026	No set date		New activity	28/05/2026
Response	Develop a section in the Incident Response Plan of how to work with Loggists and how to access Loggists		29 - Decision Logging	EPRR Lead	None	N/A	No	28/05/2026	31/07/2026	*Add into the review of the Incident Response Plan	Document / process in place	25/06/2026
Response	Ensure On Call Staff have access to all situation reporting templates		30 - Situation Reports	EPRR Lead	None	N/A	No	28/05/2026	31/07/2026	*Update on the Emergency Hub	Not started	28/05/2026
Response	Incorporate situation reporting requirements into the Incident Response Plan		30 - Situation Reports	EPRR Lead	None	N/A	No	28/05/2026	31/07/2026	*Add into the review of the Incident Response Plan	Document / process in place	25/06/2026
Response	Ensure staff have access to the Clinical Guidelines		31 - Access to Clinical Guidelines	EPRR Lead	None	N/A	No	28/05/2026	31/07/2026		Not started	15/06/2026
Warning and Informing	Communications Plan review		34 - Incident Communication Plan	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Annually	Yes	28/05/2026	23/07/2026	*Review Plan and ensure meets compliance for CS33-36 *Share internally for consultation *Share with partners for consultation *Send to Execs 20/07 for awareness. *Send to Trust Management Group 23/07 for approval.	Not started	28/05/2026
Warning and Informing	Include Communications Team and staff trained for Media Briefings in the Training Needs Analysis (TNA)		36 - Media Strategy	EPRR Lead	Communications Team	N/A	No	28/05/2026	No set date	*Include in the TNA	New activity	28/05/2026
Co-Operation	Accountable Emergency Officer (AEO) to attend 75% of LHRP meetings annually		37 - LHRP Engagement	Accountable Emergency Officer	None	Ongoing	Yes	28/05/2026	10/06/2026	Three meetings per year. *AEO to attend at least 2/3 meetings	Document / process in place	10/06/2026
Co-Operation	Organisation is represented at 75% of the HEPOG meetings annually		37 - LHRP Engagement	EPRR Lead	None	Ongoing	Yes	28/05/2026	28/08/2026	Three meetings per year. *EPRR Team to attend at least 2/3 meetings	Not started	11/06/2026

Co-Operation	Organisation to attend LRF meetings when requested by the LRF or ICB		38 - LRF Engagement	Accountable Emergency Officer, On Call or EPRR Lead	None	Ongoing	Yes	28/05/2026	28/08/2026		Activity in progress	28/05/2026
Co-Operation	Development of mutual aid arrangements for requesting, co-ordinating and managing internal requests		39 - Mutual Aid Arrangements	EPRR Lead	None	N/A	No	28/06/2026	31/07/2026	*Add into the review of the Incident Response Plan	Document / process in place	25/06/2026
Co-Operation	Develop internal information sharing processes		43 - Information Sharing	EPRR Lead	None	N/A	No	28/06/2026	31/07/2026	*Add into the review of the Incident Response Plan	Document / process in place	25/06/2026
Business Continuity	Identify the Business Continuity arrangements in place		44 - BC Policy Statement	EPRR Lead	None	N/A	No	28/06/2026	No set date	*Review arrangements already in place *Consider requirements to meet Core Standards 44-53 and expand the activities within this Work Programme	New activity	28/05/2026
HAZMAT/CBRN	Review governance arrangements for Chemical, Biological, Radiological and Nuclear (CBRN) response		55 - HAZMAT/CBRN Governance	EPRR Lead	Accountable Emergency Officer	N/A	No	28/05/2026	23/07/2026	*Add into the review of the CBRN Plan	Not started	28/05/2026
HAZMAT/CBRN	Review Risk Assessments for Chemical, Biological, Radiological and Nuclear (CBRN) response		56 - HAZMAT/CBRN Risk Assessments	EPRR Lead	Accountable Emergency Officer	Annually	Yes	28/05/2026	23/07/2026	*Ensure Risk Assessments are in place covering compliance - plan to align to the outcomes of the Risk Assessment		28/05/2026
HAZMAT/CBRN	Ensure specialist advice contact numbers are available for Chemical, Biological, Radiological and Nuclear (CBRN) response		57 - Specialist Advice for HAZMAT/CBRN Exposure	EPRR Lead	None	N/A	No	28/05/2026	23/07/2026	*Review CBRN Plan content *Ensure staff are aware of who and when to request specialist advice		28/05/2026
HAZMAT/CBRN	Chemical, Biological, Radiological and Nuclear (CBRN) Plan review		58 - HAZMAT/CBRN Planning Arrangements	EPRR Lead	Accountable Emergency Officer, external partners (consultation) and Governance (sign-off)	Annually	Yes	28/05/2026	23/07/2026	*Review Plan and ensure it meets compliance for CS55-66 *Share internally for consultation *Share with partners for consultation *Send to Execs 20/07 for awareness. *Send to Trust Management Group 23/07 for approval.		28/05/2026
HAZMAT/CBRN	Ensure there is an equipment inventory in place for Chemical, Biological, Radiological and Nuclear (CBRN) response		60 - HAZMAT/CBRN Equipment and Supplies	EPRR Lead	None	N/A	No	28/05/2026	31/07/2026			28/05/2026
HAZMAT/CBRN	Establish a Training Needs Analysis and Training Records process for Chemical, Biological, Radiological and Nuclear (CBRN) response		63 - HAZMAT/CBRN Training Resource	EPRR Lead	None	N/A	No	28/05/2026	No set date		New activity	28/05/2026
HAZMAT/CBRN	Establish a Training Programme for Chemical, Biological, Radiological and Nuclear (CBRN) response		64 - HAZMAT/CBRN Staff Training: Recognition and Decontamination	EPRR Lead	None	N/A	No	28/05/2026	No set date		New activity	28/05/2026
HAZMAT/CBRN	Plan and deliver training for Chemical, Biological, Radiological and Nuclear (CBRN) response		64 - HAZMAT/CBRN Staff Training: Recognition and Decontamination	EPRR Lead	None	Ongoing	Yes	28/05/2026	No set date		New activity	28/05/2026
HAZMAT/CBRN	Determine the Personal Protective Equipment (PPE) approach for all responding staff		65 - HAZMAT/CBRN PPE Access	EPRR Lead	Infection Prevention Control Lead	N/A	No	28/05/2026	No set date	*Align to either a Trust or a specific CBRN Risk Assessment	New activity	28/05/2026
HAZMAT/CBRN	Establish an Exercising Programme for Chemical, Biological, Radiological and Nuclear (CBRN) response		66 - HAZMAT/CBRN Exercising	EPRR Lead	None	N/A	No	28/05/2026	No set date		New activity	28/05/2026
HAZMAT/CBRN	Plan and deliver Exercises for Chemical, Biological, Radiological and Nuclear (CBRN)		66 - HAZMAT/CBRN Exercising	EPRR Lead	None	Ongoing	Yes	28/05/2026	No set date		New activity	28/05/2026

Current progress based on RAG status	
New activity	22
Activity in progress	20
Document / process in place	9
Process in place but needs development / review	0
Urgent	0
Not started	21



1.UPWARD REPORT FROM FINANCE & PERFORMANCE COMMITTEE

Date Group or Board met: 30th June 2026

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Elective activity below plan, driven by estate constraints (theatre closures, heat issues), workforce absences and limited operational flexibility • Day case (BADS) programme risk, with variable clinical engagement and inconsistent embedding of standard protocol slowing delivery. • Cancer standards not achieved, primarily due to histopathology capacity constraints • Outpatient appointments below plan year-to-date. • Private patient income below plan, posing a risk to financial delivery • Ongoing estate resilience risks, impacting theatre capacity and operational continuity	• Acceleration of day case transformation (BADS) ○ External support (GRIFFITHS), defined trajectories and dashboard development ○ Stronger executive oversight and clinical engagement • Operational recovery plans ○ Outpatient recovery trajectory in place ○ Continued focus on elective delivery and utilisation • Cancer improvement actions ○ Increased reporting capacity and reduced diagnostics turnaround times • Private patient recovery plan ○ Commercial action plan, including flexible capacity and growth initiatives • Workforce and cultural change support ○ OD-led interventions to improve engagement and pathway adoption.
POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• RTT performance exceeding trajectory • Diagnostics performance strong (~99%) • Theatre utilisation high and nationally benchmarked • Early progress in day case delivery (improving discharge rates) • Cancer recovery trajectory improving, with reduced turnaround times	• Agreed regular oversight of key transformation programmes (BADS, EPR) • Endorsed recovery plans for outpatient and operational performance • Requested clearer metrics and measurable outcomes (productivity, financial impact, workforce measures) • Confirmed Executive and Committee support to unblock delivery barriers



- Requested clearer actions on income recovery, particularly private patients

Chair's comments on the effectiveness of the meeting: The Chair considered the meeting to be effective and well-focused, with constructive challenge and meaningful discussion on key performance and financial issues. There was clear evidence of improved debate and collective understanding, with the Committee providing appropriate oversight and support to drive delivery.

**UPWARD REPORT FROM THE STAFF EXPERIENCE & OD COMMITTEE****Date Group or Board met: 24 June 2026**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Sickness absence remains above target and remains a priority – we are on track to deliver our glidepath to the 4% target by 2028. • Based on submitted 26/27 operational planning forecast, Infrastructure FTE is higher than plan • We have seen higher number of grievances over the last 6 months, themes including staff against manager conflict or disputes arising from manager's decisions • Bank expenditure increased in month, and agency expenditure is above target. There is a weekly temporary staffing meeting in place.	• The Lord Mann review was published on the 4th June which calls for a system-wide reset centred on stronger leadership, accountability and consistency in tackling racism. An action plan is being drafted, and agreement has been reached by the Executive team to adopt the definitions. • Employment Rights project group has been formed to prepare the Trust for the changes.
POSITIVE ASSURANCES TO PROVIDE	DECISIONS MADE
• The Committee welcomed a Graduate Management Programme Trainee who provided insight as to what it was like being a graduate trainee at the ROH. • Two members of staff have been accepted onto the High Potential Scheme. • We continue to see a reduction in our overall sickness absence %, and we are the only Trust in BSOL making positive rolling reductions. • The Trust is on course for trajectory for overall workforce reductions. • The latest data for the WRES and WDES has been collated and submitted to NHSE. • Good assurance has been made against Library strategy in the last year. QIOF is self-assessed at meeting 14/16 essential indicators with plans in place to achieve 16/16	• The Committee agreed to have a board workshop to discuss the risks on organisational performance, accountability and culture, setting out clear expectations. • Workforce governance is being strengthened by the introduction of two new forums which will be chaired with the Chief People Officer - Staff Engagement Forum and Workforce Group. • A review of workforce risks has been completed and all risks updated.
Chair's comments on the effectiveness of the meeting: The check and challenge of these meetings is always useful feedback, as it can be used to steer things in a different direction.	

Equality and Diversity

Annual Report 2025

The Royal Orthopaedic Hospital

A review of the year 2025



Welcome

Welcome to this report, a retrospective look back over 2025.

If you are member of the public reading this on our website, thank you for taking the time to find out a little more about who we are as an organisation, what equality and diversity is and why we think it matters to our staff and our patients, their families, relatives and friends.

Our desire here is to share with you our aims and objectives, values, measures of success and progress, and to do so in a way that is accessible and easy to understand.

Where possible we will try and avoid NHS jargon, and where we do use terms that may be unfamiliar to you, or just a bit obscure, we'll look to explain what we mean

Keep it
simple

Wherever we use any jargon that may be common in the NHS we will make sure we explain exactly what that means in plain English



EDI –Equality, Diversity and Inclusion:

EQUALITY – treating people fairly, giving them an equal chance to get on, removing barriers that hold them back; not discriminating in any way and making sure policies and processes are fair and impartial

DIVERSITY – recognising people's differences and respecting, valuing & benefitting from those different views and experiences

INCLUSION - Creating a space where everyone feels safe, welcomed and valued no matter who they are.

You may also from time to time see links to other documents or more information also.

[Royal Orthopaedic Hospital - Home](#)

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1. Introduction

A message from the Chief Executive Officer (CEO) and Chief People Officer (CPO)

2025 has been a year of continued commitment to building a fair, inclusive and supportive environment for our colleagues and patients.

We've seen meaningful progress across our equality, diversity and inclusion (EDI) priorities – including stronger staff voice, improvements in key EDI measures and further growth in representation across the Trust.

We are encouraged by the increased openness from colleagues in sharing their lived experiences as well as the positive impact of our refreshed People Promise workstreams, wellbeing initiatives and staff networks. These continue to shape a culture where people feel heard, respected and valued.

We also recognise the areas where improvements are still needed. Feedback from our staff survey and EDI data shows some colleagues continue to experience inequalities, particularly regarding harassment, discrimination, and access to opportunities. Tackling these remains a core priority for 2026 and beyond.

We are proud to maintain external recognition for our inclusive practices and to see progress in several areas of our Inclusion Plan. As we move forward our aim remains clear: to nurture a culture of belonging where every colleague can thrive and every patient receives equitable, compassionate care.

Matthew Hartland, Chief Executive and Sharon Malhi, Chief People Officer

2. The Royal Orthopaedic Hospital (ROH) Equality & Diversity Report



The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) is a specialist hospital of around 1500 staff, with a history of over 200 years of serving the people of Birmingham and beyond with a comprehensive range of surgical and non-surgical treatments.

People are at the heart of our story, and we are proud of our culture and the positive impact it has on those who work here, our patients & their friends or families.

This Equality and Diversity (E&D) Report aims to provide you with a user-friendly look back over the key information, achievements and activity around equality, diversity and inclusion during 2025.

It is a statutory requirement for every NHS organisation to compile and publish equality and diversity information related to both our staff and patients, and that this document, along with other reports, are published and available to the public on The Royal Orthopaedic Hospital's (ROH) website.

[Royal Orthopaedic Hospital - Home](#)

Led by the Trust Board, we believe in creating an equitable, diverse and inclusive workplace.

We recognise that our staff, our patients and visitors have the right to be treated fairly, regardless of their age, gender, marital status, religious belief, ethnic background, nationality, sexual orientation, disability or social status.

We are committed to promoting equality and diversity and to making the Trust a safe and inclusive place to work where people can be their true and authentic selves and have a voice.



Legal and NHS regulatory requirements

The Public Sector Equality Duty

The Public Sector Equality Duty (PSED) which applies in England, Scotland and Wales, places a statutory duty on such organisations to consider how their functions will affect people with different protected characteristics. These include their policies, programmes and services.

The Trust is required to work to Section 149(1) of the Equality Act 2010, the general duty of which requires NHS organisations to have due regard to:

- Eliminating discrimination, harassment and victimisation and other conduct prohibited under the Act
- Advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Fostering good relations between persons who share a relevant protected characteristic and persons who do not share it.

Alongside this E&D Report the Trust produces many other reports, such as the Gender Pay Gap, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), EDI Improvement plan and the Equality Monitoring Tool, as outlined in the Equality Delivery System (EDS) 2024, to ensure all areas of the Trust are evaluated for effectiveness in the areas of equality and diversity.

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

[NHS England » Equality Delivery System 2022](#)



3. Trust Values and Inclusion Commitment

Trust Values – are more than words, they define how we treat one another and how we deliver care, they all implicitly seek to foster and promote an inclusive workplace and can only hope to be fully realised where we have successfully created an inclusive culture and working environment.

**RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION**

RESPECT - Treating people with consideration and dignity, recognising and valuing their worth and opinions and acknowledging and empathising with others

COMPASSION - Supporting the health and wellbeing of our patients and colleagues, acting with kindness towards everyone and recognising when things are difficult and showing sympathy and empathy

EXCELLENCE - Taking responsibility for delivering the highest possible standard of work, understanding relevant standards or targets and consistently meeting them and aiming to be the best by communicating, collaborating, learning and being diligent

PRIDE - Taking pride in your work and the standard to which it is delivered, supporting others to achieve their work because we are all part of a team and continuously improve

OPENNESS - Being truthful and transparent, especially if a mistake is made, giving constructive feedback and being open to feedback, communicating clearly and honestly, speaks up to raise a concern

INNOVATION - Seeking ways to improve through adapting existing approaches or introducing new ideas, embracing new ways of working and change and encouraging others to do the same, making time and space and to continuously improve

[Royal Orthopaedic Hospital - Culture](#)

**RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION**

ROH Inclusion

Inclusion Commitment at the Royal Orthopaedic Hospital

At our Trust, inclusion is not an initiative, it is a fundamental part of who we are and how we care. We serve a diverse population with complex needs, and we know that the quality of our care is strengthened when every colleague feels valued, respected, and able to thrive.

Since the inception of our Inclusion strategy in 2021, we have continued commitment to building a fair, inclusive and supportive environment for our colleagues, visitors and patients. We have seen meaningful progress across our equality, diversity and inclusion (EDI) priorities – including stronger staff voice, improvements in key EDI measures and further growth in representation across the Trust.

Our inclusion vision is clear

Nurturing a connected culture of belonging, where our colleagues can bring their authentic selves to work, and patients and visitors experience a supportive and inclusive environment, ready to meet their needs



ROH Inclusion Commitment

A central part of this progress has been the growing strength of staff voice across the organisation. Colleagues have increasingly shared their lived experiences, insights and ideas through our staff networks, listening events, People Promise workstreams and local engagement forums. This openness has helped shape our priorities; influence decision-making and ensure that our inclusion work is grounded in the real experiences of our workforce. We are committed to ensuring staff voice remains a powerful driver of change, and that colleagues feel confident their feedback leads to meaningful action.

We are also encouraged by the positive impact of our refreshed wellbeing initiatives and the continued development of our staff networks. These groups play a vital role in creating safe spaces, amplifying under-represented voices and helping us build a culture where people feel heard, respected and valued.

As an NHS organisation, we remain committed to transparent and accountable reporting. Throughout 2025 we continued to meet all statutory and mandated NHS reporting requirements, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap reporting, and the Equality Delivery System (EDS).

These frameworks provide essential insight into the experiences of our workforce and help us identify where targeted action is needed. Our latest reports show encouraging progress in some areas, including improved representation in senior roles and reductions in key disparities across protected characteristics.

At the same time, we recognise that there is more to do. Feedback from our staff survey, staff networks and EDI data shows that some colleagues continue to experience inequalities, particularly in relation to harassment, discrimination and access to opportunities. Tackling these issues remains a core priority for 2026 and beyond. Strengthening staff voice — especially from groups who are under-represented or less heard — will be central to this work, ensuring that our actions are informed by those most affected.

We are proud to maintain external recognition for our inclusive practices and to see progress in several areas of our Inclusion Plan. As we move forward, our aim remains clear: **to nurture a culture of belonging where every colleague can thrive and every patient receives equitable, compassionate care.** Our commitment to robust NHS reporting, transparent data, and the continued elevation of staff voice will guide our journey toward a more inclusive future

ROH Inclusion Commitment

Our Commitment

★ We put people first

We create an environment where every patient, carer, and colleague is treated with dignity and compassion. We actively listen to the voices of those who are seldom heard and remove barriers that prevent equitable access to care or opportunity.

🤝 We celebrate inclusion, equality and diversity

We recognise and embrace the richness that comes from different backgrounds, identities, and experiences. We foster a culture where individuality is respected and where everyone can contribute fully to our shared purpose. We will continue to embed key initiatives such as RACE Equality Code, Civility and Respect and the anti racist statement

🗣️ We speak up and act

We challenge discrimination, bias, and exclusion wherever we encounter them. We empower our people to raise concerns safely and confidently, and we take meaningful action to address inequalities. We will continue to embed key initiatives such as Active Bystanders

📖 We learn and improve

We commit to continuous learning, about ourselves, our communities, and the systemic inequalities that affect health outcomes and workplace experience. We use data, insight, and lived experience to drive improvement and measure our progress. We will continue to embed key initiatives such as anti racist commitment

We lead with accountability

Our leader's model inclusive behaviours and take responsibility for creating a fair, supportive, and psychologically safe workplace. Inclusion is embedded in our decision-making, our policies, and our everyday practice.

We will continue to embed key initiatives such as

Our Promise

We will build a Trust where everyone, patients, families, and staff feel they belong. A Trust where difference is valued, equity is prioritised, and inclusion is woven into the fabric of exceptional specialist care

4. NHS People Plan and People Promises

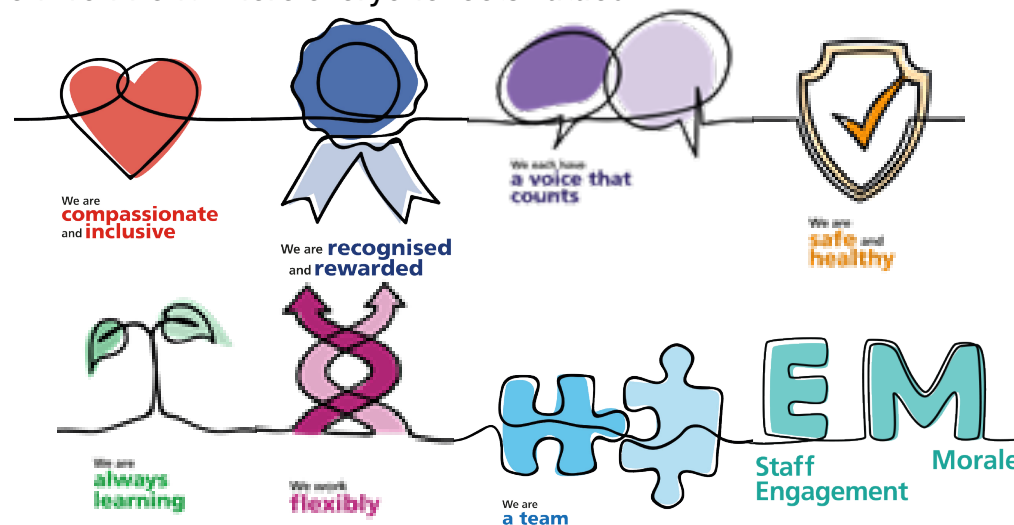
The **NHS People Plan** is designed to meet the Long-Term Plan for the NHS, a workforce strategy for delivering the sustainability of the NHS. To achieve this we need more people, working differently, in a compassionate and inclusive culture. The People Plan sets out a range of actions to deliver this. These are organised around four pillars:



1. **Looking after our people** – with quality health and wellbeing support for everyone
2. **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face
3. **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return.
4. **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience.

Below the pillars sit the **7 NHS People Promises** against which we can measure progress, and the additional measures for levels of **Staff Engagement** and **Morale**.

The delivery of equality and diversity in the workplace is both facilitated through achieving the aims of these 9 themes, and they in turn provide us with a measure of our progress towards creating a truly inclusive work environment where everyone feels valued.



[NHS England » Our NHS People](#)

5. External Work and Recognition



RACE Equality Code Quality Mark awarded by independent reviewers confirming the ROH has clearly committed to the 12 Musts of the RACE Equality Code.

theracecode.org



Maintained Level 3 Disability Confident Leader accreditation for our commitment to remove barriers and support staff and patients to flourish. We work with AccessAble to ensure visitors of all abilities can visit us with confidence and our Staff Network 'ABLE' is helping to remove the stigma associated with hidden and visible disability.



Thrive at Work Silver award maintained and working towards Gold accreditation, for creating a workplace that promotes employee health & wellbeing



The ROH is accredited as Veteran Aware, those who serve or who have served, and their families will not experience any disadvantage as a result of their service.



The ROH is part of the “Getting It Right First Time” (GIRFT) programme which is a national NHS England programme designed to improve the treatment and care of patients



Rated us as “GOOD” overall & all 5 categories, including “Well-Led”, under which EDI work is assessed. [Provider section - RRJ The Royal Orthopaedic Hospital NHS Foundation Trust \(15/10/2019\) INS2-5468751521](#)

Possibilities Beyond Limits (PBL) – A programmes run by BISOL ICS to develop band 6 & 7 managers into senior positions, open to all but with a focus on underrepresented groups within senior leadership roles.

BLACHIR - Birmingham & Lewisham African and Caribbean Health Inequalities Review - A programme to gain insights on health inequalities



BISOL ICS is the Birmingham and Solihull Integrated Care System, basically it oversees, supports and helps co-ordinate the all the various NHS Trusts in this region, be they acute, specialist, community, mental health etc. with a view to making the patient's experience consistent and joined-up and cost effective

6. Internal Work and Recognition

Anti-Racism Pledge The ROH committed itself to being an anti-racist organisation in 2025 : Our commitment to tackling racism and discrimination

The Royal Orthopaedic Hospital (ROH) is committed to being an actively anti-racist organisation, not just in words, but through action. Racism exists. It affects the health and wellbeing of both patients and staff, and it has no place in our Trust. We are taking a stand to challenge racism wherever it shows up, in behaviours, systems, and outcomes. We believe that every person deserves to feel safe, respected, and included at work and in care. This is not only a moral duty, but vitally important to better outcomes for everyone.

Our pledge commits us to: **Zero tolerance, Leadership accountability, Safe & inclusive culture, Education and empowerment, Transparency and Collaboration,**. [Anti-Racism-Statement-One-Page-V3](#)



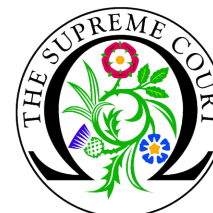
Health and Wellbeing offer is significant well communicated & supported by training & 2 annual dedicated Health and Wellbeing weeks



Sexual Safety Charter Creating a safe, respectful, and inclusive environment is core to our values and we remain fully committed to the NHS Sexual Safety Charter



Antisemitism the International Holocaust Remembrance Alliances definition of antisemitism has been formally adopted by NHSE and the ROH



Supreme Court We continue to support and work through implications with colleagues following the Supreme Court ruling that for the purposes of the Equality Act 2010, the legal definition of "woman" and "man" refers to biological sex at birth

People Directorate supporting E&D

The People Directorate comprises several teams, Human Resources, Recruitment, Organisational Development (OD) and Inclusion, Workforce Planning and ESR (Electronic Staff Records) Team, as well as Education and Training.

Much of the work undertaken directly promotes the equality and diversity agenda, inclusive employment, and reporting on the progress made towards ensuring our employees' time with us is a positive experience.

The OD & Inclusion Team supports individuals, teams and managers through development and interventions, designs and co-ordinates Trust's annual appraisal offer, compliance and quality assurance, provides the wellbeing advice and support offer, supports staff networks, delivers the civility and respect agenda, which often has an inclusion dimension to it, runs the annual NHS staff survey, and three National Quarterly Pulse Surveys, collating, analysing and communicating staff feedback and promoting change. Additionally, it produces other public reports, like this one but also Gender, Disability and Ethnicity Pay Gap reports, Workforce Race and Disability Equality Standards Reports, Equality Delivery System Reporting.



The Workforce Team also liaise with the Freedom to Speak Guardian, compile bullying and harassment reporting and have consulted with staff networks on HR policies to ensure there is an employee voice and perspective considered in their policy development.

They also routinely report on numerous key staff metrics that help us better understand what is happening with equality, diversity and inclusion within the Trust, as seen in this report. Looking at metrics like leavers' data, flexible working requests, disciplinaries or grievances, against certain key measures, like gender, ethnicity and disability, enables us to check for unexpected variances in these figures, compared to those of the wider staff population.

In 2026 we are launching a new Disciplinary process with a case assessment stage, where the case will be anonymised with key evidence reviewed by an independent manager, HR and staff side representatives. The Case Assessment has been developed to ensure consistency in approach and to eliminate bias in decision making at this key stage in conduct procedures.

Freedom To Speak Up, Unions and Professional / Regulatory Bodies



Freedom to Speak Up (FTSU) Guardians work independently, along-side the existing channels available, for staff to raise concerns.

In 2025 the Guardian handled 75 cases and saw increasingly diverse engagement, with a notable increase in reporting from overseas workers and minority staff groups, reflecting the success of ongoing engagement with these sections of the workforce. It was particularly positive to note an emerging trend of allyship, where staff members have advocated for, or raised concerns on behalf of their minority ethnic colleagues, demonstrates a growing collective responsibility for fairness across the Trust. Other work included increased visibility in specific areas where disparities were perceived, promoting integration, with overseas staff encouraged to join staff networks to address cultural issues and access moral support from peers.

Also promoting the FTSU service during National Inclusion Month, facilitating a Trust-wide inclusion event in September 2025, which particularly promoted awareness Carers, awareness of the importance of psychological safety in the workplace and Multi-generational Workplaces from an Inclusion perspective

Many staff are members of trade unions and/or regulatory and professional bodies. These seek to advocate for staff in many areas, including those related to equality, diversity and inclusion and they will promote and adhere to EDI best practice within their own codes of conduct too.

Unions have a formal role in agreeing on policies that impact on their members, and other staff, seeking to ensure they are fair and equitable in design and application. Alongside the varied clinical professional and regulatory bodies, non-clinical staff may also belong to professional bodies, such as The Chartered Institute of Personnel and Development (CIPD) for Human Resources.



Royal College
of Nursing
The voice of nursing



7. Staff Voice

The ROH has several Staff Networks and Employee Support Groups that fulfil a range of services for colleagues depending on their purpose and set up but principally offering in common

- **Safe Spaces:** A secure, confidential area for staff to discuss experiences and concerns.
- **Peer Support:** Nurturing a culture of belonging and mutual support from colleagues.
- **Supporting Inclusion Strategy & Influencing Change:** Acting as advisors to the organisation to improve and advance the equality, diversity and inclusion agenda
- **Promoting Awareness:** Networks often lead on the promotion and education, leading or supporting on various inclusion days/events relevant to them

We value the work they do in these areas an
[NHS England » Staff networks](#)



8. Staff Feedback – NHS National Staff Survey

The annual NHS National Staff Survey was undertaken in October and November 2025. This provides us with a comprehensive understanding regarding how our colleagues are feeling, covering all aspects of their work life under the headings of the 7 NHS People Promises, as well as measures for Staff Engagement and Morale. The measure for Staff Engagement is also now a performance metric for the NHS National Oversight Framework

There are specific questions relating to equality, diversity and inclusion that sit under the **We Are Compassionate and Inclusive** People Promise.

Of course, experiences related to EDI will influence other Themes too: e.g. are flexible working opportunities applied fairly, does everyone feel they have a voice or access to development, feel valued, listened to, or integrated into their teams etc.? Those experiences impact on Theme scores for **We Work Flexibly, We Each Have A Voice That Counts, We Are Always Learning** and **We Are A Team** etc.; in turn these influence overall levels for **Staff Engagement** and **Morale** too.

These results allow the Trust to track its own performance year on year. Additionally, we can gauge our progress against other Trusts working in the same part of the health sector.

This data is used to help establish Trust wide, as well as team specific, priorities in response to the feedback, involving a process of engaging with staff to identify actions and create improvement plans, with the additional input of the staff networks.

National Quarterly Pulse Surveys, in January, April and July, are much shorter and track core engagement responses in-between the main NHS Staff Survey and are useful as “temperature” checks on how colleagues are feeling.



ROH 2025 staff survey results

All NHS Trusts undertake an annual staff survey, these provide a wealth of information on the experiences of our staff, including those related to equality, diversity and inclusion. These are the 2025 results for the ROH.

We are benchmarked with 12 other Acute Specialist NHS Trusts, against the 7 NHS People Promises and the themes of Staff Engagement and Morale. All Staff are included in the survey sample and 55% of colleagues participated, which is 797 people.

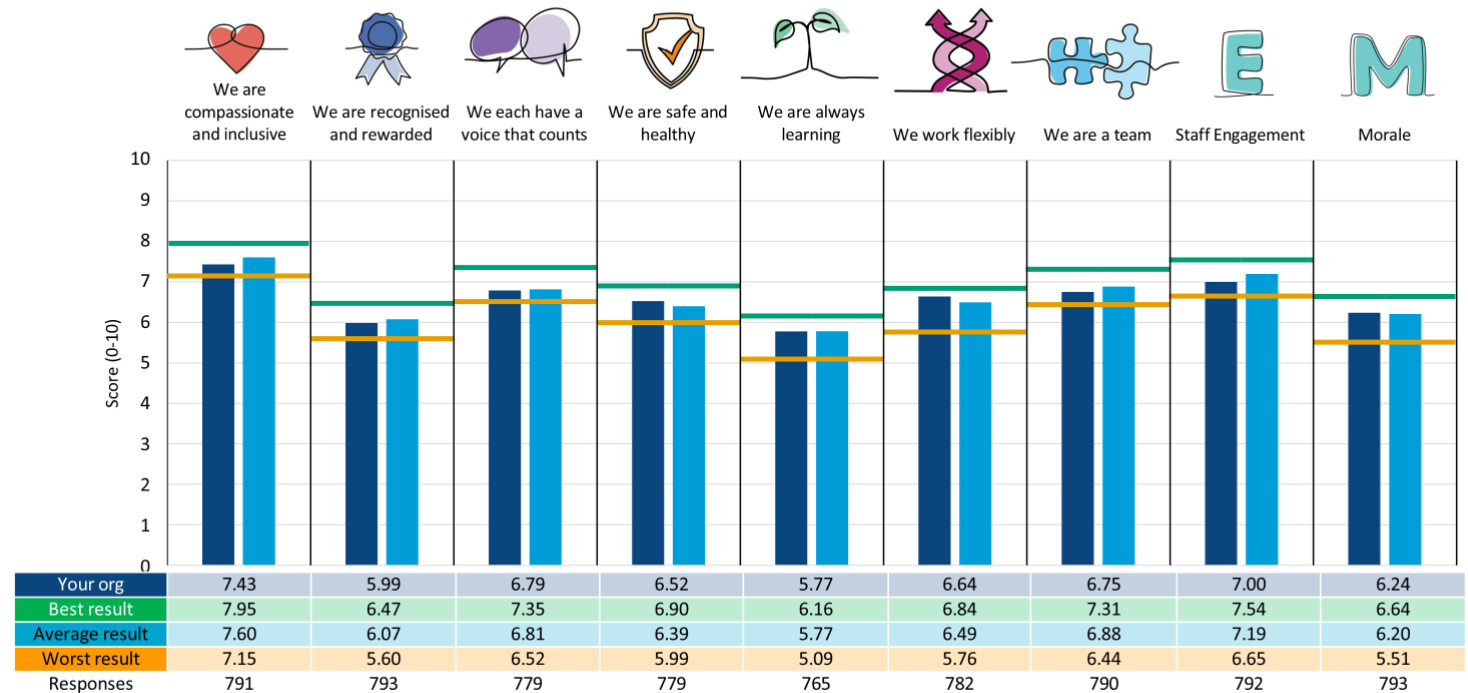
The data presents the ROH scores (out of 10) vs. the best, worst and average scores within our sector.

The Trust's , along with Directorate & Departmental results, provide invaluable insights around staff experiences, inform our priorities for future actions and also feed into other reporting.

People Promise elements and themes: Overview

Survey
Coordination
Centre **NHS**

People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.



The Royal Orthopaedic Hospital NHS Foundation Trust Benchmark report

12

9. Comparative Staff Experiences - WRES Data (Workforce Race Equality Standards)

This report tracks and addresses differing staff experiences based on race against 9 standards – the data shows a decline in 4 and improvement in 5 areas. Areas of focus identified from WRES are bullying and harassment, discrimination and inclusive recruitment and career opportunities

Performing Well

Indicator 1: Representation - We continue to see a positive increase in staff members from a BME background at the Trust from 31.8% to 35.0%.

Indicator 3: Disciplinary - The relative likelihood of ethnic minority staff entering the formal capability process, there has been a significant improvement from 2.10 to 0.67.

Indicator 4: Training - Access to non-mandatory training. There has been a further improvement from 0.91 to 0.86 . This means that it is more likely for BME staff to access these opportunities

Indicator 9: Board Representation - There has been a positive increase in this indicator from 20% to 25% The average percentage for NHS Trust Board member from a BME background is 15.6%

Work required

Indicator 2 : Shortlisting - There has been a further decline in this indicator from 1.71 to 2.3

Indicator 5 : Harassment - Ethnic minority staff reporting harassment from patients, relatives and the public There has been a decline in the indicator from 11.44% to 15.08% for BME staff.

Indicator 6 : Harassment from staff - There has been a further decline in this indicator from 22.17% to 26.98% for BME staff members

Indicator 8 : Discrimination from manager/team/colleagues - There has been a significant decline in this indicator from 12.06% to 17.86%

Getting there

Indicator 7: Career progression - Percentage of staff believing the trust provides equal opportunities for career progression or promotion There has been a slight improvement in this indicator from 45.54% to 45.88%

WDES Data (Workforce Disability Equality Standards)

This report similarly tracks disabled staff's experiences, there has been a decline in 7, an improvement in 4 and no change in 1 area. Priority areas of focus identified are bullying and harassment, discrimination, inclusive recruitment and career opportunities

Performing Well

Indicator 1: Declaration - A positive increase in staff declaring a disability from 5.9 to 6.9%. NHS average declaration rate is 4.9%

Indicator 6: Disabled staff feeling pressure from their managers to come to work, despite not feeling well- There has been an improvement in this indicator from 25.66% to 20.67% for disabled staff

Indicator 8: Adequate adjustment - Disabled staff reporting adequate adjustments saw an improvement from 74.73% to 76.8%

Indicator 9: Staff engagement - There has been an improvement from 6.75% to 6.82% for disabled staff members, non-disabled staff saw a decline from 7.16 to 7.13

Getting there

Indicator 7: staff saying they are satisfied with the extent to which the organisation values their work - There has been a small change to this indicator from 53.8% to

Work required

Indicator 2: Shortlisting - Relative likelihood of a disabled application being appointed from shortlisting, there has been a decline in this indicator from 1.01 to 1.3

Indicator 3: Disciplinary - The relative likelihood of disabled staff entering the formal capability process has declined in this indicator from 0 to 1.58

Indicator 4: Harassment, bullying, abuse from patients/public - There was a decline from 22.56% to 23.6%, although this is lower than the average score for disabled staff in the Specialist Acute sector which is 24.24

Indicator 4a: Harassment from staff - There has been a decline in this indicator from 23.1% to 24.6%, again this is lower than the sector average of 25.12%

Indicator 5: Career progression - Disabled staff believing the trust provides equal career opportunities has decline from indicator from 58.47% to 55.25%, it has also declined for non-disabled staff

Indicator 10: Board Representation – Full board members identifying as disabled declined from 13.3% to 12.5%

Review WRES and WDES detail at: [Royal Orthopaedic Hospital - Home](#)

Gender Pay Gap (GPG) 2025

We report annually on the gender pay gap, which is the difference between the average earnings for men and women at the ROH. Whilst not a statutory requirement, we have also started reporting on the ethnicity pay gap too.

The GPG matters because it highlights differences in the earning potential of female vs male staff and prompts questions as to why this is the case.

In the orthopaedic field there is a significantly higher proportion of male colleagues working in senior medical roles which has had an impact on the overall gender pay gap

We can use the results of this report to address:

- The levels of gender equality at the ROH
- The balance of male and females at different levels
- How effectively talent is being maximised and rewarded
- To get a clear set of actions to promote change

A more comprehensive analysis of the Gender Pay Gap report is available [Royal Orthopaedic Hospital - Statutory Documents](#)

The ROH mean (average) Gender Pay gap from has changed from 31.69 % in 2024 to **33.01%** in 2025. The increase in the gap for 2025 can be attributed to:

- The significantly higher proportion of male colleagues working in senior medical roles are at higher pay grades
- An increase in male new starters across all bands from **25.94%** to **31.51%** with a higher percentage at higher bands
- A decrease in female new starters to across all bands from **74.06%** to **68.49%** with a higher percentage at lower bands
- A higher than average number of female leavers at Band 8 - 12 in total with 3 retirements and 5 promotions
- **In 2025 for every £1 earned by men, the mean woman earned 67p** (compared to 68.31p in 2024)
- There has been a positive decrease in the median Gender Pay gap from **18.61%** (2024) to **16.71%** in 2025



MEDIAN - The median hourly rate is calculated by ranking all employees from the highest to the lowest paid & taking the hourly wage of the person in the middle; so the median gender pay gap is the difference between women's median hourly wage (the middle paid woman) and men's median hourly wage (the middle paid man).

10. Staff Demographics

The NHS workforce is more diverse today than at any point in its history. This matters not just because it is the equitable thing to do, it also brings clear measurable benefits for patients and taxpayers alike in the service we offer.

The NHS is built on the values of everyone counts, dignity and respect, compassion, improving lives, working together for patients, and commitment to quality. To achieve these goals, we need to increase capacity by growing our workforce and finding new ways of working to enhance productivity, by inspiring new staff to join and encouraging existing staff to stay.

Ensuring our staff work in an environment where they feel they belong, can safely raise concerns, ask questions and admit mistakes is essential for staff morale and engagement, which, in turn, directly impacts on improved patient experiences and outcomes.

Put simply...

“happier staff equate to better patient outcomes”.

You cannot achieve those patient outcomes unless you have an inclusive environment where you treat people equitably and without discrimination; delivering that kind of working environment in an organisation of any size takes deliberate focus, listening and action.

The NHS People Plan, underpinned by the 7 NHS People Promises supports 1.3 million people who work in NHS England, outlining actions to enhance their sense of ‘belonging’ in the NHS by improving their experience of engagement, equality, diversity and inclusion. By doing so we can improve the patients’ experiences and outcomes.

To support this ambition, we need to understand what our staff make-up looks like and to what extent that is representative of the surrounding population. As an inclusive employer we would want to see some broad correlation between the two, and indeed to our patient profiles as well.



Being representative of the community we serve

When looking at our staff demographics our goal would be to see our workforce being broadly representative of our community and the patients we serve.

The starting point for understanding whether our staff population, and ultimately our patient profiles, are representative of the locality we serve is to review the census data, although appreciating that this is now 5 years out of date.

We also have to consider historical and societal factors beyond our control which may influence the makeup of certain professions: for example, traditionally the training routes for becoming a Doctor have tended to favour males who haven't typically taken time out to raise a family; also, as an elective hospital, we will have patients from outside of our immediate locality.

However, we still look to see if we are broadly meeting our ambitions to be a fair, equitable and inclusive employer and service provider.

There is a huge amount of census data available, and you may wish to look into this in more depth, if so, please visit this website:

[Census Maps - Census 2021 data interactive, ONS](#)

Census maps is an interactive tool to explore Census 2021 data across England and Wales for different topics down to a neighbourhood level.



ROH Staff demographics

We will now look at the staff demographics for the ROH.

We want to be an equal opportunities employer within our local community and while we are not looking for an exact match to the local population, tracking our staff profiles allows us to identify outliers, or areas where recruitment needs to try and reach underrepresented groups; whilst allowing for historical and societal influences:

For example, historically nursing staff have always been predominately female. That does not mean males cannot be excellent nurses, nor does it mean that we should not seek to encourage the recruitment of men into nursing, but it does mean that changes may take a long time to show given the historical prevalence of female nursing staff.

The converse has historically been the case with medics, where men have tended to be far more numerous than women, medics will also hold more senior roles and as such be paid more, these long-term factors will impact on the gender split within certain professions, pay bands and seniority.



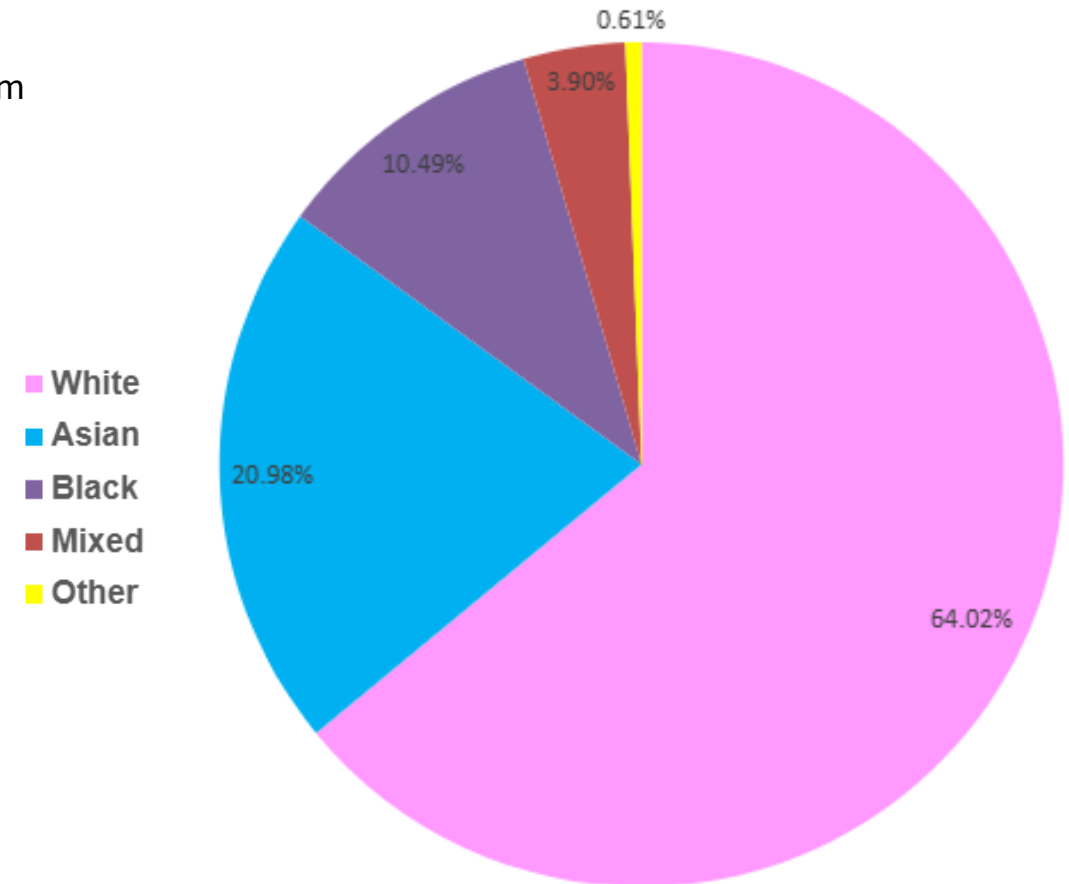
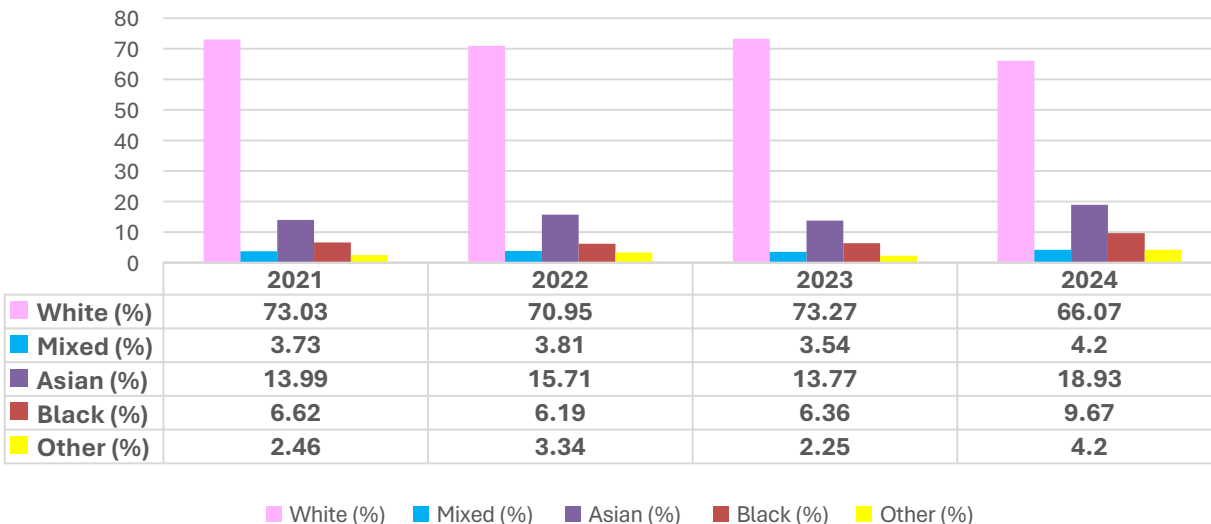
For more details related to the Gender Pay Gap please see earlier in this E&D Report or visit our website [Royal Orthopaedic Hospital - Home](#)

*Later in this report you will also be able to review demographic breakdowns for our inpatients and outpatients.

Staff ethnicity 2025

ETHNICITY Broadly, we would hope to see ethnicity breakdown of our staff being similar to that of the local population, which would indicate we have equitable recruitment processes: in the 2021 Census, around half the population of Birmingham was White, and in Northfield, where the ROH is situated, that rose to 83.2%. We increasingly reflect the wider Birmingham population, with a decrease in white staff members down to 64.02% and an increase in ethnic minority staff

[Ethnic group - Census Maps, ONS](#)



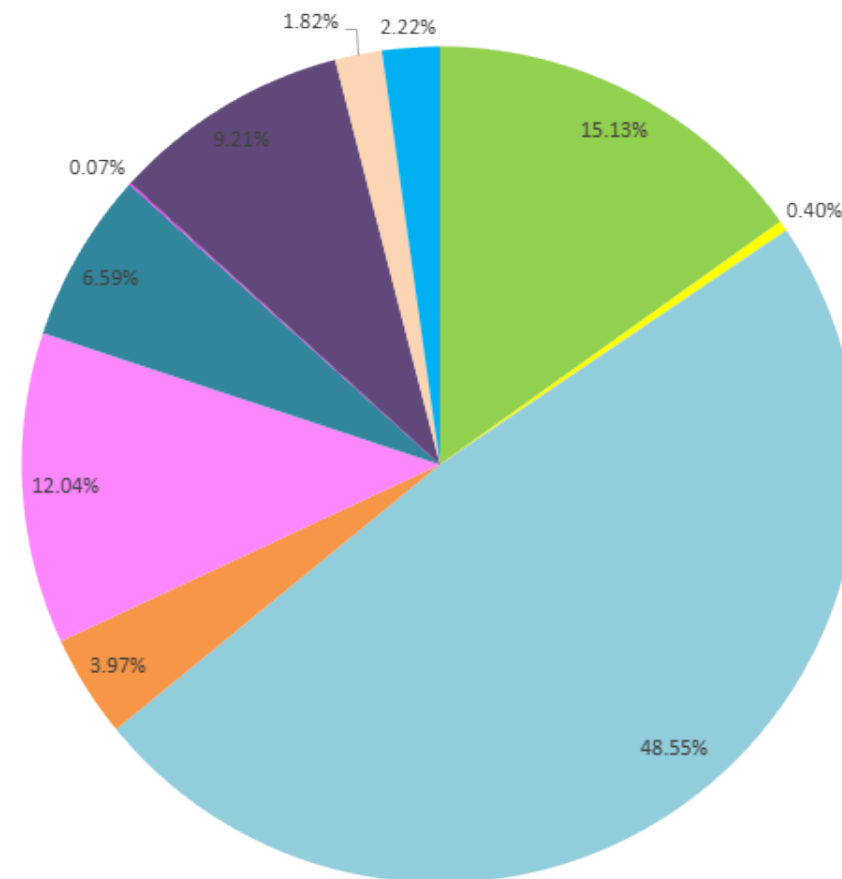
Staff religious beliefs, or none, 2025

BELIEF As an inclusive employer we want to see that our colleagues are broadly reflective of society in their range of religious beliefs, or in having no faith, we also want all staff to feel comfortable declaring any religious affiliations, in “being themselves” and having that sense of “belonging “ in the workplace without fear or favour.

Compared to the 2021 census data for Birmingham, we have a higher proportion of staff identifying as Christian, at 48.55%, vs the Birmingham figure of 34%



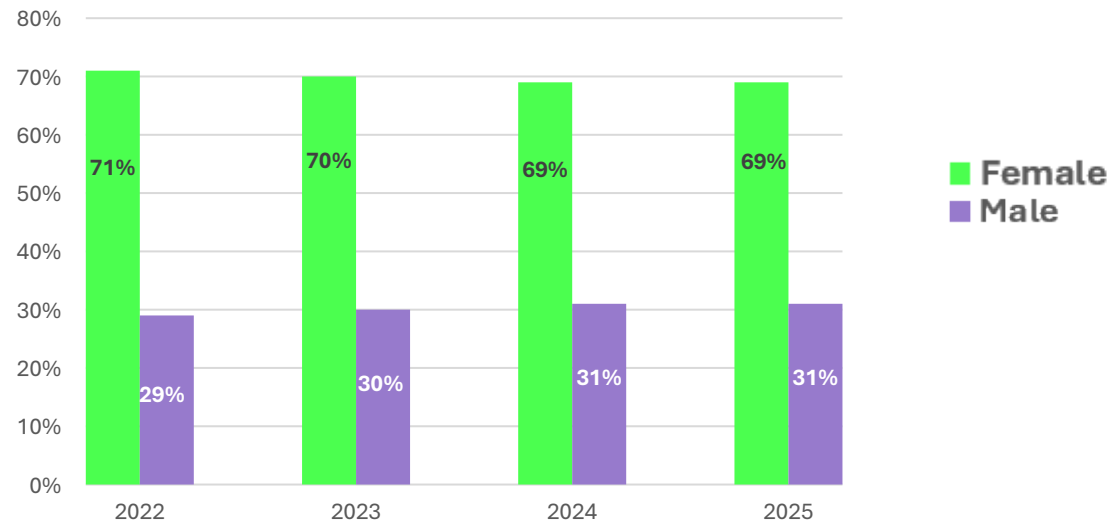
- Atheism
- Buddhism
- Christianity
- Hinduism
- Not Disclosed
- Islam
- Jainism
- Other
- Sikhism
- Unspecified



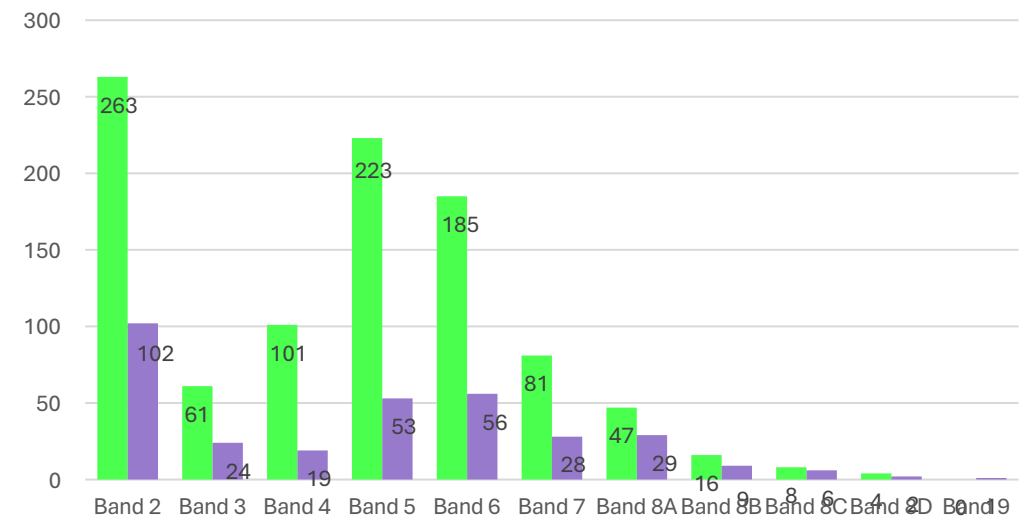
Staff gender 2025

GENDER Historically the NHS has always had a higher proportion of female staff but that may indicate societal, or organisational, presumptions about what are suitable roles for men which result in, say, fewer male nurses, when actually we may need to attract more men to nursing.

Although the ROH does have around a 70% Female to 30% Male split which is a higher proportion of males than typically seen in the NHS, where they generally make up around 25% of the workforce

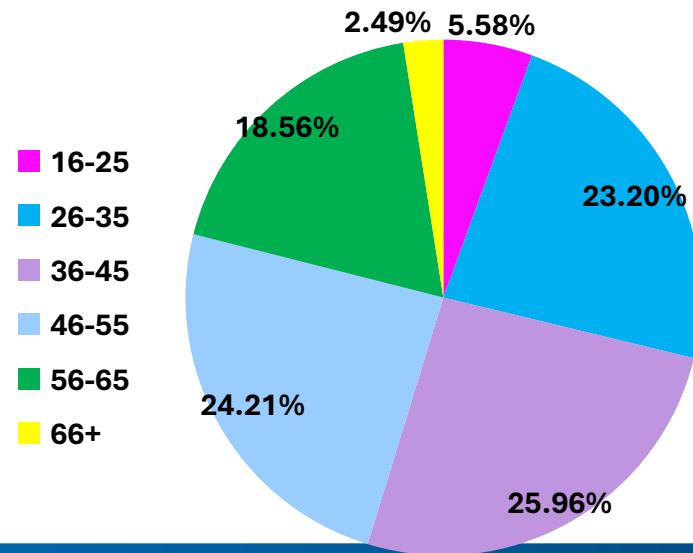


As seen previously, we also track the “Gender Pay Gap”. When trying to ascertain the causes for this we would look at things like the gender split at different pay bandings for possible causes, and solutions, to any gap – are women more likely to be in lower paid jobs than men because they leave the workforce to raise a family, miss out on development and promotion opportunities or need to work flexibly due to childcare? Ideally the overall gender split should broadly be the same at each band.

