The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Board of Directors | Public Meeting 02.07.2025

MEETING

2 July 2025 09:30 BST

PUBLISHED

1 July 2025

Agenda

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Meeting Room 1, Main Entrance	2 Jul 2025	09:30 BST

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9	Questions from the Governors and Public	Chair	12:20	-
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Board Members and Senior Leaders Declarations of Interests

First Name	Surname	Position	Type of Interest	Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)	Date interest relates From & To dd-mm-yy		Comments, including action taken to mitigate any potential conflict of interest.
					From	To	
Harry	Turner	Chairman	Non-Financial Personal Interests	Presiding Justice West Mercia judiciary	October 2006	Ongoing	
			Financial Interests	In Form Solutions Management Consultancy	February 2024	Ongoing	
Sarfraz	Nawaz	Non Executive Director / SID	Financial Interests	Executive Director of Finance at National Citizens Trust	18/09/2023	Jun-25	No conflict between role at NCS and RJAH
			Financial Interests	Wakefield Council – Chief Finance Officer	Sept 2025	Ongoing	
			Non-Financial Professional Interests	Member of CIPFA	01/2021	Ongoing	
Martin	Evans	Non Executive Director	Financial Interests	Non-Executive Director at North Staffordshire Combined Healthcare NHS Trust	28/08/2024	Ongoing	
			Financial Interests	Director at MJE Associates Ltd. (Role includes European rep at Washington State Department of Commerce – area of work focused within the energy industry)	01/04/2020	Ongoing	
Penny	Venables	Non Executive Director	Financial Interests	Consultant – In-Form Solutions Ltd, Lichfield Business Hub, Lichfield Council House, 20 Frog Lane, Lichfield, Staffordshire, WS13 6YY. Work as a management consultant via this business.	January 2021	Ongoing	
			Financial Interests	Trustee Board of Birmingham University Guild of Students	January 2025	Ongoing	
			Financial Interests	Member of the Members Council of the West Bromwich Building Society	October 2024	Ongoing	
			Non-Financial Professional Interests	Non-Executive Director – British Dietetic Association, 3rd Floor Interchange Place, 151 – 165 Edmund Street, Birmingham B3 2TA. Sit on the Board of Directors of the BDA.	June 2020	Oct-24	
			Non-Financial Personal Interests	Chair Sandwell Leisure Trust, Tipton Sports Acadamy, Wednesbury Oak Road, Tipton, West Midlands DY4 0BS.	November 2023	Ongoing	
Martin	Newsholme	Non Executive Director	Financial Interests	Non executive director of Shropshire Doctors Co-operative Limited	01/08/2019	Ongoing	To my knowledge Shropdoc and RJAH do not trade with each other
			Financial Interests	Non executive director at Warrington Housing Association	01/09/2018	Ongoing	Warrington Housing is not in the healthcare section and doesn't trade with RJAH
Lindsey	Webb	Non Executive Director	Indirect Interests	Husband is a NED at Birmingham and Solihull ICB		Ongoing	
John	Pepper	Associate Non Executive Director	Financial Interests	NHS England GP Appraiser	01/07/2022	Ongoing	
Paul	Maubach	Associate Non Executive Director	Non-Financial Professional Interests	Member of CIPFA	01/03/2023	Ongoing	
			Financial Interests	Senior Advisor for Primary Care (Department of Health	01/03/2023	31/07/2024	
			Financial Interests	Senior Advisor for Neighbourhood Health (Department of Health	01/08/2024	Ongoing	
			Financial Interests	Director and Owner of Maubach Consulting Ltd – through which I provide management consulting and advisory services to different organisations.If it transpires either at a committee or Board meeting of the Trust, the meeting is either discussing or engaging with an organisation that my company is also engaged with, then I will declare a potential conflict of interest to the Chair.	01/03/2023	Ongoing	
Atif	Ishaq	Associate Non Executive Director	Financial Interests	Data Product Director at Haleon Plc	2022	2025	
			Financial Interests	Enterprise AI & Advanced Analytics Director at Mars Inc	04/2025	Ongoing	
			Financial Interests	Owner of Digital Clinician Ltd	2018	Ongoing	
			Financial Interests	Digital Advisor and Webmaster to Pharmacy Care Matters LTD	2011	2025	
			Financial Interests	Digital Advisor and Webmaster to Quest Legal Advocates LTD	2011	Ongoing	
			Financial Interests	Webmaster for Shrawley, North Claines and Hanbury Parish Councils	2011	Ongoing	
			Financial Interests	Self-employed webhosting provider	2011	Ongoing	
			Non-Financial Personal Interests	Justice of the Peace for West Mercia Judiciary	2017	Ongoing	
Stacey	Keegan	Chief Executive Officer	Non-Financial Professional Interests	STW ICB Partner Member	01/07/2022	Ongoing	
			Non-Financial Professional Interests	A member of the National Orthopaedic Alliance Board	03/05/2024	Ongoing	
Ruth	Longfellow	Chief Medical Officer	Financial Interests	Private Practice work for RJAH	2011	Ongoing	Withdraw from discussions as appropriate.
			Financial Interests	Member of GAS (Gobowen Anaesthetic Services)	November 2019	Jun-25	GAS was set up as an LLP, but no longer functions as an LLP since the recent pension rule changes
Mike	Carr	Chief Operating Officer	Indirect Interests	Parent is Chief Executive of Midlands Partnership NHS Trust.	May 2022	Ongoing	Withdraw from discussions as appropriate.
			Non-Financial Personal Interests	Member of the Labour party.	2017	Ongoing	Withdraw from discussions as appropriate
			Non-Financial Personal Interests	Trustee at Stay Charity	February 2025	Ongoing	Withdraw from discussions as appropriate
Denise	Harnin	Chief People and Culture Officer	Non-Financial Personal Interests	Spouse is a senior partner at Johnson Fellows Charter House, Birmingham, Ad hoc HR consultancy Johnson Fellows		Ongoing	
Angela	Mulholland-Wells	Chief Finance and Commerical Officer	Non-Financial Professional Interests	BOARD TRUSTEE AND CHAIR OF AUDIT, FINANCE AND RISK COMMITTEE FOR MINES ADVISORY GROUP	Oct-23	Ongoing	

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

BOARD OF DIRECTORS – PUBLIC MEETING
WEDNESDAY 07 MAY 2025 AT 09:30AM IN BOARD ROOM AT RJAH
MINUTES OF MEETING

Voting Members in Attendance

Name	Role	Attending
Harry Turner	Chair	✓
Sarfraz Nawaz	Non-Executive Director	✓
Martin Newsholme	Non-Executive Director	✓
Penny Venables	Non-Executive Director	✓
Lindsey Webb	Non-Executive Director (via MS Teams)	✓
Martin Evans	Non-Executive Director	✓
Stacey Keegan	Chief Executive Officer	✓
Craig Macbeth	Chief Finance and Planning Officer	✓
Paul Kavanagh Fields	Chief Nurse and Patient Safety Officer	×
Ruth Longfellow	Chief Medical Officer	✓
Mike Carr	Deputy CEO and Chief Operating Officer	✓

Others in Attendance

Name	Role	Attending
Paul Maubach	Associate Non-Executive Director	✓
John Pepper	Associate Non-Executive Director	✓
Atif Ishaq	Associate Non-Executive Director	✓
Denise Harnin	Chief People and Culture Officer	✓
Sam Young	Deputy Chief Nurse and DIPC (until 9:50am)	✓
Dylan Murphy	Trust Secretary	✓
Mary Bardsley	Assistant Trust Secretary (minute secretary)	✓
Chris Hudson	Head of Communications	✓
Colin Chapman	Governor (observing)	✓
Kate Betts	Governor (observing)	✓
Jan Greasley	Governor (observing)	✓
Caroline Nokes Lawrence	Associate Chief People and Culture Officer (item 6.4)	✓

Ref	Discussion and Action Points
1.0	**Welcome and introductions**
	The Chair welcomed all attendees to the meeting.
1.1	**Apologies**
	Apologies for absence were received from Paul Kavanagh-Fields. On behalf of the Board, HT extended a warm and appreciative welcome to SY, who joined the meeting as the representative for the nursing portfolio. The Chair warmly welcomed AMW to both the Trust and her first Board meeting, expressing enthusiasm for the expertise and perspective she brings to the organisation. In addition, MS was welcomed to the meeting to support continuity during this period of transition, ensuring a seamless flow of information and alignment with ongoing initiatives. As part of the ongoing Well-Led Review, the Board was pleased to welcome Wendy Saviour (The Value Circle) to observe the meeting. Wendy's role in conducting the review was acknowledged, and Board members took the opportunity to introduce themselves individually, reflecting the Trust's commitment to openness, collaboration, and continuous improvement. It was formally confirmed that the Board was quorate, enabling the meeting to proceed with full decision-making authority.
1.2	**Declarations of Interest**

Ref	Discussion and Action Points
	The Chair reminded attendees of their obligation to declare any interest which may be perceived as a potential conflict of interest with their Trust role and their role on this Board. There were no conflicts of interest identified in relation to the items for discussion which required members to withdraw from discussion or decision-making. PM confirmed that, through another organisation, they are engaged in work with the Value Circle. It was noted that there are no conflicts of interest in relation to the matters discussed at the Board meeting. The Board was satisfied with the declaration made.
1.3	**Minutes of the previous meeting**
	The minutes of the Board of Directors (Public) Meeting held on 08 January 2025 were approved as an accurate record subject to the following amendments: • Page 7 - second paragraph, second bullet point – to be removed from the minutes. • Section 5.3 – confirmation on whether this was a MSSA or MSRA is required
1.4	**Matters Arising and Action Log**
	There were no further matters to raise. There were no actions outstanding on the action log.
2.0	**Patient Story**
	SY introduced Abby to the Board, who joined the meeting to recounts her journey through the healthcare system and her recent treatment at RJAH under the care of Mr Geraint Thomas. The following key points were noted: • Abbey was impressed by the Hospital and the passionate members of staff who go above and beyond to support patient experience • The treatment and care from Mr Geraint Thomas and the team has transformed Abbey's life. • Abbey's treated included metalwork removal following a previous right periacetabular and femoral osteotomy and was cared for by Baschurch and Ludlow Wards • Abby praises the professionalism, compassion, and responsiveness of the staff and specifically mentions: o Ana Stavaru (Staff Nurse) for emotional support during post-op insomnia. o Kim Thomas (Nursing Associate) and Hannah Roberts (HCA) for resolving food availability issues. o Rachel Lindop (Senior Orthopaedic Physiotherapist) for tailored recovery support. o Shirley Oakley (Canteen staff) and the PALS team for addressing dietary concerns. o Mr Thomas and his secretary Janet Morris for their thorough, compassionate, and patient-centred care. Abby offered constructive feedback on several areas for the Boards' consideration: • **Mobility Aid Storage**: Lack of designated spaces for walking aids across departments. • **Call Bell Placement**: Inefficient room design with call bells placed away from doors. • **MyRecovery App**: Missing TCI date and post-op exercises; overwhelming volume of content. • **Food Quality and Availability**: Repeated issues with receiving appropriate vegan meals. • **Hospital Passport**: Unclear whether it was reviewed upon admission. • **Admission Timing**: Early admission despite POTS condition and assurance of early surgery slot not honoured. • **Medication Advice**: Misinformation about breastfeeding while on oramorph; recommends consulting The Breastfeeding Network. Despite the challenges, Abby describes RJAH as the best hospital she's ever been treated at. She expresses gratitude for the staff and suggests that her positive experience may even rekindle her interest in returning to healthcare work. Finally, Abbey thanked the Board for their time and commitment to listening to patients and their journey. On behalf of the Board, HT thanked Abbey for attending the meeting to share her story recognising the intimate details and personal accounts which was shared. HT reiterated that the Board do not take the information shared for granted and explained the importance of listening to the patients

Ref	Discussion and Action Points
	experiences to improve the patient care, quality and experience which is delivered by the organisation. The Board held the subsequent discussion: • **Assurance** – through the Quality and Safety Committee, the Board will gain assurance on the actions which have been recorded following Abbey's story. It was noted that some of the actions have already been completed however, for oversight a full report will be provided to the Quality and Safety Committee in June. ACTION: add patient story assurance report to the Quality and Safety Committee workplan for June. • **Patient Experience Group** – the Board suggested Abbey joining the patient panel to help support in sharing the voice for patients which Abbey confirmed that there has already been a discussion taken place with SY. • **Personalised Care** – noting that Abbey came into the hospital for treatment, and we need to take consideration patient specific requirements. The Board challenged the Trust to consider how do we do this as an organisation, how do we work through the personal needs for patients and how can members of the Board gain an understanding on how the trust is working on personal needs. • **Board Visits** – the members of the Board noted that some of the locations which Abbey mentioned today will be visited by the members of the Board later in the day as part of the Board visits and therefore suggested the comments shared at the meetings were cascaded to members of the staff. • **Awards for Food** – noted the awards which the Trust continues to receive for their food and the links between making reasonable requested and how the Trust is sighted on making reasonable adjustments. The Trust is to consider whether the organisation is sufficiently aware of the service we are providing when reasonable adjustments are requested. • **Admission and Theatres** – noted that the Trust has trialled a phrased admission for patients who are having surgery however following feedback this has reverted to the one admission time due to the challenges which occurred throughout the trial period. To support patient experience, the fasting policy has recently been reviewed and there is a commitment from the teams to inform patients of delays. Once again, HT thanked Abbey for joining the meeting and confirmed that feedback will be provided following the assurance report via SY.
3.0	**Chair and CEO Update**
3.1	**Chair Update** HT provided the Board with the following updates: • **Simon Jones** – as part of the recent elections, Simon Jones has lost his seat and is therefore no longer able to be a Trust Governor for Shropshire Council. The Board expressed gratitude for his contributions and support during his tenure. He will be greatly missed. • **Craig Macbeth** – Craig Macbeth has officially retired since the last public Board meeting. The Board acknowledged his service and wished him well for the future. • **ICS Chair** – the nomination of the Chair has been approved by the Secretary of State. The Board was informed of this decision as soon as it was confirmed. • **Structural Changes within the System** - HT noted the ongoing structural changes within NHS England (NHSE) and the Integrated Care Board (ICB). These changes are associated cost reduction measures being implemented across provider organisations and align to the NHS 10-year plan. • **NHS current position** – HT reminded the Board of the ongoing challenging circumstances currently facing the NHS. HT emphasised the importance of being sensitive and supportive towards colleagues as it is noted to be a challenging time for many staff. • **System leadership meeting** - took place prior to the Board meeting. It was noted that this meeting served as a briefing on the continued strategic direction of the NHS. • **Strategic Objectives** - the Board are currently reviewing its set of objectives for the coming year. It was agreed that these should be updated to reflect the status and direction of the NHS. The executive team is working to consolidate these objectives to ensure alignment with national priorities.

Ref	Discussion and Action Points
	CEO Update SK highlighted the following key points as part of the CEO report: • **Chief Finance Officer Appointment** - SK extended her sincere thanks to CM for his continued support and wished him well in his retirement. She also welcomed Angela Mulholland-Wells (AWM) to her first public Board meeting. AMW has been appointed as the new Chief Finance and Commercial Officer and brings over 15 years of experience in the healthcare sector, having held senior finance leadership roles in both the independent sector and the NHS. In her new role at RJAH, AMW will lead the Trust's financial strategy and support commercial development opportunities. Her strong commercial insight and commitment to public service values make her a valuable addition to the Board and Executive Team. • **NHSE Chief Executive Update** - following a recent meeting in London, a letter from Sir Jim Mackey was circulated outlining actions being embedded to drive progress across the NHS. The letter also referenced the transition team. Significant changes are anticipated in NHS finances and the Performance Assessment Framework (PAF). A revised and streamlined draft of the framework is being circulated in May for feedback. The Board welcomed further discussion on this topic within the Private Forum. • **NHS Climate and Structural Changes** - SK highlighted the significant changes occurring across the NHS. In March, the government announced that NHS England will be abolished and reintegrated into the Department of Health and Social Care (DHSC). Changes are also expected for Integrated Care Systems (ICS), including a 50% reduction in headcount. The Board acknowledged the uncertainty this creates for colleagues at NHS Shropshire, Telford and Wrekin. These changes will impact all providers, including RJAH, requiring reductions in corporate and support staff growth. The Trust has begun to assess the implications and anticipates some complex decisions ahead. • **NHS 10-Year Plan** - the NHS 10-Year Plan is currently in development, with a draft expected to be circulated in June. The Board recognises that this process is creating uncertainty for colleagues across the NHS. • **Trust Vision Statement** - staff were recently invited to vote on a new vision statement for the Trust. Hundreds participated, and the winning statement—receiving over 50% of the votes—was *Improving lives through excellent and innovative care.* This new vision statement reflects the organisation's identity and aligns with the Trust's five-year strategy. It captures the commitment to excellence in patient care and the drive for innovation. • **Apollo Electronic Patient Record (EPR) Update** - SK thanked staff for their continued support and hard work in preparing for the launch of the Apollo EPR system. Engagement across the organisation has been strong. The system is scheduled to go live on Monday, 12 May. This marks the largest technological investment in the Trust's history. While a period of adjustment is expected, the benefits for patients and staff are anticipated to become increasingly evident in the coming weeks and months. Assurance has been provided through the relevant committees. • **Marathon – RJAH Charity** - SK extended her congratulations and gratitude to all those who ran the London Marathon on behalf of RJAH Charity. Their efforts have raised tens of thousands of pounds, which will have a lasting impact on patient care. An annual post-event reception is planned to celebrate their achievements. • **RJAH Charity – Launch of 20Thrive** – the RJAH Charity has launched a new fundraising initiative, **20Thrive**, encouraging supporters to take on a fitness challenge in 2025. The initiative offers a variety of sporting events, including running, cycling, and swimming, to promote physical activity and raise funds for RJAH. The programme builds on the popularity of the London Marathon and aims to provide more opportunities for supporters to get involved and make a difference. • **RJAH Star Awards, April Winner** - Hayley Gingell, Quality Assurance Lead, was recognised for her outstanding contributions to the Trust's digital systems and assurance processes. Her work includes the development of an electronic business continuity toolkit and dashboards supporting the GIRFT programme, CQC standards, and Trust policies. She was praised for her supportive attitude and collaborative approach. • **March Winners –** Mark Grainger and Fred Jones, Healthcare Assistants at the Midland Centre for Spinal Injuries, were recognised for their compassionate support of a long-stay patient. They went beyond by visiting the patient at the Royal Shrewsbury Hospital during his transfer, providing comfort and continuity of care.

Ref	Discussion and Action Points
	HT thanked SK for the update before opening the discussion to Board members for comments and questions. • **ICB Blueprint Document** – the Board raised a point regarding the ICB's plans to transfer services to providers and queried whether these responsibilities are being picked up through the Provider Collaborative. SK responded that this was a good question and confirmed that the team had discussed the ICB blueprint model internally. It has been added to the Executive Team meeting agenda for next week, and SK suggested it should also be added to a future Board agenda once internal discussions have taken place. It was noted that further guidance from the ICB is needed. MC added that the team is working to categorise what constitutes duplication and what is being picked up as additional responsibilities. • **Sexual Safety Training** - an update on sexual safety training was presented, confirming that it is scheduled for the June Board meeting. It was suggested that the Governors could be invited to attend the session, which will also be recorded. Additional sessions have been scheduled to ensure wider participation. • **Solar Panels** - the Board congratulated the team on the successful solar panel funding bid. Assurance was requested on how this initiative will be used to support the Trust's objectives. It was noted that the detail would be included within the Trusts' Green Plan which is scheduled be presented to the Finance and Performance Committee in the next few months. • **Shared Services** - the Board discussed the increasing collaboration between SaTH and the Trust, particularly in relation to the go-live process and the use of the shared service desk. • **Powys Update** - a query was raised regarding the intentions of the Powys Commissioner. It was noted that the Executive Team has discussed this and is arranging a meeting with senior leaders to gain further clarity. The Board noted the updates from both the Chair and CEO.
5.0	**Quality and Safety**
5.3	**Performance Report – Quality and Safety Committee**
	The following points were highlighted from the Quality and Safety performance report (by exception only): • **Complaints:** A total of 11 complaints were received in March. The primary reasons cited were concerns about the care provided, long waiting times, and appointment cancellations. There has been a continued increase in the number of complaints over the past 12 months. • **Surgical Site Infection (SSI):** One SSI was reported following surgery in January. A review of the patient's care was conducted, which demonstrated good compliance with the "One Together" audit standards. • **Patient Deaths:** Three patient deaths occurred in March. All were expected, and each case underwent a review process. The Board noted the contents of the Quality and Safety Performance Report. No concerns were raised during the meeting.
5.4	**Chair's Assurance Report – Quality and Safety Committee**
	LW highlighted the following key points from the Quality and Safety Committee Chairs Assurance report: • A review of Key Performance Indicators (KPIs) has been completed and the updated information has been included in the Board pack. • The Learning from Deaths report was presented as a separate agenda item. • The Corporate Risk Register (CRR) was discussed at the March meeting. Several risks were delegated to sub-committees for further review. A comprehensive review of the CRR over the past 12 months is required, particularly focusing on risks that have remained static. • The Clinical Safety Case was reviewed in March and again in April at the joint meeting of the Quality and Safety Committee and the Digital, Education, and Innovation Committee. • Following a peer review of Critical Care, assurance was received regarding the action plan. A further update has been requested in six months. The progress made so far was positively acknowledged.

Ref	Discussion and Action Points
	• Internal audits related to the Patient Safety Incident Response Framework (PSIRF) received a rating of substantial assurance was received. Minor actions identified are on track for completion. The Board commended the teams for their work. HT thanked LW for the update and invited questions or comments from the Board. The following was noted: • **Complaints** - the Board noted that complaint targets had not been consistently met over the past 12 months. As part of the year-end review, members questioned whether the current target date remains appropriate and whether any recurring themes have been identified. It was acknowledged that waiting times are a significant contributing factor. The Board sought assurance on whether there are additional issues that should be brought to its attention. It was confirmed that all complaints are reviewed through the Patient Experience Committee, with waiting times continuing to emerge as a recurring theme. Efforts are underway to strengthen communication with patients, particularly by providing more proactive updates regarding delays. The Board questioned whether the existing target remains suitable for the upcoming year which is something the Committee will consider. It was confirmed that all complaints are signed off by the SK as Chief Executive Officer, who reiterated that waiting lists remain the predominant theme. The Board discussed what further support could be offered to patients while they await treatment and whether additional services could be introduced to enhance their experience. There was also a focus on increasing engagement with patient groups to better understand their needs and expectations. It was noted that significant work has already commenced in this area, including the appointment of new leadership. The vision is to optimise patients' readiness for treatment, ensuring they are as prepared as possible when their care begins. The Board welcomed the ongoing collaboration with local authorities, particularly through the MSK transformation programme, which may offer further support to patients during their waiting period. It was also noted that the Quality Account will be shared, providing further insight into the care being delivered. • **Learning from Deaths** - the Board discussed a specific case involving a patient on the end-of-life pathway who experienced an inappropriate transfer. Concerns had been raised prior to the transfer, and the Board questioned whether there is a mechanism in place to escalate such issues and whether learning is being shared across organisations. It was confirmed that an engagement process exists between NHS providers, and that the Trust is commissioned to provide end-of-life care. The challenges and pressures within the system were acknowledged, and assurance was provided that close collaboration with partner organisations continues to improve the pathway. The Board acknowledged that if waiting lists are the primary issue driving complaints, this challenge is likely to persist for some time. A deep dive into the themes emerging from complaints will be undertaken to better understand and address the underlying issues through he Quality yans Safety Committee.
5.6	**Learning from Deaths (Q4 Report)**
	RL presented the Quarter 4 Learning from Deaths report to the Board of Directors, highlighting the following key points: • A total of three deaths were reported during the quarter, all of which were classified as *expected*. • Each of the three cases was reviewed by both the Medical Examiner and the Trust. No concerns were identified during these reviews. Following the presentation, the Board was assured by the findings of the report. It was noted that the terms *expected* and *unexpected* deaths are based on the national NHS definitions used in mortality reporting. The Trust confirmed that these definitions are consistently applied in its reporting processes. The Board had previously agreed to include a footnote in future reports, particularly when reporting in the public domain, to provide clarity on these definitions. *Footnote: 'Expected' refers to the national NHS definition used in reporting deaths – "a death that is anticipated to occur in the near future."*

Ref	Discussion and Action Points
6.0	**People and Workforce**
6.1	**Workforce – Performance Report**
	DH highlighted several key areas from the workforce performance report: • Overall performance was strong. • The number of leavers increased slightly within the month, with 14 recorded against a target of 11. HT thanked DH for the update and commended the strong position reflected in the report. The Board noted the contents of the workforce performance report, and no concerns were raised.
6.2	**Chair's Assurance Report – People and Culture Committee**
	PM provided a comprehensive update on the recent work of the People and Culture Committee, highlighting the following key developments: • **Refinement of KPI Measurement:** Adjustments have been made to the way Key Performance Indicators (KPIs) are measured, ensuring alignment and consistency with reporting requirements across the wider Integrated Care System. This will support more accurate benchmarking and performance tracking. • **Vacancy Rate Target Under Review:** The Committee is undertaking further consideration of the current vacancy rate target to ensure it remains both realistic and reflective of workforce planning priorities. • **Ethnicity Reporting Enhancements:** Progress continues on improving the quality and visibility of ethnicity data, with a focus on ensuring robust and transparent reporting that supports the Trust's commitment to equity, diversity, and inclusion. • **Staff Survey Insights:** The Committee reviewed the results of the most recent NHS Staff Survey, noting a decline in response rates compared to the previous year. This has prompted renewed focus on staff engagement strategies to better understand and respond to workforce sentiment. Two thematic areas—'People Promise' and 'Always Learning'—are being explored in greater depth to identify actionable insights and opportunities for cultural and organisational development. • **Staff Sickness Deep Dive:** A detailed analysis of staff sickness trends has identified seven areas with consistently high levels of absence. These areas will now be subject to routine monitoring, with targeted interventions to support staff wellbeing and reduce absence rates. • **Statutory and Mandatory Training Compliance:** The Committee discussed concerns around non-compliance with statutory and mandatory training. Questions were raised about the accuracy of reported completion rates, and support has been requested from the Quality and Safety Committee to ensure appropriate oversight and assurance. Following the update, HT thanked PM for the detailed report and invited questions and reflections from Board members: • Sickness – the Board welcomed the proactive work being undertaken to address staff sickness, recognising it as a key area of focus. • **Staff Survey** – the Trust confirmed that for all areas flagged as underperforming (red-rated), action plans are in place. Many of these build on previous initiatives and are being actively monitored. • **Performance Indicators -** commended the Committed for stretching of performance targets and acknowledged the positive trajectory in several key areas, which supports confidence in future delivery. The Board formally noted the Chair's report from the People and Culture Committee. No concerns were raised, and the Board expressed appreciation for the ongoing work to strengthen the Trust's people and culture agenda.
6.3	**Guardian of Safe Working Hours (Q4 Report)**
	RL presented the Guardian of Safe Working Hours report to the Board and highlighted the following key points: • There were no exception reports submitted during Quarter 4. This also reflects the annual summary, which confirms that no exception reports were submitted throughout the entire year. • The Trust continues to manage the exception reporting process effectively. This is a credit to Chris Marquis, the Trust's Guardian of Safe Working Hours, for his ongoing diligence and oversight.

Ref	Discussion and Action Points
	• There are ongoing challenges related to rota coordination with Wales, due to differing national guidance. Work is currently underway to review working hours, supported by diary exercises to better understand and address these issues. • A new national framework for exception reporting for doctors is being introduced. This includes improved information sharing and the need for accessible reporting mechanisms. The Trust already has the necessary software in place to support this framework, which will be fully embedded in due course. The Board discussed the following: • **Guardian of Safe Working Hours** - the Board commended the Trust on another strong performance and formally thanked Chris Marquis for his continued commitment and support in his role as Guardian of Safe Working Hours. • **Digital reporting assurance** - the Board queried whether the new system would be fully implemented by September. It was noted that discussions have taken place within DERIC. Further assurance regarding the September implementation timeline was requested. It was also noted that the Trust uses Allocate for leave booking and rostering, which will be utilised to support the new framework. The Board formally noted the Q4 report.
6.4	**Staff Survey Presentation**
	Caroline joined the meeting and contributed to the discussion in relation to the Staff Survey presentation, the following was highlighted: • The Trust was rated strongly as both a recommended place to work and a place to receive treatment. • It scored above average in areas related to compassion and inclusion, as well as team working. However, it was noted that there are departmental differences across the Trust that may influence these outcomes. • Several areas requiring attention were identified, including the processes for raising concerns, Equality, Diversity and Inclusion (EDI), the experience of staff with protected characteristics, and staff burnout. The group discussed the importance of learning from departments that are performing well in these areas. • The staff survey achieved a 52% response rate, supported by two prize draws to encourage participation. Additionally, the Bank-specific survey was undertaken for the first time, with a notable 23% response rate, the highest, in the specialist group. • During the People and Culture Committee meeting, reference was made to the Chair's report—specifically the section on the People Promise (page 84), which highlights the principle that "we each have a voice that counts." It was noted that, in comparison to peer organisations, there is room for improvement in this area. Further information has been requested on key areas of concern. • Finally, it was emphasised that staff must be aware of how to raise concerns, and that specific interventions should be completed through the ImproveWell platform to support this. The Board held the subsequent discussion: The Board held the subsequent discussion: • **Comparison** - noted that there is no significant variation between providers, as the lower categories are generally classified as "other." It was also reported from the regional people board meeting that there is slight variation across organisations and questioned whether more could be done from a regional perspective. • **Current NHS Climate** - expressed awareness of the current situation and uncertainty within the NHS which would have affected the feedback received. • **ImproveWell** - suggested enhancing the richness of insights by comparing ImprovemWell data with the staff survey results. • **Global Majority** - reflected on the representation of the global majority and proposed learning from organisations with a higher number of global majority nurses. • **Learning** - welcomed the focus on individual managers and their departmental action plans, but highlighted a gap in the objectives. The need to utilise the action plans to prioritise areas that the Trust should take forward was emphasised. • **National Education Survey** - the Trust is mandated to participate in the National Education Survey, which will overlap with the staff survey to enhance cultural feedback going forward.

Ref	Discussion and Action Points
	• **Participate rate** - concerns were raised about low participation levels and asked whether anything could be done nationally to improve this. CNL explained that both online and paper-based survey options are available and that the Trust is learning from organisations with high response rates. They are considering the use of champions to boost engagement. The Board suggested asking staff members via a survey as to why they don't complete the survey to help boost the understanding of low participation rates. AI suggested improving communications and system advertisements to increase survey participation. MC highlighted that a proportion of staff do not have access to devices to complete the surveys. CNL added that new spaces within theatres may help improve response rates and emphasised the need to make surveys accessible to wards, theatres, and staff without device access. It was proposed analysing response rates by area and breaking them down by teams to better understand participation. • **Leadership** – the Board stressed the importance of leadership in creating time and space for staff to complete surveys. The Board noted the staff survey results and looked forward to having an update on the actions being embedded via the People and Culture Committee Chair Report at future meetings.
7.0	**Operations and Finance**
7.1	**Performance Report (including long waiting patients)**

	MC presented key points from the latest performance report, with a particular focus on long-waiter metrics. The following updates were noted:
	• **Recruitment and Insourcing Capacity**: A clear recruitment forecast has been developed to support insourcing capacity. Recruitment pipelines are in place, and flexible sessional arrangements have been established to assist with backfilling requirements.
	• **18-Week RTT Performance**: Current performance stands at 46.41%, with a target of 60% by the end of March 2026. The primary focus for Q1 is on the non-admitted segment of the pathway. Insourcing for Rheumatology commenced in April, and the addition of a new DEXA scanner during the month is expected to enhance activity delivery. MBI has been commissioned to undertake a full validation of the waiting lists.
	• **England and Wales Waiting Times**: Overall waiting times for patients from both England and Wales have reduced.
	• **Long Waiters**:
	  • 52-week waiters have seen a slight increase.
	  • 65-week waiters from England and Wales have decreased.
	• **Overdue Follow-Ups**: The number of overdue follow-up appointments remains high. Interventions are in place, and a new trust-wide approach is being developed, including the redesign of clinical pathways.
	• **Diagnostics**: Demand for diagnostic services remains high across both England and Wales, exceeding projections made at the end of the previous year. This increase is largely attributed to patient flow from the Telford and Wrekin area.
	• **Job Planning and Private Patient Activity**: Both job planning and private patient activity have shown an upward trend.
	• **Patient-Initiated Follow-Up (PIFU)**: A positive trend has been observed in PIFU utilisation.
	
	In addition, MC presented a separate update specifically in relation to long waiting patients. The following was highlighted:
	• There are ongoing challenges related to both English and Welsh disparity.
	• The Trust continues to be classified as Tier 1 and will remain in Tier 1 for elective procedures.
	• The Trust is currently one of the lowest reporters of long waiters in the region, which reflects negatively on our performance, however a strong and constructive relationship has been maintained with NHS England (NHSE).
	• The Trust confirmed there are additional ideas and initiatives that will be incorporate into the Plan Plus.
	• It was confirmed that the Trust remain on track to be fully compliant by the end of the year.
	• Further detail on the Plan Plus including the introduction of a new additional theatre, can be presented through at the Finance and Performance Committee.
	
	The Board noted the verbal update, and no further queries were raised.

Ref	Discussion and Action Points
7.3	**Finance Report**
	MS provided the following key highlights from the finance report: • The Trust successfully delivered its financial plan for 2024/25, achieving a surplus of £3.9 million. • It was acknowledged that this has been a particularly challenging year, and meeting the financial target is a significant achievement. • The Board commended the Trust for the decisive actions taken to ensure financial stability. • The loss of insourcing income from July was fully mitigated, despite pressures within the non-pay expenditure category. • The Financial Improvement Group (FIG) has continued to develop and mature, contributing to improved financial governance and oversight. • The Trust received some Elective Recovery Fund (ERF) income from the Integrated Care Board (ICB), enabling the recovery of income from a national funding source. • The recurrent efficiency programme delivered savings of £5.6 million, which is a strong performance and will be critical in supporting delivery in the next financial year. • A significant capital investment of £11.2 million was made during the year, aligned with the final forecast position and supporting strategic priorities. • The Trust has set a break-even plan for 2025/26, with a financial challenge of £9.6 million—equivalent to approximately 6% of total expenditure. Key areas of focus include the delivery of the new operational model which is a significant piece of work for the Trust. The Trust reiterated its commitment to continuously review mitigation strategies and improve the overall financial position moving forward.
7.4	**Chairs' Assurance Report – Finance and Performance Committee**
	The Board received an assurance report from the Finance and Performance Committee, which highlighted the following key areas: • **Key Performance Indicators (KPIs):** A proposal to revise the KPIs was presented and the Committee confirmed satisfaction with the proposed changes. • **Financial Plan Delivery:** The importance of achieving the financial plan was reiterated, with recognition of the progress made to date. The Committee commended the Trusts' final performance for 2024/25. • **Waiting Times and Patient Equity:** Concerns were raised regarding long waiting times, particularly for English patients. The disparity between English and Welsh patient pathways was noted across both the Finance and Performance and Quality and Safety Committees. The Board acknowledged the commissioning arrangements and the need for equitable access across all patient groups. • **Efficiency Plans for 2025/26:** Efficiency plans have been submitted and currently identify sufficient measures to cover the £9.6 million target. Further clarity was requested on the risk profile of major programmes to support assurance. • **Corporate Cost Reduction:** A corporate cost reduction target, linked to headcount growth over recent years, was discussed. This is not yet reflected in the financial plan but will be considered in due course. £0.5 million is currently included in the efficiency plan in relation to this reduction. • **Acknowledgement of Staff Efforts:** The Board acknowledged the significant efforts of staff in delivering against financial and operational targets, despite ongoing challenges. The Board held the subsequent discussion: • **Welsh Patient Waits** - waiting times remain a standing item on the Activity Recovery Committee agenda, with the longest waits being actively monitored. Data presented to the Board showed an increase in Welsh patient waits over the past two years. The Board discussed whether the focus on reducing English patient waits may have inadvertently impacted Welsh patients. Clarity is being sought from the Welsh Government on any contributing factors. Increased demand in spinal services, which was not anticipated, is a key driver of current pressures. Although mutual aid is now available to Welsh patients, uptake has been limited due to travel and logistical challenges. The proportion of English and Welsh patients was noted as significant, particularly in spinal services, which have historically relied on insourcing contracts that have not been consistently delivered.

Ref	Discussion and Action Points
	The complexity of spinal cases has also contributed to the low uptake of mutual aid. Discussions are ongoing with NHS England to explore additional support. The Board acknowledged that there is currently no clear trajectory for spinal waiting lists. Conversations continue with NHS England regarding referrals, list pooling, and capacity planning. It was suggested that Welsh commissioners may need to be engaged to support the development of an action plan. The Board also requested improved documentation of actions taken and barriers encountered. **Performance and Reporting** - the need for a forward-looking trajectory and compliance plan was highlighted, to support ongoing performance monitoring. Follow-up performance was identified as an area requiring improvement. A revised action plan is expected to be presented in due course. The Board commended the delivery of the efficiency target on a recurrent basis, while noting that the target has now doubled. A trajectory report will be brought to the Finance and Performance Committee, and reporting through the Financial Improvement Group and the Committee will be strengthened. • **Data Quality and Booking Processes** - concerns were raised about data quality and booking processes. The Board asked for assurance that these issues are being prioritised. The Trust confirmed that an administrative review is underway to align service delivery with booking processes. The upcoming launch of the Electronic Patient Record (EPR) is expected to enhance data quality and provide improved insights for operational teams. Clarification was requested on which committee has oversight of data quality and booking process improvements. • **Theatre Productivity** - the Board noted the investment made in theatre services over the past 12 months and its positive impact on productivity. With the completion of the second phase of the Theatre Improvement Framework (TIF 2), a post-implementation review of the theatre department was recommended. The Trust remains committed to addressing financial and operational challenges. Engagement with NHS England continues, and the national team has acknowledged the Trust's current position. The Board expressed its appreciation for the continued efforts of staff.
7.5	**KPI Review 2025/26**
	MC provided an overview of the Integrated Performance Report (IPR) and highlighted the following key points: • Executive leads are engaged in the review process. • Committees have actively reviewed and will continue to contribute to the development of the indicators. • The coloured boxes at the bottom of the report were noted as a useful visual aid. The Board discussed the following: • It was suggested that 30 indicators may be too many for effective consultation and monitoring. • It was also noted that page 2 relating to the People and Culture Committee will be revised following the discussion which took place at the meeting. The Board thanked the teams for their work on reviewing the indication before noted the updated report.
7.5	**Digital, Education, Research, Innovation and Commercialisation Committee**
	ME presented the Chair's Assurance Report, drawing the Board's attention to several key areas of focus and development: • **Digital Strategy**: ME informed the Board that the final version of the Trust's Digital Strategy is still in development. Nevertheless, the Committee has reviewed the current draft and expressed its full support. ME requested that Board members review the draft and provide their formal endorsement outside of the meeting, once the final version is circulated it will be tabled for the public board meeting. • **Education Governance**: ME raised a point of clarification regarding the governance of educational initiatives, specifically where these elements should be most appropriately aligned—within the remit of the DERIC Committee or the People Committee. It was agreed

Ref	Discussion and Action Points
	that this matter would be resolved through further discussion outside of the meeting, with a view to establishing a clear and effective governance pathway. Following the presentation, HT thanked ME for the comprehensive update. The Board formally noted the contents of the Chair's Report. No questions were raised by member
8.0	**Any Other Business**
8.1	**Questions and Committee from the Public**
	The Board welcomed comments and questions from the governors in attendance and responded to the issues raised as follows: • **Bullying and Harassment** - the Board reaffirmed its zero-tolerance stance on bullying and harassment. It was acknowledged that the high number of new staff and the pressures placed on educators—balancing training responsibilities with operational demands—can create challenges. A suggestion was made to consider a more supportive and paced approach to educational sessions to foster a friendlier learning environment. • **Support for New Starters** - it was emphasised that staff must be well-informed about the appropriate channels available for raising concerns, particularly for new starters. The importance of equipping staff with this knowledge during induction was highlighted, including the role of the Freedom to Speak Up initiative. • **Supernumerary Staff and Workforce Planning** - the Board noted the significant volume of new starters and supernumerary staff joining teams. It was acknowledged that lessons have been learned over the past 12 months, particularly regarding the impact of concentrating large numbers of new staff in a single department. This is now being monitored more closely, and there is recognition of the need to develop a more sustainable workforce pipeline. • **Staff Survey and Communication** Access - concerns were raised about the number of staff who are unable to access the staff survey. The Board agreed that improving access is essential—not only for the survey but also for broader internal communications. It was noted that many staff do not regularly engage with electronic communications. Suggestions included increasing the use of display screens in various areas and exploring additional methods to ensure key messages reach all staff. • **Apollo System Implementation and Impact on Services** - a question was raised regarding the temporary reduction in activity due to the implementation of the Apollo system, particularly its impact on long-waiting patients. The Board confirmed that while activity levels will be reduced to ensure the safe rollout of the new system, this is a planned and monitored process. Outpatient activity will be reduced for the first four weeks, followed by a 25% reduction during weeks four to eight. A review of activity recovery is scheduled for week six to assess progress and make any necessary adjustments. On behalf of the Board, HT thanked all attendees for their valuable contributions to the meeting.
8.2	**Any Other Business**
	Farewell to John Pepper The Board formally acknowledged and thanked John Pepper for his dedicated service over the past three years. JP has made a significant contribution to the organisation through his commitment, and professionalism. His insights and efforts have been greatly valued, and he has played an important role in supporting our mission and goals. As JP moves on to new opportunities, the Board extended their sincere gratitude and best wishes for his continued success in all his future endeavours.
8.3	**Date and time of next meeting**
	Public Board of Directors Meeting | 02 July 2025 | RJAH Conference Suite, Main Entrance

Board of Directors Meeting

Updated: 30 June 2025

Action Log No.	Original Meeting Date	Minute reference	Action	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
1	07-May-2025	**Patient Story**	Add patient story assurance report to the Quality and Safety Committee workplan for June.	SY	19-Jun-2025	Complete - update received through the patient experience chair report. Action plan being compiled and shared with the patient for oversight	COMPLETED

Mercy Ships Sierra Leone

Jan 2025

Nigel Kiely

Consultant Orthopaedic Surgeon

Oswestry

Mercy Ships

Mercy Ships


Mercy Ships
Maxillofacial
Plastic Reconstructive
Orthopaedic
Obstetric Fistula
General
Ophthalmic
Dental
Palliative care
Mercy Ships UK | Speakers Network

Why Mercy Ships?

- Presentation at BSCOS
- Interesting
- Rewarding
- Personal challenge
- Appropriate for my skills
- Cowardly nature

Out charity my wife

Application process

- travel documents
- Adult Physical Evaluation new (2) (1)
- bm bs cert
- Dr. Kiely afib contract (1) (1)
- Editable - Voluhorizations 2
- hep a 1
- IGRA Negative
- imm schedule 1
- Invoice 0038975 for Nigel Terence Kiely departi...
- Mercy ship vaccine schedule
- N Kiely Offer Letter (1)
- provisional flight schedule
- references
- Temp. Reg. Applne EDITABLE (1) (1)
- yellow fever cert
- _Surgeon Pedi Ortho 1277 Sep 2022 (1)
- afob contract
- Chicken Pox (varicella) protection
- ECG sept 24
- Editable - Voluhorizations 3
- hep a 2
- imm sched 2
- Imms Evidence Kiely N
- Measles Immune
- Mercy ship vaccine schedule2
- passport copy
- Reference- Medical (1)
- Results_NIGEL_KIELY_0024M709959
- wedging paper
- 2018 Pre-Arrival Form (EDITABLE) (3) (1)
- blood tests nov 24
- dbs mercy ships
- Editable - Voluhorizations (1)
- gp med form
- Hep B - great than 100 IU
- imm sched 3
- Invoice 0038975 for Nigel Terence Kiely departi...
- mercy ship surgery manual
- MUMPs Immune
- photo
- Reference- Pastor or Spiritual Leader
- Rubella Immune
- wedgnig technique

Journey via Brussels - 24hrs

Journey

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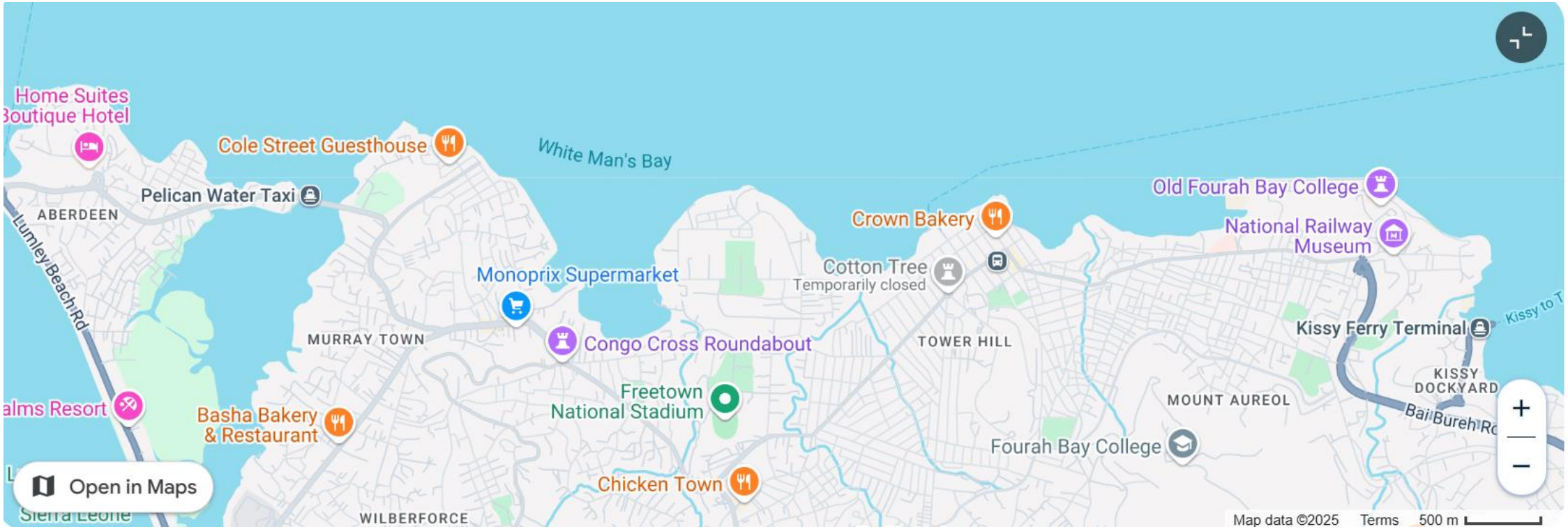
Journey


Home Suites
Boutique Hotel
Cole Street Guesthouse
White Man's Bay
Pelican Water Taxi
ABERDEEN
Lumley Beach Rd
Crown Bakery
Old Fourah Bay College
National Railway
Museum
Monoprix Supermarket
Cotton Tree
Temporarily closed
MURRAY TOWN
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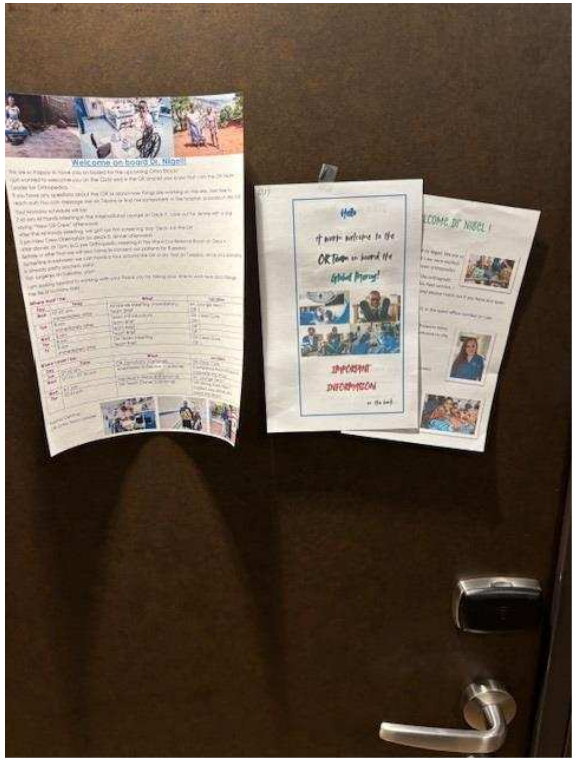
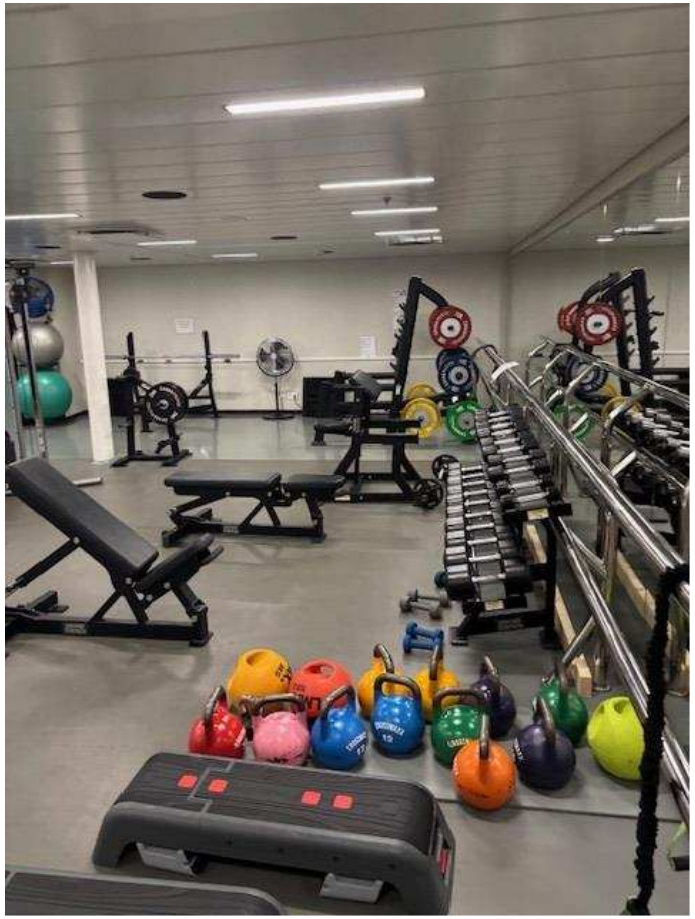
Mercy Ship



Mercy Ship

Life on board

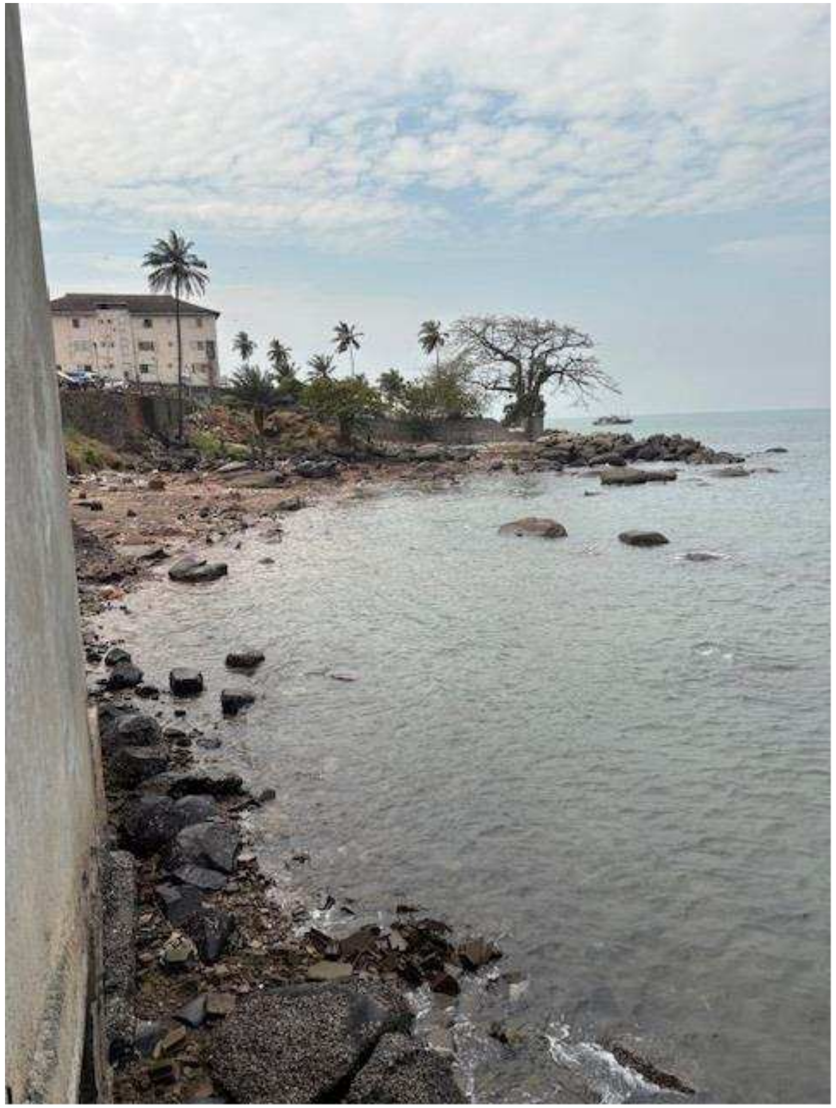


Good food!


Fried
Plantain
sharing is caring
=LiMit=4=


Jollof
Rice
(Fish, Shrimp(stock)
=Mild Spicy=

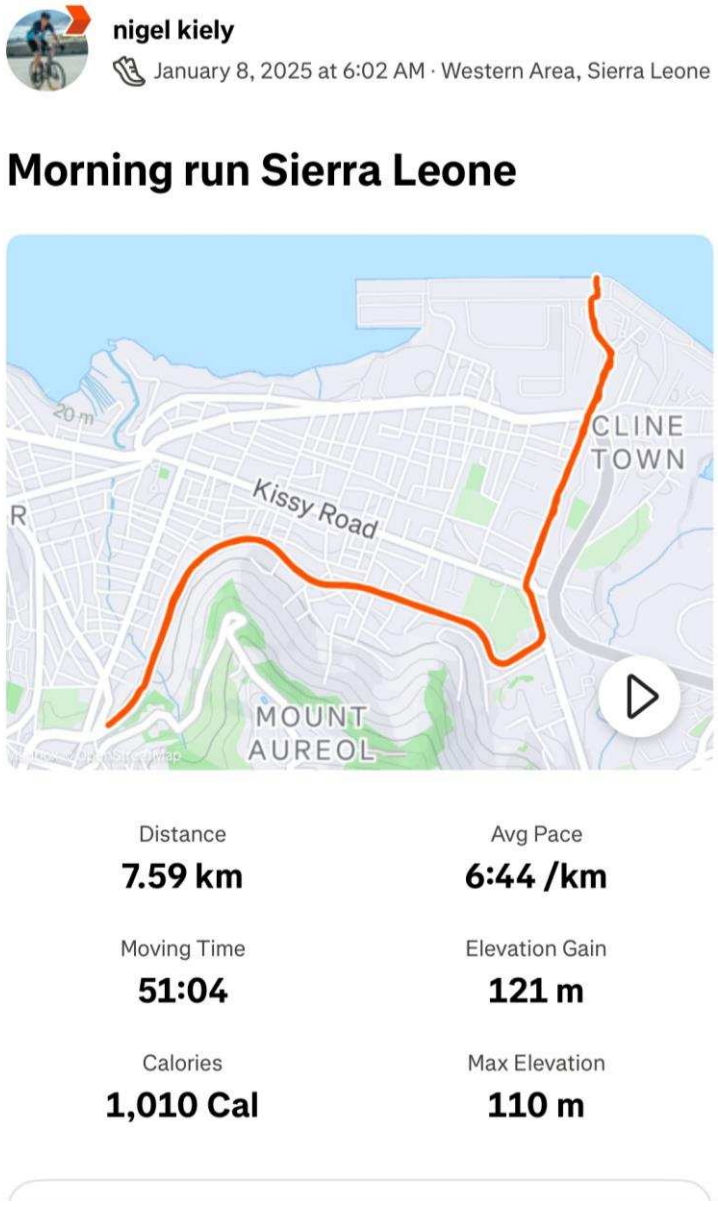
Sierra Leone- Freetown




Explore
Freedom
FREETOWN
BUNCE ISLAND
BANANA ISLANDS
GOLA RAINFOREST
OUTAMBA KILIMI
KABALA
BONTHE
TACUGAMA

Night out

Training with the Gurkhas



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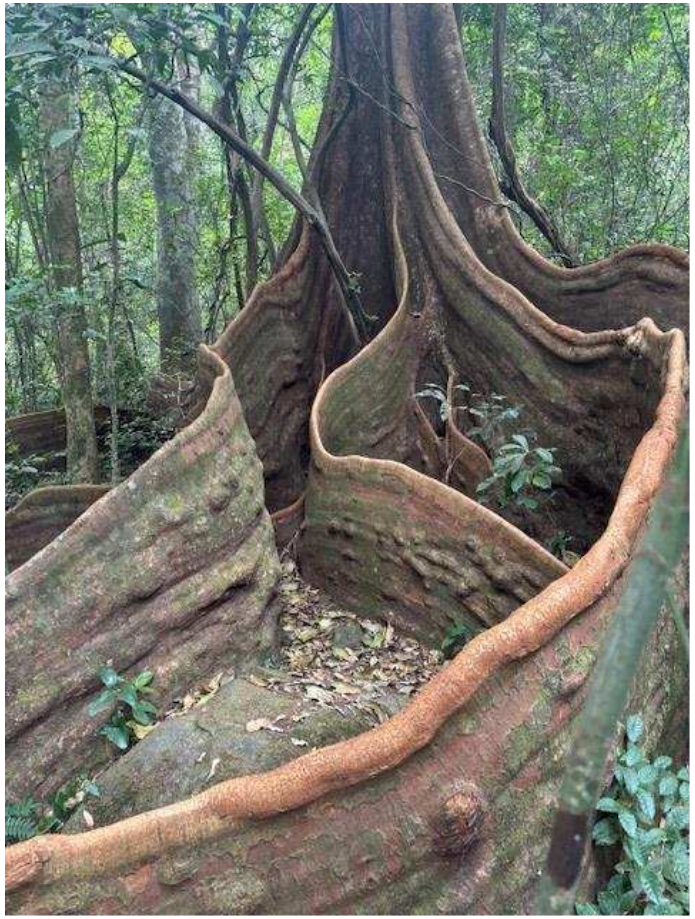
Tacugama



Hope Centre Freetown

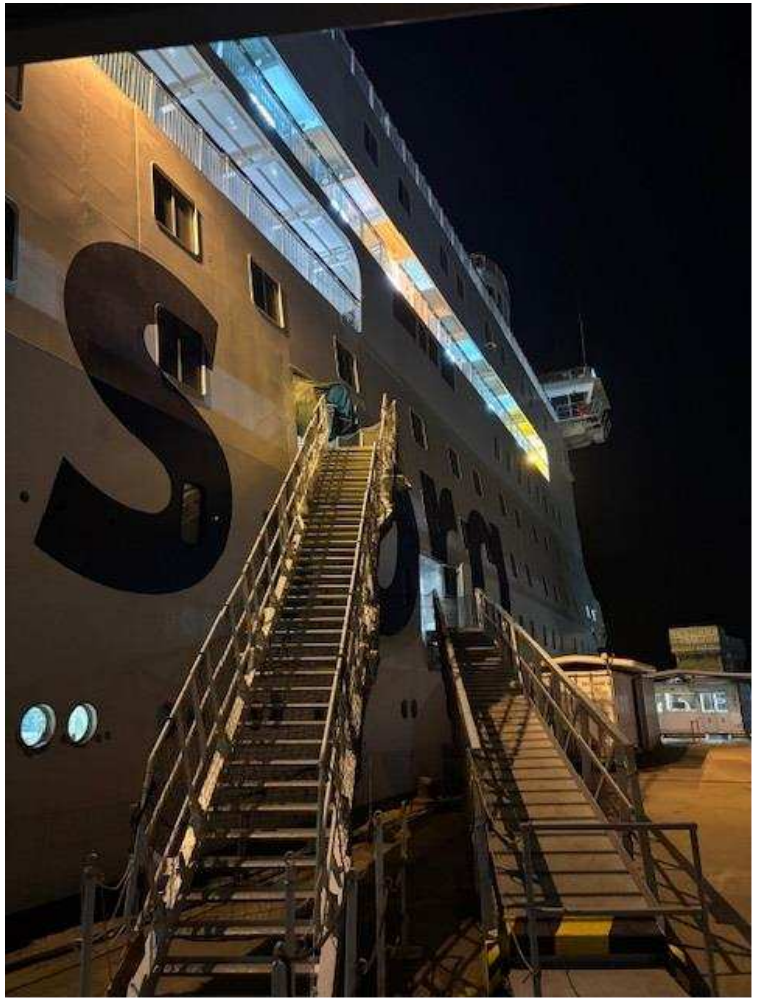
- On shore pre and post op unit
- First time in a city
- Never seen the sea or a ship!