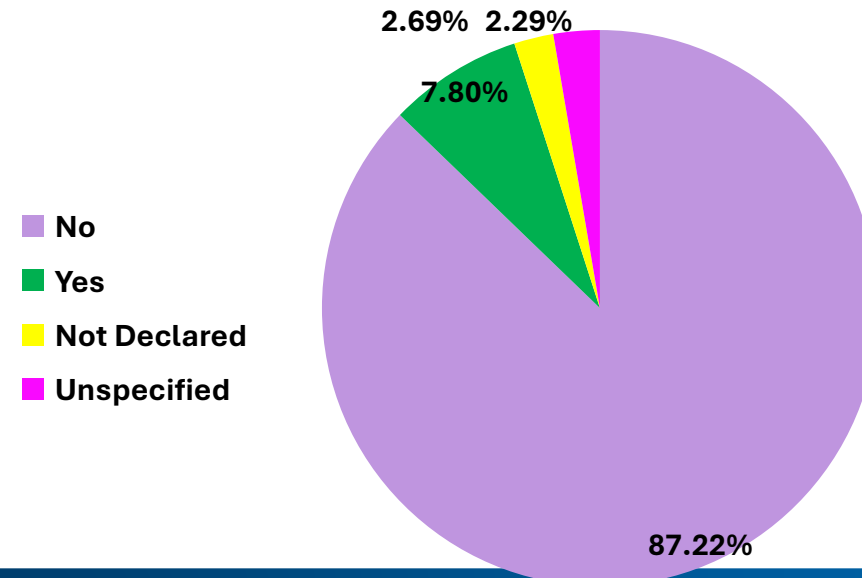


Staff age and disability 2025

AGE It is important to track age for workforce planning - an aging workforce, which wasn't being replenished by younger staff entering the NHS, would risk future services and capacity as staff retired. It is important to know that we offer an inclusive working environment that is attractive to the next generation of staff; we also need to know other age groups still view the NHS as a place that meets their needs too. 2024 to 2025 has seen little change outside of slightly fewer younger staff and slightly more in their 50s/60s

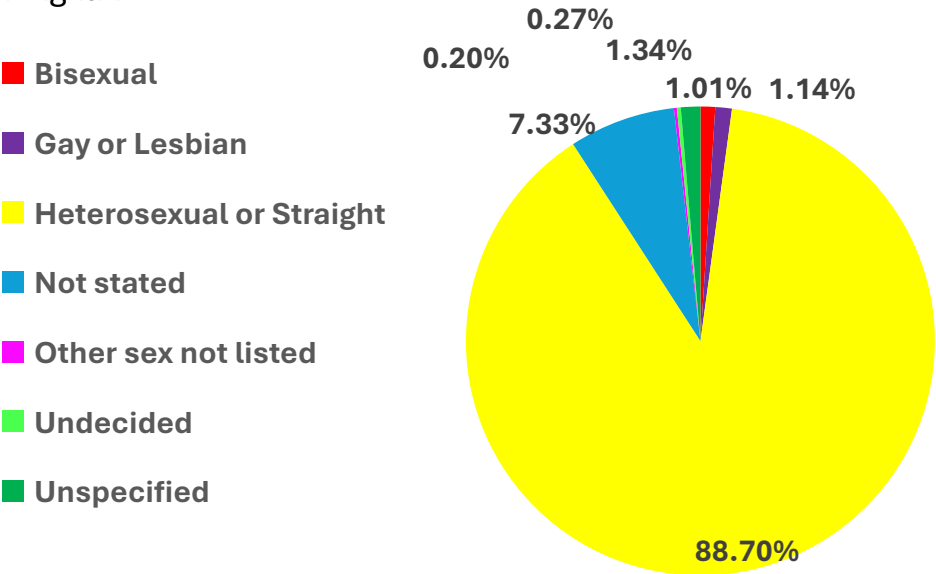


DISABILITY Disabled staff add value to our services, in their work and in bringing new perspectives from their lived experiences that our patients may share. We want to ensure that staff feel safe disclosing any disabilities, knowing that they will be supported in the workplace. There has been a drop in those declaring a disability from 2024, from 8.9% to 7.8% and a slight increase on those not declaring either way, these numbers are tracked throughout the year to see if they show statistical fluctuations or a clear trend.

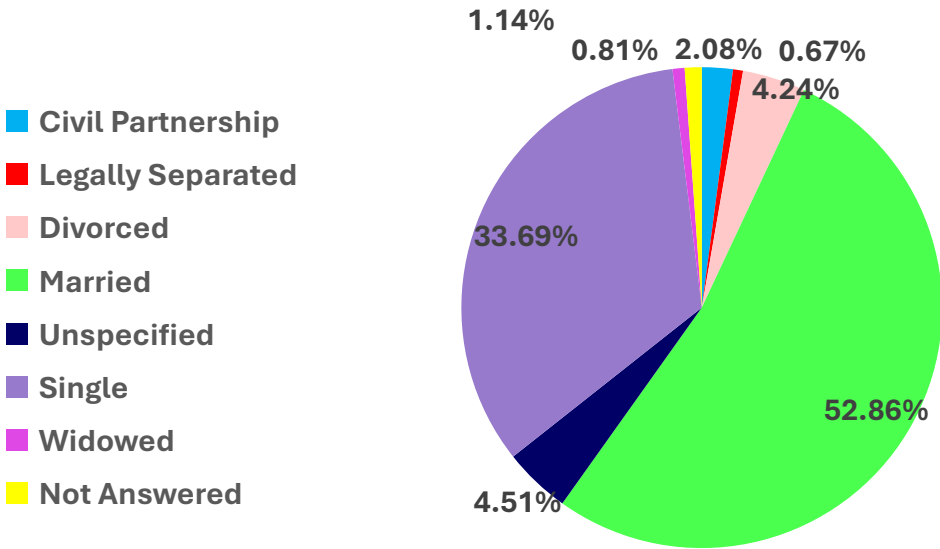


Staff sexual orientation and arital status 2025

SEXUAL ORIENTATION – Broadly speaking, the sexual orientation of our staff should reflect wider society, it helps to employ people who are reflective of our patients and their lived experiences and otherwise it may indicate some barriers felt by some staff in working for the NHS or in disclosing their sexuality. 2024 to 2025 did not see any significant changes form the previous year, although disclosure rates are slightly up which is positive, overall results are similar to the 2021 census averages for Birmingham



MARITAL STATUS – as one of the protected characteristics we also record the marital status of our colleagues. As shown here, we would expect to see a wide variety of different statuses, which gives us confidence that people feel able to be open about this and are not suffering detriment. There were no significant changes between 2024 and 2025.



11. Staff Recruitment

As an inclusive employer it is important to have robust recruitment processes and to be reassured that they are free from bias.

We recruit on merit but within that we would want to see what types of people are applying for roles, for example do applicants apply in ways that suggest, they do not feel they should put themselves forward because of the advert's wording?

We shortlist "blind", this is to help ensure there is less opportunity for bias and the decision to interview is meritocratic and based on the quality of the application.

At the interview stage there could be a potential for bias, so we work hard to make sure our interview panels are inclusive and representative of the diversity of our workforce.

To endeavour to address this the recruitment and selection policy has recently been developed to including more around inclusive recruitment practices, alongside of which Recruitment and Selection Training is delivered to managers, so we can help prevent bias and improve knowledge at interview stage.

Within the online recruitment system, we have the option to track the proportion of staff, against given characteristics, at various stages of the recruitment process from application, to shortlisting, interview and appointment into role. Our Disability Confident Level 3 – Leader accreditation illustrates the progress we have made in this area for disabled staff for example.

Once in post, staff are supported in their induction by the 100 Days programme to ensure they all feel involved and informed from their interview to their first day, through their 12-week review and ultimately throughout their career with the Trust.



12. Staff Training

We recognise the importance and added value training brings, both in developing people's awareness around inclusion but also, as a measure of how equitable and attuned to the needs of our workforce's needs the ROH's development offer is

Oliver McGowan

2025 saw the continued rollout of Part 2 of the Mandatory Training programme, raising awareness of supporting Patients with Learning Disabilities and Autism, delivered by Facilitators with lived experience of LD/Autism. Some of our staff members with LD/Autism have been involved in supporting the delivery of this programme.

Functional skills

We continue to support staff with improving their Maths and English through access to the BKSb tool, to build confidence working through online learning to prepare them for examinations.

We also have numeracy champions in the Trust who can support individuals to build confidence with finances, budgets, etc.

Widening participation

Apprenticeships in both clinical and non-clinical settings to support work force planning and creating progression pathways. Monitoring apprenticeship numbers and diversity of staff completing apprenticeships is undertaken through the NHS England Talent for Care quality data returns on age, gender, trans, ethnicity and sexuality (not disability/pregnancy or marriage).



Staff Training

Dementia Tier 2 training

This has been delivered in the Trust to raise awareness of Dementia and how we can enhance our support with patients.

Equality, Diversity & Inclusion Training

This is mandatory for all staff with regular refreshers; monthly training sessions are run by the OD and Inclusion Team to ensure everyone is compliant.

Personal Development Courses

These are provided offering topics such as Strengthening Emotional Resilience, Handling Complaints Confidently and Managing Difficult Demanding People and Situations.

Me As Manager

This offers aspiring and current managers a wide range of development opportunities, many focussed on people management and thus incorporating aspects of inclusive management and creating psychologically safe workspaces

Wellbeing Conversations and Mental Health Training

These complementary offers promote wellbeing support for staff and develop awareness and techniques for managing ones own, and others, mental health

Learning Beyond Possibilities

We promote participation in this BSol development programme, aimed at support middle managers into senior management and leadership roles; whilst open to all there is a particular emphasis on encouraging applications from staff with a neurodiverse and ethnic minority backgrounds.

Analytics

The ROH also tracked access to non-mandatory training by ethnicity to assess if this was equitable, it actually showed more BME staff attending non-mandatory than White staff

13. Patient Profiles

In this section, patient data is presented for Ethnicity, Gender, Age, Marital Status, Religion/Belief and Language*

Is it useful data to review for several reasons. Our overall patient profiles would ideally be representative of our regional demographics; we would also be looking for significant variations between inpatient and outpatient data and what these may tell us

We know health inequalities do exist, with some sections of society finding themselves less willing, or able, to access healthcare. Understanding if, and to what extent and where, access is being affected by local, regional, economic, societal, gender or cultural factors is therefore helpful when seeking to offer an equitable, truly national health service.



HEALTH INEQUALITIES are unfair & avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them.

The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. For example, someone who is unemployed may be more likely to live in poorer quality housing with less access to green space and less access to fresh, healthy food.

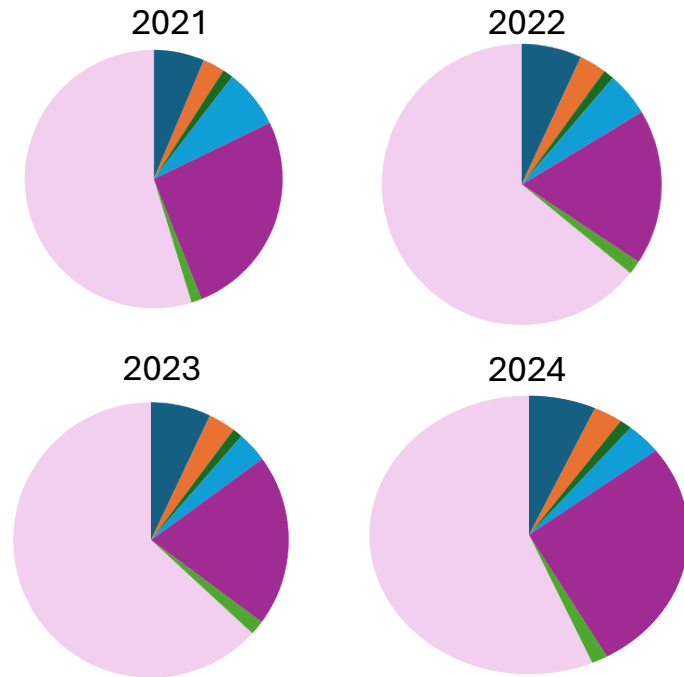
This means some groups and communities are more likely to experience poorer health than the general population. These groups are also more likely to experience challenges in accessing care



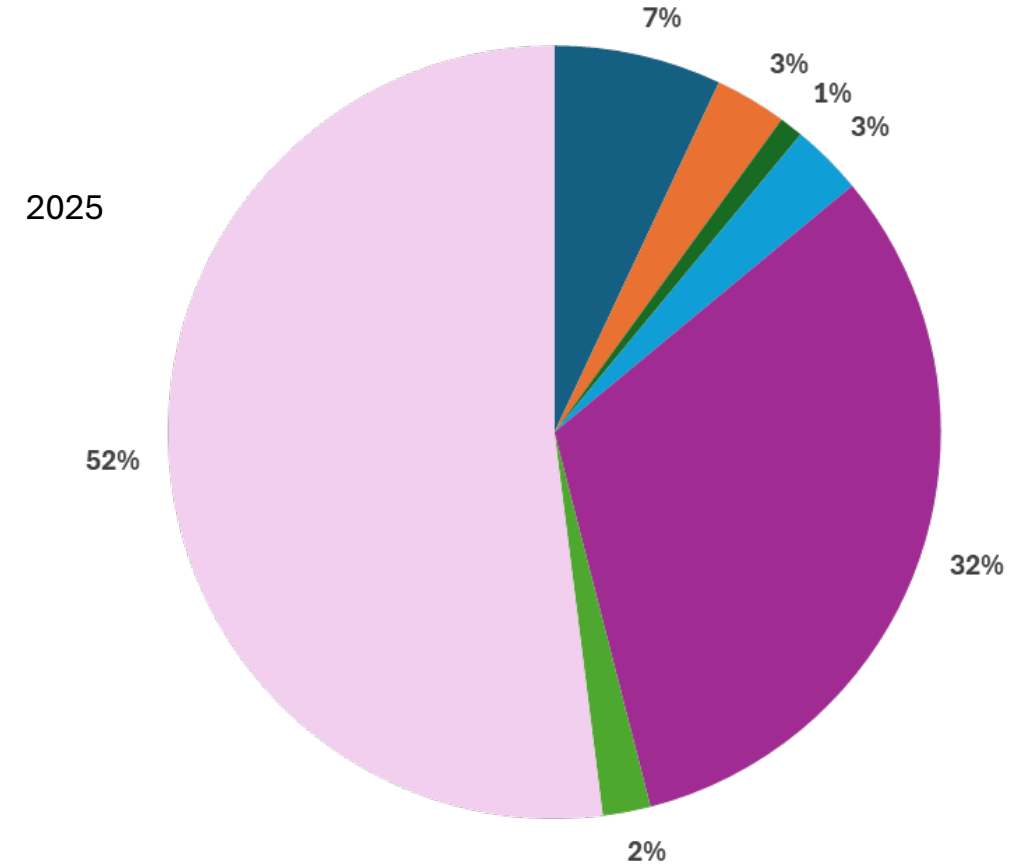
Ethnicity – Inpatient 2025

Inpatient total 12,634

The proportion of white inpatients for 2025 was close to the Birmingham population census averages.



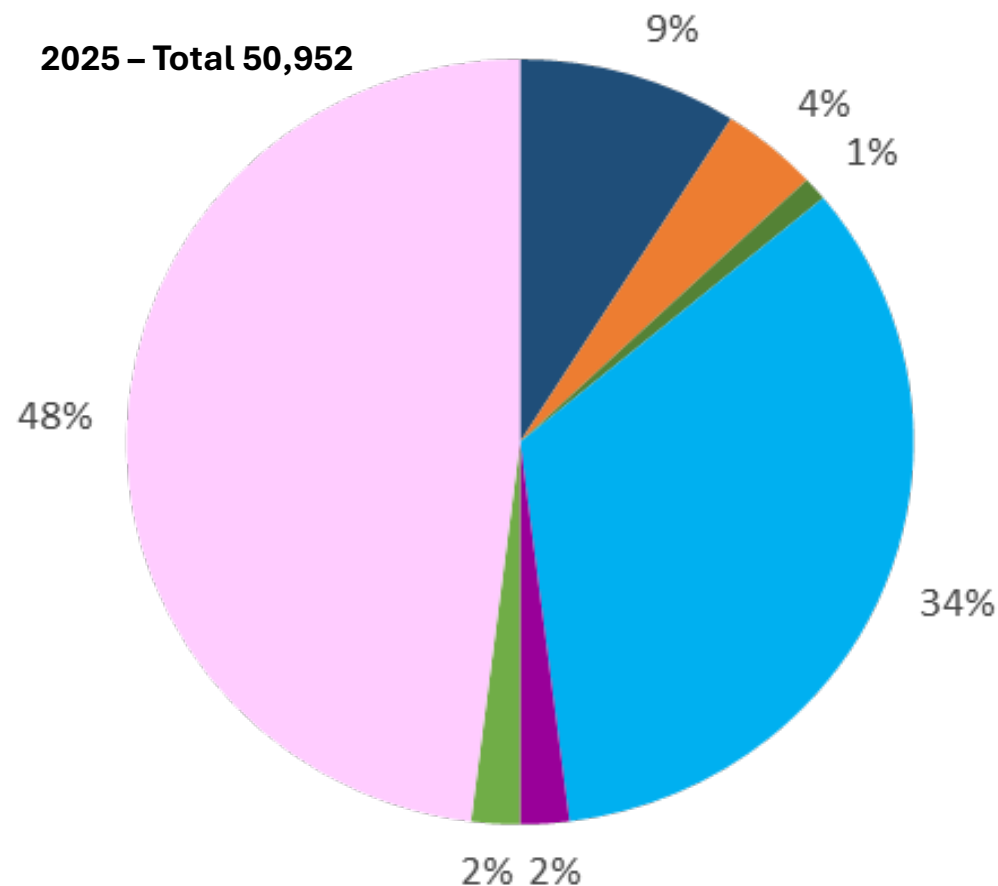
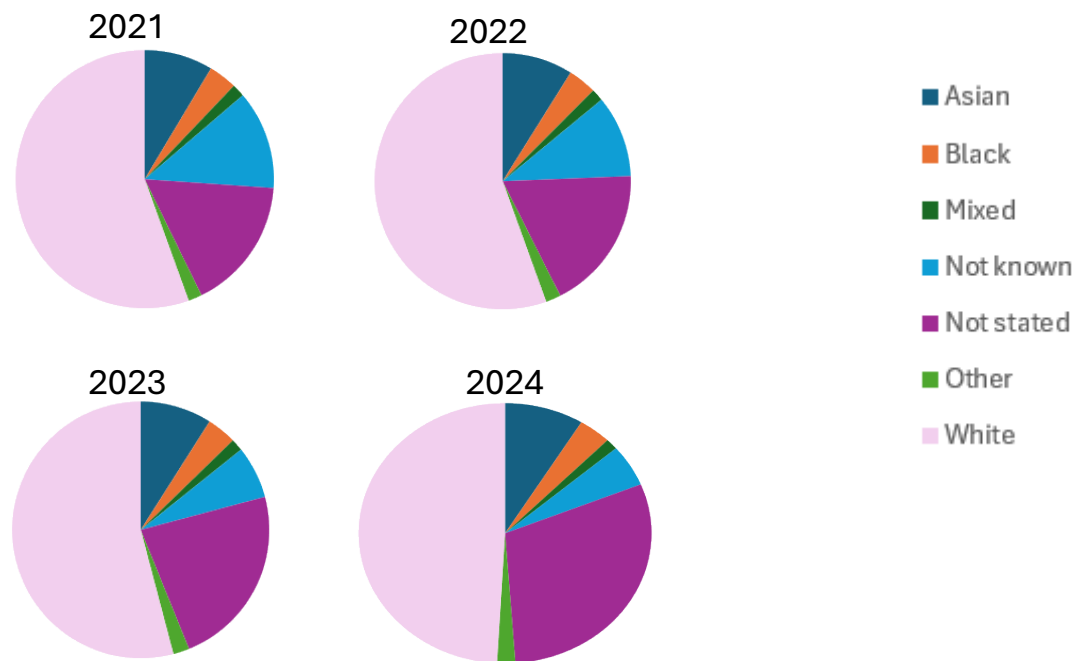
- Asian
- Black
- Mixed
- Not known
- Not stated
- Other
- White



Ethnicity - Outpatient 2025

Outpatient total 50,952

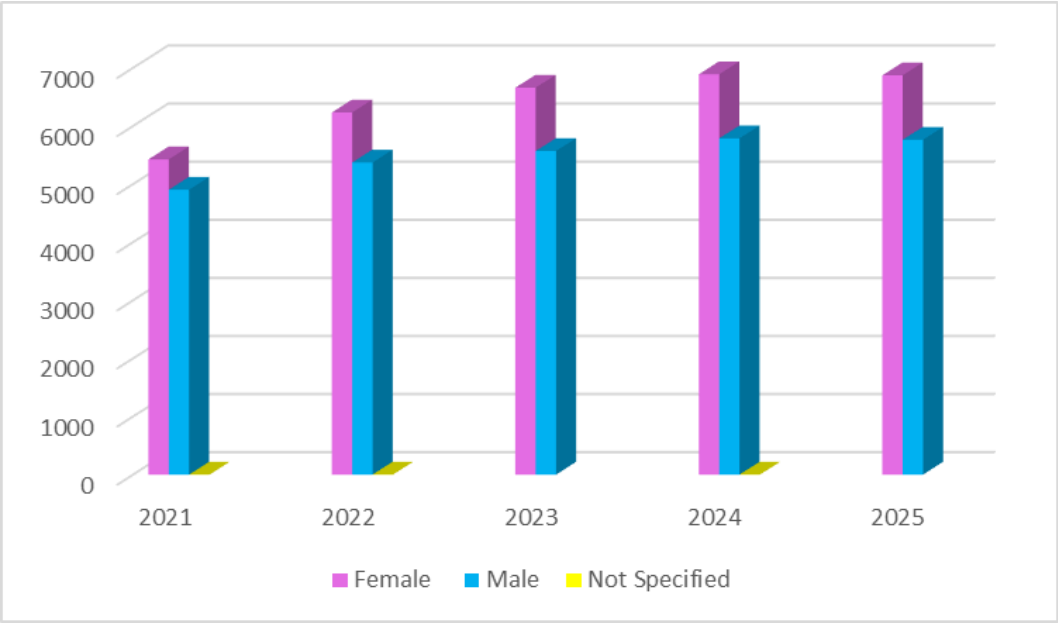
The proportion of non-white outpatients has continued to increase over the last 4 years, meaning we are more closely reflecting the local population, as per the 2021 census, which was 48.6% white



Gender – Inpatients and Outpatients 2025

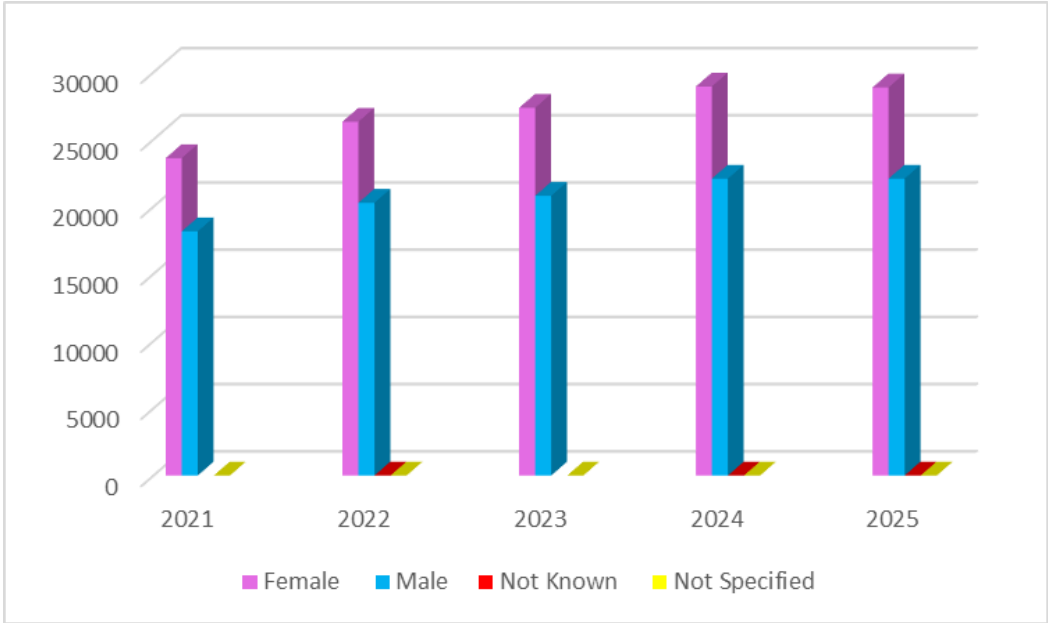
Inpatients

- 6872 Female
- 5762 Male



Outpatients

- 28,867Female
- 22,081 Male
- 1 Not known

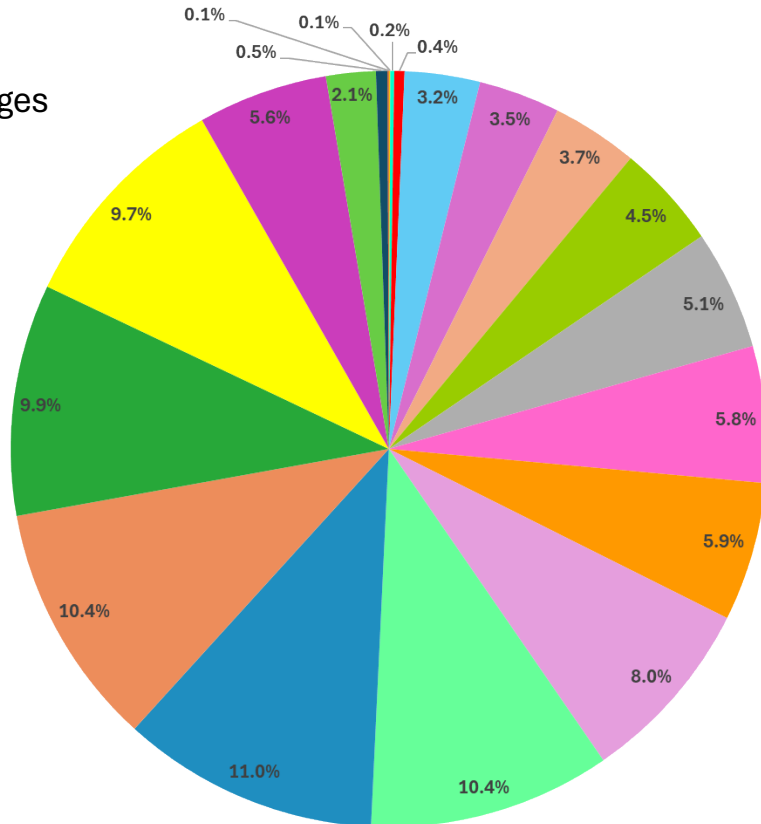


Age – Inpatients & Outpatients 2025

There was a very similar age spread across both inpatients and outpatients

Inpatients Age Ranges

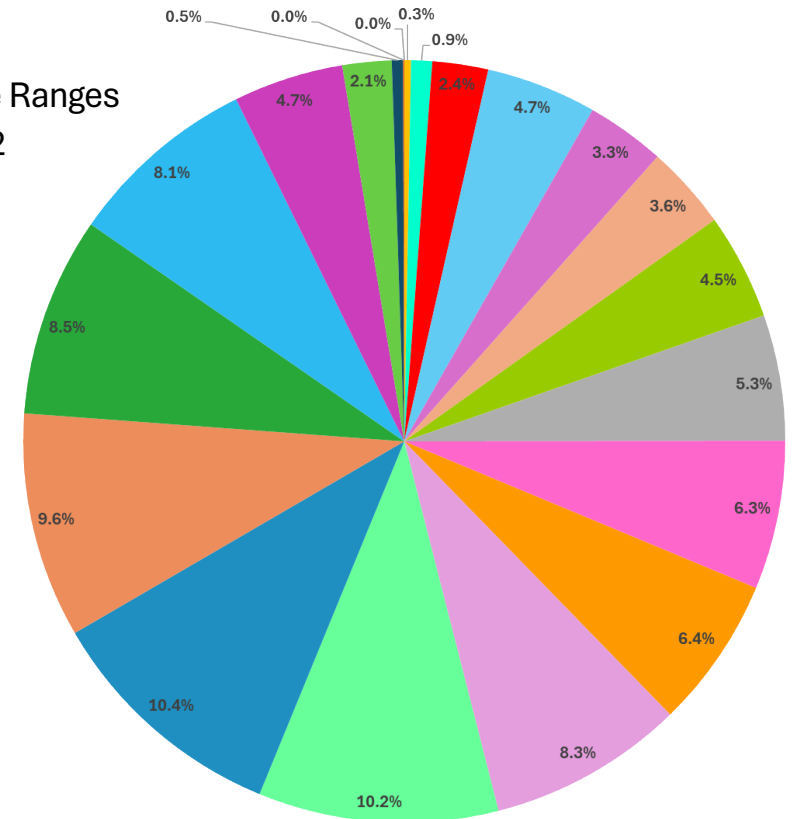
○ Total 12,634



Outpatients Age Ranges

○ Total 50,952

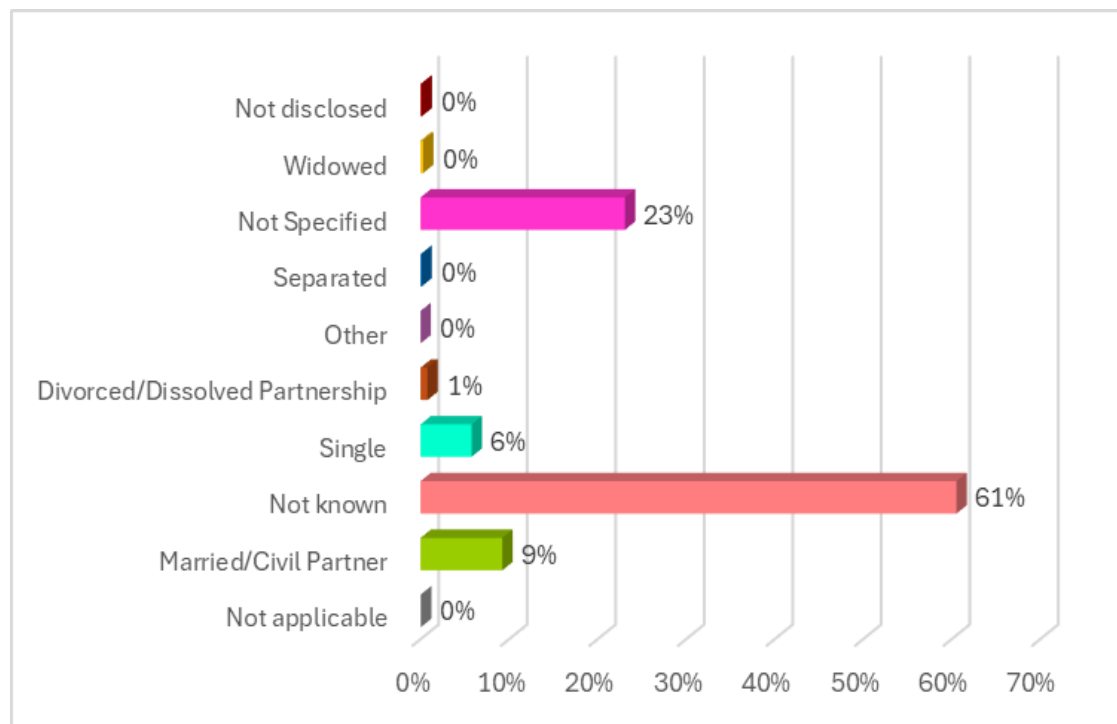
00-05
06-10
11-15
16-20
21-25
26-30
31-35
36-40
41-45
46-50
51-55
56-60
61-65
66-70
71-75
76-80
81-85
86-90
91-95



Marital Status – Inpatients & Outpatients 2025

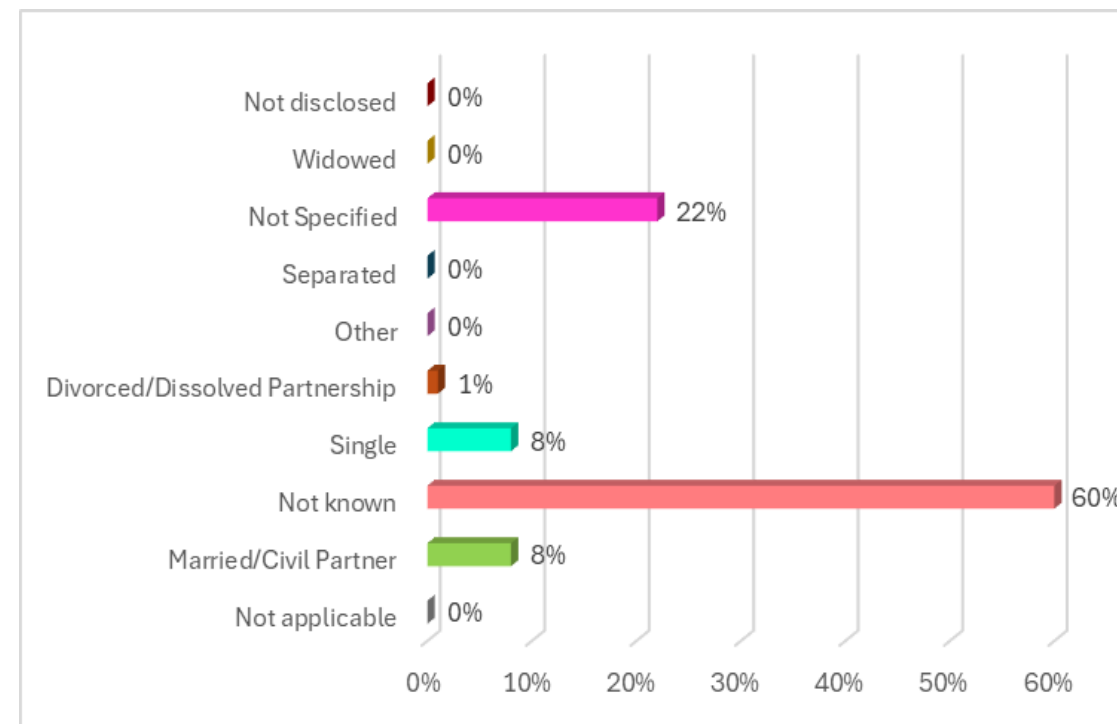
Inpatient Marital Status

○ Total 12,634



Outpatient Marital Status

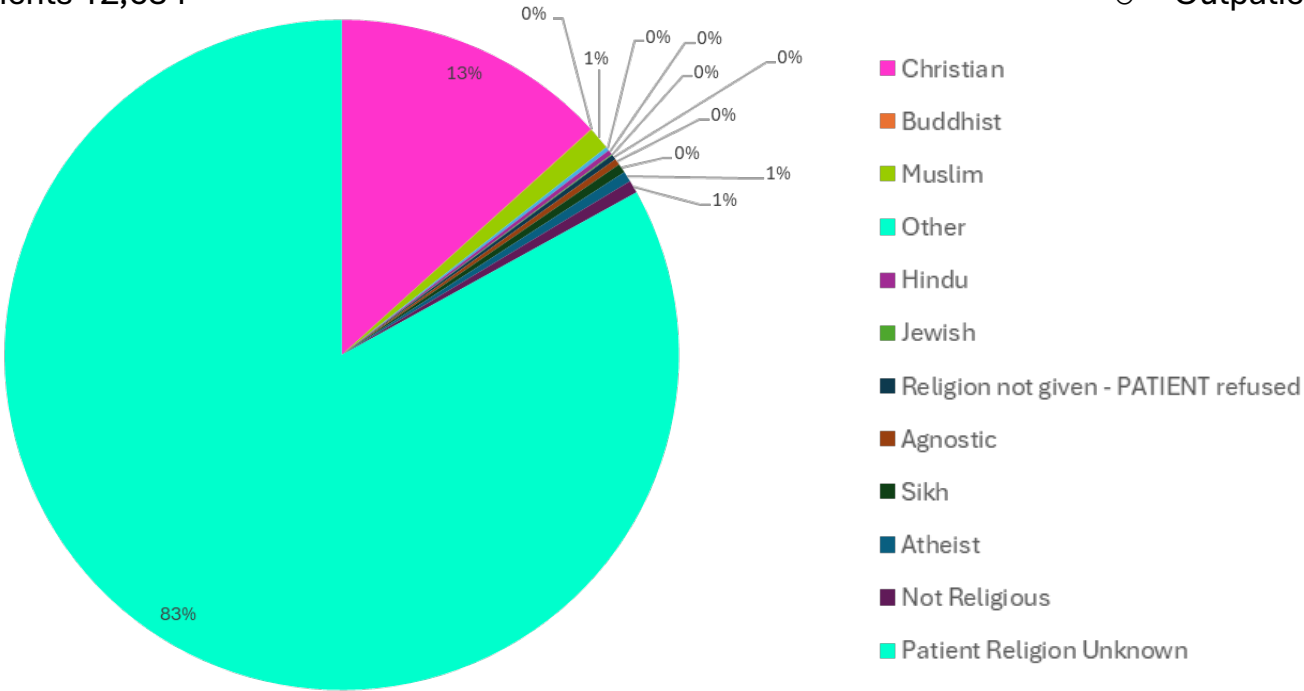
○ Total 50,952



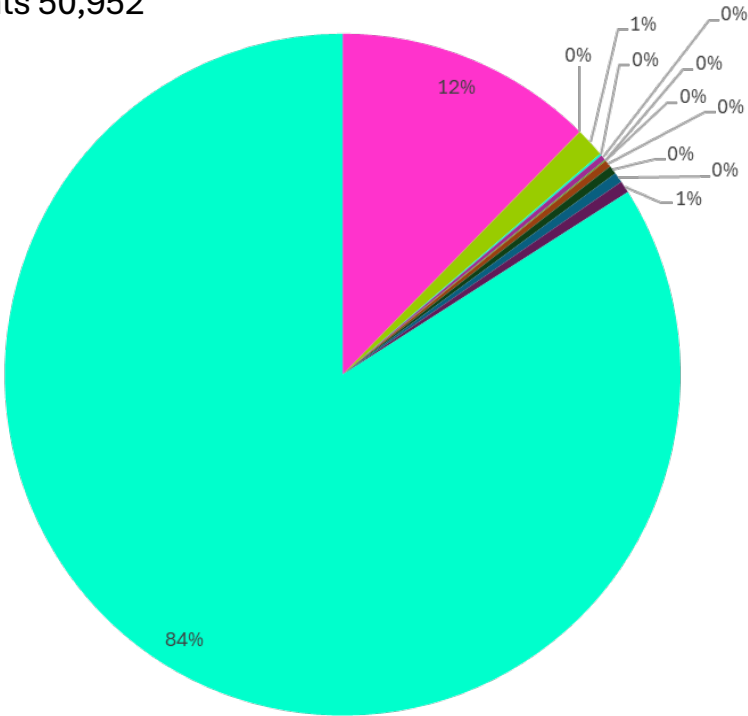
Religion – Inpatients & Outpatients 2025

There were over 60 different declarations in relation to religion recorded, as well as “unknown”, with a similar breakdown across both areas.

○ Inpatients 12,634



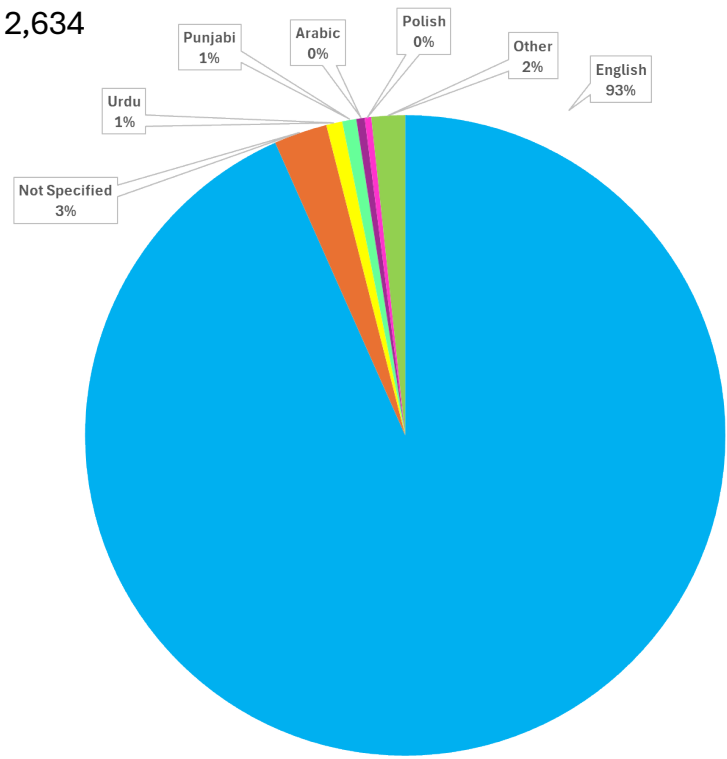
○ Outpatients 50,952



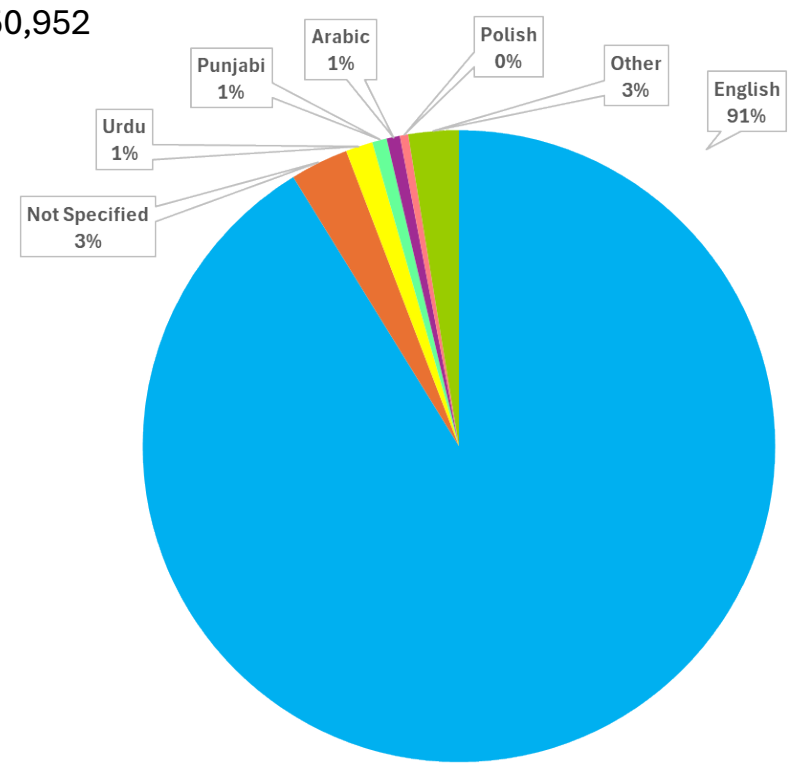
Spoken languages – Inpatients & Outpatients 2025

Whilst over 9/10 patients spoke English, there was remarkably wide range of other languages encountered, 52 recorded within inpatients and 77 within outpatients

Inpatients 12,634



Outpatients 50,952



- English
- Not Specified
- Urdu
- Punjabi
- Arabic
- Polish
- Other

14. Patient Experience

As a Trust we exist for our patients, as such their experiences of our services is paramount and one of the most important measures of how we are performing. We work hard to make sure everyone has a positive patient experience but inevitably there are times when we could do better and feedback from patients provides us with valuable learning and thus improvement opportunities.

From an equality and diversity perspective we want to be reassured that we can understand who is being impacted, for example, do some of our patients have noticeably better, or worse, experiences than others? If they do, why is that and are there patterns to those receiving worse treatment and what can we do to address / improve that?

Our patients' feedback provides us with tangible evidence on whether our aims and objectives, our policies, procedures and E&D aspirations are having practical, positive impacts on their experiences at the ROH.



PALS - Our PALS, (Patient Advice and Liaison Service) are responsible for handling both patient feedback and formal complaints.

PALS cases are concerns that require investigation, resolution and response to the patient, but they are managed more informally, rather than requiring a formal written response. PALS cases have a resolution timeline of 5-7 working days.

The PALS Team will:

- Offer advice & guidance supporting patients & their family or carers
- Help to resolve issues regarding hospital experiences
- Listen to feedback and suggestions
- Share Compliments
- Support patients with their concerns and complaints

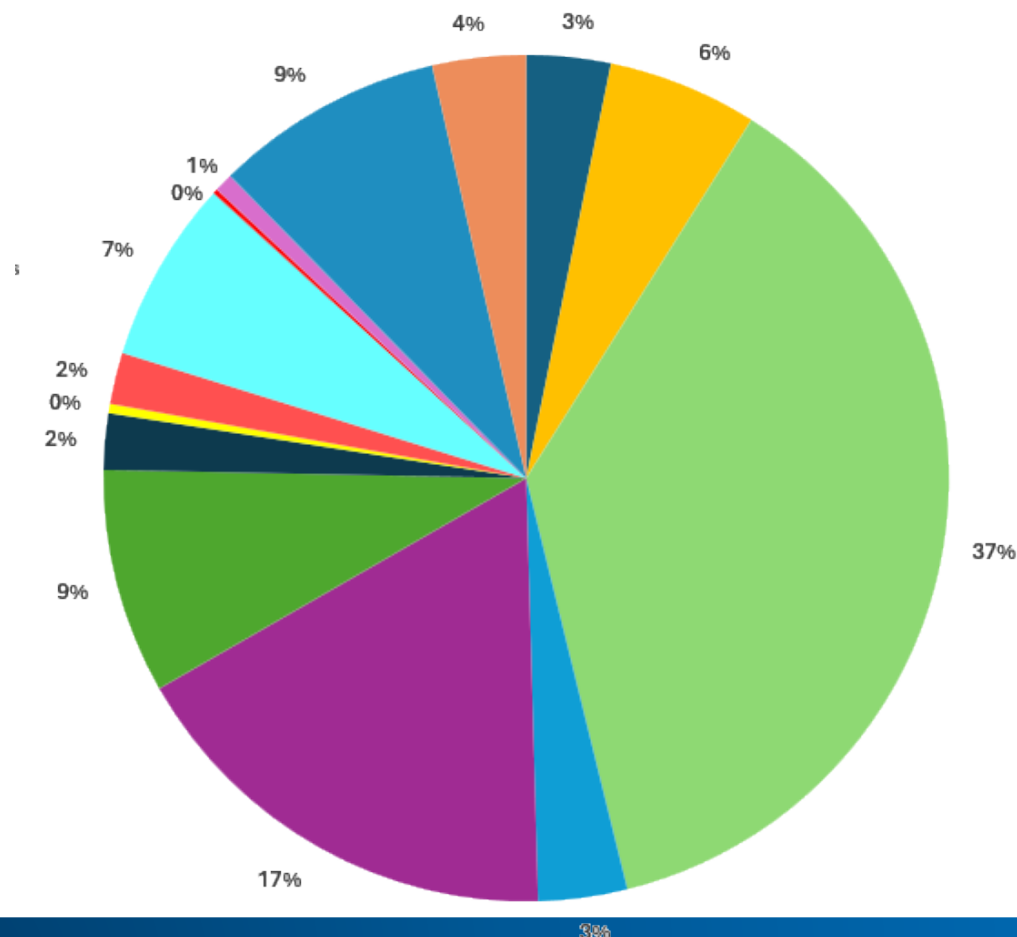
2025 PALS Cases or Informal Concerns by Category

The total number of PALS cases in 2025 was 559

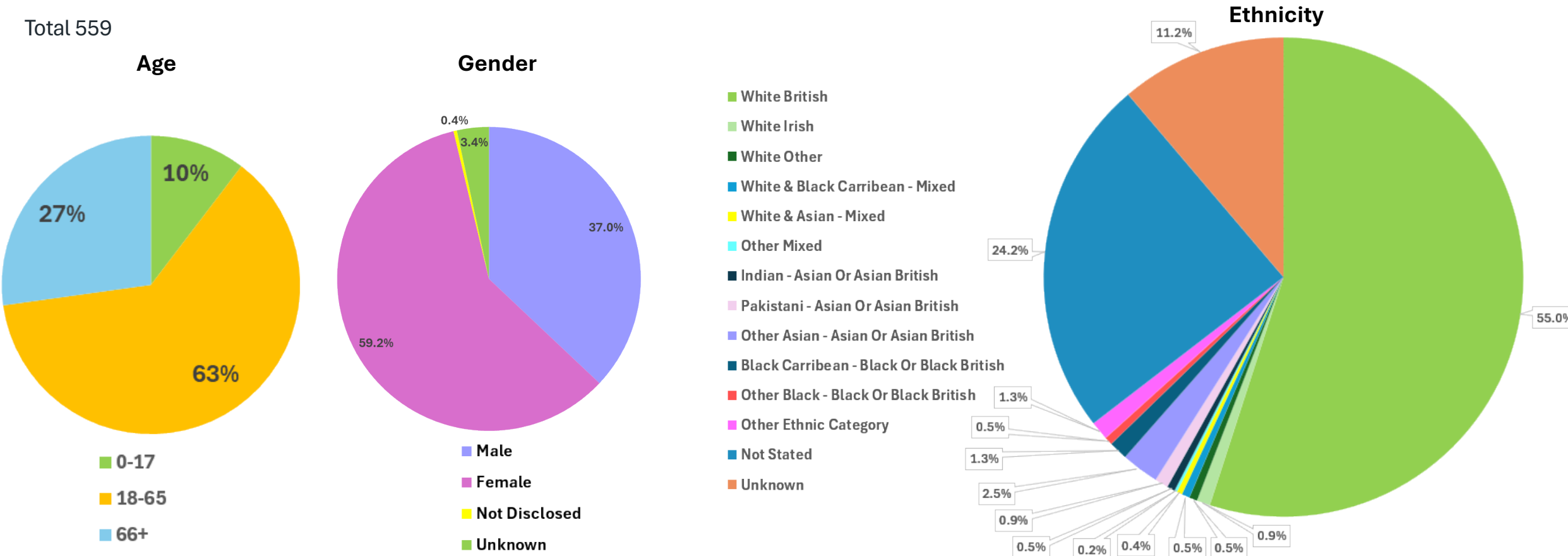
There were no concerns raised specifically related to, or citing, “protected characteristics” as the cause.

It is possible of course that other areas of concern *may* have included elements related to, or perceived as related to, equality, diversity and inclusion – for example “values and behaviours” which accounted for 9% of concerns.

- Access to Treatment or Drugs
- Admission
- Appointments
- Cancellation of Surgery
- Clinical Query
- Communication
- Discharge
- Nursing Care
- Other
- Referrals
- Transport
- Trust Administration
- Values and Behaviours
- No Category



2025 PALS Cases or Informal Concerns by Age, Gender and Ethnicity

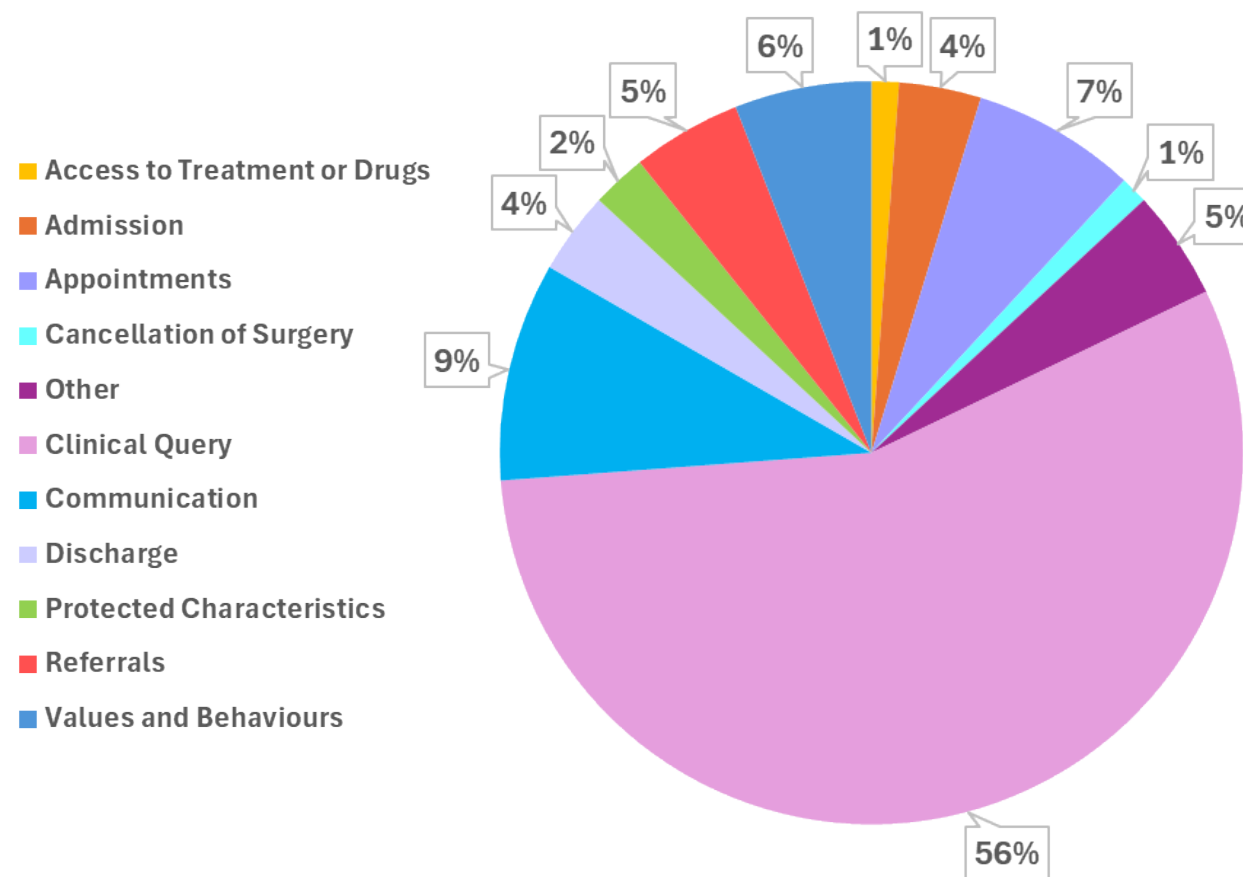


2025 Formal Complaints, by Complaint Category

In 2025 there were a total of 89 formal complaints, these consisting of 81 complaints from NHS patients, 5 from Private patients and 3 which were withdrawn without progressing.