Hospital Ship- 600 crew

- 6 ORs
- 6 wards
- 4 bed ICU
- 3 bed isolation unit
- Low care unit
- CT scanner / radiology
- Crew clinic
- Dentist
- Dietician
- Microbiology / haematology lab

Pre operative assessment

- Bloods
- Nutrition
- Vitamin D
- Malaria
- HIV
- Radiology



ITU and wards

Mercy Ships

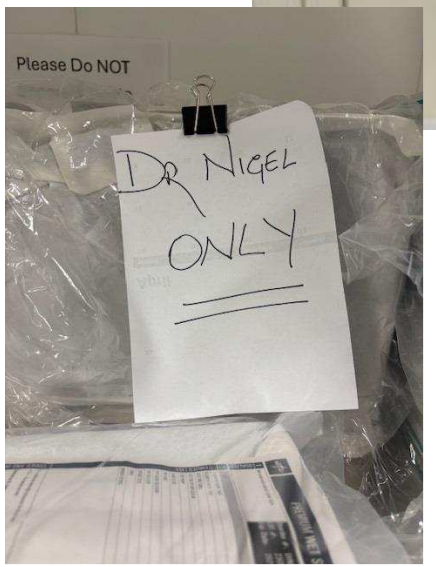
C11

Kids’ ward

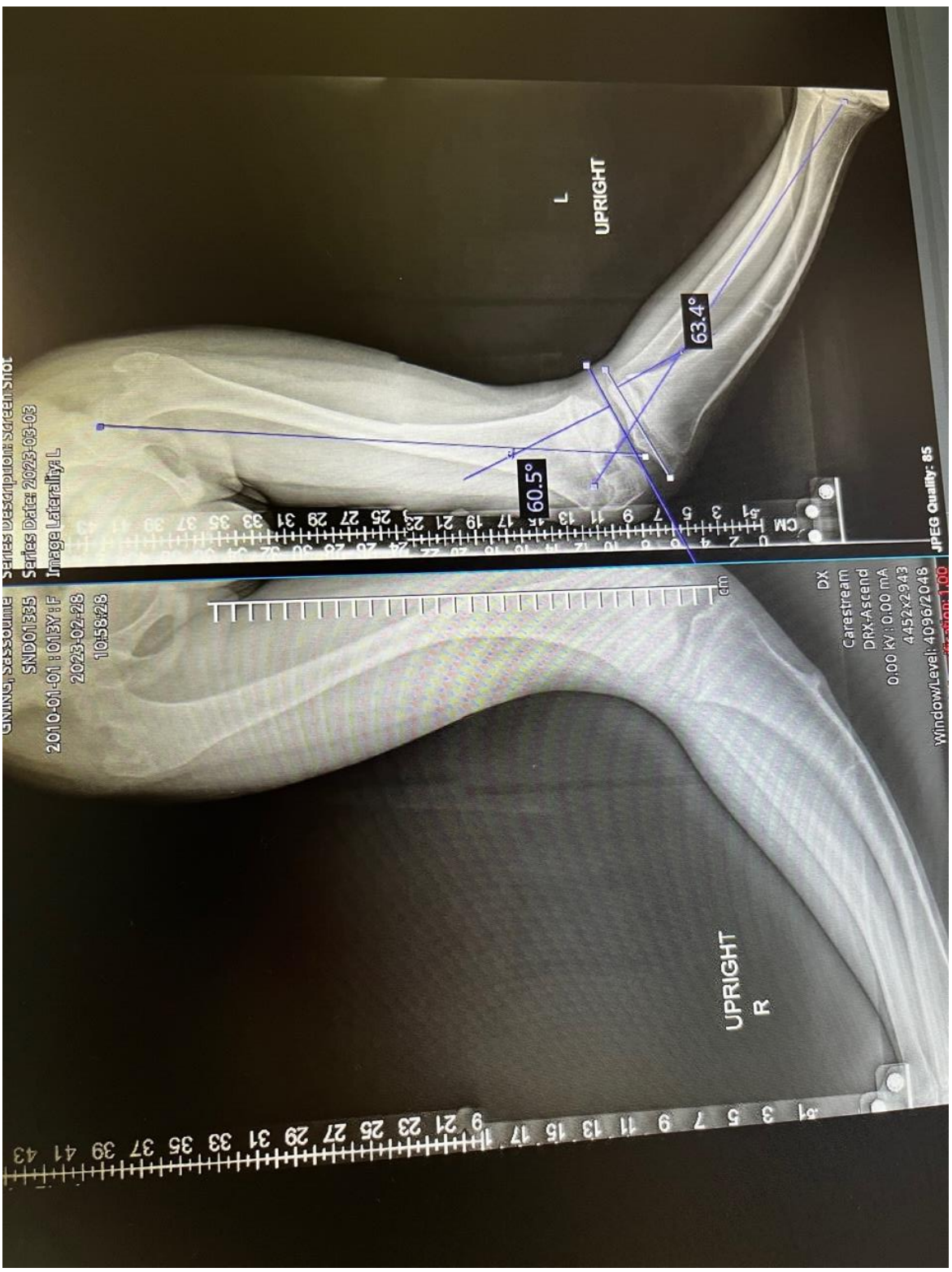
Charity publicity photo

Operating Room

Team ortho




KING
POWER
F.C.B
© 2019 Mercy Ships - Lara Arkinstall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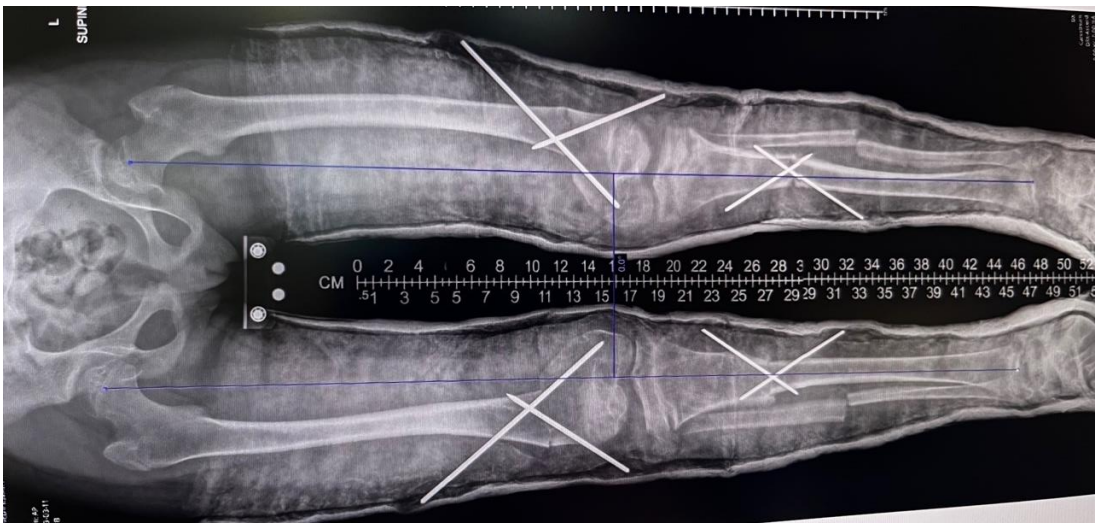
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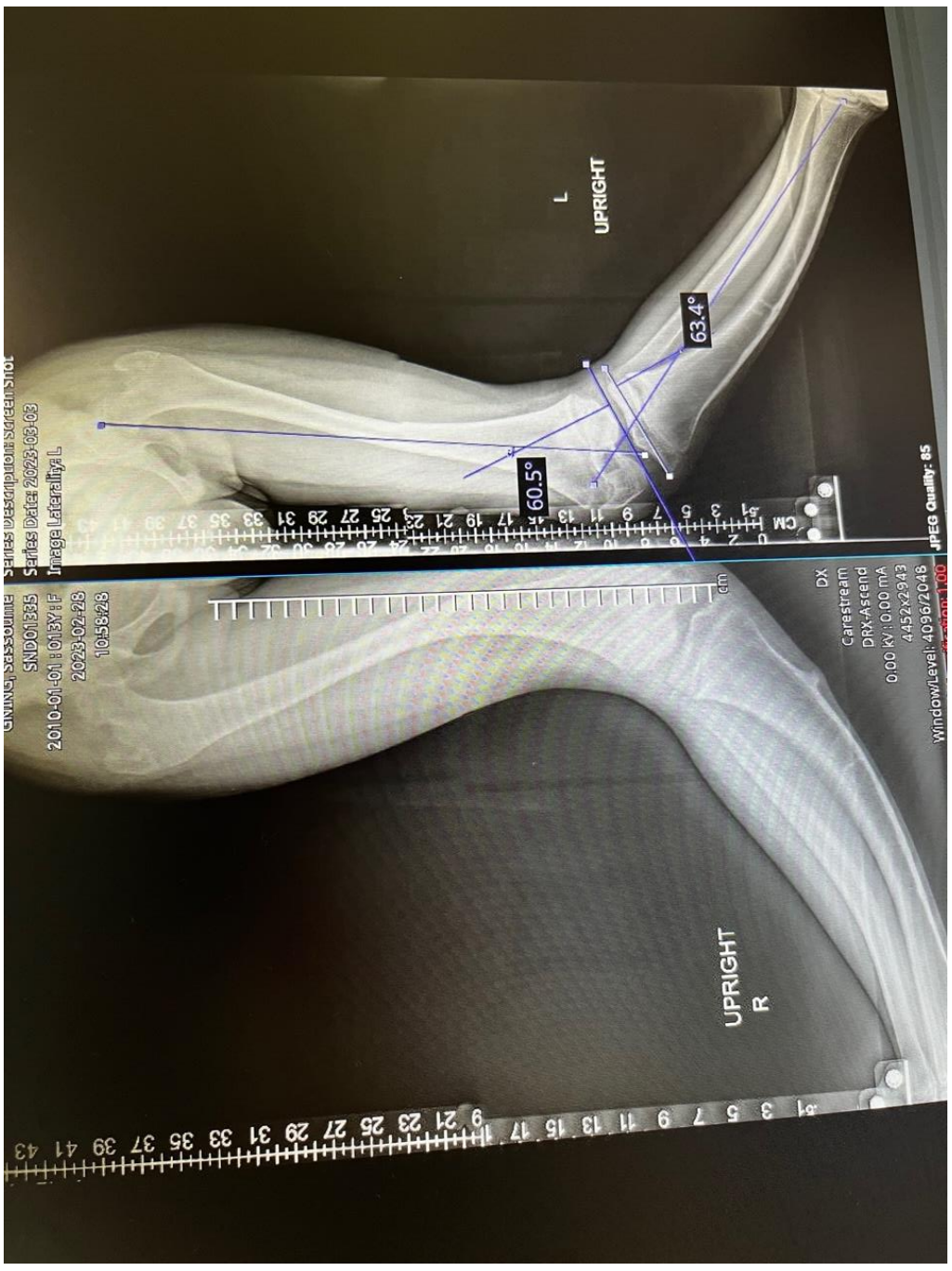
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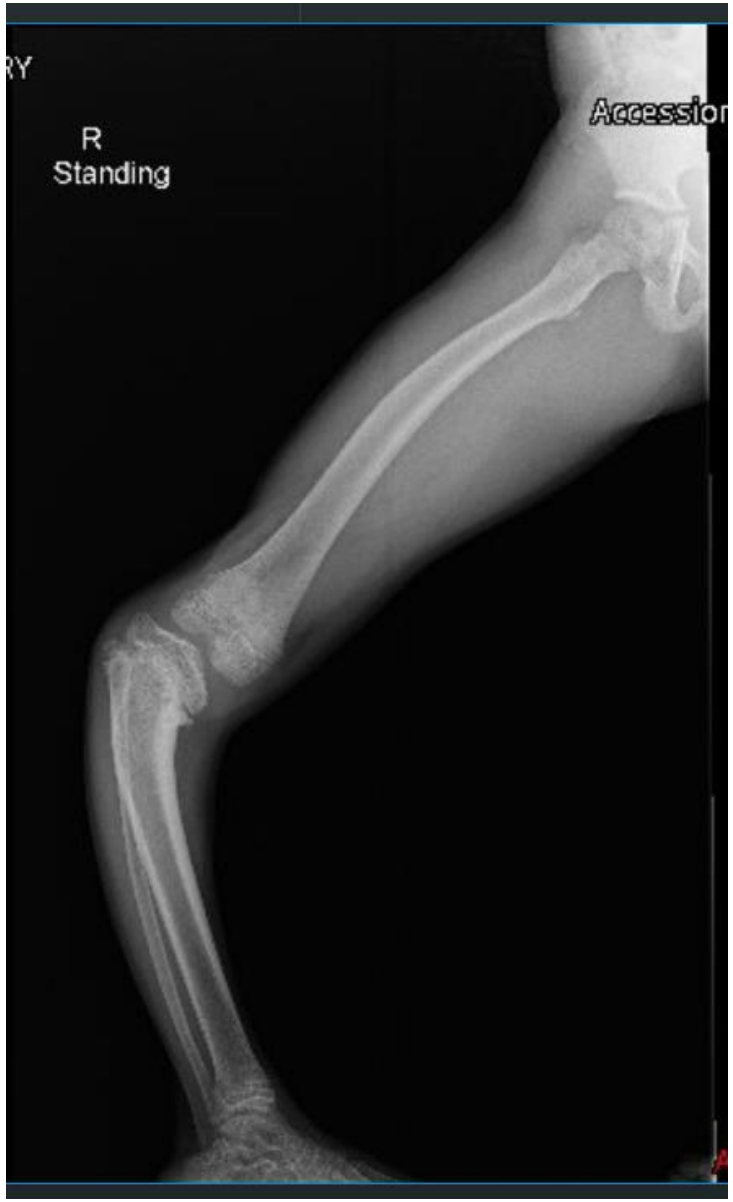
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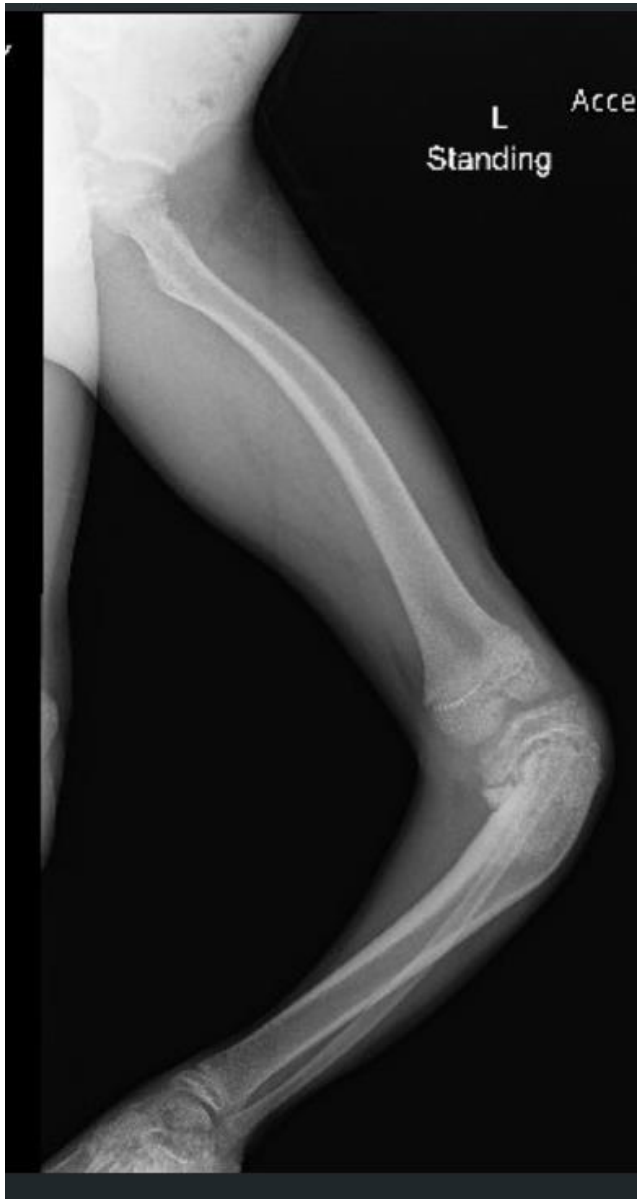
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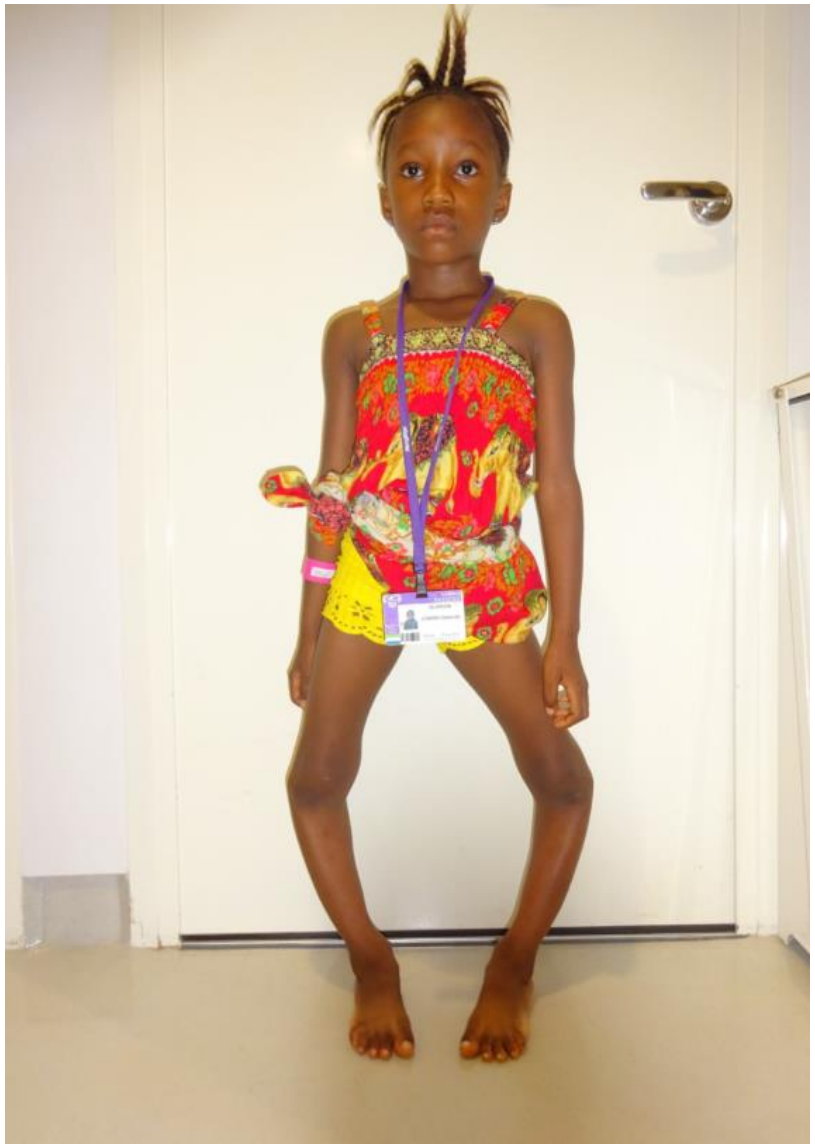

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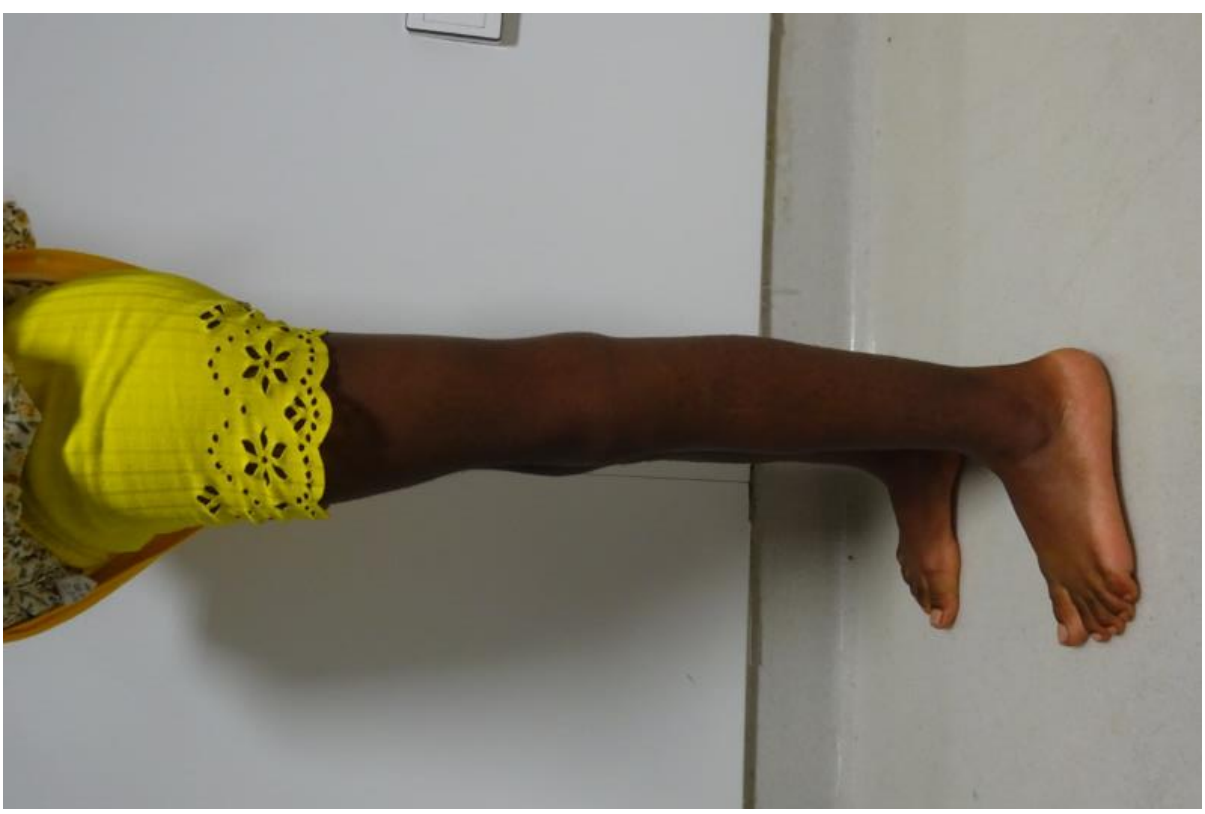
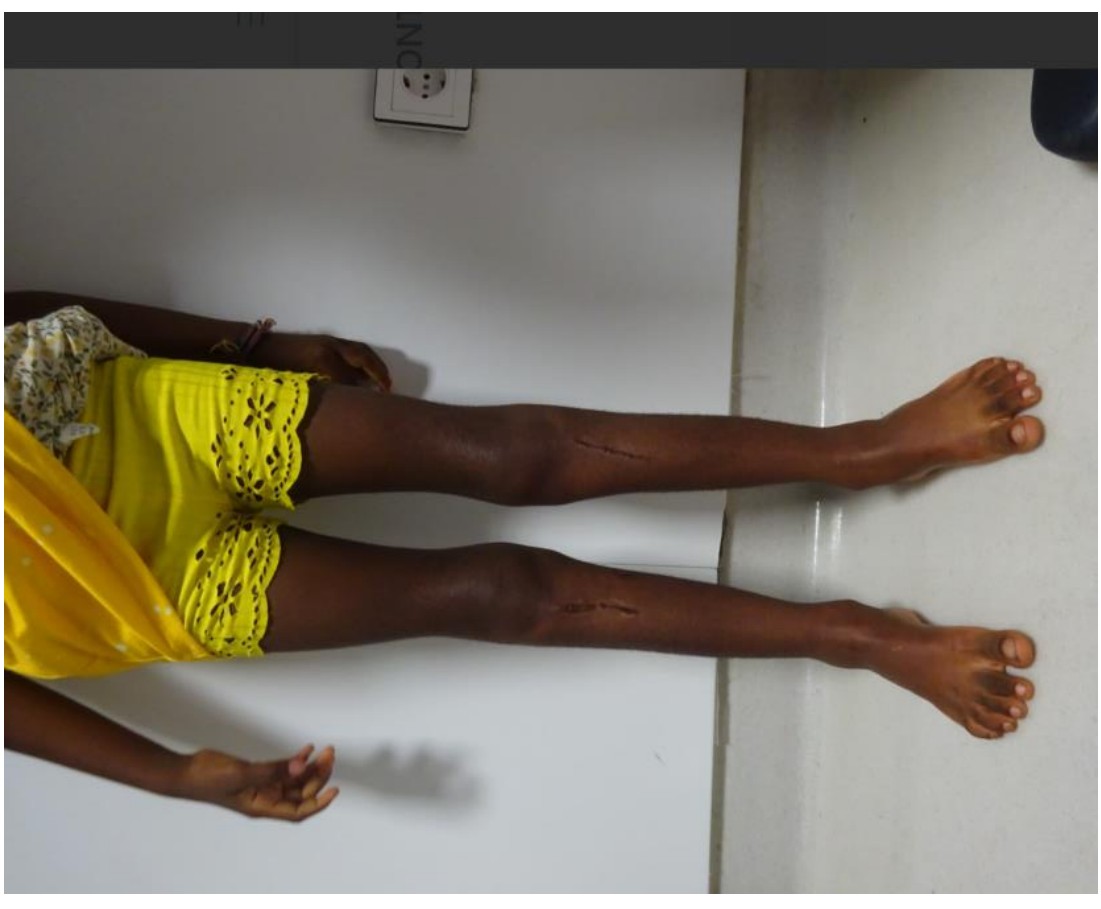




Cases

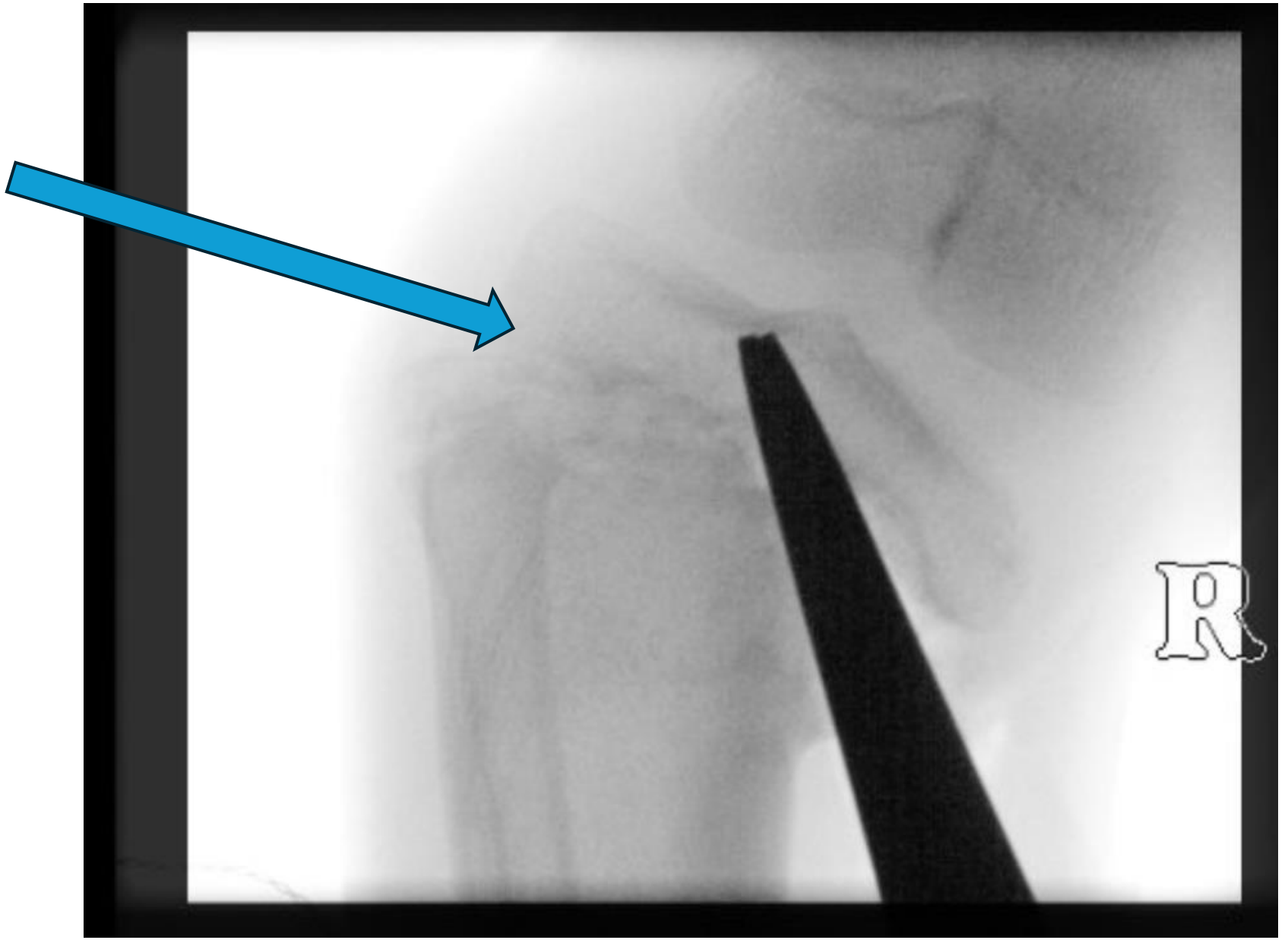
- Selected on shore months before
- Mainly lower limb angular deformities
- Varus and valgus
- Blounts
- Rickets
- Skeletal dysplasia
- Post infective
- unknown

Surgical Philosophy

- One shot- minimal follow up
- Has to be managed on shore
- Underlying disorders
- Bone health
- Bone healing
- Able to manage post op casting / wedging

Surgery

- One stop acute correction
- Closing wedge osteotomies-
- Derotation
- Soft tissue procedures
- Peroneal nerve decompression- prophylactic
- Anterior comp decompression prophylactic
- Hayden Osteotomy for Blount’s
- k wire fixation, plaster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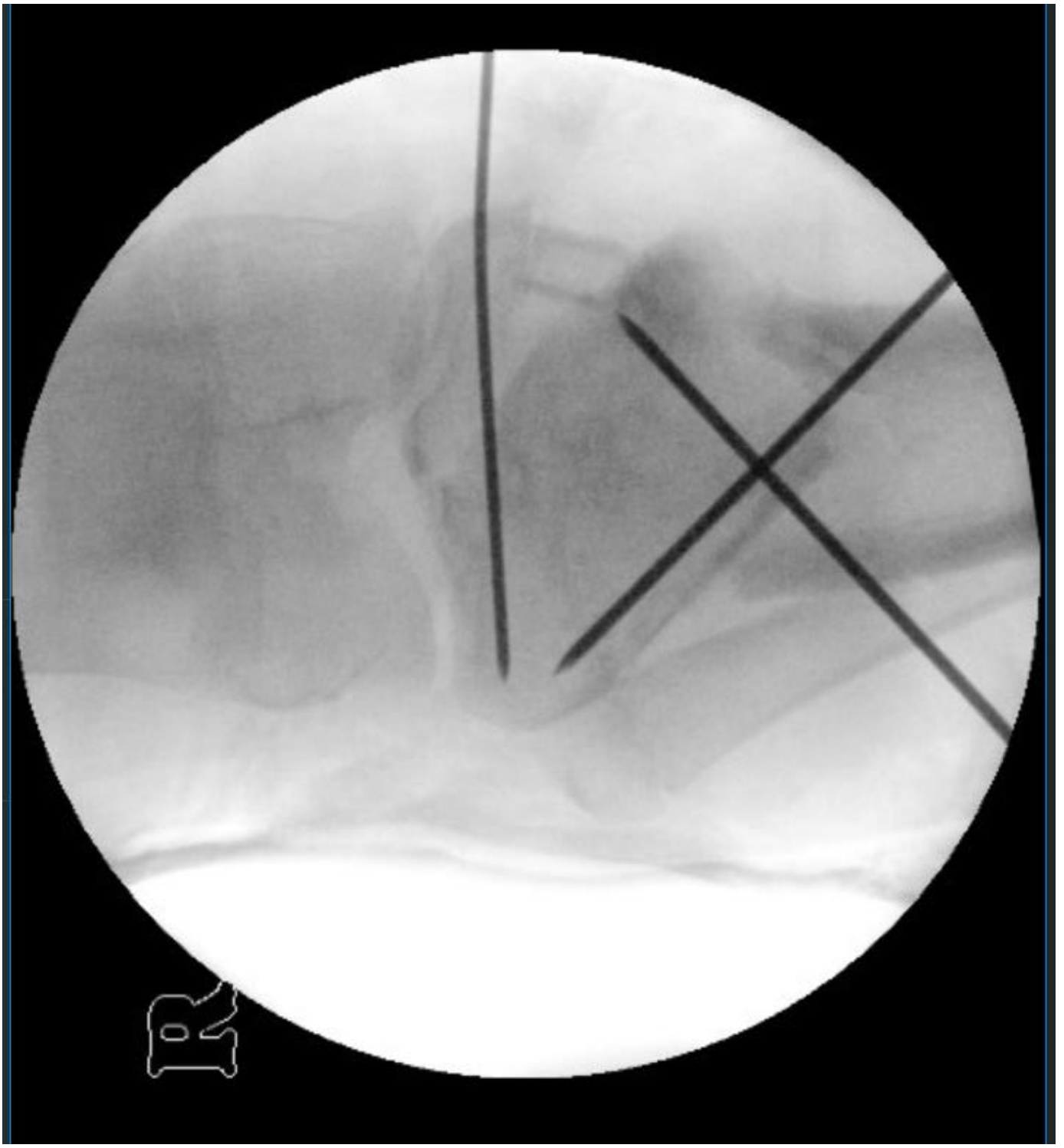
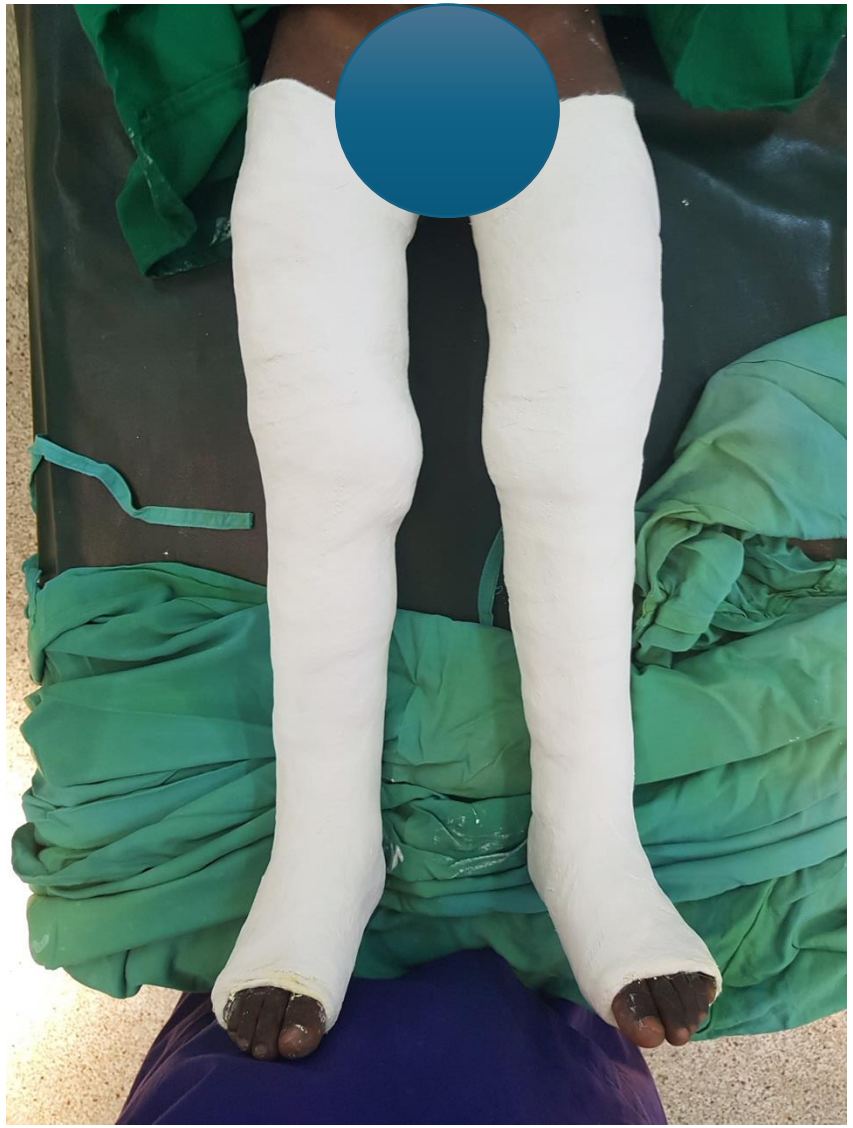
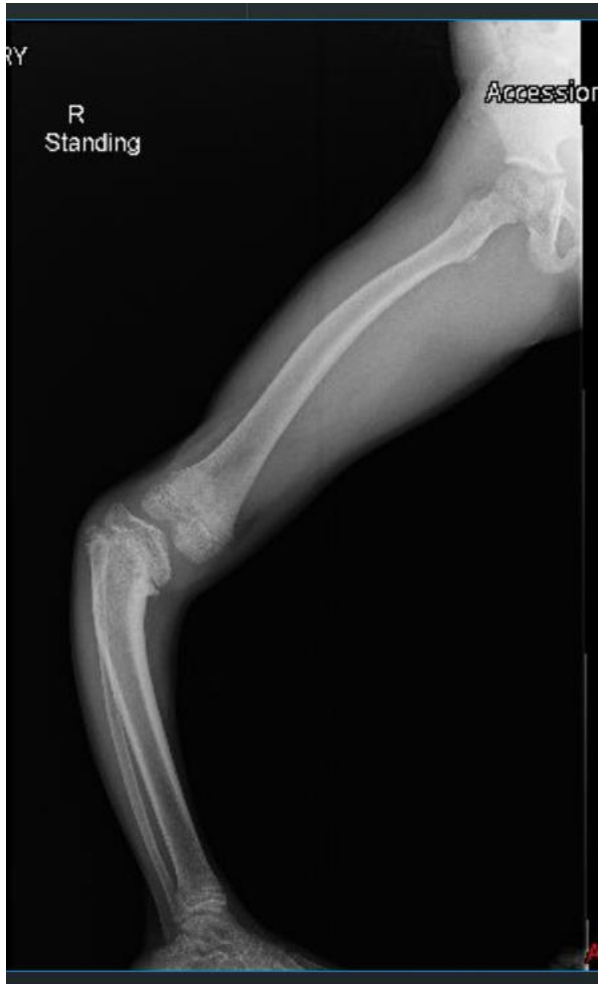
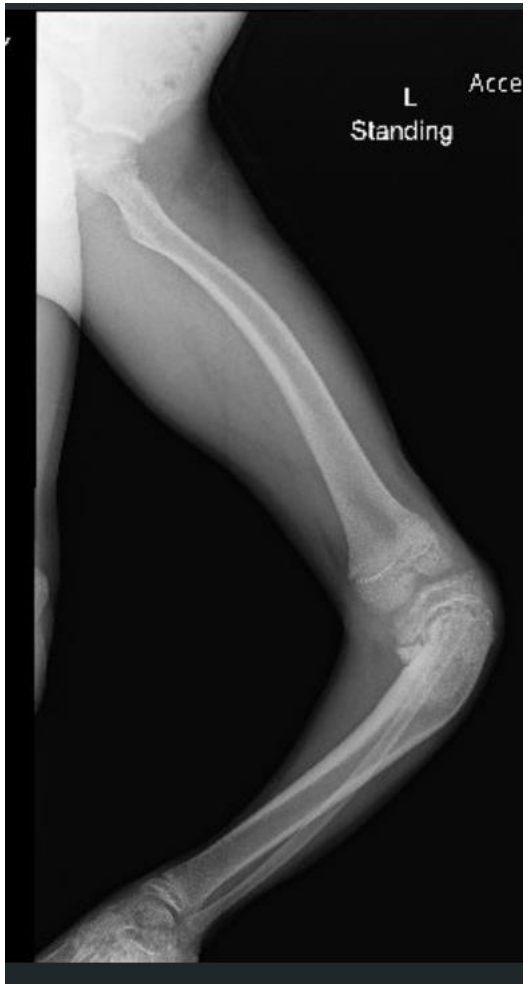
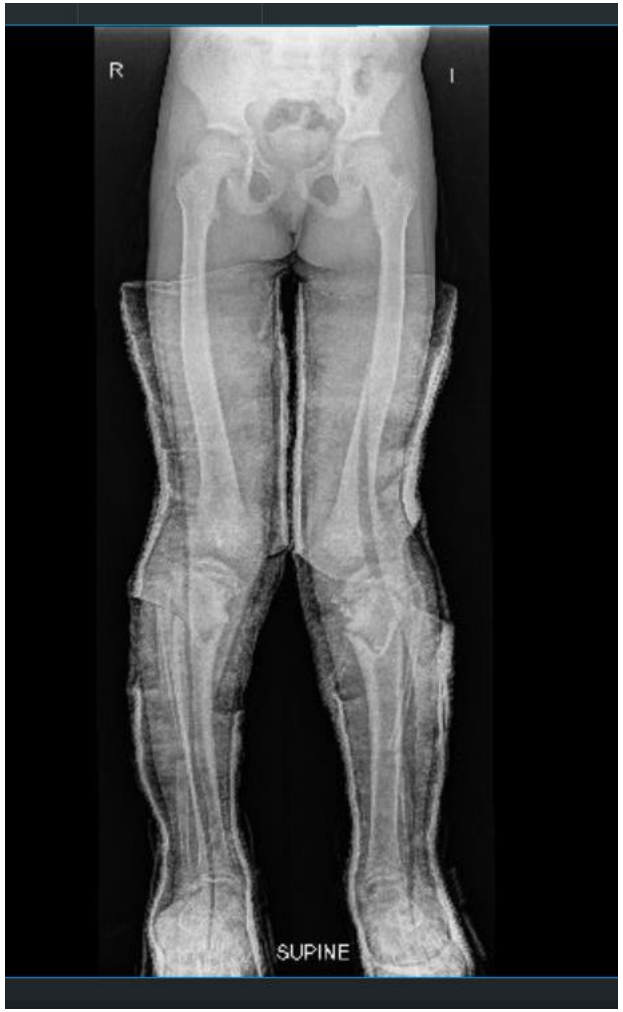


- Plaster cast
- Check x-ray when weight bearing
- Wedging of cast where required then re-xray
- Remove cast at 8 weeks if healed
- Intense therapy for several weeks




R
Standing

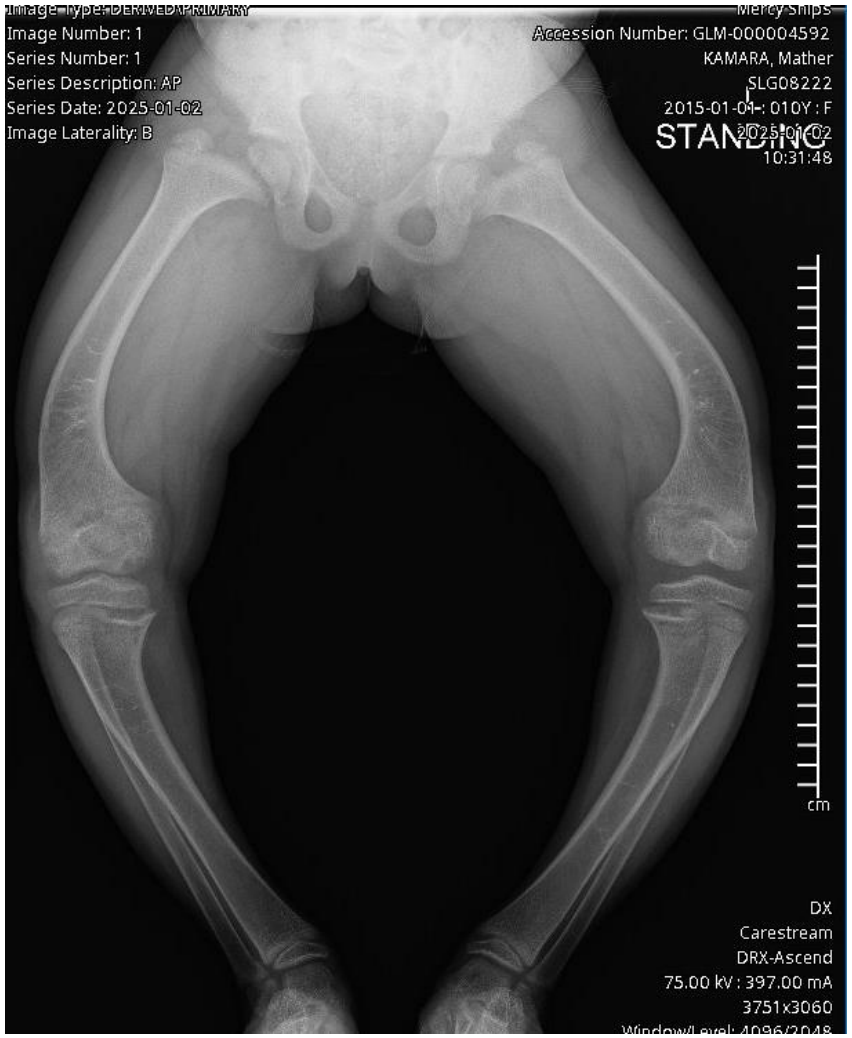

L
Standing

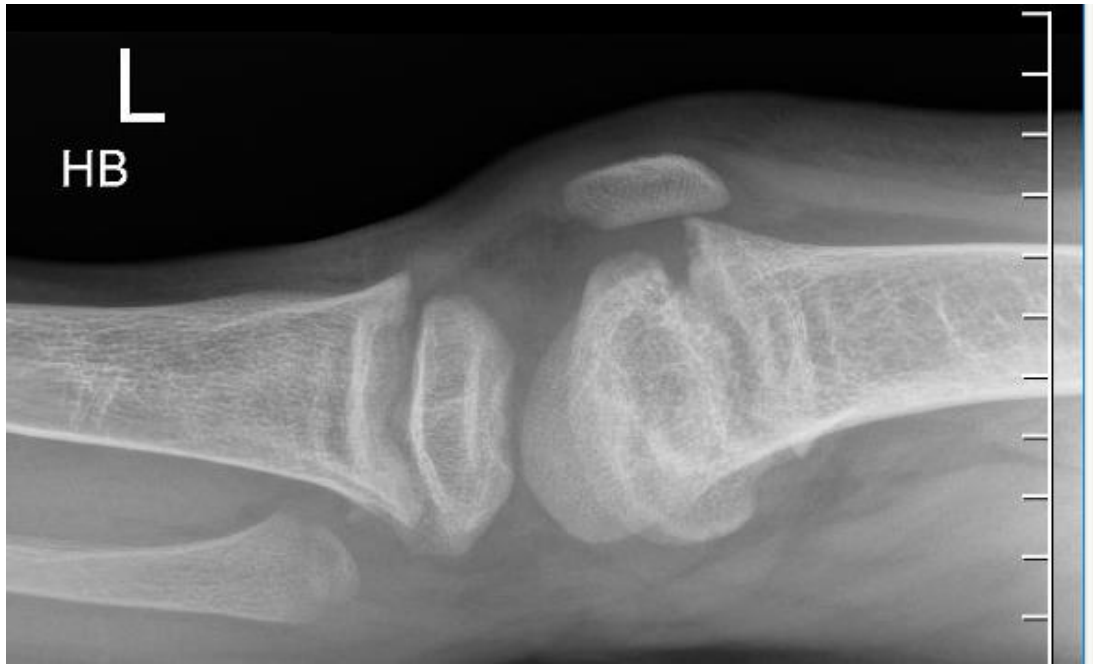

R
SUPINE

Work done

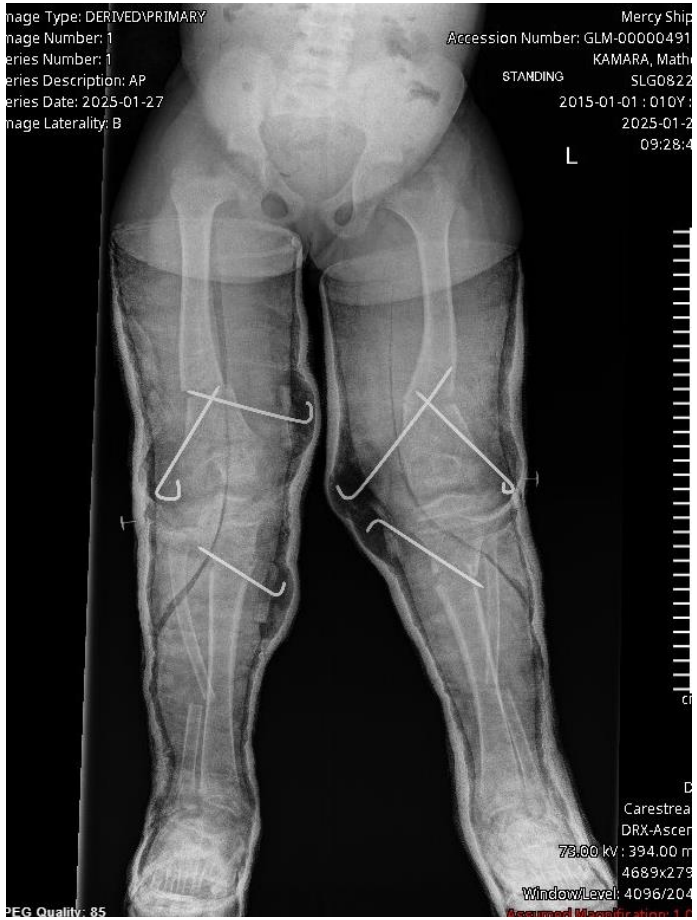
- 1 ½ days pre op
- 9 days theatre
- On call saturday
- 18 cases
- 33 long bone osteotomies (excluding fibulae)
- Soft tissue procedures
- Numerous epiphysiodesis / peroneal nerve decompressions
- others

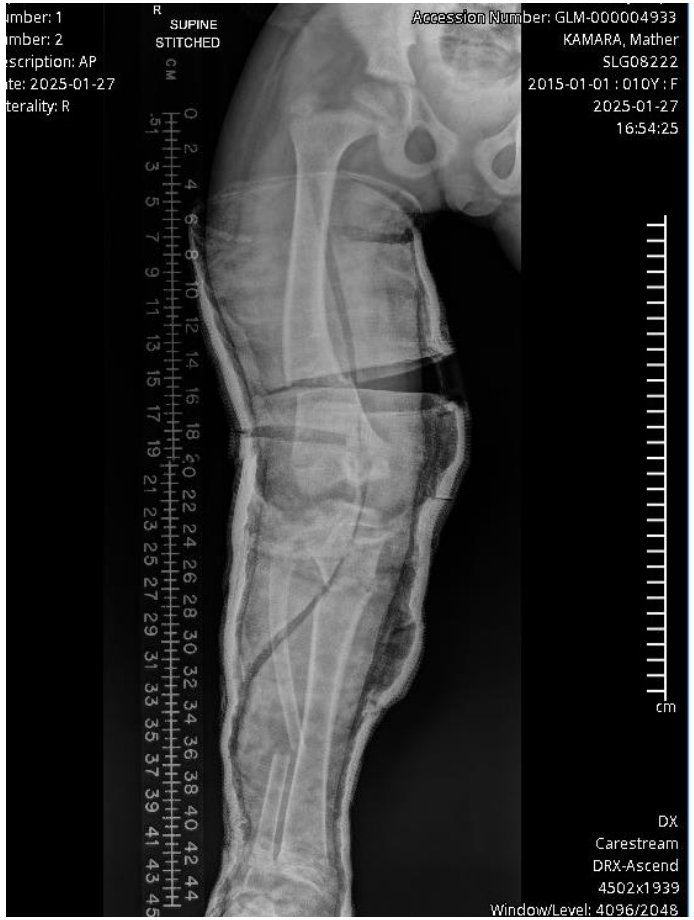
Case example – 8 yr old?





Post op-plaster and wedging



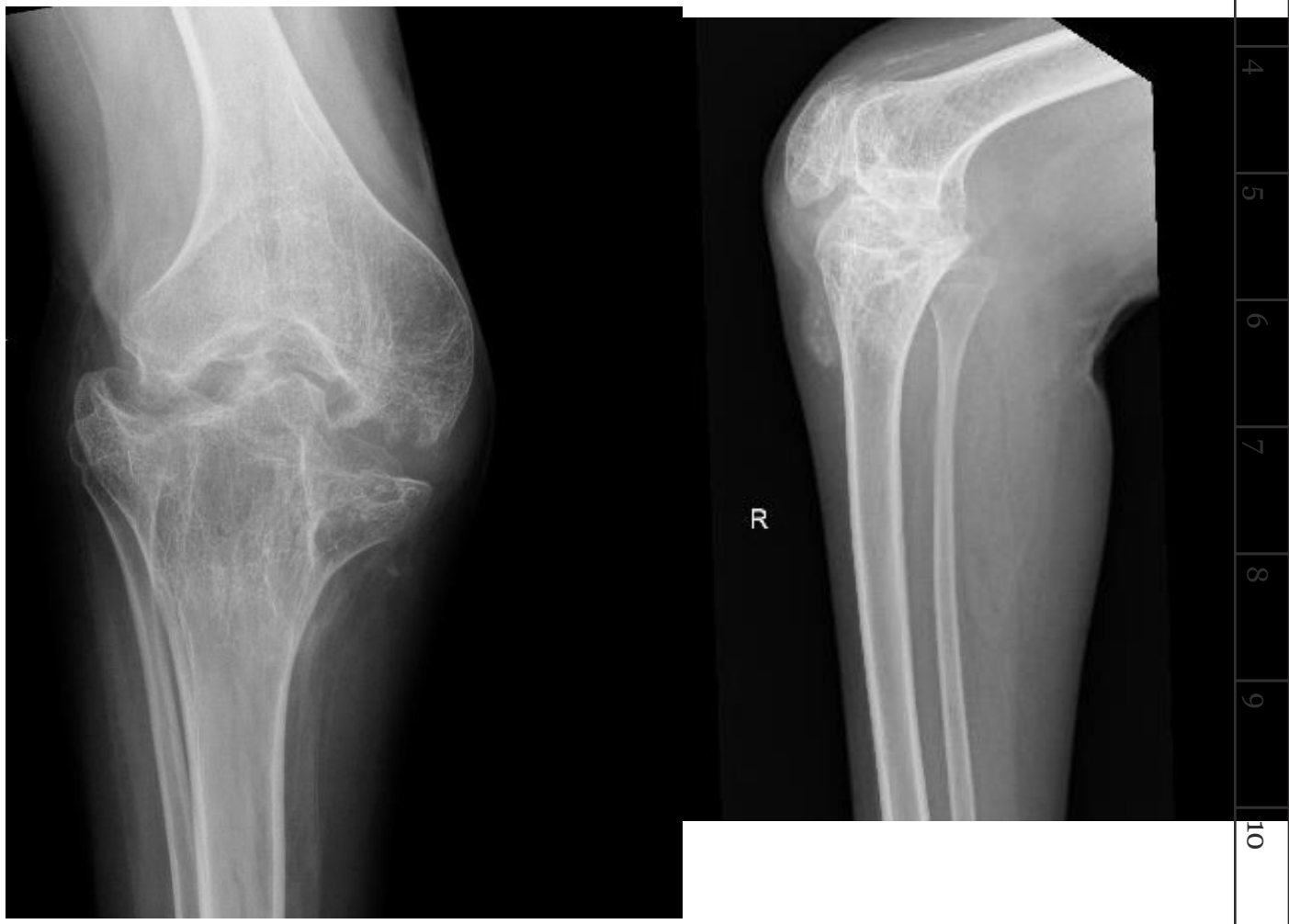


Post op complications

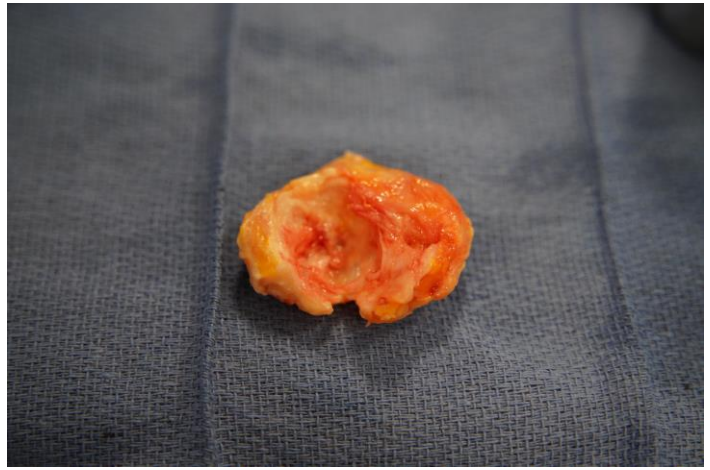
- Temperature
- Nerve injuries
- Compartment syndrome
- Infection
- Under / over correction
- Repeat surgery

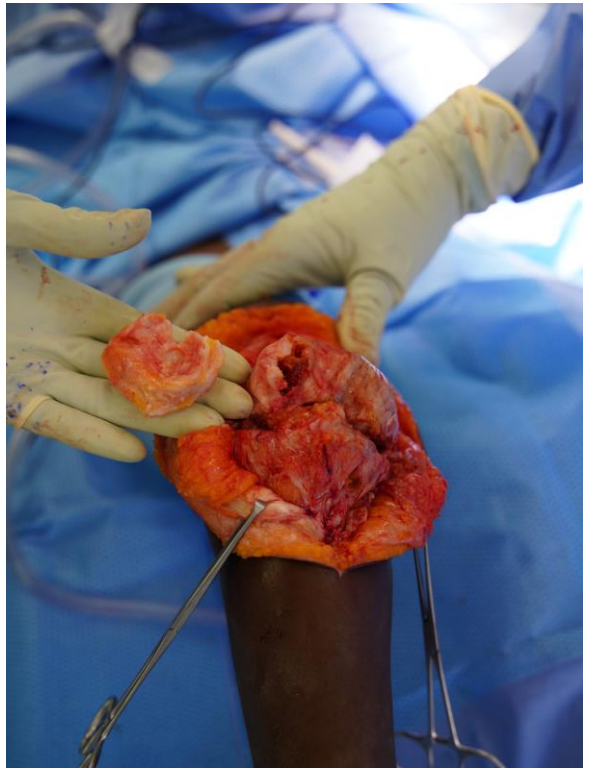
Interesting case!

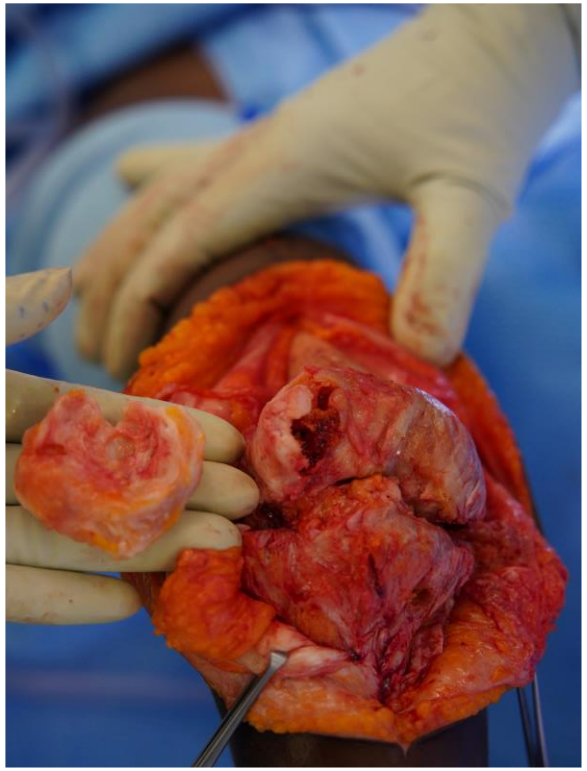
- 14 yr old girl
- Stiff painful knee
- Fixed flexion 80 deg
- Some sort of infection age 5



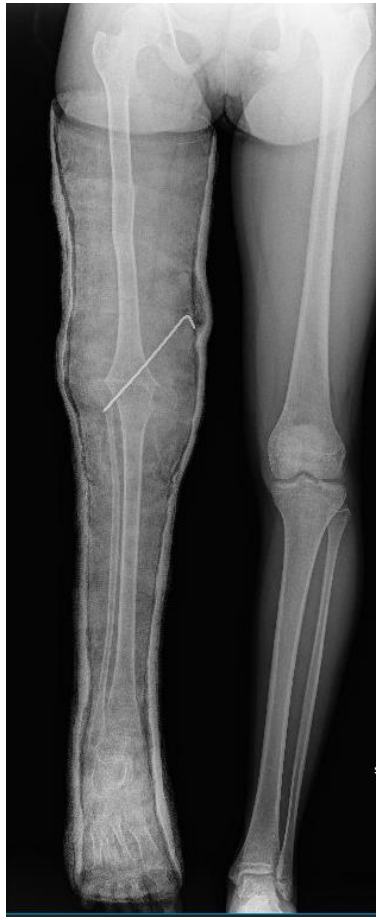
Interesting case!

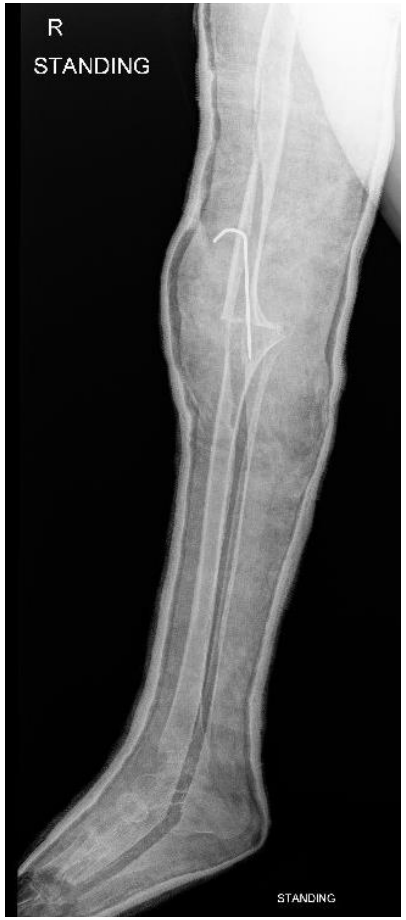


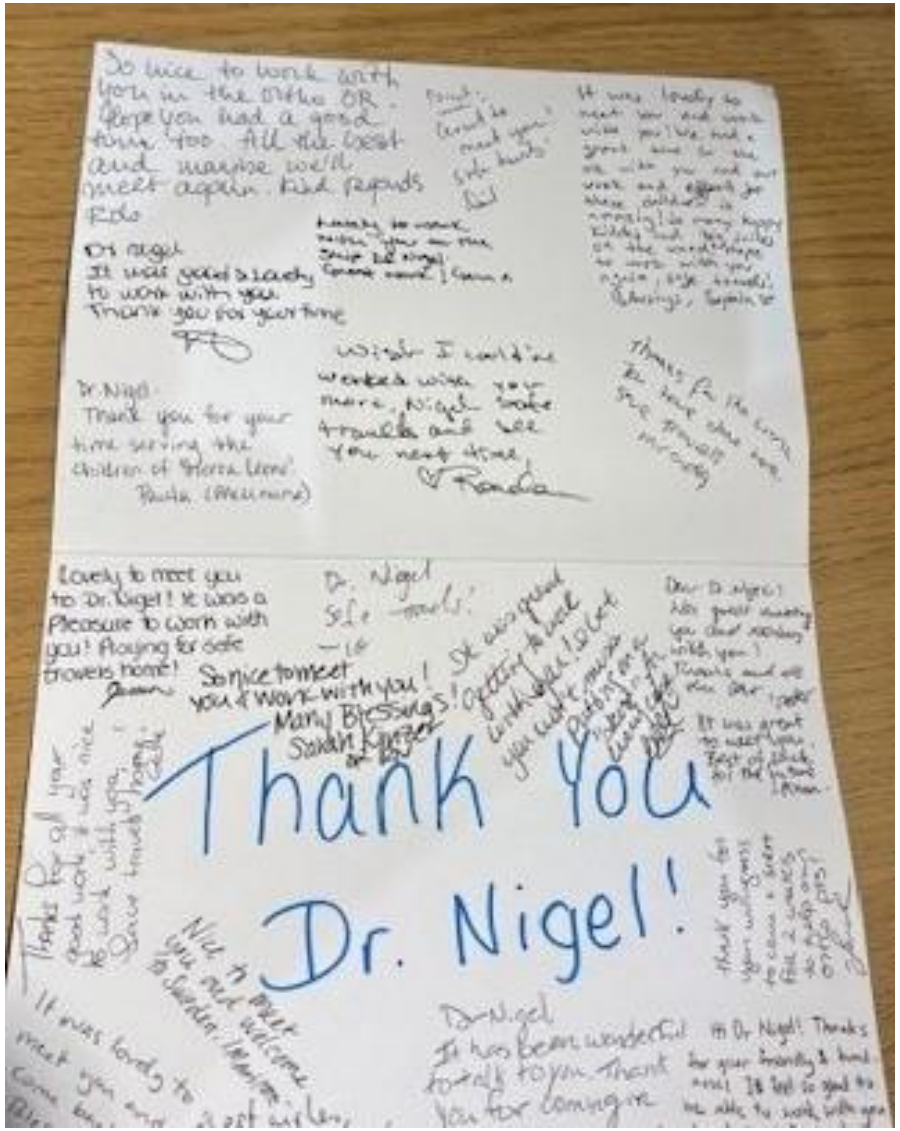




Post op knee fusion, TB treatment







Reflections

- Amazing experience!
- Made a huge difference
- Refreshing
- Appreciated and valued
- Feedback
- Different ways of working
- Working with patients with different diseases / community/ facilities

Reflections

- 600 people focussed on one task
- Enabling team to treat patients
- Using surgery as an efficient resource
- Cancellations did not occur
- Gratitude

Learning

- Personal challenge
- Go outside your comfort zone
- Applying orthopaedic principles
- Adapt to your environment / patient / disease
- Team work
- Flexibility

Non Technical Skills

- Could be an environment where human factors can go wrong
- International team
- New environment
- New conditions
- Systems in place
- Leadership
- Ship routine

Challenges

- Application process
- Sensory overload-
  - Africa
  - cultures
  - patients
  - Operations
- Ship life- lots of rules
- Religious organisation- no drink / drugs/ sex or speedos!

Summary

- Try something like this if you can
- Amazing experience
- I’m going again!

Chief Executive Officer Update

Committee / Group / Meeting, Date

Board of Director, Public Meeting, 02 July 2025

Author:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Contributors:

Chris Hudson,
Head of Communications

Report sign-off:

Stacey Keegan, Chief Executive Officer

Is the report suitable for publication:

Yes

Key issues and considerations:

This paper provides an update to Board members on key local activities across several business areas not covered within the main agenda.

This paper provides an update regarding some of the most noteworthy events and updates since the last Board from the Chief Executive Officer.

Recommendations:

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

Acronyms	
AHP	Allied Health Professional
CQC	Care Quality Commissioners
FTSU	Freedom to Speak Up
GB	Great Britain
GPs	General Practitioners
LoS	Length of Stay
NETS	National Education and Training Survey
NHS	National Health Service
NJR	National Joint Registry
NOA	National Orthopaedic Alliance
RJAH	Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust
SaTH	The Shrewsbury and Telford Hospital NHS Trust

Chief Executive Officer Update

1. Sam Young, Interim Chief Nurse and Patient Safety Officer

We are deeply saddened by the recent passing of our Interim Chief Nurse, Sam Young, following a tragic accident. Sam had served the Trust for many years in senior nursing roles, and her sudden loss has come as a profound shock to colleagues across the organisation.

Sam was an exceptional and supportive colleague—valued by fellow Board members and respected by staff at every level of the Trust. She was held in the highest regard, not only for her outstanding clinical expertise and unwavering commitment to patient care, but most of all for the warmth and integrity of her character. Sam was kind, compassionate, and brought a sense of joy and humanity to every interaction.

Sam's absence will be felt deeply. In the days and weeks ahead, we will find meaningful ways to honour Sam's legacy and celebrate the life of someone who made such a lasting impact on us all.

2. NHS Operating Model

The date of the dissolution of NHSE is still expected to be October 2026, however NHSE and DHSC teams will be working much closer together in advance of this date.

The clustering of ICBs is expected to be implemented within the next few months in order to meet NHSE requirements to reduce running costs this year. Clustering arrangements will be subject to ministerial and NHSE sign off. In Shropshire, Telford and Wrekin, conversations continue across the Midlands ICBs.

3. National Orthopaedic Alliance (NOA)

In May, I attended the NOA annual conference. Orthopaedic colleagues from across the UK came together and shared insight and good practice. As well as sharing challenges, it provided areas of opportunity to collaborate to improve orthopaedic care and outcomes.

Congratulations to all colleagues who were shortlisted for awards and for showcasing their work.