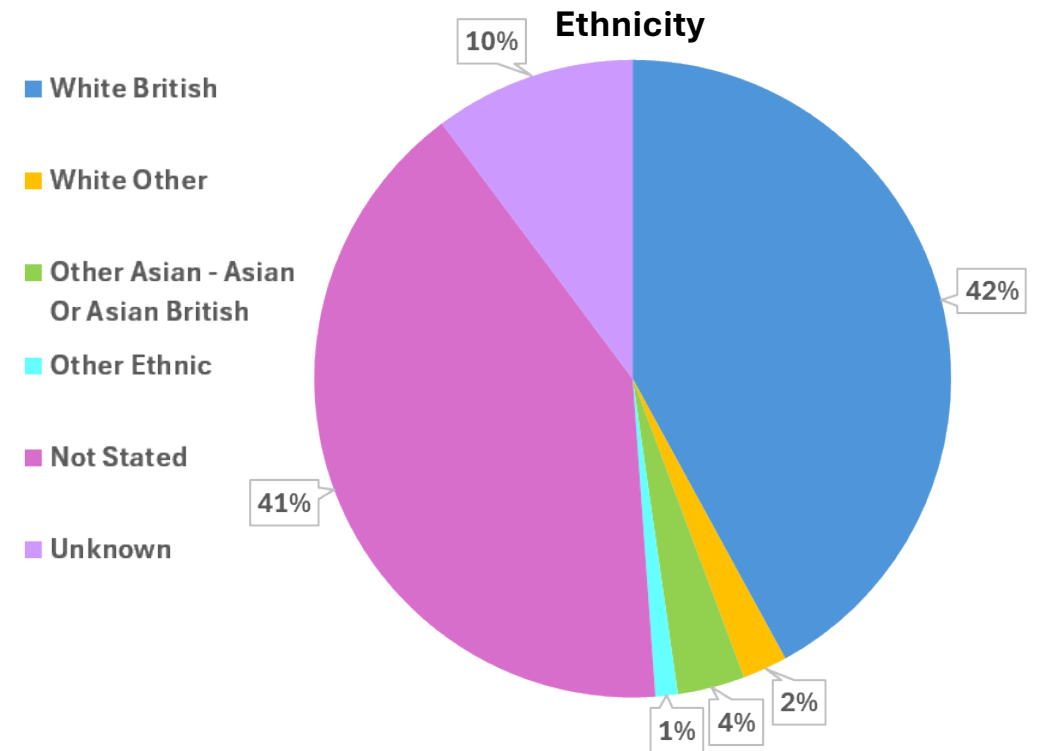
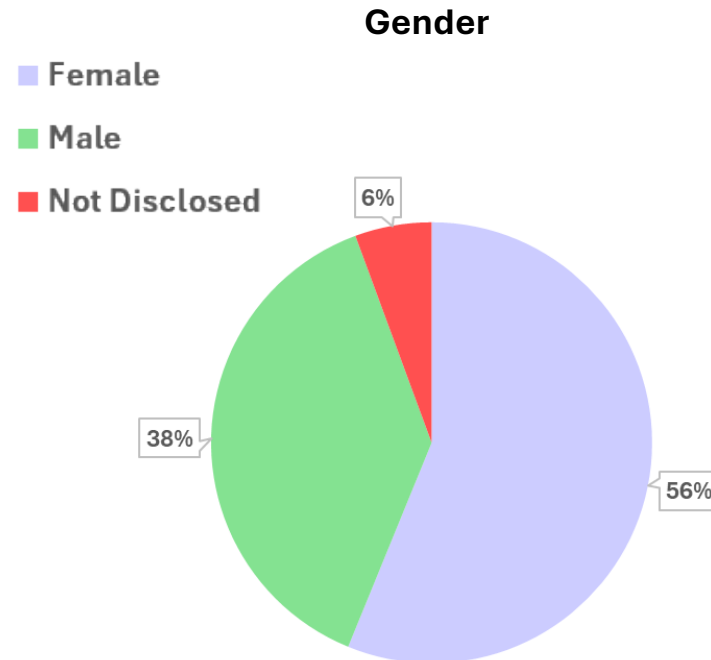
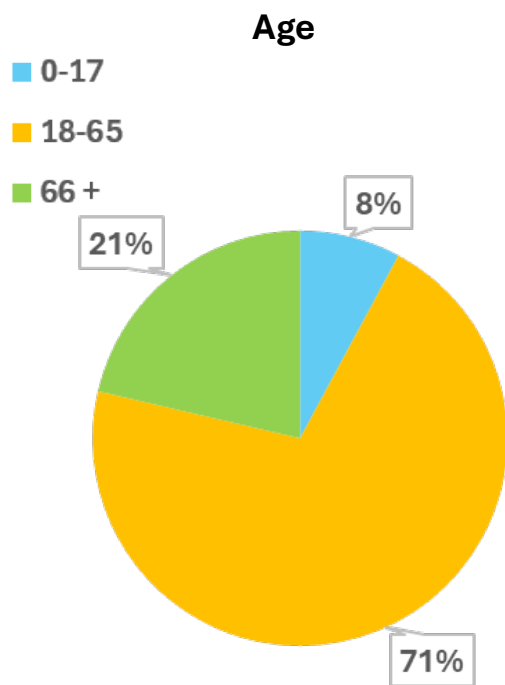
Formal complaints require both an investigation and a formal written response to the complainant to address their concern and provides us with useful insight into where there are opportunities for us to do better.

2% of the listed complaints are categorised as being related to Protected Characteristics, meaning there was some aspect relevant to equality, diversity and inclusion. Other complaint headings, such as values and behaviours or communication, may of course also have elements of EDI too.



2025 Formal Complaints, by Age, Gender and Ethnicity

Total 89 – The number of non-disclosed gender has doubled from 3% to 6% since 2024. There is an opportunity to reduce the numbers who did not disclose their ethnicity.



15. Conclusion

Thank you for reading the 2025 Equality and Diversity Report.

We are proud of the work and ongoing efforts we make in this field, and we hope you have found this report both informative and illustrative in demonstrating the value of the work we undertake as a Trust in this area.

We believe, through the depth and breadth of the ways in which we focus on the importance of equality, diversity and inclusion in the workplace, that we positively impact on the working experiences of our staff every day.

In doing this, we meet our primary goal of positively impacting on the patients' experiences throughout their time with us at The Royal Orthopaedic Hospital, as we continue to strive to improve our services.



Integrated Performance Report

Month 2

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

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

Variation Icons

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



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



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



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

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

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

Assurance Icons

Can we expect to reliably hit the target?



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



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



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



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



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

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

Integrated Performance Dashboard: Operational

Metric Grouping	Metric Name	Reporting Period	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Inpatients	IP Activity Monthly Performance %	Monthly	97.7%	97.0%	92.7%	94.3%	96.1%	90.7%	89.3%	97.9%	86.0%	92.5%	96.4%	93.6%	98.2%	96.1%		high is good			100%
Inpatients	IP Activity Electives Monthly Performance %	Monthly	97.5%	90.4%	96.3%	92.1%	95.2%	94.1%	93.5%	107.9%	85.2%	97.9%	94.0%	101.9%	96.1%	98.7%		high is good			100%
Inpatients	IP Activity Daycases Monthly Performance %	Monthly	97.3%	102.3%	90.0%	95.9%	97.9%	87.6%	86.7%	91.1%	84.5%	88.4%	97.6%	88.0%	99.7%	94.1%		high is good			100%
Inpatients	IP Activity Non-Electives Monthly Performance %	Monthly	113.43%	81.67%	99.11%	99.82%	56.18%	113.12%	73.84%	83.42%	156.87%	94.11%	112.35%	145.00%	160.00%	152.5%		-	-	-	-
Inpatients	IP Activity Monthly Discharges	Monthly	1,142	1,154	1,185	1,156	1,256	1,231	1,199	1,213	1,118	1,155	1,315	967	1,174	2,141		high is good	-	-	-
Inpatients	IP Activity Elective Discharges	Monthly	476	445	505	482	527	524	526	554	460	509	533	422	498	920		high is good	-	-	-
Inpatients	IP Activity Daycase Discharges	Monthly	641	691	658	652	716	681	657	640	624	626	756	545	676	1,221		high is good	-	-	-
Inpatients	IP Activity Non-Elective Discharges	Monthly	25	18	22	22	13	26	16	19	34	20	26	29	32	61		-	-	-	-
Outpatients	OP Activity Monthly Performance %	Monthly	104.0%	105.5%	98.4%	98.7%	108.7%	99.2%	103.7%	94.9%	99.3%	106.2%	103.9%	90.1%	81.6%	85.8%		high is good			100%
Outpatients	OP Activity First Monthly Performance %	Monthly	92.0%	95.9%	92.5%	94.5%	105.6%	91.8%	98.9%	86.1%	99.9%	109.0%	112.0%	77.3%	72.8%	75.1%		high is good			100%
Outpatients	OP Activity Follow Up Monthly Performance %	Monthly	109.0%	109.1%	101.0%	99.2%	108.0%	99.3%	101.3%	95.0%	94.7%	100.2%	95.7%	96.8%	86.2%	84.3%		high is good			100%
Outpatients	OP Activity Follow Up Procedures Monthly Performance %	Monthly	130.4%	131.3%	108.8%	125.9%	143.8%	157.4%	176.1%	166.4%	159.8%	167.6%	152.2%	128.9%	111.3%	119.9%		high is good			100%
Outpatients	OP Activity Monthly Attendances	Monthly	5,805	6,193	6,360	5,519	6,702	6,426	5,861	5,611	5,851	6,006	6,488	5,424	5,112	10,536		high is good	-	-	-
Outpatients	OP Activity First Monthly Attendances	Monthly	1,832	2,008	2,121	1,883	2,316	2,105	1,971	1,801	2,091	2,171	2,456	1,604	1,561	3,165		high is good	-	-	-
Outpatients	OP Activity Follow Up Monthly Attendances	Monthly	3,757	3,948	4,003	3,417	4,091	3,933	3,489	3,436	3,426	3,452	3,626	3,521	3,284	6,805		high is good	-	-	-
Outpatients	OP Activity Follow Up Procedures Monthly Attendances	Monthly	216	237	236	219	295	388	401	374	334	383	406	299	267	566		high is good	-	-	-

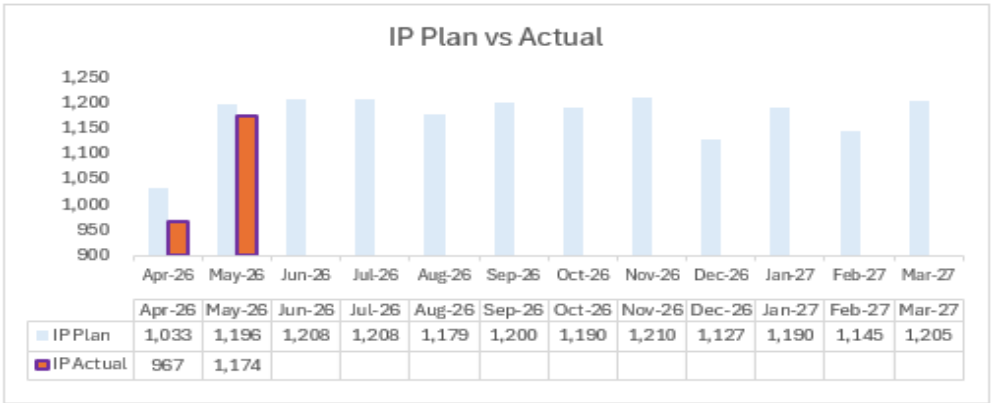
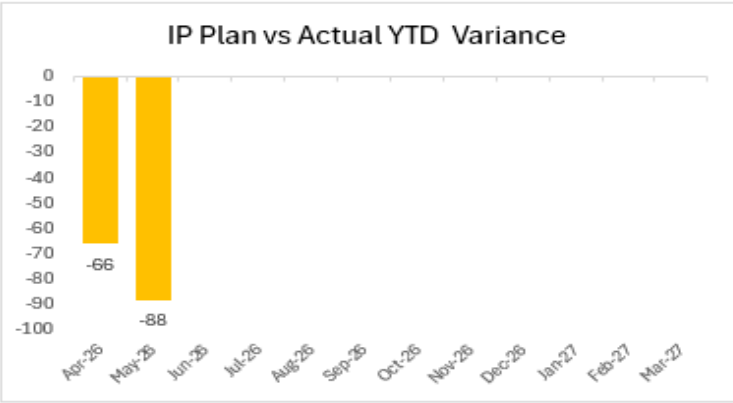
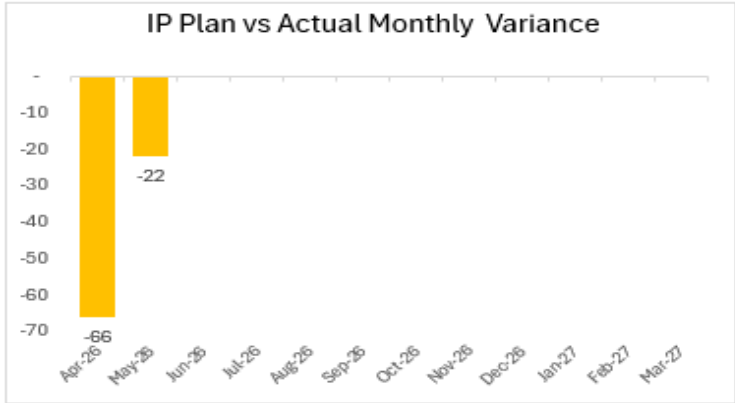
Integrated Performance Dashboard: Operational

Metric Grouping	Metric Name	Reporting Period	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Outpatients	Outpatient Did Not Attend	Monthly	7.06%	6.83%	6.14%	7.66%	6.36%	6.64%	7.72%	7.80%	8.82%	7.20%	7.06%	7.71%	6.75%	7.23%		low is good			8%
Outpatients	PIFU	Monthly	10.44%	9.78%	10.62%	11.00%	11.37%	10.89%	10.51%	10.72%	11.07%	11.29%	9.98%	12.47%	10.62%	11.55%		high is good			10%
Outpatients	Virtual Attendances	Monthly	9.91%	10.56%	10.41%	11.03%	10.43%	10.16%	10.29%	12.33%	12.90%	10.46%	10.03%	13.47%	11.99%	12.73%		high is good	-	-	-
Outpatients	OP Attendances Patients Who Waited 31 to 60 Mins to be Seen	Monthly	12.94%	15.72%	14.04%	7.79%	9.87%	10.99%	9.67%	8.13%	11.84%	10.54%	8.52%	8.67%	8.43%	8.55%		low is good	-	-	-
Outpatients	OP Attendances Patients Waited Over 60 Mins to be Seen	Monthly	4.25%	5.23%	5.77%	1.49%	3.34%	3.61%	4.04%	1.97%	3.75%	4.08%	3.73%	2.14%	3.14%	2.64%		low is good	-	-	-
referral to treatment	RTT Total Waiting List Under 18 weeks	Month Ending	58.33%	60.07%	60.35%	61.48%	62.32%	61.77%	61.83%	61.93%	62.18%	63.07%	65.50%	65.64%	67.35%	67.35%		high is good			65.62%
referral to treatment	RTT First Appointment Waiting List Under 18 weeks	Month Ending	57.78%	61.78%	62.03%	64.55%	66.54%	66.82%	66.49%	66.09%	69.19%	69.25%	74.75%	76.25%	75.51%	75.51%		high is good			70.70%
referral to treatment	RTT Total Waiting List Size	Month Ending	12,795	12,952	13,343	13,446	13,350	13,452	13,195	13,175	12,987	12,800	12,517	12,608	12,926	12,926		low is good			12,971
referral to treatment	RTT Patients Waiting 65 Week waits	Month Ending	0	0	0	0	0	1	0	0	0	0	0	0	0	0		low is good			0
referral to treatment	RTT Patients Waiting 52 week waits (52-64 weeks)	Month Ending	507	465	445	427	375	318	227	198	171	104	96	110	107	107		low is good			108
referral to treatment	RTT Proportion of Patients Waiting 52 weeks and over	Month Ending	3.96%	3.59%	3.34%	3.18%	2.81%	2.37%	1.72%	1.50%	1.32%	0.81%	0.77%	0.87%	0.83%	0.83%		low is good			0.83%
cancer	Cancer - 31 day first treatment	Monthly	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		high is good			94.00%
cancer	Cancer - 62 day (traditional)	Monthly	88.20%	75.00%	84.20%	78.60%	75.00%	84.00%	80.00%	75.00%	81.80%	71.40%	70.00%	52.60%	42.90%	42.90%		high is good			80.00%
cancer	28 days FDS	Monthly	80.60%	79.10%	80.30%	77.40%	77.40%	83.30%	73.10%	72.80%	73.80%	76.30%	72.84%	64.70%	61.70%	61.70%		high is good			80.00%
cancer	Patients over 104 days (62 day standard)	Monthly	0	0	0	0	0	0	0	0	0	0	1	2	2	2		low is good			0
diagnostics	Diagnostics Activity	Monthly	2095	2248	2260	2342	2251	2526	2123	2341	2219	2281	2500	2111	2238	4,349		high is good	-	-	-
diagnostics	Diagnostics 6 week target	Monthly	99.72%	99.90%	99.81%	99.80%	99.83%	100.00%	97.75%	99.75%	96.85%	98.66%	99.33%	99.71%	99.30%	99.3%		high is good			99.00%
diagnostics	Diagnostics Service Reporting Turnaround (days)	Monthly	12	10	21	25	30	18	19	21	29	6	5	7	4	6		low is good	-	-	-
poac	POAC Activity	Monthly	1918	2046	2305	1953	2052	2076	1893	1794	1743	1828	1941	1742	2252	3,994		high is good	-	-	-

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	May-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	506	1,035			-	-	
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%	93.85%	94.05%		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%	81.13%	82.19%		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%	78.40%	79.81%		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	3.13	3		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	0	0		low is good	-	-	-
Operational Productivity	Average Early Finishes (minutes)	Monthly	82	84	85	92	81	83	86	78	84	73	89	89	87	85	86		low is good	-	-	-
Operational Productivity	Average Patient Turnaround (minutes)	Monthly	13	17	13	16	14	16	15	16	16	15	15	14	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	23	61		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	7	15		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	9	30		low is good	-	-	-
Operational Productivity	LOS - Trust Wide All Services	Monthly	4.00	3.71	3.86	3.54	4.22	3.42	3.50	3.54	4.17	4.03	3.60	3.99	4.53	4.30	4.42		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	4.01	3.86		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	2.94	3.13		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	4.03	3.70		low is good			2.7
Operational Productivity	OP for first or follow-up Attendances attracting a procedure tariff	Monthly	32.84%	35.28%	36.25%	37.06%	38.09%	38.96%	38.80%	40.47%	38.76%	41.45%	42.52%	44.11%	35.08%	35.76%	35.42%		high is good	-	-	-
Operational Productivity	Bed Occupancy (excluding CYP and HDU)	Monthly	71.43%	73.01%	74.67%	72.21%	76.88%	69.01%	79.95%	72.67%	71.49%	74.14%	75.29%	77.00%	75.77%	77.33%	76.55%		high is good	-	-	-

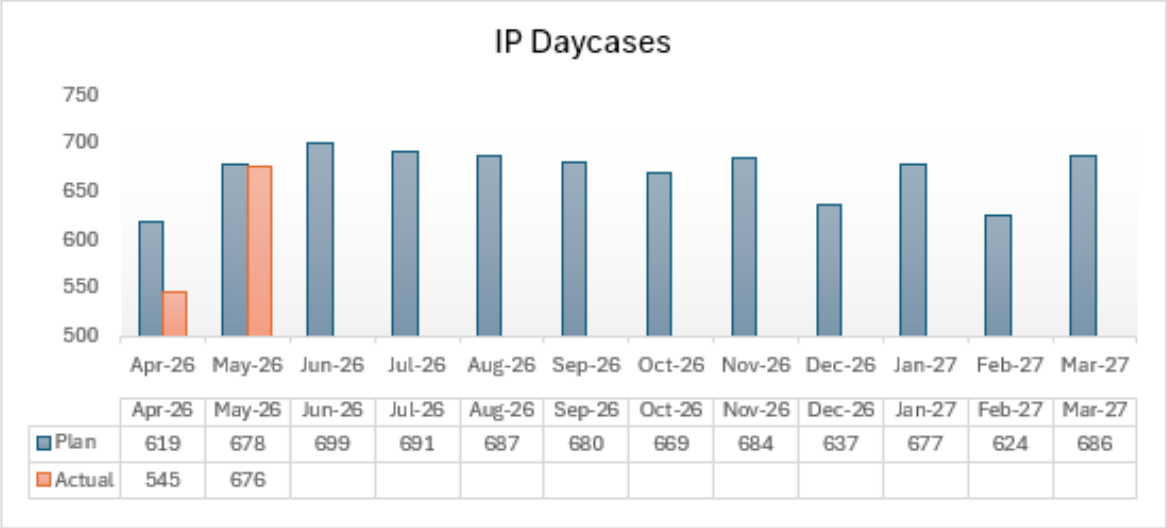
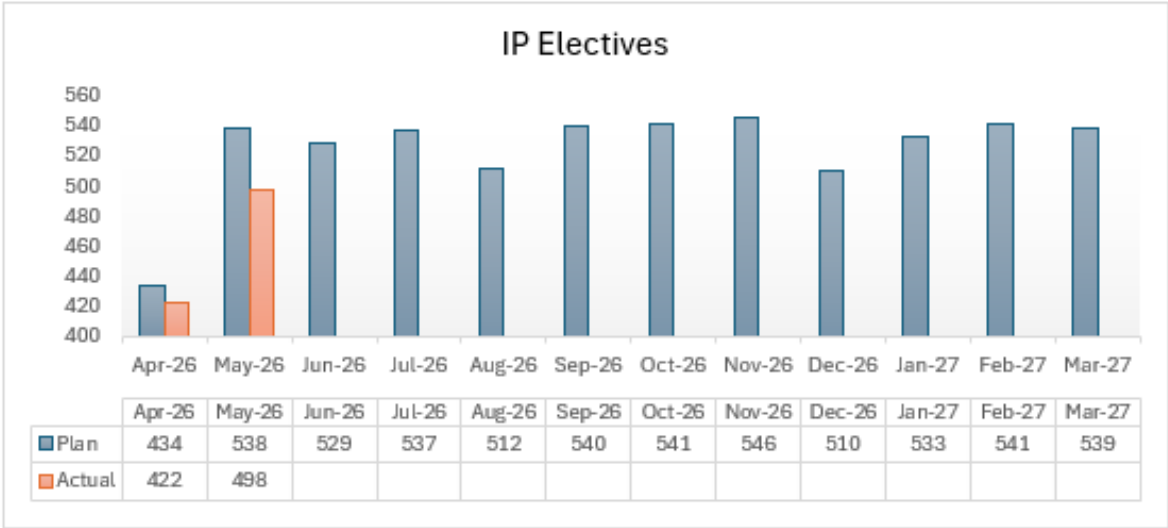


Assurance Reports: Inpatients



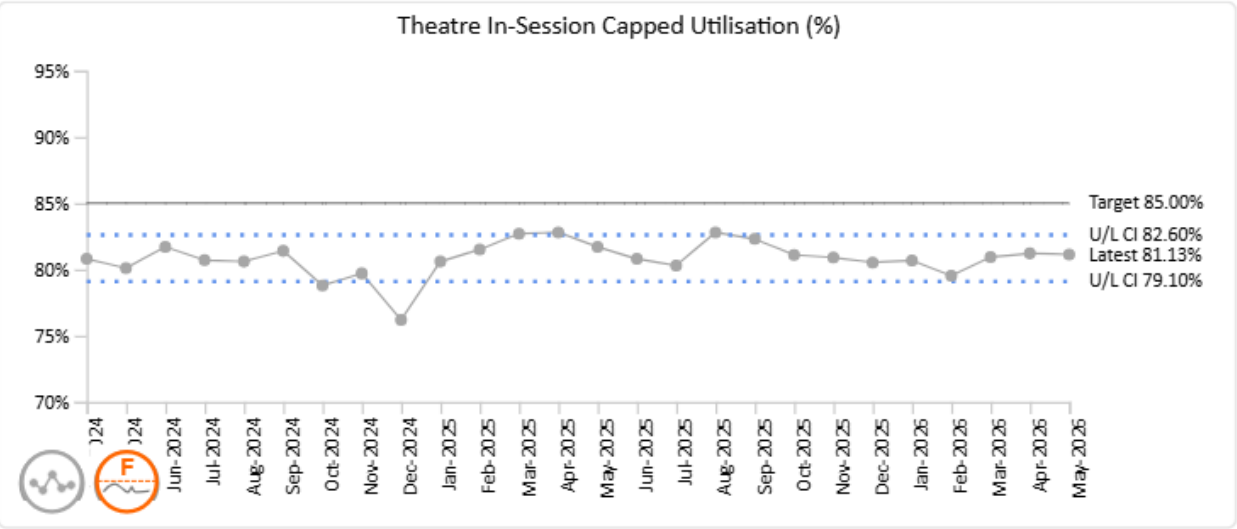
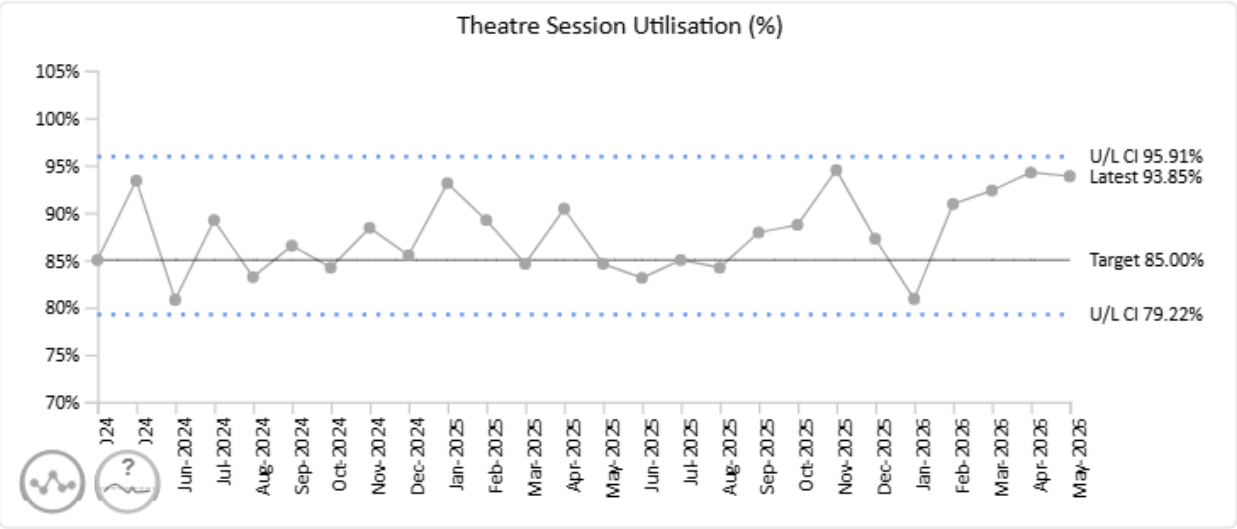
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Total activity delivered in May 2026 was 1,174 cases against a plan of 1,196, resulting in a variance of -22 cases. YTD activity is -88 below plan. The shortfall continues to be driven primarily by a combination of temporary Estate capacity constraints and unplanned medical absence. In addition, Theatre 4 continued to experience a rise in temperatures following the planned closure for maintenance. This led to a reduction in available theatre sessions and constrained elective throughput during May 2026. A ward also remained closed due to heating system issues reducing available inpatient capacity. The projected position for June 26 is that the elective plan will be achieved.	A further updated rectification plan is under review in response to ongoing and additional unplanned surgical workforce absence. This plan will focus on sustained recovery of elective activity, with delivery and trajectory performance monitored on a weekly basis through the Operational Senior Management Team (chaired by the Acting Chief Operating Officer), with escalation into the Executive meeting. Operational oversight continues through daily performance meetings chaired by the Acting Deputy Chief Operating Officer or the Associate Directors of Operations (Division 1), with a targeted focus on maximising theatre utilisation, improving scheduling resilience, and reducing avoidable theatre cancellations.	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



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
Inpatient activity in May 2026 was –40 below plan. Day case activity was –2 below plan. Non-Elective discharges were over plan resulting in a monthly position of –22. The extended closure of a ward required the operational team to re-focus on increasing day case activity. This impacted the ability to push electives during the Hub Optimisation week.	Please refer to slide 6 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 premium rate 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. Aiming to introduce regular Arthroplasty HIT lists as business as usual from July 2026	N/A	Corporate Risk Register Ref 269	High

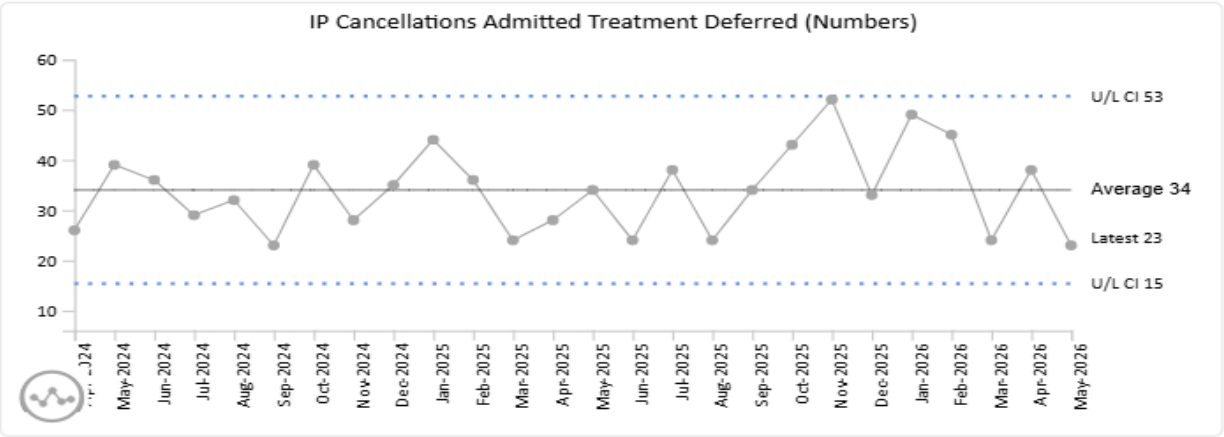
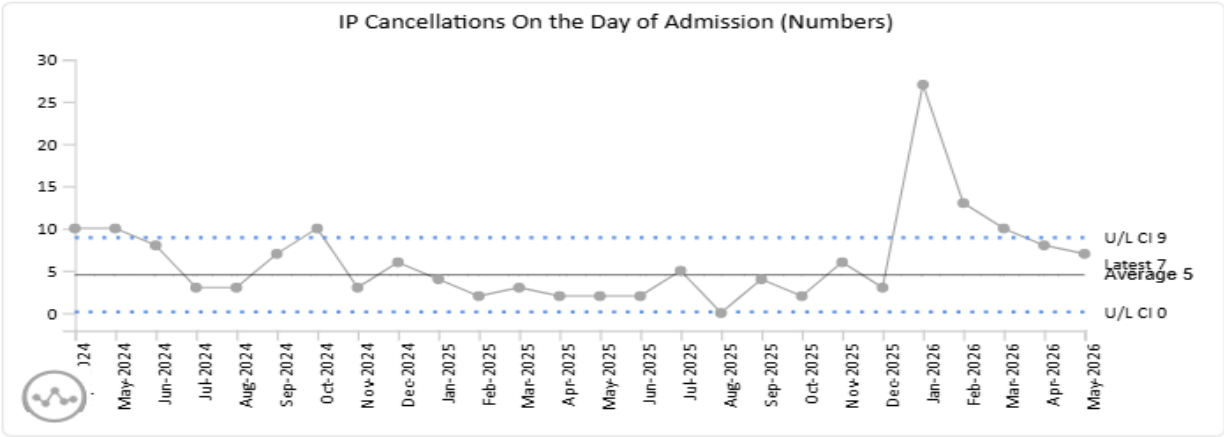
Assurance Reports: Theatres



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
May 2026 theatre performance achieved a session utilisation rate of 93.85%. However, capped theatre utilisation was 81.13%, which remained below the internal target of 85%. External benchmarking against Model Hospital data (April 2026) indicates that Trust performance remains within the top quartile nationally, with a comparative utilisation rate of 83.60%, reflecting continued strong relative performance despite local operational constraints. From a theatre estate perspective, planned theatre maintenance works were completed by the end of April 2026. However, Theatre 4 subsequently experienced an unplanned estates failure requiring additional remedial works, which reduced theatre availability and continued to impact overall utilisation and elective throughput during May 26.	Mitigation remains focused on strengthening theatre resilience, reducing unplanned downtime, and maximising utilisation across the available theatre estate. A theatre staff competency and training framework is in development, supported by internal educators and supplemented by targeted input from external system specialists. This work is being led by the Head of Nursing, and it's intended to build workforce capability, improve operational confidence, and enhance overall service resilience. An options appraisal addressing the ongoing issues in Theatre 4 has been presented to the Executive Committee. A short-term mitigation proposal has been agreed, and options are being further scoped regarding the future use of theatre 4. An Estates working group is being set up to support this.	3 – 6 months. Actions being tracked via TIG and QSG	Corporate risk ref:770	High



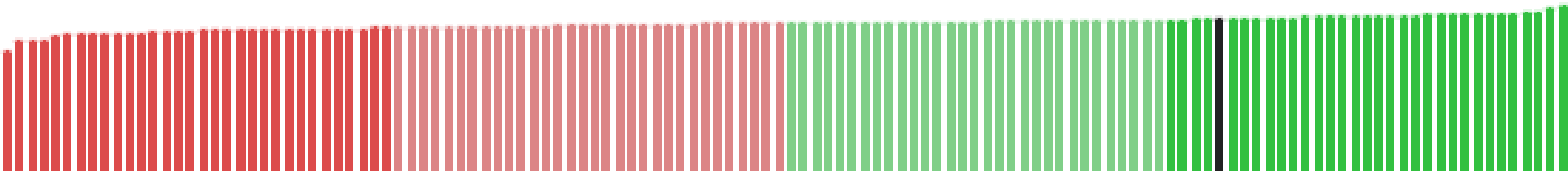
Assurance Reports: Inpatients continued



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 May 2026, a total of 30 patients were cancelled on the day of admission/admitted and deferred under the following categories: Clinical: 16 Main themes related to being medically unfit and skin integrity issues Non-clinical: 12 Main themes related to a lack of theatre time due to complexity of previous cases and cases being deferred for more urgent cases Patient choice: 2 This is a reduction on the number of patients cancelled on the day durin April 26 position	Theatre look-back meetings continue to be embedded, with lessons learned consistently captured and reviewed to support continuous improvement and performance recovery.	Ongoing	Corporate Risk Register 269	High

Assurance Reports: Theatres Benchmarking – Latest Model Hospital Data

Capped elective theatre utilisation % (monthly)



Provider value



Apr 2026



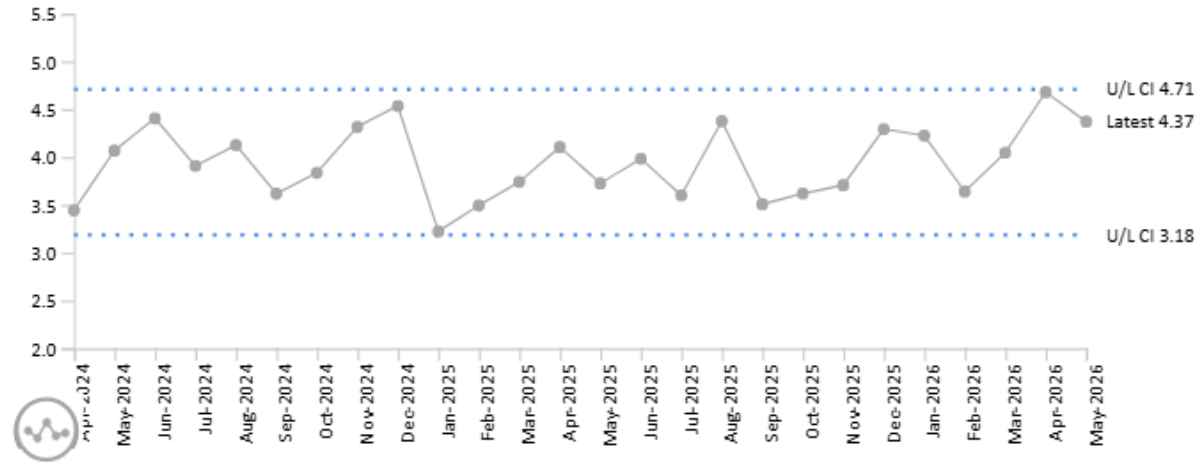
83.6%



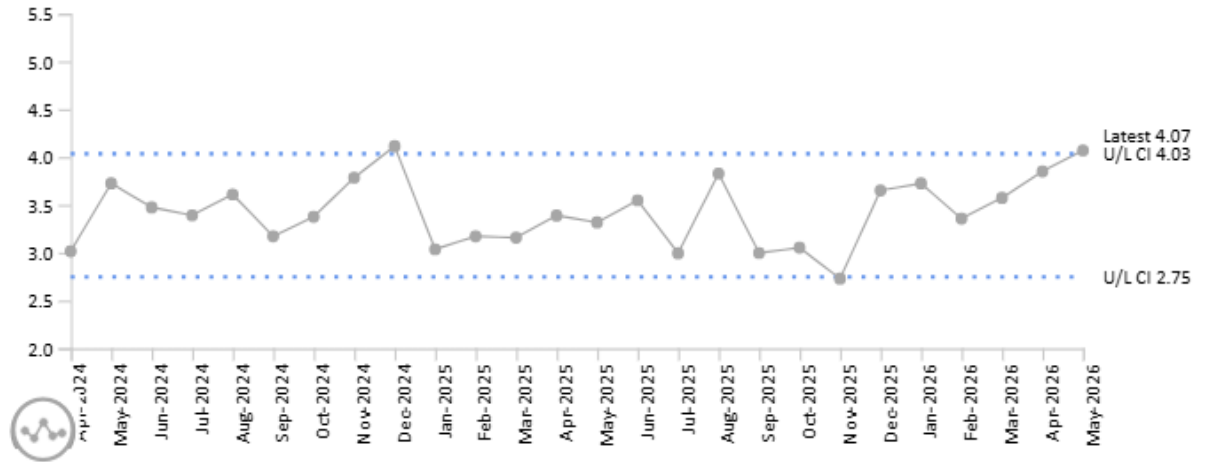


Assurance Reports: Inpatients continued

IP Elective Trust Wide Average Length of Stay (Days)



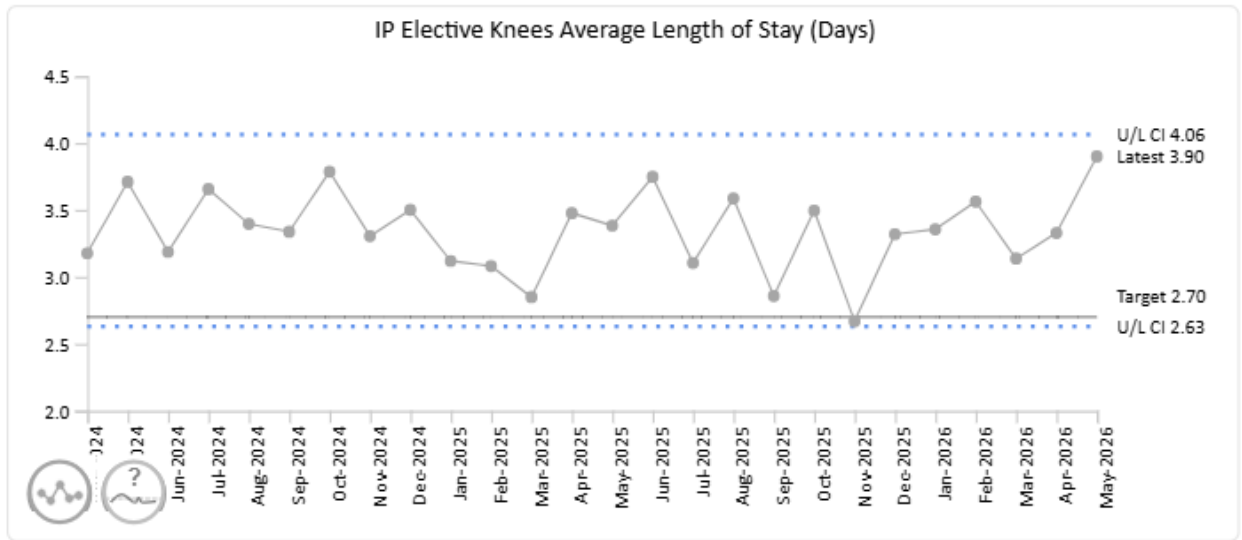
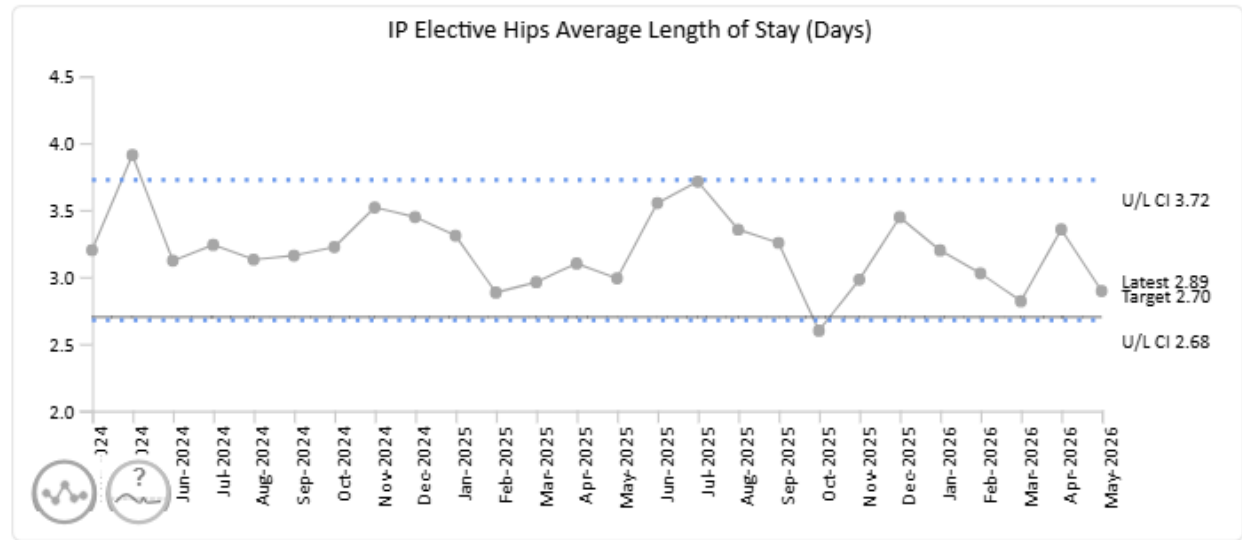
IP Elective Average Length of Stay (Days) Excluding Oncology, Paeds, YAH, and Spinal



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 decreased to 4.37 (4.54 April) Arthroplasty and Oncology arthroplasty excluding Oncology, Young Adult Hip and spinal had the longest LOS's: 11 patients (10 April) had a LOS=>14 days (longest 85 days), on review they had ongoing clinical/therapy needs. These included EPRs and revisions, 1 had an ASA score of 4 (severe systemic disease that is a constant threat to life); 6 a score of 3 (severe systemic disease; 3 a score of 2 (mild systemic disease). On review all patients were MRC/BIS patients or those having complex surgery, therapy or social needs.	Complexity of patients-clinical or social is the main contributory factor. Piece of work being undertaken by Division 2 AMD on a pathway to identify high risk patients which will support proactive pre-op management planning. 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 decreased at 2.94 days (3.32 days April 26). 4 patients had a LOS =>7days (longest 10 days-clinical and social reasons) - Primary knees have increased to 4.03 days (3.37 April 2026). 7 patients had a LOS=>7days (longest 29 days- therapy and need for rehab bed) - The average length of stay for ROH patients excluding Oncology, Young Adult Hip and Spinal has increased to 4.01 days (3.71 days April 26). All patients with LOS >7 days reviewed had on-going clinical/therapy or social care needs. ASA scores: 0 ASA 1; 76ASA 2; 4 ASA 3	Please refer to Slide 9 for action to be supported by the BADS Delivery Group.		N/A	High

Assurance Reports: BADS Quarterly Update

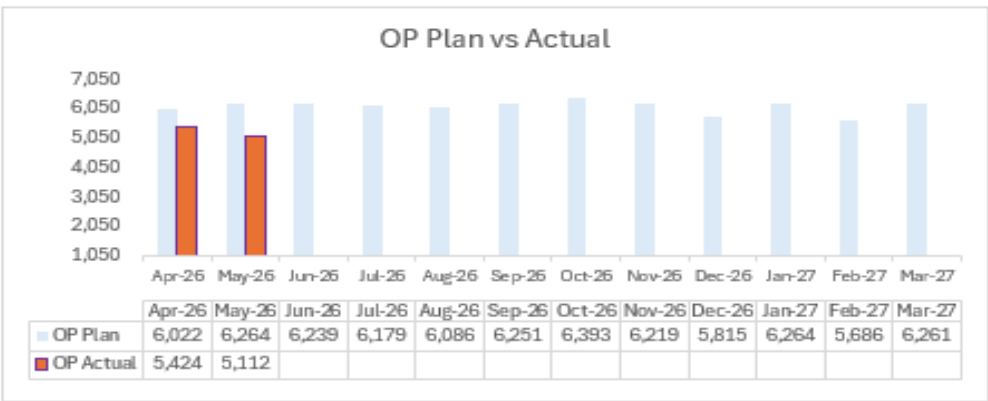
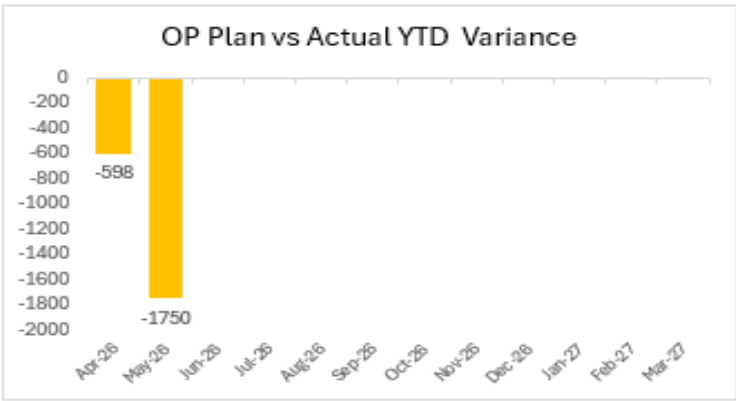
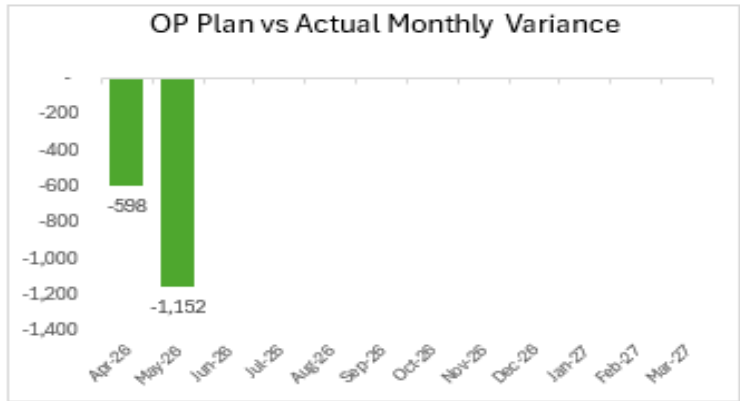
Procedure Code > Procedure Description	Daycase rate	BADS target	Pt target/mth
5.01 Therapeutic shoulder arthroscopy	85%	90%	
5.02 Anterior Cruciate Ligament Reconstruction	37%	90.0%	
5.03 Bunions	62%	90%	
5.04 Uni Knee Replacement	1%	40.0%	
5.05 Total Hip Replacement	1%	20%	5
5.06 Total Knee Replacement	0%	10.0%	10
5.07 Carpal Tunnel Release	98%	100%	10
7.01 Cervical Spine Decompression / Fusion	1%	12.5%	
7.02 Lumbar Decompression / Discectomy	2%	13%	
7.03 Lumbar Medial Branch Block / Facet Joint Injections	100%	85.0%	
7.04 Lumbar Nerve Root Block / Therapeutic Epidural Injection	98%	85%	
7.05 One or two level Posterior Fusion Surgery (PLF, TLIF, PLIF)	0%	12.5%	

	Dec	Jan	Feb	Mar	Apr	May
% One Day D/C	19.6%	20.5%	21.1%	21.3%	25.7%	25.3%
% Same Day D/C	3.0%	1.5%	0.4%	0.4%	0.6%	2.2%

Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales & assurance group or committee	Risk Register	Data Quality
The Trust has seen a sustained improvement in One Day Discharge (ODD) performance, with rates increasing from 21.3% in March 2026 to 25.3% in May 2026, representing an improvement over the last two months and maintaining performance above 25% since April. Following a temporary reduction earlier in the year, Same Day Discharge (SDD) performance improved in May, increasing to 2.2%, demonstrating early signs of recovery as revised pathways are embedded. Through the Day Case Oversight Group, which has agreed monthly delivery trajectories for hip and knee arthroplasty and spinal decompression/discectomy pathways, providing greater clarity and focus on delivery.	Reliance on a limited number of clinical champions presents a potential risk to delivery should there be periods of ill health or reduced availability. Mitigating actions include engagement with Clinical Service Leads to strengthen clinical leadership capacity and maintain momentum across the programme. To strengthen performance oversight, a dedicated Business Intelligence dashboard is being explored, enabling routine monitoring of monthly progress, variation, and opportunities for improvement. Further external support has been secured, with Getting It Right First Time (GIRFT) commencing targeted support from July 2026 to accelerate pathway transformation and share best practice.			

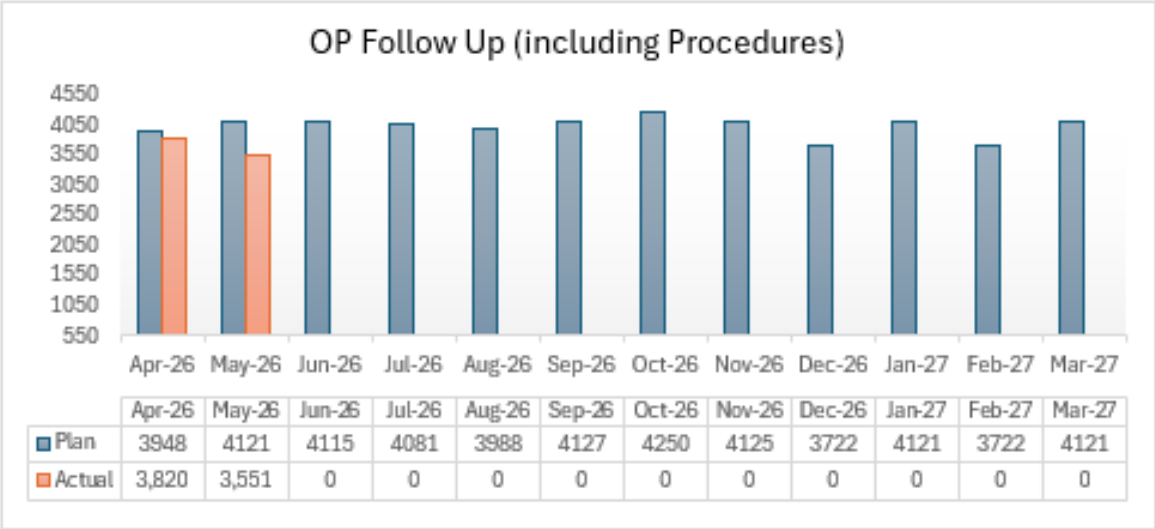
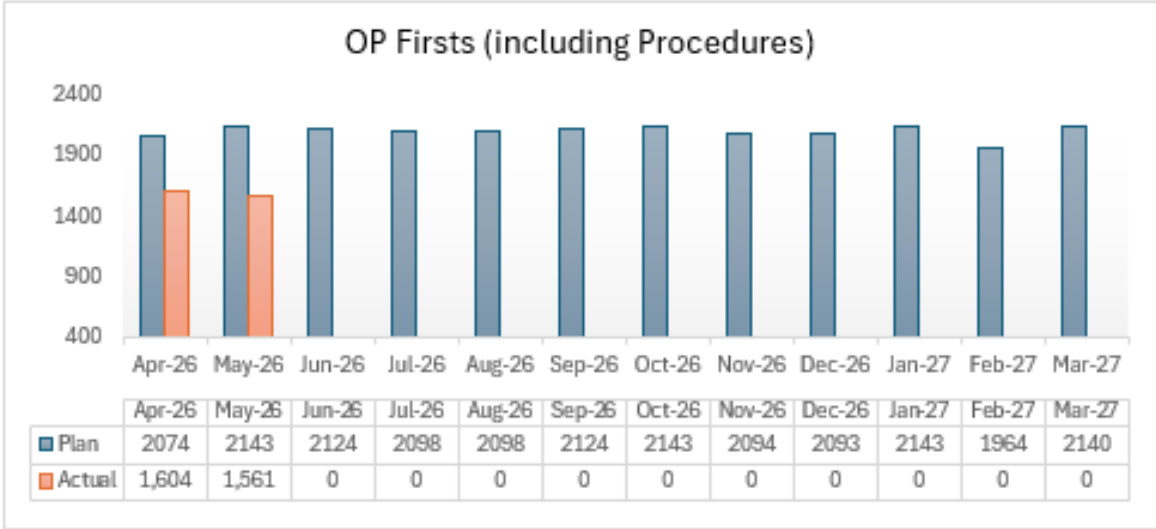


Assurance Reports: Outpatients



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
A deep dive has been undertaken revealing the following challenges/changes that have been identified since the plan was submitted: - Bank holidays – whilst factored into the phasing based on working days, did not account for the disproportionate activity levels on Monday's compared to other days. - Consultant Vacancies - Job plan changes - Unplanned Absence - Reduction in Mid-Level Provider workforce such as fellows - Service allocation of premium rate activity not spent and not flagged for reallocation. This has been rectified for June 26 onwards. - Clinic template changes - Outpatient sprint resulting in a change in the outturn for 25/26 leading to a higher stretch plan	A rectification paper has been drafted that will be discussed at the Executive team meeting in June 26.	June 2026	SR5	High

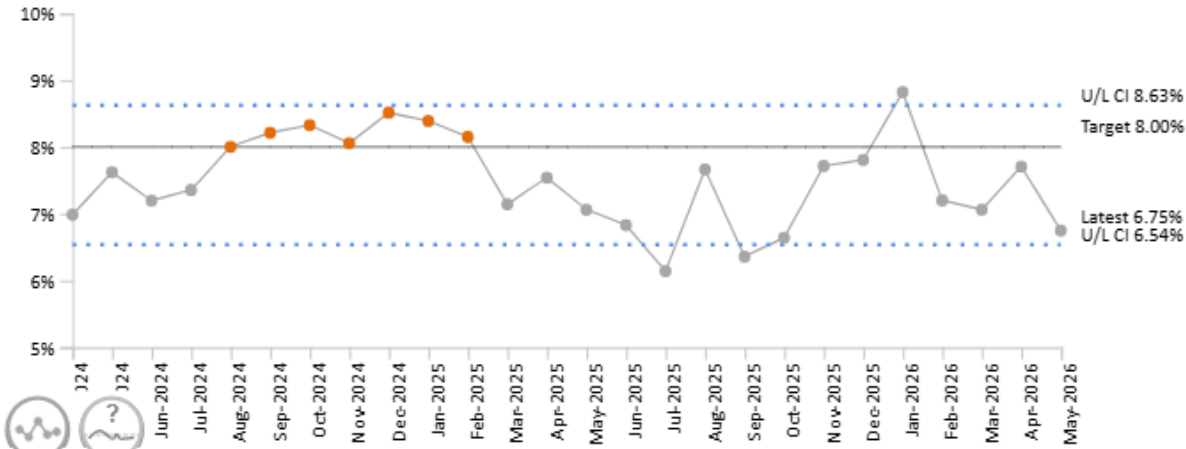
Assurance Reports: Outpatients Continued



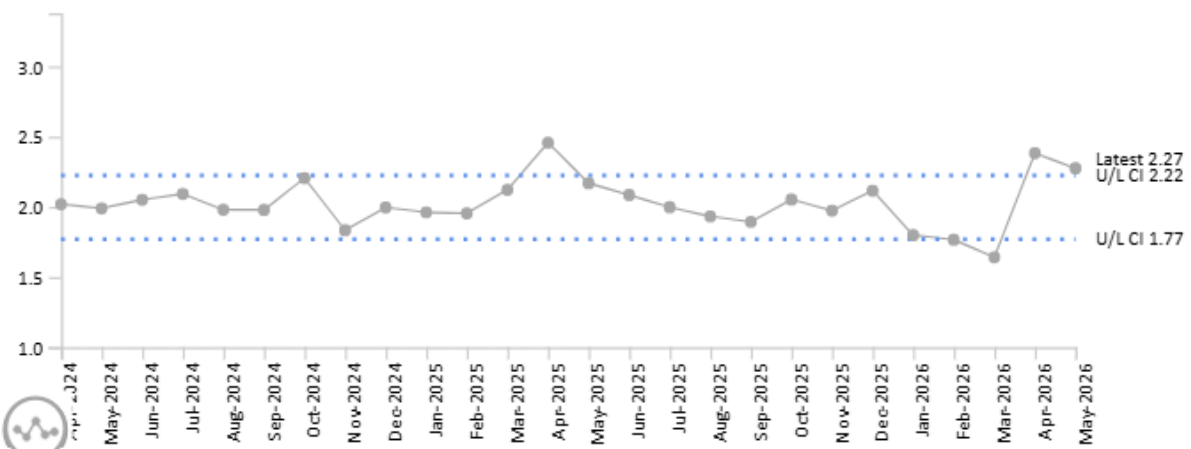
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Outpatient Firsts with procedures were below plan by 582 appointments. This is due to the issues identified on slide 13. In addition, the outpatient new sprint led to an increase in the number of RTT patients waiting for a follow up appointment. Existing capacity for some clinicians has been converted from new to follow up (job planned sessions) to continue to achieve RTT metrics and NOF status.	Further review of clinic templates to rebalance new and follow up activity. Service reviews of Further Faster guidance to benchmark post operative follow up arrangements aligned to best practice. Encourage opportunities to attract the patient not present tariff for patients on a follow up RTT pathway that can result in a clock stop with the patient not present. For instance, reviewing imaging and writing to the patient to discharge if the results are normal.	Quarter 2	SR5	High