4. Federation of Specialist Hospitals

The report produced by members of the Federation of Specialist Hospitals entitled, 'The Power of Specialism' is being discussed within NHSE with the continued ambition to inform the 10-year plan due to be published imminently.

As a Trust we have contributed both to the report and subsequently to a series of case studies that are being used to evidence and compliment the report for further discussion.

5. NHS Confed Expo 2025

In June I attended NHS Confed Expo, an opportunity for health and care leaders to come together to share, learn and collaborate. The conference provided a range of networking opportunities and plenary speakers included Sir James Mackey, CEO, NHSE, Matthew Taylor, CEO NHS Confederation and Rt Hon Wes Streeting MP, Secretary of State for Health and Social Care.

6. NHS pay award

At the end of May, the Secretary of State for Health and Social Care accepted the independent Pay Review Bodies' headline pay recommendations for NHS staff.
In summary:

- Agenda for Change staff will receive a 3.6% uplift.
- Resident Doctors (formerly Junior Doctors) will receive a 5.4% increase.
- Consultants, Specialty Doctors, Specialists, GPs, and Dentists will receive a 4% pay rise.

Reactions to the announcement have been mixed. Board members will be aware that some unions are currently consulting their members and considering next steps. Following the industrial action of recent years, we continue to monitor developments closely and will plan mitigations accordingly.

Also, NHSE has published a new pay framework for Very Senior Managers which will be considered at Remuneration Committee.

7. CQC inspection

The Care Quality Commission (CQC) visited us over two days at the end of May to inspect our surgical and critical care services. While the inspection process is still ongoing, it will also include a Well-Led assessment, which was originally scheduled for next week. This has now been postponed following the sad passing of Sam.

Despite the process not yet being complete, we have received some initial feedback from the inspectors. They noted that staff were able to clearly articulate their roles, felt well supported, and had received appropriate induction and training. Inspectors also highlighted that leaders expressed pride in the improvements made across services over the past 12 to 18 months, and that culture and morale within Theatres had notably improved since the last inspection.

One area of concern raised was the level of anaesthetic cover during overnight hours. We provided assurances regarding our mitigation measures and shared the business case that had been developed, along with updates on our recruitment efforts. Interviews for these roles were scheduled for June 2025, and the Trust has conducted interviews throughout the month.

8. Apollo

We are now in the seventh week since the launch of our Apollo Electronic Patient Record system. This transition has undoubtedly brought challenges, and I recently wrote to our staff to acknowledge the stress and difficulty many have experienced.

We always knew this would be a significant change, and I fully recognise how unsettling it can be to adapt to a completely new way of working—learning new processes and navigating an unfamiliar system. I want to thank everyone for their continued patience, resilience, and commitment during this time.

While Apollo brings many opportunities, we are also aware that there are areas where the system must improve. Please be assured that the Apollo Team is working hard to address these issues and enhance the experience for all users.

9. Freedom To Speak Up

Since the Board last met in public, we are pleased to announce the appointment of Dylan Murphy, Trust Secretary, as the Trust's new Executive Lead for Freedom to Speak Up (FTSU). Dylan will work closely with Liz Hammond, FTSU Guardian, Sarfraz Nawaz, FTSU Non-Executive Lead, and our network of FTSU Champions.

The Executive Lead plays a vital role in strengthening our culture of openness, transparency, and support—ensuring that all colleagues feel empowered and confident to speak up. In this role, Dylan will oversee the development and delivery of the Trust's FTSU vision and strategy, in alignment with the latest guidance from the National Guardian's Office.

Dylan's responsibilities will include conducting an annual review of the FTSU strategy, policy, and processes; providing quality assurance on a sample of speaking up cases; integrating learning from these cases across the organisation; and regularly assuring the Board of Directors on the effectiveness of the FTSU service.

10. Enhanced Recovery hits major milestone

I'm delighted to share a major milestone for our Enhanced Recovery service, which has now celebrated the discharge of its 1,000th 'Day Zero' patient—someone who returned home on the same day as receiving a new hip or knee. While same-day discharge isn't the primary goal of the Enhanced Recovery Programme, it's becoming an increasingly common outcome thanks to the innovative strategies the team has implemented.

The Enhanced Recovery Team has shown that the Enhanced Recovery Pathway is both safe and highly effective, reducing the average length of stay (LOS) by more than 80%. Impressively, over 20% of patients are now discharged on the day of surgery, and more than 90% leave hospital within 24 hours. This dramatic reduction in LOS is linked to significantly improved patient outcomes, including lower rates of mortality, complications, and infections.

11. National Education and Training Survey

It's truly outstanding to see the Trust ranked first in the Midlands and second nationally in the National Education and Training Survey (NETS). This remarkable achievement highlights the Trust's unwavering commitment to nurturing the next generation of healthcare professionals, creating a supportive and enriching learning environment, and upholding the highest standards of patient care.

RJAH has long been recognised for its excellence in medical education, particularly in training orthopaedic specialists. These survey results are a powerful testament to the dedication, collaboration, and hard work of everyone involved. Congratulations to all who have contributed to this success — your efforts continue to make a lasting impact.

12. New minor diabetic foot service launched

The Trust has launched a new minor diabetic foot service to provide vital surgical interventions for diabetic patients with tendon-related foot conditions. Delivered in partnership with The Shrewsbury and Telford Hospital NHS Trust (SaTH), the service is designed to support patients requiring minor procedures—such as toe tenotomies—to help prevent the progression of deformities that can lead to serious complications, including ulcers and infections.

This initiative has been introduced in response to a rising demand for specialist diabetic foot surgery in Shropshire. By offering timely and targeted care, the service aims to improve patient outcomes and reduce the risk of major interventions.

13. Opening of the Alice Ward Garden

Just a day after our most recent public Board meeting, I had the pleasure of attending the official opening of *Garden for Alice*—our beautiful new outdoor therapeutic garden created to enhance the health and wellbeing of our young patients.

The garden was formally opened by Harry Hill—comedian, TV personality, and writer—adding a touch of humour and warmth to a truly special occasion.

I was deeply impressed by the space, which has been thoughtfully designed with care, compassion, and creativity. We understand how vital the environment is to recovery and wellbeing, and this garden will provide a peaceful, welcoming place for children and their families to relax, play, and heal.

14. Paediatric Team crowned winners for transforming hospital experience

Congratulations to our Paediatric Team for winning the Supporting Patients on their Pathway Award at the prestigious National Orthopaedic Alliance (NOA) Excellence in Orthopaedics Awards!
The team was recognised for their outstanding work in enhancing the pre-admission and procedural experience for children—a project that has significantly transformed pre-operative care for young patients and their families.

Their comprehensive pre-assessment pathway supports children coming to Alice Ward, our dedicated children's ward, for surgery, rehabilitation, and other procedures. Designed to improve the overall patient journey, the service offers both face-to-face and virtual appointments, integrated support from the Play Team, and innovative digital tools such as Remcare and the Little Journey app.
Importantly, the pathway includes tailored interventions for children with high anxiety or complex needs, helping to reduce stress and improve outcomes. This achievement reflects the team's dedication to delivering compassionate, child-centred care.

15. RJAH Stars Award

Each month, I have the pleasure of presenting the RJAH Stars Award to an individual or team in recognition of exceptional achievement or performance. Since our last public Board meeting, we've celebrated two outstanding winners:

- **June Winner: Louise Naylor**, Ward Manager, Baschurch Day Unit
  Louise received an incredible 13 nominations from her team, all highlighting her exceptional support during the rollout of our Apollo Electronic Patient Record. Her colleagues praised her unwavering dedication—often arriving early, staying late, and working additional hours to ensure the ward was fully prepared for the transition. She was described as a "lifeline"

throughout the process, creating detailed flowcharts, booklets, and guidance documents tailored to staff workflows. Louise also provided one-to-one support, answering questions with patience and clarity.

- **May Winner: Kirsty Sperring**, Healthcare Assistant, Main Outpatients
  Kirsty was recognised for her compassion and professionalism after going above and beyond to support a patient with complex safeguarding needs. During an evening clinic, she identified concerns when an unaccompanied patient arrived and took immediate action to escalate the situation. Kirsty stayed well beyond her shift to ensure the patient was safe arranging a taxi and accompanying them until she was confident, they were safely on their way home.

Congratulations to both Louise and Kirsty—your dedication and care truly embody the spirit of the RJAH Stars Award.

16. Conclusion

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

System Integrated Improvement Plan

Committee / Group / Meeting, Date

Board of Directors, 02 July 2025

Author:		Contributors:
Name:	Dylan Murphy	Action Plan "Task" owners.
Role/Title:	Trust Secretary	

Report sign-off:

n/a

Is the report suitable for publication:

No – this reflects work in progress to develop a position.

Key issues and considerations:

RJAH executives were invited to an NHSE / ICB session on 3 October 2024 to discuss RJAH's contribution to the "system transition plan".

The "transition" relates to the ICB / SaTH transition from Level 4 of the NHS Oversight Framework (NOF) to Level 3 of the Framework. Though the "transition" only technically applies to organisations rated at NOF 4, the associated plan recognises that individual organisations may have limited ability to deliver sustained improvement in isolation - that improvement will be dependent on wider system working. The plan is therefore a system-wide plan. It has five areas of focus:

1. Finance;
2. Workforce;
3. Urgent and Emergency Care (U&EC);
4. Governance; and
5. Leadership.

Whilst the deliverables in the plan represent exit-criteria for the organisations in NOF 4, that is not true for RJAH (or the other contributors that are not rated at Level 4). Each provider in the system is however expected to demonstrate its commitment to supporting the plan. Each organisation therefore has its own deliverables, based on the particular contribution it can make to the wider plan.

Following the session on 3 October, the ICB circulated a more detailed template for all providers to complete and return. This was referred to as the "System Integrated Improvement Plan" (or SIIP). The SIIP template has a "***Plan***" for each of the five areas, with organisation-specific deliverables..

A request was received from the System that each provider was to confirm the monitoring arrangements against the SIIP. The Finance and Performance Committee and People and Culture Committee received elements of the Plan at their March meetings. For visibility, the full plan (as at the 18 June submission deadline) is attached.

Strategic objectives and associated risks:

This work supports all of the Trust's objectives and feeds the Board Assurance Framework.

Recommendations:

That the Board notes the progress updated in relation to the RJAH contribution to the System Integrated Improvement Plan.

Attachment: RJAH Contributions to SIIP

RJAH Contributions to System Transition Criteria

Transition Criteria	Focus Area		Metric	Key Deliverables	Proposed Metrics	Progress Inc Milestones / Tracjectories	Evidence
1	Finance	Develop and deliver a single Recovery Plan ("the Recovery Plan"), to be agreed with NHS England, that brings together the ICB, provider and additional system wide recovery initiatives, that has clear demonstrable improvement in financial performance for 2024/25 including supporting metrics such as increased efficiency delivery (cost reduction), adherence to agency rules and workforce numbers. This is to have Board agreement from all STW organisations and is signed off Regionally and Nationally. Have an agreed Capital Plan that is clearly aligned to system strategic priorities, supporting the financial recovery plan with realistically agreed funding sources.	1.1	The Trust has an agreed medium term 3-5 year financial plan (MTFP) in place that has been signed off by the Board and agreed with the ICS and NHS England Triangulation exercise - financial plan to workforce, activity and performance plans; with evidence of testing and review against the HTP model. To be included with the MTFP for sign off.	Plans are set out in the deliverables - signed off plans are the measure of success.	Annual refresh of RJAH MTFP by 31st March each year (internal system deadline 31st December).	Signed off 3-5 year MTFP Aligned with system Financial Strategy Governance: individual finance committees and Boards; System Finance Committee and Board. Evidence of full sign off through meetings with NHSE regional and national teams.
			1.2	24/25 and 25/26 financial plans agreed and signed off by RJAH aligned to the ICS plans and NHS England Plans to include a fully developed Financial Improvement Plan (i.e. CIPs) with supporting PIDs linked to the benchmarking opportunities	Development of RJAH's Plan 24/25 plan already signed off by all parties and in progress 25/26 plan - sign off by all parties will be the measure of success. RJAH financial performance plan vs actual RJAH CIP plan vs actual	Material delivery of the 24/25 agreed RJAH financial plan and subsequent 25/26 plan across the system financial plan as a whole. Fully developed Financial Improvement Plan with supporting PIDs for 24/25 by end of Sept 24 and 25/26 by end of March 25 Overall 24/25 efficiency delivery demonstrates clear cost reduction that is greater than in previous years and has a strong recurrent element when benchmarked against other Systems.	Monthly finance reports (to individual organisations and system finance committees and boards) Benchmark delivery vs peers (% variance to plan for the financial position and recurrent savings as a % of overall efficiency programme for efficiency) Financial Improvement Plan with supporting PIDs for 24/25 and 25/26
			1.3	Capital plans for 24/25 and 25/26 signed off by RJAH aligned to system plans and NHS England	RJAH financial capital performance plan vs actual RJAH Capital Delegated Expenditure Limit (CDEL)	End of year 24/25 End of year 25/26 RJAH not to exceed CDEL	Monthly finance reports (to RJAH finance committee and board) Financial Strategy (includes capital)
			1.4	Independent review of 'grip & control' - identifying RJAH's gaps (I&I phase 1 work) resulting in a plan to address gaps Follow up re-assessment review of 'grip & control'	Agreed subset of controls from the 'grip & control' checklist relevant to RJAH, plus associated impact measurement - linked to the identified gaps Wider review of all RJAH controls in the 'grip & control' checklist at the follow up re-assessment review	Quarter on quarter delivery of the RJAH impact metrics related to gaps RJAH maintain performance in areas that scored well at initial external review Follow-up review in August 2025	Data on metrics related to RJAH gaps produced monthly Results of the Follow up re-assessment review of 'grip & control' demonstrating required improvements Internal Audit findings for all finance related audits to be rated moderate or substantial External Audit Opinion, VFM
2	Workforce	Develop and deliver a workforce improvement plan, that has Board agreement from all STW organisations and is signed off Regionally and Nationally, that is clearly aligned to system strategic priorities and financially sustainable	2.1	Workforce delivery plans for 24/25 and 25/26 aligned to overall system plans and signed off by Board	Delivery against workforce plans including required reduction in agency	Material delivery of the 24/25 agreed RJAH workforce plan and subsequent 25/26 plan across the system as a whole.	Board signed off workforce delivery plans Monthly workforce actual vs plan reports Benchmark delivery vs peers
			2.2	RJAH People and OD strategy aligned to system strategy	Staff unplanned absence, unavailability (baseline 23/24) Staff retention (baseline 23/24) Reduction in funded establishment vacancy levels (baseline 23/24) Staff survey results (baseline 23/24) Staff turnover out of area as % (baseline 23/24)	Maintain levels of staff unplanned absence & retention Maintain pulse results in 24/25 & 25/26 & NHS staff survey results in 24/25 and completion rate in 25/26.	Board approved People & OD Strategy including recruitment and retention strategy Monthly workforce reports actual vs plan for absence and retention Annual staff survey results Benchmark delivery vs peers
3	U&EC	Working with system partners develop and deliver a comprehensive, system-wide Urgent and Emergency Care Improvement plan ("the Improvement Plan") which demonstrates the appropriate system actions and controls in place for improving U&EC access, quality and performance across the whole U&EC pathway	3.1.5	Working with system partners to deliver the System Discharge Alliance Plan to reduce No Criteria to Reside, and thus reduce escalation inpatient acute capacity (linking to reduced bed occupancy)	Level of NCTR and ALoS of NCTR in RJAH	Sheldon Ward NCTR to average 3 by March 25 Sheldon Ward ALoS down to 21days by Dec, Phase 2 target still to be confirmed (by Dec24) for delivery by March 25	UEC Dashboard, UEC Delivery Group reports
			3.1.3	Work with system partners to deliver alternatives to ED attendances/ admissions and Care Coordination system plan	Reduction in level of avoidable ED attendances and admissions linked to any MSK related pathways and use of Sheldon Ward Plan v Actual	Metrics to be devloped and target established by 1st December 24	UEC Dashboard, UEC Delivery Group reports Refreshed Optimity data - quaterly showing reduction in sometimes and usually avoidable targeted cohorts
			3.2	Effective, regular attendance from RJAH at UEC Delivery Group	Attendance at UEC DeliveryGroup Ongoing reduction in RJAH risks scores.	N/A	UEC Delivery Group RJAH attendance list RJAH elements of UEC System Risk Register
4	Governance	Implement sufficient programme management and governance arrangements across system providers to enable delivery and reporting of improvement, with immediate focus being on Finance and U&EC.	4.1	Individual RJAH governance structure (Level 2) for Finance, UEC and Workforce re-designed, implemented and functioning (balancing finance, quality & safety, performance and workforce)	NA - success will be measured through delivery of the RJAH elements of the finance, workforce and UEC exit criteria	Review current RJAH structure at Level 2 for UEC, Finance and workforce + interface with system governance structures - December 24. Proposals for change made to RJAH Board taking into account development of provider collaborative - March 25	RJAH governance structure and associated terms of reference documented and signed off by Board System Transformation Group monthly reports - showing progress of delivery of RJAH elements of the improvement plans

Transition Criteria	Focus Area		Metric	Key Deliverables	Proposed Metrics	Progress Inc Milestones / Tracjectories	Evidence
			4.2	RJAH elements of the system performance & accountability framework - developed and implemented	NA - success will be measured through delivery of the finance, workforce and UEC exit criteria	NA - success will be measured through delivery of the finance, workforce and UEC exit criteria	RJAH elements of system performance & accountability framework documented and signed off by RJAH board System Transformation Group monthly reports - showing progress of delivery of RJAH elements of the improvement plans
			4.3	An agreed RJAH and all STW provider wide risk management approach (including consistent policies and risk assessment tools) that is then adopted as the system and ICB approach that is implemented and functioning.	Mitigations of shared risks for finance, UEC and workforce are successfully reducing the number of risks and/or risk scores for these delivery programmes	Consistent risk management policies adopted by RJAH and all STW provider boards and being used - to include risk scoring, risk reporting/escalation, risk management procedures - April 25.	RJAH risk management approach (including consistent policies and risk assessment tools) documented and signed off by Board consistent wth other STW provider risk management approaches and system/ICB (where appropriate) Risk Registers held at Level 2 Delivery Groups System Transformation Group - monthly reporting includes risk reporting by programme
			4.4	RJAH elements of the System PMO designed, implemented and functioning	NA - success will be measured through delivery of the finance, workforce and UEC exit criteria	NA - success will be measured through delivery of the finance, workforce and UEC exit criteria	RJAH elements of system PMO structure & approach documented and signed off by RJAH board and ICB System Transformation Group monthly reports - showing progress of delivery of improvement plans
5	Leadership	Strengthen effective engagement and contribution to the System Improvement Plans	5.1	Individual RJAH elements of the functioning Provider Collaborative (aligned to the priorities within the Strategic Commissioning Plan approved by IC Board) where open and honest conversations are brokered.	Individual RJAH contribution of the Provider Collaborative elements of the Integrated System Improvement Plan e.g. UEC, Finance and Workforce RJAH elements of external assessments (initial & follow-up) of the effectiveness of the Provider Collaborative RJAH elements of the Provider Collaborative delegated programmes of work plan for 2024/25 & 25/26	RJAH contribution to the Provider collaborative elements of UEC, Finance and Workforce Integrated System Improvement Plan delivering from Sept 24 RJAH elements of the external assessment Q4 24/25 and subsequent plan to improve Follow-up assessment Q3 25/26 demonstrating planned improvement	Provider Collaborative terms of reference Agreed Provider Collaborative priorities with timelines Provider Collaborative risk register Impact of Provider Collaborative on UEC, workforce & finance Feedback from first external assessment related to RJAH RJAH plan to address findings Feedback from follow up assessment showing SCHT's improvement from first
			5.3	Demonstrate collaborative decision-making through the co-development and co-delivery of an System Integrated Improvement Plan that supports delivery of all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system.	RJAH elements of the System Integrated Improvement Plan RJAH elements of the external assessments (initial & follow-up) of collaborative decision making	RJAH elements of the System Integrated Improvement Plan by end Oct 24 RJAH elements of the external assessment Q4 24/25 and subsequent plan to improve RJAH elements of follow-up assessment Q3 25/26 demonstrating planned improvement	System Integrated Improvement Plan signed off by ICB and RJAH board and NHS England Agreed RJAH elements of evidence for all RSP exit criteria Evidence from RJAH committees and RJAH led delivery groups - agendas and minutes of decisions taken RJAH feedback from first external assessment RJAH's Plan to address findings RJAH feedback from follow up assessment showing improvement from first
			5.4	RJAH's contribution to a clear system culture and leadership improvement programme and evidence of a positive shift in staff experience through pulse survey/NHS staff survey.	RJAH's Pulse Survey results (baseline 23/24) RJAH's NHS staff survey (baseline 23/24) RJAH's involvement in CEO Organisational Development Programme RJAH's involvement in Exec development programme	Maintain RJAH pulse & NHS staff survey results in 24/25 and response rate in 25/26 RJAH's involvement in the CEO & Exec Organisational Development Programme by end of Jan 25 through to March 26.	Maintain RJAH's pulse & NHS staff survey results 24/25 & response rate for 25/26 Delivery of a CEO Organisational Development Programme with RJAH's involvement Delivery of Exec development programme with RJAH's involvement.

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1.1	The Trust has an agreed medium term 3-5 year financial plan (MTFP) in place that has been signed off by the Board and agreed with the ICS and NHS England Triangulation exercise - financial plan to workforce, activity and performance plans; with evidence of testing and review against the HTP model. To be included with the MTFP for sign off.	Angela Mulholland-Wells	RJAH 1.1.1	MTFP planning assumptions base case modelled and updated in the system MTFP	Mark Salisbury	Complete	Complete	Complete; Evidence received		MTFP agreed as system and taken through committee. This is avaialble on the sharepoint drive for all system partners.
			RJAH 1.1.2	Annual refresh of MTFP and 5 year high level financial plan (including triangulation)	Mark Salisbury	Annual	31st Dec	Complete; Evidence received	27th March. Delay due to confirmation of final plan position.	MTFP and finance strategy completed - for approval with provider finance committees and ICS finance committee in April.
			RJAH 1.1.3	Ongoing monitoring of underlying position against MTFP assumptions	Mark Salisbury	Annual	31st March	Complete; Evidence received		MTFP is used as the basis for the recurrent underlying position for financial planning, we update this regularly throughout the year along with system partners.
			RJAH 1.1.6	Ongoing monitoring of activity plans and underlying position against longer term planning assumptions	Nia Jones	Annual	31st Dec	Complete; Evidence received		**Activity is monitored monthly with regular bridge summaries provided on variance against plan and changes in future plans as part of the system planning rounds setting out key interventions that provide step changes in anticipate and actual activity. Bridge accompanies activity plan subbmisions to the ICB.**
			RJAH 1.1.7	Triangulation to activity, workforce and performance and updated for 25/26 operational planning guidance	Mark Salisbury / Nia Jones	Started	31/01/2025	Complete; Evidence received	27th March. Delay due to confirmation of final plan position.	Financial, workforce and operational plan triangulation completed. Files saved down as evidence along with feedback from NHSE.
			RJAH 1.1.8	Recovery plan trajectory based on Strategic Transformation Programmes and Benchmarking opportunities updated in RJAH and system MTFP model.	Mark Salisbury	Started	31/03/2025	Complete; Evidence received		MTFP is used as the basis for the recurrent underlying position for financial planning, we update this regularly throughout the year along with system partners. Includes assumptions on efficiency and transformation to deliver deficit reduction target over three years.
			RJAH 1.1.9	10-Year first draft capital plan developed	Mark Salisbury	Complete	Complete	Complete; Evidence received		10 year capital programme developed and updated. This is avaialble on the sharepoint drive for all system partners.
			RJAH 1.1.10	Capital MTFP update following capital allocations and guidance	Mark Salisbury	Started	31/01/2025	Complete; Evidence received		10 year capital programme updated aligned to final plan submission. Updated on the consolidated system 10 year capital plan which is on sharepoint for all organisations.
			RJAH 1.1.11	Long-Term financial plan model - capital and revenue updated to match the system LTFP	Victoria Brownrigg	Complete	Complete	Complete; Evidence received		Updated as per LTFP. Available on sharepoint. Paper saved down as evidence.
1.2	24/25 and 25/26 financial plans agreed and signed off by RJAH aligned to the ICS plans and NHS England Plans to include a fully developed Financial Improvement Plan (i.e. CIPs) with supporting PIDs linked to the benchmarking opportunities	Angela Mulholland-Wells	RJAH 1.2.1	24/25 Revenue Plan agreed by RJAH, ICS and NHSE and fully identified CIP plan	Mark Salisbury	Complete	Complete	Complete; Evidence received		24/25 plan and delivery. Final plan slides included as evidence.
			RJAH 1.2.2	25/26 Revenue Plan agreed by RJAH, ICS and NHSE	Mark Salisbury	Started	31/03/2025	Complete; Evidence received		Financial, workforce and operational plan triangulation completed. Files saved down as evidence along with feedback from NHSE.
			RJAH 1.2.3	25/26 Draft efficiency schemes high level	Victoria Brownrigg	Started	30/11/2025	Complete; Evidence received		Draft efficiencies to be presented to FIP on 23rd Jan. Draft plan slides for check & challenge included as evidence.
			RJAH 1.2.4	25/26 Draft effiiency schemes detail	Victoria Brownrigg	Started	31/01/2025	Complete; Evidence received		Draft efficiencies to be presented to FIP on 23rd Jan. Draft plan slides for check & challenge included as evidence.
			RJAH 1.2.5	25/26 Draft efficiency confirm & Challenge with executive team	Victoria Brownrigg	Started	28/02/2025	Complete; Evidence received	Evidence will be part of the detailed FIP pack for efficiencies by end March	Draft efficiencies reviewed by Financial Improvement Group in February
			RJAH 1.2.6	25/26 Efficiency plan identified	Victoria Brownrigg	Started	31/03/2025	Complete; Evidence received		Efficiency programme identified - further work to de-risk schemes
			RJAH 1.2.7	25/26 Efficiency plan PID's signed off by scheme leads and directors	Victoria Brownrigg	Started	31/03/2025	Complete; Evidence received		High level PID documentation shared as part of efficiency programme oversight.
			RJAH 1.2.9	25/26 Efficiency plan QIA's signed off by CNO / CMO	Ian Maclennan / Lisa Newton	28/02/2025	31/03/2025	Complete; Evidence received	tbc	PIDS and QIAS signed by Chief Nurse. Sign off by CMO in progress
			RJAH 1.2.10	25/26 draft operational activity plan based on D&C work	Nia Jones	Started	28/11/2025	Complete; Evidence received		D&C models refresh in D&C file on sharepoint - linked feed through to the Operational Activity plan 2025/26.
			RJAH 1.2.11	25/26 monthly review of activity plan aligned to performance and financial requirements based on development of D&C model and interventions	Nia Jones	Started	31/01/2025	Complete; Evidence received	29th April 2025 - final plan submission (	Operational plan includes D&C model and interventions. F&P committee presentations provide a breakdown of interventions for elective activit, new patients and outpatients
			RJAH 1.2.12	25/26 sign off operational activity plan	Nia Jones	Started	31/03/2025	Complete; Evidence received	29th April 2025 - final plan submission (	Operational Plan sign off and submission, signed off through F&P committee and Board.
			RJAH 1.2.13	25/26 sign offworkforce plan aligned to activity delivery	Andrea Martin	Started	31/03/2025	Complete; Evidence received	29th April 2025 - final plan submission (	Workforce plan sign off F&P 19th March 2025 and submission on the 27th March 2025.
			RJAH 1.2.14	25/26 Triangulation of finance, activity and workforce	Mark Salisbury / Nia Jones	Started	31/03/2025	Complete; Evidence received		Financial, workforce and operational plan triangulation completed. Files saved down as evidence along with feedback from NHSE.
			RJAH 1.2.15	25/26 draft cost pressures	Victoria Brownrigg	Started	30/10/2025	Complete; Evidence received		Draft plan slides for check & challenge included as evidence.
			RJAH 1.2.16	25/26 cost pressures prioritisation	Victoria Brownrigg	Started	30/11/2025	Complete; Evidence received		Draft plan slides for check & challenge included as evidence.
			RJAH 1.2.17	25/26 cost pressures internal confirm and challenge	Victoria Brownrigg	Started	31/12/2025	Complete; Evidence received		Draft plan slides for check & challenge included as evidence.
			RJAH 1.2.18	25/26 cost pressures system confirm and challenge	Victoria Brownrigg	Started	31/01/2025	Complete; Evidence received		Draft plan slides for check & challenge included as evidence.
			RJAH 1.2.19	25/26 organisational sign off draft plan submission	Mark Salisbury	Started	28/02/2025	Complete; Evidence received		Headline plan slides from finance committee saved down in folder
			RJAH 1.2.20	25/26 organisational sign off final plan submission	Mark Salisbury	Started	31/03/2025	Complete; Evidence received		Board approved final plan for submission
			RJAH 1.2.21	25/26 budget setting - pay / non pay completed	Victoria Brownrigg	Started	31/01/2025	Complete; Evidence received		Budget sign off completed confirms budget setting
			RJAH 1.2.22	25/26 budget sign off	Victoria Brownrigg	Started	31/03/2025	Complete; Evidence received		Budget sign off completed

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1.3	Capital plans for 24/25 and 25/26 signed off by RJAH aligned to system plans and NHS England	Angela Mulholland-Wells	RJAH 1.3.1	24/25 Capital Plan agreed June 24 System Finance Committee, agreed by all STW organisations and NHSE (Complete).	Mark Salisbury	Complete	Complete	Complete; Evidence received		RJAH final plan saved as evidence
			RJAH 1.3.2	24/25 Secure remedy for EPR overspend c£3.0m	Mark Salisbury	Started	31/03/2025	Complete; Evidence received		Additional PDC funding confirmed. MOU recieved confirming value.
			RJAH 1.3.3	Support system delivery of 24/25 CDEL - application of the Capital prioritisation framework in action in year. Performance monitoring through CPOG - Capital report Prioritisation Oversight Group, application of the Capital Prioritisation Framework as required. (Monthly).	Mark Salisbury	01/04/2024	31/03/2025	Complete; Evidence received		Plan delivered within CDEL envelope
			RJAH 1.3.4	Support System Capital Strategy & Capital Prioritisation Framework developed with system partners and approved at System Finance Committee June 2024. (Complete).	Mark Salisbury	Complete	Complete	Complete; Evidence received		Agreed as system partners
			RJAH 1.3.5	Draft System Infrastructure strategy developed and submitted to NHSE July 24 for review	Nick Huband	Complete	Complete	Complete; Evidence received		Several enagement meetings took place to inform document
			RJAH 1.3.6	Initial capital plan 25/26 populated in July 24	Mark Salisbury	Complete	Complete	Complete; Evidence received		Agreed as system partners
			RJAH 1.3.7	Capital prioritisation within available resource for 25/26 once funding limits following guidance is confirmed.	Mark Salisbury	01/11/2024	31/03/2025	Complete; Evidence received		Final capital programme agreed within the reduced system envelope and submitted in final FPR
			RJAH 1.3.8	Update the 25/26 Capital plan following the release of national capital guidance and sign-off by individual organisation and system governance and NHSE.	Mark Salisbury	01/11/2024	31/03/2025	Complete; Evidence received		Final capital programme agreed within the reduced system envelope and submitted in final FPR
			RJAH 1.3.9	Submission of agreed 25/26 capital plan into technical planning forms	Diana Owen	01/02/2025	31/03/2025	Complete; Evidence received		Final capital programme agreed within the reduced system envelope and submitted in final FPR
1.4	Independent review of 'grip & control' - identifying RJAH's gaps (I&I phase 1 work) resulting in a plan to address gaps Follow up re-assessment review of 'grip & control'	Angela Mulholland-Wells	RJAH 1.4.1	Phase 1 I&I - External review assessment of Individual	Mark Salisbury	Complete	Complete	Complete; Evidence received		Grip & control actions implemented. Full tracker shared regularly.
			RJAH 1.4.2	Delivery against Phase 1 I&I organisation specific intervention action plans (No PO No Pay, efficacy of vacancy and temporary staffing controls and de-risking cost efficiency schemes). Key outputs reported in finance report to finance committee monthly.	Mark Salisbury	15/08/2024	30/11/2024	Complete; Evidence received		Grip & control actions implemented. Full tracker shared regularly.
			RJAH 1.4.3	Delivery of Phase 2 I&I scope in relation to efficacy of controls (run-rate improvements) for Workforce, UEC and System PMO (high risk CIPs) - delivery of interventions post PWC Phase 2 completion by March 25.	Mark Salisbury	15/09/2024	31/03/2025	Complete; Evidence received		I&I work forms part of the delivery of the 24/25 financial plan, this is a significant mitigation to lost income throughout the year. A continuation of the expenditure controls is built into the 25/26 financial plan to support delivery of the break even control total.
			RJAH 1.4.5	External review of Individual organisation assessment against NHSE grip and control checklist & HFMA Financial Sustainability checklist and efficacy of controls.	Mark Salisbury	Complete	Complete	Complete; Evidence received		PWC action tracker saved down along with HFMA sustainability checklist.

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2.1	Workforce delivery plans for 24/25 and 25/26 aligned to overall system plans and signed off by Board	Denise Harnin	RJAH 2.1.1	Set up and deliver workshop with all planning stakeholders (People team, Workforce, Finance and Ops leads etc), across the Trust to identify the priority areas needed that support delivery of our OPERATIONAL workforce plan.	Nia Jones	started	30/11/2024	Complete; Evidence received	
			RJAH 2.1.2	Develop actions and milestones that support each priority area with time frame and actions owners.	Nia Jones	started	30/11/2024	Complete; Evidence received	
			RJAH 2.1.3	Finalise plan with fully supported narrative describing the impact and benefit of delivering the plan.	Nia jones	started	31/12/2024	Complete; Evidence received	
			RJAH 2.1.4	Capture risks to delivery of plan and any mitigations to reduce risk.	Nia Jones	started	31/12/2024	Complete; Evidence received	
			RJAH 2.1.5	Ensure actions and milestones is reported at workforce planning and assurance group and Agency reduction group. Plan agreed with system and feeds into system process.	Nia Jones	started	31/01/2025	Complete; Evidence received	
			RJAH 2.1.6	Identify baseline and outturn forecast for NUMERICAL WORKFORCE PLAN. Plan agreed with system and feeds into system process	Tina Powell	started	30/11/2024	Complete; Evidence received	
			RJAH 2.1.7	Review known changes, service changes needed, and business cases approved within 24/25. Outline any assumptions in terms of workforce metrics, turnover absence levels etc.	Tina Powell	started	31/12/2024	Complete; Evidence received	
			RJAH 2.1.8	Populate Workforce Planning Template . ongoing monitoring against plan (during 25/26) through governance and escalating actions if off plan	Tina Powell	started	31/01/2025	Complete; Evidence received	
			RJAH 2.1.9	Calculate the % Change by Staff Group	Tina Powell	started	31/01/2025	Complete; Evidence received	
			RJAH 2.1.11	Review Budget with Stakeholders/Budget holders	Tina Powell	started	28/02/2025	Complete; Evidence received	
			RJAH 2.1.12	Challenge / Sense Check Data (February 25)	Tina Powell	Feb-25	28/02/2025	Complete; Evidence received	
2.2	RJAH People and OD strategy aligned to system strategy	Denise Harnin	RJAH 2.2.1	Review system feedback and refresh RJAH Strategy	Tina Powell	started	31/03/2025	Complete; Evidence received	
			RJAH 2.2.2	Ensure alignment with the new 10-year NHS strategy	Tina Powell	started	31/03/2025	Complete; Evidence received	
			RJAH 2.2.3	Develop RJAH Engagement Strategy to support People and OD Strategy	Caroline Nokes Lawrence	started	31/03/2025	On Track	
			RJAH 2.2.4	Maintain NHS staff survey results in 24/25 and completion rate in 25/26. Through: Delivery / development of staff / leadership development programmes (and other initiatives), including staff feedback; Implementation of an Apprenticeships Policy; Early, mid and late career platform training modules Retire and return roles; Legacy mentoring; Embedding scope for growth principles in career conversations; and Itchy feet conversations	Caroline Nokes Lawrence	started	31/03/2025	Complete; Evidence received	
			RJAH 2.2.5	Translate NHS Staff Survey results to inform RJAH Strategy	Caroline Nokes Lawrence	when results available	31/03/2025	Complete; Evidence received	Results going to People Committee March 25
			RJAH 2.2.6	Board approved People & OD Strategy including recruitment and retention	Andrea Martin	when results available	31/03/2025	Complete; Evidence received	Plan approved through People Committee
			RJAH 2.2.7	Monthly IPR reports, focusing on workforce actual vs plan for absence and retention	Tina Powell / Andrea Martin	when results available	31/03/2025	Complete; Evidence received	Ongoing, provided monthly

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			RJAH 2.2.8	Outcome of National staff survey results.	Caroline Nokes Lawrence	when results available	31/03/2025	Complete; Evidence received	
			RJAH 2.2.9	Benchmark delivery of strategy vs peers	Nia Jones	when results available	31/03/2025	On Track	
			RJAH 2.2.10	Take through RJAH People Committee.	Denise Harnin	when results available	31/03/2025	Complete; Evidence received	
			RJAH 2.2.11	Take through System People and OD Collaborative for assurance	Denise Harnin	when results available	31/03/2026	On Track	

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3.1.5	Working with system partners to deliver the System Discharge Alliance Plan to reduce No Criteria to Reside, and thus reduce escalation inpatient acute capacity (linking to reduced bed occupancy)	Mike Carr	RJAH 3.1.5.1	Continue to provide access to Sath Consultants at RJAH (to support the delivery of Orthopaedic inpatient activity at RJAH on behalf of all providers).	Mike Carr	01/01/2024	Ongoing	On Track		IS UNDERWAY AND ONGOING.
			RJAH 3.1.5.2	Work collaboratively with the system discharge hub to expedite discharge delays (to reduce NCTR levels on Sheldon Ward to a maximum of 3 patients).	Mike Carr	01/01/2024	01/12/2024	Complete; Evidence received		ONGOING. A SPIKE IN NUMBERS IN JAN / DEC AS OPENED AN ADDITIONAL CARE OF ELDERLY WARD. The position has subsequently improved.
			RJAH 3.1.5.3	Work collaboratively with the system discharge hub to expedite discharge delays (to reduce LoS on Sheldon Ward to 21 days initially, then scope a further reduction phase 2.)	Mike Carr	01/01/2024	Phase 1 by 01/12/24	On Track		AS ABOVE. WORK IN PROGRESS FOR FUTURE FOR PHASE 2. LoS position continues to improve.
3.1.3	Work with system partners to deliver alternatives to ED attendances/ admissions and Care Coordination system plan	Mike Carr	RJAH 3.1.3.1	Reduction in MSK ED attendances, Metrics to be developed and target established by 01.12.24	Richard Fallows	Ongoing	01/12/24 to establish baseline target	Off Track	See 3.1.3.4 Note: **Q2, 2025/6.**	Note: off-track for original date. Using pre SATH new EPR data a simple baseline was described for Spinal related pain and ED for 5 years. There are DQ issues. Closed 11/09/24. Our focus was between the spinal pain burden in ED and CES detection. New data to start after GIRFT cMSK Recovery and launch of CES pathway - see 3.1.3.4 below. **Targets to be set pending above being implemented. As of April 25 awaiting launch of CES pathway with 24/7 MRI. STW wide end-end spinal pathway meeting 9/5/25**
			RJAH 3.1.3.2	Sheldon Ward engagement with the Care Transfer Hub	Mike Carr	Ongoing	N/A			
			RJAH 3.1.3.3	Utilise available inpatient capacity where possible (Holiday Period, Weekends)	Mike Carr		In place, with winter ward due to commence 23/12/24	Complete; Evidence received		
			RJAH 3.1.3.4	Rollout of GCA and CES pathways.	Mike Carr	01/04/2024	Nov 24 for GCA and CES	Off Track	See Note: **Q2, 2025/6.**	Note: off-track for original date. GCA Phase 1 ready to launch awaiting ICB approval. CES Phase 1 core pathway awaiting SaTH recruitment/Management of Change to staff 24/7 MRI. Was originally meant to go live in July 2024. Unknown launch date. Dependent on SaTH so cannot confirm, but an estimated launch date of Q2 2025/6. April 25 GCA Phase 1 signed off by ICB, preparing for immient launch. **GCA Phase 1 & 2 Launch set for 4th July 2025. On target.**
			RJAH 3.1.3.5	Develop waiting list prioritisation tool to prioritise patients at high risk of non-elective admission	Mike Carr	01/01/2025	01/04/2025	On Track		The tool has been designed and agreed. Data is required from the ICB before it can be implemented.
			RJAH 3.1.3.6	Enact a robust system escalation framework underpinned by dynamic risk assessment.	Mike Carr		As per system action			
			RJAH 3.1.3.7	Monitor internal metrics via the Trust IPR	Mike Carr	Ongoing	N/A			
			RJAH 3.1.3.8	System level evaluation of MSK programmes of work.	Mike Carr	Ongoing	Dec 25 update on MSST effectiveness Audit	Complete; Evidence received		Clinical Effectiveness Review undertaken and audit reported to MSK Board.
3.2	Effective, regular attendance from RJAH at UEC Delivery Group	Mike Carr	RJAH 3.2.1	Attendance at UEC Delivery Group (Mike Carr, COO)	Mike Carr	started	N/A	On Track		MC continued attendance at UEC Board, UEC Ops Group as well as regular engagement in other system meetings (including with the local authority).

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4.1	Individual RJAH governance structure (Level 2) for Finance, UEC and Workforce re-designed, implemented and functioning (balancing finance, quality & safety, performance and workforce)	Stacey Keegan	RJAH 4.1.1	Review current RJAH structure at Level 2 for UEC, Finance and workforce + interface with system governance structures	All leads	started	31/12/2024	Complete; Evidence received		SIIP action plan aligned to relevant Board committees (which received the plan during the December round of meetings).
			RJAH 4.1.2	Committee agendas – including Finance & Performance Ctte - to be reviewed to ensure continued / increased focus on key areas	All leads	started	31/12/2024	Complete; Evidence received		Activity recovery committee established.
			RJAH 4.1.3	Proposals for change made to RJAH Board taking into account development of provider collaborative(s).	Stacey Keegan	started	31/03/2025	On Track		No change to structures required - actions aligned and Activity Recovery Committee created.
			RJAH 4.1.4	Integrated Performance Reports (IPRs) to be reviewed to ensure continued focus on key performance measures for 2024/5.	Mike Carr	31/12/2024	31/03/2025	On Track		
			RJAH 4.1.5	Regular reporting in place to provide assurance to the Board, in line with the agreed arrangements.	Stacey Keegan / Dylan Murphy	01/04/2025	31/03/2026	On Track		Committees receiving reports (and have an escalation route through chairs' assurance reports).
4.2	RJAH elements of the system performance & accountability framework - developed and implemented	Stacey Keegan	RJAH 4.2.1	Agreement of SIIP approval and ongoing assurance arrangements within RJAH.	Stacey Keegan / Dylan Murphy	completed	06/11/2024	Complete; Evidence received		
			RJAH 4.2.2	RJAH elements of system performance & accountability framework documented and signed off by RJAH board	Stacey Keegan / Dylan Murphy	started	01/04/2025	Complete; Evidence received		A draft framework has been developed by the ICB and shared with providers for comment. The updated draft has been considered by system Chief Executives. The Framework was considered by the RJAH Board **on 2 April 2025.**
			RJAH 4.2.3	Development of governance arrangements to deliver MSK / elective orthopaedics on a system level, via a provider collaborative arrangement	Mike Carr	started	01/04/2025	Complete; Evidence received		ICB commissioning intentions include RJAH as the lead provider. The Board has agreed the scope of works to be undertaken to establish a formal collaborative. A draft governance structure, TOR etc have been developed and were considered by the System Transformation and Digital Committee in March 2025. The newly created MSK Operational Performance and Governance Group met on 14 April 2025. The Provider Collaborative Board is to meet, in shadow form, on 16 April 2025 .
			RJAH 4.2.4	Board to consider and approve TOR / MOU / appropriate delegations to enable the creation and operation of provider collaborative arrangements	Stacey Keegan / Dylan Murphy	started	01/04/2025	On Track	Shadow arrangements from April 2025, moving towards formal arrangements by April 2026.	Scope of the collaborative and the next steps in creation of a formal collaborative (via shadow arrangements from April 2025 onwards) agreed.
			RJAH 4.2.5	Regular reporting in place to provide assurance to the Board, in line with the agreed arrangements.	Stacey Keegan / Dylan Murphy	01/04/2025	31/03/2026	On Track		
4.3	An agreed RJAH and all STW provider wide risk management approach (including consistent policies and risk assessment tools) that is then adopted as the system and ICB approach that is implemented and functioning.	Stacey Keegan	RJAH 4.3.1	Engage with programme / governance leads to develop consistent risk management policies - to include risk scoring, risk reporting/escalation, risk management procedures.	Dylan Murphy	started	01/04/2025	On Track		A series of meetings have been held with governance leads to review existing arrangements and develop proposals for a consistent approach. Finance-specific risk rating scheme agreed and in operation.
			RJAH 4.3.2	Approve the system-agreed risk management policies - to include risk scoring, risk reporting/escalation, risk management procedures - via RJAH governance structure.	Dylan Murphy	started	01/04/2025	At Risk	Rated "amber" as certain, key elements already in place.	Principles broadly agreed. Proposals to be confirmed by ICB-lead and considered collectively by chief execs before formal adoption / implementation. **Finance-specific risk approach agreed and in operation.**
			RJAH 4.3.3	Engage with programme / governance leads to co-ordinate the implementation of agreed, system-wide arrangements.	Dylan Murphy	started	01/04/2025	At Risk	Rated "amber" as certain, key elements already in place.	Dependent on actions above. Broad approach to risk management is already consistent however. **Finance-related risk approach agreed and in operation.**
			RJAH 4.3.4	Implement the approved, system-wide risk management policies - to include risk scoring, risk reporting/escalation, risk management procedures.	Dylan Murphy	01/04/2025	01/04/2025	At Risk	Rated "amber" as certain, key elements already in place.	Dependent on actions above. Broad approach to risk management is already consistent however. **Finance-related risk approach agreed and in operation.**
			RJAH 4.3.5	Maintaining the regular review of risk management via the Board and committee structure and undertake an annual review of the wider process at the Audit and Risk Committee.	Dylan Murphy	01/04/2025	31/03/2026	On Track		
4.4	RJAH elements of the System PMO designed, implemented and functioning	Stacey Keegan	RJAH 4.4.1	Engage with programme / governance leads to develop and implement proposals	Craig Macbeth	01/10/2024	01/04/2025	Complete; Evidence received		System PMO established
			RJAH 4.4.2	RJAH elements of system PMO structure & approach documented and signed off by RJAH board and ICB	Craig Macbeth	01/10/2024	01/04/2025	Complete; Evidence received		Agreed by Board-level executive lead
			RJAH 4.4.3	Continue to drive the delivery of a system PMO with all partners	Craig Macbeth	01/10/2024	01/04/2025	Complete; Evidence received		Arrangements in operation.

Metric ID	Deliverable(s) *The outputs that you need to produce to demonstrate delivery of exit criteria*	Deliverable Owner	Task ID	Task(s) *The tasks you need to complete to produce the deliverables* (please add / remove lines as necessary)	Task Owner	Start Date	End Date	RAG	Revised Deadline Date Re	Notes
5.1	Individual RJAH elements of the functioning Provider Collaborative (aligned to the priorities within the Strategic Commissioning Plan approved by IC Board) where open and honest conversations are brokered.	Stacey Keegan	RJAH 5.1.1	Continue to lead workforce programme as SRO	Stacey Keegan	started	N/A	Complete; Evidence received		
			RJAH 5.1.2	Continue to lead planned care programme as SRO	Stacey Keegan	started	N/A	Complete; Evidence received		
			RJAH 5.1.3	Continue to lead MSK Transformation Group (working towards MSK collaborative arrangements)	Stacey Keegan / Mike Carr	started	N/A	Complete; Evidence received		
			RJAH 5.1.4	Act as 'waiting well' lead under the health inequalities workstream which will have links to UEC / exit criteria	Mike Carr	started	N/A	On Track		
			RJAH 5.1.5	As with the Governance deliverable: Agree and approve the scope of the provider collaborative and the necessary arrangements (including delegations) via RJAH governance arrangements, i.e. Audit and Risk Committee and Board of Directors	Stacey Keegan / Mike Carr	started	01/04/2025	Complete; Evidence received		See Goverance task 4.2.3. Proposals agreed at Board meeting on 2 April, shadow Provider Collaborative Board met on 16 April.
			RJAH 5.1.6	Ensure individual RJAH contribution to delivery of Options appraisal (governance and scope) for Shared services as part of wider Provider Collaborative	Mike Carr	started	01/04/2025	On Track		A representative has been identified and the Trust continues to engage in the discussion. The formal group meeting has yet to be arranged but the Trust is ready to engage as and when that happens.
			RJAH 5.1.7	Consider the findings of any external assessments and monitor progress of any associated actions, in line with 5.3.2 and 5.3.3	Stacey Keegan / Dylan Murphy	as and when undertaken	TBC, in accordance with review timetable and subsequent action plan			
5.3	Demonstrate collaborative decision-making through the co-development and co-delivery of an System Integrated Improvement Plan that supports delivery of all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system.	Stacey Keegan	RJAH 5.3.1	Contribution to system improvement process through developing and delivering an RJAH action plan.	all deliverable owners	started	31/03/2026	On Track		
			RJAH 5.3.2	Initial external assessment of collaborative decision-making monitored through the Board and relevant sub-committees (as appropriate, dependent on findings).	Stacey Keegan / Dylan Murphy	as and when undertaken	TBC, in accordance with action plan			
			RJAH 5.3.3	Action plan following initial and any follow-up assessments to be monitored via the Board and relevant sub-committees (as appropriate, dependent on findings).	Stacey Keegan / Dylan Murphy	as and when undertaken	TBC, in accordance with action plan			
			RJAH 5.3.4	Board sign-off of RJAH elements of the SIIP and ongoing assurance arrangements on delivery	Stacey Keegan / Dylan Murphy	completed	06/11/2024	Complete; Evidence received		
			RJAH 5.3.5	Board committees / Board monitoring of SIIP extracts relevant to the Board / Committee remit, i.e.: F&P for finance and UEC; P&C for workforce and elements of Leadership; Audit and Risk for Governance; The Board for aspects of Leadership and overall progress.	Stacey Keegan / Dylan Murphy	started	31/03/2026	Complete; Evidence received		
5.4	RJAH's contribution to a clear system culture and leadership improvement programme and evidence of a positive shift in staff experience through pulse survey/NHS staff survey.	Stacey Keegan	RJAH 5.4.1	Proactively participate in and contribute to System CEO OD Programme	Stacey Keegan	01/11/2024	31/03/2026	On Track		
			RJAH 5.4.2	Ensure Executive participation in the Executive Directors Development programme	Stacey Keegan	29/01/2025	31/03/2026	On Track		
			RJAH 5.4.3	Developed an action plan with key outcomes from the 2023 survey – shared with staff	Caroline Nokes Lawrence	started	completed	Complete; Evidence received		
			RJAH 5.4.4	A Staff Survey Task and Finish Group established, made up of people from across the Trust and will meet every four to six weeks to take actions forward.	Caroline Nokes Lawrence	started	completed - resuming in March 2025 for 2024 results	Complete; Evidence received		
			RJAH 5.4.5	Set up 'it's ok to ask' sessions for staff to drop in – myth busting	Caroline Nokes Lawrence	started	completed	Complete; Evidence received		
			RJAH 5.4.6	Included Bank staff for 2024 survey	Caroline Nokes Lawrence	started	review in March 2025	Complete; Evidence received		
			RJAH 5.4.7	Shared the 'you said, we did' actions	Caroline Nokes Lawrence	started	completed	Complete; Evidence received		
			RJAH 5.4.8	Linked actions to WRES/WDES action plans	Caroline Nokes Lawrence	started	completed and new plans for 2024 ongoing	On Track		

Memorandum of Understanding with ROH

Committee / Group / Meeting, Date

Board of Directors, 2 July 2025

Author: **Contributors:**

Name: Dylan Murphy
Role/Title: Trust Secretary

Report sign-off:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Is the report suitable for publication?:

YES

Key issues and considerations:

A memorandum of understanding (MOU) has been developed between The Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust (RJAH) and the Royal Orthopaedic Hospital NHS Foundation Trust (ROH), Birmingham to:

- establish an **alliance** that;
- provides a framework to **collaborate** and identify shared objectives, which can then;
- be delivered via particular **projects.**

The MOU sets out:

- the benefits to be realised through collaboration;
- the objectives of the Alliance;
- the principles of collaboration;
- the model of collaboration; and
- the governance structures the parties will put in place.

The MOU promotes the exploration of opportunities for collaboration / joint working via a 'Provider Leadership Board' model where:
"Chief executives or other directors from participating trusts come together, with common delegated responsibilities from their respective boards (in line with their schemes of delegation), such that they can tackle areas of common concern and deliver a shared agenda on behalf of the collaborative and its system partners."

There is no intention to create an extensive structure to support the Alliance, but the MOU refers to three tiers of executive-led Governance:

- The Alliance **Strategic Forum** – where Chief Execs / selected others provide strategic oversight / direction;
- The Alliance **Management Group** – where the wider executive group, plus selected others, oversee delivery of agreed programmes / projects; and
- The Alliance **Workstreams** – where relevant executives / others lead delivery of agreed programmes / projects.

The Strategic Forum would report into the RJAH and ROH Boards to provide assurance (via whichever route is deemed appropriate by the respective Boards).

Members of the Forum, Management Group and Workstreams will operate in line with their authority as defined in their respective organisation's scheme of delegation. They will work to deliver the objectives of their respective Trusts, as agreed by the respective Boards, via the Alliance (where that is the appropriate forum to support delivery).

Strategic objectives and associated risks:

The following strategic objectives are relevant to the content of this report:

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	✓
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:

System Objectives		
1	Improve outcomes in population health and healthcare	✓
2	Tackle inequalities in outcomes, experience and access	✓
3	Support broader social and economic development	✓
4	Enhance productivity and value for money	✓

Recommendations:

That the Board:

1. CONSIDER and APPROVE the content of the MOU to establish a "strategic alliance" with ROH; and
2. NOTE the next steps in supporting the operation of the "alliance".

Report development and engagement history:

BAF Strategic theme 6 is "**Responding to opportunities and challenges in the wider health and care system**". The associated strategic risk is:

IF… the Trust does not strengthen its joint-working arrangements with partners, or governance processes / funding regimes place constraints on the Trust's ability to implement arrangements

THEN…it will not maximise opportunities to address health inequalities; improve outcomes / services for patients; support national and system priorities; enhance staff experience; or deliver efficiencies

RESULTING IN…lost opportunities to contribute to the delivery of national and local objectives; potential loss of accreditation status; and potential failure to achieve NHS oversight framework targets.

One of the control measures is the development of "*strategic alliances with specialist orthopaedic providers*." In particular, an additional action was identified around "*Further collaboration with Royal Orthopaedic Hospital*".

The draft MOU has been developed to deliver those actions and has been considered by:

- The governance leads at the respective Trusts;
- The Chief Executives of the respective Trusts; and
- The executive team at RJAH.
- The RJAH Board of Directors, in private session in May 2025.
- The ROH Board, in June 2025.

Next steps:

1. Pending approval, the MOU and supporting confidentiality agreement will be formally agreed with ROH and will be signed by both parties.
2. The necessary support arrangements will be put in place to support the Alliance, as outlined in the MOU. That will include an initial Board-to-Board meeting.
3. There will be engagement with the Royal National Orthopaedic Hospital NHS Trust (RNOH), Stanmore, to explore opportunities to widen the alliance.

Attachment A Draft Memorandum of Understanding

DATED ---1 JUNE 2025 V9B---------

MEMORANDUM OF UNDERSTANDING

THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

and

THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

THIS MEMORANDUM OF UNDERSTANDING IS MADE BETWEEN:

(1) **THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST** of The Woodlands, Bristol Road South, Birmingham, B31 2AP ("**ROH**"),

and

(2) **THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST** of Twmpath Lane, Gobowen, Oswestry SY10 7AG ("**RJAH**"),

each a "Party" and, together, the "Parties".

1 Background

1.1 There are three specialist orthopaedic hospitals in England: The Royal Orthopaedic Hospital NHS Foundation Trust (ROH), Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) and the Royal National Orthopaedic Hospital NHS Trust (RNOH).

1.2 ROH, RJAH and RNOH are all members of the National Orthopaedic Association (NOA). The NOA is a membership organisation that brings together orthopaedic providers across the country to put orthopaedics at the top of the agenda. The alliance is multidisciplinary and historically has led on collaboration across all orthopaedic services by providing opportunities for members to share experiences and address shared challenges with an aim of delivering consistent, high quality care for patients nationwide. The NOA also provides a voice for member organisations who feel that alone they can't influence change.

The NOA is currently undertaking a review of its purpose and from 2025 is to predominantly focus on policy and influence, with a lesser focus on collaboration of providers.

1.3 Whilst ROH and RJAH will continue to be members of the NOA, and continue to collaborate with RNOH, it is believed that there are a number of benefits for a more formal relationship between ROH and RJAH, particularly due to the geographical location of the two Trusts. *See note at point 1.5*

The Royal Orthopaedic Hospital NHS Foundation Trust and The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust have therefore agreed to work together to develop and implement a formal Strategic Alliance between the two Trusts.

1.4 The Parties wish to record the basis on which they will collaborate with each other as an Alliance. This Memorandum of Understanding (MoU) sets out:

- the key benefits of the Alliance
- the key objectives of the Alliance
- the principles of collaboration
- the model of collaboration
- the governance structures the Parties will put in place.

1.5 There is an intention, as part of the periodic review of the effectiveness of this collaborative agreement with RJAH, that consideration will be given to the involvement and participation of RNOH as and when appropriate.

2 Key benefits

2.1 The benefits of collaboration expected to be realised from the Alliance are described below.

Subject to 4.1 below, the Alliance will:

a) Support the resilience and long-term delivery of specialist Orthopaedic and MSK services at a local, regional and national level.

b) Support long-term clinical and financial sustainability of both organisations.

c) Drive efficiencies and economies of scale from closer working between the two Trusts.

d) Provide opportunities for improved operational performance through collaboration.

e) Ensure capacity is utilised in the most effective and productive way, including formalising mutual aid.

f) Improve recruitment, retention and development of staff through effective joint workforce planning and staff wellbeing initiatives.

g) Improve population health for MSK and Orthopaedics for the populations of Birmingham, Solihull, Shropshire, Telford and Wrekin through collaboration on the reduction of health inequalities and contribution to the prevention agenda.

h) Enable innovation at greater pace through joint working.

i) As specialist elective hospitals, drive accelerated implementation of Elective Reform Plan through collaboration.

j) Drive quality improvement by peer review, sharing best practice, performance against quality metrics and benchmarking.

k) Provide a mechanism to align the contribution of ROH and RJAH to the aims of their respective ICB's/ICS's and provider collaboratives. This includes implementation of relevant priorities with respective Joint Forward Plans and system-wide strategies to achieve the three priorities of Hospital to Community; Analogue to Digital and Treatment to Prevention

l) Support the development of joint strategy for specialist orthopaedics and MSK services for the populations served.

m) Align improvement and transformation programmes where appropriate, bringing together shared learning, teaching, and joint working on common improvement.

n) Exploit the benefit of scale to enhance commercial opportunities within and external to the NHS.

o) Enhance research opportunities through joint bids, joint recruitment to trials, and stronger links across HEI in the wider Midlands.

p) Explore the potential for shared learning, cost efficiencies and benefit of scale with regard to the management and growth of respective charities.

3 Key objectives for the Alliance

3.1 Subject to 4.1 below, the Parties shall explore options to deliver a number of key objectives. These may include, but will not be limited to, the following:

a) Undertake a review of fragile/challenged services to identify if opportunities exist for shared clinical models to improve service resilience;

b) Undertake a review of common standards and pathways across orthopaedics and MSK such that areas of best practice and consistency are identified;

c) Undertake a review of the clinical and non-clinical operating model of each organisation, identifying areas of best practice and potential efficiency.

d) Undertake a review of capacity and productivity, to understand where there may be benefits from sharing resource and creating resilience;

e) Undertake a financial review of each organisation to understand key pressures and drivers to the financial health of the trusts, including benchmarking of income, spend and efficiencies with recommendations to be made to each trust.

f) Explore opportunities between trusts for shared functions and/or shared posts to create consistency and efficiency;

g) Explore commercial opportunities at local, regional, national and international level, including joint bidding opportunities that may offer a greater impact than the organisations acting in isolation;

h) Undertake a review of the Charitable position of each organisation to understand opportunities to share expertise, share cost, develop joint bids as required and celebrate success;

i) Explore opportunities to learn from, and expand, the offering for veterans;

j) Explore opportunities and develop mechanisms for mutual aid to support short-term pressures.

k) Explore opportunities to improve primary care engagement, and the profile of both NHS and private Orthopaedic and MSK services across the two organisations

l) Develop an R&D & Innovation framework between the two organisations and key partners to create a keen focus on horizon scanning, technology and future-looking systems, including AI developments; This will be for clinical and non-clinical functions.

m) Develop a benchmarking framework, i.e. ‘what good looks like’ in Orthopaedic care and MSK nationally and internationally, such that variation in service provision is identified and addressed in each organisation;

n) Undertake a programme of shared learning and best practice reviews, e.g. Clinical coding, LLPs, PSIRF, FTSU, Incidents, Policies, CQC readiness.

o) Develop a joint quality improvement framework, including peer review/support to improve the organisations’ clinical outcomes, quality metrics and embrace continuous improvement, aligned to NHS Impact

p) Agree joint messaging in relation to strategy and policy contributions to National Orthopaedic Association and Federation of Specialist Hospitals

q) Explore joint Digital opportunities to enhance patient care and deliver operational efficiencies in the short and longer term;

r) Undertake a review of financially challenged/'loss-making' services, exploring opportunities for greater alignment and resilience.

s) Consider scenarios and options available for both trusts in a model of greater provider collaboration.

t) Explore how each organisation can accelerate delivery of the Elective Reform Plan

u) Explore the benefits of joint workforce planning and development.

4 Principles of collaboration

4.1 Prior to the realisation of benefits in 2.1 above, the exploration of objectives in 3.1 above or any form of collaboration as set out in this section 4.1, the Parties agree to enter into a separate and legally binding confidentiality or non-disclosure agreement for the mutual disclosure of confidential information ('NDA') in the form attached at Schedule 1. The Parties further agree to adopt the following principles for the Alliance:

- collaborate and co-operate. Establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required;
- be accountable. Take on, manage and account to each other for performance of respective roles and responsibilities;
- be open and transparent. Communicate openly about major concerns, issues or opportunities relating to the Alliance;
- learn, develop and seek to achieve full potential. Share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;
- adopt a positive outlook. Behave in a positive, proactive manner;
- adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, data protection and freedom of information legislation;
- act in a timely manner. Recognise the time-critical nature of the elements of the programme and respond accordingly to requests for support;
- manage stakeholders effectively;
- deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and
- act in good faith to support achievement of the Key Objectives and compliance with these Principles.

5 Model of collaboration

5.1 ROH and RJAH shall collaborate under the 'Provider Leadership Board' model as described in the NHSE Provider Collaborative 2021 guidance:

- *Chief executives or other directors from participating trusts come together, with common delegated responsibilities from their respective boards (in line with their schemes of delegation), such that they can tackle areas of common concern and deliver a shared agenda on behalf of the collaborative and its system partners.*

- *This model can make use of an arrangement whereby a subset of the Board of each organisation can meet at the same time in the same place and can take aligned decisions. To ensure effective oversight of the provider leadership board, trusts should consider how to involve their non-executive directors in providing scrutiny and challenge.*

5.2 Therefore, each Board will retain its unitary status and organisations will retain their organisational sovereignty but will collaborate under the terms of the Alliance within this MOU.

5.3 There will be no change to the legal relationship of either Trust with DHSC/NHSE and their respective ICBs.

5.4 Trusts will continue to operate in line with their NHS Provider licence and the Code of Governance for the NHS.

6 Alliance Governance

6.1 Principles

The following guiding principles are agreed.

The Alliance's governance will:

- provide strategic oversight and direction;
- be based on clearly defined roles and responsibilities at organisation, function and, where necessary, individual level;
- align decision-making authority with the criticality of the decisions required;
- be aligned with the scope this MoU and appropriate for each stage (and may therefore require changes over time);
- leverage existing organisational, functional and user interfaces;
- provide coherent, timely and efficient decision-making; and
- correspond with the key features of the governance arrangements set out in this MoU.

6.2 Governance

There will be three tiers of governance:

i) **Alliance Strategic Forum**

Overall strategic oversight and direction to the Alliance shall be provided through the forum of the Alliance Strategic Forum (ASF). This will incorporate

Chief Executive Officers and other Executive Directors, as identified by the Chief Executive Officers.

ii) **Alliance Management Group**

The Alliance Management Group (AMG) provides strategic management of the Alliance at programme and workstream level. It will provide assurance to ASF that the Key Objectives are being met, and that the Alliance is performing within the boundaries set by ASF.

This group will initially consist of the Executive Teams (or equivalents) from the ROH and RJAH.

Additional members of the Alliance Management Board will be agreed at the ASF.

The Group shall be managed in accordance with the terms of reference set out in Schedule 2: to this MoU.

iii) **Alliance Workstream Forums**

Forums will be established as required.

Additionally, full Board to Board meetings will be held at least once per year

6.3 Alliance Support and Reporting

Support for the Alliance in the form of secretariat and PMO will come from the existing Trust establishment.

The Boards of ROH and RJAH will receive regular reports on the progress of the Alliance.

6.4 Conflicts

The Parties shall comply with the provisions of their respective policies for Managing Conflicts of Interest and NHSE guidance for the same.

6.5 Escalation

If either Party has any issues, concerns or complaints about the Alliance, or any matter in this MoU, that Party shall notify the other Party and the Parties shall then seek to resolve the issue by a process of discussion/consultation lead by the relevant Executives of the respective organisations. Failure to resolve any concerns through this route will require escalation to the Chief Executives of the two organisations.

6.6 Intellectual property

The Parties intend that, notwithstanding any secondment, any intellectual property rights created in the course of the Alliance shall vest in the Party whose employee created them (or in the case of any intellectual property rights created jointly by employees of both Parties, jointly in equal proportions).

Where any intellectual property right vests in either Party, that Party shall grant an irrevocable licence to the other Party to use that intellectual property for the purposes of the Alliance subject to consultation and agreement with third parties.

Nothing in this MoU shall give any Party any express or implied rights or licence to the other Party's Intellectual Property.

6.7 Announcements

Where appropriate, the parties should agree joint communications.

6.8 Term and termination

This MoU shall commence on the date of signature by both Parties and shall expire in three years.

The MoU will be reviewed annually, with a view to be agreed by 31 March each year.

Either Party may terminate this MoU by giving at least three months' notice in writing to the other Party at any time.

Any costs incurred by the parties as a result of termination shall be shared pro-rata.

For the avoidance of doubt, termination of the MoU shall not terminate the NDA which shall terminate according to its own terms.

6.9 Variation

This MoU, including the Schedule, may only be varied by written agreement of the Parties.

6.10 Charges and liabilities

Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU unless where they have jointly agreed to fund aspects of the Alliance.

The Parties agree to share the costs and expenses arising in respect of the Alliance between them on a pro rata basis (if additional and agreed at the Alliance Management Group).

Both Parties shall remain liable for any losses or liabilities incurred due to their own or their employee's actions and neither Party intends that the other Party shall be liable for any loss it suffers as a result of this MoU.

It is expressly acknowledged by the Parties that each Party is, and shall remain, solely and exclusively accountable and responsible for all aspects of its performance.

6.11 Notices

Any notice, claim or demand in connection with this MoU shall be given in writing to the relevant Party at the address stated below (or any such other address as it shall previously have notified to the other Party). Any notice sent by first class post within the United Kingdom shall be deemed received 48 hours after posting. The relevant addressee, address and email address of each Party for the purposes of this MoU is:

The Royal Orthopaedic Hospital NHS Foundation Trust

Address:	Bristol Road South, Birmingham, B31 2AP, United Kingdom
For the attention of:	Director of Governance
Tel No:	0121 685 4353
E-mail Address:	s.grainger-lloyd@nhs.net

Robert Jones and Agnes Hunt Orthopaedic Hospital Foundation Trust

Address:	Twympath Lane, Oswestry, Shropshire, SY10 7AG, United Kingdom
For the attention of:	Trust Secretary
Tel No:	01691 404000
E-mail Address:	dylan.murphy1@nhs.net

6.12 Status

Although this MoU is not legally binding it is intended to set out general principles the Parties will look to uphold in collaborating through this partnership. Notwithstanding the foregoing, the NDA attached at Schedule 1 is intended to be legally binding and shall be entered into by the Parties prior to the execution of this MoU.

Nothing in this MoU is intended to, or shall be deemed to, establish any partnership, joint venture or merged entity between the Parties, constitute either Party as the agent of the other Party, nor authorise either of the Parties to make or enter into any commitments for or on behalf of the other Party.

Signed by **MATTHEW HARTLAND** .....

for and on behalf of The Royal Orthopaedic Hospital NHS Foundation Trust **CHIEF EXECUTIVE** **DATE**

Signed by **STACEY-LEA KEEGAN** .....

for and on behalf of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust **CHIEF EXECUTIVE** **DATE**

Schedule 1: Mutual Confidentiality Agreement ("Agreement")

This Agreement is dated [INSERT DATE OF LAST SIGNATURE]

(1) THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST of The Woodlands, Bristol Road South, Birmingham, B31 2AP ("ROH"); and

(2) THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATIOIN TRUST of Twmpath Lane, Gobowen, Oswestry SY10 7AG ("RJAH").

Individually, a 'Party', collectively, the 'Parties'.

BACKGROUND

(A) ROH and RJAH acknowledge that there are a number of benefits for a more formal relationship, particularly due to the geographical location of the two Trusts.

(B) The Parties wish to record the basis on which they will collaborate with each other as an Alliance in the form of a Memorandum of Understanding ('MoU') which shall be entered into following signature of this confidentiality agreement ('Agreement').

(C) As part of the MoU, commercial opportunities and joint innovation in the form of Projects will be explored including joint bidding opportunities and the possible creation of intellectual property. The Parties intend to enter discussions relating to the Projects which will involve the exchange of Confidential Information between them.

(D) The Parties have agreed to comply with the terms of this Agreement in connection with the disclosure and use of that Confidential Information.

1. The following definitions and rules of interpretation shall apply to this Agreement:

1.1. The following words shall have the following meanings unless the context otherwise requires:

"Project"	shall mean the project referred to in the MoU that the Parties have agreed to deliver as paart of their collaborative efforts as monitored and directed by the Alliance Management Group as described in the MoU ;
"Commercially Sensitive Information"	shall mean any and all trade secrets, confidential financial information and confidential commercial information, including without limitation, copyright material supplied under restrictive licence, business plans, product development details, methodologies, application solutions, software specifications, software code, software design and development details, names and sensitive information pertaining to Disclosing Party's customers and prospects and marketing information, information relating to the terms of actual or proposed sub-contract arrangements (including bids received under competitive tendering), future pricing, business

	strategy and costs data, as may be utilised, produced or recorded by either Party, the publication of which a corporate entity in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions, providing that this shall not apply where the exchange of such information is permitted in accordance with this Agreement;
"Confidential Information"	shall mean any information which has been or will be supplied or made available directly or indirectly by Disclosing Party to Receiving Party in connection with the Project, which is generally considered by Disclosing Party to be sensitive and/or , confidential, whether or not marked confidential, private or otherwise, including but not limited to Commercially Sensitive Information and sensitive information pertaining to Disclosing Party's service users and employees;
“Disclosing Party”	shall mean the Party disclosing Confidential Information;
“Receiving Party”	shall mean the Party receiving Confidential Information; and
“Related Persons”	shall mean, in respect of the relevant Party, that Party's directors, officers, employees, advisers, agents, consultants or contractors and includes persons who, at the time they or any Party performs an act under this Agreement, occupy any of these positions in relation to that Party.

1.2. Other capitalised words or terms in this Agreement shall have the meaning set out in the MoU which shall be entered into by the Parties following the signing of this Agreement.

1.3. Words in the singular shall include the plural, and vice versa.

1.4. A reference to a person shall include a reference to a firm, a body corporate, an unincorporated association or to a person's executors or administrators.

2. Neither Party shall use the other Party’s Confidential Information for any purpose other than in connection with the carrying out of obligations under the MoU and each Party undertakes that it shall not disclose to any person any Confidential Information (howsoever obtained) concerning or in connection with the Parties, or this Agreement, except as permitted by this Agreement.

3. In consideration of the mutual exchange of Confidential Information by the Parties, each Party in respect of Confidential Information for which it is the Receiving Party shall and shall procure that its Related Persons shall:

3.1. hold such Confidential Information in strictest confidence;

3.2. take all reasonable precautions in dealing with such Confidential Information so as to prevent any third party from having access to it;

3.3. use such Confidential Information solely in connection with the Project;

3.4. permit access to such Confidential Information only to those of its personnel or Related Persons who need to know in connection with the Project;

3.5. not take copies of such Confidential Information other than is strictly necessary pursuant to Clause 3.4.

4. To the extent Confidential Information to be shared between the Parties is not already in the public domain, the Parties have, in this Agreement, set out the principles relating to information sharing and both Parties shall comply with these provisions.

5. RJAH and ROH acknowledge their duties to comply with law in relation to the provision of the health services and in particular RJAH and ROH will comply with and cooperate in respect of obligations and requirements of the law relating to health and safety and data protection.

6. Each Party may only disclose the other Party's Confidential Information:

6.1. to its Related Persons who need to know such information for the purposes of carrying out any Party's obligations in relation to the MoU;

6.2. which is in the public domain (other than as a result, whether direct or indirect, of breach of this Agreement); and

6.3. as may be required by law, court order, or any governmental or regulatory authority.

7. Prior to the disclosure of any Confidential Information to any Related Person, a Receiving Party shall inform them of the confidential nature of the material and of the provisions of this Agreement and, if requested by the Disclosing Party, it shall obtain a written undertaking from each of them in favour of the Disclosing Party to abide by the duties of confidentiality established hereunder. Whether or not the Disclosing Party makes a request pursuant to this Clause 7, each Receiving Party shall procure that each such person will observe the same restrictions on the use of the Confidential Information as are contained herein.

8. Each Party agrees that when creating data that will, or is likely to be, shared with the other Party under this Agreement and prior to disclosing any data to the other Party, it will use reasonable endeavours to exclude or anonymise any data that constitutes personal data or sensitive personal data and to the extent that any data includes personal data or sensitive personal data, where there is no legitimate reason for such data to be shared.

9. Without prejudice to the generality of Clause 3, a Receiving Party shall exercise no less a degree of care in protecting the Confidential Information than it uses to protect its own information of like sensitivity and importance.

10. The obligations of confidentiality upon a Receiving Party shall not apply to any Confidential Information to the extent that the Receiving Party can show (and it shall be for that Receiving Party to show):

10.1. was in the lawful possession of that Receiving Party before such Confidential Information was disclosed by the Disclosing Party; or

10.2. has been independently developed by any servant, agent or employee of that Receiving Party without access to or use or knowledge of the Confidential Information disclosed by the Disclosing Party; or

10.3. is in or subsequently comes into the public domain other than by breach by a Receiving Party of its obligations hereunder or under any other confidentiality agreement between any of the Parties; or

10.4. is received by that Receiving Party without restriction on disclosure or use from a third party where such third party has a lawful right to make such disclosure; or

10.5. which that Receiving Party is required to disclose by law, court order or requirement of a recognised stock exchange provided that the Receiving Party shall notify the Disclosing Party of the requirement for disclosure and, prior to making any disclosure, the Receiving Party shall assist the Disclosing Party in taking reasonable steps to resist, avoid or minimise the disclosure; or

10.6. that the Parties have agreed in writing that the information is not confidential.

11. Competition Law Guidelines

11.1. The Parties acknowledge that the Parties shall take special care to comply with the terms of this Agreement regarding any sharing or disclosure of Commercially Sensitive Information to avoid any competition law concerns.

11.2. The Parties agree to comply with the guidelines set out in this clause.

11.3. No Party shall disclose to the other Party any information that constitutes Commercially Sensitive Information, except where either side agrees it is necessary in order for a Project to be progressed.

11.4. Each Party must continue to act, make bids and try to win new business in exactly the same way that it would have done in the absence of the MoU.

11.5. The Parties are separate competitors and they will continue to make decisions on such matters as bidding strategies and entry into new contracts independently of one another and negotiate separately with their respective actual and potential customers.

11.6. If circumstances arise where the Parties participate in the same competitive tendering process, the Parties agree that their representatives shall not be permitted to be, and measures shall be put in place to prevent any representative being, involved in any capacity in the same tender process on behalf of both Parties.

11.7. Both Parties must carry out their obligations and conduct all acts pursuant to this Agreement in a way that protects Commercially Sensitive Information.

11.8. Data must not be exchanged that would allow the Receiving Party to change its commercial position and measures shall be put in place to prevent the directors of each organisation's Executive Team transferring the Disclosing Party's Commercially Sensitive Information to the Receiving Party without express consent to do so.

12. FOIA

12.1. The Parties acknowledge that they are subject to legal duties under the Freedom of Information Act 2000 (the "FOIA") which may require them to disclose, on request, information relating to this Agreement and that they are also subject to the Code of Practice on Openness in the NHS (4 August 2003).

12.2. If any Party receives a Request for Information (as defined in FOIA) relating to Confidential Information disclosed to them by the Disclosing Party, then, prior to any disclosure of information to which an exemption to FOIA may apply (the "Potentially Exempt Information"), it will:

12.2.1. immediately notify the Disclosing Party of such Request for Information;

12.2.2. discuss the Request for Information with the Disclosing Party and the Parties shall consider together whether or not an exemption to FOIA applies and the public interest factors both for and against disclosure (if applicable depending upon the potential exemption) in accordance with FOIA to determine whether the public interest in maintaining the

exemption outweighs the public interest in disclosing such Potentially Exempt Information;

12.2.3. take into account any representations made by the Disclosing Party in relation to the Request for Information and any possible exemptions; and

12.2.4. consult with the Disclosing Party in relation to any proposed disclosure as to whether any further explanatory material or advice should also be disclosed with the information in question.

13. Any Confidential Information disclosed hereunder shall remain the property of the Disclosing Party. Disclosure of any Confidential Information to a Receiving Party or its Related Persons or Associated Companies does not imply or confer any licence or permission on that Receiving Party or its Related Persons to use the relevant information for any purpose other than in connection with the Projects.

14. Upon expiry or termination of this Agreement or at any time on the written request of the Disclosing Party, each or either of the (as the case may be) Receiving Party shall and shall procure that its Related Persons shall:

14.1. return to the Disclosing Party all such Confidential Information (including all copies held by the Receiving Party or its Related Persons);

14.2. destroy all copies of any analysis, compilation, studies, reports or other documents prepared by it for its use containing or reflecting or generated in whole or in part from any Confidential Information; and

14.3. expunge and destroy any Confidential Information from any computer, word processor or other device in its possession containing such information; and

14.4. if so requested, confirm in writing to the Disclosing Party that the provisions of this Clause have been complied with, provided that it may retain a copy of the Confidential Information for record purposes or is required to be retained by applicable law; such retained copy shall remain subject to the terms of this Agreement.

15. This Agreement shall be effective from the date hereof and shall expire at the conclusion by the Parties of a further agreement in respect of the Projects which incorporates confidentiality obligations substantially similar to those contained herein; or

16. Each Receiving Party acknowledges that neither the Disclosing Party nor any of their Related Persons is making any representation or warranty under this Agreement, either expressed or implied, as to the accuracy or completeness of the Confidential Information, and none of the Disclosing Party or any of their Related Persons will have any liability to either Receiving Party or any other person resulting from a Receiving Party's or its Related Persons' use of, or reliance placed upon the Confidential Information.

17. Each Party acknowledges and agrees that it will be responsible for any breach of the terms and conditions set out in this Agreement whether by it, its personnel or any of its Related Persons.

18. Each Party acknowledges and agrees that damages may not be an adequate remedy for any breach of this Agreement and that the Disclosing Party shall be entitled to seek the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this Agreement.

19. No failure by a Party in exercising any right, power or privilege hereunder shall constitute a waiver by such Party of any such right, power or privilege, nor shall any single or partial exercise thereof preclude any further exercise of any such right, power or privilege.

20. If any provision in this Agreement is illegal, prohibited or unenforceable in any jurisdiction such illegality, prohibition or unenforceability will not invalidate the remaining provisions or affect the legality, validity or enforceability of the provisions in relation to any other jurisdiction.

21. Except as provided in this clause 21, this Agreement is made for the benefit of the parties to it and their successors and permitted assigns and is not intended to benefit, or be enforceable by, anyone else.

22. This Agreement shall be binding upon the Parties and their successors. Without prejudice to Clause 21 above, no Party shall be entitled to assign any of its rights or obligations.

23. Nothing in this Agreement is intended to, or shall be deemed to constitute any party the agent of another party, or authorise any party to make or enter into any commitments for or on behalf of the other Party. Each Party confirms it is acting on its own behalf and not for the benefit of any other person.

24. No variation of this Agreement shall be effective unless it is in writing and signed by the Parties (or their authorised representatives).

25. Any notice given to a party under or in connection with this Agreement shall be in writing and shall be sent by email to the following addresses (or an address substituted in writing by the Party to be served):

    25.1. Party 1: [ADDRESS]

    25.2. Party 2: [ADDRESS]

    25.3. Any notice shall be deemed to have been received: if sent by email, at the time of transmission, or, if this time falls outside 9.30am to 5.30pm Monday to Friday ("Business Hours") in the place of receipt, when Business Hours resume.

    25.4. This Agreement and any dispute or claim (including non-contractual disputes or claims) arising out of or in connection with it or its subject matter or formation shall be governed by and construed in accordance with the law of England and Wales.

    25.5. Each party irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim (including non-contractual disputes or claims) arising out of or in connection withs this Agreement or its subject matter or formation.

This Agreement has been entered into on the date stated at the beginning of it..

Signed by **MATTHEW HARTLAND**	.....
for and on behalf of The Royal Orthopaedic Hospital NHS Foundation Trust	**CHIEF EXECUTIVE** **DATE**
Signed by **STACEY-LEA KEEGAN**	.....
for and on behalf of Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	**CHIEF EXECUTIVE** **DATE**

Schedule 2: Alliance Management Group terms of reference

1 CONSTITUTION

This Alliance Management Group will not replace the formal Governance meeting structure of the component trusts but serves to complement it. It is hereby established to enable The Royal Orthopaedic Hospital NHS FT and Robert Jones & Agnes Hunt NHS FT to work collaboratively, with a shared purpose, on matters where there is benefit in terms of finances, efficiency, quality and innovations.

2 AUTHORITY

The Alliance Management Group is authorised by the Boards of its component NHS organisations to take all necessary actions to fulfil the remit described within these terms of reference, including commissioning reports and creating groups to deliver specific pieces of work.

The Alliance Management Group shall be fully and equally accountable to both Trust Boards for the delivery and oversight of its work.

3 PURPOSE AND SCOPE

The Alliance Management Group is designed to provide a strategic oversight framework for monitoring and directing the delivery of the projects within the Provider Collaborative, set out in its agreed Memorandum of Understanding.

4 DUTIES

The Alliance Management Group will:

- Agree a prioritised list of areas on which to focus its collaborative efforts, with the intention of delivering the Benefits and Objectives of the Alliance set out in its Memorandum of Understanding;
- Decide on the infrastructure and resource required to deliver the work of the Alliance;
- Agree on the timescales for the delivery of the Alliance's priorities;
- Receive reports on the delivery of the projects being undertaken within the context of the Alliance;
- Provide upward assurance to the Alliance Strategic Forum on the robustness and pace of delivery of the Alliance's projects;
- Receive routine benefits analyses of each Alliance project when delivered;
- Agree a common approach for communicating and celebrating the successes of the Alliance;
- Provide information for the Chief Executive updates to the component NHS Trust Boards;
- Test and challenge the articulated risks to the delivery of the work of the Alliance;

- Monitor that the component organisations are operating in line with the requirements of the Alliance's Memorandum of Understanding

5 STANDING AGENDA

Agendas will be built around the Alliance's workplan, however the Alliance Management Group will intend to operate to a standing agenda, as follows:

- Declarations of Interest
- Minutes of the previous meeting
- Actions and decisions log
- Update from Alliance Strategic Forum
- Project reports: progress updates; risk log; benefits realisation analysis
- Clarification of decisions made and agreement of key messages
- Any other business
- Self-assessment of the effectiveness of the meeting

6 ADMINISTRATION AND FREQUENCY OF THE ALLIANCE MANAGEMENT GROUP

The secretariat for the Alliance Management Group will be provided from existing resources from the component NHS organisations.

The secretariat will take responsibility for:

- Agreement of the agenda with the Chair of Alliance Management Group and organising the collation of connected papers.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Advising the Group as appropriate

7 MEMBERSHIP

The Alliance Management Group will initially comprise of members of each organisation's Executive Team (or equivalent roles)

Additional members of the Alliance Management Group will be agreed at an Alliance CEO Forum.

The chair of the Group will rotate between the Chief Executive Officers (time period to be agreed).

The quorum for the meeting is five members, including at least two representatives from each of the two NHS organisations.

5 REPORTING

Following each meeting, the minutes shall be drawn up and presented at the next Group meeting where they shall be considered for accuracy and approved.

A summary of discussions of the Alliance Management Group will be presented to the Trust Board via the regular assurance reporting arrangements.

The work of the Alliance will be presented in an annual report which will be shared with the Boards of the component NHS organisation and other interested parties by agreement of the Group.

6 REVIEW

The terms of reference should be reviewed and approved at least annually or sooner if required.

Date of adoption: **July 2025**

Date of review: **May 2026**

Corporate Objectives

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 02 July 2025

Author:

Name: Nia Jones
Role/Title: Managing Director for Planning and Strategy

Contributors:

Trust Wide contribution

Report sign-off:

Name: Stacey Keegan
Role/Title: Chief Executive Officer

Is the report suitable for publication?:

Yes

Key issues and considerations:

As set out in the Trust Strategy 2023–2028, the overarching objectives are to:

1. Deliver high-quality clinical services
2. Develop our Veterans' Service as a nationally recognised centre of excellence
3. Integrate MSK pathways across Shropshire, Telford and Wrekin (STW)
4. Grow our services and workforce sustainably
5. Innovation, education, and research at the heart of our work

The Trust's annual corporate objectives are designed to translate high-level strategic priorities into clear, actionable goals that guide the organisation's operations, performance, and service delivery. These objectives ensure alignment with national NHS priorities, local population health needs, and the Trust's continuous improvement agenda.

Corporate Objectives 2024/25 End of Year report
The Trust has reviewed progress against the 2024/5 objectives and summarised within the attached Corporate Objectives – End of Year Report. The report is an opportunity to reflect on the achievements that the Trust has made against all 5 strategic objectives.

Key areas to highlight

- The Trust has taken an increasingly proactive leadership role in the development of MSK services across Shropshire, Telford and Wrekin and will we moving to a shadow MSK lead provider role in 2025/26.
- The Trust has reviewed and approved supporting strategies across multiple domains, ensuring alignment to the overarching trust strategy.
- The Trust opened a new operating theatre in November 2024 increasing the Trust's surgical capacity.
- The Trust has re-signed the Armed Forces Covenant pledging its support to people who are serving in, or who have served in the Armed Forces
- Organisational structure changes agreed to strengthen Commercial arm of the organisation through appointment of a Chief Finance & Commercial Officer and approval to recruit to a new commercial post.

Draft Corporate Objectives 2025/26
The 2025/26 draft Corporate Objectives are being presented to the Board for approval.

The Corporate Objectives being presented to the board reflect the feedback from Board members, Senior Managers and Senior Clinicians following the Board Strategy Development workshop held in February 2025.

Corporate Objectives

The 2025/25 corporate objectives reflect the national NHS priorities, collective prioritises as a system partner, the annual objectives contained within the Trust's supporting strategies alongside key initiatives and projects for delivery in 2025/26.

Strategic objectives and associated risks:

The following strategic objectives are relevant to the content of this report:

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	✓
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

Board Assurance Framework Themes		
1	Continued focus on excellence in quality and safety	✓
2	Creating a sustainable workforce	✓
3	Delivering the financial plan	✓
4	Delivering the required levels of productivity, performance and activity	✓
5	Delivering innovation, growth and achieving systemic improvements	✓
6	Responding to opportunities and challenges in the wider health and care system	✓
7	Responding to a significant disruptive event	✓

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:

System Objectives		
1	Improve outcomes in population health and healthcare	✓
2	Tackle inequalities in outcomes, experience and access	✓
3	Support broader social and economic development	✓
4	Enhance productivity and value for money	✓

Recommendations:

Corporate Objectives, end of year review – the Board is asked to note the Corporate Objectives report which summaries 2024/25 achievements.

Corporate Objectives 2025/26 – the Board is asked to consider and approve the Corporate Objectives for 2025/26.

Report development and engagement history:

The Corporate Objectives are presented and discussed within the following forums:

- Executive Team Meeting
- Trust Management Group
- Assurance Committees
- Board of Directors

Appendices

Appendix A *Corporate Objectives – end of year review*

Appendix B *Corporate Objectives 2025/26*

Trust Strategy Update 2024/25 end of year report

Aspiring to deliver world class patient care

How we will do it	Measure	March 2025 Update
Ensure the highest standards of care for our patients	• Delivery of Trust's Quality Improvement Priorities for 2023/24 • Implementation of Quality accreditation programme • Roll-out of PSIRF (Patient Safety Incident Response Framework) • Nursing & AHP Strategy and Quality strategy signed-off	• The 2024/25 priorities are completed and new Quality Priorities for 2025/26 have been agreed • Quality Accreditation Programme has been established • Patient Safety Incident Response Plan has been revised and approved to commence April 2025 • The Nursing and AHP / Quality Strategy have been approved and quarterly progress reports are delivered
Empower departments to develop services	• Departmental-led implementation of clinical strategies • Annual Departmental Business Plan in place for each Clinical service Optimise productivity and efficiency within our services • Clinical Strategy signed-off	• Cycle of presentations through Trust Management Group in place • Annual Service level business plan reviewed annually as part of the operational planning round. • The Trust has approved its Clinical Strategy in 2024/25.
Optimise productivity and efficiency within our services	• Delivery of the performance, workforce, productivity and transformation schemes set out as part of the Trust's Operational plan • Deliver Elective Hub efficiency standards	• Progress against performance and productivity metrics impacted by reduced activity due to the cessation of the LLP contract end of June 2024. . • New Theatre opened in November 2024. • Key workforce metrics agreed to the end of March 2025 • Vacancy rate 6.47% at the end of March 2025. • Staff turnover reduced to 8.81% at the end of March 2025 • Elective Hub accreditation obtained November 2023
Ensure a fair, equal and inclusive culture across the Trust	• Delivery of the Trust's Inclusion priorities for 2023/24	• Launched the Trust's EDI Strategy and Action Plan • Launched bimonthly EDI newsletters • Set up of Staff Networks with Chair and Executive Sponsor • Published the WRES/WDES reports and action plans • Published the Gender Pay Group • Successful in receiving NHSE Innovation funding and delivered an all staff event to improve

How we will do it	Measure	March 2025 Update
Increase our workforce capacity to reflect service demand	• Increase our workforce capacity to reflect service demand	• Recruitment plan for expanding the consultant workforce with veteran's affiliation in place. Recruitment commenced in Q4 of 2025/26 and will be continuing into 2025/26.
Develop our rehabilitation facilities	• Develop our rehabilitation facilities	• Scope review completed and business case objectives refined during 23/24 and presented to F&P Committee in March 2024. • The Headley Court Veteran rehabilitation Programme Pilot will be implemented in 2025/26 for an18 month period. This pilot scheme aims to demonstrate a significant benefit in outcome by the introduction of a series of rehabilitation interventions both prior and following orthopaedic surgery. This Veterans rehabilitation pilot programme will be evaluated throughout the pilot phase to provide evidence for more extensive services to be developed.
Maintain Veterans Accreditation standards	• Maintain Veterans Accreditation standards	• Action plan in place to ensure compliance with the standards, Veterans' awareness training now in place for all staff. Data collection for veterans an area identified for improvement, which is due to be rectified with Apollo roll-out.
Strengthen partnerships with armed forces and veteran friendly organisations	• Strengthen partnerships with armed forces and veteran friendly organisations	• The Trust scoped the opportunity to bid to be a supplier of active military MSK surgical rehabilitation but was not able to meet the requirements of the service specification on this occasion. • The Trust participated in a 6 month data collection pilot to inform pathways and accreditation processes for Veterans rehabilitation going forwards. • The Trust has re-signed the Armed Forces Covenant. The Covenant represents a pledge of support to people who are serving in, or who have served in the Armed Forces.

How we will do it	Measure	March 2025 Update
Lead the MSK Transformation Board and contributing to the delivery of the transformation programme	• Establishing RJAH as the lead provider for MSK services through the development of a provider collaborative agreements • Governance structure in place for the MSK transformation programme • Work collaboratively to standardise pathways and equity of access for STW patients	• For 2025/26, the ICB will be looking to commission, one whole system MSST, Orthopaedic, Rheumatology and Pain Management service which will be commissioned via a lead provider contract held between NHS STW ICB and Robert Jones and Agnes Hunt Orthopaedic Hospital with appropriate sub contractual arrangements in place. We will undertake this in shadow form from the 1st April 2025 with formal arrangements commencing on the 1st April 2026. • Over the last 12 months the Trust has taken an increasingly proactive leadership role in the development of MSK services across STW. The further progress of the MSK programme is now being overseen by the Committee in Common. • Within the system there is now a more robust structure for MSK transformation, with an expanded scope that incorporates the full pathway. • The Trust is leading on and has led on delivering key milestones including go live of MSST, creating a single point of access for MSK services across STW and standardising the triage and interface protocols. • The Trust has also implemented a single point of access for Rheumatology services in 204/25.
Work towards Elective Hub Accreditation	• Self-assessment completed against the Elective Hub accreditation criteria	• Elective Hub accreditation obtained November 2023 for Adult and Paediatric services.

How we will do it	Measure	March 2025 Update
Recruit, support, retain and provide an exemplar experience for our staff	• Delivery of year 1 objectives contained within the RJAH People Strategy	• The Trust has been working on delivery of the associate actions within year clear progress has been made in respect of the five identified objectives and the associated measures with programmes and schemes being introduced and coordinated. Sense of belonging is supported by the introduction of staff networks and embedding just culture within core PS policies. Focus on further years of the People Strategy continues to support the workforce.
Optimise use of estate through capital investment & partnership working	• Review opportunities to utilise estates and facilities within our geographical catchment to deliver services locally and in line with our Green plan	• The Trust has been developing its work in collaboration with Powys Health Board to enhance the level of outreach and joint working with key opportunities identified in terms of improving equity of services, delivering services locally in the Powys area. • This has secured investment in 2025/26 into joint posts, RJAH provision of clinical leadership for MSK and expansion of CMATS service to north Powys residents. • The Trust will continue to expand it discussions with stakeholders during 2025/26.
Expanding our reach and specialist expertise to other providers and sectors	• Scope the appropriate resources and skills required to strengthen commercial and business expertise within the organisation	• Skills gap identified within the organisation to maximise commercial and business potential. The Trust has met with other NHS providers to review their commercial structure and seek out collaboration opportunities. • Organisational structure changes agreed to strengthen Commercial arm of the organisation through appointment of a Chief Finance & Commercial Officer and approval to recruit to a new commercial post.

5 Innovation, education & research at the heart of what we do

Hospital University level education, research and innovation

NHS

How we will do it	Measure	March 2025 Update
Create the cultural environment to promote continuous Improvement	• NHS Improvement Impact self-assessment to be completed • Roll out continuous improvement training across all staff groups • Establish Digital Education, Research and Innovation Committee	• Improvement Training has been undertaken with staff attending from all staff groups. Training offers vary and are inclusive of but not limited to, all staff Induction includes improvement training, Improvement Champions training, Improvement Advocates, Board of Directors quality improvement training. • The Trust has created an Innovation Club which aims to further encourage innovative ideas for improvement. It is open to all staff and held on alternating dates once per month. • NHS IMPACT self-assessment completed in October 2023 with board members and senior management and clinical staff invited to collaboratively undertake the assessment. The next scheduled self-assessment to take place in May 2025. • DERIC Committee established.
Enhance capability and opportunities for research across all professions	• Increase Nurse and AHP led research • Delivery of in-year objectives contained within the RJAH Research Strategy	• The Trust has co-produced a Nursing & Allied Health Professionals Strategy for the next 5 years, with key objectives centred around enhancing our Innovation, education and research opportunities. • The Trust refreshed its Research strategy in March 2025, with a formal launch to take place at the beginning of 2025/26 . This strategy will be overseen by the DERIC Committee.
Optimise the potential of digital technologies to transform care	• Implementation of the EPR programme • Appropriate digital training & awareness programme in place	• Implementation of EPR ongoing. Go live planned for Q1 2025/26. • A training programme has been developed and in place to support all elements for the rollout of the new digital Electronic Patient Record system Apollo


NHS
The Robert Jones and Agnes Hunt
Orthopaedic Hospital
NHS Foundation Trust
Corporate Objectives 2025/26
Improving lives through excellent and innovative care
NHS

How we will do it	Measure	Target Date	SRO	Delivery Lead
Ensure the highest standards of care for our patients	• 60% of our wards will achieve a rating of good or above on their Quality accreditation	March 2026	CNO	ACN and Patient Safety Officer
	• Sign off the Trust's new 3 year patient experience strategy	Sept 2025	CNO	ACN and Patient Safety Officer
	• No Welsh patients to be waiting over 104 weeks for treatment or over 52 weeks for their first outpatient appointment in line NHS Wales government standards	March 2026	COO	MD Specialist Unit
	• 60% of English patients waiting less than 18 weeks from referral to treatment, with less that 1% waiting over 52 weeks in line with NHS England government standards.	March 2026	COO	MD Specialist Unit
	• Maintain top quartile performance for theatre services against Model Health system benchmarking for theatre utilisation.	March 2026	COO	MD MSK Unit
	• 67% of English patients waiting no longer than 18 weeks for a first appointment in line with NHS England government standards.	March 2026	COO	MD Specialist Unit
Address health inequalities for our catchment population	• Health inequalities data embedded into performance reporting with quarterly board level reporting.	March 2026	COO	Head of Information & Head of Improvement and Business Insights
	• Plan services and target investment based on health inequalities.	March 2026	COO	MD Planning & Strategy
	• Working with system partners to establish preventative programmes.	March 2026	COO	MD MSK Unit
Develop our services through partnership and shared decision-making	• Target improvements to reduce variation between departments for shared decision-making outcomes against the 3 reportable domains of listening, understanding and inclusion	March 2026	CMO	Richard Potter
Ensure there is an inclusive culture across the Trust	• Implement actions to increase staff confidence in arrangements for raising and addressing concerns by end of September 2025, as evidenced by improvement in the staff survey results in the "raising concerns" category relative to the RJAH score in 2024.	March 2026	CP&CO	Trust Secretary Freedom to Speak Up Guardian
	• Implement actions to support our non-white ethnic staff groups by reducing the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months as evidenced in the staff survey results relative to the RJAH score in 2024.	March 2026	CP&CO	Associate CP&CO ACN and Patient Safety Officer
Recruit, retain and transform our workforce to provide an exemplar experience for our staff and patients	• Aligning our enhanced and advanced practice roles to national standards	March 2026	CNO	Nursing & Allied Professions Lead - Workforce
	• Sustain improved staff retention rates for 2025/26.	March 2026	CP&CO	Associate CP&CO
	• Actively recruit to substantive staff establishment to reduce reliance on bank shifts.	March 2026	CP&CO	Deputy CP&CO

How we will do it	Measure	Target Date	SRO	Delivery Lead

Veterans strategy in place that sets out the sustainable future model for veterans services.	• Veterans strategy to be agreed by October 2025 that sets out:
	  • Clinical model for veterans services based on best practice guidance, supporting their broader wellbeing and social needs.
	  • Demand and capacity assessment for Veterans activity outlining the requirements for each department
	  • Veteran affiliated Workforce plan to reflect capacity requirements
	  • Sustainable financial model and commissioning arrangements
		Oct 2025
		July 2025
		
		August 2025
		
		September 2025
		September 2025
			COO
			
			COO
			
			COO
			CF&CO
				MD Specialist Unit
				
				MD Planning & Strategy
				
				MD MSK Unit
				Deputy CFO

Develop our veterans rehabilitation pathway	• Headley Court Veteran rehabilitation Programme Pilot to commence in December 2025 and be implemented for an 18-month period with monitoring and evaluation throughout the pilot phase to inform future decision making.	December 2025	COO	MD Specialist Unit MD MSK Unit

How we will do it	Measure	Target Date	SRO	Delivery Lead
Develop a singe single seamless MSK service working collaboratively with our partners	• Establishing RJAH as the lead provider for MSK services with governance structure in place through the establishment of the MSK provider collaborative board.	March 2026	COO	Assistant Chief Executive
	• Develop a 5 year plan for MSK across Shropshire, Telford and Wrekin.	March 2026	COO	Assistant Chief Executive
Deliver an MSK service that ensures equity of access and improves population health by meeting the needs of our population	• Ensure prioritised waiting list linked to health inequalities and addressing an inclusive approach to access.	March 2026	COO	MD MSK Unit MD Specialist Unit Head of Patient Access
	• Improvements in access times for the MSST service.	March 2026	COO	MD MSK Unit
	• Pain service provision to be agreed across STW, inclusive of complex pain service provision.	October 2025	COO	MD MSK Unit
	• All Rheumatology patients for STW to be waiting less than 18 weeks for their first appointment by March 2026.	March 2026	COO	MD Specialist Unit

How we will do it	Measure	Target Date	SRO	Delivery Lead
Delivering our services sustainably to meet the needs of our patients.	• Increase substantive job planned plan capacity through consultant recruitment, team job planning, and increasing flexible sessions.	March 2026	COO	MD Specialist Unit MD MSK Unit
	• Implementation of outpatient follow up pathway protocols in line with GIRFT and other benchmarked best practice.	March 2026	CMO	Deputy CMO & Clinical Chair MSK
	• Spinal Disorders delivery model agreed that sets out the sustainable clinical, workforce and financial future model	August 2025	COO	MD Specialist Unit
	• Meet the Trusts Cost Improvement programme efficiency target of 6%.	March 2026	CF&CO	MD Specialist Unit MD MSK Unit Corporate Directors
Develop our commercial and business strategy to enable services to thrive	• Commercial Income strategy to be signed off.	December 2025	CF&CO	Deputy CFO MD Planning & Strategy
	• Recruit and develop the skills and resources required to strengthen commercial and business expertise within the organisation.	March 2026	CF&CO	Deputy CFO MD Planning & Strategy
	• Deliver the planned level of private patient activity growth for 2025/26.	March 2026	COO	MD MSK Unit
Expanding our reach and specialist expertise to other providers and sectors	• Provision of speciality leadership for orthopaedics to input into the governance and assurance of existing Powys Teaching Health Board delivered orthopaedic activity.	June 2025	CMO	Deputy CMO & Clinical Chair MSK
	• Joint Orthopaedic Consultant post appointment with Powys teaching Health Board outreaching into Llandrindod Wells Hospital.	September 2025	COO	MD MSK Unit
	• Utilising the Memorandum Of Understanding with Royal Orthopaedic Hospital to collaborate and identify shared objectives and enable particular project workstreams to be delivered collaboratively.	March 2026	CEO	Managing Directors & Corporate Directors

How we will do it	Measure	Target Date	SRO	Delivery Lead
Create the cultural environment to promote continuous Improvement	• Over 50% of all staff to have received quality improvement training	March 2026	COO	Head of Improvement and Business Insights
	• Utilisation of the Clinical Innovation fund to implement Innovation initiatives.	March 2026	CF&CO	Deputy CFO
	• Increased engagement by all professions with the Trust's Innovation Club.	March 2026	CMO	Head of Improvement and Business Insights
Enhance Leadership and Management capabilities	• Deliver the Internal leadership programme to 5 additional cohorts in 2025/26	March 2026	CPO	Associate CP&CO
	• Develop a Trust competency framework for all management posts within the organisation.	November 2025	CPO	Associate CP&CO
Enhance capability and opportunities for research across all professions	• Increase the number of patients being offered participation in research to 1.8% of total patient episodes.	March 2026	CMO	Research Manager
	• Increase the number of studies developed to full grant application by 5%.	March 2026	CMO	Research Manager
	• Increase the number of peer reviewed publications by 5%.	March 2026	CMO	Research Manager
Optimise the potential of digital technologies to transform care and improve outcomes	• Full implementation of Radar Healthcare to provide comprehensive quality management system.	March 2026	CNO	ACN and Patient Safety Officer
	• Implementation of power Business Intelligence solution.	March 2026	COO	Head of Information
	• Implementation of an ambient AI solution for outpatient services.	March 2026	CFO	Digital Director
Enhance capabilities and opportunities for Education to hospital university level standards	• Work collaboratively with Keele university to develop an agreed joint research strategy .	March 2026	CMO	Research Manager
	• Increase the core number of university clinical academics by 3 posts.	March 2026	CMO	Research Manager
	• Work towards increasing the Trust's Research Capability Funding (RCP) in line with meeting hospital university level standards	March 2026	CMO	Research Manager

Executive Summary - Quality & Safety Committee

Assurance

Variation	Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes	No Target or Moving Target
Improving varitation (high or low) or 3 months better than target				
No significant change or N/A to SPC		RJAH Acquired Tissue Viability Incidents Surgical Site Infections Theatre Cancellations On Day of Surgery	Total Deaths	Number of Patient Safety Reviews Complaints Re-opened MCSI Admissions - Average Waiting Time Medication Errors
Concerning variation (high or low) or 3 months off target		Number of Complaints Complex Complaints Respone Rate - 45 Days No of Spinal Injury Patients Fit for Admission Medication Errors with Harm 62 Day General Standard		Number of Compliments % Delayed Discharge Rate Overdue Follow Up Backlog

Please note - this is defined by the associated SPC graph within the IPR. Many KPIs show as a moving target due to the change of targets/plans as we moved into new financial year and monthly phasing.

Trust Board - Quality & Safety

May 2025 – Month 2

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Aspiring to deliver world class patient care

SPC Reading Guide

SPC Charts

SPC charts are line graphs that employ statistical methods to aid in monitoring and controlling processes. An area is calculated based on the difference between points, called the control range. 99% of points are expected to fall within this area, and in doing so are classed as 'normal variation'. There are a number of rules that apply to SPC charts designed to highlight points that class as 'special cause variation' - abnormal trends or outliers that may require attention.

There are situations where SPC is not the appropriate format for a KPI and a regular line graph has been used instead. Examples of this are list sizes, KPIs with small numbers and little variation, and zero tolerance events.

SPC Chart Rules

The rules that are currently being highlighted as 'special cause' are:

- Any single point outside of the control range
- A run of 7 or more consecutive points located on the same side of the mean (dotted line)
- A run of 6 or more consecutive points that are ascending or descending
- At least 2 out of 3 consecutive points are located within or beyond the outer thirds of the control range (with the mean considered the centre)

Different colours have been used to separate these trends of special cause variation:

Blue Points highlight areas of improvement

Orange Points highlight areas of concern

Grey Points indicate data points within normal variation

White Points are used to highlight data points which have been excluded from SPC calculations

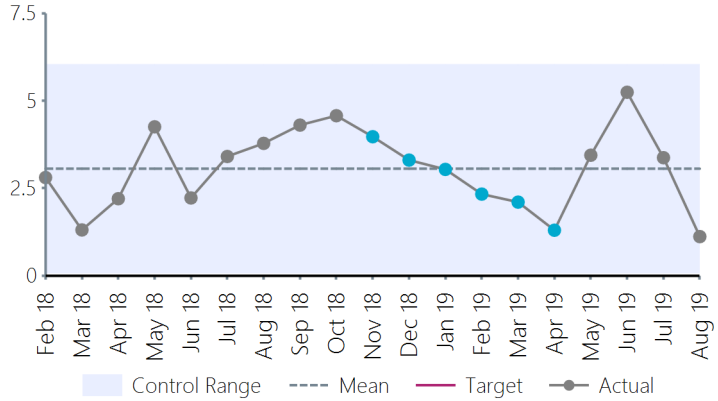
Some examples of these are shown in the images to the right:

a) shows a run of improvement with 6 consecutive descending months.

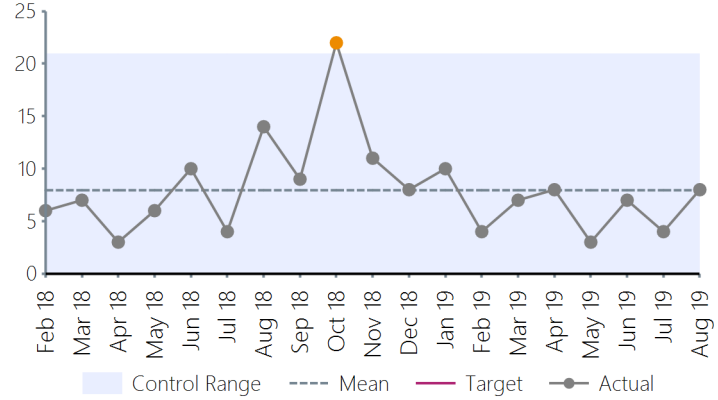
b) shows a point of concern sitting above the control range.

c) shows a positive run of points consistently above the mean, with a few outlying points that are outside the control limits. Although this has highlighted them in red, they remain above the target and so should be treated as a warning.

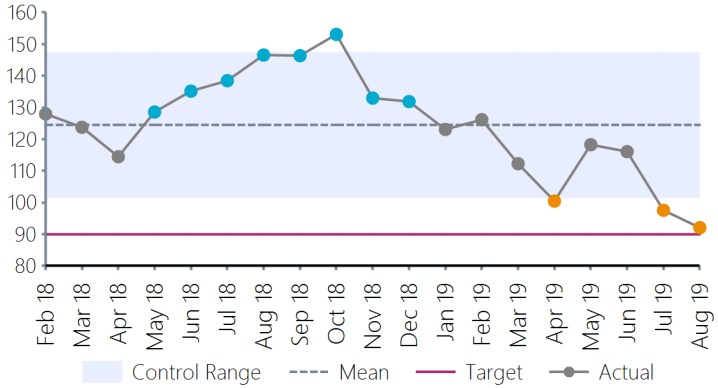
a)



b)



c)



Summary Icons Reading Guide

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

Exception Reporting

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

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

Variation Icons

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

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

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

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

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

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

Assurance Icons

Can we expect to reliably hit the target?

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

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

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

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

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

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

Data Quality Rating Reading Guide

The Data Quality (DQ) rating for each KPI is included within the 'heatmap' section of this report. The indicator score is based on audits undertaken by the Data Quality Team and will be further validated as part of the audit assurance programme.

Colours

When rated, each KPI will display colour indicating the overall rating of the KPI

Blue	Green	Amber	Red
No improvement required to comply with the dimensions of data quality	Satisfactory - minor issues only	Requires improvement	Siginficant improvement required

Dates

The date displayed within the rating is the date that the audit was last completed.

Summary - Caring for Patients

KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Patient Safety Incident Investigations		0		N/A to SPC	No Target		
Number of Complaints	8	20			?	+	
RJAH Acquired C.Difficile	0	0		N/A to SPC	P		04/03/24
RJAH Acquired E. Coli Bacteraemia	0	0		N/A to SPC	P		04/03/24
RJAH Acquired MRSA Bacteraemia	0	0		N/A to SPC	P		04/03/24
RJAH Acquired MSSA Bacteraemia	0	0		N/A to SPC	P		04/03/24
RJAH Acquired Klebsiella spp	0	0		N/A to SPC	P		04/03/24
RJAH Acquired Pseudomonas	0	0		N/A to SPC	P		04/03/24
Surgical Site Infections	0	0			?	+	04/03/24
Outbreaks	0	0		N/A to SPC	P		04/03/24

Summary - Caring for Patients

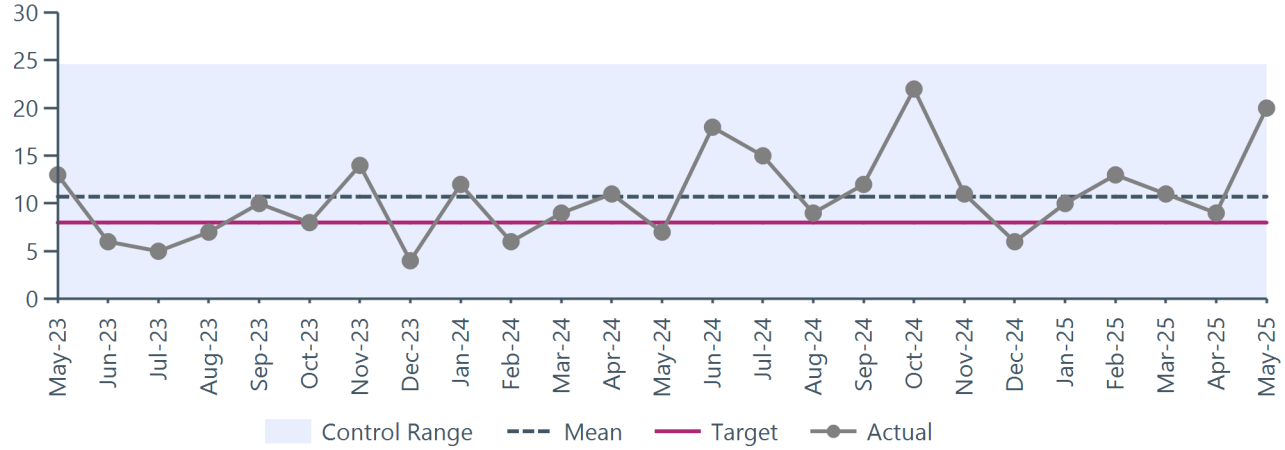
KPI (*Reported in Arrears)	Target/Plan	Latest Value	Trajectory	Variation	Assurance	Exception	DQ Rating
Number of Deteriorating Patients	5	5		N/A to SPC	P		
Total Deaths	0	1		N/A to SPC	F	+	12/09/23
WHO Quality Audit - % Compliance	100.00%	100.00%			P		

Number of Complaints

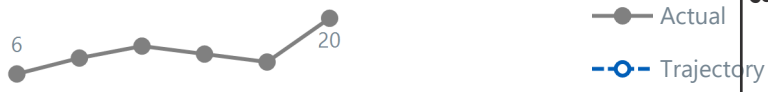
Number of complaints received in month 211105

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
8	20		



Trajectory



What these graphs are telling us

Metric is experiencing common cause variation. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

There were twenty complaints received in May. This metric is included as an exception as it has exceeded the tolerance each month this calendar year. The reasons for complaints were associated with care received/planned care (9), cancelled appointment/surgery (6), waiting times (3), catering (1) and IG issues (1).

Actions

An increase in the volume of complaints has been seen throughout the past year. A deep dive is currently in progress and will be presented to both Patient Experience Committee and Quality & Safety Committee.

Learning is identified for each complaint as part of the complaints response. Any themes are shared at Unit level and through Patient Experience Committee.

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
7	18	15	9	12	22	11	6	10	13	11	9	20

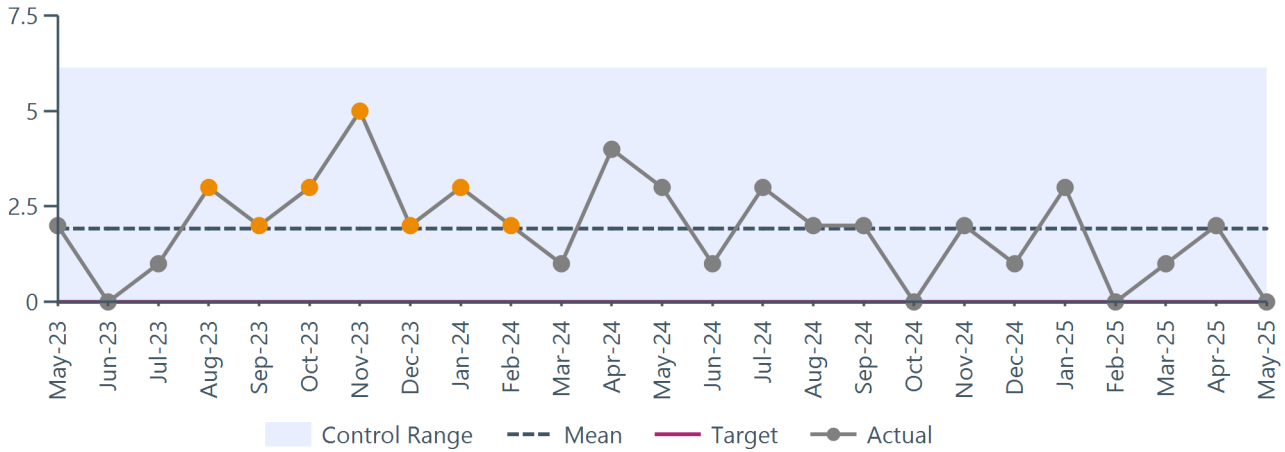
Surgical Site Infections

Surgical Site Infections reported for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement in previous twelve months.

217727

Exec Lead
Chief Nurse and Patient Safety Officer

Target/Plan	Latest Value	Variation	Assurance
0	0		



Trajectory

What these graphs are telling us

Metric is experiencing common cause variation. The assurance is indicating variable achievement (will achieve target some months and fail others).

Narrative

Surgical Site infections are monitored for patients who have undergone a spinal surgery procedure, total hip replacement or total knee replacement. They are monitored through each quarter for a period of 365 days following the procedure. The data represented in the SPC above shows any surgical site infections that have been confirmed. SSI rates are benchmarked by the UKHSA against all providers, and Trusts are notified if the data identifies them as an outlier.

There were three infections confirmed in May, relating to a procedures that took place in March-25 (1) and April-25 (2).

Actions

Out of those 3 SSIs, the IPC Team could not find evidence of MSSA decolonisation for 2 cases. This has been discussed through the Patient Safety Incident Review Group (previously known as Moderate Harms group). Pre-op have been working with the Apollo team so that there is one dedicated place for MSSA decol to be documented so this action in in progress. Other than that, no other identified common themes. SSI process remains in place, with 6 monthly MDT review which is included in the IPC quarterly reports so that QSC get oversight.

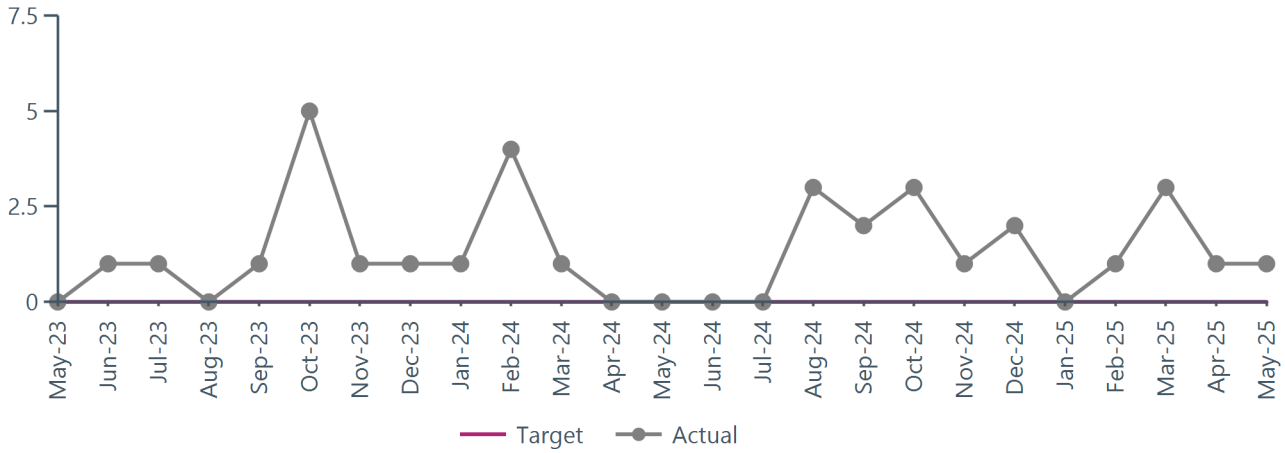
May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
3	1	3	2	2	0	2	1	3	0	1	2	0

Total Deaths

Number of Deaths in Month 211172

Exec Lead:
Chief Medical Officer

Target/Plan	Latest Value	Variation	Assurance
0	1	N/A to SPC	F



Trajectory

What these graphs are telling us

This measure is not appropriate to display as SPC. Based on number over last three months, the assurance indicates that the metric is failing the target/tolerance.

Narrative

There was one patient death within the Trust in May; this has been classified as an Expected Death.

Actions

Learning from Deaths Reviews are completed by the Trust Lead.

May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
0	0	0	3	2	3	1	2	0	1	3	1	1

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Chair's Assurance Report
Quality and Safety Committee

Committee / Group / Meeting, Date

Board of Directors Meeting, 02 July 2025

Author: Contributors:

Name: Mary Bardsley
Role/Title: Assistant Trust Secretary

Report sign-off:

Ruth Longfellow, Chief Medical Officer
Lindsey Webb, Non-Executive Director

Is the report suitable for publication:

Yes

1. Key issues and considerations:

The Trust Board has established a Quality and Safety Committee. According to its terms of reference: *"The purpose of the Quality and Safety Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes, and controls in place throughout the Trust to:*

- *Promote safety and excellence in patient care.*
- *Identify, prioritise, and manage risk arising from clinical care.*
- *Ensure efficient and effective use of resources through evidence based clinical practice."*

In order to fulfil its responsibilities, the Committee has established a number of sub-committees (known as "Meetings") which focus on particular areas of the Committee's remit. The Quality and Safety Committee receives regular assurance reports from each of these "Meetings" and escalates issues to the Board as necessary via this report.

This report provides a summary of the items considered at the Quality and Safety Committee on 22 May 2025 and 19 June 2025. It highlights the key areas the Quality and Safety Committee wishes to bring to the attention of the Board.

2. Strategic objectives and associated risks:

The following strategic objectives are relevant to the content of this report:

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	✓
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓
4	Grow our services and workforce sustainably	
5	Innovation, education and research at the heart of what we do	

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:

System Objectives		
1	Improve outcomes in population health and healthcare	✓
2	Tackle inequalities in outcomes, experience and access	✓
3	Support broader social and economic development	
4	Enhance productivity and value for money	

The following strategic themes, as outlined in the Board Assurance Framework, are overseen by this Committee. The relevant themes, and the Committee's overall level of assurance on their delivery is:

Assurance framework themes		Relevant	Overall level of assurance
1	Continued focus on excellence in quality and safety.	✓	MEDIUM
2	Creating a sustainable workforce.		
3	Delivering the financial plan.		
4	Delivering the required levels of productivity, performance and activity.		
5	Delivering innovation, growth and achieving systemic improvements.		
6	Responding to opportunities and challenges in the wider health and care system.		
7	Responding to a significant disruptive event.	✓	MEDIUM

3. Assurance Report from Quality and Safety Committee

3.1 Areas of non-compliance/risk or matters to be addressed urgently.

ALERT - The Quality and Safety Committee wishes to bring the following issues to the Board's attention as they:
Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address, OR
Require the approval of the Board for work to progress.

Apollo System Implementation – Risk to Operational Resilience and Patient Safety

The Committee continues to monitor the impact of the Apollo electronic patient record (EPR) system implementation. While no patient harm has been directly attributed to the system to date, the range and scale of operational disruptions present a clear ongoing risk. These include:

- Inaccuracies in waiting list data and migration gaps.
- Delays in producing discharge summaries and medication reconciliation.
- Challenges with data reporting and outpatient tracking.

The Committee received assurance that technical issue logs, mitigation plans, and a centralised clinical safety case are continuously developed, and a further assurance report will be presented to the Committee in July. There is a particular focus on:

- Transitioning outstanding issues into the corporate risk register.
- Strengthening governance and capturing the true impact on care continuity.
- Ensuring appropriate support and oversight for frontline staff.

Given the potential for unrecognised harm or care delays, the Committee flags this as a strategic-level risk requiring continued Board scrutiny.

Chair Report MHRA Working Group: Tissue Sample Investigation

Concerns have emerged around the governance of orthopaedic tissue samples handling for research purposes, following the internal review and MHRA Working Group. Specifically:

- There is uncertainty around the consent process for research tissue use.
- The process has been suspended pending investigation.
- There are potential implications for the Trust's research assurance, regulatory compliance, and reputational risk.

An audit is underway, and the matter has been escalated to the DERIC Committee. The Committee recommends that the Board maintains oversight of this issue, particularly as it links to future innovation, commercial activity, and compliance with MHRA expectations.

Quality Account 2024/25

The Committee endorsed the comprehensive report which included the revised priorities, safeguarding, and regulatory reference points. The Committee recommended the Board considers and approves the document for publication before 30 June.

3.2 Areas of on-going monitoring with new developments

ADVISE - The Quality and Safety Committee wishes to bring the following issues to the Board's attention as they represent areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives:

Performance Report

- **Cancellation** - Lessons from cancelled procedures and medication errors are informing quality improvement work.
- **Deaths** - A structured judgement review confirmed no causative Trust role in an external patient death, but areas of learning are being addressed.
- **Complaints** - the Committee noted a continued upward trend in complaints, with May showing a sharp increase (20 complaints, including 2 unresolved after 45 days and 5 re-opened). Themes include:
    - Cancelled procedures and appointments.
    - Communication and behavioural concerns.
    - Patient expectations around surgical outcomes.

  A full thematic deep dive is underway and due to report in July. Early indications suggest system-wide pressures (workforce capacity, Apollo-related disruptions) may be contributing factors.
- **Follow-Up Backlogs and RTT Pathway Pressure** - the number of patients overdue their follow-up appointment remains substantial, with data validation complicated by recent system changes. A focused effort is underway to:
    - Validate lists with external partners.
    - Improve tracking through Apollo.
    - Prioritise high-risk cohorts.

  In addition, day-of-surgery cancellations remain high (44 in May), and the Trust's compliance with the 62-day cancer pathway remains below target. While mitigations have been implemented (e.g. SOPs for radiology access), this remains an area of ongoing risk.

Chair Report Safeguarding Meeting - Safeguarding Training and Workforce Risks

The Committee reviewed safeguarding training compliance and flagged gaps at Level 3, particularly among patient-facing staff. While mitigations are in place (increased capacity and departmental targeting), an update will be provided in August to ensure no impact on frontline safety.

EQIA – Operational Plan

The assessment of the operational plan was prepared, identifying some interventions that could negatively affect patient experience and safety however mitigating actions are in place to reduce these risks. Most other areas of the operational plan showed neutral or positive impacts. On behalf of the board the quality and safety committee approved the assessment.

Bone Tumour

Following a review of the action plan, it was requested that a broader Trust-wide action plan on psychology support is required along with other areas such as GPICS and paediatrics.

OsCell Business Care and EQIA

The committee received a verbal update on the business case and notice that the document had been presented to the executive team on the 13th of May however there were further opportunities identified as part of the review and therefore further time has been requested in order to develop a detailed plan. The committee suggested that this business case is realigned to the Deric committee as there is a focus on research and innovation.

3.3 Areas of assurance

ASSURE – Quality and Safety Committee considered the following items and did not identify any issues that required escalation to the Board.

Annual Reports and Strategic Documents

The following were reviewed and either endorsed or recommended for Board approval:

- **Infection Prevention and Control (IPC) Annual Report** – reflects strong compliance and culture improvement.

- **Patient Complaints and Experience Annual Report** – assurance gained on policy alignment, responsiveness, and quality of data.
- **Health and Safety Annual Report** – low RIDDOR rates and improved assurance on safe sharps and CAS alerts.
- **Improving Experience in Care Framework** – approved to replace the previous Patient Experience Strategy and align with the new Quality Strategy.
- **EPRR Policy**, **Corporate Business Continuity Plan**, **Mass Casualties Plan** – all reviewed and recommended for Board approval.

PSIRF Report
PSIRF and PSII reports were reviewed in both meetings. While one PSIRF action remains behind plan, there was confidence in overall oversight and ownership.
The Committee received assurance that three recent incidents involving skin damage from tourniquets (including one moderate harm) have been reported and reviewed. The Trust is participating in national learning networks to develop standardised safety approaches and local practice has been updated.

Patient Safety Visits
The Committee noted the presentation, and the Trust agreed to revitalising the visits to align to GIRFT recommendation and current issues. There was also a discussion of ensuring the informal Board visits are recorded and reported.

Legal Claims Report
There have been 6 new CNST claims reported within quarter 4. Of the 4 claims closed, 1 was closed with damages paid. The committee discussed the need to improve the quality and completeness of the investigations into workplace staff injuries. The Trust reassured the members of the meeting and time had been scheduled for the health and safety team to explore a more proactive role in supporting managers.

Section 28 – Prevention of Future Deaths
In relation to the section 28 progress report, the committee were formed that the report included an update on the coronal activity. It was noted that medical report requests from the coroner are not uncommon due to the nature of the spinal injuries which often contribute to the cause of death. The coroner confirmed death by natural causes with no direct failures attributed to the to the Trust. The regulation 28 notice to prevent future deaths was issued to the Trust specifically in relation to the concerns about clinical observations and record keeping during the patient's care. The Trust is currently working with legal advisors to draft a comprehensive response to the coroner which provides organisational assurance on the clinical documentation and observation practises.