Assurance Reports: Outpatients

OP Consultant Led Did Not Attend Rate (%)

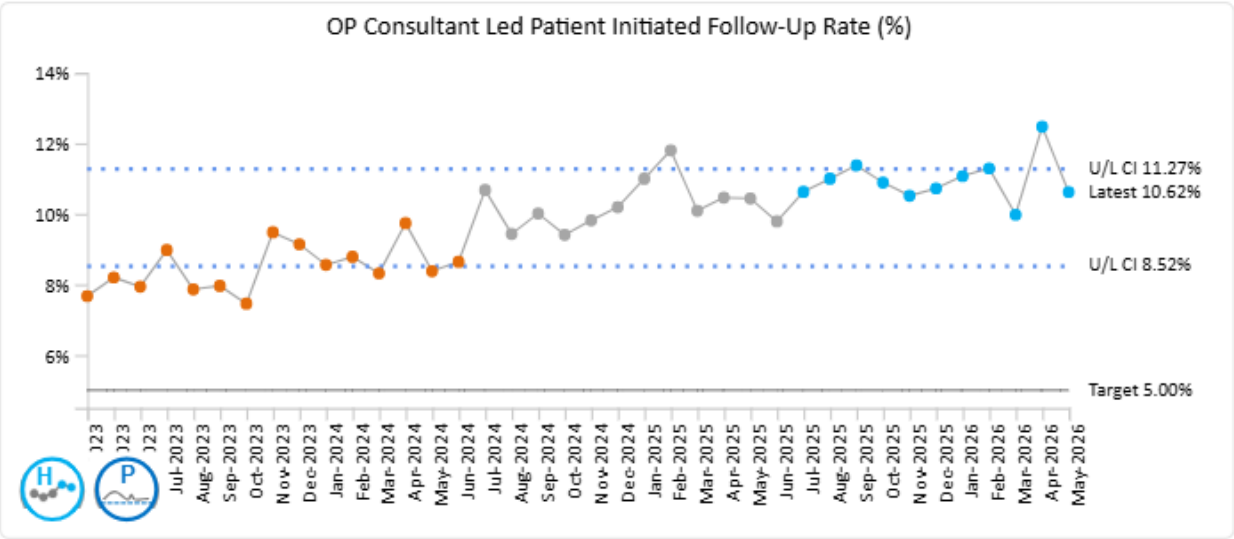
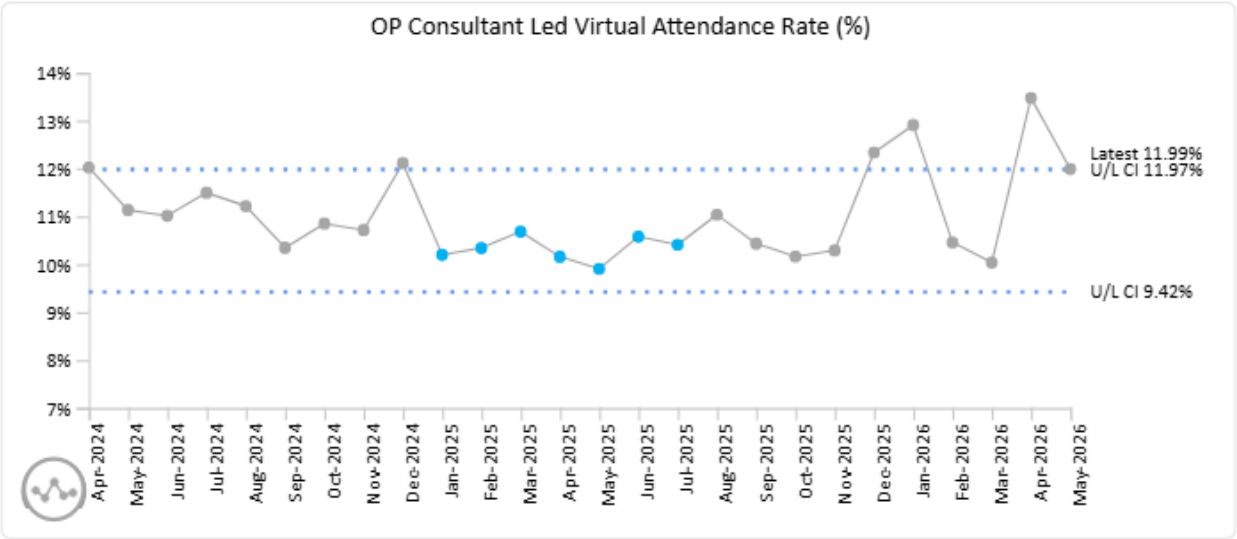


OP Consultant Led New to Review Ratio



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
A positive reduction in the Missed Appointment rate with the May 26 position being reported as 6.75% against a target of 8%.	As predicted the electronic clinic letters have improved patient access to clinic information via the NHS App. The letters went live on 27/04/2026 To improve accessibility, subsidised travel remains in place 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).	Complete	SR5	High
The new-to-follow-up ratio has reduced in May 26.	Further review of follow ups aligned to GIRFT	Quarter 2	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
Virtual appointments remained high in May at 11.99%, slightly below the April peak but still amongst the highest levels in over two years. This reflects sustained use of virtual follow-up clinics and continued embedding of digital pathways.	Continued trialling virtual super-new and discharge clinics	April 2026	N/A	High
PIFU reduced from 12.47% in April to 10.62% in May but remains above historical levels and continues to show a positive and statistically significant uptrend. The April peak was driven by increased conversion of follow-up patients onto PIFU following diagnosis and management planning during a period of high review activity.	Monitoring of PIFU conversion rates and targeted intervention in hotspots. Asynchronous PIFU rollout – trial with 1 clinician commenced and conclusion delayed slightly to first week of July to measure impact	July 2026	N/A	High

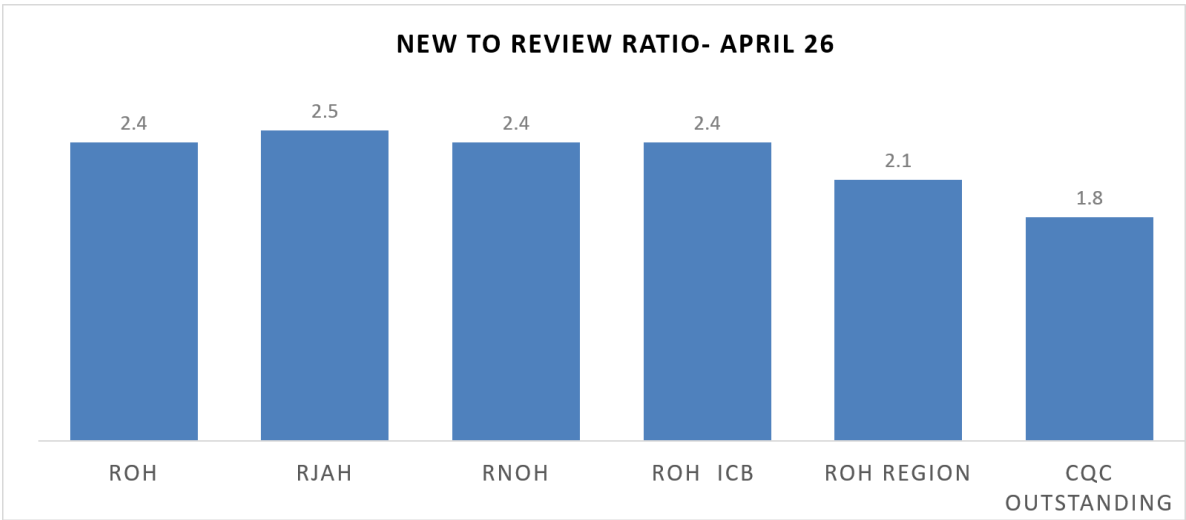
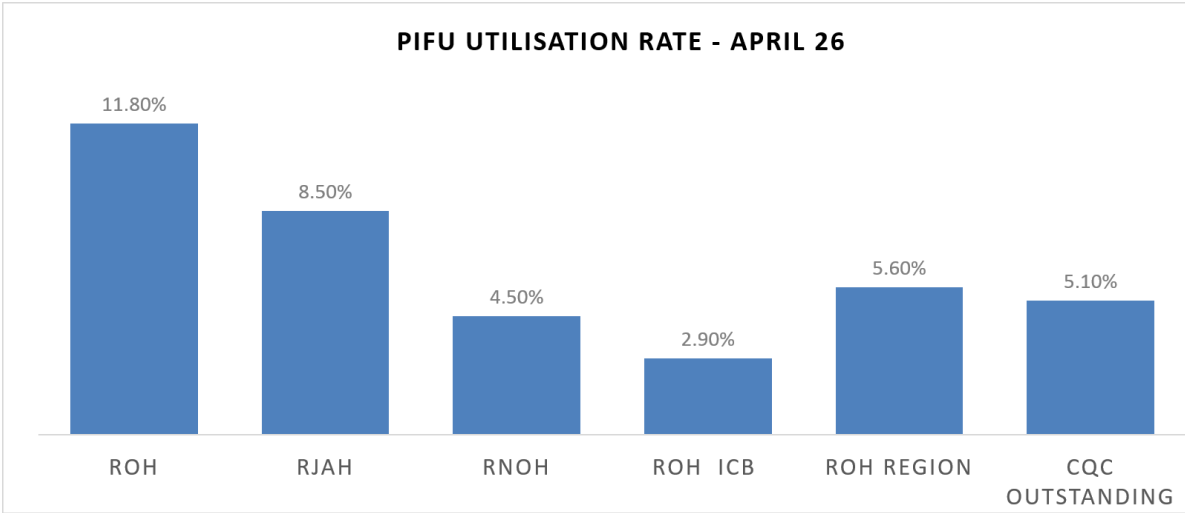
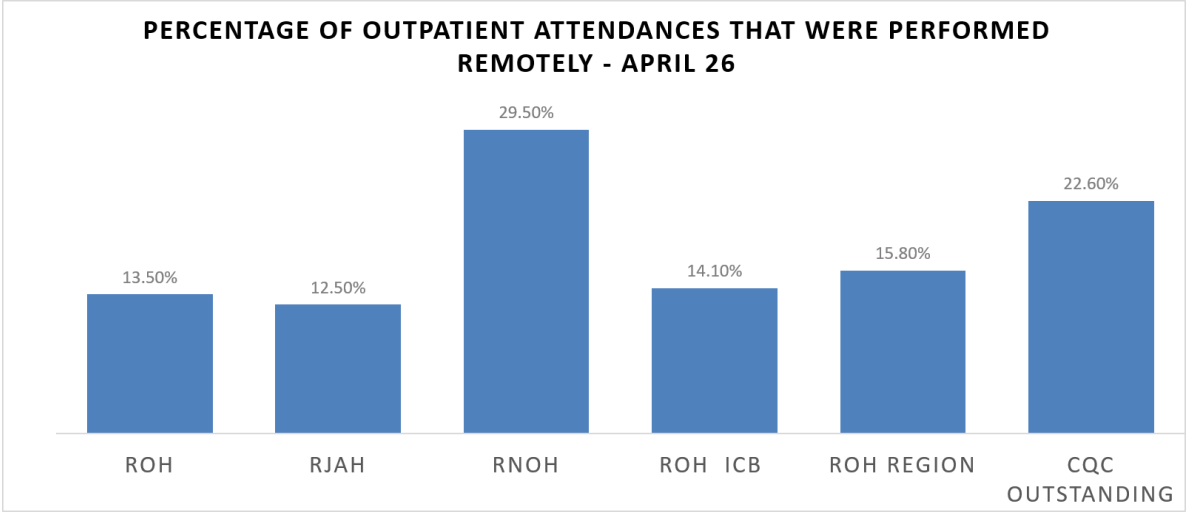
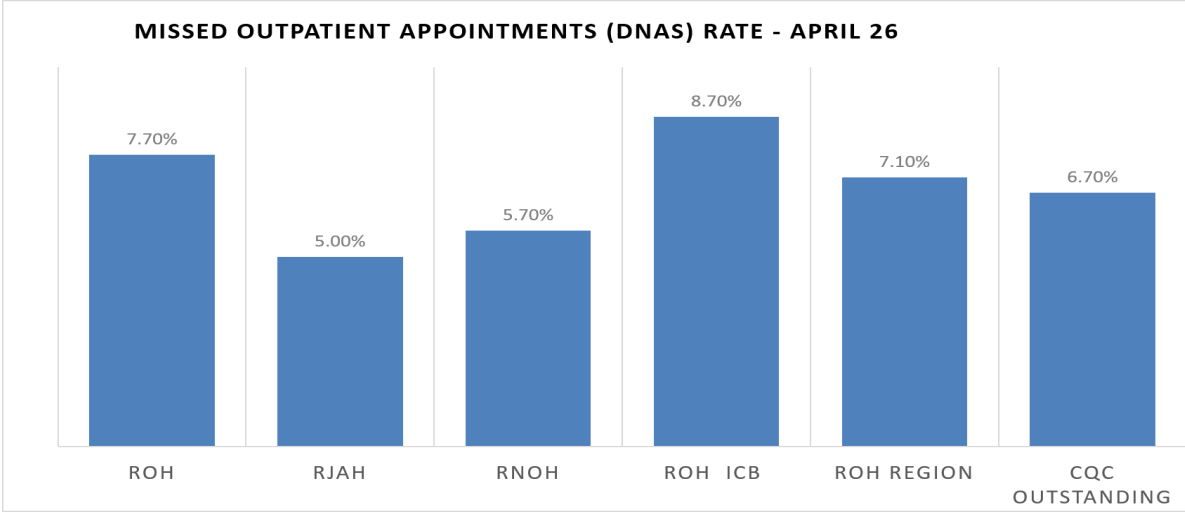


Assurance Reports: Outpatients continued



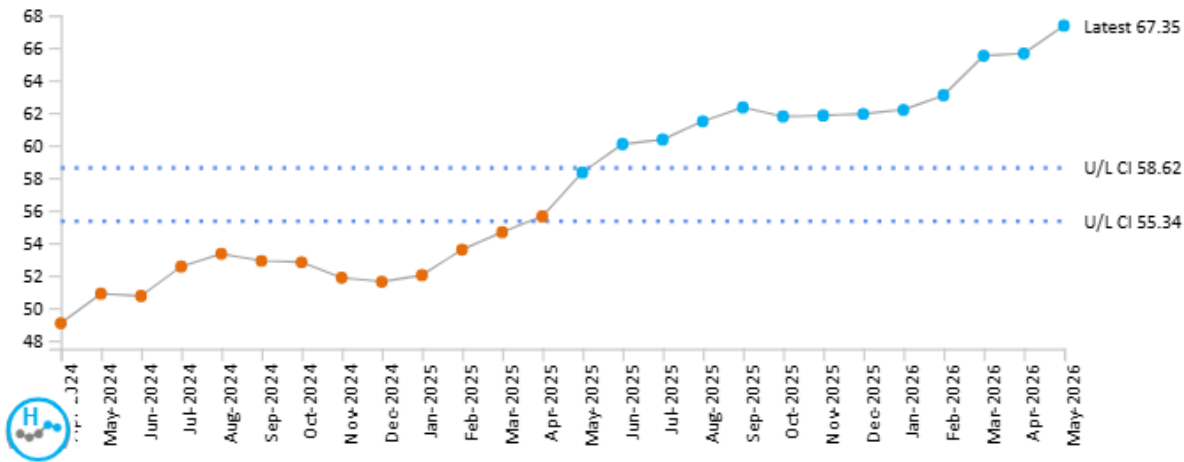
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Performance in May remained stable and continued to sit below the Trust KPI threshold of 10%, maintaining the recovery achieved following earlier pressures at the start of 2026. The latest position shows a slight improvement on April, indicating sustained control of waiting times despite ongoing demand. The over 60-minute waiting time KPI also remained within target; although there was a marginal increase from April's low of 2.09%. Performance in May stayed comfortably below the 5% threshold, at 3.14%. Overall performance continues to reflect the resolution of the temporary Imaging capacity constraints experienced earlier in the year.	Monitoring of clinics where there are routinely complex patients to understand how they can be supported to avoid delays	ongoing	N/A	High

Assurance Reports: Outpatients Benchmarking Model Hospital

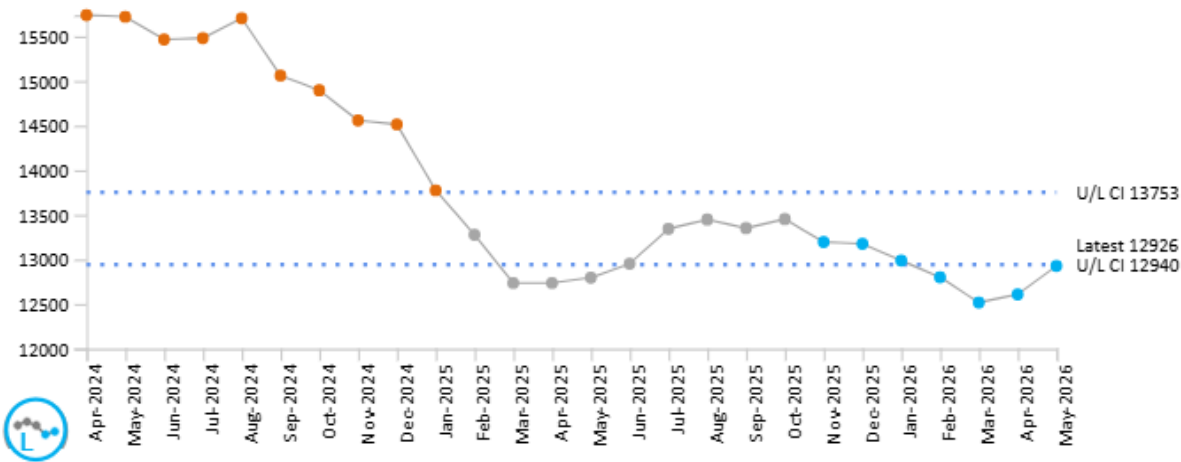


Assurance Reports: Referral to Treatment

RTT Total Waiting List Percentage



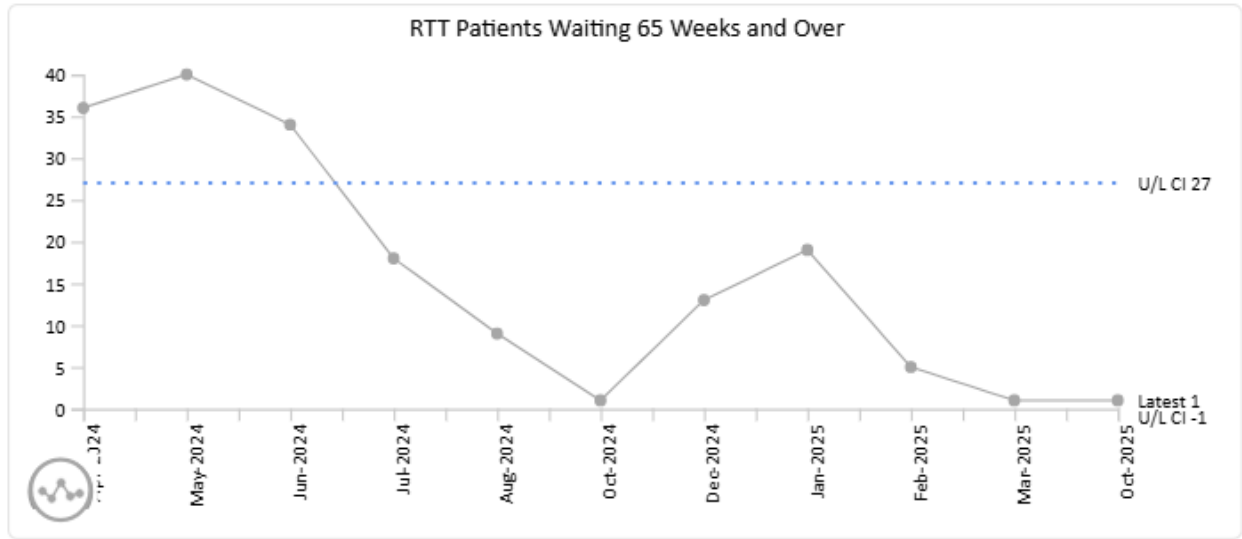
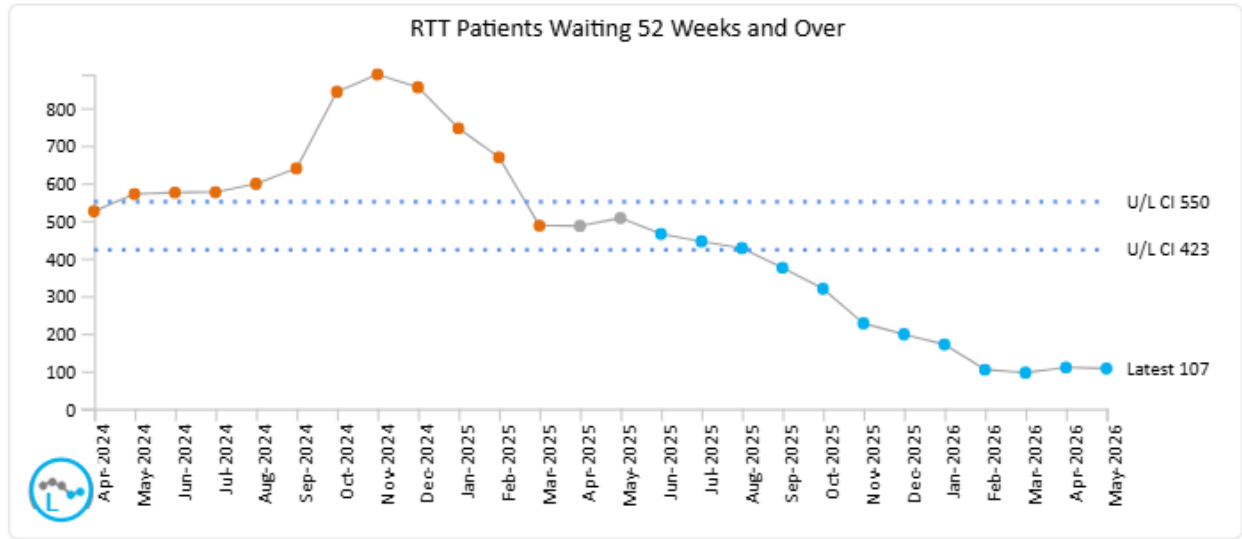
RTT Total Waiting List Size



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 continues to improve the monthly RTT Total Waiting List Percentage performance, in May 26 achieving a performance of 67.35% against a target of 65.62%. This month-on-month improvement demonstrates the team's continued focus on effective pathway management, service coordination of waiting lists and sustaining patient flow. The monthly RTT Total Waiting List Size, shows another slight increase in the RTT waiting list size during May, however the Trust remained ahead of plan, closing the month with a waiting list below the target position of 12,926. This demonstrates continued effective management of elective demand.	To sustain this level of performance and ensure delivery of the 2026/27 targets, 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



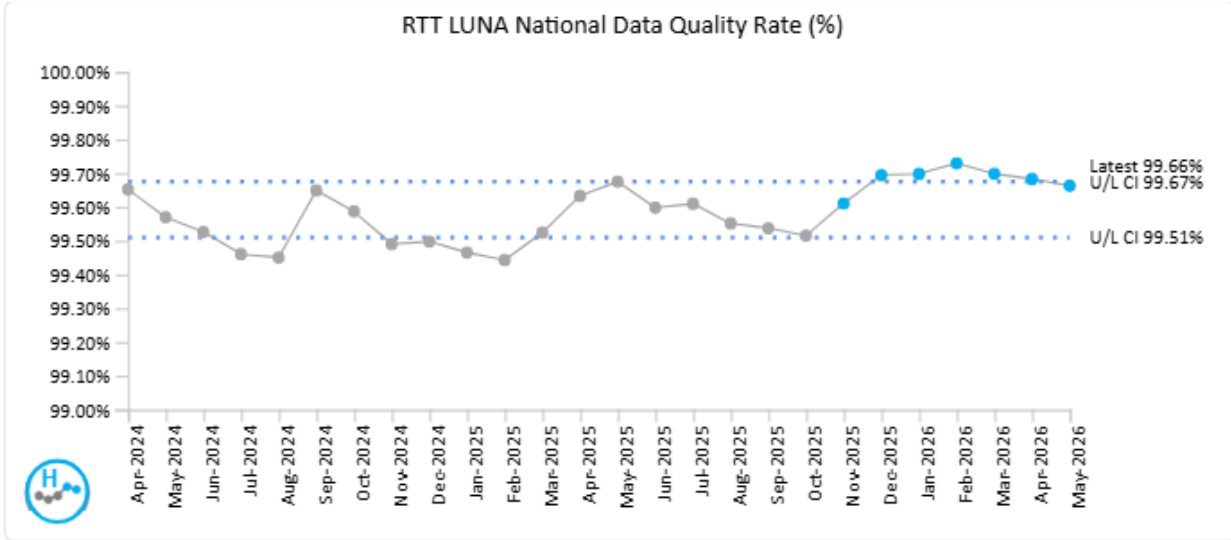
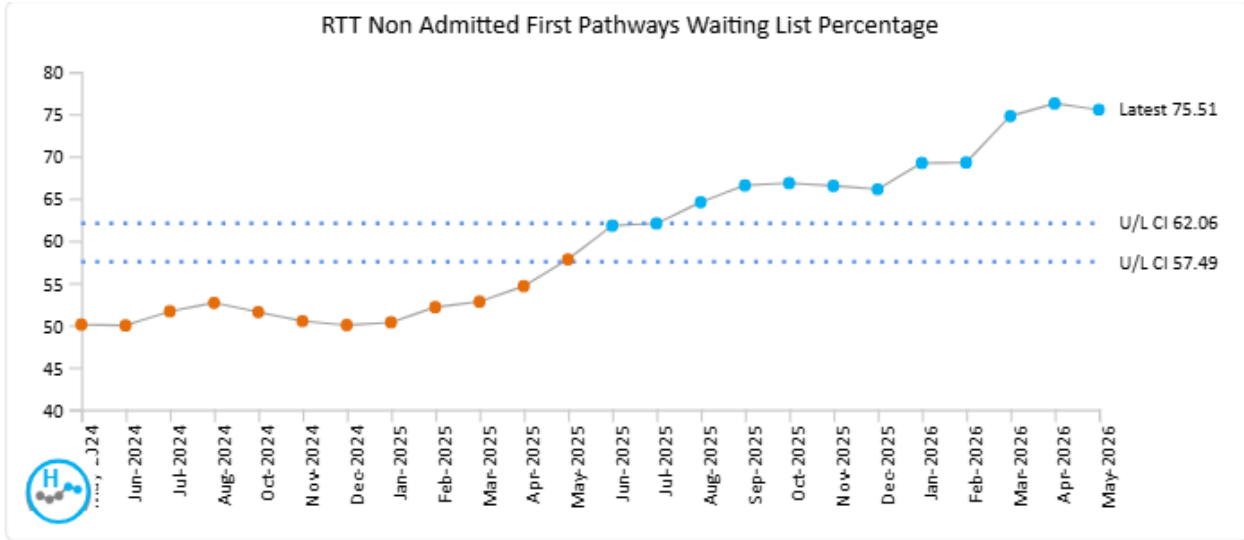
Assurance Reports: Referral to Treatment continued



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 decreased slightly to 107 during May; and performance remained ahead of the monthly target of 108. 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

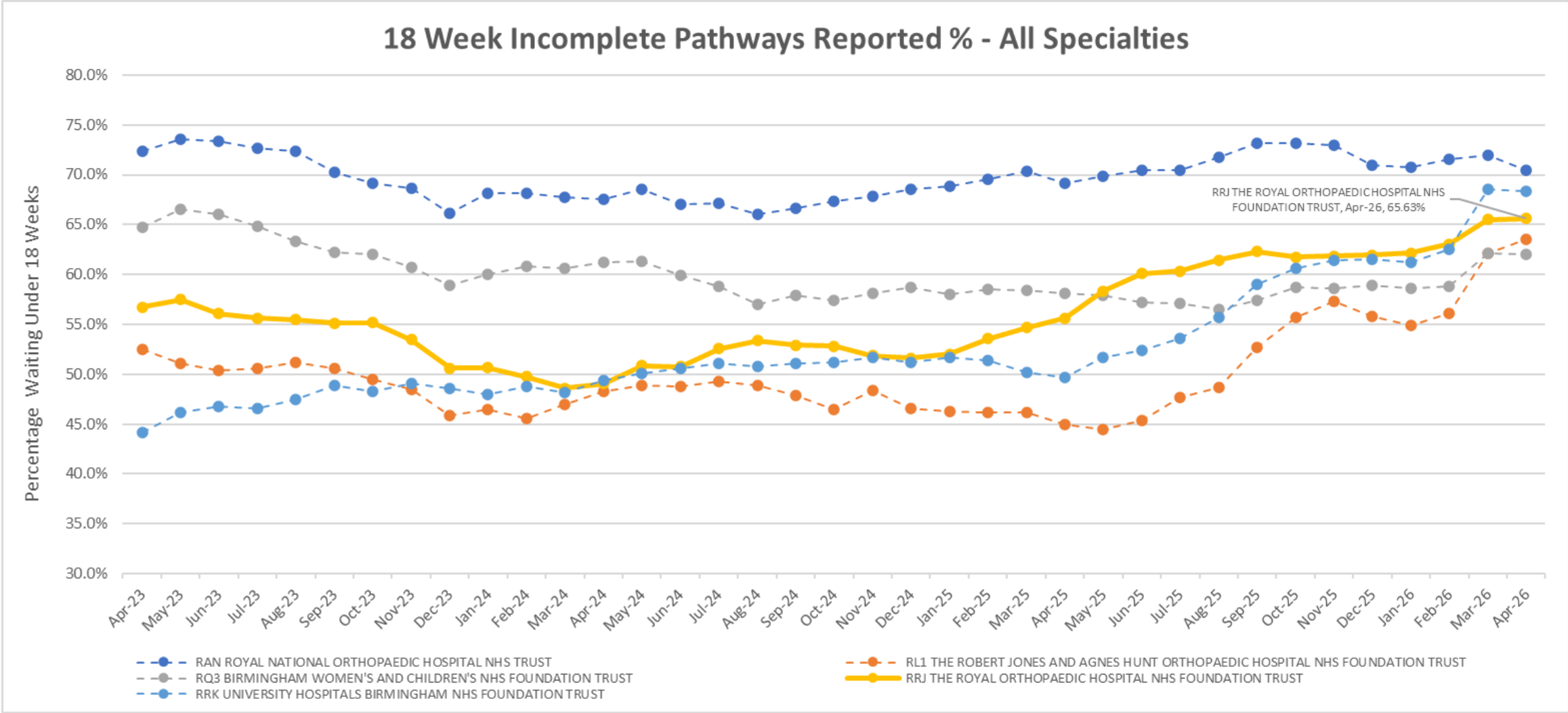


Assurance Reports: Referral to Treatment continued



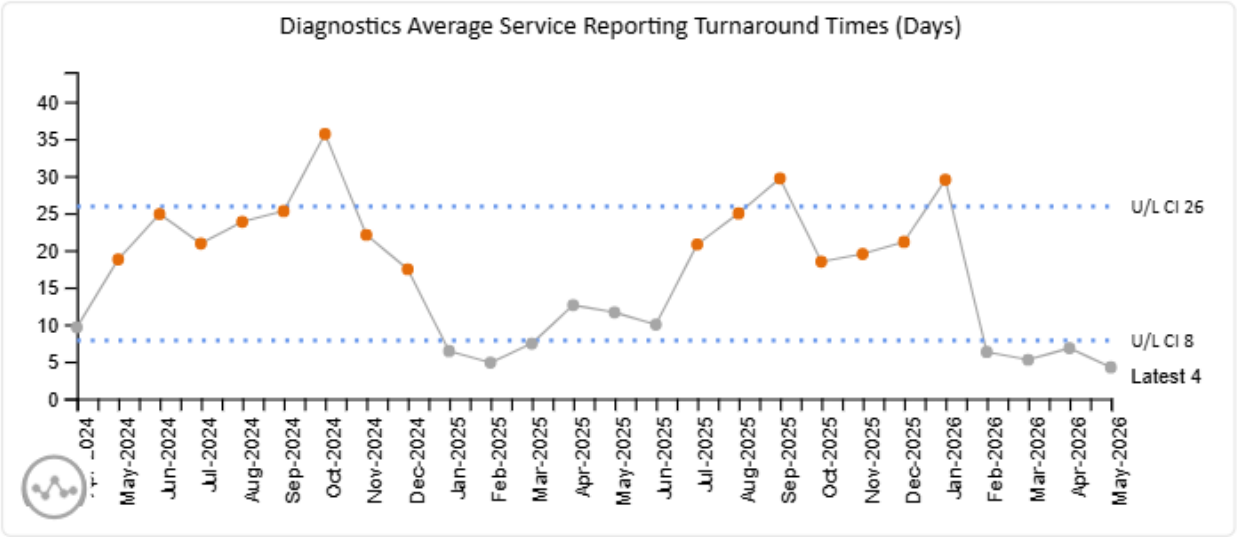
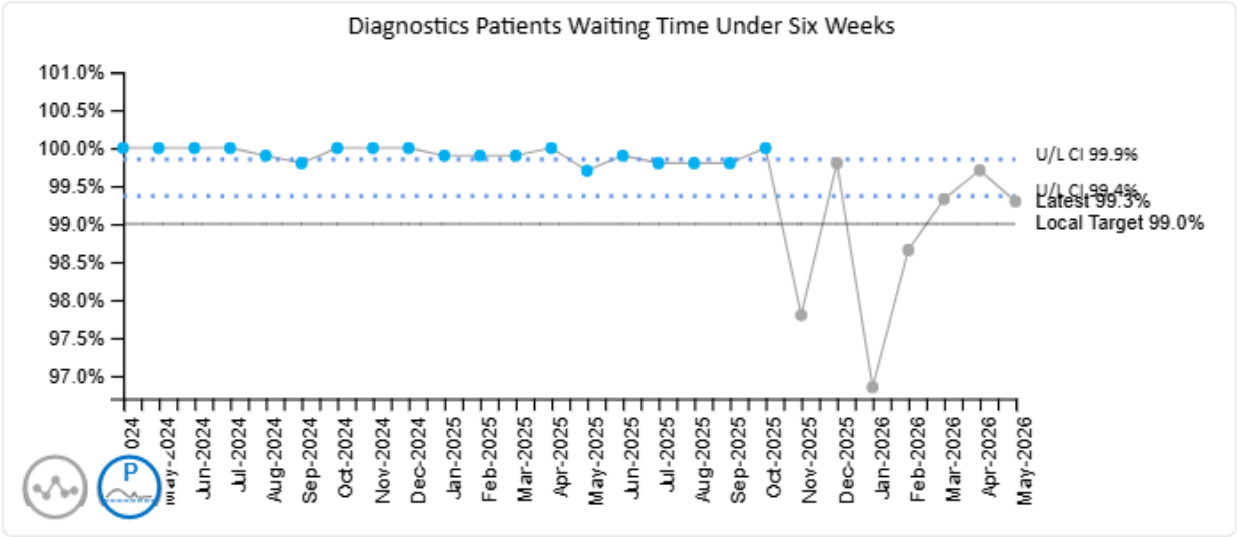
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
75.51% of patients are now waiting under 18 weeks for an RTT first new outpatient appointment exceeding the planned target of 70.70%. 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 Oversight Group	N/A	High

Assurance Reports: Referral to Treatment Benchmarking Model Hospital





Assurance Reports: Diagnostics

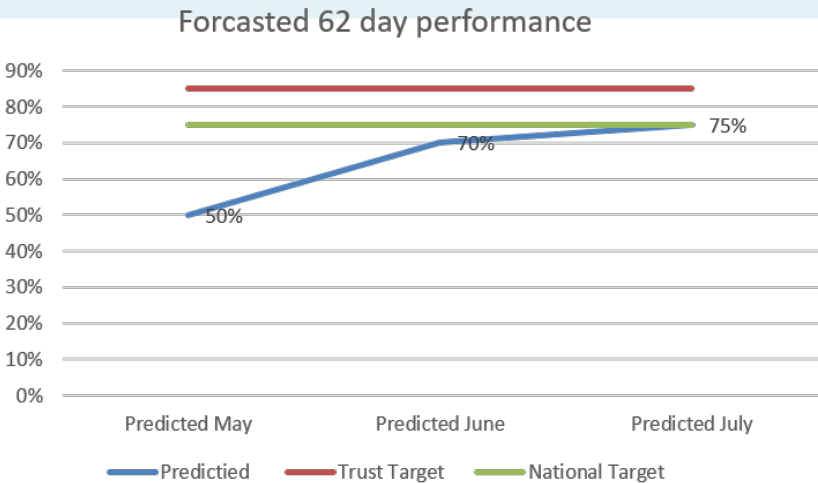


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Diagnostics achieved 99% in May 26 meeting the trust target and exceeding the national target. Reporting turnaround times for routine images is continuing to decrease and is now within RCR Guidelines of 4 weeks for routine imaging. 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. 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. Continued monitoring of downtime. Escalated to highest level with manufacturer.	N/A 2082 Ongoing 2080, 2148	High

Assurance Reports: Cancer

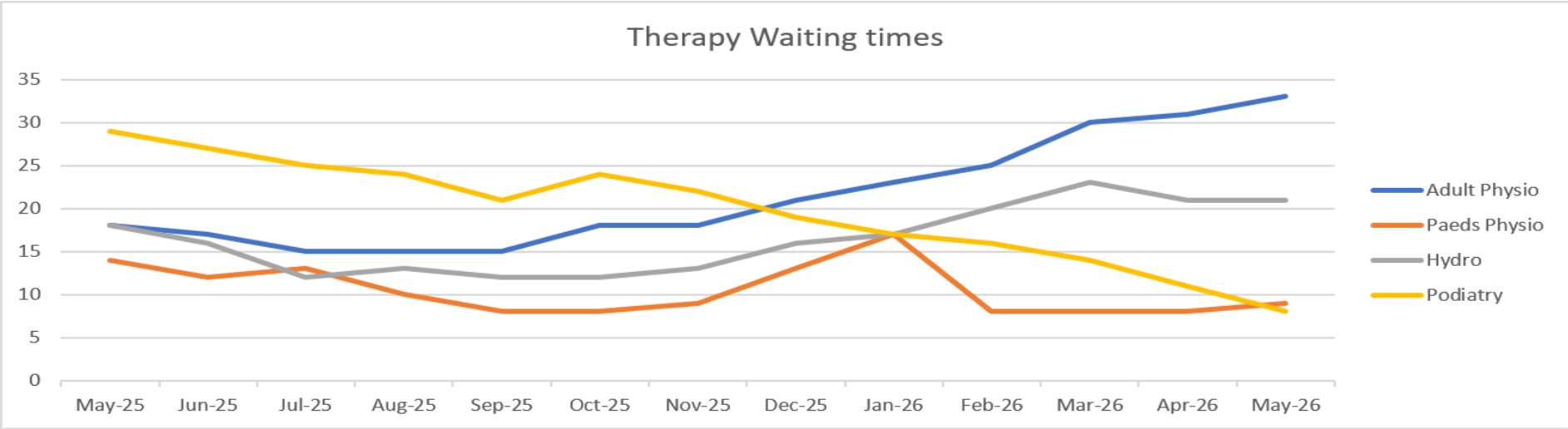
April 26 Performance

Target Description	Patients	Compliant	Breach	Total Accountable	%	Target
31 Day	14	14	0	14	100%	96%
62 Day	9.5	5	4.5	9.5	52.6%	75%
28 Day FDS	68	44	24	68	64.7%	80%
104 days treated at ROH			2			



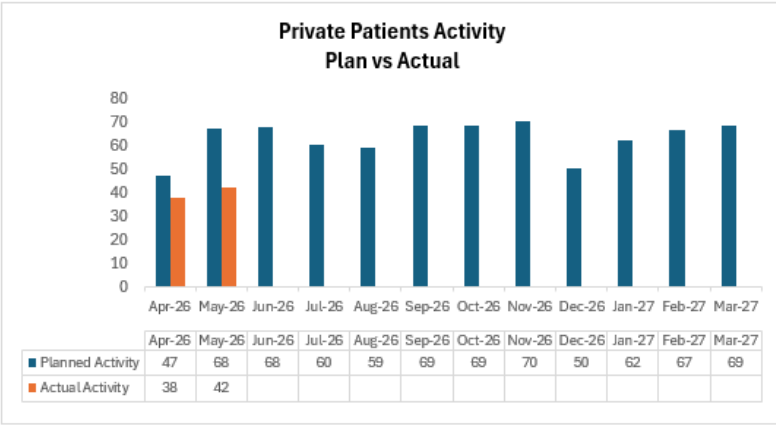
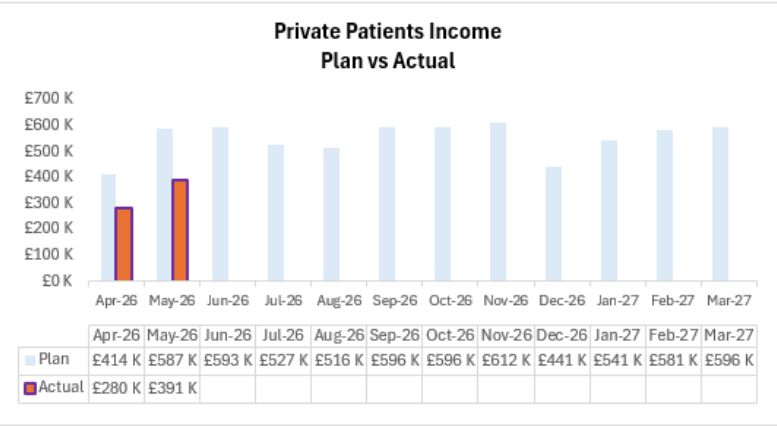
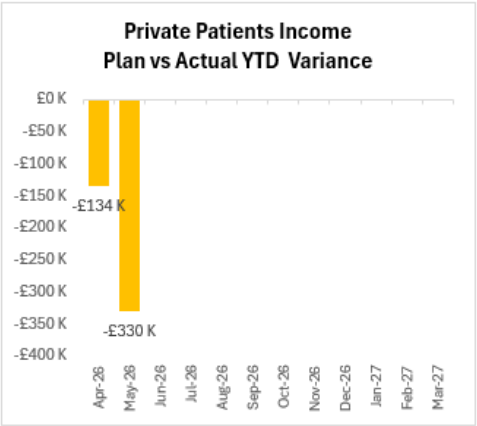
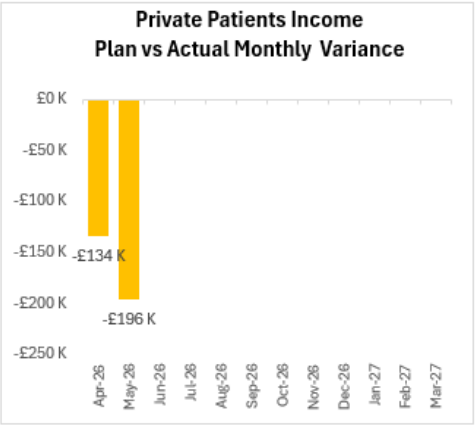
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
The Trust did not meet the Faster Diagnostic Standard or the 62-day cancer standard, primarily due to challenges with Histopathology services provided by UHB. Improvements in the 62-day performance are forecast from early Q2, supported by additional mitigations including increased reporting capacity. Delivery of the FDS remains a concern, largely driven by continued extended TATs at UHB. These delays are attributed to ongoing factors such as laboratory processing issues and the requirement for more complex diagnostic testing in more complex cases. This forms part of a longer-term improvement programme across all UHB laboratories, supported by NHSE.	Monthly executive meetings are held with NHS England to provide regional and national support aimed at reducing delays across the pathway. These meetings will also monitor progress towards establishing a resilient national pathology service for PMBTs 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. Daily touch point with UHB/ROH Ops colleagues to monitor individual patient level 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 are continuing to increase due to workforce challenges and increased referral numbers. Further turnover of staff due to staff moving into alternative roles, EPR requirements and personal reasons. Paediatric Physio waits remain stable at 9 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. Trust workshop took place in April led by the COO. Exec support required for mutual aid request to QE and text reminders. Support received via VCP for Band 6 posts which are now following recruitment processes. 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 post approval to be requested from VCP for backfill of EPR roles and further resignation. 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 now early July, awaiting final comms input. Recruitment processes underway for several posts. Reports to DMB for oversight.	No. 1573 Div 2 - Physio Divisional risk	High

Assurance Reports: Private Patients



All figures shown in thousands (000s) unless otherwise stated
performance and forecast

Income performance improved compared to month 1, reflecting an increase in activity and a higher average value per procedure. May remains below plan, with total income of £390,595 against a planned position of £587,000. Thirteen patient cancellations resulted in approximately £98,388 of lost income.

Cancellations during the month were attributable to a combination of factors. Clinical cancellations (3) included patients being deemed unfit for surgery. Non-clinical cancellations (5) related to consultant unavailability due to bereavement and lack of an appropriate theatre assistant for a complex procedure. Patient choice cancellations (5) included patients electing to delay treatment due to work commitments, declining surgery following further consideration of risks and benefits, accepting treatment elsewhere, or choosing not to proceed due to cost.

Most cancellations were driven by factors outside the direct control of the service; however, operational issues relating to theatre support have been escalated through the appropriate channels, and patient feedback and cancellation themes continue to be monitored to identify opportunities to improve conversion and support future activity growth.

Review theatre assistant support requirements with surgical teams and operational colleagues to ensure appropriate assistance is available across all days of the week, reducing the risk of avoidable non-clinical cancellations.

The Private Practice Oversight Group has been reinvigorated to provide greater operational oversight, monitor performance, identify risks earlier and support delivery of agreed actions.

A consultant engagement session is scheduled at the next QIDD supported by the Head of Private Patients and the Acting COO. The session will focus on sharing service performance, outlining future ambitions and seek feedback on what support consultants require to increase activity into the service. An action will be developed post meeting

Ongoing review of cancellation themes, market conditions and patient feedback to identify opportunities to improve conversion rates and support sustainable activity growth.

June activity currently shows a positive trajectory, with 51 inpatient procedures booked to date, providing confidence in improved activity levels and income performance compared to May 26.

and assurance	Register	Quality
Action Timescale: QIDD presentation 23.6.26	Risk 2164	High
Further commercial initiatives with proposals continue to be brought through Commercial Group.		

Integrated Performance Dashboard: Finance

Metric Grouping	Metric Name	Reporting Period	May'25	Jun'25	Jul'25	Aug'25	Sep'25	Oct'25	Nov'25	Dec'25	Jan'26	Feb'26	Mar'26	Apr'26	May'26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Finance	I&E Surplus / (Deficit) (£k)	Monthly	402	(242)	(164)	(231)	(17)	102	51	40	(409)	7	2604	(59)	(18)	(77)		highisgood	-	-	(27)
Finance	I&E Margin (%)	Monthly	3.30%	(2.10%)	(0.90%)	(2.50%)	(0.10%)	0.90%	0.40%	0.49%	(3.70%)	0.10%	1.14%	4.50%	(0.10%)	(0.10%)		highisgood	-	-	1%
Finance	I&E Variation from Plan	Monthly	635	(71)	(110)	(220)	(64)	(64)	2	9	(505)	(74)	2,235	8	9	17		lowisgood	-	-	0
Finance	EBITDA (%)	Monthly	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%	4.50%		highisgood	-	-	6%
Finance	OP Value	Monthly	575	484	418	549	683	961	581	441	582	352	636	316	299	615		highisgood	-	-	7,764
Finance	OP Performance	Monthly	105.70%	89.99%	60.23%	70.20%	84.99%	115.09%	69.99%	55.33%	54.20%	67.20%	49.92%	48.84%	46.21%	46.21%		highisgood	-	-	0
Finance	Agency Expenditure	Monthly	121	117	115	106	99	113	95	92	77	123	56	4	88	92		lowisgood	-	-	888
Finance	Agency % of total pay/bill	Monthly	1.70%	1.70%	1.60%	1.50%	1.40%	1.60%	1.30%	1.30%	1.10%	1.70%	0.44%	0.10%	1.29%	1.00%		lowisgood	-	-	1.5%
Finance	Capital - Variation to Plan (including impact of IFFS 16)	Monthly	65	275	111	245	(121)	(140)	167	551	445	453	4,903	0	0	0		lowisgood	-	-	3,857
Finance	Cash Balance at end of month	Monthly	835	4,034	3,238	8,158	6,666	8,494	8,538	8,653	7,701	21,336	6,964	6,648	7,822	7,822		highisgood	-	-	11,580
Finance	BFPC Invoices Paid < 30 days (Volume %)	Monthly	73.00%	74.10%	76.50%	78.70%	78.70%	79.60%	80.40%	81.20%	80.40%	81.00%	81.10%	86.10%	83.90%	83.90%		highisgood	-	-	100%
Finance	BFPC Invoices Paid < 30 days (Value %)	Monthly	68.50%	67.90%	68.10%	67.60%	71.20%	72.90%	71.10%	71.70%	70.70%	69.90%	77.20%	86.90%	83.10%	83.10%		highisgood	-	-	100%
Finance	Creditor Days	Monthly	113	121	113	108	89	99	85	95	89	86	82	112	120	120		lowisgood	-	-	30
Finance	Debtor Days	Monthly	64	48	54	43	41	42	35	32	30	30	26	37	38	38		lowisgood	-	-	30
Finance	Operating Expenditure Days	Monthly	12	11	9	23	17	23	22	24	21	54	13	18	20	20		highisgood	-	-	n/a

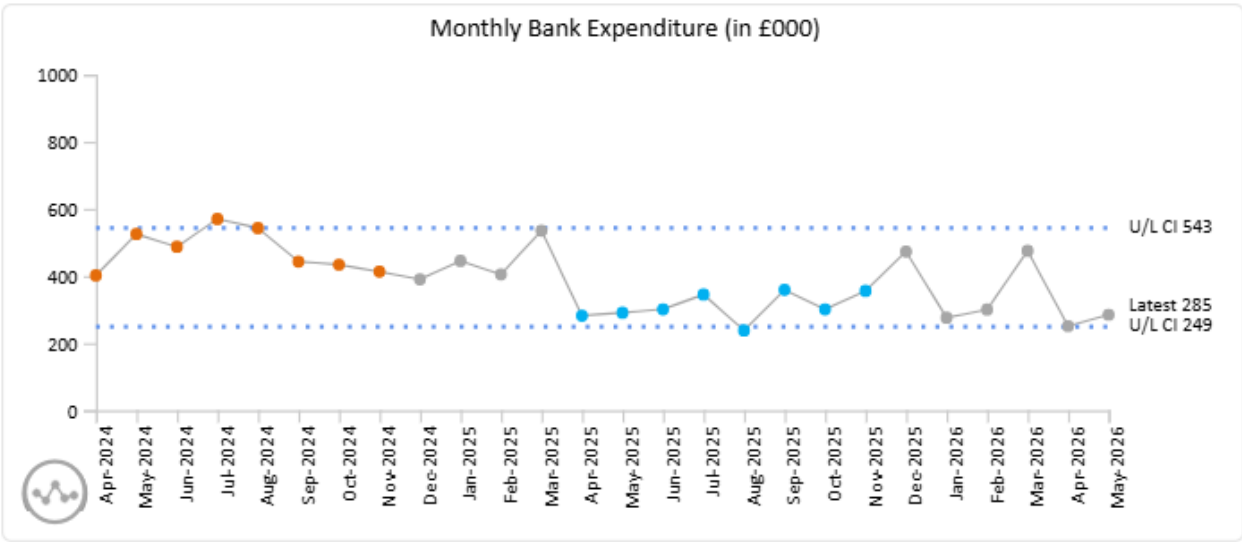
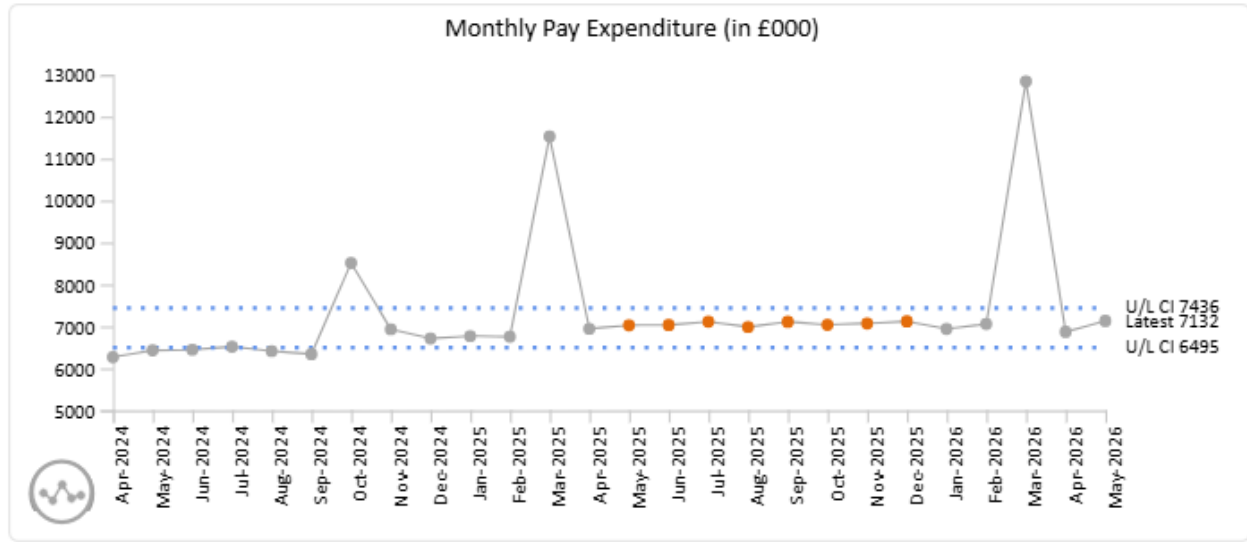
Assurance Reports: Finance Commissioner Income

	1	2	Grand Total	Plan	Variance
Day Cases	£901,827	£946,299	£1,848,125	£1,994,812	-£146,687
Elective	£2,648,854	£3,017,510	£5,666,364	£5,528,513	£137,851
Excess bed days EL	£78,118	£178,348	£256,466	£195,554	£60,912
Outpatient First Consultant Led	£343,427	£314,047	£657,474	£872,983	-£215,509
Outpatient First consultant <u>Non Face</u> to Face	£21,819	£30,462	£52,281		£52,281
Outpatient Procedures FA	£26,851	£5,222	£32,072	£79,337	-£47,265
Outpatient Procedures FUP	£36,969	£40,239	£77,208		£77,208
Grand Total	£4,057,863	£4,532,127	£8,589,990	£8,671,198	-£81,208
Deconstructing block adjustment					-£85,742
Diagnostics	£147,643	£157,060	£304,702	£321,526	-£16,824
Private patients	£296,000	£393,000	£689,000	£1,102,000	-£413,000
Passthrough income	£208,000	£274,000	£482,000	£478,000	£4,000
	£8,767,369	£9,888,314	£10,065,692	£10,572,724	-£507,032

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 performance improved in month compared to Month 1, performing below plan by £403k year to date. Commissioner income improved to £14k favourable variance year to date, and private patient income by £413k against plan year to date.	A focused delivery 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 • Review of elective and outpatient activity profiles, including validation of planning assumptions (productivity, case mix, chargeable activity) against the actual delivery in year • 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)	- 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