Risk Management and Oversight: Board Assurance Framework and Corporate Risk Register
- A revised approach to corporate risk and BAF development is underway, with scheduled strategic objectives review to inform evolution.
- Risk descriptors for rheumatology (Risk 3228) and weekend cover (Risk 3203) are being updated.
- Apollo-related risks are being transitioned into formal risk structures, rather than treated as project-level issues.

Cost Improvement Plans
The Committee were assured with the processes in place to complete a QIA for all cost improvement plans,

Chairs Assurance Reports
- **Patient Safety Meeting** – compliance issues which have previously been raised regarding the EPALs training have since been achieved.
- **Patient Experience Meeting** – the information provided within the most recent Board patient story has been reviewed and an action plan is being compiled to share with the patient.

- **Infection and Prevention** Meeting – it has been agreed that peer to peer audits would be discontinued as increased assurance has been embedded as part of business-as-usual reporting.
- **Health Inequalities** – the committee noted the report, there were no issues to escalate.
- **Health and Safety Meeting** – the committee noted the report, there were no issues to escalate.
- **Regulatory Oversight Meeting** - the committee noted the report, there were no issues to escalate.

Recommendation

The Board is asked to:

1. CONSIDER the overall assurance level listed at section 2,
2. CONSIDER the content of section 3.1 and agree any action required.
3. NOTE the content of section 3.2 and CONSIDER whether any further action is required; and
4. NOTE the content of section 3.3.

Quality and Safety Committee Annual Report 2024/25

Committee / Group / Meeting, Date

Board of Directors, 02 July 2025

Author:

Name: Mary Bardsley / Dylan Murphy
Role/Title: Assistant Trust Secretary / Trust Secretary

Contributors:

Report sign-off:

Name: Dylan Murphy, Trust Secretary
Quality and Safety Committee, 24 April 2025

Is the report suitable for publication?:

Yes

Key issues and considerations:

The Committees of the Board have been established in accordance with the Trust's constitution and each committee is required to produce a self-assessment and annual report.

The purpose of the Quality and Safety Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit Committee and Risk Management Committee to ensure that there are adequate and appropriate quality governance structures, processes, and controls in place throughout the Trust. Its particular responsibilities are set out at section 1 of the following report.

In line with good practice, the committees of the Board undertake an annual review of their operation and effectiveness. This involves:

- Reviewing the role of the committee, its key responsibilities, membership and business considered during the year.
- A questionnaire on the effectiveness of the operation of the committee (completed by individual members / core attendees).
- A self-assessment against key governance questions (for collective consideration).
- Review of the terms of reference to ensure the focus of the Committee remains relevant in 2025/26

Strategic objectives and associated risks:

The following strategic objectives are relevant to the content of this report:

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	✓
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	✓
4	Grow our services and workforce sustainably	✓
5	Innovation, education and research at the heart of what we do	✓

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:

System Objectives		
1	Improve outcomes in population health and healthcare	✓
2	Tackle inequalities in outcomes, experience and access	✓
3	Support broader social and economic development	✓
4	Enhance productivity and value for money	✓

Recommendation

That the Board note that, at the April meeting, the Committee:

1. **Noted** the report;
2. **Considered** the outcome of the committee effectiveness survey and did not identify any required actions;

3. **Considered and agreed** the draft self-assessment document (as included at section 8);
4. **Noted** the 2024/25 Decision / activity log (as included at attachment A).
5. **Considered** the draft Terms of Reference for 2025/26 (as included at attachment B) and recommended that the Board approve them.

The Board is therefore asked to consider and approve the proposed terms of reference for 2025/6.

Report development and engagement history:

This report has been produced from existing documentation. The self-assessment and TOR are initial drafts for consideration – they have not been considered or approved by any other forum or individual.

Next steps:

The committee-approved report will be presented to the Board meeting in May, to provide assurance that the Committee has fulfilled its role and responsibilities during the year.

Any issues of concern, or apparent gaps in the governance arrangements, that are identified will be reported to the Audit and Risk Committee for consideration.

Appendices

Attachment A	Committee Activity/Decision Log 2024/25
Attachment B	Terms of Reference 2025/26

1. Committee Roles and Responsibilities (2024/25)

The key responsibilities of the Committee are as follows:

- Promote excellence in patient care in all aspects of quality and safety, and monitor and review the "Quality Improvement Strategy".
- To ensure the Trust is meeting core standards and is compliant with national guidelines to include (but not be limited to) prevention and control of infection and effective and efficient use of resources through evidence based clinical practice.
- To consider NHSE Quality Governance Framework in the delivery of its key responsibilities
- To receive an agreed level of clinical data and trend analysis from clinical forums and working groups, which provides adequate clinical matrix to inform and analyse the clinical services provided at the Trust.
- To ensure that the Committee has adequate information on which to advise and assure the Board on standards of care provision.
- To receive reports chair reports the following assurance meetings which report into the Committee.
- The Quality and Safety Committee shall review the draft Quality Accounts before submission to the Trust Board
- The Committee shall ratify such policies as the Board has not reserved to itself and as required by the Trust's Policy Approval Framework.
- Clinical outcomes
    - Monitoring the effectiveness of the Trust's arrangements for the systematic monitoring of mortality and other patient outcomes.
    - Receiving and commenting on action plans and progress reports proposed by management in response to monitoring data on patient outcomes.
- Incident reporting and investigation
    - Monitoring the effectiveness of the Trust's compliance with the requirements of the Patient Safety Incident Response Framework.
    - Reviewing the outcomes of investigations, ensuring that the information is presented in sufficient detail to enable systemic failings in patient care to be identified; receiving and commenting on action plans and progress reports proposed by management in response to SIs, near misses and other incidents.
- Patient Experience
    - Monitoring the effectiveness of the Trust's systems for complaints handling and reviewing complaints for trends and themes.
    - Monitoring the effectiveness of the Trusts systems for advocacy and the encouragement of feedback from patients and relatives.
- Review of compliance with statutory and regulatory requirements relevant to the remit of the Committee, including CQUIN and CQC requirements.
- Patient Information Governance
    - Monitoring the arrangements to ensure the security of personally identifiable data.

2. Membership (2024/25)

The membership section of the current terms of reference is:

- Up to four Non-Executive members
- Chief Medical Officer
- Chief Nurse and Patient Safety Officer
- Chief Operating Officer/Deputy Chief Executive Officer

3. Meetings (2024/25)

During 2024/25, the committee met on 12 occasions (monthly). It was noted that all meetings were quorate.

The Committee also took part in Joint meetings with DERIC Committee as part of the EPRR launch.

4. Committee Attendance (2024/25)

Overall, good attendance has been noted from all core members of the meeting.

Name	Title	Attendance
Core Membership		
Lindsey Webb	Non-Executive Director (Chair)	11 / 12
Penny Venables	Non-Executive Director	10 / 12
Martin Newsholme	Non-Executive Director	11 / 12
John Pepper	Associate Non-Executive Director	12 / 12
Ruth Longfellow	Chief Medical Officer	10 / 12
Mike Carr	Chief Operating Officer	11 / 12
Paul Kavanagh-Fields	Chief Nurse and Patient Safety Officer	06 / 10
*Stacey Keegan	Chief Executive Officer	05 / 12
In Attendance		
Dylan Murphy	Trust Secretary	08 / 12
Kirsty Foskett	Head of Clinical Governance and Quality	12 / 12
Sam Young	Deputy Chief Nurse and DIPC	12 / 12
Fiona Bevan	Chief Pharmacist	11 / 12

*The Chief Executive Officer has an open invitation to the meeting.

5. Committee Activity and Decision Log (2024/25)

The business considered by the Committee during the year is included at attachment A.

6. Conduct of Meetings (2024/25)

The Committee conducted its business in accordance with the provisions of the Trust's constitution and terms of reference.

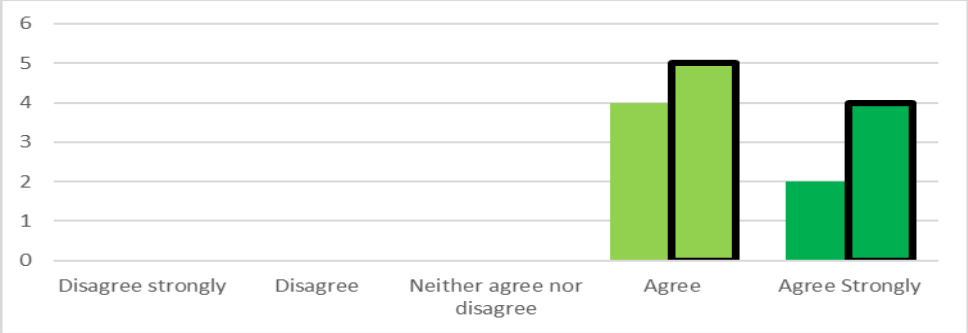
Formal minutes of the meeting were produced which included a record of the attendees present at the meeting. The Committee provided an update to the Board via the Chair's Assurance Report to the Board of Directors following each meeting.

7. Committee Effectiveness Survey (2024/25)

The Committee effectiveness survey was circulated to a total of 9 people (core members and frequent attendees of the meeting). There was a total of 9 responses received.

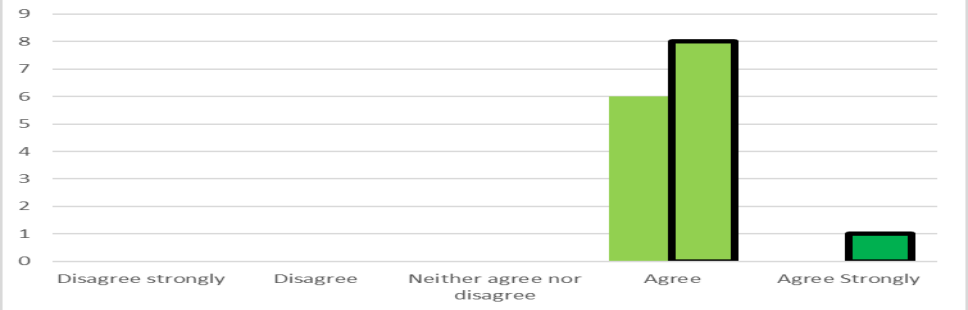
The 2024/25 results (the second of the two columns, with the black outline) are displayed alongside the 2023/24 results (based on the 6 returns received last year).

Q1 The work plan gives appropriate coverage to the areas which I consider that it should be covering
Responses – 2023/24 and **2024/25**



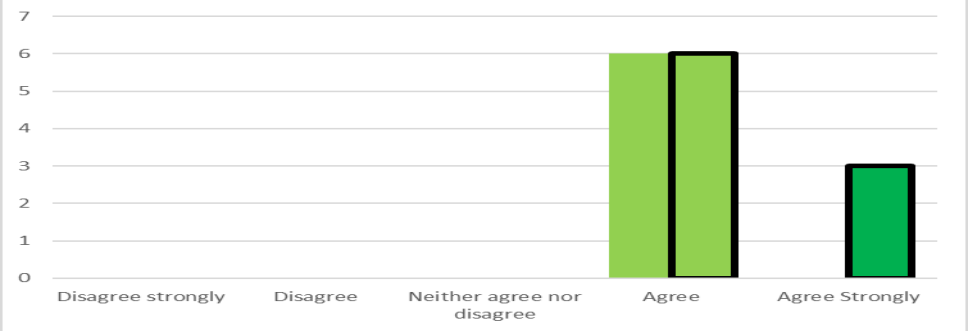
Comments
• the deep dive discussions are helpful

Q2 Current workload facilitates adequate scrutiny of areas delegated to the Committee
Responses – 2023/24 and **2024/25**



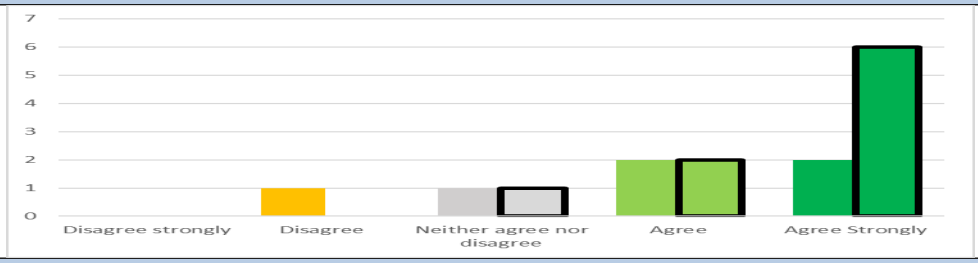
Comments
• agendas can be full and challenging at times • The agenda can be full and at times we have to rapidly review at pace. There is a tighter control on submission times of papers which has increased time to review prior to meetings. This allows greater scrutiny during meetings.

Q3 I have the appropriate skills and training to provide valuable input into the Committee
Responses - 2023/24 and **2024/25**



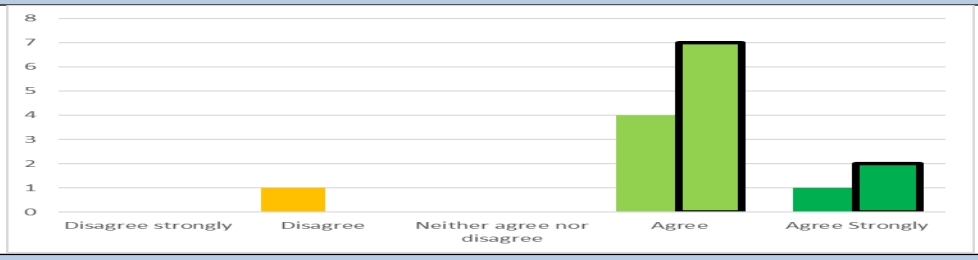
Comments
• There are no responses.

Q4 I consider that the meetings are well chaired and that members are given sufficient opportunity to contribute
Responses – 2023/24 and **2024/25**



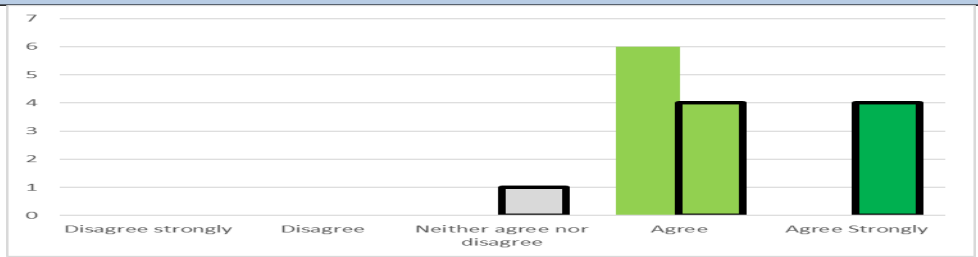
Comments
• for others to say

Q5 I consider that the time spent on each agenda item is appropriate and sufficient for scrutiny and challenge as required
Responses – 2023/24 and **2024/25**



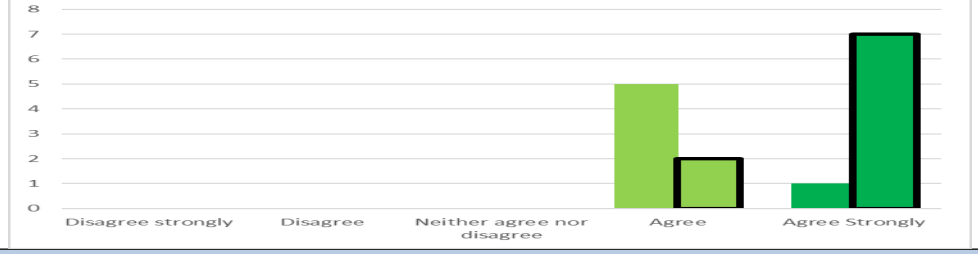
Comments
• There are no responses.

Q6 I have received the information which I require to consider the Trust's quality risks and their mitigations
Responses – 2023/24 and **2024/25**



Comments
• There are no responses.

Q7 The Committee has added value to the Trust's assurance processes
Responses – 2023/24 and **2024/25**

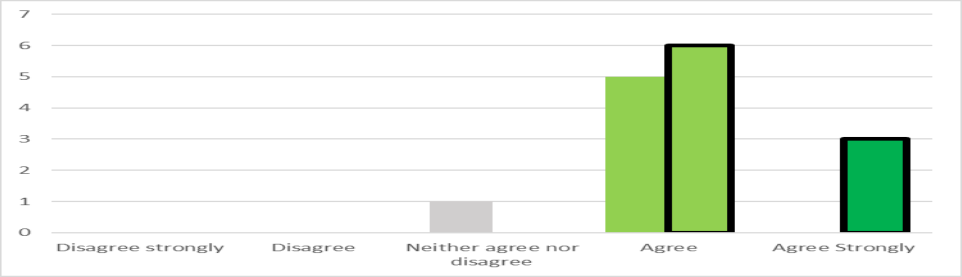


Comments
• There are no responses.

Q8 The Committee has had sufficient time/information to consider patient safety matters
Responses – 2023/24 and **2024/25**

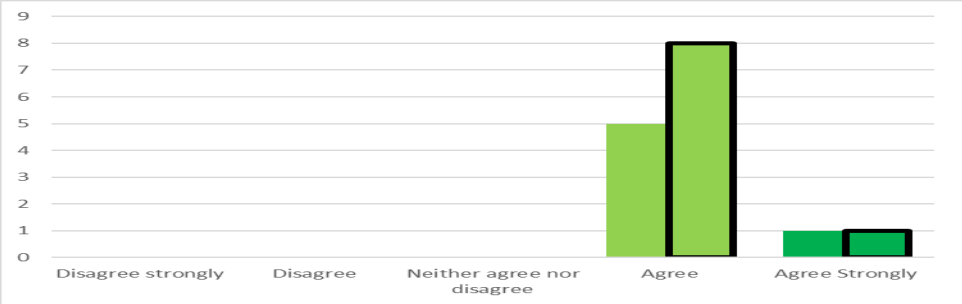
Comments
• There are no responses.

Q9 The quality of the papers and presentations ensure the Committee can add value and rigour to quality and safety governance
Responses – 2023/24 and **2024/25**



Comments
• There are no responses.

Q10 I consider that the Committee receives sufficient information on the people KPIs to gain assurance on the Trust's performance in these areas
Responses – 2023/24 and **2024/25**



Comments
• The Q&S committee has a wide remit which is well managed • I believe that there could be improvements in informatics and this has just recently been reviewed.

8. Committee Self-Assessment (2024/25)

Area / Question	Response	Comments / Action
Composition, Establishment and Duties		
Does the committee have written terms of reference that adequately and realistically define the Committees role?	Yes	Approved by the Audit and Risk Committee on behalf of the Trust Board and incorporated into the Board Governance Pack.
Have the terms of reference been adopted by the Board?	Yes	As above.
Are the terms of reference reviewed annually to take into account governance developments and the remit of other committees within the organisation?	Yes	Yes annual review is included in the work plan with ad hoc changes made as and when required throughout the year.
Are committee members independent of the management team?	Yes	The committee is chaired by a Non-Executive and has another 3 Non-Executives within its membership.
Are members, particularly those new to the committee provided with relevant training?	N/A	There is no formal training for this Committee but the Chief Nurse and Chief Medical Officer/Chair of the Committee would be available as required to talk through the role of the committee, the nature of the discussion etc for any new attendees. A discussion is also held as part of the NED induction meetings.
Has the committee established a plan for the conduct of its own work across the year?	Yes	This is set for the financial year ahead and reviewed on a monthly basis as a standard agenda item for the meeting.
Are changes to the current and future workload discussed and approved at Board level?	Yes	The remit is set by the Board through approval of the terms of reference and the workplans are reviewed at each committee meeting with an overview of any changes presented to the Board via the Chair's Report.
Does the committee report to the Board regularly?	Yes	The chair of the committee presents an assurance report to the Board on a monthly basis.
Does the committee assess its own effectiveness periodically?	Yes	This is undertaken annually as part of the committee annual report.
Does the committee prepare an annual report on its work and performance in the preceding year?	Yes	It is presented to the Committee and considered alongside the self-assessment.
Has the committee been quorate for each meeting this year?	Yes	This is confirmed by the minutes of the meeting and reported to the Board as part of the assurance report.
Compliance with the Law and Regulations Governing the NHS		
Does the committee review assurance and regulatory compliance reporting processes?	Yes	This is undertaken by the committee in relation to issues of quality and safety and assurance is provided to the Board via the Chair's report.

Does the committee have a mechanism to keep it aware of topical, legal and regulatory issues?	Yes	These would be escalated through the Trust's governance framework. The Trust's Executive Team provide updates as required.
Internal Control		
Has the committee formally considered how it integrates with other committees?	Yes	All committee work plans have been reviewed simultaneously to ensure timely flow of information from one to another. Through the Chair's report and the Executive Lead, matters can be escalated up, down or sideways to appropriate committees.
Has the Committee formally considered how its work integrates with the wider performance management and standards compliance?	Yes	The Committee receives an update on the KPIs from the Integrated Performance Report and commissions deep dives as required for assurance purposes.
Has the Committee reviewed whether the reports it receives are timely and have the right format and content to ensure its responsibilities are discharged?	Yes	The Trust launched the Corporate Stands Manual in 2023/24 which supports with the correct format and content of the reports. There are occasions where papers are marked to follow due to the reporting timelines.
Administrative Arrangements		
Does the committee have a plan of matters to be dealt with over the coming year?	Yes	This is set for the financial year ahead and reviewed on a monthly basis as a standard agenda item for the meeting.
Are papers circulated in good time and are minutes received as soon as possible after the meetings?	Yes	There are occasions when papers need to be delayed but the packs are circulated with good time and updated with papers that have been delayed for genuine reasons. If papers have been delayed to such an extent that the committee would not have sufficient time to consider them, they are deferred to the next meeting.
Does the committee meet the appropriate number of times a year?	Yes	The committee meets on a monthly basis.
Other Issues		
Does the Annual Report include a description of the committee's establishment and activities?	Yes	This is included in the Annual Governance Statement

9. Forward look into 2025/26

To support with continuous improvement of the Quality and Safety Committee, members are asked to review the Terms of Reference and consider any required revisions for 2025/26.

10. Recommendation

That the Board note that, at the April meeting, the Committee:

1. **Noted** the report;
2. **Considered** the outcome of the committee effectiveness survey and did not identify any required actions;
3. **Considered and agreed** the draft self-assessment document (as included at section 8);
4. **Noted** the 2024/25 Decision / activity log (as included at attachment A).
5. **Considered** the draft Terms of Reference for 2025/26 (as included at attachment B) and recommended that the Board approve them.

The Board is therefore asked to consider and approve the proposed terms of reference for 2025/6.

Quality and Safety Committee - ACTIVITY / DECISION LOG

Updated: 20 March 2025

Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE *"Decision" Types* tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward sumbission?	If a recommendation - date of subsequent consideration at approval body
1	18-Apr-2024	Corporate Risk Register	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
2	18-Apr-2024	Integrated Performance Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
3	18-Apr-2024	KPI Proposal for 2024/25	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
4	18-Apr-2024	Quality Priorities for 2024/25	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
5	18-Apr-2024	Quality Accreditation	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
6	18-Apr-2024	PSIRF Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
7	18-Apr-2024	Patient Safety Visits	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
8	18-Apr-2024	Legal Claims Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
9	18-Apr-2024	Clinical Audit Forward Plan 2024/25	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
10	18-Apr-2024	HTA Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
11	18-Apr-2024	Chair Reports	None noted	Noted - chair reports from the following meetings were noted by the Committee: clinical effectiveness, patient experience, patient safety, IPC, health inequalities.			
12	18-Apr-2024	Committee Effectiveness and Annual Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
13	18-Apr-2024	Terms of Reference	None noted	Approved - The Committee discussed the circulated report and subsequently approved.		*Board of Directors*	01-May-24
14	18-Apr-2024	Policy Tracker	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
15	23-May-2024	Board Assurance Framework	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
16	23-May-2024	Integrated Performance Report	None Noted	Noted - The Committee discussed the circulated report and subsequently noted.			
17	23-May-2024	IPC Theatre Assurance Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
18	23-May-2024	Learning from Deaths Q4 Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
19	23-May-2024	Inpatient Survey Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
20	23-May-2024	Patient Safety Report (PSIRF)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
21	23-May-2024	Clinical Audit Annual Report	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
22	23-May-2024	IPC Annual Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
23	23-May-2024	Health and Safety Annual Report	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
24	23-May-2024	Patient Safety Alerts Annual Report	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
25	23-May-2024	Chair Reports	None noted	Noted - chair reports from the following meetings were noted by the Committee; health and safety, adult and childrens safeguarding, patient safety, patient experience, IPC, ICS quality meeting/system update			
26	23-May-2024	Modern Slavery Statement	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
27	23-May-2024	Deteriorating Patient Escalation Policy	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
28	23-May-2024	Committee Annual Report	None noted	Recommend - The Committee recommended the report be taken to Trust Board for approval.		*Board of Directors*	
29	23-May-2024	Work Plan/Attendance Matrix	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
30	20-Jun-2024	National Oversight Framework Dashboard	None noted	Noted - The Committee considered the circulated report and subsequently noted.			

Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE *"Decision" Types* tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward sumbission?	If a recommendation - date of subsequent consideration at approval body
31	20-Jun-2024	Corporate Risk Register	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
32	20-Jun-2024	Integrated Performance Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
33	20-Jun-2024	Patient Safety Report (PSIRF)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
34	20-Jun-2024	Mortuary Assurance Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
35	20-Jun-2024	HAVS Assurance Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
36	20-Jun-2024	CIP QIA Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
37	20-Jun-2024	Medicines Supply Assurance Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
38	20-Jun-2024	Food and Drink Strategy	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
39	20-Jun-2024	Quality Account 2023/24	None noted	Endorsed - The Committee recommended the report for onward approval at Trust Board.		*Board of Directors*	
40	20-Jun-2024	Security Annual Report	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
41	20-Jun-2024	Patient Complaints and Experience Annual Report	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
42	20-Jun-2024	Safeguarding Annual Report	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
43	20-Jun-2024	Controlled Drug and Accountable Officer Annual Report	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
44	20-Jun-2024	IPC Annual Report	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
45	20-Jun-2024	Chair Reports	None noted	Noted - chair reports from the following meetings were noted by the Committee; IPC, patient experience, patient safety, drugs and therapeutic, clinical effectiveness, regulatory oversight group, health inequalities group, ICS quality meeting/system update.			
46	20-Jun-2024	Policy Tracker	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
47	20-Jun-2024	Work Plan/Attendance Matrix	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
48	25-Jul-2024	Patient Story with Des Turner	None noted	Noted - The Committee noted the story presented by Des Turner.			
49	25-Jul-2024	Quality Accreditation	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
50	25-Jul-2024	Quality Strategy Action Plan	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
51	25-Jul-2024	Quality Priorities for 2024/25	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
52	25-Jul-2024	Integrated Performance Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
53	25-Jul-2024	Patient Safety Report (PSIRF)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
54	25-Jul-2024	Deep Dive - Pre-op Project, on the day cancellations	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
55	25-Jul-2024	Chair Reports	None noted	Noted - chair reports from the following meetings were noted by the Committee: patient safety, health and safety, IPC.			
56	25-Jul-2024	Work Plan/Attendance Matrix	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
57	22-Aug-2024	Board Assurance Framework	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
58	22-Aug-2024	NHSE Letter of concern and action plan	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
59	22-Aug-2024	Medical Associates Professions (MAPS)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
60	22-Aug-2024	Response to Board Story (Veterans)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
61	22-Aug-2024	Integrated Performance Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
62	22-Aug-2024	Patient Safety Report (PSIRF)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			

Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE *"Decision" Types* tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward sumbission?	If a recommendation - date of subsequent consideration at approval body
63	22-Aug-2024	PSII: Medication Omission	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
64	22-Aug-2024	CIP QIA Report (Q1)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
65	22-Aug-2024	Patient Safety Visits (Q1)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
66	22-Aug-2024	IPC Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
67	22-Aug-2024	IPC Improvement Plan	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
68	22-Aug-2024	Cleanliness and Estates Report (Q1)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
69	22-Aug-2024	Annual Fire Safety Audit Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
70	22-Aug-2024	Chair Reports	None noted	Noted - chair reports from the following meetings were noted by the Committee: IPC, Patient Experience, Patient Safety, Adult and Children's Safeguarding, Clinical Effectiveness, Regulatory Oversight, Health Inequalities.			
71	22-Aug-2024	Work Plan/Attendance Matrix		Noted - The Committee considered the circulated report and subsequently noted.			
72	19-Sep-2024	Chief Nurse/DIPC and Chief Medical Officer Update	None noted	Noted - The Committee considered the verbal update and subsequently noted.			
73	19-Sep-2024	Improvement Presentation	None noted	Noted - The Committee considered the circulated presentation and subsequently noted.			
74	19-Sep-2024	Apollo/Clinical Safety Case Update	None noted	Noted - The Committee considered the verbal update and subsequently noted.			
75	19-Sep-2024	MAPS Self-Assessment/Action Plan	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
76	19-Sep-2024	Rheumatology Service	None noted	Noted - The Committee considered the verbal update and subsequently noted.			
77	19-Sep-2024	Integrated Performance Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
79	19-Sep-2024	Patient Safety Report (PSIRF)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
80	19-Sep-2024	Inpatient Survey Results	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
81	19-Sep-2024	Premises Assurance Model Report 2024	None noted	Recommend - The Committee recommended the report be taken to Executive Team Meeting for approval.			
82	19-Sep-2024	Chair Report from Patient Safety Meeting	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
83	19-Sep-2024	Chair Report from Health Inequalities	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
84	19-Sep-2024	Chair Report from IPCC Meeting	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
85	19-Sep-2024	IPC Cleanliness Metrics	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
86	19-Sep-2024	Chair Report from Health and Safety Meeting	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
87	19-Sep-2024	Chair Report from Regulatory Oversight Group	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
88	19-Sep-2024	Review of the Workplan and Attendance Matrix	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
89	19-Sep-2024	Policy Tracker	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
90	24-Oct-2024	Chief Nurse/DIPC and Chief Medical Officer Update	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
91	24-Oct-2024	Corporate Risk Register	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
92	24-Oct-2024	Response to Board Story (MSST)	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
93	24-Oct-2024	Bone Tumour Action Plan	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
94	24-Oct-2024	Rheumatology Outlier Action Plan	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
95	24-Oct-2024	Progress update on the day cancellations	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			

Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE *"Decision" Types* tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward sumbission?	If a recommendation - date of subsequent consideration at approval body
96	24-Oct-2024	Performance Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
97	24-Oct-2024	Patient Safety Report (PSIRF)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
98	24-Oct-2024	PSII: Never Event	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
99	24-Oct-2024	Patient Safety Visits Q2	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
100	24-Oct-2024	Legal Claims Report Q2	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
101	24-Oct-2024	Learning from Deaths Report Q2	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
102	24-Oct-2024	Quality Priorities Update Q2	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
103	24-Oct-2024	Quality Accreditation Q2	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
104	24-Oct-2024	Health, Safety and Welfare Policy	None noted	Ratified - The Committee ratified the circulated policy.			
105	24-Oct-2024	Chair Reports	None noted	Noted - chair reports from the following meetings were noted by the Committee: Health Inequalities, Regulatory Oversight Group, Clinical Effectiveness, Patient Safety, Patient Experience, Drugs and Therapeutics.			
106	24-Oct-2024	Work Plan/Attendance Matrix	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
107	21-Nov-2024	Board Assurance Framework	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
108	21-Nov-2024	MHRA Inspection Update	None noted	Noted - The Committee discussed the update and subsequently noted.			
109	21-Nov-2024	Theatre Culture (re patient safety) Plan Update	None noted	Noted - The Committee discussed the update and subsequently noted.			
110	21-Nov-2024	Harms Review	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
111	21-Nov-2024	CIP Quality Impact Assessment Q2 Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
112	21-Nov-2024	Review of Critical Care Review	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
113	21-Nov-2024	Integrated Performance Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
114	21-Nov-2024	Quality Strategy Action Plan	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
115	21-Nov-2024	Patient Safety Report (PSIRF)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
116	21-Nov-2024	HTA Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
117	21-Nov-2024	PLACE Results	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
118	21-Nov-2024	IPC Quality Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
119	21-Nov-2024	IPC Improvement Plan	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
120	21-Nov-2024	Cleanliness and Estates Report (Q2)	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
121	21-Nov-2024	Legal Claims Policy	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
122	21-Nov-2024	Chair Reports	None noted	Noted - chair reports from the following meetings were noted by the Committee: regulatory oversight group, adult and childrens safeguarding meeting, patient safety meeting, ipcc meeting, health and safety meeting.			
123	21-Nov-2024	Regulatory Oversight Group Effectiveness Review	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
124	21-Nov-2024	Review of the Workplan and Attendance Matrix	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
125		Bone Tumour (outcome of national review)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
126	20-Dec-2024	Corporate Risk Register	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
127	20-Dec-2024	Integrated Performance Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			

Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE *"Decision" Types* tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward sumbission?	If a recommendation - date of subsequent consideration at approval body
12	20-Dec-2024	Patient Safety Report (PSIRF)	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
129	20-Dec-2024	Draft Clinical Strategy	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
130	20-Dec-2024	Chair Reports	None noted	Noted - chair reports from the following meetings were noted by the Committee; patient safety meeting, patient experience meeting, IPCC meeting, clinical effectiveness meeting, regulatory oversight meeting, health inequalities group, theatre safety culture review group, ICS quality meeting.			
131	20-Dec-2024	Review of the Workplan and Attendance Matrix	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
132	20-Dec-2024	Policy Tracker	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
133	23-Jan-2025	Integrated Performance Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
134	23-Jan-2025	Patient Safety Report (PSIRF)	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
135	23-Jan-2025	PSII: Never Events Progress Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
136	23-Jan-2025	On the day cancellations Progress Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
137	23-Jan-2025	Learning from Deaths Report Q3	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
138	23-Jan-2025	Legal Claims Update Q3 Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
139	23-Jan-2025	Quality Accreditation Q3	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
140	23-Jan-2025	Quality Strategy Action Plan	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
141	23-Jan-2025	EPRR Annual Report Submission	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
142	23-Jan-2025	Chair Reports	None noted	Noted - chair reports from the following meetings were noted by the Committee: regulatory oversight meeting, health and safety meeting, patient safety meeting, ipcc meeting, MHRA working group,			
143	23-Jan-2025	Regulatory Oversight Meeting Terms of Reference	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
144	23-Jan-2025	MHRA Working Group Terms of Reference	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
145	27-Feb-2025	Board Assurance Framework	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
146	27-Feb-2025	Integrated Performance Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
147	27-Feb-2025	Patient Safety Report (PSIRF)	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
148	27-Feb-2025	PSIRF Evaluation and Revised Patient Safety Incident Response Plan	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
149	27-Feb-2025	PSII Report: Incompatible Implant	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
150	27-Feb-2025	MHRA Patient Safety Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
151	27-Feb-2025	Quality Priorities 2024/25	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
152	27-Feb-2025	CIP Quality Impact Assessment Q2 Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
153	27-Feb-2025	IPC Quality Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
154	27-Feb-2025	IPC Improvement Plan and HCSA/IPC BAF	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
155	27-Feb-2025	Cleanliness and Estates IPC Report	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
156	27-Feb-2025	Complaints Policy	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			
157	27-Feb-2025	PSIRF Policy	None noted	Approved - The Committee discussed the circulated report and subsequently approved.			

Decision Ref No.	Meeting Date	Topic/Agenda item	Conflicts of interest considered and agreed treatment of the conflict	Conclusion/Decision (e.g. Approved, Noted, Recommended ... etc. SEE *"Decision" Types* tab for guidance)	If applicable - results of vote and/or dissenting views	If Recommendation - destination for onward sumbission?	If a recommendation - date of subsequent consideration at approval body
158	27-Feb-2025	Chair Reports	None noted	Noted - chair reports from the following meetings were noted by the Committee: MHRA working group, regulatory oversight meeting, clinical effectiveness meeting, health inequalities group, drugs and therapuetics meeting, patient safety meeting, IPCC meeting, patient experience meeting, adult and childrens safeguarding meeting.			
159	27-Feb-2025	Review of the Workplan and Attendance Matrix	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
160	20-Mar-2025	Corporate Risk Register	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
161	20-Mar-2025	Deep Dive - Pre-op Project, on the day cancellations	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
162	20-Mar-2025	Draft Clinical Safety Report (Apollo)	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
163	20-Mar-2025	Integrated Performance Report	None noted	Noted - The Committee discussed the circulated report and subsequently noted.			
164	20-Mar-2025	Patient Safety Report (PSIRF)	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
165	20-Mar-2025	Quality Priorities 2025/26	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
167	20-Mar-2025	Chair Reports	None noted	Noted - chair reports from the following meetings were noted by the Committee: MHRA working group, health inequalities, patient safety meeting, ipcc meeting, patient experience meeting, drugs and therapeutics meeting.			
168	20-Mar-2025	Review of the Workplan and Attendance Matrix	None noted	Noted - The Committee considered the circulated report and subsequently noted.			
169	20-Mar-2025	Policy Tracker	None noted	Noted - The Committee considered the circulated report and subsequently noted.			

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Quality and Safety Committee. The Committee is a Non-Executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Quorum

The Committee shall be appointed by the Board from the Non-Executive Directors (including the Associate Non-Executive Directors) and the Executive Directors of the Trust and shall consist of:

- Up to four Non-Executive members
- Chief Medical Officer
- Chief Nurse and Patient Safety Officer
- Chief Operating Officer/Deputy CEO

Non-Executive members may be drawn from the Non-Executive Director membership of the Board or the Associated Non-Executive Directors.

In exceptional circumstances a deputy may attend in place of an Executive Director. The nominated deputy can act on behalf of the absent Executive Director. This is to be noted at the beginning of the meeting.

The Board of Directors will appoint a Committee Chair from the Non-Executive Director members of the Committee. In the absence of the appointed Chair, the Committee will appoint another Non-Executive member to chair the meeting.

A quorum will be two Non-Executive members and two Executive members. Deputies representing Executive members will count towards the quorum but at least one of the Executive members must be drawn from the listed membership.

3. Attendance

The Trust Secretary, ~~and the Head of Clinical Governance and Quality~~ Deputy Chief Nurse and DPIC, Assistant Chief Nurse and Patient Safety Officer, and Chief Pharmacist will be expected to attend each meeting.

The Chair of the Trust may attend at the invitation of the Chair of the Committee.

The Chief Executive Officer will receive a standing invitation to attend.

The ICB will receive a standing invitation to send a representative of the ICB Quality Team.

Senior Managers and Unit Representative will be required to attend the meeting when presenting a paper.

The Trusts governors are invited to observe the meetings.

4. Frequency of meetings and meeting administration

The Committee will meet at least 10 times a year for regular business. The Chair of the Committee may call additional meetings.

The Chief Nurse and Patient Safety Officer shall agree the agenda with the Chair of the Committee and other attendees. The Assistant Trust Secretary will organise the collation and distribution of the papers and keep a record of matters arising and issues to be carried forward.

5. Authority

The Committee is authorised by the Board to investigate any activity and is expected to make recommendations to the full board, within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise if it considers this necessary.

6. Reporting

A written Chair's Assurance Report will be presented to the Board no later than the Board meeting the following month (or the soonest available meeting if a Board meeting does not fall that month). The Chair's Report shall:

1. Alert the Board to any issues that:
   - Represent non-compliance with required standards or pose a significant risk to the Trust's ability to deliver its responsibilities or objectives and therefore require action to address; OR
   - Require the approval of the Board for work to progress.
2. Advise the Board of any areas for ongoing monitoring, a potentially worsening position, or an emerging risk to the Trust's ability to deliver its responsibilities or objectives.
3. Assure the Board on other items considered where the Committee did not identify any issues that required escalation to the Board.

The Committee will undertake an Annual self-assessment, which will be presented to the Trust board, along with an Annual Report.

7. Key responsibilities

- Promote excellence in patient care in all aspects of quality and safety, and monitor and review the "Quality Improvement Strategy".

- The purpose of the Quality and Safety Committee is to assist the Board obtaining assurance that high standards of care are provided and any risks to quality identified and robustly addressed at an early stage. The Committee will work with the Audit Committee and Risk Management Committee to ensure that there are adequate and

appropriate quality governance structures, processes and controls in place throughout the Trust to:

- Promote safety and excellence in patient care
- Identify, prioritise and manage risk arising from clinical care
- Ensure efficient and effective use of resources through evidence based clinical practice

- To ensure the Trust is meeting core standards and is compliant with national guidelines to include (but not be limited to) prevention and control of infection and effective and efficient use of resources through evidence based clinical practice.

- To consider NHSE Quality Governance Framework in the delivery of its key responsibilities

- To receive an agreed level of clinical data and trend analysis from clinical forums and working groups, which provides adequate clinical matrix to inform and analyse the clinical services provided at the Trust.

- To ensure that the Committee has adequate information on which to advise and assure the Board on standards of care provision.

- To receive reports from the following assurance meetings:
  - Adult and Children Safeguarding Meeting
  - Infection Prevention and Control Meeting
  - Clinical Effectiveness Meeting
  - Patient Safety Meeting
  - Patient Experience Meeting
  - Health and Safety Meeting
  - Drugs and Therapeutics Meeting
  - Health and Inequalities Meeting
  - ~~MRHA Meeting~~
  - Regulatory Oversight Meeting

- The Quality and Safety Committee shall review the draft Quality Accounts before submission to the Trust Board

- The Committee shall ratify such policies as the Board has not reserved to itself and as required by the Trust's Policy Approval Framework.

- Clinical outcomes
  - Monitoring the effectiveness of the Trust's arrangements for the systematic monitoring of mortality and other patient outcomes.
  - Receiving and commenting on action plans and progress reports proposed by management in response to monitoring data on patient outcomes.

- Clinical audit

- Monitoring the effectiveness of the Trust's arrangements for undertaking clinical audits and addressing the recommendations made during those audits.

- Incident reporting and investigation
  - Monitoring the effectiveness of the Trust's compliance with the requirements of the Patient Safety Incident Response Framework.
  - Reviewing the outcomes of investigations, ensuring that the information is presented in sufficient detail to enable systemic failings in patient care to be identified; receiving and commenting on action plans and progress reports proposed by management in response to SIs, near misses and other incidents.

- Patient Experience
  - Monitoring the effectiveness of the Trust's systems for complaints handling and reviewing complaints for trends and themes.
  - Monitoring the effectiveness of the Trusts systems for advocacy and the encouragement of feedback from patients and relatives.

- Medicines Management
  - Monitoring the effectiveness of the Trust's arrangements for ensuring sound medicines management practices (through oversight of the governance arrangements in place and consideration of relevant performance reporting).

- Safeguarding
  - Monitoring the effectiveness of the Trust's arrangements for delivering its statutory responsibilities in relation to safeguarding.

- Health and Safety
  - Monitoring the effectiveness of the Trust's arrangements for delivering its statutory responsibilities in relation to health and safety.

- Emergency Preparedness, Resilience and Response
  - Monitoring the effectiveness of the Trust's arrangements for ensuring it has robust, compliant plans and procedures in relation to emergency preparedness, resilience and response .

- Review of compliance with statutory and regulatory requirements relevant to the remit of the Committee, including ~~CQUIN and~~ CQC requirements.

- ~~Patient Information Governance~~
  - ~~Monitoring the arrangements to ensure the security of personally identifiable data.~~

Quality Account 2024-25

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 02 July 2025

Author:	**Contributors:**
Kirsty Foskett, Assistant Chief Nurse and Patient Safety Officer	Mary Bardsley, Assistant Trust Secretary

Report sign-off:

Sam Young, Interim Chief Nurse and Patient Safety Officer
Quality and Safety Committee, 19 June 2025

Is the report suitable for publication?:

Yes

Key issues and considerations:

Each NHS Trust is required to produce an annual report on quality as outlined in the National Health Service (Quality Account) Regulations 2010. A Quality Account is a published report about the quality of services and improvements offered by an NHS healthcare provider.
The quality of services is measured by looking at:

- patient safety
- how effective patient treatments are
- patient feedback about care provided

The quality account is published every year on our website and enables us to explain our progress to the public and allows leaders, clinicians, governors, and staff to demonstrate their commitment to continuous, evidence-based quality improvement.

Strategic objectives and associated risks:

The following strategic objectives are relevant to the content of this report:

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	
4	Grow our services and workforce sustainably	
5	Innovation, education and research at the heart of what we do	✓

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

Board Assurance Framework Themes		
1	Continued focus on excellence in quality and safety	✓
2	Creating a sustainable workforce	✓
3	Delivering the financial plan	✓
4	Delivering the required levels of productivity, performance and activity	
5	Delivering innovation, growth and achieving systemic improvements	✓
6	Responding to opportunities and challenges in the wider health and care system	
7	Responding to a significant disruptive event	

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:

System Objectives		
1	Improve outcomes in population health and healthcare	✓
2	Tackle inequalities in outcomes, experience and access	✓
3	Support broader social and economic development	
4	Enhance productivity and value for money	

Report development and engagement history:

The Quality account for 2024-25 has been produced in collaboration with the following teams and individuals.

- Mary Bardsley, Assistant Trust Secretary
- Clinical Governance Team
- Clinical Audit
- IPC
- Outcomes
- Safeguarding

The Quality Account was considered and endorsed at the Committee meeting in June 2025.

Next steps:

Following a recommendation from the Quality and Safety Committee, the Board is asked to consider and approve the Quality Account for 2024/25.

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Quality Account
2024/2025

Contents

Introduction

The safety and quality of the care that we deliver at Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is our highest priority. To support this, we undertake a review of the quality of our services on an annual basis and outline the progress we have made against our agreed quality priorities. As well as this we take the opportunity to acknowledge the challenges that we have faced in delivering care to the standard to which we aspire.

Each NHS Trust is required to produce an annual report on quality as outlined in the National Health Service (Quality Account) Regulations 2010. A Quality Account is a published report about the quality of services and improvements offered by an NHS healthcare provider.

The quality of services is measured by looking at:

- patient safety
- how effective patient treatments are
- patient feedback about care provided

The quality account is published every year on our website and enables us to explain our progress to the public and allows leaders, clinicians, governors, and staff to demonstrate their commitment to continuous, evidence-based quality improvement.

Through increased patient choice and scrutiny of healthcare service, patients have rightfully come to expect a higher standard of care and accountability from the providers of NHS services. Therefore, a key part of the scrutiny process is the involvement of relevant stakeholders. To that end, one of the requirements for inclusion with the quality account is a statement of assurance from these key stakeholders and evidence of how the stakeholders have been engaged.

In addition, as NHS Foundation Trust we are required to follow the guidance set out by NHS England regarding the quality account and for which there are several national targets set each year which we monitor the quality of the services we provide.

Through this quality account, we aim to show how we have performed against these national targets. We will also report on locally set targets and describe how we intend to improve the quality and safety of our services moving forward.

Foreword from the Chief Nurse and Patient Safety Officer and the Chief Medical Officer

The Trust's aspiration is to improve lives through excellent and innovate care; with quality, safety, and patient experience sitting firmly at the core of this.

During 2024/25 our focus has been to continue reducing our waiting times across all our specialities, working with the Getting it Right the First Time (GiRFT) teams to ensure our patient pathways are effective, to optimise both patient experience and our operational capacity that will enable to see our patients quicker. The Trust continues to build on the significant improvements made in relation to Infection Prevention and Control, to ensure that providing quality care remains at the heart of everything we do, every day.

Despite these challenges we continued with our aim to deliver outstanding patient care to every patient, every day. Our staff have adapted and continue to deliver the high level of care of which we are so proud. This has been reflected in the feedback received from our patients.

As we move into 2025/26 our focus will be to deliver on the Trust strategic objective of delivering high quality clinical services by:

- Ensuring the highest standards of care for our patients.
- Empowering departments to develop services.
- Optimise productivity and efficiency within our services.
- Ensure a fair, equal and inclusive culture across the Trust.

PART 1
Statement on Quality from the Chief Executive Officer

It gives me great pleasure to introduce our annual Quality Account, sharing with you our achievements and celebrations over the past year, as well as the challenges and the improvements made. This Quality Account sets out our key achievements in 2024/25, as well as sharing our priorities for 2025/26.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has recently redefined its vision, stating a goal of improving lives through excellent and innovative care. It is a clear statement – and one that we have shaped in collaboration with our own staff. Having launched it recently, it will be a statement that guides us in our work. Our Quality Strategy is at the core of our vision, as it ensures that quality and patient safety are at the heart of everything we do.

This year has been a milestone year for RJAH. Our efforts to reduce waiting times and improve access to care were given a major boost with the official opening of a new theatre, which will play a key role in our ability to meet government targets for elective recovery in the coming months.

Among the other notable highlights, our commitment to improving end-of-life care was reinforced as we pledged our support to the national Swan Model of Care. This initiative will enhance the experience of patients and families during the end-of-life journey, with a focus on personalised, compassionate care.

The Trust's unwavering support for Armed Forces personnel was also reinforced as we renewed our commitment to the Armed Forces Covenant. This reaffirmation underscores our dedication to veteran care and supporting Armed Forces staff transitioning into NHS roles.

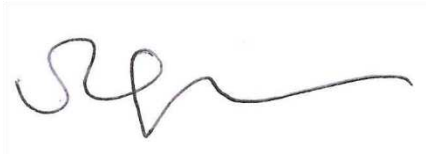
We also saw validation of our work from a number of staff and patient surveys. The National NHS Staff Survey, which is undertaken by more than 300 NHS organisations, again provided very positive feedback. We were ranked third nationally for overall patient experience. Our dedication to excellence in cleanliness and food standards was also once again recognised. We are proud to have achieved the distinction of having the cleanest wards and rooms in the NHS for the fourth consecutive year, and our food was rated the best in the country for the 18th time in the past 19 years. This continues to reinforce our commitment to providing an environment that promotes patient safety and comfort.

September 2024 saw the publication of the Care Quality Commission Adult Inpatient Survey 2022. Once again, we were delighted with the excellent feedback we received from our patients over the past year. We were ranked second for overall care and treatment and, additionally, we were named one of only nine Trusts in

England delivering results "much better than expected,". This is a testament to the hard work and dedication of our staff.

Quality is at the heart of every decision we take and, with the significant contribution of staff from across the hospital, we will strive to keep improving in 2025/26 to deliver ever higher levels of patient experience and care.

I confirm that to the best of my knowledge the information outlined in this document is true.



Stacey Keegan,
Chief Executive Officer
XX June 2025

PART 2
Priorities for improvement

Our Quality Improvement Priorities for 2025/26

Deciding on our quality priorities for the coming year

This part of the report describes the areas for improvement that the Trust have identified for the year 2025/26. The quality priorities have been derived from a range of information sources, including any emerging national quality priorities, learning from patient safety reviews and improvements that have been identified as part of introducing the Trusts Quality Accreditation Programme.

This year saw the introduction of the Trusts Quality Accreditation Programme. The Quality Accreditation Programme is quality assurance audit based upon the five key lines of enquiry as set by the CQC. Each ward has now received their first assessment, and this will be rolled out to other departments in 2025/26.

Each of the quality priorities outlined below were monitored throughout the year via existing governance structures which will be described in more detail below.

Patient Safety	
1. Inpatient Falls Prevention	
Objectives	• To improve documentation and record keeping in relation to falls risk assessments and management plans. • To Improve the use of visual aids that highlight if a patient is at risk of falls. • To introduce the new post-fall toolkit
Rationale	An area of improvement identified through the quality accreditation programme, was the need the need to improve record keeping in relation to falls prevention and to ensure visual aids that highlights a patient being at risk of falling is consistent across all inpatient wards.
Measures	• Improved compliance with completion of risk assessments and management plans. • Improved compliance with the use of visual aids.
Board Sponsor	Sam Young, Interim Chief Nurse, and Patient Safety Officer
Oversight Committee	Patient Safety Meeting with upward reporting to Quality and Safety Committee.

Patient Safety	
2. Recognising and Managing Deteriorating Patient	
Objectives	• To introduce a deteriorating patient simulation study day, to improve the early recognition and management of the unwell patient • To improve the use of fluid balance charts across the Trust
Rationale	An area identified through completed patient safety reviews and the quality accreditation programme, is the need to support staff in the early recognition of

	a deteriorating patient and to improve the use of fluid balance charts, across the Trust, ensuring their use is meaningful and when used, that they are comprehensively completed.
Measures	• Reduction in the number of patient safety reviews requested due deterioration • Uptake of simulation training amongst clinical staff • Improved compliance (through Tendable audit) in the completion of fluid balance charts
Board Sponsor	Ruth Longfellow, Chief Medical Officer
Oversight Committee	Patient Safety Meeting with upward reporting to Quality and Safety Committee.

Clinical Effectiveness	
3. Improving the effectiveness of clinical information sharing	
Objectives	• To introduce bedside nursing handovers • To introduce visual Quality Dashboards in ward/departmental areas • To review the effectiveness of safety huddles in the ward environment • To review the effectiveness of "Link Nurse" meetings • To introduce new patient bed boards across the trust
Rationale	An area of improvement identified through the quality accreditation programme, was the need the need to improve communication across clinical staff in a variety of ways, as outlined in the above objectives.
Measures	• Improved communication with staff in understanding ward (quality) performance • Reduction in incidents relating to communication in ward area • Improved scores through Well-led on the quality accreditation assessment
Board Sponsor	Sam Young, Interim Chief Nurse, and Patient Safety Officer
Oversight Committee	Patient Safety Meeting with upward reporting to Quality and Safety Committee.

Patient Experience	
4. Introduction of a complex care pathway for patients with mental health needs, learning disability and/or autism	
Objectives	• Improving the experience of those patients with LD&/or A or mental health needs
Rationale	Learning from patient safety reviews and patient experience has identified the need to introduce a pathway for patients with additional needs. Identifying patients who require reasonable adjustments earlier in their patient pathway will offer a more co-ordinated and positive experience, when visiting the hospital.
Measures	• Reduction in the number of communication incidents reported • Reduction in the number of patient complaints
Board Sponsor	Sam Young, Interim Chief Nurse, and Patient Safety Officer
Oversight Committee	Patient Experience Meeting with upward reports to Quality and Safety Committee.

Statements of Assurance from the Board

In this section we report on matters relating to the quality of NHS services provided as stipulated in regulations. The content is common to all providers so that as can be compared across NHS Trusts.

Review of Services

During 2024/25, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provided three NHS services, in Musculo-skeletal surgery, medicine and rehabilitation.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all these health services.

The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of NHS services by The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust for 2024/25.

Participation in Clinical Audit

During 2024/25, 11 National clinical audits covered NHS services that the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust provides.

During that period, The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in 11 out of 11 (100%) National Clinical Audits that it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust participated in during 2024/25 were as follows:

- National Falls & Fragility Fracture Audit Programme - National Audit of Inpatient Falls
- Learning from lives and deaths - People with a learning disability and autistic people (LeDeR)
- KO41A Return - NHS Complaints
- NCEPOD - Emergency (non-elective) procedures in children and young people
- NCEPOD - Blood Sodium
- Perioperative Quality Improvement Programme
- National Joint Registry
- ICNARC Case Mix Programme (CMP)
- National Comparative Audit of Blood Transfusions
- Epilepsy 12: National Clinical Audit of Seizures and Epilepsies for Children and Young People
- National Early Inflammatory Arthritis Audit (NEIAA)

The reports of 16 local clinical audits were reviewed by the provider in 2024-2025 and The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust intends to take the actions set out in below to improve the quality of healthcare provided.

No.	Project Ref	Action Plan
1	2223_037 Blood Sample Collection and Labelling National Comparative Audit of Blood Transfusion	1. Training new medical professionals – addition to medical professional induction 2. Include in venepuncture skills training 3. Visual aid to be put on all blood trolleys
2	2324_022 Compliance with NG 199: Clostridioides difficile infection: antimicrobial prescribing	1. Quicker access to antibiotics for CDI diagnosis 2. Immediate prescribing of antibiotics when a confirmed diagnosis of CDI 3. Medication review and fluid chart to be undertaken for all patients with CDI 4. Delays of antibiotics for CDI patients should be reported as a patient safety incident
3	2223_032 Epidemiological Study of OPLL in a Western Tertiary Hospital	1. Share findings with the Unit
4	2223_052 Clinical Audit of adult cardiac surveillance in DMD	1. Discuss with bookings team to speak to patients about bringing their slings to appointments when confirming booking 2. Liaise with ECHO techs to find out when patients are seen locally for deep dive
5	2324_025 Tofacitinib prescription and NICE guidance	1. Better documentation of DAS-28 / PsARC scores 2. Education on including lipid screening and CVS risk assessments for patients starting JAKi
6	2425_003 Outcomes of new patient referrals to Spinal Disorders at RJAH	1. More timely investigations to be included with referral 2. Vetting referral form to be completed by the referrer
7	2324_012 The Rheumatology Advice Line	1. Share findings with team 2. Update patient information leaflet 3. Review messaging for service on website and voicemail service
8	2425_009 Documentation of relevant comorbidities on discharge summaries at RJAH	1. Co-morbidity recording to be mandatory on patient records 2. Discharge summary to include co-morbidities
9	2021_038 Audit of the Critical Care Operational Policy	1. Improve documentation of time and decision to admit patient on HDU note 2. Identify patients at pre-op stage who needs a HDU stay – implement frailty scoring
10	2324_021 Timing of the most recent imaging of patients undergoing elective Foot & Ankle surgery	1. Ask Bookings to plan x-ray for same day as pre-op 2. Review date of scan at pre-op to ensure it is within 6 months 3. Sharing findings with medical professionals

11	2425_015 Re-audit of compliance with IR(ME)R procedure	1. Maintain compliance following the introduction of e-referrals 2. Maintain IRMER training for radiographers
12	2223_048 Bilateral Knee Replacements - A review of immediate post-surgical outcomes	1. Share findings with unit
13	2324_032 Post Operative Blood Test SOP Audit	1. Share findings at MDCAM 2. Add guidelines in medical professional induction
14	2425_010 Upper GI Bleed Re-Audit 2021_001	1. Present at medical weekly lunchtime meet to share the need for a risk assessment 2. Share the need to contact Gastroenterology team if upper GI bleed is possible 3. Share the need to inform GP if patient is considered to have upper GI bleeding
15	2425_019 Soft Tissue Cryoablation Treatment Procedure Safety at RJAH	1. Arrange baseline MRI with contrast 2. Schedule follow up scans at 3, 6 and 12 months 3. Improve documentation of patient pain before and after procedure
16	2425_037 Learning Response Review	1. Improve information available to individuals invited to AAR/MDTs 2. Continuously capture feedback from key stakeholders about process 3. Include Quality Improvement initiatives to agenda for Patient Safety, SNAHP and Unit Governance 4. Update the PSIRP plan with revised patient safety priorities

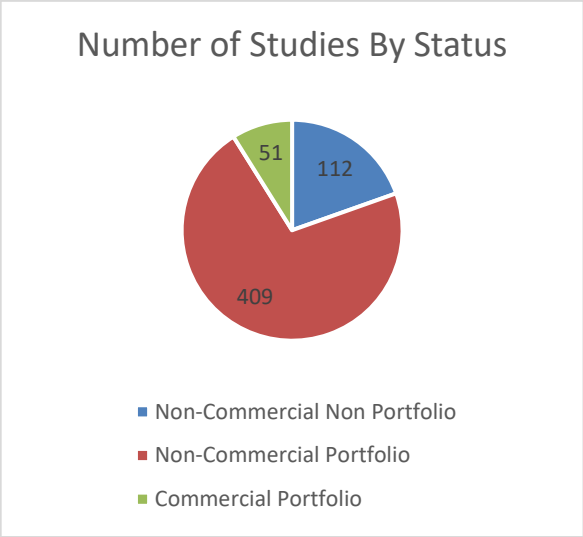
12 Service Evaluation projects reports were reviewed by the provider in 2024 – 2025 as follows:

No.	Project Ref	Action Plan
1	2324_029 Evaluation of surgical booking length of stay for paediatric patients	1. Review Trust data to compare to national metrics 2. Ensure Bluespier consultant templates are accurate, and IP/DC status is considered when booking
2	2324_011 The effect of the inability to alter and supply same day insoles to HBC patients	1. Improve direct communication between admin, workshop, and orthotic assistants for 1-week urgent referral patients 2. Submit an insole technician mini workshop business care at SaTH
3	2324_017 Patient outcomes from Offloading knee braces for uni-compartmental Osteoarthritis	1. Change OA knee brace stock to Unireliever
4	2425_001 Patient & Parent/Care Service Feedback Audit	1. Produce patient information leaflet 2. Improve provisions for teenagers admitted onto the ward

		3. Arrange paediatric specific pain training
5	2425_020 Patient Centred Care within Radiology Service Evaluation	1. Develop clear and agreed standards for patient-centred care 2. Improve reception and waiting area signage
6	2223_006 An Evaluation of Operative Rates in Osteochondritis Dissecans of the Knee	1. Agree pathway between Paediatrics and Knee Sports departments 2. Follow up MRI requests
7	2324_031 Service Evaluation of the Safeguarding Checklist for Inpatients	1. Create a resource bank for patients and visitors 2. Create CPD resource bank for staff to increase awareness around reasonable adjustments 3. Record any reasonable adjustment requirements on new EPR 4. Distinguish complex care from safeguarding concerns 5. Capture feedback from LD&A patients about their experience at RJAH
8	2223_043 Service Evaluation of major paediatric surgery at RJAH	1. Create a flow chart for SOP, to indicate pre-op assessment pathways for all paediatric major surgery 2. Anaesthetic day 1 index review documented in standardised place
9	2425_013 Mepilex Border Post-Op Evaluation	1. Share findings at Patient Safety Working Group
10	2223_053 Service Evaluation for implementation of Enhanced Recovery Arthroplasty	None
11	2324_020 Assessing patient perspective of being in research study in the ASCOT Clinical Trial	None
12	2425_002 Radiological investigations in children - the role of the play specialist	1. Develop standardised pathway for referrals 2. Plan for the future; need and expansion of play specialist input 3. Understand patient/parental views of service

Participation in Clinical Research

Research at The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) continues to grow. The total number of studies active at the Trust during 2024/25 was 76, representing a 1.3% increase from the previous year. 54 of these were adopted onto the National Institute for Health Research (NIHR) portfolio, representing a 2% increase from the previous year.



The number of participants that were enrolled in research eligible for inclusion in the NIHR portfolio was 460 (Figure 1). This represents a 14% reduction on 2023/24 (538). The total number of patients recruited in 2024/25 was 572 (Figures 1 and 2). This is a 57% reduction on 2023/24 and reflects a reduction in the number of studies with large recruitment targets in 2024/25. For FY 2023/24, the number of patients approached and offered the opportunity to participate in research accounted for 2.5% of total patient episodes. Recruitment to research opportunities accounted for 2.3% of total patient episodes. At the time of preparing this report, data for 2024/25 was not available. Increasing the number of patients being offered particpation in research as a percentage of total patient episodes, and thereby, increasing the number of patients participating in research as a percentage of total patient episodes remain clear objectives of the Research Department going forward.

Overall, across the West Midlands RRDN (Regional Research Delivery Netwrok), recruitment is 5% lower than last year with non-acute, primary care and wider care settings being most impacted. This is further reflected in the overall reduction is commercial recruitment in 2024/25 which is 75% behind on 2023/24 across the West Midlands RRDN. Non-actue settings are 46% behind on commercial studies and 1% behind on non-commercial activity compared to 2023/24. Recruitment/100k of population is third lowest in the West Midlands compared to other regions although the percentage of recruitment in interventional studies is second highest, and the actual number is fourth highest compared to other regions.

Balancing the portfolio of commercial and non-commercial studies will be an important focus over the coming years and we continue to support home-grown studies sponsored by the Trust. These studies accounted for 21% of our research in 2024/25 and when this extended to include collaborations between clinicians and local academics, sponsored studies accounted for 25% of research studies in 2024/25. 62% of our projects are hosted studies and involve academic and non-academic sponsors. Commercial studies, which bring in the most money for the Trust, made up 22% of RJAH based projects in FY 2024/25. These studies fall into the RRDN speciality areas of Cancer, Children, Dementia and Neurodegeneration, Neurology, Public Health, Trauma and Emergency Care, Surgery, Musculoskeletal and Orthopaedics, and Anaesthesia, Peri-operative Medicine, and Pain Management.

The West Midlands has had its highest ever annual number of responses (49% ahead of 1533 target) to the PRES survey (Participant in Research Experience Survey) which had a stretch target of 2,000 responses. RJAH remains in the top third for PRES numbers. This is reflective of engagement between the researchers, the research Department and research participants at RJAH.

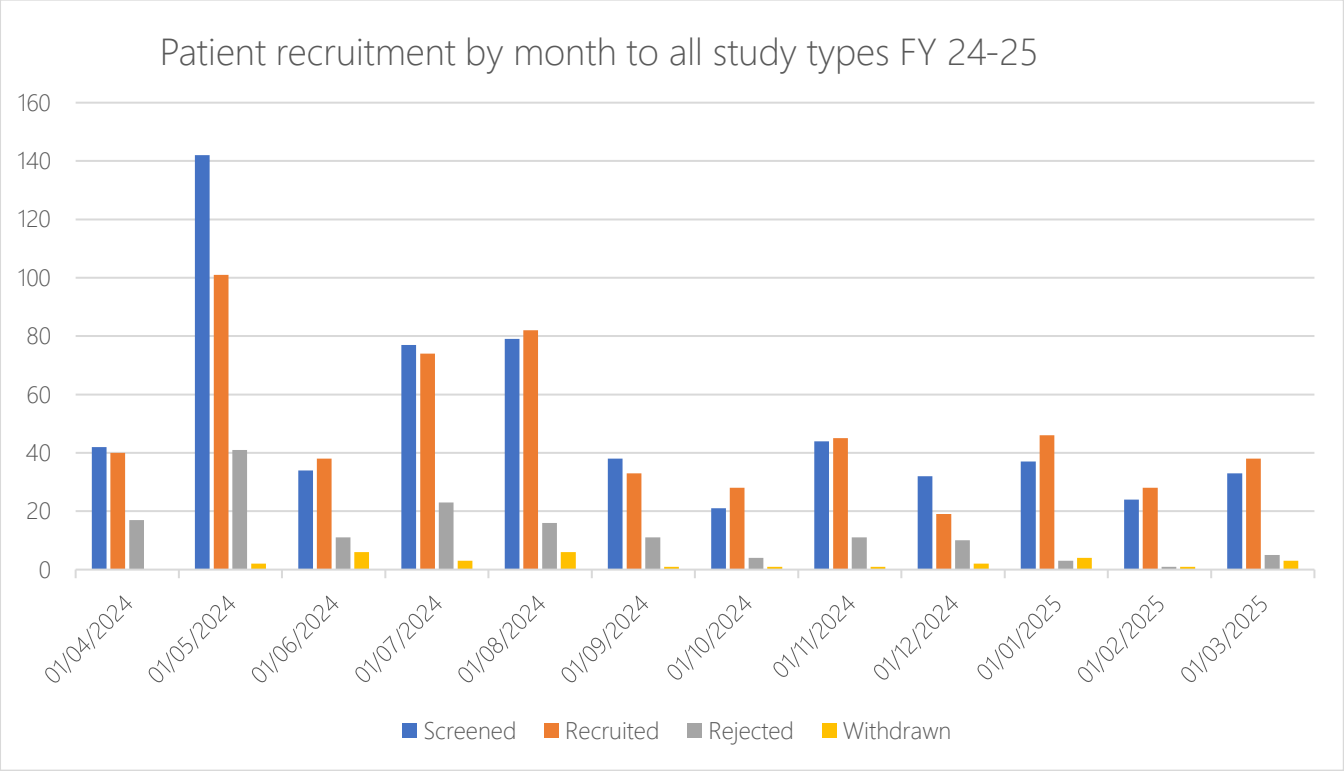


Figure 2. Patient recruitment by month to all study types for the year 24/25.

John Charnley Laboratory and MHRA Inspection

The John Charnley Laboratory is a licensed manufacturing unit under the Medicines and Healthcare products Regulatory Agency (MHRA) that produces Oscell used in Autologous Chondrocyte Implantations (ACI) for articular cartilage lesions.

The MHRA is an executive agency of the Department of Health and Social Care, responsible for ensuring that facilities involved in the manufacturing of medicines and medical devices comply with good manufacturing practice (GMP). Any facility with a MHRA licence must demonstrate evidence of GMP compliance as a minimum standard. The activities concerning manufacturing process within the laboratory are therefore regulated under the MHRA licence. In addition, the unit has MHRA MIA (IMP) licence for manufacturing advanced therapy medicinal product (ATMP) under which the unit is able to manufacture chondrocyte preparations for clinical trials.

Following inspection in September 2024 by the MHRA, the unit was considered to have unsafe practices and procedures with two critical and two major deficiencies identified. The unit was referred to the MHRA Action group and both licences for the Trust have been suspended until September 2025. This has meant that the unit has ceased manufacturing cells for surgical procedures, although manufacturing for research purposes (using cadavers) has been continued as this does not fall under the licence of the MHRA. In view of the MHRA licence

suspension, the business continuity plan for treating patients with ACI has commenced using an external provider (Spherox). Spherox are a manufacturing company based in Europe who provide the cell manufacturing element of the ACI procedure and are not subject to MHRA licencing in the United Kingdom.

In response to the inspection findings the Trust has commissioned an expert external provider (EPIC) to review the findings of the MHRA inspection and to support the Trust with a gap analysis and actions required to regain the licence to manufacture. EPIC have advised the Trust that to regain the MHRA licence the unit requires significant investment involving workforce, equipment, and quality assurance.

In addition to the Trust commissioning a review by EPIC, the trust has internally reviewed governance arrangements for service areas that are strictly regulated and the function of the Regulatory Oversight Group. The terms of reference for the meeting have been revised and re-established as the Regulatory Oversight Meeting, chaired by the Chief Medical Officer, which now directly reports to the Quality and Safety Committee.

The Trust are currently scoping most cost-effective options available to maintain the Trusts ability to provide an ACI service and understand the impact on research within the unit.

CQC registration

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration is without conditions. The Care Quality Commission has not taken any enforcement action against The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in 2024/25.

During December 2018, the CQC conducted an inspection of the Trust and at this time, the Trust was given an overall rating of 'Good' with care found to be 'Outstanding', with the breakdown of ratings show in the table below:

Ratings for The Robert Jones and Agnes Hunt Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Surgery	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Critical care	Requires improvement →← Feb 2019	Requires improvement →← Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Requires improvement ↓ Feb 2019	Requires improvement →← Feb 2019
Services for children and young people	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Outpatients	Good Feb 2019	N/A	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Diagnostic imaging	Good Feb 2019	N/A	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Overall*	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019

The full CQC inspection report can be found at the following link: https://www.cqc.org.uk/provider/RL1/services

In response to the inspection report from February 2019, the Trust put in place and completed a robust action plan to address the areas for improvement highlighted by the CQC. A further inspection was planned during 2020 however this continues to be deferred by the CQC.

Secondary Uses Service Submission

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust submitted records during 2024/25 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the latest published data (December-24) which included the patient's valid NHS number was:

- 99.8% for admitted patients care.
- 99.5% for outpatient care

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patients care.
- 100% for outpatient care

The following has been maintained throughout 2024/25:

Continuing to raise the awareness and profile of data quality, developing within the Trust a positive culture, through encouraging best practise and promoting new processes, and ensuring that all staff recognise that they have a responsibility for ensuring a high standard of data quality.

- Regular Data Quality Assurance Group meetings held.
- A robust Audit framework that provides assurance for key performance indicators as reported in the Trust's Integrated Performance Report (IPR).
- Compliance with all data quality standards as specified within the Data Security and Protection Toolkit.

Throughout 2024/25 the major focus for Data Quality has been the support provided to implementation of the new EPR system (Apollo). This includes:

- Validation and testing of migrated data from current EPR to new EPR
- Support to Apollo and Operational Teams with configuration of new system
- Dashboards built in readiness for Go Live to monitor data quality throughout implementation period.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, personal identifiable information. The NHS Information Governance Framework is supported by a data security and protection toolkit and the annual submission process provides assurances to the Trust, other organisations and to individuals that personal information is dealt with legally, securely, efficiently, and effectively.

The Trust has an established information governance management framework and continues to develop information governance processes and procedures in line with the Data Security and Protection Toolkit (DSPT). The Trust`s Information Governance status is the subject of ongoing review by the Information Governance Meeting which is responsible for reviewing policy and monitoring compliance with Department of Health and Social Care Guidelines. This process is overseen by the Audit and Risk Committee which also has a role in ensuring that all serious data governance risks or incidents are brought to the attention of the appropriate Board Committee. The Trust has in place the Chief Medical Officer as the Caldicott Guardian, and the Director of Digital as the Senior Information Risk Owner (SIRO). Further, Trust Secretary is the Data Protection Officer.

The requirements of the Data Security and Protection Toolkit (DSPT) are designed to encompass the National Data Guardian review's ten data security standards.

The Robert Jones and Agnes Hunt Orthopaedic NHS Foundation Trust's Information Governance DSPT score overall for 2024/25 has not yet been determined as the final submission date is 30 June 2024.

For 2023/24 the Trust's score was STANDARDS MET.

During 2023/24 the Trust identified and reported no serious IG breaches.

Seven Day Working

The seven-day services programme has been designed to ensure patients receive high quality consistent care across all seven days of the week. As an elective centre, the Trust does not receive emergency admissions in the same way as an acute hospital, being aware of emergency admissions in advance which enable the Trust to ensure appropriate multidisciplinary teams are in place. The Trust offers several seven-day services appropriate to the service requirements of an orthopaedic elective centre. This is regularly reviewed based upon patient requirements and feedback, to ensure our services reflect the needs of our patients.

NHS Outcomes Framework: Review of performance against mandated indicators

Summary

The NHS Outcomes Framework (NHS OF) is a set of indicators developed by the Department of Health and Social Care to monitor the health outcomes of adults and children in England. The framework provides an overview of how the NHS is performing. This report provides information about the indicators updated in this release.

Proposals for changes to the NHS Outcomes Framework were proposed as part of a wide-ranging consultation on statistical outputs that ran from December 2023 to March 2024. The results of this consultation are now in their final stages of approval.

The latest publication updates five of the NHS OF indicators that are expected to continue in future, regardless of the results of the consultation.

Highlights

The February 2025 release provides new data for the following indicators:

- 2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- 2.3.ii Unplanned hospitalisation for asthma, diabetes, and epilepsy in under 19s
- 3a Emergency admissions for acute conditions that should not usually require hospital admission
- 3.2 Emergency admissions for children with lower respiratory tract infections (LRTIs)
- 5.1 Deaths from venous thromboembolism (VTE) related events within 90 days post discharge from hospital

Mortality

The Trust has a Learning from Deaths Policy in place in line with national requirements. This policy ensures that the Trust reviews all deaths in line with the NHSE framework and supports the requirements of the new Medical Examiner Service. We record all our expected and unexpected deaths, and all have a mortality review completed. These results are reviewed through the Trust Mortality and Resus Meeting. We have a lead consultant who chairs this meeting and reports to the Patient Safety Meeting. A quarterly Learning from Deaths report is presented at Trust Board.

Due to the small numbers of deaths across the organisation the HSMR and SHIMI are not monitored by the Trust. Further, the standardised mortality rates for hospitals, produced nationally by Dr Foster are not applicable to small specialist Trusts like The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust, again because the numbers of deaths that occur are too small for change to be statistically significant. However, there is ongoing monitoring of all deaths which occur within the Trust with oversight by the Quality and Safety Committee, which reports to the Trust Board.

During 2024/25 fifteen patients of Robert Jones and Agnes Hunt Orthopaedic Hospital died. This comprised of the following number of deaths which occurred in each quarter of that reporting period: zero in the first quarter; five in the second quarter; six in the third quarter and four in the fourth quarter.

As of 31 March 2025, eleven case record reviews and two coroner's investigations have been conducted (case review outstanding in four cases from March 25) in relation to the fifteen deaths. In all cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was conducted were: zero in the first quarter; five in the second quarter; six in the third quarter and zero in the fourth quarter.

No patient deaths, representing 0% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. Due to the small number of deaths that occur in the hospital, it is possible for every death to be tracked and reviewed and the data provided above is therefore accurate.

In 2024/25 the trust had zero deaths where COVID appeared on the death certificate.

Through the case record reviews and investigations the Trust identified an opportunity to improve liaison between the wards and critical care around the planning of limits for treatment. This has prompted a discussion between the MCSI Clinical Lead and HDU Clinical Lead for providing an opinion on treatment limits planned. A newly formed working group has reviewed the end-of-life care process, improving both training and links with local hospice.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described due to the small numbers of death that occur at the hospital it is possible for every death to be reviewed in detail. The Trust has continued with the implementation of the ongoing Learning from Deaths Policy including Medical Examiner Service introduced during 2023.

Helping people recover from episodes of ill health or following injury.

Readmission Rates

During 2024/25 the percentage of patients aged 0-15 years old, readmitted to the hospital within 28 days of discharge was 0% and for 16+ years old it was 0.55%.

Activity	No. of readmissions	% readmissions
01/04/2024	6	0.91%
01/05/2024	6	0.87%
01/06/2024	10	1.44%
01/07/2024	4	0.64%
01/08/2024	2	0.35%
01/09/2024	0	0.00%
01/10/2024	1	0.15%
01/11/2024	2	0.30%
01/12/2024	0	0.17%
01/01/2025	7	0.97%
01/02/2025	2	0.29%
01/03/2025	2	0.29%

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- No comparative data is currently available.
- Data is submitted and checked monthly as part of regular performance reporting

Quality Outcomes

The Trust contributes to the National Registries to collect outcomes data. Currently these include:

- British Spine Registry (BSR)
- National Ligament Registry
- UK Hand Registry
- Foot and Ankle Registry (BOFAS)
- British Hip Registry (NAHR)
- National Joint Registry (NJR)

RJAH continues to be awarded the 'NJR Quality Data Provider' award. This scheme has been devised to offer hospitals public recognition for achieving excellence in supporting the promotion of patient safety standards through their compliance with the mandatory National Joint Registry (NJR) data submission quality audit process and by awarding certificates the scheme rewards those hospitals who have met the targets. From the 2022/23 audit year onwards, a new three-tier, gold, silver, and bronze awarding system is being applied. The Trust achieved Gold-level in the last audit period and demonstrates the high standards being met towards ensuring compliance with the NJR.

The Trust also collects large volumes of PROMs (patient reported outcome measures) for total hip and knee procedures to submit to the national PROMS programme. The programme led by NHS England focuses on specific procedures. Health gains are monitored and reported on based on patient responses to a questionnaire before and after surgery. Published Patient Reported Outcome Measures (PROMS) data is available:

The data shows the scores for all the Trusts involved in the NHS PROMS programme in England. This programme monitors the improvement seen in joint replacements. Patient data is collected within a 12-week timeframe before their operation and 6-9 months following their surgery. Data is only representative of questionnaires that have been populated both before and after surgery. This does mean that the number of modelled records is less than the number of procedures actually carried out in that period.

Four areas are reported on by NHS England, Primary Hip replacements, Revision Hip replacements, Primary Knee replacements and Revision Knee replacements.

Oxford Hip Score (OHS) and Oxford Knee Score (OKS) are short 12-item questionnaires that are developed and designed specifically to assess patients function and pain. Each question can have a score of 0-4 and the overall total can provide a score from 0-48, the higher the score resulting in the best possible outcome. The EQ5D is a

separate questionnaire providing a quality-of-life score and is used wider than orthopaedics, similarly the higher the number the better the score.

The Trust's most recent data was published in July 2023 and provides the latest figures for 2020/21. Due to the pandemic, there are a lower number of submissions for this year, but the results still show that the Trust achieves good outcomes for its patients, particularly given the complex nature of the procedures it carries out.

The published data is shown below and provides the National Average for all NHS Trust involved in the National NHS PROMs programme in England. It also provides the Highest Score achieved and the Lowest Score achieved within England. Over the years the Trust is seen to be exceeding or meeting the National Average.

Primary Hip Replacement

	EQ5D Index						Oxford Score					
	2016/17	2017/18	2020/21	2019/20	2020/21	2021/22	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
National Average	0.445	0.468	0.465	0.459	0.472	0.462	21.8	22.68	22.68	22.687	22.981	22.847
Highest Score	0.537	0.566	0.557	0.539	0.574	0.534	25.123	26.299	25.376	25.547	25.702	26.004
Lowest Score	0.310	0.376	0.348	0.352	0.393	0.376	16.428	18.871	18.752	17.059	17.335	7.310
Robert Jones and Agnes Hunt	0.453	0.489	0.496	0.468	0.470	0.522	22.211	23.574	24.429	24.135	24.129	24.933

Revision Hip Replacement

	EQ5D Index						Oxford Score					
	2016/17	2017/18	2020/21	2019/20	2020/21	2021/22	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
National Average	0.290	0.289	0.287	0.307	0.336	0.317	13.512	13.901	13.864	14.065	15.445	14.624
Highest Score	0.362	0.322	0.396	0.38	0.413	0.402	16.504	17.664	18.961	16.130	17.328	17.301
Lowest Score	0.239	0.142	0.206	0.238	0.253	0.323	10.253	10.735	7.853	10.648	13.338	13.724
Robert Jones and Agnes Hunt	0.334	0.298	0.248	0.297	*	*	13.719	15.912	10.387	14.177	*	*

Primary Knee Replacement

	EQ5D Index											
	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22
National Average	0.325	0.338	0.338	0.335	0.315	0.324	16.546	17.259	17.330	17.486	16.886	17.625
Highest Score	0.404	0.417	0.405	0.419	0.403	0.417	19.884	20.635	20.011	20.688	20.25	20.634
Lowest Score	0.242	0.234	0.266	0.215	0.181	0.246	12.335	13.156	13.774	12.622	11.916	14.267
Robert Jones and Agnes Hunt	0.318	0.354	0.361	0.364	0.358	0.350	17.843	18.541	17.74	19.188	19.681	19.547

Revision Knee Replacement

	EQ5D Index						Oxford Score					
	2016 /17	2017/ 18	2018/ 19	2019/ 20	2020 /21	2021 /22	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	2021 /22
National Average	0.273	0.292	0.288	0.295	0.299	0.317	12.346	13.124	13.598	13.840	13.499	14.624
Highest Score	0.296	0.328	0.297	0.394	0.230	0.323	13.781	15.444	15.784	16.384	12.425	13.772
Lowest Score	0.156	0.196	0.196	0.168	0.207	0.303	8.602	9.374	9.014	8.650	8.701	11.726
Robert Jones and Agnes Hunt	0.251	0.328	0.279	0.326	*	*	10.946	14.392	15.113	12.439	*	*

The above data is no longer published by NHS England but over the past couple of years work has taken place to expand our outcomes collection throughout the organisation and ensure that these measures are collected and analysed across all procedures and treatment taking place in the trust. Electronic data collection has allowed us to further expand to all teams within the organisation and any services that patients may require along the pathway. Regular data collection is now evolving for all teams and services that are listed below. We continue to work with other areas to ensure the work supports outcomes monitoring for all areas.

- Hip & Knee Arthroplasty
- Upper Limb
- Knee & Sports Injuries
- Foot and Ankle
- Spinal Disorders
- Physiotherapy
- Anaesthetics

Outcomes data is being used regularly in the organisation to monitor patients pain scores and quality of life while on the waiting list and following surgery/treatment. Data collected will support identifying areas of improvement for patient care and services. Patients signed up to the electronic data collection platform can monitor their own scores and can submit pains scores daily. The uptake of electronic data collection from patients is continuing to improve. Out of the four teams that are onboarded onto Myrecovery Upper Limb, Knee & Sports Injuries, Foot and Ankle and Hip & Knee Arthroplasty the below table displays the overall uptake.

	Financial Year	
	23/24	24/25
Patients Invited	9887	9575
Patient Registered	4268	5421
Registered %	43%	57%

As the PROMs data now starts to filter in to monitor health gains post operatively, regular reports on this data are currently in development and will be singed of in the next financial year. This data will be presented in the 2025/26 trust reporting.

Shared Decision Making

CollaboRATE is a questionnaire used to measure and support the evidence that shared decision making is taking place in the trust. Patients are asked three questions after their initial outpatient appointment has taken place about whether they have understood their health issues; how much effort was made to listen and how included patients felt when working through their options. The total score can range from 27 to 0, higher the score represents the more shared decision making took place. The table below displays the total amount completed and average score, split by the financial year the initial outpatient appointment took place.

	Financial Year	
	23/24	24/25
Patients Invited	9887	9575
Patient Registered	4268	5421
Registered %	43%	57%

The overall average is displaying as a positive score and that a satisfactory level of shared decision making is taking place with our patients overall. Further work is taking place to increase patient uptake.

NHS National Staff Survey

The principal aim of the staff survey is to gather information which will help the Trust to improve the working lives of our staff and so help to provide better care for patients. The staff survey provides the Trust with a wealth of information detailing staff views about working at the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust.

In 2024 the staff survey is aligned to the NHS People Plan, and the People Promise. The Trust holds monthly focus groups to look at the top three concerns, areas to focus on and good practice.

Key headlines:

- Completed questionnaires = 851

- Response rate = 47%
- Recommended as a place to work = 74% *(2023 data = 75.63%)*

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described as the Trust continues to participate and improve the Staff survey results.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by

- Implementation of the NHS People Plan
- Holding myth busting and 'it's ok to ask' sessions
- Monthly Staff Survey Focus Group
- Staff Network Groups

Ensuring that people have a positive experience of care.

Responsiveness to Inpatient's Personal Needs

The table below presents patient experience measured by scoring the results of a selection of questions from the National Inpatient Survey focussing on the responsiveness to personal needs.

	2018	2019	2020	2021	2022	2023	2024
National Average	8.1	8.1	8.4	8.1	8.1	8.1	Data not published until July 25
RJAH ORTHOPAEDIC HOSPITAL NHS TRUST	9.1	9.2	9.5	9.4	9.4	9.3	
Highest	9.1	9.2	9.5	9.4	9.4	9.3	

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described as the Trust has a robust patient experience programme in place that facilitates learning and implementing changes based on patient experience.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve its performance:

- Monitoring delivery of the Patient Experience Strategy
- Continued use of real time feedback on patient experiences
- Improved patient involvement in the review of patient safety events
- The production and completion of action plans in response to complaints

Patient Friends and Family Test

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. Patients are asked to answer the following question: "How likely are you to recommend our organisation to friends and family if they needed similar care or treatment" on the day of discharge or after they have had a clinic appointment. They are invited to respond to the question by choosing one of six options, ranging from "Very good" to "Very poor".

	2020/21	2021/22	2022/23	2023/24	2024/25
National Average	94%	94%	94%*	94%*	94%*
Highest Score	100%	100%	100%*	100%*	100%*
Lowest Score	65%	64%	73%*	75%*	69%*
The Robert Jones and Agnes Hunt	98%	98%	98%	98%	98%

**Data only available nationally up to Jan 25*

Treating and caring for people in a safe environment and protecting them from avoidable harm

VTE Assessment

Our patients often have difficulties mobilising which places them at an increased risk DVT or PE and as such the Trust's VTE assessment is of utmost importance to ensure that patients do not develop an avoidable DVT or PE.

The Trust has in place a robust system of audit to measure compliance with the VTE assessment process. Further, any incidence of DVT or PE is subject to a full incident analysis review to ensure that learning is taken. The Quality and Safety Committee receives regular reports on the Trust's work on VTE prevention.

The chart below outlines the percentage compliance for VTE assessments for the year (up to March 2025).

	2018-19	2020-21	2021-22	2022-23	2023-24	2024-25
ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS TRUST	99.90%	99.90%	99.72%	99.80%	99.78%	99.83%
NHS England						90.6% *
HIGHEST	100%	100%				100% *
LOWEST	63.20%	67.50%				0% *

** Based on Q3 2024/25 Published data - Release Date 10 April 2025*

There was no national data comparison from 2020/21 to 2023/24. In 2024/25 the national submission was reinstated, therefore data for Q3 2024/25 is included for comparison in the table above.

The Trust monitors the monthly performance through its Integrated Performance Report and VTE Committee

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has in place a clinical lead for VTE who champions the VTE process amongst the clinical staff.
- Regular reviews and audits are undertaken to check compliance with follow up actions where required.
- The Quality and Safety Committee through the Patient Safety Meeting, receives regular reports on compliance with VTE assessments.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:
Established a VTE Group which reviews all events relating the VTE.

- Any themes or trends are monitored through this group and recommendations for improvement are shared with the Patient Safety Meeting members.

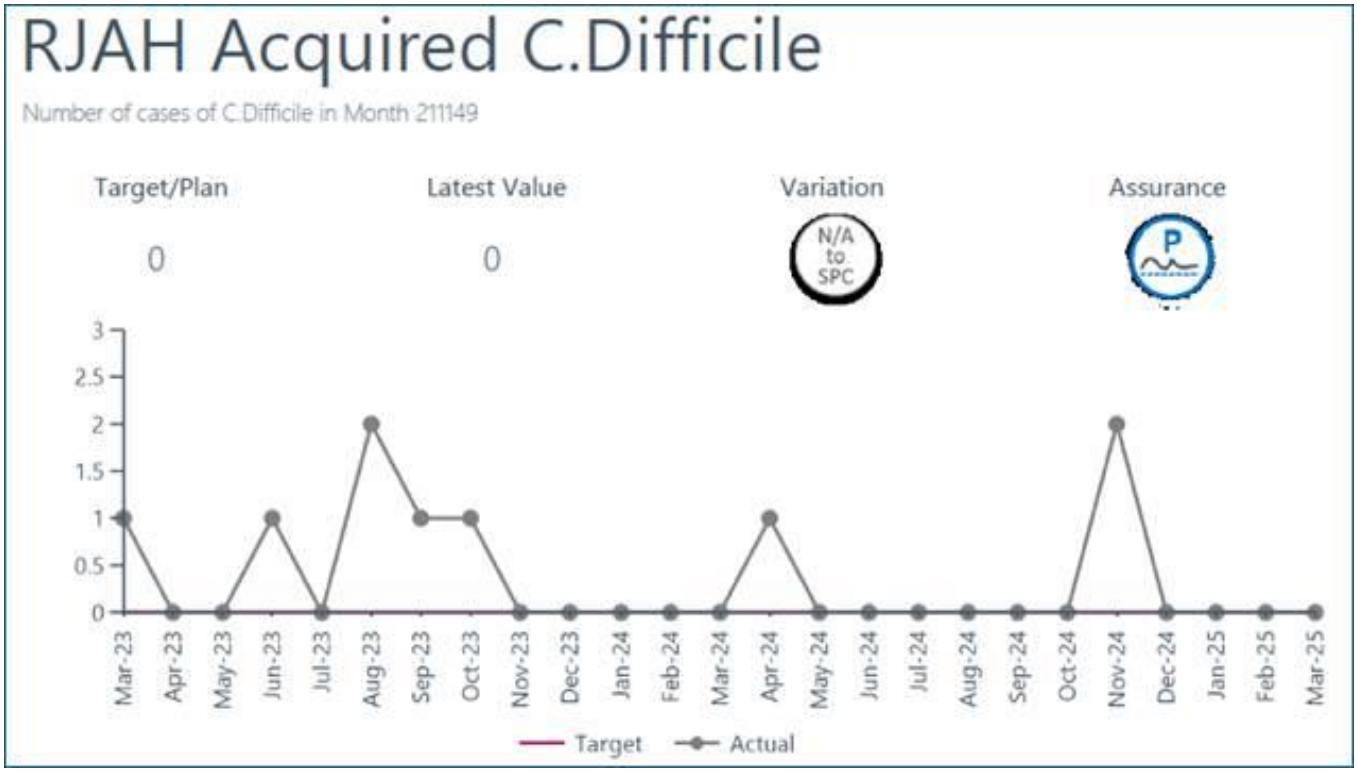
Clostridioides Difficile Infections (CDI)

The Trust measures infection control performance as a rate of Trust apportioned cases per 100,000 bed days of cases amongst patients.

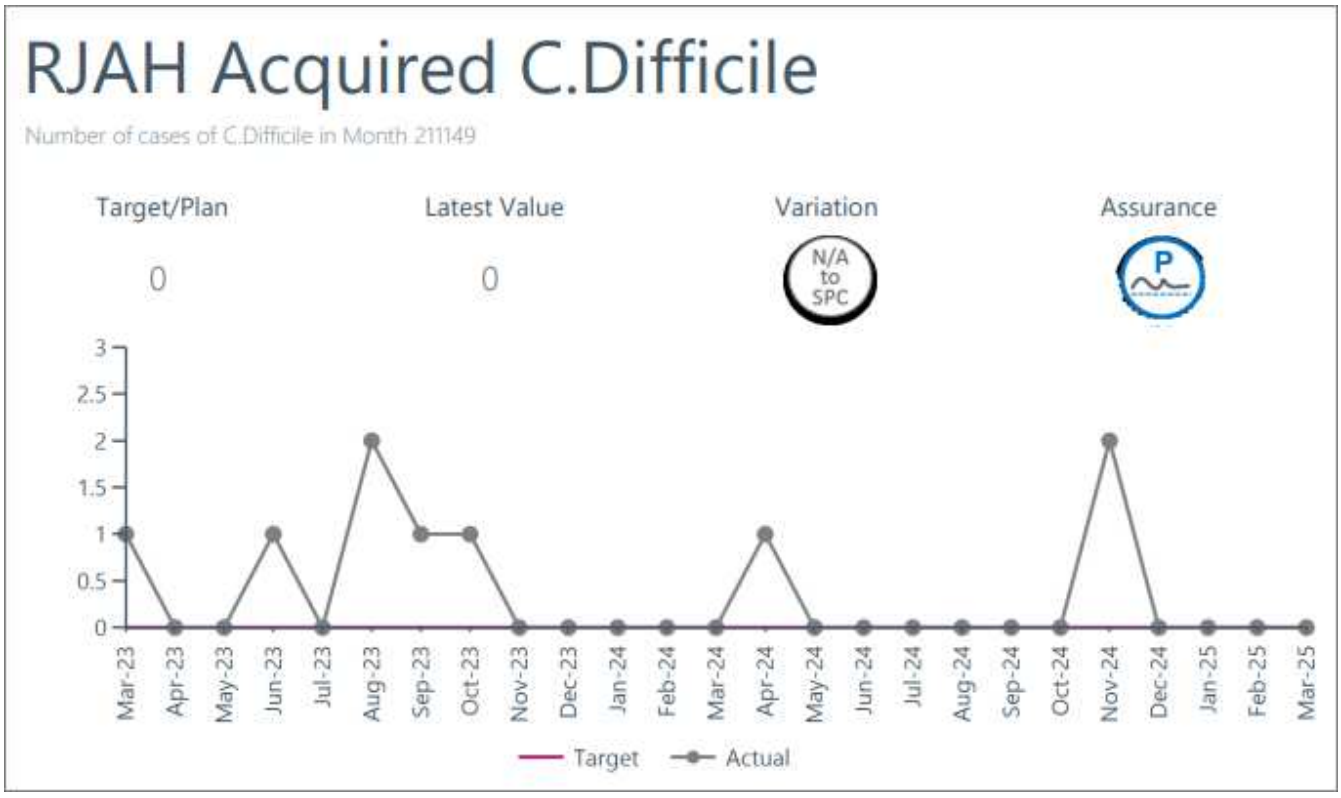
The Trust has had two attributable cases of CDI for the year 2024/25. This was against a target of four. Post infection reviews for both cases concluded that both cases were unavoidable.

A rise of hospital onset CDI has been observed nationally following the COVID-19 pandemic, whereas prior to this, rates were declining with some fluctuations. This change in trend to a steady increasing trajectory is of major concern and is the only data collection where there has been a major shift post pandemic. The UKHSA is conducting a review of the current surveillance dataset for CDI, to ensure the current questions are still relevant for the intended purpose.

Number of RJAH Acquired CDI



CDI Rates Per 100,000 Bed Days



The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described due to the data is reported and monitored monthly.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

- Continuing to conduct individual case reviews on all hospital acquired infections to ensure the Trust can learn and improve the quality of its care, and to share our findings with other NHS providers and NHSE.

Number of patient safety incidents and percentage resulting in severe harm/death

The hospital has a robust and established incident management process in place. The Trust uses an electronic reporting system which enables all incidents to be tracked from the point of reporting and on-going monitoring until closure of an incident, therefore promoting a timely response to notifiable incidents.

The tables below show the number of patient safety incidents reported each month during the reporting period and a breakdown by severity grading for these, including the proportion of incidents resulting in severe harm or death.

Patient Safety Incidents Reported per 1000 Bed Days

Period of Coverage	Rate of incidents	Number of incidents
Oct 24 - Mar 25	53.3	1397
Apr 24 - Sep 24	57.9	1527
Oct 23 - Mar 24	56.2	1480
Apr 23 - Sep 23	45.4	1196
Oct 22 - Mar 23	44.9	1176
Apr 22 - Sep 22	42.5	1119
Oct 21 - Mar 22	42.6	1116
Apr 21 - Sep 21	41.4	1092
Oct 20 - Mar 21	27.3	716

Patient Safety - Severe Harm / Death

Period of Coverage	Rate of incidents	Number of incidents	Comments
Oct 24 - Mar 25	0.34	9	9 deaths (3 end of life and 6 expected) and no severe harm incidents
Apr 24 - Sep 24	0.23	6	5 deaths (3 end of life and 2 expected) and 1 severe harm incident
Oct 23 - Mar 24	0.27	7	7 deaths (3 unexpected and 4 expected) and no severe harm incident.
Apr 23 - Sep 23	0.23	6	5 deaths (3 unexpected and 2 expected) and 1 severe harm incident.
Oct 22 - Mar 23	0.31	8	6 deaths (1 unexpected and 5 expected) and 2 severe harm incidents
Apr 22 - Sep 22	0.23	6	6 Deaths (3 unexpected and 3 expected) and 0 severe harm incidents
Oct 21 - Mar 22	0.38	10	10 Deaths (1 unexpected, 9 expected) and 0 severe harm incidents
Apr 21 - Sep 21	0.04	1	1 Deaths (1 expected) and 0 severe harm
Oct 20 - Mar 21	0.34	9	6 Deaths (1 unexpected, 5 expected) and 3 severe harm incidents

Footnote: Definition of Severe Harm/Death:

- Severe Harm: Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.
- Death: Any unexpected or unintended incident that directly resulted in the death of one or more persons.

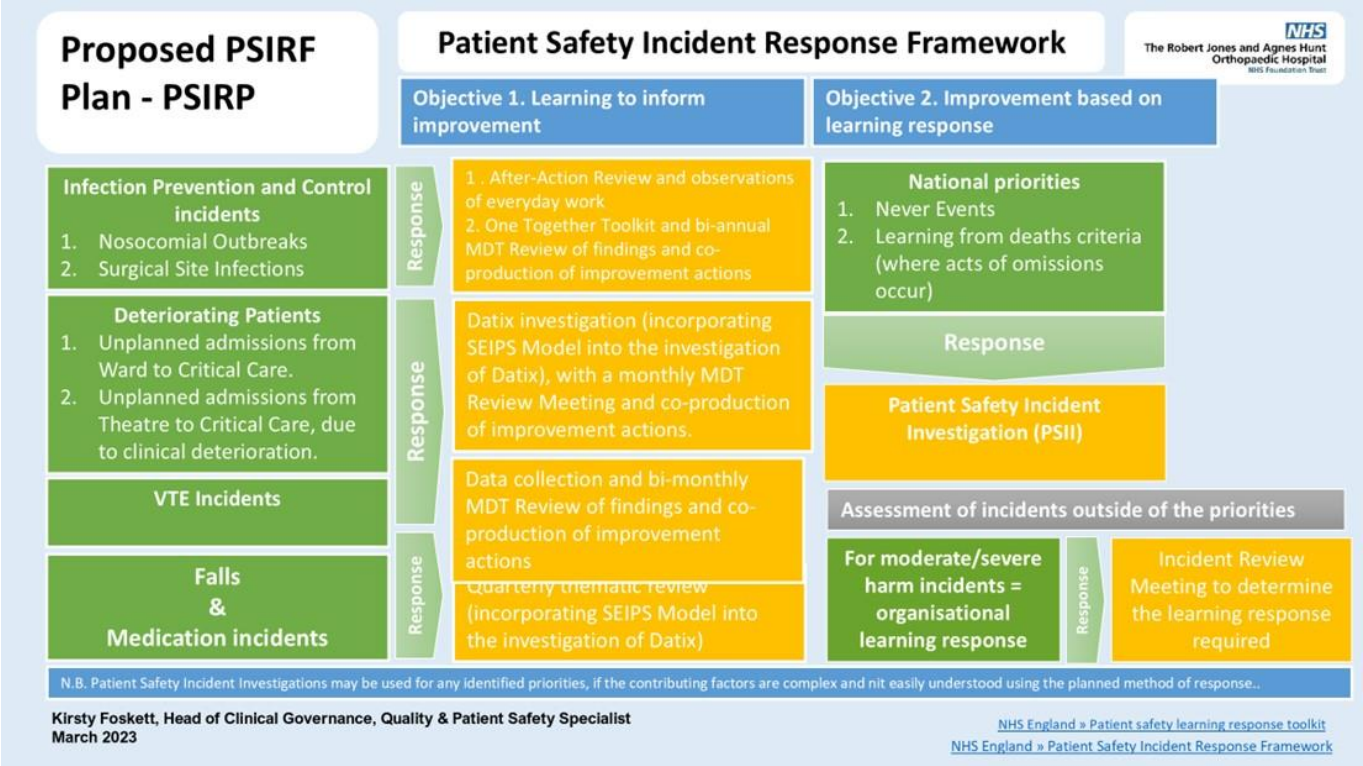
Patient Safety Incident Response Framework (PSIRF)

In October 2023, the Trust transitioned to the new Patient Safety Incident Response Framework (PSIRF), as part of NHS England's patient safety strategy. The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS.

PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

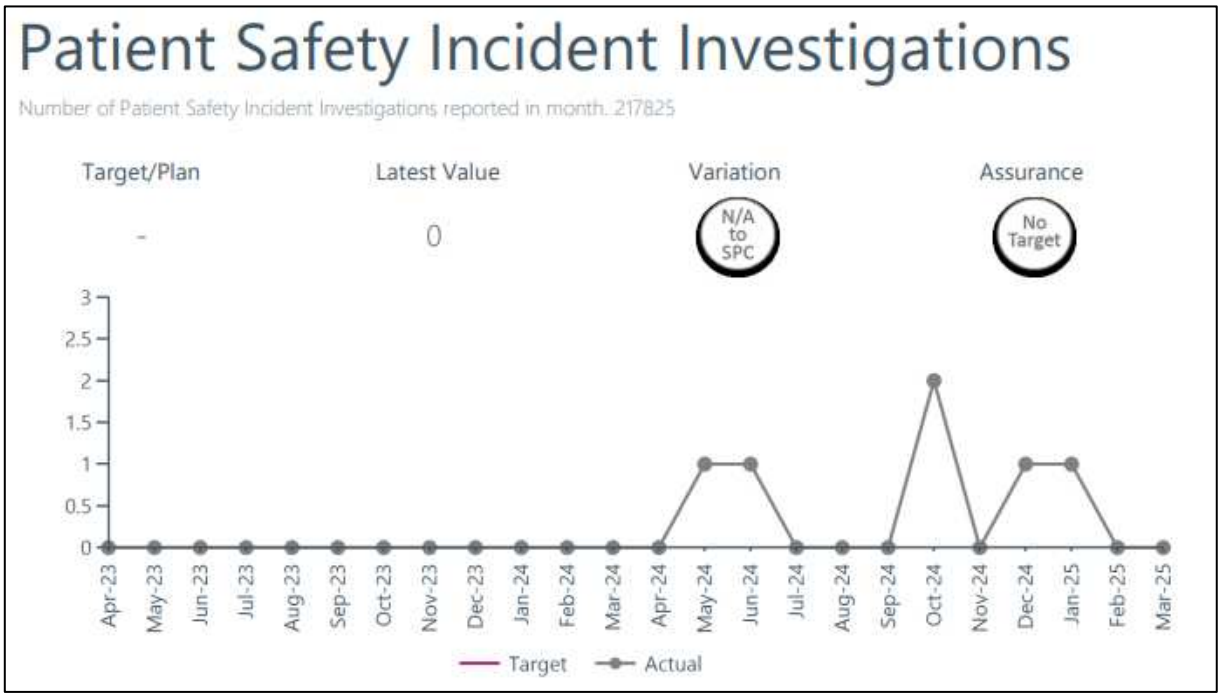
- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approached to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents
- Supportive oversight focused on strengthening response system functioning and improvement.

Across 2024/25 the Trust has worked hard to embed the Trusts PSIRF policy and the deliver the priorities as outlined in the Trusts Patient Safety Incident Response Plan.



National PSIRF Priorities

Under PSIRF, the Trust are required to undertake a full Patient Safety Incident Investigation (PSII) if a patient safety event aligns with a national priority. There are several national priorities, two of which are particularly relevant for this Trus - Never Events and Learning from deaths criteria, where acts or omissions may have contributed to a patient's death.



In 2024/25 the Trust commissioned 4 PSII's that align the national PSIRF priorities, all of which were Never Events. Never Events are events that are considered to be wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

The four reported Never Events pertained to:

- Wrong Implant/Prothesis (2)
- Retained foreign object post procedure (2)

In comparison to 2023/24 only one never event was reported, relating to a wrong sided block.

A key learning point for the Trust from the PSII's that have been completed has been to introduce the revised National Safety Standards for Invasive Procedures (NatSIPPS2) across all departments in the Trust. As part of updating current practice to be in line with the revised standards, there has also been a focus on ensuring there is a robust audit process of the NatSIPPS2, as a source of ongoing assurance that the required standards are being met.

It is recommended that Trusts review their response plans, every 12-18 months to ensure that local priorities under PSIRF reflect the patient safety profile of the organisation. An evaluation of PSIRF was conducted through Q3 and small working group formed to review the outputs of the evaluation and to the local priorities to be included in the response plan.

In March 2025, the Trust Board received a presentation on the evaluation of PSIRF and recommendations to the update the Trusts Patient Safety Incident Response Plan, which were approved from April 2025 onwards.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has continued to undertake reconfiguration work on Datix to ensure more accurate capture of themes and trends in the categories of incident.
- Through the Patient Safety Meeting, the Trust is provided an overview of incident management within its Units.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this rate and so the quality of its services, by:

- Benchmarking of incident reporting against other Specialist Trusts
- Inclusion of patient safety events in the Multi-Disciplinary Clinical Audit Meeting attending by a cross section of clinical staff
- Embedding the principles of NatSIPPS2 and establishing a robust audit process as a source of ongoing assurance.

PART 3
Review of Quality

Summary of Performance Status for Quality Priorities Set for 2024/25

In line with the Trust's Quality Improvement Strategy, and in discussion with the Board of Directors, Council of Governors and other relevant stakeholders, the Trust identified the following key priorities for 2024/25:

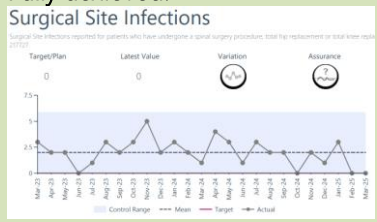
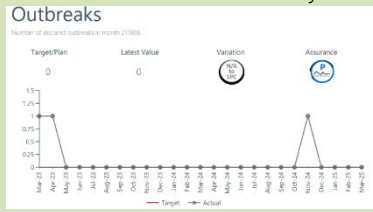
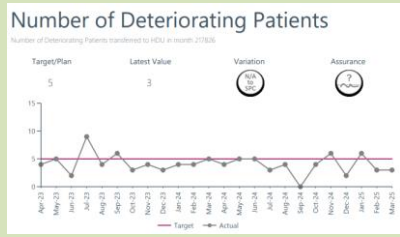
- Patient Safety: Learning from Infection Prevention and Control patient safety events, including Surgical Site Infections (SSIs) and nosocomial outbreaks
- Patient Safety: Learning from deteriorating patient, patient safety events
- Patient Safety: Learning from incidents of VTE
- Patient Safety: Learning from Medication safety events
- Patient Safety: Learning from Inpatient falls
- Clinical Effectiveness: Implementation of the GIRFT Pre-op Improvement Plan
- Patient Experience: Enhancing the experience of patients with Learning Disabilities, Autism and Dementia, who access our services.

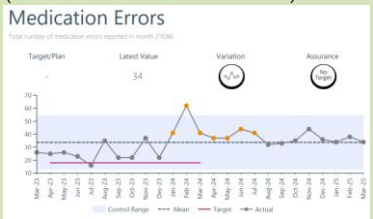
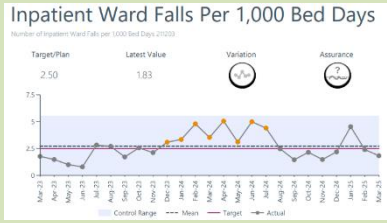
Progress made for quality priorities 2024/25

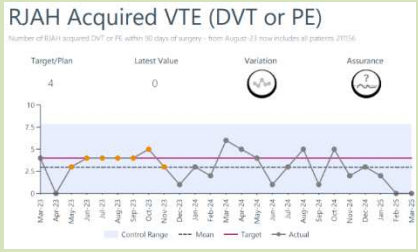
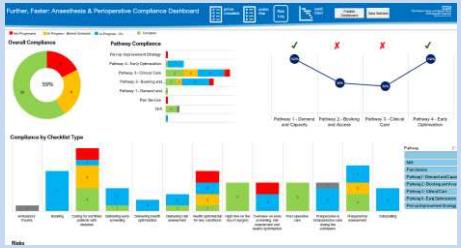
The following table gives an overview of the progress we have made for each of the quality priority areas and how the improvement work will be maintained in the coming year or continued.

It is important to remember that even though some priorities may be retired, this is not to say that the work ceases, but rather that the processes and systems for continued management of the improvement goal are well established and can be maintained outside of the Quality

Account process.

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
PATIENT SAFETY				
1. Learning from Infection Prevention and Control patient safety events, including Surgical Site Infections (SSIs) and nosocomial outbreaks	To ensure that a systems-based approach is embedded in our learning response methods used to review SSIs or nosocomial outbreaks.	• A reduction in the number of SSIs • A reduction in the number of nosocomial outbreaks • Evidence of learning from safety events to identify areas for improvement.	• A well-established infection MDT is now in place, ensuring consistency in the cases defined as an SSI. • A review of the One Together pathway • Each patient confirmed to have an SSI has a review against the One Together standards. • Introduction of six-monthly SSI reviews using a systems-based approach to identify learning for improvement. • Introduction of After-Action Reviews, in line with PSIRF for all nosocomial outbreaks.	Fully achieved.  A decreased in surgical site infections has been noted across the year.  There was only 1 outbreak reported in 2024-25
2. Learning from deteriorating patient, patient safety events	To ensure that a systems-based approach is embedded in our learning response methods used to review deteriorating patient, patient safety events.	• Annual Deteriorating Patient Audit • Increase in NEWS2 Audit compliance. • Monitoring of the Deteriorating Patient KPI • Evidence of learning from safety events to identify areas for improvement. • Reduction in the number of deteriorating patient events, associated with the management of diabetes.	• Established weekly Patient Safety Incident Review Group, where all incidents of note are discussed and agreed if a further review is required. • Learning from deteriorating patient reviews has led to the implementation of guidance in pre-op to include frailty scoring and a review of how patients are booked for a critical care stay, post-surgery. • A review of diabetic policies, including variable infusion rates. • Learning from deteriorating patient reviews led to a review of the non-elective surgical admission passport.	Partially Achieved. NEWS2/Deteriorating patient Audit planned to be completed in Q1 2025/26. The number of deteriorating patients remains static across 2024-25. Through patient safety reviews the learning identified has been used to shape the Trusts quality priority for 25/26 

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
3. Learning from Medication Safety Events.	To ensure that a systems-based approach is embedded in our learning response methods used to review medication safety events.	• Reduction in number of medication incidents with harm • Evidence of learning from safety events to identify areas for improvement.	• Established weekly Patient Safety Incident Review Group, where all incidents of note are discussed and agreed if a further review is required. • Introduction of quarterly thematic reviews of all medication events, using a systems-based approach to identify learning for improvement. • Introduction of MSO/Matron task and finish group to address improvements from learning reviews • Medication event categories on Datix updated to reflect the contributing factors such as, administration, prescribing, storage, or supply of medications.	Partially Achieved. While we have seen a reduction in the number of medication errors being reported. In Q4 we saw an increase in the errors with harm being reported (albeit a low level of harm).  
4. Learning from Inpatient Falls	To ensure that a systems-based approach is embedded in our learning response methods used to review inpatient falls.	• Inpatient falls per 1000 bed days • Reduction in the number of falls resulting in harm. • Evidence of learning from safety events to identify areas for improvement.	• Introduction of quarterly thematic reviews of all medication events, using a systems-based approach to identify learning for improvement. • Established weekly Patient Safety Incident Review Group, where all incidents of note are discussed and agreed if a further review is required. • Specific improvement project established focused on reducing falls in inpatient bathrooms.	Fully Achieved.  The trust has achieved a sustained reduction in the number of inpatient falls, per 1000 bed days and the number of falls resulting in harm.

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
5. Learning from VTE events	To ensure compliance against the Trusts VTE policy.	• Number of VTE events • To achieve 100% compliance with the Trusts VTE Policy • Evidence of learning from safety events to identify areas for improvement.	• Established weekly Patient Safety Incident Review Group, where all incidents of note are discussed and agreed if a further review is required. • VTE Group reviews all RJAH acquired VTE, with shared learning feedback to colleagues. • Launch of the new VTE policy. • Retrospective Audit of VTE compliance underway	Fully Achieved.  The trust has seen a reduction in the number of RJAH acquired VTE and on review of VTE incidents, an increase in compliance with the VTE Policy.
CLINICAL EFECTIVENESS				
6. Implementation of the Getting It Right First Time (GIRFT) Preoperative Improvement Plan	To deliver the GIRFT preoperative improvement plan	• Reduction of cancellations on the day due to medical reasons. • Improved patient experience • Implement streamed pathway at decision to treat - increasing the % of patients who commence optimisation (where required) at that point."	• Workforce review in pre-op to enable changes and different ways of working. • Established working group, with clear project plan to deliver key deliverables in relation to demand and capacity, booking and access, clinical care, and early optimisation.	Partially achieved.  The trust continues to work through the identified improvement opportunities for perioperative services. The work remains a priority for the Trust and will be monitored through Patient Safety and the Trusts Operational Performance Meeting.

Priority	Objective	Measure of Success	Actions completed/taken	Achieved
PATIENT EXPERIENCE				
7. **Enhancing the experience of patients with Learning Disabilities and Autism and Dementia who access our services.**	Improve patient experience with patients with learning disabilities and autism and patients with dementia who access our services.	• Improved % with training compliance for dementia awareness. • Increased feedback from patients with LD, Autism and Dementia • Improved scores in the disability and dementia domains on the PLACE audit for 2024	• LD and Autism tier 1 awareness training rolled out and now achieving >90% compliance trust wide. • NHS Benchmarking audit completed for 2024/25 • Patient video 'What to expect when visiting the hospital' filmed and available to patients accessing RJAH services on Trust Internet. • Commenced implementation of Oliver McGowan training with good compliance trajectories noted.	Fully Achieved

Local Quality Indicators

In addition to the Quality Priorities for 2024/25 the Trust has selected a number of local quality indicators that have continued to be monitored throughout the year and continued to embed the national Patient Safety Strategy.

Safety

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust is committed to continuously improve patient safety and delivering the NHS Patient Safety Strategy.

The NHS Patient Safety Strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. RJAH have three members of staff who adopt the role of patient safety specialist, allowing them to oversee and support patient safety activities across our organisation. The patient safety specialists help to embed the strategy providing dynamic, senior leadership, visibility, and expert support to the patient safety work at RJAH. The aim of the patient safety specialists is to support the development of a patient safety culture and ensure that systems thinking, human factors understanding and just culture principles are embedded in all patient safety processes.

A Patient Safety Meeting forms part of the quality governance framework and is led by the Chief Nurse and Patient Safety Officer; this is a multi-disciplinary meeting which monitors patient safety improvement action plans, risks, and associated policies. The Patient Safety Meeting receives upward reports from the Patient Safety Working Group which supports the work in relation to the Trusts Patient Safety Incident Response Plan.

A key focus for the patient safety specialists this year has been to embed the Patient Safety Incident Response Framework, which the trust adopted in October 2023.

Introducing Martha's Rule

This year the Trust were successful in our application to be considered as part of the phase one role out of Martha's Rule.

Martha's Rule is a patient safety initiative led by NHS England that grants patients, families, and staff a rapid review from a critical care outreach team if they have concerns about a patient's rapidly deteriorating condition. There are three components to Martha's Rule:

1. Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
2. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.

3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital

The Trust went 'live' with Call for Concern in December 2024, which provides patients, families, and carers with direct access to our Critical Care Outreach Team, should they feel that their (or family members) condition is deteriorating. This was shortly followed by the introduction of daily Wellness Checks on our inpatient wards across February 2025.

Patient Harm reviews

At RJAH, we are committed to ensuring the safety and well-being of our patients. Since 2021, we have been conducting patient harms reviews to monitor and address any potential risks for our long waiters.

Any patient waiting over 52 weeks receives a clinical 'harms review,' and those identified as potentially coming to harm are expedited and seen in clinic within 3 weeks.

As part of our commitment, we have been actively participating in ICS wide harms review meetings, with a particular focus on 104 weeks and cancer targets. Our dedication and progress in addressing patient harms have been recognised by the system.

For the MSK cohorts, we are pleased to report that cohorts 1 and 2 have been fully completed without any need for re-prioritisation or identification of harms. This demonstrates our effective management and monitoring processes.

Regarding the Specialist Cohorts, we have successfully completed and closed cohorts 1, 2, and 3. Cohorts 4 and 5 are currently being finalised, with the remaining patients primarily being those we have been unable to contact. Cohort 6 was released in January 2025, and we are on track to complete it by the end of June 2025.

To date, we have completed over 15,000 harms reviews and successfully expedited a small number of patients that had the potential to come to harm.

Considering recent national guideline changes, we are reviewing our policy and plan to submit it to the Quality and Safety (Q&S) Committee in April 2025.

As a Trust, we remain committed to continuing with this process until we no longer hold a backlog waiting list - this is vital to ensure those in our care receive the treatment they require with a timeframe that does not negatively impact on their health or the outcome.

Safeguarding

The Children Act 1989, and the 2004, the Mental Capacity Act 2005, the Care Act 2014, Working Together to Safeguarding Children Statutory Guidance (2023), Statutory Guidance for Integrated Care Boards (ICBs) and the England Safeguarding Accountability and Assurance Framework (SAAF 2022) places a duty on all partners across the safeguarding platform to protect and promote the welfare of children, young people and adults at risk.

At RJAH, national and local safeguarding laws and policies are strictly followed. The Trust has made significant investments in the Safeguarding Team, including the recruitment of a dedicated Named Nurses for Adults and Children, to enhance and support the organisational safeguarding agenda. In addition, the Domestic Abuse and Sexual Violence Lead has been appointed.

Improvements have been observed across the organisation regarding the safeguarding priorities for 2024/2025, with a steady increase in mandatory safeguarding children training throughout the year. There was

an evident growth in awareness and confidence across the Trust in recognising and reporting and potential safeguarding concerns, including domestic abuse. The patient facing Trust website with Learning Disability resources have been set up with the support of the Trust's communication team.

Safeguarding governance contributes to a wide range of performance and quality measures both internally and externally, in accordance with the Care Quality Commission (CQC), Shropshire Safeguarding Community Partnership (SSCP) and our local Integrated Care System (ICS). This includes:

- Mandatory Training
- Deprivation of Liberty Safeguards (DoLS) Applications.
- Referrals to Adult Social Care
- Referrals to Children Social Care
- Section 42 Enquiries
- SARs and DHRs
- Prevent/Channel Pannel requests.
- Domestic Abuse Stalking and Harassment (DASH) Risk Assessments.
- Safeguarding Activity for children and adults
- Domestic Abuse Stalking and Harassment (DASH) Risk Assessments
- Safeguarding supervision and advice given to staff
- LADO and PIPOT
- WNB rates

Safeguarding Training

Safeguarding training compliance is monitored through the Trust Safeguarding Meeting. In line with the intercollegiate document, different levels of training are required based on the role of individual.

Training	Trust wide compliance position for 24/25
Level 3 Safeguarding Adults	71%
Level 3 Safeguarding Children	82%
Child Sexual Exploitation	88.7%
Oliver McGowan Training Part 1	89.5%
Oliver McGowan Teir 1	41%
Oliver McGowan Tier 2	37%
PREVENT training	96%

Level 3 safeguarding is currently below the 92% target set by the Trust, although the Trust has seen an improvement in compliance across children's safeguarding.

Discussions with Education, Training, and Development have identified that the decline in compliance was significantly impacted by:

- Staff sickness during winter months.
- Winter pressures leading to low attendance
- Training cancellation by the external provider in quarter four

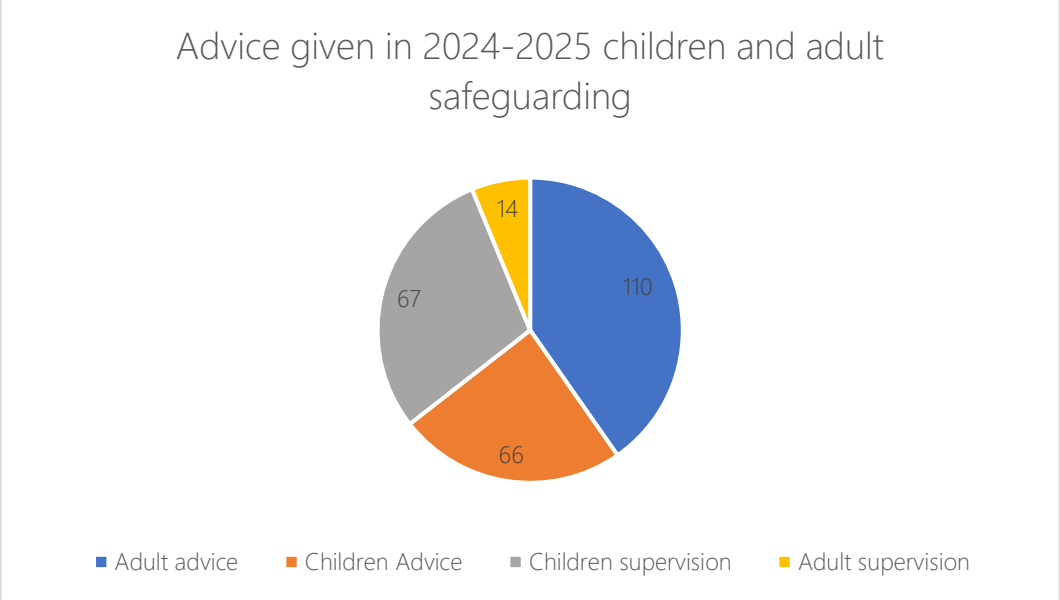
With the expanded classroom capacity and improved communication, compliance for Level 3 Safeguarding Adults training is expected to recover steadily. Full compliance is projected by July 2025.
In July 2024 Child Sexual Exploitation (CSE) online training was introduced onto ESR and has been meeting its training trajectory at the expected level

Additional Safeguarding Training and Development introduced across 2024-2025

- ✓ Mental Capacity Training
- ✓ Dementia Training for Health Care Assistant
- ✓ Butterly Scheme Re- Launch
- ✓ Dementia Communication Training
- ✓ Conflict Resolution Training and De-escalation training delivered by the Innovation Team
- ✓ Communication in Dementia Care and Management of a patient who requires Enhanced Supervision
- ✓ Consent and Legal Responsibility co-delivered by the Safeguarding Team and the Trust Solicitors
- ✓ Mental Capacity and Best Interest Toolkit Lunch and Learn
- ✓ Study day on Alice Ward on Children as stand-alone victims of Domestic Abuse
- ✓ Lunch and Learn sessions or Safeguarding and Parental Responsibility
- ✓ Child and young person neglect training (half day)

Safeguarding Supervision and Advice

In 2024-2025 we provided a total of 177 instances of advice or supervision to staff across various clinical areas regarding adult and children safeguarding concerns. Of which 110 were related to adults and 56 related to children.



Safeguarding group supervision was accessed by 91 staff across the Trust with children supervision delivered to ORLAU, MUSCLE and Orthotics team (67 staff attended). And 14 staff accessing adult group supervision on Sheldon Ward.

Safeguarding Activity

Children who were not brought to their appointment. (WNB)

The WNB figures remained around 5.7%, there has been an excellent work undertaken in the health inequality workstream to reduce the WNB rate and update from colleagues was requested to be shared with the Safeguarding Meeting.

Safeguarding children 0-19 Liaison Forms

The liaison forms were created to follow up children with two or more Was Not Brought (WNB), pattern of WNB or any other safeguarding concerns and from June to March 2025- so many liaisons have been completed which resulted in referral to children social care for one child and attending Child in Need (CIN) meeting for one child. The named nurse liaised with the 0-19 teams regarding 41 children and young people.

Deprivation of Liberty Safeguards (DoLS) Applications

There were 49 DoLS applications have been completed during in RJAH in 2024-2025

Local authority Adult Safeguarding referrals

There have been 19 referrals to the Local Authority Adult Safeguarding. For one of the referrals the trust reported itself as a potential source of harm, and the case has since been closed by the local authority safeguarding team.

Children Social Care referrals

There have been 5 referrals to children social care as well as two referrals to the Early Help service.

Section 42 Enquiries

Safeguarding Team is aware of two cases referred to Adult Social Care regarding care undertaken at RJAH. In accordance with the Care Act 2015, Section 42, all agencies have a statutory requirement to engage with social care and respond to allegations or concerns made in relation to adults at risk. Both cases were responded to within the agreed timescale and to date neither of these cases have concluded. Both referrals made to the local authority in quarter 2 have now been closed with no further action.

Staff Allegations

There was a total of seven staff allegations- two led to PIPOT referral in accordance with Person in a Position of Trust processes and two being referred to the Local Authority Designated Officer (LADO), of which both cases are now closed. Two of these staff allegations led to staff being referred to the professional body.

Pressure Ulcers

In accordance with national guidance (*Safeguarding Adults Protocol: Pressure Ulcers and the Interface with a Safeguarding Enquiry Process*), where staff identify multiple category 2, category 3 or 4 pressure ulcer, the protocol should be accessed and scored against the decision guide. 15 of the ulcers were within these criteria; 13 did not have the pressure ulcer protocol completed and two did. Neither necessitated a referral to Adult Social Care.

- Q1: 27 pressure ulcers reported; 5 acquired at RJAH, 22 pre-admission
- Q2: 4 identified in outpatients; 5 patients admitted with existing ulcers
- Q3: 41 total; 12 RJAH-acquired, 29 pre-admissions. None met safeguarding thresholds.
- Q4: 26 total; 2 RJAH-acquired, 24 pre-admission (13 from MCSI).

17 were complex (multiple or category 3+); 15 triggered safeguarding questions on Datix. Two cases escalated to safeguarding: one (Birmingham) closed after initial review, one (Shropshire) closed on receipt, with further internal review ongoing.

Prevent /Channel requests

There were 21 requests for information, made under Section 26 of the Counter Terrorism and Security Act 2015; i.e. Prevent requests with 13 requests related to children.

Complex Care

All patients who attend Pre-Operative Assessment Clinic and who require, or may require, reasonable adjustments, or who have (or potentially have) a safeguarding concern, will have a pre-op alert form completed, which is then emailed to the Booking Office and Safeguarding Team. The team subsequently monitors these alerts, reviewing patients as required and providing specialist support and advice to ward staff where appropriate.

Over the year, a total of 147 pre-op or ward alerts were received by the Safeguarding Team for patients requiring additional support. This includes:

Safeguarding Adult Reviews and Domestic Homicide Reviews

Domestic Homicide Reviews (DHRs) and Safeguarding Adult Reviews (SARs). Under the Domestic Violence Act 2004 and Care Act 2014, DHRs and SARs are undertaken when serious harm or death has occurred. In 2024–2025, the Safeguarding Team responded to multiple review requests:

- Q1: Two scoping requests (1 DHR, 1 SAR); outcomes pending.
- Q2: One SAR involving RJAH, with learning around self-neglect and mental health. RJAH also contributed to three DHRs (2 Telford & Wrekin, 1 Cheshire West).
- Q3: Three scoping requests (2 DHRs, 1 SAR); outcomes pending.

Learning Reviews

There have been no children safeguarding reviews that RJAH was involved in.

Initial scoping reviews

There has been one scoping review for a child known to RJAH

Domestic Abuse (DA)

There were 27 disclosures of domestic abuse made by service users and staff. Of these, 9 Caada DASH Risk Assessment were completed. There has been a significant increase in completion of Caada Dash risk assessments completed in quarter 3 following disclosures of DA.

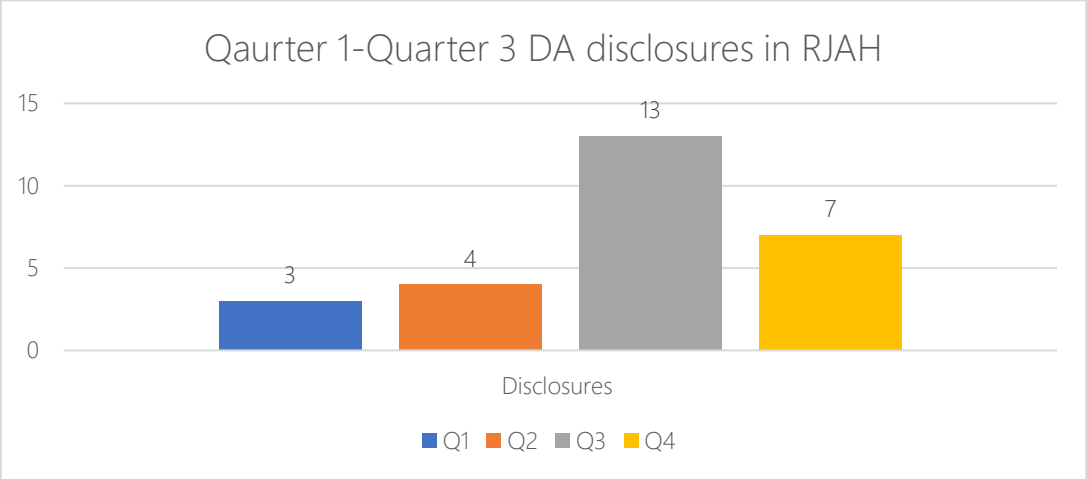


Table 3. DA disclosures in 2024-2025

Learning Disability & Autism

- The Safeguarding Team has been actively involved in The Oliver McGowan Mandatory Training STW Stakeholder Group.
- The Carers Policy has been presented to the Patient Experience group and references the Triangle of Care.
- Reasonable adjustment flagging system has been agreed with the Apollo team.
- The team continued attending the LeDeR Governance Panel and LeDeR steering committee and shared good practice and innovations Trust Wide.
- The patient facing RJAH Learning Disabilities and Autism website has been launched and is updated regularly as recent updates emerge. In the future the website will link in with the ICB LD&A webpage once that is developed. The awareness of this resource has been raised through the Patient Engagement Group and SNAHP.