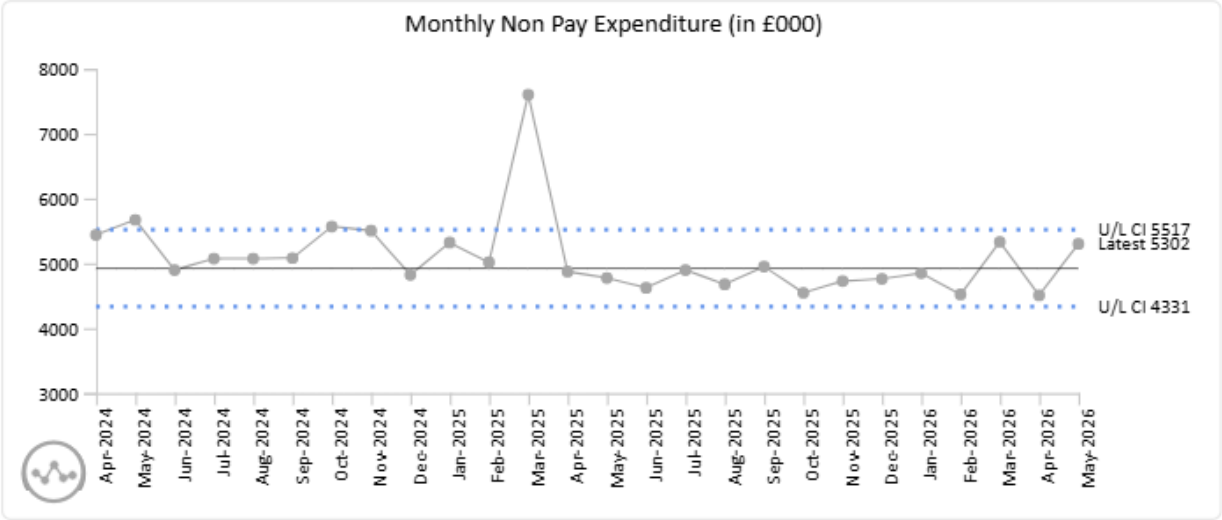


Assurance Reports: Finance Pay Expenditure



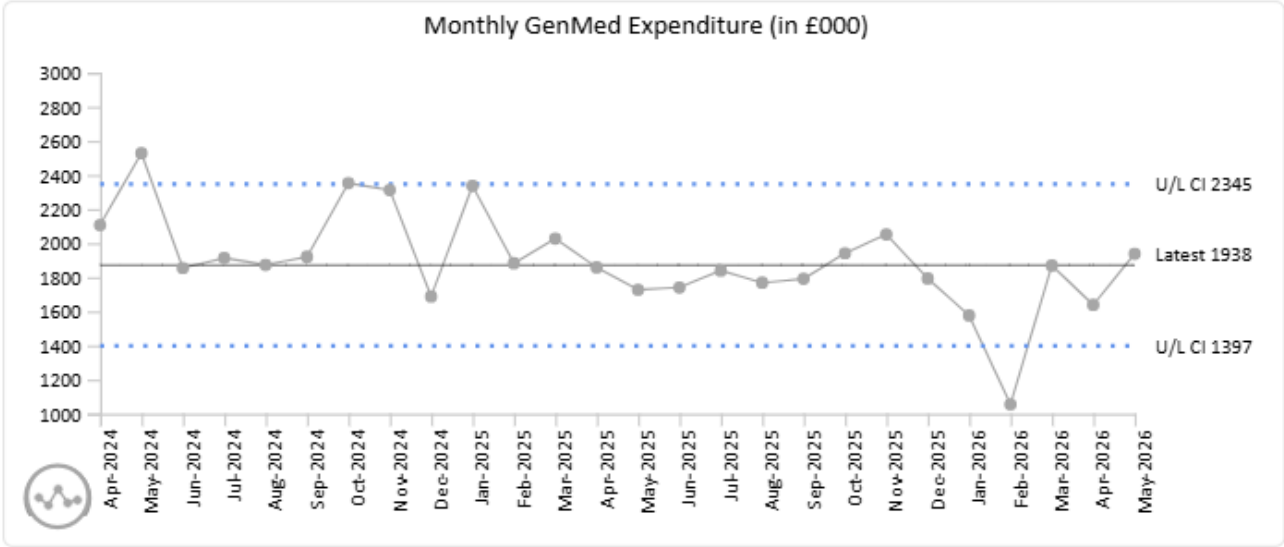
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Pay expenditure is overspent in month by £121k, totalling £19k favourable variance year to date. Agency spend reduced in month, being less than 1% of paybill, with an underspend of £57k year to date. Bank expenditure has reduced in month compared to previous month spend but is overspent year to date by £38k.	•Delivery of 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 trailed 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



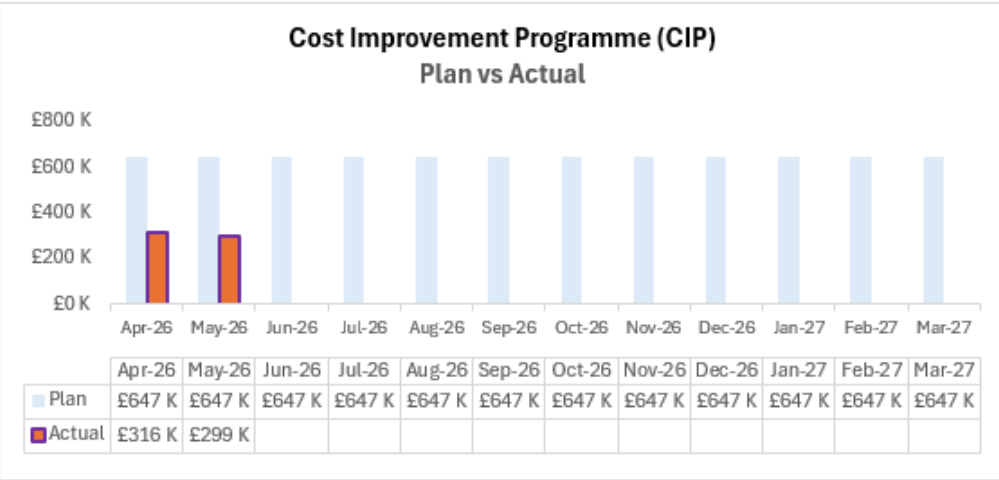
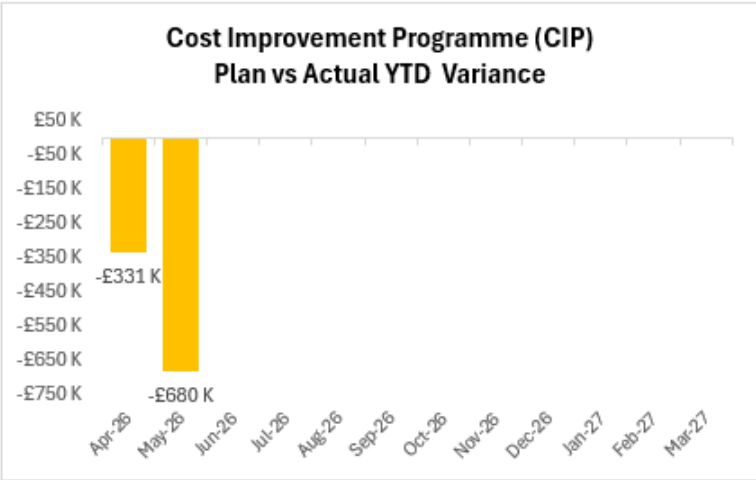
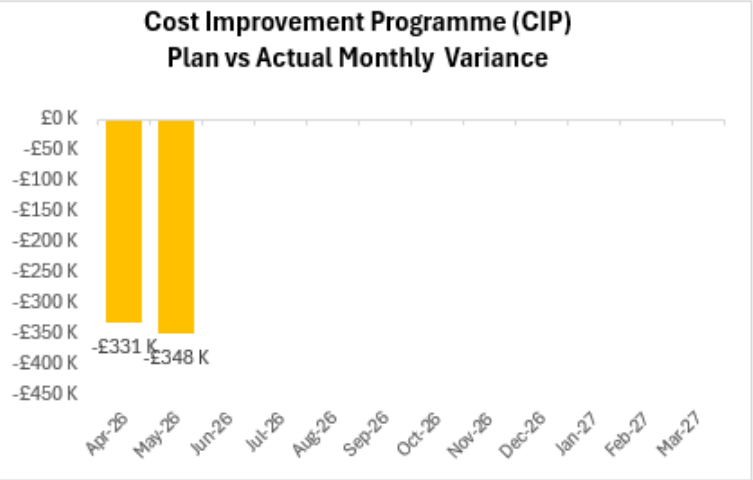
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
Non pay expenditure overspent in month by £229k reducing the year to date favourable variance to £275k. 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. LLP spend in month 2 overspent against planned expenditure by £47k. Year date spend totalling £243k against plan of £224k, generating an adverse variance of £20k.	- 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 for financial year 26/27 aligned to planned activity and capacity plan.	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 increased in month, which was a reflection of the activity undertaken comparatively to Month 1. The general trend for Genmed spend remains in line with expectation. Conversations are ongoing with Genmed to progress the CIP targets aligned with the contract this year, which should result in further reduced spend throughout the year. 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)



All figures shown in thousands (000s) unless otherwise stated

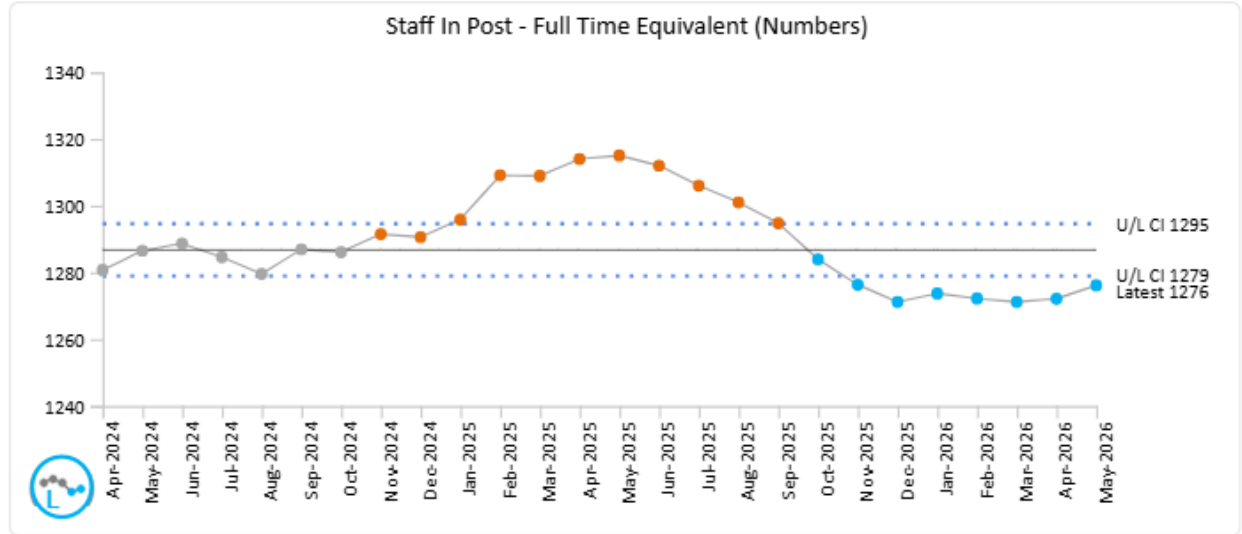
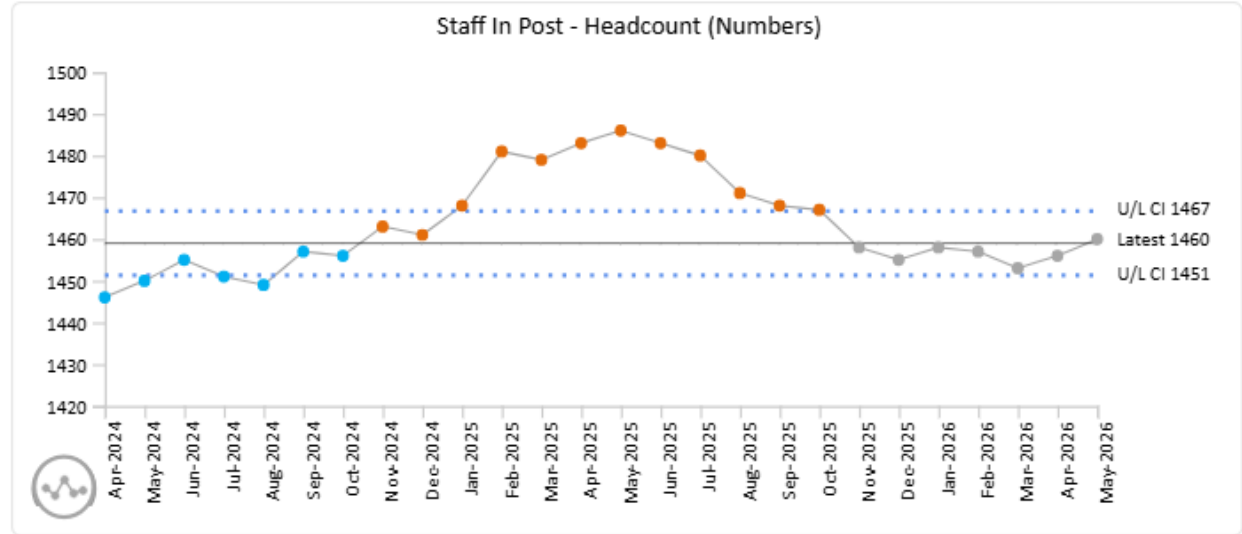
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
CIP identification has progressed in month with the 5% CIP delivery target fully identified, totalling £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 completed following Internal Audit review; - Revamp of Financial Sustainability improvement group meeting - New documentation for CIP submission - New Performance Review Panel meeting held in June as a trial with Division 1. This helps to strengthen the oversight of CIP delivery.	- Financial plan agreed at March Trust Board - Financial sustainability improvement group terms of reference updated and under review by the group	n/a	High

Integrated Performance Dashboard: Workforce

Metric Grouping	Metric Name	Reporting Period	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Workforce	Staff In Post - Headcount	Monthly	1,486	1,483	1,480	1,471	1,468	1,467	1,458	1,455	1,458	1,457	1,453	1,456	1,460	1,460			-	-	-
Workforce	Staff In Post - Full Time Equivalent	Monthly	1,315	1,312	1,306	1,301	1,295	1,284	1,276	1,271	1,274	1,272	1,271	1,272	1,276	1,276			-	-	-
Workforce	Staff Turnover Percentage - Adjusted	Monthly	10.73%	10.64%	10.15%	10.10%	8.88%	10.34%	10.43%	10.27%	10.33%	9.73%	9.60%	9.95%	10.29%	10.29%		low is good			10.5%
Workforce	Total Whole Time Equivalent Employed as a Percentage of Establishment - Clinical	Monthly	88.43%	87.97%	88.40%	91.17%	91.17%	89.23%	89.20%	89.12%	89.26%	87.31%	87.31%	87.31%	83.95%	83.95%		high is good			92%
Workforce	Total Whole Time Equivalent Employed as a Percentage of Establishment - Non-Clinical	Monthly	90.25%	90.44%	90.20%	91.62%	91.62%	90.23%	88.09%	88.69%	89.26%	89.37%	89.37%	89.37%	88.49%	88.49%		high is good			96%
Workforce	Percentage of Attendance	Monthly	94.27%	94.01%	93.93%	94.53%	94.38%	93.79%	94.52%	94.52%	94.38%	94.23%	94.01%	94.66%	94.93%	94.93%		high is good			96%
Workforce	Percentage of Staff Received Mandatory Training last 12 months	Monthly	86.63%	87.43%	86.82%	82.85%	83.13%	84.14%	85.47%	88.79%	91.45%	91.61%	92.08%	91.41%	92.12%	92.12%		high is good			93%
Workforce	Percentage of Staff Received Formal PDR/Appraisal last 12 months	Monthly	85.58%	79.52%	83.10%	86.61%	90.00%	90.56%	90.59%	89.50%	90.85%	90.67%	89.21%	79.20%	68.62%	68.62%		high is good			95%
Workforce	Percentage of Sickness Trust Wide Long Term	Monthly	4.45%	4.04%	4.08%	3.93%	3.57%	3.70%	3.65%	3.55%	2.87%	2.90%	3.39%	3.14%	3.00%	3.00%		low is good	-	-	-
Workforce	Percentage of Sickness Trust Wide Short Term	Monthly	1.61%	2.08%	1.99%	1.46%	2.09%	2.52%	2.00%	3.21%	2.75%	2.86%	2.59%	2.21%	2.07%	2.07%		low is good	-	-	-
Workforce	Return to Work Completion %	Monthly	61.22%	66.24%	69.33%	65.37%	67.01%	67.50%	69.27%	73.96%	68.35%	85.06%	66.83%	76.35%	72.73%	72.73%		high is good			80%

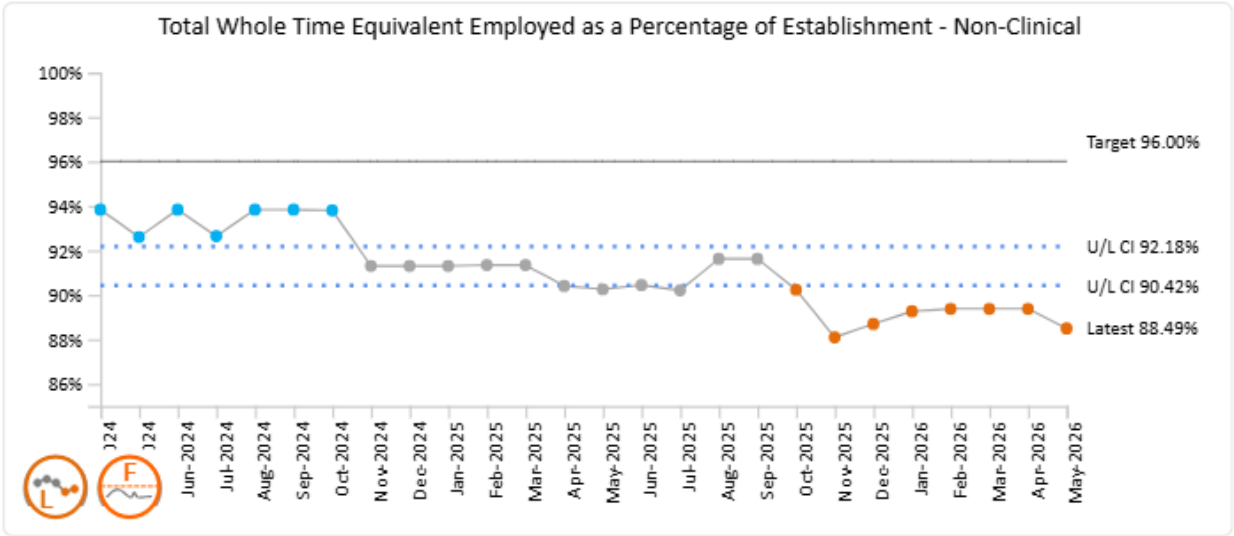
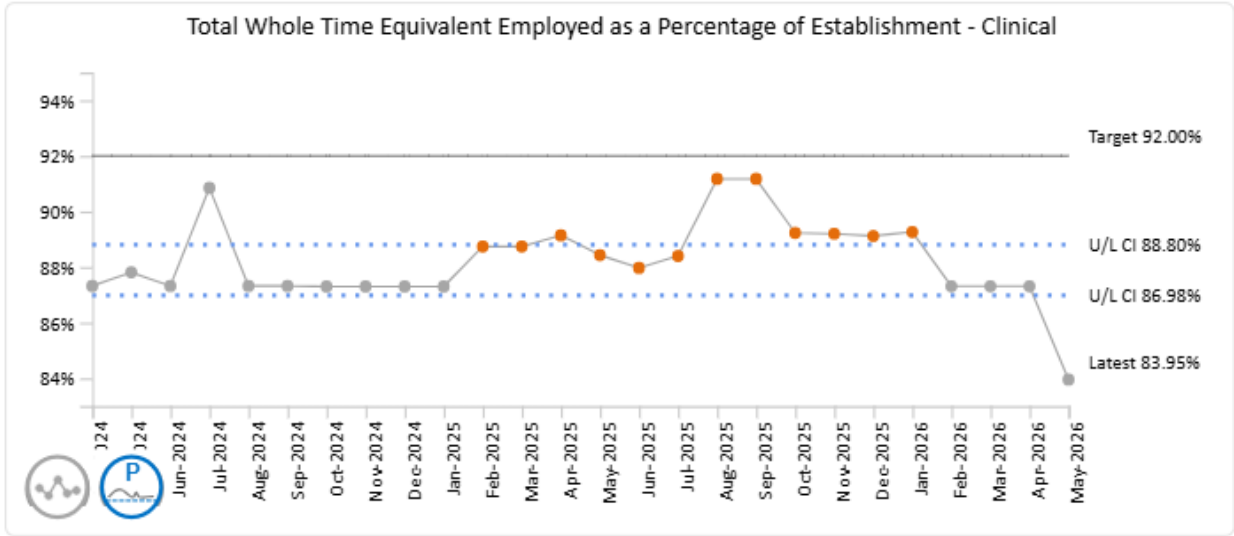


Assurance Reports: Workforce



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There is a risk that we have the wrong number of staff in the wrong areas, balancing pay spend with workforce need.	- We have tight vacancy controls in place, requiring any recruitment to be appropriately assessed, only recruited if high need and alternative approaches are fully considered. - Workforce planning is becoming more embedded in the Trust, with several core services receiving workforce planning support. - Training on workforce planning in place as part of Me as Manager.	Vacancy controls strengthened by new system to include all pay related changes – Jan 26 Assurance committee: Staff Experience and Organisational Development (SE&OD)	Risk 2059	High

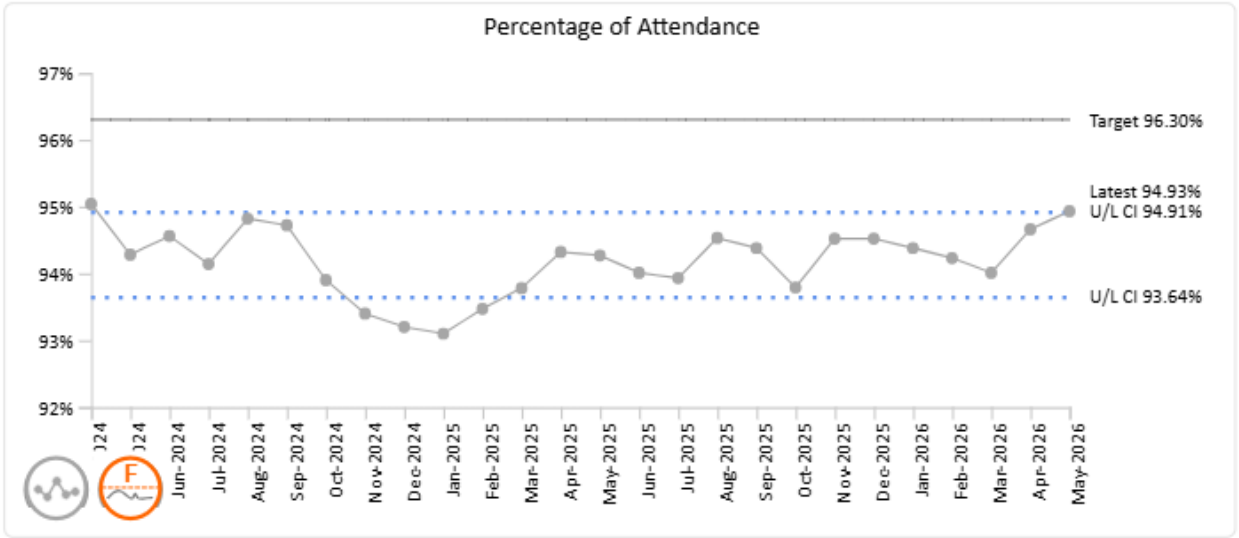
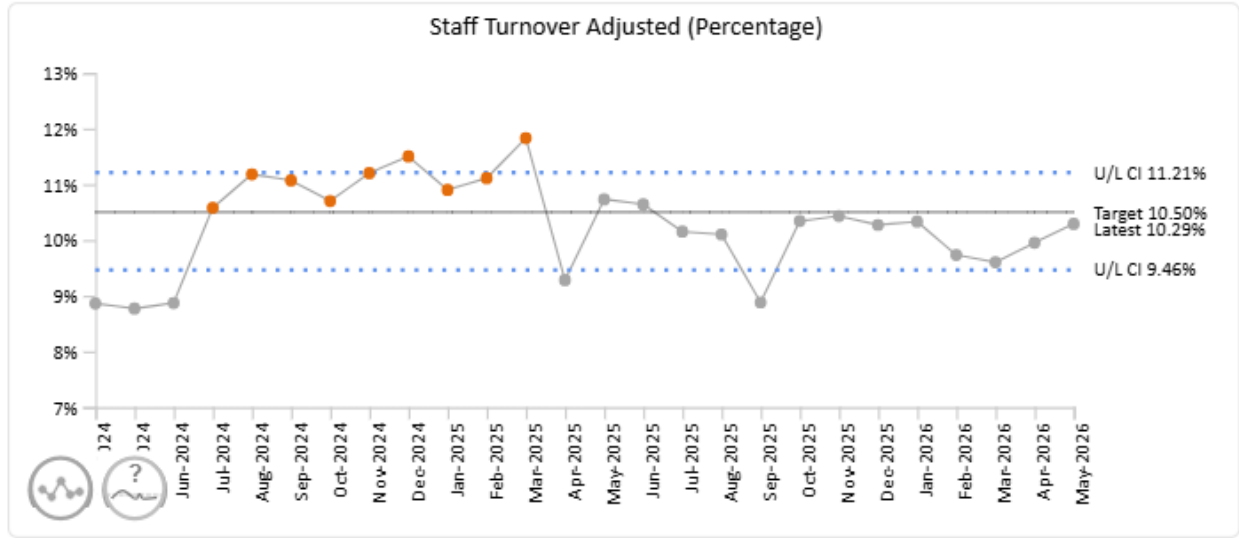
Assurance Reports: Workforce continued



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
- There is a risk that 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 remains within national target. 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



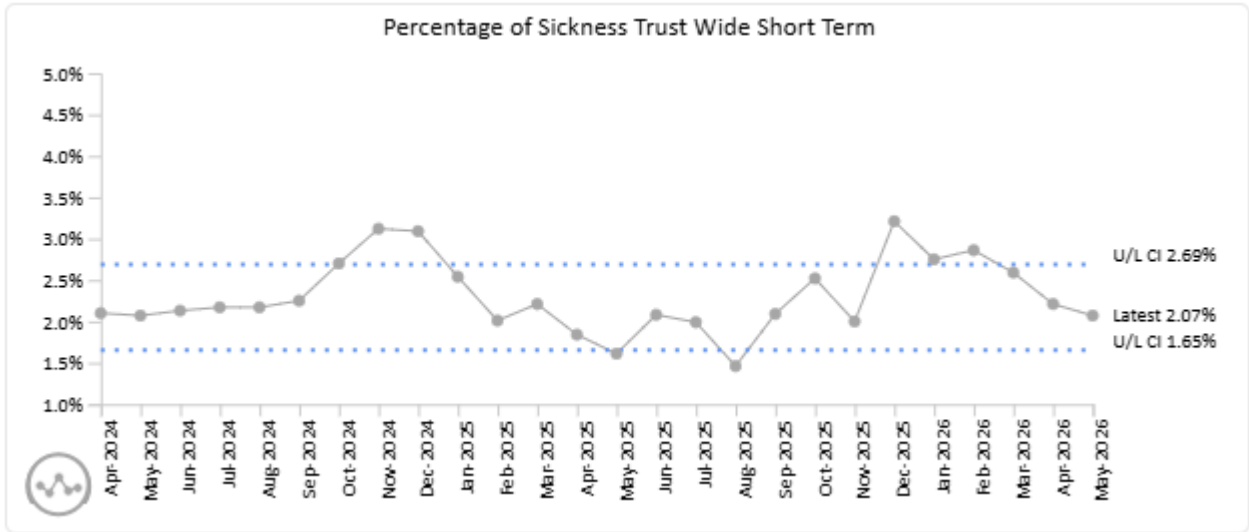
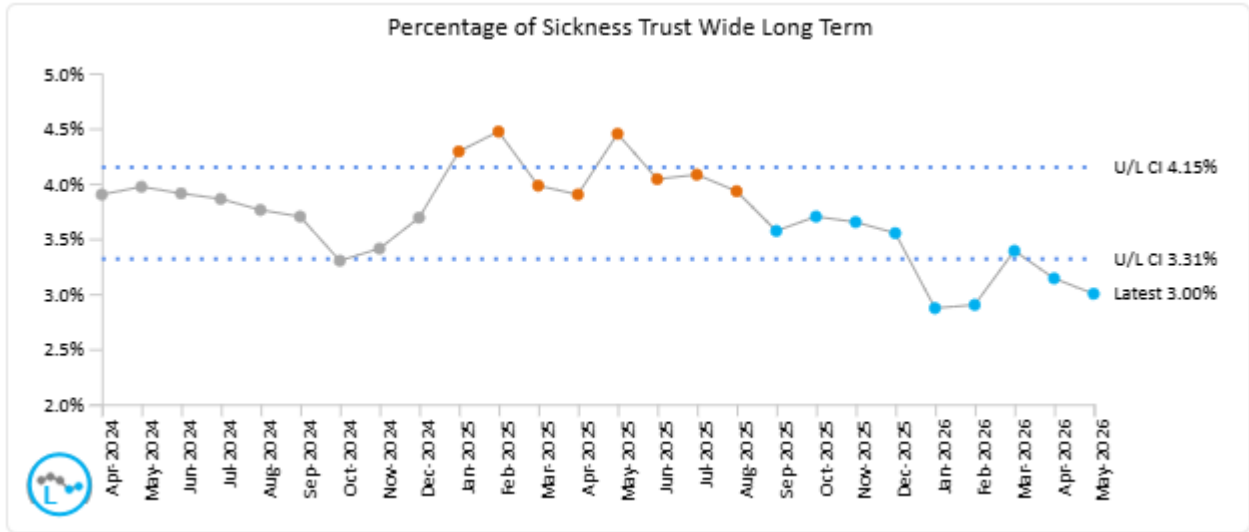
Assurance Reports: Workforce continued



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

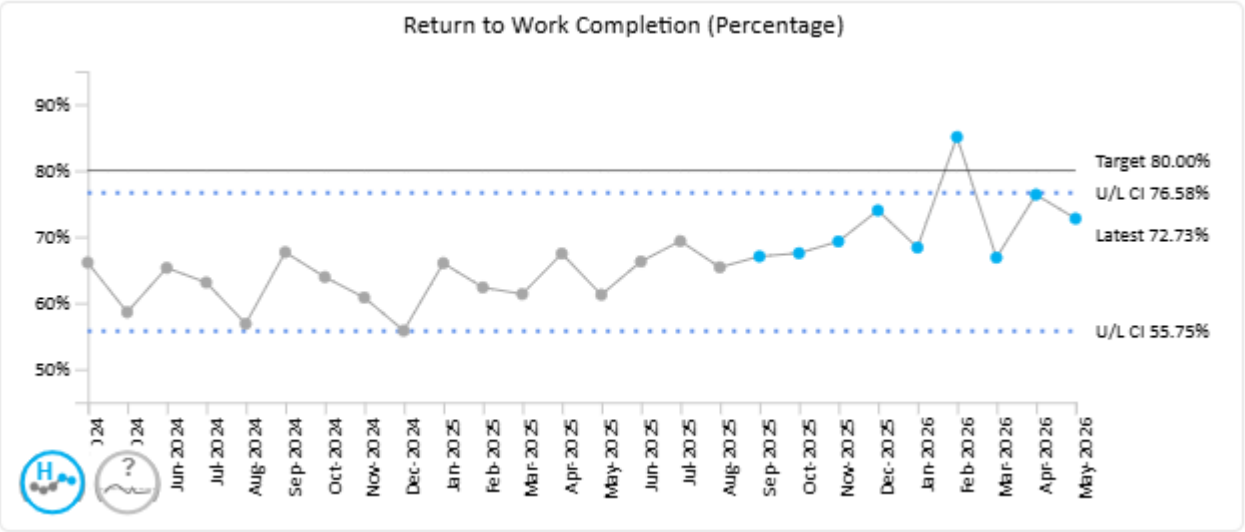


Assurance Reports: Workforce continued



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. May 2026 saw the highest attendance level since April 2024. Monthly estimated cost of sickness has reduced from a high of £289,292 in January 2025 to £217,117 in May 2026 and equates to an improvement of c. 700 days (additional 22.5 FTE) that would otherwise been lost due to sickness.	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

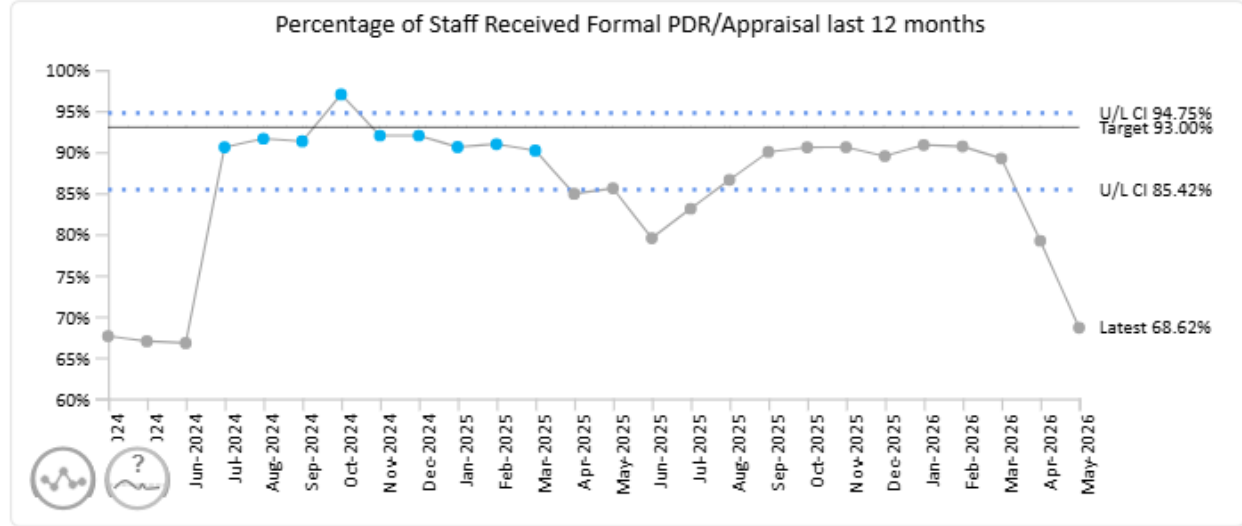
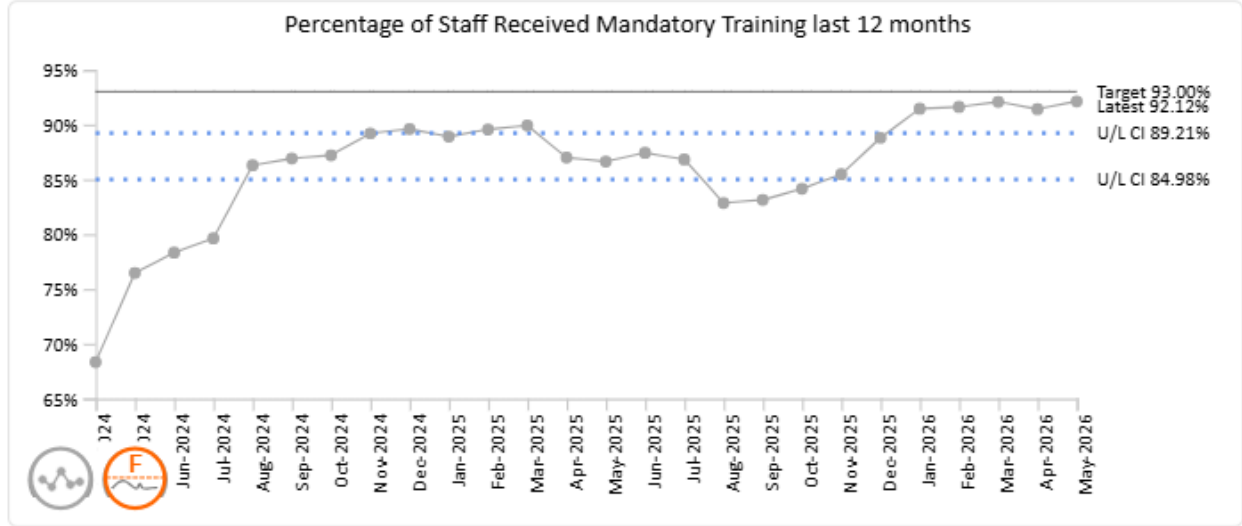
Assurance Reports: Workforce continued



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 May 2026 which is the highest figure for 6 years. - T&D team working closely with the NHSE StatandMand review project to align activity, with the potential to reduce "time" completing training. - Fire safety has been changed to 2 yearly as of March in line with national guidance. - 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	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
Governance	Number of Incidents Reported	Monthly	284	316	337	295	267	311	303	256	282	268	247	239	252	491		high is good	-	-	
Governance	Number of PSII (Patient Safety Incident Investigations)	Monthly	1	1	1	1	1	0	0	0	0	0	0	0	0	0		low is good			0
Governance	Number of Inpatient Deaths	Monthly	0	1	1	0	0	1	1	2	1	0	0	0	0	0		low is good			0
Governance	Number of Deaths within 30 days of discharge	Monthly	1	3	0	3	3	1	1	2	1	3	1	1	0	1		low is good			0
Governance	Number of Never Events	Monthly	1	0	0	1	1	0	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	1	0	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			0
Governance	Number of Inpatient Falls	Monthly	10	5	4	7	9	3	4	7	4	9	17	7	7	14		low is good			0
Governance	Number of Infection Incidents (Reportable)	Monthly	0	0	0	1	0	0	0	0	0	0	1	0	0	0		low is good			0
Governance	Number of Complaints	Monthly	5	6	9	12	7	8	6	10	8	5	6	5	5	10		low is good	-	-	-
Governance	Number of PAL contacts	Monthly	57	40	46	44	53	45	52	37	41	27	37	37	40	77		low is good	-	-	-
Governance	Number of Claims	Monthly	2	1	1	0	0	0	0	0	2	1	0	0	2	2		low is good	-	-	-
Governance	Number of Inquests	Monthly	0	0	0	0	0	2	1	0	0	0	0	1	1	2		low is good	-	-	-
Governance	Number of Medication Incidents	Monthly	13	8	5	5	7	7	5	7	4	5	7	6	9	15		low is good	-	-	-
Governance	Number of Deteriorating Patients Transfers to HDU	Monthly	2	1	5	4	4	3	3	1	2	3	2	2	2	4		low is good	-	-	-
Governance	Number of Deteriorating Patients Emergency Transer OUT	Monthly	1	1	5	5	3	3	6	1	0	4	1	5	4	9		low is good	-	-	-
Governance	Number of RIDDOR- Reportable Staff Incidents	Monthly	3	0	0	1	0	1	1	0	2	0	0	1	0	1		low is good	-	-	-

Integrated Performance Dashboard: Infection Control

Metric Grouping	Metric Name	Reporting Period	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-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		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		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		P	0
Infection Control	Hospital-onset healthcare-associated Escherichia coli Bacteraemia	Monthly	0	0	0	0	0	0	0	0	0	1	0	0	0	0		low is good		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		P	0
Infection Control	Hospital-onset healthcare-associated C. difficile Toxin +ve (reportable)	Monthly	0	0	0	1	0	0	0	0	0	0	1	0	0	0		low is good		P	0
Infection Control	All C. difficile cases identified on or during admission	Monthly	0	0	1	1	0	0	1	0	0	0	2	0	1	1		low is good		?	0
Infection Control	Healthcare-associated MRSA (acquisition)	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good		P	0
Infection Control	Healthcare-associated Influenza	Monthly	0	0	0	0	0	0	0	3	0	0	0	0	0	0		low is good		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		P	0
Infection Control	Respiratory Infection Outbreaks	Monthly	0	0	0	0	0	0	0	1	0	0	0	0	0	0		low is good		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		P	0
Infection Control	Surgical Site Infections (inpatient & readmission - month of primary surgery)	Monthly	1	2	3	1	2	1	5	1	2	3	2	2	0	2		low is good		F	0
Infection Control	Hand Hygiene Audit - Trust total %	Monthly	91%	99%	100%	99%	99%	99%	99%	99%	100%	100%	99%	100%	99%	100%		high is good		P	90%

Quality Report

Month 2

May 2026

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

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

Variation Icons

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



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



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



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

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

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

Assurance Icons

Can we expect to reliably hit the target?



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



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



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



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



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

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



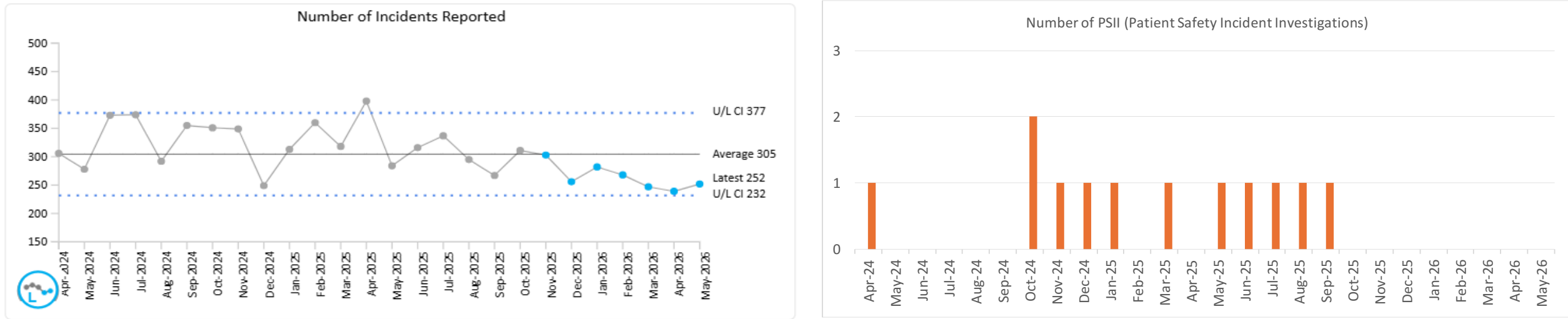
Integrated Performance Dashboard: Governance

Metric Grouping	Metric Name	Reporting Period	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target	
Governance	Number of Incidents Reported	Monthly	284	316	337	295	267	311	303	256	282	268	247	239	252	491		high is good	-	-		
Governance	Number of PSII (Patient Safety Incident Investigations)	Monthly	1	1	1	1	1	0	0	0	0	0	0	0	0	0	0		low is good			0
Governance	Number of Inpatient Deaths	Monthly	0	1	1	0	0	1	1	2	1	0	0	0	0	0	0		low is good			0
Governance	Number of Deaths within 30 days of discharge	Monthly	1	3	0	3	3	1	1	2	1	3	1	1	0	1	1		low is good			0
Governance	Number of Never Events	Monthly	1	0	0	1	1	0	0	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	1	1	1		low is good			0
Governance	Number of Category 3 Pressure Ulcer Incidents ROH acquired	Monthly	0	0	0	0	0	0	0	0	0	0	0	1	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	0		low is good			0
Governance	Number of Inpatient Falls	Monthly	10	5	4	7	9	3	4	7	4	9	17	7	7	14	14		low is good			0
Governance	Number of Infection Incidents (Reportable)	Monthly	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0		low is good			0
Governance	Number of Complaints	Monthly	5	6	9	12	7	8	6	10	8	5	6	5	5	10	10		low is good	-	-	-
Governance	Number of PAL contacts	Monthly	57	40	46	44	53	45	52	37	41	27	37	37	40	77	77		low is good	-	-	-
Governance	Number of Claims	Monthly	2	1	1	0	0	0	0	0	2	1	0	0	2	2	2		low is good	-	-	-
Governance	Number of Inquests	Monthly	0	0	0	0	0	2	1	0	0	0	0	1	1	2	2		low is good	-	-	-
Governance	Number of Medication Incidents	Monthly	13	8	5	5	7	7	5	7	4	5	7	6	9	15	15		low is good	-	-	-
Governance	Number of Deteriorating Patients Transfers to HDU	Monthly	2	1	5	4	4	3	3	1	2	3	2	2	2	4	4		low is good	-	-	-
Governance	Number of Deteriorating Patients Emergency Transer OUT	Monthly	1	1	5	5	3	3	6	1	0	4	1	5	4	9	9		low is good	-	-	-
Governance	Number of RIDDOR- Reportable Staff Incidents	Monthly	3	0	0	1	0	1	1	0	2	0	0	1	0	1	1		low is good	-	-	-

Integrated Performance Dashboard: Infection Control

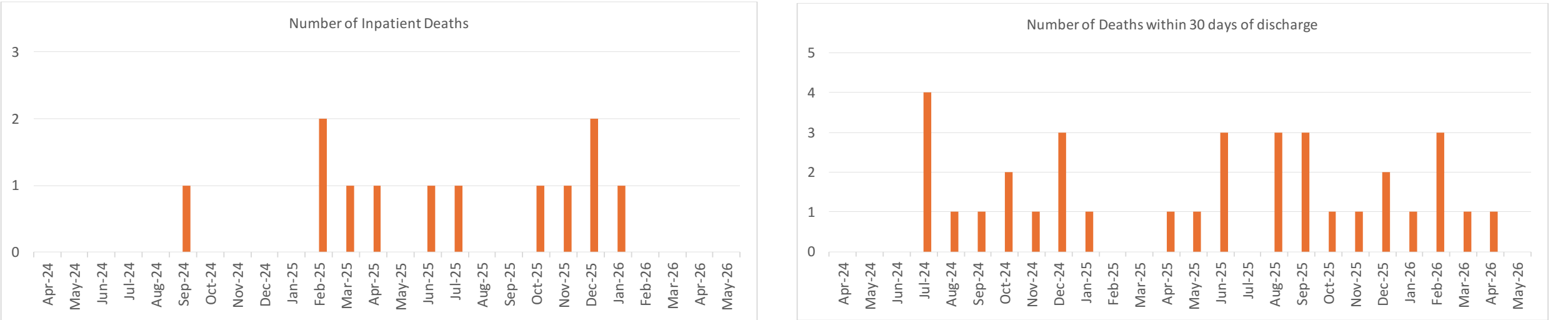
Metric Grouping	Metric Name	Reporting Period	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	YTD	Trend	Direction of Travel	Latest Variation Monthly	Latest Assurance Target	Target
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Infection Control	Hospital-onset healthcare-associated MSSA Bacteraemia	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good		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		P	0
Infection Control	Hospital-onset healthcare-associated Escherichia coli Bacteraemia	Monthly	0	0	0	0	0	0	0	0	0	1	0	0	0	0		low is good		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		P	0
Infection Control	Hospital-onset healthcare-associated C. difficile Toxin +ve (reportable)	Monthly	0	0	0	1	0	0	0	0	0	0	1	0	0	0		low is good		P	0
Infection Control	All C. difficile cases identified on or during admission	Monthly	0	0	1	1	0	0	1	0	0	0	2	0	1	1		low is good		?	0
Infection Control	Healthcare-associated MRSA (acquisition)	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0		low is good		P	0
Infection Control	Healthcare-associated Influenza	Monthly	0	0	0	0	0	0	0	3	0	0	0	0	0	0		low is good		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		P	0
Infection Control	Respiratory Infection Outbreaks	Monthly	0	0	0	0	0	0	0	1	0	0	0	0	0	0		low is good		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		P	0
Infection Control	Surgical Site Infections (inpatient & readmission - month of primary surgery)	Monthly	1	2	3	1	2	1	5	1	2	3	2	2	0	2		low is good		F	0
Infection Control	Hand Hygiene Audit - Trust total %	Monthly	91%	99%	100%	99%	99%	99%	99%	99%	100%	100%	99%	100%	99%	100%		high is good		P	90%

Assurance Reports: Incidents



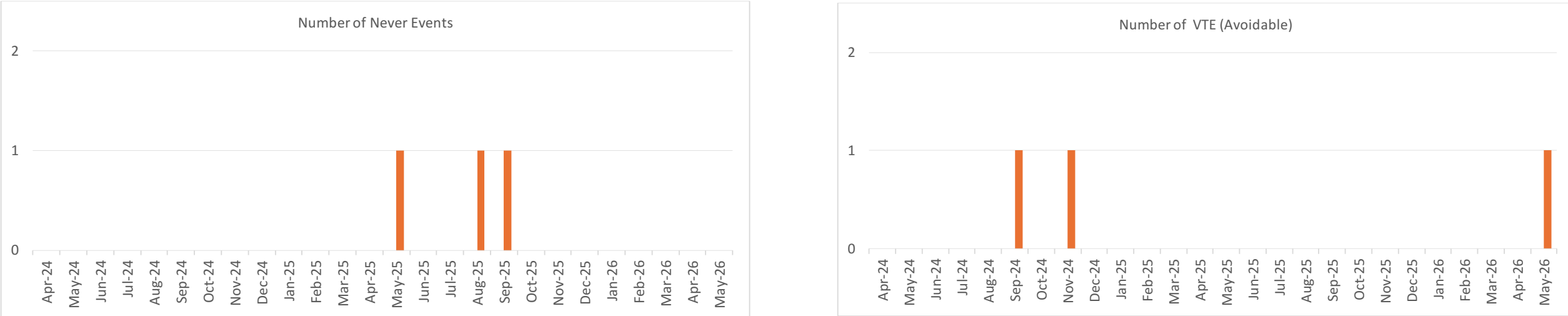
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There were 252 incidents reported within the Trust during May 2026, a slight increase compared to previous months. There were no PSII's commissioned in May.	Review of PSIRF priorities underway.		NA	High

Assurance Reports: Learning from Deaths



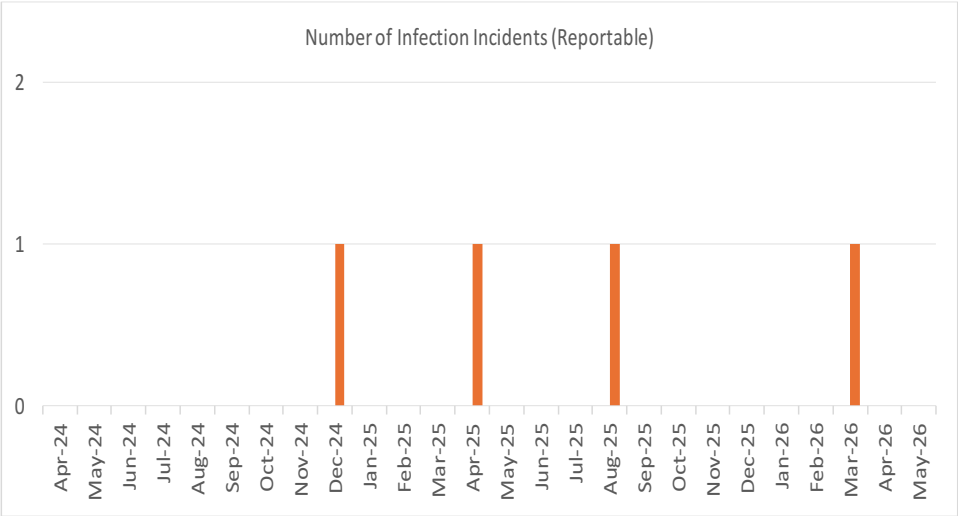
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There were no inpatient deaths or deaths within 30 days of discharge reported in May 2026. HED & PAS 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.		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 May 2026: xx% (Confirmed) No Never Events reported in May 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

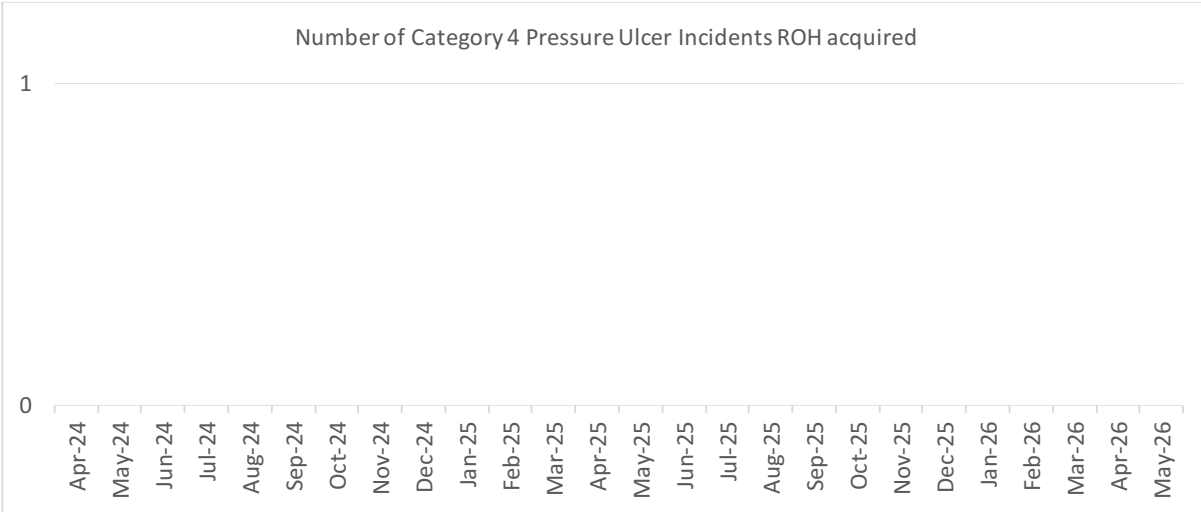
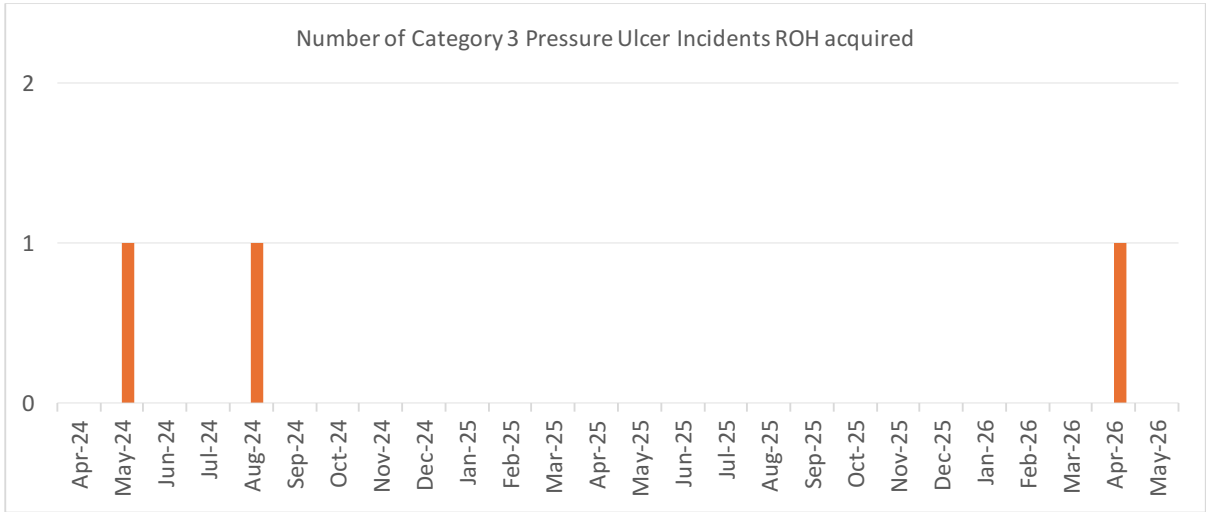


Infections Recorded in month and Year to Date (YTD)	MAY 2026	YTD*
Methicillin-Resistant <i>Staphylococcus aureus</i> (MRSA) bloodstream infection	0	0
HOHA/COHA toxin positive <i>Clostridioides difficile</i> infection (CDI)	0	0
Methicillin-Sensitive <i>Staphylococcus aureus</i> (MSSA) bloodstream infection	0	0
<i>E. coli</i> bloodstream infection	0	0
<i>Klebsiella spp.</i> bloodstream infection	0	0
<i>Pseudomonas aeruginosa</i> bloodstream infection	0	0

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

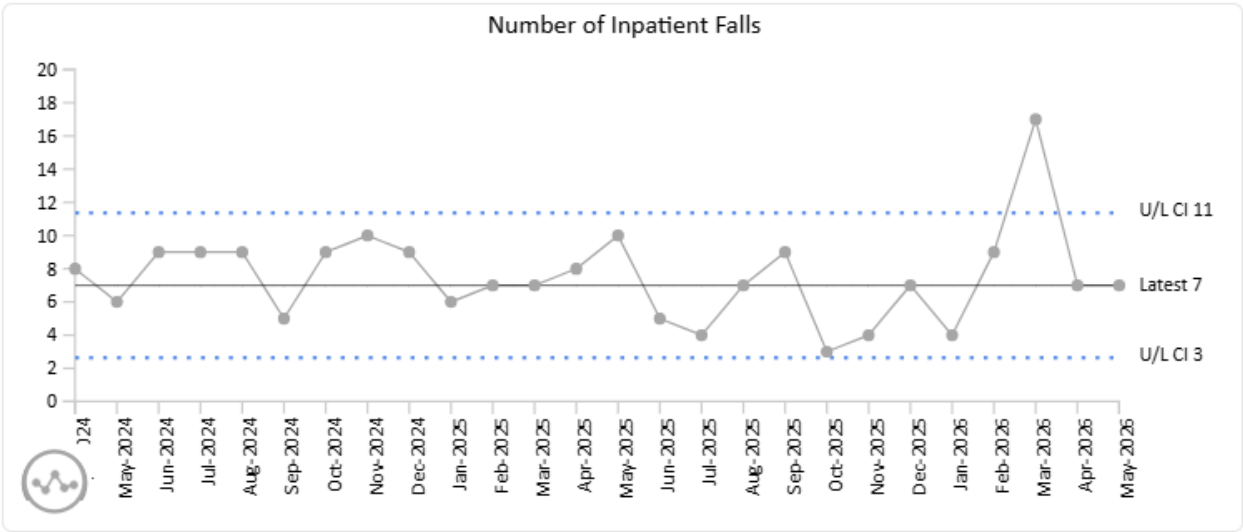
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
No reportable incidents reported in May.	Details of IPC QI work is reported to the IPC Committee and 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