Mental Health

Mental health liaison continues to support the inpatient service, on a 24/7 telephone contact and face to face visit on a weekly basis.

Infection Prevention and Control

Infection Prevention and Control (IPC) is a key priority for the Trust and every member of our staff is committed to following safe and effective IPC practices and procedures.

Following the launch of the IPC strategy in January 2023, throughout 2024/25, the Trust has been working toward achieving excellence in IPC practice. Progress has been achieved through all 4 domains of integrated working; education; digital technology and enhanced engagement.

Challenges in the management of infections have been experienced nationally with not only an increase in resistant micro-organisms, but also the number of patients experiencing infections. Despite this, the Trust has remained below target threshold for all mandatory reportable infections. We continue to investigate and share learning from all healthcare associated infections and have supported a group who have led on several

workstreams with a focus on preventing bloodstream infections. We continue to share our learning with our system colleagues in the Integrated Care System and have led on the development of a system wide CDI improvement plan.

The IPC Team have redesigned the audit system to align all questions to national standards of IPC, and followed a peer audit approach to allow a fresh lens upon each area, providing an objective approach to audits. The IPC team have supported clinical teams to enhance auditing skills and increase confidence amongst colleagues. Ward/department managers and Matrons take ownership for IPC within their respective areas and show great understanding of roles and responsibilities for IPC. This has provided opportunities to identify and rectify IPC issues in a timely way.

We continue to monitor Surgical Site Infections through Statistical Process Control charts. These allow us to track trends and variations and triggering investigations when our control limits are reached. The IPC Team conduct in-depth reviews into all surgical site infections to establish any learning or quality improvements. The Theatres team are fully engaged with all aspects of surgical site infection prevention strategies. We have also been collaborating closely with colleagues from the Royal Orthopaedic Hospital to share best practice on infection prevention.

It was a pleasure to welcome our NHSE and ICB colleagues to the Trust to showcase our improvements within the Therapies department. They noted significant improvements to the estate, including new floors, walls, and improvements to the hydrotherapy pool. The Therapies team used a 'productive ward' approach to reviewing their storage, which has improved the environment and reduced clutter.

The IPC Team have been revised all IPC policies to align with the National IPC Manual for England. This strengthens our Trust's IPC practices and procedures, guiding our staff with the most up to date information and advice on IPC prevention and management.

The IPC Quality Management system continues to strengthen assurance to processes and compliance to national requirements including the Health and Social Care Act, National IPC Manual, and the IPC Board Assurance Framework. In addition, the system also captures all actions and improvements on the Trusts IPC Quality Improvement Plan. The data warehouse consolidates all IPC related data and displays a dashboard providing a live position for IPC governance.

The continues to be evidence of increased ownership and engagement from teams around IPC. The improvements made could not have been achieved without the continued dedication and commitment from staff across all disciplines across the organisation.

Medication Incidents

Medication incidents are any patient's safety incidents (PSIs) where there has been an error in the process of prescribing, preparing, dispensing, and administering, monitoring, or providing advice on medicines. Within the Trust there is an open dialogue and reporting culture relating to medication incidents. A repot is produced monthly detailing any harms, number of incidents, key incident themes, and sharing of identified learning. This is shared across the Trust.

Medication incidents are identified as a local priority in the Trusts PSIRP. As outlined in the Trusts PSIRP a quarterly thematic review, using a systems-based approach is completed. The aim of the thematic review is to identify areas of improvement in relation to medicines safety, which are shared at the Trusts Patient Safety Meeting and safety actions agreed for implementation.

The Trust benchmark and share medicines safety themes through the Shropshire Telford and Wrekin ICB Medicines Safety Group, the regional Medicines Safety Officer Group and the CD Lin with the Chief Pharmacist network having oversight of all groups.

Learning Lessons from incidents

- The learning from the patient safety reviews are shared widely across the Trust via relevant meetings such as the Patient Safety meeting, Unit Governance meetings and at the Trusts Multi-disciplinary Clinical Audit Meeting (MDCAM) ensuring that shared leaning and awareness of issues is cascaded across all areas.
- The Trust continues to involve patients in patient safety reviews with a nominated Patient/Family Liaison person for each learning response that is conducted. The learning responses are shared with patients and where applicable their families and opportunities are provided for the investigation to be discussed with clinical and governance staff.
- The Trust holds debrief meetings with relevant teams and support from the Clinical Governance Team in which the reports are shared with the staff involved. These are conducted in a way that promotes the principles of PSIRF, compassionately engaging with those affected by patient safety incidents.
- Areas of good practice are shared following any patient safety review, focusing the learning on both good practice and areas of improvement that may be required.
- Over the last year there has been an increased focus on improving the quality of the incident investigations and the Trust have introduced a framework on our internal reporting system, which promotes a systems-based approach to investigating and learning.
- Infographics are produced, following patient safety reviews to aid dissemination of learning throughout the organisation. These are shared at unit governance, patient safety, and senior nursing meetings.

Quality Accreditation Programme

During 2024/25 the Trust saw the introduction of a local Quality Accreditation Programme.

All wards, units, and departments at RJAH will aim to achieve the highest level of quality accreditation to improve efficiency, productivity, patient outcomes and to enhance patient and staff experience. This underpins the goals of the RJAH Nursing and AHP Strategy, RJAH Quality Strategy and wraps a framework around demonstrating regulatory compliance and best practice.

The objective of this assessment was to assess the ward for the newly developed quality accreditation aligned to the CQC key principles of Safe, Effective, Caring, Responsive and Well Led.

The assessment is based on the criteria tabled below.

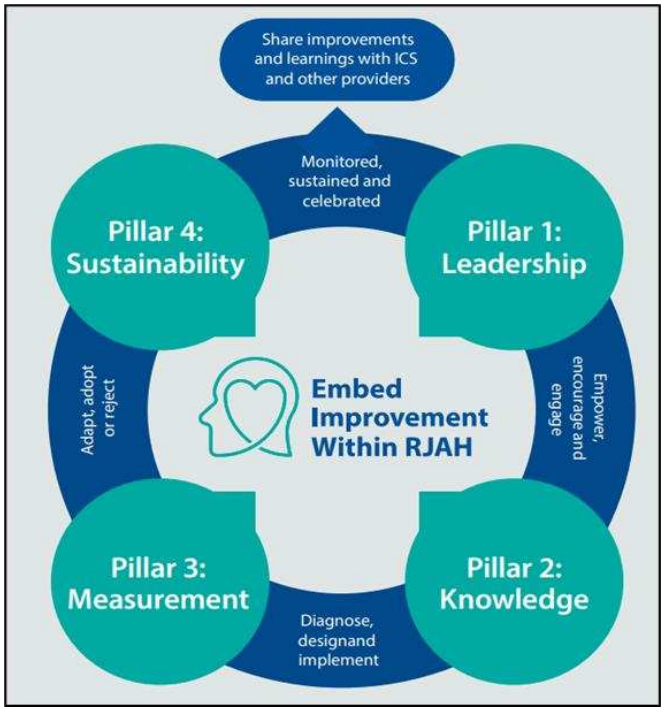
Rating system	Criteria	Frequency of Peer Review	Description	Award period
Outstanding	4 Reports at GREAT	1 year	Significantly exceeds the RJAH standard expectation of what a ward or unit should achieve	1 year
Great	2 areas of partial compliance per domain	6 months	Greatly exceeds the RJAH standard expectation of what a ward or unit should achieve. Some measures may require improvement	1 year
Good	6 areas of partial compliance per domain	6 months	Exceeds the satisfactory standard. Some measures require improvement	6 months
Satisfactory	Any number of areas of partial compliance, 1 or more areas of no compliance	3 months	Minimum standard expected from a ward or unit. Some measures require improvement	3 months

Quality Improvement

At the end of 2022/23, The Trust launched its Quality Improvement (QI) Framework to support embedding improvement within our organisation. The Trust has further progressed its improvement journey during 2024/25. The Trust's ambition is to develop and evolve improvement-led delivery through effective leadership behaviours and by building capabilities. This will improve the quality, safety, productivity and experience of our patients and workforce.

The QI framework describes the approach to improvement which highlights four instrumental pillars to support the embedment:

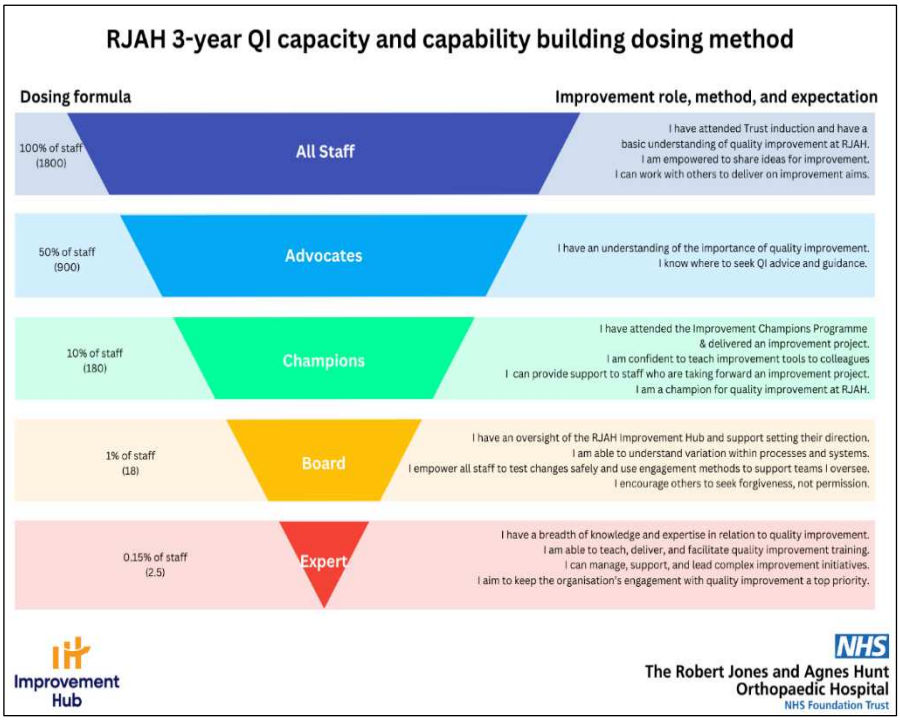
- Leadership: Embedding effective leadership behaviours to understand and champion improvement.
- Knowledge: Developing our staff's knowledge on improvement and ensuring we are building on the capacity and capability for continuous improvement.
- Measurement: Evidence driven improvements using quantitative and qualitative intelligence.
- Sustainability: Learn, share, and celebrate our improvements whilst continually checking changes are still having the desired effect.



During 2024/25 the Quality Improvement journey has involved:

- Improvement in job descriptions and Personal Development Reviews (PDRs): A commitment to continuous improvement is now listed in all new job descriptions and retrospectively in PDRs. This ensures improvement is seen as everybody's responsibility and begins the conversation to discuss improvements which could be made within services.

- Improvement Champions: Following a hugely successful cohort 5 in 2023, another three cohorts have taken place through this financial year. The Improvement Champions course runs across four days with staff working on a specific improvement project whilst learning about topics such as the history of improvement, improvement in healthcare, improvement tools and techniques, emotional intelligence and resilience, and measurement. All cohorts have a celebration event whereby they present their project posters to the Board of Directors and other senior leaders.
- Improvement Advocates: The success of Improvement Champions has seen a new one-day training programme developed which provides an overview and understanding of improvement.
- Dosing Model: Recognising that not everyone in the organisation needs to know or do the same things to contribute to improvement initiatives. NHS IMPACT suggests at least 80% of our staff should have some form of improvement training. Therefore, the Improvement Team have developed a dosing approach to suit RJAH. This will be monitored.



- Legacy Nurse Mentor in Quality Improvement: The Trust have been extremely fortunate to have a Legacy Nurse join the Improvement Team in July 2024. A legacy mentor within the NHS are experience nurses, or colleagues in other professions, usually in late career, who provide coaching and mentoring to support other NHS staff. They provide essential advice, education, and guidance and pass on a 'legacy.' This has provided the team with a clinical link for improvement and further supporting the improvement agenda at RJAH.
- #ImproveTheNextJourney: As part of our co-production agenda, this initiative was launched for our post-operative patients. The feedback from patients is hugely positive and there has been little opportunity for improvement with our patients to date under this initiative. However, the initiative is going to be launched into our Therapies team in the coming year to identify improvements which can be co-produced with our patients. The #ImproveTheNextJourney initiative has increased awareness of co-production across teams with patients being contacted for their thoughts.

The Trust will further assess its progress against the NHS England's NHS IMPACT (Improving Patient Care Together) domains released during 2023/24 (NHS England » NHS IMPACT). An NHS IMPACT self-assessment

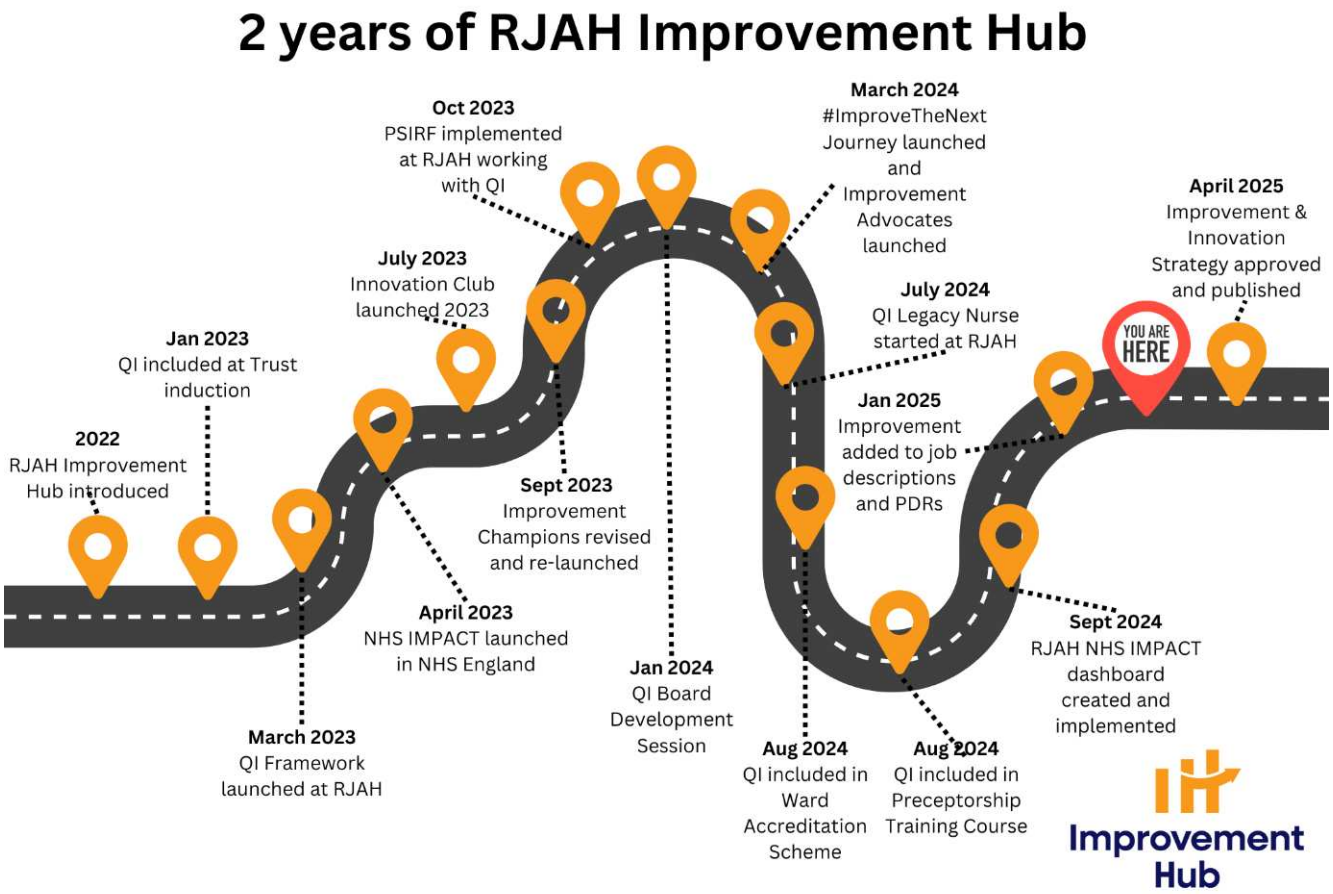
supporting some of the actions and focus to date was undertaken in October 2023 with a further self-assessment planned in May 2025. NHS IMPACT's five components form the 'DNA' of all evidence-based improvement methods, these principles underpin a systematic approach to continuous improvement:

1) Building a shared purpose and vision
2) Investing in people and culture
3) Developing leadership behaviours
4) Building improvement capability and capacity
5) Embedding improvement into management systems and processes

Early 2025 will see the Quality Improvement (QI) Framework replaced with first combined Improvement and Innovation Strategy further outlining and supporting our approach to improvement and ambition for innovation.

We also aim to have both Improvement Advocates and Improvement Champions CPD certified by the end of 2025.

The below road map shows the incredible journey of improvement at RJAH to date:



Staff Survey results further support and contribute to monitoring the progress the Trust is making on its improvement journey to date. For 2024, the Staff Survey results against 3) improvement related questions were:

- 76.22"% of staff feel they can make suggestions to improve the work of their team / department.
- "56.41"% of staff feel they are involved in deciding on changes introduced that affect their work area / team / department,
- "59.43"% of staff feel they can make improvements happen in their area of work.

Patient Safety Visits

The programme provides an opportunity for members of the Trust Board to engage with patients, relatives, and staff through regular visits to clinical areas. The purpose of the visits is to provide visible leadership by the Board on quality and safety and to talk to patients, families, and staff about their experience of care in the Trust.

Leadership walk rounds are recognised nationally as a critical leadership intervention, as described by the Institute of Health Improvements (IHI). Regular walk rounds are a sign of the Trust's safety culture and approach to improving quality in the organisation. This has provided members of the Board with the opportunity to talk to staff specifically about quality, safety, and improvement programmes and to get feedback to help achieve these improvements across the organisation. The programme provides the Non-Executive Directors, Executive Directors and Governors the opportunity to engage with patients, relatives, and staff and to discuss standards relating to quality and safety with clinicians and managers during the visits.

The purpose is:

- Demonstrate commitment to safety.
- Fuel culture for change pertaining to patient safety.
- Provide opportunities for senior executives to learn about patient safety.
- Identify opportunities for improving safety.
- Establish lines of communication about patient safety among employees, executives, managers, and employees
- Establish a plan for the rapid testing of safety-based improvements.

There are five key lines of enquiry the walkabout investigates which mirror Care Quality Commission (CQC) questions; safe, effective, caring, responsive, well led. Staff from across the organisation are asked what is going well in their opinion and areas which require a more sustained focus of improvement. Any actions following the visits are brought to the attention of the relevant Executive Director to consult with their team. A quarterly presentation shared with the Quality and Safety Committee and Council of Governors, highlighting positive feedback and areas of improvements.

Effectiveness

The National Institute for Health & Clinical Excellence (NICE) guidance -

All published NICE Guidance was reviewed monthly by Clinical Audit Quality Lead and the Consultant Lead for NICE Guidance. A total of 142 guidelines were reviewed, to which 136 were deemed not applicable to the services provided to RJAH; one is currently under review for whether it is relevant to the Trust and five of the guidelines were deemed applicable.

There have been four clinical audits completed or started in 2024/2025 in relation to our compliance to published NICE guidelines.

- 2324_025 Adherence to NICE guidelines in Management of inflammatory Arthritis with Tofacitinib (JAK inhibitor)
- 2425_010 Upper GI Bleed Re-Audit
- 2425_026 Delirium Re-Audit
- 2223_017 BSG, NICE & Scottish for suspected cancer for pelvic & appendicular sarcomas

List of NICE publications received and considered applicable to RJAH (5).

Date Issued	Ref	Title	Outcome
31/07/2024	QS119	Anaphylaxis	BAT Completed – Fully Compliant
07/08/2024	TA991	Abaloparatide for treating osteoporosis after menopause	Approved to Trust Formulary
07/08/2024	TA993	Burosumab for treating X-linked hypophosphataemia in adults	Approved to Trust Formulary
03/09/2024	IPG793	Single-step scaffold insertion for repairing symptomatic chondral knee defects	For information only – confirmed by clinical audit lead
16/10/2024	NG148	Acute kidney injury: prevention, detection, and management	Audit Results – 98.2%

Health and Safety

The Chief Finance and Planning Officer retained Board-level responsibility for health and safety. The Trust employed a health and safety team comprising of a manager and an advisor to comply with the requirement to appoint a competent person under section 7(1) of the Management of Health and Safety Regulations 1999.

The Trust's health and safety performance was reported to, and monitored by, the Health and Safety Meeting which escalated any issues of concern to the Quality and Safety Committee via a Chair report. The Health and Safety Meeting met bi-monthly, chaired by the Director of Estates and Facilities, and included health and safety representatives from staff side unions in compliance with the Safety Representatives and Safety Committees Regulations, 1977.

Incidents involving specified injuries, occupational disease, or resulting in a member of staff taking more than seven days off work because of a work-related accident, were also reported to the Health and Safety Executive (HSE) under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). During 2024/25 there were six incidents reported to the HSE under the requirements of the RIDDOR regulations. No regulatory action or sanction was received in respect of the reported incidents.

RIDDOR Description	2024-25	2023-24	2022-23
Occupational Disease	0	4	0
Slips, Trips and Falls	1	2	2
Lifting and handling injuries	5	1	5

Patient Experience

Listening to Patients and Carers

Listening to people's experience of care plays a crucial part in delivering services that are truly safe, effective, and continuously improving.

The experience that a person has of their care, treatment and support is one of the three parts of high-quality care, alongside clinical effectiveness, and safety. A person's experience starts from their very first contact with the health and care system, right through to their last contact of their patient journey.

Collecting patient experience data is an important part of monitoring the quality of care provided at the RJAH and helps promote an open learning culture by identifying and sharing examples of good complaints practice and learning that was identified through patient feedback.

The table below shows overall patient feedback in 2024/25 compared to 2023/24:

Feedback	2023/24	2024/25	Diff from 2023/24 to 2024/25	% Change
Complaints	98	144	46	47%
PALS concerns	424	618	194	46%
PALS enquiries	4483	5413	930	21%
Compliments	13189	13207	18	0%
FFT result	98%	98%	-	-

Learning from Patient Feedback

Listening and acting on patients and carers experience of care plays a crucial part in delivering services that are truly safe, effective, and continuously improving.

The experience that a person has of their care, treatment and support is one of the three parts of high-quality care, alongside clinical effectiveness, and safety. A person's experience starts from their very first contact with the health and care system, right through to their last contact of their patient journey.

In 2024/25 the Trust has continued to work towards achievement of the commitments identified in our Patient Experience Strategy, to provide the best experience of care at each phase of the patient pathways and interactions with our staff to ensure that patient centred care is provided to all our patients.

Patient Experience Strategy commitments are:

1. We will work in partnership with our patients and actively involve them in decisions about their care.
2. We will communicate to our patients in a manner that is accessible and appropriate to their own individual needs whilst listening to our patients about their priority of care and what matters most to them.
3. We will involve our patients and services users and the public in decisions regarding the way we deliver services and any future developments.
4. We will engage with our patients to facilitate patients to manage their own health conditions and get the best out of their wellbeing.
5. We will further develop the role of volunteers to ensure we maximise their input to enhance patient experience.

Insight on what our patient thinks of using our Services does not come from a single source. Patient insight and feedback is not just about collecting performance data. The Trust uses the data collected to help improve the quality of every person's experience, particularly looking at how people feel about hugely important issues such as dignity, compassion, and respect.

The Trust offers many opportunities for patients and carers to give their feedback including Trust email, Twitter and Facebook, local and national patient feedback surveys, Friends, and Family Test (FFT) survey, patient stories, patient engagement forums, Trust Governor forums and comments received direct. All feedback is shared with the clinical areas and is responded to by the Communications Team or the Patient Advice and Liaison Service (PALS) Team.

The Trust uses Patient feedback as a key measure of monitoring the quality of care, this an important "health check" for the services we provide as well as promoting a strong culture of listening to patients to help improve services.

In addition, the Trust has robust processes in place which enables patients to raise their concerns formally via the Complaints process and informally via the Patient Advice and Liaison Service (PALS). These concerns are investigated in with the Trust's complaints policy and action plans are put in place (where applicable), to ensure learning and improvement.

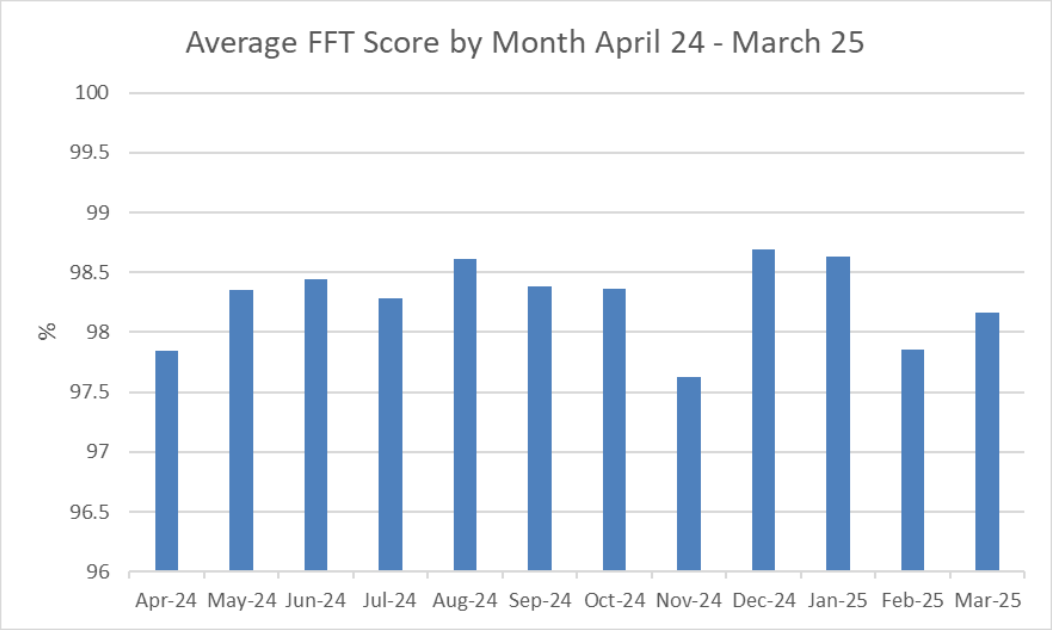
Patient Friends and Family Test

The NHS Friends and Family Test (FFT) "Overall, how was your experience of our service" was created to help Trusts understand whether patients are happy with the service provided, or to provide suggestions on any improvements needed. It's a quick and simple way for patients to give their views after receiving NHS care or treatment.

The results from FFT provides insights into how we can improve or celebrate the positive patient feedback received with the staff delivering the services.

FFT data is collected in real time using the IQVIA patient feedback system and patients are sent a text to invite them to complete a FFT survey electronically (after discharge or clinic appointment).

For 2024/25, 25,035 patients completed a FFT survey and 98.27% of patients (inpatients and outpatients) said they would rate their experience as good or very good. The chart below shows the average FTT score per month:



The Trust is committed to improving the percentage of patients who would rate their experience as good or very good.

Staff are sent an email alert in real time as soon as a low FFT score is received, and comments are immediately uploaded into IQVIA for staff to respond to within department. The FFT results are shared in Unit, department, and Speciality level Governance Quality reports with trends of low scores monitored monthly.

The results for the Trust over the last five years are as follows based on the average percentage of FFT score (inpatients and outpatients).

	2020/21	2021/22	2022/23	2023/4	2024/25
National Average	94%	94%	94%*	94%*	94%*
Highest Score	100%	100%	100%*	100%*	100%*
Lowest Score	65%	64%	73%*	75%*	69%*
The Robert Jones and Agnes Hunt	98%	98%	98%	98%	98%

*For 2023/23 and 2023/24 national data includes up to January

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust considers that this data is due to the Trust having a robust patient experience programme in place, which facilitates learning and implementing changes based on patient experience

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust has taken the following actions to improve this percentage:

- In 2024/25 the Trust has continued to work towards achievement of the commitments identified in our Patient Experience Strategy
- Continuous monitoring and collection of real time FFT patient feedback and sharing any negative FFT scores and comments with the relevant Departmental Manager for their action
- Robust reporting of the FFT results and trends at departmental/Speciality and Unit Governance meetings.

Patient Led Assessments of the Care Environment (PLACE)

PLACE assessments are conducted annually, providing a patient's perspective on the patient environment. The assessment captures responses to questions on cleanliness; food; privacy, dignity, and wellbeing; condition, appearance, and maintenance; dementia and disability.

Each year questions are updated/added to reflect what is deemed as best practice - ensuring safe, supportive, and high-quality patient experiences are advocated through the associated action plan.
The Trust uses the outcome of PLACE less as a benchmarking tool, more as a tool to actively drive improvement of the patient experience, this has been called out as part of the Exemplar Trust recognition as one of the strengths of the Trust.

The feeling of the teams on the day was very positive, and all groups noted where recent refurbishments have improved the overall environment in specific clinical areas. Scoring was negatively impacted by questions which bridged multiple criteria, particularly actions relating to Dementia & Disability. Over thousands of questions asked there were 131 resulting actions, with these actions monitored regularly through the Patient Experience Meeting. Outside of the scores detailed below, patient assessors noted that whilst many wards and departments felt modern and refreshed, some further focus on use of colour, muras and/poor lighting would ensure areas are consistently welcoming for all service users.

Domain	2022	2023	2024	Indication
Cleanliness	99.91%	98.84%	100%	↑
Food	93.85%	88.60%	94.82%	↑
Privacy, Dignity & Wellbeing	92.38%	91.84%	87.97%	↓
Condition, Appearance & Maintenance	99.04%	95.75%	98.71%	↑
Dementia	83.11%	79.40%	76.76%	↓
Disability	83.21%	80.42%	78.35%	↓

In 2024, the assessment panel included representatives from Healthwatch, Trust volunteers and students from The Marches sixth form, offering differing perspectives, ensuring the Trust assessment remains well rounded and representative of our patient population. For the first time, the improvement team were represented as part of the staff panel and are working collaboratively to identify where actions can be embedded into existing improvement projects or included in upcoming Quality Improvement Champion projects.

Health Inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. In March 2021, NHS England set out five national priorities for tackling health inequalities.

- Priority 1: Restoring NHS services inclusively.
- Priority 2. Mitigating against digital exclusion.
- Priority 3. Ensuring datasets are complete and timely.
- Priority 4. Accelerating preventative programmes.
- Priority 5. Strengthening leadership and accountability.

For the period of 2023-24 and 2024-25 NHS England's views on how relevant NHS bodies should exercise their powers to collect, analyse and publish information on health inequalities include the need to:

- Understand healthcare needs including by adopting population health management approaches, underpinned by working with people and communities.
- Understand health access, experience and outcomes including by collecting, analysing, and publishing information on health inequalities set out in the Statement.
- Publish information on health inequalities within or alongside annual reports in an accessible format.
- Use data to inform action including as outlined in the Statement.

The Trust has in place a Health Inequalities & Population Health working group. This group scopes opportunities alongside available health inequalities intelligence to further understand health access, experience, and outcomes. The group is a multi-disciplinary working group with attendance from system partners too; this is in recognition that to serve communities well, relevant NHS bodies and partner organisations should work together to understand the collective health and care needs of local people and populations, as well as healthcare access, experience, and outcomes. Some areas of focus through this group for 2024/25 have included:

Prevention and waiting well initiatives to improve health and wellbeing.

As referenced by The State of Musculoskeletal Health 2024: - Data Versus Arthritis report (the-state-of-musculoskeletal-health-2024.pdf):

"People who experience more deprivation are more likely to be overweight or obese than those experiencing less deprivation. Deprived areas have increased prevalence of osteoarthritis. The increased prevalence of obesity in these areas accounts for 50% of the extra risk for knee osteoarthritis."
Local Authority colleagues from Shropshire and Telford have been in attendance of the working group as part of discussions and action to signpost to available services i.e. smoking cessation and weight management. This work will further evolve as part of ongoing transformation to improve the pre-operative pathway for our patients.

Did Not Attend (DNA) / Was Not Brought (WNB)

There is a recognised difference in the volume of patients from the most deprived areas not attending an appointment. We have consistently seen statistically significant differences in the DNA rates of patients with different IMD quintiles, and that has persisted in March 2025. For example, the most deprived English quintile had a DNA rate of 7.07%, whereas the most affluent English quintile had a DNA rate of 2.50%. This was not seen however in Welsh patients, with no significant difference in the DNA rates of patients with different IMD quintiles.

The Trust has processes in place to support patients who are financially struggling, and work is ongoing with local charities to further support access for patients.

While the Trust's overall DNA rates remain low, we are making efforts to understand health inequalities experienced by our patients that may cause disparities in the DNA rates seen in different demographics. In particular, the Trust has been focusing on its paediatric WNB rates. Our Paediatric Orthopaedics team was identified as an outlier for its high WNB rates compared to other teams in the Trust, which the team has been working to reduce.

The Trust is currently collecting and investigating data on why these patients are not being brought, to understand the root causes and help deliver targeted improvement work. Work is also being done to strengthen relationships between our paediatric teams and both Shropshire Council and Telford & Wrekin Council. The aim is to use the work already done in councils to support children and their families in attending their appointments, whether that be using existing close relationships with a social worker, or services offered by councils that support families

System Transfer Health Inequalities Assessments

Assessments have involved understanding datasets split by Index of Multiple Deprivation (IMD). This is a relative measure of deprivation. This means it can tell you if one area is more deprived than another. Out of all RJAH teams, Rheumatology is the only one with a significantly different IMD distribution in its English referral-to-treatment (RTT) waiting list compared to pre-pandemic. This is following a transfer of the service from another system provider to RJAH. In January 2024, the proportion of these Rheumatology patients living in the most deprived quintile was 7.9%. Then in February 2024, after the system transfers had begun, this shot up to 18.5%. It has since slowly decreased to 14.3% at February 2025 month end. The monitoring of this impact alongside further intelligence is ongoing.

Alongside the healthcare intelligence the Trust also recognises its place as an Anchor Institution with community engagement activities regularly undertaken at RJAH. Other activities are inclusive of local procurement with the Trust now being recognised as a Love British Food hero in recognition of our procurement practices to support local suppliers. The Trust also participates in programmes supporting our population back into work, as part of this the Trust has successfully engaged with the 'Stepping in To Work' programme ran by Telford College within estates and facilities workforce.

During July 2025, a presentation was given to the Trust Public Board describing some of the work that had taken place to date. Health inequalities intelligence and programmes of work are continuously reviewed and form part of plans for 2025/26 to continue and further evolve. The Trust's Health Inequalities & Population Health working group updates are reported through the Quality and Safety committee which is a sub-committee of the Trust Board. In addition, Health Inequalities disaggregated intelligence is presented as part of performance report updates to both the Quality and Safety and Finance and Performance committees.

Freedom to Speak Up Guardians

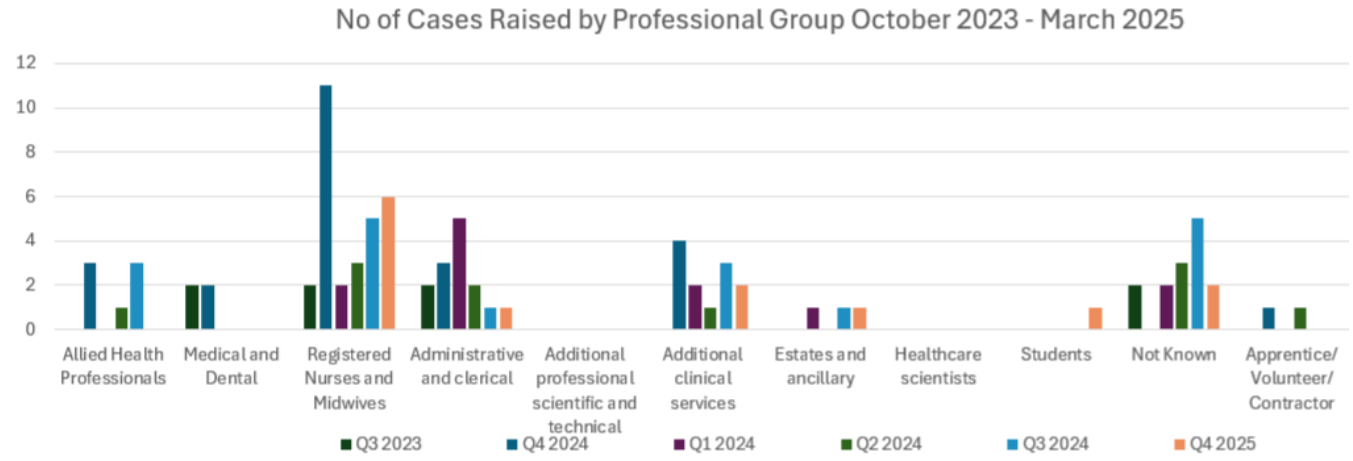
In 2024/2025 The FTSU Portfolio sits under Corporate, with the Chief Nurse as the Executive Lead for FTSU. The Freedom to Speak Up at RJAH reports into the People committee on a quarterly basis.

The role of FTSU is to encourage staff to speak up about anything that gets in the way of patient care or affects staff working life. It encourages a culture where staff feel safe and confident to raise concerns about patient care, safety, or workplace issues, ensuring that lessons are learned, and improvements are made.

The Trust currently has twelve FTSU Champions across the organisation. This year we have recruited several champions from the global majority, and several champions with protected characteristics.

The total number of cases raised in 2024-25 was 54 cases, compared with 46 cases in 2023/24. This is 20% increase on last year.

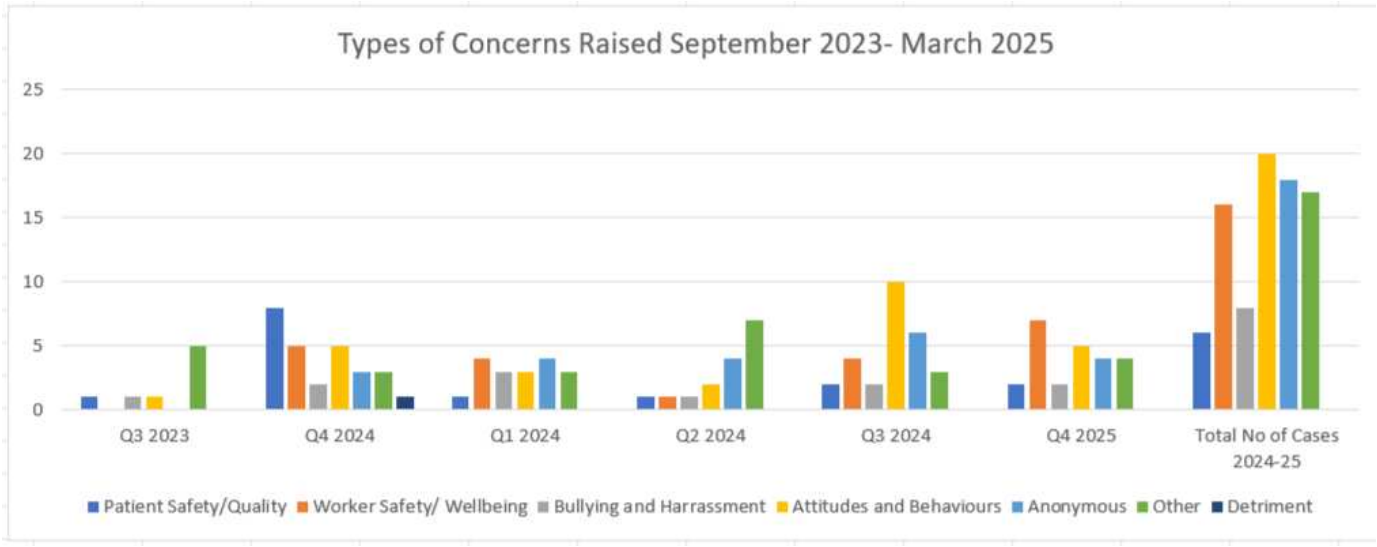
The FTSU team have received concerns from a broad range of professional groups across the Trust. Registered Nurses raised the most concerns with 29.63%, followed by Administration and Clerical 16.66% and then Additional clinical services with 14.81%. Twenty-two percent of concerns did not wish to share their professions or were anonymous concerns.



Below is the data required of the different 'Types of concerns' raised. The National Guardian Office have categorized concerns, under Patient Safety/Quality, Attitudes and Behaviours, Worker Safety and Wellbeing, Bullying and Harassment, Other (procedures, policies, fraud etc) and the number of anonymous concerns.

When staff raise a concern, it can have more than one element to the concern and therefore would be enter into several categories. In 2024-25 Attitudes and behaviours have been the most consistent concerns raised followed by Other concerns.
Attitudes and behaviours = 29.85%, Patient Safety 8.96%, bullying and harassment 11.94%, Other 25.37%, Detriment 1.49% and anonymous 26.87% of the total number of types of concerns raised over this last 12 months.

Cases have taken from one day to four months to close over the past year.



In 2024/25 the FTSU RJAH have promoted FTSU across the Trust by updating Posters of the Champions and Non-exec, executive lead, and Guardian for FTSU. In October, the Champions and Guardians promoted FTSU by having a walk about, explaining about FTSU and explaining how they can raise a concern.

Mandatory FTSU e-learning was introduced last year. This included three modules and is a one-off training session. Speaking Up is for every member of staff, Listening Up is an additional module for Managers and the Follow Up module is for senior manager/ executive managers as well as the other two modules.

This year 92.2% of staff have completed the Speaking Up module, 83.4% have completed the Listening Up module and 81.6% have completed the Follow up module. FTSU Champions are also asked to complete all three modules.

The introduction of QR code for a Microsoft FTSU raising concerns form has been completed. This form enables anyone wishing to raise a concern either anonymously or by name can do so by scanning the code. Once the person has submitted the form this is sent directly to the Guardian, computer identification is not traceable, therefore if some wishes to stay anonymous they can. If contact detail is added then the Guardian can contact the person to discuss the concern, signpost them to appropriate departments and give feedback, as necessary.

Completed actions for 2024-25

- Completion of the National Guardian Office Reflection and planning tool.
- The additional appointment of three global majority FTSU champions, bringing the total of champions up to twelve. The Champion's role is to raise the profile of FTSU in their department and signpost staff to an appropriate person for advice or escalation.
- The Guardian has introduced a closed, information portal, for the Champions. The Guardian can share updates from the National Guardian Office. There is also a separate digital chat room and What's App group, so Champions can ask questions and gain support from each other. Bi-monthly face to face meetings are also available.
- A Microsoft from for Champions to record concerns raised to them has been developed. This enables accurate data to be collected and shared with the Guardian in real time.

- Ensuring face to face presentations on FTSU at Trust induction and development days, and Preceptorship programme.
- The implementation of a staff survey feedback form. This form is sent in batches, to staff who have raised concern, and the cases have been closed. The feedback form is anonymous so that staff can give honest feedback about the FTSU service.
- Additional data are being collected around protected characteristics, if any staff with protected characteristics are raising more concerns than staff without.

National Quality Indictors

Staff Survey Results

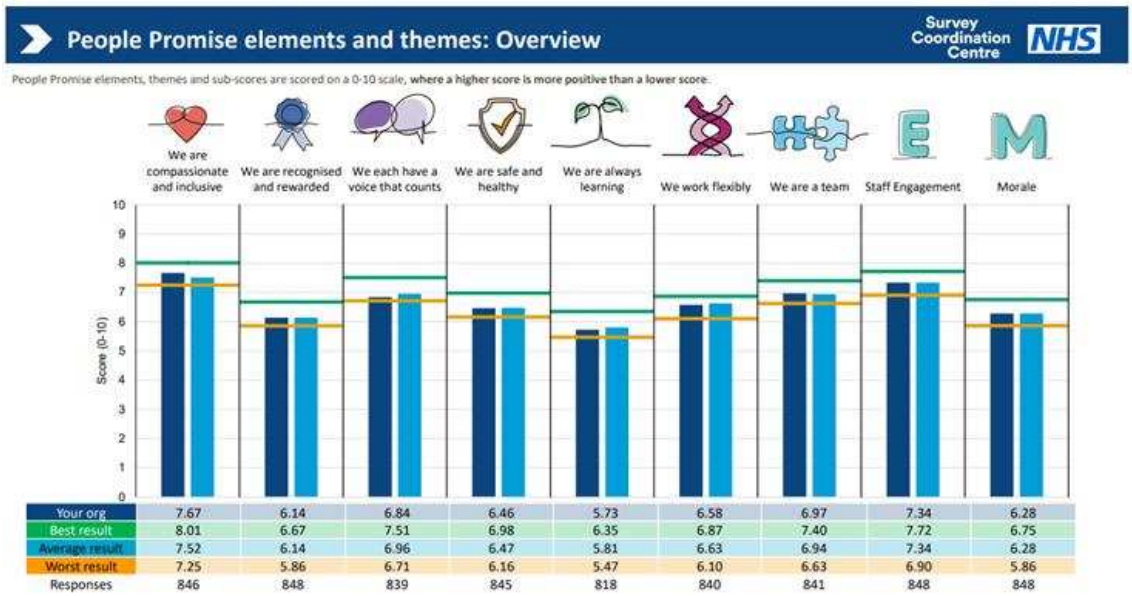
In the 2024 NHS Staff Survey, 92% of respondents said they would be happy with the standard of care provided if a friend or relative needed treatment.

Key headlines:

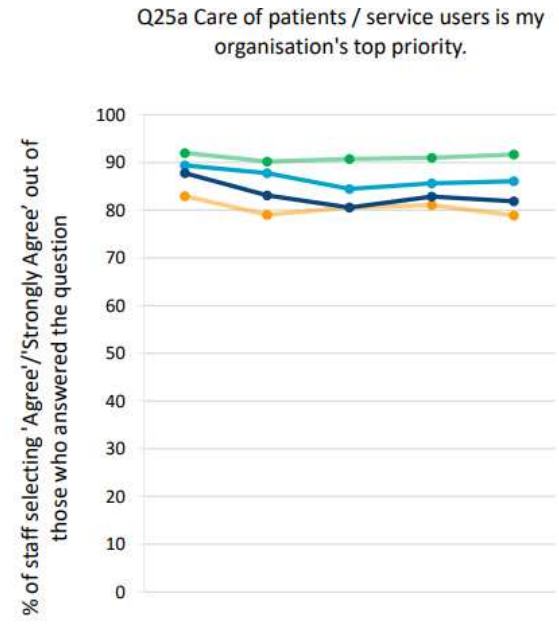
- Recommended treatment to a friend or relative = 92% (2023 data = 94.02% slight decline) but above the average result of 89%

The overall response rate, and themed results are detailed below:

Response Rate	2018	2019	2020	2021	2022	2023	2024
	44.9%	62%	57%	52%	52%	52%	47%



Our overall staff engagement score was comparable with other acute specialist trusts.



	2020	2021	2022	2023	2024
Your org	87.75%	83.09%	80.54%	82.87%	81.87%
Best result	91.98%	90.20%	90.74%	90.97%	91.69%
Average result	89.38%	87.74%	84.45%	85.64%	86.06%
Worst result	82.94%	79.02%	80.54%	81.07%	78.89%
Responses	893	840	834	902	845

Oversight Framework

The following section outlines the Trust's performance against the relevant indicators and performance thresholds set out in the NHS Improvement Oversight Framework where this data does not appear elsewhere in the report.

	Info taken from the published annual accounts							
Indicator for Disclosure	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate	89.49%	90.26%	88.85%	54.41%	55.96%	53.45%	49.06%	47.62%
All cancers: 62day wait for first treatment from: * Urgent GP referral for suspected cancer * NHS Cancer Screening Service referral	75.76%	73.91%	86.84%	75.00%	65.63%	80.85%		
62 Day General Standard							75.44%	65.88%
Maximum 6 week wait for diagnostic procedures	99.57%	98.97%	97.94%	59.00%	77.45%	64.68%	81.88%	83.10%
Venous thromboembolism (VTE) risk assessment	99.90%	99.88%	99.89%	99.74%	99.77%	99.80%	99.78%	99.83%

NHSE issued updated Cancer Waits Guidance in 2023/24 and now reporting is against the 62 Day General Standard, as presented in the table above.

Statement of Directors' responsibility in respect of the Quality Account

Organisations are required under the Health Act 2009 and subsequent Health and Social Care Act 2012 to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum

NHSE has issued guidance NHS foundation trusts are no longer required to produce a Quality Report as part of their annual report. NHS foundation trusts will continue to produce a separate quality account. The National Quality Board has approved a refresh of Quality Accounts to update and improve the process, bringing it in line with changes to legislation and NHS structures and policy.

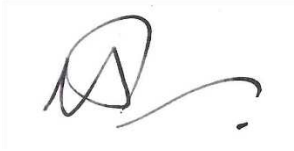
to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

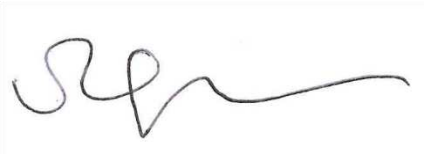
- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust guidance.
- The content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2024 to March 2025
  - Papers relating to quality reported to the board over the period April 2024 to March 2025
  - Feedback from Shropshire Telford and Wrekin ICS
  - Feedback from the Trust's Lead Governor
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The latest national patient survey 2024 and national staff survey 2024
  - The most recent CQC inspection report
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board



Harry Turner, Chairman



Stacey Keegan, Chief Executive Officer

NHS Shropshire, Telford and Wrekin

RJAH Quality Account Statement from Shropshire Telford and Wrekin ICB 2024/25

Re: Quality Account 1 April 2024 - 31 March 2025

NHS Shropshire Telford and Wrekin Integrated Care Board (the ICB) are pleased to have had the opportunity to review the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) Quality Account for 2024/25.

The ICB supports the Trust's quality priorities for 2025/26 including falls and further supporting those with complex needs including those with mental health challenges and people with a

Learning Disability and Autism.

The ICB was pleased to note RJAH's ongoing commitment to supporting local and national audits demonstrated though participation in the11 National audits they were eligible to participate in as well as 16 local clinical audits. RJAH also completed 12 service evaluation

projects which identified opportunities to improve the provision of urgent orthotics and creation of a safeguarding checklist, contributing the integrated care system's ambitions to drive

continuous quality improvement.

Maintaining attention on the experience of the workforce, the NHS staff survey results for 2024 were extremely positive showing that 74% of staff would recommend RJAH as a place to work. Actions identified from the survey included implementation of the NHS People Plan, focus groups and staff network groups. Actions taken forward include real time feedback on patient experiences, patient involvement in safety events and completion of action plans in response to complaints. RJAH Friends and Family Test also remains consistently above 95% of patients

scoring the Trust very good or good.

The management of healthcare acquired infections is an area that the ICB has worked closely with RJAH and the system on in recent years. Reporting was pleasing. The ICB is pleased to see the ongoing priority in this area with positive outcomes including only 2 cases of *Clostridioides difficile* Infections (CDI) in 2024/25 against a target of 4.

RJAH reported four Never Events for 2024/25. These were investigated using the Patient Safety Incident Response Framework (PSIRF) principles. Key learning identified from the investigations included the introduction of the revised National Safety Standards for Invasive Procedures

(NatSIPPS2) across all departments in the Trust.

Longer waiting times for some appointments has been a challenge and RJAH have been undertaking harm reviews to monitor and address potential risk following a local policy. The ICB is keen to continue to understand the learning from these and how any harm can be minimised.

The ICB was delighted that RJAH was identified as an early implementor site for Martha's rule. The patients/family and staff can request a review from the Critical Care Outreach Team with plan from February 2025 to introduce daily wellness checks on inpatient wards. This is an

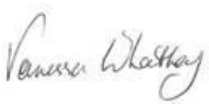
important national development, and we look forward to further sharing of this experience in the system.

In conclusion, the ICB views the 2024/5 Quality Account as an accurate picture of the challenges the Trust faces and evidence of improvements in key quality and safety measures.

The ICB supports the trust priorities for 25/26 and recognises the Trust's commitment to

working as a partner in the system to ensure the ongoing delivery of safe, high-quality services for the population of Shropshire Telford and Wrekin.

Yours sincerely,



Vanessa Whatley, Chief Nursing Officer, NHS STW

Lead Governor's Submission on the Quality Account Report for 2024/25 of the Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

The Quality Account Report 2024/25 demonstrates the continued significant achievements the Trust has made over the last year in despite of the challenges faced. This is particularly evident through the Inpatient Survey Results there is continued evidence of the Trust's work to strive for improvement.

The Governors continue to support the Trust and partake in patient safety visits, attending committees meeting and holding governors' surgery. Within 2024/25, the Governors have been more involved in events, patient safety and patient experience initiatives, and they welcome these opportunities to provide input on behalf of their members. In addition, seeing how the services run and hearing directly from patients about their experiences provides assurance to the Council of Governors that the patient needs are consistently being met.

It is reassuring that the hospital continues to be a place staff would recommend to their friends and family as a place of treatment and further as a place to work. This really is testimony to the quality of the care that the Trust continues to provide.

On behalf of the Council of Governors, I would like to congratulate the Trust on its quality performance for 2024/25.

Victoria Sugden, Lead Governor
DD June 2025

Acronyms

ACL	Anterior Cruciate Ligament
ASIA	American spinal injury association
BBE	Bare below the elbow
BMI	Body Mass Index
BOFAS	British Orthopaedic Foot & Ankle Society
BSCOS	British Society for Children's Orthopaedic Surgery
BSR	British Spinal Registry
CAP	Community required Pneumonia
CD	Controlled Drug
CDI	Clostridioides Difficile Infections
CEO	Chief Executive Officer
CLD	Criteria Led Discharge
CMC	Carpometacarpal
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSP	Chartered Society of Physiotherapist
CURB-65	Severity Score for Pneumonia
DIPC	Director of Infection Prevention and Control
DMARDS	Disease-modifying anti-rheumatic drugs
DMD	Duchenne Muscular Dystrophy
DSPT	Data Security and Protection Toolkit
DVT	*Deep vein thrombosis*
EDD	Estimated Date of Discharge
EPR	Electronic Patient Record
EQ5D	Equality Health Index Score
FFFAP	Falls, Fragility Fracture Audit Programme
FFT	Family and Friends Test
FTSU	Freedom to Speak Up
GIRFT	Getting It Right First Time
HCAI	Healthcare Acquired Infection
HCPC	Health and Care Professionals Council
HDU	High Dependency Unit
HSE	Health and Safety Executive
HSIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
ICS	Integrated Care System
IG	Information Governance

IHI	Institute of Health Improvement
IHOT	Intensive Health Outreach Teams
IM	Intramuscular
IPC	Infection Prevention and Control
IPR	Integrated Performance Report
IQVIA	Patient Experience monitoring system
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
ISNCSCI	International Standards for Neurological Classification of Spinal Cord Injury
KLOEs	Key Line of Enquiry's
KPI	Key Performance Indicator
LD	Learning Disabilities
LOS	Length of Stay
MADE	Multi Agency Discharge Event
MAHR	Non-Arthroplasty Hip Registry
MDT	Multidisciplinary Team
MPFT	Midland Partnership Foundation Trust
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphylococcus Aureus
MSCI	Midlands Spinal Cord Injury
NDFA	National Diabetes Foot Audit
NEIAA	National Early Inflammatory Arthritis Audit
NHS	National Health Service
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
NJR	National Joint Register
NMR	Non-medical Referrer
OHS	Oxford Hip Score
OKS	Oxford Knee Score
OT	Occupational Therapist
PALS	Patient Advice and Liaison Service
PE	pulmonary embolism
PEoLC	Palliative and End of Life Care
PLACE	Patient Led Assessment of the Care Environment
PQIP	Peri-operative Quality Improvement Programme
PR	Peri Rectum Examination
PROMs	Patient Reported Outcomes Measures
PSAG	Patient Status at a Glance
PSI	Patient Safety Incident
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan

QI	Quality Improvement
RCA	Route Cause Analysis
RCOT	Royal College of Occupational Therapists
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RJAH	Robert Jones and Agnus Hunt
RSH	Royal Shrewsbury Hospital
RTT	Referral to Treatment Time
SCI	Spinal cord injury
SCIM	Spinal cord independence measure
SEIPS	System Engineering Imitative for Patient Safety
SHMI	Summary Hospital-level Mortality Indicator
SHOT	Serious hazards of transfusion
SI	Serious Incident
SIF	Serious Incident Framework
SIRO	Senior Information Risk Owner
SOF	Single Oversight Framework
SOOS	Shropshire Orthopaedic Outreach Service
SSCP	Shropshire Safeguarding Community Partnership
SSI	Surgical Site Infections
SWAN	Signs Words Actions Needs
TER	Total Elbow Replacement
THR	Total Hip Replacement
TIF	Targeted Investment Fund
TKR	Total Knee Replacement
TQ Pressure	Tourniquet Pressure
TSR	Total Shoulder Replacement
VTE	*Venous Thromboembolism*
WTE	Whole Time Equivalent

Policy Ratification – EPRR Policy

Committee / Group / Meeting, Date

Board of Directors – Public Meeting, 02 July 2025

Author:	**Contributors:**
Name: Hannah Howells Role/Title: Health and Safety Advisor	EPRR Group Health and Safety Meeting. STW Stuart Allen: ICB EPRR Lead. NHS England Midland Region EPRR Team.

Executive Director sign-off:

Mike Carr, Accountable Emergency Officer / Deputy CEO
Quality and Safety Committee, 22nd May 2025

Is the report suitable for publication?

Yes

Key issues and considerations:

1. **Does the policy take account of relevant:**

   a) **Legislation** — **YES**

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health.

All acts place EPRR duties on NHS England and the NHS in England.

   b) **Regulatory requirements** — **YES**

Regulations (The Civil Contingencies Act 2004 (Contingency Planning) Regulations 2012) (the Regulations)

NHS core standards for emergency preparedness, resilience and response (EPRR)

   c) **Statutory guidance** — **YES**

Expectations and indicators of good practice set for category 1 and 2 responders.

NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.

2. **Has appropriate expert / professional advice been sought and taken into account?** — **YES**

   - Shropshire Telford and Wrekin Integrated Care Board (ICB) Senior EPRR Lead, Stuart Allen.
   - NHS England Midland Region EPRR Team.

3. **Have the relevant advisory / decision-making groups within the Trust been involved in its production and does it reflect their views / comments?** — **YES**

   - EPRR Group
   - Health and Safety Meeting

4. **Have key external stakeholders been engaged in the production of the policy and does it reflect their views / comments?** — **YES**
   - Various RJAH staff and leads at meetings.
   - Shrewsbury and Telford Hospital EPRR Teams and leads.
   - Shropshire Community Health Trust Senior EPRR Lead.

- Shropshire Telford and Wrekin Integrated Care Board (ICB) Senior EPRR Lead, Stuart Allen.
- NHS England Midland Region EPRR Team

5. What arrangements are in place to ensure / monitor adherence to the policy?

RJAH EPRR Group, NHS Core standards for EPRR annual assessment.

Strategic objectives and associated risks:

The following strategic objectives are relevant to the content of this report:

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	
4	Grow our services and workforce sustainably	
5	Innovation, education and research at the heart of what we do	

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

Board Assurance Framework Themes		
1	Continued focus on excellence in quality and safety	
2	Creating a sustainable workforce	
3	Delivering the financial plan	
4	Delivering the required levels of productivity, performance and activity	
5	Delivering innovation, growth and achieving systemic improvements	
6	Responding to opportunities and challenges in the wider health and care system	
7	Responding to a significant disruptive event	✓

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:

System Objectives		
1	Improve outcomes in population health and healthcare	✓
2	Tackle inequalities in outcomes, experience and access	
3	Support broader social and economic development	
4	Enhance productivity and value for money	

Recommendations:

Following consideration at the Quality and Safety Committee, it is recommended the Board approves the EPRR policy.

Next steps:

The policy will be reviewed during the NHS core standards for EPRR self-assessment in August 2025. The policy has already been shared with RJAH staff and will be published on Percy when approved. The policy is monitored via the EPRR group. The policy is assessed annually in line with the training and exercising requirement under NHS Standards for EPRR.

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Title:	Emergency Preparedness, Resilience and Response (EPRR) Policy		
Unique Identifier:		**Document Type:**	Policy
Version Number:	3	**Status:**	Draft
Responsible Director:	Chief Operating Officer / Accountable Emergency Officer (AEO)		
Author:	Health and Safety Advisor		
Scope:			
Replaces:	2		
To be Read in Conjunction with the Following Documents:	Incident Response Plan		
Keywords:	Emergency Preparedness, Resilience and Response.		

Considered By Responsible Director:	Accountable Emergency Officer (AEO)	**Date Considered:**	12/02/2025
Approved By:	EPRR Group Health & Safety Meeting Quality & Safety Committee	**Date Approved:**	27/03/2025 30/04/2025 22/05/2025
Consulted By:	Senior EPPR Lead, NHS Shropshire, Telford & Wrekin ICB EPRR Engagement Manager NHS England (Midlands)	**Date Reviewed:**	29/01/2025 31/01/2025
Issue Date:	tbc	**Review Date:**	12/02/2026
Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

Contents

1.0 Introduction

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care.

This programme of work is referred to, in the health community as emergency preparedness resilience and response (EPRR). In the NHS, EPRR is designed to meet the statutory requirements placed upon responding organisations under the Civil Contingencies Act 2004 (CCA 2004). The CCA 2004 defines specific statutory duties for responding organisations depending on them being a Category 1 or Category 2 responder.

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust (RJAH) is a designated Category 1 responder under the Civil Contingencies Act 2004. RJAH has a legal duty to:

1. Assess the risk of emergencies occurring to inform contingency planning
2. Put in emergency plans
3. Put in place business continuity management arrangements
4. Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
5. Share information with other local responders to enhance coordination
6. Co-operate with other local responders to enhance coordination and efficiency
7. Provide advice and assistance to businesses and voluntary organisations about business continuity management

This document sets out the emergency preparedness, resilience and response (EPRR) arrangements within the Trust. Arrangements are put in place for emergency preparedness, resilience and response which:

- Ensure the Accountable Emergency Officer's commitment to the plans and give a member of the executive management board and/or governing body overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management agendas.
- Assess risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plan.
- Put in place Business Continuity Management arrangements.
- Share information with other local responders to enhance co-ordination.
- Cooperate with other local responders to enhance coordination

2.0 Purpose and Scope

The NHS England Core Standards for Emergency Preparedness, Resilience and Response EPRR (NHS England, requires organisations, including NHS Foundation Trusts, to have an overarching EPRR policy in place for building resilience across the organisation so that EPRR and business continuity issues are mainstreamed in processes, strategies and action plans across the organisation.

The document relates to all The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust (RJAH) staff, who in the course of their work undertake duties in relation to the NHS England Core Standards for EPRR.

This includes staff working directly in clinical services and also those working in corporate services, including for example, Finance, Estates and Facilities and People Services. The

document is to be read in conjunction with the Trust Incident Response Plan and other emergency plans and policies. The Trust Incident Response Plan and other emergency plans and policies are stored electronically on the Trust Intranet dedicated EPRR Page (see hyperlink below). Hard copies are stored in the Trust Incident Control Centre (ICC) cupboard (CSM Office location 21) and at Switchboard.

https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832

3.0 Definitions

LHRP – Local Health Resilience Partnership. The Strategic Planning Group made up of Trust Accountable Emergency Officers with responsibility for Emergency Preparedness, Resilience and Response.

RJAH – The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust.

Emergency Preparedness is defined as: The extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies.

Resilience is defined as: Ability of the community, services, area, or infrastructure to detect, prevent and, if necessary, to withstand, handle and recover from disruptive challenges.

Response is defined as: Decisions and actions taken in accordance with the strategic, tactical, and operational objectives defined by emergency responders.

Under Section 1 of the Civil Contingencies Act (CCA) 2004 an “emergency” means:

(a) “an event or situation which threatens serious damage to human welfare in a place in the UK; “

(b) “an event or situation which threatens serious damage to the environment in a place in the UK;”

(c) “war, or terrorism, which threatens serious damage to the security of the UK”.

3.1 Incident Classifications

There are three main types of incident classifications used within the NHS, which are set out below. Each could potentially impact on service delivery within our Trust and would therefore require our business continuity plans to be implemented.

The three main types of incidents used within the NHS are: -

3.1.1 Business Continuity Incident - A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation’s normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)

3.1.2 Critical Incident - A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring

extraordinary measures and support from other agencies, to restore normal operating functions.

3.1.3 Major Incident - A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS this will include any event defined as an emergency below.

- An incident that significantly impacts health services and requires a coordinated response (any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented).
- An event that causes a surge in casualties beyond normal capacity, requiring special measures.
- A situation that disrupts NHS services such as hospitals, primary care, or emergency response.
- A public health emergency such as an infectious disease outbreak or contamination event.
- A critical infrastructure failure affecting the delivery of healthcare, like IT system failures or power outages.

3.2 Incident Levels

As an event evolves it may be described in terms of its level as shown. For clarity these levels must be used by all organisations across the NHS when referring to incidents.

Level 1	An incident that can be responded to and managed by an NHS-funded organisation within its respective business as usual capabilities and business continuity plans.
Level 2	An incident that requires the response of a number of NHS-funded organisations within an Integrated Care System (ICS) and NHS coordination by the Integrated Care Board in liaison with the relevant NHS England region.
Level 3	An incident that requires a number of NHS funded organisations within an NHS England region to respond. NHS England to coordinate the NHS response in collaboration with the ICB. Support may be provided by the NHS England Incident Management Team (National).
Level 4	An incident that requires NHS England national command and control to lead the NHS response. NHS England Incident Management Team (National) to coordinate the NHS response at the strategic level. NHS England regions to coordinate the NHS response, in collaboration with the ICB, at the tactical level.

3.2.1 Statutory requirements and underpinning principles of EPRR

Under the NHS Constitution the NHS is there to help the public when they need it most, this is especially true during an incident or emergency. Extensive evidence has shown following incidents such as the Terrorist attacks in London and Manchester, the Ebola threat faced by the UK and Large-Scale Flooding events that good planning and preparation for any incident saves lives and expedites recovery. All NHS funded services must therefore ensure they

have robust and well tested arrangements in place to respond to and recover from these situations.

4.0 Roles and Responsibilities

The Chief Executive Officer - The Chief Executive Officer for has overall responsibility for health and safety within our Trust and must ensure the identification and control of all risks, including EPRR, is undertaken and managed.

The Chief Finance Officer - The Chief Finance Officer will ensure that adequate resources are made available to enable the organisation to meet the requirements of The NHS Core Standards for EPRR. This budget and resource must be proportionate to the size and scope of the organisation.

The Chief Operating Officer is the Accountable Emergency Officer (AEO):

The Chief Operating Officer / AEO is responsible for and will assume overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management including:

- Assume responsibility to the Board of Directors to ensure compliance with The NHS Core Standards for EPRR.
- The AEO as a duty to attend the West Mercia LHRP. The LHRP will provide a strategic forum for NHS organisations to facilitate health sector preparedness and planning for emergencies. As a minimum the AEO must attend 75% of the West Mercia LHRP meetings, unless due to annual leave/unexplained absence etc, they nominate an Executive Director to attend on their behalf.
- Overall responsibility and accountability for the management of the on-call arrangements within our Trust and ensuring all on-call staff are appropriately trained and equipped supported by the Business Operations Manager.
- Reporting to the Executive and Trust Board as the AEO on Business Continuity Preparedness within our Trust.
- Provide an annual report to the Board of Directors on the organisation's final self-assessed position of the NHS Core Standards for EPRR; ensuring any sub-contractors are compliant with the EPRR requirements as set out in the CCA 2004, the 2005 Regulations, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract, including this Framework and The NHS Core Standards for EPRR.

The Director of Estates and Facilities will:

- Chair the Trust-wide EPRR Group on behalf of the AEO, to ensure coordination of the EPRR portfolio seeking feedback on draft plans and policies and potential training and exercising, share best practice and act proactively to embed EPRR within teams across the organisation.
- In conjunction with the EPRR Lead ensure this document is reviewed on an annual basis to ensure its continued relevance.

The Director of Digital will:

- The Director of Digital is responsible for ensuring that digital systems and infrastructure support EPRR requirements.

- This includes overseeing the critical IT systems, ensuring robust cybersecurity measures, and maintaining digital communication channels for emergency coordination.
- Ensure that essential digital services have suitable backups to facilitate DR processes and ensure that monitoring is carried out,
- Support business continuity planning and align digital strategies with national EPRR standards.

The EPRR Lead is responsible for:

- Providing an operational lead on EPRR matters across all Trust business.
- Prepare EPRR Plans and Policies and ensure these are distributed for consultation by the EPRR Group and externally as appropriate.
- Consult with staff at all levels as appropriate to assist with their understanding of EPRR requirements.
- Provide the EPRR Group with an annual EPRR training and exercising schedule for approval, and deliver what has been approved.
- Represent the Trust at external meetings and exercises.
- Provide operational support with regard to EPRR matters in the event of a Critical or Major Incident.
- Consult with the Trust Secretary to ensure EPRR risks are considered within internal risk processes.
- Provide six monthly updates on the EPRR annual work programme to Trust Quality and Safety Committee.

The Business Operations Manager is responsible for:

- Supporting the AEO and the management of the on-call arrangements within our Trust and ensuring all on-call staff are appropriately trained and equipped.
- Manage and maintain the Trust's Business Continuity Management System in accordance with the legal duty RJAH has as a Category 1 responder identified under the Civil Contingencies Act 2004.

Managing Directors / Ward / Department Managers are responsible for:

- Ensuring that their departments/areas have reviewed the Trust Incident Response Plan and are aware of the impact on their departments.
- Ensuring that all relevant staff have a clear understanding of and have received training in the plan.
- Managing Directors / Ward/ Department Managers are responsible for ensuring Business continuity plans are in place, reviewed and tested periodically for each of their areas with the support of the Business Operations Manager.

All Staff - All Staff are responsible for ensuring that they are aware of the contents of our Trust's Incident Response Plan and their individual responsibilities should the plan be activated.

The Trust Incident Response Plan and other emergency plans and policies are stored electronically on the Trust Intranet dedicated EPRR Page (see hyperlink below). Hard copies are stored in the Trust Incident Control Centre (ICC) cupboard (CSM Office location 21) and at Switchboard.

https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832

5.0 Underpinning principles of EPRR

The NHS Core Standards for EPRR apply to the arrangements the Trust has in place to prepare for and respond to an emergency. Emergency Plans and Policies will:

- Have a change control process and version control detailed for each document. RJAH documents have version control n the front page and a version control table on the last page of each document.
- Each new version will have a new version number displayed on the documents front page. For example, version 1.0 would become version 2.0. Any draft copies of the documents will be included within the version control table.
- Changes to all EPRR Plans and Policies will be subject to an annual review at RJAH, and approval by the appropriate Trust Committee.
- Take account of changing business objectives and processes. This will be detailed and led from the Trust's Strategy and Trust Clinical Strategy, by the Board of Directors.
- Take account of any changes in the organisation's functions and/ or organisational and structural and staff changes. Where changes to structure and staff take place that directly impact on EPRR, plans and policies must be updated immediately. All EPRR Plans and Policies will be reviewed by the EPRR Group in light of any changes to the Trust's function, organisational structure or staff.
- Take account of change in key suppliers and contractual arrangements.
- Use consistent unambiguous terminology and include glossaries where required.
- Include appropriate distribution lists.
- Be available on the Trust Intranet Percy – see below hyperlink - Hard copies are stored in the Trust Incident Control Centre (ICC) cupboard (CSM Office location 21) and at Switchboard.

  https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832

- Have an expectation that a lesson's identified report must be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place.
- Include references to other sources of information and supporting documentation.
- Adhere to Trust policy with regard to different groups of people and different needs of people with protected characteristics and ensure plans take into account, e.g., age, disability, race, sex, sexual orientation, gender reassignment, pregnancy and maternity, marriage and civil partnership, religion or belief and disadvantaged groups.

5.1 Risk Assessment

- The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally. The Trust's process for this is detailed within the Trust's Risk Management Policy. This document is available on the Trust's Intranet page "Percy":

  Risk Management Policy - Percy

- The Trust EPRR Group will agree the Trust's EPRR Risk Register based on information contained within the Shropshire, Telford and Wrekin EPRR Risk Register and risks contained within the Trust Corporate Risk Register.
- The information within the EPRR Risk Register will then inform the Trust emergency and business continuity plans. This information will be cascaded to staff via the Trust EPRR Group and EPRR Lead.

- The AEO will attend the West Mercia LRF and collaboratively with System partners review new, emerging and existing risks which may impact the Trust, community, system partners and other agencies.
- If any external risk information is received this will be cascaded by the AEO or the EPRR Lead to the EPRR Group who will decide if an amendment to the Trust EPRR Risk Register is required

5.2 Preparedness and Anticipation

RJAH needs to anticipate and manage consequences of incidents and emergencies through identifying the risks and understanding the direct and indirect consequences, where possible.
All individuals and Departments/Units that might have to respond to incidents will be properly prepared, including having clarity of roles and responsibilities, specific and generic plans, and will rehearse arrangements periodically. RJAH will have a clear training and exercising schedule that delivers against this principle led by the EPRR Lead.

5.3 Continuity

The response to incidents must be grounded within RJAH's existing functions and their familiar ways of working – although inevitably, actions will need to be carried out at greater pace, on a larger scale and in more testing circumstances during response to an incident.

5.4 Subsidiarity

Decisions within RJAH will always be taken at the lowest appropriate level, with coordination at the highest necessary level. Responders within individual departments will be the building block of any response for an incident of any scale.

5.5 Communication

Good two-way communications will be critical to RJAH in achieving an effective response. Reliable information must be passed correctly and without delay between those who need to know, including the public, emergency services, responders etc.

As per the Trust's Incident Response Plan, communication would be received and cascaded viathe Incident Management Team, and their outlined roles during an incident.

The Trust Incident Response Plan is stored electronically on the Trust Intranet dedicated EPRR Page (see hyperlink below). Hard copies are stored in the Trust Incident Control Centre (ICC) cupboard (CSM Office location 21) and at Switchboard.

https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832

5.6 Cooperation and Integration

Please refer to Trusts Information Sharing Procedure –

https://rjah.interactgo.com/Utilities/Uploads/Handler/Uploader.ashx?area=composer&filename=Information%2bSharing%2bProcedure.doc&fileguid=7da9bb22-8ea6-4a2a-981f-78aea845b283

Positive engagement based on mutual trust and understanding will facilitate information sharing. Effective coordination will be exercised between other NHS and multi-agency

organisations along with interfacing as appropriate with local, regional, and national tiers of a response. Active mutual aid will be provided upon request, within the UK as appropriate. The Trust's process for Mutual aid during an incident is detailed within the Trust's Incident Response plan: The Trust Incident Response Plan is stored electronically on the Trust Intranet dedicated EPRR Page (see hyperlink below). Hard copies are stored in the Trust Incident Control Centre (ICC) cupboard (CSM Office location 21) and at Switchboard.

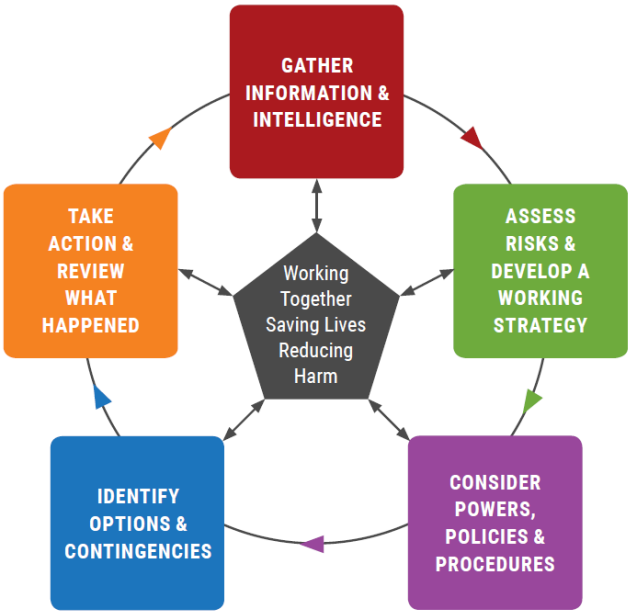
https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832

5.6.1 Joint Decision Model (JDM)

One of the difficulties facing incident commanders/coordinators from different agencies is how to bring together the available information, reconcile potentially differing priorities and then make effective decisions together.

The Joint Decision Model (JDM), shown below, was developed to resolve this issue. All joint decisions, and the rationale behind them, should be recorded in a 'joint decision log'.

Responding agencies should work together to build shared situational awareness, recognising that this requires continuous effort as the situation, and responders' understanding, will change over time. The sections following work through the various elements of the model.



5.7 Direction

Clarity of purpose will be delivered through an awareness of the strategic aim and supporting objectives for the response. These will be agreed and understood by all involved in managing the response to an incident in order to effectively prioritise and focus the response.

6.0 Corporate Responsibility Obligations

Our Trust also has a number of specific corporate responsibilities and obligations relating to patient safety and staff welfare that support Emergency Preparedness, Resilience and Response good practice. These include:

- Health & Safety – RJAH will, so far as is reasonably practicable, act in accordance with the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations 1999 and associated legislation and approved codes of practice. It will provide and maintain, so far as is reasonable, a working environment for employees which is safe, without risks to health, with adequate facilities and arrangements for health at work.
- Risk Management - Our Trust's emergency and incident response plans are informed by the assessment of risks within the national, regional, and local area, as well as internal risks within the organisation. Our Trust will record any specific emergency planning risks on the Corporate Risk Register.
- Equality Act 2010 and the Public-Sector Equality Duty - RJAH will act in accordance with the Equality Act 2010, which bans unfair treatment and helps achieve equal opportunities in the workplace.
  The Equality Duty has three aims, requiring public bodies to have due regard to:
  - eliminating unlawful discrimination, harassment, victimization and any other conduct prohibited by the Act.
  - advancing equality of opportunity between people who share a protected characteristic and people who do not share it; and
  - fostering good relations between people who share a protected characteristic and people who do not share it.
- Information governance – RJAH recognises that its records and information must be managed, handled, and protected in accordance with the requirements of the Data Protection Act 2018, UKGDPR 2021 and other legislation, not only to serve its business needs, but also to support the provision of highest quality patient care and ensure individual's rights in respect of their personal data are observed. As per the Trust's Corporate Records Management Policy, Trust documents will be retained for 20 years.
- As per the Trust's Corporate Records Management Policy, it is responsibility of the author of each plan/policy to retain/store this documentation.
- Emergency Preparedness, Resilience and Response - 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. Under the Civil Contingencies Act (2004), NHS organisations and sub-contractors must show that they can deal with these incidents while maintaining services to patients. This work is referred to in the health service as 'emergency preparedness, resilience and response' (EPRR).

7.0 Command, Control, Coordination and Communication

An integral element of Command and Control within RJAH is a clear chain of command from the top of the organisation to the lowest level and across agencies as required. Every person involved in the response to an incident must exactly know their roles and responsibilities.

- **Command** is the exercise of vested authority that is associated with a role or rank within the organisation to give direction in order to achieve defined objectives

- **Control** is the application of authority, combined with the capability to manage resources, in order to achieve defined objectives
- **Coordination** is the integration of multi-agency efforts and available capabilities, which may be interdependent, in order to achieve defined objectives. The coordination function will be exercised through control arrangements and requires that command of individual organisations' personnel and assets is appropriately exercised in pursuit of the defined objectives.
- **Communication –** sharing information to support the response.

RJAH will follow the nationally recognised **'Strategic, Tactical and Operational'** framework as laid out in the Trust Incident Response Plan.

The Trust Incident Response Plan is stored electronically on the Trust Intranet dedicated EPRR Page (see hyperlink below). Hard copies are stored in the Trust Incident Control Centre (ICC) cupboard (CSM Office location 21) and at Switchboard.

https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832

7.1 Communication and Information Sharing

RJAH has a duty to communicate with the public in the event of any health emergencies as well as cooperating and sharing information with other responders. Our Trust subscribes to the arrangements in place through West Mercia LRF and the specific guidance Data Protection and Sharing – Guidance for Emergency Planners and Responders.

RJAH has a duty to work with partners in the multi-agency Local Resilience Forum (LRF) and health sector Local Health Resilience Partnership (LHRP) to ensure that it is part of a joined-up planning, response, and recovery process.

The Trust must ensure that the engagement and information shared, with Trust partners and stakeholders of West Mercia LRF and LHRP, enhance any response and recovery phase during and following an incident.

Please refer to Trusts Information Sharing Procedure –

https://rjah.interactgo.com/Utilities/Uploads/Handler/Uploader.ashx?area=composer&filename=Information%2bSharing%2bProcedure.doc&fileguid=7da9bb22-8ea6-4a2a-981f-78aea845b283

8.0 Recovery

In contrast to the response to an emergency, the recovery may take months or even years to complete as it seeks to address the enduring human, physical, psychological, environmental, social, and economic consequences. Response and recovery are not; however, two discrete activities and the response and recovery phases may not occur sequentially.

Recovery will be an integral part of the combined response within our Trust from the beginning, as action taken at all times during an emergency can influence the long-term outcomes for communities.

Recovery expectations, timescales and proposed core names to enable this are detailed within the Trust's Incident Response Plan.

9.0 Debriefing and Supporting

RJAH will be responsible for debriefing and provision of support to staff where required following an emergency. This is the responsibility of individual line managers, coordinated by the Accountable Emergency Officer (AEO).

Debriefing may also be on a multi-agency footprint. After any incident or emergency, a debrief will be held to ensure any lessons learned are captured so that any policies, procedures, and other preparedness measures can be reviews and emended if required. The debriefing process will be co-ordinated by the EPRR Team and outcomes of these debriefs will form part of reports to Trust Board.

The following debriefs, and reports must be carried out within the stated timeframes:

- hot debrief – immediately after the incident or period of duty, but within 48 hours of stand down
- cold/structured/organisational debrief – within 28 days post incident
- multi-agency debrief – within eight weeks of the close of the incident (actual timing will be set by the lead organisation for the response)
- post-incident reports – within four weeks of the debrief.

10.0 Post Incident Reports

The post incident report must be written within 6 weeks of the incident. The report will be supported by action plans and recommendations in order to update any relevant plans with achievable timeframes as agreed by the AEO. In addition, other investigations may be conducted as per the ICB's relevant policies.

Post incident reports will be presented to the EPRR Group and then to Quality and Safety via the six-monthly chair report.

11.0 Continuous Improvement

Identifying Lessons from Incidents and Exercises: A structured approach is essential to effectively identify lessons from both live incidents and planned exercises. This process for RJAH includes:

- Post-Incident/Exercise Debriefs: Conducting immediate hot debriefs for initial observations, followed by structured cold debriefs within the defined timescale set out within section 10 of this policy.
- Multi-Agency Reviews: Engaging with relevant System partners, including West Mercia Local Health Resilience Partnerships/Forum (LHRP/LRF) to identify cross-organisational learning.
- Data and Trend Analysis: Reviewing reports, key performance indicators (KPIs), and audit findings to identify recurring themes and systemic issues requiring action for RJAH. This will take place through the Trust EPRR Group following an incident.

Capturing Lessons and Establishing Clear Ownership: Ensuring that lessons are captured effectively:

- Lessons identified will be recorded in a structured lesson tracker and reviewed for continuous improvement at the Trust EPRR Group. Lessons (actions) will have an assigned lead (e.g., EPRR Lead, AEO, or Ward/Department Managers), ensuring clear responsibility for action.

- Formal Reporting Channels: Regular submission of findings to West Mercia LRF/LHRP and HEPOG) to ensure oversight and shared learning.

Embedding Learning into Organisational Processes : For lessons to drive meaningful change at RJAH following an incident, the Trust EPRR Group will embed learning within policies, training, and operational practices.

- Integrating lessons into ongoing staff EPRR training and future EPRR exercises to reinforce learning and practical application.

- Evaluation of previously identified lessons to ensure corrective actions are sustained.

Regional Lessons Process: Reporting, Assessment, and Monitoring: To align with wider regional learning mechanisms, the Trust will remain engaged in regional forums, including LHRP/LHRF, to track implementation progress and assess whether shared lessons have been effectively embedded.

12.0 Testing and Monitoring of Plans

RJAH's emergency plans will be reviewed annually as required by the Accountable Emergency Officer. As part of our Trust's emergency preparedness and planning, our Trust will participate in exercises both locally and across the Midlands with our partners.

This helps staff to understand their roles and responsibilities when a situation occurs. In line with NHS England requirements, a tabletop exercise will be held annually.

Live incidents which require the plans to be evoked, have a debrief process and lead to review / improvements of the plans will be considered as the annual test where applicable

13.0 Record Keeping

All staff in the response of any incident must keep records of actions or decisions taken and submit these to the Accountable Emergency Officer within 72 hours. Loggist's will be required to record actions throughout any major incident and submit these to the Accountable Emergency Officer within 72 hours. The Trust Incident Response Plan details the role and responsibility of a Loggist during an incident, including the requirement of NO ELBOWS (No, Erasures, Leaves torn out, Blank pages, Overwriting, Writing between the Lines, Spare Pages). Hyper below to electronic copy of Trust Incident Response Plan.

https://rjah.interactgo.com/Interact/Pages/Section/Default.aspx?section=4832

14.0 Implementation and Monitoring

14.1 Training and Dissemination

There are no specific training needs in relation to this document, but the following staff will need to be familiar with its contents. Awareness will be raised via all staff email and direct email to staff from the EPRR Lead.

- Accountable Emergency Officer (Chief Operating Officer)
- Director of Estates and Facilities
- Director of Digital
- EPRR Lead
- Managing Directors
- Assistant Chief Nurses
- Matrons
- Ward Managers
- Department Managers
- Individual Business Continuity Plan Authors

14.2 Implementation Plan

This document will be available on the Trust Document Centre and will be the responsibility of all Ward and Department managers to ensure all their staff have read and understood the content.

14.3 Monitoring / Audit

The effectiveness of the document will be monitored by the EPRR Group with a six-monthly chair report being presented to the Quality and Safety Committee by the Accountable Emergency Officer.

15.0 Review Date

This document will be subject to review no later than 12 months.

16.0 References

All of the below documents are stored electronically on the Trust Intranet on the dedicated EPRR Page (see below), and hard copies are stored in the ICC (Incident Control Centre, cupboard).

EPRR - Percy

- The NHS England Core Standards for Emergency Preparedness, Resilience and Response EPRR (NHS England, 2022)
- The Civil Contingencies Act 2004 (CCA 2004).
- RJAH Emergency Preparedness, Resilience and Response Policy
- RJAH Health, Safety and Welfare Policy
- RJAH Lockdown Policy
- RJAH Incident Response Plan

17.0 Version Control tracker

Record of Amendments: EPRR Policy			
Version No	**By Who**	**Amendment**	**Date**
3	STW EPRR Lead	Amendments made to whole document following input from ICB Lead.	29/01/2025
3	EPRR Engagement Manager (Staffordshire and Stoke-On-Trent, Derbyshire and West Mercia) NHS England - Midlands Region	Amendments made to whole document following input from NHSE Midlands Region Team	31/01/2025

Policy Ratification – Corporate Business Continuity Plan

Committee / Group / Meeting, Date

Board of Directors, 02 July 2025

Author:	**Contributors:**
Name: Hannah Howells Role/Title: Health and Safety Advisor	EPRR Group Health and Safety Meeting. STW Stuart Allen: ICB EPRR Lead. NHS England Midland Region EPRR Team.

Executive Director sign-off:

Mike Carr, Accountable Emergency Officer / Deputy CEO
Quality and Safety Committee, 22nd May 2025

Is the report suitable for publication?

Yes

Key issues and considerations:

1. **Does the policy take account of relevant:**

   a) **Legislation** — **YES**

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health.

All acts place EPRR duties on NHS England and the NHS in England.

   b) **Regulatory requirements** — **YES**

Regulations (The Civil Contingencies Act 2004 (Contingency Planning) Regulations 2012) (the Regulations)

NHS core standards for emergency preparedness, resilience and response (EPRR)

   c) **Statutory guidance** — **YES**

Expectations and indicators of good practice set for category 1 and 2 responders.

NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.

2. **Has appropriate expert / professional advice been sought and taken into account?** — **YES**

   - Shropshire Telford and Wrekin Integrated Care Board (ICB) Senior EPRR Lead, Stuart Allen.
   - NHS England Midland Region EPRR Team.

3. **Have the relevant advisory / decision-making groups within the Trust been involved in its production and does it reflect their views / comments?** — **YES**

   - EPRR Group
   - Health and Safety Meeting

4. Have key external stakeholders been engaged in the production of the policy and does it reflect their views / comments? **YES**

- Various RJAH staff and leads at meetings.
- Shrewsbury and Telford Hospital EPRR Teams and leads.
- Shropshire Community Health Trust Senior EPRR Lead.
- Shropshire Telford and Wrekin Integrated Care Board (ICB) Senior EPRR Lead, Stuart Allen.
- NHS England Midland Region EPRR Team

5. What arrangements are in place to ensure / monitor adherence to the policy?

RJAH EPRR Group, NHS Core standards for EPRR annual assessment.

Strategic objectives and associated risks:

The following strategic objectives are relevant to the content of this report:

	Trust Objectives	
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	
4	Grow our services and workforce sustainably	
5	Innovation, education and research at the heart of what we do	

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

	Board Assurance Framework Themes	
1	Continued focus on excellence in quality and safety	
2	Creating a sustainable workforce	
3	Delivering the financial plan	
4	Delivering the required levels of productivity, performance and activity	
5	Delivering innovation, growth and achieving systemic improvements	
6	Responding to opportunities and challenges in the wider health and care system	
7	Responding to a significant disruptive event	✓

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:

	System Objectives	
1	Improve outcomes in population health and healthcare	✓
2	Tackle inequalities in outcomes, experience and access	
3	Support broader social and economic development	
4	Enhance productivity and value for money	

Recommendations:

Following consideration at the Quality and Safety Committee, the Board are recommended to approve the corporate business continuity plans.

Next steps:

The plan will be reviewed during the NHS core standards for EPRR self-assessment in August 2025. The plan has already been shared with RJAH staff and will be published on Percy when approved. The plan is monitored via the EPRR group. The plan is assessed annually in line with the training and exercising requirement under NHS Standards for EPRR.

The Robert Jones and Agnes Hunt Orthopaedic Hospital

NHS Foundation Trust

Title:	Corporate Business Continuity Plan		
Unique Identifier:		**Document Type:**	Plan
Version Number:	6	**Status:**	Draft
Responsible Director:	Accountable Emergency Officer		
Author:	Health and Safety Advisor		
Scope:	All staff		
Replaces:	5		
To be Read in Conjunction with the Following Documents: (list related policies)	EPRR Policy Incident Response Plan		
Keywords:	Business continuity		

Considered By Executive Owner:	Chief Operating Officer.	**Date Considered:**	12/02/2025
Endorsed By:	EPRR Group	**Date Endorsed:**	27/03/2025
Approved By:	Health and Safety Meeting Quality & Safety Committee	**Date Approved:**	30/04/2025 22/05/2025
Issue Date:	tbc	**Review Date:**	

Security Level:	**Open Access** ✓	**Restricted**	**Confidential**

Trust Values

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

Corporate Business Continuity Plan

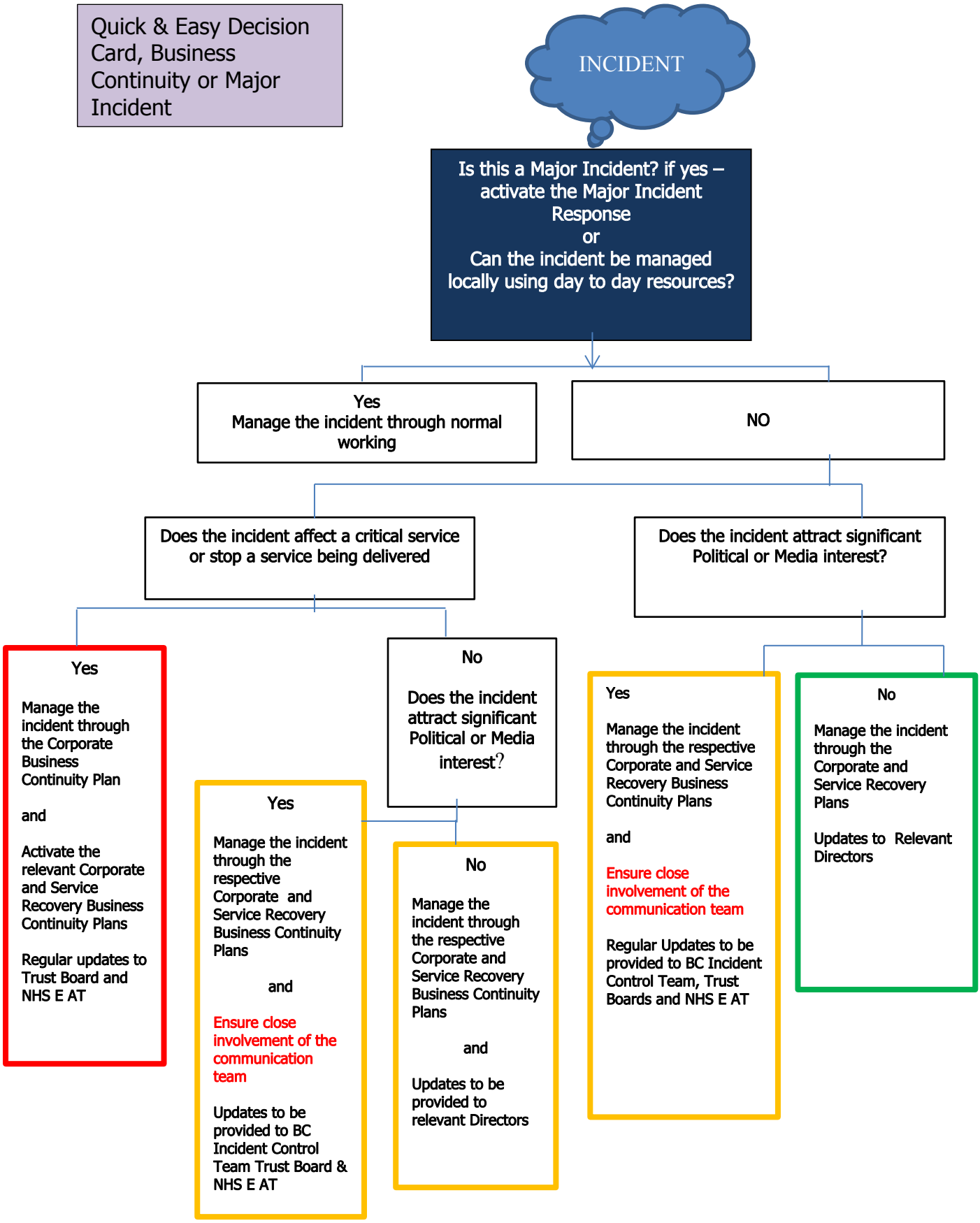
If a service interruption is suspected immediately refer to Annex 2

ACTION CHECKLIST FOR SERVICE LEAD DURING A SERVICE DISRUPTION

and Annex 3

BUSINESS IMPACT ASSESSMENT – INITIAL SITUATION REPORT

Quick & Easy Decision Card, Business Continuity or Major Incident



Document Version Control

Version Number	Date	Author	Description of Change
0.1	June 2018	Pete Old	Complete review of BCM arrangements and new plan.
0.3	January 2019	Nicki Bellinger/Pete Old	Complete review of BCM arrangements and new plan.
0.4	January 2023	Hannah Howells, Health and Safety Advisor	Complete review of BCM arrangements and new plan.
0.5	January 2024	Hannah Howells, Health and Safety Advisor	Complete review of BCM arrangements and new plan.
0.6	January 2025	Hannah Howells, Health and Safety Advisor	Document review and annual refresh. Approved by AEO 12/02/25.

Distribution List

INTERNAL **EXTERNAL**

Name	Name
Full electronic copies: Trust's Intranet Full paper copies:	RJAH Orthopaedic Hospital Foundation Trust
Managing Directors – MSK Delivery Unit and Specialist Delivery Unit	
Nominated Emergency Planning Officer	
Silver control (co ordination centre)	
Hospital Switchboard	
CSM's/Hospital Cover	

Introduction

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (the "Trust") business continuity corporate plan is intended to provide a framework for the Trust to follow in responding to an incident or any other emergency that may impact upon the delivery of daily operations of the Trust.

The purpose of the plan is to make the Trust ready and able to anticipate, prepare for, prevent, respond and recover from disruptions, whatever their source and whatever part of the business they affect, so that priority patient services can be maintained.

It describes the proposed plan for implementing and maintaining a suitable business continuity process, including roles and responsibilities of the officers with the responsibility for implementation of the policy and plans.

RJAH is identified under the Civil Contingencies Act (CCA) 2004 as a 'category one' responders. This means we have a legal duty to develop robust business continuity management arrangements which will help to maintain their critical functions if there is a major emergency or disruption. This could include, for example, an infectious disease outbreak, severe weather, fuel shortages, industrial action, loss of accommodation, loss of critical information, loss of communication technology (ICT) and supply chain failure.

Business continuity forms part of the national core standards for EPRR assessed annually by NHS England and commissioners. The standards for Business Continuity are;

- ISO 22301 Societal Security - Business Continuity Management Systems – Requirements1
- ISO 22313 Societal Security - Business Continuity Management Systems – Guidance
- PAS 2022 - Framework for Health Services Resilience

This plan is working toward the standards set out in national guidance.

NHS England describes a business continuity incident as;

''an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level''. (NHS England. Emergency Preparedness, Resilience and Response Framework. 2015).

Although it is not possible to predict all incidents that may occur, the Trust has reviewed and identified risks which could cause disruption to its services (Table 2.1 page 9). By following this plan and the Unit Recovery Plans, recovery of the Trust's services should be achieved, preventing complete failure and reducing the negative impact on service provision.

To ensure the plan remains effective and fit for purpose, it will be tested annually, and lessons learned from these exercises and any actual incidents will be incorporated into the plan.

This plan is a live document and will be reviewed regularly to ensure it reflects current best practice and that our trusts critical services have continuity arrangements in place.

Where there is an event causing multiple service disruption, or where all of the Trust services are affected (i.e., pandemic influenza, fuel shortage, industrial action) this plan and the Trust's Emergency Response Arrangements (the "major incident plan") will be activated simultaneously and co-ordination of the response will be passed to the Incident Management Team under the remit of the major incident plan. Several recovery teams will be convened at this time to ensure proper coordination of the response.

Table of Contents

1. Aim of Plan

The aim of this plan is to outline procedures and strategies to be implemented in the event of a service disruption affecting the ability of a Specialist Orthopaedic Hospital to deliver its normal service obligations.

1.1 Trust Definition of Business Continuity

The strategic and tactical capability of the organisation to plan for and respond to, incidents that cause or could cause business disruptions to continue business operations at an acceptable predefined level.

1.2 Objectives

- Identify the risks faced by the Trust (Risk Assessment)
- Put measures in place to prevent or mitigate impact of the identified risks
- Ensure priority clinical and lifesaving services are maintained during the disruption
- Outline recovery plan to ensure all services can be returned to normal practices in a timely manner and within acceptable timeframe (Recovery Plan)

1.3 Plan Ownership and Review

This plan is required by the Trust and will be reviewed on an annual basis as a minimum requirement. However, as business continuity planning is part of the normal business responsibility of the Trust and thus subject to regular review, especially in the event of any changes which would impact on the workability of the plan. Day to day management of the corporate plan is the responsibility of the emergency planning lead, however maintenance of Site and Unit operational business continuity plans are the responsibility of unit or department managers.

1.4 Training and Exercising

- The Trust will ensure training is made available and completed to ensure staff are familiarised with the Trust and Service plans.
- An exercise will be carried out annually to test the response outlined in the business continuity policy and supporting service plans.
- Following any exercise or live incident, this plan and any service specific plans will be reviewed and revised considering any lessons learned.

1.5 Commitment to ISO Standard 22301

ISO 22301 is the international standard for Business Continuity Management Systems (BCMS). It provides a framework for organisations to plan, establish, implement, operate, monitor, review, maintain, and continually improve a documented management system to protect against, reduce the likelihood of, and ensure recovery from disruptive incidents.

In the UK, the British version of this standard is known as BS EN ISO 22301. Implementing ISO 22301 helps organisations minimize the impact of incidents, keep critical functions running during crises, and demonstrate resilience to customers and suppliers.

At the Robert Jones & Agnes Hunt Orthopaedic NHS Foundation Trust (RJAH) we recognise the critical importance of maintaining our operations/services during disruptive incidents. We are committed to implementing and maintaining a robust Business Continuity Management System (BCMS) in alignment with ISO 22301. Our commitment includes:

1. **Leadership Support**: The Trust Executive leadership team actively champions business continuity efforts, ensuring that resources are allocated appropriately and that all employees understand their roles in maintaining continuity.
2. **Risk Assessment and Mitigation**: The Trust regularly assess risks to our critical functions and implement measures to mitigate their impact. This includes identifying dependencies, vulnerabilities, and recovery strategies.
3. **Training and Awareness**: The Trust invest in training and awareness programs to educate employees about business continuity principles, response procedures, and their individual responsibilities.
4. **Testing and Exercises**: The Trust conduct regular exercises and tests to validate our BCMS, refine our plans, and enhance our ability to respond effectively during crises.
5. **Continuous Improvement**: The Trust review and update our business continuity plans based on lessons learned, changes in our organisation, and evolving threats.

By adhering to these principles, we demonstrate our commitment to organisational resilience, customer trust, and the well-being of our stakeholders.

2.0 High Level Risk Assessment

Risk assessments are regularly carried out as a part of the Trust's daily business. In relation to business continuity management, a risk assessment looks at the probability and impact of specific threats that could cause disruption to the delivery of services. Threats in this context refer to issues that have the capability of impacting on the ability of the trust to deliver its services and therefore place patients at risk.

The assessment of threats is not intended to be comprehensive but a pragmatic view of events that would either prevent services from operating as normal, or, place patients at risk from services that would be interrupted.

The Trust's approach to assessing threats for the purpose of continuity management plans is to identify in advance key threats and key alternatives to service provision, including during the contracting process. However, actual events may not exactly match what has been anticipated. Recognising the complex nature of the trust and the skills of its staff, the Trust will construct a management team of the right managers and staff that will address the potential consequences of threats and put in place alternative arrangements, dynamically – according to the specific nature of the threat or incident that emerges at the time.

2.1 Key High Level Risks

This assessment is specific to this plan, other risk assessments exist which provide a comprehensive risk assessment (i.e., Local Health Resilience Partnership Risk Assessment, Shropshire and Telford Silver Partnership Risk Assessment)

Table 2.1

Threat	Impact	Mitigation
Influenza Pandemic outbreak	Loss of staff due to illness, caring responsibilities, fear, bereavement. Increase in patients, who are at increased risk. Disruption to national supply chains. Disruption to national infrastructure. Staff at increased risk – contact with symptomatic patients	Multi-agency, NHS England and Trust Pandemic Influenza Plan Stockpile of personal protective equipment for NHS staff. Infection control procedures as per Government guidance Service by service BCM Plans to mitigate loss of staff. Covid Vaccinations for all NHS Staff Annual Flu immunisation for staff Staff working from home where possible
Loss of Utilities **Water** **Electricity** **Gas/Oil**	Disruption to services; increased risk to patients and staff in community hospital settings and potential need for evacuation. Loss of phones. Where the trust occupies properties and it is not the landlord it expects the landlord to have BCM arrangements in place	Estates services have robust BCM arrangements for water, electricity, gas. There is also a built-in redundancy of certain equipment to ensure key parts of the trust infrastructure are not affected should critical equipment fail.
Loss of skilled staff or general staff for example due to industrial action	Potential disruption to patient care may put some patients at risk and also risk reputation/contractual obligation	Pre identification of priority services, flexible working, cross training where appropriate, staff retention and staff recruitment planning
Critical supply chain – specialist theatre equipment	Failure of the supply of equipment such as prosthetics result in cancelled operations and potential morbidity of patients.	Critical supplies identified and arrangements in place within the each departmental area to acquire alternative products.
Severe Weather	Loss of access to buildings. Staff unable to get to work placing patients at risk. Trust unable to deliver elective work with resulting financial consequence. Localised increased demand beyond resource available. Potential loss of utilities telecommunications and IT	Severe weather warnings are circulated to raise staff awareness Working from home Sharing Staff (reporting to NHS location closest to home) Re-prioritise patients for home care
Loss of, or access to buildings	Evacuation of patients No access to patient records IT loss of stored data New ways of working	Fire evacuation plans Pre-identified suitable alternative locations Some ability to expand capacity at other sites
Major disruption to fuel supplies	Staff delayed or unable to come to work placing patients at risk. Trust unable to deliver elective work with resulting financial consequence.	Fuel Plan providing access to fuel for essential services. Flexible rota management and changes base location for some
Loss of IT and telecommunications systems	Loss of data, corporate knowledge and business planning Loss of contractual activity monitoring Loss of communications	IT Disaster Recovery Plan meets industry standards.

Threat	Impact	Mitigation
	Phones linked to IT systems	
Supply Chain Failure	Interruption to catering and clinical services resulting in potential sub optimal care/conditions for patients	Service continuity plans identify critical supplies and alternative suppliers for specialist supplies Local site plans outline alternative suppliers. Catering has dry/canned good contingency stock.

3.0 Service Continuity Plans

3.1 Overview

This plan is one of a suite of emergency plans owned by the Trust, common to each of these plans are the command, control and coordination arrangements that would be implemented by the Trust to coordinate its internal response to disruptive challenges.

This plan has a list of annexes called Departmental/Unit Business Continuity Plans which are completed by senior managers of the organisation who manage key services. These more detailed documents provide information at an operational level within the trust that prioritise each element of the service (to maintain or restore) and identify key staff, estate, equipment, and supplies that are required by that service to maintain or restore its critical services. Services with a lower priority rating would be assessed for their ability to backfill staff within critical services.

It recognised that the Trust relies on other stakeholders to have business continuity arrangements in place that allow the trust to continue some of its critical activities. Departmental plans recognise any interdependencies and build into contract planning the cost of contracting with providers or suppliers in providing resilient services.

3.2 Site or Service Business Continuity Plans

These are operational plans containing departmental or site business impact analysis and outline the priority services and resources required to resume and/or continue providing these specified services at an acceptable level to fulfil the Trust's obligations. These plans also describe the site from which the service operates, identifies an alternative location from which to deliver the critical services (If possible) and key property details, contact numbers and emergency procedures for:

- Fire evacuation Procedures
- Lock down Procedure
- IT failure
- Incident impact assessment form and,
- Incident Management arrangements procedure

The Business Impact Analysis is conducted at an operational level to help understand corporate risk and prioritise services to ensure critical functions are up and running as soon as possible after a disruption and also and sets out a timetable for normal resumption services.

3.3 Maximum Period of Tolerable Disruption (MPTD) - Timescales

The prioritisation of services has been set out as recovery timescales, i.e. the maximum tolerable time limit before that service is recovered and is operational again.

The recovery timescales have been set out as follows:

P1 – Immediate/Within four hours

P2 – Within 24 hours

P3 – Within 24-48 hours

P4 – Within 1 Week

4.0 Activation of Corporate or Site/Service Business Continuity Plans

The notification of an incident that may or has interrupted a Trust service can originate from any source. Warnings of potential disruption can come in the form of, for example, severe weather warnings (i.e. snow/ice, storms, extreme heat or flooding), or from an incident reported by partner organisation such as the Fire and Rescue Service or Police who might be dealing with an incident that might have an impact on the Trust's service provision (i.e. road closure, evacuation of a community, public disorder). However, most incidents that prevent a service from delivering normal levels of service provision come from internal issues such as loss of telephones.

All managers and senior staff within the Trust are expected to understand their services in some depth and will understand what will stop their service from operating. It is part of the day-to-day responsibility of managers to take such steps (see table 4.1 for a guide to **STEPS**) within their sphere of authority and expertise as required to, ensure their services continue to deliver against their objectives and when normal service is at risk of or is being disrupted then local business continuity plans must be implemented and if severe then the use this plan must be considered.

Receive and Record Information	Risk assessment (Service and Safety)	Consider Policy and Procedures	What are the Options	Take actions based on prior steps	Apply continuous review of actions
Consequence analysis	**Record**		Defendable/Proportionate/ **Record**		**Record**

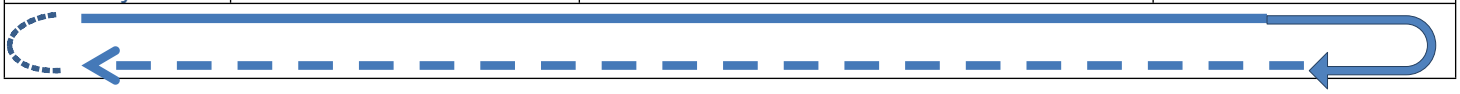


Table 4.1 STEPS

4.1 The formal criteria to implement this plan is:

- If a critical service or more than one service is threatened with or is disrupted.

The appropriate Service Lead can activate their own service business continuity plan. However, any potential or actual interruption to service delivery must be reported to the appropriate Director as soon as possible.

If a service interruption is suspected immediately refer to Annex 2

ACTION CHECKLIST FOR SERVICE LEAD DURING A SERVICE DISRUPTION

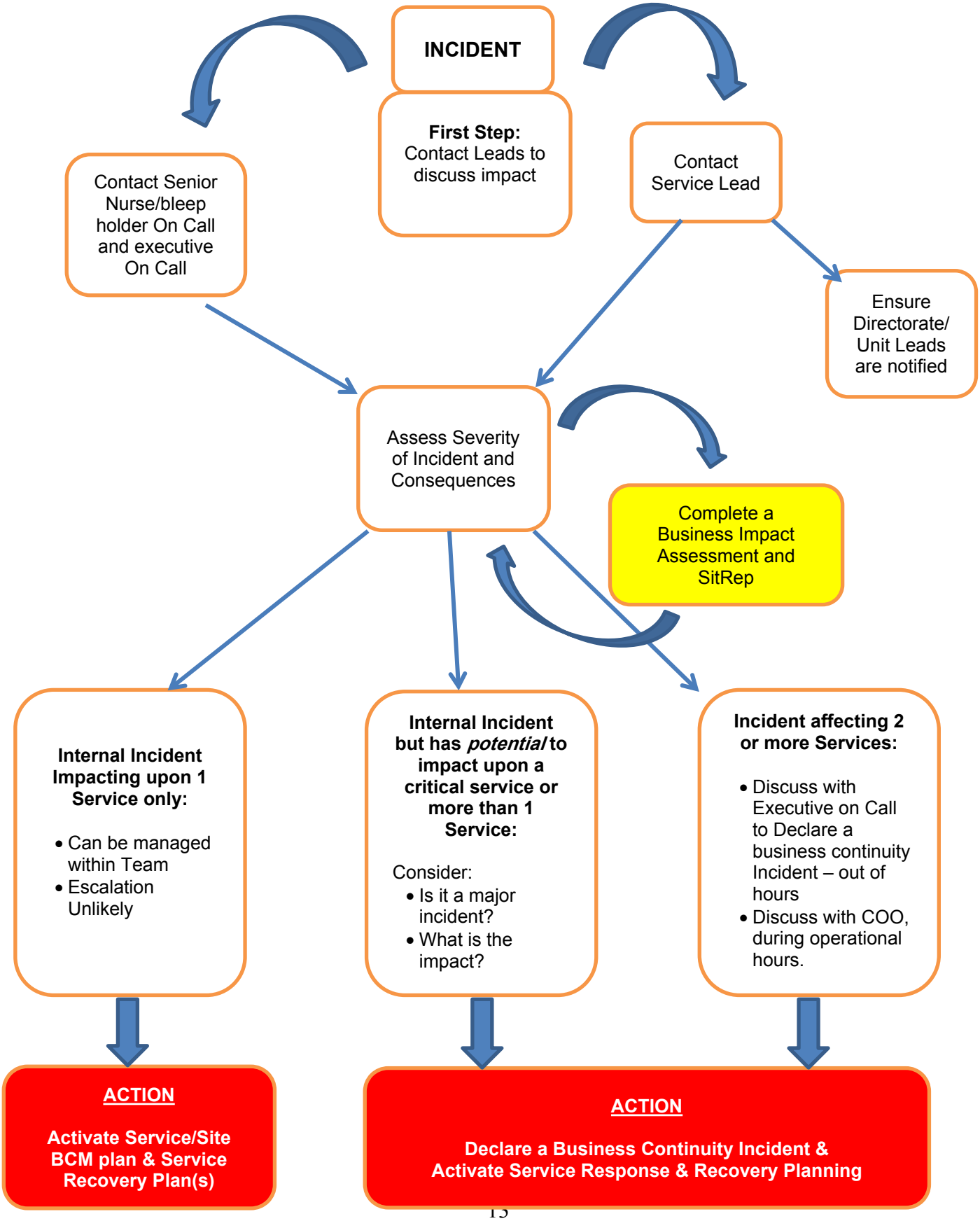
AND Annex 3

BUSINESS IMPACT ASSESSMENT – INITIAL SITUATION REPORT

The activation flowchart on the next page outlines the full activation sequence.

4.2 PLAN ACTIVATION FLOWCHART

Out of Hours **In Hours**



4.3 Phases of Activation

As with a major incident, there are three activation phases, which must be utilised:

Business Continuity 'Stand By' – Business Continuity Incident 'Declared' – Business Continuity 'Stand Down'

4.3.1 Business Continuity "Standby"

Will be used as an early warning of a situation which might at some later stage escalate and thus require implementation of this Plan. "Standby" allows key officers time to think, brief staff, start a business interruption log and prepare for the deployment of resources should an "Implement" message be received.

This is particularly important if an interruption occurs towards the end of a shift and staff may need to be asked to stay at work until the situation becomes clear.

Resources are not normally deployed at this stage (although this will largely depend upon circumstances) and a "Stand Down" may follow this type of alert.

4.3.2 "Business Continuity Incident - Implement Plan"

Will be used to activate the plan in its entirety, especially the Business Continuity Incident Control Team

4.3.3 "Business Continuity Stand Down"

Will be used to signify the de-activation of the Plan or that an anticipated risk has resolved. It is important that everyone in the organisation knows when the establishment has returned to 'business as usual'. It is also important that all staff and all stakeholders who helped in the response are thanked for their efforts.

5.0 Roles and Responsibilities

During a disruption, there will be a need for several people across the Trust to help in the response. The following table outlines some of the people/services required:

Individual/Team	Day to Day Role	Level of Disruption	Responsibilities
Service Leads	Normal roles and responsibilities within directorate	Individual service or one or more services affected	Coordinate response in line with plan; notify upwards within Trust; maintain communication
Units Managers/Senior Managers/Directors	Normal operational management of service responsibilities	Threatened or actual disruption	Follow STEPS table 4.1 If isolated to one directorate/service, manage with existing resources. Implement options to maintain critical services.

Incident Control Team (ICT)		Business Continuity incident may be called dependant on impact of service outage; one or more services disrupted	Overall corporate and strategic coordination of the response. Consider. Alerting Board, Integrated Care System/Board, Integrated Care System and NHS England Area Team of disruption; alert and work with commissioners where services have been disrupted; Staff welfare;
Communications (Trust Lead)	Dealing with communications internally and externally	If individual service affected; internal communication via Service Lead; external messaging to be routed through Trust Lead. If one or more service is affected this will be coordinated through ICT and Trust Communications Lead	Providing direct support to managers and/or Incident Command team if established.
Corporate Issues (i.e., finance, legal and insurance matters)	Via normal routes	Any	Maintain finance functions; ensure adequate insurance coverage; establish cost codes; ensure any legal advice is available and taken
IT and Telecommunications	Normal roles i.e., advising the Trust on inward and outward facing communications and media response	Any	Ensuring that IT services throughout are available to support the recovery of services
Estates & Facilities	Managing functional and safe property from which services are delivered	Threatened or actual disruption, recovery planning	Report when an estates issue threatens service provision; support the incident control team advising on impacts and corrective actions.

Table 6.1

6.0 Command, Control and Coordination

The Corporate Business Continuity Plan, if implemented, could trigger the implementation of the Trust Emergency Response Arrangements plan to achieve a trust wide response.

Some key risks have resulted in the production of specific plans that supplement the arrangements in the Trust Emergency Response Arrangements Plan. The Incident Management Team (outlined Trust Major Incident Plan and EPRR Policy) led by the Chief Executive, including the Chief Operating Officer and/or nominated Deputy, will provide strategic direction on the response to the incident. Media messages will be sanctioned by the Incident Management Team via the Media and Communications Lead to ensure continuity of messaging to the Press and public.

While the Incident Management Team will lead the response to the incident, a Business Recovery Group will be established to initiate the recovery process by working with the service areas recovery plans. This group will be led by the Executive Director lead of the service area E.g., Operations, for patient services

6.1 Business Continuity Incident Control Team (Gold/Strategic)

Comprising the Executive Team

Roles and Responsibilities:

- Provide strategic direction and overview to ensure an effective response is being undertaken.
- Establish and maintain clear communication channels / provide briefings to media and public.
- Manage potential harm to the reputation of the Trust.
- Provide representation at multi-agency Business Continuity meetings / groups.
- Authorise expenditure.
- Authorise implantation of Corporate BCP
- Liaise as necessary with ICB's NHS E AT other formal structures implemented such as Tactical Silver Coordinating Group etc.
- Keep partners / key stakeholders informed.
- Receive and consider situation reports.
- Consider requesting assistance from other local authorities/agencies/parties.
- Plan and co-ordinate the recovery phase of the incident.
- Maintain an accurate log of decisions made and actions taken during the incident to facilitate feedback, debrief and review. The log may also be called as evidence in an enquiry.

As a minimum, the Strategic Incident Control Team must include:

- Incident Director (Chief Executive or Nominated Deputy)
- Tactical Advisor (Chief Operating Officer/AEO)
- Communications Lead (to co-ordinate Trust media response and liaise with Interagency Media Leads)
- Administrative Co-ordinator (to ensure adequate resource and deployment of administrative support, telecommunications and establishment of an incident record filing system)
- Loggist(s) (to record all actions and minute Incident Team Meetings)

- People Services Lead – especially if staff affected or re-located
- Estates and Facilities Director
- Director of Digital
- Other Executives/Directors if deemed required.

6.2 Business Continuity Response and Recovery Group (Silver/Operational)

This group will take direction from the Gold/Strategic ICT and work to identify solutions and workarounds that will re–establish service provision based on the priorities set out in individual Service Recovery Plans. This group will also provide regular information to the Incident Control Team that will include actions taken, progress, and on-going impacts to service provision.

Roles and Responsibilities are:

- Manage the Trust's operational response to the Incident, providing a single focus for decisions likely to affect the whole organisation.
- To co-ordinate the Trust's operational response in liaison with other Trust managers.
- Ensure prioritisation of critical services
- Provide appropriate advice on tactical issues to Gold & Bronze
- Liaison between Gold & Bronze
- Implement, coordinate and monitor Service level continuity plans
- Provide representation at multi-agency Business Continuity meetings / groups where implemented
- Co-ordinate the call-in of additional staff and ensure that briefings are undertaken, and action cards are followed (See Trust Major Incident Plan)
- Provide consistent messages/ information to staff.
- Ensure effective liaison with partner agencies

The Business Continuity and Response and Recovery Group must include:

- Incident Manager(s) - if predominantly affecting patient services, this must be both Managing Directors from both Clinical Units.
- Leads for the Service Areas affected (Service Managers)
- Emergency Planning lead
- Loggist
- Communications representative
- Head of Estates and Facilities
- Ward Managers (if predominantly affecting patient services)
- Other Senior Managers if deemed required.

6.3 Business Continuity Response & Recovery Managers (Bronze/Tactical)

An initial response to an incident will be managed by the Senior Nurse/bleep holder or can be other individuals such as team leaders, case manager or hospital managers or ward staff depending on the nature of incident how widespread it is and what elements of the command, control and coordination structure has been implemented.

Their role is to take instruction and implement action given by the Business Recovery Group and report on going actions and information back to this group.

Roles and Responsibilities are;

- Manage and deliver critical services, providing a Business Impact Analysis detailing the service specific functions affected and mitigating actions being undertaken
- Assist other Trust Services (if required and able to do so)
- Collate information & provide situation reports as requested
- Respond to requests for staff by the Business Continuity Response and Recovery Group
- Implement Service level continuity plans
- Inform recovery actions that will be developed and agreed following stand down from the incident response

6.4 Incident Control Room

Smaller business interruptions must be managed, if possible, at the place closest to the point where a service is under threat. Larger business interruptions should refer to the Trust Major Incident Plan to determine command locations.

7.0 Upward Reporting Arrangements

The Trust is required to escalate any disruption to its service to the Integrated Care System/Board (ICS/ICB) the Executive on call will be responsible for judging whether to escalate based on impact of the disruption and time of day.

7.1 Key contacts for escalation

Organisation	Criteria	Contact Number
The escalation pathway will always be to the ICS first, however if unable to contact them within a reasonable time contact the NHS E Area team		
Shropshire, Telford and Wrekin ICS	Any short- or long-term suspension or stop to a contracted activity	ICS Director on Call via SATH
NHS England	Serious disruption to service delivery.	

Table 8.1

8.0 Corporate Services Business Continuity Plans – Other Trust Plans

Trust Corporate Services - Business Continuity Plans

The tables below list the Business Continuity Plans for each Corporate Service, the standard Site/Service Business Continuity Plan must be used.

8.1

CORPORATE SERVICE	PEOPLE SERVICES
Specific planning areas • ESR data type/availability • Industrial action plan	Subject Specialists: Chief People Officer Ref to policies supporting org & staff example severe weather/contact in major incident

8.2

CORPORATE SERVICE	FINANCE DEPARTMENT
Specific planning areas • Staff pay • IT systems • Emergency budget arrangements	Subject Specialists: Chief Finance Office Ref other docs i.e., SFI

8.3

CORPORATE SERVICE	ESTATES & FACILITIES
Specific planning areas • Estate list with resilience i.e. power UPS/generation/stored potable water • Estate list with key holder for each property • Phone failure plan – how to divert phones in property failure Utilities failure plans for all owned properties	Subject Specialists: Director of Estates & Facilities Please refer to ECP/FCP held on Switchboard and in Silver Command Control Centre

8.4

CORPORATE SERVICE	IM&T
Specific planning areas • IT Disaster Recovery Plan • Manager on-call IT advice sheet	Subject Specialists: Digital Director Informatics BCM - Defined within document

8.5 Other Trust Plans / Documentation

Document/Plans	Location
Emergency Response Arrangements	Trust Intranet Percy Hard copies in ICC Cupboard and Main Switchboard.
IPC responsibilities NOIDS Pandemic Influenza Outbreak Management	
Trust Major Incident Plan (including Action Cards)	
EPRR Policy	
Senior Managers on Call Policy (SMOC)	
Evacuation and Shelter	
CBRN/HAZMAT	
Lockdown	
Facilities Contingency (Mortuary)	
Trust Adverse Weather and Heat Plan	

APPENDIX 1

ANNEX 1 SERVICE IMMEDIATE RESPONSE CHECKLIST		
Incident Response – HAVE YOU	**☑**	**ACTIONS TAKEN**
Assessed the severity of the incident?	☐	
Contacted Emergency Services?	☐	
Evacuated the site if necessary?	☐	
Accounted for everyone?	☐	
Identified any injuries to persons?	☐	
Implemented your Incident Response Plan?	☐	
Started an Event Log?	☐	
Activated staff members and resources?	☐	
Appointed a spokesperson?	☐	
Gained more information as a priority?	☐	
Briefed team members on incident?	☐	
Allocated specific roles and responsibilities?	☐	
Identified any damage?	☐	
Identified critical business activities that have been disrupted?	☐	
Kept staff informed?	☐	
Contacted key stakeholders?	☐	
Understood and complied with any regulatory/compliance requirements?	☐	
Initiated media/public relations response?	☐	

ANNEX 2
ACTION CHECKLIST FOR SERVICE LEAD DURING A SERVICE DISRUPTION

ACTIONS FOR CONSIDERATION:	Tick When Complete
Start Incident Log	
Obtain full details from caller and request further information as required: **1** **Clarify** whether a service disruption has occurred or is developing. Evaluate impact of situation: - **Can the affected service manage the incident?** - **Will other services be impacted** - **What is the impact on the community/other NHS organisations** - **IF this disruption has the potential to affect more than one service or disrupt other NHS organisations consider escalating to Major Incident – contact Chief Executive**	
Liaise with Chief Executive/Executive Team and Director of Service Area	
IF agreed Activate Business Continuity Plan	Yes/No
Locate copy of Service Recovery Plan of affected areas.	
Ensure Service Impact Analysis is carried out.	
Review Service Area Priorities in light of interruption and timing and the need to suspend non-critical functions in affected areas.	
Activate Incident Room (choose most appropriate site) if necessary	Yes/No
Alert Support Staff	
Alert other relevant staff that Plan has been activated	
Assign time for First Meeting and Advise appropriate staff	
Review Service Area Priorities in light of interruption and timing	
Decide on course of action to be taken, and record alternative actions considered and the reasons for rejection.	
Develop initial rota for Incident Room to cover all areas of responsibility for next few days	

Authorise all business interruption response expenditure as appropriate, liaising with Finance Lead as appropriate	
Continue regular briefings to staff	
Consider briefing business partners if appropriate	
Establish recovery timetable	
Consider own domestic arrangements if situation escalates	
Consider shift working, rest periods and refreshments for all staff	
Collect and collate log sheets to prepare final report	
Ensure copies of all reports are kept and filed securely.	
Thank all staff involved in response to service interruption	

Have You Considered	▪ The impact on Council and independent sector residential and nursing homes. ▪ Does the Public need warning of the incident, specific action to take, disruption to services. ▪ Will the incident impact on health staff getting to work.
Longer Term	▪ Stand people down who turn up to help early to ensure availability tomorrow or to continue providing a service within their own units. ▪ Services which have been stood down must eventually be restored. Remember the "Backlog". Always review the possibility of restoring activities as soon as practical to avoid impact of backlog. ▪ Will there be an investigation – ensure all paperwork is archived. ▪ Start thinking about a formal report of the incident to other parties such as police or trust board.

ANNEX 3
BUSINESS IMPACT ASSESSMENT – INITIAL SITUATION REPORT

Complete the following Impact Assessment when a disruption is reported/or is already occurring and will affect the Service Delivery Team. Once completed, use to make an assessment using the Service Delivery Team Continuity Plan to identify priorities and to assist in the recovery.

Service Delivery Team	
Service Delivery Manager	

Date of Disruption Occurring	Time of Disruption	Date Disruption Reported	Time Disruption Reported

Name, job title and service area of Person who made the report of the disruption	
Disruption Description (What, why, where and how)	
Impact/potential impact of incident on services / critical functions and patients	
Impact on other service providers	

Mutual Aid Request Made (Y/N) and agreed with?	
Media interest expected/received	
Staff Impact	
Premises Impact	
ICT/Servers Impact	
Paper Files Impact	
Equipment Impact	
Contractor Impacts	

Time Scale	Estimated Impact on Service
First 24 Hours	
First 3 Days	
First 7 Days	
Over 7 Days	

ANNEX 4
INCIDENT CONTROL TEAM FIRST MEETING AGENDA

No	Item	Action	Action By Who	Action By When
1	**Analysis of Impact** ▪ Review Service Impact Analysis Sheets ▪ Brief team on nature, severity and impact of disruption. ▪ Identify information gaps			
2	**Confirm Roles** ▪ Agree roles and responsibilities of staff during the disruption. ▪ If required revise roles and determine if additional staff/deputies are required. ▪ Identify additional team members that they may be required ▪ Stand down members not required			
3	**Confirm Key Contacts at Scene of Disruption** ▪ Main points of contact for on-going information updates			
4	**Logs** ▪ Ensure personal logs in place (written record of significant events throughout the crisis and written record of all communications)			
5	**Recovery Management** ▪ Review recovery priorities ▪ Determination of support requirements.			
6	**Welfare Issues** ▪ Have members of staff, visitors or third parties been injured? ▪ What is their location?			

	▪ What immediate support and assistance is required? ▪ What ongoing support and assistance might be required?			
7	**Communications** ▪ Who should we inform? ▪ Are Trust's Communications Officers required? ▪ Professional Public Relations/Media advisors required? ▪ Determine which if any external regulatory bodies should be notified. ▪ Determine any internal communications that need to take place (other sites, affected services etc).			
8	**Media Strategy** ▪ Determine the media strategy to be implemented. ▪ What is the story? What is the deadline?			
9	**Legal Perspective** ▪ Determine what legal action or advice is required.			
	Next meeting ▪ Date, time, place and attendees of next meeting			