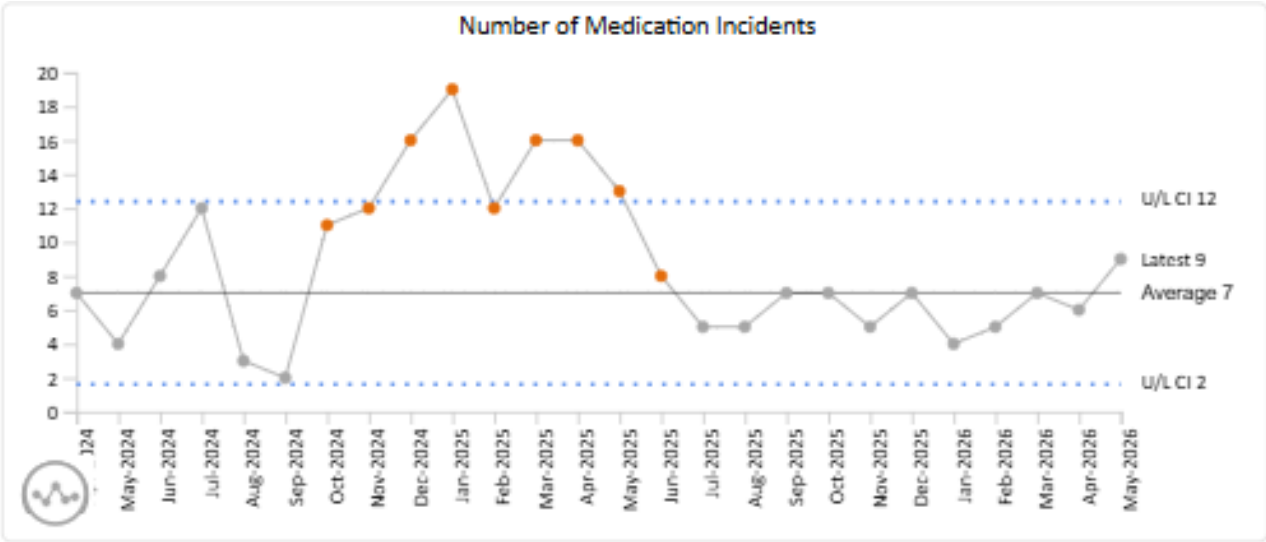
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There were no category 3 or 4 pressure ulcers reported in May 2026.		Joint report with Theatre Matron 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
There were 7 inpatient falls reported in May 2026, 6 of the incidents were reported as no harm and 1 low harm. Themes identified from falls incidents:- 4 falls were recorded on ward 3 6 falls were unwitnessed 4 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/trolleys and maintenance ongoing - Focus group set up to review previous months increase in in-patient falls			

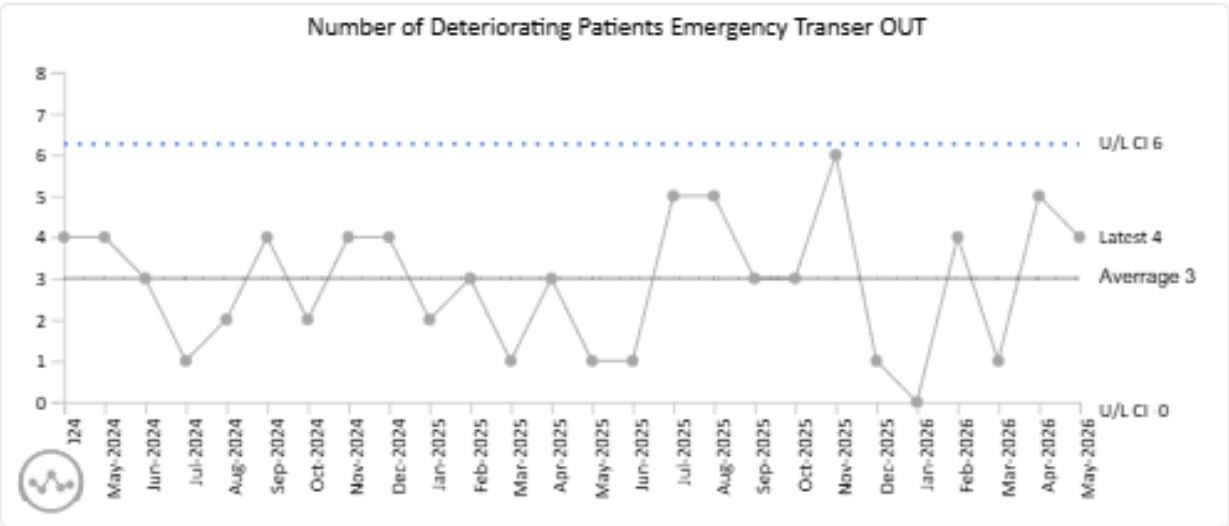
Assurance Reports: Medication Incidents



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 9 Medication incidents reported in May 2026, that currently meet the desired criteria for review. There has been a drive to raise awareness of medication errors through improving competency through bespoke training by the Pharmacy department and reminders regarding process and procedures.		DTC	N/A	High

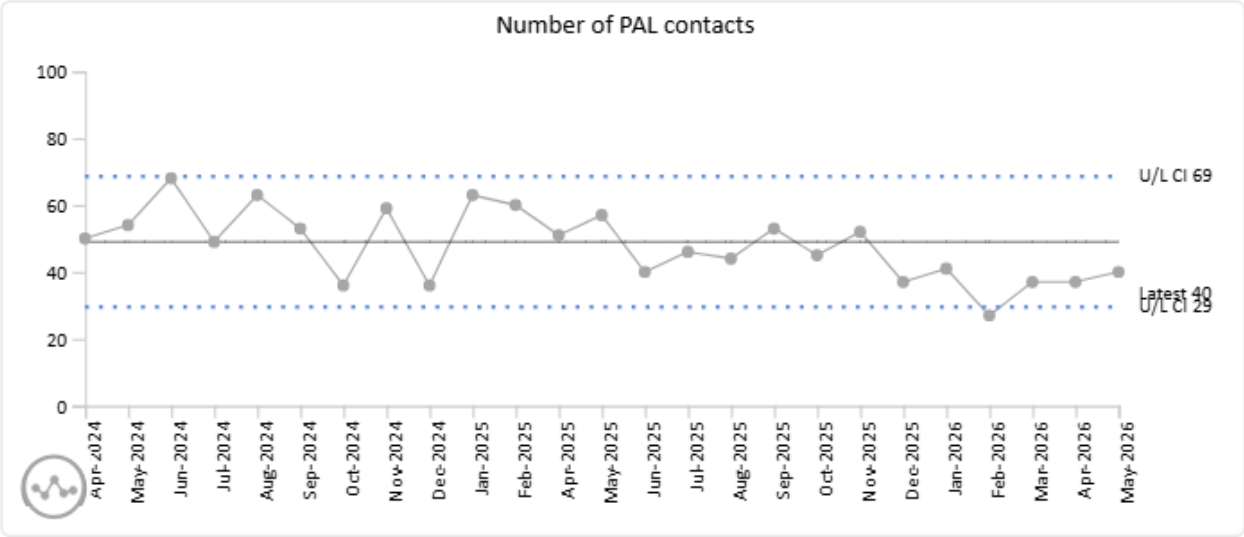
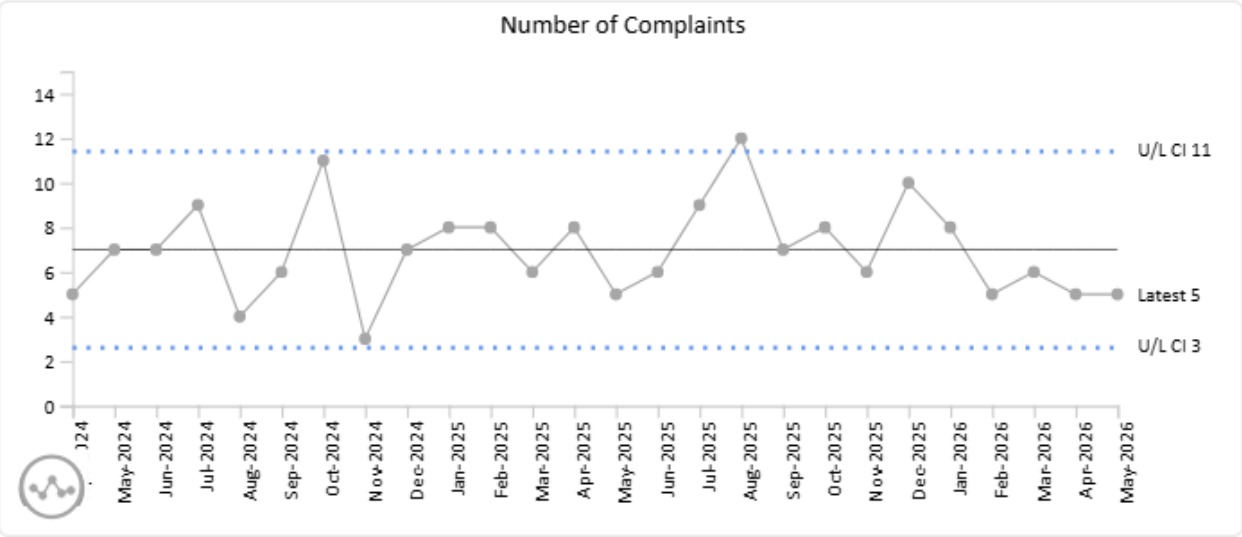
Number of Deteriorating Patients Transfers to HDU

Month	Latest 2	Average 4	Average 12
May 2024	5.0	3.0	2.0
Jun 2024	1.0	1.0	2.0
Jul 2024	1.0	1.0	2.0
Aug 2024	2.0	2.0	2.0
Sep 2024	2.0	2.0	2.0
Oct 2024	0.0	0.0	2.0
Nov 2024	1.0	1.0	2.0
Dec 2024	1.0	1.0	2.0
Jan 2025	6.0	4.0	2.0
Feb 2025	4.0	4.0	2.0
Mar 2025	4.0	4.0	2.0
Apr 2025	3.0	3.0	2.0
May 2025	2.0	2.0	2.0
Jun 2025	1.0	1.0	2.0
Jul 2025	5.0	4.0	2.0
Aug 2025	4.0	4.0	2.0
Sep 2025	4.0	4.0	2.0
Oct 2025	3.0	3.0	2.0
Nov 2025	3.0	3.0	2.0
Dec 2025	1.0	1.0	2.0
Jan 2026	2.0	2.0	2.0
Feb 2026	3.0	3.0	2.0
Mar 2026	2.0	2.0	2.0
Apr 2026	2.0	2.0	2.0
May 2026	2.0	2.0	2.0



ROHFP (04-22) 004 Finance & Performance Report

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 May 2026. Of these, all remain open but within agreed timescales as of 31st May 2026 resulting in a May KPI achievement of 100%. On 31/05/2026 The trust had 14 formal Complaints remaining open, of which 3 had breached the agreed timescales. This provides a May month end KPI of 71% which is a 6% increase on last month's KPI. In May 2026 the Trust received no new requests for a resolution meeting and there were no pre arranged resolution meetings. There were no requests for complaints to be re-opened ROHFP (04-22) 004 Finance & Performance Report	- 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 compliance across the theatre complex remains high, with the majority of theatres achieving 100% compliance during May 2026. This reflects the ongoing commitment of theatre teams to maintaining safe, organised, and compliant clinical environments.	Whilst compliance scores remain positive, audit completion rates vary considerably between areas, limiting the level of assurance that can be obtained in some theatres.		N/A	High

Area	Mar-26	Number of audits	April 26	Number of audits	May 26	Number of audits	Progress
Th1	100%	10	Closed	N/A	100%	10	↔
Th2	100%	10	100%	9	100%	10	↑
Th3	100%	1	100%	1	100%	1	↔
Th4	Closed	N/A	Closed	N/A	99.7%	10	
Th5	100%	8	100%	7	100%	10	↔
Th6	100%	10	100%	10	99.7%	10	↓
Th7	100%	10	100%	10	100%	10	↔
Th8	99.70%	10	100%	6	100%	10	↔
Th9	100%	10	100%	10	100%	10	↔
Th10	100%	10	100%	10	100%	4	↓
Th11	0	0	100%	10	100%	10	↔
Th12	100%	10	100%	10	100%	10	↔
Th14	100%	4	100%	8	100%	4	↓
Th15	100%	10	100%	10	100%	2	↓

Assurance Reports: CAS Alerts

CAS Alerts Received 1- 31 MAY 2026

Reference	Alert Title	Originated By	Issue date	Response	Deadline
N/A					

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 May.			N/A	High

Assurance Reports: Outstanding CAS Alerts - Actioned

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: Clinical guidance document developed and implemented. Confirmation of all actions complete received (email from JD patient safety team 06.05.26) Alert now closed – all actions complete.	12 Jun 2026

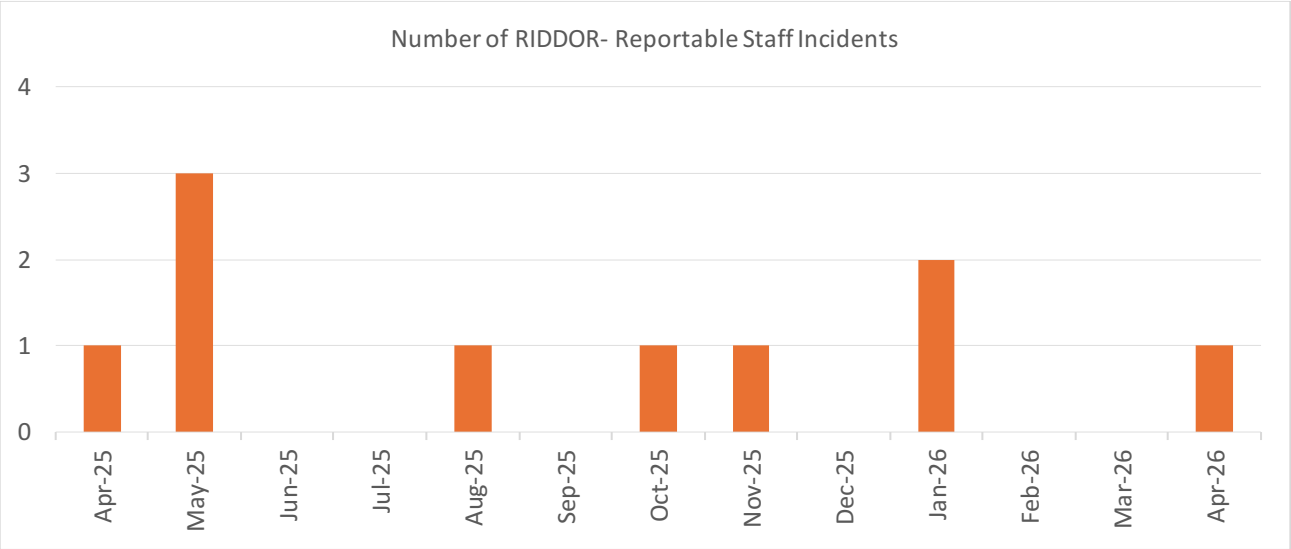
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality

Assurance Reports: Outstanding CAS Alerts – Open

Reference	Alert Title	Originated By	Issue date	Response	Deadline
NatPSA/2025/006/NHSPS	Harm from incorrect recording of a penicillin allergy as a penicillamine allergy. 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



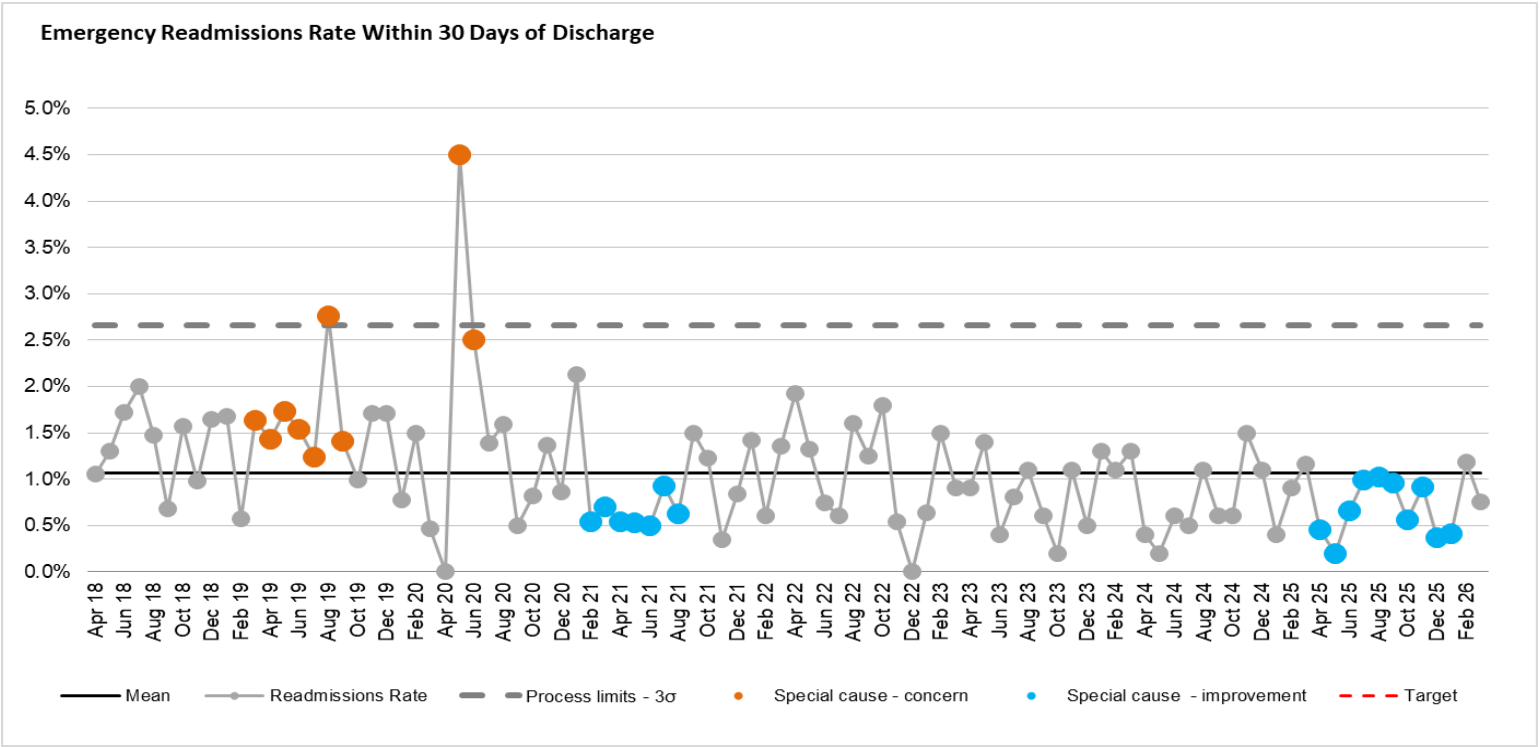
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Action timescales and assurance group or committee	Risk Register	Data Quality
There were no RIDDOR reportable staff incidents reported in May 2026.	•Improvements to training / awareness 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.		N/A	High



Assurance Reports: Safeguarding Training

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 three concerns raised to FTSUG in May 2026. Concerns reported were related to the following themes: - Inappropriate attitude and behaviour - workers safety and wellbeing Nature of concerns: - Current operational demands causing burnt-out related absence. Upon return-to-work staff absorbed extra workload without occupational health guidance being implemented and continue to feel overwhelmed. - Failure to maintain confidentiality causing staff to feel hesitant to raise further grievance. - Inappropriate and offensive office conversations regarding cultural blame, which included discriminatory statements that individuals not born in the UK should be identified as such, and that British citizenship does not constitute being truly British. Note: Staff consulted the FTSUG for support and guidance, following this, they were satisfied to escalate their concerns to the relevant manager.	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: Safe Staffing Summary

Alert	Advise
The team wishes to bring the following issues to the committee attention: Nil	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: <u>Sickness</u> Ward 4: 1.63% (↓ from 9.99%) Ward 12: 12.29% (↑ from 9.55%) Theatres: 8.44% (↓ from 8.88%) Overall sickness shows a mixed position when compared to April, with improvements seen in some areas; however, levels remain elevated in specific areas, notably Ward 12 & HDU <u>RN day fill rates</u> RN day fill rates reduced in Ward 1 and Ward 12. Ward 1: 85% → 80% (↓). Ward 12: 84% → 81% (↓) Ward 2: 81% → 80% (→) Ward 3: 96% → 101% (↑) Ward 4: 97% → 100% (↑) CYP OPD: 19% - Tolerated Run rate - Template being reviewed alongside the current service review. <u>Falls</u> Falls reduced and sustained. Falls 7 (6, ↓ 17 in March, 16 Inpatients and 2 Outpatients). Although improved, this remains an area for continued monitoring through divisional governance, Dementia and Falls Working Group and Falls and Prevention Focus Group. <u>Pressure ulcers</u> Pressure ulcers 1 (↓ 5). Reduction noted; however, this remains an area for continued monitoring and increased focus on higher grade pressure ulcers and reporting requirements. Further review required to ensure consistency in Training/ grading and reporting. <u>Enhanced Therapeutic Observation Care (ETOC)</u> Although reduced, enhanced care activity remains elevated. Reflecting ongoing patient dependency and observation requirements. Total ETOC 854.5 hours (↓ 1198). (312 Registered Nurse hours and 542.5 HCA hours). (172 hours bank and 370.5 Substantive hours) <u>Red flags</u> Red Flags 0 (→ 0). Work is fully underway in background, outcome of the work will be shown in the next reporting period.

Assurance Reports: Safe Staffing Summary

Assure	Recommendation
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. Whilst variability remains within fill rate data, this does not fully reflect actual staffing levels due to the contribution of Registered Nurse Associate roles and local operational factors. Patient safety indicators remain stable overall, with no evidence of staffing related harm or deterioration. Falls have reduced and remain under ongoing review through established governance groups, and pressure ulcers have reduced in month, with continued focus on accurate reporting, grading, and training. Sickness demonstrates a mixed position, with improvement in some areas; however, targeted support and management remains in place for areas with higher levels of absence, supported through HR and divisional governance processes. Patient dependency remains high, reflected in continued elevated Enhanced Therapeutic Observation Care (ETOC) activity, although reduced in month. Multiple patients required enhanced observation concurrently, and staffing was provided to support safe care delivery. Red flag reporting remains at zero; however, work is underway to strengthen the consistent interpretation, recording, and escalation of red flags, with further assurance expected in the next reporting period.	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																					
	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	77.0%	108.0%	13.0%	110.0%	376.25	0	0%	0%	2.08%	2.16%	557.00	7.1	0	0	72	5	1	0	0	0	48.00%
Ward 2	81.0%	109.0%	122.0%	148.0%	397.5	22	0%	0%	3.64%	3.69%	579.00	8.0	0	0	653.5	0	0	2	1	1	60.00%
Ward 3	86.0%	100.0%	101.0%	103.0%	276	99	0%	0%	5.39%	1.77%	645.00	6.3	0	0	0	0	0	4	0	0	74.00%
Ward 4	102.0%	101.0%	103.0%	129.0%	36.5	0	0%	0%	1.63%	3.27%	459.00	9.0	0	0	129	0	0	0	0	0	77.00%
Ward 12	78.0%	98.0%	100.0%	100.0%	48	0	0%	0%	12.29%	0.00%	49.00	10.5	0	0	0	0	0	0	0	0	50.00%
HDU	84.0%	67.0%	88.0%	-	0	0	0%	2%	10.54%	4.82%	126.00	20.2	0	0	0	0	0	0	0	0	79.00%
total combined	-	-	-	-	1134.25	121.00	-	-	-	-	2415.00	61.1	0	0	855	5	1	6	1	1	-
Total Average	84.7%	97.2%	87.8%	118.0%	189.0417	20.167	0%	0%	5.9%	2.6%	403	10.18	0	0	142	-	-	-	-	-	65%

Assurance Reports: Safe Staffing Summary

Core Services																			
	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%	80%	-	-	0	-	0.00%	0%	4.09%	5.10%	0	0	0	0	0	0	1	0	19.00%
CYP OPD	19%	90%	-	-	0	-	-	-	-	-	-	-	-	0	0	0	0	0	91.00%
ADCU	60%	76%	-	-	179.75	-	0.00%	0%	3.56%	0.00%	0	0	0	0	0	1	0	0	20.00%
POAC	100%	87%	-	-	0	-	0.00%	0%	6.48%	2%	0	0	0	0	0	0	1	0	5.00%
Theatres	84%	70%	-	-	54.5	-	0.00%	1%	8.44%	2.80%	0	0	0	0	0	0	0	0	n/a
Theatres recovery	89%	84%	-	-	0	-	-	-	-	-	-	-	-	0	0	0	0	0	n/a
Discharge Lounge	110%	68%	-	-	0	-	-	-	-	-	-	-	-	0	0	0	0	0	24.00%
Total/Combined	-	-	-	-	234.25	-		1%			0	0	0	0	0	1	2	0	-
Total Average	78%	79%	-	-	33.4643	-	0.00%		6%	3%	0	0	0	-	-	-	-	-	31.80%

Allied Health Professionals													
	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%	61%	-	-	-	-	-	-	-	-	-	-	-
Outpatient Physio	100%	37%	-	-	-	-	-	-	-	-	-	-	-
Radiology MRI	66%	59%	-	-	-	-	-	-	-	-	-	-	-
Radiology X-Ray/CT	72%	72%	-	-	-	-	-	-	-	-	-	-	-
Total Combined	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Average	85%	57%	-	-	-	-	-	-	-	-	-	-	-

Workforce Performance Report

Prepared by:

Matt Dingle, Head of Human Resources

Clare Mair, Head of OD & Inclusion

David Richardson, Head of Education and Training

Ref: June 2026/ HR&OPS

Scorecard

Topic	KPI	April	May	TREND
Turnover (adjusted)	10.5%	9.95%	10.29%	
Staff in post - FTE	N/A	1272.11	1276.14	
Sickness absence	4%	5.34%	5.07%	
Appraisals	95%	78.55%	68.62%	
Disability declaration rate	7.5%	6.99%	6.97%	
Mandatory Training	93%	91.41%	92.12%	
Time to hire	56	55.9	48.9	

People Heat Map

Department	Establishment FTE Taken from ESR	NSS 2025 Engagement Score	Mandatory Training	AFC Appraisal	Monthly Sickness	12 Month Sickness	Return to Work Meetings Completed	12 month Adjusted Turnover	Vacancy Rate	Overall Health Score	Trend	3 month trend
303 Communications Department	8.91	7.48	95.8%	77.8%	0.0%	0.2%	#N/A	0.0%	2.6%		-	
303 Education and Training Department	13.80	8.15	100.0%	61.5%	1.5%	5.0%	100.0%	15.0%	9.8%		-	
303 EPMA Department	15.40	6.67	90.2%	93.8%	0.6%	1.2%	#N/A	15.4%	11.8%		↓	
303 Finance	11.00	6.66	98.6%	80.0%	8.2%	2.4%	#N/A	9.5%	12.7%		↓	
303 Governance	11.84	8.06	97.1%	100.0%	0.0%	0.5%	#N/A	0.0%	4.0%		-	
303 Human Resources	22.60	6.74	96.4%	90.5%	0.0%	2.2%	#N/A	4.8%	4.2%		-	
303 IM&T Department	38.60	6.66	88.8%	87.2%	1.3%	2.3%	50.0%	10.0%	15.8%		-	
303 IPC	10.60	8.10	100.0%	27.3%	0.0%	4.4%	#N/A	0.0%	13.3%		↑	
303 Knowledge Management	13.39		93.8%	85.7%	1.7%	4.2%	0.0%	14.5%	21.6%		-	
303 Nursing Administration Corporate	23.63	6.78	98.9%	66.7%	5.3%	8.5%	66.7%	26.7%	32.4%		-	
303 Clinical Admin	33.29	5.87	81.3%	82.9%	7.6%	6.5%	20.0%	9.6%	20.5%		↓	
303 Division 1 Management	17.81		74.3%	58.8%	10.3%	4.8%	0.0%	11.9%	-14.9%		↓	
303 Ward 4	30.57	6.36	97.8%	48.3%	1.6%	8.0%	33.3%	2.0%	26.9%		-	
303 Large Joint	111.71	6.83	94.9%	42.9%	4.5%	6.0%	83.3%	8.3%	23.6%		-	
303 Oncology	85.66	7.75	93.2%	62.3%	3.4%	3.3%	75.0%	4.5%	15.8%		↑	
303 Outpatients	48.12	7.20	97.3%	55.6%	5.9%	8.4%	100.0%	18.6%	2.3%		-	
303 Small Joint	24.00	6.83	86.7%	87.5%	2.3%	3.0%	100.0%	5.6%	-1.4%		-	
303 Spinal Surgery	68.53		92.2%	43.2%	3.9%	4.9%	100.0%	8.0%	6.9%		-	
303 Pharmacy	30.35	7.08	98.6%	70.8%	3.0%	5.5%	100.0%	22.9%	31.8%		-	
303 Pre Admission Screening (POAC)	39.43	7.00	93.3%	82.1%	6.5%	7.6%	100.0%	8.1%	26.3%		-	
303 Radiology	57.18	6.86	93.1%	97.8%	7.6%	7.5%	84.6%	13.2%	11.0%		-	
303 Theatres, Anaesthetics and Critical Care	286.84	6.72	88.8%	66.9%	6.1%	6.7%	65.9%	7.7%	12.8%		-	
303 Therapy Services	99.21	6.70	95.5%	83.0%	4.0%	4.7%	85.7%	13.4%	11.2%		-	
303 Estates Department	18.95	6.65	89.4%	47.4%	0.0%	1.5%	#N/A	21.5%	10.4%		-	
303 Facilities Department	95.75	6.89	82.3%	70.3%	10.5%	8.7%	71.4%	11.6%	6.0%		-	

* Departments with less than 8 FTE not included in the Heat Map

** 2025 Staff Survey scores based on Trust slide deck, some departments are combined (e.g Finance and IM&T).

*** Vacancy and staff survey scores are for information purposes only and are not currently included in the overall health score for departments

Occupied
establishment,
starters & leavers

Summary:

- The Trust is on course for trajectory for overall workforce with just 2.1 WTE difference.
- Turnover has risen slightly but remains within target.
- Time to hire is steadily below national targets, but fluctuates due to lower numbers of recruitment activity.

Areas for Improvement:

- The Trust closed the gap on staff perception that there are not enough staff in the organisation to do their job (slide 10) however we remain above average.
- Around 40% of the workforce do unpaid hours above contractual which is below benchmark but still a concern.

Risks / Issues:

- There was an increase in staff survey results linked to staff looking for other roles. This is usually a negative indicator, but some circumstances could be due to financial and promotional reasons.
- We are off plan for infrastructure headcount reduction

Action Plan:

- Recruit in line with plan for clinical areas
- Continue to focus on infrastructure headcount reduction with extraction from business plans of opportunities for reduction

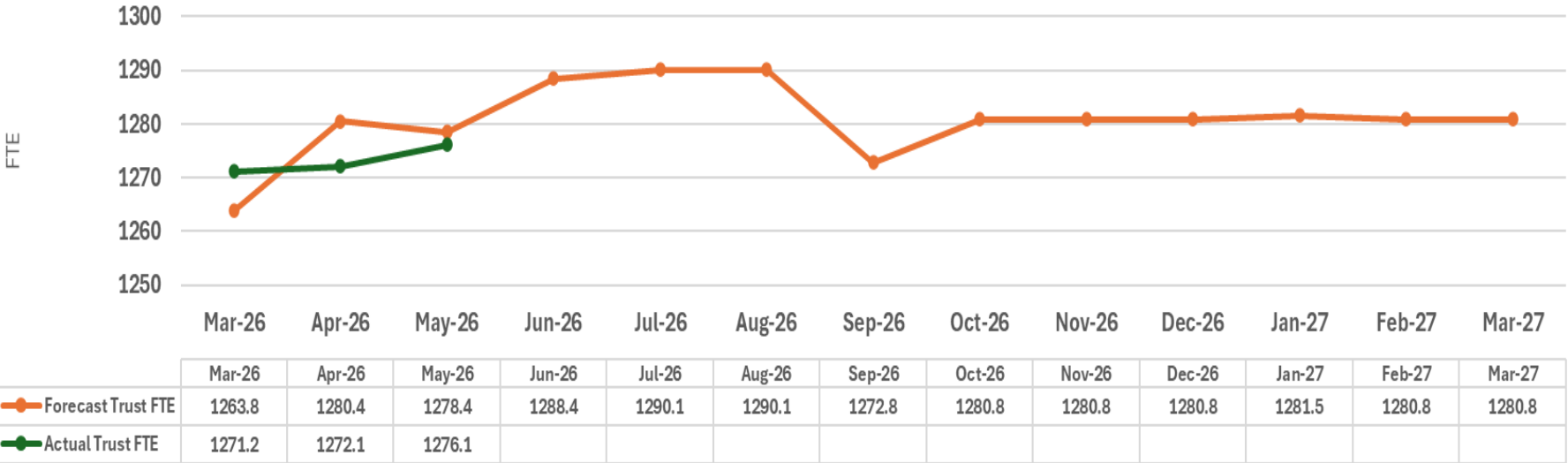
Substantive FTE versus Plan

KPI 100%

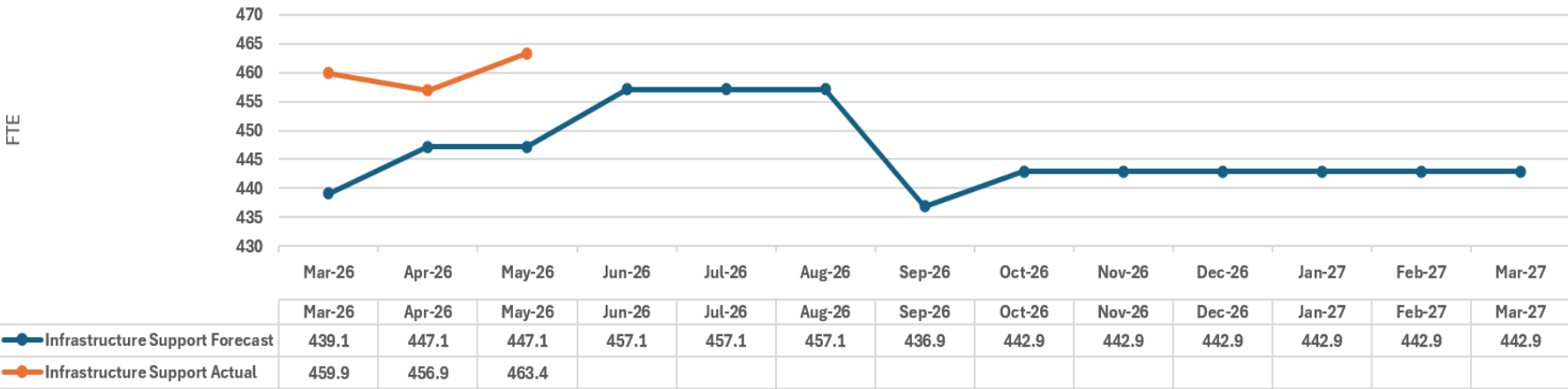
May 2026 99.8%

Trend 

Substantive FTE - Forecast Versus Actual

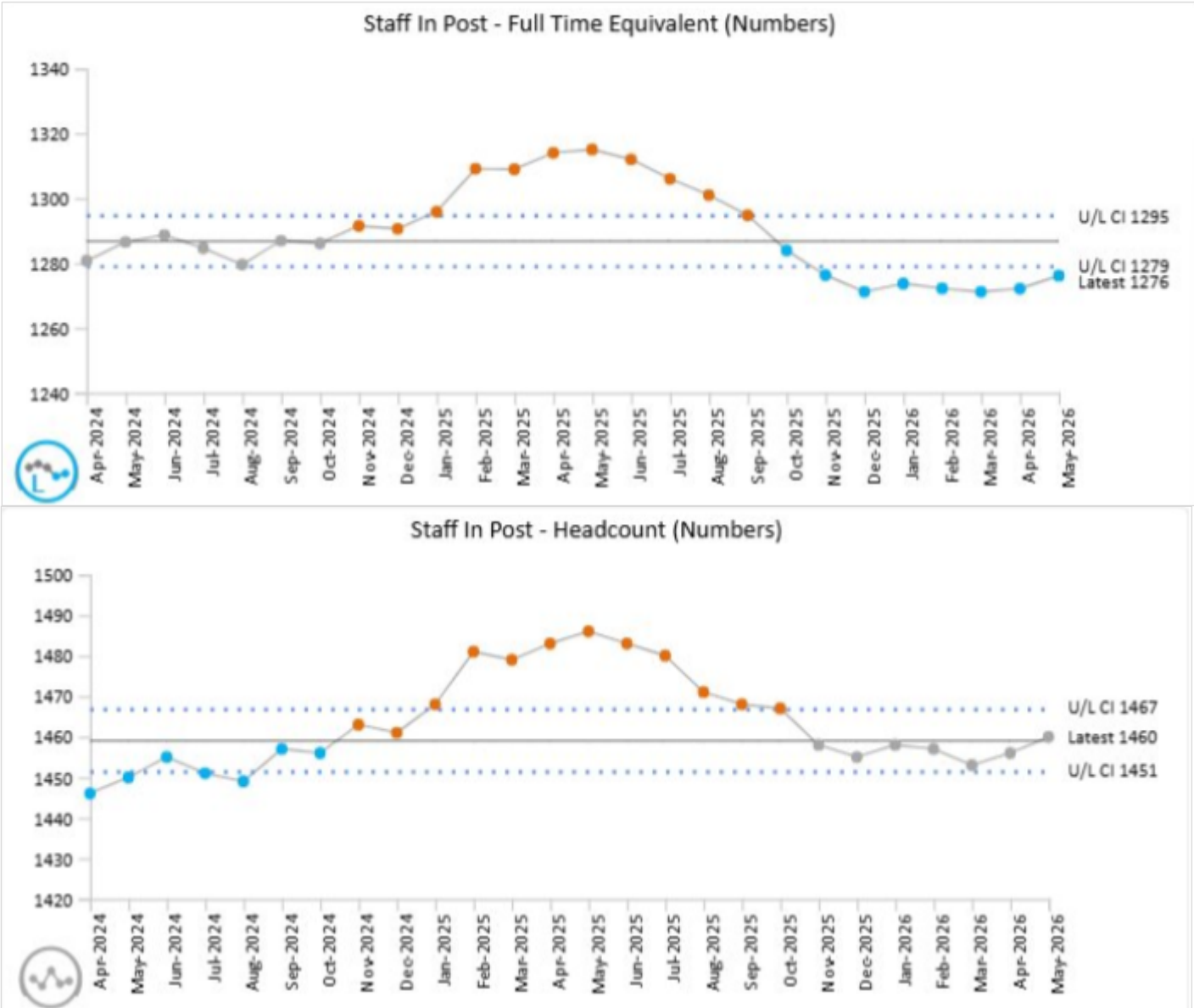


Substantive Infrastructure FTE - Forecast Versus Actual



Based on submitted 2026/27 operational planning forecast versus ESR actual FTE.

Staff in post



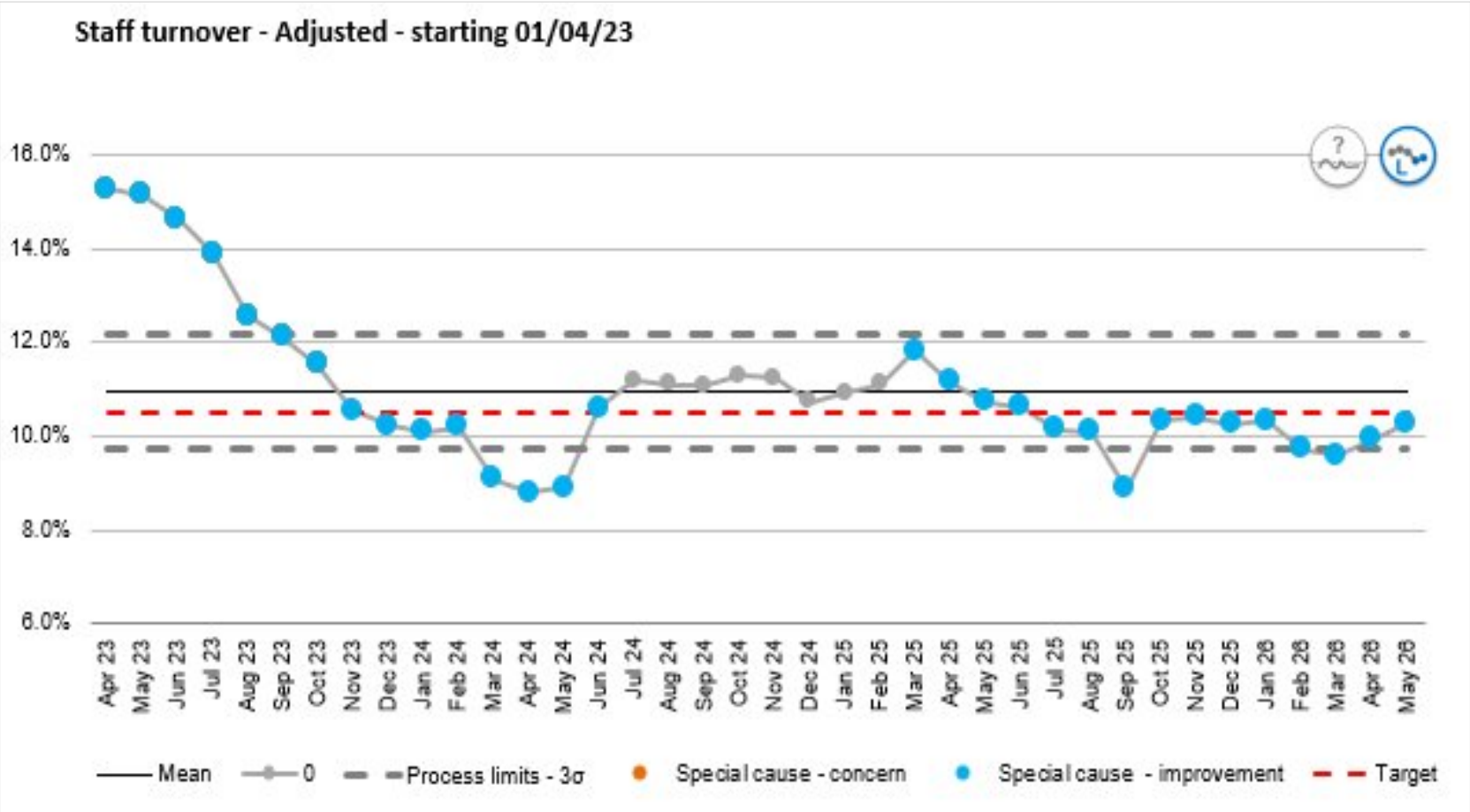
Turnover (adjusted)

KPI	10.5%
May 2026	10.29%
Trend	

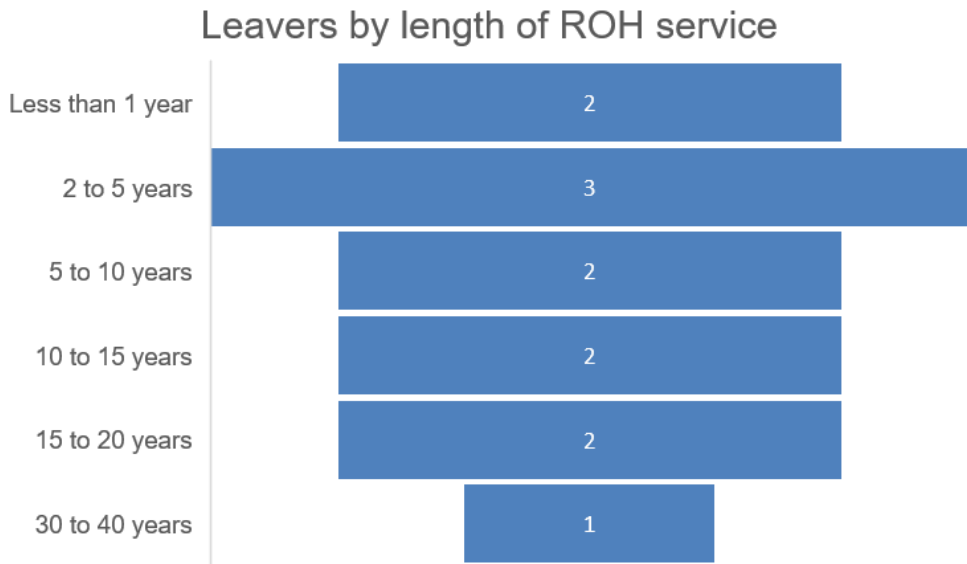
Adjusted turnover is all turnover minus:

- Junior doctor rotation
- Flexible retirement
- End of FTC

Adjusting turnover provides more meaningful data around Trust performance



May
leavers



- Voluntary Resignation - Relocation
- Retirement Age
- Dismissal - Capability
- Voluntary Resignation - Promotion



Starters – May 2026

New starters - May

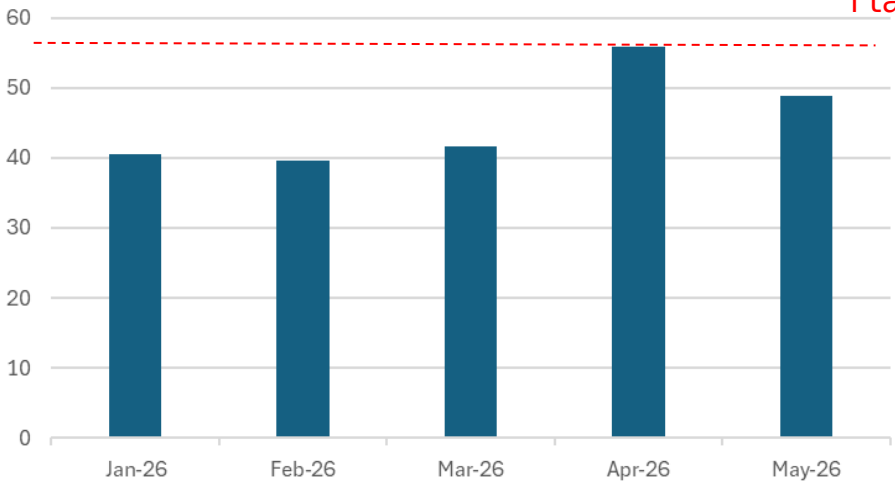


- Add Prof Scientific and Technic
- Administrative and Clerical
- Nursing and Midwifery Registered
- Additional Clinical Services
- Medical and Dental

Admin relates to:

- 5 x clinical support admin (e.g. appointments)
- 2 x EPR

Time to hire - advertisement to checks complete



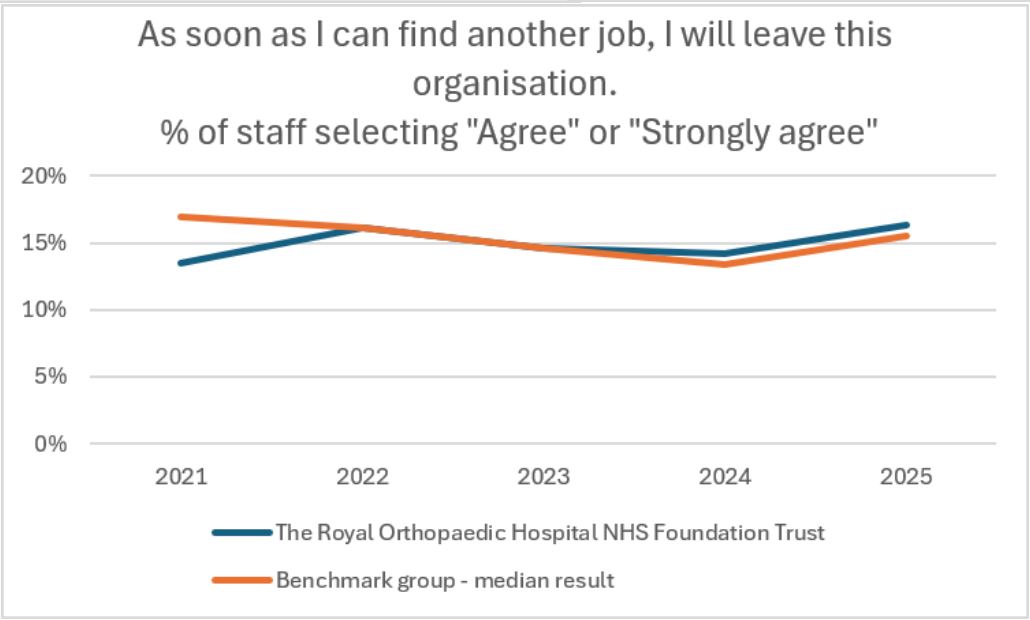
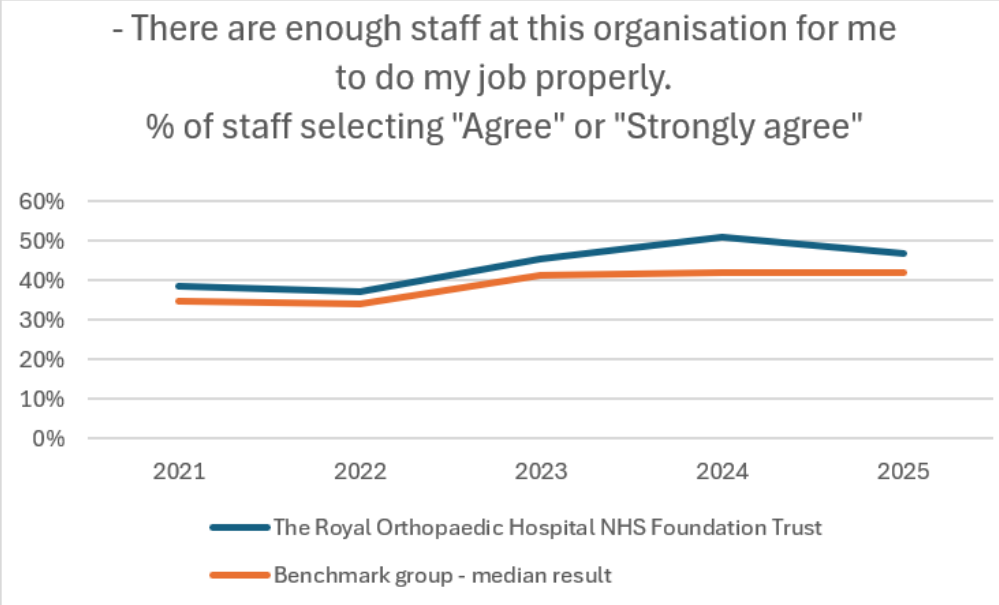
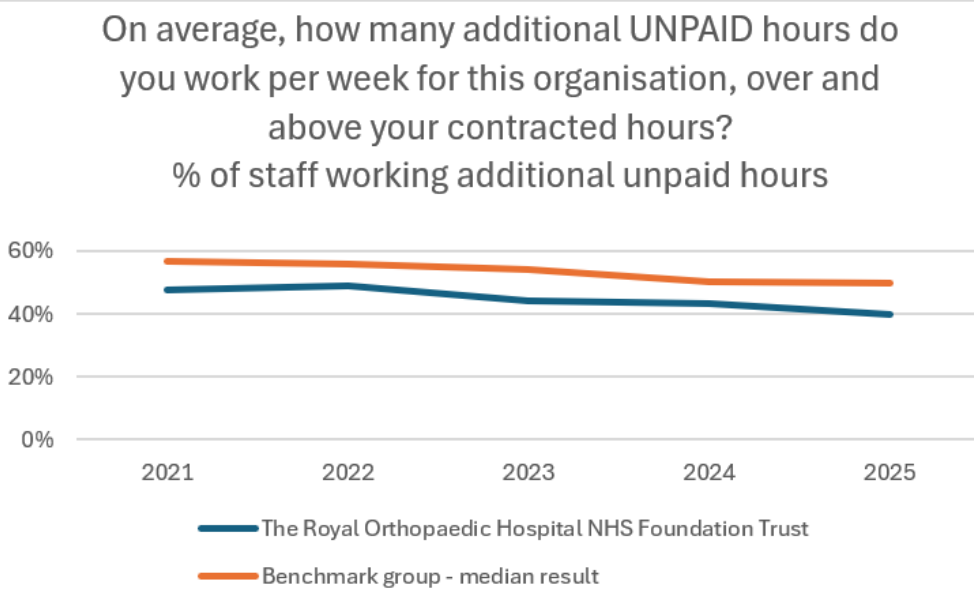
National
target

A reasonable time for recruitment could be:

- Time to approve – 7 days
- Advertisement – 14 days
- Shortlisting – 7 days
- Interview – 7 days
- Clearances – 20 – 30 days (depends on role)
- Total = 55 to 65 days**

Occupied
establishment,
starters & leavers

What our
staff say –
Staff Survey
2025



Employee Relations

Summary:

- 50% of ER case work has been closed since the last workforce report in April, we closed a considerable proportion of stage 3 cases.
- Grievances are still a concern with case numbers static and the advisory team managing a handful of cases at an informal level which may progress to formal cases if individuals do not feel resolutions are satisfactory

Areas for Improvement:

- Increase the number of trained investigators – low numbers attributable to delays in progressing cases.
- There are capability cases where we have delayed instigating the capability process until much of the local support has been exhausted, this leads to a prolonged process which can then lead to sickness and grievances

Risks / Issues:

- We are seeing a higher proportion of appeals and ETs as more stage 3 hearings are resulting in termination of contract.
- We have seen higher grievance numbers over the last 6 months, themes including staff against manager conflict or disputes arising from managers decisions. This matches the staff survey feedback associated with bullying and harassment where we have seen an increase in staff perceiving bullying, harassment or abuse from colleagues and managers.
- New diversity data suggests disparities with workforce representation Vs Casework representation, particularly in capability cases

Action Plan:

- Advisory team reaching out to departments to collate a list of potential investigators
- Review Capability Policy, rename and rebrand to "improving performance" to try and tackle stigma around utilisation of the policy alongside the manager awareness continuing with MAM module
- Civility and Respect work remains ongoing in core areas of concern.



Employee Relations

Case Type	Cases open			Total	Suspended/ Excluded	Cases Closed in April/May/June to date
	<8 Weeks	8- 12 Weeks	>12 Weeks	21		16
Disciplinary			1	1		0
Grievance	3	1	1	5		4
Formal Capability		3	1	4		0
MHPS	2			2		1
Final Stage Sicknes s	4			4		8
Appeals	3			3		1
ACAS/ET			2	2		0
Management of Change	1			1		2

Key Themes:

- The >12-week grievance is scheduled to be closed with a meeting this month
- The >12-week capability case is being managed for closure in June
- The >12-week conduct case has been on hold following a period of LTS, closure informally this month
- Active Stage 3s – 2x IHR and 2 due to frequent STS
- No current suspensions or exclusions
- Appeals have dates scheduled for June and July closures, 1 is appealing a termination, the other 2 are from grievance outcomes.
- Employment tribunals stay active with cases submitted and preliminaries scheduled for August and December – legal assessment finds cases are low risk in terms of likelihood of successful claim/

Employee Relations Diversity

Division	Cases open					Total
	White	White Other	Asian or Asian British	Black or Black British	Mixed	19
Disciplinary	1					1
Grievance	3	1		1		5
Sickness	2			1		4
Capability				4		4
MHPS	1		1			2
Appeals	1		1	1		3

Key Themes:

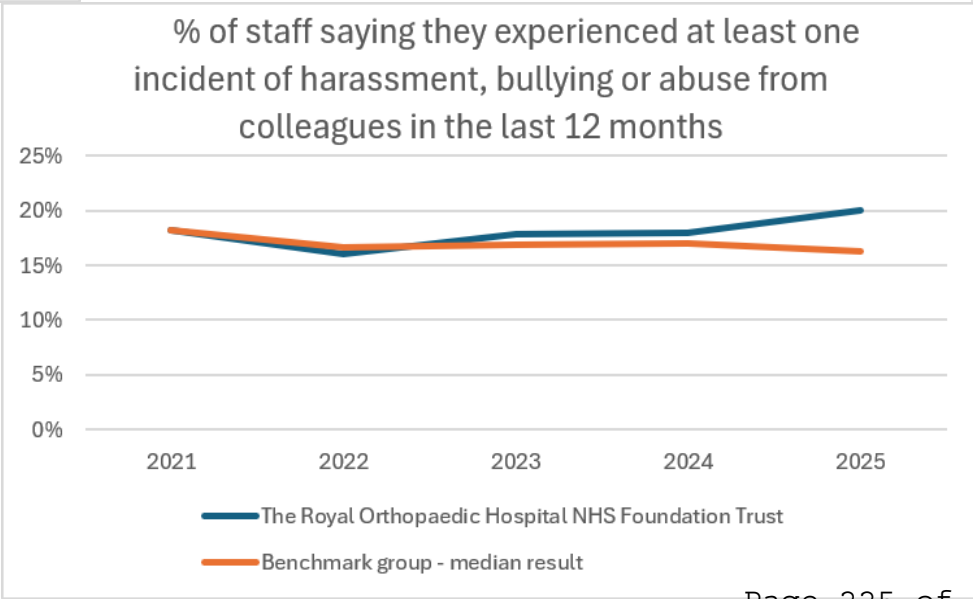
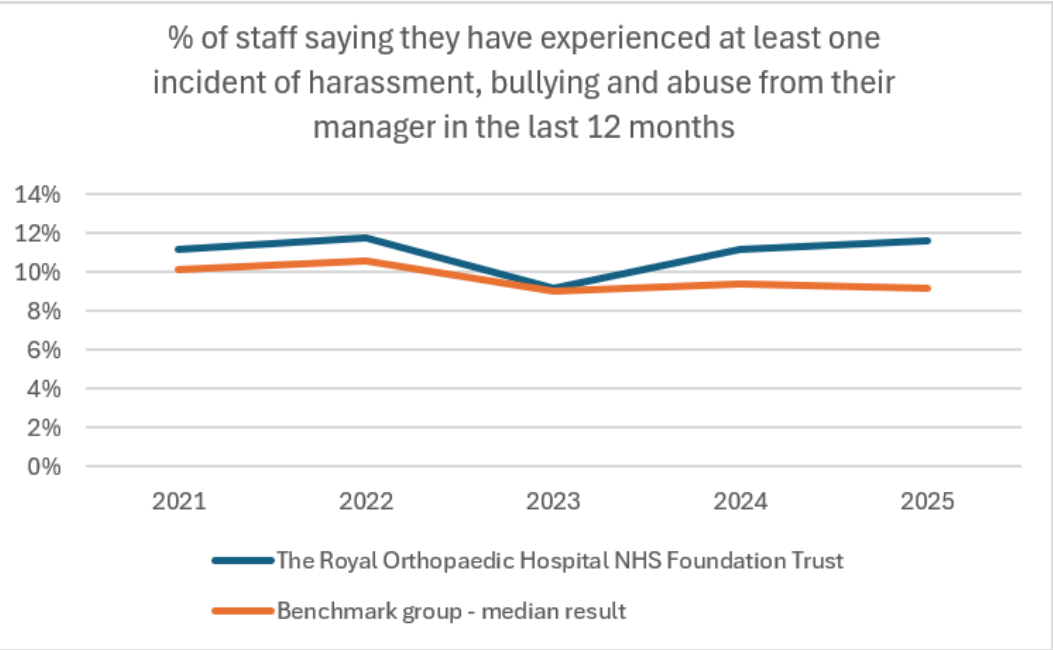
42.1% of case work is staff members categorised as white this compares with 64% of our workforce representation

100% of the capability cases are staff members categorised as Black or Black British, these are all nursing staff who were recruited via the centralised international nurse's recruitment programme, 9.67% of the workforce representation is Black or Black British.

Taking capability cases out of the figures, brings that figure down to 20% ER Casework representation for Black or Black British staff still higher than the overall workforce representation.

Employee Relations

What our staff say – Staff Survey 2025





Sickness absence

Summary:

- Sickness in May decreased by 0.22%, this is lower than the sickness % for May 25, was a continued reduction on the moving annual average figure, for the fifth month in a role and most importantly we continue to deliver the figures in our glidepath to the 4% target which was shared with NHSE. We are the only Trust in BSOL making positive reductions this year.
- The new process adopted for return-to-work compliance chase emails is working with the KPI sat in and around 70% for 2026 a significant improvement on previous compliance.
- Both long and short term sickness continue to decrease

Areas for Improvement:

- MAM Attendance Management Attendance continued low attendance
- Significant use of phased returns
- Although sickness % is on a downward trajectory Stress continues to be a leading cause for absence

Risks / Issues:

- Added reliance on bank causing a financial burden
- Although improving we remain high in NOF rankings for sickness

Action Plan:

- Continued implementation and completion of Priority 1 & 2 Sickness Workstream actions
- Analysis is underway on phased return utilisation to decide if clearer stipulations need to be implemented
- Reviewing format of MAM course with Education and training to amalgamate with wellbeing conversations and health related risk assessments
- Exploring Staff Resilience Training utilisation and Stress Support Pathway to address elevated levels of stress related absence

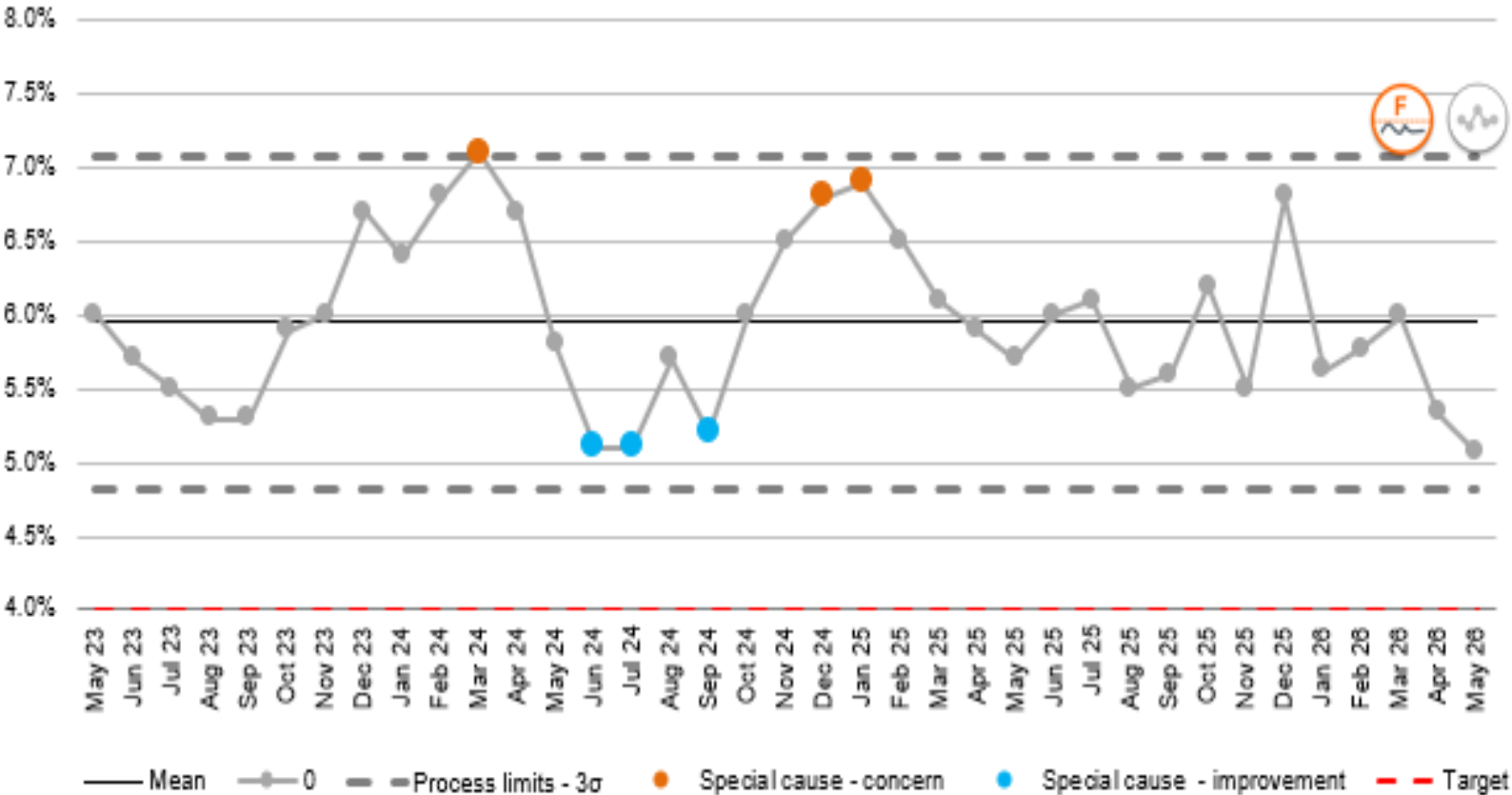
Sickness

KPI 4%

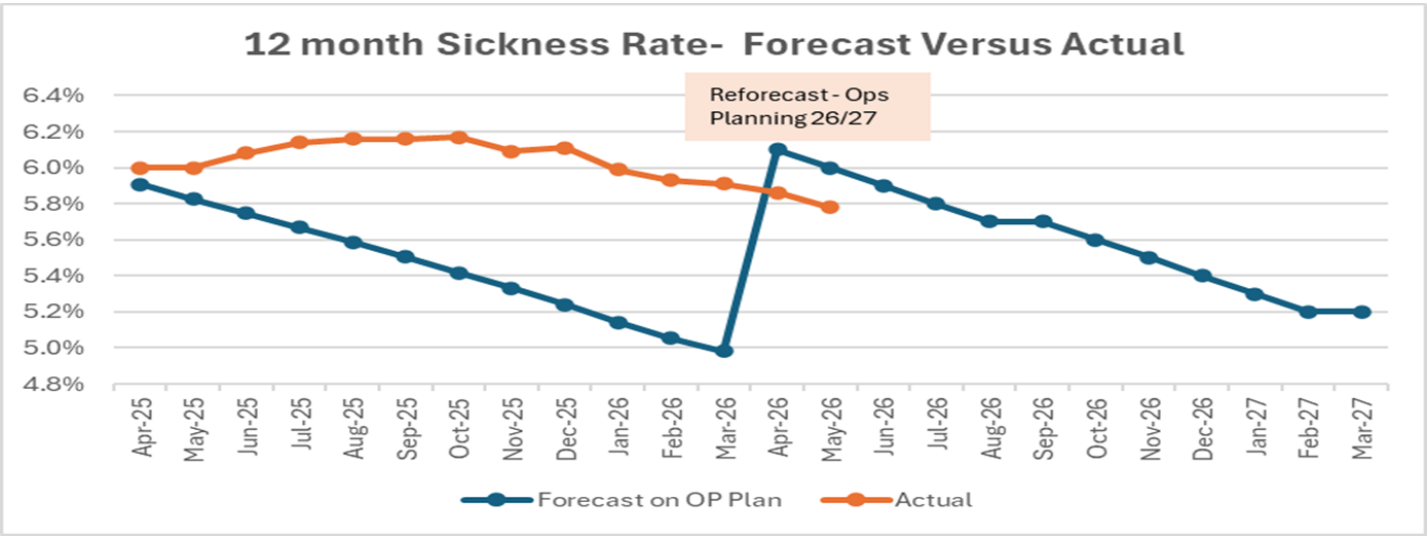
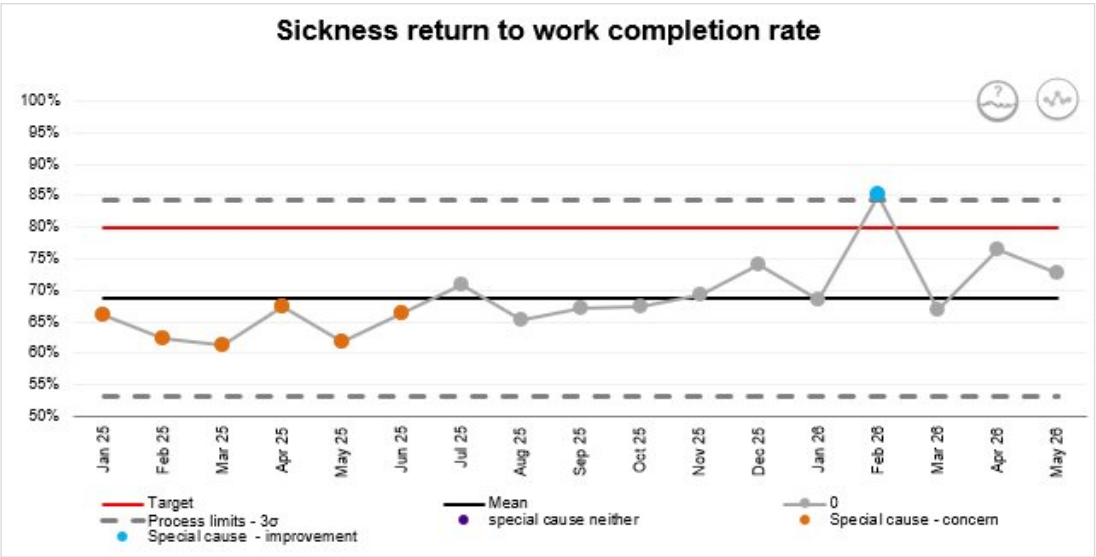
May 2026 5.07%

Trend 

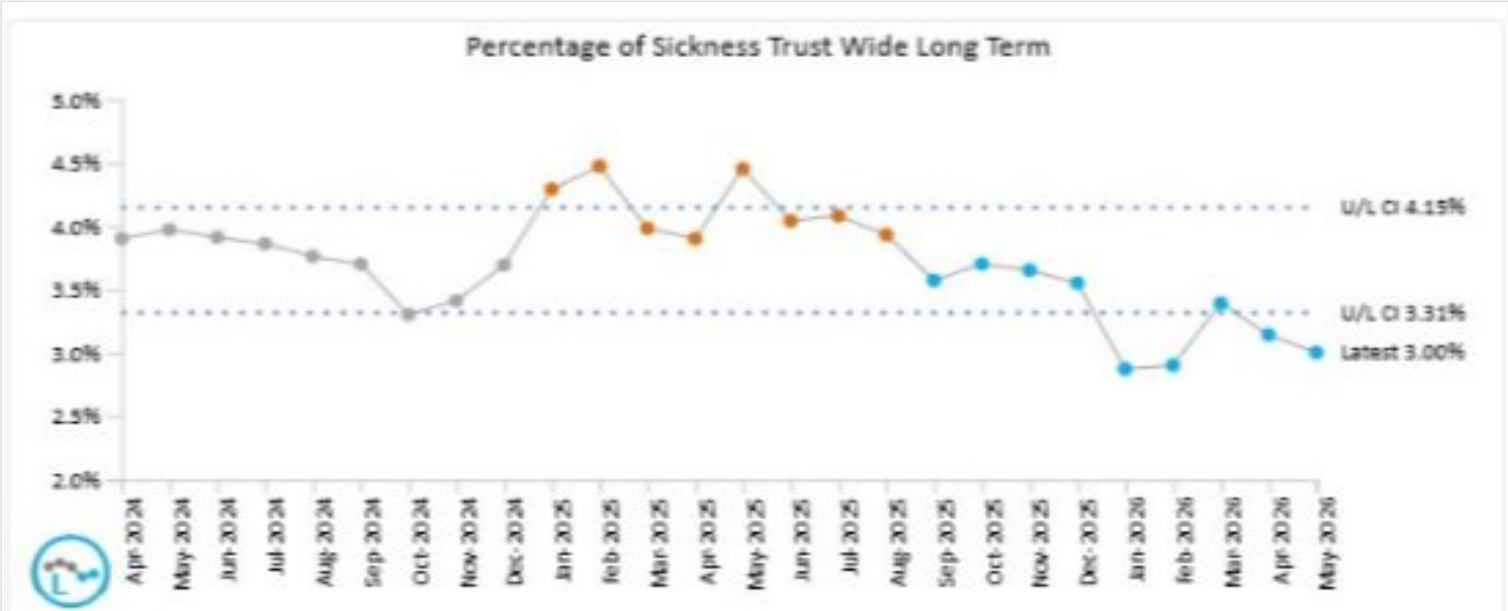
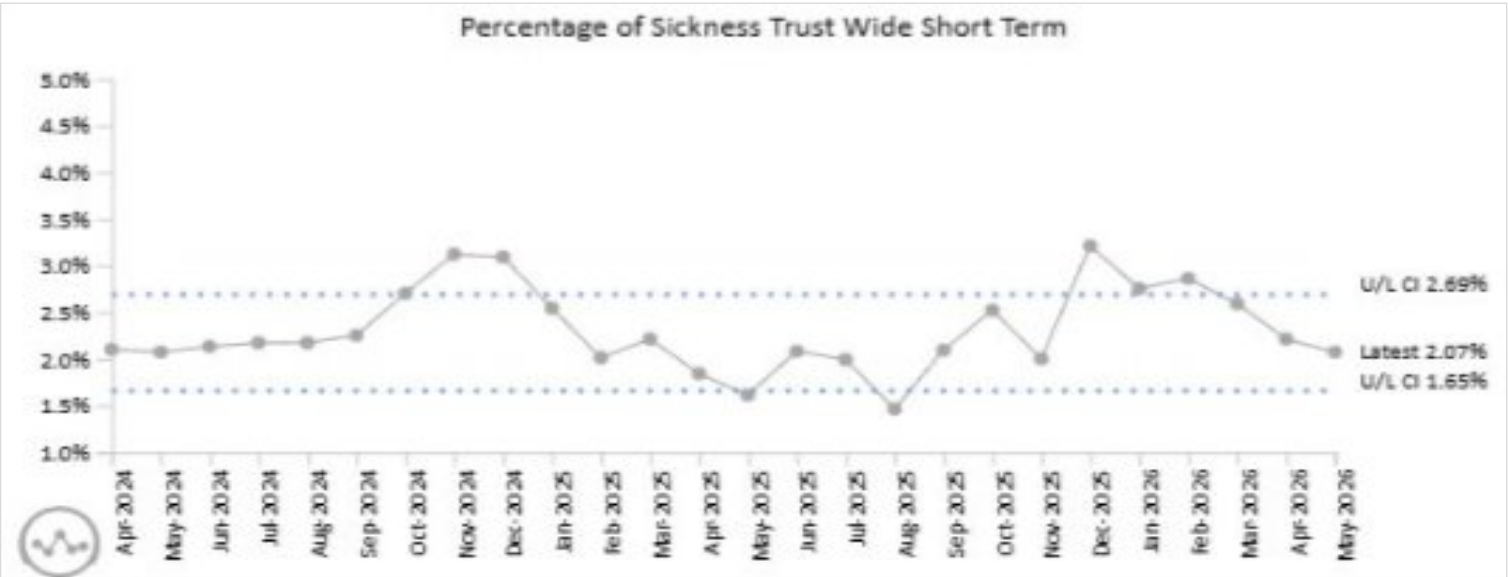
Trust Monthly Sickness Absence Rate- starting 01/05/23



Sickness absence

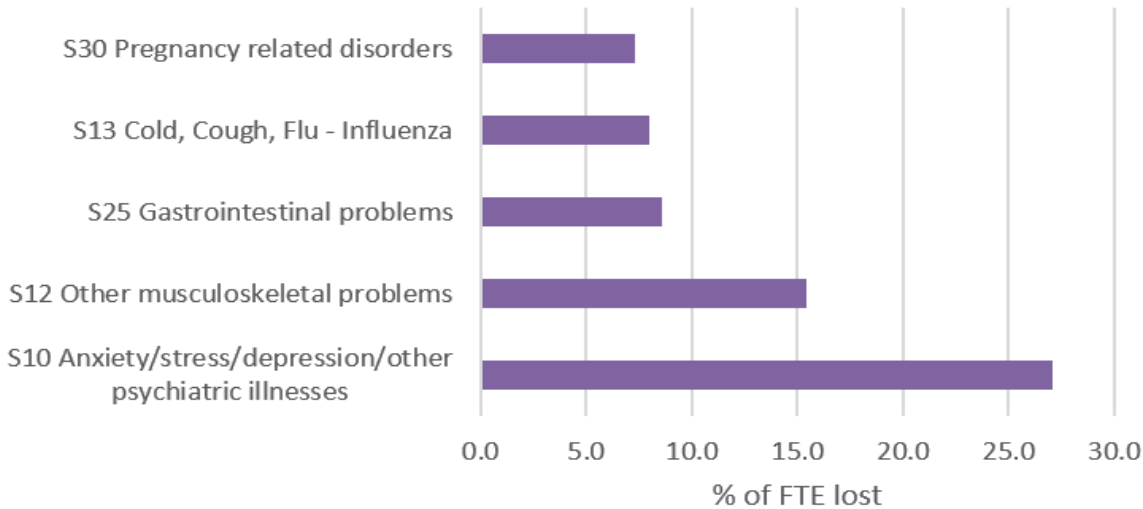


Sickness absence

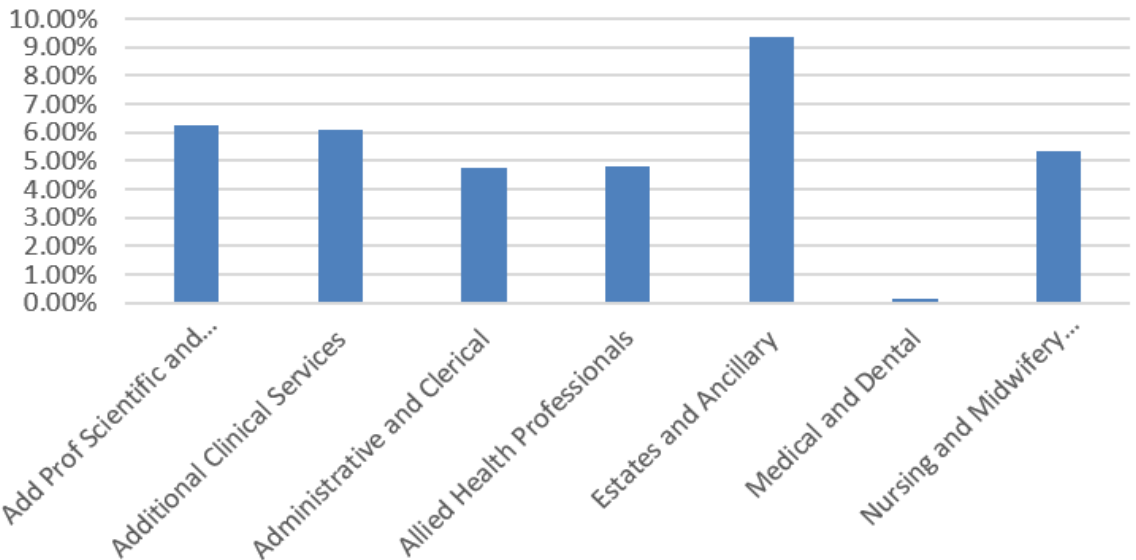


Sickness absence

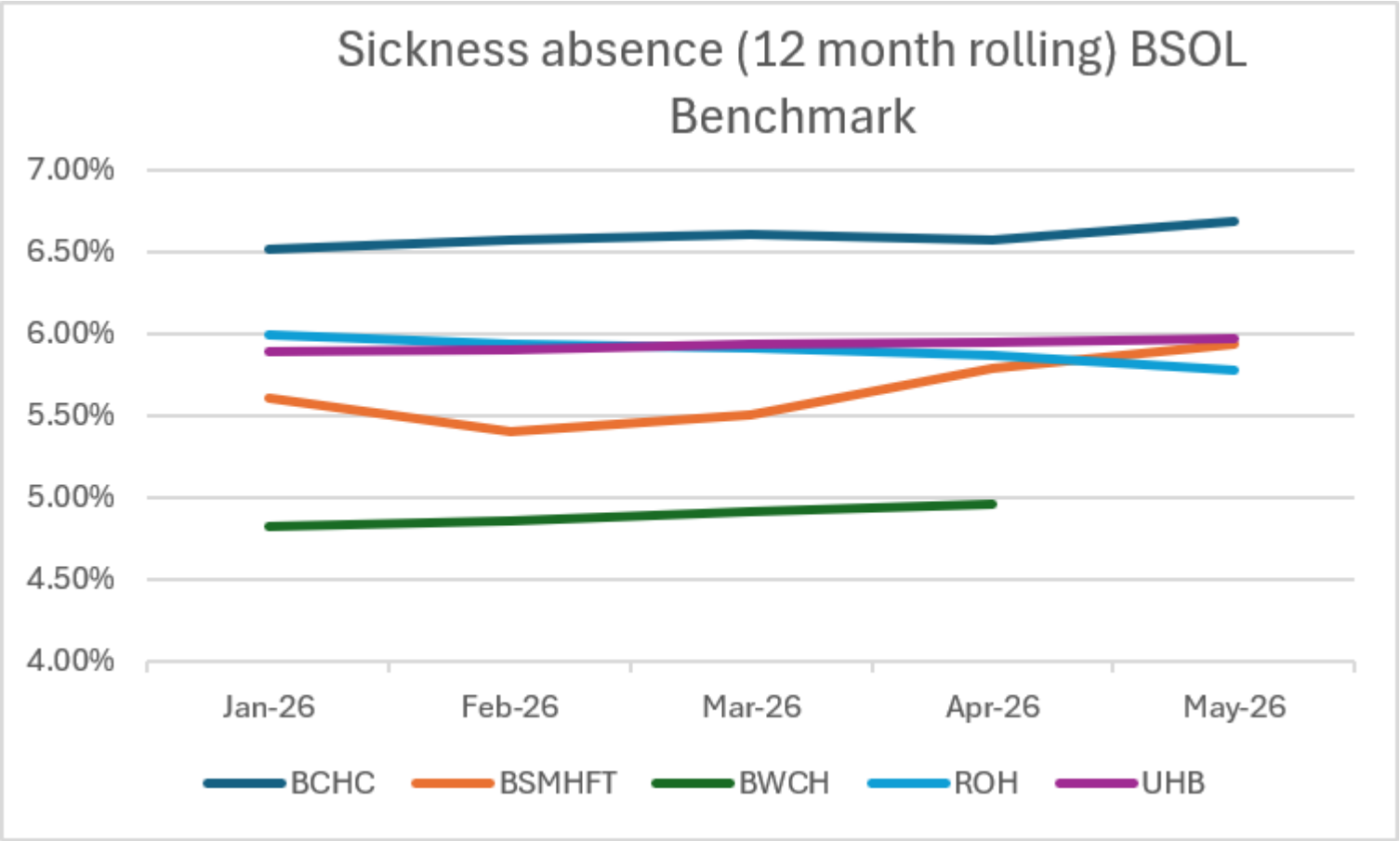
Top 5 absence reasons in month by FTE lost



Absence FTE by Staff Group %



Sickness absence

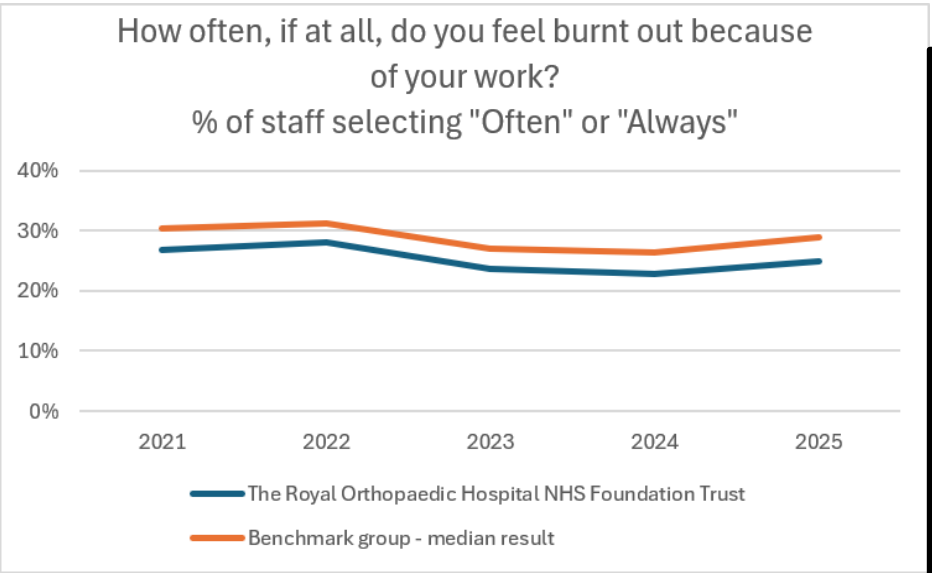
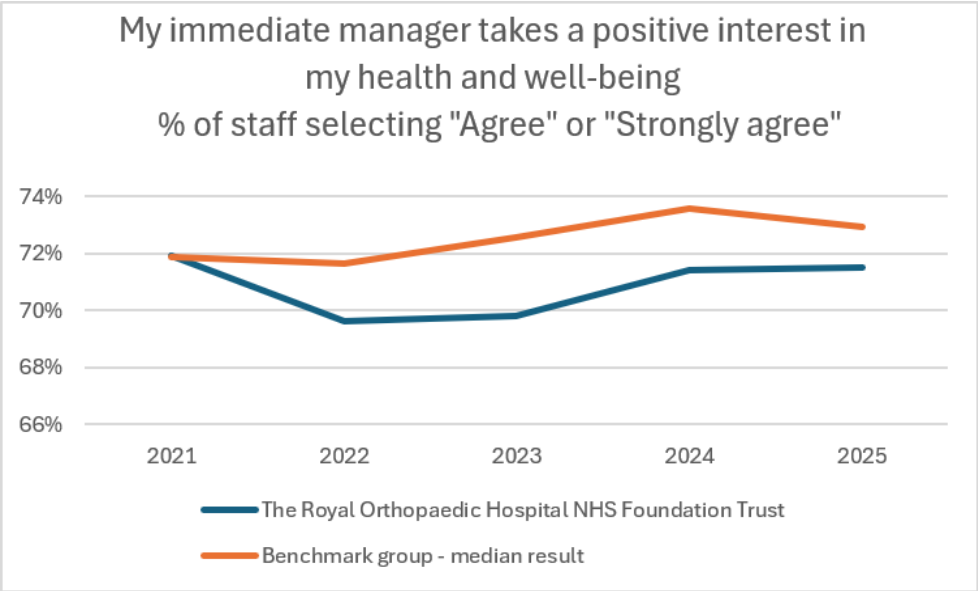
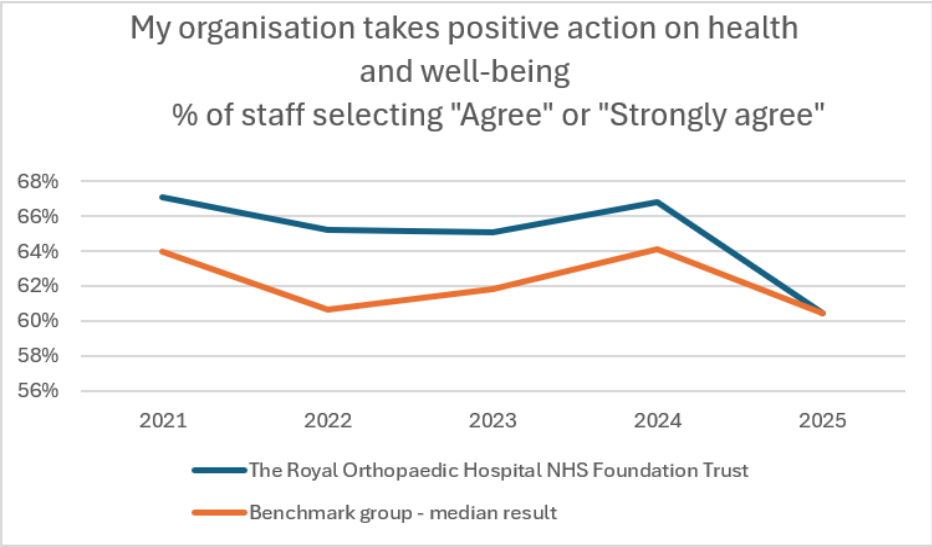


Sickness absence

Early Stages	Mid Way through delivery	Near Completion/delivered
Stress Support Pathway	Sickness Policy Update	Return to Work Videos
Staff Stress & Resilience Training	Temporary Redeployment Process	Health Roster How to Videos
Wellbeing Support Guide for staff off long term	Wellbeing conversation compliance	Workfit Launched and embedded
Review Stage 3 Process	ESS Approach Pilot (delayed due to operational changes)	Intranet Sickness Landing Page
Barriers to attending wellbeing events	MAM Reviewing Training format	Sickness Templates redesigned
Running and Walking Clubs	Stress Questionnaire	Speciality Report Template
Working Time Directive Audit	Phased Return Data analysis	Sickness Workbook Tool

Sickness absence

What our staff say – Staff Survey 2025



- There has been a positive increase in managers taking positive action and this will be strengthened further with work on wellbeing conversations
- The 'positive action' is in line with the benchmark group but it has declined - more work is needed on ensuring wellbeing activities align with staff needs and to support sickness reduction. The latest wellbeing week focussed on stress and MSK – this is currently being evaluated
- Burnout has increased and work is needed to ensure that managers are supporting teams with managing workloads and priorities with an increasing performance focus.



Workforce availability

Summary:

- It can be seen from the annual leave data that the Trust has seen an increase in leave over the last 3 months with correlates with the start of the performance but also the need to take carried over leave in the first 3 months of the year
- Special leave has reduced over the last 3 months with May being at its lowest level for >14 months
- When viewing sickness, annual leave and special leave together, December, March and August show the highest levels of unavailability.

Areas for Improvement:

- Map unavailability against productivity forecast
- Encourage all staff to book annual leave across the holiday year with active oversight by managers to ensure there isn't disproportionate leave in March (end of performance year) or significant carry over the following performance year.

Risks / Issues:

- There is no current benchmark for special leave, so we are measuring this unavailability without a comparator. We will seek a method for attaining this information from other BSOL Trusts.

Action Plan:

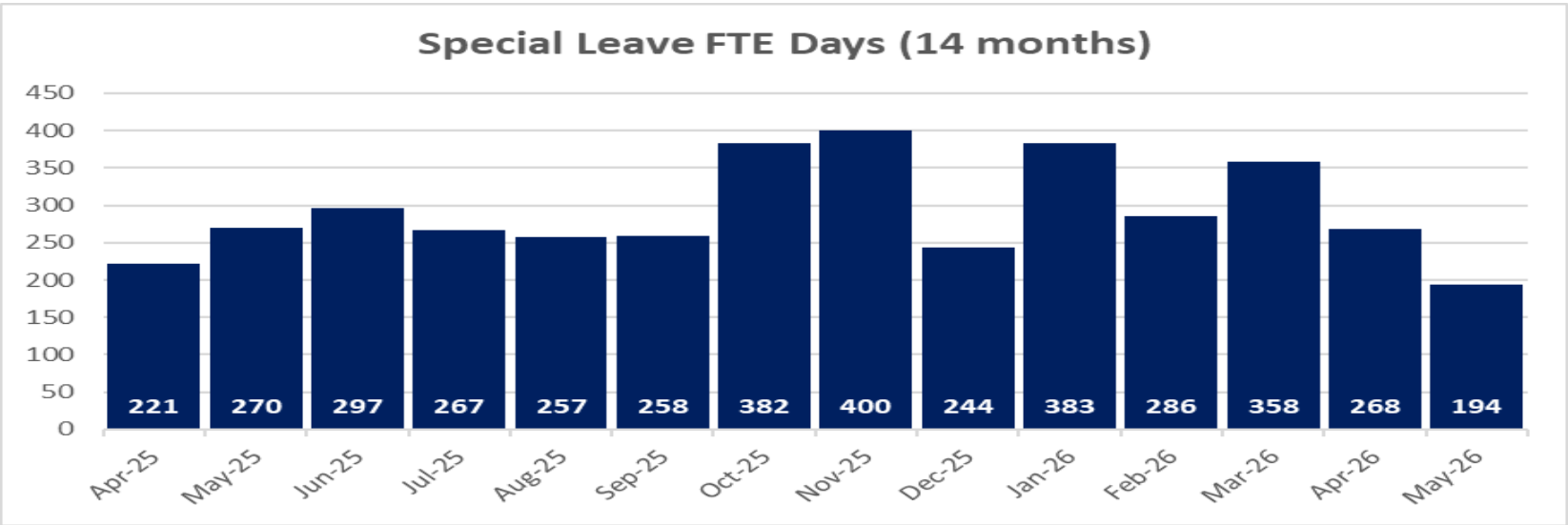
- Regular annual leave communications throughout the year and early reporting via business forums.

Workforce availability



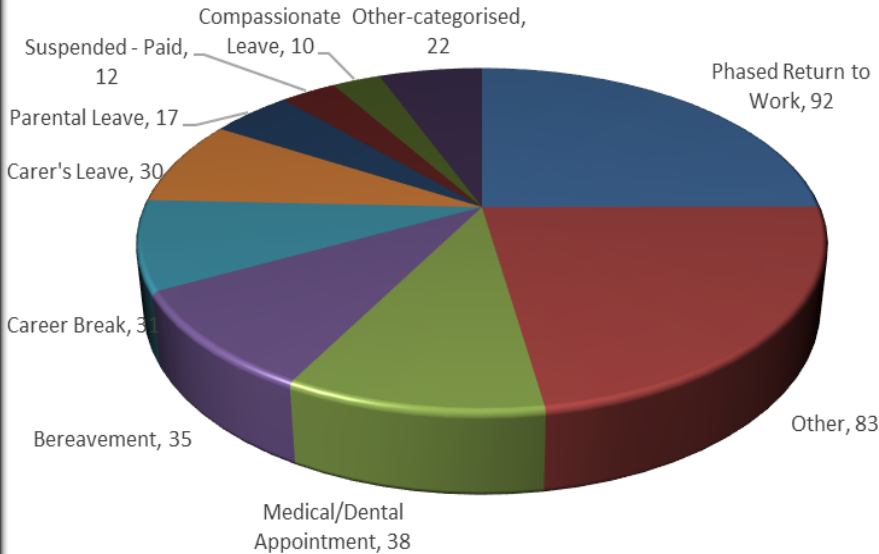
Special Leave

Type of leave	Mar-26		Apr-26		May-26		3 month total		12 months	
	FTE days taken	% of FTE days available	FTE days taken	% of FTE days available	FTE days taken	% of FTE days available	FTE days taken	% of FTE days available	FTE days taken	% of FTE days available
Annual Leave	4006	10.2%	3550	9.3%	3756	9.5%	11312	9.7%	40124	8.5%
Maternity	962	2.4%	670	1.8%	749	1.9%	2382	2.0%	10141	2.2%
Paternity Birth	0	0.0%	2	0.0%	20	0.0%	21	0.0%	32	0.0%
Special Leave	358	0.9%	268	0.7%	194	0.5%	820	0.7%	3593	0.8%
Study Leave	11	0.0%	1	0.0%	4	0.0%	15	0.0%	40	0.0%
Grand Total	5337	13.5%	4491	11.8%	4722	12.0%	14551	12.4%	53931	11.5%

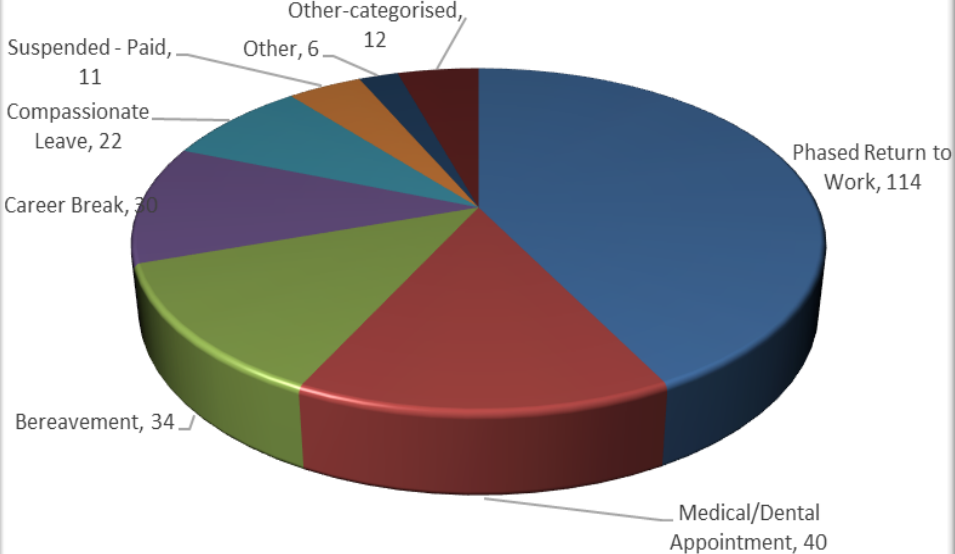


Special Leave

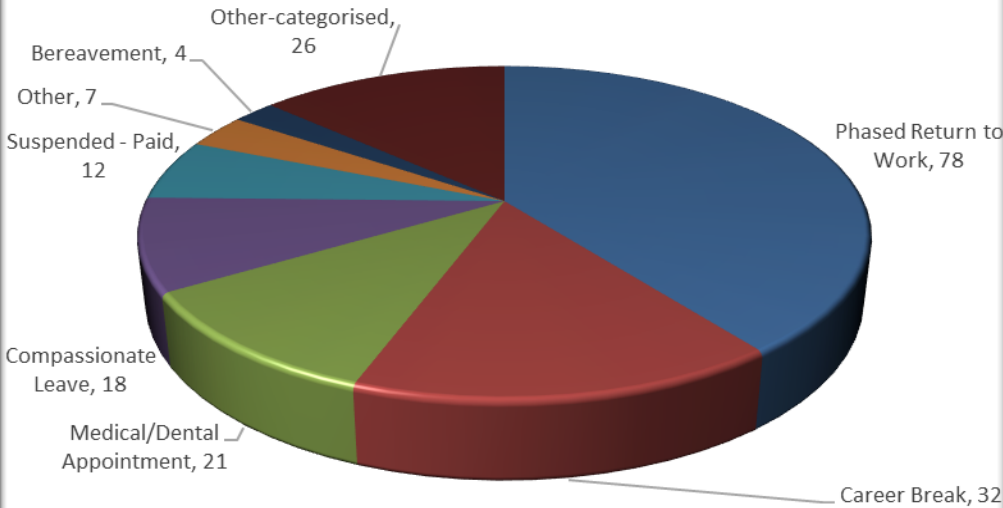
March-26 Special Leave Reasons



April-26 Special Leave Reasons



May-26 Special Leave Reasons



Other – categorised:

- TOIL
- Unauthorised leave
- Antenatal
- Disability leave
- Industrial action
- Infection precaution
- Interview leave
- Court appearance
- Training with reserves and cadets

Special leave

March-2026

Staff Group	FTE Days Lost.	Days per FTE
Add Prof Scientific and Technic	5.9	0.13
Additional Clinical Services	98.4	0.49
Administrative and Clerical	73.4	0.21
Allied Health Professionals	19.3	0.17
Estates and Ancillary	16.7	0.16
Medical and Dental	18.6	0.14
Nursing and Midwifery Registered	136.4	0.44
Grand Total	368.8	0.29

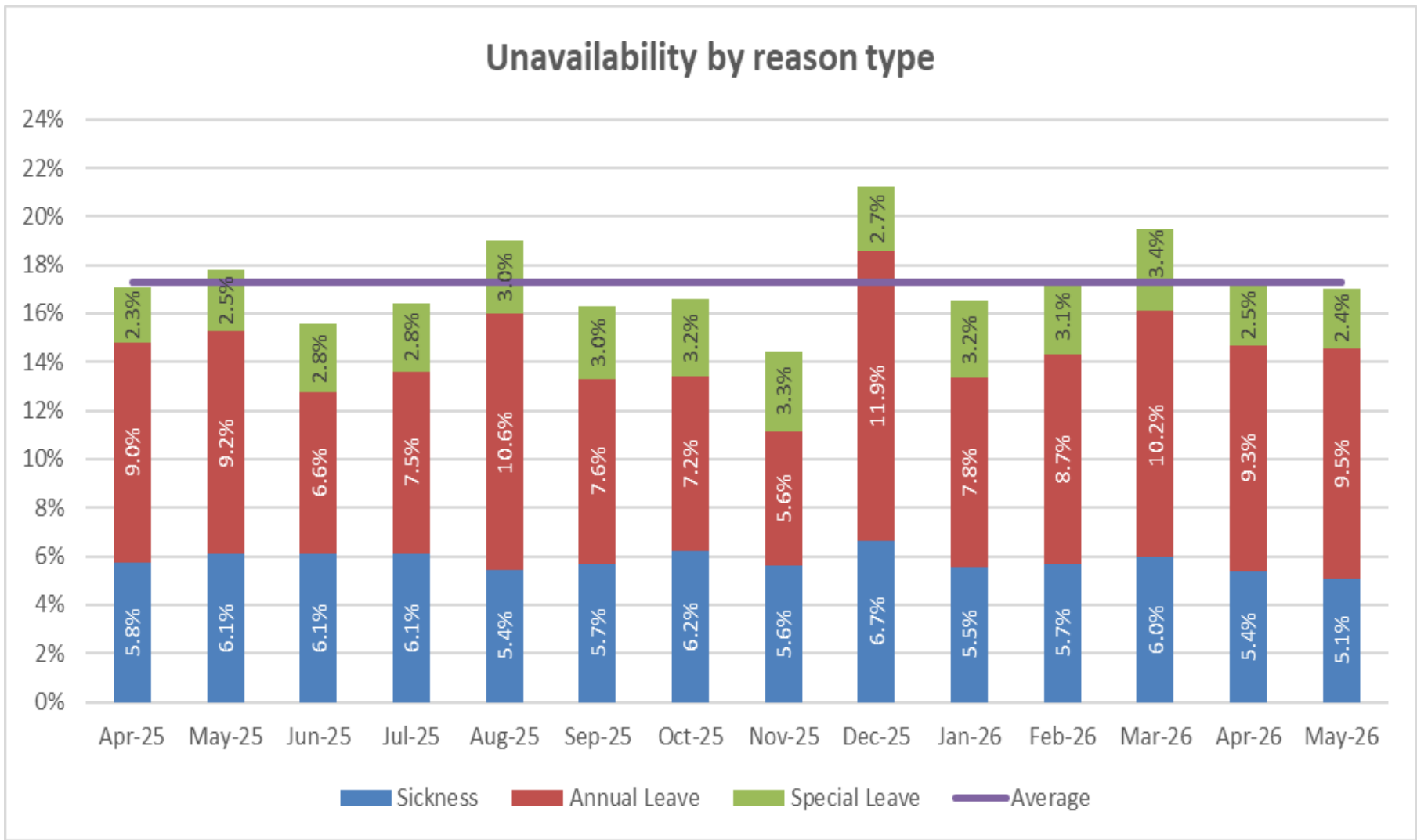
April-2026

Staff group	FTE Days Lost.	Days per FTE
Add Prof Scientific and Technic	4.8	0.11
Additional Clinical Services	51.6	0.26
Administrative and Clerical	41.7	0.12
Allied Health Professionals	17.0	0.14
Estates and Ancillary	9.4	0.09
Medical and Dental	14.1	0.10
Nursing and Midwifery Registered	130.6	0.41
Grand Total	269.1	0.21

May-2026

Staff Group	FTE Days Lost.	Days per FTE
Add Prof Scientific and Technic	11.6	0.26
Additional Clinical Services	41.1	0.21
Administrative and Clerical	11.0	0.03
Allied Health Professionals	4.8	0.04
Estates and Ancillary	9.7	0.10
Medical and Dental	16.2	0.12
Nursing and Midwifery Registered	103.5	0.33
Grand Total	197.8	0.15

Unavailability



Temporary Workforce

Summary:

- Bank and Agency spend increased in May with both tracking slightly above forecast
- Temporary workforce group meeting on a fortnightly basis to review bank spend and work with departments to identify and implement opportunities to reduce spend
- Escalation meetings take place where added support and scrutiny is identifies

Areas for Improvement:

- We are continuing to see a regular expenditure in infrastructure bank and our current focus is on Appointments.
- There is continued reliance on medical agency and we are supporting a more sustainable workforce plan

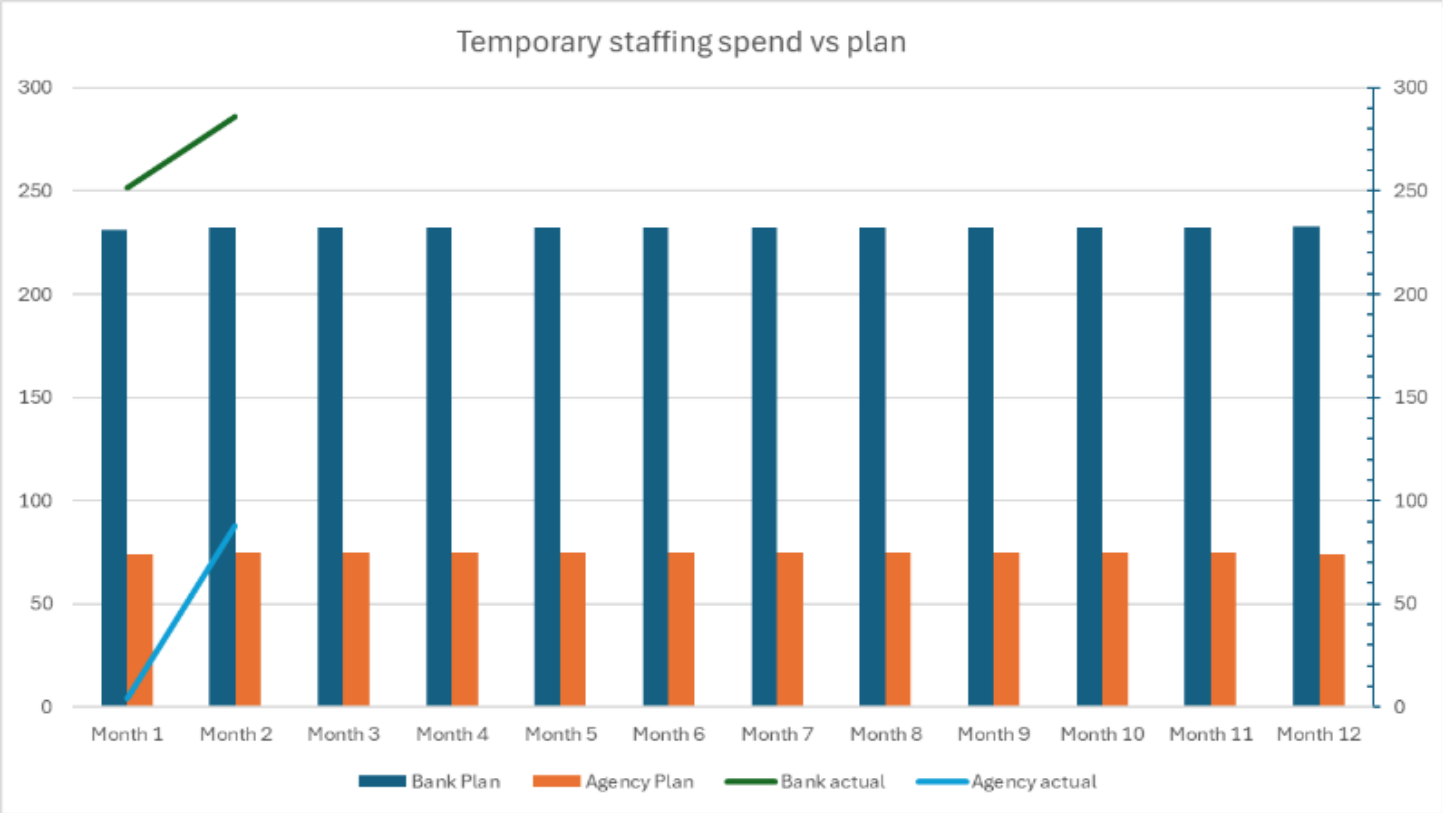
Risks / Issues:

- There is a risk that the Trust does not meet it's financial aims through overreliance on temporary staffing usage
- New NOF measure related to temporary staffing cost relevant to band

Action Plan:

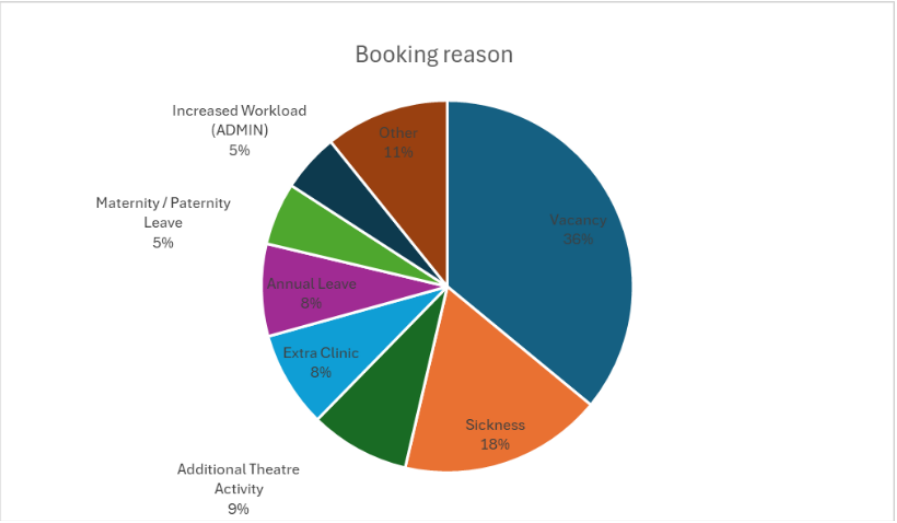
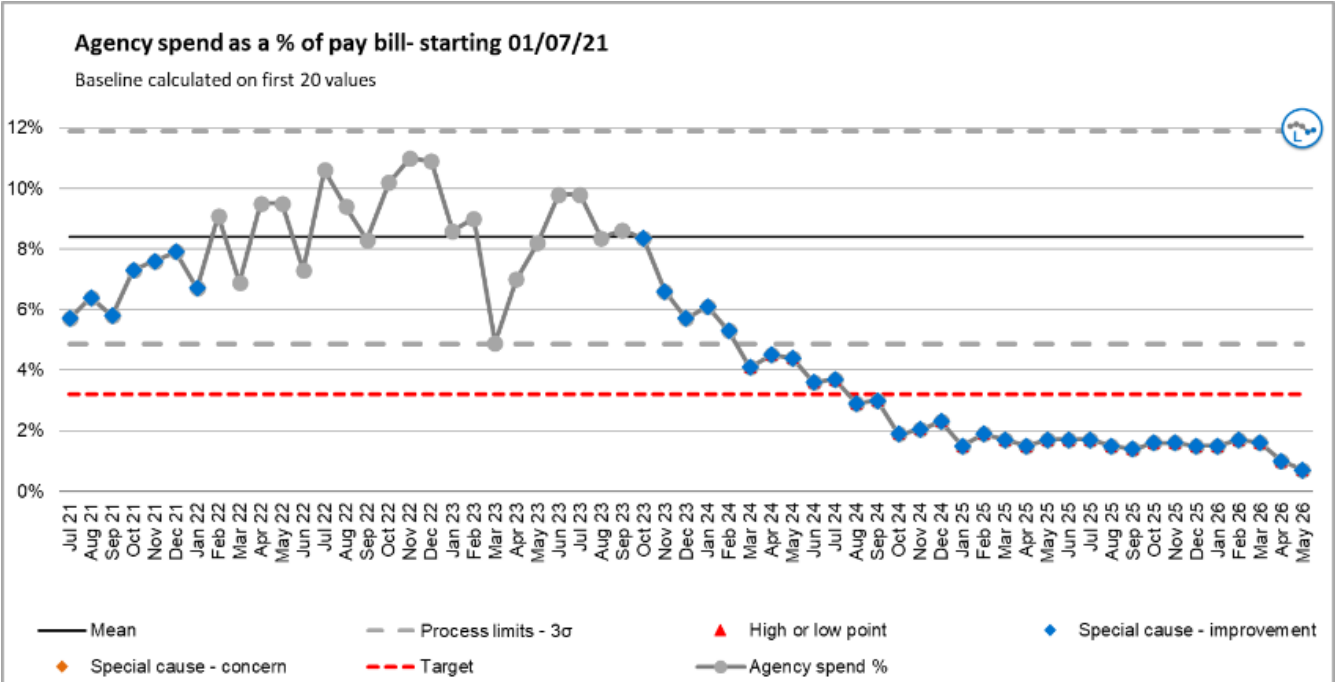
- Preparation is underway for the Employment Rights Act changes in January 2027 which will fundamentally change how we can utilise temporary staffing
- Plan in place to remove medical agency and replace with more sustainable staffing model
- Final decision to be made on enhanced rates for Theatres staff, once sustainable substantive staffing model is in place

Temporary Workforce



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Bank Plan	231	232	232	232	232	232	232	232	232	232	232	233
Bank actual	251	286										
Bank variance	(20)	(54)										
Agency Plan	74	75	75	75	75	75	75	75	75	75	75	74
Agency actual	4	88										
Agency variance	70	(13)										

Temporary Workforce



Appraisals

Summary:

Appraisals are now input onto the LMS system rather than via word or paper based forms. This allows for central recording of all AfC appraisals. Managers and individuals will also be able to make better use of LMS appraisal conversation detail for one to ones during the year. Using the LMS also allows for reporting at organisational level for key fields e.g. wellbeing conversations. There is also an additional focus on improving the quality of the appraisal conversation.

Areas for Improvement:

- Additional support has been put in place to upskill managers and individuals in how to use the LMS.
- Appraisal training for managers have been updated to focus on ensuring a quality appraisal conversation
- Regular reporting at Directorate levels enables additional support is provided to departments, where needed

Risks / Issues:

- Work pressures are impacting the ability for managers to undertaken quality conversations in some areas
- There has been an increase across National staff survey scores (NSS) for appraisals but more progress is needed to ensure all conversations are meaningful, supportive and effective

Action Plan:

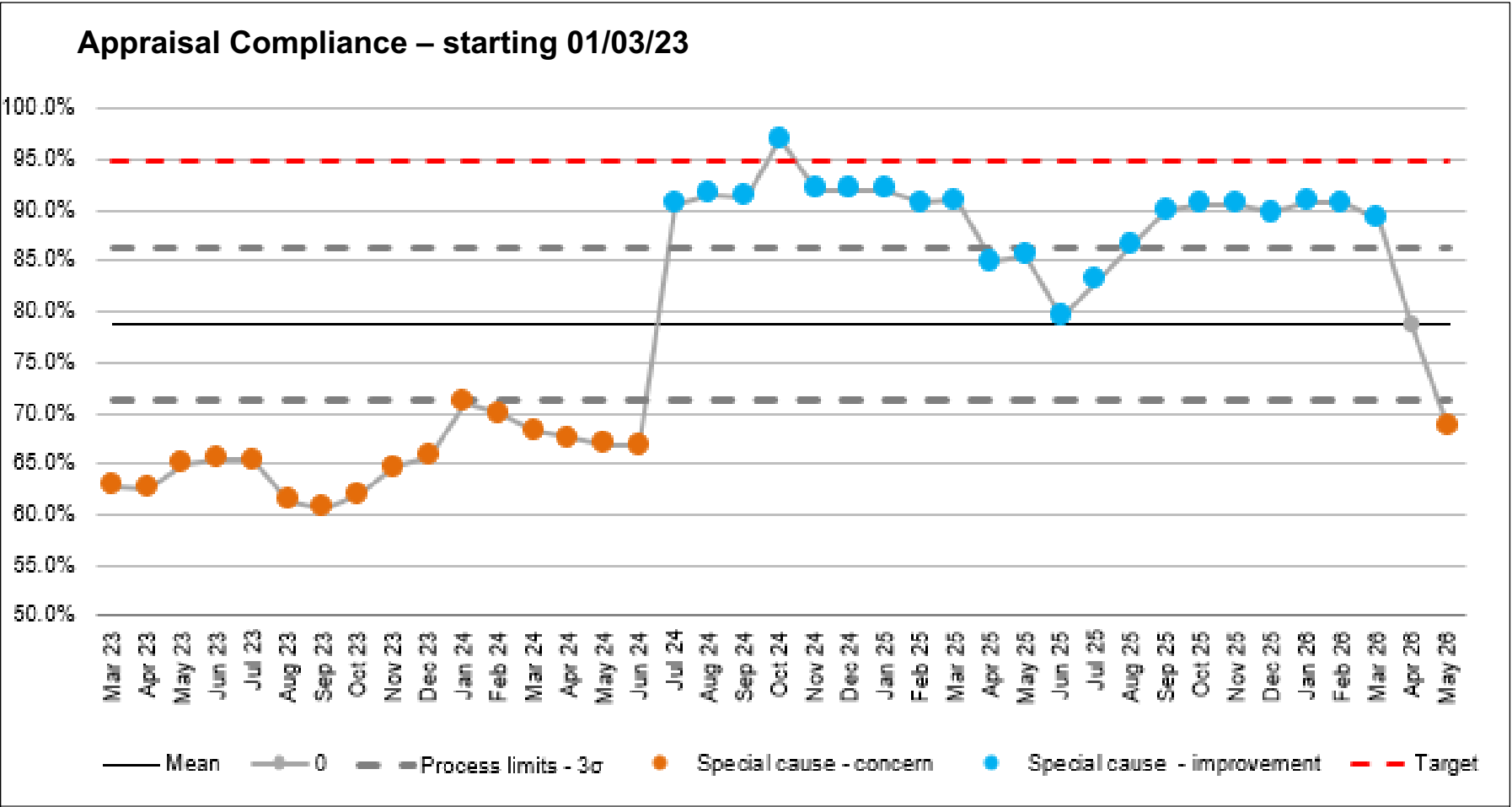
- Team to review completions of appraisals on new LMS to ensure information is being updated correctly
- Further development of LMS reporting
- An evaluation for this appraisal window will be undertaken

Appraisals AFC

KPI 95%

May 2026 68.62%

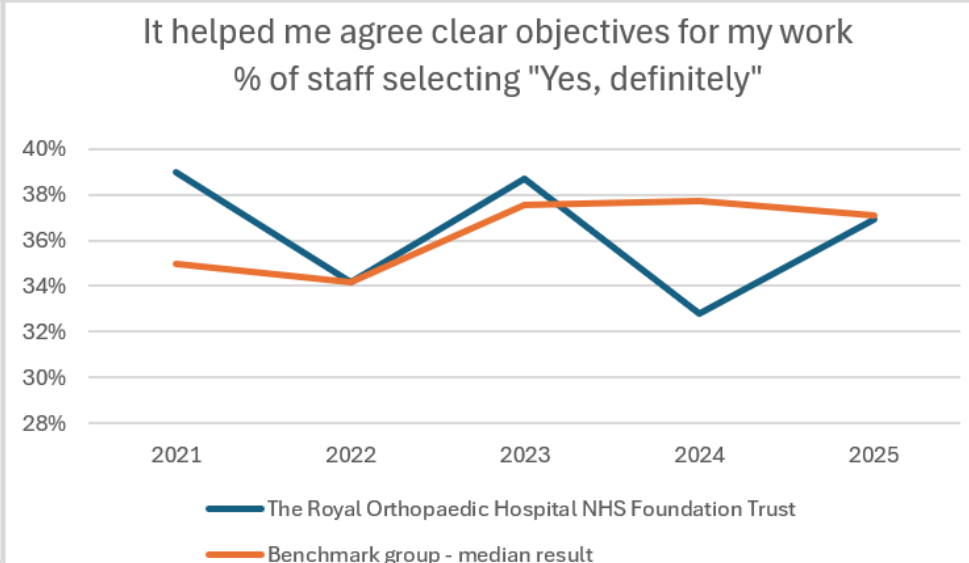
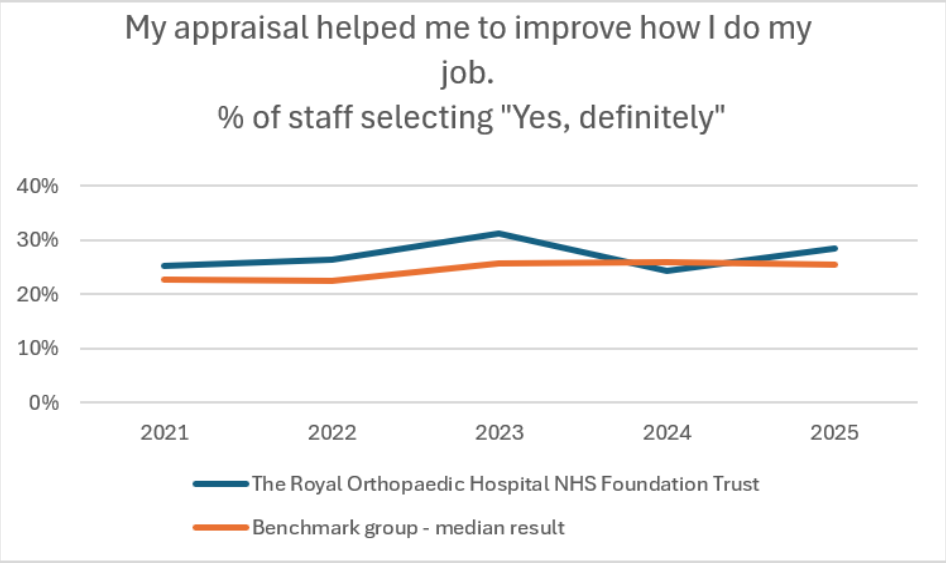
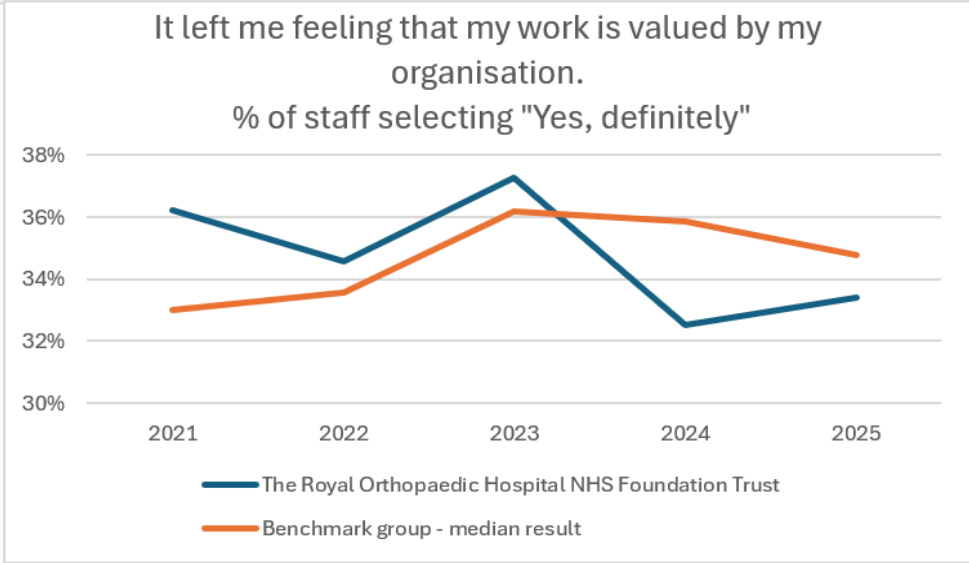
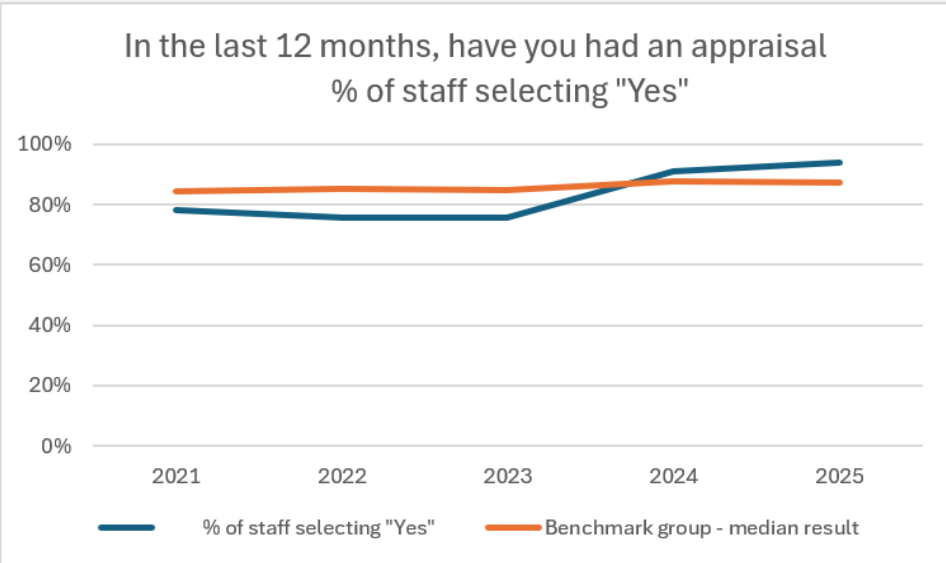
Trend



The Appraisal window is now underway and is being supported through a programme that includes manager training, drop-in sessions, intranet guidance and targeted team support where required. Current compliance stands at **68.6%**, which is expected at this stage as staff appraisals continue to progress toward the 31 July deadline. Additional communication has been issued to reinforce the importance of following the cascade process to ensure consistency and timely completion. For the first year, appraisals will be input on the LMS system and support is available for staff and managers

Appraisals

What our staff say – Staff Survey 2025



Education and Training

Summary:

Apprenticeship Activity – achieved 4 new starts against a target of 33 since April 2026. 12 in discussion. Currently strong utilisation of the apprenticeship levy, due to considerable number of high value, higher level apprenticeships starting in 2024 and 2025. Mandatory Training figure currently stands at 92.08%, highest figure for 6 years just under the target of 93%. Fire Safety has been changed to 2 yearly as of March in line with National guidance.

Areas for Improvement:

- Bank staff have been allocated Oliver McGowan Part 2 Tier 1 or Tier 2 according to job roles
- Resus Officer is working with Theatres on their compliance levels.

Risks / Issues:

- Introduction of new Growth and Skills levy, reform of the Apprenticeship levy will have a significant impact on how we offer apprenticeships, and removed all management and leadership development qualifications from accessing the funding.
- We are in the process of changing the module for Consent and currently this is unavailable for staff.

Action Plan:

- Workforce, OD and Education meeting in April to review apprenticeship reforms and develop mitigation strategies.

Apprenticeship Activity

2026/27 KPI

33
(2.3% headcount)

Current YTD

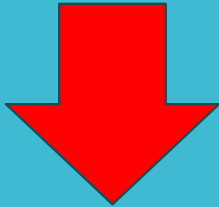
4/33

2025/26

29/34

2024/25

30/33

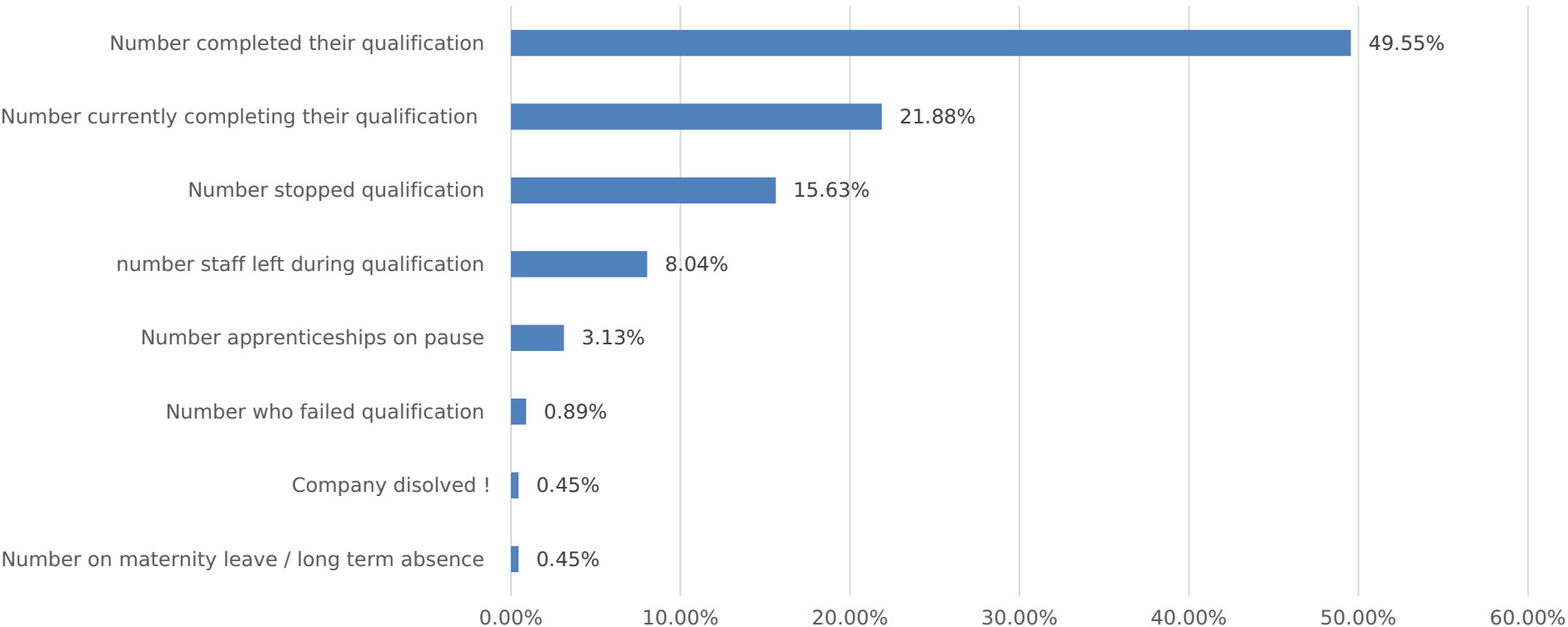


Apprenticeship Qualifications At 31st May 2026	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	Total	%age
Number currently completing their qualification	0	0	0	0	0	0	4	19	22	4	49	21.88%
Number completed their qualification	6	17	17	9	17	15	23	7	0	0	111	49.55%
Number apprenticeships on pause	0	0	0	0	0	0	3	1	3	0	7	3.13%
number staff left during qualification	1	1	2	1	4	2	3	2	2	0	18	8.04%
Number stopped qualification	0	6	7	7	5	6	3	0	1	0	35	15.63%
Number on maternity leave / long term absence	0	0	0	0	0	0	0	1	0	0	1	0.45%
Number who failed qualification	0	1	0	0	0	1	0	0	0	0	2	0.89%
Company dissolved !	0	0	1	0	0	0	0	0	0	0	1	0.45%
Number of GIFTED qualifications						2	1	19	21	0	43	224
Number of apprenticeships in discussion phase							0	0	1	12	13	
Number external apprenticeship in pre-employment							0	0	0	0	0	
Number internal apprenticeships in sign up stage							0	0	0	0	0	
Number internal apprenticeships in recruitment							0	0	0	0	0	
Number new apprenticeship qualifications commenced during the year	7	25	27	17	26	24	36	30	28	4	224	22
potential apprenticeships in progress	1	8	10	8	9	9	9	4	29	16		
Applications that didn't progress following initial interest	0	7	9	11	6	11	8	15	17	0	84	37.50%
recruited substantive instead				1							1	
Annual Target: 2.3% of workforce	24	23	25	26	28	28	29	33	34	33	284	28
Percentage of qualifications to national annual target	29.66%	107.51%	109.71%	64.27%	93.73%	84.22%	122.09%	91.34%	82.48%	11.99%	78.94%	78.94%
Trust headcount	1026	1011	1070	1150	1206	1239	1282	1428	1476	1450	12338	1234
Apprenticeships as a percentage of workforce headcount (2.3% target)	0.68%	2.47%	2.52%	1.48%	2.16%	1.94%	2.81%	2.10%	1.90%	0.28%	1.82%	1.82%

The table above details the numbers of apprenticeship qualifications, by year of commencement, and their progress towards completion. The annual target is set at 2.3% of Trust head count. Year to date we have 4 new apprenticeship starts with 12 in discussion

Apprenticeship Activity:

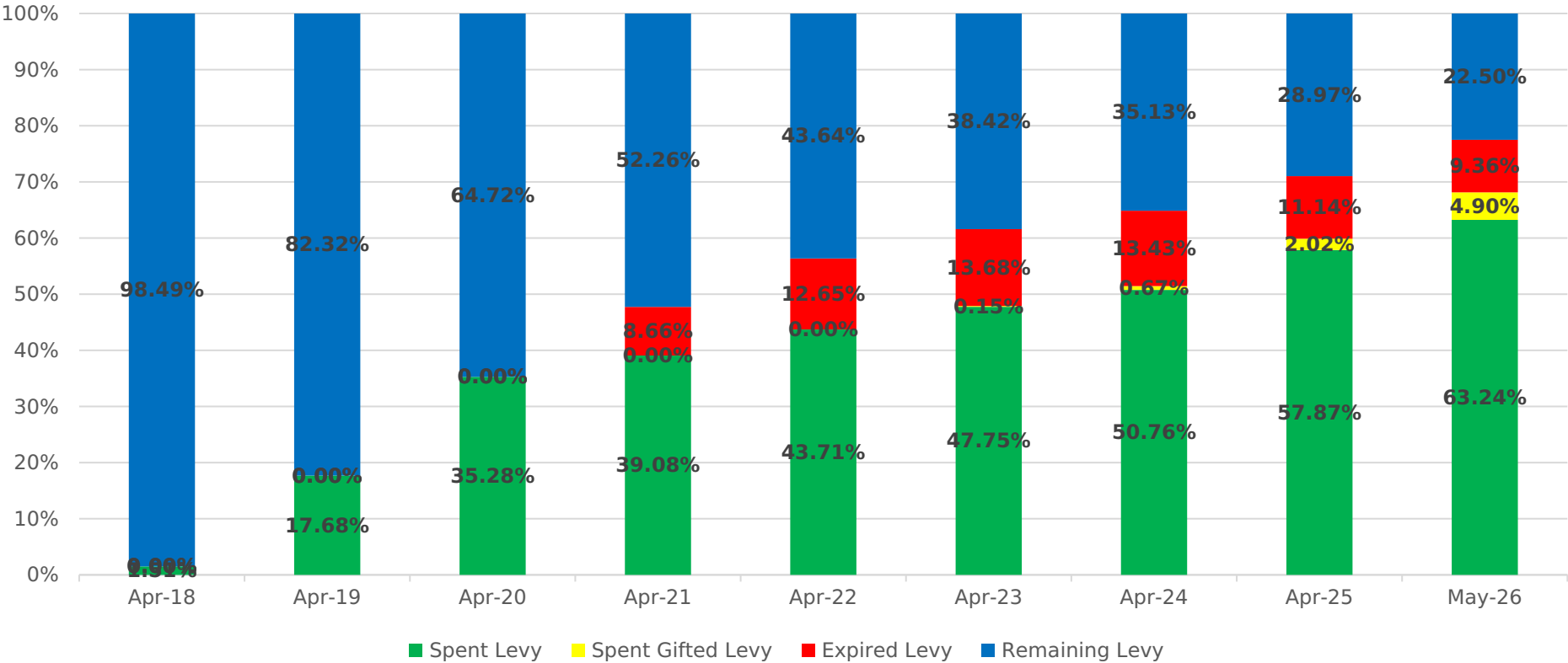
Summary of apprenticeship progress since April 2017 as a percentage of total apprenticeship starts



The graph above details the progress towards completing all apprenticeship qualifications since 2017. Of the 224 qualifications that have commenced, 49.55% have now completed their qualification (111). Only 8% left the Trust whilst completing their qualifications. Of the 16% that withdrew from finishing their qualification, 53% of these (19/36) was due to the implications during the COVID pandemic, and only 2 have withdrawn since April 2024.

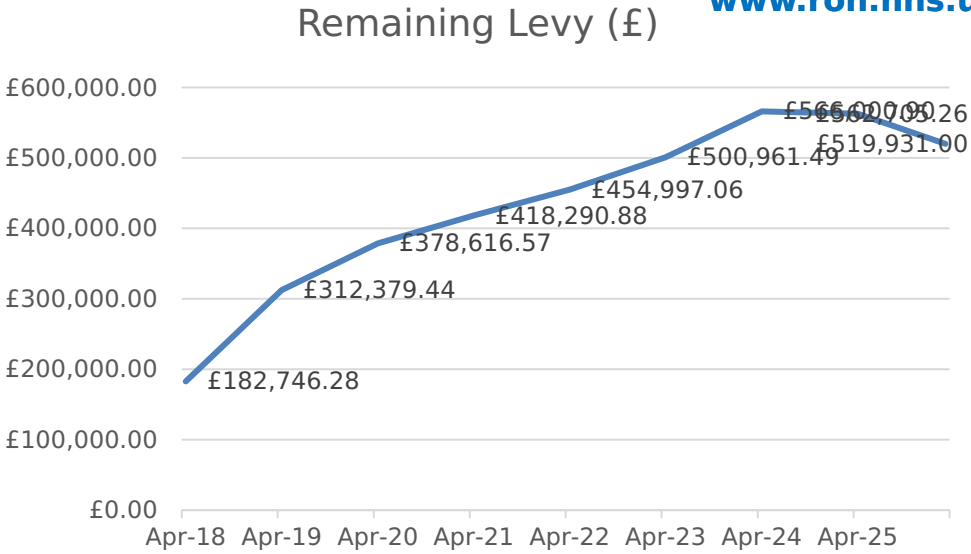
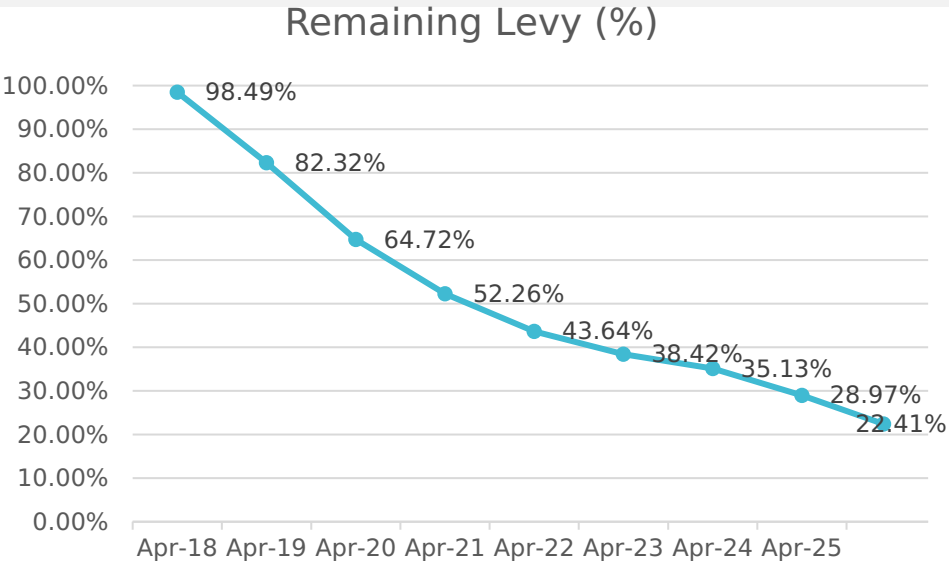
Apprenticeship Levy Funding	
Total Levy	£2,311,936.41
Levy Charges	63.25%
Gifted Levy	4.90%
Levy Expired	9.36%
Remaining Levy	22.49%

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



The graphs above detail the utilisation of the Trust Levy funding since 2017. At 31st May 2026, the Trust has invested £2.31 million into the Levy. Of this, 68% has been invested in providing qualifications (4.9% of this has been gifted to other local charitable organisations), and only 9.4% has expired. The Trust started expiring funding during the COVID pandemic and has not expired any funds since April 2024.

Apprenticeship Levy Funding	
Total Levy	£2,311,936.41
Levy Charges	£1,462,287.48
Gifted Levy	£113,306.05
Levy Expired	£216,411.89
Remaining Levy	£519,931.00



	May 2026 (£)	May 2026 (%)	May 2025 (£)	May 2025 (%)	Change (%)	Shift	Change (£)
Total Levy	£2,311,936.41		£1,969,987.71				£341,948.70
Levy Charges	£1,462,287.48	63.25%	£1,146,159.12	58.18%	5.07%	↑	£316,128.36
Gifted levy charges	£113,306.05	4.90%	£42,618.59	2.16%	2.74%	↑	£70,687.46
Levy Expired	£216,411.89	9.36%	£216,411.89	10.99%	-1.62%	↓	£0.00
Remaining levy pot	£519,931.00	22.49%	£564,798.12	28.67%	-6.18%	↓	£-44,867.12

The graphs above illustrate the Trust’s remaining levy fund both as a percentage of the total allocation and in absolute financial terms. They show a steadily increasing surplus from 2017 to 2024, largely driven by the Trust not meeting annual targets for new apprenticeship starts and therefore underutilising the levy.

Over the past two years, there has been a slight reduction in this surplus. This is primarily due to increased investment in higher-level, higher-cost apprenticeships (for example, Level 7 Senior Leader programmes), as well as a rise in the transfer of levy funds to charities and smaller care providers.

However, with the removal of access to higher-level apprenticeships and the shortening of the timeframe before unused levy funds expire, there is a growing risk that the Trust will begin to forfeit unspent levy funding.

Resident Doctor Experience / 10-point plan



Resident Doctor Experience Metrics	Metrics / Target	Compliance / Errors	Comments
1. Workplace wellbeing –	Ensuring that audit has taken place and improvement plans developed to address any gaps, supported by Resident Doctor Peer Lead. Target: 94% outcome	May 2026: Compliant Self Audit: 90.67%	Audit completed and action plan in place: September 25: 84% December 25: 81%
2. Rota transparency –	Compliance with 8-week schedules, 6-week rotas with improvement plans in place where required. Target: 100%	8 week schedule compliance 6 week rota compliance 100%	Assurance reporting process in development. 100% reported at last rotation
3. Annual leave reform –	Adoption of national best practice initiatives, and policy implemented	Partial Compliance	Draft of new Resident Doctor Annual Leave Policy in consultation
5. Payroll accuracy –	Reduction in payroll errors Monthly error reporting compliance undertaken Target: Zero errors	Partial Compliance : Feb 26: 1 error reported	1 error during February rotation, resolved within 24 hours
7. Exception reporting –	Implemented local and national data reporting requirements Target: Zero exceptions reported	Compliant zero exceptions reported	No exceptions reported awaiting confirmation / assurance report from HR
8. Expense reimbursement –	Meeting target reimbursement time of 6 weeks following submission Target 100% compliance	100% Compliant	Implemented new reimbursement approach from December 2025.
NHS NETS Overall Satisfaction	Doctor satisfaction meeting ≥80% target Local Target: ≥ 90% by March 2029	March 2026: 86.06%	National Average: 77.4%: BSOL ICB: Average: 75.8%
GMC NTS Overall Satisfaction	Doctor satisfaction meeting ≥80% target Local Target: ≥ 90% consistently or achieve my March 2029.	August 2025: T&O : 91.67% Anaesthetics: 86%	National Average August 2025: T&O : 80.9% Anaesthetics: 83.5%
Actions: Annual Leave Policy drafted, and in circulation for feedback. Monitoring payroll activity around rotations. GMC NTS Survey 2026 closed May 2026, results due in August 2026. Implementing reporting process for rota compliance, payroll accuracy, exception reporting and expense reimbursement to the Resident doctors forum for monitoring.			
Risks: NETS survey has identified areas of improvement around Sexual Safety, Bullying and undermining, discrimination and wellbeing. With 2 or more areas of speciality training identifying these areas of concern. NETYS action group is being set up with first meeting on 23rd June 2026.			

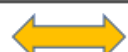
Training compliance summary – 31st May 2026

Mandatory Training

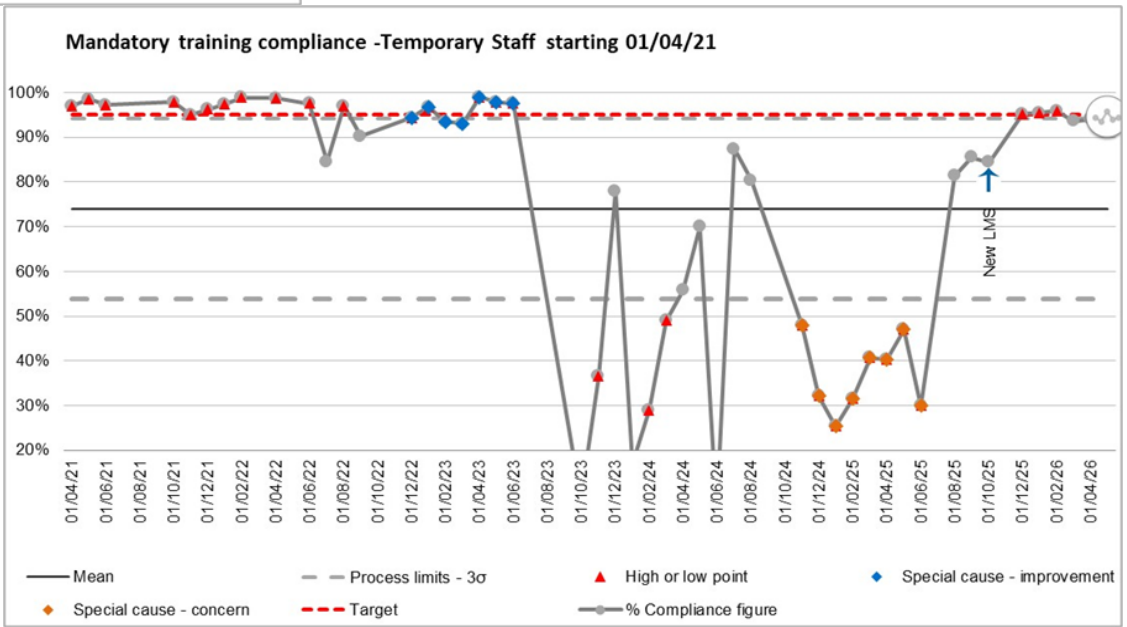
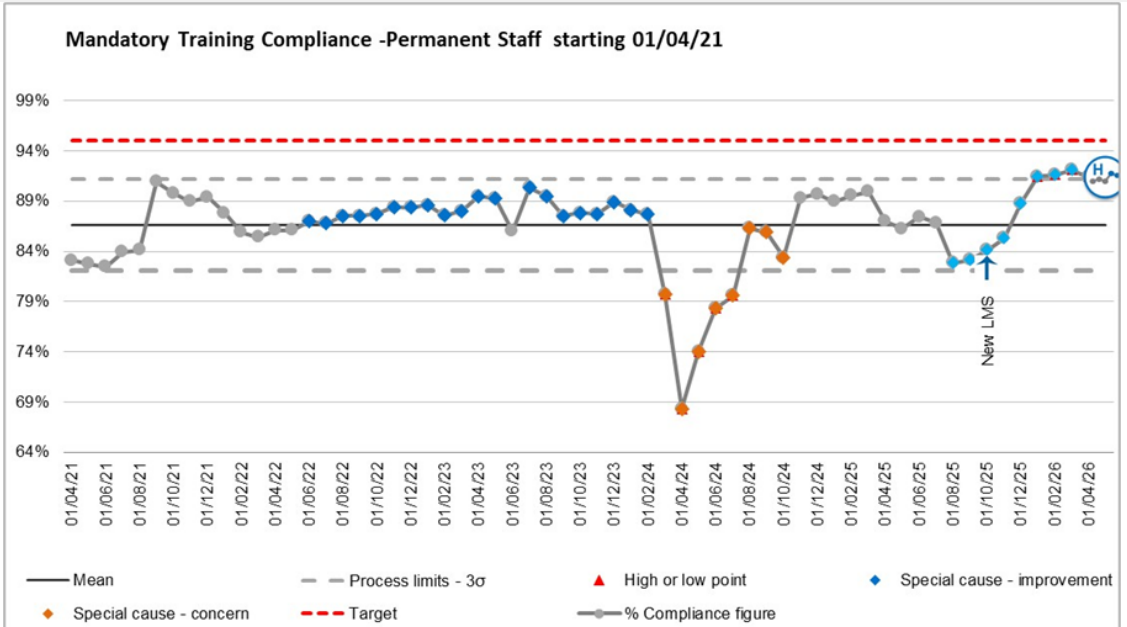
KPI 93%

May 2026 92.14%

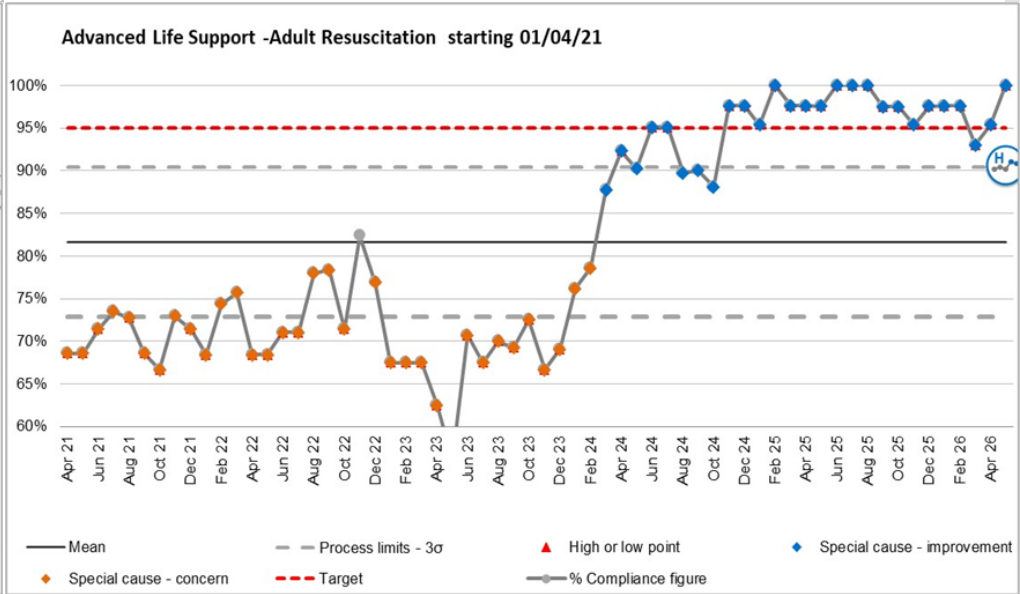
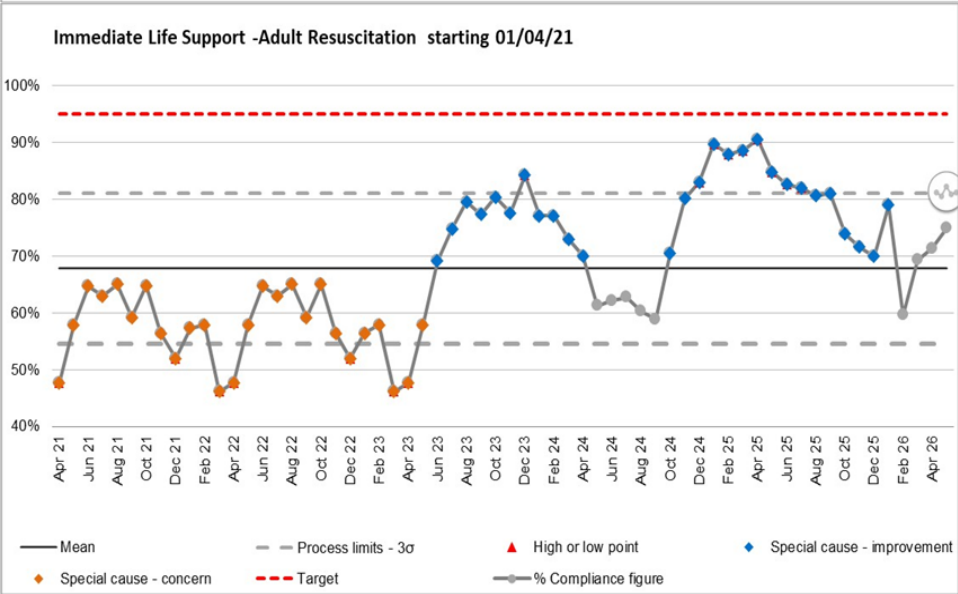
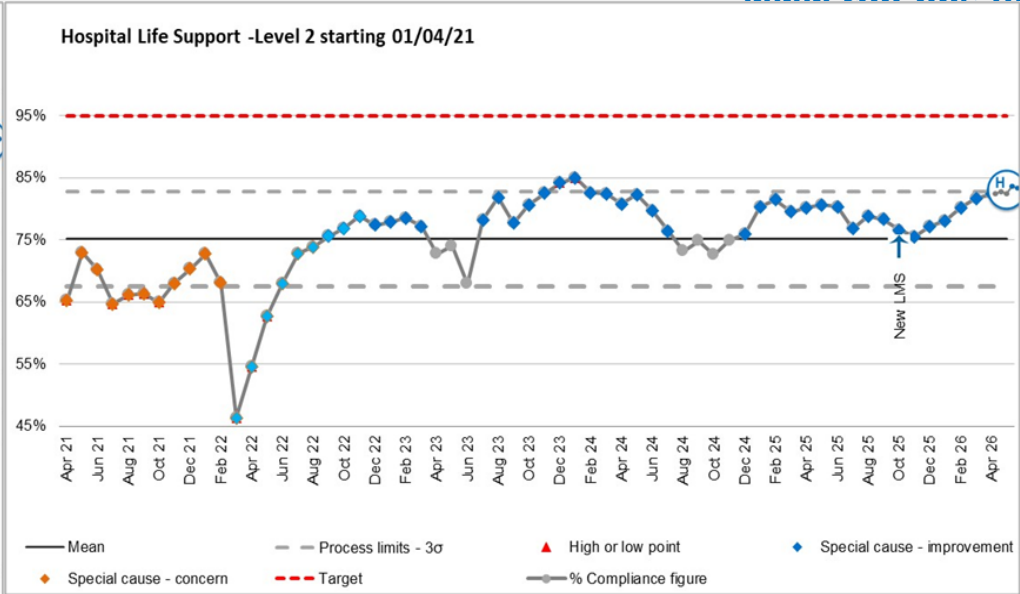
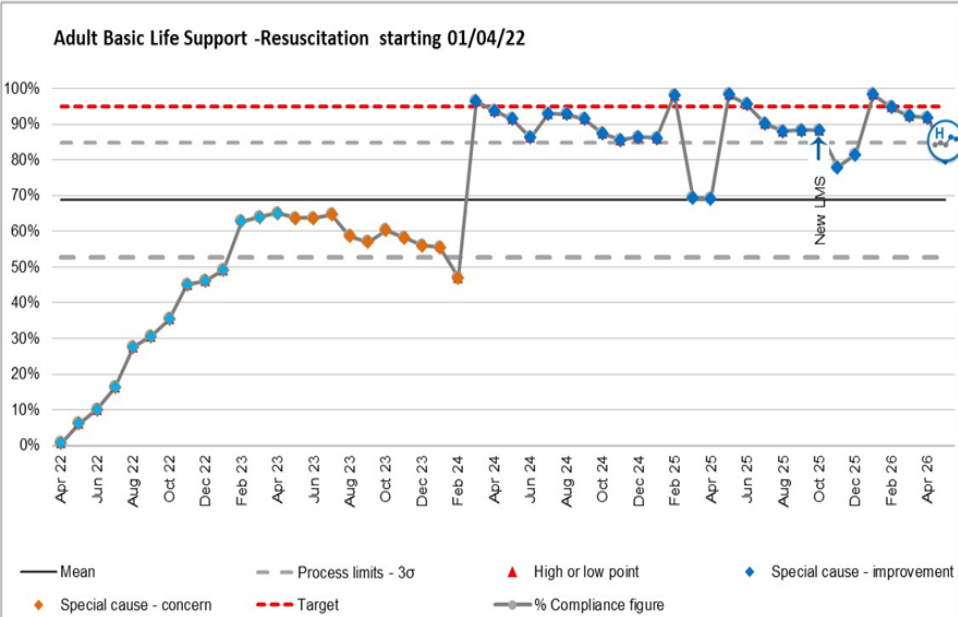
TREND 

Pg.	COURSE	Compliance %age	COMMENTS	TREND
4	Core Mandatory Training – Permanent Staff	92.14%	If we break this down per compliance module it increases further for some elements of the Core Skills Training Framework (CSTF). IG & Cyber have made significant improvements over the last month. Fire Safety has been changed to 2 yearly now so this has increased compliance.	
4	Core Mandatory Training – Temporary Staff	92.28%	Based on staff working on the Bank who are compliant with training. Bank Office have been targeting staff to complete their training.	
6	Cyber	90.72%	Compliance has been static, a slight decrease this month. Digital/IT have been driving completions through chasers and potential lockouts. Lockouts have been implemented.	
6	IG	89.47%	Compliance has increased slightly this month. IG have been driving completions and chasing those not compliant.	
7	Basic Life Support – Level 1	80.68%	Audience is non-clinical staff. Leaflets were sent out to non-compliant staff in January.	
7	Hospital Life Support – Level 2	81.40%	Continuing to see DNAs, compliance has dipped during the last three months. We have seen a slight increase this month, as QIDD captured some of the M&D staff.	
8	Immediate Life Support	74.86%	Increase on previous months of 20%. Regular sessions scheduled.	
8	Advanced Life Support	100%	Consistent and significant improvement since February 2024, helped by in-house delivery/Saturday courses and targeting attendance. One person needs to complete and are booked on a future date.	
9	Paediatric Immediate Life Support	84.62%	Challenging due to our small numbers to maintain compliance but Resus Officer is looking at ways to improve this through commercial offer which will also support our learners with a wider network.	
10	Patient Handling	84.20%	Been hovering around 85% for the past year. We have some new trainers and dates are all scheduled/available to book via the LMS.	
10	Conflict Resolution	87.94%	Incremental improvements each month.	
11	NEWS2	95.72%	Consistently achieves target	
11	Safe use of Insulin	91.55%	Consistently at target	
11	VTE	95.44%	Consistently at target	
12	CONSENT	80.02%	Recent change of provider. New module is now available on the LMS. All those identified as requiring this training have been chased for completion. Anticipate recovery of compliance within the next couple of months.	

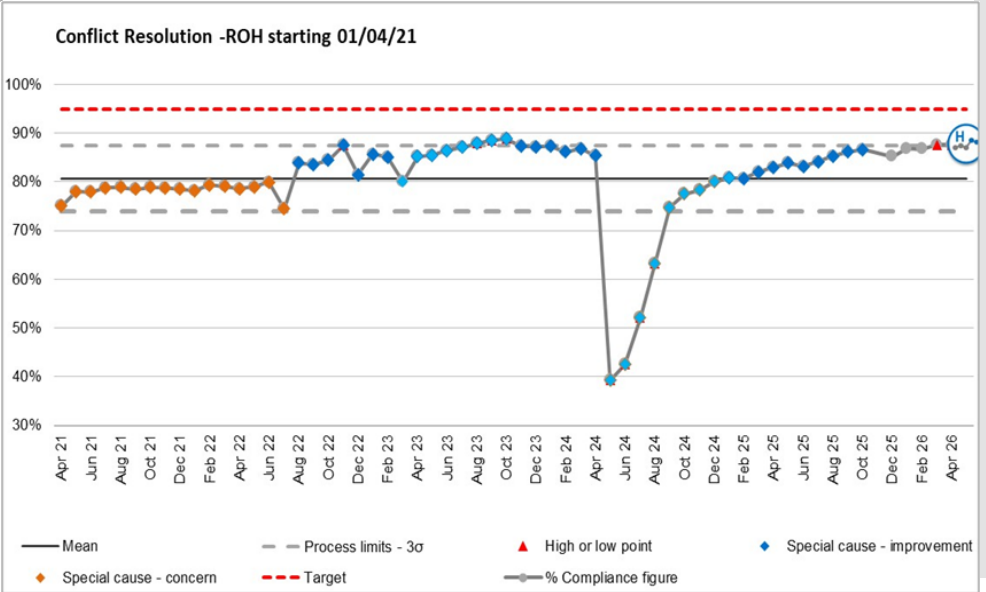
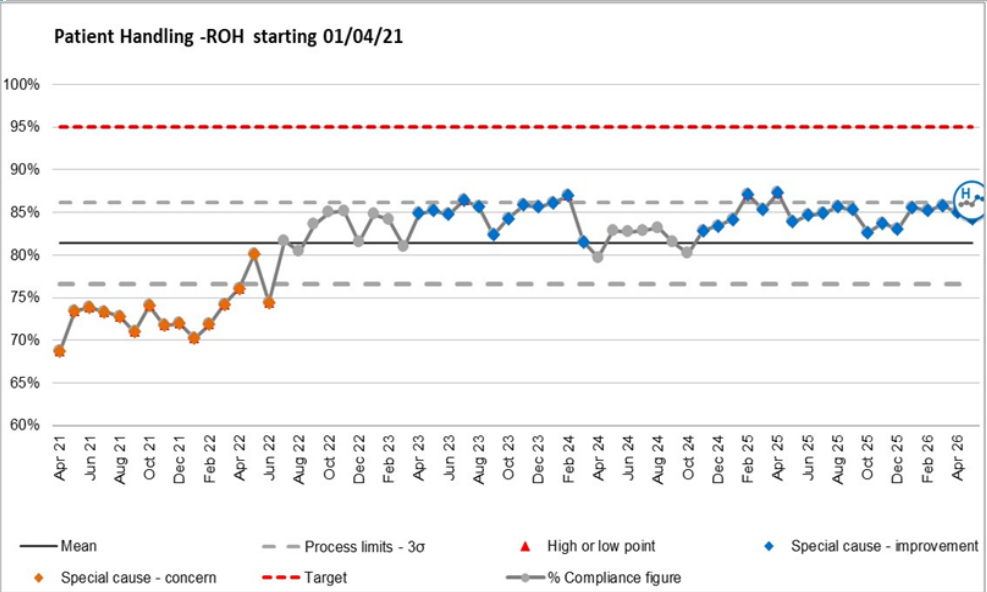
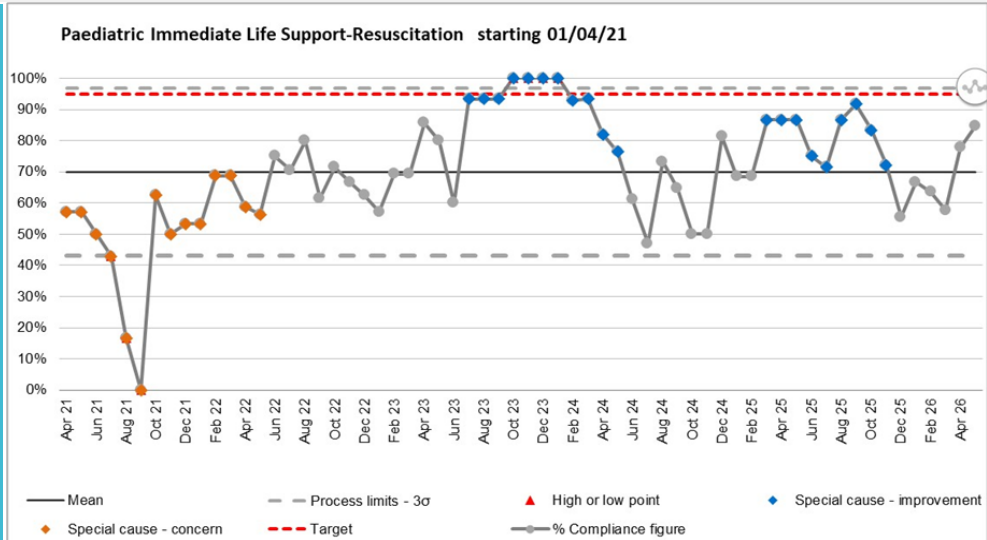
Core Mandatory Training: Permanent and Temporary Staff



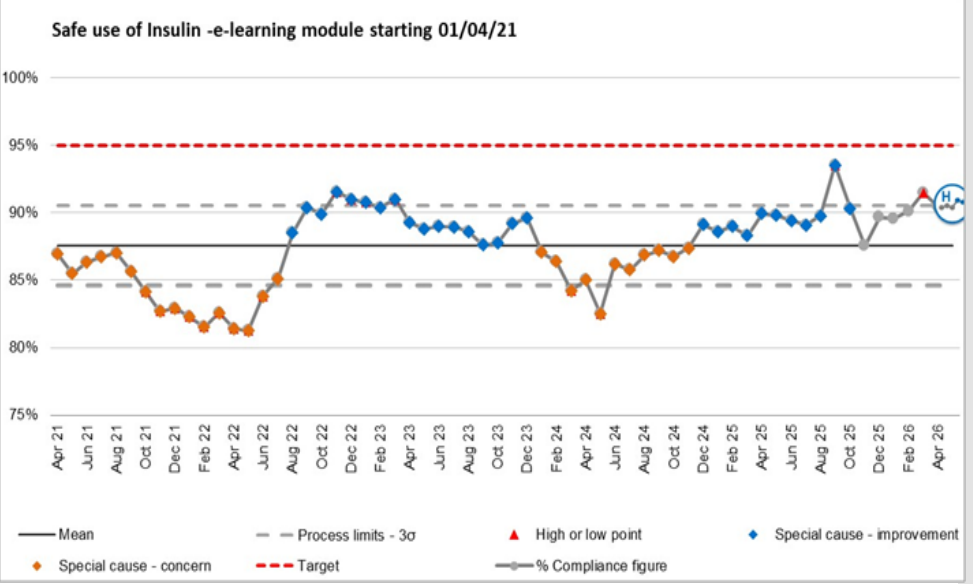
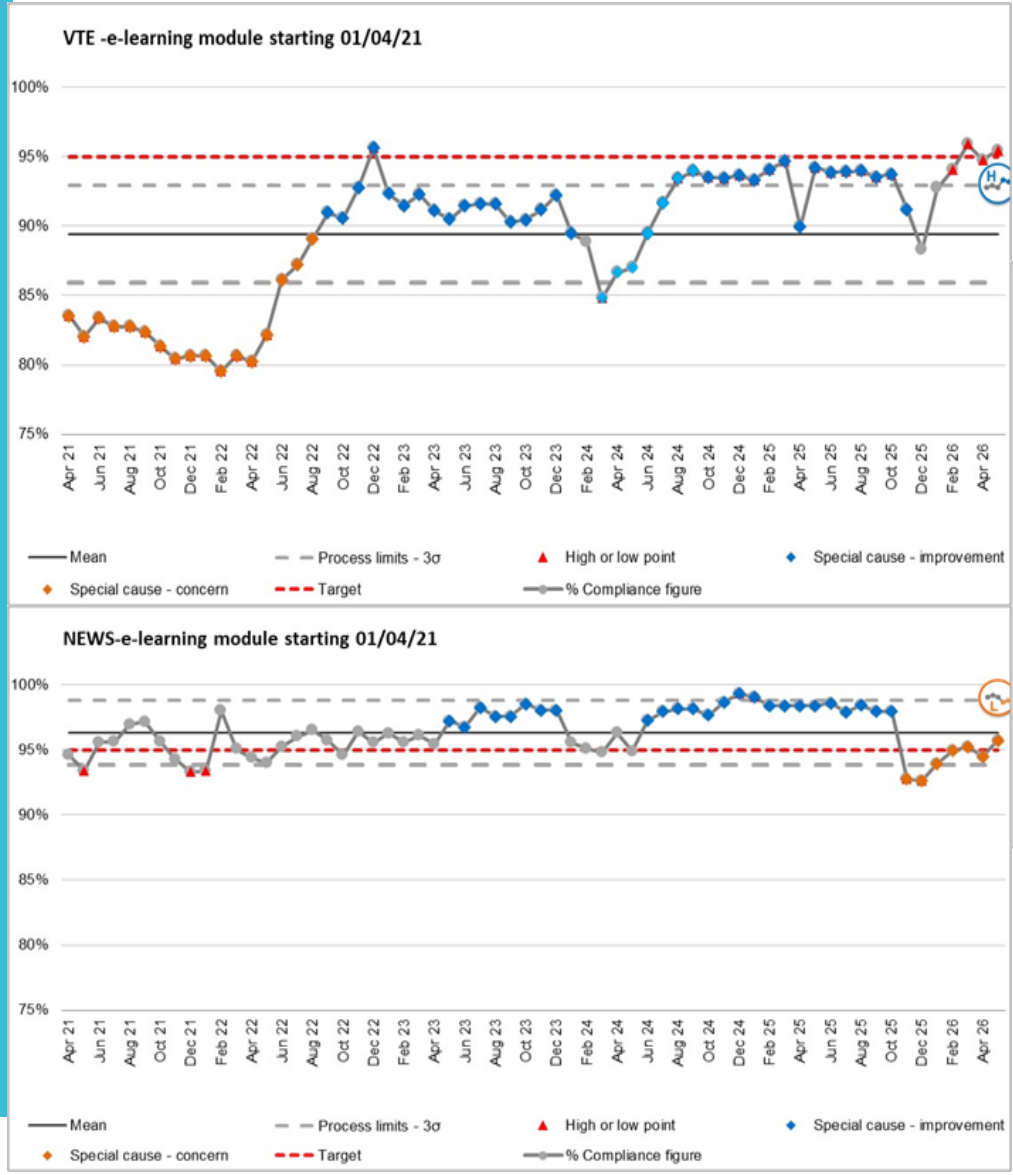
Resuscitation Training:
Adult



PILS,
Conflict
Resolution
Patient
Handling



VTE, Safe use of Insulin, NEWS2



IPC Level 2, Food Hygiene Consent

